Opioid use disorder: Psychosocial management

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Literature review current through: **Oct 2023.**
This topic last updated: **Oct 24, 2023.**

INTRODUCTION

Opioids have analgesic and central nervous system depressant effects, as well as the potential to cause euphoria. They are used medically for pain relief, can be lethal in overdose, and are highly addictive. Patients can develop an opioid use disorder through misuse of pharmaceutical opioids (either prescribed or not) and through use of illicitly obtained heroin. Opioid use disorder is typically a chronic, relapsing illness, associated with significant morbidity and mortality.

Medication for opioid use disorder, consisting of treatment with an opioid agonist or antagonist and of multiple psychosocial services, is first-line treatment for most patients with the disorder, after medically supervised withdrawal, if needed. Some patients prefer psychosocial treatment alone, also known as nonmedication treatment, typically consisting of multiple psychosocial services.

This topic reviews psychosocial interventions for opioid use disorders. The epidemiology, pharmacology, clinical manifestations, course, assessment, and diagnosis of opioid use disorder is reviewed separately. Pharmacotherapy for opioid use disorder, medically supervised opioid withdrawal, and misuse of prescription drugs are also reviewed separately. Prevention of lethal opioid overdose in the community is also reviewed separately.

- (See "Opioid use disorder: Epidemiology, clinical features, health consequences, screening, and assessment".)
- (See "Opioid use disorder: Pharmacologic management".)

- (See "Opioid withdrawal: Medically supervised withdrawal during treatment for opioid use disorder".)
- (See "Prescription drug misuse: Epidemiology, prevention, identification, and management".)
- (See "Prevention of lethal opioid overdose in the community".)

APPROACH TO TREATMENT — Our approach to selecting treatment for opioid use disorder is described separately. (See "Opioid use disorder: Treatment overview".)

OVERVIEW

For most individuals with opioid use disorder, our first line of treatment is pharmacologic management with an opioid agonist or antagonist and adjunctive psychosocial treatment. In this context, psychosocial interventions can also be used to encourage and target initiation of medication and adherence to treatment.

Despite its lesser efficacy compared with medication for opioid use disorder (MOUD), some patients prefer to receive psychosocial treatment alone or nonmedication treatment. (Other more problematic names include drug-free or abstinence-based treatment.) Nonmedication treatment typically consists of multiple psychosocial interventions, such as cognitive-behavioral treatment, motivational interviewing, or contingency management, along with addiction counseling and participation in a mutual help group.

Regulatory requirements in the United States — Regulatory requirements in the United States and other countries encourage patients engaging in MOUD to receive adjunctive psychosocial treatment. Methadone treatment programs (known in the United States as opioid treatment programs) are required to provide addiction counseling. Clinicians treating patients with buprenorphine are required to have the capacity to provide or refer patients to psychosocial treatment. (See "Opioid use disorder: Pharmacologic management", section on 'Regulation of methadone in United States' and "Opioid use disorder: Pharmacologic management", section on 'Regulation of buprenorphine in United States'.)

Opioid treatment programs are a unique, highly regulated treatment setting, designed to serve a high volume of opioid dependent individuals. Randomized clinical trials that take place in these settings, and are reported on in the topic, may not be generalizable to other settings such as office-based buprenorphine MOUD settings.

SELECTING PSYCHOTHERAPY

Our selection of psychosocial intervention is influenced by the patient's clinical presentation, treatment history, preference, and the treatment availability. We often use the framework of the readiness to change model [1], whereby interventions are selected to address patient stage of change. (See "Brief intervention for unhealthy alcohol and other drug use: Goals and components".)

- For individuals in the precontemplation or contemplation stages of change, we typically offer motivational interviewing to enhance motivation to change. (See "Substance use disorders: Motivational interviewing".)

  Contingency management can also serve as a bridge to change for individuals with lower motivation. (See 'Contingency management' below.)

- For individuals in preparation or action stages of change (who are likely better matched with action-orientated or skill building interventions, such as cognitive-behavioral therapy [CBT] and its variants), we recommend pairing CBT with wraparound social services.

  Community reinforcement approach, a cognitive-behavioral approach often used in alcohol use disorders, can also be used for individuals in the preparation or action stages of change. (See "Substance use disorders: Psychosocial management", section on 'CBT-based therapies' and "Substance use disorders: Psychosocial management", section on 'Community reinforcement approach'.)

- For individuals in the action or maintenance stages of change, we typically offer mutual help groups or other forms of peer-supported recovery. These individuals may develop a sense of "giving back" and mentoring those whose recovery is less stable. (See 'Mutual help groups' below and "Opioid use disorder: Treatment overview", section on 'Adjunctive psychosocial intervention'.)

Variability in stage of change is common. We manage changes in motivation (eg, return to use in individuals who are abstinent) collaboratively with the patient. Furthermore, psychosocial treatments (eg, motivational interviewing, contingency management), can be conducted at any point in the individual's treatment trajectory.

Due to the heterogeneity of treatments and small sample sizes, there is limited empirical evidence on the specific type of psychosocial treatment that is most effective in combination with specific medication treatments. Further research is needed regarding differential effectiveness of the various psychosocial approaches combined with medical treatments and their effects on different patient populations and in different settings. (See "Opioid use disorder: Treatment overview", section on 'Adjunctive psychosocial intervention'.)

CONTINGENCY MANAGEMENT

Across substance use disorders, contingency management is the psychosocial treatment that consistently shows the best evidence for producing positive outcomes including reduced substance use [2]. Contingency management is a behavioral intervention that uses therapeutically applied incentives and other reinforcements to increase one or more target behaviors (eg, reductions in drug use, medication compliance, or treatment attendance). There is a large and robust body of research that has tested contingency management for substance use disorder, with a variety of reinforcement schedules, contingency types, and other variations. The majority of the studies testing contingency management use 12 weeks of weekly contingency management as a standard for treatment. We typically use this intervention when a specific patient population can be identified to target (eg, individuals exhibiting ongoing opioid use) and the setting has appropriate infrastructure to implement it in an adherent way. While it is effective in the treatment of substance use disorders, it is not universally available, can be difficult to implement in office-based settings, and is subject to regulatory oversight. (See "Substance use disorders: Principles, components, and monitoring during treatment with contingency management" and "Substance use disorders: Training, implementation, and efficacy of treatment with contingency management".)

Implementation — Contingency management can be applied as adjunctive programming to ongoing individual or group counseling. Compared with other psychosocial interventions, contingency management principles and associated clinical skills are relatively easy to learn, and the intervention can be conducted adherently by counselors or case managers with relatively little training [3]. One contingency management implementation trial among patients dispensed methadone at an opioid treatment program demonstrated intervention sustainability after an initial trial period [4].

Technology-enhanced delivery of contingency management may be a mechanism for addressing implementation barriers. As an example, in a large, urban outpatient substance use disorder program, 85 adults with opioid use disorder used a smartphone-based application facilitating contingency management over four months [5]. These individuals were retrospectively compared to matched controls. Individuals in the smartphone application group had a greater percentage of negative urine drug screens (18 percent greater at four months) and higher treatment attendance (20 percent greater at four months) than individuals in the control group. Additionally, participants using the smartphone application reported high levels of acceptability and usability of the application.

Efficacy — Meta-analyses of clinical trials generally support the efficacy of contingency management for enhancing clinical outcomes in treatment of substance use disorders [6-9]. (See "Substance use disorders: Training, implementation, and efficacy of treatment with contingency management", section on 'Efficacy'.)

Treatment with contingency management is associated with improved attendance, improved adherence, and reduced use of other substances (eg, stimulants) among those receiving medication for opioid use disorder (MOUD) [2,10-17]. As examples, in a meta-analysis that included 60 randomized clinical trials and 10,444 adults receiving MOUD, contingency management was associated with medium to large effect sizes for abstinence from illicit opioid use (Cohen's d measure of effect size 0.58, 95% CI 0.3-0.86) and medication adherence (Cohen's d 0.75, 95% CI 0.3-1.21) and small to medium effect size for improved therapy attendance (Cohen's d 0.43, 95% CI 0.22-0.65) [18]. In another trial involving 256 individuals with opioid use disorder, individuals randomized to contingency management had a higher rate of retention (82 versus 68 percent) and more negative drug tests for morphine (68 versus 58 percent) than those in treatment as usual group [19].

MOTIVATIONAL INTERVIEWING

Motivational interviewing is a psychotherapeutic approach designed to explore and resolve ambivalence to behavior change. Principles of motivational interviewing include expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy [10,11]. Other tenets of motivational interviewing, including accurate empathy, a nonjudgmental stance, the use of reflections and open-ended questions, are foundational in building rapport and collaboratively working towards change. (See "Substance use disorders: Motivational interviewing", section on 'Motivational interviewing'.)

Motivational interviewing can be brief (one to four sessions). Conversely, it can be applied as needed within longstanding therapeutic relationships. Instead of a prescribed number or frequency of sessions, motivational interviewing is best applied when there is an identified behavior (eg, substance use) that can be targeted for change. Several features of patients with opioid use disorder are well suited to motivational interviewing:

- Opioid use disorder is typically a chronic and progressive disease, characterized by cycles of abstinence and relapse. These cycles often reflect vacillations in patients' levels of motivation to change/maintain change. Clinicians benefit their patients by understanding the ebb and flow of motivation. In times of active drug use, clinicians skilled in

motivational interviewing can nonjudgmentally redirect patients towards contemplating change.

- Patients with opioid use disorder receiving medication for opioid use disorder (MOUD) in an opioid treatment program can have therapeutic relationships lasting years or decades. During a lengthy course of treatment, opioid use disorder-specific problems may stabilize, leaving open the opportunity for clinicians to apply motivational interviewing towards other behaviors (eg, polysubstance use, smoking cessation, or seeking appropriate medical care for the plethora of health-related concerns that arise from years of drug use).

- Motivational interviewing can be easily integrated into the various settings and modalities involved in opioid use disorder and can be used by the diverse types of providers (eg, counselors, clinicians, nurses). As an example, motivational interviewing is a component of behavioral naltrexone treatment [12].

Efficacy — Motivational interviewing has been found to be efficacious in substance use disorder generally; evidence in opioid use disorder is positive but more limited. A meta-analysis of 59 randomized trials with a total of 13,342 adult participants with substance use disorder found that, compared with no treatment, motivational interviewing resulted in a significant reduction in substance use postintervention (standardized mean difference 0.79, 95% CI 0.48-1.09) and at subsequent follow-up for as long as 12 months (standardized mean difference 0.15, 95% CI 0.04-0.25) [13]. (See "Substance use disorders: Motivational interviewing".)

Furthermore, motivational interviewing appears to be efficacious as an adjunct to MOUD. For example, in a clinical trial including 256 individuals receiving methadone maintenance, participants were randomized to either individual motivational interviewing, group motivational interviewing or a nurse-led hepatitis health promotion program. While no group differences were noted during the intervention period, at six-month follow-up the motivation interviewing groups (individual and group treatment) showed improvements in drug use behavior versus the health promotion program [20]. In another trial, motivational interviewing as an adjunct to MOUD (methadone) led to longer periods of abstinence and fewer opiate related problems [14].

COGNITIVE-BEHAVIORAL THERAPY

Cognitive-behavioral therapy (CBT) is based on the perspective that thoughts, emotions, and physical sensations can affect behaviors such as opioid use, and vice versa. As examples, CBT can help people develop an awareness of their cognitive distortions that negatively impact the person's mood and likelihood of relapse. CBT focuses on building awareness of these

aforementioned domains and development of skills to modify or accept them. These therapies are reviewed in greater detail separately. (See "Substance use disorders: Psychosocial management".)

Components of CBT include combinations of the following:

- Psychoeducation.
- Functional analysis – Helping patients better understand the function of their substance use, including factors precipitating use.
- Identifying triggers to drug use and coping skills that help patients manage emotions without drugs.
- Enhancing interpersonal functioning.
- Increasing recovery-focused activities.
- Promoting behavioral activation – Engagement in activities that improve mood and increase pleasure.
- Enhancing drug refusal and problem solving skills.
- Teaching skills designed to improve management of negative emotions.
- Identification of maladaptive thinking patterns that may precipitate or increase the likelihood of returning to substance use.

Clinicians receive training in order to provide CBT for substance use disorder, guided by detailed manuals [21]. In published studies, the duration of CBT was an average of 18 sessions, typically delivered weekly [22]. Since opioid use disorder is chronic and progressive, and medication for opioid use disorder (MOUD) can be of an indefinite length, clinicians can individualize use of CBT.

As an example, clinicians may choose to frontload treatment with weekly CBT, then draw from CBT material and encourage the use of learned skills throughout the duration of treatment. Alternatively, clinicians may want to wait until patients have stabilized in treatment to begin weekly CBT.

Mindfulness-based relapse prevention and acceptance and commitment therapy (ACT) are variants of CBT. Mindfulness-based relapse prevention includes the teaching and practice of mindfulness meditation to help patients change their relationship to drug cravings and other

negative emotional states [23]. ACT emphasizes acceptance (eg, acceptance of aversive internal experiences) to increase cognitive flexibility and reduce experiential avoidance. ACT includes a mindfulness component as well.

Efficacy — Clinical trials of CBT for opioid use disorder as adjunct to MOUD have found mixed results [22,24,25].

Several trials have suggested efficacy of CBT (eg, treatment retention or lower rate of drug-positive urine tests) [24,26,27].

As an example, in a clinical trial, 73 individuals with opioid dependence who were treated with methadone, were randomly assigned to group CBT (20 weekly one-hour sessions) or treatment as usual (weekly counseling) [24]. After 20 weeks of treatment, no difference was found between groups in their rate of negative urinalyses. However, at six-month follow-up, the CBT group had a lower rate of drug-positive urine tests compared with the control group. This result may highlight the CBT "sleeper effect," whereby CBT has increasing effectiveness during follow-up. This been demonstrated in other trials examining CBT in substance use disorder treatment [28,29].

> However, other clinical trials have found no improvement in treatment retention or reduced opioid use. In three clinical separate clinical trials totaling 398 primary care-based individuals treated with buprenorphine, no improvements were noted in individuals treated with the addition of CBTs versus medical management alone [30-32].

Technology-enhanced delivery — Technology-enhanced delivery of CBT-based interventions has shown mixed results:

- An online intervention containing 65 modules based upon CBT principles was examined in a clinical trial with 160 patients with opioid use disorder receiving dispensed methadone in an opioid treatment program [33]. Patients were randomly assigned to receive the online intervention and 30 minutes of counseling per week or (as a control condition) 60 minutes of counseling per week. The patients receiving the web-based intervention were more likely to achieve abstinence with no differences in treatment retention. A smartphone application based on this intervention has been developed [34].

- In a study examining an interactive voice response system based on CBT, 82 MOUD (methadone) patients were randomized to treatment as usual or to use of the automated self-management system plus treatment as usual. No differences were found between groups in urine screen outcomes; however, participants in the interactive voice response group reported more treatment attendance than the treatment as usual group [35].

- A 12-week pilot study with 20 patients receiving buprenorphine compared a web-based training in CBT to standard buprenorphine treatment [36]. Results indicated that participants in the intervention group had a higher rate of opioid-negative drug screens compared with the standard group (91 versus 64 percent). The intervention group also completed a mean of 83 versus 69 days of treatment.

FAMILY THERAPY

Several family therapies have been applied to opioid use disorder patients and their families/partners who express interest in family therapy wherein the focus is a person's opioid use:

Behavioral family counseling — Behavioral family counseling or behavioral couples therapy are interventions leveraging behavioral principles to reinforce abstinence and involve an abstinent family member (or partner, as in the case of behavioral couples therapy) [37]. (See "Substance use disorders: Psychosocial management", section on 'Behavioral couples therapy'.)

Behavioral family counseling has been found to improve treatment adherence and substance use disorder outcomes in patients with opioid use disorder [38,39]. As an example, in a clinical trial of behavioral family counseling, 124 men with an opioid use disorder who lived with a family member were randomly assigned to receive the intervention or control [38]. Compared with the control intervention, participants in the behavioral family counseling condition ingested more doses of naltrexone, attended more counseling sessions, and had more days of abstinence.

Community reinforcement and family training — Community reinforcement and family training is a treatment designed for family members or loved ones of people who have a substance use disorder. This approach is designed to help the family influence the person with a substance use disorder (identified participant) reduce substance use and seek treatment [40].

Network therapy — Network therapy engages the family and friends of individuals with a substance use disorder and is designed to help the patient utilize their networks for enhance treatment engagement and compliance [41,42]. A clinical trial tested the efficacy of network therapy as an adjunct to buprenorphine maintenance treatment [43]. Sixty-six patients receiving buprenorphine for illicit heroin use were randomly assigned to receive network therapy or medication management, a control condition. Over the course of the trial, patients assigned to network therapy had a higher proportion of negative opioid urine screens compared with the medication management group.

ADDICTION COUNSELING

Addiction counseling is a broadly used term to describe abstinence-oriented individual and group therapies provided by credentialed addiction counselors in a formal treatment setting. Programs vary widely in their content (eg, regarding specific education provided or a basis in an established therapeutic orientation). (See "Substance use disorders: Psychosocial management", section on 'Addiction counseling'.)

Efficacy — Evidence of efficacy from clinical trials is weak for addiction counseling as an adjunct to medication for opioid use disorder (MOUD) for opioid use disorder. Clinical trials comparing medication treatment that includes general addiction counseling versus medication treatment alone have found mixed results [44-47]. Of the five clinical trials examining addiction counseling among 1446 individuals being treated with MOUD, only one study showed that the addition of addiction counseling was associated with increases in efficacy [48,49]. The remaining studies showed no substantive benefit in adding addiction counseling [44-47].

As an example, a clinical trial randomly assigned 230 opioid dependent adults to be treated with methadone for 12 months to one of three conditions: emergency counseling only for the first four months (after which they were assigned to routine counseling), routine counseling, or routine counseling with counselors who had smaller caseloads [44]. At 12 months, there were no differences among groups in treatment retention (60.6 versus 54.8 and 37.8) or urine tests positive for opioids.

Administration — The frequency and duration of counseling can be individualized to provide what is necessary to help the patient stabilize in treatment while taking into account the patient's desires and their other employment and family obligations.

MUTUAL HELP GROUPS

Mutual help groups may involve peer groups or meetings, as well as opportunities to engage in one-on-one support, recovery activities, and service work. Participation in peer support may or may not be integrated into a person's formal treatment program. Mutual help groups generally focus on enabling group members to achieve and maintain abstinence from drugs such as opioids. Fellowship and spirituality are typically key components in mutual help programs.

Individuals with opioid use disorders can utilize specific types of mutual help groups that cater to opioid use, including:

- Narcotics Anonymous (NA)
- Methadone Anonymous
- Medication-Assisted Recovery Services

NA, like its well-established predecessor Alcoholics Anonymous (AA), involves peer-based support based on 12-step principles. NA groups occur throughout the United States and other parts of the world; such groups are considered a potentially useful part of treatment support and aftercare for individuals struggling with opioid use disorders.

Patients with opioid use disorder attending mutual help groups such as NA may encounter stigma associated with receiving medication for opioid use disorder (MOUD). Clinicians can help patients choose mutual self-help meetings that support the use of MOUD, such as Methadone Anonymous. A MOUD-friendly alternative to the 12-step model includes Medication-Assisted Recovery Services, a peer-initiated and peer-led recovery community usually integrated into opioid treatment program settings.

Clinicians should engage in discussion about stigma towards patients on MOUD in mutual self-help groups. Clinician coaching helps prepare patients to achieve the benefits of participation in mutual self-help groups. Twelve-step and other mutual aid may provide a source of critical support and fellowship for patients seeking stable long-term recovery. Although official NA policy welcomes participants on MOUD to join meetings, it does recommend restrictions on some of the roles those members can play (eg, leading a meeting or being a sponsor) [50]. Individual NA groups can follow any policy they choose, so some groups may be more restrictive, whereas others may be more open to members on MOUD. Patients on MOUD should seek the more accepting NA groups and may choose not to mention their participation in MOUD at all.

Efficacy — There are no randomized clinical trials testing the efficacy of mutual help groups in patients with opioid use disorder. Studying NA's efficacy has been challenging, in part because participants are assured of anonymity. Findings from research studies with less rigorous designs have supported NA use:

- In a cohort study of 142 drug-dependent patients initiating residential treatment, the frequency of attendance at NA or AA was found to be associated with higher posttreatment abstinence rates among opioid users [51]; the study could not assess the causality of the relationship.

- A study examining 300 African-American individuals starting outpatient buprenorphine treatment at programs that encouraged involvement in 12-step meetings [52]. Most (86 percent) attended at least one 12-step meeting in the six months after initiating treatment.

Meeting attendance was associated with treatment retention and abstinence while controlling for other variables that might account for these outcomes.

- A survey of 332 patients enrolled in MOUD for opioid use disorder and participating in NA found that more than three-quarters of patients reported that NA was “very” or “extremely” helpful to them. People with opioid addictions can and do attend AA; some find AA provides more structure and has a stronger spiritual base than NA [53].

While individuals enrolled in opioid treatment programs have been shown to attend 12-step meetings, they may not engage in the full range of potentially helpful components of NA, such as sponsorship, attending 12-step activities, or active step work [53]. Enrollees in MOUD (with an opioid agonist) have reported feeling stigmatized within the 12-step community [54], in part due to the perceived or real lack of acceptance among other group members who do not use medication in substance use disorder treatment. Some participants felt that the agonist medication use was viewed as a “crutch” by other group members and that the medication adversely affected their “clean time” [52].

Alternative approaches to mutual help for this population (eg, Methadone Anonymous), provides an environment similar to 12-step programs that additionally capitalizes on the shared experience of individuals engaged in MOUD. Medication-Assisted Recovery Services is developing as an organized network offering a number of services including training in medication-assisted recovery, support groups, social activities, as well as peer leader training and mentoring [55].

PEER SUPPORT STRATEGIES

Peer support strategies involve enlisting individuals with prior experiences with substance use disorders as coaches and supports for people considering or engaged in medications for opioid use disorder (MOUD). Peer services are increasingly integrated into settings that serve people with an opioid use disorder.

While there is a paucity of data examining this type of program and there is variability in methods and outcomes measured, peer programming appears to be best suited to MOUD initiation and opioid abstinence.

In one trial including 80 individuals with opioid overdose in the past six months and recent opioid-positive drug screens, subjects were randomized to receive peer recovery support services in the form of a phone call from a trained peer versus control (eg, overdose education) [56]. At 12-month follow-up, individuals in the intervention group had a higher rate of MOUD

enrollment than the control group (32.5 versus 17.5 percent) and a lower rate of opioid overdose (12.5 versus 32.5 percent).

PSYCHOSOCIAL TREATMENT ALONE

Psychosocial treatment alone, also known as nonmedication treatment, typically follows medically supervised withdrawal and aims to maintain abstinence using multiple psychosocial interventions, including the components below:

- Addiction counseling. (See 'Addiction counseling' above.)
- Participation in a mutual help group.
- One or more structured psychosocial interventions shown in clinical trials to reduce opioid use (eg, cognitive-behavioral treatment, contingency management, or motivational interviewing, or 12-step facilitation). (See 'Cognitive-behavioral therapy' above and 'Contingency management' above and 'Motivational interviewing' above.)

They also commonly include structured groups focused on skills training, employment support ("job club"), or prosocial recreational activities, and regular urine testing [57].

Most clinical trials comparing medication for opioid use disorder (MOUD) and psychosocial treatment alone have found MOUD to result in less substance use and greater rates of abstinence compared with nonmedication treatment.

Efficacy — Evidence is insufficient to determine whether psychosocial treatment alone (ie, without medications) is effective in treating opioid use disorder [58]. A review of the psychosocial treatment alone for opioid use disorder, including five randomized clinical trials with 389 participants, concluded that enhanced outreach counseling and brief reinforcement based intensive outpatient counseling interventions may be more efficacious compared with controls (which varied across studies).

Examples of psychosocial treatment programs found to reduce drug use in clinical trials include:

- **Reinforcement-based treatment** – Reinforcement-based treatment is a psychosocial treatment program developed to treat poor, urban patients with the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) heroin dependence [59]. It is based on the community reinforcement approach [60,61]. The program includes individual and group counseling (which takes place within a day-

treatment context), abstinence-contingent housing, food, and recreational activities, as well as job skills training. (See "Substance use disorders: Psychosocial management", section on 'Community reinforcement approach'.)

Randomized clinical trials have shown positive results for this treatment compared with controls [59,61]. As an example, a clinical trial randomly assigned 243 patients with DSM-IV opioid dependence who completed medically supervised withdrawal to receive: usual care; housing contingent upon drug negative urine tests; or abstinence contingent housing plus reinforcement-based treatment, including weekly group and individual counseling for 12 to 26 weeks [61]. At three months postenrollment, patients assigned to combined abstinent contingent housing plus reinforcement-based therapy had a greater proportion of drug-free urine tests compared with patients assigned to receive recovery housing alone or usual care (50 versus 37 and 13 percent); similar findings were seen at one and six months following enrollment.

- **Intensive counseling/contingency management** – A secondary analysis of results from a randomized clinical trial comparing contingency management with a control condition in patients treated for opioid dependence found that contingency management was effective in patients receiving psychosocial treatment alone, as well as in patients receiving MOUD [59,61,62]. (See 'Contingency management' above.)

FAMILY INVOLVEMENT AND EDUCATION

If appropriate, medical clinicians can leverage support networks of opioid-using patients to encourage recovery efforts and treatment. Clinicians can facilitate this process by using the community reinforcement approach and family training (CRAFT). This is an intervention that targets family members of people who use opioids and other substances. CRAFT is designed to support family members and does not need to involve the person who uses substances.

Studies suggest that family members who undergo CRAFT experience less depression, anger, and anxiety after completing the

intervention [63]. CRAFT can offer practical approaches for family members to help their loved one reduce opioid use and engage in treatment. Family involvement in CRAFT has resulted in reduced opioid use by the family member [64].

Other ways that providers can help support family members and loved ones of people with opioid use disorder include:

- Offering accurate information in plain language about opioid use disorder and recommended treatment options for opioid use disorder patients (see resources below).
- Continuing to destigmatize medication for opioid use disorder (MOUD).
- Educating support networks about opioid poisoning risks, including those associated with taking/not taking medications targeting opioid use disorder.
- Distributing naloxone accompanied by training in opioid poisoning reversal. Family members trained in overdose prevention and naloxone rescue kits may feel empowered to save the lives of their opioid using loved ones [65]. (See "Prevention of lethal opioid overdose in the community".)
- Validating the difficulties faced by family members and loves ones of an individual with opioid use disorder.
- Encouraging members of the network to seek out their own support, either in the form of mutual help (eg, Al-Anon; Nar-Anon), individual therapy, or other support means available.
- Supporting family members and loved ones in defining and setting appropriate limits with their opioid using family member/partner/friend.

To achieve these ends, medical clinicians may want to keep resources on hand to disseminate, including:

- Local schedules for mutual help groups for family and loved ones with a substance use disorder.
- Local resources for obtaining naloxone and opioid poisoning prevention education.
- Helpful educational resources that contain current and accurate information about opioid use disorder and MOUD:
    - National Institute on Drug Abuse: Patients and families
    - Recovery Research Institute: Guide for family members
    - Addiction Treatment Forum
    - Faces and Voices of Recovery
    - StopOverdose.org: Support for families

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Opioid use disorder and withdrawal".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, “The Basics” and “Beyond the Basics.” The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on “patient info” and the keyword(s) of interest.)

- Basics topics (see "Patient education: Prescription drug misuse (The Basics)" and "Patient education: Opioid use disorder (The Basics)")

SUMMARY

- Our approach to selecting treatment for opioid use disorder is described separately. (See "Opioid use disorder: Treatment overview".)
- Medication for opioid use disorder (MOUD), consisting of treatment with an opioid agonist or antagonist and adjunctive psychosocial treatment, is first-line treatment for most patients with opioid use disorder following medically supervised withdrawal when needed to initiate an antagonist (naltrexone). Some patients prefer psychosocial treatment alone, also known as nonmedication treatment, typically consisting of multiple psychosocial services. (See 'Overview' above and "Opioid use disorder: Treatment overview".)
- Contingency management is a behavioral intervention that uses incentives and other reinforcements to increase treatment engagement and decrease substance use. Contingency management is typically added to other interventions, such as addiction

counseling or cognitive-behavioral therapy (CBT). It has generally been found to be efficacious in opioid use disorder. (See 'Contingency management' above.)

- Motivational interviewing is a psychotherapeutic approach designed to explore and resolve ambivalence to behavior change, and is used to treat patients with opioid use disorder who are explicitly ambivalent or are have difficulties ceasing their use. Clinical trials have found the intervention to reduce substance use in patients with substance use disorder and, in fewer trials, in patients with opioid use disorder. (See 'Motivational interviewing' above.)

- CBT, including variants such as acceptance and commitment therapy, can help people with opioid use disorder increase awareness of their thoughts, emotions, physical sensations, and automatic behavior. Skills learned through CBT help patients leverage their awareness and respond skillfully to triggers and high-risk situations. (See 'Cognitive-behavioral therapy' above.)

- Addiction counseling is a broadly used term to describe individual and group therapies that encourage abstinence. Programs vary widely (eg, regarding specific education provided or a basis in an established therapeutic orientation). Clinical trials comparing medication treatment that includes addiction counseling versus medication treatment alone have found mixed results. (See 'Addiction counseling' above.)

- Patients with opioid use disorder attending mutual help groups such as Narcotics Anonymous may encounter stigma associated with receiving MOUD. Clinicians should discuss this with patients and help them choose mutual self-help meetings that support MOUD, such as Methadone Anonymous. (See 'Mutual help groups' above.)

- Individuals being treated with MOUD can also get training or become involved in MOUD-specific peer-based communities like Medication-Assisted Recovery Services. Clinician coaching is encouraged to prepare patients to achieve the benefits of participation in mutual help groups. (See 'Mutual help groups' above.)

ACKNOWLEDGMENT

The UpToDate editorial staff acknowledges Michael Weaver, MD, John Hopper, MD, and Eric Strain, MD, who contributed to an earlier version of this topic review.

Topic 99647 Version 14.0