

rare in clinical psychiatric practice. Therefore the next step was to design an effectiveness trial to see whether mental health nurses, without prior experience of CBT could be trained over a short period and then supervised to effectively and safely deliver brief CBT to large numbers of people with schizophrenia in the community. As this involved raters being masked to group allocation, this was therefore not an 'open-label' trial.

In relation to the effect size, it is certainly true that when an antipsychotic is compared with a placebo in drug-naïve patients a much larger effect is demonstrable. The patients recruited to this trial were, however, almost entirely stabilised on antipsychotics and had already achieved such improvement from them. The effect size with any psychological treatment added to antipsychotics is always likely to be less than that initially achieved by the medication. We acknowledge that the effect size on symptoms at follow-up is modest but the impact on relapse is significant, clinically and in terms of resource savings, for such a brief intervention.

**National Institute for Clinical Excellence (2002)**

*Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care.* NICE.

**Sensky, T., Turkington, D., Kingdon, D., et al (2000)**

A randomized controlled trial of cognitive-behavioral therapy for persistent symptoms in schizophrenia resistant to medication. *Archives of General Psychiatry*, **57**, 165–172.

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### Contingency management for substance misuse

Petry (2006) provides a welcome review of contingency management in substance misuse settings and expresses surprise that it has not been employed more widely in Europe, particularly given the greater acceptance of 'harm minimisation' here than in the USA, where contingency management has been championed. This is broadly true but some UK drug services are experimenting with interventions informed by reinforcement principles.

The injectable opiate clinic at the Chelsea and Westminster Hospital in London

has for some years used reinforcement principles to target illicit opiate and crack cocaine use. Urine samples are regularly tested and the results used alongside clinical judgement to determine the proportion of a client's total daily opiate dose which may be administered intravenously as opposed to orally. In this way, access to injectable rather than oral opiate preparations is the 'reward' for positive behaviour. Staff increase or decrease the injectable proportion of the client's prescription depending on the client's stability.

As a first step towards developing an intervention study (Medical Research Council, 2000) we completed qualitative interviews with staff and clients to assess attitudes towards the further development of reinforcement methods. Staff and clients both cautiously supported reinforcement principles, and staff perceived clients to be more stable and less likely to use illicit substances under the present reinforcement scheme. Nevertheless, challenges were also highlighted. Most staff had reservations about developing voucher-based contingency management, citing possible increased workloads and a potential for damage to staff-client relationships. Despite a strong commitment to harm minimisation strategies at the clinic, some staff also had ethical objections to the development of voucher-based contingency management.

Our study was small and more research is required to explore the feasibility of voucher- or prize-based contingency management. However, as Petry emphasises, contingency management strategies have a good evidence base in a complex and challenging client group where positive outcomes are elusive. It is surely time to evaluate whether contingency management has a place in UK drug treatment services. Our work suggests that debate about the theoretical basis of contingency management and its ethical implications is needed to win support for experimentation among hard-pressed drug treatment workers in the UK.

**Medical Research Council (2000)** *A Framework for Development and Evaluation of RCTs for Complex Interventions to Improve Health.* Medical Research Council.

**Petry, N. M. (2006)** Contingency management treatments. *British Journal of Psychiatry*, **189**, 97–98.

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**Author's reply:** McQuaid *et al* report that clinicians working in their injectable opiate clinic were cautiously supportive of the use of injectable opiates for reinforcement but more hesitant about the use of voucher- and prize-based contingency management procedures.

These perceptions mimic those of clinicians in the USA. Upon initial exposure to contingency management interventions, many clinicians express concerns ranging from hesitation to outright opposition. However, after observing the beneficial effects in practice great shifts in attitude occur. Some who were initially the greatest critics become the strongest supporters of contingency management once they see its benefits with particularly difficult clients.

As in the London programme, critics often evoke 'ethics' to dismiss contingency management. This denunciation is paradoxical, as reinforcement principles upon which contingency management interventions are based are operative in every facet of life. Furthermore, one must wonder about the ethics of withholding an efficacious intervention. It was not long ago that opiate substitution treatment, now considered one of the most effective prevention interventions for HIV transmission, was itself labelled unethical.

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### Depression and anxiety after myocardial infarction

Dickens *et al* (2006) stress the importance of detection and treatment of anxiety and depression for quality of life after myocardial infarction and point to the mediating role of energy and fatigue.