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Behavioral Counseling Content for Optimizing the Use of Buprenorphine for Treatment of Opioid Dependence in Community-Based Settings: A Review of the Empirical Evidence

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Abstract

There is growing empirical evidence of buprenorphine's effectiveness in treating opioid dependence in community-based settings in the U.S. Decades of research indicates that in order for buprenorphine to have a sizable effect, it must be appropriately supported by behavioral counseling. Studies to date have not established the optimal behavioral counseling content for supporting buprenorphine treatment. The objective of this article is: 1) to review evidence of the key treatment-relevant issues posed by opioid-dependent patients in community-based settings in the U.S.; and 2) to review behavioral counseling content that may optimize the use of buprenorphine for treating opioid dependence in such settings. Evidence points toward the use of behavioral counseling aimed at enhancing patients' motivation during treatment entry followed by an emphasis on improving coping/relapse prevention skills during the primary phase of treatment.

Keywords

Buprenorphine; behavioral counseling; opioid dependence; substance abuse treatment; cognitive behavioral therapy; motivational interviewing; motivational enhancement techniques

INTRODUCTION

Buprenorphine is a partial mu-opioid receptor agonist and kappa-opioid antagonist that is approved by the Food and Drug Administration for treating opioid dependence (1). Unlike conventional opioid agonist treatments (e.g., methadone maintenance), buprenorphine is approved for use within a range of nonspecialized addiction treatment settings (2) and requires relatively infrequent patient-physician contact due to the duration of its pharmacological effects and the greatly diminished concerns relating to patient safety (i.e., overdosing) and diversion. The requirement for much less patient contact represents an enormous advantage to treatment providers since it may prove to be more cost-effective than existing approaches and feasible for implementation across nonaddiction treatment settings. Other advantages pertain to patients. These include the potential for enhanced patient privacy and decreased stigmatization compared with, for example, large methadone maintenance facilities in which stabilized patients must continuously interact with less stable patients who may be less invested in treatment (3). As a result, buprenorphine is often a more convenient and less restrictive pharmacological approach.

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Buprenorphine and methadone treatments have demonstrated similar retention rates (approximately 52%) in research settings in the U.S. (4). There is growing evidence of buprenorphine's efficacy for treating opioid dependence across a wide range of patient populations in the U.S. even when compared with the long-standing methadone maintenance (5). As a result of decades of research, evidence appears definitive that opioid dependence is most effectively treated using a combined pharmacological and behavioral approach (6–9). The consensus statement on the proper use of buprenorphine is informed by this evidence and emphasizes the necessity for concurrent behavioral counseling (2). Federal guidelines (e.g., TIP 40) (10) encouraging the inclusion of behavioral counseling with buprenorphine treatment have also been widely disseminated in the U.S. Importantly, the quantity and content of the adjunctive behavioral counseling, however, has yet to be established.

Controlled studies have begun to test the impact of varying the frequency, duration, and skill of the professional providing behavioral counseling, yet have failed to provide further guidance (11). The crucial question of what the optimal behavioral counseling *content* should be has not been systematically addressed. The objective of this article is thus to extend the literature by: 1) reviewing evidence of the primary treatment-relevant issues posed by opioid-dependent patients in community-based settings in the U.S.; and 2) reviewing the behavioral counseling content that may optimize buprenorphine treatment in such settings based on the efficacy *and* transportability of the content. Adjunctive behavioral counseling services already exist as an integral function of most community-based settings (including not-for-profit service organizations, drug treatment programs, methadone maintenance programs, AIDS service organizations, and prison-release programs) in contrast to other settings where buprenorphine can be prescribed (e.g., physician office settings). Our review therefore focuses on community-based settings.

TREATMENT-RELEVANT CHARACTERISTICS OF OPIOID-DEPENDENT PATIENTS

Opioid-dependent patients often present to community-based settings with a host of challenges, many of which cannot be directly addressed by clinical care itself (e.g., impoverished environment, minimal health care coverage, dependence on public assistance, low literacy, neurocognitive deficits). Below, we review three interrelated treatment-relevant factors that are well-documented in the research literature, that *can* be addressed by clinical care, and that warrant consideration in formulating behavioral approaches to be combined with buprenorphine treatment.

Low Retention in Treatment

Even with the increased availability of pharmacological agents such as buprenorphine, research with opioid-dependent persons has consistently shown treatment retention to be a challenge across various treatment settings and patient populations. Montoya et al. reported a 50% retention rate among opioid- and cocaine-dependent patients through a 70-day maintenance phase of buprenorphine treatment (8). In a clinical trial evaluating the use of buprenorphine for supervised opioid withdrawal of opioid-dependent patients, Ling et al. reported only a 60% retention rate over a 14-day outpatient program (12). Other studies have reported a 48% retention rate among higher functioning opioid-dependent patients treated with buprenorphine for 24 weeks in an office-based setting (11). Studies including lower functioning opioid-dependent patients in community-based settings report similarly low retention rates (e.g., 52% retention over 12-week treatment using buprenorphine) (13). Importantly, retention rates reported above were from research studies in which patients were reimbursed for participation and likely overestimate the retention rates in settings where participant remuneration is not feasible.

Continued Illicit Drug Use

Inversely related to retention in treatment are issues surrounding continued illicit drug use among opioid-dependent patients while in treatment. Substantial illicit drug use—particularly cocaine—has been reported among patients in methadone maintenance programs (14) indicating that mere participation in agonist therapy alone is insufficient. Continued illicit drug use also poses a challenge among patients receiving buprenorphine in community-based settings. In fact, researchers have reported that cocaine use tended to increase over time among patients participating in a thrice-weekly buprenorphine treatment in a drug treatment program even if patients were initially cocaine-negative at treatment entry (15). Across various treatment settings (7,8,11,16), researchers have typically found that over 50% of patients concurrently use cocaine while receiving buprenorphine. Not surprisingly, cocaine use among participants of a 24-week buprenorphine trial in a drug treatment program was associated with an array of negative treatment outcomes (17) as was the case in a study involving patients participating in methadone maintenance (18).

Low Motivation for Treatment

Individuals who enroll in treatment at community-based settings often present with relatively low levels of motivation to establish and maintain abstinence from illicit drug use. The importance of motivation in treatment outcome is now widely recognized across a variety of addictive disorders and treatment settings. George et al. reported that greater pre-treatment motivation was associated with greater treatment retention and enhanced treatment completion in a study of patients with a range of addictive disorders across a range of settings including long-term residential, outpatient methadone, and outpatient drug-free programs (19). These investigators found that motivation for treatment was a stronger predictor of initial engagement and treatment retention than sociodemographic, drug use, and other background variables.

Active cocaine use among opioid-dependent persons entering treatment may reflect low motivation to modify illicit drug use as part of treatment (17). Researchers assert that opioid-dependent patients often enter treatment less motivated to abstain from illicit drug use than treatment providers may presume (18). Further, although patient motivation tends to be assessed and targeted during treatment entry (20), motivation may exert a critical influence over the course of treatment for many opioid-dependent patients. For example, despite excluding heavy cocaine users from a buprenorphine trial, Stein et al. found significant levels of illicit drug use throughout treatment and concluded that low motivation for abstinence may be an ongoing obstacle to treatment success even among less-severely addicted patients (16).

In summary, evidence suggests that treatment-seeking opioid-dependent persons have the potential to present with interrelated treatment-relevant factors that negatively influence their participation in buprenorphine treatment. In the next section, we summarize evidence indicating what behavioral counseling content may be most useful for addressing these factors concurrently with buprenorphine treatment in community settings.

BEHAVIORAL STRATEGIES THAT MAY ENHANCE RETENTION AND OUTCOMES

Over the past two decades, behavioral interventions have demonstrated evidence of effectiveness particularly when combined with pharmacological therapies for treating a range of addictive disorders including opioid dependence (15,17–19). Reports to date suggest the benefits of delivering structured behavioral content that is tailored to accommodate individual patient needs at different stages of treatment.

Treatment Entry

Enhancing participants' motivation to remain in treatment has emerged as a primary objective during the treatment entry process in studies including participants with a range of addictive disorders including opioid-dependence. In a multi-site study, Carroll et al. evaluated the impact of integrating motivational interviewing (MI) content (21) into initial treatment intake sessions among all patients seeking outpatient substance abuse treatment (20). The use of MI content was found highly effective at improving retention at 28 days following enrollment. Importantly, these investigators found that MI content could be skillfully delivered by trained real world clinicians employed by drug treatment settings (20).

Rothenberg et al. reported the usefulness of incorporating primarily motivational and supportive counseling components during the initial phase of a behavioral naltrexone therapy for opioid-dependent patients (22). Others have reported that clinicians' use of a nonconfrontational therapeutic style—a central component of MI content—was critical to treatment retention among opioid-dependent patients participating in agonist (LAAM) therapy who were recruited from primarily community-based programs (22).

To date, no randomized controlled trial has evaluated the efficacy of combining motivation-focused behavioral content, such as MI, with buprenorphine for the treatment of opioid-dependence in community-based settings. Empirical support for the use of motivation-focused behavioral content, however, has been found in studies treating an array of other health-related problems, e.g., HIV risk reduction (23), alcohol and cocaine dependence (24), smoking (25). Combining motivation-focused content with buprenorphine for treating opioid dependence thus appears promising as such content is explicitly designed to target the primary treatment-relevant challenges commonly posed by opioid dependent patients entering community-based settings (Table 1).

Primary Treatment Phase

Few studies to date have evaluated the impact of integrating evidence-based behavioral interventions with buprenorphine treatment within community-based settings. Moreover, not all efficacious behavioral interventions appear to be readily transportable to real world settings because of their relative expense or other factors that complicate their broad implementation (26). A review of the behavioral research literature reveals that the interventions that show promise—in terms of both efficacy *and* transportability to community settings—incorporate very similar cognitive-behavioral content designed to enhance patients' coping skills in order to establish sobriety and skills to avoid or manage relapse to illicit drug use (7,8,21,27).

In a ground-breaking trial and secondary evaluation, researchers examined the efficacy of a standardized, individual, weekly, cognitive-behavioral intervention integrated with buprenorphine treatment for opioid- and cocaine-dependent patients (8). These investigators reported that greater attendance at counseling sessions was associated with improved outcomes in terms of opioid- and cocaine-negative urine testing. Further, outcomes became more pronounced over the course of treatment indicating the emergence of intervention effects over time analogous to that reported in seminal investigations of cognitive-behavioral therapies for cocaine dependence (28). Given the high co-morbidity rate that exists between opioid and cocaine dependence (13), these results are particularly noteworthy.

Similar outcomes were reported in an evaluation of a cognitive-behavioral group intervention that was combined with methadone maintenance for treating opioid-dependence (27). Manual-driven, weekly, cognitive-behavioral group sessions were delivered to patients over the course of 20 weeks in which they received methadone. At a 6-month follow-up point, participants in the cognitive-behavioral group condition showed less illicit drug use than controls and, similar

to prior research (28), intervention effects pertaining to drug use tended to emerge over time rather than decay.

Historically, cognitive-behavioral approaches have demonstrated efficacy when combined with pharmacological therapies designed to treat a range of addictive disorders, e.g., opioid dependence (29), cocaine dependence (30), alcohol dependence (31). Evidence to date points more specifically to the promise of including cognitive behavioral content focused on building coping skills to initiate and maintain sobriety as well as skills for preventing or managing relapse during the primary phase of buprenorphine treatment for opioid dependence (7,8,27). Such approaches appear particularly compatible with the treatment-relevant needs that tend to be most pressing to opioid dependent patients in community-based settings (Table 1).

CONCLUSIONS

The pharmacological agent buprenorphine appears likely to have a positive impact on patients, treatment providers, and public health in the U.S., if appropriately supported by behavioral counseling. This will be particularly important when integrated into HIV treatment settings where the goal is to retain individuals in clinical care, introduce antiretroviral therapy, and to reduce HIV risk-taking behaviors (32). Because of its relative infancy in the research literature, controlled studies to date have not reported on the efficacy of combining various behavioral techniques with buprenorphine treatment. The available empirical evidence, however, points toward the promise of incorporating motivation-focused behavioral content during treatment entry and cognitive behavioral content during the primary phase of buprenorphine treatment (Table 1). These approaches are specifically designed to tackle the treatment-related challenges commonly posed by opioid-dependent patients in community-based settings. In short, evidence points to the need to support buprenorphine treatment with behavioral counseling aimed at enhancing patients' motivation during the initial stage of treatment followed by an emphasis on improving coping/relapse prevention skills during the primary phase of treatment. Importantly, evidence from the HIV risk reduction literature indicates that such behavioral approaches may be skillfully delivered by a range of nonprofessionals and that brief behavioral approaches may be readily integrated into routine services offered in community-based settings (33,34,35).

One objective of incorporating behavioral counseling is to stabilize opioid-dependent patients so that they may optimally benefit from the treatment services they receive from their physicians. Though clearly beyond the scope of the current review, given the potential portability of buprenorphine to multiple clinical care settings, future studies should consider the potential feasibility and effectiveness of different treatment models that take into account the full range of opioid-dependent patient populations (36) who may present to various treatment settings with differing levels of motivation that must be addressed. A primary goal of initially implementing a motivation-focused behavioral counseling approach is to establish each patient's current level of motivation and then to adjust their treatment plan (including treatment setting) as needed to provide optimal care. For example, lower functioning patients (e.g., high addiction severity, low motivation, active cocaine use, co-morbid mental illness, neurocognitive effects of HIV and/or HCV) may benefit most from completing the buprenorphine induction phase within a traditional drug treatment program and, once stabilized, transfer to an individual treatment provider while higher functioning patients may require the less intensive clinical services that are more characteristic of primary care settings. Future controlled studies should also provide additional empirical guidance by establishing what specific behavioral components create optimal synergy when combined with buprenorphine for treating opioid dependent patients within different clinical care settings.

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Suggested behavioral content to support buprenorphine in community-based settings in the U.S.

Table 1

Content	Objective
Treatment entry phase—use of MI content (e.g., Miller and Rollnick, 2002): Ask open-ended questions Providing choices for treatment Removing barriers to treatment Providing feedback about functioning Reflective listening Eliciting self-motivational statements Rolling with resistance to treatment Primary treatment phase—Cognitive-behavioral content (e.g., Carroll et al., 2000): Building coping skills Building relapse prevention skills Managing thoughts Problem solving Developing drug refusal skills Planning for emergencies Coping with lapses Seemingly irrelevant decisions Optional coping skills based on individual needs (e.g., anger management, assertiveness training, enhancing social support)	Develop rapport with patient/set the tone Understand current level of functioning Clarify expectations for treatment Enhance motivation to continue treatment Set specific realistic objectives for treatment Understand and develop skills to initiate sobriety Practice coping with cravings to use drugs Improve awareness of and ability to monitor thoughts relating to drug use Identify and practice skills for avoiding relapse Improve assertiveness/communication skills Develop skills to avoid or manage lapses Understand, improve, monitor decision making relating to relapse Supplement and reinforce core coping skills for maintenance of sobriety