

# Drug misuse in over 16s: psychosocial interventions

Clinical guideline

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## 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 and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services 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 complying 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.

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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 a [guideline 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 1 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 [guideline on opioid detoxification for drug misuse](#), a [guideline on drug misuse prevention: targeted interventions](#), [technology appraisal guidance on methadone and buprenorphine for the management of opioid dependence](#) and [naltrexone for the management of opioid dependence](#).

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 [Office for Health Improvement and Disparities alcohol and drug misuse prevention and treatment guidance](#).

# 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 2 sessions each lasting 10 to 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 3 tests per week for the first 3 weeks, 2 tests per week for the next 3 weeks, and 1 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 or 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.



# Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in [NICE's information on making decisions about your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

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.

NICE has also 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.

## 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 (see [NICE's guideline on supporting adult carers](#))
- 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 5 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 2 sessions each lasting 10 to 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 2 sessions each lasting 10 to 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 National

Treatment Agency for Substance Misuse (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 and 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 3 tests per week for the first 3 weeks, 2 tests per week for the next 3 weeks, and 1 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 or 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 2 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 [NICE's guidelines on depression in adults](#) and [generalised anxiety disorders and panic disorder in adults: management](#)) 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.

# Recommendations for research

The Guideline Development Group has made these recommendations for research.

## 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 and 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.

## 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.

### **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 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.

# 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 5,000 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 and 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, 4 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.

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.

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.

## References

Higgins ST, Badger GJ, Budney, AJ (2000) Initial abstinence and success in achieving longer term cocaine abstinence. *Experimental and Clinical Psychopharmacology* 8: 377–86

Kellogg SH, Burns M, Coleman P, et al. (2005) Something of value: the introduction of contingency management interventions into the New York City Health and Hospital Addiction Treatment Service. *Journal of Substance Abuse Treatment* 28: 57–65

Kirby KC, Benishek LA, Dugosh KL, et al. (2006) Substance abuse treatment providers' beliefs and objections regarding contingency management: implications for dissemination.

Drug and Alcohol Dependence 85: 19–27

McGovern MP, Fox TS, Xie H, et al. (2004) A survey of clinical practices and readiness to adopt evidence-based practices: dissemination research in an addiction treatment system. *Journal of Substance Abuse Treatment* 26: 305–12

McQuaid F, Bowden-Jones O, Weaver T (2007) Contingency management for substance misuse. *British Journal of Psychiatry* 190: 272

Messina N, Farabee D, Rawson R (2003) Treatment responsiveness of cocaine-dependent patients with antisocial personality disorder to cognitive-behavioral and contingency management interventions. *Journal of Consulting and Clinical Psychology* 71: 320–9

Petry N (2006) Contingency management treatments. *British Journal of Psychiatry* 189: 97–8

Ritter A, Cameron J (2007) Australian clinician attitudes towards contingency management: comparing down under with America. *Drug and Alcohol Dependence* 87: 312–5

## Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE

For full details of the evidence and the guideline committee's discussions, see the [full guideline](#). You can also find information about [how the guideline was developed](#), including details of the committee.

NICE has produced [tools and resources](#) to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see [resources to help you put guidance into practice](#).

## Update information

### Minor changes since publication

**March 2020:** Cross reference to NICE's guideline on supporting adult carers was added to recommendation 1.1.2.1.

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## Accreditation

