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NICE GUIDELINES

Psychosocial interventions and opioid detoxification for drug misuse: summary of NICE guidance

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Why read this summary?

Drug misuse is an increasing problem that not only impairs the physical and mental health of people who misuse drugs but also negatively affects their families and wider society (for example, in its association with crime). Recently expanded drug services in the United Kingdom involve general practitioners to a considerable degree, who care for at least a third of opioid misusers in treatment. Many clinicians remain pessimistic, however, about the possible benefits of any treatment and how to engage drug users in treatment.¹ This article summarises two new National Institute for Health and Clinical Excellence (NICE) guidelines that identify the most effective, safe detoxification regimens for primary and secondary care, the most cost effective psychosocial interventions, and effective ways to promote patient engagement.^{2 3}

Recommendations

NICE recommendations are based on systematic reviews of best available evidence. When minimal evidence is available, a range of consensus techniques is used to develop recommendations. In this summary, recommendations derived primarily from consensus techniques are indicated with an asterisk (*).

Opioid detoxification*General principles*

For all patients who are opioid dependent and have expressed an informed choice to become abstinent, services should:

- Offer detoxification as a readily available and effective treatment option;
- Provide detailed information about detoxification and the associated risks, including:
 - The physical and psychological aspects of opioid withdrawal, including the duration and intensity of symptoms
 - How such symptoms may be managed, including non-pharmacological approaches
 - The loss of opioid tolerance after detoxification, and the ensuing increased risk of overdose and death from illicit drug use (this risk may be potentiated by alcohol or benzodiazepine use)
 - The importance of continued support, and

psychosocial and appropriate pharmacological interventions, to maintain abstinence, treat comorbid mental health problems, and reduce the risks of serious adverse events (including death) that may arise as a result of reduced opioid tolerance;

- *Offer a community based detoxification programme routinely, except to individuals who:
 - Have not benefited from previous community based detoxification
 - Need medical and/or nursing care because of significant additional physical or mental health problems
 - Require complex polydrug detoxification (for example, concurrent detoxification from alcohol or benzodiazepines)
 - Are experiencing considerable social problems that may substantially limit the benefit of a community based detoxification programme.

Pharmacological interventions

- Offer buprenorphine or methadone as first line treatment, depending on:
 - Whether the patient is receiving maintenance treatment with either drug, as detoxification should normally be started with the same medication
 - The service user's preference;
- Consider lofexidine, particularly for those with mild or uncertain dependence, but warn patients that this necessitates the use of adjunct medications to manage withdrawal symptoms such as nausea, vomiting and shivering as lofexidine may not sufficiently attenuate the noradrenergic storm, and that outcomes are likely to be no better than for buprenorphine or methadone;
- Do not use clonidine routinely because its outcomes are likely to be no better than for buprenorphine or methadone and because of the associated risk of hypotension;
- Do not use opioid antagonists (such as naltrexone) to precipitate or accelerate withdrawal as it seems to increase severity of withdrawal, necessitates the use of increased adjunctive medication, and no consistent

This is one of a series of BMJ summaries of new NICE guidelines, which are based on the best available evidence; they will highlight important recommendations for clinical practice, especially where uncertainty or controversy exists

Further information about the guidance**Methods**

The guidelines were developed according to NICE guideline methodology (see www.nice.org.uk/page.aspx?o=114219) by the National Collaborating Centre for Mental Health. The collaborating centre convened a development group of clinicians and patient and carer representatives for each guideline to oversee the work and develop the recommendations. The groups conducted extensive systematic reviews of the clinical and economic literature and assessed the quality of this literature. The guidelines went through an external consultation with stakeholders. The development groups assessed the comments, reanalysed the data where necessary, and modified the guidelines. NICE has produced four different versions of each guideline: a full version; a quick reference guide (which combines both guidelines); a version known as the "NICE guideline" that summarises the recommendations; and a version for patients and the public. All these versions are available from the NICE website (see www.nice.org.uk/CG051 and www.nice.org.uk/CG052). Future updates of the guidelines will be produced as part of the NICE guideline development programme.

evidence exists for improved long term outcomes;

- Do not routinely use drugs such as benzodiazepines, minor analgesics, or antidiarrhoeals to manage opioid withdrawal symptoms. This is to reduce the risks associated with specific drugs, drug interactions, and problems with adherence. Only use these medications when clinically indicated;
- Do not offer ultrarapid detoxification under general anaesthesia or heavy sedation (where the airway needs to be supported) owing to the risk of serious adverse events, including death.

Psychosocial interventions in drug misuse

Formal psychosocial interventions have not been widely used in UK drugs services, but the evidence reviewed by NICE shows that increased use of these interventions can bring real benefits.

Individual healthcare staff

- Offer opportunistic brief interventions focused on motivation to people in limited contact with services (for example, those attending a needle and syringe exchange or primary care settings). These interventions should:
 - Comprise one or two sessions of 10-45 minutes' duration
 - Express empathy with the service user; explore ambivalence about drug use and possible treatment options; and provide non-judgmental feedback aimed at increasing motivation to change behaviour;
- Routinely provide information about self help groups, often based on 12-step principles (for example, Narcotics Anonymous and Cocaine Anonymous).

Drug misuse services

- Consider introducing contingency management

as part of a phased implementation programme led by the National Treatment Agency to reduce illicit drug use and/or promote engagement with services for people in methadone maintenance programmes or who misuse stimulants.

- Contingency management should include:
 - Incentives such as vouchers or privileges, contingent on each presentation of a drug negative test result (for example, free from cocaine or non-prescribed opioids); such vouchers may be exchanged for goods or services, and privileges to increase the service user's choice (for example, use of take-home methadone doses); vouchers should have monetary values that start at about £2 (€3; \$4) and increase with each additional, continuous period of abstinence;
 - Drug tests (three tests a week for the first three weeks, two tests a week for the next three weeks, and once weekly thereafter until stability is achieved); urine analysis is the preferred method of testing, but oral fluid tests may be used as an alternative.
- For those at risk of physical comorbidity from drug misuse, consider material incentives (such as shopping vouchers of up to £10 in value) on a one-off basis or over a limited duration, contingent on concordance with specified harm reduction activities, particularly for:
 - Hepatitis B or C and HIV testing
 - Hepatitis B immunisation
 - Tuberculosis testing.

Overcoming barriers

In recent years drug treatment has focused on harm reduction rather than abstinence as a goal, but the evidence on detoxification makes clear that abstinence is an effective treatment option. Furthermore, although psychosocial interventions for drug misuse are not well developed, the evidence suggests that they can bring real benefits, in part through increasing the value of currently used treatments.

Contingency management has been little used in the UK, is open to misunderstanding by clinicians and the general public, and will require considerable training of staff and service development if it is to be introduced appropriately and effectively. It involves a new way of thinking, with the use of positive incentives instead of negative approaches such as the withholding of treatment. The evidence is that, particularly with this patient population, behaviour can be positively shaped with incentives, whereas threats and punishment have little influence. Overseas trials involving more than 5000 patients across more than 25 studies have consistently shown that such an approach reduces illicit drug use, is cost effective, and improves engagement in harm reduction and treatment programmes.

To tackle these challenges, it is proposed that the National Treatment Agency in the UK will establish a network of demonstration centres, which will develop

materials to support a phased implementation of contingency management, support staff training and supervision programmes, and assess the relative value of different incentive systems.

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Competing interests: Both JS and CG have received funding from pharmaceutical companies and government agencies for advisory services, and both are members of the UK Department of Health Clinical Guidelines on Drug Misuse and Dependence Group.

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- 1 Strang J, Sheridan J, Hunt C, Kerr B, Gerada C, Pringle M. The prescribing of methadone and other opioids to addicts: national survey of GPs in England and Wales. *Br J Gen Pract* 2005;55:444-51.
- 2 National Institute for Health and Clinical Excellence. *Drug misuse: psychosocial interventions*. London: NICE, 2007. (www.nice.org.uk/CG051)
- 3 National Institute for Health and Clinical Excellence. *Drug misuse: opioid detoxification*. London: NICE, 2007. (www.nice.org.uk/CG052)

INTERACTIVE CASE REPORT

A patient with suspected miscarriage is found to have hypertension, renal failure, and thrombocytopenia: case outcome

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Four weeks ago we described the case of a 46 year old woman who presented with possible miscarriage, severe hypertension, acute renal failure, pulmonary oedema, microangiopathic haemolytic anaemia, and seizures (*BMJ* 2007;334:1372. 30 June). The diagnoses we considered are malignant hypertension, intrinsic renal disease, a primary microangiopathic process—such as haemolytic uraemic syndrome or thrombotic thrombocytopenic purpura, or eclampsia with HELLP syndrome. She was started on intermittent haemodialysis, an angiotensin converting enzyme inhibitor, and plasma exchange (*BMJ* 2007;335:44. 7 July). A magnetic resonance imaging scan of the brain showed posterior leucoencephalopathy consistent with hypertensive encephalopathy.

Her platelet count, metabolic abnormalities, and breathlessness improved and she had no further seizures. At one week she was well but remained dependant on dialysis. Bisoprolol and amlodipine were added to control her blood pressure.

Renal Doppler ultrasound showed poor renal perfusion so we performed angiography to exclude renovascular disease. This showed normal renal vessels (fig 1), suggesting a microangiopathic infrarenal process.

Renal biopsy demonstrated florid myxoid intimal thickening in interlobular arteries (fig 2), widespread acute tubular damage, and glomerular ischaemic changes. There was little thrombotic change to suggest haemolytic uraemic syndrome or thrombotic thrombocytopenic purpura. These appearances are consistent with a diagnosis of malignant hypertension or scleroderma renal crisis.

The table summarises the other investigations and blood tests. These were negative except for a strongly positive speckled antinuclear antibody at a titre of more than 1/1000. The staining pattern was consistent with

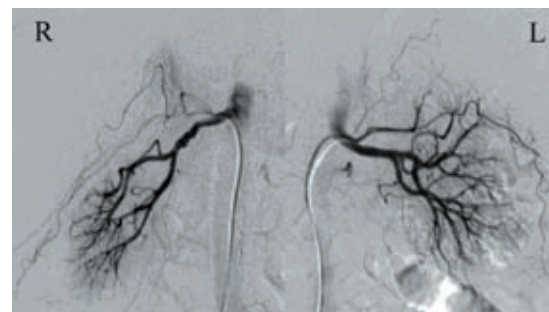


Fig 1 The patient's bilateral renal angiography showing normal renal vessels

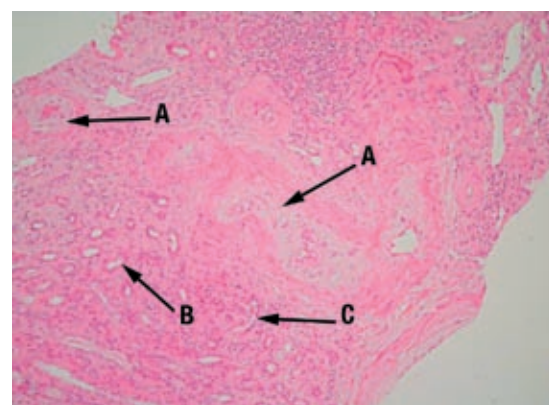


Fig 2 The patient's renal biopsy showing florid myxoid intimal thickening in interlobular arteries (A), widespread acute tubular damage (B), and glomerular ischaemic changes (C)

anti-RNA polymerase antibodies and this was confirmed with immunoprecipitation.

Anti-RNA polymerase antibodies are strongly associated with scleroderma renal crisis, and we consider

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This is the final part of a three part case report, which describes the outcome and summarises the comments made by readers during the presentation of a real patient's story. Further responses are welcome through bmj.com