A Review of Group-Based Treatment of Opioid Use Disorder: Key Components for Implementation

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Introduction

Coupling buprenorphine prescribing with psychotherapy has been encouraged as a best practice.[1] However, several studies have called the benefits of therapy into question.[2,3] While the efficacy and feasibility of providing individual counseling concurrent with buprenorphine prescribing is questionable, group counseling with buprenorphine has received less attention and has the potential to increase access to care.

The primary aim of this paper is to:

- Examine the existing medical research related to group-based treatment in office-based opioid treatment with B/N
- Assess for efficacy, feasibility, and acceptability of group treatment
- Identify common characteristics across groups as well as key logistical components for implementing different forms of group visit formats

Methods

Literature Review:

A literature review was done on feasibility, acceptability, and efficacy of group-based buprenorphine treatment.

- Searches were done using Pubmed, PsycINFO, and Medline Ovid
- Inclusion criteria: studies of group-based treatment in which patients were prescribed buprenorphine, English language studies
- Exclusion criteria: studies in which only methadone was delivered via group format

Case Studies:

Five buprenorphine providers were interviewed who run direct types of group-based OBOT care, including 3 forms of shared medical appointments, one form of integrated primary care group counseling, and one intensive outpatient program.

Results

Literature Review Summary and Implications of OBOT groups

Study	Group Type	Implications
Roll, Spottswood & Huang (2015)[4]	Shared Medical Appointments (SMA)	Acceptability from patient perspective, feasibility from provider perspective, and efficacy of improved social outcomes
Suzuki et al (2015)[5]	Shared Medical Appointments (SMA)	Acceptability from patient perspective, efficacy including improved relapse rates, cravings, and mood outcomes
Berger et al (2014)[6]	Monthly group psychotherapy	Efficacy of group model compated to individual delivery of Buprenorphine for retention rates but not for relapse rates
Miotto et al (2013)[7]	Weekly psychotherapy groups based on the manualized Matrix Model (MMM) of Cognitive Behavioral Therapy	Feasibility of B/N delivery in all formats based on similarities in relapse rates and participation levels, efficacy of group versus individual counseling at drug-facility versus individual counseling could not be determined
Pugatch et al (2014)[8]	Weekly psychotherapy group	Acceptability from patient perspective, efficacy including improved relapse rates and lower high risk behavior
Mitchell et al (2013)[9]	• Outpatient program (OP) consisting of less than 9 hours a week of group psychotherapy • Intense outpatient program (IOP) consisting of more than 9 hours a week of group psychotherapy	Efficacy of both forms of group therapy related to relapse and retention rates, criminal activity, QOL scores, and HIV risk behaviors
Monico et al (2015)[10]	12-step recovery group	Efficacy in terms of relapse and retention rates for patients already attending group visits and receiving Buprenorphine prescriptions

Group Delivery of OBOT with B/N: Shared Components Across 5 Part Case Series

Patient Critera	• Exclusion criteria: serious chronic mental health disorder, pain requiring opioid medications, polysubstance abuse
Referral to Group	• Primary care physicians from within the practice refer to group, while the PCP continues to manage ongoing medical issues; at some sites, medical and psychological problems are handled individually before or after group by the B/N provider
Prior to Starting Group	• Patient meets with individual provider who runs group to assess fit and lay down expectations of participating in group
Format	• At some sites, patients complete a survey that ask about drug use over the past week • Group begins with reading of the ground rules created by patients, time is spent as a mix of pschoeducation with patient check-ins, and finally group concludes with pre-printed distribution of B/N prescriptions
Content and Facilitation of Psychoeducation	• Psycho-educational content includes a mix of addiction self-management skills, self-care, and associated medical problems • Various facilitators, including physicians, addiction-trained RNs/LPNs, medical assistants, psychologist, and social workers
Duration	• Most groups are 1 hour long, while the IOP groups can range from 45 – 90 minutes
Size	• The group size cap on each group is different at each site and ranges from 8-15
Frequency	• All sites offer weekly meetings, some offer twice-a-month and monthly meetings, and the IOP site offers meetings 3 mornings a week
Care outside of group	• All patients are encouraged but not required to attend outside support groups, such a 12-step programs AA or NA, or individual therapy
Monitoring	• MA's collect urine for urine toxicology testing before each group visit starts
Handling of aberrant behavior	• Every site treats relapse as part of recovery; patients are encouraged to embrace honesty and discuss it with the group; if relapse becomes a trend, the patient is referred to a higher level of care (the IOP program) • Providers will discharge patients for behaviors considered more severe, such as tampering with urine sample, verbal or physical threats, selling or sharing medication, or engaging in a sexual relationship with another patient
Rewarding Success in Recovery	Patients meeting success criteria will receive privileges by being spaced out to less frequent meetings
Dosing of B/N	• Most patients are on the standard dose of 16 mg buprenorphine (range: 2-24 mg)
Documentation & Billing	• Each patient receives an individual note in their chart via EHR with a template that is completed and takes about 3-5 minute to write each note • Visits are billed as mostly as CPT code 99213. Some are billed as CPT code 99214 if the patient requires treatment beyond addiction management and is seen individually, OAS bills as 60-minute psychotherapy sessions (CPT code 90853)

Discussion

Only two studies were designed to properly isolate the benefits of group delivery of B/N (Berger et al 2014; Miotto et al 2013). Despite uncertainty about efficacy, several studies do point out the feasibility and acceptability of delivering B/N via a group visit approach, as demonstrated through reduction in depression, lower levels of craving, higher retention rates, fewer aberrant urines, and positive patient satisfaction surveys (Roll et al 2015; Suzuki et al 2015; Pugatch et al 2014). Our case series provides a framework for practitioners looking to implement group-based treatment, demonstrating common operational and logistic components as well as variation in practice patterns required for group visits in each unique setting.

Conclusion

While we found that the small number of studies and study design limited conclusions that could be drawn about the efficacy of B/N delivery via a group visit model, these studies did point to the potential feasibility and acceptability of this approach. The practices outlined in the literature review and in our case series of five different groups share commonalities that could be used as a guide when operationalizing groups while also pointing out variations in practice that can optionally be adopted to other settings. Large randomized controlled trials studies are needed to assess efficacy.

References

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