National Institute for Health and Clinical Excellence

Quick reference guide

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Drug misuse

Psychosocial interventions and opioid detoxification

NICE clinical guidelines 51 and 52
Developed by the National Collaborating Centre for Mental Health

About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in 'Drug misuse: psychosocial interventions' (NICE clinical guideline 51) and 'Drug misuse: opioid detoxification' (NICE clinical guideline 52).

Who should read this booklet?

This quick reference guide is for healthcare professionals and other staff who care for people who misuse drugs. It contains what you need to know to put the guidelines' recommendations into practice.

Who wrote the guidelines?

The guidelines were developed by the National Collaborating Centre for Mental Health, which is a partnership between the Royal College of Psychiatrists and the British Psychological Society. The Collaborating Centre worked with healthcare professionals (including consultants, GPs and nurses), service users and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

For more information on how NICE clinical guidelines are developed, go to www.nice.org.uk

Where can I get more information about the guidelines?

The NICE website has the recommendations in full, summaries of the evidence they are based on, summaries of the guidelines for people who misuse drugs and their families and carers, and tools to support implementation (see page 18 for more details).

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This guidance is written in the following context
This guidance represents the view of the Institute, 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. The guidance does not, however, 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.

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Person-centred care

Treatment and care should take into account service users' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow service users to reach informed decisions about their care. If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

The NICE guidelines on drug misuse should be read in conjunction with the forthcoming publication 'Drug misuse and dependence – guidelines on clinical management: update 2007' (also known as the 'Orange Book'). See www.nta.nhs.uk for more information.

NICE has also produced technology appraisals of methadone/buprenorphine and naltrexone for the management of opioid dependence, and public health intervention guidance on substance misuse in children and young people (see page 18).

Key priorities for implementation: psychosocial interventions

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.

Key priorities for implementation: opioid detoxification

Providing information, advice and support

- Detoxification should be a readily available treatment option for people who are opioid dependent and have expressed an informed choice to become abstinent.
- In order to obtain informed consent, staff should give detailed information to service users about detoxification and the associated risks, including:
  - the physical and psychological aspects of opioid withdrawal, including the duration and intensity of symptoms, and how these may be managed
  - the use of non-pharmacological approaches to manage or cope with opioid withdrawal symptoms
  - the loss of opioid tolerance following detoxification, and the ensuing increased risk of overdose and death from illicit drug use that may be potentiated by the use of alcohol or benzodiazepines
  - the importance of continued support, as well as psychosocial and appropriate pharmacological interventions, to maintain abstinence, treat comorbid mental health problems and reduce the risk of adverse outcomes (including death).

Continued overleaf

The choice of medication for detoxification

- Methadone or buprenorphine should be offered as the first-line treatment in opioid detoxification. When deciding between these medications, healthcare professionals should take into account:
  - whether the service user is receiving maintenance treatment with methadone or buprenorphine; if so, opioid detoxification should normally be started with the same medication
  - the preference of the service user.

Ultra-rapid detoxification

- Ultra-rapid detoxification under general anaesthesia or heavy sedation (where the airway needs to be supported) must not be offered. This is because of the risk of serious adverse events, including death.

The choice of setting for detoxification

- Staff should routinely offer a community-based programme to all service users considering opioid detoxification. Exceptions to this may include service users who:
  - have not benefited from previous formal community-based detoxification
  - need medical and/or nursing care because of significant comorbid physical or mental health problems
  - require complex polydrug detoxification, for example concurrent detoxification from alcohol or benzodiazepines
  - are experiencing significant social problems that will limit the benefit of community-based detoxification.

Organising and developing care for people who misuse drugs

- At initial contact and at formal reviews, explain options for abstinence-oriented, maintenance-oriented and harm-reduction interventions.
- Discuss with people who misuse drugs whether to involve families and carers in their assessment and treatment plans. Respect the service user's right to confidentiality.
- Ensure that there are clear and agreed plans to facilitate effective transfer of people who misuse drugs between services, to reduce loss of contact.

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

Supporting families and carers

- Discuss with families and carers the impact of drug misuse on themselves and other family members, including children.
  - Offer an assessment of their personal, social and mental health needs.
  - Give advice and written information on the impact of drug misuse.
- Where the needs of families and carers have been identified:
  - offer guided self-help (usually a single session with written material provided)
  - inform them about support groups – for example, self-help groups specifically for families and carers – and facilitate contact.
- If families and carers continue to have significant problems, consider offering individual family meetings (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
  - promote effective coping behaviours.

Identification and assessment

Asking questions about drug misuse

- In mental health and criminal justice settings (in which drug misuse is known to be prevalent), routinely ask service users about recent legal and illicit drug use, including type, method of administration, quantity and frequency.
- In settings such as primary care, general hospitals and emergency departments, consider asking people about recent drug use if they have symptoms that suggest the possibility of drug misuse, such as:
  - acute chest pain in a young person
  - acute psychosis
  - mood and sleep disorders.

Initial assessment

- When making an assessment and developing and agreeing a care plan, 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.
- When delivering and monitoring the care plan:
  - agree the plan with the service user
  - maintain a respectful and supportive relationship with the service user
  - help the service user to:
    - identify when he or she is vulnerable to drug misuse, and
    - explore alternative coping strategies
  - ensure that all service users have full access to a wide range of services
  - remember the importance of maintaining the service user's engagement with services
  - review regularly the care plan of a service user receiving maintenance treatment to ascertain whether detoxification should be considered
  - collaborate with other care providers.
- Use biological testing (for example, of urine or oral fluid) as part of a comprehensive assessment of drug use, but do not rely on it as the sole method of diagnosis and assessment.

Brief interventions and self-help

- At routine contacts and opportunistically (for example, at needle and syringe exchanges), provide information and advice to all people who misuse drugs about reducing exposure to blood-borne viruses.
  - Give advice on reducing sexual and injection risk behaviours.
  - Consider offering testing for blood-borne viruses.
- Do not routinely provide group-based psychoeducational interventions that give information about reducing exposure to blood-borne viruses and/or about reducing sexual and injection risk behaviours.
- If concerns about drug misuse are identified by the service user or a staff member, offer opportunistic brief interventions focused on motivation to people:
  - in limited contact with drug services (for example, those attending a needle and syringe exchange or primary care settings)
  - not in contact with drug services (for example, in primary or secondary care settings, occupational health or tertiary education).

  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.

- Routinely provide information about self-help groups.
  - These groups should normally be based on 12-step principles; for example, Narcotics Anonymous and Cocaine Anonymous.
  - Consider facilitating initial contact, for example by making the appointment, arranging transport and accompanying the person to the first session.

Formal psychosocial interventions

Contingency management

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
- abstinence and/or engagement with services for people who primarily misuse stimulants.

Principles of contingency management

- Ensure that:
  - the target is agreed with the service user
  - incentives are provided in a timely and consistent manner
  - the service user 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.
- Offer incentives contingent on each drug-negative test, usually either:
  - vouchers that can be exchanged for goods or services of the service user's choice, or
  - privileges, such as take-home methadone doses.
- The value of vouchers should start in the region of £2 and increase with each additional, continuous period of abstinence.
- There should be three tests per week for the first 3 weeks, two tests per week for the next 3 weeks, and then one per week until stability is achieved.
  - Use urinalysis, but consider oral fluid tests as an alternative.

Contingency management to improve physical healthcare

- For people at risk of physical health problems resulting from drug misuse, consider offering material incentives (for example, shopping vouchers worth up to £10) for concordance with or completion of specified harm-reduction interventions, in particular for:
  - hepatitis B/C and HIV testing
  - hepatitis B immunisation
  - tuberculosis testing.

Implementing contingency management

Contingency management should be introduced to drug services in a phased implementation programme led by the NTA. The programme should include training for staff to enable them to deliver contingency management effectively and be competent in near-patient testing methods. It may also include:

- 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
- a partnership with service users to raise awareness about contingency management and involve them in any service design.

As part of the implementation programme, staff training and the development of service delivery systems should be carefully evaluated. The outcome of this evaluation should be used to inform the full-scale implementation of contingency management.

For more information see the NICE guidelines (www.nice.org.uk/CG051 and www.nice.org.uk/CG052).

Behavioural couples therapy

- Consider behavioural couples therapy 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.

Cognitive behavioural therapy and psychodynamic therapy

- Consider evidence-based psychological treatments (in particular, cognitive behavioural therapy [CBT]) for comorbid depression and anxiety disorders in line with existing NICE guidance (see pages 18–19) for people who:
  - misuse cannabis or stimulants
  - have achieved abstinence or are stabilised on opioid maintenance treatment.
- Do not routinely offer CBT and psychodynamic therapy focused on the treatment of drug misuse to people who misuse cannabis or stimulants or those receiving opioid maintenance treatment.

Opioid detoxification

Detoxification should be a readily available option for people who are opioid dependent and have expressed an informed choice to become abstinent.

Assessment for detoxification

- Assess people presenting for detoxification to establish the presence and severity of opioid dependence and use of other substances, including alcohol, benzodiazepines and stimulants.
  - Use urinalysis; other near-patient testing methods such as oral fluid or breath testing may also be considered.
  - Clinically assess any signs of opioid withdrawal (consider formal rating scales only as an adjunct).
  - Take a history of drug and alcohol misuse and any treatment.
  - Take a history of physical and mental health problems and any treatment.
  - Consider risks of self-harm, loss of opioid tolerance and the misuse of drugs or alcohol as a response to opioid withdrawal symptoms.
  - Consider the person's social and personal circumstances.
  - Consider the impact of drug misuse on family members and any dependants.
  - Develop strategies to reduce the risk of relapse, taking into account the person's support network.
- If opioid dependence or tolerance is uncertain, use confirmatory laboratory tests in addition to near-patient testing, particularly when:
  - a young person first presents for detoxification
  - a near-patient test result is inconsistent with clinical assessment
  - complex patterns of drug misuse are suspected.

Near-patient and confirmatory testing should be conducted by appropriately trained healthcare professionals in accordance with standard operating and safety procedures.

Providing information and advice

- Provide detailed information about detoxification and the associated risks. Cover:
  - physical and psychological aspects of opioid withdrawal, including the duration and intensity of symptoms and their management
  - the use of non-pharmacological approaches to cope with withdrawal symptoms
  - loss of opioid tolerance following detoxification, and the ensuing increased risk of overdose and death from illicit drug use that may be potentiated by the use of alcohol or benzodiazepines
  - the importance of continued support, as well as psychosocial and pharmacological interventions, to maintain abstinence, treat comorbid mental health problems and reduce the risk of adverse outcomes (including death).

- Advise service users on aspects of lifestyle that need attention during detoxification, including diet, hydration, sleep and exercise.
- Encourage people considering self-detoxification to seek detoxification in a structured treatment programme or, at a minimum, to maintain contact with a drug service.
- Provide information about self-help groups (such as 12-step) and support groups (such as the Alliance) and consider facilitating engagement.
- Provide families and carers with information about detoxification and the settings in which it may take place.

Pharmacological interventions in opioid detoxification

Choice of medication

- Offer either methadone or buprenorphine as first-line treatment.
  - Normally start detoxification with the same medication as used for any maintenance treatment
  - Consider the preference of the service user.

- Lofexidine may be considered for people:
  - who have made an informed and clinically appropriate decision:
    - not to use methadone or buprenorphine for detoxification, or
    - to detoxify within a short time period
  - with mild or uncertain dependence (including young people).
- Do not routinely use clonidine or dihydrocodeine.

Dosage and duration

- When determining starting dose, duration and regimen (for example, linear or stepped), take into account, in discussion with the service user, the:
  - severity of dependence (exercise caution if dependence is uncertain)
  - stability of the service user (including polydrug and alcohol use, and comorbid mental health problems)
  - pharmacology of the detoxification medication and adjunctive medications
  - setting of detoxification.
- Detoxification should normally last:
  - up to 4 weeks in an inpatient/residential setting
  - up to 12 weeks in the community.

Accelerated detoxification

- Do not use ultra-rapid detoxification under general anaesthesia or heavy sedation (where the airway needs to be supported) because of the risk of serious adverse events, including death.

- Do not routinely offer ultra-rapid or rapid detoxification using precipitated withdrawal.
- Rapid detoxification should only be considered for people who specifically request it, clearly understand the associated risks and are able to manage the adjunctive medication. In these circumstances, ensure during detoxification that:
  - the service user is able to respond to verbal stimulation and maintain a patent airway
  - adequate medical and nursing support is available to monitor the service user's level of sedation and vital signs
  - staff have competence to support airways.
- Do not routinely offer accelerated detoxification using opioid antagonists at lower doses to shorten detoxification.

See the NICE guideline for further information (www.nice.org.uk/CG052).

Adjunctive medications

- Only use adjunctive medications when clinically indicated, such as when agitation, nausea, insomnia, pain and/or diarrhoea are present.
- Use the minimum effective dosage and number of drugs needed to manage symptoms.
- Be alert to the risks of adjunctive medications, as well as the interactions between them and with the opioid agonist.

Monitoring

- Be aware that medications used in opioid detoxification are open to misuse and diversion. Consider:
  - monitoring concordance
  - methods of limiting the risk of diversion, including supervised consumption.

Special considerations

- Do not routinely offer detoxification to people:
  - with a medical condition needing urgent treatment
  - in police custody, or serving a short prison sentence or a short period of remand; consider treating opioid withdrawal symptoms with opioid agonist medication
  - who present in acute or emergency settings; address the immediate problem, treat withdrawal symptoms and refer to drug services if appropriate.
- For women who are opioid dependent during pregnancy, detoxification should only be undertaken with caution.
- Treat comorbid physical or mental health problems alongside opioid dependence. Follow available NICE guidance (see pages 18–19).

People who also misuse alcohol or benzodiazepines

- If a person presenting for opioid detoxification also misuses alcohol, consider the following.
  - Even if the person is not alcohol dependent, attempt to address their alcohol misuse.
  - If the person is alcohol dependent:
    - offer alcohol detoxification before starting opioid detoxification in a community or prison setting
    - consider offering alcohol detoxification concurrently with opioid detoxification in an inpatient setting, or with stabilisation in a community setting.
- If a person presenting for opioid detoxification is also benzodiazepine dependent, consider benzodiazepine detoxification.
  - Take into account the person's preference and the severity of dependence for both substances when deciding whether benzodiazepine detoxification should be carried out concurrently with, or separately from, opioid detoxification.

Psychosocial interventions during and after detoxification

Contingency management

- Consider contingency management aimed at reducing illicit drug use both during and for up to 3–6 months after opioid detoxification (see box on page 10).

Interventions for people taking naltrexone

- For people receiving naltrexone maintenance treatment to help prevent relapse to opioid dependence, consider:
  - contingency management (see box on page 10)
  - behavioural couples therapy or behavioural family interventions for people in close contact with a non-drug-misusing family member, carer or partner (based on the principles described on page 11 for behavioural couples therapy).

Continued treatment and support after detoxification

- After successful opioid detoxification, and irrespective of the setting in which it was delivered, offer all service users continued treatment, support and monitoring to help maintain abstinence. This should normally last for at least 6 months.

Settings of care

Community, inpatient and residential settings

The same range of psychosocial interventions should be available in inpatient and residential settings as in the community.

- Consider residential treatment for people who are seeking abstinence and who have significant comorbid physical, mental health or social problems. The person should have completed a residential or inpatient detoxification programme and have not benefited from previous community-based psychosocial treatment.
- Urgently assess people who have relapsed to opioid use during or after inpatient or residential treatment. Consider prompt access to alternative community, residential or inpatient support, including maintenance treatment.

Settings for opioid detoxification

- Routinely offer a community-based detoxification programme. Exceptions may include people who:
  - have not benefited from previous formal community-based detoxification
  - need medical and/or nursing care because of comorbid physical or mental health problems
  - require complex polydrug detoxification
  - have significant social problems that will limit the benefit of community-based detoxification.
- Residential detoxification should normally only be considered for people who:
  - have significant comorbid physical or mental health problems, or
  - require concurrent detoxification from opioids and benzodiazepines or sequential detoxification from opioids and alcohol, or
  - have less severe opioid dependence, for example those who are early in their drug-using career, or
  - would benefit significantly from residential rehabilitation during and after detoxification.
- Inpatient detoxification should normally only be considered for people who need a high level of medical and/or nursing support for:
  - significant and severe comorbid physical or mental health problems, or
  - concurrent detoxification from alcohol or other drugs.

Delivering detoxification

Community detoxification should normally include:

- prior stabilisation of opioid use through pharmacological treatment
- effective coordination of care by specialist or competent primary practitioners
- psychosocial interventions, where appropriate, during stabilisation and maintenance.

Inpatient and residential detoxification should be conducted with 24-hour medical and nursing support commensurate with the service user's drug misuse and comorbid physical and mental health problems. Pharmacological and psychosocial interventions should be available to support treatment.

Criminal justice system

Access to and choice of treatment for drug misuse should be the same whether people participate voluntarily or are legally required to do so.

Prisons

Treatment options, including detoxification, should be comparable to those in the community.

- When choosing treatment, take into account:
  - length of sentence or remand period, and possibility of unplanned release
  - risks of self-harm, death or post-release overdose
  - for people receiving opiate detoxification, practical difficulties in assessing dependence and the associated risk of opioid toxicity early in treatment.
- Consider offering people with significant drug misuse problems access to a therapeutic community developed specifically for treating drug misuse in prison.
- Consider residential treatment as part of an overall care plan for people who have made an informed decision to remain abstinent after release.

Implementation

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website (www.nice.org.uk/CG051 and www.nice.org.uk/CG052). 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.
- 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.

Further information

Ordering information

You can download the following documents from www.nice.org.uk/CG051 and www.nice.org.uk/CG052

- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- NICE guidelines 51 and 52 – all the recommendations.
- 'Understanding NICE guidance' – information for people who misuse drugs and their families and carers.
- The full guidelines – all the recommendations, details of how they were developed, and summaries of the evidence they were based on.

For printed copies of the quick reference guide or 'Understanding NICE guidance', phone the NHS Response Line on 0870 1555 455 and quote:

- N1289 (quick reference guide)
- N1290 ('Understanding NICE guidance').

Related NICE guidance

For information about NICE guidance that has been issued or is in development, see the website (www.nice.org.uk).

- Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. NICE public health intervention guidance 4 (2007). Available from www.nice.org.uk/PHI004
- Methadone and buprenorphine for the management of opioid dependence. NICE technology appraisal guidance 114 (2007). Available from www.nice.org.uk/TA114
- Naltrexone for the management of opioid dependence. NICE technology appraisal guidance 115 (2007). Available from www.nice.org.uk/TA115
- Obsessive–compulsive disorder: core interventions in the treatment of obsessive–compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005). Available from www.nice.org.uk/CG031

- Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26 (2005). Available from www.nice.org.uk/CG026
- Depression (amended): management of depression in primary and secondary care. NICE clinical guideline 23 (amended) (2004, amended 2007). Available from www.nice.org.uk/CG023
- 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). Available from www.nice.org.uk/CG022
- 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). Available from www.nice.org.uk/CG016
- Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE clinical guideline 9 (2004). Available from www.nice.org.uk/CG009

Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be posted on the NICE website (www.nice.org.uk/CG051 and www.nice.org.uk/CG052).

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