Psychosocial support for the management of psychostimulant use disorders

Q5: Is psychosocial support effective for the management of psychostimulant use disorders in non-specialist settings?

**Background**

Substance use disorders constitute a major public health problem with high costs for society, including the costs of the treatment, related health problems, absenteeism, lost of productivity among others. The motivation for using psychoactive substances is, in part, related to effects of these on mood, cognition and behaviour and patients with substance use disorders frequently present a long history of repeated episodes of intoxication and withdrawal, with a chronic course of disease.

There have been recent advances in substance abuse research, but to translate this knowledge into treatment interventions that significantly impact long-term maintenance of abstinence remains a challenge. Regarding psychosocial approaches, authors suggest some specific techniques are superior to supportive therapy for substance abusers, including cognitive-behavioural therapy (CBT).

**Population/Intervention(s)/ Comparison/Outcome(s) (PICO)**

- **Population:** adults and young people
- **Interventions:** psychosocial and case management
- **Comparisons:** basic supportive counseling or treatment as usual
- **Outcomes:**
  - drug use
  - abstinence

**List of the systematic reviews identified by the search process**

Systematic reviews included in narrative review:
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Narrative description of the studies that went into the analysis

In the NICE 2008 guideline, for the review of standard CBT, two trials met the eligibility criteria, providing data on 370 participants. Both trials were for cocaine dependence and were published in peer-reviewed journals. In the review of relapse-prevention CBT, nine trials met the eligibility criteria, providing data on 1,314 participants. Of these trials, six were on cocaine dependence and three were on cannabis dependence. All trials were published in peer-reviewed journals. For contingency management, 14 trials met the eligibility criteria, providing data on 1,498 participants. Of these trials, six were for cocaine dependence, one for cocaine and/or heroin dependence, three for methamphetamine dependence and three for cannabis dependence. All trials were published in peer-reviewed journals. Electronic MEDLINE, EMBASE, CINAHL, HMIC, PsycINFO, databases Cochrane Library Date searched Database inception to May 2006; table of contents December 2005 to November 2006 Study design RCT All trials were published in peer-reviewed journals and were for people who were cocaine dependent or heroin dependent (all participants in these trials underwent detoxification, if required, before receiving the intervention). For family-based and social-systems interventions for young people, six trials met the eligibility criteria, providing data on 708 participants. All trials were published in peer reviewed publications. For psychodynamic interventions, one trial met the eligibility criteria, providing data on 247 participants. This trial was published in a peer-reviewed journal and as for cocaine dependence. For interpersonal therapy, one trial met the eligibility criteria, providing data on 42 participants. This trial was published in a peer-reviewed journal and was for cocaine dependence.


Quantitative or qualitative analyses

No quantitative analysis was possible and a narrative review was done instead.
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Results of analyses, including statistical summaries (as appropriate)

People presenting to treatment with stimulant misuse (including cocaine and amphetamines') receiving contingency management were more likely to be abstinent for longer periods of time during treatment than people in the control group. Both prize- and voucher-based reinforcement were found to be effective. Psychodynamic therapy was ineffective during treatment and at follow-up in significantly reducing cocaine use. Direct comparisons of relapse-prevention CBT and contingency management for stimulant misuse demonstrated the superior effectiveness of contingency management during treatment but not at follow-up. It is unclear whether the lack of difference between contingency management and relapse-prevention CBT at follow-up is due to a delay in the benefits of CBT, being observable only at follow-up, and/or a weakening of the effects of contingency management after treatment has ended.

Case management did not have a significantly advantageous effect on abstinence compared to standard care for out of treatment drug users (RR 1.16, (0.59, 2.31).

Methodological limitations
Studies lack standardized interventions, appropriate comparators, and standardized outcome measures. There is rarely masking of outcome assessment.

Directness (in terms of population, outcome, intervention and comparator)

Directness is compromised as studies were from high income countries and interventions were not always compared to basic drug counseling.

Narrative conclusion

Cognitive-behavioural interventions reduced dropouts from treatment and use of cocaine when compared with drug counseling. Behavioural interventions also clearly performed better than clinical management (psychotherapy sessions attended), usual care (lower rates of cocaine users at 1 and 3 months), information and referral (non-attendance). Contingency management was shown to be more effective than basic supportive counselling and CBT.

Any additional information (safety and tolerability issues, cost, resource use, other feasibility issues, as appropriate)

Despite the lack of evidence of the impact of basic psychosocial support compared to no treatment, it is likely some elements of basic psychosocial support (listening in a non judgemental way, providing information, inquiring about coping strategies, problem solving, making links to social supports when available) will not be harmful, and it would be difficult to justifiably deny them to patients when the capacity to provide them is there. Specific psychosocial therapies require more extensive training of health care providers than basic counselling and clinical management. There may also be more stigma attached to undertaking psychosocial therapies compared to more informal drug counselling.
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References


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From evidence to recommendations

<table>
<thead>
<tr>
<th>Factor</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>Narrative summary of the evidence base</td>
<td>In total there have been 25 studies, in over 3000 participants on this topic. Despite this, there is no evidence to compare the effectiveness of basic psychosocial support to no treatment. There is some evidence that CBT and contingency management (CM) techniques offer advantages over basic psychosocial support and that CM is more effective than CBT based approaches, although whether this effect persists after the contingency is removed is unclear. Methodological difficulties make more exact comparisons difficult.</td>
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<tr>
<td>Summary of the quality of evidence</td>
<td>Despite the many studies, the overall quality of the evidence that addresses the question of interest is low.</td>
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<td>Balance of benefits versus harms</td>
<td>There is unlikely to be harm from the provision of basic psychosocial support.</td>
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<td>Define the values and preferences including any variability and human rights issues†</td>
<td>Access to basic psychosocial support through the health system may be seen as a human right, despite the lack of evidence of its effectiveness.</td>
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<td>Define the costs and resource use and any other relevant feasibility issues*†</td>
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<td>Recommendation(s)</td>
<td>Brief interventions, based on motivational principles, should be offered for the treatment of stimulant use disorders in non-</td>
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Patients with stimulant use disorders who do not respond to short duration psychological treatment may be referred for treatment in a specialist setting, when available.

Strength of recommendation: STANDARD