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A framework and toolkit  
for implementing NICE-  
recommended treatment  
interventions

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# **ROUTES TO RECOVERY: PSYCHOSOCIAL INTERVENTIONS FOR DRUG MISUSE**

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# PSYCHOSOCIAL INTERVENTIONS FOR DRUG MISUSE

A framework and toolkit for implementing NICE-recommended treatment interventions

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The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

The NTA works in partnership with national, regional and local agencies to:

- Ensure the efficient use of public funding to support effective, appropriate and accessible local services
- Promote evidence-based and coordinated practice, by distilling and disseminating best practice
- Improve performance by developing standards for treatment, promoting user and carer involvement, and expanding and developing the drug treatment workforce
- Monitor and develop the effectiveness of treatment.

The NTA has led the successful delivery of Department of Health's targets to:

- Double the number of people in treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year

The NTA is in the frontline of a cross-government drive to reduce the harm caused by drugs. Its task is to improve the quality of treatment in order to maximise the benefit to individuals, families and communities. Going forward, the NTA will be judged against its ability to deliver better treatment and outcomes for a diverse range of drug misusers.

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# 1 Executive summary

Psychosocial Interventions for Drug Misuse was commissioned by the National Treatment Agency for Substance Misuse (NTA) from the British Psychological Society (BPS) to provide support for drug treatment providers and commissioners wishing to develop or to introduce a range of evidence-based psychosocial interventions for those with drug misuse problems.

The document is designed to support drug treatment services in the effective delivery of evidence-based psychosocial interventions both for drug misuse and for common co-morbid mental health problems. It focuses on evidence-based treatment interventions recommended by the National Institute for Health and Clinical Excellence (NICE) and provides a range of tools to support effective implementation.

The document is primarily relevant to practitioners, service managers and commissioners, but may also be of interest to service users and carers as a guide to a number of NICE-recommended treatment options.

The framework used in the document for describing the specific psychosocial interventions adopts a systematic, competence-based approach. The majority of the interventions described are likely to be delivered as adjuncts to standard care (including keyworking and pharmacological interventions) and it is important that staff delivering them are competent in these core interventions. Hence, this can usefully be read in conjunction with established guidance on keyworking and keyworker competences.

In addition to the information and tools presented in the appendices of this document, a range of other resources for the delivery of psychosocial interventions is accessible at the NTA's Psychosocial Interventions Resource Library (PIRL) at [www.nta.nhs.uk/PIRL](http://www.nta.nhs.uk/PIRL). The key evidence-based psychosocial interventions (categorised as either low- or high-intensity) that are discussed in detail in the document are:

- **For the management of drug misuse:**
  - Motivational interventions (low-intensity)
  - Contingency management (low-intensity)
  - Behavioural couples therapy (high-intensity).

- **For the management of common mental health problems:**

- Cognitive behavioural therapy by guided self help (low-intensity)
- Behavioural activation (low-intensity)
- Cognitive behavioural therapy for depression and anxiety (high-intensity).

The interventions are categorised within a framework of either low- or high-intensity, that allows ease of application of the 'stepped approach' to care that the document describes. The likely role of keyworkers in low- and high-intensity psychosocial interventions is discussed, so that these evidence-based and NICE-recommended approaches can be easily integrated into normal systems of care planned and coordinated care, and within existing clinical governance and quality assurance frameworks.

The document describes for each psychosocial intervention the key competences for that intervention, presenting these within a common framework for describing such competences that is discussed in some detail. It also provides a specimen training curriculum for each intervention, a specimen protocol for implementation, specimen audit criteria, and adherence measures that can be used either for direct supervision and monitoring, or within wider clinical governance activity. Most of these tools are available in the appendices.

The following sections elaborate on the purpose and structure of the document, on the categorisation of interventions by intensity, on the underlying framework for describing psychosocial and related competences, and finally on their implementation. The appendices provide the detailed summary of the specific competences and the related useful specimen tools. This structured approach allows for the incorporation of future interventions into a similar framework where this may be useful.

## 2 Introduction

### 2.1 Aim and scope

Psychosocial Interventions for Drug Misuse is designed to support drug treatment services in the effective delivery and evaluation of NICE-recommended, evidence-based psychosocial interventions, which can significantly improve outcomes for those misusing drugs over and above standard care (NICE, 2007a; NICE, 2007b).

In addition to direct psychosocial interventions for drug misuse, the framework addresses common co-morbid mental health problems (that is, depression and anxiety disorders) that have a high prevalence in those with drug misuse problems (Kessler, 2004). Research commissioned by the Department of Health and summarised by the NTA (Weaver, 2004) showed that co-morbid mental health problems had a negative impact on social functioning, and that many services users' needs for treatment in this area were unmet.

### 2.2 Who the framework is for

The framework is a guide to, and a source of reference information on, evidence-based psychosocial interventions for drug misusers. It has relevance to a wide range of staff working in drug treatment, including practitioners, service managers and commissioners. For practitioners whose primary responsibilities are to adult service users being treated for drug misuse (with or without co-morbid mental health problems), the document can support the development of their practice in psychosocial interventions. For service managers and practitioners, the document provides a framework and toolkit that can be utilised within any local system of clinical governance for assuring the delivery of high quality psychosocial interventions, including specimen protocols for the development of training, supervision and evaluation of practice. This will also be of interest to commissioners in considering potential service development opportunities.

While service users and carers are not the intended primary audience, they too may find the document useful in providing additional detail on treatment options recommended by NICE (see also Roth & Pilling (2007a) for a service user's guide to CBT for common mental health problems).

### 2.3 Approach and key cross references

This document describes a competence-based framework to support those implementing NICE-recommended psychosocial interventions for drug misusers. It is not intended to replace current relevant documents on both keyworking (NTA 2006a; 2006b; Department of Health 2007b) and on the competences of keyworkers set out in Drug and Alcohol National Occupational Standards (DANOS) (Skills for Health, 2007). The majority of the interventions described in this document are delivered as adjuncts to standard care: both keyworking and pharmacological interventions. It is important that all involved in the delivery of these interventions have a sound understanding of the standard care and treatment for drug misuse.

The document should also be read in conjunction with the high quality evidence base on which it draws, namely National Institute for Health and Clinical Excellence (NICE) guidelines on drug misuse and on common mental disorders (NICE 2004a; 2004b; 2005a; 2005b; 2007a; 2007b) and the 2007 Clinical Guidelines (DH & devolved administrations, 2007).

### 2.4 Content

The document comprises:

- **Section 3** A classification of the interventions described, into low- and high-intensity, and into drug-specific or for common mental health problems
- **Section 4** A description of the competence-based framework used for the specific interventions
- **Section 5** Advice on the practical measures needed to deliver the interventions:

5.2 Training

5.3 Supervision

5.4 Protocols

5.5 Quality assurance.

Appendices provide detail as follows:

| Psychosocial intervention      | Competences and delivery |                    |                                   | Examples of adherences measures |
|--------------------------------|--------------------------|--------------------|-----------------------------------|---------------------------------|
|                                | Competences              | Specimen curricula | Specimen implementation protocols |                                 |
| Motivational interviewing      | Appendix B               | Appendix H         | Appendix L                        | Appendix Q                      |
| Contingency management         | Appendix C               | Appendix I         | Appendix M                        | Appendix R                      |
| Behavioural couples therapy    | Appendix D               | *                  | *                                 | *                               |
| CBT-based guided self-help     | Appendix E               | Appendix J         | Appendix N                        | *                               |
| Behavioural activation         | Appendix F               | Appendix J         | Appendix N                        | *                               |
| CBT for depression and anxiety | Appendix G               | *                  | *                                 | *                               |

\* Where specimen curricula, protocols or adherences measures are not provided in this framework, it may be that they already exist or are integral to a specific therapeutic training programme or practice. Improving Access to Psychological Therapies (IAPT) curricula for high-intensity and low-intensity therapies, and other resources, are accessible from the Psychosocial Interventions Resource Library (PIRL) at [www.nta.nhs.uk/PIRL](http://www.nta.nhs.uk/PIRL)

## 3 Classifying psychosocial interventions

This document describes in some detail NICE-recommended psychosocial interventions for the treatment and management of both drug misuse and common mental disorders and categorises them as either low-intensity or high-intensity, consistent with their likely place in any 'stepped care' framework of provision. For example, in the promotion of motivational interviewing or low-intensity interventions for common mental health problems, there is an expectation that the least intrusive, most effective intervention should be provided first (NICE, 2007c; NICE, 2007d). High-intensity interventions will be required for those who have failed to benefit from low-intensity interventions or who are judged to require immediate treatment with a high-intensity intervention, usually reflecting the severity of their disorder or past failure to benefit from treatment. Such an approach can not only benefit the service user but also lead to the more cost-effective use of healthcare resources. It is not the specific purpose of this document to provide guidance on the construction and development of stepped care approaches to treatment. However, implicit in its construction is an acknowledgement that such approaches are increasingly adopted for the delivery of psychological interventions in the NHS ([www.iapt.nhs.uk](http://www.iapt.nhs.uk)).

For the purposes of use in a stepped-care approach, the following definitions are used:

- **Low-intensity interventions** will generally be delivered by keyworkers. Drug-specific interventions are defined as motivational and treatment engagement tools to reduce substance misuse. For common mental health problems, they are defined as those interventions that retain an element of self-help where the staff member acts as a facilitator of the use of a particular psychosocial intervention, be this guided self-help, structured assignments or computerised cognitive behavioural therapy.
- **High-intensity interventions** are defined as formal psychological therapies delivered by a specialist psychological therapist.

With reference to Models of Care: Update 2006 (NTA, 2006b), the majority of the low-intensity and all of the high-intensity interventions could be subsumed under the "structured psychosocial interventions" (NTA, 2006b), being provided as tier 3 or 4 interventions. This refers to interventions

targeting drug misuse that are evidence-based, care-planned and delivered by competent practitioners with adequate training and supervision. However, some of the low-intensity interventions may fit better within other structured interventions, or in some case, even as more opportunistic tier 2 harm reduction interventions.

**Low-intensity drug-specific interventions** are particularly suited to engaging service users in treatment and supporting early changes in drug using behaviour as well as achieving harm reduction goals. Low-intensity mental health interventions normally require service users to have engaged with services and to have achieved some stability in their drug misuse.

**High-intensity interventions**, both for drug problems and for common mental health problems, are suited to service users with a sufficient degree of stability and in those who may be working towards being drug-free.

In most cases, it is important to deliver high- and low-intensity interventions in the context of an agreed care plan, co-ordinated by a keyworker. Indeed keyworkers will, in many cases, already be delivering the majority of the low-intensity interventions provided – as their work already utilises components from motivational interviewing along with components drawn from other interventions such as relapse prevention. The categorisation here into a framework that is based on intensity is intended to support further the integration of these evidence-based interventions into routine care planned treatment. The categorisation by intensity may also be particularly helpful in facilitating the development of effective treatments of common mental health problems in drug services (through the use of guided self-help and other low-intensity CBT interventions), as there may be currently only limited experience in many. In practice, these different interventions may be executed in parallel as part of a comprehensive treatment plan agreed with the service user. Some of the interventions, such as motivational interviewing, and the competences required to deliver them, will be familiar and commonly practiced in drug services. Others, such as behavioural activation, may be less familiar and will require specific training. All would need to be supported by competently delivered supervision in order to optimise assurance that the interventions are effectively provided.



In addition to psychosocial interventions focused on the service user and interventions such as behavioural couples therapy that work with service users and their partners, NICE guidelines identify the need to respond to family members affected by drug misuse in their own right. Family members in these circumstances often suffer significant levels of physical and psychological stress-related symptoms. Interventions specifically for family members, and including guided self-help intervention, provide the opportunity to explore their situation, provide specific targeted information and explore a family member's interactions with the service user (for example, see Copello et al., 2000 and Copello et al., 2009). Additional guidance has been produced by the National Treatment Agency for commissioners and service providers in relation to responses to families (NTA, 2008a).

### 3.1 Low-intensity interventions

The key low-intensity, evidence-based psychosocial interventions for drug misusers, identified by NICE and integrated within this framework, are as follows:

#### 3.1.1 Drug-specific low-intensity interventions

These interventions: motivational interviewing and contingency management, focus primarily on the presenting drug problem with the aim of reducing drug misuse or reducing drug-related harm.

**Motivational interviewing (MI)** is a directive, service user-centred counselling style for eliciting behaviour change by helping service users to explore and resolve ambivalence. Compared with non-directive counselling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counsellor is intentionally directive in pursuing this goal (Miller & Rollnick, 1995).

MI for people who misuse cannabis or stimulants, and who are not in formal drug treatment, appears to produce benefits both in terms of increased abstinence and reduced drug use. There is some evidence to suggest that people who misuse opiates and who are not in formal drug treatment may also benefit from MI. In contrast, for people already receiving formal drug treatment, an additional brief intervention did not appear to have much effect on abstinence or drug use in most studies. A fuller account of the evidence base underlying MI can be found in the relevant NICE guidelines (NICE, 2007a; NICE, 2007b) and the full NICE guidelines (Gerada et al., 2007; Strang et al., 2007).

**Contingency management (CM)** provides a system of incentives or reinforcers to encourage and support abstinence from drugs (Griffith et al., 2000) or to support engagement in treatment or health promoting activities such as hepatitis B vaccination. Incentives are provided in exchange for evidence of the desired behaviour, such as biological samples (usually urine) that are negative for tested drugs. Commonly used incentives have been:

- Vouchers representing monetary values that can be exchanged for goods
- Clinic privileges (increased flexibility in dispensing regimes)
- Prize-draw entries.

(NICE, 2007a)

CM appears to be considerably more successful than standard care or outreach in increasing concordance with a range of harm reduction interventions such as vaccinations for hepatitis B and is also more likely to promote abstinence in stimulant misusers than standard care. It also reduces illicit drug use in those on methadone maintenance programmes. A fuller account of the evidence base underlying CM can be found in the relevant NICE guideline documents (NICE, 2007a; NICE, 2007b; Gerada et al., 2007; Strang et al., 2007).

It is expected that keyworkers or equivalent staff in drug misuse services may often provide both CM and MI (either sequentially or in parallel).

#### 3.1.2 Low-intensity interventions for common mental health problems

Common mental health problems such as depression and anxiety have a high prevalence in the drug misuser population (estimates range between 30 and 60%) but often go unrecognised and therefore untreated (Kessler, 2004; Weaver et al., 2002; Scott et al., 1998). A range of evidence-based psychological interventions are available for depression and anxiety disorders (NICE, 2007c; NICE, 2007d), while pharmacological treatments for common mental disorders can present some challenges for routine use in a drug misusing population (Scott et al., 1998). Together, this supports their increased use in drug misuse services (NICE, 2007a). There is considerable evidence that low-intensity interventions can reduce the level of both depression and anxiety. The interventions are more likely to be effective for mild to moderate depression and are not

recommended in NICE guidelines for moderate to severe depression. For depression, the evidence supports the use of guided or facilitated self-help (including the use of computer delivered cognitive behavioural therapy). In anxiety, the evidence that facilitation is required is less strong but guided self-help is the model described in this document for both anxiety and depression. A fuller account of the evidence base underlying these interventions can be found in the relevant full NICE guidelines (Goldberg et al., 2004<sup>1</sup>; McIntosh et al., 2004).

**Guided self-help** is a self-administered intervention designed to treat anxiety and depression, which makes use of a range of books or a self-help manual that is based on an evidence-based intervention (in the case of this framework, cognitive behavioural therapy) and designed specifically for the purpose. A healthcare professional (or para-professional) facilitates the use of this material by introducing, monitoring and reviewing the outcome of such interventions (NICE, 2007c).

**Behavioural activation (BA)** is one of a group of effective cognitive and behavioural therapies for depression developed originally by Lewinsohn (1975), and further refined by Jacobson and colleagues (Martell et al., 2001) and Hopko et al. (2002). BA describes depression in terms of a low rate of positive rewarded and rewardable behaviour. The therapy therefore focuses on encouraging the service user to develop more rewarding and task-focused behaviours (NICE, 2007c). Recent results in substance misuse populations are encouraging (Daughters et al., 2008).

Within the IAPT programme and related research studies both in the UK and the United States, these low-intensity interventions have been delivered by both mental health professionals and staff such as case managers or graduate workers with no formal mental health training (Richards and Suckling, 2007; Richards et al., 2007; Pilling et al., 2007). In the case of low-intensity interventions the staff member acts more as a facilitator or coach than a therapist and the interventions are usually delivered to tightly defined protocols with high levels of repeated outcome measurement. These studies strongly support the view that these interventions can be delivered by keyworkers providing routine

care in drug misuse services (indeed in some services this may already be the case). Typically the intervention would be relatively brief, with an initial assessment followed by three to six further contacts (of 20 to 30 minutes duration) of which a significant proportion (perhaps 50%) may be delivered by telephone.

Successful implementation of evidence-based interventions for common mental health disorders will not only require trained and competent staff who are adequately supervised but also requires that systems are in place for the identification of common mental disorders. Such systems are already expected to be included in the standard comprehensive assessment of any drug misuse service, and part of the general healthcare assessment (NTA, 2006a; NTA, 2006c; Department of Health, 2007b).

## 3.2 High-intensity interventions

High-intensity interventions, in contrast to low-intensity interventions, are of longer duration (up to 20 sessions, often around 60 minutes in length) and are delivered by qualified mental health professionals with specific expertise in the delivery of the intervention.

### 3.2.1 Drug-specific high-intensity intervention

One drug-specific high-intensity intervention, behavioural couples therapy (BCT) (Fals-Stewart et al., 2002) was identified in the NICE guideline (NICE, 2007a) as having a good evidence base.

**Behavioural couples therapy (BCT)** is a behavioural couples-based intervention that focuses on promoting abstinence or reducing illicit drug misuse in the drug-using member of the couple. It involves:

- The person who misuses drugs stating his or her intention not to use drugs each day and his or her partner expressing support for the former's efforts to stay abstinent
- Teaching more effective communication skills, such as active listening and expressing feelings directly
- Helping to increase positive behavioural exchanges between partners by encouraging them to acknowledge pleasing behaviours and engage in shared personal and recreational activities.

<sup>1</sup> This guidance was partially updated and replaced by **Depression: The Treatment and Management of Depression in Adults (update)** in October 2009. See the NICE website, [www.nice.org.uk](http://www.nice.org.uk), for details.

BCT is effective for individuals who have contact with a family member or carer and who are in receipt of methadone maintenance treatment, as it has been shown to lead to reduction in the use of illicit opiates or cocaine. See the full NICE guideline (Strang et al., 2007) for details of the evidence supporting the use of BCT.

### 3.2.2 High-intensity interventions for common mental health problems

As was noted above, common mental health problems such as depression and anxiety have a high prevalence in the drug misuse population and are also associated, particularly in their moderate to severe forms, with greater persistence of both the mental health and drug problem (Kessler, 2004; Weaver et al., 2002). This means that high-intensity interventions are likely to be required for those who have failed to benefit from low-intensity interventions or who are judged to require immediate treatment with a high-intensity intervention (this will usually reflect the severity of the disorder or past failure to benefit from treatment). The evidence base for these high-intensity interventions is summarised in current NICE guidelines for common mental disorders and is too extensive to summarise in any detail in this framework.

The treatment modality with the largest evidence base is cognitive and behavioural therapy (CBT). It is the only high-intensity intervention for which there is good evidence of efficacy across all the common mental disorders. Because of the strength and broad coverage of the evidence for CBT, it is also the intervention focused on in this document. Details of the evidence base for CBT are available for depression (NICE, 2007c; Goldberg et al., 2004), for panic disorder and generalised anxiety disorder (NICE, 2007d; McIntosh et al., 2004), obsessive compulsive disorder (NICE, 2005a; Freeston et al., 2006), post-traumatic stress disorder (NICE, 2005b; Bisson et al., 2005) and antenatal and postnatal mental health (NICE, 2007e; Tomson et al., 2007).

## 4 A framework for the delivery of psychosocial interventions in drug misuse

### 4.1 Why a competences framework?

An advantage of adopting the high and low intensity classification described in the previous section is that this work is compatible with the Department of Health's programme in Improving Access to Psychological Therapies (IAPT) (Department of Health, 2007; Turpin et al., in press). Although the IAPT programme is initially focused on adults with common mental health problems, it has relevance for the provision of psychological interventions across the whole range of mental health and substance misuse services, and across all age groups. This framework builds on the work done in the IAPT programme to support the development and implementation of psychosocial interventions for drug misuse.

The various sets of competences in this framework form the basis on which treatment protocols, training curricula and supervisory programmes are then built. They also inform any potential developments in service design and re-configuration, and support relevant quality assurance and audit systems. The competences framework therefore acts as a central point of reference for all activities recommended in this document. It provides a practical implementation resource which at its simplest level may be used by individuals to highlight specific competency sets as part of their reflective practice.

It is helpful to make a distinction between this competences framework and clinical guidelines, for example the 2007 Clinical Guidelines (DH & devolved administrations, 2007) and the recent NICE guidelines on drug misuse (NICE, 2007a; 2007b). The purpose of clinical guidelines is to recommend appropriate treatment and care for specific diseases and conditions. They make specific recommendations as to which populations may benefit from specific interventions in order to obtain particular outcomes. In addition, they also provide information on the intensity, frequency and duration of interventions, and in this regard they share much in common with treatment manuals.

While this competences framework draws on the same evidence base used to develop the guidelines mentioned above, recommendations

about the specific uses are explicitly excluded, as they are clearly the role of clinical guidelines. The role for this competences framework is to support the effective implementation of relevant guidelines. The integration of this framework with clinical guidance, other national service guidance, and the outcome frameworks should be determined through appropriate clinical governance and managerial structures.

Although the competences framework draws heavily upon treatment manuals, it enables a more comprehensive approach to implementation than a manual alone can provide. The advantages of adopting a competences framework are that:

- There is compelling evidence that variation in therapist competence and performance is a significant, and probably the single largest, contributor to variance in outcomes in psychosocial interventions. Recent research suggests that there may be differences of over 100% in outcomes between therapists that cannot be accounted for by service user variables (such as severity or comorbidity), setting or intervention variables (Brown et al., 2005; Okiishi et al., 2006). For example, in the Okiishi et al study, involving over 7,500 patients and 149 therapists, recovery rates for patients in treatment with the best performing therapists (the top 25%) were 100% better (22.40% vs. 10.61%) and, more worryingly, the rates of deterioration were 100% worse (5.20% vs. 10.56%) for those treated by therapists in the bottom 25%
- A large number of competences not fully elucidated in treatment manuals are generic and the essential building blocks of any psychosocial intervention. Consequently, it is often necessary that the framework goes beyond what is made explicit in manuals, to include these essential competences which may otherwise have been omitted. This is consistent with the emphasis placed on common factors in achieving positive outcomes in psychological therapies literature. Therefore in order to avoid a possible diminution in effectiveness, it is important not to stress the technical aspects/competences of particular interventions at the expense of the generic competences such as the importance of relationship building and the management of the therapeutic process

- There is considerable variation in the way treatment manuals are written and their general availability as not all treatment manuals are published
- It allows a degree of flexibility and adaptation at the level of the individual service user. Such flexibility may not be present in a particular manual, the development of which may instead be rooted in a specific service in a particular health care setting
- It provides a framework in which a range of materials necessary to the development and improvement of psychosocial interventions can be placed: in this sense it goes beyond treatment manuals in identifying the competences, and draws on other sources for evidence-based practice (e.g. clinical trials, fidelity measures, implementation studies)
- It provides a form that promotes the effective use of psychological interventions across a range of settings. The association with training and quality assurance provides a better means of linking the evidence base with a wider range of activities than simply the provision of a manual for direct clinical interventions
- It is similar to the approach taken by Skills for Health in the development of DANOS (Skills for Health, 2007) for substance misuse services and is compatible with the NHS Knowledge and Skills Framework (KSF).

These competence frameworks can therefore provide and/or contribute to the development of:

- **Curricula for training** examples of this can be seen in the curricula/learning outcomes set out for specific interventions located in the appendices of this document
- **Procedures for identifying competent practice** examples are set out for these in the fidelity measures in the appendices
- **A framework for supervision**, as can be seen from the section on supervision competences, draws on both the evidence base for effective supervision, which is often of a generic or pan-modality/theoretical nature, and also on the competences for specific modalities (for example, see the competences for low and high-intensity CBT interventions ([www.ucl.ac.uk/CORE](http://www.ucl.ac.uk/CORE))).

To use this framework successfully will require that services have the capabilities and capacity

to fully implement and effectively deliver psychosocial interventions specified in the competences frameworks. This requires more than the simple dissemination of the framework. Specifically, in order to gain the full benefits of this framework, services need knowledgeable and skilled individuals who are competent to deliver:

- The training (or at least monitor its delivery by external agencies)
- The supervision
- The evaluation and quality assurance of the interventions.

If services do not have such individuals in place, it will severely limit the capacity of the framework to effect real benefits for service users and staff alike. For this reason, section 5.5: The development of a quality assurance framework, highlighting quality assurance explicitly, sets out the requirement to have senior staff in place who are able to support the effective dissemination of the framework.

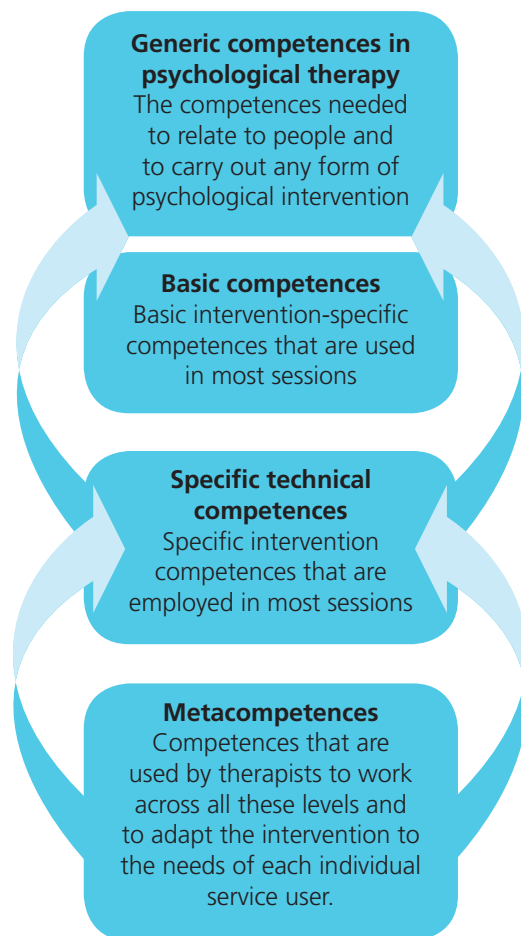
## 4.2 Developing a competences framework

This framework and toolkit will be reviewed against the new suite of National Occupational Standards (NOS) for Psychological Therapies (see [www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk) for more information). The new NOS are expected to be published by the end of 2009.

In the development of the specific psychosocial competences for this framework, the methods and structure developed for cognitive behavioural treatments for common mental health treatments as part of the IAPT programme (Roth & Pilling, 2007a) were used. This method, developed specifically for psychological interventions, uses a different method (and one that is more suited to psychological interventions) to those generally adopted for other Skills for Health projects. It draws directly from the treatment manuals used in exemplar trials of evidence-based interventions.

In reviewing the competences for CBT for common mental health problems, Roth and Pilling (2007a) developed a model for organising the competences for psychological therapies which was designed to facilitate the understanding and use of the competences. The structure adopted can be seen in Figure 1 and a further explanation of the terms used is set out overleaf.

**Figure 1: Outline model for intervention competences (adapted from Roth and Pilling, 2007a)**



#### 4.2.1 Generic competences

These are employed in any psychological or psychosocial intervention, to reflect the fact that all these interventions share some common features. Often referred to as 'common factors' in psychological therapy, it is important that the competences in this domain are not overlooked or treated as an afterthought but are recognised as the basis on which any psychological or psychosocial intervention is built (e.g. establishing a positive relationship with the service user, establishing good relationships with relevant professionals or gathering background information).

#### 4.2.2 Basic competences

These competences establish the structure for the effective delivery of both high and low-intensity interventions, and form the context and structure for the delivery of a range of specific techniques (e.g. establishing the motivational interviewing (MI) approach, knowledge of contingency management

(CM) principles or knowledge of family approaches to drug misuse and mental health problems).

#### 4.2.3 Specific techniques

These are the core technical interventions employed in the application of any specific intervention (e.g. specific MI techniques, drug testing for a CM programme or information-giving specific to behavioural activation). They form the set of commonly applied techniques which are found to a lesser or greater extent in any particular therapeutic modality, for example they are common to most forms of cognitive behavioural therapy. They may vary according to the nature of the presenting problem, for example, the use of re-living experiences in the treatment of post-traumatic stress disorder (PTSD).

Distinguishing 'basic competences' from 'specific techniques': There is a fine line between these domains. The distinction between the two is as much pragmatic as conceptual, and is intended to improve the legibility and utility of the model. Essentially, 'basic competences' are employed in both high and low intensity interventions, while many of those which come under the domain of specific techniques are more usually associated with high-intensity interventions.

#### 4.2.4 Metacompetences

A common observation is that carrying out a skilled task requires the person to be aware of why and when to do something (and, just as important, when not to do it). This is a critical skill that needs to be recognised in any competence model. Reducing psychosocial interventions to a series of rote operations would make little sense because competent practitioners need to be able to implement higher-order links between theory and practice in order to plan and, where necessary, to adapt an intervention to the needs of individual service users. These are referred to as 'metacompetences' in this framework: they are the procedures used to guide practice and they operate across all levels of the model. These competences are more abstract than those in other domains because they usually reflect the intentions of the person delivering the intervention. These can be difficult to observe directly but can be inferred from their actions, and may form an important part of discussions in supervision. Although there is a sense in which these are higher-order competences, it is important that they are not seen as the preserve of high-intensity interventions. For example, metacompetences which focus on the ability to implement models in a manner that is flexible and tailored to the needs of the individual service



user would be employed in both high and low-intensity interventions.

#### 4.2.5 Identifying the competences

The development of the competences framework for psychosocial interventions for drug misuse follows the method that was developed for the IAPT programme for the development of competences for cognitive behavioural therapies for common mental disorders (Roth & Pilling 2007b, 2008)<sup>2</sup>. The method, which had four elements, is briefly described below:

- 1 The identification of evidence-based psychosocial interventions for drug misuse – existing NICE guidelines for drug misuse (NICE 2007a; 2007b) and common mental health problems (NICE 2005a; 2005b; 2007c,d,e) were used as the source
- 2 The identification of exemplar trials and their associated manuals for evidence-based interventions – this was done by consulting trial reports and where necessary intervention developers or other experts
- 3 The extraction of the list of competences from the manuals (using the framework developed for the IAPT programme).

The research team completed the first three of these tasks. Manuals were identified from trial reports and where this was not possible trial investigators were approached directly. The initial lists of competences were extracted by a researcher familiar with the evidence base for substance misuse interventions. This initial list was reviewed by a senior clinician, who again was familiar with the evidence base for substance misuse and had developed the original method. Where disagreements arose about the content of the initial lists, attempts were made to resolve them by discussion.

- 4 The validation of the competences (for both the overall model and the individual competences) by an expert reference group (listed in Appendix A) and an international peer review process using the developers of the interventions as the primary reviewers (also in Appendix A).

The expert reference group also commented on the design and structure of the low- and high-intensity

framework and the competences framework and advised on the content of the competence lists in light of the feedback from the peer review process and their application to a UK setting.

#### 4.2.6 The competences for specific interventions

The competences for the drug-specific evidence-based interventions are set out in the relevant appendices as follows:

- **Appendix B** Motivational interviewing
- **Appendix C** Contingency management
- **Appendix D** Behavioural couples therapy.

The competences required to provide evidence-based low-intensity interventions for common mental disorders as developed by Roth & Pilling (2007b) are set out in:

- **Appendix E** Guided self-help
- **Appendix F** Behavioural activation.

The full list of the competences for high-intensity interventions (see Roth and Pilling, 2007b for an account of their development) is very substantial and is therefore not included in this document. However an overall map of the competences for common mental disorders is included in Appendix G. The full list of the competences for high-intensity interventions for common mental disorders is available from the CORE website ([www.ucl.ac.uk/core](http://www.ucl.ac.uk/core)).

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<sup>2</sup> Note that part of the original remit for the development of the CBT competences was to develop a method that was robust enough to apply to other psychological interventions. Competences frameworks for psychodynamic, systemic and person-centred experiential psychological interventions are in development along with additional CBT competences. Some of the competences developed as part of this programme of work may have application to drug misuse and alcohol disorders. The current framework has therefore been developed so that it can integrate with this other work.

# 5 The delivery of competence-based psychosocial interventions in drug misuse

## 5.1 Introduction

Where a decision has been made by a service provider to develop or to enhance competence-based psychological interventions, a number of components are likely to be necessary for effective delivery. This document is intended to provide a useful contribution in describing those key elements. Effective delivery will not be achieved simply by the publication of the competences or simply by the implementation of appropriate training programmes. It has been shown that adequate supervision is also needed to consolidate training and maximise the benefit of the investment in time and resources (Gauntlett, 2005; Tober et al., 2005). Moreover, in addition to further work on practice development and supervision, quality assurance and audit frameworks need to be in place along with clear protocols for the delivery of the interventions and the right service structures/systems to support their implementation. Such overarching clinical governance and quality assurance issues would need to be addressed through the relevant mainstream governance processes, which are not described in detail in this document. However, specific tools that can be used – for example, for auditing or supervising adherence to the protocol of a particular psychosocial intervention – are described.

The more specific elements are summarised below and detailed in the following sections:

- **5.2** Appropriate training curricula for staff delivering low-intensity interventions and advice on their implementation
- **5.3** A supervisory framework for staff delivering high and low-intensity interventions and advice on its implementation
- **5.4** Protocols for the delivery of low-intensity interventions and advice on their implementation<sup>3</sup>
- **5.5** Specimen audit criteria and adherence measures are introduced.

Staff in drug misuse services in keyworking or similar roles could be involved in the provision

of low-intensity psychosocial interventions both for drug-specific interventions and for common mental disorders. For some staff, this will already form a key element of their role and duties (for example, motivational interviewing). However, for many, delivery of interventions would need to be integrated into their current role and for this to occur effectively a review of their existing duties and responsibilities may be required. The precise duties of staff will be for local services to determine. Some services may expect all staff to deliver low-intensity interventions, and in other services a phased approach to the delivery of these interventions may be developed. In still others, only certain groups may deliver some or all of the low-intensity interventions. Nevertheless, whichever model of service delivery for low-intensity interventions is chosen, it is likely that if the overall quality of care is to be improved there will be significant training implications (c.f. Mills et al., 2003). This potentially represents a significant investment in training and such interventions would probably need to be phased in a way that reflects both the emerging priorities of local commissioners and providers of services and also the timing of any anticipated key evidence such as, for example, the report on the demonstration sites for contingency management.

This document therefore provides suggested training curricula for each of the low-intensity interventions which can inform suitable training plans for staff. Subsequent supervision will be crucial to any effective delivery. Training for high-intensity interventions is beyond the scope of this framework. For information on training in high-intensity interventions readers should consult the relevant Department of Health ([www.iapt.nhs.uk](http://www.iapt.nhs.uk)) and British Association of Behavioural and Cognitive Psychotherapies ([www.babcp.com](http://www.babcp.com)) websites.

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<sup>3</sup> Note that in contrast to high-intensity interventions low-intensity interventions are more protocol driven.



## 5.2 The content of training for low-intensity interventions for drug misuse

This section and its appendices include a number of exemplar training programmes and learning outcomes. It should be noted that the specific detail of these may, and will, vary from service to service and therefore they provide a set of learning objectives to guide training. Effective training therefore requires individuals with appropriate expertise in the delivery of training in psychosocial interventions to be employed to deliver tailored training programmes within their services. In this respect, training is no different from psychological therapies. Training that is delivered by individuals without proper expertise will lead to poor outcomes in just the same way as inadequately delivered treatment will do.

As can be seen from the relevant appendices on low-intensity interventions (Roth and Pilling, 2007a), the competences for low-intensity interventions both for drug misuse and for common mental health problem follow a common framework. They share a set of generic competences in psychological interventions which have considerable overlap with those required of keyworkers in drug misuse to deliver and coordinate effective care. Training in these competences will therefore reinforce keyworking skills but for some staff may be unnecessary. The training curricula set out in this document are based on the assumption that they will primarily be delivered to keyworkers, the majority of whom will already be competent in basic counselling skills. However, it is recognised that this will not always be the case. In this situation, it is recommended that consideration be given to the use and adaptation of the more substantial training programme developed by Professor David Richards and colleagues at the University of York for the IAPT programme for low-intensity interventions (Department of Health, 2008a; Richards and Whyte, 2008). This comprehensive and well-designed programme is developed for individuals with no or limited mental health experience. It covers not only direct training in the interventions but also values, diversity, the health and social care system and employment-related activities.

Typically, low-intensity interventions are provided within clearly specified protocols where there is a clear specification of the range of required staff behaviours to determine the need for and the nature of the delivery of interventions. For example, assessments are problem focused and a key aim is to understand whether or not the individual service user's needs are likely to be met

by the care provided. This has implications for the content of training programmes, the supervision for low-intensity interventions and the model within which care is delivered. The aim therefore is not to achieve a diagnosis but to determine if there is a problem that would benefit from a low-intensity intervention and of equal importance to be clear when a low-intensity intervention would not be of benefit. This has implications for the content of training programmes, the supervision for low-intensity interventions and the model within which care is delivered. The framework and the training therefore need to be compatible with a stepped care model (which had its origins in the treatment of substance misuse problems) where the principle of providing the least intrusive, most effective intervention first guides delivery of treatment. For some disorders this may mean no provision of low-intensity interventions, for example there is no good evidence that low-intensity interventions are effective for the treatment of post-traumatic stress disorder (PTSD) (NICE, 2005b). A summary guide to the effectiveness of low-intensity interventions for specific common mental health problems can be found in the IAPT Commissioning Toolkit (Department of Health, 2008b).

Outline curricula for the three low-intensity interventions covered in this document are set out in:

- **Appendix H** Curriculum for motivational interviewing
- **Appendix I** Curriculum for contingency management
- **Appendix J** Curriculum for common mental health problems.

As can be seen, this provides a broad curriculum for training which is intended to inform local providers and educational institutions of the likely structure and content of these interventions, rather than to specify in detail the content. There is however a close relationship between the content of this training and the competences required, and it is expected that educational institutions will provide courses which develop the specified competences in staff.

These curricula were developed on the basis of existing materials. In the case of motivational interviewing there are well-developed training programmes both in the UK and internationally. For example, the MIA:STEP (Martino et al., 2006) is an extensive manual to support training

and supervision systems which was developed explicitly to address concerns about inadequate implementation of MI. It contains useful material not only on training but on supervision and adherence measures (see Psychosocial Interventions Resource Library (PIRL) at [www.nta.nhs.uk/PIRL](http://www.nta.nhs.uk/PIRL)). In addition, members of the expert reference group (in particular Dr Paul Davis, who has extensive experience in training in MI and made available his training materials) contributed to the design and development of the curricula.

In contrast, in the UK at least, at the time of publication there have been no well-established, widely available training programmes for either contingency management or low-intensity interventions for common mental disorders<sup>4</sup>. The curriculum set out for contingency management draws on programmes developed in the United States by Professor Nancy Petry and Professor Stephen Higgins, which were initially developed to support clinical trials.

The curriculum set out for low-intensity common mental health problems draws on programmes developed in the UK by Professor David Richards from the University of York and Judy Leibowitz from Camden PCT. These training programmes, in association with clinical trials, have demonstrated the efficacy of these interventions. Richards' and Leibowitz's work also informed the IAPT competences framework for low-intensity interventions (see Psychosocial Interventions Resource Library (PIRL) at [www.nta.nhs.uk/PIRL](http://www.nta.nhs.uk/PIRL)).

The precise duration of training and its content will vary according to the knowledge and experience of existing staff. Training in low-intensity interventions in most services will be a high-volume activity, closely linked to continuing supervision. It is therefore desirable that all services have the capacity to provide training themselves, or be closely linked to organisations, such as local higher education units, which can directly provide the training with a significant collaborative team or work-based element (see Graham, 2004 for a discussion of the advantages of such models). All organisations are likely to benefit from having at least one individual who is competent to deliver such training so that training needs can be assessed and training delivered relevant to the specific service context.

No curricula for high-intensity psychological interventions are included. Only one drug-specific

intervention was included in the competences framework, behavioural couples therapy (BCT), for which extensive training programmes have been developed (see [www.addictionandfamily.org](http://www.addictionandfamily.org)) and which need to be delivered by experts in the field. Given the relatively low demand for this intervention and its provision by specialist psychologist therapists it is likely that training for this intervention should be organised by services on an individual basis. For high-intensity interventions for common mental disorders a number of mental health professionals (predominantly clinical psychologists) will have the necessary training and competence to deliver these interventions. Providing these interventions and BCT routinely and successfully in drug misuse services will then rest largely on the availability of specialist psychological therapists and existing systems (principally effective supervision) to ensure therapist competence and the effectiveness of the interventions they provide.

### 5.3 The development of a supervision framework

Although training is an important part of implementing interventions, the value of regular and continued supervision to ensure the success of an intervention should not be underestimated (Miller et al., 1995; Tober et al., 2005; Stitzer and Kellogg, 2008). Therefore, services delivering psychosocial interventions for drug misuse need to ensure that staff are in post who are competent to deliver effective supervision. Supervision is the predominant method by which the quality of psychological interventions are assured, although the evidence for its effectiveness is limited and the recognition of value in assuring good practice is varied among senior staff (including senior managers) who may not always accord it a proper priority (Cape and Barkham, 2001).

This document sets a competences framework for the delivery of supervision for evidence-based psychological interventions that was developed by Roth and Pilling (2008b) under the IAPT programme. The framework will require no or minimal adjustment for use in drug misuse, as the majority of supervision competences are pan-modality and apply across all disorders. The key elements include a focus on outcome measurement, a focus on the creation of a learning and developmental approach to supervision, case management, and use of material from actual sessions (for example, audio recordings or written records).

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<sup>4</sup> A parallel programme for high and low-intensity interventions is being developed by IAPT. IAPT training courses were launched in October 2008 – see [www.iapt.nhs.uk](http://www.iapt.nhs.uk) for further details.

The map of supervision competences can be found in Appendix K<sup>5</sup>. The competences framework for supervision also draws the distinction between low and high-intensity interventions. In the supervision of both high and low-intensity interventions a sound knowledge of the presenting disorder and the context in which it is treated is essential. For low-intensity interventions this latter issue is of particular importance: supervisors need to help staff delivering low-intensity interventions to understand the limitations as well as the benefits of the intervention, and the appropriate time to 'step-up' to high-intensity interventions.

Supervision is an essential element of the effective delivery of all psychosocial interventions, is common to all well conducted trials of effective interventions and should therefore not be seen as an optional extra (Roth and Pilling, 2008). Therefore in addition to having staff in place to deliver effective supervision, a key consideration for any service will be to ensure it has also built in adequate time to both deliver and receive supervision to the routine work plan of all staff.

## 5.4 The development of protocols for the delivery of low-intensity interventions

The effective provision of low-intensity interventions in clinical trials is based in clear and well-developed protocols for their delivery (Roth and Pilling, 2007a). The framework sets out protocols for the delivery of the following interventions:

- **Appendix L** Protocol for the delivery of motivational interviewing
- **Appendix M** Protocol for the delivery of contingency management
- **Appendix N** Protocol for the delivery of guided self-help and behavioural activation.

These specimen protocols were again developed from trial manuals and associated materials (these are listed in the relevant appendices). They are designed to be flexible, adaptable for local service use and to be compatible with both the competences frameworks developed in this document and the care pathways set out in Models of Care: Update 2006 (NTA, 2006). Evidence from clinical trials and implementation studies suggests that following the protocols

without an understanding of the necessary competences required to deliver the intervention, adequate training or supervision, is unlikely to lead to a positive outcome for the service user. The requirement for these elements to be in place is set out in the quality assurance framework and associated audit criteria.

In addition to the training and supervision requirements, additional resource-based elements need to be in place for there to be effective implementation of low-intensity interventions. These vary with the nature of the intervention but in all cases fall broadly into three areas:

- Adequate staff time to deliver the intervention
- Adequate resources to support the delivery of the intervention (e.g. near patient testing facilities for contingency management)
- Routine outcome measurement.

The implications of these three areas for each low-intensity intervention are considered below.

### 5.4.1 Motivational interviewing (MI)

Effective implementation of MI would likely require the least amount of resource development as it is already routinely used in many services. Motivational interviewing has now become an integral part of routine care in drug services in the UK, although the US literature would suggest that questions might need to be asked of the competency of its practitioners (Miller et al., 2004). The development of the competences framework for MI is intended to directly address this. However, the varied application of MI means that the competences framework should have applicability across a wide range of settings, and yet do so in a way which maintains fidelity to the model and does not decrease the effectiveness of MI. Consequently, it will be for local services to tailor MI to their own specific needs while bearing in mind that this should be done within the overall context of the competences framework, using appropriate fidelity measures (see Appendix Q and [www.oregon.gov/DHS/mentalhealth/ebp/fidelity/mi.pdf](http://www.oregon.gov/DHS/mentalhealth/ebp/fidelity/mi.pdf)).

However, services may need to review existing supervision arrangements to ensure staff trained in this approach, are competent and able to maintain MI skills and practice. If MI is to be used effectively as part of the standard assessment protocol within a service, the amount of time

<sup>5</sup> The full detail of the supervision competences can be found at [www.ucl.ac.uk/clinical-psychology/CORE/supervision\\_framework.htm](http://www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm)

required for assessment may well increase (see MIA:STEP (Martino et al., 2006) for an example of this). Furthermore, where opportunistic use of MI is part of the service such as in a Needle Exchange service, additional time may also need to be allocated for staff to carry out MI during their routine work. Although specific outcome measurement is not appropriate for MI, routine monitoring of important variables such as retention in treatment, completion of care-planned interventions and outcomes measured by the TOP (Treatment Outcomes Profile) can potentially be of value in exploring, with practitioners, their practice. In addition, audits of clinical notes should be carried out to determine if MI has been implemented in line with agreed local policy in the assessment process.

#### 5.4.2 Contingency management (CM)

The effective implementation of CM is likely to require considerable additional resource in all three areas referred to above as there has been little use of CM in any UK substance misuse service. If it becomes established in the UK, CM may increasingly be delivered by keyworkers as part of the routine care they provide. In some cases where it is used to encourage attendance for vaccinations, for example, this may involve less work. However, where further monitoring and more prolonged engagement is required, for example in a methadone maintenance programme, staff may be faced with considerable additional monitoring and discussion of the outcomes of that monitoring (but with potentially significant improvements in outcomes).

In addition to the potential increased demands on staff time, CM will also require resources for routine outcome measurement such as near patient testing materials and appropriate facilities for testing to take place in. As CM requires the use of immediate reinforcers, systems will also need to be in place to ensure that these reinforcers are readily available. Finally, effective delivery of CM will require robust systems for aggregating routine outcome data and for the proper administration of all reinforcement systems.

#### 5.4.3 Interventions for common mental disorders

As with CM, the delivery of both guided self-help and behavioural activation will be done largely by staff in keyworking or similar roles. Given that interventions in this area are currently limited it will very likely require added input from staff. This may therefore need to be reflected in the caseload expectations of staff. Self-help materials will need to be readily available (see

Leibowitz, 2007). Most protocols for the low-intensity interventions also require session by session outcome monitoring. For most common mental disorders however, use of the two brief assessment measures as mandated by the IAPT programme will be sufficient. These are the PHQ-9 for depression and the GAD-7 for anxiety (see Appendix O).

### 5.5 The development of a quality assurance framework

The quality assurance framework for psychosocial interventions has two main foci. The first is to ensure that the service systems are properly established to support the effective delivery of psychosocial interventions. The second is to ensure that interventions are effectively delivered to service users by staff. In order to address the first issue the framework is designed to be compatible with the NTA's Auditing Drug Treatment (NTA, 2008b). Where possible it draws on existing audit criteria, for example those developed for relevant NICE guidelines. The method adopted follows that set out for the development of audit criteria in NICE guidelines (NICE, 2002). Given the very variable provision of psychosocial interventions for drug misuse services, no specific benchmarks are set out in this document. However it would be expected that, in conjunction with the NTA and local commissioners, the audit criteria set out in Appendix P could provide the basis from which local and possibly national benchmarks could be developed.

In seeking to ensure that individual interventions are delivered appropriately, recommendations are made for using specific adherence measures developed as part of the formal evaluation of the interventions, but which have been adapted for routine use. These measures can be seen in Appendix Q for motivational interviewing and Appendix R for contingency management. Specific guidance on the use of these measures can be found in the relevant manuals and associated texts which are also referenced in Appendices Q and R. The most frequent use of these measures is likely to be in supervision (including self-rating by therapist) and in the evaluation of individual competence as part of specific training programmes. To be applied effectively they will typically need to be used in conjunction with video or audio taped material, or by direct observation of clinical practice. This is compatible with the model of supervision, particularly in training, which stresses the use of such material in order to improve staff learning. No adherence measures currently exist for low-intensity interventions for common mental disorders, but these are likely to be developed as part of the IAPT programme.

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# Appendix A: Expert group members and reviewers

## A.1 Members of Expert Reference Group

|                               |  |
|-------------------------------|--|
| <b>Dr Janet Brotchie</b>      | <b>Lead Psychologist in Substance Misuse</b><br><i>Central and North West London Mental Health NHS Trust.</i>  |
| <b>Professor Alex Copello</b> | <b>Professor of Addiction Research</b><br><i>School of Psychology, The University of Birmingham.</i><br><b>Consultant Clinical Psychologist</b><br><i>Birmingham and Solihull Substance Misuse Services.</i> |
| <b>Dr Paul Davis</b>          | <b>Consultant Clinical Psychologist</b><br><b>Head of Substance Misuse Psychology</b><br><i>Camden and Islington Foundation Trust.</i>   |
| <b>Dr Luke Mitcheson</b>      | <b>Consultant Clinical Psychologist</b><br><b>Lambeth Lead Addictions Psychologist</b><br><i>South London and Maudsley NHS Foundation Trust.</i>   |
| <b>Dr Frank Ryan</b>          | <b>Consultant Clinical Psychologist</b><br><i>Central and North West London Mental Health NHS Trust.</i><br><b>Vice-Chair, Faculty of Addiction</b><br><i>British Psychological Society.</i>                 |

## Peer reviewers

|                                       |  |
|---------------------------------------|--|
| <b>Professor William Fals-Stewart</b> | <b>Professor of Psychology</b><br><i>University of Rochester School of Nursing,<br/>Rochester, USA.</i>                            |
| <b>Professor Stephen Higgins</b>      | <b>Professor of Psychiatry &amp; Psychology</b><br><i>University of Vermont, USA.</i>  |
| <b>Dr Jim McCambridge</b>             | <b>Senior Lecturer in Behaviour Change</b><br><i>London School of Hygiene and Tropical Medicine,<br/>University of London, UK.</i> |
| <b>Professor Nancy Petry</b>          | <b>Professor of Psychiatry</b><br><i>University of Connecticut, USA.</i>   |
| <b>Professor Stephen Rollnick</b>     | <b>Professor of Health Care Communication</b><br><i>University of Cardiff, UK.</i>   |



# Appendix B: Competences for motivational interviewing

## Sources used in development:

Martino S, Ball SA, Gallon SL, Hall D, Garcia M, Ceperich S, Farentinos C, Hamilton J, and Hausotter W (2006). *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency*. Salem, OR: Northwest Frontier Addiction Technology Transfer Center, Oregon Health and Science University

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Miller WR, Rollnick S (1991). *Motivational Interviewing: Preparing People to Change. Addictive Behavior*. New York: Guilford Press

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## B.1 Generic competences

### Knowledge of drug misuse and mental health problems

- A knowledge and understanding of drug misuse problems
- A knowledge and understanding of mental health problems
- A knowledge of and ability to operate within professional and ethical guidelines
- A knowledge of motivational interviewing and the application of the model in practice.

### Establishing a positive relationship with the service user

- An ability to:
  - Develop an empathetic, warm and genuine relationship
  - Communicate effectively through appropriate use of empathic statements, reflection, clarification, verbal and non-verbal behaviours
  - Deal with emotional content of sessions.

### Establishing good relationships with relevant professionals

- An ability to communicate effectively with professionals about the nature of the service user's difficulties, the intervention(s) and the outcomes.

### Gathering background information

- An ability to:
  - Gain an overview of the service user's current life situation, any specific stressors and the level of social support

- Gather information relating to the impact of drug misuse including work, home, social and private leisure and close personal relationships
- Elicit information regarding current problems, past history and present life situation
- Gather information on current and past treatment (including medical psychological, social and pharmacological interventions)
- Use appropriate information gathering techniques
- Use open and closed question styles appropriately, flexibly and responsively
- Phrase questions unambiguously
- Use agreed protocols to assess risk to self and others and self neglect (distinguishing between ideation and intent).

### Giving service users information about drug misuse

- An ability to impart accurate information on the nature and course of drug misuse and to discuss this with the service user.

## B.2 Basic motivational interviewing competences

- An ability to:
  - Adopt an empathetic, non-confrontational, collaborative and non-judgmental approach
  - Adopt an evocative tone throughout the intervention which draws out the service user's ideas, feeling and wants
  - Draw out, identify and discuss the service user's intrinsic motivation for change
  - Draw from the service user a distinction

between how important it is for the service user to change and how confident they are they can maintain this change

- Respect the individual autonomy of the service user and responsibility for change
  - Communicate to the service user a sense of safety and support
  - Convey acceptance of the service user and to avoid confrontation or the use of persuasion
  - Assist the service user in developing discrepancy between their current situation and future goals
  - ‘Roll with the resistance’ and avoid direct confrontation of resistance
  - Support and enhance a service user’s belief in their ability to carry out a specific activity
  - Help the service user explore and resolve their ambivalence in favour of change
- A knowledge of basic principles of stages of change (pre-contemplation; contemplation; preparation; action and maintenance).

### B.3 Specific motivational interviewing techniques

- An ability to:
  - Use affirmative statements to acknowledge service user efforts and strength
  - Use open-ended questions
  - Avoid the use of ‘traps’ including: question-answer traps; labelling traps; premature focus traps; talking side traps; blaming traps; and expert traps
- A knowledge of the levels of reflection including: repeating; re-phrasing; paraphrasing; and reflecting feeling
- An ability to use reflective listening through:
  - Forming hypotheses about the meaning of service user statements
  - Testing hypotheses by reflective statements to the service user
  - Using different types of reflective statements including simple reflection, amplified reflection; double-sided reflection
- An ability to elicit ‘change talk’ in a collaborative manner through:
  - Recognising, empathising and reflecting on desire, ability, reasons and need focused change statements
  - Recognising and strengthening commitment language
- An ability to:
  - Build rapport through identifying the service user’s concerns
  - Centre discussion around the service user’s concerns and needs
  - Reframe discussion positively
  - Conclude a session with summaries and open-

ended discussion on behaviour change

- Use decisional balance tools to facilitate the exploration of ambivalence
- Elicit discrepancy between current behaviour and future goals
- Elicit dissonance between beliefs and behaviours
- Enhance the service user’s perception of the importance for change and their confidence they can make this change
- Diffuse blame
- Invite service users in a non-confrontational manner to consider new perspectives
- Support self-efficacy via affirmation and positive reinforcement
- Offer specific information and advice, but only when solicited
- Elicit discussion of the benefits and drawbacks of changing problem behaviour
- Develop, in collaboration with the service user, a plan for behaviour change.

### Monitoring in motivational interviewing

- An ability to identify the service user’s readiness for change, both from structured assessment and open-ended discussion through:
  - Using informal measures of change such as readiness, importance and confidence rulers and other basic measures of change
  - Using key questions to assess readiness to change both to assess and facilitate readiness to change
- An ability to:
  - Provide summaries during sessions to demonstrate understanding of the service user’s problem, structure the intervention and emphasise positive change focused service user statements
  - Refer to, and elicit open-ended discussion from, assessment data
  - Provide positive and constructive feedback and open-ended discussion on behaviour change during and at the end of sessions
  - Make use of self-monitoring tools to reflect on and improve performance
  - Make use of supervision, and the associated assessment and feedback.

### B.4 Metacompetences in motivational interviewing

- An ability to:
  - Adapt motivational interviewing according to the setting in which it is provided
  - Pace the rate of the intervention as relevant to service user needs
  - Set agendas on an ongoing basis in order

to clarify session topics and behaviour change targets

- Recognise service user need for motivational interviewing as it arises, and to deliver it opportunistically
- Elicit and be responsive to service user's feedback
- Integrate motivational interviewing into routine assessment systems.

# Appendix C: Competences for contingency management

## Sources used in development:

Higgins ST, Silverman K and Heil SH (eds) (2007). *Contingency Management in Substance Abuse Treatment*. New York: Guilford Press

Kellogg SH, Burns M, Coleman P, Stitzer M, Wale JB, Kreek MJ (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

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## C.1 Generic competences

### Knowledge of drug misuse and mental health problems

- A knowledge and understanding of drug misuse problems
- A knowledge and understanding of mental health problems
- A knowledge of and ability to operate within professional and ethical guidelines
- A knowledge of the model of intervention, and the ability to understand and employ the model in practice.

### Establishing a positive relationship with the service user

- An ability to:
  - Develop an empathetic, warm and genuine relationship
  - Communicate effectively through appropriate use of empathic statements, reflection, clarification, verbal and non-verbal behaviours.

### Establishing good relationships with relevant professionals

- An ability to communicate effectively with professionals about the nature of the service user's difficulties, the intervention(s) and the outcomes.

### Gathering background information

- An ability to:
  - Gain an overview of the service user's current life situation, any specific stressors and the level of social support
  - Gather information relating to the impact of drug misuse including work, home, social and private leisure and close personal relationships
  - Elicit information about current problems, past

and present life situation

- Gather information on current and past treatment (including medical psychological, social and pharmacological interventions)
- Use appropriate information gathering techniques
- Use open and closed question styles flexibly and responsively
- Phrase questions unambiguously
- Use agreed protocols to assess risk to self and others and self neglect (distinguishing between ideation and intent).

### Giving service users information about drug misuse

- An ability to impart accurate information on the nature and course of drug misuse and to discuss this with the service user.

## C.2 Basic contingency management competences

### Knowledge of contingency management principles

- Knowledge of the behavioural principles of contingency management
- An ability to explain and demonstrate the rationale for contingency management to service users.

### Structuring a contingency management programme

- An ability to:
  - Identify appropriate target behaviours such as abstinence or attendance for testing
  - Work with the service user to set an agreed agenda for each session that is consistent with contingency management principles
  - Set an agenda that is appropriate to the service user's needs and the stage of intervention, and is

consistent with contingency management principles

- Adhere to the agenda.

### **Managing the relationship with a service user in a manner consistent with contingency management principles**

- An ability to:
  - Engage and interact with the service user in a positive and rewarding manner, in particular when the service user achieves a target behaviour
  - Understand and use the results of self report of drug misuse in a manner consistent with contingency management principles
  - Understand and use the results of drug testing in a manner consistent with contingency management principles
  - Interact in a non-punitive but non-rewarding manner, where the service user fails to demonstrate target behaviour, or behaves anti-socially
  - Deliver incentives, in a timely and appropriate manner where necessary in liaison with other professionals
  - Use regular within-session summarising in a manner appropriate to the issues under discussion (for example, a rewarding approach were target behaviours are achieved).

## **C.3 Specific contingency management competences**

### **Drug testing for a contingency management programme**

- A knowledge and understanding of near-patient/on-site testing methods for drugs and alcohol (including urine and oral fluid drug screens and breath alcohol tests) and their limitations (sensitivity, specificity, detection time window)
- A knowledge and understanding of the necessary near-patient testing regimes to support contingency management programmes
- An ability to explain the rationale and method of drug testing to service users
- An ability and readiness to collect valid biological samples
- An ability to:
  - Motivate and support users in completing drug tests who are ambivalent about doing so
  - Use and interpret near-patient/on-site testing methods
  - Identify attempts to falsify near-patient test results (for example, temperature checking, adulterants)
  - Communicate in a timely, positive and rewarding manner the outcomes of a test where the service user has achieved the identified target behaviour
  - Communicate in a timely, non-punitive but

non-rewarding manner, where the service user has not achieved the identified target behaviour.

### **Assessment for a contingency management programme**

- An ability to:
  - Identify realistic and objectively verifiable target behaviours
  - Identify appropriate incentives (for example, vouchers, clinic privileges, money) in line with local clinic policies
  - Within the overall framework for the local policy for contingency management (e.g. vouchers, clinic privileges) identify incentives which are high value for individual service users and to facilitate their choice in identifying them
  - Develop and agree with the service user the appropriate magnitude of incentives in line with local clinic policies
  - Identify appropriate behaviours to shape service user behaviour to agreed target behaviours (for example, phased, short term reductions in drug or alcohol levels)
  - Use formal assessment methods (such as drug use records and diaries) in establishing and evaluating contingency management programmes
  - Relate the outcome of objective measures of drug misuse, including positive tests, to service user self-report in a manner appropriate to the identified target behaviour.

### **Establishing a contingency management programme**

- An ability to:
  - Develop behavioural contracts, with specific details including: target behaviour, method and frequency of verification, nature and value of incentives, consequences of not demonstrating target behaviour
  - Explain clearly the specifics of the behavioural contingencies and to seek the service user's understanding and agreement
  - Use priming to promote the use of incentives in contingency management programmes
  - Develop, implement and monitor escalating reinforcement schedules and adjust them in light of service user's achievement of target behaviour
  - Assess the service user's response to incentives.

### **Delivering and monitoring contingency management programme**

- An ability to:
  - Implement contingency management plans rigorously and consistently
  - Effectively manage the administration of incentives
  - Adjust the use of incentives in line with

achievement of target behaviours and the agreed reinforcement schedule

- Manage the exchange of agreed incentives (e.g. vouchers) for back-up reinforcers in line with locally agreed clinic policy
- Manage and account for the use of agreed incentives in line with local clinic policies
- Communicate with the service user at each session the current status of the incentive schedule
- Liaise with other professionals and providers involved in the use of incentives (for example, clinic privileges)
- Routinely monitor the service user's response to incentives through the use of cumulative records and where appropriate through the use of normative data on expected rates of change
- Maintain a positive focus on the service user's overall aim and to communicate confidently on progress towards this aim
- Manage a missed session and determine if the absence was excusable and to adjust the incentive schedule in light of this
- Adjust (reset) incentive schedules in light of missed targets or unexplained absences and to communicate the rationale for this to the service user
- Consistently use praise and immediate verbal feedback to reward the achievement of target behaviours in addition to the use of agreed incentives
- Use problem solving techniques in conjunction with service users to overcome difficulties in achieving target behaviours
- Enthusiastically validate and reinforce the service user's choice of incentive
- Use written feedback on service user progress in a manner consistent with contingency management principles.

#### **Managing relationships with external agencies concerning contingency management**

- An ability to:
  - Explain the rationale for contingency management to other relevant professionals
  - Communicate the content and outcomes of specific contingency management programmes to other relevant professionals
  - Explain the rationale for contingency management to family members and other carers
  - Refer the service user to an appropriate clinician to deal with specific problem behaviour(s).

#### **Ending the intervention**

- An ability to:
  - Negotiate an appropriate end to the intervention which includes discussion of

strategies the service user can follow to manage relapse

- Help the service user identify incentives in their own environment which will support the maintenance of target behaviours.

### **C.4 Metacompetences in contingency management**

- An ability to:
  - Judge the level and approach of contingency management intervention required
  - Design a contingency management schedule in accordance with behavioural principles
  - Adapt a contingency management schedule to the characteristics and needs of individual service users including the nature of their drug misuse
  - Adapt the contingency management intervention according to the setting in which it is delivered
  - Identify barriers to effective intervention and to resolve these within the boundaries of the agreement with the service user and the overall objectives of the service setting
  - Make use of supervision, assessment and feedback on performance as a contingency management therapist.

# Appendix D: Competences for behavioural couples therapy

## Sources used in development:

Fals-Stewart W, O'Farrell TJ, Birchler GR and Gorman C (2006). *Behavioural Couples Therapy for Drug Abuse and Alcoholism: A 12 Session Manual* (2nd Edition). Buffalo, New York: Addiction and Family Research Group

## D.1 Generic competences

### Knowledge of drug misuse and mental health problems

- A knowledge and understanding of drug misuse problems
- A knowledge and understanding of mental health problems
- A knowledge of and an ability to operate within professional and ethical guidelines
- A knowledge of the model of intervention, and the ability to understand and employ the model in practice.

### Engaging service user(s)

- An ability to:
  - Show satisfactory levels of warmth, concern, confidence and genuineness (matched to service user need) while maintaining professional boundaries
  - Engender trust and develop rapport
  - Adapt personal style so that it meshes with that of the service user
  - Recognise the importance of discussion and expression of service user's emotional reactions
  - Adjust the level of in-session activity and structuring of the session to the service user's needs
  - Convey an appropriate level of confidence and competence
  - Avoid negative interpersonal behaviours (such as impatience, aloofness, or insincerity).

### Establishing good relationships with relevant professionals

- An ability to communicate effectively with professionals about the nature of the service user's difficulties, the intervention(s) and the outcomes.

### Dealing with the emotional content of sessions

- An ability to:
  - Facilitate the processing of emotions by the service user – to acknowledge and contain emotional levels that are too high (e.g. anger, fear, despair) or too low (e.g. apathy, low motivation)

- Deal effectively with emotional issues that interfere with effective change (e.g. hostility, anxiety, defusing excessive anger, avoidance of strong affect).
- Help the service user access, differentiate and express his/her emotions in a way that facilitates change.

### Gathering background information

- An ability to:
  - Gain an overview of the service user's current life situation, any specific stressors and the level of social support
  - Gather information relating to the impact of drug misuse including work, home, social and private leisure and close personal relationships
  - Elicit information regarding current problems, past history and present life situation
  - Gather information on current and past treatment (including medical psychological, social and pharmacological interventions)
  - Use appropriate information gathering techniques
  - Use open and closed question styles flexibly and responsively
  - Phrase questions unambiguously
  - Use agreed protocols to assess risk to self and others and self neglect (distinguishing between ideation and intent).

### Giving service users information about drug misuse

- An ability to impart accurate information on the nature and course of drug misuse and to discuss this with the service user.

## D.2 Basic BCT competences

### Knowledge of family approaches to drug misuse and mental health problems

- A knowledge and understanding of:
  - Family and couple relationships
  - The impact of drug misuse on family and couple relationships



- The dysfunctional interaction styles in couples where drug misuse is present
- The impact of mental health problems on family and couple relationships.

### Assessment of couples with drug misuse problems

- An ability to:
  - Conduct a detailed assessment of drug misuse, in particular a detailed description of drug use or urges to use drugs while in treatment
  - Assess the appropriateness of BCT in meetings the needs of the couple
  - A knowledge of and the ability to assess the contraindications (including diagnostic and legal) to BCT
- An ability to:
  - Assess motivation for treatment in the couple and in the individuals
  - Identify the key areas in the couple's relationship that have been damaged
  - Identify positive aspects of a couple's relationship
  - Conduct a Communication Sample, using videotape where appropriate, to identify patterns of effective communication, patterns that perpetuate conflict and misunderstanding and the need for the development of additional coping skills
  - Identify risks associated with drug misuse for the couple and other family members
  - Use a range of formal paper and pencil measures of the relationship (e.g. Marital Happiness Scale, Response to Conflict Scale)
  - Explain the rationale for and support the couple in the use of the Continuing Recovery Inventory
  - Feedback the outcome of the assessment to the couple, where appropriate using the '7Cs' framework.

### Knowledge and rationale of BCT

- A knowledge of:
  - The rationale and key components of BCT
  - The principles of limited confidentiality
  - The highly structured format of BCT, its content and sequencing
- An ability to:
  - Explain the rationale and the key components of BCT to the couple
  - Inform couples of and operate within the principles of limited confidentiality
  - Explain the rationale of the highly structured format of therapy at the beginning of treatment and at each session
  - Explain the purpose of in-session behavioural rehearsal and home practice assignments.

## D.3 Specific BCT competences

### Establishing the therapeutic approach in BCT

- An ability to:
  - Empathise with both partners and develop a collaborative approach to treatment
  - Facilitate a discussion of the potential impact of BCT on a couple's relationship
  - Establishment agreement with the couple on the joint and individual goals of therapy
  - Explain the rationale for and establish the four key 'promises' of BCT: no threats of divorce or separation; no angry touching or contact; attendance and active participation; and a focus on present and future
  - Develop in conjunction with the couple a Recovery Contract which sets out the agreement to participate in the Daily Abstinence Discussion, to comply with the self-help commitments and not to discuss past or future drug use or fears of future use when at home
  - Explain and implement the use of limited confidentiality through the use of the No Secrets Policy
  - Explain and implement the use of strategies to improve relationship functioning including: Catch and Tell, Sharing Rewarding Activity and Caring Days
  - Explain and implement the use of specific strategies to improve communication skills including: verbal and non-verbal communication, barriers to communication, direct and indirect communication, 'I' messages and active listening
  - Explain and implement the use of specific strategies to improve active listening skills by helping the couple develop Mirroring, Validating and Empathizing skills
  - Explain and implement the Relationship Agreement to consolidate communication skills and to develop skills in Positive Specific Requests, Negotiation and Compromise, and Negotiated Agreements
  - Describe different modes of conflict (verbal and physical aggression and the means to support effective conflict resolution verbal reasoning, the use of Time Out and the use of previous acquired communication skills)
  - Explain and implement the use of strategies to improve problem solving skills through the use of the S.O.L.V.E. method
  - Explain and implement the Continuing Recovery Model to assist the couple in recognising gains made, the distinction between lapse and relapse, the use of coping skills and importance of planned avoidance of high risk situations
  - Explain and implement the Action Plan to promote the use of abstinence supporting options and strategies for coping with high risk situations.



### Monitoring of treatment progress in BCT

- An ability to:
  - Use session by session biological tests and other measures/diaries to guide therapy and to monitor progress and outcomes of treatment
  - Encourage and facilitate the couple's use of within and between session measures and diaries to monitor home practice, service user problems and progress, and outcomes of treatment
  - Provide positive and constructive feedback
  - Accept positive and constructive feedback from the couple
  - Use the Round Table approach to review progress focusing on positive gains before identifying problems
  - Provide clear and concise goal orientated overviews of the sessions and of overall treatment progress.

### Monitoring of drug and alcohol misuse and associated risks in BCT

- An ability to:
  - Administer and interpret blood-alcohol breath tests and urine drug screens
  - Administer and interpret self-reported drug and alcohol misuse measures
  - Discuss the results, both positive and negative, of the alcohol and drug tests in a manner consistent with BCT
  - Determine the need for specialist medical assessment for drug or alcohol intoxication and to refer/arrange for such assessment were necessary
  - Assess the risk of blood-borne viruses and advice on ways of reducing the couple's exposure to such risks
  - Handle disclosures of positive HIV status in accordance with professional, ethical and legal guidelines.

### Ensuring effective delivery of BCT

- An ability in conjunction with the couple to develop an agreed agenda for each session in line with the agreed structure of BCT (including drug testing, other measures, urges/drug use, relationship issues, review of promises, new material and home practice)
- An ability to:
  - Promote an approach to treatment that avoids the use of blame and defuses it where it arises
  - Help the couple develop appropriate verbal communication skills which are positive, direct, assertive and empathic
  - Help the couple develop non-verbal communication skills including appropriate eye contact, tone of voice and gesture
  - Help the couple develop active listening skills

through in-session and through home practice plans

- Help the couple develop conflict resolution techniques (where necessary within the session): including making use of speaking and active listening skills, and reaching compromises
- Diffuse anger in the session, for example by the use of Time Out, or modelling effective diffusion techniques
- Use in-session role plays to demonstrate effective communication skills and facilitate use of in-session role play by couples
- Discuss issues relating to sexual intimacy within the scope of BCT
- Develop home practice plans with the couple which relate to the stage of therapy reached and the specific problems identified during sessions
- In conjunction with the couple, use the wider social network to support treatment goals, in particular the management of identified high risk situations.
- Work positively and constructively with a second therapist, for example in the modelling in-session of communication skills
- Make effective therapeutic interventions by telephone outside of sessions
- End a session; by reviewing the problems addressed, the skills developed, the home practice and other treatment goals and any other concerns raised by the couple.

### Relapse prevention

- An ability to:
  - End therapy in a planned manner and to plan for long-term maintenance of gains after treatment ends
  - In conjunction with the couple, use the wider social network to support continuing recovery in particular the management of identified high risk situations.
  - Assess the need for and to deliver booster sessions
  - Facilitate the couple's development of an Action Plan as a relapse prevention tool to support continuing recovery
  - Identify abstinence supporting options when faced with high-risk situations and to develop strategies in the case of a lapse/relapse.

## D.4 Metacompetences in BCT

- An ability to:
  - Adapt sessions responsively in relation to service user feedback
  - Implement BCT in a manner consonant with its underlying philosophy
  - Select and skilfully apply the most appropriate BCT intervention techniques

- Structure sessions and maintain appropriate pacing
- Identify and manage obstacles to treatment participation and goals both in and out of session
- Identify and respond appropriately to non-substance related problems which may interfere with BCT or present increased risks for the couple, their family or the wider social network.

# Appendix E: Competences for CBT-based guided self-help interventions

## Sources used in development:

Training and service manuals developed by Professor David Richards. University of York.

Training protocols developed by Dr Judy Leibowitz for Camden PCT guided self-help programme.

## E.1 Generic competences

### Establishing a positive relationship with the service user

- An ability to:
  - Develop an empathetic, warm and genuine relationship
  - Communicate effectively through appropriate use of empathetic statements, reflection, clarification, verbal and non-verbal behaviours.

### Establishing good relationships with relevant professionals

- An ability to communicate effectively with professionals about the nature of the service user's difficulties, the intervention(s) offered and the resulting outcomes.

### Gathering background information

- An ability to:
  - Gain an overview of the service user's current life situation, any specific stressors and level social support
  - Elicit information regarding diagnosis, past history and present life situation
  - Gather information relating to the impact of emotional distress including work, home, social and private leisure and close personal relationships.

### Establishing a context for the service and providing rationale for the service user of the self-help model

- An ability to:
  - Help the service user understand that the main purpose of the intervention is to facilitate the use of self-help material(s)
  - Provide a rationale for guided self-help to service users in an encouraging and realistic manner
  - Establish a context for the intervention, through clear explanation of the practitioner role
  - Ensure that the service user understands the nature and the timing of sessions and the schedule of contacts

- Convey to the service user the service-user-led, collaborative nature of a self-help intervention.

### Giving service users specific information relevant to the intervention

- An ability to:
  - Impart accurate information on the nature, course and frequency of the presenting problem
  - Give the service user information about alternative available evidence-based psychological therapies treatment-choices, as set out in the agreed protocol for the delivery of guided self-help
  - Give realistic information regarding outcomes and the prognosis for the service user's condition relevant to the self-help interventions.

### Assessing the service user's main problems using a semi-structured interview

- An ability to:
  - Use open and closed question styles flexibly and responsively
  - Phrase questions unambiguously
  - Give the service user regular summaries during the interview
  - Assess, using agreed protocols; risk to self, others and self neglect (distinguishing between thoughts, actions and plans) and establish preventative factors
  - Gather information on current and past treatment (including relevant medical, psychological, social and pharmacological interventions)
  - Gather relevant information on drug and alcohol use
  - Identify the key problem(s) through appropriate information gathering relating to the impact of emotional distress including work, home, social and private leisure and close personal relationships.

### **Gathering information using formal assessment methods**

- An ability to:
  - Administer and interpret formal measures of mental health (e.g. PHQ-9, CORE-OM, the BDI, problem and goal statements)
  - Support the service user in the completion of formal measures of mental health and to support the service user in using these to monitor their progress
  - Support the service user in use of formal measures of mental health to determine the content and pace of the intervention.

### **Decision making regarding the appropriateness of the intervention**

- An ability to:
  - Agree on the suitability of the self-help intervention for the service user
  - Collaboratively negotiate and agree with a service user the next steps in contact including organisational and therapeutic arrangements
  - Where necessary in conjunction with a supervisor, identify service users whose problems lie outside the scope of low-intensity interventions and when alternative interventions are required
  - Recognise, where necessary in conjunction with a supervisor, when referral to another part of the service is appropriate.

## **E.2 Basic CBT competences**

### **Socialising the service user to a CBT model**

- An ability to:
  - Communicate the essential components of a cognitive, and/or behaviourally based self-help programme
  - Communicate the options available to a service user within a CBT based self-help programme.

### **Agreeing the aims of the intervention**

- An ability to:
  - Summarise information gathered from the assessment into a concise problem summary which is shared and checked with the service user (which includes information on environmental and/or intrapersonal triggers, physiological, behavioural and cognitive components of the main problem and the broader impact of this problem on the service user's functioning)
  - Use the problem summary to agree intervention goals with the service user
  - Negotiate and agree the specific components of a self-help CBT based intervention.

### **Facilitating service user self-monitoring**

- An ability to:
  - Support self-monitoring through the use of service-user-completed diaries (including activity schedules, sleep and thought diaries)
  - Review diary records with the service user, and to discuss any implications of these observations with the service user.

### **Facilitating service user led interventions**

- An ability to:
  - Understand the use of appropriate self-help materials (including written materials) and self-monitoring materials, and support the service user in the use of relevant and effective materials
  - Help the service user problem solve difficulties encountered in the use of written materials, and self-monitoring materials
  - Help the service user think through the rationale for performing homework and related tasks, and to identify and problem solve any anticipated difficulties in carrying out tasks
  - Communicate effectively about the delivery, implementation and monitoring of self-help interventions both in face-to-face contacts and in telephone contacts.

### **Ending the intervention**

- An ability to negotiate an appropriate ending to the intervention, including discussion of relapse prevention.

## **E.3 Metacompetences in CBT**

- An ability to:
  - Maintain a clear distinction between acting as a facilitator of self-help and taking on the more extensive role of a therapist
  - With service users who are not making progress or who show low motivation, to identify when to persist with the intervention and when to re-evaluate its appropriateness
  - In the context of indicators of service user progress, maintain fidelity to the intervention model in the face of service user complexity
  - Use supervision to identify gaps in knowledge and understanding, and reflect on and to learn from experience.

# Appendix F: Competences for behavioural activation

## Sources used in development:

Lejuez CW, Hopko DR, Hopko SD (2001). A brief behavioral activation treatment for depression: Treatment manual. *Behavior Modification* 25: 255-286

Richards D. *Case Management for Depression* (MRC Trial Manual) (University of York)

## F.1 Generic competences

### Establishing a positive relationship with the service user

- An ability to:
  - Develop an empathetic, warm and genuine relationship
  - Communicate effectively through appropriate use of empathetic statements, reflection, clarification, verbal and non-verbal behaviours.

### Establishing good relationships with relevant professionals

- An ability to communicate effectively with professionals about the nature of the service user's difficulties, the intervention(s) and the outcomes.

### Giving service users information about depression

- An ability to impart accurate information on the nature and course of depression, and to discuss this with the service user.

### Assessing the service user's main problems using a semi-structured interview

- An ability to:
  - Help the service user identify key problem area(s) and to identify the impact of emotional distress on work, home, social and private leisure and close personal relationships
  - Elicit information regarding diagnosis, past history and present life situation
  - Gather information on current and past treatment (including medical, psychological, social and pharmacological interventions)
  - Gain an overview of the service user's current life situation, any specific stressors and their level of social support
  - Use agreed protocols to assess risk to self and others and self neglect (distinguishing between ideation and intent)
  - Gather information on drug and alcohol use
- An ability to:
  - Use appropriate information gathering techniques:
  - Use open and closed question styles flexibly

and responsively

- Phrase questions unambiguously
- Use regular within-interview summarising.

### Gathering information using measures

- An ability to:
  - Administer and interpret formal measures of mental health (e.g. PHQ-9, the BDI, activity problem and goal schedules), and to use these both initially and to monitor progress
  - Help service users who need support to complete formal measures
  - Support the service user in use of formal mental health measures to determine the pace of the intervention.

## F.2 Basic behavioural activation competences

### Establishing a service context for the intervention

- An ability to:
  - Convey that the intervention is service user led and collaborative in nature
  - Convey a context for the intervention, through providing the service user with a clear explanation of the practitioner role
  - Support that the service user in understanding the nature and the timing of sessions and the schedule of contacts.

### Providing a rationale for behavioural activation

- An ability to:
  - Provide the rationale for behavioural activation to service users in an encouraging but realistic manner
  - Help the service user understand that the main focus of behavioural activation is to increase activities bring a sense of pleasure or accomplishment
  - Give realistic information regarding outcomes from behavioural activation.

### Decision making regarding the appropriateness of the intervention

- An ability to:
  - Reach agreement with the service user that the

service is suitable for their needs

- Help the service user decide if behavioural activation (and the circumscribed nature of treatment) is appropriate for their current problems
- Help the service user assess whether they are motivated to engage in a behavioural activation programme (bearing in mind the link between depressive symptoms and low motivation)
- Negotiate and agree with the service user the next steps in contact (i.e. organisational and therapeutic arrangements)
- Identify service users whose problems lie outside the scope of low-intensity behavioural activation and to liaise with a supervisor to consider referral to alternative interventions.

#### **Agreeing the aims of the intervention**

- An ability to:
  - Construct and to share a concise problem summary with the service user (which includes information on environmental and/or intra-personal triggers, physiological, behavioural and cognitive components of the main problem and the broader impact of this problem on the service user's functioning)
  - Use check the accuracy of the problem summary with the service user and to agree intervention goals
  - Negotiate and agree the specific components of a BA-based intervention
  - Help the service user prioritise key problem area(s) and identify their goals for the intervention.

#### **Facilitating service user self-monitoring**

- An ability to:
  - Introduce the rationale for self-monitoring and to help the service user undertake this using diaries (including behavioural activation, exposure, sleep and thought diaries)
  - Review diary records with the service user, and to discuss any issues or implications which arise from these observations.

#### **Facilitating service user-led interventions**

- An ability to:
  - Help the service user use self-help materials, including written materials and the use of self-monitoring materials
  - Help service users problem solve any difficulties they encounter when using written materials and self-monitoring materials
  - Help the service user think through the rationale for performing homework and related tasks, and to help identify and problem solve any anticipated difficulties in carrying out tasks.

#### **Ending the intervention**

- An ability to negotiate an appropriate finish to the intervention, including discussion of relapse prevention.

### **F.3 Specific behavioural activation competences**

#### **Assessment specific to a low-intensity behavioural activation programme**

- An ability to:
  - Gather information relevant to an ABC model (antecedents, behaviours and consequences)
  - Identify disruptions to the service user's routine pleasurable and necessary activities
  - Identify environmental cues for behavioural deficits and excesses
  - Help a service user identify desired routine, pleasurable and necessary activities for a programme of behavioural activation
  - Help a service user set up, structure and review behavioural activation hierarchy lists necessary activities for a programme of behavioural activation.

#### **Information-giving specific to behavioural activation**

- An ability to:
  - Discuss with the service user the essential components of a behavioural activation programme, including the concepts of depressed and healthy behaviours and avoidance
  - Use written material to communicate the rationale and essential components of a behavioural activation programme
  - Help the service user to use written tools for a behavioural activation programme, including hierarchies and behavioural activation diaries
  - Assimilate, review and reflect back to service user information collected in their behavioural activation diaries.

#### **Shared decision-making specific to behavioural activation**

- An ability to:
  - Support the service user in determining the specific components of their behavioural activation programme
  - Support the initiation of a structured behavioural activation programme in a collaborative, service user-centred manner
  - Adjust the pace and content of a behavioural activation programme according to a service user's progress and wishes.

### **Facilitating behavioural activation**

- An ability to:
  - Understand the use, by the service user, of behavioural activation materials (including written materials) and self-monitoring materials, and an ability to support the service user in their use
  - Help the service user think through the rationale for performing homework and related tasks, and to identify and problem solve any difficulties they anticipate in carrying out tasks
  - Communicate effectively about the delivery, implementation and monitoring of a behavioural activation programme both in face to face contacts and in telephone contacts
  - Help the service user identify and use appropriate rewards for achieving their identified goals
  - Help a service user problem-solve any areas of the BA programme where progress is less than expected.

### **Ending the intervention**

- An ability to negotiate an appropriate end to the intervention which includes discussion of strategies the service user can follow to manage relapse.

## **F.4 Metacompetences in behavioural activation**

- An ability to:
  - Maintain a clear distinction between acting as a facilitator of behavioural activation and taking on the more extensive role of a therapist
  - With service users who are not making progress or who show low motivation, identify when to persist with the intervention and when to re-evaluate its appropriateness
  - In the context of indicators of service user progress, maintain fidelity to the intervention model in the face of service user complexity
  - Use supervision to identify gaps in knowledge and understanding, and reflect on and to learn from experience.

# Appendix G: CBT competences for depression and anxiety

These CBT competences for depression and anxiety are also contained in an online map at [www.ucl.ac.uk/clinical-psychology/CORE/CBT\\_Competences/CBT\\_Competences\\_Map.pdf](http://www.ucl.ac.uk/clinical-psychology/CORE/CBT_Competences/CBT_Competences_Map.pdf), which includes clickable links direct from the activities to their required competences.

## G.1 Generic competences

- Knowledge and understanding of mental health problems
- Knowledge of, and ability to operate within, professional and ethical guidelines
- Knowledge of a model of therapy, and the ability to understand and employ the model in practice
- Ability to:
  - Engage client
  - Foster and maintain a good therapeutic alliance, and to grasp the client's perspective and 'world view'
  - Deal with emotional content of sessions
  - Manage endings
  - Undertake generic assessment (relevant history and identifying suitability for intervention)
  - Make use of supervision.

## G.2 Basic CBT competences

- Knowledge of:
  - Basic principles of CBT and rationale for treatment
  - Common cognitive biases relevant to CBT
  - The role of safety-seeking behaviours
- Ability to:
  - Explain and demonstrate rationale for CBT to client
  - Agree goals for the intervention
- Ability to structure sessions:
  - Sharing responsibility for session structure and content
  - Adhering to an agreed agenda
  - Planning and reviewing practice assignments ('homework')
  - Using summaries and feedback to structure the session.
- Use measures and self monitoring to guide therapy and to monitor outcome
- Devise a maintenance cycle and use this to set targets
- Problem solving
- Ability to end therapy in a planned manner, and to plan for long-term maintenance of gains after treatment.

## G.3 Specific behavioural and cognitive therapy

- Exposure techniques
- Applied relaxation and applied tension
- Activity monitoring and scheduling
- Guided discovery and Socratic questioning:
  - Using thought records
  - Identifying and working with safety behaviours
  - Detecting, examining and helping client reality test automatic thoughts/images
  - Eliciting key cognitions/images
  - Identifying and helping client modify assumptions, attitudes and rules
  - Identifying and helping client modify core beliefs
  - Employing imagery techniques
  - Planning and conducting behavioural experiments.
- Ability to:
  - Develop formulation and use this to develop treatment plan/case conceptualisation
  - Understand client's inner world and response to therapy.

## G.4 Problem-specific competences

- Specific phobias
- Social phobia – Heimberg; Clark
- Panic disorder (with or without agoraphobia) – Clark; Barlow
- Obsessive compulsive disorder (OCD) – Steketee; Kozac
- Generalised anxiety disorder (GAD) – Borkovec; Dugas and Ladouceur; Zinbarg, Craske and Barlow
- Post-traumatic stress disorder (PTSD) – Foa and Rothbaum; Resick; Ehlers
- Depression – high-intensity interventions:
  - cognitive therapy – Beck
  - behavioural activation – Jacobson.
- Depression – low-intensity interventions:
  - behavioural activation
  - guided CBT self help.



## G.5 Metacompetences in CBT for depression and anxiety

Generic metacompetences:

- Capacity to:
  - Use clinical judgment when implementing treatment models
  - Adapt interventions in response to client feedback
  - Use and respond to humour.

CBT specific metacompetences:

- Capacity to:
  - Implement CBT in a manner consonant with its underlying philosophy
  - Formulate and to apply CBT models to the individual client
  - Select and apply most appropriate BT and CBT method
  - Structure sessions and maintain appropriate pacing
  - Manage obstacles to CBT therapy.

# Appendix H: Specimen curriculum for motivational interviewing<sup>6</sup>

These CBT competences for depression and anxiety are also contained in an online map at [www.ucl.ac.uk/clinical-psychology/CORE/CBT\\_Competerences/CBT\\_Competerences\\_Map.pdf](http://www.ucl.ac.uk/clinical-psychology/CORE/CBT_Competerences/CBT_Competerences_Map.pdf), which includes clickable links direct from the activities to their required competences.

## H.1 Aims

Staff in substance misuse services aid clinical improvement through a service user-centred, directive approach (Miller & Rollnick, 2002). Their role is to encourage a change in behaviour by facilitating the exploration and resolution of a service user's ambivalence around specified target behaviours such as, attending keyworking sessions, reducing drug use, uptake of a hepatitis B vaccination programme or medication compliance. In order to achieve this, support should be focused and goal-orientated to enable people to express their co-existing opposing attitudes and move towards a behavioural change. Training in motivational interviewing will therefore equip workers with a good understanding of both the spirit and technical aspects of motivational interviewing, while highlighting the difference between this approach and more confrontational methods.

## H.2 Learning outcomes

- Demonstrate:
  - Knowledge and understanding of the basic spirit and principles of motivational interviewing
  - In-depth understanding of, and competence in, the use of motivational interviewing as a low-intensity intervention for drug misuse
  - Competence in developing and maintaining a collaborative therapeutic alliance with service users that allows them to explore their experiences and ambivalence
  - Competence in use of appropriate communication techniques to foster a service user-centred, empathic and supportive atmosphere. Specifically, the use of open-ended questions, affirmations, summaries and reflective listening
- An ability to:
  - Recognise and respond to 'change talk' and commitment language in order to provide effective reinforcing feedback to encourage change

- Use strategies and brief interventions to elicit 'change talk'
- Recognise and respond to service user resistance without opposing it, in order to maintain successful communication and provide respectful and reflective feedback
- Competence in planning and negotiating a suitable and acceptable change plan for the service user at the appropriate time.

## H.3 Competences

The learning outcomes above summarise the more comprehensive list of competences described in Appendix B.

## H.4 Learning and teaching strategy

Knowledge will be developed through a combination of lectures, seminars, discussion groups, guided reading and independent study. Skills based competences will be learned through a combination of clinical simulation in small groups working under close supervision with peer and tutor feedback and supervised practice through supervised direct contact with service users in the workplace.

## H.5 Assessment of competence

A standardised role-play scenario or direct recording of an MI session with a service user where staff are required to demonstrate skills in planning and executing an MI session. This will be video/audio taped and assessed by teaching/supervisory staff using a standardised assessment measure.

Successful completion of the following:

- The identification of service users' substance misuse and related problems, and key areas to address as part of an initial care-plan using motivational interviewing techniques and strategies
- Demonstration of:
  - An approach congruent with the spirit of motivational interviewing, necessary to develop and maintain individualised therapeutic alliances which enable service users to successfully engage

<sup>6</sup> These modules have a common framework which is modelled on that developed for the IAPT curriculum for low-intensity interventions

in a motivational interviewing intervention

- Motivational interviewing techniques and active listening skills
- High quality case recording and systematic evaluation of the process and outcomes of the interventions, adapting care on the basis of these evaluations.

## H.6 Duration

Theoretical teaching and structured clinical simulation to be delivered over a minimum of two days, delivered as two full days over two weeks or one half day per week for four weeks. Practice-based supervision following training is essential to develop these skills. This will require further direct monitoring by a supervisor/recording of two sessions with service users, with protected time for staff between sessions to reflect and develop practice. This may need to be extended to bring staff to the required level of competence. This individualised approach can be supplemented by attendance at structured supervision groups to support this process, and develop peer support structures for the ongoing use of motivational interviewing.

## H.7 References

*Motivational Interviewing: Training for New Trainers* (TNT) (2004). The Motivational Interviewing Network of Trainers, [www.motivationalinterview.org](http://www.motivationalinterview.org) (only accessible to trainers who have completed the TNT workshop).  
Miller WR, Rollnick S (2002). *Motivational Interviewing: Preparing People for Change*, 2nd edn. New York: Guilford Press.

# Appendix I: Specimen curriculum for contingency management

## I.1 Aims

Staff in drug misuse services aid drug abstinence, uptake of vaccination programmes, medication compliance and retention of service users in treatment, or other target behaviours, through the provision of reinforcers, information and support. Contingency management (CM) may be used separately or as an adjunct to existing maintenance drug treatment and other pharmacological treatments prescribed for drug misuse and related health problems. CM encourages behaviour modification by providing positive reinforcement when the target behaviour is achieved. Support is specifically designed to define, monitor and assess the target behaviour and provide suitable reinforcement contingent on it being met. Training will therefore equip staff with a good understanding of the process of contingency management, the underlying behavioural principles and ways in which to deliver the above aspects of the intervention. Skills teaching will develop workers' general and 'specific factors' competences in the delivery of contingency management.

## I.2 Learning outcomes

- Demonstrate:
  - In-depth understanding of, and competence in, the use of a contingency management protocol and underlying behavioural principles
  - Competence in developing and maintaining a therapeutic alliance with service users during their treatment programme, including dealing with issues and events that threaten the alliance (e.g. positive biological sample)
  - Competence in shaping the CM intervention to each service user, such that the correct target behaviour and reinforcers are chosen
  - Competence in carrying out biological tests and subsequent reporting of results in a manner appropriate to the outcome of the test
  - An ability to effectively communicate both the current and possible future reward schedule to the service user, praising efforts of abstinence where appropriate
  - An ability to deal with self-report of drug misuse and relate it to objective indicators and consequences of a positive sample.

## I.3 Competences

The learning outcomes above summarise the more comprehensive list of competences described in Appendix C.

## I.4 Learning and teaching strategy

Knowledge will be developed through a combination of lectures, seminars, discussion groups, guided reading and independent study. Skills-based competences will be learned through a combination of clinical simulation in small groups working under close supervision with peer and tutor feedback and supervised practice through supervised direct contact with service users in the workplace.

## I.5 Assessment of competence

A standardised role-play scenario or direct recording of a CM session with a service user where staff are required to demonstrate skills in planning and implementing a CM intervention will be video/audio-taped and assessed by teaching/supervisory staff using a standardised assessment measure.

- Successful completion of the following:
  - The correct use of a CM protocol in relation to a number of typical scenarios while maintaining a service user-centred and positive therapeutic alliance
  - Negotiating with service users a range of appropriate motivational incentives within the parameters of an agreed CM protocol
  - High quality case recording and completion of standardised CM recording tools
  - Systematic evaluation of the process and outcomes of the interventions in order to adapt care on the basis of these evaluations.

## I.6 Duration

A minimum of three days, one half day per week for six weeks, spent in theoretical teaching and clinical simulation. Practice-based supervision following training is required to develop skills in CM. This will also require further direct monitoring by a supervisor/recording of two sessions with service users, with protected time for staff between sessions to reflect and develop practice. This may need to be extended to bring staff to the required level of competence. This individualised approach can be supplemented by attendance at structured supervision groups to support this process and develop peer support structures for the ongoing use of CM.

## I.7 References

Kellogg SH, Burns M, Coleman P, Stitzer M, Wale JB, Kreek MJ (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  
Petry NM (2000). A comprehensive guide to the application of contingency management procedures in general clinic settings. *Drug and Alcohol Dependence.* 58:9-25  
Petry NM, Simcic F Jr (2002). Recent advances in the dissemination of contingency management techniques. *Journal of Substance Abuse Treatment.* 23:81-86

# Appendix J: Specimen curriculum for common mental health problems

## J.1 Aims

Staff working in substance misuse services can bring clinical improvement through the provision of information and support for evidence-based low-intensity psychological treatments for common mental health problems. These will be provided alongside a range of interventions focused specifically on drug misuse. This curriculum assumes that staff are competent in the generic competences to deliver psychosocial interventions. Where this is not the case a fuller training programme, such as that developed by Professor David Richards and colleagues from the University of York for the IAPT programme (Department of Health, 2008; Richards and Whyte, 2008), will be required. Low-intensity psychological treatments (e.g. guided self-help and brief behavioural activation) place a greater emphasis on service user self-management, and are designed to be less burdensome to people undertaking them than traditional psychological treatments. Support is specifically designed to enable people to optimise their use of self-management and may be delivered through face-to-face, telephone, email or other contact methods. Training should therefore equip staff with a good understanding of the therapeutic support process and the management of individuals. Skills teaching should develop general and disorder-defined 'specific factors' competences in the delivery of CBT-based low-intensity interventions.

## J.2 Learning outcomes

- Critically evaluate a range of evidence-based low-intensity interventions and strategies to assist service users manage their psychological problems
- Demonstrate:
  - Knowledge and understanding of common mental health problems and substance misuse problems
  - Competence in developing and maintaining a therapeutic alliance with service users during their intervention, including dealing with issues and events that threaten the alliance
  - An ability to gather information to gain an overview of the service user's current life situation, mental health and the impact substance misuse has on this
  - Knowledge and competence in low-intensity basic, intervention-specific, problem-specific and meta-CBT competences such as behavioural activation and CBT based guided self-help
  - Critically evaluate the role of low-intensity and

stepped care approaches to managing common mental health problems in a substance misuse service

- Demonstrate:
  - Competence in delivering low-intensity interventions using a range of methods including face-to-face, telephone and electronic communication
  - The ability to work effectively across various sectors of the care system and understand the limits of low-intensity interventions in order to facilitate individuals movement through the system should they require further treatment.

## J.3 Competences

The learning outcomes above summarise the more comprehensive list of competences described in appendix G.

## J.4 Learning and teaching strategy

Knowledge will be learned through a combination of lectures, seminars, discussion groups, guided reading and independent study. Skills based competences will be learned through a combination of clinical simulation in small groups working intensively under close supervision with peer and tutor feedback and supervised practice through supervised direct contact with service users in the workplace.

## J.5 Assessment strategy

A standardised role-play scenario or direct recording of a session with a service user where staff are required to demonstrate skills in planning and executing a low-intensity treatment programme. This will be video/audio taped and assessed by teaching/supervisory staff using a standardised assessment measure.

- Successful completion of the following practice outcomes:
  - The identification and management of service users' psychological problems through the use of interpersonal skills and evidence-based interventions
  - Demonstrating the techniques necessary to develop and maintain a therapeutic alliance that enable service users to be collaboratively involved in their care
  - High quality case recording and systematic evaluation of the process and outcomes of mental health interventions, adapting care on the basis of these evaluations.

## **J.6 Duration**

A minimum of four days, one half day per week for eight weeks, spent in theoretical teaching and clinical simulation. Practice-based supervision following training is required to develop skills in low-intensity interventions for common mental health problems. This will also require further direct monitoring by a supervisor/recording of two sessions with service users, with protected time for staff between sessions to reflect and develop practice. This may need to be extended to bring staff to the required level of competence. This individualised approach can be supplemented by attendance at structured supervision groups to support this process and develop peer support structures for the ongoing use of these interventions.

## **J.7 References**

Department of Health (2008). *Improving Access to Psychological Therapies – Implementation Plan: Curriculum for Low-intensity Therapies Workers*. London: Department of Health

Richards D and Whyte M (2008). *Reach Out: National Programme Educator Materials to Support the Delivery of Training for Practitioners Delivering Low Intensity Interventions*. London: Rethink



# Appendix K: Supervision competences framework

## K.1 Generic supervision competences

- An ability to:
  - Employ educational principles which enhance learning
  - Enable ethical practice
  - Foster competence in working with difference
  - Take into account the organisational context for supervision
  - Form and maintain a supervisory alliance
  - structure supervision sessions
  - Help the supervisee present information about clinical work
  - Help supervisee's ability to reflect on their work and on the usefulness of supervision
  - Use a range of methods to give accurate and constructive feedback
  - Gauge supervisee's level of competence.
- An ability for supervisor to reflect (and act) on limitations in own knowledge and experience.

## K.2 Specific supervision competences

- An ability to:
  - Help the supervisee practice specific clinical skills
  - Incorporate direct observation into supervision
  - Conduct supervision in group formats
  - Apply standards.

## K.3 Applications of supervision to specific models/contexts

- Supervision of:
  - Overall caseload
  - Low-intensity interventions
  - Cognitive and behavioural therapy.

## K.4 Metacompetences in supervision

### Adapting process and content of supervision

- An ability to:
  - Match the process and content of supervision to the supervisee's stage of development
  - Identify gaps in knowledge and skills and to identify the best learning strategies for managing these
  - Use professional judgment to monitor the supervisee's learning and emotional needs as these relate to client work and to any organisational issues
  - Balance attention to process issues with the need to advance the supervisee's learning and clinical practice

- Use professional judgment in order to balance the need to ensure that the supervision agenda is comprehensive in its coverage against the need to be responsive to current and specific supervisee needs
- Use professional judgment to decide whether and how to adapt supervision in response to supervisee feedback.

### Giving feedback

- An ability to:
  - Balance positive and negative feedback
  - Prioritise areas for feedback (i.e. which areas to discuss and which to hold in mind for later sessions) with a view to sustaining the supervisee's capacity to learn from feedback.

### Managing concerns about the supervisee's ability to use supervision

- An ability to use professional judgment to identify when obstacles to supervision are sufficient to warrant explicit discussion with the supervisee.

### Managing serious concerns about practice

- An ability to:
  - Use professional judgment to take appropriate action when the supervisee's clinical practice raises serious concerns
  - Identify and manage any adverse impacts of such actions on the supervisory relationship
  - Balance a focus on the supervisee's educational development with an obligation to identify and prevent practice which could be harmful or unhelpful to clients.

### Low intensity supervision

- An ability to undertake supervision of low-intensity work in a manner which recognises and values:
  - The integrity of this approach (i.e. as an effective intervention in its own right, and not merely as a precursor to more intensive therapy)
  - The distinctive role and contribution of the low intensity worker.

# Appendix L: Protocol for motivational interviewing

Motivational interviewing (MI) requires clinicians to be sensitive to service users' readiness to change and to adapt the intervention accordingly. If a service user appears to be highly resistant to talking about a particular behaviour, or to considering change, it is important to focus the discussion on a neutral area that is less threatening to the service user. Conversely, if a service user expresses an intention to change, it may be counter-productive to seek to elicit ambivalence about that behaviour. MI should be adapted to the needs of the individual service user and practice of MI under supervision will enable workers to develop the appropriate skills to do this. A basic example framework is outlined below for conducting a session using MI. It utilises some of the intervention's key strategies and assumes that it is delivered by workers who are competent and familiar with the spirit of MI. The protocol contains a simple algorithm for working through a typical session and reaching a satisfactory conclusion for the service user based on their level of readiness to change. However, this protocol need not be rigidly followed – its primary use may be as an aid to supervised practice.

## L.1 Introduction, rapport-building and agenda setting

Take a few minutes to introduce yourself. Thank them for agreeing to see you (e.g. *I'm really pleased you've agreed to discuss the results of that questionnaire you filled in about your drinking*). Introduce yourself honestly but avoid stigmatising labels if you are an alcohol or drugs or dual diagnosis specialist (e.g. rather than introducing yourself as the Hospital Alcohol Liaison Nurse you could say you are a nurse employed to talk about peoples' drinking and to find out if there's anything to do with lifestyle that might be helpful with their current health problem).

Give an overview of the session unless this is inappropriate: how long (up to 40 minutes) you will be meeting for and what your goals are, but with an emphasis on explaining that within these limits it is the service user's own goals that will be the focus. Map out the topics with the service user and agree focus. Describe the approach (as set out below). Here is an example of what you might say:

*Before we begin, I'm just going to explain a little about what this is about. You've already spent some time (doing the questionnaire/being assessed) and probably having lots of tests and investigations on (reason for being in hospital/ being in this service). However, in this meeting*

*we are just going to discuss the questionnaire you did/your assessment and how drinking/drugs might affect your problem or how you might be helped better for the future. I should also explain right from the start that I want to find out what you want for you; I'm not going to lecture you or try to make you change anything you don't want to change. I hope that this meeting will help you think about your present situation and consider what, if anything, you might want to do. If there are any changes to be made, you will be the one to make them. Nobody can tell you what to do; nobody can make you change. I may be able to give you some information about yourself and maybe some advice, but what you do with all of that after our meeting together is completely up to you. The only person who can decide whether and how you change is you. How does that sound to you?*

Remember, service users can be powerfully affected by the arguments they hear themselves make, rather than being lectured to by you. Your job is to raise awareness and motivation to change and to facilitate decision-making.

## L.2 Review of current situation, exploration of ambivalence and change talk

- Briefly discuss with the service user their current situation and their perception of their pattern of drinking/drug use and level of consumption
- A good opener might be:  
*Tell me about how things are going for you at the moment*
- Listen for statements that indicate ambivalence about the target behaviour
- Reflect these back to the service user and include in capsule summaries
- Affirm service users, where appropriate, stating their strengths, resourcefulness, problem-recognition or commitment to thinking about their substance use.

## L.3 Elicit change talk

Involves: recognition of a problem around drugs/ alcohol, concerns about this, intention to change, optimism about change and commitment to change

- Problem recognition :  
Some open-ended questions you can ask:  
*Can you tell me more about your current drinking?*  
*What problems are causing you concern? How might these be affected by your drugs/drinking do you think?*

*What concerns do you have about your current use/drinking?*

- Alternatively, use a decision balance if appropriate here. Start with the positives: *Tell me about the good things about using/drinking for you. What do you enjoy about drinking/drugs, what do you get out of it that is helpful or enjoyable?*
- Allow time for elaboration, use reflections and ask open-ended questions
- Then the flip side: *Tell me about the not so good things about your cannabis/drug/drinking, what kind of problems or difficulties does this cause to you or others?*
- If you are using a decision balance as a technique, you could write the points down (or better still, get the service user to write them down)
- Use the examples given above for other questions relevant to other levels of change talk
- Use importance and confidence scaling questions if appropriate to this service user. Remember to ask the follow up questions designed to elicit change talk:  
*Why are you at a ... and not 0?*  
*What would it take for you to go from ... to (a higher number)?*  
Remember not to ask, *Why are you at ... and not 10?*  
Where appropriate use other techniques described above for eliciting change talk but do not go beyond 'where the service user is at' in terms of motivation for change.

#### L.4 Providing feedback and giving advice

- Elicit the service user's understanding of the health issue and seek permission to provide information about it
- *Other people with this level of drinking and with this kind of health problem are very likely to...* This helps avoid the service user feeling in a corner
- *This might not necessarily work for you, but other people have found keeping a drink/drug diary / talking the options through with someone trained in this field / having a period of abstinence / getting their levels below five units per day with at least two alcohol-free days / doing the "Down Your Drink" programme, etc. has helped prevent the kinds of medical and mental health problems you have from getting worse*
- Elicit the service user's understanding of the information provided and any questions they may have
- If the service user seems uninterested in the information and there is further work to do

around problem recognition, repeat L.3 or go to L.6 to end the session

- If the service user is ready to consider change, move to the next section.

#### L.5 Moving towards action

- If the service user is willing to consider change, give a summary of the things they have said that indicate their wish to change. Ask the 'what next?' question
- If a service user appears resistant to considering change then go back to L.2 or L.3 as appropriate or end the session as in L.6. Remember it will be more productive to defer a discussion for another session than persist when a service user clearly has no interest
- If appropriate start to negotiate a change plan
- Seek to set out with the service user a change plan that has SMART (specific, measurable, achievable, realistic and timed) goals and a particular emphasis on a clear commitment to a course of action
- Remember that service users may still be ambivalent about change so the use of strategies in L.3 may be useful.

#### L.6 Ending

Check with the service user if there's anything else they would like to find out from you. If there's anything the service user has said they will do, go over how they will do this and if possible get this written down and left with the service user. You are always polite and respectful, but try to add to this with thanks to the service user and affirmation.

*I realise you've probably got other things to do than talk about your drinking/drug use to me / it isn't easy talking about personal stuff like we have, so well done. I really respect you for being willing to spend this time talking to me about your drugs/drinking. I know it's not easy, but I hope this has been helpful to you.*

#### L.7 Reference

Martino S, Bali SA, Gallon SL, Hall D, Garcia M, Ceperich S, Farentinos C, Hamilton J, and Hausotter W (2006). *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency*. Salem, OR: Northwest Frontier Addiction Technology Transfer Center, Oregon Health and Science University Training Materials: Dr Paul Davis, Camden and Islington Foundation Trust.

# Appendix M: Protocol for contingency management

This protocol sets out a general approach to the delivery of contingency management for drug misuse problems. It assumes that an initial assessment has been undertaken and the nature of the drug misuse problem has been identified and deemed suitable for contingency management in line with locally agreed policies for its use. The precise details of the protocol, including target behaviours and reinforcement schedules, will vary depending on the nature of the substance misuse.

## M.1 Developing a contingency management programme

Identify a population: This may well be a sub-group of clinic attendees, for example those who not responding to treatment (e.g. illicit drug use while on methadone) or are assessed at high risk (e.g. intravenous drug users who have not had a hepatitis B vaccination).

Identify target behaviour that is to be altered, ensuring it can be objectively quantified and occurs frequently. It should be the behaviour in most need of change (and expectations for change must not be set too high in the first instance. If the behavioural change required is considerable, the target behaviour may need to be broken down into a number of smaller and more easily achieved behaviours.

Identify a reinforcer: This is a crucial element of any programme and it should be valued by the service users. The type of reinforcer (e.g. vouchers or clinic privileges) offered will be determined by the target behaviour, setting of the intervention, the resources of the service and the procedures for agreeing it should be set out in locally agreed policies.

Use behavioural principles to guide the intervention: These will help determine the magnitude of the reinforcer, the frequency of the reinforcement schedule (and its possible variation over time), the immediacy of a tangible reinforcer and the duration of the intervention that is compatible with the change in target behaviour required taking into account the overall treatment programme. These should be set out in an agreed reinforcement schedule which is simple to implement and follow, and can be understood by the service user.

Establishing a behavioural contract: Once the target behaviour is agreed and the reinforcement schedule is in place, a contract should be drawn up with the service user. This should be specific and cross-checked to eradicate ambiguities and loopholes.

Implementing the programme: The behavioural contract should be consistently applied and all staff involved in the implementation of the programme should be aware of the procedures they should follow. Constant reminders of the desired behaviours and consequences can be useful.

Planning for the future: This should have two elements; first working with service users to support the generalisation of the programme benefits through internalisation of the changes and the use of wider social reinforcers to support and maintain the target behaviours. Secondly, records of what works and what doesn't work throughout an intervention should be made, to be shared with staff and service users to improve future programme implementation.

## M.2 Assessment and eligibility

Although any person entering a contingency management programme will already have had a general substance misuse assessment, there are some specific issues that should be carefully re-assessed before a person enters such a programme. These are concerned in the case of assessment not only with the individual but also with the environment.

In the specific assessment and planning of the intervention it is important to consider:

- The target behaviours to be measured are objectively quantifiable
- The use of successive approximations to an agreed target behaviour may be necessary where it is unlikely that an all or nothing process will always be effective in the first instance
- The environment should be rearranged so target behaviour is readily detectable (objective measurement required)
- Tangible reinforcers (which are perceived to be of value by the service user) should be consistently and promptly given when the target behaviour is achieved.

In addition services should have pre-determined eligibility criteria in place which should be achieved before entering a CM programme. These will vary with the nature of the target population. Some examples are given below, which are not intended as rules to be followed by all services.

**Sample eligibility criteria for a CM programme for those using illicit drugs on a methadone maintenance programme:**

- Enrolled in methadone treatment programme for 30 days
- Submitted positive urine samples of specified substances in 30 days prior to implementation of CM
- Demonstrated understanding of the purpose of CM and agreed to take part in programme.

#### Examples of reasons to reinforce:

- Drug abstinence
- Attendance for a vaccination (e.g. hepatitis B) or test (e.g. TB or HIV)
- Abstinence from illicit drug use in a methadone maintenance programme
- Compliance with treatment plans/medication.

#### Reinforcers:

- Vouchers redeemable for items consistent with service user's care-planned objectives. These should be negotiated in advance with the service user, be immediately available and redeemable in line with agreed local policies
- Clinic privileges (take-home methadone doses)
- Prize-draw entries.

### M.3 Drug testing procedure (where relevant)

For many, but not all CM programmes, drug testing forms an essential element of the programme. The following issues need to be considered in any testing programme:

- On-site/near-patient testing is required, with a sample produced (where necessary using a same sex observer to ensure validity, or by other means if they are in place) using tests (urine/saliva) that can immediately confirm the presence/absence of the targeted substance
- Tests should be substance-specific, and linked to agreed target behaviour
- Validity tests for samples should be considered where possible including by temperature strip and possible checks for pH, creatinine, glutaraldehyde and nitrate. If urine fails validity test, service users need to supply another sample
- Test results should be fed back and this should be done immediately, and the implications for the programme considered.

Service users may also be required to provide a breath test for presence of alcohol if appropriate.

### M.4 Progression through programme

The duration of the programme should be set out clearly at the beginning of the programme. Typically many programmes will last for 12 weeks from the first urine test, but this may vary depending on the nature of the target behaviour. A number of factors may result in

an earlier ending of the programme; again these should be clearly set out at the beginning of the programme and be known to the service user. They could include:

- Non-attendance at the programme for a period of 30 days or more during the 12-week period
- Non-participation in normal keyworking sessions or compliance with agreed medication in line with existing treatment schedule
- Refusal to supply biological samples in line with the agreed reinforcement schedule.

However, as CM is typically an adjunct to usual services, participants should be able to decline/ disengage from the service without fear of jeopardising their ongoing care.

Services users who inform staff about an expected absence should not be penalised and continue from the level of reinforcement where their last appointment left off. However, at least one biological sample a week is necessary to be eligible for escalating reinforcers.

In many CM programmes reinforcement schedules are varied with the use of escalating reinforcers as the service user progresses through the programme. Two examples are given below:

#### Example of reinforcement schedule for programme to enhance drug abstinence:

- A negative drug toxicology result allows the service user to receive a voucher
- Value of vouchers may increase each week if all submitted samples are free from the primary drug target
- Value of vouchers returns to original level after an unexplained absence or submission of positive primary sample
- As initial values may be low (when it is most important to get service user 'on-board'), this can be off-set by awarding a larger incentive after two consecutive weeks of abstinence.

#### Example of reinforcement schedule for BBV testing and compliance with vaccines:

- Attendance for an assessment and initial blood test allows the service user to receive the first voucher
- A second voucher can be provided for each successive appointment attended or vaccine received
- A final bonus voucher twice the value of a standard voucher is provided after successful completion of the vaccination programme.

## M.5 References

- Kazdin AE (1994). *Behavior Modification in Applied Settings* (5th ed.). Pacific Grove, CA: Brooks/Cole Publishing Co
- Kellogg SH, Burns M, Coleman P, Stitzer M, Wale JB, and Kreek MJ (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
- Petry NM (2000). **A comprehensive guide to the application of contingency management procedures in clinical settings.** *Drug and Alcohol Dependence*, 58, 9-25
- Petry NM, Alessi SM, Marx J, Austin M, and Tardif M (2005). **Vouchers versus prizes: Contingency management treatment of substance abusers in community settings.** *Journal of Consulting and Clinical Psychology*, 73, 1005-1014



# Appendix N: Protocol for low-intensity interventions for common mental health problems

This protocol sets out a general approach to the delivery of low-intensity interventions for both guided self-help (GSH) and behavioural activation (BA). It assumes that an initial assessment has been undertaken and the nature of the problem (depression or an anxiety disorder) has been identified and is deemed suitable for a low-intensity intervention. The precise details of the protocol will vary depending on the nature of the anxiety disorder and as they will with the nature of the problems faced by an individual with depression.

## N.1 Establishing guided self-help or behavioural activation

This will normally take place entirely during the first contact and will require the following:

- An assessment of relevant symptoms (using formal measures such as the PHQ-9 and GAD-7) and the impact on a person's functioning, any associated risks, motivation to engage in the programme, and experience and response to previous treatments
- An agreed set of goals (which have emerged from a shared decision making process) and the administration of materials (e.g. behavioural record sheets) to support the treatment plan.
- Psycho-education about the nature of the problem including summarising (and normalising) the problem in a manner which facilitates the establishment of the intervention
- The identification and advice on the use of the specific written materials relevant to the particular problem and identified goals
- Education about the model of the intervention (emphasising the focus on service self-directed care and the role of the therapist in supporting this self-help approach) to be used and its relationship to the agreed problem(s) and goals identified
- An agreed plan for the duration of the intervention and the frequency, nature and duration of the individual sessions (e.g. face-to-face contacts or telephone contacts), and the system for reviewing progress, including when necessary the process for 'stepping-up' care.

## N.2 Duration and frequency of sessions

The duration of sessions will vary according to the service user's need but the initial session would not normally last more than 45 minutes, subsequent sessions typically would be expected to be of no more than 30 minutes duration but may be less in the case

of telephone contacts. The frequency of sessions will vary with service user need but might involve weekly contacts initially for two to three weeks but then could be fortnightly depending on the response to the intervention. The intervention would normally involve a minimum of eight contacts but in some cases may be less. It should not last longer than 12 weeks including, when necessary, a follow-up session. The routine monitoring of the outcome to the intervention and the degree of support needed by the service user should influence the frequency of contact.

## N.3 Record keeping and outcome monitoring

This has four elements:

- The recording of the service user's mental and behavioural state and any variation in assessed risk
- The use of service user's diary and record sheets to monitor progress and to revise and plan further interventions
- The use of formal ratings such as the PHQ-9 and the GAD-7 to monitor progress
- Direct feedback from the service user on progress in treatment and their satisfaction with the content and manner of delivery of the intervention.

All three elements should be used in each subsequent session to evaluate progress (in discussion with the service user) and shape the future treatment plans.

## N.4 Subsequent treatment sessions

All subsequent sessions should follow the same broad agenda, this will include:

- An agreed agenda for the meeting
- A review of progress using both the diary and record sheets and the formal measures and an assessment of any change in risk status
- Reinforcement of progress made
- Advice on further refinement/revision of goals and advice on overcoming obstacles to the achievement of particular goals
- Advice on how progress may be maintained by building in generalisation and social reinforcers of service user achieved change.

## N.5 Final session and ending the intervention

- An agreed agenda for the meeting
- A review of overall progress against initial and subsequent goals (using service user feedback and formal and informal assessment materials)
- Review and revise plans to maintain



generalisation and social reinforcers including specific advice on personal and environmental strategies to reduce the likelihood of future relapse.

Where an individual has not benefited from a low-intensity intervention, they should be stepped-up to a high-intensity intervention unless they decline the offer to do so. The decision to step-up should be based on clearly agreed and objective criteria (e.g. failure to show significant improvement on the PHQ-9 or GAD-7) which should be in place before embarking on a low-intensity interventions and which should be known to the service user at the beginning of the intervention. There should be locally agreed protocols in place for 'stepping up' to a higher level intervention, agreed with low and high-intensity treatment providers.

## Appendix O: Depression and anxiety questionnaires

The questionnaires included in this appendix are not intended to be used alone for diagnosis. Their primary purpose here is to assess the outcome of low-intensity interventions for depression and anxiety. They were originally developed as part of the PRIME-MD programme supported by Pfizer<sup>7</sup>. They are used throughout the IAPT programme and are free to copy and use. Further details can be found in Kroenke et al. (2001) and Spitzer et al. (2006).

### References

- Kroenke K, Spitzer RL, Williams JBW (2001). **The PHQ-9: Validity of a brief depression severity measure.** *J Gen Intern Med*; 16 606-613
- Spitzer RL, Kroenke K, Williams JBW, Löwe B (2006). **A brief measure for assessing generalized anxiety disorder: the GAD-7.** *Arch Intern Med*; 166 1092-1097

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<sup>7</sup> The names PRIME-MD® and PRIME-MD TODAY® are trademarks of Pfizer Inc. To obtain PHQ-9, including permission for clinical/research use, go to [www.phqscreeners.com](http://www.phqscreeners.com)

## 0.1 Patient Health Questionnaire – 9 (PHQ-9)

Use to indicate your answer

| Over the last two weeks, how often have you been bothered by any of the following problems?   | Not at all | Several days | More than half the days | Nearly every day |
|---|------------|--------------|-------------------------|------------------|
| Little interest or pleasure in doing things   |            |              |                         |                  |
| Feeling down, depressed, or hopeless  |            |              |                         |                  |
| Trouble falling or staying asleep, or sleeping too much   |            |              |                         |                  |
| Feeling tired or having little energy   |            |              |                         |                  |
| Poor appetite or overeating   |            |              |                         |                  |
| Feeling bad about yourself – or that you are a failure or have let yourself or your family down   |            |              |                         |                  |
| Trouble concentrating on things, such as reading the newspaper or watching television   |            |              |                         |                  |
| Moving or speaking so slowly that other people could have noticed? <i>Or</i> being so fidgety or restless that you have been moving around a lot more than usual? |            |              |                         |                  |
| Thoughts that you would be better off dead or of hurting yourself in some way   |            |              |                         |                  |

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### PHQ-9 depressive symptoms scoring

This is calculated by assigning scores of 0, 1, 2, and 3, to the categories of 'not at all', 'several days', 'more than half the days' and 'nearly every day' respectively. PHQ-9 total score for the nine items ranges from 0 to 27. Scores of 5, 10, 15, and 20 can be seen as 'cut-off points' relating to mild, moderate, moderately severe and severe depression, respectively. However, these cut-offs alone should not be used to arrive at a diagnosis. The primary purpose of the questionnaire in this framework is to assess the outcome of low-intensity interventions.

## 0.2 Generalized Anxiety Disorder – 7 (GAD-7)

Use \_\_\_\_\_ to indicate your answer

| Over the last two weeks, how often have you been bothered by any of the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|------------|--------------|-------------------------|------------------|
| Feeling nervous, anxious or on edge   |            |              |                         |                  |
| Not being able to stop or control worrying  |            |              |                         |                  |
| Worrying too much about different things  |            |              |                         |                  |
| Trouble relaxing  |            |              |                         |                  |
| Being so restless that it is hard to sit still  |            |              |                         |                  |
| Becoming easily annoyed or irritable  |            |              |                         |                  |
| Feeling afraid as if something awful might happen   |            |              |                         |                  |

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### GAD-7 anxiety symptoms scoring

This is calculated by assigning scores of 0, 1, 2, and 3, to the categories of 'not at all', 'several days', 'more than half the days' and 'nearly every day' respectively. GAD-7 total score for the seven items ranges from 0 to 21. Scores of 5, 10, and 15 can be seen "cut-off points" relating to mild, moderate, and severe anxiety, respectively. However, these cut-offs alone should not be used to arrive at a diagnosis. The primary purpose of the questionnaire in this framework is to assess the outcome of low-intensity interventions.

# Appendix P: Audit criteria for psychosocial interventions

## P.1 Objective of the audit

The aim of the audit is to assist healthcare organisations determine whether the service is implementing, and is compliant with, the NICE recommendations for the delivery of psychosocial interventions for drug misuse. The audit criteria are designed to support the implementation of the framework for psychosocial interventions. Users can cut and paste these into their own programmes or they can use this template.

## P.2 Service user group to be included in the audit

Service users being treated with the psychosocial interventions recommended for the treatment of drug misuse and associated common mental health problems.

## P.3 Sample for the audit

It is suggested that the audit should cover all service users who commenced treatment. However, even if organisations are unable to commit to an audit of this scale there is considerable value in undertaking a structured audit of the guidance for a shorter period of time.

## P.4 Data source for the audit

The audit criteria require data to be collected from a range of sources, including client records and administration systems.

## P.5 Frequency of the audit

The audit should be repeated periodically, depending on the local audit strategy and the time required to implement any necessary action arising from the first audit. This will allow trusts to monitor progress towards full compliance. However, the frequency of repeat audits needs to be considered alongside other priorities for audit.

## P.6 Using the audit criteria to audit implementation of the guidance

An audit reporting template is included after the audit criteria. It is recognised that some organisations will have their own well-developed systems for reporting audit results and for retaining results to allow progress over time to be monitored. The reporting template is provided for those trusts that might find it useful.

## P.7 Calculation of compliance

Where compliance (%) with the guidance should be calculated as a measure, this is calculated as follows:

$$\frac{\text{Number within the population group whose care is consistent with the criterion}}{\text{Number within the population group to whom the measure applies (that is, the total population group less any exceptions)}} \times 100\%$$

In addition to the percentage compliance it may be useful to report the numerator and denominator to give an idea of the population size.

## P.8 Review of audit findings

The NTA encourages the local discussion of audit findings and where there is an identified lack of compliance with the guidance, the development of an action plan. Progress against the plan can then be monitored and reported to show that progress towards desired improvements is being achieved.

| Criterion no. | Criterion   | Exceptions   | Definition of terms and/or general guidance  | Data source   |
|---------------|---|--|--|---|
| 1             | <p><b>Contingency management (CM)</b></p> <p>The percentage of service users identified for inclusion in a CM programme for:</p> <ul style="list-style-type: none"> <li>• Illicit drug use</li> <li>• Blood borne virus testing and vaccination</li> </ul>  | None   | It is important that local services set out their agreed criteria for the inclusion of service users in a CM programme. Should service users meet these criteria, they should automatically be enrolled.   | Service user management plan/ case notes / NDTMS reporting.   |
| 2             | <p><b>Contingency management</b></p> <p>The service provider has sufficient resources to support a contingency management programme</p>   | None   | Service planning should be clear about what resources would be needed to successfully run a CM programme.<br><i>Standard = 100%</i>  | Budget reports / service costing framework / monitoring reports for DAAT / PCT / local area treatment plan. |
| 3             | <p><b>Motivational interviewing (MI)</b></p> <p>The percentage of service users offered MI:</p> <ul style="list-style-type: none"> <li>• As part of an initial triage assessment (in mainstream substance misuse services)</li> <li>• As part of a full assessment/induction into treatment phase</li> <li>• Opportunistically, e.g. in needle exchanges</li> </ul>                           | None   | It is important that local services have agreed criteria to determine who will be offered MI as a treatment for substance misuse and able to specify the use of MI in a treatment care-pathway. Contraindications for the provision of MI would include intoxication, mental health crises or immediate risk to self or others. <i>Standard = 100%</i>                       | Service user management plan/case notes.  |
| 4             | <p><b>Behavioural couples therapy (BCT)</b></p> <p>The percentage of people in a stable couple relationship and identified as needing high-intensity treatment, who are offered BCT</p>   | Applies only to those in a stable relationship where one partner is not using drugs  | It is important that local services have agreed criteria to determine who is eligible for BCT as treatment for substance misuse.<br><i>Standard = 100%</i>   | Service user management plan/case notes.  |
| 5             | <p><b>Common mental health problems (CMHP)</b></p> <p>The percentage of service users who are identified as requiring low and high-intensity interventions for CMHP.</p> <p>The percentage of service users who are offered low and high-intensity interventions for CMHP.</p> <p>The percentage of service users who initiate and complete low and high-intensity interventions for CMHP</p> | This will apply only to those who are in regular contact with services and have in place an agreed management plan for their drug misuse problem | Common mental health problems may often be ignored when there is a more salient substance misuse problem. It is important that these CMHP are not overlooked. The assessment and service user management plan should contain questions to identify the intensity of intervention needed for CMHPs as well as how these interventions are provided.<br><i>Standard = 100%</i> | Service user management plan/case notes.  |

| Criterion no. | Criterion  | Exceptions | Definition of terms and/or general guidance  | Data source  |
|---------------|--|------------|--|--|
| 6             | <b>Common mental health problems (CMHP)</b><br>Percentage of service users receiving a high or low-intensity intervention for CMHP, for whom problem specific routine outcome measures are in use  | None       | Standard = 100%  | Service user management plan/case notes.                                       |
| 7             | <b>Care pathways</b><br>Agreed care pathways are in place which detail the access to and provision of high and low-intensity psychosocial interventions  | None       | Care pathways should specify: case identification & referral criteria; interventions to be provided; supervision systems; quality assurance systems.<br>Standard = 1 pathway per evidence-based intervention               | Local service specification.   |
| 8             | <b>Training</b><br>The percentage of staff delivering:<br><ul style="list-style-type: none"> <li>• Low-intensity drug misuse interventions who have received training</li> <li>• Low-intensity CMHP interventions who have received training</li> </ul>  | None       | Staff should not be delivering interventions without some form of formal training<br>Standard = 100%   | Service records of training programmes.<br>Formal staff evaluation/ appraisal. |
| 9             | <b>Training</b><br>The percentage of services who have in-house capacity to monitor training   | None       | There should be at least one person in the service who can provide/monitor the required staff training.<br>Standard = A designated person is able to monitor training/ requirements  | Local service specification.   |
| 10            | <b>Treatment protocols</b><br>The service has a protocol in place for delivering:<br><ul style="list-style-type: none"> <li>• Low-intensity drug misuse – separate protocols for MI and CM (BBV and MMT)</li> <li>• Low-intensity CMHP</li> <li>• High-intensity drug misuse</li> <li>• High-intensity CMHP</li> </ul> | None       | Protocols must be in place and clearly specified to inform staff of best practice.<br>Standard = A delivery protocol for each intervention is included in the service specification  | Local service specification.   |
| 11            | <b>Supervision</b><br>A service must have a protocol in place for the delivery of supervision that states nature and frequency of supervision  | None       | Applies to both high and low-intensity interventions. Services should have policy in place that states nature and frequency of supervision.<br>Standard = Protocol for delivery of supervision is in service specification | Local service specification.   |



| Criterion no. | Criterion   | Exceptions | Definition of terms and/or general guidance  | Data source  |
|---------------|---|------------|--|--|
| 12            | <p><b>Supervision</b><br/>A service must have staff in place who are competent to deliver supervision in high and low-intensity psychosocial interventions</p>    | None       | <p>Applies to both high and low-intensity interventions. <i>Standard = Staff in place who are trained to offer supervision (number should be proportionate to the total number of staff employed within service)</i></p> | Local service specification.   |
| 13            | <p><b>Supervision</b><br/>The percentage of staff delivering psychosocial interventions who are in receipt of supervision for that work, once every two weeks</p> | None       | <p>Supervision is a key component of delivering effective interventions and provision should be made within the service to ensure sufficient supervision can be provided. <i>Standard = 100%</i></p>                     | <p>Formal staff evaluation/<br/>appraisal<br/>Service user<br/>management plan/case<br/>notes.</p> |

## Appendix Q: Adherence measures for motivational interviewing

The Motivational Interviewing Treatment Integrity (MITI) Code: Version 2.0 (developed by Theresa B. Moyers, Tim Martin, Jennifer K. Manuel & William R. Miller [www.oregon.gov/DHS/mentalhealth/ebp/fidelity/mi.pdf](http://www.oregon.gov/DHS/mentalhealth/ebp/fidelity/mi.pdf)) is the gold standard behavioural coding system that is used to assess competences in motivational interviewing and provides structured formal feedback to practitioners. Supervisors trained in the use of the MITI listen to a 20 minute segment of a recorded session and make global ratings of empathy and motivational interviewing spirit as well as a number of counts of specific practitioner behaviour. Summary scores are produced from these scores to determine overall MI competence. Becoming proficient in the use of the MITI requires coders to achieve competence measured by inter-rater reliability and matched to a set standard.

An example of an alternative measure adapted from one used in a UK treatment trial is included overleaf. This requires supervisors to listen to a practitioner's clinical material and make ratings on a series of seven-point scales.

### Therapist Evaluation – MOTIVATIONAL INTERVIEWING SKILLS<sup>8</sup>

Please assess the therapist's skill in the areas listed below. Circle N/A only if there was no opportunity in the session to use that skill.

**RATING SCALE 7=excellent, 6=very good, 5=good, 4=acceptable, 3=mediocre, 2=poor, 1=very poor**

|  |   |   |   |   |   |   |   |     |
|--|---|---|---|---|---|---|---|-----|
| Listened effectively, allowed service user to speak and did not needlessly interrupt | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Used open-ended questions  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Used reflections instead of directing conversation                                   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Worked collaboratively with the service user to set goals                            | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Reinforced service user's personal choice  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Communicated at service user's level of understanding                                | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Clarified important misconceptions   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Solicited service user's feedback  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Consistently provided reinforcement to the service user                              | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Established rapport  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Reinforced service user for all positive intentions, thoughts and behaviours         | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Used summarising statements  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Elicited change talk   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Appropriately handled resistance   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Avoided advice-giving  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |
| Demonstrated the spirit of motivational interviewing                                 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A |

<sup>8</sup> Taken from Abou-Saleh M, Davis P, Rice P, Checinski K, Drummond C, Maxwell D, Godfrey C, John C, Corrin B, Tibbs C, Oyefeso A, DeRuiter M and Ghodse H (accepted for publication) **The effectiveness of behavioural interventions in the primary prevention of hepatitis C among injecting drug users: a randomised controlled trial and lessons learned.** *Harm Reduction Journal*.

# Appendix R: Adherence measures for drug-free contingency management<sup>9</sup>

This information is intended to help supervisors assess and discuss staff members' fidelity to the CM programme's protocol and performance, and to facilitate improvement.

|                   |                         |
|-------------------|-------------------------|
| Date              | Start time              |
| Staff name        | Stop time               |
| Service user      | Session duration (mins) |
| Supervisor's name |                         |

For each of questions 1-10, circle one number for quantity and one for quality. Answer 7 and 8 only if the service user reported substance misuse. 11-13 have quality only.

## 1. To what extent did the therapist discuss outcomes of urine or oral sample monitoring?

|          |                 |                 |                        |                 |                  |                   |                |
|----------|-----------------|-----------------|------------------------|-----------------|------------------|-------------------|----------------|
| Quantity | 1<br>Not at all | 2<br>Negligible | 3<br>Infrequent        | 4<br>Somewhat   | 5<br>Quite a bit | 6<br>Considerable | 7<br>Extensive |
| Quality  | 1<br>Very poor  | 2<br>Poor       | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good        | 6<br>Very good    | 7<br>Excellent |

## 2. Did the therapist state how much was earned at this session?

|          |                |  |                        |                 |           |                |                |
|----------|----------------|--|------------------------|-----------------|-----------|----------------|----------------|
| Quantity | 1<br>No        | 4<br>Service user received incentive,<br>but value was unclear | 7<br>Yes               |                 |           |                |                |
| Quality  | 1<br>Very poor | 2<br>Poor  | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good | 6<br>Very good | 7<br>Excellent |

## 3. Did the therapist state how much would be earned at the next session if the service user's sample were drug-free?

|          |                |  |                        |                 |           |                |                |
|----------|----------------|--|------------------------|-----------------|-----------|----------------|----------------|
| Quantity | 1<br>No        | 4<br>Incentives mentioned but<br>value was unclear | 7<br>Yes               |                 |           |                |                |
| Quality  | 1<br>Very poor | 2<br>Poor  | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good | 6<br>Very good | 7<br>Excellent |

## 4. To what extent did the therapist assess the service user's desire for items that could be purchased?

|          |                 |               |                        |                 |                  |                   |                |
|----------|-----------------|---------------|------------------------|-----------------|------------------|-------------------|----------------|
| Quantity | 1<br>Not at all | 2<br>A little | 3<br>Infrequent        | 4<br>Somewhat   | 5<br>Quite a bit | 6<br>Considerable | 7<br>Extensive |
| Quality  | 1<br>Very poor  | 2<br>Poor     | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good        | 6<br>Very good    | 7<br>Excellent |

## 5. To what extent did the therapist express enthusiasm for the service user's preference for items?

|          |                 |               |                        |                 |                  |                   |                |
|----------|-----------------|---------------|------------------------|-----------------|------------------|-------------------|----------------|
| Quantity | 1<br>Not at all | 2<br>A little | 3<br>Infrequent        | 4<br>Somewhat   | 5<br>Quite a bit | 6<br>Considerable | 7<br>Extensive |
| Quality  | 1<br>Very poor  | 2<br>Poor     | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good        | 6<br>Very good    | 7<br>Excellent |

<sup>9</sup> Used with the kind permission of Professor Nancy Petry, Professor of Psychiatry, University of Connecticut and adapted for the purposes of this framework.

**6. To what extent did the therapist discuss the service user's self-report of substance use?**

|          |                 |               |                        |                 |                  |                   |                |
|----------|-----------------|---------------|------------------------|-----------------|------------------|-------------------|----------------|
| Quantity | 1<br>Not at all | 2<br>A little | 3<br>Infrequent        | 4<br>Somewhat   | 5<br>Quite a bit | 6<br>Considerable | 7<br>Extensive |
| Quality  | 1<br>Very poor  | 2<br>Poor     | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good        | 6<br>Very good    | 7<br>Excellent |

**7. If the service user self-reported substance use, to what extent did the therapist relate self-report of substance use to objective indicators of substance use?**

|          |                 |               |                        |                 |                  |                   |                |
|----------|-----------------|---------------|------------------------|-----------------|------------------|-------------------|----------------|
| Quantity | 1<br>Not at all | 2<br>A little | 3<br>Infrequent        | 4<br>Somewhat   | 5<br>Quite a bit | 6<br>Considerable | 7<br>Extensive |
| Quality  | 1<br>Very poor  | 2<br>Poor     | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good        | 6<br>Very good    | 7<br>Excellent |

**8. If the service user self-reported substance use, to what extent did the therapist relate self-report of substance use to consequences of positive samples?**

|          |                 |               |                        |                 |                  |                   |                |
|----------|-----------------|---------------|------------------------|-----------------|------------------|-------------------|----------------|
| Quantity | 1<br>Not at all | 2<br>A little | 3<br>Infrequent        | 4<br>Somewhat   | 5<br>Quite a bit | 6<br>Considerable | 7<br>Extensive |
| Quality  | 1<br>Very poor  | 2<br>Poor     | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good        | 6<br>Very good    | 7<br>Excellent |

**9. To what extent did the therapist compliment or praise service users' efforts toward being drug-free?**

|          |                 |               |                        |                 |                  |                   |                |
|----------|-----------------|---------------|------------------------|-----------------|------------------|-------------------|----------------|
| Quantity | 1<br>Not at all | 2<br>A little | 3<br>Infrequent        | 4<br>Somewhat   | 5<br>Quite a bit | 6<br>Considerable | 7<br>Extensive |
| Quality  | 1<br>Very poor  | 2<br>Poor     | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good        | 6<br>Very good    | 7<br>Excellent |

**10. To what extent did the therapist communicate confidence that service users' efforts will yield success in the future?**

|          |                 |               |                        |                 |                  |                   |                |
|----------|-----------------|---------------|------------------------|-----------------|------------------|-------------------|----------------|
| Quantity | 1<br>Not at all | 2<br>A little | 3<br>Infrequent        | 4<br>Somewhat   | 5<br>Quite a bit | 6<br>Considerable | 7<br>Extensive |
| Quality  | 1<br>Very poor  | 2<br>Poor     | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good        | 6<br>Very good    | 7<br>Excellent |

**General skillfulness**

**11. General skilfulness/effectiveness (demonstrates expertise, competence and commitment, engages all service users in discussion, interventions made at appropriate times – not missed or made too early).**

|         |                |           |                        |                 |           |                |                |
|---------|----------------|-----------|------------------------|-----------------|-----------|----------------|----------------|
| Quality | 1<br>Very poor | 2<br>Poor | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good | 6<br>Very good | 7<br>Excellent |
|---------|----------------|-----------|------------------------|-----------------|-----------|----------------|----------------|

**12. Maintaining session's structure (maintains session focus, sets appropriate tone and structure, appropriate level of therapist activity/directiveness, appropriate duration)**

|         |                |           |                        |                 |           |                |                |
|---------|----------------|-----------|------------------------|-----------------|-----------|----------------|----------------|
| Quality | 1<br>Very poor | 2<br>Poor | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good | 6<br>Very good | 7<br>Excellent |
|---------|----------------|-----------|------------------------|-----------------|-----------|----------------|----------------|

**13. Empathy (conveys warmth and sensitivity, demonstrates genuine concern and a non-judgmental stance, understands and expresses service users' feelings and concerns).**

|         |                |           |                        |                 |           |                |                |
|---------|----------------|-----------|------------------------|-----------------|-----------|----------------|----------------|
| Quality | 1<br>Very poor | 2<br>Poor | 3<br>Barely acceptable | 4<br>Acceptable | 5<br>Good | 6<br>Very good | 7<br>Excellent |
|---------|----------------|-----------|------------------------|-----------------|-----------|----------------|----------------|



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