DRUG & ALCOHOL FINDINGS *Analysis*

This entry is our analysis of a document considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original document was not published by Findings; click Title to order a copy. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text The Summary conveys the findings and views expressed in the document. Below is a commentary from Drug and Alcohol Findings.

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▶ Drug misuse in over 16s: psychosocial interventions.

National Institute for Health and Care Excellence and National Collaborating Centre for Mental Health.
[UK] National Institute for Health and Care Excellence, 2007.

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After examining the evidence for psychosocial therapies for problem drug use, the UK's official health advisers recommend behavioural couples therapy and contingency management, argue against cognitive-behavioural therapies, and pose residential rehabilitation as a last resort – in some respects surprising and controversial recommendations.

SUMMARY This clinical guideline covers psychosocial interventions for adults and young people who misuse opioids, cannabis or stimulants (for example, cocaine or amphetamines). 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.

Itwas developed by the National Collaborating Centre for Mental Health, which worked with a group of health-care professionals, patients, carers, and technical staff who reviewed the evidence and drafted recommendations finalised after public consultation.

Health-care professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override their individual responsibilities to make decisions appropriate to the circumstances of an individual patient, in consultation with the patient and/or guardian or carer. Implementation of this guidance is the responsibility of local commissioners and/or providers.

Though published in 2007, the guideline was checked in July 2016; no new evidence was found which affected the recommendations.

Key points
From summary and commentary

NICE clinical guidelines are key quality yardsticks for NHS services and those commissioned by the NHS.

After examining the evidence for psychosocial therapies for problem drug use, NICE recommended behavioural couples therapy and contingency management, argued against cognitive-behavioural therapies, and saw residential rehabilitation as a last resort.

These in some respects surprising and controversial recommendations seem in part based on questionable interpretations of the evidence base.

The general principles advanced by NICE form the basis for a humane treatment system which affords drug misusers the same priority and right to choice and quality care as other patients.

Main findings

General considerations

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 initial contact and subsequent formal reviews. Staff should discuss with them whether to involve their families and carers in their assessment and treatment plans, ensuring that the service user's right to confidentiality is respected.

To reduce loss of contact when people transfer between services, staff should ensure that there are clear and agreed plans to facilitate effective transfer.

All interventions should be delivered by staff who are competent in delivering the intervention and who receive appropriate supervision.

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

Supporting families and carers

Staff should ask families and carers about, and discuss concerns regarding, the impact of drug misuse on themselves and other family members, including children, offer family members and carers an assessment of their personal, social and mental health needs, and provide information and advice on the impact of drug misuse on them and on service users.

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

Where families 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. Over normally at least five weekly sessions, these should provide information and education about drug misuse, help to identify sources of stress related to drug misuse, and explore and promote effective coping behaviours.

Identification and assessment of drug misuse

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

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.

When making an assessment and developing and agreeing a care plan, staff should consider the service user's medical, psychological, social and occupational needs, their history of drug use and experience of previous treatment, goals in relation to drug use, and treatment preferences.

Staff responsible for delivery and monitoring of the care plan should: establish and sustain a respectful and supportive relationship with the service user; help them identify situations or states when they are vulnerable to drug misuse and explore alternative coping strategies; ensure all service users have full access to a wide range of services and that maintaining engagement with services remains a major focus of the care plan; and maintain effective collaboration with other care providers.

Health-care 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.

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) or in limited contact (such as attendees at needle and syringe exchanges and community pharmacies).

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.

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 routinely be provided.

Opportunistic brief interventions focused on motivation should be offered to people in limited contact with drug services (for example, those attending a needle exchange or primary care settings) if concerns about drug misuse are identified by the service user or staff member. Over normally two sessions each lasting 10–45 minutes, these should provide non-judgemental feedback and explore ambivalence about drug use and possible treatment with the aim of increasing motivation to change behaviour. Similar interventions should be offered to people not in contact with drug services if concerns about drug misuse are identified.

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.

If a person who misuses drugs has expressed an interest in attending a 12-step self-help group, staff should consider facilitating 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.

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.

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 or participation in health-promoting interventions. For example, an incentive is offered when a service user submits a biological sample that is negative for specified drug(s). Reinforcing positive behaviours 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. 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.

Drug services should introduce contingency management programmes – as part of the phased implementation programme led by the National Treatment Agency for Substance Misuse [now absorbed into Public Health England] – to reduce illicit drug use and/or promote engagement with services for people receiving methadone maintenance treatment, and for the same purposes in services for people who primarily misuse stimulants.

Staff delivering contingency management programmes should ensure that the targeted behaviour is agreed in collaboration with the service user, incentives are provided in a timely and consistent manner and are perceived to be reinforcing and supportive of a healthy/drug-free lifestyle, and that the service user fully understands the relationship between the treatment goal and the incentive schedule.

For people at risk of physical health problems (including transmittable diseases) resulting from their drug misuse, material incentives 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, and tuberculosis testing.

Implementation of contingency management presents a significant challenge for drug services, in particular with regard to staff training and service delivery systems. Drug services should ensure that staff are trained and competent in appropriate drug 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 National Treatment Agency for Substance Misuse [now absorbed into Public Health England], in which staff training and the development of service delivery systems are carefully evaluated. The outcome of this evaluation should be used to inform full-scale implementation.

Behavioural couples therapy

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 and consist of at least 12 weekly sessions.

Cognitive-behavioural therapy and psychodynamic therapy

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

For people who misuse cannabis or stimulants, and for those who have achieved abstinence or

are stabilised on opioid maintenance treatment, 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.

Residential, prison and inpatient care

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.

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. They should have completed a residential or inpatient detoxification programme and have not benefited from previous community-based psychosocial treatment.

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.

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.

Prison-based treatment options should be comparable to those available in the community. Health-care 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, and risks of self-harm, death or post-release overdose.

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.

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.

FINDINGS COMMENTARY Experts from the British Psychological Society have developed guidance on implementing the main psychosocial therapies recommended in the featured report, emphasising “flexibility and adaptation at the level of the individual service user”. This emphasis is important because researchers often prefer to deliver interventions according to a set schedule and time period to standardise them, limit costs, equalise time spent with therapists in a comparison therapy, and have a set end date from which the follow-up period can begin. These regimens gather an evidence base around them and authorities like NICE may be persuaded that this is also how treatment should be delivered outside a research context – not necessarily the case, and certainly not for each individual patient.

The general principles put forward by NICE form the basis for a humane treatment system which affords drug misusers the same priority and right to choice and quality care as other patients. However, some of the specific recommendations seem surprising, and in part based on questionable interpretations of the evidence base.

Questionable choice of therapies

Among the questionable elements of this impressively evidenced guidance is its embracing of contingency management, despite research at that time and now providing little evidence of lasting impacts. Typically the promising results which persuaded the NICE committee were seen during the time rewards and sanctions were in place, often just 12 weeks; many trials do not go beyond that time to see if benefits persist. These often transient benefits must be set alongside ethical concerns, including the possible aggravation of health inequality if only already advantaged patients qualify for prizes and benefit from any therapeutic effects, professional and public resistance to rewarding what most people do in their own interests and to stay within the law, the common finding that in-treatment gains do not persist, and some evidence that intrinsic motivation may be undermined if patients see themselves as ‘just doing it for the prizes’.

Surprisingly, the guidelines relegated cognitive-behavioural therapies – a mainstay of

addiction treatment in the UK and elsewhere – to the treatment of co-occurring mental health problems, and recommended against these approaches as a routine treatment for drug problems. In contrast, later guidelines drafted by the same centre, but for the treatment of problem drinkers, saw these therapies as candidates both for the treatment of drinking and of mental health problems. The analyses on which the judgement for drug users was based did not show that cognitive-behavioural therapies were *in*effective, just not convincingly *more* effective than other well structured therapies, a conclusion confirmed by an amalgamation of research findings published two years after the guidance. This later review nevertheless concluded that these therapies had demonstrated their utility across a large and diverse sample of studies and for different types of substance use dependencies.

Cumulated findings suggest that the decision between bona fide therapies can be taken on the grounds of what makes most sense to patient and therapist, the therapist's training, availability, and cost. In respect of cost and availability, cognitive-behavioural therapies may (more evidence is needed) prove to have two important advantages. The first is that effects may persist and even amplify without having to continue in therapy. The second is that they lends themselves to being packaged as an interactive computer program and made available in services lacking trained therapists – potentially a crucial advantage for widespread implementation.

Residential rehabilitation a 'last resort'?

Somewhat controversial was the guidance's advice that residential treatment be reserved for substance users with "significant comorbid physical, mental health or social (for example, housing) problems", who should have "not benefited from previous community-based psychosocial treatment". This formula poses residential rehabilitation as a last resort for multiply problematic substance users who must already have tried and been failed by non-residential treatments, potentially perpetuating its very minor role in current treatment systems. Though not contradicted by the evidence, it is questionable whether this line is positively supported by evaluation findings.

NICE's experts reached this conclusion based partly on not even a handful of studies recording no overall advantage for residential care over alternatives. Most influential among the studies reviewed for NICE was a randomised comparison of a non-residential therapeutic community versus a residential version for US crack users. It found no lasting anti-relapse benefits from the residential setting but – as in several other trials – the researchers had to limit the severity of their subjects so that all could safely be allocated either to residential or non-residential care. The result was that nearly three-quarters of potential participants could not join the study, and those who could were the ones least likely to need and differentially benefit from residential care.

Critics of NICE's 'last resort' position argue that the reason why some residential clients are in such poor mental, physical and/or social states is that residential rehabilitation had been denied them earlier in their drug using careers when they had a greater chance of succeeding before deterioration became too deep. The opposing argument is that trying residential services first risks unnecessary expenditure which drains treatment resources because it is impossible to predict with any certainty who will do well and who badly after their spell at the rehabilitation centre.

NICE did briefly allude to a possible role for residential rehabilitation with people not yet at the last-resort position: "While traditional practice in the UK has been for service users to be referred for residential treatment when they have failed a long period of community care, there is some evidence to suggest that those less well established in their drug using careers may benefit from residential care." However, this observation was not examined in any further detail, nor reflected in the recommendations.

Last revised 30 August 2017. First uploaded 22 August 2017

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