Group Counseling for People in Medication Treatment for Opioid Use Disorder

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Introduction

Group counseling has long been a mainstay in addiction treatment. However, group format and content need to keep pace with the changing landscape of treatment for opioid use disorder (OUD): evidence-based medications are prioritized for treating OUD, and the field has become more compassionate about and tolerant of ongoing substance use. An emphasis on continual engagement has become increasingly important. Group counseling for people enrolled in medication treatment for OUD (MOUD) can evolve to: 1) include topics around medication; and 2) fit into the diverse array of settings that offer MOUD. The changing landscape of MOUD has meant that "treatment" is no longer limited to specialty agencies; services can be offered in variety of settings (e.g., hospitals, primary care clinics, syringe exchange services), by different types of providers (e.g., prescribers, nurses, Peer Specialists, navigators).

This info brief discusses how group counseling can adapt to OUD treatment models wherein medications are a primary component. It should be noted that we discuss group counseling, and not mutual aid groups (e.g., Narcotics Anonymous). Even though there is overlap between the benefits of each, this brief is aimed at professionals who provide group counseling in treatment, health care, behavioral health or other service settings.

Objectives

1. Consider group counseling *formats, content, and approaches* that benefit people in MOUD.
2. Discuss clinical considerations relevant for group counseling in MOUD.
3. Review research on counseling for people enrolled in MOUD.

Creating Group Counseling that Works for People in MOUD

How can we maximize group counseling engagement, but stop short of requiring participation? One starting place may be to create groups that are convenient to attend, fit the patients' needs and interests, are evidence-based, and play to staff strengths. That is, create group counseling that people want and that is valuable to them.

Lowering the Barrier to Group Counseling Participation

The opioid epidemic has prompted innovation and change in systems of care. Lowering barriers to services is one approach to quickly engage people with services (Hood et al., 2020; Kourounis et al., 2016). In terms of group counseling, lowering barriers might look like offering "drop-in" groups, whereby many groups are offered at different times of the day, with various topics and leaders. Having a menu of options allows MOUD patient to choose the frequency and type of groups they want to participate in. In one opioid treatment program where such a model was successfully implemented (Madden et al., 2018), counselors noted that patients appreciated the choice and flexibility drop-in groups offered (Oberleitner et al., 2021). Counselors said the advantages of

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drop-in groups extend to their own work in that a team approach allows counselors to support each other in the care of all patients instead of being responsible for a particular set of patients. These same researchers also noted the disadvantages of drop-in groups: unpredictability and lack of structure/community, which can affect workflow, treatment environment, and the patient experience. Drop-in groups will not work in all settings, and Recovery Community Centers (e.g., Recovery Cafes) may serve as an option that can fill the gap in terms of offering drop-in groups.

Another way to lower the barrier to group participation is to couple prescribing and group counseling appointments in the same visit. Group-based opioid treatment, which includes shared medical appointments, adopts this approach and has emerged as a feasible and acceptable way to deliver MOUD (Sokol et al., 2018). This model has other advantages for patients and providers: reduction of stigma around medication treatment, as all participants are receiving medication; efficiency for providers; and increased counseling attendance due to the connection with prescribing.

Finally, COVID-related telehealth implementation has transformed healthcare, and MOUD is no exception. Group counseling offered through telehealth may lower barriers for attendance for specific groups of people, in particular people who: are in rural areas, lack transportation or childcare, want to avoid the stigma associated with a MOUD clinic, have mental health conditions such as social anxiety, or have medical conditions that make travel difficult. One MOUD clinic found that a higher percentage of appointments were attended after COVID-related implementation of telehealth group and individual counseling (88% versus 77% in the months before COVID; Hughto et al., 2021). Such results show that telehealth is a viable option for MOUD group counseling, and authors suggest pursuing a hybrid model for in-person/telehealth connections.

Groups that MOUD Patients Want

When asked, people with OUD and a history of MOUD report that an "ideal" treatment center would include a menu of options, which includes different types of groups (Andraka-Christou, Randall-Kosich & Totaram, 2021). These same respondents suggested that participants want access to non-12-Step support groups, as well as non-clinical services like housing support and financial literacy. The former finding suggests that people may have had previous negative experiences in 12-Step groups, a critique consistently leveled by MOUD patients (Monico et al., 2015; White et al., 2013). The latter suggestion denotes the importance of patient-centered care, treating the whole person versus just the disease.

Conceptualizing groups in this way may prompt creativity in the makeup of groups for MOUD patients. For example, groups could provide education around financial literacy, housing supports, or other quality of life enhancers like recreation and exercise. Or, MOUD patients may want to focus on other aspects of their care, like mental health concerns, which was another suggestion that emerged from the research on the "ideal" treatment center. Such research provides a useful starting point, but ultimately asking the individual MOUD patients in your setting will yield the best information about how to create groups that serve them.

Evidence-based Group Counseling Approaches for People in MOUD

Research shows that people enrolled in MOUD benefit from the same behavioral interventions as people in other types of treatment for substance use disorders. We discuss evidence-based interventions for MOUD patients that can be delivered in a group format, namely, behavioral therapies such as Contingency Management, Cognitive Behavioral Therapy, and mindfulness-based approaches.

In Contingency Management (CM), participants are offered incentives when they demonstrate a specific behavior, for example a negative drug screen or medication compliance. Not a standalone group, CM fits well as an add-on to existing group counseling (Petry, Martin, & Simcic, 2005). CM can be powerful in a group setting, as group members can celebrate when individuals reach their goals, emphasizing the social reinforcement

aspect of CM. In MOUD, CM has been shown to affect the behaviors of opioid use (Chen et al., 2013; Hser et al., 2011), cocaine use (Ghitza et al., 2007; Groß et al., 2006), counseling attendance (Hartzler et al., 2014; Kidorf et al., 1994), and medication compliance (Jarvis et al., 2017). CM has the strongest evidence-base of all behavioral approaches, and as such is recommended as a supplement to group counseling. That said, some settings may not have the infrastructure set up to support ongoing CM, and the intervention works best when CM principles are adhered to and those conducting the interventions need to do so with CM skills in mind.

As mentioned, CM can be a great addition to existing groups, like dessert at the end of a meal. The "main course", or the primary group approach and content, is wide open for group members and leaders to shape. Group participants wanting a skills-based, time-limited group can opt for behavioral interventions including mindfulness-based approaches, which incorporates mindfulness as a tool to manage thoughts and feeling, or cognitive behavioral therapy (CBT). CBT helps people: 1) identify the relationships between emotions, thoughts, and behavioral patterns; and 2) learn skills to interrupt existing processes. In their review of CBT and buprenorphine for OUD, the authors conclude: "that there are some promising findings regarding non-individual CBT and buprenorphine" (Gregory & Ellis, 2020, p. 528). Specifically, one study in which buprenorphine patients were randomized to one of three sites, one of which employed weekly CBT group, indicated that the CBT site had better treatment retention (Miotto et al., 2012).

What aspects of behavioral interventions are especially useful for people with OUD? Many people with OUD have extensive histories of using opioids to relieve feelings of stress or handle stressors in their environments, leading them to be especially reactive to stress (i.e., outsized physical responses to stress). While medication can manage opioid cravings and withdrawal, people in MOUD may still be left with a high degree of stress reactivity, which is a predictor of MOUD dropout (Panlilio et al., 2019). Researchers have identified stress reactivity as a possible intervention target, and as such CBT-based and mindfulness-based interventions are being developed (as of 2021) to test these approaches with MOUD patients (McHugh et al., 2020; Zinzow et al., 2020). That there are studies like this in the pipeline demonstrate a recognition that MOUD may be further improved with behavioral approaches.

Clinical Considerations for Group Counseling with People in MOUD

When developing a group, there are decisions to be made about type, length, group members, etc. The following are questions to ask in the process of creating groups for people enrolled in MOUD. There are no correct answers to the questions, and the right decision depends on the participants, setting, staffing, and other factors.

1. Should the group be limited to certain "types" of people?

Such groups are also called *homogenous* groups, examples include: groups that focus on a specific issue, like a particular mental health concern (e.g., trauma, depression, etc.), or target a specific population (e.g., pregnant women). Groups *not* based on certain criteria are referred to as "mixed" or *heterogeneous*. Relevant to MOUD patients, a homogenous group might include only those who are currently taking medication for OUD.

Advantages of homogenous groups	Advantages of heterogeneous groups
Come together more quickly and easily.	Opportunity to learn from a diverse set of people.
Less likely to have conflict within the group.	Opportunities to practice overcoming conflict.

Groups limited to people who are taking medications for an OUD provide safe places to discuss the role medications in their treatment or recovery, which may be unavailable in the community (i.e., members of 12-step groups may voice disapproval of medications).	Groups not limited to people who are taking medications for an OUD can help normalize medications to treat OUD, and reduce isolation this group from other people who struggle with addiction. Conversely, people on medication have exposure to people in recovery, who do not take medication.
Some people with a history of MOUD indicate that they prefer groups to be more homogenous in terms of demographics like age; they also reported a preference for groups with a specific focus, like trauma (Andraka-Christou, Randall-Kosich & Totaram, 2021).	"All comers" may not have as many problems around finding enough people to fill the group or keep the group filled in an ongoing way. Group "recruitment" is easier, because inclusion in the group is not limited. Therefore, such groups may be easier to implement and sustain.
Not sure if a homogenous or heterogeneous group is the right choice? Ask the potential group members what they think!	

2. Should the group be structured, like learning and practicing skills? Or, should the group be more support-oriented, where the content is flexible and focus is on group members' supporting each other?

Relevant to MOUD patients, process/support groups can be a place where medication stigma can be safely processed, leveraging the shared experience aspect of groups. Structured groups could include psychoeducation with specific content related to medication, like: duration of treatment; medication adherence; decisions around dose; and medication interactions with other medications, alcohol, cannabis, and other drugs.

Advantages of task-oriented groups	Advantages of support-oriented groups
Best if group members want to learn and practice skills useful for recovery.	Content can be flexible to fit the needs of the group members.
Group leader drives the content, leads the discussion, or teaches material, increasing the likelihood that the group stays more focused.	Group members can take more ownership of what they want to talk about.
Importance placed on learning and skill development.	Importance placed on relationships in the group.
It doesn't have to be either/or! Group members may have different preferences based on where they are in their recovery. For example, a person new to MOUD might want more information and structure (task-oriented group), whereas someone who has been in treatment for a while might be looking for connection with others or an opportunity to help others (support-oriented group). Conversely a person recovering from methamphetamine use may have temporary learning deficits and support oriented groups may be more engaging. In deciding what groups to offer, it's important to ask group members what they want.	

3. Should the group be time-limited/closed or rolling/open-ended?

Open-ended groups allow members to join at any time, whereas in closed groups members start and complete the group together. The decision about whether to offer open or closed groups may depend on the needs of group members. Closed groups take organization on the part of leader and member, making these groups a poor match for people who have difficulties organizing themselves for any reason (i.e., ongoing substance use; houselessness). Open groups can be more flexible to meet the needs of the individual. However, some of the most critical elements of group counseling, like developing a support network, are diluted in open versus closed groups.

Advantages of time-limited, closed groups	Advantages of open-ended groups
More trust and cohesion; the same members are there at each session, and move through the experience as a unit.	More range and variety of topics available for group members; more diversity of group members.
Offers group members more stability and predictability.	Fewer barriers for group members to get started; easier for staff to implement and sustain.
Lend themselves to focusing on learning and practicing skills week to week.	More opportunities to practice initiating relationships and adapting to change.
Having set start and end dates allows people the opportunity to complete something whole, instilling a feeling of accomplishment.	People will be at different stages, allowing newer group members to learn from those who have been there for longer or are at a different stage of their recovery.

Counseling for People in MOUD: What Does the Research Tell Us?

One way to determine how well counseling "works" for MOUD patients is by conducting randomized controlled trials. These studies are done by taking a group of MOUD patients and randomizing them to either receive counseling or not. These groups are then statistically compared to see if there is a significant difference between groups, due to the treatment. These trials may be the standard for measuring the *efficacy* of a particular intervention, but do not tell the whole story. Here, we first present results from randomized controlled trials measuring counseling for MOUD patients, and then put the results in the larger context of what we know about "whole person care" in the treatment opioid use disorder.

Four studies show that individual counseling added on has no impact on opioid use above that provided by methadone or buprenorphine (Moore et al., 2012; Fiellin et al., 2013; Ling et al., 2013; Weiss et al., 2011). That is, results indicated no differences in opioid use outcomes between groups of participants randomized to counseling versus no counseling conditions. Such results should not be taken to mean that counseling is unimportant, and do not provide the whole story. To provide a more comprehensive picture, we offer additional and important considerations.

First, the above studies measured various outcomes, but emphasize opioid use outcomes. Opioid use is effectively targeted with medications, and in fact the effect of medications on OUD may be strong enough to limit our ability to detect the additional benefits of counseling above and beyond what the medication does. Medications are unmatched in terms of managing opioid cravings and withdrawal, and account for the majority of the effect of treatment. Measuring the effect of counseling is therefore difficult given how effective

medications are. Another challenge in measuring treatment effectiveness is that medications and counseling target different important outcomes: one outcome is "keep the person alive" (which medications are very good at) and another outcome is "develop a life worth living" (better achieved through counseling). Specifically, group counseling can help people:

- Have a sense of hope; people change/recovery/get better
- Be in a space surrounded by others who share their experiences
- Understand they are not alone
- Experience the benefit of helping others
- Feel supported by a community
- Learn from others with similar experiences
- Be accountable to others
- Practice social skills, model social skills for others
- Learn skills to cope with difficult situations and emotions
- Gain a different perspective
- Have rewarding experiences that do not involve substance use

Unlike people in other types of substance use disorder treatment, individuals enrolled in MOUD have other challenges that underscore the importance of connecting them with group counseling:

- People in MOUD can experience an additional layer of stigma beyond just having OUD, as some people and organizations incorrectly believe that a person on medications is not really in recovery. This can further increase feelings of isolation and shame. Feeling as though "I'm not alone", is a powerful factor in group counseling and can support MOUD patients who feel stigmatized or judged based on their treatment choice.

- MOUD patients may not have access to mutual aid groups (e.g., 12-step groups) because of medication status i.e., groups may prohibit participation for those on medications.

- Some settings may not have group counseling built in, for example, buprenorphine prescription from one's primary care provider. Patients who receive services in these settings have less exposure to group counseling, highlighting a need to expand opportunities more broadly for MOUD-specific group counseling.

Second, another study (Schwartz et al., 2017) showed that if patients are *given a choice*, many choose to go to counseling even if it is not mandated. Specifically, this study took place in an Opioid Treatment Program, where methadone was the medication used for OUD. The researchers randomized patients into counseling or no counseling groups, but in this case the "no-counseling group" could access counseling if they wanted. Results indicated: 1) no differences between groups in opioid use outcomes; and 2) there were *no group differences in the number of counseling sessions attended*. In other words, if counseling is mandatory or voluntary, patients attend about the same number of sessions. These results seem to imply that people are interested in counseling, but requiring counseling does not increase attendance. Indeed, when people perceive limits on their autonomy (i.e., they are required to do something), they may have a negative response ("reactance"; Brehm, 1966; Brehm & Brehm, 2013). Reactance can then cause people to behave in ways that will restore their freedom to choose (i.e., refuse to attend counseling when it is mandated). Furthermore, when counseling is mandated, the alliance between MOUD patient and the "enforcer" can suffer, undercutting the benefits of counseling.

Taken altogether, what can we make of the above research examining counseling for MOUD patients?

- Research shows that counseling probably does not have a significant impact on opioid use above and beyond the impact of medications. This is fine because medication is effective at managing opioid use. While medication is superior at managing cravings and withdrawal, it does not bolster people's support systems, teach skills, or provide people a life worth living. These, and other benefits, have the potential to be gained through group counseling. Figure 1 shows how group counseling and medication can work together.
- People enrolled in MOUD generally *want* counseling, and given a choice they prefer it.
- While many MOUD patients want counseling, we can assume that most people do not want to be forced to go to counseling. Therefore, *we should not mandate people participate in group counseling in order to continue receiving services*, particularly medication receipt. If medication is discontinued based on failure to attend group counseling, we can expect that a certain percentage of people will "fail" and lose access to medication, increasing their likelihood of death (Fugelstad et al., 2007; Pierce et al, 2016; Sardo et al., 2017).

An alternative to coercing people to engage in group counseling is to create groups MOUD patients want to attend.

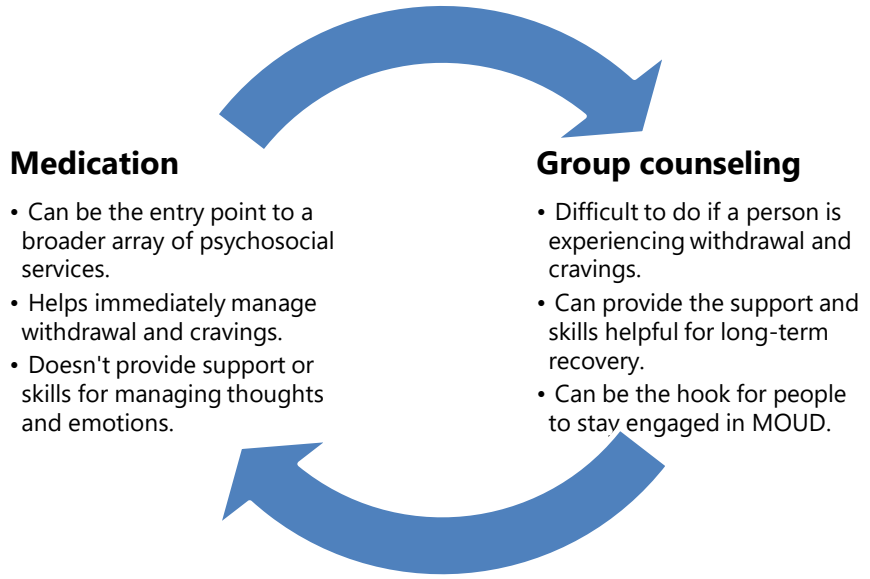

Figure 1. Group counseling and medication work together.

Conclusion

Group counseling in addiction treatment has stood the test of time for good reasons. There are elements unique to group counseling that cannot be replicated in other aspects of treatment. MOUD patients are unique in that they may face an extra layer of stigma based on their treatment preference, while simultaneously have less access to group counseling and group support. Lowering barriers to group counseling and developing evidence-based groups that MOUD patients want can increase attendance and enhance engagement. Creating groups for MOUD patients requires planning and consideration, but if done well can result in positive experiences for patients and providers, while supporting people in their goals for building the lives they want.

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