National Institute for Health and Clinical Excellence

CG51 Drug Misuse Psychosocial Interventions
Guideline Review Consultation Comments Table
24 January 2011 –7 February 2011 (9am)

Stakeholder	Agree?	Comments	Comments on areas excluded from original scope	Comments on equality issues
RCGP	YES		More exploration of the efficacy of 12 step models. Evidence for residential psychosocial programmes.	
NHS Direct	NO	As this guideline covers the support and treatment required and that patients can expect to be offered I would have thought that it would be beneficial to review these so as to help identify / shape the services required under what will be new commissioning arrangements. That said, there is little new evidence that I am aware of that might change the current recommendations and so perhaps a 12 month extension for review would be in order.		
Addiction Recovery Agency	NO	The Guidelines do not provide a balanced set of guidelines to assist practitioners in delivery treatment focused on recovery. The Guidelines reflect the priorities of	As opposite	The limitations of the NICE research base i.e. range and quantity of research drawn upon, should be

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		research rather than the effectiveness of psychosocial interventions. In particular the guidelines are over weighted in respect of contingency management and poorly weighted in terms of 12 Step based recovery. In this latter respect Prof John Strang has commented: ' Worldwide 12 Step Recovery is probably the single most commonly utilised pathway for recovery - both community based and also through specific residential structured 12 Step Recovery Programmes.' This is not reflected in the guidelines which instead rely on research studies on the effectiveness of contingency management while ignoring the experience of the millions who have recovered through a 12 step programme. The absence of ' scientific proof ' is not reason enough when producing guidelines to ignore the experience of millions simply because they have not been subjected to ' double blind ' research. To do so is to live in some kind of Alice in Wonderland world and the advice given is of no help to practitioners and of serious detriment to those suffering from drug or alcohol dependency.. Further the guidelines do not fully articulate the benefits of self help groups 12 Step or		emphatically stated and the use of the term ' Guidelines ' withdrawn and replaced by ' Limited evidence of effectiveness based on limited and incomplete research findings.' To do otherwise would be to ignore the experience of millions of people who have recovered from drug misuse from various interventions, notably 12 Step Recovery but who have not be subjected to a research project. It would also doom many people to partial and possibly inadequate treatment interventions should their treatment practitioner adopt the NICE 'Guidelines ' in practice.

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		SMART (which is not referred to) to be of any use to practitioners again in contrast to the amount of space devoted to contingency management. This imbalance should be addressed in revised guidelines. Point 1.5.1.2 is erroneous and seriously questionable when it suggests that referrals to residential treatment should be restricted to those who have ' not benefited from previous community based psychosocial treatment.' This contradicts the basis of treatment interventions being ' person centred' and flies in the face of experience which has shown clearly that gains from community based psycho social interventions can be built upon and consolidated through placements in residential rehabilitation leading to lasting long term recovery.		
British Association for Psycho - pharmacology	YES	The review will become appropriate when there is new evidence, e.g. reporting from current trials of contingency management.		
The Royal College of	YES		We are concerned that the role of Family/Systemic therapy	

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Psychiatrists, Faculty of child and Adolescent Psychiatry			interventions for Substance misuse was not considered by the review Process. There is sufficient RCTs about this area, albeit from the USA, reg the above in both adults and adolescents. A few related studies (e.g MST studies that addressed the issue of conduct disorder has clearly shown benefits of family based interventions. We would hope that the above issue will be considered in the next review process, as the outcome of the UK MST studies will be available by then.	
Addiction Recovery Foundation (charity no 328133)	NO The original document is life-threateningly flawed and must be reviewed; if nothing else, review chapter 8 & 1.5.1.2.	• Only 2% of people in the so-called treatment system are enabled to get drug free. This because the original document is life-threateningly flawed and must be AMENDED not merely updated/reviewed. In particular, Chapter 8 on Psychological Interventions omits 12-Step Facilitation which has been proven to yield the most clinically effective as well as cost effective service. 8.6.5 refers to "intensive referral" and links to 12-Step-based treatment programmes but it does not discuss the proven technique of 12	The Guideline Development Group Members drew up the original – but, bar perhaps one or two – do NOT know how to get addicts drug free. It must be rewritten by those who do have this proven knowledge and experience, and the development group membership must be appropriate this time round in order to do so, headed up not by prescribers but those who have a track record in getting people off	

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		Step facilitation. Below is a list of only some errors. • Clause 1.5.1.2 states that addicts who have had community-based psychosocial treatment cannot be referred to abstinent rehabs – thus fatally blocking continuum of care and sacrificing the principle of "first do no harm". This clause has led to such incidents as patients being admitted to rehab after years on methadone and being found to have, despite reports saying no physical problems, broken clavicle and limbs, a stroke and vomiting blood (www.addictiontoday.org/addictiontoday/2011/01/successfully-leaving-treatment.html) • Point 1.5.1.2 is erroneous in a related context when it suggests that referrals to residential treatment should be restricted to those who have 2not benefited from previous community based psychosocial treatment". This contradicts the basis of treatment interventions being 'person centred' and flies in the face of experience which has shown clearly that gains from community-based psychosocial interventions can stabilise patients enough to be admitted to residential rehabilitation, leading to sustainable long-term recovery. • In Chapter 8 and elsewhere, there is no mention of the NHS's own research on how	drugs and into rewarding lifestyles. Due to the fatal errors and omissions in the first version of the Psychosocial Guidelines, psychological interventions with a track record of getting people off drugs have been excluded from commissioning and contracts, leading to loss of lives including methadone becoming the second-greatest drug killer in the UK. This preventable loss of lives has led to demoralisation across the whole spectrum of care in best-practice agencies which are denied the ability to give appropriate care, including NHS and tier 2/3 agencies as well as tier 4.	

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		amending existing therapeutic techniques even slightly to entice clients into free after/mutual-aid groups can save money and lives. • It omits mention of the eclectic therapeutic techniques developed by providers of “classic” recovery which can be used by rehabs and community and prison settings to encourage same, to enable addicts to sustain drug-free recovery and all the attendant benefits of rebuilding relationships, gaining work, reducing recidivism and breaking the generational chain of addiction and dysfunctional behaviours. • Residential and other treatment are not adequately compared, nor the different diagnoses of clients using residential rather than non-residential. • The current document does not provide a balanced set of guidelines to assist practitioners in delivery treatment focused on recovery. The Guidelines reflect the priorities of research rather than the effectiveness of psychosocial interventions. In particular, they are over weighted in respect of contingency management and poorly weighted in terms of 12-step based recovery. In this latter respect, even Prof John Strang commented: “Worldwide 12 Step Recovery is probably the single most		

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		client may benefit from both individual attention and as a participant in a group experience. The group becomes an ongoing personal resource. • Interpersonal group therapy (as per Yalom) is critical to clients understanding themselves and the way they relate to others, a key to relapse prevention. • The chapter fails to recognise the treatment journey as such, which might involve progress/regress and that all opportunities allowing access to programmes facilitating active recovery should be available and accessible. There should be no rigid prescription of the journey. • Life-saving research and evidence was excluded and incorrect conclusions disseminated, perhaps because it was overseen by people without experience in getting addicts alcohol/drug-free. Throughout the NICE Psychosocial guidelines for drugs is the authors' underlying inclination to manage from a position of low expectation rather than from a position of encouragement and optimism – it reads as if written by people with no track record in successful drug-free outcomes. • "User groups" have consistently tended to be a term used to denote those maintained on prescriptions – eg, members of the		

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		[Methadone] Alliance – including representation on the Board of the NTA and has tended to exclude those who are living examples of abstinent (drug free) recovery. The voice of recovery should become normalised and not made to seem eccentric. • In the context of withdrawal and critical part of the recovery journey, reference should be made to the psychological withdrawal which brings prior to, continues through and after the process of physical withdrawal (detoxification). • Motivational enhancement has a part to play in helping clients through the inevitable ambivalence about giving up and changing a lifestyle • 8.6.7.2 Should not only say "consider facilitating…." But should "proactively facilitate initial contact with the groups or people who are currently benefitting from them • NTA 'expert' groups on patient placement criteria are discussing these flawed NICE Psychosocial Guidelines – by adopting them, they will create a domino effect of fatal errors. • If Chapter 8 is not corrected, the UK *Drug Strategy 2010* will fail. Chapter 8 of the document at www.nice.org.uk/CG51 must		

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		be corrected/amended to save lives and money. References to the National Treatment Agency are at best outdated; it has been abolished.		
Pierpoint Addiction Treatment Centres	No	• Only 2% of people in the so-called treatment system are enabled to get drug free. This because the original document is life-threateningly flawed and must be AMENDED not merely updated/reviewed. In particular, Chapter 8 on Psychological Interventions omits 12-Step Facilitation which has been proven to yield the most clinically effective as well as cost effective service. 8.6.5 refers to "intensive referral" and links to 12-Step-based treatment programmes but it does not discuss the proven technique of 12 Step facilitation. Below is a list of only some errors. • Clause 1.5.1.2 states that addicts who have had community-based psychosocial treatment cannot be referred to abstinent rehabs – thus fatally blocking continuum of care and sacrificing the principle of "first do no harm". This clause has led to such incidents as patients being admitted to rehab after years on methadone and being found to have, despite reports saying no physical problems, broken clavicle and limbs, a stroke and vomiting blood	The Guideline Development Group Members drew up the original – but, bar perhaps one or two – do NOT know how to get addicts drug free. It must be rewritten by those who do have this proven knowledge and experience, and the development group membership must be appropriate this time round in order to do so, headed up not by prescribers but those who have a track record in getting people off drugs and into rewarding lifestyles. Due to the fatal errors and omissions in the first version of the Psychosocial Guidelines, psychological interventions with a track record of getting people off drugs have been excluded from commissioning and contracts, leading to loss of lives including methadone becoming the second-greatest drug killer in the UK. This preventable loss of lives has led to demoralisation across the	

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		behaviours. • Residential and other treatment are not adequately compared, nor the different diagnoses of clients using residential rather than non-residential. • The current document does not provide a balanced set of guidelines to assist practitioners in delivery treatment focused on recovery. The Guidelines reflect the priorities of research rather than the effectiveness of psychosocial interventions. In particular, they are over weighted in respect of contingency management and poorly weighted in terms of 12-step based recovery. In this latter respect, even Prof John Strang commented: “Worldwide 12 Step Recovery is probably the single most commonly utilised pathway for recovery - both community based and also through specific residential structured 12 Step Recovery Programmes”. This is not reflected in the guidelines which instead rely on research studies on the effectiveness of contingency management while ignoring the experience of the millions who have recovered through a 12 step programme. It is not reasonable to ignore the experience of millions simply because they have not been subjected to selective ' double blind ' research. • Further the guidelines do not fully articulate		

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		accessible. There should be no rigid prescription of the journey. • Life-saving research and evidence was excluded and incorrect conclusions disseminated, perhaps because it was overseen by people without experience in getting addicts alcohol/drug-free. Throughout the NICE Psychosocial guidelines for drugs is the authors' underlying inclination to manage from a position of low expectation rather than from a position of encouragement and optimism – it reads as if written by people with no track record in successful drug-free outcomes. • "User groups" have consistently tended to be a term used to denote those maintained on prescriptions – eg, members of the [Methadone] Alliance – including representation on the Board of the NTA and has tended to exclude those who are living examples of abstinent (drug free) recovery. The voice of recovery should become normalised and not made to seem eccentric. • In the context of withdrawal and critical part of the recovery journey, reference should be made to the psychological withdrawal which brings prior to, continues through and after the process of physical withdrawal (detoxification).		

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Royal College of Nursing	YES			
Broadreach House	NO The original document is life-threateningly flawed and	• Only 2% of people in the so-called treatment system are enabled to get drug free. This because the original document is life-threateningly flawed and must be AMENDED not merely updated/reviewed. In particular,	The Guideline Development Group Members drew up the original – but, bar perhaps one or two – do NOT know how to get addicts drug free. It must be	

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Association for Family Therapy and Systemic Practice (AFT)	NO	The recommendations for a 'whole systems' approach suggests that systemic approaches have a value – and there is considerable evidence for the effectiveness of including families and important relationships in treatments for drug misuse (and for alcohol dependence). Liddle. H., Dakof, G.A. et al (2008): Treating adolescent drug abuse: a randomised trial comparing multidimensional family therapy and cognitive behavioural therapy. Addiction. 103: 1660-1670. Liddle. H. , Rowe, et al (2009): Multidimensional family therapy: A science-based treatment for adolescent drug abuse. In Bray & Stanton (eds): the Wiley-		

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		Blackwell handbook of family psychology. Wiley-Blackwell. Malden (pp341-354.) Robbins, M.S., Szapocznik, J. et al (2008): The efficacy of structural ecosystems therapy with drug-abusing/dependent African American and Hispanic American Adolescents. Journal of Family Psychology. 22 (1), 51. It may also be useful to see Stratton, P.(2010): '*The evidence base of systemic family and couples therapies*' Association for Family Therapy, UK. www.aft.org.uk . The website includes: Stratton, P., Silver, E., Nascimento, N., Powell, G., McDonnell, L. and Novotny, E. : Review of family, couples and systemic therapy outcome research 2000-2009. see Adult substance misuse pp12-25; Children and adolescence Substance misuse pp 58-65.		
Centre for Policy Studies Prisons and Addictions Forum	NO	They do not constitute a balanced set of guidelines to assist practitioners in delivering treatment focused on recovery. Nor do they reflect the overall research evidence base on the variable effectiveness of different drug treatment interventions and settings over time. Randomised Control Trials, as Sir Michael Rawlins has pointed out, "are often carried out on specific types of patients for a relatively	There appears to be no review of the significant US evidence base regarding the efficacy of therapeutic communities, settings and fellowships (De Leon) The guidelines do no articulate the known scientific evidence base for the efficacy of 12 step or AA fellowship groups for alcohol	Clause 1.5.1.2 states that addicts who have had community-based psychosocial treatment cannot be referred to abstinent rehabs – thus fatally blocking a possible treatment continuum. It is

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		short period of time, whereas in clinical practice the treatment will be used on a much greater variety of patients - often suffering from other medical conditions - and for much longer. There is a presumption that, in general, the benefits shown in an RCT can be extrapolated to a wide population; *but there is abundant evidence to show that the harmfulness of an intervention is often missed in RCTs*".[i] Contingency management, is a case in point. The trials are of short duration. Over a longer term this intervention might be seen as counter intuitive to the diagnosis of addiction, as it involves an element of bribe as opposed to setting clear non negotiable rules of engagement. It is notable that Sir Michael has also said that *observational studies* can provide an important source of evidence about both the benefits and harms of therapeutic interventions. Yet in such sources **have not been drawn on** to guide treatment decisions or treatment appropriateness. The two key UK observational studies, NTORS and DORIS, both show, and DORIS, startlingly so, improved clinical and other 'recovery' outcomes for those assigned to residential rehab treatment settings.[ii] Clinicians deserve to be guided by the knowledge that the DORIS survey (findings at 36 months) found that 29.4 per cent of those who went through rehab had a 90-day drug-free period compared with 6.4% on methadone. The emphasis on contingency management in the absence of longer terms	recovery – a clear model for drug recovery,(Keith Humphreys et al). Yet lead addiction psychiatrists like Owen Bowden Jones point out that the majority of clients have both alcohol and drug problems or swing between the two. It is likely therefore that alcohol evidence is highly pertinent and could inform drug treatment. The American epidemiological evidence is clear – it through such peer support programmes that the majority of people historically have recovered (see Addiction a Disorder of Choice, Gene Heyman) yet this is not mentioned.	astonishing and nothing less than saying to a cancer patient who has had the benefit of radio therapy that they are ineligible for chemotherapy The limitations of the NICE research base i.e. range, the quantity and quality of research drawn on is disenfranchising in itself. The use of the term ' Guidelines ' is misleading as they effectively curtail some interventions in favour of others and needs to be replaced by ' Limited evidence of effectiveness' or 'A review of limited and incomplete research findings.' To do otherwise is to ignore the experience of millions of people who have recovered from drug misuse from various interventions, notably, but not only, 12 Step Recovery, which have

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		outcomes is surprising. The guidelines also fail to drawn on the evidence base regarding the benefits of abstinence which both clinicians and treatment clients need to inform their decisions and choices. These findings, again from DORIS are clear: "on the basis of a range of key outcome measures: arrested over the last 17 months, having committed any crime and any acquisitive crime over the last 17 months, having been in employment and education over the last 17 months, self-reported health over the last 17 months, attempted suicide/self-harm over the last 17 months) it is evident that those drug users who reported a 90-day period of abstinence were fairing better than those who were continuing in their drug use, were more likely to have been on an educational course or in employment; less likely to have attempted suicide or self-harmed; less likely to have been arrested; less likely to be drinking excessively; less likely to have committed a crime or an acquisitive crime; and more likely to rate their health as much better or somewhat better. All of these associations were statistically significant at the 5% level. These results taken at 36 months after treatment recruitment correlated with residential rehabilitation. They believe the current guidelines which state that referrals to residential treatment should be restricted to those who have ' not benefited		not been subjected to a limited duration RCT research project. The danger of discrimination and of even causing harm by relying on short term research and (in the absence of longitudinal evidence) of over generalising from it is exemplified by the recently published Edinburgh longitudinal methadone research (Kimber et al, BMJ July 2010)

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		from previous community based psychosocial treatment.' There is no evidence to support this conclusion. It is erroneous and misleading in the context of the current knowledge base. There is also an urgent need to review the psycho social guidelines regarding the relative efficacy of psycho social discrete interventions such as cognitive behaviour therapy and contingency management and psycho social 'settings'. Do they working in real life as well as` in experimental settings. Are they a waste of money? .There seems to have been little attempt to explore evidence of recovered addicts assessments of what interventions most helped their recovery. Dr David Best's research concluded that rehab was the only intervention regarded as helpful or contributing to recovery (published in Addiction Today) Also ignored is that person centred or a holistic approaches to recovery in real life are often incompatible with the operation of community drug services where both continuity and contact is sparse and where the client is typically moved between different services in relation to the different dimensions of his problem – one for BBV testing, another for script collection , and another for counselling (if he or she is lucky). This is before negotiating other heath, education or housing support services. The good rehab supports client personally through all these `hurdles' as well		

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Stakeholder	Agree?	Comments	Comments on areas excluded from original scope	Comments on equality issues
		as providing a 24/7 availability. i)Rcplondon.ac.uk [Internet]. Royal College of Physicians: Sir Michael Rawlins attacks traditional ways of assessing evidence. [updated 2008 Oct 16; cited 2011 Jan 27] Available from http://pressrelease.rcplondon.ac.uk/Archive/2008/Attack-on-traditional-ways-of-assessing-the-evidence-of-therapeutic-interventions [ii)]McKeganey N. Abstinence and drug abuse treatment: Results from the Drug Outcome Research in Scotland study. ***Drugs*: *Education*, *Prevention and Policy***, 2006;13(6) -- --		

organisations were approached but did not respond:

ADAPT (Alcohol and Drug Addiction Prevention & Treatment)
Addaction
Adfam

Adults Strategy and Commissioning Unit

Alliance, The
Altrix Healthcare plc
Amber Valley PCT
Anglesey Local Health Board
Association for Cognitive Analytic (ACAT) Therapy
Association For Family Therapy and Systemic Practice in the UK (AFT)
Association for Psychoanalytic Psychotherapy in the NHS (APP)

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Association of Child Psychotherapists
Association of Clinical Biochemists, The
Association of Dance Movement Psychotherapy UK
Association of Directors of Adult Social Services (ADASS)
Association of Psychoanalytic Psychotherapy in the NHS
Association of the British Pharmaceuticals Industry (ABPI)
Association of Therapeutic Communities
Avon and Wiltshire Mental Health Partnership NHS Trust
Avon and Wiltshire MHP NHS Trust
Barnsley PCT
Barton Surgery
Birmingham Drug Action Team
BMJ
Bradford & Airedale PCT
Brent PCT
Brighton Oasis Project
Britannia Pharmaceuticals Limited
British and Irish Orthoptic Society
British Association for Behavioural & Cognitive Psychotherapies (BABCP)
British Association for Counselling and Psychotherapy
British Association of Art Therapists
British Association of Drama Therapists
British Geriatrics Society
British Maternal and Fetal Medicine Society (BMFMS)
British National Formulary (BNF)
British Psychological Society, The
Calderdale PCT
Camden and Islington Mental Health and Social Care Trust
Care Quality Commission (CQC)
Chatham House
City and Hackney Teaching PCT
Clouds
College of Emergency Medicine

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College of Mental Health Pharmacy
College of Occupational Therapists
Community Practitioners and Health Visitors Association
Compass
Connecting for Health
Co-operative Pharmacy Association
Cornwall Acute Trust
Cotswold and Vale PCT
CRISIS
Cyrenians
David Lewis Centre, The
Department for Communities and Local Government
Department for Work and Pensions
Department of Community Health Sciences
Department of Health
Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)
Det Norske Veritas - NHSLA Schemes
Devon PCT
DrugScope
European Association for the Treatment of Addiction
Faculty of Forensic and Legal Medicine
Faculty of Public Health
Federation of Drug & Alcohol Professionals (FDAP)
First Person Plural
Flintshire County Council
Food for the Brain Foundation

Forensic Arts Therapies Advisory Group

Fremantle Hospital
Gloucestershire Partnership NHS Trust
Greater Manchester West Mental Health NHS Foundation Trust

Hampshire Partnership NHS Foundation Trust

Hayward Medical Communications

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Health and Safety Executive
Hertfordshire Partnership NHS Trust
Home Office
Howard League for Penal Reform, The

Human Givens Institute

Humber NHS Foundation Trust
Janssen
Kent & Medway NHS and Social Care Partnership Trust
Lancashire Care NHS Foundation Trust
Leicestershire Community Project Trust
Lifeline
Liverpool PCT
London School of Hygiene and Tropical Medicine
Medicines and Healthcare Products Regulatory Agency (MHRA)
Mencap
Mental Health Nurses Association
Merck Sharp & Dohme (Formerly Schering-Plough Ltd)
Mersey Care NHS Trust
Milton Keynes PCT
Ministry of Defence (MoD)
Napp Pharmaceuticals
National Addiction Centre
National AIDS Trust (NAT)
National CAMHS Support Service
National Children's Bureau (NCB)
National Drug Prevention Alliance
National Forum of Consultant Nurses: DRUGS ALCOHOL & MENTAL HEALTH

National Institute for Mental Health in England (NIMHE)

National Offender Management Service

National Patient Safety Agency (NPSA)
National Public Health Service for Wales
National Treatment Agency for Substance Misuse

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National Youth Advocacy Service
Newcastle PCT
NHS Bedfordshire

NHS Clinical Knowledge Summaries Service (SCHIN)

NHS Plus
NHS Quality Improvement Scotland
NHS Sheffield
NHS Western Cheshire
Niger Delta University
North East Council of Addictions
North Staffordshire Combined Healthcare NHS Trust
North Yorkshire and York PCT
Nottingham City PCT
Nottinghamshire Acute Trust
Obesity Management Association
Outcome Consultancy
Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust
Oxleas NHS FoundationTrust
P.M.S (Instruments) Ltd
PAPYRUS (Prevention of Suicides)
Paracetamol Information Centre
PERIGON Healthcare Ltd
Pfizer Limited
Phoenix Futures
Pierpoint Addiction Treatment Centres
Prison Reform Trust
PROMIS Recovery Centre
Reckitt Benckiser Healthcare (UK) Ltd
Rehabilitation of Addicted Prisoners Trust
Release
Rethink
Rethink - Accommodation Plus
Rotherham NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners Wales

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Royal College of Midwives

Royal College of Obstetricians and Gynaecologists

Royal College of Paediatrics and Child Health
Royal College of Pathologists

Royal College of Physicians London

Royal College of Radiologists
Royal College of Surgeons of England
Royal Pharmaceutical Society of Great Britain
Safeline
Samaritans
Sandwell & West Birmingham Hospitals NHS Trust
SANE
Scottish Intercollegiate Guidelines Network (SIGN)
Sheffield Children's NHS Foundation Trust
Sheffield PCT
Social Care Institute for Excellence (SCIE)

Society for Academic Primary Care

Solent Healthcare
Solve It
South Essex Partnership NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Southampton City Council
Specialist Clinical Addiction Network (SCAN)
St Andrew's Healthcare
St James Priory Project
St Mungos
Staffordshire Moorlands PCT
Stockport PCT
Substance Misuse Management in General Practice (SMMPG)
Surrey and Border Partnership Trust
Sussex Partnership NHS Foundation Trust
Tees Esk & Wear Valleys NHS Trust

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The British Psychological Society
The Methadone Alliance
The National Pharmaceutical Association
The Neurological Alliance
The Royal Society of Medicine
The Sainsbury Centre for Mental Health
The South Asian Health Foundation
Trafford Primary Care Trust
UK Harm Reduction Alliance
UK Specialised Services Public Health Network
Unite / Mental Health Nurses Association
University College London Hospitals (UCLH) Acute Trust
University of North Durham
University of York
Walsall PCT
Welsh Assembly Government
Welsh Scientific Advisory Committee (WSAC)
West London Mental Health NHS Trust
Western Cheshire Primary Care Trust

Western Counselling

York Teaching Hospital NHS Foundation Trust

Young People's Unit

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[i] Rcplondon.ac.uk [Internet]. Royal College of Physicians: Sir Michael Rawlins attacks traditional ways of assessing evidence. [updated 2008 Oct 16; cited 2011 Jan 27] Available from http://pressrelease.rcplondon.ac.uk/Archive/2008/Attack-on-traditional-ways-of-assessing-the-evidence-of-therapeutic-interventions

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[ii] McKeganey N. Abstinence and drug abuse treatment: Results from the Drug Outcome Research in Scotland study. ***Drugs*: *Education*, *Prevention and Policy***, 2006;13(6)

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