NICE National Institute for Health and Care Excellence

NICE guideline

Drug misuse in over 16s: psychosocial interventions

Clinical guideline

Published: 25 July 2007
nice.org.uk/guidance/cg51

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The application of the recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline is the basis of QS23.

Overview

This guideline covers using psychosocial interventions to treat adults and young people over 16 who have a problem with or are dependent on opioids, stimulants or cannabis. It aims to reduce illicit drug use and improve people's physical and mental health, relationships and employment.

NICE has also produced guidelines on drug misuse in over 16s: opioid detoxification.

Who is it for?

- Healthcare professionals
- Commissioners and providers
- People who work in specialist residential and community-based treatment settings
- People who work in prisons and criminal justice settings
- Adults and young people over 16 who misuse opioids, stimulants or cannabis and their families and carers

Introduction

This guideline makes recommendations for the use of psychosocial interventions in the treatment of people who misuse opioids, stimulants and cannabis in the healthcare and criminal justice systems. The patterns of use vary for these drugs, with cannabis the most likely to be used in the UK. Cocaine is the next most commonly used drug in the UK, followed by other stimulants such as amphetamine. Opioids, although presenting the most significant health problem, are used less commonly. A large proportion of people who misuse drugs are polydrug users and do not limit their use to one particular drug. This guideline will not deal with recreational drug use, although opportunistic brief interventions for people who misuse drugs but who are not in formal drug treatment are included. The guideline also does not specifically address drug misuse in pregnancy.

Opioid misuse is often characterised as a long-term, chronic condition with periods of remission and relapse. Although abstinence may be one of the long-term goals of treatment, it is not always achieved. The patterns of cannabis and stimulant misuse vary considerably and are less well understood.

Pharmacological approaches are the primary treatment option for opioid misuse, with psychosocial interventions providing an important element of the overall treatment package. Pharmacological treatments for cannabis and stimulant misuse are not well developed, and therefore psychosocial interventions are the mainstay of effective treatment.

In order to ensure that all people to whom this guidance applies obtain full benefit from the recommendations, it is important that effective keyworking systems are in place. Keyworking is an important element of care and helps to deliver high-quality outcomes for people who misuse drugs. Keyworkers have a central role in coordinating a care plan and building a therapeutic alliance with the service user. The benefits of a number of the recommendations in this guideline will only be fully realised in the context of properly coordinated care.

NICE has also developed a clinical guideline on opioid detoxification for drug misuse, public health intervention guidance on substance misuse in children and young people, and technology appraisals of methadone/buprenorphine and naltrexone for the management of opioid dependence (see section 6).

This guideline should be read in conjunction with the Department of Health's Drug misuse and dependence – guidelines on clinical management: update 2007, also known as the 'Orange Book', which provides advice to healthcare professionals on the delivery and implementation of a broad

range of interventions for drug misuse, including those interventions covered in the present guideline. For more information see the National Treatment Agency for Substance Misuse.

Person-centred care

This guideline offers best-practice advice on the care of people who misuse drugs.

Treatment and care should take into account service users' needs and preferences. People who misuse drugs should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If service users do not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act. In Wales, healthcare professionals should follow advice on consent from the Welsh Government.

Good communication between staff and service users is essential. It should be supported by evidence-based written information tailored to the service user's needs. Treatment and care, and the information service users are given about it, should be culturally appropriate. It should also be accessible to people with additional needs, such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need.

Key priorities for implementation

Brief interventions

Opportunistic brief interventions focused on motivation should be offered to people in limited contact with drug services (for example, those attending a needle and syringe exchange or primary care settings) if concerns about drug misuse are identified by the service user or staff member. These interventions should:

- normally consist of two sessions each lasting 10–45 minutes
- explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgemental feedback.

Self-help

Staff should routinely provide people who misuse drugs with information about self-help groups. These groups should normally be based on 12-step principles; for example, Narcotics Anonymous and Cocaine Anonymous.

Contingency management

Introducing contingency management

Drug services should introduce contingency management programmes – as part of the phased implementation programme led by the National Treatment Agency for Substance Misuse (NTA) – to reduce illicit drug use and/or promote engagement with services for people receiving methadone maintenance treatment.

Principles of contingency management

Contingency management aimed at reducing illicit drug use for people receiving methadone maintenance treatment or who primarily misuse stimulants should be based on the following principles:

- The programme should offer incentives (usually vouchers that can be exchanged for goods or services of the service user's choice, or privileges such as take-home methadone doses) contingent on each presentation of a drug-negative test (for example, free from cocaine or non-prescribed opioids).

- The frequency of screening should be set at three tests per week for the first 3 weeks, two tests per week for the next 3 weeks, and one per week thereafter until stability is achieved.
- If vouchers are used, they should have monetary values that start in the region of £2 and increase with each additional, continuous period of abstinence.
- Urinalysis should be the preferred method of testing but oral fluid tests may be considered as an alternative.

Contingency management to improve physical healthcare

For people at risk of physical health problems (including transmittable diseases) resulting from their drug misuse, material incentives (for example, shopping vouchers of up to £10 in value) should be considered to encourage harm reduction. Incentives should be offered on a one-off basis or over a limited duration, contingent on concordance with or completion of each intervention, in particular for:

- hepatitis B/C and HIV testing
- hepatitis B immunisation
- tuberculosis testing.

Implementing contingency management

Drug services should ensure that as part of the introduction of contingency management, staff are trained and competent in appropriate near-patient testing methods and in the delivery of contingency management.

Contingency management should be introduced to drug services in the phased implementation programme led by the NTA, in which staff training and the development of service delivery systems are carefully evaluated. The outcome of this evaluation should be used to inform the full-scale implementation of contingency management.

1 Guidance

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the guidance (see section 5 for details).

1.1 General considerations

1.1.1 Care of people who misuse drugs

1.1.1.1 To enable people who misuse drugs to make informed decisions about their treatment and care, staff should explain options for abstinence-oriented, maintenance-oriented and harm-reduction interventions at the person's initial contact with services and at subsequent formal reviews.

1.1.1.2 Staff should discuss with people who misuse drugs whether to involve their families and carers in their assessment and treatment plans. However, staff should ensure that the service user's right to confidentiality is respected.

1.1.1.3 In order to reduce loss of contact when people who misuse drugs transfer between services, staff should ensure that there are clear and agreed plans to facilitate effective transfer.

1.1.1.4 All interventions for people who misuse drugs should be delivered by staff who are competent in delivering the intervention and who receive appropriate supervision.

1.1.1.5 People who misuse drugs should be given the same care, respect and privacy as any other person.

1.1.2 Supporting families and carers

1.1.2.1 Staff should ask families and carers about, and discuss concerns regarding, the impact of drug misuse on themselves and other family members, including children. Staff should also:

- offer family members and carers an assessment of their personal, social and mental health needs

- provide verbal and written information and advice on the impact of drug misuse on service users, families and carers.

1.1.2.2 Where the needs of families and carers of people who misuse drugs have been identified, staff should:

- offer guided self-help, typically consisting of a single session with the provision of written material
- provide information about, and facilitate contact with, support groups, such as self-help groups specifically focused on addressing families' and carers' needs.

1.1.2.3 Where the families of people who misuse drugs have not benefited, or are not likely to benefit, from guided self-help and/or support groups and continue to have significant problems, staff should consider offering individual family meetings. These should:

- provide information and education about drug misuse
- help to identify sources of stress related to drug misuse
- explore and promote effective coping behaviours
- normally consist of at least five weekly sessions.

1.2 Identification and assessment of drug misuse

1.2.1 Asking questions about drug misuse

1.2.1.1 Staff in mental health and criminal justice settings (in which drug misuse is known to be prevalent) should ask service users routinely about recent legal and illicit drug use. The questions should include whether they have used drugs and, if so:

- of what type and method of administration
- in what quantity
- how frequently.

1.2.1.2 In settings such as primary care, general hospitals and emergency departments, staff should consider asking people about recent drug use if they present with symptoms that suggest the possibility of drug misuse, for example:

- acute chest pain in a young person
- acute psychosis
- mood and sleep disorders.

1.2.2 Assessment

1.2.2.1 When making an assessment and developing and agreeing a care plan, staff should consider the service user's:

- medical, psychological, social and occupational needs
- history of drug use
- experience of previous treatment, if any
- goals in relation to his or her drug use
- treatment preferences.

1.2.2.2 Staff who are responsible for the delivery and monitoring of the agreed care plan should:

- establish and sustain a respectful and supportive relationship with the service user
- help the service user to identify situations or states when he or she is vulnerable to drug misuse and to explore alternative coping strategies
- ensure that all service users have full access to a wide range of services
- ensure that maintaining the service user's engagement with services remains a major focus of the care plan
- maintain effective collaboration with other care providers.

1.2.2.3 Healthcare professionals should use biological testing (for example, of urine or oral fluid samples) as part of a comprehensive assessment of drug use, but they should not rely on it as the sole method of diagnosis and assessment.

1.3 Brief interventions and self-help

1.3.1 Brief interventions

Brief interventions can be used opportunistically in a variety of settings for people not in contact with drug services (for example, in mental health, general health and social care settings, and emergency departments) and for people in limited contact with drug services (such as at needle and syringe exchanges, and community pharmacies).

1.3.1.1 During routine contacts and opportunistically (for example, at needle and syringe exchanges), staff should provide information and advice to all people who misuse drugs about reducing exposure to blood-borne viruses. This should include advice on reducing sexual and injection risk behaviours. Staff should consider offering testing for blood-borne viruses.

1.3.1.2 Group-based psychoeducational interventions that give information about reducing exposure to blood-borne viruses and/or about reducing sexual and injection risk behaviours for people who misuse drugs should not be routinely provided.

1.3.1.3 Opportunistic brief interventions focused on motivation should be offered to people in limited contact with drug services (for example, those attending a needle and syringe exchange or primary care settings) if concerns about drug misuse are identified by the service user or staff member. These interventions should:

- normally consist of two sessions each lasting 10–45 minutes
- explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgemental feedback.

1.3.1.4 Opportunistic brief interventions focused on motivation should be offered to people not in contact with drug services (for example, in primary or secondary care settings, occupational health or tertiary education) if concerns about drug misuse are identified by the person or staff member. These interventions should:

- normally consist of two sessions each lasting 10–45 minutes

- explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgemental feedback.

1.3.2 Self-help

1.3.2.1 Staff should routinely provide people who misuse drugs with information about self-help groups. These groups should normally be based on 12-step principles; for example, Narcotics Anonymous and Cocaine Anonymous.

1.3.2.2 If a person who misuses drugs has expressed an interest in attending a 12-step self-help group, staff should consider facilitating the person's initial contact with the group, for example by making the appointment, arranging transport, accompanying him or her to the first session and dealing with any concerns.

1.4 Formal psychosocial interventions

A range of psychosocial interventions are effective in the treatment of drug misuse; these include contingency management and behavioural couples therapy for drug-specific problems and a range of evidence-based psychological interventions, such as cognitive behavioural therapy, for common comorbid mental health problems.

1.4.1 Contingency management

Contingency management is a set of techniques that focus on changing specified behaviours. In drug misuse, it involves offering incentives for positive behaviours such as abstinence or a reduction in illicit drug use, and participation in health-promoting interventions. For example, an incentive is offered when a service user submits a biological sample that is negative for the specified drug(s). The emphasis on reinforcing positive behaviours is consistent with current knowledge about the underlying neuropsychology of many people who misuse drugs and is more likely to be effective than penalising negative behaviours. There is good evidence that contingency management increases the likelihood of positive behaviours and is cost effective.

For contingency management to be effective, staff need to discuss with the service user what incentives are to be used so that these are perceived as reinforcing by those participating in the programme. Incentives need to be provided consistently and as soon as possible after the positive behaviour (such as submission of a drug-negative sample). Limited increases in the value of the incentive with successive periods of abstinence also appear to be effective.

A variety of incentives have proved effective in contingency management programmes, including vouchers (which can be exchanged for goods or services of the service user's choice), privileges (for example, take-home methadone doses) and modest financial incentives.

For more information on contingency management, see appendix C.

1.4.1.1 Drug services should introduce contingency management programmes – as part of the phased implementation programme led by the NTA – to reduce illicit drug use and/or promote engagement with services for people receiving methadone maintenance treatment.

1.4.1.2 Drug services should introduce contingency management programmes – as part of the phased implementation programme led by the NTA – to reduce illicit drug use, promote abstinence and/or promote engagement with services for people who primarily misuse stimulants.

1.4.1.3 Staff delivering contingency management programmes should ensure that:

- the target is agreed in collaboration with the service user
- the incentives are provided in a timely and consistent manner
- the service user fully understands the relationship between the treatment goal and the incentive schedule
- the incentive is perceived to be reinforcing and supports a healthy/drug-free lifestyle.

1.4.1.4 Contingency management aimed at reducing illicit drug use for people receiving methadone maintenance treatment or who primarily misuse stimulants should be based on the following principles.

- The programme should offer incentives (usually vouchers that can be exchanged for goods or services of the service user's choice, or privileges such as take-home methadone doses) contingent on each presentation of a drug-negative test (for example, free from cocaine or non-prescribed opioids).
- If vouchers are used, they should have monetary values that start in the region of £2 and increase with each additional, continuous period of abstinence.

- The frequency of screening should be set at three tests per week for the first 3 weeks, two tests per week for the next 3 weeks, and one per week thereafter until stability is achieved.
- Urinalysis should be the preferred method of testing but oral fluid tests may be considered as an alternative.

1.4.2 Contingency management to improve physical healthcare

1.4.2.1 For people at risk of physical health problems (including transmittable diseases) resulting from their drug misuse, material incentives (for example, shopping vouchers of up to £10 in value) should be considered to encourage harm reduction. Incentives should be offered on a one-off basis or over a limited duration, contingent on concordance with or completion of each intervention, in particular for:

- hepatitis B/C and HIV testing
- hepatitis B immunisation
- tuberculosis testing.

1.4.3 Implementing contingency management

The implementation of contingency management presents a significant challenge for current drug services, in particular with regard to staff training and service delivery systems. The following recommendations address these two issues (for further details please refer to appendix C).

1.4.3.1 Drug services should ensure that as part of the introduction of contingency management, staff are trained and competent in appropriate near-patient testing methods and in the delivery of contingency management.

1.4.3.2 Contingency management should be introduced to drug services in the phased implementation programme led by the NTA, in which staff training and the development of service delivery systems are carefully evaluated. The outcome of this evaluation should be used to inform the full-scale implementation of contingency management.

1.4.4 Behavioural couples therapy

1.4.4.1 Behavioural couples therapy should be considered for people who are in close contact with a non-drug-misusing partner and who present for treatment of stimulant or opioid misuse (including those who continue to use illicit drugs while receiving opioid maintenance treatment or after completing opioid detoxification). The intervention should:

- focus on the service user's drug misuse
- consist of at least 12 weekly sessions.

1.4.5 Interventions to improve concordance with naltrexone treatment

Naltrexone is an opioid antagonist that eliminates the positive experiences associated with opioid use. It may provide some benefit in sustaining abstinence among people who have completed opioid detoxification. Psychosocial interventions can improve concordance with naltrexone treatment.

1.4.5.1 For people receiving naltrexone maintenance treatment to help prevent relapse to opioid dependence, staff should consider offering:

- contingency management to all service users (based on the principles described in recommendations 1.4.1.3 and 1.4.1.4)
- behavioural couples therapy or behavioural family interventions to service users in close contact with a non-drug-misusing family member, carer or partner (based on the principles described in recommendation 1.4.3.1 for behavioural couples therapy).

1.4.6 Cognitive behavioural therapy and psychodynamic therapy

1.4.6.1 Cognitive behavioural therapy and psychodynamic therapy focused on the treatment of drug misuse should not be offered routinely to people presenting for treatment of cannabis or stimulant misuse or those receiving opioid maintenance treatment.

1.4.6.2 Evidence-based psychological treatments (in particular, cognitive behavioural therapy) should be considered for the treatment of comorbid depression and anxiety disorders in line with existing NICE guidance (see section 6) for people

who misuse cannabis or stimulants, and for those who have achieved abstinence or are stabilised on opioid maintenance treatment.

1.5 Residential, prison and inpatient care

1.5.1 Inpatient and residential settings

1.5.1.1 The same range of psychosocial interventions should be available in inpatient and residential settings as in community settings. These should normally include contingency management, behavioural couples therapy and cognitive behavioural therapy. Services should encourage and facilitate participation in self-help groups.

1.5.1.2 Residential treatment may be considered for people who are seeking abstinence and who have significant comorbid physical, mental health or social (for example, housing) problems. The person should have completed a residential or inpatient detoxification programme and have not benefited from previous community-based psychosocial treatment.

1.5.1.3 People who have relapsed to opioid use during or after treatment in an inpatient or residential setting should be offered an urgent assessment. Offering prompt access to alternative community, residential or inpatient support, including maintenance treatment, should be considered.

1.5.2 Criminal justice system

1.5.2.1 For people who misuse drugs, access to and choice of treatment should be the same whether they participate in treatment voluntarily or are legally required to do so.

1.5.2.2 For people in prison who have drug misuse problems, treatment options should be comparable to those available in the community. Healthcare professionals should take into account additional considerations specific to the prison setting, which include:

- the length of sentence or remand period, and the possibility of unplanned release
- risks of self-harm, death or post-release overdose.

1.5.2.3 People in prison who have significant drug misuse problems may be considered for a therapeutic community developed for the specific purpose of treating drug misuse within the prison environment.

1.5.2.4 For people who have made an informed decision to remain abstinent after release from prison, residential treatment should be considered as part of an overall care plan.

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover..

This guideline covers psychosocial interventions for adults and young people who misuse opioids, cannabis or stimulants (for example, cocaine or amphetamine). The guideline will be of relevance to the NHS, in particular inpatient and specialist residential and community-based treatment settings, and related organisations, including prison services. Although the guideline may comment on the interface with other services, such as those provided by the voluntary sector, it will not provide specific recommendations directed solely at non-NHS services, except in so far as they are provided under contract to the NHS.

The guideline does not specifically cover:

- people with dual diagnoses
- people who misuse alcohol, prescription drugs or solvents
- diagnosis or primary prevention
- people younger than 16 years.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information about how NICE clinical guidelines are developed on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is available.

3 Implementation

The Healthcare Commission assesses the performance of NHS organisations in meeting core and developmental standards set by the Department of Health in 'Standards for better health', issued in July 2004. Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that national agreed guidance should be taken into account when NHS organisations are planning and delivering care.

NICE has developed tools (listed below) to help organisations implement the recommendations in this guideline as well as those in 'Drug misuse: opioid detoxification'. The tools for these guidelines have been integrated with tools for other NICE guidance on drug misuse.

- An information briefing, which explains the implementation support available and contains links to relevant tools/documents.
- Slides highlighting key messages for local discussion.
- Costing tools
    - costing report to estimate the national savings and costs associated with implementation.
    - costing template to estimate the local costs and savings involved.
- Audit criteria to monitor local practice.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and care of service users in the future.

4.1 Implementation of contingency management

Which methods of implementing contingency management (including delivering and stopping incentives) and which settings (including legally mandated, community-based and residential) – compared with one another and with standard care – are associated with the longest periods of continued abstinence and reduced drug misuse, and with maintenance of abstinence/reduction of drug misuse at follow-up?

Why this is important

Although the efficacy of contingency management for drug misuse has been extensively investigated, there is a lack of large-scale and well-conducted implementation studies. The implementation of contingency management programmes in the UK would be aided by research assessing specific components of the programme.

4.2 Testing within contingency management programmes

For people who misuse drugs and who are participating in contingency management, which method of testing – urinalysis, sweat analysis or oral fluid analysis – is most sensitive, specific, cost effective and acceptable to service users?

Why this is important

There is a lack of data comparing the sensitivity and specificity, cost effectiveness and acceptability to service users of these methods of testing. Identifying drug use during treatment is an important aspect of contingency management; identifying which testing methods are the most effective is important for health and social care services intending to implement contingency management programmes.

4.3 Psychosocial interventions within needle and syringe exchange programmes

For people who inject drugs, do needle and syringe exchange programmes with a greater psychosocial content reduce injection and sexual risk behaviours and rates of seroprevalence of blood-borne virus infection more than programmes with minimal psychosocial content? Examples of greater psychosocial content include distribution of syringes and needles by staff and/or provision of psychoeducation on reducing the risk of blood-borne viruses. Examples of minimal psychosocial content include machine dispensing of syringes and needles and provision of minimal or no information on reducing blood-borne virus risk.

Why this is important

There is extensive literature assessing whether needle and syringe exchange programmes reduce injection and sexual risk behaviours and HIV seroprevalence rates. However, there is very little research that seeks to distinguish the impact of the provision of sterile needles from that of the psychosocial interventions often offered within such programmes. Psychosocial contact and interventions require substantial resources; therefore it is important to assess whether these additional elements are clinically and cost effective.

4.4 Residential treatment

Is residential treatment associated with higher rates of abstinence or reduction in drug misuse than community-based care?

Why this is important

There have been some studies comparing residential treatment with community-based treatment. However, these studies are often based on small sample sizes, lack methodological quality and have produced inconsistent results. Residential treatment requires significantly more resources than community-based treatment, so it is important to assess whether residential treatment is more effective.

5 Other versions of this guideline

5.1 Full guideline

The full guideline, Drug misuse: psychosocial interventions, contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health.

5.2 Information for the public

NICE has produced information for the public explaining this guideline.

We encourage NHS and third sector, including voluntary organisations, to use text from this information in their own materials about psychosocial interventions in drug misuse.

6 Related NICE guidance

Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).

Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. NICE public health intervention guidance 4 (2007).

Methadone and buprenorphine for the management of opioid dependence. NICE technology appraisal guidance 114 (2007).

Naltrexone for the management of opioid dependence. NICE technology appraisal guidance 115 (2007).

Obsessive–compulsive disorder: core interventions in the treatment of obsessive–compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005).

Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26 (2005).

Depression (amended): management of depression in primary and secondary care. NICE clinical guideline 23 (amended) (2004, amended 2007). [Replaced by NICE clinical guideline 90]

Anxiety (amended): management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE clinical guideline 22 (amended) (2004, amended 2007). [Replaced by NICE clinical guideline 113]

Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE clinical guideline 16 (2004).

Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE clinical guideline 9 (2004).

7 Updating the guideline

NICE clinical guidelines are updated as needed so that recommendations take into account important new information. We check for new evidence 2 and 4 years after publication, to decide whether all or part of the guideline should be updated. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations.

Appendix A: The Guideline Development Group

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Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The Panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

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Consultant Radiologist, Royal Cornwall Hospital NHS Trust

Mr Mike Baldwin
Project Development Manager, Cardiff Research Consortium

Dr Ash Paul
Deputy Medical Director, Health Commission Wales (Specialist Services)

Mr Barry Stables
Patient representative

Appendix C: Contingency management – key elements in the delivery of a programme

The introduction of contingency management into drug misuse services in the NHS presents a considerable challenge. This is primarily because contingency management has not been widely used in the NHS; hence staff are not trained in the technique and a major training programme will be required to implement it. Another challenge is address the concerns of staff, service users and the wider public about contingency management, in particular concerns that:

- the intervention may 'reward' illicit drug use
- the effects will not be maintained in the long term
- the system is open to abuse as people may 'cheat' their drug tests
- incentive-based systems will not work outside the healthcare system (that of the United States) in which they were developed.

The aim of this appendix, firstly, is to provide a brief introduction to contingency management for those not familiar with this intervention. Secondly, it will address the issues outlined above by setting out a possible strategy for implementation in the NHS, drawing on an evidence base from the United States, Europe and Australia.

Introduction to contingency management

Contingency management refers to a set of techniques that focus on the reinforcement of certain specified behaviours. These may include abstinence from drugs (for example, cocaine), reduction in drug misuse (for example, illicit drug use by people receiving methadone maintenance treatment), and promoting adherence to interventions that can improve physical health outcomes (for example, attending for hepatitis C tests) (Petry, 2006). To date, over 25 trials of contingency management have been conducted, involving over 5000 participants, which constitute the largest single body of evidence for the effectiveness of psychosocial interventions in drug misuse. In the formal studies of contingency management, incentives have included vouchers (exchangeable for goods such as food), cash rewards (of low monetary value), prizes (including cash and goods) and clinic privileges (such as non-supervised consumption). All the incentives have been shown to be effective, although it was the view of the guideline development group that vouchers and clinic privileges would generally be more easily implemented in the NHS.

The following principles underlie the effective delivery of contingency management (Petry 2006).

- Robust, routine testing for drug misuse should be carried out.
- Targets should be agreed in collaboration with the service user.
- Incentives should be provided in a timely and consistent manner.
- The relationship between the treatment goal and the incentive schedule should be understood by the service user
- Incentives should be perceived by the service user to be reinforcing and to support a healthy/ drug-free lifestyle.

Implementing contingency management in the NHS

Although contingency management has not yet been implemented in the NHS (but see McQuaid et al. 2007 for a report of a pilot study), there have been a number of major studies looking at its uptake in the United States, Europe and Australia. Crucially, these studies give an account of its implementation in services where initially there was considerable resistance on the part of both staff and people who misuse drugs. They report positive shifts in staff attitudes as the understanding of contingency management increased and its beneficial impact on the lives of people who misuse drugs became apparent (McGovern et al. 2004; Kellogg et al. 2005; Kirby et al.2006; Ritter and Cameron 2007).

Studies have also looked at the organisational development required to support successful implementation. Kellogg et al. (2005) identified, in addition to the principles outlined above, four key aspects of the uptake of contingency management in the public healthcare system in New York:

- endorsement of the programme by senior managers and clinicians, and their engagement with the concerns of direct care staff
- provision of a comprehensive education and training programme that provided clear direction for staff, many of whom were unfamiliar with the basic principles of contingency management
- recognition by staff that contingency management is an intervention aimed at changing specific key behaviours, and does not simply reward people for general good behaviour
- a shift in the focus of the service to one that is incentive-orientated, where contingency management plays a central role in promoting a positive relationship between staff and service users.[1]

In a series of interviews and discussions with staff and service users, Kellogg et al. (2005) found that contingency management increased the motivation of service users to undergo treatment, facilitated therapeutic progress, increased staff optimism about treatment outcomes and their morale, and promoted the development of more positive relationships both between service users and staff and among staff members. As a result, there was a shift from viewing contingency management as an intervention that would be difficult to integrate with other interventions to it becoming the main focus of interventions with service users. Other studies (for example, Higgins et al. 2000) also provide important advice on how the effects of interventions can be maintained once incentives are discontinued.

In the NHS, several other factors will need to be considered when developing an implementation programme. These may include:

- the integration, where appropriate, of contingency management with the keyworking responsibilities of staff
- the identification of those groups of people who misuse drugs who are most likely to benefit from contingency management (for example, it might be expected that about 30% of people receiving methadone maintenance treatment will be considered for contingency management)
- the development of near-patient testing
- the impact on service-user government benefits.

The implementation process

Where possible, implementation in the NHS should draw on the experience so far (albeit limited) of contingency management in the NHS and on the experience of agencies such as the National Treatment Agency for Substance Misuse (NTA) in the implementation of service developments in drug misuse. The NTA, with its lead role in drug misuse, is best placed to lead an implementation programme, as it has both the national and regional infrastructure and the experience (for example, through its work on the International Treatment Effectiveness Project). Any implementation programme should include the following elements:

- the establishment of a series of demonstration sites
- dissemination of the findings, including those emerging from demonstration sites, to inform the field

- an agreement with local commissioners where change of contracts or service level agreements are required
- a review of service readiness to implement contingency management and the involvement of senior management, clinicians and key workers in any required service developments
- training programmes for staff to enable them to deliver contingency management
- working with service users to raise awareness about contingency management and involve them in local service design
- evaluation of the implementation programme.

The provision of training to deliver contingency management may include a requirement for service managers, supervisors and front-line staff to acknowledge the need for institutional change and staff 'buy in'. Training could be designed to provide a foundation covering the theory, practice and research findings of contingency management, including the factors associated with its successful implementation (Kellogg et al. 2005). A major focus of the training programme will be on identifying and developing staff competencies to deliver contingency management in a manner that emphasises the positive, reinforcing aspects of the intervention.

The structure of any evaluation of contingency management could follow that of the implementation programme and may examine the following issues using quantitative and qualitative methods:

- service design (the feasibility of establishing contingency management in services, structures associated with effective uptake and barriers to uptake)
- the most effective training models associated with sustained uptake
- the experiences of staff and service users.

Conclusion

This appendix sets out the background and process by which contingency management may be implemented in drug misuse services in the NHS. Successful implementation of contingency management will have considerable benefits for people who misuse drugs, their families and wider society.

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[1] The emphasis on incentives is consistent with current knowledge about the underlying neuropsychology of many people who misuse drugs; specifically that people with antisocial personality disorder (ASPD) (who account for a significant proportion of long-term drug users) are much more likely to respond to positive than to punitive approaches. Messina et al. (2003) found that people with ASPD who received contingency management were more likely to abstain from cocaine use than both participants without ASPD receiving contingency management or cognitive behavioural therapy and participants with ASPD receiving cognitive behavioural therapy.

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Mental Health. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

We have produced information for the public explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also available.

Changes after publication

June 2012: minor maintenance

November 2012: minor maintenance

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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