Richtlijn Screening, assessment en behandeling van jongeren met drugmisbruik (herziening van de finale versie)

Namens de ADAPTE-youth project groep

Auteurs: Trudy Bekkering, Karen Smets, Martine Goossens, Mieke Autrique, David Möbius, Marijs Geirnaert, Bert Aertgeerts, Paul Van Royen, Karin Hannes

Inhoud

Richtlijn Screening, assessment en behandeling van jongeren met drugmisbruik (herziening van de finale versie)

Namens de ADAPTE-youth project groep

Auteurs: Trudy Bekkering, Karen Smets, Martine Goossens, Mieke Autrique, David Möbius, Marijs Geirnaert, Bert Aertgeerts, Paul Van Royen, Karin Hannes

Inhoud

Jongeren van 12-18 jaar die (mogelijk) drugs misbruiken

Screening van jongeren:
- Vraag naar druggebruik (in settings waar misbruik vaak voorkomt) (AB1)
- Instrumenten: CRAFFT, SEM-j, CPQ-A-, CAST (AB2)
- Signalen van misbruik: acute pijn op borst, acute psychose, stemmings- en slaapstoornissen (AB 3)

Assessment van jongeren:
- Houd o.a. rekening met behoeften en noden, eerdere ervaringen, persoonlijke doelen (AB 4)
- Onderzoek de opiaatafhankelijkheid bij jongeren die zich aanmelden voor detox (AB 5)
- Drugtests moeten adequaat worden uitgevoerd (AB 6)

Behandeling jongeren

Geen afhankelijkheid ⟷ Volledige afhankelijkheid

Noodzakelijke randvoorwaarden: Samenwerken met ouders en omgeving, indien de jongere dit wil (AB 7, 9). Duidelijke uitleg behandelopties - 'informed decisions' (AB 8). Behandel met respect en neem privacy regels in acht (AB 10). Zorg voor duidelijke en door beide partijen gedragen behandelplannen (AB 11). Zorg voor competente stafmedewerkers (AB 12).

Ondersteun ouders: Vraag ouders naar de invloed van druggebruik op henzelf en maak zorgen bespreekbaar (AB 18). Bied begeleide zelfhulp en verstrek informatie over ondersteuningsgroepen (AB 19). Geef specifieke informatie over detoxificatie bij opiaatafhankelijkheid (AB20).

Niet-medicamenteuze interventies
- Geef informatie en advies over schadebeperking bij routinematig en opportunistisch contact (AB 13)
- Geef psychoeducatie niet routinematig groepsgewijs (AB 14)
- Bied opportunistische, korte interventies voor jongeren met beperkt of zonder contact met drughulpverlening (AB 15, 16)

Opiaatdetoxificatie
Detox moet beschikbare behandeloptie zijn (AB 21). Medicatie: Methadone of buprenorphine is de eerste keuze (AB 22, 23, 24). Stem dosis en duur af op de jongere, geen versnelde detox (AB 25, 26). Geef bijkomende medicatie alleen indien nodig (AB 27). Monitor de therapietrouw bij medicatie (AB 28). Setting detoxificatie: community-based is de eerste keuze (AB29). Indicaties voor residentiële opname (AB17). Stappen binnen ambulante detox (AB30). Bekijk opties medicatie voor zwangere vrouwen (AB31).

Gecombineerde interventies voor opiaatafhankelijkheid:
Altijd psychosociale interventies, eventueel samen met medicatie voor opiaatafhankelijkheid en -ontwenning (AB 34,35)

Jongeren die naast drugs ook alcohol misbruiken
Zonder alcoholafhankelijkheid: pak eerst alcoholmisbruik aan. Met alcoholafhankelijkheid: -ambulant of in gevangenis- eerst alcohol- dan opiaatontwenning, intramuraal gelijktijdige ontwenning (AB 32). Bij benzomisbruik: gelijktijdig of afzonderlijk ontwennen in overleg met jongere(AB 33).

Follow-up na detoxificatie: vervolg therapie, steun en monitoring (AB 36)

A. Aanbevelingen

1.1 Inleiding

Jongeren experimenteren steeds vaker en vroeger met drugs. In Vlaanderen heeft 26% van de 16-jarigen ooit illegale drugs gebruikt, jongens iets vaker dan meisjes (29 en 22%, ESPAD 2011). Vier procent rapporteerde gebruik vanaf 13-jarige leeftijd (jongens 5%, meisjes 3%). Cannabis wordt het meest gebruikt en het gebruik in Wallonië is iets hoger dan in Vlaanderen. Van de 15/16 jarigen heeft 24,6 % van de Vlaamse jongeren ooit cannabis gebruikt. In Wallonië is dit 29,6%. Bij de 17-18 jarigen hebben respectievelijk 43,5% en 47,0% van de jongeren drugs gebruikt (HBSC 2005-2006). Na cannabis is cocaïne de meest gebruikte drug door jongeren. Het gebruik van amfetamines, heroïne of opiaten komt slechts sporadisch voor bij jongeren in de algemene bevolking. In andere settings zoals de bijzondere jeugdzorg en justitie komt misbruik van deze middelen vaker voor.

Risico's en gevolgen

Regelmatig en/of overmatig druggebruik heeft negatieve effecten op de psychosociale en lichamelijke conditie van jongeren. Op korte termijn kan cannabis de cognitieve functies, waaronder het korte termijngeheugen en de aandacht, tijdelijk verstoren. Dit kan, in combinatie met het effect op andere mentale functies, leiden tot slechtere schoolprestaties vlak na het gebruik (Kinable, 2008). Cocaïnegebruik kan samengaan met depressie, een laag zelfbeeld, verstoring van het korte termijngeheugen en concentratie, hyperthermie, een beroerte en hartritmestoornissen (Hermans & Schrooten, 2005). Het combineren van alcohol en drugs inname of het combineren van meerdere soorten drugs houdt extra risico's in, omdat de effecten moeilijker in te schatten zijn (Hermans & Schrooten, 2005).

Op lange termijn bestaat het risico op afhankelijkheid. Het risico op afhankelijkheid hangt samen met het type drug, de hoeveelheid drugs, de persoon (deels genetisch bepaald) en de leeftijd waarop men begint te gebruiken. Druggebruik kan ook leiden tot sociale problemen, zoals verstoring van relaties of financiële problemen. Vooral bij kwetsbare jongeren bestaat er een samenhang tussen druggebruik en problemen op andere leefgebieden: psychiatrische problemen, delinquent gedrag en sociaal-economische omstandigheden (Adviescommissie kwetsbare jeugd & verslaving, 2011).

Jongeren zijn een zeer kwetsbare groep en dus meer vatbaar voor druggebruik. Enerzijds zullen zij vanwege hun biologische en psychologische ontwikkelstadium eerder geneigd zijn om te experimenteren met drugs. Anderzijds lopen zij extra risico's, omwille van de effecten van drugs op het zich ontwikkelend brein (Adviescommissie kwetsbare jeugd & verslaving, 2011) en omdat zij in vergelijking met volwassenen sneller afhankelijk zijn.

Motivatie voor de richtlijn

Jongeren die drugs misbruiken krijgen vaak niet de hulp die zij nodig hebben. Jongeren zoeken geen hulp omdat zij het gebruik onderschatten en tegelijk de negatieve gevolgen ervan nog niet ervaren. Ook associëren zij de drugshulpverlening, onterecht, alleen met ernstige vormen van verslaving (Van Hout, 2012). Dit vraagt een betere afstemming tussen de vraag van de jongeren en het aanbod van de hulpverlening. Mogelijk wordt het druggebruik door jongeren ook onderschat door hun ouders en

hulpverleners. Daarnaast is behoefte aan meer samenwerking tussen de voorzieningen en een betere samenwerking tussen overheid en hulpverleners op de werkvloer (Van Hout, 2012). Deze richtlijn beoogt een samenhangend beleid uit te tekenen over diverse disciplines heen, dat gebruikt kan worden door de gezondheidswerkers en andere professionals die te maken hebben met jongeren met drugmisbruik.

Doel van de richtlijn

De aanbevelingen in deze richtlijn zijn richtinggevend en bedoeld als ondersteuning en leidraad bij het nemen van beslissingen binnen de gezondheidszorg, de welzijnssector, scholen en de Belgische samenleving. We beogen hiermee wetenschappelijk onderbouwde informatie te geven over effectieve strategieën met betrekking tot screening, assessment en behandeling van jongeren met een (mogelijk) drugprobleem. Het te verwachten voordeel is dat met behulp van deze richtlijn de kwaliteit van de zorg voor deze jongeren verbeterd kan worden, onder andere door het terugdringen van onverklaarbare variatie en het beter op elkaar afstemmen van het aanbod van hulpverlening.

Deze richtlijn beschrijft de zorg die voor een gemiddelde jongere wetenschappelijk gezien het beste beleid is. De jongere zelf, en zijn of haar ouders of verzorgenden, zijn volwaardige partners bij het nemen van beslissingen omtrent zorg. De rol van de hulpverlener is het verduidelijken van de vraag van de jongere door een gepaste communicatie te voeren en het geven van informatie over alle aspecten van de mogelijke behandelopties. Daarna maakt de hulpverlener samen met de jongere de keuze voor een bepaald beleid. Het kan voorkomen dat de hulpverlener en jongere op basis van argumenten voor een ander beleid kiezen dan hier beschreven.
Een participatieve basishouding van de hulpverlener is van belang voor een goede omgang met jongeren en dus voor het uitvoeren van deze richtlijn. Jongeren waarderen de volgende kenmerken in de houding van een hulpverlener: authenticiteit, empathie, gelijkwaardigheid, openheid, onvoorwaardelijkheid, positieve ingesteldheid, professionele nabijheid, betrouwbaarheid en respect.

Deze richtlijn is gebaseerd op bestaande internationale richtlijnen en op wetenschappelijk onderzoek. Indien een bepaald onderwerp niet in de bestaande richtlijnen besproken werd, is het ook niet in deze richtlijn opgenomen. Bepaalde onderwerpen, zoals ‘opiaatdetoxificatie’ werden uitgebreid belicht in bestaande richtlijnen en hebben dus ook een prominente plaats in deze richtlijn. Dit verwijst geenszins naar bepaalde voorkeuren voor onderwerpen van de betrokken medewerkers en experten. Ook is het veld van wetenschappelijk onderzoek rondom drugmisbruik bij jongeren volop in ontwikkeling. Hierdoor zijn de richtlijn en de aanbevelingen voor een bepaalde klinische vraag niet exhaustief. Dit wil zeggen dat als een bepaald beleid niet in de richtlijn of in de aanbevelingen vermeld staat, dit niet betekent dat men dit niet zou moeten of mogen uitvoeren. De voorgestelde aanbevelingen dekken in de meeste gevallen niet de hele klinische vraag. Zo zijn de mogelijkheden om te screenen breder dan beschreven in aanbevelingen 1, 2 en 3. Daarnaast is er over bepaalde onderwerpen geen informatie gevonden, zoals de ontwikkelingspsychologische aspecten van de adolescentie of over psychosociale re-integratie, zaken die met betrekking tot het onderwerp, zeer relevant zouden zijn om te belichten. Dit heeft te maken met een gebrek aan wetenschappelijke informatie. De richtlijn dient gelezen en geïnterpreteerd te worden als een ‘werk in ontwikkeling’ waarbij inzichten uit bijkomende, kwaliteitsvolle wetenschappelijke studies, reviews en richtlijnen systematisch geïntegreerd moeten worden. Voor meer informatie over de procedure van richtlijnontwikkeling verwijzen we naar de onderbouwing van deze richtlijn (deel B).

Setting

Deze richtlijn is relevant voor alle voorzieningen en personen die vanuit hun beroepsfunctie contact hebben met jongeren in België. Hieronder vallen de volgende groepen: eerstelijnsgezondheidszorg professionals, gezondheidswerkers in ambulante instellingen, - gezondheidswerkers in residentiële instellingen, straathoekwerkers, preventie adviseurs, maatschappelijke welzijn werkers (JAC, OCMW), sociaal-culturele werkers (inclusief vrijwilligers van onder andere jongeren organisaties) en medewerkers van scholen (inclusief vrijwilligers). Daarnaast kan de richtlijn relevant zijn voor informele netwerken rondom jongeren die (mogelijk) drugs misbruiken, onder andere ouders en familie. Echter, niet alle aanbevelingen zijn relevant voor iedere voorziening of persoon. Dit betekent dat gebruikers van deze richtlijn een inschatting moeten maken van wat geldig, gepast en betekenisvol is voor de eigen beroepsfunctie en context.

De richtlijn beschrijft welke zorg het meest effectief is, maar niet welke hulpverlener dit zou moeten uitvoeren omdat dit afhankelijk is van veel lokale factoren. Gebruikers van deze richtlijn moeten een inschatting maken rond welke zorg zij zelf kunnen bieden en wanneer een jongere moet worden doorverwezen naar naar collega's.

Doelpopulatie

Deze richtlijn betreft jongeren tussen 12 en 18 jaar en betreft alle niveaus van drugmisbruik, inclusief afhankelijkheid. De richtlijn is bedoeld voor jongeren zonder belangrijke co-morbiditeit, vanwege een gebrek aan wetenschappelijke studies over jongeren met co-morbiditeiten. De hulpverlener dient de eventuele toepasbaarheid van deze richtlijn voor jongeren met co-morbiditeit na te gaan.

Er bestaan 2 gerelateerde richtlijnen, één over de preventie van alcohol en drugmisbruik bij jongeren (ADAPTE-youth 3) en één over screening, assessment en behandeling van alcoholmisbruik bij jongeren (ADAPTE-youth 1). Daar waar de aanbevelingen specifiek zijn voor een deel van deze groep, bijvoorbeeld jongeren tot 15 jaar of jongeren van 16 en 17 jaar zal dit worden vermeld. De hulpverlener dient de eventuele toepasbaarheid van een aanbeveling voor een andere doelgroep na te gaan.

Vanwege de minderjarigheid van de doelgroep, dienen hulpverleners de ouders en/of verzorgenden als wettelijke vertegenwoordigers onder bepaalde voorwaarden te informeren en/of om toestemming te vragen. Daarnaast hebben de jongeren recht op privacy (zie rechten van de jongere).

Ouders

Uitgangspunt van deze richtlijn is dat de opvoeding van het kind de taak is van de ouders en niet van de hulpverleners. Binnen de opvoeding zijn zowel steun als controle essentieel. Het gaat het om het vinden van evenwicht tussen dialoog en grenzen stellen, met als basis een positieve ouder-kindrelatie. Deze positieve relatie is een voorwaarde om grenzen te stellen en afspraken te maken. Het houdt in dat er openheid is in de communicatie tussen ouders en kinderen en dat de kinderen zich ondersteund weten door hun ouders. Enkel een ondersteunende relatie en open communicatie is echter niet voldoende: jongeren hebben nood aan structuur en grenzen. Het is belangrijk dat ze duidelijk weten welke grenzen gelden in hun gezin en wat het gevolg is als ze deze overschrijden.

Klinische vragen

De richtlijn wil een antwoord geven op onderstaande vragen met betrekking tot drugmisbruik bij jongeren:

1. Hoe dienen hulpverleners te screenen naar drugmisbruik bij jongeren?
2. Hoe wordt een assessment bij jongeren die drugs misbruiken best uitgevoerd?
3. Aan welke voorwaarden moet een efficiënt behandelingstraject voldoen?
4. Welke niet-medicamenteuze (psycho-sociale) interventies kan men best toepassen?
5. Wanneer is residentiële opname van jongeren die drugs misbruiken nodig?
6. Welke interventies zijn effectief om gezinsleden van jongeren die drugs misbruiken te ondersteunen?

Voor enkele vragen gaven de richtlijnen alleen een antwoord voor jongeren met opiaatafhankelijkheid:

7. Welke medicijnen moet men voorschrijven? Wanneer dient men deze voor te schrijven?
8. Welke gecombineerde interventies (medicamenteus en psychosociaal) kan men best gebruiken en wanneer?
9. Hoe lang is follow-up minstens nodig? Waaruit dient deze follow-up te bestaan?

De klinische vragen zijn opgesteld door een panel bestaande uit experts op het gebied van jongeren en middelenmisbruik (zie Kader 1). Het panel heeft andere vragen geformuleerd, die niet in deze richtlijn konden worden opgenomen omdat hiervoor geen wetenschappelijke informatie werd gevonden in de opgezochte richtlijnen. Deze vragen waren:

- Welke anamnestische vragen kan men best stellen en welke lichamelijk en technische onderzoeken worden best uitgevoerd?
- Welke instrumenten zijn betrouwbaar en valide om de diagnose en de ernst van drugmisbruik te stellen?
- Wanneer dienen professionals uit de eerstelijnsgezondheidszorg jongeren die drugs misbruiken te verwijzen naar de tweedelijn?

<u>Opbouw van het document</u>

In deze richtlijn is een onderscheid gemaakt tussen twee uiterste patiëntprofielen: aan de ene kant jongeren die mogelijk drugs misbruiken en aan de andere kant jongeren met een diagnose van afhankelijkheid. In de praktijk zullen de meeste jongeren zich ergens tussen beide profielen bevinden. De hulpverlener dient in te schatten welke interventies bij welke jongeren het best kunnen worden toegepast.

Onder iedere vraag staan de relevante aanbevelingen genoteerd. Per aanbeveling is de sterkte van het wetenschappelijk bewijs samengevat met behulp van de GRADE systematiek (GRADE, 2008). Dit bestaat uit het cijfer 1 of 2 en de letter A, B of C. Het cijfer 1 staat voor een sterke aanbeveling. Dit betekent dat de voordelen van deze aanbevelingen zwaarder wegen dan de nadelen. Het cijfer 2 staat voor een zwakke aanbeveling. Dit betekent dat de voordelen en nadelen in balans zijn of er dat er meer nadelen dan voordelen zijn. De letters staan voor de omvang en kwaliteit van de wetenschappelijke studies: A is goed, B matig en C zwak of onbekend. Onder elke aanbeveling staat een toelichting, met informatie over de praktische uitvoering ervan. Hierbij is de herkomst van de toelichting genoteerd; dit kan zijn de bronrichtlijn, het panel of de stakeholders die de richtlijn hebben gepiloteerd.

<u>Methodiek</u>

Deze richtlijn is ontwikkeld volgens de ADAPTE procedure (Fervers et al, 2006), een stapsgewijs proces voor het adapteren van (inter)nationale richtlijnen naar de lokale context. Voor deze procedure werd een panel met experts samengesteld. Deze experts hebben de klinische vragen geformuleerd en alle relevante aanbevelingen beoordeeld op relevantie en haalbaarheid voor de Belgische context. Wanneer een aanbeveling werd weerhouden, formuleerde het panel de graad van aanbeveling (zie boven). Meer details over de onderbouwing van de aanbevelingen en de methodiek zijn beschreven in deel B.

Kader 1. Samenstelling van het panel

Het panel bestond uit de volgende personen:

Inhoudelijk deskundigen:

- Cis Dewaele, Coördinator Vlastrov (koepelorganisatie straathoekwerk Vlaanderen) en stafmedewerker Steunpunt Algemeen Welzijnswerk, Berchem
- Michel Vanhalewyn, huisarts Brussel; staflid en richtlijnontwikkelaar SSMG
- Kris Van Gerwen, hoofdverpleegkundige / MDFT therapeut, Cannabis clinic UCV Brugmann, Brussel
- Hannelore Sanders, coördinator ambulante drugzorg, Drugzorg VZW Kompas, Roeselare/Kortrijk
- Koen Leysens, Pedagoog/psychotherapeut, CGG Vagga, Antwerpen
- Arlette Wertelaers, centrumarts Katarsis vzw ' Centrum voor verslaafdenzorg' te Genk; Logo arts bij de LOGO's Limburg
- Anja Schillebeeks, therapeutisch verantwoordelijke Katarsis vzw 'Centrum voor verslaafdenzorg' te Genk
- Georges Vanderstraten, directeur, Therapeutische Gemeenschap Trempoline asbl, Châtelet
- Johan Sools, gedragstherapeut/klinisch psycholoog, Psychiatrische Kliniek Broeders Alexianen Tienen
- Twee vertegenwoorders van Alanon (wensen anoniem te blijven), Vereniging voor familie en vrienden van Alcoholisten, Antwerpen en Brussel
- Bert Mostien, beleidsmedewerker/drugcoordinator, Drugpreventie Provincie Oost-Vlaanderen, Gent
- Lore Willam, wetenschappelijk medewerker vakgroep Klinische Psychologie, KU Leuven, Leuven

Voorzitter, secretaris en co-moderator

- Paul van Royen, huisarts, diensthoofd, vakgroep Eerstelijns- en Interdisciplinaire Zorg, Universiteit Antwerpen, covoorzitter Commissie Aanbevelingen Domus Medica, voorzitter
- Trudy Bekkering, epidemioloog, Centrum voor Methodologie van Pedagogisch Onderzoek, KU Leuven, secretaris
- Karen Smets, huisarts, vakgroep Eerstelijns- en Interdisciplinaire Zorg, Universiteit Antwerpen, co-moderator
- Karin Hannes, agoog, Centrum voor Methodologie van Pedagogisch Onderzoek, KU Leuven, co-moderator

Alle panelleden verklaarden geen conflicterende belangen te hebben.

Definities, begrippen en afkortingen

Drugmisbruik: (Eng: 'substance misuse') is de intoxificatie door, regelmatig overmatig gebruik en/of afhankelijkheid van psychoactieve stoffen, die leiden tot sociale, psychologische, fysieke of legale problemen. Het omvat problematisch gebruik van zowel legale als illegale middelen (inclusief alcohol wanneer dit in combinatie met andere middelen worden gebruikt) (overgenomen uit: NICE, 2007a).

Afhankelijkheid (Eng: 'dependence') is gedefinieerd door de WHO als een sterk verlangen of gevoel van dwang om een middel te nemen, moeite om het gebruik ervan te controleren, de aanwezigheid van een fysieke status van ontwenning, tolerantie in het gebruik van de drug, het verwaarlozen van andere genoegens en interesses en het voortgezet gebruik van het middel ondanks besef van schade aan zichzelf en anderen (uitgenomen uit: NICE, 2007b). (zie kader 2)

Kader 2. Criteria voor afhankelijkheid

De criteria zijn:

- Tolerantie:
  - een behoefte aan duidelijk toenemende hoeveelheden van het middel om een intoxicatie of de gewenste werking te bereiken;
  - een duidelijk verminderd effect bij voortgezet gebruik van dezelfde hoeveelheid van het middel.
- Onthouding:
  - het voor het middel karakteristieke onthoudingssyndroom;
  - gebruik van hetzelfde middel om onthoudingsverschijnselen te verlichten of te vermijden.
- Het middel wordt vaak in grotere hoeveelheden of gedurende een langere tijd gebruikt dan aanvankelijk gepland.
- Men is niet in staat het gebruik te stoppen of te minderen.
- Een groot deel van de tijd gaat op aan activiteiten die samenhangen met middelengebruik.
- Belangrijke sociale of beroepsmatige bezigheden of vrijetijdsbesteding worden opgegeven of verminderd vanwege het gebruik van het middel.
- Het gebruik van het middel wordt voorgezet ondanks besef van schade.

(Möbius, 2009)

Abstinentiegeoriënteerde behandeling beoogt het drugmisbruik van de jongere te verminderen met het uiteindelijke doel om dit te stoppen. Na een periode van abstinentie kan deze handeling het risico op overdosis verhogen, omdat de drugtolerantie is verlaagd (overgenomen uit: NICE, 2007b).

Schadebeperking (Eng: 'harm reduction') beoogt de negatieve gevolgen die geassocieerd zijn met drugmisbruik te voorkomen of te verminderen, zowel voor de jongere zelf als voor de maatschappij. Een reductie in het eigenlijke drugmisbruik is niet essentieel (alhoewel dit wel één van de mogelijkheden is om verdere schade te voorkomen). Een voorbeeld is de spuitruil die de overdracht van bloed overdraagbare virussen tracht te verminderen, door het stimuleren van een meer veilige manier om drugs te injecteren (overgenomen uit: NICE, 2007b).

Onderhoudsbehandelingen/gecontroleerd gebruik verwijzen naar het medicamenteuze onderhoud van jongeren die opiaat afhankelijk zijn, door het voorschrijven van opiaat substituten (methadon of buprenorphine). Deze behandeling beoogt het illegale drugmisbruik en de hiermee samenhangende schade te verminderen of te stoppen (overgenomen uit: NICE, 2007b).

Screening: de activiteit waarbij men tracht een niet eerder gediagnosticeerd drugmisbruik bij een jongere of een groep jongeren te identificeren. Men maakt hierbij gebruik van testen of vragenlijsten die een onderscheid

kunnen maken tussen jongeren die (waarschijnlijk) drugs misbruiken en jongeren die niet gebruiken (Van Driel en Chevalier, 2008).

Kortdurende interventies (Eng: 'brief interventions') bestaan uit maximaal 2 sessies. Het belangrijkste doel is het versterken van de motivatie om het drugmisbruik te veranderen. Dit kan gericht zijn op abstinentie of op het verminderen van schadelijk gedrag. Kortdurende interventies omvatten het uiten van empathie naar de jongere en het zich niet verzetten tegen weerstand en feedback. Ze zijn erop gericht de ambivalentie over druggebruik terug te dringen en een mogelijke behandeling te induceren (overgenomen uit: NICE, 2007b).

Detoxificatie is het proces waarbij een jongere ontwent van de effecten van psychoactieve stoffen. Het is een klinische procedure die gesuperviseerd en uitgevoerd moet worden op een veilige en effectieve wijze, zodat de ontwenningsverschijnselen tot een minimum kunnen worden beperkt (overgenomen uit: NICE, 2007b).

Psycho-educatie combineert het informeren van jongeren over bloed overdraagbare virussen (zoals HIV of hepatitis C) met het aanleren van vaardigheden zoals assertiviteit, communicatievaardigheden en veilig seksueel en injectie-risicogedrag. Het biedt jongeren ook de gelegenheid om vragen te stellen en relevante feedback te ontvangen. Deze interventies worden veelal gegeven over vier tot zes sessies in een verscheidenheid van instellingen, waaronder centra gericht op onderhoudsbehandeling met methadon, spuitruilprogramma's, en 'outreach' programma 's (overgenomen uit: NICE, 2007b).

Community-based programma's zijn ingebed in de gemeenschap en zorgen voor de ontwikkeling ervan. De praktijk van zelfhulpgroepen, waarbij cliënten gemeenschappelijk zelf zoeken naar oplossingen, staan in verband met het community-based werken. Community-based programma's zijn laagdrempelig en voor iedereen toegankelijk (overgenomen uit: VAD 2009).

Versnelde (Eng: 'precipitated') ontwenning: is gelinkt aan plotse en snel opkomende ontwenningsverschijnselen. Het komt voor wanneer een antagonist (of een gedeeltelijke antagonist, zoals buprenorfine) toegediend wordt aan iemand die afhankelijk is van agonistische opiaten. Omdat buprenorfine een hogere bindende kracht heeft met de opiaatreceptor dan opiaten, gaat buprenorfine zich binden aan de receptor en vervangt het de aanwezige opiaten. Hierdoor zal het verlies van het opiaateffect voelbaar worden en treden ontwenningsverschijnselen op (overgenomen uit: VAD, 2009).

Nazorg: is begeleiding aangeboden met een lage en afnemende intensiteit, maar met langdurig karakter. De begeleiding is gericht op het handhaven van de therapeutische effecten die in de voorafgaande fase van de primaire behandeling zijn verkregen, met als doel het re-integreren in de maatschappij en het verhogen van de zelfverantwoordelijkheid (De Wildt & Verster, 2005).

Rechten van jongeren binnen de wettelijke kaders

Wettelijk gezien vallen jongeren onder het gezag van hun ouders, en zouden ouders beslissingen kunnen nemen voor hun kind. Volgens twee wettelijke regelingen kan de jongere bepaalde rechten zelf uitoefenen indien de hulpverlener van mening is dat de jongere bekwaam is. Bekwaamheid houdt in dat de jongere voldoende kan inschatten wat in zijn belang is en voldoende kan inschatten wat de gevolgen zijn van zijn beslissingen of daden. Welke wettelijke regeling van kracht is hangt af van de beroepsgroep en sector waarin de hulpverlener werkzaam is.

De **Wet Patiëntenrechten** betreft alle beroepsbeoefenaars in de gezondheidszorg. Deze wet bepaalt onder andere dat jongeren gehoord en betrokken moeten worden bij het nemen van beslissingen. Bij heel jonge kinderen zal de stem van de ouder het zwaarst doorwegen. Afhankelijk van factoren als de leeftijd en de ontwikkelingsfase van het kind, wordt de stem van de jongere sterker tot aan volledige zelfstandigheid. De invasiviteit van de beslissing dient hierbij in overweging te worden genomen door de hulpverlener. Deze wet

voorziet niet in een specifieke leeftijd waarop de minderjarige bekwaam wordt geacht (Wet "Rechten van de patiënt, 2007).

Het **Decreet 'Rechtpositie van de minderjarige in de integrale jeugdhulp'** (alleen geldig voor Vlaanderen) beschrijft de rechten van de jongere in de sectoren van de integrale jeugdhulp. Deze omvatten: algemeen welzijnswerk, centra voor leerlingenbegeleiding, geestelijke gezondheidszorg, gehandicaptenzorg, Kind en Gezin, bijzondere jeugdbijstand, centra voor integrale gezinszorg. Dit Decreet hanteert als uitgangspunt dat jongeren zelf beslissingen kan nemen vanaf het ogenblik dat hij 'voldoende oordeelsvermogen' heeft, en dat wordt over het algemeen vermoed het geval te zijn vanaf 12 jaar (Databank jeugdrecht: 2006-03).

Belangrijk bij de uitvoering van deze wetten is dat hulpverleners moeten proberen de jongere te motiveren om belangrijke beslissingen gezamenlijk te nemen met hun ouders. Indien de jongere echt niet wil, heeft deze – minstens vanaf een zekere leeftijd of rijpheid – wel de laatste stem.

Hulpverleners hebben beroepsgeheim. Dit beroepsgeheim geldt ook bij minderjarigen, zelfs ten aanzien van de ouders. Hulpverleners mogen dus niet zomaar de ouders van een jongere over alles en nog wat inlichten. Hiervoor is best de instemming van de jongere nodig. Onder bepaalde voorwaarden kan dit wel, bijvoorbeeld indien een kind onvoldoende onderscheidingsvermogen heeft, bij het nemen van werkelijk fundamentele beslissingen met betrekking tot bijvoorbeeld een ingrijpende medische behandeling, of wanneer afwijken van het beroepsgeheim in het belang is van het kind. Dit kan slechts voor zover de jongere zich daartegen niet uitdrukkelijk verzet of indien uit de gedragingen van de jongere de stilzwijgende instemming kan worden afgeleid. Belangrijk hierbij is dat de hulpverlener in de eerste plaats de jongere stimuleert om de desbetreffende informatie zelf bekend te maken aan zijn omgeving.

Het beroepsgeheim kan worden doorbroken indien het stilzwijgen van de hulpverlener ernstig of acuut gevaar kan opleveren voor de jongere of voor anderen. Het meedelen van een minimum aan gegevens aan de ouders wordt algemeen aanvaard op voorwaarde dat de jongere hiertegen geen bezwaar heeft.

Leerkrachten, ook vertrouwensleerkachten, hebben geen beroepsgeheim. Zij kennen wel een ambtsgeheim of discretieplicht en moeten zorgvuldig omgaan met informatie. Medewerkers van het CLB hebben wel beroepsgeheim. Het nagaan of iemand al dan niet door het beroepsgeheim gebonden is, is belangrijk in het bekijken welke informatie met wie gedeeld kan worden. Als hulpverlener is het dus belangrijk om hierover duidelijkheid te krijgen alvorens informatie uit te uitwisselen. Ook is het van belang transparant te zijn naar de jongere toe (Databank jeugdrecht: 2006-06 en 2011-09/10).

Afkortingen

CAST	Cannabis Abuse Screening Test
CAW	Centrum voor Algemeen Welzijnswerk
CLB	Centrum voor Leerlingenbegeleiding
CPQ-A-S	Cannabis Problems Questionnaire, verkorte versie
CRAFFT	Car, Relax, Alone, Forget, Friends, Trouble (screening instrument)
ESPAD	European School Survey Project on Alcohol and Other Drugs
GRADE	Grading of Recommendations Assessment, Development and Evaluation
FIST	Zelfhulpgroep van ouders van gebruikers
HBSC	Health Behaviour in School-aged Children
HIV	Human Immunodeficiency Virus
JAC	Jongeren Advies Centrum
KB	Koninklijk Besluit
NICE	National institute for Clinical Excellence (UK)
OCMW	Openbare Centra voor Maatschappelijk Welzijn

SEM-j	Individueel Screeningsinstrument Ervaringen met Middelengebruik - jongeren
SIGN	Scottish Intercollegiate Guidelines Network (Scotland)
VAD	Vereniging voor Alcohol- en andere Drugsproblemen
WHO	World Health Organization

1.2 Screening

Om de leesbaarheid van deze richtlijn te bevorderen is gekozen voor het volgende taalgebruik:
Met het bezittelijk voornaamwoord 'zijn' worden beide geslachten bedoeld. Met de term 'ouders' worden ouders en/of verzorgenden en/of opvoedingsverantwoordelijken bedoeld en de term 'gezinsleden' betreft zowel ouders, broers en zussen, alsook anderen die deze rol invullen.

Hoe dienen hulpverleners te screenen naar drugmisbruik bij jongeren?

Aanbeveling 1

Bevraag binnen settings waar drugmisbruik vaak voorkomt jongeren systematisch naar hun recent druggebruik. Bevraag het soort middel, de methode van toediening, de hoeveelheid en de frequentie van het gebruik.
(consensus)

Aanbeveling 2

Gebruik bestaande screenings- en evaluatie- instrumenten bij jongeren die drugs misbruiken of bij diegenen met een risico op misbruik.
(consensus)

Toelichting

Bronrichtlijn: Settings waar drugmisbruik vaak voorkomt kunnen o.a. zijn de geestelijke gezondheidszorg of justitie. Momenteel hebben we echter niet meer inzichten vanuit de wetenschappelijke literatuur om deze settings méér te specifiëren.

Panel: De volgende instrumenten kunnen relevant zijn. CRAFFT is een kort instrument en kan door alle hulpverleners worden gebruikt, inclusief diegenen die tewerkgesteld zijn in de eerstelijnsgezondheidszorg. SEM-j is een meer uitgebreid instrument en is bedoeld voor medewerkers van de bijzondere jeugdzorg, CLB en JAC. Om specifiek te screenen op cannabis misbruik worden de CPQ-A-T en de CAST aanbevolen.

CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble, Knight et al 1999) (zie bijlage)
Dit instrument is bedoeld voor het opsporen van alcohol en drugmisbruik bij jongeren en bestaat uit 6 vragen. Elke vraag die met 'ja' wordt beantwoord levert 1 punt op. Bij 2 of meer punten bestaat er een verhoogd risico op problemen door alcohol of drugmisbruik.

SEM-j (individueel Screeningsinstrument Ervaringen met Middelengebruik –jongeren)
Met dit instrument kan een ernstinschatting worden gemaakt van het middelengebruik van een jongere en van de nood aan verdere alcohol- en drugspecifieke begeleiding. Dit kan worden afgenomen in het kader van een individuele begeleiding van een jongere (12-18 jaar). Randvoorwaarden voor het gebruik van de SEM-j zijn dat de hulpverleners voldoende tijd kunnen maken en getraind zijn in het afnemen van dit instrument. Een online versie is beschikbaar via: http://www.vad.be/sectoren/onderwijs/secundair-onderwijs/sem-j.aspx

CPQ-A-S (Proudfoot et al, 2010) is een kort screeningsinstrument om jongeren met een hoog risico op cannabismisbruik op te sporen (zie bijlage). Het bestaat uit 12 items. Elke vraag die met 'ja' wordt beantwoord levert 1 punt op. Bij 3 of meer punten wordt een bijkomende, meer gedetailleerde assessment aanbevolen.

CAST Cannabis Abuse Screening Test (Legleye et al, 2007). Dit instrument bestaat uit 6 items en is speciaal ontwikkeld om patronen van cannabismisbruik bij jongeren te detecteren. Men kan er eventuele problemen om het gebruik te controleren en potentiële negatieve gevolgen voor de gezondheid of sociale relaties mee bevragen.

Stakeholders: Hulpverleners geven aan dat een belangrijke randvoorwaarde in het gebruik van deze instrumenten is dat men hiervoor voldoende opgeleid is.

Aanbeveling 3

Vraag binnen settings zoals de eerstelijnsgezondheidszorg en algemene ziekenhuis- en spoedafdelingen naar recent drugmisbruik bij jongeren met symptomen die kunnen wijzen op drugmisbruik, zoals:

- Acute pijn op de borst
- Acute psychose
- Stemmingsstoornissen en slaapstoornissen

(consensus)

Toelichting

Bronrichtlijn: Mensen die drugs misbruiken (vooral opiaatgebruikers) kunnen zich presenteren met een verscheidenheid aan gezondheids- en sociale problemen, waaronder

- Lichamelijke problemen (bijvoorbeeld trombose, abcessen, overdosis, hepatitis B en C, HIV en circulatie en cardiale problemen).
- Mentale problemen (bijvoorbeeld depressie, angststoornissen, paranoïde en suïcidale gedachten).
- Sociale problemen (bijvoorbeeld relatieproblemen, financiële problemen, werkloosheid en dakloosheid).
- Strafrechtelijke problemen.

Panel: Deze aanbeveling is zeer relevant omdat de link tussen deze symptomen en mogelijk drug misbruik te weinig wordt gelegd. Echter, deze lijst is niet volledig.

Stakeholders: Het merendeel van de bevraagde jongeren zou meewerken aan een dergelijke bevraging indien het verband met hun hulpvraag duidelijk is.

1.3 Assessment

Hoe wordt een assessment bij jongeren die drugs misbruiken best uitgevoerd?

Aanbeveling 4

Houd gedurende de assessment van jongeren tussen 16 en 18 jaar rekening met:

- Medische, psychologische en sociale behoeften en noden van de jongere.
- Voorgeschiedenis van drugmisbruik.
- Mogelijke ervaringen met eerdere behandelingen.
- Doelstellingen op het vlak van druggebruik.
- De voorkeur van de jongere voor een bepaalde behandeling.

(consensus)

Toelichting

Bronrichtlijn: Een goed assessment is essentieel voor de zorg van jongeren die een behandeling overwegen. Het assessment is een continu proces dat plaatsvindt tijdens elk contact met de jongere en zijn of haar hulpverlener, sociaal werker en kan verschillende jaren duren.

Het doel van het assessment is: het bevestigen van het drugmisbruik (met behulp van anamnese, lichamelijk onderzoek, urineonderzoek), het onderzoeken van de mate van afhankelijkheid, het opsporen van eventuele druggerelateerde problemen, het evalueren van risicogedrag, het identificeren van andere medische, sociale en mentale gezondheidsproblemen en de motivatie om te veranderen, het in kaart brengen van het meest passende niveau van expertise dat nodig is, het bepalen van de noodzaak voor substitutiemedicatie, en het verwijzen naar of organiseren van een samenwerking met jeugdzorg, specialisten en andere hulpverleners, waar nodig.
Bovendien zou ook onmiddellijk advies moeten worden gegeven over schadebeperking, inclusief eventuele toegang tot steriele naalden en spuiten, het testen op hepatitis B en C en HIV en vaccinatie tegen hepatitis B.

Panel: Deze aanbeveling is enkel geldig voor medische en niet zozeer voor niet-medische hulpverleners in de gezondheidzorg. De anamnese zou niet alleen van de jongere moeten komen. Het doel is om de noden en behoeften te inventariseren. Bij jongeren kan een hetero-anamnese worden afgenomen. Deze vragen zijn globaal gezien ook relevant voor jongeren tot 16 jaar, maar er kunnen andere accenten worden gelegd (bijvoorbeeld familie en school zijn dan belangrijke onderdelen van de sociale context). Ook de manier van bevragen zou aangepast moeten worden aan de leeftijd van de jongere.

Stakeholders: De hulpverleners geven aan dat voldoende tijd en middelen en een opleiding belangrijke randvoorwaarden zijn voor het uitvoeren van een assessment.

Aanbeveling 5

Bij jongeren met opiaatafhankelijkheid die willen ontwennen, onderzoek de aanwezigheid en ernst van de afhankelijkheid en het gebruik van andere middelen (alcohol, benzodiazepines en stimulerende middelen). De volgende onderdelen maken deel uit van het assessment:

- Urineanalyses; ook sneltests zoals een speeksel- of ademtest zijn mogelijk.
- Maak een klinisch assessment van opiaatontwenningsverschijnselen (eventueel met officiële meetschalen als hulpmiddel). Deze meetschalen zijn geen vervanging van het klinisch onderzoek.
- Informeer naar de voorgeschiedenis van drug- en alcoholmisbruik bij de jongere en naar eventuele behandelingen die reeds gegeven werden.
- Informeer naar de voorgeschiedenis van lichamelijke en psychiatrische gezondheidsproblemen en eventuele behandelingen.
- Houd rekening met het risico op zelfverwonding, verlies van opiaattolerantie en misbruik van drugs of alcohol als reactie op de opiaatontwenningsverschijnselen.
- Houd rekening met de sociale en persoonlijke situatie van de jongere, inclusief werkgelegenheid en financiële status, woonregelingen, sociale ondersteuning en criminele activiteiten.
- Houd rekening met de impact van het drugmisbruik op ouders en andere familieleden.
- Ontwikkel strategieën om het risico op herval te beperken, rekening houdend met het ondersteunende netwerk van de jongere.

(consensus)

<u>Toelichting</u>

Bronrichtlijn: Het klinisch assessment is van belang om te bepalen of detoxificatie aangewezen is voor de jongere (met andere woorden of hij opiaatafhankelijk is). In voorkomend geval dient te worden bepaald hoe de detoxificatie het meest effectief kan worden aangepakt.

Klinisch assessment van afhankelijkheid
Het merendeel van de jongeren die zich melden voor detoxificatie zullen een duidelijke voorgeschiedenis van opiaatafhankelijkheid hebben, mogelijk omdat ze methadon of buprenorphine op voorschrift krijgen, of door klinische tekenen van illegaal heroïnegebruik (zoals vele injectielittekens). Sommigen zullen opiaten misbruiken bovenop de voorgeschreven medicatie. Afhankelijkheid van opiaten gaat vaak samen met afhankelijkheid en/of misbruik van benzodiazepines, alcohol of stimulantia zoals cocaïne of amfetamine.

Opiaatafhankelijkheid wordt meestal primair gediagnosticeerd door een klinisch onderzoek maar kan mede gebaseerd zijn op bloed- of urinetesten of door het gebruik van psychometrische schalen. In een klinisch onderzoek dient men verder na te vragen wat het patroon, de aard en de ernst is van het drugmisbruik en welke behandelepisodes in het verleden werden doorlopen, om de mate van afhankelijkheid vast te stellen. (DH, 1999).

Er is wetenschappelijk bewijs voor een verbetering van de behandeluitkomsten door het betrekken van de omgeving op verschillende momenten in het behandelproces, voor zowel de jongeren als voor de omgeving die door het misbruik wordt beïnvloed (Copello et al 2005).

Panel: Bij jongeren dient de familie zeker bij het assessment betrokken te worden. Familieleden bekijken de problemen vanuit een andere invalshoek (bijvoorbeeld school of werk), waardoor men een meer gedifferentieerd beeld krijgt van de problemen van de jongere. Daarnaast wordt medicatie vaak via de ouders gegeven om de therapietrouw van de jongeren te bevorderen.

Aanbeveling 6
Bij jongeren met een diagnose van afhankelijkheid dienen drugtesten uitgevoerd te worden door speciaal opgeleide gezondheidswerkers, in overeenstemming met de standaard werk- en veiligheidsprocedures.
(consensus)

1.4 Behandeling

Aan welke voorwaarden moet een efficiënt behandelingstraject voldoen?

Aanbeveling 7
Werk samen met ouders, sociale onderwijsvoorzieningen, geestelijke jeugdgezondheidszorg, CLB of andere specialisten om:

- De jongere steun te geven.
- De jongere, in voorkomend geval naar andere diensten (zoals sociale zorg, huisvesting of werkgelegenheid) te verwijzen, gebaseerd op een wederzijds overeengekomen plan. Het plan moet rekening houden met de behoeften van de jongere en afspraken bevatten met betrekking tot evaluatie.

(consensus)

Toelichting

Panel: Het werken met ouders alleen is niet voldoende. Hulpverleners zouden mensen uit de omgeving een andere attitude/perceptie tegenover de jongere moeten aanleren. Ook het aspect zelfzorg voor mensen uit de omgeving is hierin zeer belangrijk. Dit past binnen de algemene trend van 'patient-centered' zorg, waarin het van belang is dat de hulpverlener een goed zicht krijgt op de redenen van het langskomen van de jongere, vervolgens bekijkt wat de hulpvragen zijn en wat hem of haar onrustig maakt. Daarnaast verlangt de jongere begrip voor zijn gehele persoon, voor zowel emotionele behoeften als andere kwesties. De jongere wil ook graag overeenstemming met de hulpverlener vinden over wat zijn probleem is en hoe dat aangepakt gaat worden. Vervolgens is het belangrijk dat bij 'patient-centered' zorg de preventie en het bevorderen van de gezondheid voorop staat. Ten slotte is een consistente relatie tussen jongere en hulpverlener belangrijk (Stewart, 2001).

Aanbeveling 8

Om jongeren geïnformeerde beslissingen te kunnen laten maken over hun behandeling en zorg adviseren we dat gezondheidswerkers bij het eerste contact en bij alle formele evaluaties de mogelijkheden voor behandeling gericht op abstinentie, op gecontroleerd gebruik en op schadebeperking uitleggen.
(consensus)

Toelichting

Panel: In alle gevallen dient abstinentie voor jongeren het eerste doel te zijn. In het eerste contact zouden geen andere mogelijkheden mogen worden genoemd. Indien blijkt dat abstinentie echt niet haalbaar is, dienen de andere behandeldoelen zoals schadebeperking bespreekbaar gemaakt te worden, om te voorkomen dat jongeren het contact verliezen met de hulpverlening. De relatie tussen de hulpverlener en jongere krijgt hierin prioriteit. Hulpverleners dienen zich altijd af te vragen of de jongere in staat is een weloverwogen keuze te maken.

Aanbeveling 9

Bespreek met jongeren die drugs misbruiken en/of die zich aanmelden voor detoxificatie of hun familie bij het assessment en het behandelplan betrokken moet worden. Zorg ervoor dat het recht op vertrouwelijkheid wordt gerespecteerd.
(consensus)

Toelichting

Bronrichtlijn: Uit onderzoek blijkt dat veel gezinsleden zich buitengesloten voelen van deelname in de behandeling van hun gezinslid. Sommige families hebben het gevoel dat hulpverleners zich verschuilen achter de term 'vertrouwelijkheid', terwijl ze misschien best algemene informatie over de behandeling zouden kunnen verstrekken (Bancroft et al 2002).

Panel: De vertrouwelijkheid rondom zorg bij jongeren is vastgelegd in het decreet rechtspositie minderjarigen. Voor meer informatie zie de lijst begrippen.
Stakeholders: Geheimhouding kan bijdragen aan het instandhouden van het drugprobleem.

Aanbeveling 10

Geef jongeren die drugs misbruiken dezelfde zorg, privacy en respect als ieder andere persoon.
(consensus)

Aanbeveling 11

Wanneer jongeren met drugmisbruik overgaan naar een andere zorginstelling, zorg voor een effectieve overdracht van duidelijke en met de jongere overeengekomen behandelplannen om contactverlies te voorkomen.
(GRADE 1C)

Aanbeveling 12
Alle interventies voor jongeren met drugmisbruik dienen te worden uitgevoerd door gezondheidswerkers die competent zijn in het geven van deze interventies -of die onder passende supervisie staan.
(consensus)

Toelichting
Panel: Deze en bovenstaande aanbevelingen hebben betrekking op het ontwikkelen en onderhouden van een goede relatie met de patiënt. Dit is cruciaal voor het behalen van positieve resultaten, zeker bij jongeren.

Welke niet-medicamenteuze (psycho-sociale) interventies kan men best toepassen?

Aanbeveling 13
Geef tijdens routinematige en opportunistische contacten aan alle jongeren die drugs misbruiken informatie en een kort advies over hun potentiële blootstelling aan bloed overdraagbare virussen. Dit omvat ook advies over het verminderen van het seksuele en injectierisicogedrag. Hulpverleners moeten overwegen om testen voor bloed overdraagbare virussen aan te bieden.
(GRADE 1C)

Toelichting
Stakeholders: Dit is reden voor doorverwijzing naar specialistische hulpverlening.

Aanbeveling 14
Geef jongeren die drugs misbruiken niet routinematig psycho-educatieve interventies (gericht op harm reductie zoals informatie over de blootstelling aan bloed overdraagbare virussen en/of over vermindering van het seksuele en injectierisicogedrag) in groepsverband.
(consensus)

Toelichting
Panel: Het aanbieden van groepsbehandelingen aan jongeren die drugs misbruiken zou nadelige effecten kunnen hebben, zoals een verhoging van het gebruik. De samenstelling van de groep heeft daar mogelijk een impact op (Kaminer, 2005).

Aanbeveling 15 en 16
Als een jongere of een hulpverlener specifieke zorgen heeft aangaande drugmisbruik, geef een opportunistisch, kort advies aan jongeren zonder contact met drughulpverlening of aan jongeren met een beperkt contact met drughulpverlening. Deze interventie:

- Bestaat gewoonlijk uit twee sessies van elk 10–45 minuten
- Verkent ambivalentie over drugmisbruik en mogelijke behandeling, met de bedoeling de motivatie van de jongere te verhogen, zijn gedrag te veranderen en feedback te geven op een niet-beoordelende manier.

(GRADE 1C)

Toelichting

Bronrichtlijn: De voordelen van kort advies-interventies in de behandeling van drugmisbruik zijn tweeledig. Ze zijn gemakkelijk uit te voeren en het kost minder moeite om deze jongeren in de zorgverlening te houden. Het verstrekken van dergelijk kort advies wordt vaak toegepast bij de behandeling en begeleiding van alcohol-gerelateerde problemen (SIGN, 2003).

Opgemerkt moet worden dat een aanzienlijk deel van de jongeren die opiaten, stimulerende middelen en cannabis misbruiken ook alcohol misbruiken. Kort advies-interventies kunnen worden uitgevoerd in verschillende voorzieningen, waaronder ook niet-medische voorzieningen. Ze kunnen worden aangeboden aan jongeren die niet in formele drugsbehandeling zijn of als aanvulling op formele drugsbehandelingen (Ashton, 2005).

Panel: Deze benadering is de enige juiste als jongeren ervoor kiezen te blijven gebruiken. Echter, deze interventie moet gekaderd worden binnen een volledige aanpak.

Zie de Evidence Review voor bijkomende inzichten uit recente literatuuroverzichten over motivationele interventies, ambulante behandelingen zoals CBT en familie therapie en groepsbehandelingen.

Wanneer is residentiële opname van jongeren die drugs misbruiken nodig?

Aanbeveling 17

Overweeg residentiële behandeling bij jongeren die abstinent willen worden en die belangrijke bijkomende problemen hebben op lichamelijk, geestelijk of sociaal vlak (bv huisvesting). De jongere moet onvoldoende baat hebben gehad bij eerdere psychosociale, community-based interventies.
(GRADE 1C)

Toelichting

Bronrichtlijn: Het is algemeen aanvaard dat residentiële behandelcentra een belangrijke rol spelen in de zorg voor jongeren die drugs misbruiken in bepaalde stadia van hun behandeling. Echter, een wetenschappelijk bewijs voor de werkzaamheid van behandelingen binnen residentiële centra vergeleken met community-based alternatieven ontbreekt. Bovendien is er weinig gekend over welke subgroepen van jongeren het meeste baat zullen hebben bij residentiële behandelingen, de werkzaamheid en de kosteneffectiviteit van de verschillende soorten behandelingen, en wat de meest kosten-effectieve duur van het verblijf in deze eenheden is. Dit zijn mogelijk redenen voor het beperkte aanbod in residentiële diensten.

Panel: Residentiële behandeling zou niet alleen aan die jongeren moeten worden aangeboden die zelf abstinent willen worden. Jongeren kunnen hun problemen soms ontkennen en in dat geval kunnen volwassenen voor jongeren beslissen tot een residentiële behandeling. Bij jongeren is motivatie bij het begin van de behandeling ook nog geen echte randvoorwaarde. Dit is iets waar in de behandeling aan wordt gewerkt.

Stakeholders: Hulpverleners vinden de veiligheid van de jongere ook reden tot residentiële opname. De helft van de jongeren gaf aan niet akkoord te gaan met een residentiële opname.

Welke interventies zijn effectief om gezinsleden van jongeren die drugs misbruiken te ondersteunen?

Stakeholders: Alle bevraagde ouders zouden het op prijs stellen betrokken te worden bij de behandeling van hun kind. Ze geven verder aan dat hulpverleners hen mogen bevragen over de impact van het misbruik op henzelf, en en hulp en advies mogen aanbieden. De meerderheid van de jongeren zou het betrekken van de familie niet op prijs stellen. Hulpverleners dienen zich van deze discrepantie bewust te zijn.

Aanbeveling 18

Vraag ouders en verzorgers naar de impact van het drugmisbruik op henzelf en andere gezinsleden. Maak een gedetailleerde beschrijving van hun persoonlijke, sociale en psychologische gezondheidsbehoeften. Verstrek advies en schriftelijke informatie over de impact van drugmisbruik. (GRADE 1C)

Toelichting

Bronrichtlijn: Het is belangrijk om de impact van het drugmisbruik door jongeren op hun ouders in kaart te brengen. Hierdoor verkrijgt men een beter inzicht in de specifieke problemen waarmee ouders worden geconfronteerd en kunnen de meest effectieve manieren om ze te helpen en te ondersteunen worden ingezet.
Stakeholders: Hulpverleners vinden het belangrijk ouders te betrekken in de re-integratie van de jongere na residentiële opname.

Aanbeveling 19

Identificeer de behoeften van ouders van jongeren die drugs misbruiken. We adviseren om hierna

- Begeleide zelfhulp aan te bieden (meestal één sessie met verstrekking van schriftelijk materiaal).
- Hen te informeren over ondersteuningsgroepen, bijvoorbeeld zelfhulpgroepen specifiek voor ouders. Breng hen hier eventueel mee in contact.

(GRADE 2C)

Aanbeveling 20

Geef ouders van jongeren die opiaatafhankelijk zijn bovendien informatie over

- Detoxificatie en de settings waar deze behandeling kan worden gegeven.
- Zelfhulp- en ondersteuningsgroepen voor ouders.

(consensus)

Toelichting

Bronrichtlijn: Er is een toenemend besef alsook een erkenning voor het feit dat drugmisbruik door een jongeren invloed heeft op de hele familie en de hele gemeenschap waarin deze gezinnen leven. Er zijn aanwijzingen dat gezinsleden van gebruikers meer problemen hebben op het vlak van sociale relaties, werk en vrije tijd in vergelijking met gezinnen zonder gebruikers. Echter, een directe vergelijking wordt bemoeilijkt door verschillen tussen deze gezinnen.

De impact op de leden van de familie lijkt te verschillen afhankelijk van de rollen en verantwoordelijkheden binnen het gezin. Adfam (Sims, 2002) heeft de behoeften van families van mensen die drugs en alcohol misbruiken in kaart gebracht. Eén van de meest belangrijke punten was het omgaan met stigma. Het stigma was een grote belemmering voor ouders en familieleden om zelf hulp te zoeken. Dit betrof zowel een uitsluiting van zorg door eerstelijnsdiensten als zelfuitsluiting door angst om te worden beoordeeld.
Een verdere noodzaak was de toegang tot zorg. Het zorgaanbod voor families van mensen die drugs misbruiken bleek eerder beperkt (Zie ook Bancroft et al., 2002). Zelfs indien zorg beschikbaar was, waren veel gezinnen zich hiervan niet bewust of wisten ze niet hoe toegang tot deze zorg te krijgen.

De volgende organisaties voor familieleden van mensen met drugmisbruik zijn actief in België:

- Similes (www.similes.org): voor gezinsleden en mensen die van nabij betrokkenen zijn bij personen met psychiatrische problemen
- Via de druglijn (www.druglijn.be)
- Via de website van Trefpunt Zelfhulp (www.zelfhulp.be):
    - Familiegroepen (verbonden aan behandelcentra): zoals de Sleutel, de Kiem, CAW De Kempen, Kompas,…
    - FIST (Zelfhulpgroep voor ouders van gebruikers)
    - Nar-anon familiegroep Antwerpen

Hierbij dient onderscheid te worden gemaakt tussen oudergroepen ter ondersteuning van de ouders en zelfhulpgroepen, die primair gericht zijn op de jongeren zelf.

Panel: Beschikbaarheid en zichtbaarheid zijn belangrijke randvoorwaarden voor deze ondersteuningsgroepen. Een aantal centra organiseren zelfhulpgroepen voor ouders van jongeren die drugs misbruiken, maar het is de vraag of dit aanbod in België voldoende beschikbaar is. Ouders geven vaak aan nood te hebben aan dergelijke ondersteuning, maar kunnen deze hulp moeilijk vinden.

1.5 Detoxificatie bij jongeren met opiaatafhankelijkheid

Detoxificatie (ontgiften of afkicken) heeft tot doel op een veilige en effectieve manier de effecten van opiaten weg te nemen (WHO, 2006). Medicatie speelt een cruciale rol bij het vergroten van de kans op een succesvolle detoxificatie, waarbij ontwenningsverschijnselen worden geminimaliseerd. Detoxificatie is geen behandeling op zich en zou alleen gegeven moeten worden in combinatie met psychosociale ondersteuning. Dit verkleint de kans dat de jongere vroegtijdig afhaakt en vergroot de kans op deelname aan een verdere behandeling.

Om de geïnformeerde toestemming van de jongere te bekomen, dienen hulpverleners aan de jongere gedetailleerde informatie te verstrekken over detoxificatie en de bijhorende risico's, waaronder:

- De lichamelijke en psychologische aspecten van opiaatdetoxificatie, inclusief de duur, intensiteit en de ernst van de symptomen en hoe deze kunnen worden opgevangen.
- Het gebruik van niet-farmacologische interventies om ontwenningsverschijnselen op te vangen.
- Het verlies van opiaattolerantie na de detoxificatie en het hiermee samenhangende, verhoogde risico op overdosis en overlijden als gevolg van illegaal druggebruik, wat kan worden versterkt door het gebruik van alcohol of benzodiazepines.
- Het belang van langdurige ondersteuning en van psychosociale en farmacologische interventies om abstinentie te behouden, comorbide psychiatrische gezondheidsproblemen te behandelen en het risico op nadelige uitkomsten (inclusief overlijden) te beperken.

Toelichting

Panel: Er bestaat in België een wettelijk kader voor substitutiebehandeling bij opiaatverslaving (Koninklijk Besluit (KB) van 19 maart 2004 (BS 30/04/04), gewijzigd door het KB van 6 oktober 2006 (BS 21/11/2006). Dit kader beschrijft dat substitutiebehandeling dient te gebeuren onder de supervisie van personen (artsen en anderen) competent in de problematiek van toxicomanie. Artsen die gelijktijdig aan meer dan twee patiënten een substitutiebehandeling voorschrijven, moeten aan specifieke voorwaarden voldoen. Dit omvat onder andere de registratie bij een erkend opvangcentrum.

Aanbeveling 21

We adviseren dat detoxificatie een direct toegankelijke behandeloptie is voor jongeren met een opiaatafhankelijkheid die met een geïnformeerde toestemming kiezen voor een detoxificatie.
(consensus)

Toelichting

Panel: In België zijn er voor jongeren te weinig mogelijkheden voor detoxificatie. Indien hospitalisatie nodig is, is er vaak een wachtlijst. Dit kan het effectief volgen van deze aanbeveling bemoeilijken.

Stakeholders: Jonge adolescenten die opiaten misbruiken verwijst men best door naar de gespecialiseerde hulpverlening.

Welke medicijnen moet men voorschrijven? Wanneer dient men deze voor te schrijven?

Aanbeveling 22

Geef methadon of buprenorphine als eerste keuze in de behandeling van opiaatdetoxificatie. Houd bij het kiezen tussen deze twee middelen rekening met:

- Of de jongere op dit moment methadon of buprenorphine gebruikt als onderhoudsbehandeling. Indien dit het geval is wordt de detoxificatie normaal gezien gestart met dezelfde medicatie.
- De voorkeur van de jongere.

(GRADE 1C-voor keuze van medicatie)

Toelichting

Bronrichtlijn: De meest eenvoudige vorm van detoxificatie is het over een periode verminderen van de dosis van een opioidvervangend medicijn, bijvoorbeeld methadon of buprenorfine. Deze medicatie moet de symptomen van ontwenning tegengaan. Afhankelijk van de medicatie en begindosis, kan detoxificatie dagen tot maanden duren.

Methadon en buprenorphine blijken allebei effectief in het verminderen van de ontwenningssymptomen wanneer ze worden vergeleken met andere ontwenningsmedicatie, zoals alpha2 adrenerge agonisten. Dihydrocodeine lijkt niet effectief in vergelijking met buprenorphine. Het is niet duidelijk of er verschil is in effectiviteit tussen methadon en buprenoprhine voor de detoxificatie. Het gebruik van clonidine geeft meer bijwerkingen.

Panel: In België is er meer ervaring met het gebruik van methadon, maar buprenorphine wordt in toenemende mate gebruikt.

Aanbeveling 23

Geef niet routinematig clonidine in de behandeling van opiaatdetoxificatie.
(GRADE 1C)

Toelichting

Bronrichtlijn: Clonidine wordt niet aanbevolen vanwege minder goede effecten vergeleken met buprenorphine, Gebruikers van clonidine hebben een hoger risico op hypotensie vergeleken met gebruikers van methadon.

Aanbeveling 24

Om de startdosis, de duur en het regime (bijvoorbeeld lineair of getrapt) van opiaatdetoxificatie te bepalen adviseren we om, in overleg met de jongere, rekening te houden met:

- De ernst van de afhankelijkheid (men dient met name voorzichtig te zijn wanneer de mate van afhankelijkheid onbekend is).
- De stabiliteit van de jongere (let ook op polydrug- en alcoholmisbruik, en bijkomende geestelijke gezondheidsproblemen).
- De farmacologie van de gekozen detoxificatiemedicatie en eventuele bijkomende medicatie.
- De setting waarbinnen de detoxificatie uitgevoerd zal worden.

(GRADE 2C)

Toelichting

Panel: Bruikbare informatie over het toedienen van methadon of buprenorphine is te vinden in richtlijnen over opiaatontwenning via www.vad.be/evidence-based-werken/richtlijnen.aspx of in het Dossier Heroine dat bruikbare informatie geeft over het toedienen van methadon of buprenorphine (Kinable en Verstuyf, 2010; bijlage 12.4. productfiche methadon, en bijlage 12.5 productfiche buprenorphine).
Alle opiaatafhankelijke jongeren die in een programma terechtkomen gericht op abstinentie, moeten goed voorgelicht worden over het feit dat ze door een verminderde opiaattolerantie een verhoogd risico lopen op een overdosis bij terugval (Kinable & Verstuyf, 2010).
Bij het instellen van de medicatie dien men rekening te houden met de leeftijd en het gewicht van de jongere.

Aanbeveling 25 en 26

Bied geen snelle en ultra-snelle detoxificatie aan.
Bied geen ultra-snelle detoxificatie aan onder algemene anesthesie of zware sedatie (waarbij ondersteuning van de luchtwegen nodig is).
(beide GRADE 1C)

Toelichting

Bronrichtlijn: Bij snelle en ultra-snelle detoxificatie wordt gebruik gemaakt van opiaat antagonisten, zoals naltrexon of naloxone. Dit gebeurt meestal onder algemene verdoving of zware sedatie. Het doel is om een ontgifting te induceren en het detoxicatie-proces te versnellen, waarbij de ontwenningsverschijnselen door de anesthesie of sedatie worden beperkt.
Versnelde detoxificatieprogramma's worden niet aanbevolen vanwege de complexe bijkomende medicatie en het hoge niveau van verpleegkundige en medische supervisie dat nodig is. Daarnaast is er een risico op ongewenste effecten, inclusief overlijden.

Aanbeveling 27

Het voorschrijven van bijkomende medicatie tijdens de opiaatdetoxificatie zou:

- Alleen moeten gebeuren wanneer dit klinisch aangewezen is, bijvoorbeeld bij klachten als agitatie, misselijkheid, slapeloosheid, pijn en/of diarree.
- De minimale, werkzame dosis en het minimum aantal geneesmiddelen moeten bevatten die noodzakelijk zijn om de symptomen te behandelen.

Hulpverleners moeten alert zijn op de risico's van bijkomende medicatie, alsook op de wisselwerking tussen deze geneesmiddelen met de opiaatagonist.
(consensus)

Toelichting

Panel: Alle opiaten geven vergelijkbare onthoudingssyndromen, waarvan het tijdstip van aanvang, de intensiteit en de duur aanzienlijk kunnen verschillen. De ernst hangt af van de gebruikte drug, de totale dagelijkse dosering, het interval tussen de doses, de duur van het gebruik en de individuele gevoeligheid.

Klachten en symptomen treden meestal op binnen 6-12 uur na het stoppen van het gebruik van kortwerkende opiaten (zoals heroïne) en binnen 12 tot 48 uur na het stoppen van langwerkende preparaten (zoals methadon). De acute klachten omvatten onder andere angst, dysforie, craving, verhoogde sympathische activiteit, slaapproblemen, maag-darmproblemen, spierkrampen en botpijnen. Na de acute fase volgt de chronische onthoudingsfase, die gekarakteriseerd wordt door een verminderd algemeen welbevinden (bron: Franken & Van der Brink, 2009).

Bijkomende medicatie kan worden gebruikt om ontwenningsverschijnselen tegen te gaan. De term 'bijkomende medicatie' verwijst naar een grote verscheidenheid aan middelen en indicaties. Hieronder valt bijvoorbeeld ook medicatie gericht op het noradrenalinesysteem, zoals clonidine. Dit middel wordt gebruikt bij ontwenningsverschijnselen bij het afkicken van opiaten, zoals heroïne, morfine en methadon.

De indicatie voor clonidine is toenemende rusteloosheid in de extremiteiten. Naast een droge mond, lethargie, sedatie en zwakte zijn de belangrijkste nevenwerkingen hypotensie en duizeligheid. Omwille van het grote risico op hypotensie wordt geadviseerd clonidine niet ambulant toe te passen (bron: Franken & Van der Brink, 2009).
Andere bijkomende medicatie is gericht op het verlichten van bepaalde symptomen, zoals een antispasmoliticum voor darmkrampen of een verzameling van symptomen, bijvoorbeeld benzodiazepinen voor angststoornissen en sedatie of antipsychotica voor agitatie of sedatie.

Bijkomende medicatie is vooral belangrijk wanneer detoxificatie gebeurt met non-opiaten, zoals clonidine, omdat die niet alle ontwenningsverschijnselen onderdrukken. Ze worden ook gebruikt om verschijnselen te onderdrukken tijdens de detoxifcatie met buprenorphine en methadon.

Benzodiazepines kunnen een belonend effect hebben bij jongeren met een voorgeschiedenis van drugmisbruik en/of drugverslaving (alcohol en illegale drugs) (VAD, 2008). De Belgische richtlijn over het voorschrijven van benzodiazepines aan illegale druggebruikers beveelt aan om bij gebruikers van illegale drugs meer terughoudendheid/voorzichtigheid te tonen bij het overwegen van het opstarten van benzodiazepines in het kader van de behandeling van een slaap- en/of angststoornis. Echter het niveau van de aanbeveling is laag.

Aanbeveling 28

Wees je ervan bewust dat medicatie voor de ontwenning van opiaten misbruikt en/of verspreid kan worden (geven, doorgeven, verkopen, verhandelen). Overweeg daarom:

- Therapietrouw te monitoren.
- Maatregelen te nemen om het risico op verspreiding te beperken, inclusief de inname van medicatie onder toezicht, indien nodig.

(consensus)

Welke gecombineerde interventies (medicijnen en psychosociaal) kan men best gebruiken voor opiaatdetoxificatie en wanneer?

Aanbeveling 29

Bied jongeren die opiaatdetoxificatie overwegen routinematig community-based programma's aan. Uitzonderingen hierop zijn jongeren die:

- Geen baat hebben gehad bij eerdere community-based detoxificatie.
- Medische en/of verpleegkundige zorg nodig hebben vanwege ernstige comorbide lichamelijke of psychiatrische gezondheidsproblemen.

- Moeten ontwennen van een polydrugverslaving, bijvoorbeeld het gelijktijdig ontwennen van alcohol en benzopiazepines.
- Ernstige sociale problemen hebben, waardoor de voordelen van community-based detoxificatie beperkt zijn.

(GRADE 1C)

Toelichting

Bronrichtlijn: Detoxificatie van opiaten kan plaatsvinden in verschillende voorzieningen, inclusief intramurale settings, residentiële voorzieningen en gevangenissen. Op dit moment is er geen wetenschappelijk bewijs dat detoxificatie in één bepaalde setting beter is dan in een andere setting en is er weinig informatie om professionals te ondersteunen in hun keuze voor wat betreft setting en begeleiding.

Klinische detoxificatie wordt meestal aangeboden indien community-based behandeling meerdere malen niet succesvol was (SCAN, 2006). Ook vindt dit vaak plaats voordat een residentiële behandeling wordt aangeboden, omdat de meeste programma's eisen dat de gebruikers drugvrij zijn voordat ze binnen komen. Daarnaast wordt klinische detoxificatie meestal aangeboden aan diegenen met de meest complexe zorgvragen (SCAN, 2006). Dit zijn bijvoorbeeld jongeren met polydrug verslavingen, jongeren met fysieke en psychologische gediagnosticeerde gezondheidsproblemen en jongeren zonder sociaal netwerk.

Panel: De volgende criteria zijn bruikbaar (bron: Kinable & Verstuyf, 2010)
Ambulante detoxificatie is verantwoord als (De Jong et al, 2004):
1. De gebruiksperiode kort is; de hoeveelheid beperkt is; de heroïne wordt gerookt; de patiënt jong is;
2. Het gebruik niet gekoppeld is aan (andere) rituelen;
3. Er geen afhankelijkheid bestaat van andere psychoactieve stoffen;
4. Ontwenningsverschijnselen door adequate instelling op methadon verdwenen zijn;
5. Er geen lichamelijke aandoening aanwezig is die de detoxificatie beïnvloedt of dit in het verleden gedaan heeft;
6. De zelfzorg niet heeft geleden onder het middelengebruik;
7. Niet eerder is getracht te stoppen of indien eerdere ambulante pogingen succesvol zijn geweest, met langdurige abstinentie als gevolg;
8. Er geen duidelijk psychiatrisch ziektebeeld is;
9. Er minimaal 1 niet gebruikende persoon op de hoogte is van de detoxificatie en bereid is om de poging te ondersteunen;
10. De wens bestaat om ambulant te ontwennen.

Intramurale detoxificatie is aangewezen als (De Jong et al, 2004):
1. Jarenlang heroïne en/of methadon werd gebruikt, met in het laatste jaar dagelijks meer dan 1 gram heroïne of meer dan 60 mg methadon;
2. De hele dag door heroïne en/of methadon wordt gebruikt en het dagelijkse leven draait rond het verwerven van deze middelen;
3. Het gebruik wordt gecombineerd met één of meerdere psychoactieve middelen;
4. Hevige ontwenningsverschijnselen zich eerder hebben voorgedaan;
5. De lichamelijke conditie slecht is of als er sprake is van zwangerschap of een lichamelijke ziekte die naar verwachting de detoxificatie negatief zal beïnvloeden of dat in het verleden heeft gedaan;
6. De zelfzorg slecht is;
7. Na eerdere detoxificaties snel terugval opgetreden is; twee eerdere detoxificaties onsuccesvol waren, intramurale detoxificaties moeizaam verliepen of voortijdig werden afgebroken;
8. Een psychiatrisch toestandsbeeld naar verwachting het resultaat van de detoxificatie negatief zal beïnvloeden of dat in het verleden al gedaan heeft;

9. Er nauwelijks niet-gebruikende contacten zijn;
10. De wens bestaat voor een intramurale detoxificatie.

Aanbeveling 30

Community-based detoxificatie bestaat normaal gezien uit het volgende:

- Voorafgaande stabilisatie van opiaat gebruik door farmacologische behandeling.
- Effectieve coördinatie van de zorg door specialisten of door competente huisartsen.
- Waar nodig, het verstrekken van psychosociale interventies gedurende de stabilisatie- en onderhoudsfases.

(consensus)

Toelichting

Panel: Het Dossier Heroïne (Kinable & Verstuyf, 2010) beschrijft de indicatie voor onderhoudsbehandeling met een opiaatagonist als volgt: "alle cliënten die opiaatafhankelijk zijn conform DSM-IV- of ICD-10-criteria met lichamelijke afhankelijkheid en voor wie er geen specifiek contra-indicaties zijn. Ze moeten wel in staat zijn een 'informed consent' te geven over de behandeling en in de meeste landen geldt ook een minimumleeftijd die varieert van 18 tot 25 jaar ."

Aanbeveling 31

Voer detoxificatie bij vrouwen die opiaatafhankelijk zijn gedurende een zwangerschap alleen uit met de nodige voorzichtigheid.

(consensus)

Toelichting

Panel: Deze aanbeveling zou duidelijker zijn als precies wordt gedefinieerd wat met 'voorzichtigheid' wordt bedoeld. Voorlopig werd daar geen wetenschappelijke informatie over gevonden.

Aanbeveling 32

Indien jongeren die opiaatdetoxificatie willen ondergaan ook alcohol misbruiken, adviseren we om het volgende te overwegen:

- Bij jongeren zonder alcoholafhankelijkheid: tracht het alcoholmisbruik aan te pakken, omdat dit kan toenemen als een reactie op opiaat- ontwenningsverschijnselen. Alcohol kan ook een vervanging worden voor het bestaande opiaatmisbruik.
- Bij jongeren met alcoholafhankelijkheid: bied alcoholdetoxificatie aan. In de lokale gemeenschap of in een gevangenisinstelling wordt alcoholdetoxificatie uitgevoerd vóór opiaatdetoxificatie, maar in een intramurale setting of met stabilisatie in de lokale gemeenschap kan dit gelijktijdig worden uitgevoerd.

(consensus)

Aanbeveling 33

Als een jongere die zich meldt voor opiaatdetoxificatie ook afhankelijk is van benzodiazepines, adviseren we om benzodiazepinedetoxificatie overwegen. Om te beslissen of dit gelijktijdig of afzonderlijk van de opiaatdetoxificatie moet worden uitgevoerd, houden de professionals rekening met de voorkeur van de jongere en de ernst van de afhankelijkheid voor beide middelen.

(consensus)

Toelichting
Panel: Afhankelijk van de patiënt kiest men ervoor om het samen of apart te behandelen.

Aanbeveling 34
Bied bij de behandeling van opiaatafhankelijkheid routinematig psychosociale steun aan.
(GRADE 1B)

Toelichting
Panel: Cruciaal is dat psychosociale ondersteuning altijd nodig is bij de behandeling voor afhankelijkheid en dat de behandeling niet alleen farmacologisch zou mogen zijn. In de ontwenningsfase is alleen medicatie nodig, maar de vervolgbehandeling zou moeten bestaat uit een combinatie van medicatie met psychosociale interventies of alleen psychosociale interventies.

Aanbeveling 35
Bied routinematig psychosociale ondersteuning aan, in combinatie met medicamenteuze behandeling van opiaatontwenning.
(GRADE 1C)

Toelichting
Panel: Een opiaatontwennings behandeling kan ook bestaan uit alleen psychosociale interventies.

Hoe lang is follow-up nodig bij jongeren die drugs misbruiken? Waaruit dient deze follow-up te bestaan?

Aanbeveling 36
Bied alle jongeren na een succesvolle opiaatdetoxificatie, een vervolgbehandeling, steun en monitoring aan, met het doel ze te helpen om abstinent te blijven. Normaal gezien is dit voor een periode van tenminste 6 maanden. Dit is onafhankelijk van de setting waarin de detoxificatie werd uitgevoerd.
(consensus)

Toelichting
Panel: Terugval na succesvolle behandeling is eerder regel dan uitzondering. Nazorg lijkt een positieve invloed te hebben op het handhaven van de resultaten die zijn bereikt in de klinische behandeling, met name als het gaat om het minimaliseren van de ernst, de duur en de ernst van een terugval (Bron: De Wildt en Verster, 2005).
Nazorg is gericht op het handhaven van de therapeutische effecten die in de voorafgaande fase van de primaire behandeling zijn verkregen (De Wildt en Verster, 2005), met als doel het re-integreren van de jongere in de maatschappij en het verhogen van de zelfverantwoordelijkheid. Nazorg zou niet zozeer het verkrijgen of behouden van absolute abstinentie tot doel hebben, maar juist gericht moeten zijn op het leren omgaan met perioden van gebruik en het weer onder controle krijgen van gebruik.
De vorm en setting lijken niet veel uit te maken: er wordt geen verschil in effectiviteit gevonden tussen interventies met verschillende referentiekaders (bijv. terugvalpreventie en interpersoonlijke therapie), noch tussen groepsgerichte nazorg, telefonische counseling en individuele nazorg. Langdurige interventies lijken effectiever dan korte. Ook een verhoogde frequentie geeft betere resultaten. Interventies gericht op het stimuleren van jongeren om de nazorgactiviteiten langer vol te houden kunnen daarom belangrijk zijn

(De Wildt en Verster, 2005).
Een follow-up van ten minste 6 maanden is zeker voor opiaatmisbruik belangrijk. Voor misbruik van andere middelen, zoals cannabis, kan dat anders liggen omdat men daar vooral de familie probeert te versterken in de steun naar de jongere toe, zodat intensieve follow-up door professionelen niet of minder nodig is.
Het aanbieden van ambulante nazorg aan jongeren die in een residentiële setting begeleid worden, is minder evident. Deze jongeren hebben gedurende hun verblijf een vertrouwensband opgebouwd met de hulpverleners daar. Het is voor hen niet vanzelfsprekend om nadien hun verhaal opnieuw te moeten doen aan andere hulpverleners waarmee ze opnieuw een vertrouwensband mee dienen op te bouwen. Een ambulante follow-up bij de hulpverleners die zij al kennen van tijdens hun opname is in de huidige organisatie van de verslavingszorg in België niet mogelijk.

Toelichting
Stakeholders: De meerderheid van de bevraagde jongeren zou meewerken aan een dergelijke follow-up na een behandeling.

Financiering
Deze richtlijn is ontwikkeld met behulp van financiering door de Federale Overheid - Cel Drugs (BELSPO). De financierder heeft geen invloed gehad op de inhoud van de richtlijn.

Referenties

- ADAPTE-youth 1. Trudy Bekkering, Karen Smets, Martine Goossens, Mieke Autrique, David Möbius, Marijs Geirnaert, Bert Aertgeerts, Paul Van Royen, Karin Hannes. Richtlijn screening, assessment en behandeling van jongeren met alcoholmisbruik. Leuven, 2013.
- ADAPTE-youth 3. Trudy Bekkering, Mieke Autrique, David Mobius, Karen Smets, Martine Goossens, Bert Aertgeerts, Paul van Royen, Marijs Geirnaert, Karin Hannes. Richtlijn voor de preventie van alcohol en drugmisbruik bij adolescenten. Leuven, 2013.
- Adviescommissie Kwetsbare Jeugd & Verslaving. Van kwetsbaar naar weerbaar. Verslaving bij kwetsbare jongeren voorkomen en adequaat begeleiden. Bevorderen gezondheid en weerbaarheid. Vergroten veiligheid. Besparen kosten. Amersfoort: Stichting Resultaten Scoren, 2011.
- Ashton, M. The motivational hallo. Drug and Alcohol Findings 2005, 13, 23–30 (Geciteerd in: NICE 2007b).
- Bancroft, A., Carty, A., Cunningham-Burley, S., et al. Support for the Families of Drug Users: a Review of the Literature. Edinburgh: Scottish Executive Interventions Unit, 2002 (Geciteerd in NICE, 2007b).
- Copello, AG, Velleman RDB, Templeton LJ. Family interventions in the treatment of alcohol and drug problems. Drug Alcohol Rev 2005; 24:369 – 385.
- Databank jeugdrecht: 2006-03 Decreet betreffende de rechtspositie van de minderjarige in de integrale jeugdhulp (http://www.jeugdrecht.be/?action=artikel_detail&artikel=66).
- Databank jeugdrecht: 2006-06 Beroepsgeheim van een hulpverlener bij minderjarige cliënten (http://www.jeugdrecht.be/?action=artikel_detail&artikel=63).
- Databank jeugdrecht: 2011-09/10 De school en de hulpverlener in gesprek: beroepsgeheim en ambtsgeheim (http://www.jeugdrecht.be/?action=artikel_detail&artikel=336).
- De Jong C., van Hoek, A., Jongerhuis, M. (2004). Richtlijn detox. Amersfoort: GGZ Nederland (Geciteerd in: Kinable H en Verstuyf G, 2010).
- Department of Health (DH) (1999) Drug Misuse and Dependence - Guidelines on Clinical Management. London: Stationery Office (Geciteerd in: NICE, 2007c).
- De Wildt WAJM en Verster A. Nazorg na deeltijd en klinische behandeling. Utrecht: Stichting Resultaten Scoren, 2005.

- ESPAD (2011). The European School Survey Project on Alcohol and other Drugs. The 2011 ESPAD report. Bron: http://www.espad.org/en/Reports--Documents/ESPAD-Reports/
- Fervers B, Burgers JS, Haugh MC, et al. Adaptation of clinical guidelines: literature review and proposition for a framework and procedure. Int J Qual Health Care 2006; 18: 167-76.
- Franken, I. ,Van den Brink, W. Handboek Verslaving. Utrecht: De Tijdstroom, 2009.
- GRADE. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ 2008;336:924. Zie ook: www.gradeworkinggroup.org
- HBSC 2005-2006 Health Behaviour in School-aged Children (HBSC) study. Bron: http://www.emcdda.europa.eu/publications/country-overviews/be#gps
- Hermans L, Schrooten J. Dossier cocaine. Brussel: Vereniging voor Alcohol- en andere Drugproblemen vzw, 2005.
  Bron: http://www.vad.be/alcohol-en-andere-drugs/info-drugs/productinfodossiers/cocaine.aspx
- Kaminer Y. Challenges and opportunities of group therapy for adolescent substance abuse: A critical review. Addictive behaviors 2005, 30 (9): 1765-74.
- Kinable H. Dossier cannabis. Brussel: Vereniging voor Alcohol- en andere Drugproblemen vzw, 2008. Bron: http://www.vad.be/alcohol-en-andere-drugs/info-drugs/productinfodossiers/cannabis.aspx
- Kinable H en Verstuyf G. Dossier heroine. Brussel: VAD, Vereniging voor Alcohol- en andere Drugproblemen vzw, 2010.
- Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med. 1999 Jun; 153(6):591-6.
- Legleye S, Karila L, Beck F, Reynaud M: Validation of the CAST, a general population Cannabis Abuse Screening Test. J Subst Use 2007, 12:233–242.
- NICE public health guideline 4. Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people (PHI 004). London: National Institute of Health and Clinical Excellence, 2007a.
- NICE clinical guideline 51. Drug misuse: psychosocial interventions (CG51). London: National Institute for Health and Clinical Excellence, 2007b.
- NICE clinical guideline 52. Drug misuse: opioid detoxification (CG52). London: National Institute for Health and Clinical Excellence, 2007c.
- Proudfoot H, Vogl L, Swift W, Martin G, Copeland J. Development of a short cannabis problems questionnaire for adolescents in the community. Addict Behav 2010, 35:734–737.
- SCAN (Specialist Clinical Addiction Network) Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service: SCAN Consensus Project/ Final Report of the SCAN Inpatient Treatment Working Party. London: SCAN, 2006 (Geciteerd in NICE, 2007c).
- SIGN (Scottish Intercollegiate Guidelines Network). The Management of Harmful Drinking and Alcohol Dependence in Primary Care. National Clinical Guideline No. 74. Edinburgh: SIGN, 2003 (Geciteerd in NICE 2007b).
- Sims, H. Families in Focus: a Report on a Series of Consultative Conversations Held in Urban and Rural Areas of England During Late 2001 and Early 2002. London: Adfam, 2002 (Geciteerd in: NICE, 2007c).
- Stewart M. Towards a global definition of patient centred care. BMJ 2001 February 24; 322(7284): 444–445.
- VAD. Richtlijnen bij het voorschrijven van benzodiazepines aan illegaledruggebruikers. Brussel: Vereniging voor alcohol en Andere Drugs, 2008. Bron: http://www.vad.be/media/17365/benzos_inhoudprefin.pdf
- VAD. Kernaanbevelingen Opiaatdetoxificatie, 2009 (Gebaseerd op de samenvatting van NICE Clinical Guideline 52: Opiate Detoxification).
- Van Driel M en Chevalier P. Verklarende woordenlijst Evidence-Based Medicine. Gent; Minerva vzw, 2008.

- Van Hout K. Verslaafd! En dan? Kwalitatief onderzoek bij begeleiders van jongeren met een drug- en/of alcoholprobleem. Masterproef aangeboden tot het verkrijgen van de graad van Master of science in de Psychologie. KU Leuven, 2011-2012.
- World Health Organization (WHO) (2006) Lexicon of Alcohol and Drug Terms. Published by the World Health Organization. Available at: http://www.who.int/substance_abuse/terminology/who_lexicon/en/

Bijlagen screeningsinstrumenten

CRAFFT (Knight et al, 1999)

1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?
4. Do you ever FORGET things you did while using alcohol or drugs?
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?

Each positive question counts for 1 point. A sum score of 2 or more reflects an increased risk of drug problems.

CPQ_A-S (Proudfoot et al, 2010)

In relation to your cannabis use:

1. Have you tended to smoke more on your own than you used to?
2. Have you worried about meeting people you don't know when you are stoned?
3. Have you spent more time with smoking friends than other kinds of friends?
4. Have your friends criticised you for smoking too much?
5. Have you found yourself worried about the amount of money you have been spending on cannabis?
6. Have you been in trouble with the police due to your smoking?
7. Have you been physically sick after smoking?
8. Have you passed out after a smoking session?
9. Have you had pains in your chest or lungs after a smoking session?
10. Have you had a persistent chest infection or cough?
11. Have you felt paranoid or antisocial after a smoking session?
12. Have you worried about getting out of touch with friends or family?

Score 1 for each 'yes' answer. Tentative cut-off indicating need for further assessment is 3.

Cannabis Abuse Screening Test (CAST) (Legleye et al, 2007)

(1) Have you ever smoked cannabis before midday?
Never (0) – rarely (0) – from time to time (0) – fairly often (1) – very often (1)

(2) Have you ever smoked cannabis when you were alone?
Never (0) – rarely (0) – from time to time (0) – fairly often (1) – very often (1)

(3) Have you ever had memory problems when you smoked cannabis?
Never (0) – rarely (0) – from time to time (0) – fairly often (1) – very often (1)

(4) Have friends or members of your family ever told you that you ought to reduce your cannabis use?
Never (0) – rarely (0) – from time to time (0) – fairly often (1) – very often (1)

(5) Have you ever tried to reduce or stop your cannabis use without succeeding?
Never (0) – rarely (0) – from time to time (0) – fairly often (1) – very often (1)

(6) Have you ever had problems because of your use of cannabis (argument, fight, accident, bad result at school, etc.)?
Never (0) – rarely (0) – from time to time (0) – fairly often (1) – very often (1)

Evidence review

2.1 Introduction

Basic attitude of a caregiver

The caregivers' attitude is essential for the way young people experience the given care. Based on the principles of integrated youth care, literature and interviews with minors, a study group composed a list with nine characteristics of ideal care givers (Integrale jeugdhulp, 2008).

According to young people, the ideal caregiver:

- Is real and sincere and is not afraid to show his personality to the young person. At the same time he pays attention to the impact of his own behavour and appearance on the young person (authenticity).
- Has empathy. He is sympathetic and shows understanding as the young person tells something (empathy).
- Is willing to engage the young person in dialogue and give him/her full partnership (equivalence).
- Accepts the young person in his individuality, with his beliefs, norms and values. He acts from an open look for and to other persons and situations (openness).
- Supports the young person unconditionally (unconditionality).
- Maps strengths and possibilities, in addition to problems (positive attitude).
- Exhibits a clear and involved commitment to the young person. In function of the growth of the young person he can be near and far in the relationship at the same time (professional proximity).
- Is discreet in function of the privacy of the young person (reliability)
- Has respect for the pace of the young person (respect).

Role of parents

Several reviews reported an association between a poor parent-child relationship and an increased use of alcohol (Foxcroft et al, 1991; Vakalahi, 2001; Ryan et al, 2010). These reviews included predominantly cross-sectional studies or studies that did not control for previous alcohol use. A recent systematic review of longitudinal studies reported a weak association between a negative parent-child relationship and an increase of alcohol use by the child (Visser et al, 2012), possibly due to differences between cross-sectional and longitudinal studies. This needs further investigation.

Methodology

This guideline was developed using the ADAPTE procedure (Fervers et al, 2006), a stepwise process to adapt (inter)national guidelines to a local context (ADAPTE manual, 2009). This procedure has been developed by the ADAPTE Working Group and is regarded as a valid framework for guideline development by several large guideline developing organizations.

The first step of the ADAPTE process is the search for relevant guidelines and to assess the methodological quality of these guidelines using AGREE II (Brouwers et al, 2010). The following steps include the assessment of the relevance of the content of the guidelines with respect to our health questions, the methodological and clinical consistence between the evidence and the recommendation, and whether the recommendations are applicable and acceptable for the Belgian setting. Remaining steps (selection of health questions, updating literature and external review by target users and experts) are conducted similar to developing de novo guidelines.

A panel was established, consisting of experts of several important stakeholders for this guideline, including representation of family members of drug misusers. In a first meeting, the panel determined health questions for which they were seeking an answer based on experience and the self-rated expectations of the targeted health professionals and the young people. A first step for the determination of the clinical questions was given by the authors group, based on the clinical questions included in the selected guidelines. These questions were

presented to the panel of experts, which were asked to comment on the wording of these questions and on the need to have any other additional questions.

Searching for guidelines

A sensitive search was performed aiming to identify all relevant international and national guidelines.* In June 2011, we searched the following electronic databases: Medline, Embase, Cinahl, PsychInfo, and ERIC using the following search terms:

1. guidelines [MeSH] OR guideline [publication type] OR practice guideline [publication type] OR guideline [title or abstract] OR guidelines [title or abstract]
2. substance-related disorders [MeSH] OR alcohol drinking [MeSH] OR street drugs [MeSH] OR designer drugs [MeSH] OR cannabis [MeSH] OR marijuana smoking [MeSH] OR heroin [MeSH] OR opium [MeSH] OR cocaine [MESH] OR amphetamines [MeSH] OR cannabis OR marijuana OR heroin OR opium OR cocaine OR amphetamine$ OR speed OR ecstacy
3. drug abuse$ OR drug use$ OR drug misuse$ OR drug dependenc$ OR substance abuse$ OR substance use$ OR substance misuse$ OR substance dependenc$
4. #1 AND #2 AND #3

* One search was performed for three guidelines: assessment and treatment of alcohol misuse, assessment and treatment of drug misuse and prevention of alcohol and drug misuse.

In addition, we searched for guidelines in the following databases using the search terms above: Guidelines International Network; The National Guideline Clearinghouse; The New Zealand Guidelines Group; the Scottish Intercollegiate Guidelines Network (SIGN); Domus Medica; Nederlands Huisartsen Genootschap (NHG); Dutch Institute of Healthcare Improvement CBO; Société Scientifique de Médecine Générale (SSMG); National Institute of Clinical Excellence (NICE); Database 'evidence-based guidelines' van Duodecim (Finland, as part of the Digital Library of Health of the Center of Evidence-Based Medicine (CEBAM); WHO.

The Association for Alcohol and Other Drugproblems [Vereniging voor Alcohol en andere Drugsproblemen (VAD) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) provide an overview of (European) guidelines for alcohol and drug misuse and these were all screened (http://www.vad.be/evidence-based-werken/richtlijnen.aspx; http://www.emcdda.europa.eu/themes/best-practice/standards) In addition, we searched the internet sites of the following organizations: 'National Drug and Alcohol Research Center' (USA), 'Australian Drug Information Network', 'Alcohol Studies Database' (USA). We searched Google using the search terms described above. Selected guidelines were screened for references to other potentially relevant guidelines and national experts in addiction research were contacted for other guidelines that may have been missed in our search.

Inclusion criteria

We included evidence-based practice guidelines on the prevention, screening, assessment or treatment of alcohol or illicit drug misuse in adolescents aged 12 to 18 years. Guidelines on alcohol or drug misuse adjacent to other problems, including psychological comorbidity, and guidelines on misuse of caffeine and tobacco were excluded. Guidelines had to be published from January 2006 onwards in the Dutch, English, French or German language.

The first selection was based on title and abstract. Potential relevant documents were downloaded or retrieved and screened in full. All titles and abstracts were screened by 1 reviewer with a second reviewer screening a random sample of 10% in duplicate. The agreement between the reviewers was substantial.

Two independent reviewers assessed the quality of the relevant guidelines using the AGREE II instrument (Brouwers et al, 2010). 32 guidelines were assessed and only the guidelines that scored over 50% of the subscale methodology were selected for the ADAPTE procedure for one of three guidelines. Nine guidelines

remained. The content of these nine guidelines was assessed whether they answered one of our health questions. The relevant recommendations were listed together with a summary of the evidence for that recommendation. The evidence was graded using the GRADE system (GRADE collaboration).

GRADE

The GRADE system classifies the quality of evidence in three levels—high (A), moderate (B), low (C).
Evidence based on randomised controlled trials begins as high quality evidence, but our confidence in the evidence may be decreased for several reasons, including:

- Study limitations: important (-1) or very important (-2) problems with study quality
- Inconsistency of results: important (-1) or very important (-2) inconsistency
- Indirectness of evidence: some (-1) or major (-2) concerns about directness of evidence
- Imprecision: important (-1) or very important (-2) imprecision.
- Reporting bias: high (-1) or very high (-2) risk of publication bias.

Observational studies (for example, cohort and case-control studies) start with a "low quality" rating. Upgrading may be warranted if there is

- Strong evidence of an association (significant RR>2 (<0.5), based on consistent evidence of at least 2 observational studies without plausible confounders (+1)
- Very strong evidence of association (significant RR >5 (<0.2) based on consistent evidence without major threats of validity (+2)
- Evidence of a dose-response association (+1)
- All plausible biases would decrease the magnitude of an apparent treatment effect (+1)

For a number of recommendations, the source guideline states that the recommendation is based on inference derived from literature (IDE). Because it is not clear which literature was used and therefore it is not possible to assess its quality, no GRADE level was assigned..

The levels can be interpreted as follows:
A: further research will probably NOT change our confidence in the estimation of the effect.
B: further research will probably have an important impact on our confidence in the estimation of the effect.
C: further research will most likely have a major influence on our confidence in the estimation of the effect and will probably change this estimate or any estimate of the effect is very uncertain

<u>How recommendations were made</u>

During the 2nd en 3rd meeting (and one skype meeting) all selected recommendations were discussed using the following questions:

1. Is the recommendation clear?
2. Does the recommendation answer our question well?
3. Is the recommendation relevant?
    - Do we have the required expertise?
    - Are there organization barriers?
    - Are there economic barriers?
    - Can the recommendation be extrapolated to our patient population?
4. What to do with the recommendation?
    - Adopt; Adapt (why and how?); Reject (why?)
5. How strong do we recommend the recommendation?
    - Strong (advantages outweigh disadvantages); Weak (advantages are smaller or equal to disadvantages)

The selected recommendations were included in the guideline. If applicable the panel formulated other considerations, which is the result on an interdisciplinary group discussion. Scientific evidence was searched and added where possible for these considerations, but typically little was found.
For each selected recommendation we added, if available, an explanation about how to implement the recommendation. This information was derived from the source guideline. This was shortened if needed, for example if information was not relevant to our population of young people. The contents of this explanatory section were checked with the panel in a last meeting.

During the 2 meetings we discussed 140 recommendations (on alcohol and drug misuse). From these, 37 recommendations from 4 source guidelines were included in this guideline on drug misuse (see Table 1).

Table 1. Source guidelines that were used for the ADAPTE procedure for our guideline on drug misuse

Guideline	Title	Recommendation
NICE, 2007a	Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people.	2, 7
NICE, 2007b	Drug misuse: psychosocial management of drug misusers in the community and prison	1, 3, 4, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19
NICE, 2007c	Drug misuse: opioid detoxification	5, 6, 9, 10, 11, 12, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 36
WHO, 2009	Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence.	34, 35

The strengths and weakness of the scientific evidence for each recommendation was evaluated by assessing the validity and coherence of the evidence for each selected recommendation. This was performed in line with the manual (ADAPTE manual, 2009) but with some modifications to make this process feasible within our limited time and budgets. The evidence for a certain recommendation was considered valid if:

- The method of searching for studies is adequate; and
- The protocol of these studies fits the research question; and
- The quality of studies was reported.

The evidence for a certain recommendation was considered coherent if:

- The patients and treatment in the studies are comparable to the patients and treatments in the recommendation; and
- The conclusions of the several studies point in the same direction (are consistent); and
- The results of the studies are important (clinically relevant); and if applicable
- Is explained why an intervention is recommended despite limited evidence.

This this assessment, we used documentation of the guidelines only. This included evidence reviews, however no original publications were retrieved for this purpose.
Benefits for health and complications and risk were weighted if this was done by the source guideline.

Perspective of target population

The perspective of the target population was investigated by piloting this guideline among two groups of adolescents: 1. students of a secondary school and 2. adolescents who have misused drugs. Both groups were asked how they felt about a selection of recommendations of this guideline.

For this pilot phase, recommendations from all ADAPTE guidelines were screened and recommendations that directly affected young people or recommendations for which cooperation of young people was needed to be implemented were selected. For example, recommendation 4 on the development and implementation of a community-based prevention program was, among others, not selected. Recommendations for very specific populations i.e. opiate dependent young people or recommendations with a low level of detail were also not selected. The selection was performed by one person and checked by a second person.
The participants were asked whether they would or would not agree/ comply with the recommendations. We also asked to explain the answers. 27 adolescents from a secondary school, aged 16 years, were interviewed at school. This interview took place in one large group. Four adolescents aged between 15 and 18 years who followed an obligatory drug education course were interviewed one-by-one. The following recommendations were selected for adolescents: 1, 10, 15, 17 and 36.

The guideline was also piloted among eight parents of children who have misused drugs. These parents were member of a self-help group for parents and during one of their meetings they were interviewed in a similar way as the group of adolescents. Only a few recommendations were selected as parents were less often involved in the implementation of the recommendations. The following recommendations were selected for parents: 17, 18 and 19. Both groups of adolescents and parents were convenient samples.

The results of the interviews were added to the guideline in the explanation paragraph together with any reasons they gave to clarify their views.

External review

The draft guideline was externally reviewed by clinical experts and methodological experts.

Clinical experts: Three clinical experts (two from Flanders and one from Wallonia) have assessed the applicability of the draft guideline 'screening, assessment and treatment on drug misuse among young people'. Two worked in the primary care setting and 1 in residential care.

First, the clinical experts were asked to assess the guideline as a whole. They could answer with 'completely not, mostly not, mostly, completely'. We converted this to a score from 1 to 4 and calculated the mean score across the experts (see table 2 below).

Table 2. Assessment of clinical experts on the guideline on drug misuse (mean score on a 4-p scale from 'completely not' to 'completely')

	Mean score
1. Is this guideline valuable for you?	2.3
2. Is the treatment approach in this guideline consistent to the approach used in your setting?	3
3. Is the treatment approach in this guideline consistent with your approach?	3
4 Is the approach in this guideline, according to you, consistent with the expectations from young people?	2.8
5. Can you envisage yourself applying this guideline in your practice?	2.8
6. Would you recommend the use of this guideline to your colleagues?	2.8
7. Do you think it is feasible to implement this guideline in your sector in Belgium?	2.8

The scores represent as follows: 1= completely not, 2=mostly not, 3=mostly, 4=completely

Second, the experts were also asked to assess each recommendation whether or not it was applicable in practice and provide comments or other feedback. All comments were listed and for each comment a reply was given by the authors together with potential changes to the guideline. This is available on the following website https://ppw.kuleuven.be/home/english/research/mesrg/publications-of-research-projects. Sixty-four

percent of the remarks resulted in changes to the text of the guideline. The majority of changes concerned explanation of the topics discussed in the introduction of the guideline, for example the target group, the attitude of care givers and topics that are relevant for our population but not covered in this guideline. Also some minor changes to wording of recommendations were made.

Methodological experts: Two persons with ample research experience in the field of adolescent alcohol and drug misuse evaluated the methodological quality of the draft guidelines using the AGREE II instrument (Brouwers et al, 2010). All 23 items were rated on a 7-item Likert scale from 1 (strongly disagree) to 7 (strongly agree). One AGREE form was completed for the three ADAPTE-youth guidelines as the same methodology was used.

Seventeen AGREE-items received a mean score of five or higher. The mean score for overall quality of the guidelines was 6. The following items received a score below 5: The views and preferences of the target population (patients, public, etc.) have been sought; the views of the funding body have not influenced the content of the guideline; competing interests of guideline development group members have been recorded and addressed; and a procedure for updating the guideline is provided. All but one item were amended for the final version of this guideline. One remaining issue could not be addressed within the timeframe of this project, which is 'The guideline presents monitoring and/or auditing criteria'.

Any comments of these experts were added to the list of comments (see above) and a reply was formulated. Details results can be found on the following website:
https://ppw.kuleuven.be/home/english/research/mesrg/publications-of-research-projects

Update literature

A systematic literature search was performed in November 2013 to search for recent evidence that may have an impact on the recommendations adapted from existing guidelines published up to 2007. We searched PubMed, Cochrane Library of Systematic Reviews and the DARE database for systematic reviews published from 2007 onwards. Included were systematic reviews on screening, diagnosing or treating alcohol misuse in adolescents. Reviews with less than half of included studies on participants older than 18 or reviews that did not assess and report the methodological quality of the studies were excluded. The search identified 380 records of which 8 were considered relevant for this guideline. These reviews were assessed whether the results and conclusions would change the content or the level of evidence of a recommendation. Eight new systematic reviews were found. None of the reviews necessitate changes to the recommendations. However five reviews cover interventions that were not included in the guidelines, such as motivational interviewing and outpatient therapy. A summary of the reviews is integrated in the evidence summary. The guideline refers to the new evidence as well. Details on the methods are reported in appendix B1.

Updating the guideline

Consistent with the procedure of KCE for updating Domus Medica guidelines (Dirven et al, 2006), we recommend that these guidelines are checked between 2016 and 2018 to determine whether an update is needed. This guideline was financed by the Federal Government as part of a fixed-term research project. New funding need to be sought for the update of this guideline.

References

- ADAPTE Manual for Guideline Adaptation Version 2.0 - 2009. www.adapte.org
- Brouwers M, Kho ME, Browman GP, Burgers JS, Cluzeau F, Feder G, Fervers B, Graham ID, Grimshaw J, Hanna S, Littlejohns P, Makarski J, Zitzelsberger L. for the AGREE Next Steps Consortium. (2010). AGREE II: Advancing guideline development, reporting and evaluation in healthcare. Canadian Medical Association Journal, 182, e839-e842. The instrument is available from: www.agreetrust.org

- Dirven K, De Sutter A, Van Royen P, Mambourg, F, Van den Bruel A. Herziening bestaande praktijkrichtlijnen. KCE reports vol. 43A, Brussel: Federaal Kenniscentrum voor de Gezondheidszorg / Centre Fédéral d''Expertise des Soins de Santé, 2006.
- Fervers B, Burgers JS, Haugh MC, et al. Adaptation of clinical guidelines: literature review and proposition for a framework and procedure. Int J Qual Health Care 2006, 18:167-76.
- Foxcroft DR, Lowe G. Adolescent drinking behaviour and family socialization factors: a meta-analysis. J Adolesc 1991, 14(3):255–273.
- GRADE Collaboration. www.gradeworkinggroup.org/index.htm
- Integrale jeugdhulp. Advies participatieve basishouding. De basishouding van de hulpverlener: van visie tot plan van aanpak. 20 oktober 2008 – ontwerp. Beschikbaar via: http://wvg.vlaanderen.be/jeugdhulp/14_west-vlaanderen/databank_rsg/Advies%20participatieve%20basishouding.pdf
- NICE public health guideline 4. Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people (PHI 004). London: National Institute of Health and Clinical Excellence, 2007a.
- NICE clinical guideline 51. Drug misuse: psychosocial interventions (CG51). London: National Institute for Health and Clinical Excellence, 2007b.
- NICE clinical guideline 52. Drug misuse: opioid detoxification (CG52). London: National Institute for Health and Clinical Excellence, 2007c.
- Ryan SM, Jorm AF, Lubman DI. Parenting factors associated with reduced adolescent alcohol use: a systematic review of longitudinal studies. Aust N Z J Psychiatry 2010, 44(9):774–783.
- Vakalahi HF. Adolescent substance use and family-based risk and protective factors: a literature review. J Drug Educ 2001, 31(1):29–46.
- Visser L, De Winter AF and Reijneveld SA. The parent–child relationship and adolescent alcohol use: a systematic review of longitudinal studies. BMC Public Health 2012, 12:886.
- WHO. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. Geneva: World Health Organization, 2009.

2.2 Screening

(Note from authors: in this Evidence Review we included the original recommendation as this makes it easier to assess the summary of evidence and to see any differences to the adapted recommendations. Original recommendations are stated in Italics in the original language.)

How should professionals screen adolescents for drug misuse?

Recommendation 1

Staff in mental health and criminal justice settings (in which drug misuse is known to be prevalent) should ask service users routinely about recent legal and illicit drug use. The questions should include whether they have used drugs and, if so:

- *Of what type and method of administration*
- *In what quantity*
- *How frequently*

The source guideline (NICE, 2007b) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Recommendation 2

Use existing screening and assessment tools to identify vulnerable and disadvantaged children and young people aged under 25 who are misusing– or who are at risk of misusing – substances.

The source guideline (NICE, 2007a) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Evidence summary

CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) is a short screening instrument to identify alcohol and drug misuse in young people (Knight, 1999). Dhalla et al. (2011) performed a systematic review and concluded that CRAFFT has adequate psychometric properties for detecting alcohol use disorders and substance use disorders in adolescents. At optimal cut-points, sensitivities of the CRAFFT ranged from 0.61 to 1.00, and specificities ranged from 0.33 to 0.97. The CRAFFT showed modest to adequate internal consistency values ranging from 0.65 to 0.86, and high test-retest reliability.

SEM-j (individueel Screeningsinstrument Ervaringen met Middelengebruik –jongeren)

This questionnaire is based on the Personal Experience Screening Questionnaire (PESQ), which is one of the most usable, reliable and valid screening instruments for substance misuse in young people (Lecresse & Waldron, 1994; Weinberg et al. 1998, Winters 1992; Winters et al. 2002). The PESQ was translated and adapted to the Flemish context. A Dutch manual can be found via: (http://www.vad.be/media/30366/handleiding%20-%20def.pdf)

CPQ-A-S (Cannabis Problems Questionnaire for Adolescents – shortened version)

This test has shown adequate reliability (Cronbach's alpha coefficient of 0.70) and validity. The optimum cut-off according to the ROC curve for detecting the presence of cannabis dependence following DSM-IV TR criteria is 3 points. This threshold shows sensitivity of 83% (95%CI 68.6 to 92.2) and specificity of 77.5% (95%CI 68.0 to 85.4). The percentage of correctly classified participants using this cut-off point is 79.2% (Fernandez-Artamendi et al. 2012).

CAST (Cannabis Abuse Screening Test)

This test has also shown adequate reliability, with a Cronbach's alpha coefficient of 0.84. Optimum cut-off point to maximize detection of cannabis dependence is 5, with sensitivity of 83% (CI95%: 58.9–85.7) and specificity of 87% (CI95%: 85.8–97.1). The percentage of correctly classified participants using this cut-off point is 85.4% (Fernandez-Artamendi et al. 2012).

The CAST is shorter and psychometrically more robust than the CPQ-A-S. However no statistically significant differences were found between the two tests in their sensitivity and global discriminative capacity to detect cannabis dependence (Fernandez-Artamendi et al. 2012).

References

- Dhalla S, Zumbo BD, Poole G. A review of the psychometric properties of the CRAFFT instrument: 1999-2010. Curr Drug Abuse Rev 2011, Mar;4(1):57-64.
- Fernandez-Artamendi S, Fernández-Hermida JR, Muñiz-Fernández J, et al. Screening of cannabis-related problems among youth; the CPQ-A-S and CAST questionnaires. Subst Abuse Treat Pr 2012; 7: 13.
- Knight JR, Shrier L, Bravender T, Farrell M, Vander Bilt J, Shaffer H. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med 1999;153: 591- 596.
- Lecesse M and Waldron H. Assessing adolescent substance use: a critique of current measurement instruments. Review. J Subst Abuse Treat 1994, 11 (6), 553-563.
- Weinberg N, Rahdert E, Colliver J and Glantz M. Adolescent substance abuse: review of the past 10 years. J Am Child and Adolescent Psychiatry 1998, 37 (3), 252-261.
- Winters KC. Development of an Adolescent Alcohol and Other Drug Abuse Screening Scale: Personal Experience Questionnaire; Addict Behav 1992, 17(5):479-90.

- Winters K, Latimer W and Stinchfield R. Clinical issues in the assessment of adolescent alcohol and other drug use. Behavioral Research and Therapy 2002, 40, 1443-1456.

Recommendation 3

In settings such as primary care, general hospitals and emergency departments, staff should consider asking people about recent drug use if they present with symptoms that suggest the possibility of drug misuse, for example:

- *Acute chest pain in a young person*
- *Acute psychosis*
- *Mood and sleep disorders*

The source guideline (NICE, 2007b) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

2.3 Assessment

How should professionals perform an assessment on drug misuse in adolescents?

Recommendation 4

When making an assessment, staff should consider the service user's:

- *Medical, psychological, social and occupational needs*
- *History of drug use*
- *Experience of previous treatment, if any*
- *Goals in relation to his or her drug use*
- *Treatment preferences*

The source guideline (NICE, 2007b) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Recommendation 5

People presenting for opioid detoxification should be assessed to establish the presence and severity of opioid dependence, as well as misuse of and/or dependence on other substances, including alcohol, benzodiazepines and stimulants. As part of the assessment, healthcare professionals should:

- *Use urinalysis to aid identification of the use of opioids and other substances; consideration may also be given to other near-patient testing methods such as oral fluid and/or breath testing*
- *Clinically assess signs of opioid withdrawal where present (the use of formal rating scales may be considered as an adjunct to, but not a substitute for, clinical assessment)*
- *Take a history of drug and alcohol misuse and any treatment, including previous attempts at detoxification, for these problems*
- *Review current and previous physical and mental health problems, and any treatment for these*
- *Consider the risks of self-harm, loss of opioid tolerance and the misuse of drugs or alcohol as a response to opioid withdrawal symptoms*

- *Consider the person's current social and personal circumstances, including employment and financial status, living arrangements, social support and criminal activity*
- *Consider the impact of drug misuse on family members and any dependants*
- *Develop strategies to reduce the risk of relapse, taking into account the person's support network.*

The source guideline (NICE, 2007c) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Recommendation 6

Near-patient and confirmatory testing should be conducted by appropriately trained healthcare professionals in accordance with established standard operating and safety procedures.

The source guideline (NICE, 2007c) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Which conditions should be met for an efficient treatment process?

Recommendation 7

Work with parents or carers, education welfare services, children's trusts, child and adolescent mental health services, school drug advisers or other specialists to:

- *Provide support (schools may provide direct support)*
- *Refer the children and young people, as appropriate, to other services (such as social care, housing or employment), based on a mutually agreed plan. The plan should take account of the child or young person's needs and include review arrangements.*

This recommendation was based on consensus within the working group of the source guideline (NICE, 2007a).

Recommendation 8

To enable people who misuse drugs to make informed decisions about their treatment and care, staff should explain options for abstinence-oriented, maintenance-oriented and harm-reduction interventions at the person's initial contact with services and at subsequent formal reviews.

The source guideline (NICE, 2007b) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Recommendation 9

Staff should discuss with people who misuse drugs whether to involve their families and carers in their assessment and treatment plans. However, staff should ensure that the service user's right to confidentiality is respected (NICE, 2007b).

Staff should discuss with people who present for detoxification whether to involve their families and carers in their assessment and treatment plans. However, staff should ensure that the service user's right to confidentiality is respected (NICE, 2007c).

The source guidelines (NICE, 2007bc) do not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Recommendation 10

*People who misuse drugs should be given the same care, respect and privacy as any other person***.**

The source guidelines (NICE, 2007bc) do not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Recommendation 11

In order to reduce loss of contact when people who misuse drugs transfer between services, staff should ensure that there are clear and agreed plans to facilitate effective transfer.

GRADE 1C

The source guidelines (NICE, 2007bc) found evidence of moderate quality, which consistently suggests that both intensive referral and case management is effective at engaging service users in treatment at different stages of the treatment process. In terms of effects on illicit drug use, however, the evidence is mixed, with the overall suggestion of the meta-analysis that there is no improvement in outcomes compared with standard care. This would match GRADE B. We downgraded it to C as these studies were only or predominantly on adults (indirectness of evidence).

Evidence is valid but not coherent because there is large variation in the sample populations and in content of the interventions (differences between studies in what constitutes 'case management'). Also, the effects differ per outcome measure.

Evidence Summary

The review team of the source guidelines (NICE, 2007bc) conducted a new systematic search for RCTs that assessed the efficacy of case management.

The following definitions were used: Case management. There is no unified definition of case management, and programmes vary depending on clinical populations and treatment systems. The guiding principle, consistent with a long-term view of drug problems, is that of coordinating episodes of care both over time and across health and social care systems. In practice, a case manager works with the service user in order to enroll the service user in the required services and coordinate the various services required for the complex array of problems. Intensive referral. This intervention aims to engage service users in treatment via an initial needs assessment and referral session, but does not provide the element of ongoing contact that is considered here as characteristic of case management. Standard referral. Service users are provided with a list of contact details and are expected to make their own appointments.

For trials of intensive referral versus standard referral, two RCTs (Strathdee 2006; Zanis 1996) met the eligibility criteria, providing data on 286 participants. For trials of case management with ongoing contact versus

standard care, eight RCTs (Coviello 2006; Martin 1993; Mejta 1997; Morgenstern 2006; Needels 2005: Study 1; Needels 2005: study 2; Saleh 2002; Sorensen 2005) met the eligibility criteria providing data on 2,623 participants. The results of the systematic review are summarized below (Table 3).

Table 3. Summary of results of the systematic review on the effectiveness of case management (NICE, 2007b)

Intensive referral vs standard care for people not in formal drug treatment		
N studies, N participants, mean age	Quality of evidence	Results: Outcome measure, point estimate (95% confidence interval), N participants in the analysis
2 RCTs, n=286 41-42 yrs	moderate quality of evidence	Started any treatment RR 2.92 (0.52 to 16.35), n=286
Case management (with ongoing contact) vs standard care for people not in formal drug treatment		
8 RCTs, n=2623, 17-45 yrs	moderate quality of evidence	Drug-free days per month: SMD -0.13 (-0.47 to 0.20), n=140 Point abstinence at FU: Cannabis: RR 1.14 (0.97 to 1.35), N=1,538 Cocaine: RR 1.26 (0.81 to 1.98), N=1,538 Opioids: RR 1.34 (0.63 to 2.87), N= 192 All drugs: RR 1.16 (0.59 to 2.31), N= 565 Started any treatment RR 1.34 (1.04 to 1.72), n=2028 Time taken to enter treatment SMD -1.63 (-1.88 to -1.37), n=316 <u>Retention in treatment</u> In treatment at follow-up: RR 1.20 (0.84 to 1.74), N=1,530 Completed at least one outpatient programme: RR 1.92 (1.35 to 2.72), N=302 Retained in any treatment for at least 3 mo: RR 2.29 (1.55 to 3.39), N= 302 Time retained in treatment: SMD -0.93 (-1.16 to -0.70), N=316

(*N=number; mo=months; RR > 1 favours intervention, negative SMD values favour intervention)

<u>References</u> (cited from: NICE, 2007b)

- Coviello DM, Zanis DA, Wesnoski SA, et al. The effectiveness of outreach case management in re-enrolling discharged methadone patients. Drug and Alcohol Dependence 2006, 85, 56–65.
- Martin SS and Scarpitti FR. An intensive case management approach for paroled IV drug users. The Journal of Drug Issues 1993, 23, 43–59.
- Mejta CL, Bokos PJ, Mickenberg J, et al. Improving substance abuse treatment access and retention using a case management approach. Journal of Drug Issues 1997, 27, 329–340.
- Morgenstern J, Blanchard KA, McCrady BS et al. Effectiveness of intensive case management for substance-dependent women receiving temporary assistance for needy families. American Journal of Public Health 2006, 96, 2016–2023.
- Needels K, James-Burdumy S and Burghardt J. Community case management for former jail inmates: its impacts on rearrest, drug use, and HIV risk. Journal of Urban Health 2005, 82, 420–433.
- Saleh SS, Vaughn T, Hall J et al. Effectiveness of case management in substance abuse treatment. Care Management Journals: Journal of Case Management 2002, 3, 172–177.
- Sorensen JL, Masson CL, Delucchi K et al. Randomized trial of drug abuse treatment-linkage strategies. Journal of Consulting and Clinical Psychology 2005, 73, 1026–1035.
- Strathdee SA, Ricketts EP, Huettner S et al. Facilitating entry into drug treatment among injection drug users referred from a needle exchange program: results from a community-based behavioral intervention trial. Drug and Alcohol Dependence 2006, 83, 225–232.
- Zanis DA, McLellan AT, Alterman AI et al. Efficacy of enhanced outreach counseling to reenroll high-risk drug users 1 year after discharge from treatment. The American Journal of Psychiatry 1996, 153, 1095–1096.

Recommendation 12

*All interventions for people who misuse drugs should be delivered by staff who are competent in delivering the intervention and who receive appropriate supervision***.**

The source guidelines (NICE, 2007bc) do not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

2.4 Treatment

Which psycho-social interventions should be used?

Recommendation 13

Brief interventions (to reduce drug-related harm)

During routine contacts and opportunistically (for example, at needle and syringe exchanges), staff should provide information and advice to all people who misuse drugs about reducing exposure to blood-borne viruses. This should include advice on reducing sexual and injection risk behaviours. Staff should consider offering testing for blood-borne viruses.

GRADE 1C

The source guideline (NICE, 2007b) found moderate evidence that psychoeducational programmes have little or no effect on injection risk behavior and a limited and inconsistent impact on the reduction of sexual risk behavior in people who misuse drugs. Interpretation of the research is made difficult by the lack of data on HIV seroconversion rates. This would match GRADE B. We downgraded this to C as there is no indication that these studies were performed in adolescents (indirectness of evidence).

Only one RCT was found that compared psychosocial interventions with a control in needle and syringe exchange programmes. No statistically significant differences were found between the brief intervention group and the two control groups in terms of reduction of risk behaviour. Further research is required to assess the efficacy of additional interventions within these programmes.

Evidence is valid and coherent.

Evidence Summary

A systematic review of RCTs evaluating the efficacy of psychosocial interventions to reduce sexual and injection risk behavior was conducted. Included were:

15 RCTs on psychoeducation (4721 participants) (Avants 2004; Baker 1993; Colon 1993; Eldridge 1997; Epstein 2003; Harris 1998; Kotranski 1998; Malow 1994; Margolin 2003; ONeill 1996; Schilling 1991; Siegal 1995; Sorensen 1994 Study 1; Sorensen 1994: Study 2; Sterk 2003; Wechsberg 2004) and 5 trials on standard education (735 participants) (Baker 1993; Baker 1994; Gibson 1999: Study 1; Gibson 1999: Study 2; Tucker 2004a).

Psychosocial interventions within needle and exchange programmes: 1 RCT (Kidorf 2005), a narrative review (Dolan 2003) and 2 descriptive studies (Jacob and Stover 2000; Nelles 1998).

Table 4. Summary of results of a systematic review on the efficacy of psychosocial interventions to reduce risk behavior (NICE, 2007b)

Psychoeducation vs standard HIV education		
N studies, N participants, mean age	Quality of evidence	Results: Outcome measure, point estimate (95% confidence interval), N participants in the analysis

13 RCTs, N=4412, age not reported	moderate quality of evidence	Injection risk behavior: engaging in risk behavior RR 0.95 (0.73 to 1.23) (N=841), various measures SMD -0.21 (-0.42 to 0.00) N=353 Sexual risk behavior: engaging in risk behaviours endpoint RR 0.91 (0.73 to 1.12) N=1123, 6 months FU RR 0.94 (0.82 to 1.07) N=460; various measures SMD -0.30 (-0.47 to -0.13) N=541 (Avants 2004; Baker 1993; Colon 1993; Eldridge 1997; Epstein 2003; Harris 1998, Kotranski 1998; Malow 1994; Margolin 2003; ONeill1996; Siegal 1995; Sterk 2003; Wechsberg 2004)
Psychoeducation vs self-help booklet		
4 RCTs, N=334, age not reported	moderate quality of evidence	Injection risk behavior: various measures SMD -0.02 (-0.33 to 0.29) N=166 Sexual risk behavior: engaging in risk behaviour RR 0.58 (0.35 to 0.98) N=92; various measures SMD -0.32 (-0.57 to -0.07) N=240 (Baker 1993; Schilling 1991; Sorensen 1994 Study 1; Sorensen 1994 Study 2)
Standard education vs self-help booklet		
5 RCTs, N=735, age not reported	moderate quality of evidence	Injection risk behavior: engaging in risk behavior 3 months FU RR 0.89 (0.53 to 1.50) (N=296), various measures 1 to 3 months FU SMD -0.04 (-0.29 to 0.21) N=243; 4 to 6 months FU SMD -0.17 (-0.50 to 0.16) N=140 Sexual risk behavior: engaging in risk behaviours 3 months FU RR 0.94 (0.74 to 1.21) N=296, various measures 1 to 3 months FU SMD -0.09 (-0.34 to 0.17) N=243; 6 months FU SMD -0.06 (-0.27 to 0.39) N=140 (Baker 1993; Baker 1994; Gibson 1999 Study 1; Gibson 1999 Study 2; Tucker 2004a)
Psychoeducation vs standard education for at-risk subgroup		
4 RCTs, N=2816, age not reported	moderate quality of evidence	Injection risk behavior: unsafe at baseline, safer at endpoint RR 1.09 (0.98 to 1.21) (N=1261) Sexual risk behavior: unsafe at baseline, safer at endpoint RR 1.56 (1.25 to 1.95) N=1195 (Colon 1993; Kotranski 1998; Malow 1994; Siegal 1995)

RR > 1 or negative SMD favours intervention

Psychosocial components of needle and syringe exchange programmes

There are no studies that directly compare machine-distributed needle exchanges with counsellor-distributed needle exchanges. Some brief indirect comparisons can be made, although conclusions are difficult to draw from such studies (Dolan 2003; Jacob & Stover 2000; Nelles 1998).

Assessment of the efficacy of additional psychosocial interventions within needle and syringe exchange programmes requires comparison with a minimal control or no treatment group. Only one RCT was found that compared psychosocial interventions with a control in needle and syringe exchange programmes. Kidorf and colleagues (2005) compared the use of a one-session brief intervention with standard referral and an attentional control. No statistically significant differences were found between the brief intervention group and the two control groups in terms of reduction of risk behaviour. Further research is required to assess the efficacy of additional interventions within these programmes.

References (cited from: NICE, 2007b)

- Avants SK, Margolin A, Usubiaga MH et al. Targeting HIV-related outcomes with intravenous drug users maintained on methadone: a randomized clinical trial of a harm reduction group therapy. Journal of Substance Abuse Treatment 2004, 26, 67–78.
- Baker A, Heather N, Wodak A et al. Evaluation of a cognitive-behavioural intervention for HIV prevention among injecting drug users. AIDS 1993, 7, 247–256.
- Baker A, Kochan N, Dixon J et al. Controlled evaluation of a brief intervention for HIV prevention among injecting drug users not in treatment. AIDS Care 1994, 6, 559–570.
- Colon HM, Robles RR, Freeman D et al. Effects of an HIV risk reduction education program among injection drug users in Puerto Rico. Puerto Rico Health Sciences Journal 1993, 12, 27–34.
- Dolan K, Rutter S and Wodak AD. Prison-based syringe exchange programmes: a review of international research and development. Addiction 2003, 98, 153–158.
- Eldridge GD, St Lawrence JS, Little CE et al. Evaluation of the HIV risk reduction intervention for women entering inpatient substance abuse treatment. AIDS Education and Prevention 1997, 9 (Suppl. 1), 62–76.

- Epstein DH, Hawkins WE, Covi L et al. Cognitive-behavioral therapy plus contingency management for cocaine use: findings during treatment and across 12-month follow-up. Psychology of Addictive Behaviors 2003, 17, 73–82.
- Gibson DR, Lovelle-Drache J, Young M et al. Effectiveness of brief counseling in reducing HIV risk behavior in injecting drug users: final results of randomized trials of counseling with and without HIV testing. AIDS and Behavior 1999, 3, 3–12.
- Jacob J and Stover H. The transfer of harm-reduction strategies into prisons: needle exchange programmes in two German prisons. The International Journal on Drug Policy 2000, 11, 325–335.
- Harris RM, Bausell RB, Scott DE et al. An intervention for changing high-risk HIV behaviors of African American drug-dependent women. Research in Nursing and Health 1998, 21, 239–250.
- Kidorf M, Disney E, King V et al. Challenges in motivating treatment enrolment in community syringe exchange participants. Journal of Urban Health 2005, 82, 456–467.
- Kotranski L, Semaan S, Collier K et al. Effectiveness of an HIV risk reduction counseling intervention for out-of-treatment drug users. AIDS Education and Prevention 1998, 10, 19–33.
- Malow RM, West JA, Corrigan SA et al. Outcome of psychoeducation for HIV risk reduction. AIDS Education and Prevention 1994, 6, 113–125.
- Margolin A, Avants SK, Warburton LA et al. A randomized clinical trial of a manual-guided risk reduction intervention for HIV-positve injection drug users. Health Psychology 2003, 22, 223–228.
- Nelles J, Fuhrer A, Hirsbrunner H et al. Provision of syringes: the cutting edge of harm reduction in prison? British Medical Journal 1998, 317, 270–273.
- O'Neill K, Baker A, Cooke M et al. Evaluation of a cognitive-behavioural intervention for pregnant injecting drug users at risk of HIV infection. Addiction 1996, 91, 1115–1125.
- Schilling RF, El-Bassel N, Schinke SP et al. Building skills of recovering women drug users to reduce heterosexual AIDS transmission. Public Health Reports 1991, 106, 297–304.
- Siegal HA, Falck RS, Carlson RG et al. Reducing HIV needle risk behaviors among injection-drug users in the Midwest: an evaluation of the efficacy of standard and enhanced interventions. AIDS Education and Prevention 1995, 7, 308–319.
- Sorensen JL, London J, Heitzmann C et al. Psychoeducational group approach: HIV risk reduction in drug users. AIDS Education and Prevention 1994, 6, 95–112.
- Sterk CE, Theall KP, Elifson KW et al. HIV risk reduction among African-American women who inject drugs: a randomized controlled trial. AIDS and Behavior 2003, 7, 73–86.
- Tucker T, Fry CL, Lintzeris N et al. Randomized controlled trial of a brief behavioural intervention for reducing hepatitis C virus risk practices among injecting drug users. Addiction 2004a, 99, 1157–1166.
- Wechsberg WM, Lam WK, Zule WA et al. Efficacy of a womanfocused intervention to reduce HIV risk and increase self-sufficiency among African American crack abusers. American Journal of Public Health 2004, 94, 1165–1173.

Recommendation 14

Group-based psycho educational interventions that give information about reducing exposure to blood-borne viruses and/or about reducing sexual and injection risk behaviours for people who misuse drugs should not be routinely provided.

From the source guideline (NICE, 2007b) it is unclear whether the studies above (from recommendation 13) examined group-based or individual psycho-educational interventions. Therefore we assumed this was based on consensus.

Recommendation 15

Opportunistic brief interventions focused on motivation should be offered to people in limited contact with drug services (for example, those attending a needle and syringe exchange or primary care settings) if concerns about drug misuse are identified by the service user or staff member. These interventions should:*

- *normally consist of two sessions each lasting 10–45 minutes*

- *explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide nonjudgemental feedback.*

Recommendation 16

Opportunistic brief interventions focused on motivation should be offered to people not in contact with drug services (for example, in primary or secondary care settings, occupational health or tertiary education) if concerns about drug misuse are identified by the person or staff member. These interventions should:*

- *normally consist of two sessions each lasting 10–45 minutes*
- *explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide nonjudgemental feedback.*

GRADE 1C

The source guideline (NICE, 2007b) found 5 RCTs (4 high/moderate quality and 1 low quality) People who misuse cannabis or stimulants, and are not in formal drug treatment, appear to respond well to brief interventions both in terms of increased abstinence levels and reduced drug use. There is some evidence to suggest people who misuse opioids who are not in formal drug treatment may also benefit from such interventions. 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. This would match GRADE B. We downgraded this to GRADE C as almost all participants of these studies are adults (indirectness of evidence).

Evidence is valid and coherent.

Evidence summary

The review team conducted a new systematic search for RCTs that assessed the efficacy of brief interventions. For the stand-alone brief-intervention review for people not in formal drug treatment or for those seeking treatment, seven trials were included, providing data on 2,701 participants. In four trials brief interventions were assessed for people who misuse cannabis (Copeland 2001; McCambridge 2004; Stephens 2000; Stephens 2002), in three trials for people who misuse stimulants (Baker 2005; Bernstein 2005; Marsden 2006) and in one trial for people who misuse opioids (Bernstein 2005).

For the brief-intervention review for people within formal drug treatment, four trials were included (Carroll 2006a; Miller 2003; Mitcheson 2007; Stotts 2001), providing data on 625 participants. In all four trials brief interventions were assessed for people who misuse stimulants, in one trial for people who misuse cannabis (Carroll 2006a) and in one trial for people who misuse illicit opioids (Miller 2003).

For the review comparing brief interventions and relapse-prevention CBT, four trials were included, providing data on 807 participants. In three trials comparisons between brief interventions and relapse-prevention CBT were examined for people who misuse cannabis (Copeland 2001; Stephens 2000; Stephens 2002) and in one trial for people who misuse stimulants (Baker 2005).

Standalone brief interventions

This section assesses brief interventions for people who are not in formal drug treatment (for example, opportunistic interventions for people who are presenting for a physical health problem in primary care) and people who are not in drug treatment but who are seeking treatment for a drug problem.

Most studies were for people who misuse cannabis or stimulants, for whom brief interventions were associated with greater abstinence and reduced drug use compared with no treatment or minimal control

groups across follow-up periods ranging from 3 to 12 months. One trial conducted on people misusing opioids suggests brief interventions may also be effective for this group.

There were mixed results for comparisons of brief interventions with relapse- prevention CBT. For people who misuse cannabis, individual relapse-prevention CBT, but not group relapse-prevention CBT, appeared to be more effective than brief interventions, but it should be noted that the relapse-prevention CBT interventions provided in both trials had four times as many sessions as the brief intervention. For people who misuse stimulants (amphetamines), no differences were found between individual relapse-prevention CBT and brief interventions.

Table 5. Summary of results from a systematic review on standalone brief interventions (NICE, 2007b)

Brief intervention vs control for stimulants or opioids		
N studies, N participants, mean age	Quality of evidence	Results: Outcome measure, point estimate (95% confidence interval), N participants in the analysis
3 RCTs, N=1,268, 32 to 36 yrs	high quality of evidence	Point abstinence Stimulants 6 months FU RR 1.30 (1.09 to 1.55) n=1268 Heroin FU RR 1.54 (1.09 to 2.16) n=1175 Heroin and cocaine FU RR 1.45 (1.02 to 2.05) n=1175 Drug use Cannabis 3 months FU (adjusted for baseline differences) B=11.54 (6.91 to 16.18) n=200
Brief intervention vs control for cannabis		
4 RCTs, N=764, 16 to 38 yrs,	moderate quality of evidence	Point abstinence Continuous duration cannabis 3-4 months RR 3.33 (1.99 to 5.56) n=613 Proportion days not using cannabis 3 months FU DMD -0.42 (-0.81 to -0.03) n=105 Cont. duration abstinence of cannabis 8-12 mo RR 2.41 (-1.01 to 5.73) n=345 Drug use Cannabis 4 months FU SMD -0.68 (-0.88 to -0.49) n=432
Individual relapse-prevention CBT vs brief intervention		
3 RCTs, N=602, 30 to 36 yrs	moderate quality of evidence	Point abstinence Cannabis FU RR 2.60 (1.45 to 4.66) n=462; FU SMD 0.24 (-0.13 to 0.51) n=102 Amphetamine RR 0.89 (0.57 to 1.39) n=140 Drug use Cannabis 9 months FU: SMD -0.43 (-0.58 to -0.17) n=245
Group relapse prevention CBT vs brief intervention		
1 RCT, N=205, 34 yrs,	low quality of evidence	Drug use Cannabis 12 months FU: SMD 0.03 (-0.65 to 0.23) n=179

FU=follow-up; RR >1 favours intervention; in comparisons of CBT and brief interventions RR >1 favours CBT; negative SMD favour interventions; in comparisons of CBT and brief interventions negative SMD favour CBT; B>1 favours interventions.

Results on brief interventions for people who are receiving drug treatment:

Brief interventions have also been assessed as an adjunct to formal drug treatment programmes. This section is concerned with whether such an additional intervention for people already engaged in formal treatment improves abstinence and drug-use outcomes.

The use of brief interventions as an adjunct to formal drug treatment did not have any important effects on drug use compared with standard care. Miller (2003) found no statistically significant differences between the brief intervention and standard care groups for days abstinent from illicit drugs or for treatment attendance. This finding was consistent for inpatient and outpatient samples, and for primary cocaine and heroin users. Similarly, Carroll (2006a) found no statistically significant differences in days using primary substances.

Mitcheson (2007), in a UK cluster-randomised trial, also found no statistically significant differences between the brief intervention and control groups on the primary outcome of crack cocaine use. However, the brief intervention group reported a statistically significant reduction in heroin use compared with control.

In contrast, Stotts (2001) found that an adjunctive brief intervention reduced cocaine use during cocaine detoxification. However, the intervention appeared to be more effective for those with lower motivation at baseline. This offers a possible explanation for why the effect of the brief intervention was more pronounced in this study than the others. Participants in other studies receiving formal drug treatment may have already felt motivated to change their drug use and therefore did not require an additional motivational intervention.

Table 6. Summary of results from a systematic review on brief interventions who are receiving drug treatment (NICE, 2007b)

Brief intervention vs standard care for people who misuse drugs and/or alcohol		
N studies, N participants, mean age	Quality of evidence	Results: Outcome measure, point estimate (95% confidence interval), N participants in the analysis
1 RCT, N=336, 33 yrs	low quality of evidence	Days of primary substance use at 1 month FU: SMD -0.11 (-0.33 to 0.10), at 3 months FU: SMD 0.04 (-0.18 to 0.25)
Brief intervention vs standard care for people undergoing cocaine detoxification		
1 RCT, N=52, 35 yrs	moderate quality of evidence	Abstinent from cocaine after detox RR 1.44 (1.03 to 2.01)
Brief intervention vs standard care for people undergoing MMT		
1 cluster RCT, N=29, 39 yrs	moderate quality of evidence	Days of crack-cocaine use in last 30 days SMD -0.07 (-0.81 to 0.67)
Brief intervention vs standard care for people who primarily misuse stimulants or heroin		
1 RCT, N=208, 33 yrs	low quality of evidence	Abstinence: F (1,55)=1.12, p<.29; illicit drug use F (3,157)=0.89, p<.45

RR>1 or negative SMD favours intervention

Clinical summary

The majority of meta-analyses of brief interventions do not state the context in which the intervention is conducted. The results of the current systematic review, discussed above, suggest this is important. People who misuse cannabis or stimulants, and are not in formal drug treatment, appear to respond well to brief interventions both in terms of increased abstinence levels and reduced drug use. There is some evidence to suggest people who misuse opioids who are not in formal drug treatment may also benefit from such interventions. 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.

Although one study did find evidence of benefit, this was mainly accounted for by participants with lower motivation at baseline. The majority of studies were for people who misuse stimulants, although similar findings were also found for people who misuse cannabis or heroin. Ashton (2005), in a review of brief interventions, suggested that such interventions are effective for people who are ambivalent about change but ineffective for people who are motivated to change and already receiving treatment.

Results were mixed for comparisons of brief interventions with longer interventions for people who misuse cannabis or amphetamines. All the studies were for people seeking drug treatment. Individual relapse-prevention CBT, lasting between four and nine sessions, was associated with greater levels of abstinence and reductions in drug use for people who misuse cannabis, although interventions of such duration are effectively brief treatments. However, no differences were found for group relapse-prevention CBT for cannabis misuse or individual relapse-prevention CBT for amphetamine misuse. Further research is required to assess the efficacy of brief interventions in comparison with individual and group relapse-prevention CBT, other interventions, and with people who misuse drugs other than cannabis.

References (cited from: NICE, 2007b)

- Ashton M. The motivational hallo. Drug and Alcohol Findings 2005, 13, 23–30.

- Baker A, Lee NK, Claire M, et al. Brief cognitive behavioural interventions for regular amphetamine users: a step in the right direction. Addiction 2005, 100, 367–378.
- Bernstein J, Bernstein E, Tassiopoulos K, et al. Brief motivational intervention at a clinic visit reduces cocaine and heroin use. Drug and Alcohol Dependence 2005, 77, 49–59.
- Carroll KM, Ball SA, Nich C, et al. Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: a multisite effectiveness study. Drug and Alcohol Dependence 2006a, 81, 301–312.
- Copeland J, Swift W, Roffman R, et al. A randomized controlled trial of brief cognitive-behavioral interventions for cannabis use disorder. Journal of Substance Abuse Treatment 2001, 21, 55–64.
- Marsden J, Stillwell G, Barlow H, et al. An evaluation of a brief motivational intervention among young ecstasy and cocaine users: no effect on substance and alcohol use outcomes. Addiction 2006, 101, 1014–1026.
- McCambridge J and Strang J. The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: results from a multi-site cluster randomized trial. Addiction 2004, 99, 39–52.
- Miller WR, Yahne CE and Tonigan JS. Motivational interviewing in drug abuse services: a randomized trial. Journal of Consulting and Clinical Psychology 2003, 71, 754–763.
- Mitcheson L, McCambridge J and Byrne S. Pilot cluster-randomised trial of adjunctive motivational interviewing to reduce crack cocaine use in clients on methadone maintenance. European Addiction Research 2007, 13, 6–10.
- Stephens RS, Roffman RA and Curtin L. Comparison of extended versus brief treatments for marijuana use. Journal of Consulting and Clinical Psychology 2000, 68, 898–908.
- Stephens RS, Babor TF, Kadden R, et al. The Marijuana Treatment Project: rationale, design and participant characteristics. Addiction 2002, 97 (Suppl. 1), 109–124.
- Stotts AL, Schmitz JM, Rhoades HM, et al. Motivational interviewing with cocaine-dependent patients: a pilot study. Journal of Consulting and Clinical Psychology 2001, 69, 858–862.

Evidence update

Five systematic reviews were found to report on interventions that are relevant for treating substance misusing adolescents.

Barnette et al (2012) summarized the effects of motivational interviewing (MI) interventions for substance misuse in adolescents. 39 studies were included of which 9 targeted alcohol use, 10 tobacco use, 9 marijuana use and 13 substance use. All studies on marijuana misuse were RCTs but quality differed between these studies. The authors used a continuous measure of quality, summing the presence of reported use of a manual, MI training/supervision, and coding for fidelity. Three studies reported 1 criteria, 5 studies reported 2 and 1 study reported 3. Of 13 studies on substance misuse, 2 were quasi-randomised and others were RCTs. One study reported no criteria, 7 studies reported 1 criteria, 4 reported 2 criteria and 1 reported 3 criteria. The level of evidence was classified as 'low'. Overall 67% of studies reported statistically significant improved substance use outcomes (alcohol n=7, tobacco n=6, marijuana n=7, substance use n=8). Chi square results show no significant difference between interventions using feedback or not, or interventions combined with other treatment versus MI alone. Comparisons of different modalities suggest that 1) involving parents may improve results, 2) there is no difference between telephone or in-person follow-ups, and 3) providing feedback face-to-face is superior to computerized feedback.

Tanner-Smith et al (2013) summarized the effects of outpatient treatment for adolescents with substance use disorders. The review included 45 studies assessing adolescents aged 12-20 years .The first analysis examined effect sizes for the substance use outcomes of adolescents receiving different types of treatment relative to the respective comparison groups. As a category, family therapy programs were found to be more effective than their comparison conditions, whereas no treatment programs were less effective. However, not all treatment types were compared with each other in the available research, making it difficult to assess the comparative effectiveness of the different treatments. To provide a more differentiated picture of the relative improvement in substance use outcomes for different treatments, a second analysis examined pre–post effect

sizes measuring changes in substance use for adolescents in the separate treatment and comparison arms of the studies. The adolescents in almost all types of treatment showed reductions in substance use. The greatest improvements were found for family therapy and mixed and group counseling. Longer treatment duration was associated with smaller improvements, but other treatment characteristics and participant characteristics had little relationship to the pre–post changes in substance use. The authors conclude that family therapy is the treatment with the strongest evidence of comparative effectiveness, although most types of treatment appear to be beneficial in helping adolescents reduce their substance use.

Becker and Curry (2008) assessed randomized trials of outpatient interventions for adolescent substance misuse on attributes of trial quality. The review included 31 studies and assessed 14 methodological attributes. Frequently reported methodological attributes included presence of an active comparison condition, reporting of baseline data, use of treatment manuals, and verification of self-reported outcomes. Six methodologically sound studies evaluated ecological approaches. Three of these studies found that ecological models, delivered alone or integrated with juvenile court services, had superior outcomes to other active treatment conditions (e.g., service as usual through a shelter, juvenile court services, adolescent group therapy). Meanwhile, 3 studies found that ecological models had comparable outcomes with those of treatment as usual in the community as well as those of integrated models of CBT and motivation enhancement therapy. Three of the four methodologically stronger studies found favorable evidence for brief motivational interventions, whereas one study found no differences between a one-session intervention and the provision of information. CBT represented the intervention supported by the greatest proportion of methodologically stronger studies (100%; n = 4). Two studies were supportive of CBT as having superior effectiveness to group interactional therapy and treatment as usual, while the other two studies found that CBT had comparable outcomes with group psychoeducation and family behavior therapy. Treatment models with evidence of immediate superiority in 2 or more methodologically stronger studies included ecological family therapy, brief motivational interventions, and cognitive– behavioral therapy. It should be noted that this review did not present any quantitative data on effectiveness of the interventions.

Waldron and Turner (2008) synthesized findings from studies since 1998 regarding evaluation of outpatient treatments for adolescent substance misuse. Methodological rigor of studies was evaluated and interventions were classified as 'well-established' and 'probably' efficacious. 17 studies on 46 treatment conditions were included, 7 on individual CBT, 13 group-based CBT, 17 on family therapy and 9 on minimal treatment interventions. The findings showed significant differences in outcomes before and after the minimal treatment interventions. The mean effect size of the minimal interventions was lower compared to the mean effect size of the other active interventions. There was significant heterogeneity among the estimated effect sizes. Results for family therapy and group-based CBT were larger compared to minimal intervention but no significant difference between individual CBT and minimal interventions were found. The authors conclude that three treatment approaches, multidimensional family therapy, functional family therapy, and group CBT emerged as well-established models for substance misuse treatment. However, a number of other models are probably efficacious, and none of the treatment approaches appeared to be clearly superior to any others in terms of treatment effectiveness for adolescent substance misuse.

Engle and Maggowan (2009) reviewed the empirical research on adolescent alcohol and other drug (AOD) misuse group treatments. The review included 13 studies, of which 12 recruited youngsters between the age of 12 and 18 years. All of the reviewed treatments used manuals or checklists of key treatment topics. Eight of the 12 studies were experimental designs with random assignment to comparison treatment conditions. Five of the 12 studies did not report follow-up assessments beyond six months. Ten of the studies' samples included more than 30 participants per condition. Eight studies described the reliability and validity of the AOD measures employed. All of the studies utilized self-reports of substance use, and most included other reporting sources as well. All but two studies measured substance use at multiple units of analysis (e.g., use frequency, clinical reductions, and/or abstinence). Finally, 10 studies tracked alcohol, and all 12 tracked marijuana use. No treatments met the criteria for being efficacious, but two (Waldron et al.'s (2001) Psychoeducational Therapy

group and Liddle et al.'s (2001) AGT) could be classified as being possibly efficacious. Interestingly, these two treatments exhibited ''sleeper effects'' not present at post-test but rather emerged at follow-up assessments. Meanwhile, eight additional treatments provided some indication of positive outcomes by exhibiting statistically significant pre- to post-test and/or follow-up reductions in the use of one or more substances, and three treatments achieved no positive substance use outcomes.
The authors conclude that these results support conclusions of previous reviews that adolescent group treatment can be effective. The results also suggest that treatments without an adequate theory or empirical basis are less likely to produce desired effects. The two treatments meeting the possibly efficacious criteria shared several treatment components, including didactic presentations, exploration of psychosocial developmental issues and/or expectancies and consequences of AOD use, personalized skills training, and an emphasis on self-efficacy.

References

- Barnett E, Sussman S, Smith C et al. Motivational interviewing for adolescent substance use: A review of the literature. Addictive Behav 2012; 37: 1325-34.
- Becker SJ and Curry JF. Outpatient Interventions for Adolescent Substance Abuse: A Quality of Evidence Review. Journal of Consulting and Clinical Psychology 2008; 76 (4), 531–543.
- Engle B and Maggowan MJ. A Critical Review of Adolescent Substance Abuse Group Treatments. Journal of Evidence-Based Social Work 2009: 6: 217–243.
- Tanner-Smith EE, Wilson SJ, Lipsey MW. The comparative effectiveness of outpatient treatment for adolescent substance abuse: A meta-analysis. J Subst Abuse Treat 2013; 44: 145-58.
- Waldron HB and Turner CW. Evidence-Based Psychosocial Treatments for Adolescent Substance Abuse. Journal of Clinical Child & Adolescent Psychology 2008; 37(1): 238–261.

When should adolescents be admitted to a residential treatment center?

Recommendation 17

Residential treatment may be considered for people who are seeking abstinence and who have significant comorbid physical, mental health or social (for example, housing) problems. The person should have completed a residential or inpatient detoxification programme and have not benefited from previous community-based psychosocial treatment.

GRADE 1C

The source guideline (NICE, 2007b) found a lack of well-conducted studies assessing the efficacy of residential in comparison with community-based treatment for drug misuse and the efficacy of specific types of residential treatment. There is some indication of benefit from cohort studies but in the absence of RCT evidence few conclusions can be drawn from them.

Evidence is valid but not coherent, because the recommendation is broader than what the evidence is about. Additionally, many studies (for example, Finney et al., 1998) contain samples that have large proportions of participants who do not misuse drugs.

Evidence summary

A systematic review was conducted searching for RCTs and cohort studies assessing the efficacy of residential interventions. For the review of therapeutic communities, two RCTs (Greenwood 2001; Nemes 1999) met the eligibility criteria, providing data on 673 participants. For the review of 12-step residential treatment, one cohort study (Finney 1998) met the eligibility criteria, providing data on 3,018 participants. For the review

comparing residential and day treatments, three RCTs (Alterman 1993; Greenwood 2001; Schneider 1996) met the eligibility criteria, providing data on 429 participants. The results of this review are summarized in Table 7 below.

Table 7. Summary of results of a systematic review on the effectiveness of therapeutic communities (NICE, 2007b)

Residential TC (therapeutic communities) vs day treatment TC		
N studies, N participants, mean age	Quality of evidence	Results: Outcome measure, point estimate (95% confidence interval), N participants in the analysis
1 RCT, n=261, 33 yrs,	not reported	No differences in abstinence at 12-month (RR = 0.90; 95% CI, 0.67 to 1.22) or 18-month follow-up (RR = 0.86; 95% CI, 0.65 to 1.14) were found between a residential therapeutic community and a day treatment therapeutic community programme. (Greenwood 2001)
10 months residential + 2 months aftercare vs 6 months residential + 6 months aftercare		
1 RCT, n=412, age not reported	not reported	Abstinence from crack/cocaine at 12 mo FU RR 1.10 (0.90 to 1.35) (residential vs day treatment RR>1 favours residential) (Nemes 1999)

(Residential versus day treatment: RR > 1 favours residential; 10 months 2 months versus 6 months 6 months: RR > 1 favours 10 months 2 months.)

Nemes and colleagues (1999) found that a 12-month course of treatment that included at least 6 months in a residential therapeutic community followed by community aftercare was as effective as 10 months in a residential therapeutic community followed by 2 months of community aftercare in terms of abstinence outcomes. However, the lack of an adequate comparison group (for example, community-based treatment or treatment as usual) makes it difficult to assess the efficacy of either treatment programme. It is very difficult to draw conclusions from this data due to the sparseness of the evidence.
This evidence is consistent with Smith and colleagues (2006), who conducted a systematic review and concluded that there is a lack of research assessing the effectiveness of therapeutic communities or whether one type of therapeutic community is better than another.

One large cohort study (Finney 1998) (n=3018, age 43 yrs, quality of evidence not reported) compared 12-step-based residential treatment with relapse-prevention CBT and eclectic (combining elements of 12-step and CBT approaches) residential treatments.
At 12-month follow-up, participants receiving 12-step-based treatment were more likely to remain abstinent and had fewer substance use problems than those in the relapse-prevention CBT and eclectic programmes. However, for both comparisons the effect was small and would equate to a risk difference of 0.09 (95% CI, 0.05 to 0.13) and number needed to treat of 11 (95% CI, 7.69 to 20.00) for 12- steps compared with the relapse-prevention CBT group. For 12-steps compared with the eclectic group a risk difference of 0.05 (95% CI, 0.01 to 0.10) and a number needed to treat of 20 (95% CI, 10 to 100) was found.

Table 8. Summary of results of a systematic review comparing residential versus day treatment (NICE, 2007b)

Residential treatment vs day treatment		
N studies, N participants, mean age	Quality of evidence	Results: Outcome measure, point estimate (95% confidence interval), N participants in the analysis
3 RCTs, n=429, 31 to 40 yrs	low quality of evidence	Point Abstinence for TC at 12-mo FU: RR 0.90 (0.67 to 1.22), N=261 Point Abstinence at 3–4 mo FU: RR 1.14 (0.57 to 2.28), N=168 Point Abstinence at 6–7 mo FU: RR 1.07 (0.75 to 1.51), N=355 (Cocaine dependence (100%): Alterman 1993, Schneider 1996; Crack cocaine (67%): Greenwood 2001; Heroin (13%): Greenwood 2001; Alcohol (10%): Greenwood 2001) (3 months: Schneider 1996; 4 months and 7 months: Alterman 1993; 7 months, 12 months to 5 years: Greenwood 2001)

(RR>1 favours residential)

One trial compared therapeutic communities in residential and day treatment (Greenwood 2001). All participants received their treatment in the same treatment centre; the first 6 months of treatment was focused on drug misuse problems and the last 6 months helped participants develop independent employment and living arrangements. The main differences between the groups were that the day treatment group did not have the 24-hour structure experienced by the residential group. Additionally, the requirement of abstinence from illicit drugs was more stringent for the residential group, who were immediately expelled from the programme for noncompliance. Although abstinence was also a requirement for the day treatment group, this was enforced more flexibly.

Two trials compared eclectic residential and day treatment. One intervention was for 2 weeks (Schneider 1996) and the other for 4 (Alterman 1993). For both trials the residential group was more intensive than the day treatment group. (Alterman: Residential: 48 hours/week – group meetings that focus on overcoming denial and helping participants learn to cope with everyday problems and stresses. Day treatment: 27 hours/week – group meetings that focus on overcoming denial and helping participants learn to cope with everyday problems and stresses. SchneiderR: Residential: 30–42 hours/week for 2 weeks – group psychoeducation, relapse-prevention CBT, 12-step facilitation Day treatment: 25 hours/week for 2 weeks – group psychoeducation, counselling, relapse-prevention CBT, 12-step facilitation.)
At follow-up periods of up to 12 months, no differences were found between residential and day treatment groups, although there was some heterogeneity for 3- to 4-month and 6- to 7-month follow-ups. At follow-up, one study (Alterman 1993) marginally favoured day treatment, whereas the others marginally favoured residential treatment at 3-month (Schneider 1996) and 6-month follow-up (Greenwood 2001). Despite some heterogeneity, the overall conclusion of all three trials is that there is little difference between outcomes in residential and day treatment groups.

Evidence update

One systematic review examined the quality of research regarding the effectiveness of residential treatment centers for substance-misusing adolescents (Tripodi, 2009). Eight studies were included, and methodological quality was relatively weak. The most common problem encountered are lack of randomization, selectivity bias, not including dropouts in the analysis, outcomes collected by personnel who are cognizant of whether the participant was in the treatment group, not using outcomes with demonstrated reliability and validity, and reliance on parental and/or self-report. Out of the four most rigorous studies reviewed, two found significant differences in substance use reduction between the treatment and comparison groups. Of the remaining studies, despite having strong selectivity bias, only one found significant differences between treatment and comparison groups, and it was for females only at the one-year follow-up. The authors concluded that currently it is not possible to know whether residential treatment centers are effective for substance-misusing adolescents due to methodological limitations of the primary studies.

References

- Alterman AI, O'Brien CP and Droba M. Day hospital vs. inpatient rehabilitation of cocaine abusers: an interim report. NIDA Research Monograph 1993, 135, 150–162(cited from: NICE, 2007b).
- Finney JW, Noyes CA, Coutts AI, et al. Evaluating substance abuse treatment process models: I. Changes on proximal outcome variables during 12-step and cognitive-behavioral treatment. Journal of Studies on Alcohol 1998, 59, 371–380 (cited from: NICE, 2007b).
- Greenwood GL, Woods WJ, Guydish J, et al. Relapse outcomes in a randomised trial of residential and day drug abuse treatment. Journal of Substance Abuse Treatment 2001, 20, 15–23 (cited from: NICE, 2007b).

- Nemes S, Wish ED and Messina N. Comparing the impact of standard and abbreviated treatment in a therapeutic community. Findings from the district of Columbia treatment initiative experiment. Journal of Substance Abuse Treatment 1999, 17, 339–347 (cited from: NICE, 2007b).
- Schneider R, Mittelmeier C and Gadish D. Day versus inpatient treatment for cocaine dependence: an experimental comparison. Journal of Mental Health Administration 1996, 23, 234–245.
- Smith LA, Gates S and Foxcroft D. Therapeutic communities for substance related disorder. Cochrane Database of Systematic Reviews, 1, CD005338, 2006 (cited from: NICE, 2007b).
- Tripodi SJ. A Comprehensive Review: Methodological Rigor of Studies on Residential Treatment Centers for Substance-Abusing Adolescents. Journal of Evidence-Based Social Work 2009; 6 (3), 288-299.

Which interventions are effective to support family members of adolescents who misuse drugs?

Recommendation 18

Staff should ask families and carers about, and discuss concerns regarding, the impact of drug misuse on themselves and other family members, including children. Staff should also:

- *Offer family members and carers an assessment of their personal, social and mental health needs.*
- *Provide verbal and written information and advice on the impact of drug misuse on service users, families and carers.*

GRADE 1C

The source guideline (NICE, 2007b) found some evidence of unclear quality of a strong impact on families and carers, which is both psychological and physical. It appears the impact on family members may differ depending on the roles and responsibilities within the family.

Evidence summary

Velleman and colleagues' (1993) report of 50 close relatives of people who misuse drugs suggested a strong impact on families and carers, which is both psychological (for example, feelings of loneliness, isolation, anxiety and depression) and physical (including raised blood pressure, ulcers, and so on).

Hudson and colleagues (2002) assessed the social adjustment of 65 female family members and significant others of people who misuse drugs using the Social Adjustment Scale – Self-Report. They compared SAS-SR scores for family members and significant others of people who misuse drugs with 'standard' control conditions derived from two other published studies (Rorty et al., 1999; Weissman et al., 1978). Family members and significant others of people who misuse drugs were found to have greater difficulties in relation to social, work, social/leisure and extended family adjustment than a 'standard' comparison group. However, the rather problematic nature of the comparison group (derived from other studies with clear geographical and temporal differences) limits the ability to make a genuine comparison between the two groups. It appears the impact on family members may differ depending on the roles and responsibilities within the family.

Lewis and Williams (1994), in their study of a family support group for African-American grandparents, found that grandparents often took the role of primary carer for their grandchildren because their children had difficulties fulfilling parental responsibilities, due to drug misuse, serving prison sentences, and so on. This sometimes resulted in financial problems as government funding for childcare was not always passed on to the grandparents.

Velleman and colleagues (1993) found partners were more likely to report physical violence, threatening behaviour and pressure for money, while parents were more likely to report lying, manipulation and self-neglect by the person who misuses drugs.

Hudson and colleagues (2002) also compared the experiences of partners and parents of people who misuse drugs and found that partners tended to have slightly greater adjustment problems than parents. The main difference appeared to be financial, with partners of people who misuse drugs experiencing greater financial problems than parents.

A report by Adfam (Sims, 2002) identified a number of needs for families of people who misuse drugs and alcohol. One of the most important of these reported by families was coping with stigma. It was argued that stigma was a major barrier in preventing carers or family members from accessing services, both in terms of actual exclusion from primary care services and self-exclusion through fear of being judged.

Provision of services for families of people who misuse drugs was found to be rather limited (see also Bancroft et al., 2002), but even where these services were available, many families were either not aware of them or how to access them. Many families also perceived themselves to be excluded from participation in the treatment provided for their family member. Some families felt that workers were hiding behind confidentiality when they could have provided general information about treatment.

References (cited from: NICE, 2007b)

- Bancroft A, Carty A, Cunningham-Burley S, et al. Support for the Families of Drug Users: a Review of the Literature. Edinburgh: Scottish Executive Interventions Unit, 2002.
- Hudson CR, Kirby KC, Firely ML, et al. Social adjustment of family members and significant others (FSOs) of drug users. Journal of Substance Abuse Treatment 2002, 23, 171–181.
- Lewis ID & Williams C. Grandparents parenting the second time around. Association of Black Nursing Faculty Journal 1994, 5, 110–111.
- Rorty M, Yager J, Buckwalter JG, et al. Social support, social adjustment, and recovery status in bulimia nervosa. The International Journal of Eating Disorders 1999, 26, 1–12.
- Sims H. Families in Focus: a Report on a Series of Consultative Conversations Held in Urban and Rural Areas of England During Late 2001 and Early 2002. London: Adfam, 2002.
- Velleman R, Bennett G, Miller T, et al. The families of problem drug users: a study of 50 close relatives. Addiction 1993, 88, 1281–1289.
- Weissman MM, Prusoff BA, Thompson, et al. Social adjustment by selfreport in a community sample and in psychiatric outpatients. The Journal of Nervous and Mental Disease 1978, 166, 317– 326.

Recommendation 19

Where the needs of families and carers of people who misuse drugs have been identified, staff should:

- *Offer guided self-help, typically consisting of a single session with the provision of written material*
- *Provide information about, and facilitate contact with, support groups, such as self-help groups specifically focused on addressing families' and carers' needs.*

GRADE 2C

The source guideline (NICE, 2007b) found some evidence that self-help interventions are as effective as more intensive psychological interventions in reducing stress and improving psychological functioning for carers and families of people who misuse drugs.

The evidence is not valid because the study quality is not reported. The evidence is not coherent because of the lack of detailed information about the study population.

Evidence summary

The review team of the source guideline (NICE, 2007b) conducted a new systematic search for RCTs that assessed the efficacy and/or safety of community reinforcement and family training and 5-step for families/carers of people who misuse drugs. For community reinforcement and family training, two trials (Kirby et al., 1999; Meyers et al., 2002) met the eligibility criteria, providing data on 152 participants. For the 5-Step

intervention, one trial (Copello et al., 2007) met the eligibility criteria, providing data on 114 participants. In the three trials, age and study quality were not reported.

Community reinforcement and family training

In both trials community reinforcement and family training was compared with 12-step-based self-help groups (including 12-step facilitation) for carers. The primary outcomes of these studies were to encourage people who misuse drugs and who had refused treatment into treatment, to reduce carers' reported problems (social/emotional, relationship and health-related) and improve their psychological functioning (mood and social adjustment). Neither study found statistically significant differences between community reinforcement and family training and 12-step-based self-help groups in relation to carer problems and psychological functioning. Kirby and colleagues (1999) found statistically significant changes from baseline for both groups in relation to carer problems and psychological functioning. However, Meyers and colleagues (2002) found no statistically significant differences (after Bonferroni corrections for multiple testing) in changes from baseline at 12-month follow-up.

5-Step intervention

Copello and colleagues (2007) conducted a cluster-randomised trial (number of clusters = 137, number of participants = 143) comparing two intensities of a 5-step intervention. Primary care professionals were trained how to offer the 5-step intervention and asked to recruit and deliver the intervention to family members of people who misuse drugs and/or alcohol. All family members had experienced significant distress and lived with the person who misuses drugs or alcohol in the last 6 months. The majority of the sample were relatives of people who misuse alcohol; only 41.2% were relatives of people who misuse drugs. The largest proportions of family members included in the study were wives (43.1%) and children (35.3%).

Each primary care professional was treated as a cluster and was randomised to either the full intervention or guided self-help condition. The 'full intervention' consisted of up to five sessions, while guided self-help comprised one session where the primary care professional introduced the self-help manual (based on the 5-stepmodel used in the full intervention) to the family member and encouraged him or her to work through it in his or her own time.

The two primary outcomes related to physical and psychological health (symptom rating test) and coping (the coping questionnaire). No statistically significant differences were found between the full intervention and the guided self-help conditions for both physical and psychological health (WMD = 0.23; 95% CI, =4.11 to 3.65) and coping (WMD = 0.12; 95% CI, =5.42 to 5.19).

Clinical summary

For both community reinforcement and family training and 5-step intervention, there were no statistically significant differences found between these more intensive interventions and self-help (that is, 12-step self-help groups and guided self-help). It appears that self-help interventions are as effective as more intensive psychological interventions in reducing stress and improving psychological functioning for carers and families of people who misuse drugs.

References (cited from: NICE, 2007b)

- Copello A, Templeton L, Orford J, et al. The relative efficacy of two levels of a primary care intervention for family members affected by the addiction problem of a close relative: a randomised trial. [Unpublished manuscript] 2007
- Kirby KC, Marlowe DB, Festinger DS, et al. Community reinforcement training for family and significant others of drug abusers: a unilateral intervention to increase treatment entry of drug users. Drug and Alcohol, Dependence 1999, 56, 85–96.
- Meyers RJ, Miller WR, Smith JE, et al. A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. Journal of Consulting and Clinical Psychology 2002, 70, 1182–1185.

Recommendation 20

Staff should ask families and carers about, and discuss concerns regarding, the impact of drug misuse on themselves and other family members, including children. Staff should also:

- *Offer family members and carers an assessment of their personal, social and mental health needs.*
- *Provide verbal and written information and advice on the impact of drug misuse on service users, families and carers.*
- *Provide information about detoxification and the settings in which it may take place.*
- *Provide information about self-help and support groups for families and carers.*

The source guideline (NICE, 2007c) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

2.5 Opioid detoxification

Recommendation 21

Detoxification should be a readily available treatment option for people who are opioid dependent and have expressed an informed choice to become abstinent.

The source guideline (NICE, 2007c) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Which medication should be used? When should this be used?

Recommendation 22

Methadone or buprenorphine should be offered as the first-line treatment in opioid detoxification. When deciding between these medications, healthcare professionals should take into account:*

- *Whether the service user is receiving maintenance treatment with methadone or buprenorphine; if so, opioid detoxification should normally be started with the same medication.*
- *The preference of the service user.*

***GRADE: 1C**

The source guideline (NICE, 2007c) found moderate evidence that both methadone and buprenorphine are effective in comparison with other detoxification treatments such as alpha2 adrenergic agonists and other opioid agonists. However, it is not clear if there is any difference in efficacy between methadone and buprenorphine for detoxification. This would match GRADE B. We downgraded this to GRADE C as these studies were performed among adults (indirectness of evidence).
The evidence is valid and coherent.

No evidence was found in the source guideline (NICE, 2007c) for the remainder of this recommendation. Therefore we assumed this was based on consensus.

Summary of evidence

The review team of the source guideline (NICE, 2007c) conducted a new systematic search for RCTs that assessed the efficacy and safety of pharmacological detoxification. In addition, a further search for

observational studies was undertaken to assess the safety of pharmacological detoxification. The following treatments were included in the review: methadone, buprenorphine, dihydrocodeine, clonidine, lofexidine, naltrexone, naloxone, benzodiazepines, carbamazepine. Most trials compare active treatments with one another rather than placebo or minimal control groups.

Results on the following medications are omitted since these are not available in Belgium for substance misuse and dependence: lofexidine, LAAM, propoxyphene, tramadol.

Methadone

For comparisons of methadone against other opioid agonists, clonidine or lofexidine, 12 RCTs were found. Six trials (n=566) compared methadone to clonidine (Gerra 2000, Jiang 1993, Kleber 1985, San 1990, Umbricht 2003, Washton 1980). All studies were performed in adults (Table 9). Methadone appeared to have a better adverse-events profile as a strong trend was found associated with increased hypotension for participants receiving clonidine. Other comparison medications are not available in Belgium and therefore the results are not presented here.

Table 9. Summary of results of a systematic review comparing methadone and clonidine (NICE, 2007c)

Methadone vs clonidine		
N studies, N participants, mean age	Quality of evidence	Results: Outcome measure, point estimate (95% confidence interval), N participants in the analysis
6 RCTs, n=566, 24-40 yrs	moderate quality of evidence	Drug use: abstinence during treatment: 52% vs 42%, RR 1.25 (0.68 to 2.29), N=49; At endpoint: 39% vs 38%, RR 1.04 (0.58 to 1.85), n=75; At 6 mo FU 36% vs 17%, RR 2.16 (0.77 to 6.09), n=71. Completion of treatment: 67% vs 51%, RR 1.20 (0.70 to 2.07), N=287 Self-rated withdrawal severity, change from baseline: SMD 0.25 (-0.40 to 0.91), N=36. Side effects rating: SMD -0.92 (-1.18 to -0.66), n=250.

Buprenorphine

Twelve RCTs (n=653) compared buprenorphine with methadone, clonidine or lofexidine. Four studies compared buprenorphine with methadone (Johnson 1992, Petitjean2002; Seifert 2002; Umbricht 2003). In one study all participants received carbamazepine in both the buprenorphine and methadone groups (Seifert 2002). Eight RCTs and 1 cluster-randomized RCT compared buprenorphine versus clonidine (Cheskin 1994; Janiri 1994; Ling 2005; Lintzeris 2002; Marsch 2005; Nigam 1993; O'Connor 1997; Ponizovsky 2006, Umbricht 2003). Of these, one study, comparing buprenorphine with clonidine included adolescents (Marsch 2005).

Table 10. Summary of results of a systematic review comparing buprenorphine and methadone (NICE, 2007c)

Buprenorphine vs methadone		
N studies, N participants, mean age	Quality of evidence	Results: Outcome measure, point estimate (95% confidence interval), N participants in the analysis
4 RCTs, n=212, 32-40 yrs	moderate quality of evidence	Drug use: relapsed during treatment: 7% vs 17%, RR 0.43 (0.04 to 4.16), N=26 Completion of treatment: 44% vs 30%, RR 1.10 (0.82 to 1.48), N=212 Self-rated withdrawal severity, change from baseline: SMD -0.44 (-1.08 to -0.20), N=39
Buprenorphine vs clonidine		
8 RCTs, 1 cluster RCT (n=631), 17 yrs (Marsch 2005), other: 21-45 years	high quality of evidence	Abstinence: throughout study 22% vs 5%, RR 4.18 (1.26 to 13.9), n=114; endpoint 40% vs 8%, RR 4.11 (2.5 to 6.74), n=458; 4 wks post treatment 9% vs 2%, RR 4.83 (0.58 to 40.03), n=114. Drug use at 1 mo FU: SMD -0.61 (-1.03 to -0.19), n=91. Completion of treatment: 74% vs 56%, RR 1.32 (1.15 to 1.52), n=427. Self-rated withdrawal severity, change from baseline: SMD -0.04 (-0.50 to

		0.42), N=73. Left study early due to adverse events: RR 0.19 (0.03 to 1.03), n=106

For abstinence, completion and initiation of naltrexone, RR > 1 favours buprenorphine. For relapse and adverse events, RR < 1 favours buprenorphine. For withdrawal, negative SMD favours buprenorphine.

All individual RCTs were included in the meta-analyses. Buprenorphine did not differ significantly from methadone on completion rate for detoxification; however, no extractable data were available for abstinence outcomes (Table 10). People who underwent buprenorphine detoxification achieved clearly better outcomes on most measures, including completion, abstinence and withdrawal severity, compared with those who used clonidine.

References (cited from: NICE, 2007c)

- Cheskin LJ, Fudala PJ & Johnson RE. A controlled comparison of buprenorphine and clonidine for acute detoxification from opioids. Drug and Alcohol Dependence 1994, 36, 115–121.
- Gerra G, Zaimovic A, Rustichelli P, et al. Rapid opiate detoxification in outpatient treatment: relationship with naltrexone compliance. Journal of Substance Abuse Treatment 2000, 18, 185–191.
- Janiri L, Mannelli P, Persico AM, et al. Opiate detoxification of methadone maintenance patients using lefetamine, clonidine and buprenorphine. Drug and Alcohol Dependence 1994, 36, 139–145.
- Jiang Z. Rapid detoxification with clonidine for heroin addiction. A comparative study on its efficacy versus methadone. Chinese Journal of Neurology and Psychiatry 1993, 26, 10–13.
- Johnson RE, Jaffe JH and Fudala PJ. A controlled trial of buprenorphine treatment for opioid dependence. The Journal of the American Medical Association 1992, 267, 2750–2755.
- Kleber HD, Riordan CE, Rounsaville B, et al. Clonidine in outpatient detoxification from methadone maintenance. Archives of General Psychiatry 1985, 42, 391–394.
- Ling W, Amass L, Shoptaw S, et al. A multi-center randomised trial of buprenorphine-naloxone versus clonidine for opioid detoxification: findings from the National Institute on Drug Abuse Clinical Trials Network. Addiction 2005, 100, 1090–1100.
- Lintzeris N, Bell J, Brammer G, et al. A randomised controlled trial of buprenorphine in the management of short-term ambulatory heroin withdrawal. Addiction 2002, 97, 1395–1404.
- Marsch LA, Bickel WK, Badger GJ et al. Comparison of pharmacological treatments for opioid-dependent adolescents: a randomized controlled trial. Archives of General Psychiatry 2005, 62, 1157–1164.
- Nigam AK, Ray R & Tripathi BM. Buprenorphine in opiate withdrawal: a comparison with clonidine. Journal of Substance Abuse Treatment 1993, 10, 391–394.
- O'Connor PG, Carroll KM, Shi JM, et al. Three methods of opioid detoxification in a primary care setting. Annals of Internal Medicine 1997, 127, 526–530.
- Petitjean S, Von Bardeleben U, Weber M, et al. Buprenorphine versus methadone in opiate detoxification: preliminary results. Drug and Alcohol Dependence 2002, 66, Suppl. 138.
- Ponizovsky AM, Grinshpoon A, Margolis A, et al. Well-being, psychosocial factors, and side-effects among heroin-dependent inpatients after detoxification using buprenorphine versus clonidine. Addictive Behaviours 2006, 31, 2002–2013.
- San L, Cami J, Peri JM, et al. Efficacy of clonidine, guanfacine and methadone in the rapid detoxification of heroin addicts: a controlled clinical trial. British Journal of Addiction 1990, 85, 141–147.
- Seifert J, Metzner C, Paetzold W, et al. Detoxification of opiate addicts with multiple drug abuse: a comparison of buprenorphine vs. methadone. Pharmacopsychiatry 2002, 35, 159–164.
- Umbricht A, Hoover DR, Tucker MJ, et al. Opioid detoxification with buprenorphine, clonidine, or methadone in hospitalized heroin-dependent patients with HIV infection. Drug and Alcohol Dependence 2003, 69, 263–272.
- Washton AM & Resnick RB. Clonidine versus methadone for opiate detoxification. Lancet 1980, 2, 1297.

Recommendation 23

Clonidine should not be used routinely in opioid detoxification.

GRADE 1B

The source guideline (NICE, 2007c) found high quality evidence that clonidine performs worse on most outcomes when compared to buprenorphine and moderate evidence that clonidine has a worse side-effects profile compared to methadone This would match GRADE B. We downgraded this to GRADE C as these studies were performed among adults (indirectness of evidence).

The evidence is valid and coherent.

Evidence summary (see summary of recommendation 22).

Recommendation 24

When determining the starting dose, duration and regimen (for example, linear or stepped) of opioid detoxification, healthcare professionals, in discussion with the service user, should take into account the:

- *Severity of dependence (particular caution should be exercised where there is uncertainty about dependence)*
- *Stability of the service user (including polydrug and alcohol use, and comorbid mental health problems)*
- *Pharmacology of the chosen detoxification medication and any adjunctive medication*
- *Setting in which detoxification is conducted.*

GRADE 2C

The source guideline (NICE, 2007c) found some evidence that a higher starting dose of methadone is superior to a standard dose. Regarding the duration of detoxification, neither a long methadone taper (up to 70 days) nor a fairly short programme (14 days) was any better than a standard 21-day taper. There is a lack of data assessing dosage and duration for detoxification using buprenorphine or alpha2 adrenergic agonists. Therefore it is not yet possible to draw conclusions on these issues at present.

The evidence is not valid because the quality of the studies is not reported. The evidence is not coherent because the recommendation is broader than the evidence given.

Evidence summary

The authors of the source guideline (NICE, 2007c) conducted a systematic review on the dosage and duration of detoxification.

Dosage methadone

Two RCTs were found (Banys 1994, Strain 1999). In both studies participants were on methadone and on what may be considered as slow taper regimens, consisting of a 6-month stabilisation phase followed by a detoxification phase of 70 days (Strain 1999) or 78 days (Banys 1994).

It appears that for this type of detoxification regimen, beginning with a high dose of methadone at the stabilisation phase is more effective than a moderate dose and that this continues to affect abstinence during treatment and completion of detoxification.

Table 11. Summary of results of a systematic review comparing high and moderate doses of methadone (NICE, 2007c)

Methadone: high dose (80-100 mg) vs moderate dose (40-50 mg)		
N studies, N participants, mean age	Quality of evidence	Results: Outcome measure, point estimate (95% confidence interval), N participants in the analysis
2 RCTs, n=135, 18-65 yrs	moderate quality of evidence	Proportion opioid-pos urines during treatment : SMD -0.59 (-0.97 to -0.21), n=111

		Completion of treatment: 32 vs 22%, RR 1.45 (0.83 to 2.54), n=142

(RR>1 and negative SMD favours high dose)

Duration methadone taper

Three double-blind RCTs compared different durations of methadone detoxification (Senay 1981; Stitzer 1984; Gossop 1989). No quality assessment was made.

Senay and colleagues (1981) randomised participants to an 84-day methadone taper (n =37), or a 21-day taper followed by placebo for the remainder of the study period (n = 35). The two groups did not differ in completion rate or abstinence at the end of the active medication period, or abstinence at 1-year follow-up. Sorensen and colleagues (1982) similarly found no significant difference in completion rate for a 21-day methadone taper (n=15) versus a 42-day methadone taper (n= 18).

Stitzer and colleagues (1984) randomised participants undergoing a 90-day detoxification programme to taper from 60 mg methadone over 70 days (n= 13), or from 30 mg over 28 days (n= 13). There was no significant difference between groups in treatment retention.

In addition, one quasi-experimental study conducted by Gossop and colleagues (1989) in two inpatient detoxification facilities in London compared a 10-day methadone taper (n= 50) against a 21-day methadone taper (n = 82). The 10-day group reported a significantly higher peak withdrawal score on the OWS than the 21-day group ($t = 1.79$, $p < 0.05$), although there was no significant difference in the total duration of withdrawal symptoms. The two groups also did not differ in completion rate for detoxification (70.5% for the 10-day group, and 78.8% for the 21-day group; RR 0.88, 95% CI= 0.71 to 1.09).

Regulation of methadone dosage schedules

Three RCTs were found (Dawe 1991; Green & Gossop 1988; Strang & Gossop 1990). No quality assessment was made.

In a study lasting 42 days, Dawe and colleagues (1991) randomised participants to a fixed schedule methadone taper (n= 15), or were allowed to regulate their own dosage schedule with the aim of completing detoxification (that is, reaching zero dose) within the study period (n= 24). The fixed group were significantly more likely to complete detoxification (53% versus 17%, $chi^2= 4.49$, $p< 0.05$), and in a significantly shorter time frame (35 days versus 47 days, $t= 1.97$, $p< 0.05$). However, urinalysis suggested no significant difference between groups in illicit opioid use at 6-week follow-up.

Green and Gossop (1988) randomised participants undergoing a 21-day methadone taper to the 'informed group' (n= 15), who received detailed information about aspects of the detoxification programme such as dosages and expected symptomatology, and the 'uninformed group' (n= 15), who received a routine clinical interview. The informed group were more likely to complete detoxification (46.7% versus 80.0%, $Chi^2= 32.12$, $p< 0.01$), and reported significantly lower withdrawal scores on the final day of detoxification ($t= 2.48$, $p< 0.05$) as well as over the 25-day post-detoxification period ($F=3.93$, $p< 0.05$).

Strang and Gossop (1990) randomised participants undergoing a 10-day methadone detoxification programme to a linear (n= 43) or exponential (n= 44) taper schedule. Both groups were equally likely (84%) to complete detoxification but the exponential group reported significantly higher withdrawal severity on the OWS during the acute phase of withdrawal ($F= 4.34$, $p< 0.05$).

Dosage and duration for buprenorphine

One RCT was found (Assadi 2004).

The typical duration of detoxification using buprenorphine is between 4 and 8 days. There is one RCT (Assadi et al., 2004) that compared regimens using a high dose of buprenorphine in the first 24 hours only, with a more typical regimen reducing buprenorphine over 5 days. At high doses, buprenorphine may effectively act as an antagonist and hence precipitate withdrawal. Buprenorphine was given intramuscularly; the high dose (12 mg; 6 x 1.5 mg doses) was equivalent to 21.3 mg sublingual and the reducing regimen started at 1.5 mg of intramuscular buprenorphine twice a day. No significant differences in treatment retention, successful detoxification (negative naloxone challenge test) or severity of withdrawal were reported. Adjunctive

medications (trazodone and indomethacin) were used more by the high-dose group than when buprenorphine was reduced with equal amounts of the others (diazepam, chlorpromazine and hyoscine).

References (cited from: NICE, 2007c)

- Assadi SM, Hafezi M, Mokri A, et al. Opioid detoxification using high doses of buprenorphine in 24 hours: a randomized, double blind, controlled clinical trial. Journal of Substance Abuse Treatment 2004, 27, 75–82.
- Banys P, Tusel DJ, Sees KL, et al. Low (40 mg) versus high (80 mg) dose methadone in a 180-day heroin detoxification program. Journal of Substance Abuse Treatment 1994, 11, 225–232.
- Dawe S, Griffiths P, Gossop M, et al. Should opiate addicts be involved in controlling their own detoxification? A comparison of fixed versus negotiable schedules. British Journal of Addiction 1991, 86, 977–982.
- Gossop M, Griffiths P, Bradley B, et al. Opiate withdrawal symptoms in response to 10-day and 21-day methadone withdrawal programmes. The British Journal of Psychiatry 1989, 154, 360–363.
- Green L ad Gossop M. Effects of information on the opiate withdrawal syndrome. British Journal of Addiction 1988, 83, 305–309.
- Senay EC, Dorus W and Showalter CV. Short-term detoxification with methadone. Annals of the New York Academy of Sciences 1981, 362, 203–216.
- Sorensen JL, Hargreaves WA and Weinberg JA. Withdrawal from heroin in three or six weeks. Archives of General Psychiatry 1982, 39, 167–171.
- Stitzer ML, McCaul ME, Bigelow GE, et al. Chronic opiate use during methadone detoxification: effects of a dose increase treatment. Drug and Alcohol Dependence 1984, 14, 37–44.
- Strain EC, Bigelow GE, Liebson IA, et al. Moderate- vs high-dose methadone in the treatment of opioid dependence: a randomised trial. The Journal of the American Medical Association 1999, 281, 1000–1005.
- Strang J and Gossop M. Comparison of linear versus inverse exponential methadone reduction curves in the detoxification of opiate addicts. Addictive Behaviours 1990, 15, 541–547.

Recommendation 25 and 26

Ultra-rapid and rapid detoxification using precipitated withdrawal should not be offered. This is because of the complex adjunctive medication and the high level of nursing and medical supervision required.

Ultra-rapid detoxification under general anaesthesia or heavy sedation (where the airway needs to be supported) must not be offered. This is because of the risk of serious adverse events, including death.

GRADE 1C

Accelerated detoxification under minimal or light sedation

The source guideline (NICE, 2007c) found that adding an opioid antagonist to clonidine, lofexidine or buprenorphine detoxification had no effect on completion rates, but showed a trend for increased withdrawal severity, as might be expected from a process that accelerates withdrawal. Data for abstinence at follow-up were inconsistent, with one study showing a trend favouring an opioid antagonist at 9-month follow-up while another study showed the opposite trend at 6-month follow-up.

GRADE 1C

Rapid detoxification under moderate sedation

The source guideline (NICE, 2007c) found that no firm conclusions could be drawn from the limited evidence base concerning the safety and efficacy of this detoxification method. It was apparent however that precipitating withdrawal necessitated the polypharmacy of adjunct medications for managing symptoms; this is likely to carry inherent risks (for example, increased likelihood of medication interactions), particularly if detoxification occurs within a setting with minimal medical supervision (for example, at home).

GRADE 1C

Ultra-rapid detoxification under general anaesthesia

The source guideline (NICE, 2007c) found moderate evidence that, although the evidence suggests that ultra-rapid detoxification is a very effective way of initiating individuals onto naltrexone maintenance (compared with detoxification with clonidine) and that it may have better abstinence outcomes at 3- to 6-month follow-up, these benefits are outweighed by the considerable risks. This would match GRADE B. This level was downgraded as none of these studies was conducted in adolescents (indirectness of evidence).

The evidence is valid and coherent.

Evidence Summary

The review team of the source guideline (NICE, 2007c) conducted a new systematic search for RCTs that assessed the efficacy and safety of ultra-rapid and rapid detoxification under sedation and/or general anaesthesia. In addition, a further search for observational studies was undertaken to assess the safety of ultra-rapid and rapid detoxification under sedation and/or general anaesthesia. There were too few studies in each meta-analysis to check for publication bias using funnel plots. However, publication bias is possible as the review team of the source guideline did not have access to any unpublished data.

Table 12. Summay of results of a systematic review on the safety of rapid detoxification under light sedation (NICE, 2007c)

Opioid antagonist-accelerated detoxification under minimal or light sedation		
N studies, N participants, mean age	Quality of evidence	Results: Outcome measure, point estimate (95% confidence interval), N participants in the analysis
5 RCTs, N=399, age 18-56 years	moderate quality of evidence	Abstinence. 6-mo FU: 44% vs 53%, RR 0.82 (0.49 to 1.37), N=64; maintained abstinence at 9-mo FU: 20% vs 9%, RR 2.30 (0.76 to 6.94), N=91; Abstinent in past mo at 9-mo FU: 36% versus 26%, RR 1.36 (0.73 to 2.55), N=91 Completion of treatment 78% versus 77%, RR 1.01 (0.86 to 1.17) N= 335 Concordance with naltrexone maintenance. 75% versus 53%, RR 1.41 (0.96 to 2.07), N=64 Self-rated withdrawal severity. Peak: SMD 0.95 (-1.20 to 3.10), N=184; Overall: SMD 0.51 (-0.58 to 1.60) N=162; Left study early due to withdrawal: RR 1.75 (0.35 to 8.84), N=60 (Naloxone with lofexidine: Beswick 2003a; Naltrexone with clonidine: Gerra 1995, Gerra 2000; O'Connor1997; Naltrexone with buprenorphine: Umbricht 1999)

In this approach, unlike ultra-rapid and rapid detoxification regimens using opioid antagonists to precipitate full withdrawal, detoxification had already commenced (Beswick 2003a; Gerra 1995) and/or a low dose of the opioid antagonist was given (O'Connor 1997; Umbricht 1999). In addition, in these protocols, other adjunct medication was used or available, such as clonidine and benzodiazepines. Using a low dose of naltrexone (12.5 mg) is different from the so-called 'Asturian method', where 50 mg of naltrexone is given at the start with a greater range and higher doses of medication to treat opioid withdrawal symptoms (Carreno 2002).

Table 13. Summary of results of a systematic review on the safety of rapid detoxification under moderate or heavy sedation (NICE, 2007c)

Rapid detoxification under moderate sedation		
N studies, N participants, mean age	Quality of evidence	Results: Outcome measure, point estimate (95% confidence interval), N participants in the analysis
1 RCT, N=80, 30 years	moderate quality of evidence	Abstinence. 1 month FU: 39% vs 30%, RR 1.30 (0.59 to 2.84), N=80 Completion of treatment 88% vs 28%, RR 3.11 (1.86 to 5.20), N=80 Concordance with naltrexone maintenance. Started with 50 mg maintenance dose: 86% vs 50%, RR 1.72 (1.09 to 2.72), N=80; archieved 100% concordance over 4 wk FU: 56% vs 40%, RR 1.39 (0.75 to 2.56), N=80 Self-rated withdrawal severity. Mean change from baseline (completers analysis): SMD -1.70 (-2.56 to -0.84), N=41 (Arnold-Reed 2005)
Ultra-rapid detoxification under general anaesthesia or deep (or heavy) sedation Ultra-rapid detoxification under general anaesthesia versus detoxification under light or minimal sedation		
6 RCTs, N=845, 30–36 yrs	moderate quality of evidence	Abstinence. 1-month FU: 66% vs 58%, RR 1.54 (0.66 to 3.59), N=302; 3-months FU: 30% vs 14%, RR 2.08 (1.18 to 3.68), N=169; 6-months FU: 22% vs 8%, RR 2.70 (0.92 to 7.91), N=101; 12-months FU: 20% vs 14%, RR 1.40 (0.58 to 3.39), N=101. Completion of treatment. 84% vs 54%, RR=1.67 (0.88 to 3.18), N=270 Concordance with naltrexone maintenance. Started 50 mg maintenance dose Versus clonidine control group: 61% vs 19%, RR 3.87 (1.03 to 14.54), N=240; Versus naltrexone control group: 90% vs 99%, RR 0.91 (0.86 to 0.97) N=272 Serious adverse events: RR 3.62 (1.36, 9.61), N=644 (Propofol anaesthesia (versus clonidine without general anaesthesia): Collins 2005, Favrat 2006, McGregor 2002; Propofol anaesthesia (versus methadone without general anaesthesia): Krabbe 2003; Propofol anaesthesia (versus naltrexone without general anaesthesia): De Jong 2005; Propofol with midazolam (versus light sedation with same agents): Seoane 1997

(For benefits, RR> 1 and negative SMD favour ultra-rapid detoxification. For adverse events, RR< 1 favours ultra-rapid.)

References (cited from: NICE, 2007c)

- Arnold-Reed DE and Hulse GK. A comparison of rapid (opioid) detoxification with clonidine-assisted detoxification for heroin-dependent persons. Journal of Opioid Management 2005, 1, 17–23.
- Beswick T, Best D, Bearn J, et al. The effectiveness of combined naloxone/lofexidine in opiate detoxification: results from a double-blind randomized and placebo-controlled trial. American Journal on Addictions 2003, 12, 295–305.
- Carreno JE, Bobes J, Brewer C, et al. 24-hour opiate detoxification and antagonist induction at home – the 'Asturian method': a report on 1368 procedures. Addiction Biology 2002, 7, 243–250.
- Collins ED, Kleber HD, Whittington RA, et al. Anaesthesia-assisted vs. buprenorphine- or clonidine-assisted heroin detoxification and naltrexone induction: a randomized trial. The Journal of the American Medical Association 2005, 294, 903–913.
- DeJong CA, Laheij RJ and Krabbe PF. General anaesthesia does not improve outcome in opioid antagonist detoxification treatment: a randomized controlled trial. Addiction 2005, 100, 206–215.

- Favrat B, Zimmermann G, Zullino D, et al. Opioid antagonist detoxification under anaesthesia versus traditional clonidine detoxification combined with an additional week of psychosocial support: a randomized clinical trial. Drug and Alcohol Dependence 2006, 81, 109–116.
- Gerra G, Marcato A, Caccavari R, et al. Clonidine and opiate receptor antagonists in the treatment of heroin addiction. Journal of Substance Abuse Treatment 1995, 12, 35– 41.
- Gerra G, Zaimovic A, Rustichelli P, et al. Rapid opiate detoxification in outpatient treatment: relationship with naltrexone compliance. Journal of Substance Abuse Treatment 2000, 18, 185–191.
- Krabbe PF, Koning JP, Heinen N, et al. Rapid detoxification from opioid dependence under general anaesthesia versus standard methadone tapering: abstinence rates and withdrawal distress experiences. Addiction Biology 2003, 8, 351–358.
- McGregor C, Ali R, White JM, et al. A comparison of antagonist- precipitated withdrawal under anesthesia to standard inpatient withdrawal as a precursor to maintenance naltrexone treatment in heroin users: outcomes at 6 and 12 months. Drug and Alcohol Dependence 2002, 68, 5–14.
- O'Connor PG, Carroll KM, Shi JM, et al. Three methods of opioid detoxification in a primary care setting. Annals of Internal Medicine 1997, 127, 526–530.
- Seoane A, Carrasco G, Cabre L, et al. Efficacy and safety of two new methods of rapid intravenous detoxification in heroin addicts previously treated without success. The British Journal of Psychiatry 1997, 171, 340–345.
- Umbricht A, Montoya ID, Hoover DR, et al. Naltrexone shortened opioid detoxification with buprenorphine. Drug and Alcohol Dependence 1999, 56, 181–190.

Recommendation 27

When prescribing adjunctive medications during opioid detoxification, healthcare professionals should:

- *Only use them when clinically indicated, such as when agitation, nausea, insomnia, pain and/or diarrhoea are present.*
- *Use the minimum effective dosage and number of drugs needed to manage symptoms.*
- *Be alert to the risks of adjunctive medications, as well as interactions between them and with the opioid agonist.*

The source guideline (NCE, 2007c) does not present clear evidence to support this recommendation. Therefore we assumed this was based on consensus.

Recommendation 28

Healthcare professionals should be aware that medications used in opioid detoxification are open to risks of misuse and diversion in all settings (including prisons), and should consider:

- *Monitoring of medication concordance*
- *Methods of limiting the risk of diversion where necessary, including supervised consumption.*

The source guideline (NICE, 2007c) does not present clear evidence to support this recommendation. Therefore we assumed this was based on consensus.

Evidence update

Two recent Cochrane reviews were found assessing the effectiveness of detoxification and maintenance treatment for opiate dependent adolescents (Minozzi et al, 2009ab).

The review on detoxification included two studies involving 190 participants (Minozzi et al, 2009a). The methodological quality of the included studies was quite good. One study compared buprenorphine with

clonidine for detoxification. No difference was found for drop out: RR 0.45 (95%CI: 0.20 - 1.04) and acceptability of treatment: withdrawal score WMD: 3.97 (95%CI -1.38, 9.32). More participants in the buprenorphine group initiated naltrexone treatment: RR 11.00 (95%CI 1.58, 76.55). The other study compared maintenance treatment vs detoxification treatment: buprenorphine-naloxone maintenance vs buprenorphine detoxification. For drop-out, the results were in favour of maintenance treatment: RR 2.67 (95%CI 1.85, 3.86), as well as for results at follow up RR 1.36 (95%CI 1.05, 1.76); no differences for use of opiate. The authors conclude that it is difficult to draft conclusions on the basis of two trials with few participants. Furthermore, the two studies included did not consider the efficacy of methadone that is still the most frequent drug utilized for the treatment of opioid withdrawal.

The review on the effectiveness of maintenance included two studies involving 187 participants (Minozzi et al, 2009b). One study was from 1973 and was of poor quality. The other study was judged to have a low risk of bias for all domains but allocation concealment which appears to be inadequate. One study compared methadone with LAAM for maintenance treatment lasting 16 weeks after which patients were detoxified, the other compared maintenance treatment with buprenorphine - naloxone with detoxification with buprenorphine. No meta-analysis could be been performed because the two studies assessed different comparisons. Maintenance treatment seemed more efficacious in retaining patients in treatment but not in reducing patients with positive urine at the end of the study. Self reported opioid use at 1 year follow up was significantly lower in the maintenance group even if both group reported high level of opioid use and more patients in the maintenance group were enrolled in other addiction treatment at 12 month follow up. The authors conclude that it is difficult to draft conclusions on the basis of only two trials.

References:

- Minozzi S, Amato L, DavoliM. Detoxification treatments for opiate dependent adolescents. Cochrane Database of Systematic Reviews 2009a, Issue 2. Art. No.: CD006749.
- Minozzi S, Amato L, Davoli M. Maintenance treatments for opiate dependent adolescent. Cochrane Database of Systematic Reviews 2009b, Issue 2. Art. No.: CD007210.

Which combined interventions (medication and psychosocial) should be used for opiate detoxification in adolescents?

Recommendation 29

Staff should routinely offer a community-based programme to all service users considering opioid detoxification. Exceptions to this may include service users who:

- *Have not benefited from previous formal community-based detoxification*
- *Need medical and/or nursing care because of significant comorbid physical or mental health problems*
- *Require complex polydrug detoxification, for example concurrent detoxification from alcohol or benzodiazepines*
- *Are experiencing significant social problems that will limit the benefit of community-based detoxification.*

GRADE 1C

The evidence base comparing detoxification in inpatient and community-based settings is limited. There is some evidence suggesting inpatient detoxification is more effective than community-based detoxification. This matches GRADE C.

The evidence found in the source guideline (NICE, 2007c) is not valid because of methodological problems (Wilson 1975; Gossop 1986) and not coherent because of moderate report of studies.

Evidence summary

Currently, the evidence for the importance of setting in affecting the outcome for detoxification is very sparse, with little research being available to guide clinicians about the service and setting in which users are likely to do well.

The review team of the source guideline (NICE, 2007c) conducted a new systematic search for RCTs and observational studies that assessed the efficacy of detoxification in inpatient, residential and community-based settings.

In the review comparing inpatient/residential detoxification with community-based detoxification, three trials (Day 2006; Gossop 1986; Wilson 1975) met the eligibility criteria, providing data on 171 participants.

In the review comparing detoxification in a specialist community-based drug clinic and detoxification in a community-based primary care clinic, one trial met the criteria (Gibson 2003), providing data on 115 participants.

Table 14. Summary of results of a systematic review comparing in-patient and community-based detoxification (NICE, 2007c)

Inpatient vs community-based detox		
N studies, N participants, mean age	Quality of evidence	Results: Outcome measure, point estimate (95% confidence interval), N participants in the analysis
2 RCTs, n=111, age not reported	low quality of evidence	Completion of detox 53% vs 36%, RR 1.60 (1.05 to 2.42), n=111 (Day 2006; Wilson 1975)

(RR>1 favours inpatient detox)

Participants receiving inpatient detoxification were more likely to complete their detoxification than those receiving this treatment in the community (RR 1.60; 95% CI, 1.05 to 2.42). However, this should be interpreted with caution as results are more modest (RR 1.38; 95% CI, 0.79 to 2.42) for the recent UK trial (Day 2006) in comparison with Wilson and colleagues' (1975) earlier US trial (RR 1.91; 95% CI, 1.03 to 3.55). This latter trial was hampered by serious methodological problems.

A third trial (Gossop 1986) was not included in the meta-analysis because randomised and non-randomised data were combined. Consistent with the data above, this trial found statistically significant differences between inpatient and community-based detoxification. Sixty participants, who were opioid dependent, were elected to receive either inpatient or community-based detoxification. Participants were assigned to one of four groups: preferred inpatient, preferred community-based, randomised inpatient and randomised community-based. Forty participants expressed strong preferences and were assigned to the appropriate groups. The remaining 20 subjects were randomly assigned to one of the randomised groups. Differences between inpatient and community-based settings were much more pronounced in this trial compared with the trials mentioned above (Day 2006; Wilson 1975). In total, 81% of the inpatient group was successfully detoxified from opioids compared with 17% in the community based group (RR 4.68; 95% CI 2.07 to 10.58).

The main finding of the study was that supervised inpatient detoxification was more successful than the community-based comparison group. However, there are two main problems with this study. Firstly, data comparing outcomes in the community based and inpatient settings were combined from participants who were assigned by preference and participants who were randomly assigned. There was a strong trend favouring participants in the preferred group (RR 1.64; 95% CI 0.85 to 3.16). In addition, the level of support and therapy within the inpatient group was significantly higher, although of a shorter duration (21 days), whereas the community-based detoxification programme was for 8 weeks and no support was provided outside the clinic.

Specialist community-based versus generic community-based

Only one study (Gibson et al., 2003) from Australia compared community-based buprenorphine detoxification in a specialist clinic setting with a similar regimen in a primary care setting (5-day detoxification with assessment on day 8). Participants attended daily to receive a supervised dose of buprenorphine. The primary care group received their doses from the GP's surgery on weekdays and from the specialist clinic at weekends. The specialist clinic group received all their doses from this setting. At each visit, practitioners were encouraged to review side effects, dose adequacy, participants' goals and post-detoxification treatment options. They found that the settings had similar efficacy and cost effectiveness: with 71% completing detoxification in the primary care setting and 78% in the specialist clinic setting (RR 1.09; 95% CI, 0.88 to 1.35). Additionally, 23% reported no opioid use during detoxification treatment in the primary care group compared with 22% in the specialist clinic group (RR 0.95; 95% CI, 0.48 to 1.87).

References (cited from: NICE, 2007c)

- Day E. Outpatient vs Inpatient Opioid Detoxification (OPIOiD) Study. Unpublished manuscript, 2007.
- Gibson AE, Doran CM, Bell JR, et al. A comparison of buprenorphine treatment in clinic and primary care settings: a randomised trial. The Medical Journal of Australia 2003, 179, 38–42.
- Gossop M, Johns A and Green L. Opiate withdrawal: inpatient versus outpatient programmes and preferred versus random assignment to treatment. British Medical Journal 1986, 293, 103–104.
- Wilson BK, Elms RR and Thomson CP. Outpatient vs hospital methadone detoxification: an experimental comparison. The International Journal of the Addictions 1975, 10, 13–21.

Recommendation 30

Community detoxification should normally include:

- *Prior stabilisation of opioid use through pharmacological treatment*
- *Effective coordination of care by specialist or competent primary practitioners*
- *The provision of psychosocial interventions, where appropriate, during the stabilisation and maintenance phases*

The source guideline (NICE, 2007c) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Recommendation 31

For women who are opioid dependent during pregnancy, detoxification should only be undertaken with caution.

The source guideline (NICE, 2007c) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Recommendation 32

If a person presenting for opioid detoxification also misuses alcohol, healthcare professionals should consider the following.

- *If the person is not alcohol dependent, attempts should be made to address their alcohol misuse, because they may increase this as a response to opioid withdrawal symptoms, or substitute alcohol for their previous opioid misuse.*
- *If the person is alcohol dependent, alcohol detoxification should be offered. This should be carried out before starting opioid detoxification in a community or prison setting, but may be carried out concurrently with opioid detoxification in an inpatient setting or with stabilisation in a community setting.*

The source guideline (NICE, 2007c) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Recommendation 33

If a person presenting for opioid detoxification is also benzodiazepine dependent, healthcare professionals should consider benzodiazepine detoxification. When deciding whether this should be carried out concurrently with, or separately from, opioid detoxification, healthcare professionals should take into account the person's preference and the severity of dependence for both substances.

The source guideline (NICE, 2007c) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Recommendation 34

Psychosocial support should be offered routinely in association with pharmacological treatment for opioid dependence.

GRADE 1B

The source guideline (WHO, 2009) found high quality evidence that comparing methadone plus psychosocial treatment to methadone alone, the pooled analysis found no difference in treatment retention; however, heroin use was significantly reduced with the addition of psychosocial treatment. This would match GRADE A. However this was downgraded as there were no indications that these studies were conducted among adolescents (indirectness of evidence).

Evidence is valid but not coherent. Evidence is about methadone, but recommendation is broader ("pharmacological treatment"). Results are inconsistent (positive result for one outcome, but no difference for 3 others).

Evidence summary

Efficacy

A recent Cochrane Collaboration review identified eight RCTs (Abrahams 1979, Khatami 1982, Milby 1978, Preston 2000, Stitzer 1992, Thornton 1987, Woody 1995) that addressed the issue of whether psychosocial interventions should be used in addition to pharmacological maintenance treatments.

Comparing methadone plus psychosocial treatment to methadone alone, the pooled analysis found no difference in treatment retention (8 RCTs, RR 0.94, 95%CI 0.85 to 1.02, high-grade evidence); however, heroin use was significantly reduced with the addition of psychosocial treatment (5 RCTs [Abbott 1998, McLellan 1993, Stitzer 1992, Thornton 1987, Woody 1995], RR 0.69, 95%CI 0.53 to 0.91, high-grade evidence). Also no significant difference was found for retention in treatment at the end of FU (3 RCTs [Khatami 1982, Iguchi 1997, Woody 1983], RR 0.90, 0.76 to 1.07, high quality) and abstinent at the end of FU (2 RCTs [Khatami 1982, Woody 1983], RR 0.88, 0.67 to 11.5, low quality).

Cost effectiveness

Cost effectiveness studies in the United States found that methadone with moderate intensity psychosocial services (1–2 hours per week) are more cost effective than methadone either without psychosocial services or with high intensity services (i.e. several hours a day) [Kraft 1997, McLellan 1993, Avants 1999].

Limitations of data

Studies have used different techniques, including hypnotherapy, psychotherapy, acceptance and commitment therapy, interpersonal psychotherapy, supportive–expressive psychotherapy, counselling, cognitive behavioural therapy (CBT), contingency management, dialectic behaviour therapy and comprehensive validation therapy. It is difficult to compare these interventions in meta-analyses.

Contingency management studies have the most consistently positive findings, regardless of whether vouchers, take-home methadone privileges or prize draw incentives are used. It is not clear whether these interventions can be generalised to settings outside the one in which they were carried out (mainly the United States).

References (cited from: WHO, 2009)

- Abbott PJ, Weller SB, Delaney HD and Moore BA. Community reinforcement approach in the treatment of opiate addicts. American Journal of Drug and Alcohol Abuse 1998, 24(1):17-30.
- Abrahms JL. A cognitive-behavioral versus nondirective group treatment program for opioid-addicted persons: an adjunct to methadonemaintenance. International Journal of Addiction 1979, 14(4):503-511.
- Avants SK, Margolin A, Sindelar JL, Rounsaville BJ, Schottenfeld R, Stine S, Cooney NL, Rosenheck RA, Li SH and Kosten TR. Day treatment versus enhanced standard methadone services for opioid-dependent patients: a comparison of clinical efficacy and cost. American Journal of Psychiatry 1999, 156(1):27-33.
- Khatami M, Woody G, O'Brien C and Mintz J. Biofeedback treatment of narcotic addiction: a double-blind study. Drug and Alcohol Dependence 1982, 9(2):111-117.
- Kraft MK, Rothbard AB, Hadley TR, McLellan AT and Asch DA. Are supplementary services provided during methadone maintenance really cost- effective? American Journal of Psychiatry 1997. 154(9):1214-1219.
- Iguchi MY, Belding MA, Morral AR, Lamb RJ and Husband SD. Reinforcing operants other than abstinence in drug abuse treatment: an effective alternative for reducing drug use. Journal of Consulting and Clinical Psychology 1997, 65(3):421-428.
- McLellan AT, Arndt IO, Metzger DS, Woody GE and O'Brien CP. The effects of psychosocial services in substance abuse treatment. Jama 1993, 269(15):1953-1959.
- Milby JB, Garrett C, English C, Fritschi O and Clarke C. Take-home methadone: contingency effects on drug-seeking and productivity of narcotic addicts. Addictive Behaviors 1978, 3(3-4):215-220.
- Preston KL, Umbricht A and Epstein DH. Methadone dose increase and abstinence reinforcement for treatment of continued heroin use during methadone maintenance. Archives of General Psychiatry 2000, 57(4):395-404.
- Stitzer ML, Iguchi MY and Felch LJ. Contingent take-home incentive: effects on drug use of methadone maintenance patients. Journal of Consulting and Clinical Psychology 1992, 60(6):927-934.
- Thornton PI, Igleheart HC and Silverman LH. Subliminal stimulation of symbiotic fantasies as an aid in the treatment of drug abusers. International Journal of Addiction 1987, 22(8):751-765.
- Woody GE, Luborsky L, McLellan AT, O'Brien CP, Beck AT, Blaine J, Herman I and Hole A. Psychotherapy for opiate addicts. Does it help? Archives of General Psychiatry 1983, 40(6):639-645.
- Woody GE, McLellan AT, Luborsky L and O'Brien CP. Psychotherapy in community methadone programs: a validation study. American Journal of Psychiatry 1995, 152(9):1302-1308.
- WHO. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. Geneva: World Health Organization, 2009.

Recommendation 35

Psychosocial services should be routinely offered in combination with pharmacological treatment of opioid withdrawal.

GRADE 1C

The source guideline (WHO, 2009) found low to moderate evidence that combined psychosocial and pharmacological assistance increases the chance of successfully completing opioid withdrawal for those who wish to withdraw from opioids. The evidence is strongest for contingency management approaches. This would match level B. This was downgraded to C because there is no indication that these studies were performed among adolescents.

Evidence is valid and coherent.

Evidence summary

Efficacy

The pooled results of five RCTs (184 participants) indicate that combined psychosocial and pharmacological assistance results in greater rates of completion of treatment (5 RCTs [Bickel 1997, Higgins 1984, McCaul 1984, Rawson 1983, Robles 2002], RR 1.68, 95%CI 1.11 to 2.55, moderate quality evidence), lower rates of relapse at follow-up (3 RCTs [Bickel 1997, Rawson 1983, Yandoli 2002], RR 0.41, 95%CI 0.27 to 0.62, moderate-quality evidence), despite a trend towards higher rates of opioid use during detoxification (3 RCTs [Bickel 1997, McCaul 1984, Rawson 1983] , RR 1.3, 95%CI 0.99 to 1.70, moderate quality evidence). There were no differences in rates of other substance use during detoxification (all substances 1RCT very low quality Bickel 1997).

Treatment considerations

The types of psychological assistance provided in the studies were contingency management, community reinforcement, psychotherapeutic counseling and family therapy. The data show no clear advantage of one technique over the others, although the evidence (from four studies) is strongest for contingency management approaches combined with methadone or buprenorphine.

Benefits

Psychosocial assistance can:

• help patients to clarify their goals around their drug use;
• increase patients' motivation to stop or reduce their drug use; and
• increase accountability for the outcomes of the attempted opioid detoxification.

In addition, psychosocial support can help to educate patients about the sort of withdrawal symptoms they will experience, provide them with useful strategies for minimizing withdrawal and help them to interpret the current withdrawal phenomena. It can also facilitate transfer to post-withdrawal treatment options, and assist with reintegration into society.

Undesirable effects and consequences

There is a theoretical risk that psychosocial interventions to assist people undertaking opioid withdrawal may inadvertently encourage people to continue with opioid detoxification instead of moving to more effective longer term interventions, such as opioid agonist maintenance treatment.

References (cited from: WHO, 2009)

- Bickel WK, Amass L, Higgins ST, Badger GJ and Esch RA. Effects of adding behavioral treatment to opioid detoxification with buprenorphine. Journal of Consulting and Clinical Psychology 1997, 65(5):803-810.
- Higgins ST, Stitzer ML, Bigelow GE and Liebson IA. Contingent methadone dose increases as a method for reducing illicit opiate use in detoxification patients. NIDA Research Monograph 1984, 55:178-184.
- McCaul ME, Stitzer ML, Bigelow GE and Liebson IA. Contingency management interventions: effects on treatment outcome during methadone detoxification. Journal of Applied Behavioral Analysis 1984, 17(1):35-43.

- Rawson RA, Mann AJ, Tennant FS, Jr. and Clabough D. Efficacy of psychotherapeutic counselling during 21-day ambulatory heroin detoxification. NIDA Research Monograph 1983, 43:310-314.
- Robles E, Stitzer ML, Strain EC, Bigelow GE and Silverman K. Voucher-based reinforcement of opiate abstinence during methadone detoxification. Drug and Alcohol Dependence 2002, 65(2):179-189.
- Yandoli D, Eisler I, Robbins C, Mulleady G and Dare C. A comparative study of family therapy in the treatment of opiate users in a London drug clinic. The Association for Family Therapy and Systemic Practice 2002, 24(4):402-422.
- WHO. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. Geneva: World Health Organization, 2009.

How long is follow-up needed?

Recommendation 36

Following successful opioid detoxification, and irrespective of the setting in which it was delivered, all service users should be offered continued treatment, support and monitoring designed to maintain abstinence. This should normally be for a period of at least 6 months.

The source guideline (NICE, 2007c) does not report any evidence for this recommendation. Therefore we assumed this was based on consensus.

Appendix B1. Methods and results of literature update

Search strategy

We searched Medline (using Pubmed), the Cochrane Database of Systematic Reviews and the Database of Reviews of Effects (DARE) in November 2013.

The following search strategy was used:
1. substance-related disorders [MeSH] OR alcohol drinking [MeSH] OR street drugs [MeSH] OR designer drugs [MeSH] OR cannabis [MeSH] OR marijuana smoking [MeSH] OR heroin [MeSH] OR opium [MeSH] OR cocaine [MESH] OR amphetamines [MeSH] OR cannabis OR marijuana OR heroin OR opium OR cocaine OR amphetamine$ OR speed OR ecstasy
2. abuse$ OR misuse$ OR use$ OR dependen$ OR drink$ OR smoke$
3. adolescent [MeSH] OR adolescent$ OR teenager$ OR teen$ OR young OR youth$
4. treatment OR management OR therapy OR diagn$ OR screen$ OR intervention$
The four search lines were combined with the boolean operator AND. The results were limited with the broad filter to select systematic reviews and to publication date of 2007 or later.

Inclusion criteria

The following criteria were used to select review:
1. The design was a systematic review, meaning that a systematic search and an assessment of study quality were performed.
2. The interventions had to be related to screening, diagnosing and treating alcohol and drug misuse. Interventions on tobacco were allowed if more than half of the studies were on alcohol or illicit drugs.
3. The studies were on adolescents, i.e persons aged 12-18 years. Reviews were excluded if more than half of the studies include predominantly older or younger participants (mean >18 yrs).

Results

The searches yielded 403 records. 365 were excluded based on title and abstract and 38 records were screened based on full text. Twenty-six were excluded, 16 because the review did not (primarily) focus on adolescents, 9 because the reviews were not considered to be systematic reviews and 1 because it was relevant to the prevention of substance misuse (see list of excluded reviews). Twelve reviews were included, 4 on alcohol misuse, 7 on drug misuse and 1 on both alcohol and drug misuse.

Two reviews were already included in one of the guidelines. These were:

- Tripodi SJ, Bender K, Litschge C, et al. Interventions for reducing adolescent alcohol abuse: a meta-analytic review. Arch Pediatr Adolesc Med 2010; 164: 85–91.
- Dhalla S, Zumbo BD, Poole G. A review of the psychometric properties of the CRAFFT instrument: 1999-2010. Curr Drug Abuse Rev 2011; 4(1): 57-64

The other relevant reviews were assessed whether their results and conclusion would change the recommendations either on content or with respect to the level of evidence. Recommendations could be changed when the review's conclusions did not support the recommendation or when they would provide more detailed recommendations. The level of evidence could be changed if the conclusion of the review is a higher grade/level of evidence or the conclusion was derived in more direct studies (i.e. in studies in adolescents compared to studies in adults).

Guideline on drug misuse

The following eight new systematic reviews were identified:

- Barnett E, Sussman S, Smith C et al. Motivational Interviewing for adolescent substance use: A review of the literature. Addictive Behav 2012; 37: 1325-34.
- Tanner-Smith EE, Wilson SJ, Lipsey MW. The comparative effectiveness of outpatient treatment for adolescent substance abuse: A meta-analysis. J Subst Abuse Treat 2013; 44: 145-58.
- Tripodi SJ. A Comprehensive Review: Methodological Rigor of Studies on Residential Treatment Centers for Substance-Abusing Adolescents. Journal of Evidence-Based Social Work 2009; 6 (3), 288-299.
- Engle B and Maggowan MJ. A Critical Review of Adolescent Substance Abuse Group Treatments. Journal of Evidence-Based Social Work 2009: 6: 217–243.
- Becker SJ and Curry JF. Outpatient Interventions for Adolescent Substance Abuse: A Quality of Evidence Review. Journal of Consulting and Clinical Psychology 2008; 76 (4), 531–543.
- Waldron HB and Turner CW. Evidence-Based Psychosocial Treatments for Adolescent Substance Abuse. Journal of Clinical Child & Adolescent Psychology 2008; 37(1): 238–261
- Minozzi S, Amato L, Davoli M. Maintenance treatments for opiate dependent adolescent. Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD007210.
- Minozzi S, Amato L, DavoliM. Detoxification treatments for opiate dependent adolescents. Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD006749.

None of the reviews necessitate changes to the recommendations. However a number of reviews cover interventions that were not included in the guidelines, such as motivational interviewing and family therapy. A summary of the reviews is integrated in the evidence summary.