

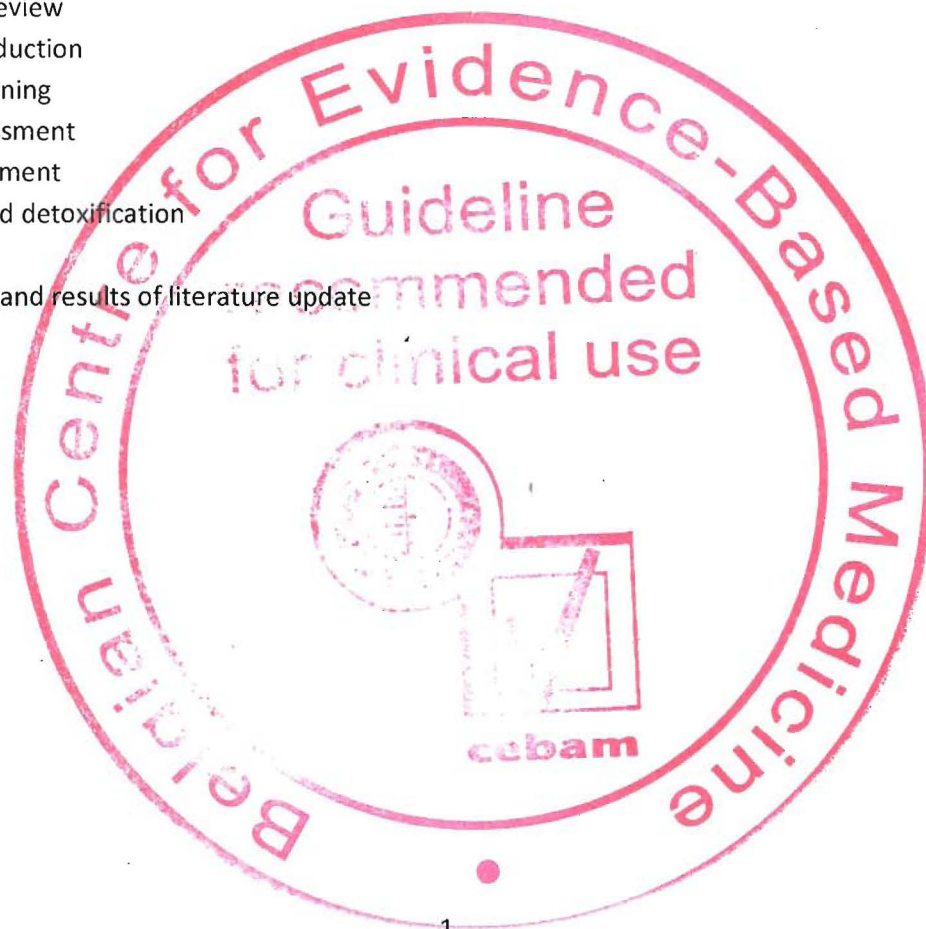
Guide de bonne pratique Dépistage, évaluation et traitement de l'abus de drogues (Révision de la version finale)

Pour le groupe d'étude ADAPTE-youth

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

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Jeunes de 12-18 ans présentant un abus de drogues (possible)

Dépistage chez le jeune :

- Questionner la consommation de drogues (dans des contextes où l'abus de drogues est fréquent) (Recom. 1)
- Outils de dépistage : CRAFFT, SEM-j, CPQ-A-, CAST (Recom. 2)
- Signes d'abus : douleur thoracique aiguë, psychose aiguë, troubles de l'humeur et du sommeil (Recom. 3)

Évaluation des jeunes :

- Tenir entre autres compte des besoins, expériences antérieures, objectifs personnels (Recom. 4)
- Évaluer la présence et la sévérité de la dépendance aux opiacés chez le jeune qui se présente pour détoxication (Recom. 5)
- Les tests de drogues doivent être réalisés adéquatement (Recom. 6)

Traitement jeunes

Pas de dépendance



Dépendance totale

Conditions préalables indispensables : collaborer avec les parents et l'entourage, avec consentement du jeune (Recom. 7,9), offrir des explications univoques sur les options thérapeutiques – décision éclairée (Recom. 8), offrir les mêmes soins, le même respect (de la vie privée) qu'à tout autre patient (AB 10), Mise en œuvre de schémas thérapeutiques clairs et acceptés d'un commun accord (Recom. 11), équipe de soins compétente (Recom. 12)

Soutien des parents : Questionner les parents sur l'influence de la consommation de drogues sur eux-mêmes et aborder les préoccupations (Recom. 18), offrir une aide personnelle accompagnée et informer sur le groupes de soutien (Recom. 19), donner des informations spécifiques à l'égard de la détoxication en cas de dépendance aux opiacés (Recom. 20)

Interventions non médicamenteuses

- Informations et conseils concernant la réduction des risques délivrés lors d'un contact routinier et opportuniste (Recom. 13)
- Psychoéducation : à ne pas proposer de manière routinière aux groupes (Recom. 14)
- Interventions brèves opportunistes pour le jeune sans contact ou ayant un contact limité avec les services d'aide aux toxicomanes (Recom. 15, 16)

Détoxication de la dépendance aux opiacés

La détoxication doit être une option thérapeutique disponible (Recom. 21), Médicaments : la méthadone ou la buprénorphine sont les médicaments de premier choix (Recom. 22, 23, 24), dose et durée sur mesure du jeune, pas de détoxication accélérée (Recom. 25, 26), médicaments complémentaires uniquement en cas de besoin (Recom. 27), contrôle de l'adhérence médicamenteuse (Recom. 28), contexte de détoxication basé sur la communauté constitue le premier choix (Recom. 29), indications pour admission en service résidentiel (Recom. 17), comment réaliser une détoxication en ambulatoire (Recom. 30), chez la femme enceinte (Recom. 31)

Interventions combinées en cas de dépendance aux opiacés :
Toujours offrir des interventions psychosociales, éventuellement associées à un traitement médicamenteux pour dépendance aux opiacés et sevrage (Recom. 34, 35)

Les jeunes abusant tant de drogues que d'alcool.

Sans dépendance à l'alcool, d'abord prendre en charge l'abus d'alcool.
Avec dépendance à l'alcool : prise en charge en ambulatoire ou en prison : d'abord sevrage à l'alcool avant sevrage aux opiacés, sevrage concomitant intra muros (Recom. 32). En cas d'abus aux benzodiazépines : sevrage concomitant ou séparé en concertation avec le jeune (Recom. 33)

Suivi après détoxication : poursuite du traitement, offrir un soutien et contrôle (monitoring) (Recom. 36)

Partie 1. Recommandations

1.1 Introduction

Chez les jeunes, la consommation de drogues est de plus en plus précoce et fréquente. En Flandre, 26% des jeunes de 16 ans ont déjà utilisé des drogues illicites, les garçons un peu plus que les filles (29 et 22%, ESPAD 2011). 4 % déclarent avoir utilisé des drogues illicites à partir de 13 ans (garçons 5%, filles 3%). Le cannabis est le plus utilisé; son utilisation est un peu plus élevée en Wallonie qu'en Flandre. En Wallonie 29,6% des jeunes de 15-16 ans ont déjà utilisé le cannabis, et en Flandre 24,6% ; dans le groupe des 17-18 ans, respectivement 47,0% et 43,5% des jeunes ont utilisé des drogues (HBSC 2005-2006). Après le cannabis, c'est la cocaïne qui est la drogue la plus utilisée parmi les jeunes. L'usage d'amphétamines, d'héroïne ou d'opiacés n'est que sporadique parmi les jeunes dans la population générale. Dans d'autres contextes tels que les services d'aide à la jeunesse et la justice l'abus de ces substances est plus fréquente.

Risques et conséquences

La consommation régulière et/ou excessive de drogues a des effets négatifs à court terme sur l'état psychosocial et physique des jeunes. Ainsi, à court terme, le cannabis peut perturber temporairement les fonctions cognitives, entre autres la mémoire immédiate et la faculté d'attention, ce qui, associé à un effet sur d'autres fonctions mentales, peut conduire à de moins bonnes performances scolaires juste après consommation. (Kinable, 2008). La consommation de cocaïne peut s'accompagner de troubles dépressifs, image négative de soi, troubles de la mémoire immédiate et de concentration, hyperthermie, accident vasculaire cérébral et troubles du rythme cardiaque (Hermans & Schrooten, 2005). Le risque lié à un usage concomitant d'alcool et de drogues ou de plusieurs types de drogues est plus élevé car il s'avère difficile d'en évaluer les effets (Hermans & Schrooten, 2005).

Le risque de dépendance à long terme est réel. Le risque de dépendance dépend du type de drogue, de la quantité, de la personne (prédisposition génétique en partie) et de l'âge où la consommation a débuté. La consommation de drogues peut également conduire à des problèmes sociaux, tels que des relations perturbées ou des problèmes financiers. Surtout chez les jeunes vulnérables, il existe une corrélation avec d'autres problèmes à d'autres niveaux : problèmes psychiatriques, comportement délinquant, circonstances comportementales et socio-économiques (Adviescommissie kwetsbare jeugd & verslaving, 2011)

Les jeunes représentent un groupe très vulnérable, et ils sont donc plus susceptibles de consommer des drogues. D'une part, ils ont, vu le stade de développement biologique et psychologique dans lequel ils se trouvent, tendance à vouloir expérimenter avec les drogues. Ils courent d'autre part plus de risques vu les effets des drogues sur leur cerveau en plein développement (Adviescommissie kwetsbare jeugd & verslaving (Commission consultative Jeunes vulnérables et assuétude), 2011) et parce qu'ils développent plus vite une dépendance que les adultes.

Motivation du guide de bonne pratique

Souvent, les jeunes consommant de la drogue ne reçoivent pas l'aide dont ils auraient besoin. Les jeunes ne recherchent pas d'aide parce qu'ils sous-estiment leur consommation et ne perçoivent pas encore les conséquences liées à leur usage. Il est possible que les parents et les intervenants sous-estiment la consommation de drogues du jeune. De plus, ils associent l'aide, à tort, à des formes graves de dépendance (Van Hout, 2012). L'offre d'aide devrait mieux correspondre à la demande des jeunes. Une plus grande coopération devrait s'instaurer entre les différentes structures d'assistance existantes, et entre les autorités et les assistants sociaux sur le terrain (Van Hout, 2012). Ce guide de bonne pratique se propose de tracer, pour les diverses disciplines, une prise en charge cohérente pouvant être utilisées par les différents travailleurs de la santé et les autres professionnels qui s'occupent de jeunes présentant un abus de drogues.

Objectifs du guide de bonne pratique

Les recommandations dans ce guide de bonne pratique sont indicatives et ont but de servir de fil conducteur lors des prises de décisions dans les secteurs belges des soins de santé, de la sécurité sociale ainsi que dans les écoles et au niveau de la société. Nous nous proposons ainsi de fournir des informations étayées scientifiquement à propos de stratégies efficaces pour le dépistage, l'évaluation et le traitement des jeunes présentant un (éventuel) problème de drogues. Le bénéfice escompté est l'amélioration de la qualité des soins prodigués à ces jeunes grâce à ce guide de bonne pratique, notamment en réduisant l'inexplicable variation et en proposant une aide mieux adaptée.

Ce guide de bonne pratique décrit les soins qui, du point de vue scientifique, sont les mieux adaptés aux jeunes dans leur ensemble. Le jeune lui-même, considéré comme suffisamment capable, est un partenaire à part entière dans les prises de décisions concernant les soins (voir aussi les droits du jeune). Le rôle de l'intervenant est de clarifier la question du jeune par le biais d'une communication adaptée et de lui donner des informations sur tous les aspects des options thérapeutiques possibles. L'intervenant et le jeune choisissent ensuite ensemble une stratégie déterminée. Il se peut que, sur la base d'une série d'arguments, l'intervenant et le jeune optent pour une autre stratégie que celles qui sont décrites ici.

Il est important que l'intervenant adopte une attitude fondamentalement participative de manière à établir de bons rapports avec les jeunes ; c'est essentiel pour l'application de ce guide de bonne pratique. Les caractéristiques que les jeunes apprécient dans le comportement de l'intervenant sont l'authenticité, l'empathie, l'équivalence, l'ouverture, l'inconditionnalité, attitude positive, la proximité professionnelle, la fiabilité et le respect.

Ce guide de bonne pratique s'appuie autant que possible sur les guidelines internationaux existants et sur la recherche scientifique. Si un guideline existant n'aborde pas un thème particulier, celui-ci n'est pas non plus repris dans ce guide de bonne pratique. Certains sujets, comme la détoxification des opiacés, ont été traités en détail dans guidelines existants et ont donc une place prépondérante dans le présent guide de bonne pratique. Il ne s'agit aucunement de préférences pour certains thèmes de la part des collaborateurs et des experts concernés. De plus, la recherche scientifique portant sur l'abus de drogues parmi les jeunes est un domaine en plein développement, de sorte que le guide de bonne pratique et les recommandations pour une question clinique particulière ne sont pas exhaustifs. En d'autres termes, si une stratégie particulière ne figure pas dans ce guide de bonne

pratique, ni parmi les recommandations, cela ne signifie pas pour autant qu'elle ne devrait pas être appliquée. Dans la plupart des cas, les recommandations proposées ne recouvrent pas la totalité de la question clinique. Ainsi, les possibilités de dépistage sont plus vastes que celles qui sont décrites dans les recommandations 1, 2 et 3. De plus, aucune information n'a été trouvée concernant certains thèmes comme les aspects psychologiques du développement à l'adolescence et la réintégration psychosociale, thèmes en rapport avec le sujet et qu'il serait très intéressant de développer. Cela a à voir avec un manque de données scientifiques. Le guide de bonne pratique doit être lu et interprété comme un « travail en développement » qui devra intégrer de manière systématique les connaissances issues des études scientifiques et synthèses de qualité ainsi que des guides de bonne pratique. Pour de plus amples informations sur l'élaboration de ce guide de bonne pratique, veuillez vous reporter à l'argumentaire (partie B).

Contexte

Ce guide de bonne pratique présente un intérêt pour toutes les structures d'assistance et professions en contact avec des jeunes en Belgique. Il s'agit des groupes suivants : les professionnels des soins de première, les professionnels de la santé actifs dans les institutions ambulatoires, les professionnels de la santé actifs dans les institutions résidentielles, les éducateurs de rue, les conseillers en prévention, les travailleurs sociaux (CPAS, Centre de Conseil de la Jeunesse (JAC, pour « Jongeren Advies Centrum »)), les animateurs socioculturels (y compris les bénévoles des organisations de jeunes, entre autres) et les collaborateurs des écoles (y compris les bénévoles). De plus, le guide de bonne pratique présente également un intérêt pour les réseaux informels s'articulant autour des jeunes qui présentent (éventuellement) un abus de drogues, notamment les parents et la famille. Cependant, les recommandations ne présentent pas toutes un intérêt pour chaque structure d'assistance ou chaque personne. Cela signifie que les utilisateurs de ce guide de bonne pratique doivent évaluer ce qui est valable, adapté et significatif pour leur propre fonction professionnelle et dans le contexte qui est le leur.

Ce guide de bonne pratique décrit bien quels soins sont les plus efficaces, mais par contre pas quel intervenant devrait les prodiguer, étant donné que cela dépend de tas de facteurs locaux. Les utilisateurs du présent guide de bonne pratique doivent déterminer quels soins ils peuvent offrir eux-mêmes et quelles sont les situations dans lesquelles il convient d'orienter un adolescent vers un autre collègue.

Population cible

Ce guide de bonne pratique concerne les jeunes âgés de 12 à 18 ans, quels que soient leurs excès sur le plan de la consommation de drogues, y compris la dépendance. En raison du manque d'études scientifiques portant sur les jeunes présentant une comorbidité, le guide de bonne pratique est destiné aux jeunes qui ne présentent pas de comorbidité importante. L'intervenant doit vérifier si les recommandations de ce guide de bonne pratique peuvent éventuellement s'appliquer aux jeunes atteints de comorbidité.

Il existe deux guides de bonne pratique interconnectés : le guide sur la prévention de l'abus d'alcool et de substances parmi les jeunes (ADAPTE-youth 3) et le guide sur le dépistage, l'évaluation et le traitement des jeunes présentant un abus de drogues (ADAPTE-youth 1).

Il sera mentionné lorsque les recommandations sont spécifiques à une partie de ce groupe, par exemple les jeunes jusqu'à 15 ans ou les jeunes de 16 et 17 ans. L'intervenant devra vérifier si une recommandation peut s'appliquer à un autre groupe cible.

Comme il s'agit de mineurs, les intervenants doivent, sous certaines conditions, informer les parents ou les soignants en tant que représentants légaux ou leur demander leur accord. En outre, les jeunes ont droit au respect de leur vie privée (voir les droits des jeunes).

Parents

Le principe de ce guide de bonne pratique est que l'éducation de l'enfant est la tâche des parents et non des intervenants. Le soutien et le contrôle sont des éléments essentiels de l'éducation. Il s'agit de trouver un équilibre entre le dialogue et le maintien de limites, équilibre s'appuyant sur une relation parents-enfant positive, laquelle est nécessaire pour pouvoir poser des limites et conclure des accords. Elle implique une ouverture dans la communication entre les parents et les enfants, ces derniers se sentant soutenus par leurs parents. Mais une relation de soutien et une communication ouverte ne suffisent pas : les jeunes ont besoin d'une structure et de limites. Il est important qu'ils sachent clairement quelles sont les limites qui comptent dans leur famille et aussi quelles sont les conséquences s'ils les franchissent.

Questions cliniques

Le guide de bonne pratique entend répondre aux questions suivantes qui portent sur l'abus de drogues parmi les jeunes :

1. Comment les intervenants doivent-ils dépister un abus de drogues chez les jeunes ?
2. Comment les intervenants peuvent-ils réaliser au mieux une évaluation chez les jeunes présentant un abus de drogues ?
3. Quelles sont les conditions auxquelles une démarche thérapeutique efficace doit répondre ?
4. Quelles interventions non médicamenteuses (psycho-sociales) vaut-il mieux délivrer ?
5. Quand une admission en service résidentiel est-elle nécessaire pour les jeunes présentant un abus de drogues ?
6. Quelles sont les interventions efficaces pour offrir un soutien à la famille du jeune avec un abus de drogues ?

Quelques questions cliniques ne semblaient pertinentes que pour les jeunes présentant une dépendance aux opiacés

7. Quels médicaments faut-il prescrire ? Et quand faut-il les prescrire ?
8. Quelles interventions combinées (pharmacologiques et psycho-sociales) faudrait-il délivrer et quand ?
9. Quelle est la durée minimale du suivi ? En quoi le suivi doit-il consister ?

Les questions cliniques ont été formulées par un panel constitué d'experts dans le domaine des jeunes et de l'abus de substances (voir Cadre 1). Le panel a formulé encore d'autres questions qui ne n'ont pas été reprises dans ce guide de bonne pratique parce qu'aucune information scientifique à ce sujet n'a été trouvée dans les directives internationales existantes :

- Quelles sont les questions qu'il vaut mieux poser lors de l'anamnèse, et quels examens cliniques ou techniques est-il préférable d'effectuer ?
- Quels sont les outils fiables et valides pour poser le diagnostic d'abus de drogues et d'en déterminer la gravité ?
- Quand faut-il référer en première ligne de soins le jeune avec un abus de drogues aux structures de la seconde ligne?

Structure du document

Ce guide de bonne pratique fait la distinction entre deux extrêmes dans le profil de consommation des patients : le jeune présentant un éventuel abus de drogues, d'une part, et le jeune diagnostiqué avec une dépendance, d'autre part. Dans la pratique, la plupart des jeunes se trouvent quelque part à mi-chemin entre les deux extrêmes. L'intervenant devra déterminer quelles sont les interventions les plus adaptées aux différents jeunes.

Chaque question clinique est suivie de la (des) recommandation(s) pertinente(s). Le système de gradation des niveaux de preuve scientifique utilisé est le système GRADE (GRADE, 2008). Le grade que porte la recommandation se compose du chiffre 1 ou 2 et de la lettre A, B ou C. Le chiffre 1 indique un haut niveau de preuve, ce qui signifie que les avantages de la recommandation sont plus importants que ses inconvénients. Le chiffre 2 indique un faible niveau de preuve, ce qui signifie que les avantages et les inconvénients sont en équilibre ou qu'il y a plus de désavantages que de bénéfices. Les lettres indiquent l'ampleur et la qualité des études scientifiques : A signifie « bon », B signifie « moyen », et C « faible » ou « inconnu ». Chaque recommandation est suivie d'un argumentaire avec des informations sur sa mise en application dans la pratique. Nous avons chaque fois indiqué d'où provient l'argumentaire : il s'agit soit du guideline source, soit du panel, soit des acteurs ayant évalué le guide de bonne pratique

Méthodologie

Ce guide de bonne pratique a été élaboré selon la procédure ADAPTE (Fervers et coll., 2006), une procédure destinée à 'adapter' par étapes les guidelines nationaux et internationaux au contexte local. Un panel d'experts a été réuni pour suivre cette procédure. Ils ont formulé les questions cliniques et ont évalué toutes les recommandations quant à leur pertinence et leur applicabilité dans le contexte belge. Lorsqu'une recommandation fut sélectionnée, le panel lui a attribué un grade (voir plus haut). Le fondement de ces recommandations est détaillé dans la partie B.

Cadre 1. Composition du panel

Le panel se composait des personnes suivantes :

Experts sur le fond :

- Cis Dewaele, éducateur de rue, coordinateur de Vlastrov (fédération flamande des travailleurs sociaux de rue), Berchem
- Michel Vanhalewyn, médecin généraliste à Bruxelles ; collaborateur et auteur de recommandations de bonne pratique, Société scientifique de médecine générale (SSMG)
- Kris Van Gerwen, infirmier en chef / thérapeute en thérapie familiale multidimensionnelle, Cannabis clinic CHU Brugmann, Bruxelles
- Hannelore Sanders, coordinatrice des soins ambulants en matière de toxicomanie, Drugzorg VZW Kompas, Roulers/Courtrai
- Koen Leysens, pédagogue/psychothérapeute, centre de santé mentale Vagga, Anvers
- Arlette Wertelaers, médecin du centre Katarsis, centre de détoxication des toxicomanes, à Genk ; médecin LOGO (réseaux de santé locorégionaux) au service Santé publique de la province du Limbourg.
- Anja Schillebeeks, thérapeute du centre Katarsis, centre de détoxication des toxicomanes, à Genk
- Georges van der Straten, directeur de la communauté thérapeutique Trempline asbl à Châtelet
- Johan Sools, thérapeute comportementaliste / psychologue clinique, clinique psychiatrique Broeders Alexianen, à Tirlemont
- Deux représentants d'Al-Anon (qui souhaitent garder l'anonymat), Association pour parents et amis d'alcooliques, Anvers et Bruxelles
- Bert Mostien, cadre / coordinateur en matière de drogues, Lutte contre la drogue, province de Flandre-Orientale, Gand
- Lore Willem, collaboratrice scientifique de l'unité d'enseignement et de recherche en Psychologie clinique, Université catholique de Leuven (KUL)

Président, secrétaire et modérateur adjoint

- Paul van Royen, médecin généraliste, chef de service, coprésident de l'unité d'enseignement et de recherche en soins de première ligne et interdisciplinaires de l'Université d'Anvers, vice-président de la commission Recommandations de Domus Medica
- Trudy Bekkering, épidémiologue, Centre pour la méthodologie de la recherche pédagogique, Université catholique de Leuven (KUL), secrétaire
- Karen Smets, médecin généraliste, unité d'enseignement et de recherche en soins de première ligne et interdisciplinaires, Université d'Anvers, modératrice adjointe
- Karin Hannes, éducatrice sociale, Centre pour la méthodologie de la recherche pédagogique, Université catholique de Leuven (KUL), modératrice adjointe

Tous les membres du panel déclarent ne pas avoir de conflit d'intérêt.

Définitions, concepts et abréviations

Abus de drogues : (Angl. Substance misuse) intoxication par des substances psychoactives ou consommation régulièrement excessive et/ou dépendance, entraînant des problèmes sociaux, psychologiques, physiques ou d'ordre juridique. Ce terme recouvre la consommation problématique de substances, qu'elles soient légales ou illicites (y compris l'alcool lorsque sa consommation va de pair avec celle d'autres substances) (d'après NICE, 2007a).

Dépendance : (Angl. Dependence) l'OMS définit la dépendance comme la forte envie de prendre une substance ou l'impression d'être contraint de la prendre, la difficulté d'en maîtriser la consommation, la présence d'un état physique de manque, la tolérance dans la consommation de la drogue, la négligence des autres plaisirs et intérêts et la poursuite de la consommation de la substance malgré la conscience des dommages pour soi-même et pour les autres (d'après NICE, 2007b). (voir Cadre 2)

Cadre 2. Critère de la dépendance

Les critères sont les suivants :

- Tolérance :

- besoin de quantités nettement majorées de la substance pour obtenir une intoxication ou l'effet désiré ;
- effet nettement diminué en cas d'usage prolongé de la même quantité de substance.

- Sevrage :

- syndrome de sevrage propre à la substance consommée ;
- prise de la même substance pour soulager ou éviter les symptômes de sevrage.

- La substance est souvent prise en quantité supérieure ou sur un laps de temps plus long que ce que la personne avait envisagé.

- Impossibilité d'arrêter ou réduire la consommation.

- Temps considérable consacré aux activités liées à la consommation.

- D'importantes activités sociales, occupationnelles ou de loisir sont abandonnées ou réduites en raison de la consommation de la substance.

- Poursuite de l'utilisation de la substance malgré la conscience des problèmes qu'elle engendre.

(Möbius, 2009)

Traitement axé sur l'abstinence : l'objectif est que le jeune diminue l'abus de drogue pour finalement arrêter tout à fait d'en consommer. Ce traitement peut augmenter le risque de surdosage après une période d'abstinence parce que la tolérance aux drogues diminue (d'après NICE, 2007b).

Limitation des dommages/réduction des risques : vise à prévenir ou réduire les conséquences négatives associées à l'abus de drogues, pour les jeunes eux-mêmes ou plus largement à l'échelle de la société. Il n'est pas nécessaire que la consommation proprement dite diminue (bien que ce soit une des possibilités pour éviter d'autres dommages). Par exemple, les services d'échange de seringues et d'aiguilles visent à réduire les infections dues à des virus transmissibles par le sang en stimulant des modes d'injection des drogues plus respectueux de la sécurité (d'après NICE, 2007b).

Traitements de maintenance / consommation contrôlée : il s'agit de maintenir sous médicaments le jeune dépendant des opiacés en lui prescrivant des substituts des opiacés (méthadone ou buprénorphine). Ce traitement a pour but de réduire ou stopper la consommation de drogues illicites et de diminuer voire faire disparaître les dommages qui y sont associés (d'après NICE, 2007b).

Dépistage : Activité par laquelle on tente d'identifier un abus de drogues non encore diagnostiqué chez un jeune ou dans un groupe de jeunes. Pour ce faire, on utilise des tests ou des questionnaires permettant de faire

la distinction entre les jeunes qui (vraisemblablement) abusent de drogues et ceux qui n'en consomment pas (Van Driel M et Chevalier P, 2008).

Interventions brèves (Angl. : brief interventions) : interventions se composant tout au plus de deux séances et dont le but essentiel est de renforcer la motivation pour modifier la consommation abusive de drogues. Elles peuvent viser l'abstinence ou la réduction du comportement néfaste associé. Les interventions brèves consistent à exprimer de l'empathie à l'égard du jeune, à laisser la place à la résistance et à faire des commentaires. Elles visent la résolution de l'ambivalence à propos de la consommation de drogues et l'instauration un traitement possible (d'après NICE, 2007b).

Détoxication : processus par lequel le jeune se désaccoutume des effets des substances psychoactives. En tant qu'acte médical, la détoxication doit être supervisée et réalisée avec efficacité dans le respect de la sécurité pour réduire au minimum les symptômes de sevrage (d'après NICE, 2007b).

Psychoéducation : combine l'éducation sur les virus transmissibles par le sang (tels que le VIH et le virus de l'hépatite C) et l'acquisition d'aptitudes comme l'affirmation de soi, des compétences en communication et le respect de la sécurité en matière de comportement sexuel à risque et d'injections comportant des risques. Elle offre aussi aux jeunes l'occasion de poser des questions et de recevoir des réponses appropriées. Cette intervention se compose le plus souvent quatre à six séances et se déroule dans des cadres divers comme les centres orientés sur le traitement de maintenance à la méthadone, les programmes d'échange de seringues et les programmes de proximité (d'après NICE, 2007b).

Programmes communautaires : programmes encadrés par la communauté et visant le développement de celle-ci. La pratique des groupes d'entraide où les clients, en communauté, recherchent des solutions par eux-mêmes est en lien avec les travaux communautaires. Les programmes communautaires sont accessibles à tous (d'après VAD 2009).

Sevrage précipité : lié à l'apparition rapide et brutale des symptômes de sevrage. Se produit lorsqu'un antagoniste (ou un antagoniste partiel, tel que la buprénorphine) est administré à un client dépendant des agonistes opiacés. Comme la buprénorphine se lie aux récepteurs des opiacés avec plus de force que les opiacés, elle en déloge les opiacés présents. Dès lors, le client ressent la perte de l'effet des opiacés, et les symptômes de sevrage apparaissent (d'après VAD, 2009).

Prise en charge post-thérapeutique : accompagnement d'intensité faible et décroissante proposé sur le long terme, axé sur le maintien des effets thérapeutiques obtenus au cours de la phase précédente du traitement primaire, avec pour objectif la réintégration dans la société et une plus grande autoresponsabilité (Source : De Wildt et Verster, 2005).

Droit des jeunes dans les cadres légaux

Du point de vue juridique, les jeunes sont sous l'autorité de leurs parents, et les parents devraient pouvoir décider pour leur enfant. En vertu de deux règles législatives, le jeune peut exercer lui-même certains droits si l'intervenant est d'avis qu'il en a la capacité. La capacité suppose que le jeune soit suffisamment capable d'estimer quel est son intérêt et quelles sont les conséquences de ses décisions ou de ses actes. La règle législative en vigueur dépend de la catégorie professionnelle et du secteur dans lequel l'intervenant est actif.

La loi relative aux droits du patient concerne tous les professionnels des soins de santé. Cette loi stipule entre autres que les jeunes doivent être écoutés et impliqués dans les prises de décisions. Pour les très jeunes enfants, la voix ayant le plus de poids est celle du parent. En fonction de facteurs tels que l'âge et la phase de développement de l'enfant, la voix du jeune prendra de plus en plus de poids jusqu'à ce qu'il soit tout à fait

indépendant. À cet égard, l'intervenant doit faire entrer en ligne de compte le caractère invasif de la décision. Cette loi ne prévoit pas un âge déterminé à partir duquel les mineurs sont tenus pour capables (Loi relative aux droits du patient, 2007).

Le décret relatif au statut du mineur dans l'aide intégrale à la jeunesse (valable uniquement en Flandre) décrit les droits du jeune dans les différents secteurs de l'aide intégrale à la jeunesse. Il s'agit de l'aide sociale générale (*Algemeen welzijnswerk*), des centres d'encadrement des élèves (CLB, *Centrum voor Leerlingenbegeleiding*), de la santé mentale, des soins aux personnes avec un handicap, de Kind en Gezin, de la Bijzondere Jeugdbijstand, des Centra voor Integrale Gezinszorg. Ce décret présuppose que les jeunes peuvent eux-mêmes prendre des décisions à partir du moment où ils disposent d'une « capacité de discernement suffisante », et l'on suppose en général que c'est le cas à partir de l'âge de douze ans. (Banque de données Droit de la jeunesse : 2006-03)

Pour la mise en application de ces lois, il est important que les intervenants tâchent de motiver les jeunes à prendre les décisions importantes avec leurs parents. Si le jeune ne le veut vraiment pas, c'est lui qui a le dernier mot – tout au moins à partir d'un certain âge ou degré de maturité.

Les intervenants ont tenus au secret professionnel. Le secret professionnel est également requis pour ce qui concerne les mineurs d'âge, même vis-à-vis des parents. Les intervenants ne peuvent donc pas donner aux parents d'un jeune n'importe quelle information le concernant ; il vaut mieux avoir l'accord du jeune. Mais c'est toutefois possible dans certaines circonstances, notamment lorsque l'enfant ne jouit pas du discernement suffisant, lorsque des décisions vraiment importantes doivent être prises, par exemple à propos d'un traitement médical important, ou lorsqu'il est de l'intérêt de l'enfant de déroger au secret professionnel. Ceci n'est possible que pour autant que le jeune ne s'y oppose pas expressément ou si l'on peut déduire de sa conduite qu'il a donné son consentement tacite. À cet égard, il est important que l'intervenant stimule d'abord le jeune à communiquer lui-même à son entourage les informations en question.

Le secret professionnel peut être rompu dans les cas où le silence de l'intervenant pourrait représenter un danger grave ou imminent pour le jeune ou pour d'autres personnes. Communiquer un minimum de données aux parents est en général accepté à condition que le jeune n'y voie pas d'inconvénient.

Le secret professionnel au sens strict n'existe pas pour les enseignants ni pour les enseignants de confiance. Le secret professionnel auquel ils sont soumis est un devoir de discrétion, et ils doivent faire preuve de prudence lorsqu'ils communiquent des informations. En revanche, pour les professionnels des centres PMS, il existe bien un secret professionnel au sens strict. Lorsque l'on envisage de partager des informations, il est important de vérifier si les interlocuteurs sont ou non tenus au secret professionnel. L'intervenant doit d'abord clarifier ce point avant de communiquer des informations. La transparence vis-à-vis du jeune a également son importance (Banque de données Droit de la jeunesse : 2006-06 et 2011-09/10).

Abréviations

AR : Arrêté royal

CAST : Cannabis Abuse Screening Test (test de dépistage de la consommation excessive de cannabis)

CAW : Centrum Algemeen Welzijnswerk (Centre d'aide aux personnes, CAP)

CLB : Centrum voor Leerlingenbegeleiding (centre d'encadrement des élèves)

CPAS : Centre public d'aide sociale

CPQ-A-S : Questionnaire sur les problèmes liés au cannabis, version abrégée

CRAFFT: Car, Relax, Alone, Forget, Friends, Trouble (voiture, détente, solitaire, oubli, amis, problèmes). Outil de dépistage

ESPAD : European School Survey Project on Alcohol and Other Drugs (projet d'enquête paneuropéenne sur l'alcool et d'autres drogues en milieu scolaire)

FIST : Groupe d'entraide pour parents de toxicomanes

GRADE : Grading of Recommendations Assessment, Development and Evaluation

HBSC : Health Behaviour in School-aged Children (enquête sur les comportements de santé des élèves)

JAC : Jongeren Advies Centrum (Centre de Conseil de la Jeunesse)

NICE : National institute for Clinical Excellence (UK)

OMS : Organisation mondiale de la santé

SEM-j : Individueel Screeningsinstrument Ervaringen met Middelengebruik – jongeren (outil de dépistage individuel des expériences en matière de consommation de substances – pour les jeunes)

SIGN : Scottish Intercollegiate Guidelines Network (Écosse)

VAD : Vereniging voor Alcohol en andere Drugs (Association flamande pour les problèmes d'alcool et autres drogues)

VIH : Virus de l'immunodéficience humaine

1.2 Dépistage

Pour une lecture aisée, le présent guide de bonne pratique adopte les règles linguistiques suivantes :
Le masculin l'emporte sur le féminin et désigne des personnes des deux sexes.
Par « parents », on entend les parents et/ou soignants du jeune et/ou les responsables de son éducation.
Par « membres de la famille », on entend les parents et les frères et sœurs ainsi que les autres personnes qui remplissent ces rôles.

Comment les intervenants doivent-ils détecter un abus de drogues chez les jeunes ?

Recommandation 1

Dans les lieux où l'abus de substances se rencontre fréquemment, questionner systématiquement les jeunes pour rechercher la consommation récente de drogues et pour connaître le type de substance, le mode d'administration, la quantité consommée ainsi que la fréquence d'administration.
(consensus)

Recommandation 2

Utiliser les outils existants pour le dépistage et l'évaluation chez les jeunes qui font une consommation abusive de drogues et chez ceux qui présentent un risque d'abus.
(consensus)

Argumentaire

La consommation abusive de drogues peut être fréquente dans les structures entre autres des soins de santé mentale et de la justice. À ce jour toutefois, la littérature scientifique ne donne pas d'informations plus précises sur ces structures.

Panel : les outils suivants peuvent être pertinents. Le questionnaire CRAFFT est un outil abrégé pouvant être utilisé par tous les intervenants, y compris ceux qui sont employés dans les soins de première ligne. Le SEM-j est un outil plus détaillé destiné aux agents de l'aide spéciale à la jeunesse (*bijzondere jeugdzorg*), des centres d'encadrement des élèves (CLB, *Centrum voor Leerlingenbegeleiding*) et du Centre de Conseil de la Jeunesse (JAC, *Jongeren Advies Centrum*). Pour le dépistage spécifique de la consommation abusive de cannabis, les outils recommandés sont le CPQ-A-S et le CAST.

CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble (voiture, détente, solitaire, oubli, amis, problèmes) (Knight et al 1999) (voir annexe)

Cet instrument est destiné à détecter l'abus d'alcool et de drogues chez les jeunes. Il se compose de six questions. Chaque question à laquelle le jeune répond par l'affirmative donne 1 point. Un résultat final de 2 ou plus indique un risque accru de problèmes dus à l'abus d'alcool ou de drogues.

SEM-j (outil de dépistage individuel des expériences en matière de consommation de substances – pour les jeunes).

Cet instrument permet d'évaluer le niveau de gravité de la consommation de substances chez un jeune ainsi que la nécessité d'assurer un suivi par un accompagnement spécifique aux consommateurs d'alcool et de drogues. Il peut être utilisé dans le cadre de l'accompagnement individuel d'un jeune (de 12 à 18 ans). L'utilisation du SEM-j présuppose une formation spécifique de l'intervenant, qui doit aussi disposer de

suffisamment de temps. Une version en ligne est disponible à l'adresse suivante : <http://www.vad.be/sectoren/onderwijs/secundair-onderwijs/sem-i.aspx> (en néerlandais).

CPQ-A-S (Proudfoot et al, 2010) : outil de dépistage abrégé destiné à détecter les jeunes présentant un risque élevé de consommation abusive de cannabis (voir annexe). Il comporte douze items. Chaque question à laquelle le jeune répond par l'affirmative donne 1 point. Lorsque le score atteint ou dépasse 3 points, une évaluation complémentaire plus détaillée est recommandée.

CAST (Cannabis Abuse Screening Test (test de dépistage de la consommation excessive de cannabis), Legleye et al, 2007). Cet instrument, comportant 6 items, a été développé spécialement pour détecter la consommation abusive de cannabis chez les jeunes. Il permet également de poser des questions sur d'éventuelles difficultés à maîtriser la consommation et sur les conséquences négatives pour la santé ou les relations sociales.

Acteurs :

Les intervenants font observer qu'une formation suffisante est une condition importante pour l'administration de ces instruments.

Recommandation 3

Dans les lieux comme les soins de première ligne, les services hospitaliers généraux et les services des urgences, questionner les jeunes qui présentent des symptômes pouvant signaler l'abus de substances afin de rechercher la consommation récente de drogues. Parmi les symptômes possibles, citons :

- les douleurs thoraciques aiguës
 - la psychose aiguë
 - les troubles de l'humeur et les troubles du sommeil
- (consensus)

Argumentaire

Les personnes présentant un abus de drogues (principalement les consommateurs d'opiacés) peuvent se présenter avec toute une série de problèmes de santé et de problèmes sociaux, tels que :

- problèmes physiques (par exemple thrombose, abcès, overdose, hépatite B et hépatite C, VIH, problèmes circulatoires et problèmes cardiaques),
- problèmes mentaux (par exemple dépression, angoisses, pensées paranoïdes et suicidaires) ;
- problèmes sociaux (par exemple problèmes relationnels, problèmes financiers, chômage et situation de sans-abri) ;
- problèmes d'ordre pénal.

Panel : Cette recommandation est particulièrement pertinente car le lien entre ces symptômes et la possibilité d'une consommation abusive de drogues est trop peu établi. Cependant, cette liste n'est pas exhaustive.

Acteurs : La plupart des jeunes interrogés seraient prêts à répondre à ces questions si elles sont clairement en lien avec leur demande d'aide.

1.3 Évaluation

Comment les intervenants peuvent-ils réaliser au mieux une évaluation chez les jeunes présentant un abus de drogues ?

Recommandation 4

Au cours de l'évaluation des jeunes âgées de 16 à 18 ans, prendre en considération les éléments suivants :

- besoins médicaux, psychologiques et sociaux du jeune
- antécédents d'abus de drogues
- expériences éventuelles de traitements antérieurs
- objectifs en matière de consommation de drogues
- préférence du jeune pour un traitement déterminé

(consensus)

Argumentaire

Une bonne évaluation est essentielle pour la prise en charge des jeunes qui envisagent un traitement. L'évaluation est un processus continu se déroulant à chaque contact entre le jeune et l'intervenant et qui peut durer plusieurs années.

L'évaluation poursuit l'objectif suivant : confirmer qu'il y a consommation abusive de drogues (par l'anamnèse, l'examen physique, l'analyse d'urine), déterminer le degré de dépendance, détecter d'éventuels problèmes liés à la consommation de drogues, évaluer le comportement à risques, identifier d'autres problèmes médicaux, sociaux et mentaux ainsi que la motivation pour un changement, déterminer le niveau approprié d'expertise nécessaire ainsi que la nécessité d'un médicament de substitution, et, au besoin, orienter vers ou coopérer avec l'aide à la jeunesse, des spécialistes et d'autres intervenants ou coopérer avec eux.

En outre, il faudrait également donner immédiatement des conseils concernant la réduction des dommages notamment par l'accès éventuel à des aiguilles et des seringues stériles, ainsi que le test de dépistage de l'hépatite B et C et du VIH et la vaccination contre l'hépatite B.

Panel : Cette recommandation s'adresse plutôt aux médecins qu'aux autres intervenants du secteur des soins de santé. L'anamnèse ne devrait pas se limiter au jeune car elle a pour but de faire l'inventaire des besoins. Il faut aussi interroger l'entourage. De manière générale, ces questions sont également pertinentes pour les jeunes jusqu'à 16 ans, la liste des questions est globalement la même, mais l'accent pourra porter davantage sur certains aspects (la famille et l'école notamment sont alors des éléments importants de leur environnement social). Par ailleurs, la manière de poser les questions devrait être adaptée à l'âge du jeune.

Acteurs : Les intervenants font observer que, pour réaliser l'évaluation, il est nécessaire de disposer de suffisamment de temps et de moyens et d'avoir été formé à l'effectuer.

Recommandation 5

Rechercher la présence d'une dépendance aux opiacés et sa gravité ainsi que la consommation d'autres substances (alcool, benzodiazépines et stimulants) chez les jeunes qui veulent suivre une cure de détoxication de la dépendance aux opiacés. L'évaluation comporte les points suivants :

- Réaliser une analyse d'urine. Des tests rapides tels qu'un test sur la salive et un test de l'haleine sont également possibles ;
- Effectuer une évaluation clinique des symptômes de sevrage aux opiacés (éventuellement au moyen des échelles de mesure officielles). Les échelles de mesure ne remplacent pas l'examen clinique ;
- S'enquérir des antécédents de consommation abusive de drogues et d'alcool chez les jeunes et des traitements éventuels déjà suivis ;
- S'enquérir des antécédents de troubles médicaux physiques et psychiatriques et des traitements éventuels ;
- Tenir compte du risque d'acte autodestructeur, de perte de tolérance aux opiacés et d'abus de drogues ou d'alcool en réaction aux symptômes de sevrage aux opiacés ;
- Tenir compte de la situation personnelle et sociale du jeune, y compris de sa situation en matière d'emploi et de sa situation financière, de son logement, du soutien social et des activités criminelles ;
- Tenir compte de l'impact de l'abus de drogues sur les parents et les autres membres de la famille ;
- Développer des stratégies pour limiter le risque de rechute, en tenant compte du réseau de soutien du jeune.

(consensus)

Argumentaire

L'évaluation clinique est importante pour déterminer si la détoxification est indiquée chez un jeune (en d'autres mots, pour déterminer s'il est dépendant des opiacés). Le cas échéant, il faudra déterminer l'approche la plus efficace pour la mise en œuvre de la détoxification.

Evaluation clinique de la dépendance

La plupart des jeunes qui se présentent pour une détoxification ont des antécédents manifestes de dépendance aux opiacés : de la méthadone ou de la buprénorphine leur a éventuellement été prescrite ou ils présentent des signes cliniques de consommation illégale d'héroïne (tels que de nombreuses cicatrices d'injections). Certains font une consommation abusive d'opiacés en plus des médicaments prescrits. La dépendance aux opiacés va souvent de pair avec l'abus et/ou la dépendance aux benzodiazépines, à l'alcool ou aux stimulants tels que la cocaïne ou les amphétamines.

Le diagnostic de dépendance aux opiacés est le plus souvent posé initialement après un examen clinique, mais il peut aussi s'appuyer sur des analyses de sang et d'urine ou sur des échelles psychométriques. Pour évaluer la dépendance, l'examen clinique doit chercher à déterminer le modèle de consommation de drogues, la nature et l'ampleur de l'abus de drogues et les épisodes thérapeutiques antérieurs. (DH, 1999)

Des faits scientifiques probants permettent d'affirmer qu'on obtient de meilleurs résultats, tant pour les jeunes que pour l'environnement influencé par l'abus, en impliquant l'environnement tout au long du traitement. (Copello et coll. 2005)

Panel : Chez les jeunes, il faut certainement mettre la famille à contribution dans l'évaluation. Les membres de la famille voient les problèmes d'un autre point de vue (par exemple l'école, le travail), ce qui permet de se faire une idée plus personnalisée des problèmes du jeune. En outre, les médicaments sont souvent donnés par le biais des parents pour favoriser l'adhérence au traitement.

Recommandation 6

En cas de diagnostic de dépendance chez un jeune, des professionnels de la santé spécialement formés effectueront les tests de dépistage de drogues conformément aux normes déterminant les procédures de travail et de sécurité.

(consensus)

1.4 Traitement

Quelles sont les conditions auxquelles une démarche thérapeutique efficace doit répondre ?

Recommandation 7

Collaborer avec les parents, les structures sociales d'enseignement, les soins de santé mentale pour les jeunes, les centres d'encadrement des élèves ou d'autres spécialistes pour :

- apporter un soutien au jeune.
- au besoin, adresser le jeune à un autre service (tel que service d'aide sociale, service des logements ou service de l'emploi), sur la base d'un plan accepté d'un commun accord. Le plan doit tenir compte des besoins du jeune et comporter des entretiens concernant l'évaluation.

(consensus)

Argumentaire

Panel : Le travail avec les parents ne suffit pas. Les intervenants devraient apprendre aux personnes de l'entourage d'adopter une autre attitude vis-à-vis du jeune, une autre perception à son égard. L'aspect « soins autonomes » est également très important pour les personnes de l'entourage. Ceci cadre avec la tendance générale des soins « centrés sur le patient », où il est important que l'intervenant connaisse bien les raisons de l'arrivée du jeune, qu'il examine les demandes d'aide et explore ce qui le trouble. Par ailleurs, le jeune souhaite de la compréhension pour sa personne dans sa globalité, tant pour ses besoins émotionnels que pour les autres questions. Le jeune désire aussi être d'accord avec l'intervenant sur la nature de son problème et sur la manière de le traiter. Ensuite, il est important que les soins centrés sur le patient soient une priorité de la prévention et qu'ils favorisent la santé. Enfin, une relation cohérente entre le jeune et l'intervenant est un élément important. (Stewart, 2001).

Recommandation 8

Pour que les jeunes puissent, en toute connaissance de cause, prendre des décisions concernant leur traitement et leur prise en charge, nous conseillons que, lors du premier contact et de toutes les évaluations formelles, les professionnels de la santé expliquent les possibilités de traitement axées sur l'abstinence, le contrôle de la consommation et la limitation des dommages.

(consensus)

Argumentaire

Panel : Chez le jeune, l'abstinence doit être l'objectif premier dans tous les cas. Lors du premier contact, aucune autre possibilité ne devrait être mentionnée. S'il apparaît que l'abstinence n'est pas réalisable, on peut parler des autres objectifs thérapeutiques, tels que limiter les dommages, pour éviter que les jeunes ne perdent le contact avec l'aide sociale. A cet égard, la relation entre l'intervenant et le jeune est l'élément

prioritaire. Les intervenants doivent toujours se demander si le jeune est capable de faire un choix mûrement réfléchi.

Recommandation 9

Discuter avec les jeunes qui font une consommation abusive de drogues et/ou se présentent pour une détoxification afin de savoir s'il faut impliquer leur famille ou leurs soignants dans le plan de traitement. Veiller au respect de la confidentialité des informations.

(consensus)

Argumentaire

Il ressort d'une étude que nombreux sont les membres des familles qui se sentent exclus de la participation au traitement du jeune. Certaines familles avaient l'impression que les intervenants se retranchaient derrière le principe de « confidentialité » alors qu'ils auraient pu donner des informations sur le traitement. (Bancroft et al 2002)

Panel : La confidentialité en matière de prise en charge des jeunes est inscrite dans le décret relatif au statut du mineur. Pour de plus amples informations, se reporter à la liste des concepts.

Acteurs: La confidentialité peut contribuer au maintien des problèmes de drogue..

Recommandation 10

Prodiguer aux jeunes présentant un abus de drogues les mêmes soins qu'à toute autre personne et leur accorder le même respect. Respecter de même leur vie privée.

(consensus)

Argumentaire

Acteurs : Si leurs parents n'étaient pas (encore) au courant de leur abus de drogues, la majorité des jeunes ayant un contact avec l'assistance sociale ne le leur diraient pas, parce qu'ils souhaitent résoudre eux-mêmes leurs problèmes ou ne veulent pas accabler leurs parents.

Recommandation 11

Lorsque les jeunes présentant un abus de drogues sont adressés à un autre établissement de soins, transmettre avec efficacité un plan de traitement clair et accepté d'un commun accord afin d'éviter la perte de contact.

(GRADE 1C)

Recommandation 12

Toutes les interventions pour les jeunes présentant un abus de drogues sont effectuées par des professionnels de la santé compétents ou correctement supervisés.

(consensus)

Argumentaire

Panel : Cette recommandation (et celles qui précèdent) porte(nt) sur l'établissement et le maintien d'une bonne relation avec le patient. Ce point est crucial pour arriver à des résultats positifs, certainement chez les jeunes.

Quelles interventions non médicamenteuses (psycho-sociales) vaut-il mieux délivrer ?

Recommandation 13

Au cours des contacts systématiques ou opportuns avec les jeunes, donner à tous ceux qui font une consommation abusive de drogues des informations et un conseil minimal sur leur éventuelle exposition aux virus transmissibles par le sang. Y inclure des conseils pour diminuer le comportement sexuel à risque et les injections comportant des risques. Les intervenants doivent envisager de proposer des analyses sanguines pour dépister la présence de virus transmissibles par le sang. (GRADE 1C)

Argumentaire

Acteurs : Il sied d'orienter vers une aide spécialisée.

Recommandation 14

Sans le faire systématiquement, proposer aux jeunes qui font une consommation abusive de drogues des interventions psycho-éducatives en groupes (au cours desquelles des informations sont données sur l'exposition aux virus transmissibles par le sang et/ou sur la diminution du comportement sexuel à risque et des injections comportant des risques (*harm reduction*)). (consensus)

Argumentaire

Panel : Offrir des traitements en groupe à des jeunes qui font une consommation abusive de drogues pourrait avoir un effet néfaste, comme une augmentation de la consommation. La composition du groupe pourrait avoir une influence sur cet effet (Kaminer, 2005).

Recommandation 15 et 16

Si un jeune ou un intervenant exprime des préoccupations particulières concernant l'abus de drogues, donner avec opportunisme un conseil minimal axé sur la motivation aux jeunes qui sont sans contact avec l'assistance sociale ou qui ont un contact limité avec elle. Ces interventions :

- se composent habituellement de deux séances de 10 à 45 minutes chacune ;
- explorent l'ambivalence concernant l'abus de drogues et le traitement possible, dans le but d'augmenter la motivation du jeune à changer son comportement et de faire des commentaires sans porter de jugement.

(GRADE 1C)

Argumentaire

Le conseil minimal dans le traitement de l'abus de drogues comporte deux avantages, à savoir sa facilité d'application et le fait qu'il entraîne moins de problèmes pour le maintien de la prise en charge des jeunes présentant un abus de substance. Le conseil minimal est souvent donné lors du traitement et de l'accompagnement des problèmes liés à la consommation d'alcool (SIGN, 2003).

Il convient de noter qu'une proportion importante des personnes qui font une consommation abusive d'opiacés, de stimulants et de cannabis abusent aussi de l'alcool. Le conseil minimal est une intervention qui peut être réalisée en divers lieux, notamment en institution non médicale. Il peut être donné à des jeunes qui ne suivent pas un traitement conventionnel de la toxicomanie ou comme complément à un traitement structuré conventionnel de la toxicomanie (Ashton, 2005).

Panel : Cette approche ne se justifie que si le jeune choisit de continuer à l'utiliser. Toutefois, cette intervention doit se dérouler dans le cadre d'une approche complète. Le panel est aussi d'avis que des traitements en groupe risquent de provoquer une augmentation de la consommation.

Acteurs : La moitié des jeunes ayant un contact avec l'assistance sociale seraient d'accord à ce que soit délivrée une intervention brève, l'autre moitié pas. À ce propos, ils jugent important que le jeune lui-même veuille cette aide. Pour un abus de cannabis, les jeunes trouvent cette intervention inutile. L'abus de cannabis n'est pas considéré comme problématique.

Pour les connaissances scientifiques provenant de récentes revues de la littérature concernant les interventions motivationnelles, les traitements ambulatoires tels que la TCC et la thérapie familiale et des traitements en groupe, reportez-vous à l'aperçu des données probantes

Quand une admission en service résidentiel est-elle nécessaire pour les jeunes présentant un abus de drogues ?

Recommandation 17

Envisager un traitement en service résidentiel pour les jeunes qui souhaitent devenir abstinentes et qui présentent d'autres problèmes importants sur le plan physique, mental ou social (par exemple en matière de logement). Le jeune doit avoir déjà suivi une détoxification en service résidentiel ou en hôpital, et il faut qu'un traitement psychosocial communautaire précédent se soit avéré insuffisant. (GRADE 1C)

Argumentaire

Il est généralement admis que les centres de traitement en service résidentiel jouent un rôle important dans la prise en charge des jeunes présentant un abus de drogues, et ce aux différents stades de leur traitement. Cependant, on ne dispose pas d'éléments probants pour comparer l'efficacité relative des centres résidentiels et des alternatives communautaires. En outre, on ne sait pas bien à quels sous-groupes de jeunes les traitements résidentiels seraient le plus profitables, on sait très peu de choses sur l'efficacité des différentes approches thérapeutiques et sur leur rapport coût/efficacité, et l'on ignore quelle est la durée de séjour dans ces unités qui correspond au meilleur rapport coût-efficacité. Ces différents éléments pourraient expliquer l'offre restreinte dans les services résidentiels.

Panel : Le traitement en service résidentiel ne devrait pas être limité à ceux qui veulent eux-mêmes devenir abstinentes. Il arrive que le jeune méconnaisse son problème, et, dans ce cas, les adultes doivent pouvoir prendre pour lui la décision d'un traitement en service résidentiel. Chez les jeunes, la présence d'une motivation en début de traitement n'est pas non plus une condition nécessaire. La motivation fait l'objet d'un travail en cours de traitement.

Acteurs : Les intervenants estiment que la sécurité du jeune est également un motif d'admission en service résidentiel. La moitié des jeunes déclarent ne pas être d'accord avec une admission en service résidentiel.

La majorité des jeunes ayant un contact avec l'assistance sociale ne seraient pas d'accord avec une hospitalisation pour un abus de cannabis, mais bien en cas d'abus de substances plus fortes comme la cocaïne ou l'héroïne.

Quelles sont les interventions efficaces pour offrir un soutien à la famille du jeune avec un abus d'alcool ?

Acteurs : Tous les parents interrogés apprécieraient d'être impliqués dans le traitement de leur enfant. Ils indiquent aussi que les intervenants peuvent les questionner sur l'impact de l'abus pour eux-mêmes et leur proposer de l'aide et leur donner des conseils. La majorité des jeunes n'apprécieraient pas que leur famille soit impliquée. Les intervenants doivent être conscients de ce décalage.

Recommandation 18

Interroger les parents et les soignants sur l'impact de l'abus de drogues pour eux-mêmes et pour les autres membres de la famille. Décrire en détail leurs besoins personnels, sociaux et psychiatriques en matière de santé. Donner des conseils et des informations écrites sur l'impact de l'abus de drogues. (GRADE 1C)

Argumentaire

Directive source : Il est important de déterminer l'impact de la consommation abusive de drogues par des jeunes sur leurs parents. Cela permet de mieux connaître les difficultés particulières auxquelles les parents sont confrontés et de mettre en place les meilleures manières de les aider et de les soutenir.

Acteurs : Les intervenants estiment qu'il est important d'impliquer les parents dans la réintégration du jeune après une admission en service résidentiel.

Recommandation 19

Identifier les besoins des parents des jeunes qui font une consommation abusive de drogues.

Ensuite, nous conseillons de

- leur proposer une auto-assistance accompagnée (le plus souvent une seule séance avec remise de documents) ;
- leur donner des information sur les groupes de soutien, par exemple les groupes d'entraide spécifiques pour les parents. Éventuellement les mettre en contact avec eux.

(GRADE 2C)

Recommandation 20

Aux parents de jeunes dépendants des opiacés, donner aussi des informations sur

- la détoxification et les établissements où ce traitement peut être suivi ;
- les groupes d'entraide et groupes de soutien pour les parents.

(consensus)

Argumentaire

Directive source : On a de plus en plus conscience et il est de plus en plus reconnu que la consommation de drogues a une influence sur l'ensemble de la famille et sur les communautés où vivent ces familles. Certains éléments indiquent que les membres des familles de consommateurs ont plus de problèmes que les autres sur

le plan social, au travail et dans leurs loisirs. Cependant, les différences entre ces familles rendent difficile une comparaison directe.

La différence de l'impact sur les membres des familles semble dépendre des rôles et responsabilités au sein de la famille. Adfam (Sims, 2002) a répertorié les besoins des familles des personnes qui présentent un abus de drogues et d'alcool. Un des besoins les plus importants était de parvenir à s'accommoder de la stigmatisation. Pour les parents et les membres des familles, la stigmatisation constituait un obstacle important les empêchant de demander de l'aide. Il s'agissait autant d'une réelle exclusion des services de première ligne que d'une auto-exclusion de crainte d'être jugés.

Une autre nécessité était l'accès aux soins. L'offre de soins pour les familles des personnes présentant un abus de drogues paraissait assez limitée (voir aussi Bancroft et coll., 2002). Même si les soins étaient accessibles, de nombreuses familles n'en étaient pas conscientes ou ne connaissaient pas les démarches à suivre pour pouvoir bénéficier des soins.

En Belgique, les organisations suivantes sont actives pour les membres de la famille des personnes présentant un abus de drogues :

- Similes (www.similes.org) : association pour les membres des familles et les proches des personnes qui ont des problèmes psychiatriques
- www.infordrogues.be
- Via le site Web de Trefpunt Zelfhulp :
 - Groupes familiaux (liés aux centres de traitement) : tels que Sleutel, Kiem, CAW¹ De Kempen, Kompas
 - FIST (groupe d'entraide pour parents de consommateurs)
 - groupe familial Nar-anon Anvers

A ce propos, il convient de faire une distinction entre groupes de parents, destinés à soutenir les parents, et groupes d'entraide, axés principalement sur les jeunes eux-mêmes.

Panel : La disponibilité et la visibilité sont des conditions préalables des groupes de soutien. Un certain nombre de centres organisent des groupes d'entraide pour les parents des jeunes qui abusent de drogues, mais le tout est de savoir si ces groupes sont en nombre suffisant en Belgique. D'après les parents, ce soutien est nécessaire, mais ils éprouvent des difficultés à trouver cette assistance.

1.5 Détoxification des jeunes présentant une dépendance aux opiacés

Le but de la détoxification est d'éliminer les effets des opiacés, et ce sans danger et de manière efficace (OMS, 2006). Les médicaments ont un rôle crucial pour accroître les chances de réussite, avec réduction au minimum des symptômes de sevrage. La détoxification n'est pas un traitement en soi, elle ne doit être administrée qu'en association avec un soutien psychosocial de manière à diminuer le risque de voir les jeunes abandonner prématurément et à augmenter les chances de participation à la poursuite du traitement.

¹ CAW : Centrum Algemeen Welzijnswerk (Centre d'aide aux personnes, CAP)

Pour obtenir le consentement éclairé du jeune, les intervenants doivent lui fournir des informations détaillées sur la détoxication et sur les risques qu'elle comporte. Ces informations couvrent les points suivants :

- les aspects physiques et psychologiques de la détoxication des opiacés, y compris la durée, l'intensité et la sévérité des symptômes et leur prise en charge ;
- l'utilisation d'interventions non pharmacologiques pour maîtriser les symptômes de sevrage ;
- la perte de la tolérance aux opiacés après la détoxication et donc le risque accru de surdosage et de décès en cas de consommation de drogues illicites, risque encore augmenté en cas de consommation d'alcool ou de benzodiazépines ;
- l'importance du soutien à long terme et des interventions psychosociales et pharmacologiques pour maintenir l'abstinence, traiter les troubles psychiatriques concomitants et limiter le risque d'issue fâcheuse (y compris le décès).

Argumentaire

Panel : En Belgique, il existe un cadre juridique pour le traitement de substitution en cas de dépendance aux opiacés (Arrêté royal (AR) du 19 mars 2004 (MB 30/04/04), modifié par l'AR du 6 octobre 2006 (MB 21/11/2006). Ce cadre stipule que le traitement de substitution doit se dérouler sous la supervision de personnes (médecins et autres) qui sont compétentes sur la problématique de la toxicomanie. Tout médecin qui prescrit des traitements de substitution à plus de deux patients simultanément doit remplir certaines conditions. Il doit entre autres être enregistré auprès d'un centre d'accueil agréé.

Recommandation 21

Nous conseillons que la détoxication soit une option thérapeutique directement accessible pour les jeunes dépendants des opiacés qui choisissent cette intervention en donnant leur consentement éclairé.

(consensus)

Argumentaire

Panel : Les possibilités de détoxication pour jeunes sont insuffisantes en Belgique. En cas de nécessité d'une hospitalisation, il y a souvent une liste d'attente. Ces éléments peuvent entraver la mise en œuvre de cette recommandation.

Acteurs : Il est conseillé d'orienter vers une aide spécialisée les jeunes adolescents qui font une consommation abusive d'opiacés.

Quels médicaments faut-il prescrire ? Et quand faut-il les prescrire ?

Recommandation 22

Donner de la méthadone ou de la buprénorphine en première intention pour le traitement de détoxication des opiacés. Le choix entre ces deux médicaments tiendra compte des éléments suivants :

- Le jeune prend-il actuellement de la méthadone ou de la buprénorphine comme traitement de soutien ? Dans l'affirmative, la détoxication débute normalement avec le même médicament.
- Le jeune a-t-il une préférence ?

(GRADE 1C pour le choix du médicament)

Argumentaire

Directive source : L'approche la plus simple en matière de détoxication consiste à diminuer la dose d'un médicament de substitution des opiacés, par exemple de la méthadone ou de la buprénorphine, pendant une certaine période. Ce médicament doit empêcher l'apparition des symptômes de sevrage. En fonction du médicament et de la dose de départ, la détoxication peut durer de plusieurs jours à plusieurs mois.

Comparativement aux autres médicaments de cure de détoxication tels que les agonistes alpha2-adrénergiques et les autres agonistes opiacés, la méthadone et la buprénorphine semblent toutes deux efficaces pour diminuer les symptômes de sevrage. La dihydrocodéine ne semble pas efficace comparativement à la buprénorphine. On ignore si, pour la détoxication, il y a une différence entre la méthadone et la buprénorphine en termes d'efficacité. La clonidine entraîne plus d'effets secondaires.

Panel : En Belgique, on a plus d'expérience avec la méthadone, mais la buprénorphine est de plus en plus utilisée.

Recommandation 23

La clonidine ne doit pas s'utiliser en routine pour la détoxication des opiacés.
(GRADE 1C)

Argumentaire

Directive source : La clonidine n'est pas recommandée. Ses effets sont plus faibles que ceux de la buprénorphine. La clonidine donne un risque plus élevé d'hypotension que la méthadone.

Recommandation 24

Pour déterminer la dose de départ pour une détoxication des opiacés, sa durée et le schéma (par exemple linéaire ou par paliers), nous conseillons de tenir compte des éléments suivants, en concertation avec le jeune :

- la gravité de la dépendance (la prudence est de rigueur spécialement lorsqu'on ne connaît pas le degré de dépendance) ;
- la stabilité du jeune (y compris la consommation de plusieurs drogues et d'alcool, et les problèmes de santé mentale concomitants) ;
- la pharmacologie des médicaments choisis pour la détoxication et celle des éventuels médicaments supplémentaires ;
- l'endroit où la détoxication aura lieu.

(GRADE 2C)

Argumentaire

Panel : Tout comme le Dossier Héroïne, les recommandations sur la détoxication aux opiacés, à la page www.vad.be/evidence-based-werken/richtlijnen.aspx, comportent des informations utiles sur l'administration de méthadone ou de buprénorphine (Kinable et Verstuyf, 2010 ; annexe 12.4. de la fiche du produit pour la méthadone, et annexe 12.5 de la fiche du produit pour la buprénorphine).

Tous les jeunes dépendants des opiacés qui rejoignent un programme ou un établissement axé sur l'abstinence doivent être bien informés du risque accru d'une diminution de la tolérance aux opiacés lors d'un surdosage en cas de rechute (Kinable et Verstuyf, 2010).

Lors de l'application de cette recommandation, il convient de tenir compte également de l'âge et du poids du jeune.

Recommandation 25 et 26

Ne pas proposer de détoxication rapide ou ultra-rapide. (GRADE 1C)

Ne pas proposer de détoxication ultra-rapide sous anesthésie générale ou sédation profonde (avec nécessité d'une respiration artificielle). (GRADE 1C)

Argumentaire

Pour la détoxication rapide et la détoxication ultra-rapide, on a recours à des antagonistes opiacés, tels que la naltrexone ou la naloxone, le plus souvent sous anesthésie générale ou sous sédation profonde. Le but est d'induire une détoxication et, par là, d'accélérer le processus, les symptômes de sevrage étant limités par l'anesthésie ou la sédation.

Les programmes de détoxication accélérée ne sont pas conseillés en raison de la complexité des médicaments complémentaires et du degré élevé de supervision infirmière et médicale nécessaire. En outre, ils comportent des risques d'effets indésirables, y compris le décès.

Recommandation 27

La prescription de médicaments supplémentaires pendant la détoxication des opiacés devrait répondre aux conditions suivantes :

- n'avoir lieu que si c'est indiqué sur le plan clinique, par exemple en cas d'agitation, de nausées, de somnolence, de douleur ou de diarrhée ;
- dose efficace minimale et nombre minimum de médicaments nécessaires pour contrôler les symptômes.

Les intervenants doivent être attentifs aux risques découlant des médicaments ajoutés et aux interactions entre ces derniers et l'agoniste opiacé.

(consensus)

Argumentaire

Panel : Les syndromes de sevrage est comparable avec tous les opiacés ; cependant, le délai d'apparition, l'intensité et la durée peuvent être très différents. La gravité du syndrome de sevrage dépend de la drogue consommée, de la dose quotidienne totale, de l'intervalle entre les doses, de la durée de la consommation et de la sensibilité individuelle. Les troubles et les symptômes apparaissent généralement dans les 6 à 12 heures après l'arrêt de la consommation d'un opiacé à courte durée d'action (tel que l'héroïne) et dans les 12 à 48 heures après l'arrêt de la consommation d'une préparation à longue durée d'action (tel que la méthadone). Les plaintes aiguës se composent d'anxiété, de dysphorie, de fringales, d'activité sympathique accrue, de troubles du sommeil, de problèmes gastro-intestinaux, de crampes musculaires et de douleurs osseuses. La phase aiguë est suivie d'une phase de sevrage chronique caractérisée par une diminution du sentiment de bien-être général. (Source : Franken et Van der Brink, 2009)

Des médicaments complémentaires sont administrés pour empêcher l'apparition d'un syndrome de sevrage. Le terme « médicaments complémentaires » recouvre une grande variété de médicaments et d'indications, notamment les médicaments agissant sur le système noradrénergique, tels que la clonidine, qui est administrée en cas de symptômes de sevrage pendant la cure de détoxication des opiacés comme l'héroïne, la morphine et la méthadone.

La clonidine est indiquée en cas d'agitation croissante des membres. Ce médicament provoque une sécheresse de la bouche, de la léthargie, de la sédation et de la faiblesse, et ses effets secondaires les plus importants sont l'hypotension et les vertiges. Étant donné le risque élevé d'hypotension, il est conseillé de ne pas administrer de clonidine en ambulatoire. (Source : Franken et Van der Brink, 2009)

D'autres médicaments complémentaires visent à soulager certains symptômes (comme un antispasmodique en cas de crampes intestinales) ou un ensemble de symptômes (comme des benzodiazépines en cas d'angoisses et pour une sédation, ou des antipsychotiques en cas d'agitation ou pour une sédation).

Les médicaments complémentaires sont surtout importants dans les détoxications par d'autres médicaments que les opiacés, comme la clonidine, qui n'empêchent pas tous les symptômes de sevrage, mais ils sont aussi administrés pour soulager les symptômes au cours de la détoxication par buprénorphine ou méthadone.

Les benzodiazépines peuvent avoir un effet bénéfique chez les jeunes ayant des antécédents d'abus de drogues ou de dépendance aux drogues (alcool et drogues illicites) (VAD, 2008). Le guide belge de bonne pratique pour la prescription des benzodiazépines aux consommateurs de drogues illicites recommande la réserve/prudence lorsqu'on envisage d'instaurer des benzodiazépines pour des troubles du sommeil ou de l'angoisse chez les toxicomanes. Cependant, le niveau de preuve pour cette recommandation est faible.

Recommandation 28

Il convient d'avoir à l'esprit que les médicaments pouvant être administrés pour la détoxication des opiacés peuvent aussi faire l'objet d'une consommation abusive ou être mis en circulation (donnés, vendus...). Il convient donc de considérer les points suivants :

- surveiller l'adhérence du client au traitement ;
- adopter une méthode permettant de limiter le risque de mise en circulation, notamment faire prendre le médicament sous surveillance, au besoin.

(consensus)

Quelles interventions combinées (pharmacologiques et psycho-sociales) faut-il délivrer pour la détoxication des opiacés, et quand ?
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Recommandation 29

Proposer systématiquement des programmes communautaires aux jeunes qui envisagent une détoxication des opiacés. Les exceptions sont les suivantes :

- jeunes qui n'ont pas tiré profit d'une détoxication communautaire antérieure ;
- jeunes qui nécessitent des soins médicaux ou infirmiers en raison de la gravité des problèmes médicaux ou psychiatriques concomitants ;
- jeunes qui doivent suivre une cure de détoxication pour une dépendance à plusieurs substances, par exemple l'alcool et des benzodiazépines ;
- jeunes qui ont d'importants problèmes sociaux limitant les avantages que l'on peut escompter d'une détoxication communautaire.

(GRADE 1C)

Argumentaire

Directive source La détoxification des opiacés peut avoir lieu dans divers établissements : hôpitaux, institutions résidentielles et prisons. A l'heure actuelle, on ne dispose pas de preuve scientifique indiquant que la détoxification aurait de meilleurs résultats dans un contexte de soins déterminé plutôt que dans un autre, et il existe peu d'informations sur lesquelles les professionnels peuvent s'appuyer pour le choix d'un établissement et d'un accompagnement.

Une détoxification en hôpital est généralement proposée après plusieurs échecs du traitement communautaire (SCAN, 2006). Elle a généralement lieu avant que l'on ne propose une détoxification en service résidentiel parce que la plupart des programmes exigent des consommateurs qu'ils soient désaccoutumés avant de les accepter. En outre, une détoxification en hôpital est généralement proposée à ceux pour qui la demande de soins est la plus complexe (SCAN, 2006). Il s'agit par exemple de jeunes dépendants de plusieurs drogues, de jeunes chez qui des problèmes médicaux et mentaux ont été diagnostiqués et de jeunes sans réseau social.

Panel : Les critères utilisables sont les suivants (Source : Kinable et Verstuyf, 2010)

La détoxification en ambulatoire se justifie dans les cas suivants (De Jong et al, 2004) :

1. La période de consommation est brève, la quantité est limitée, l'héroïne est fumée, le patient est jeune ;
2. La consommation n'est pas associée à d'autres rituels éventuels ;
3. Il n'y a pas de dépendance à d'autres substances psychoactives ;
4. Les symptômes de sevrage ont disparu suite à l'instauration de la méthadone de manière adéquate ;
5. Absence de pathologie physique influençant ou ayant influencé la détoxification ;
6. Les soins autonomes n'ont pas souffert de la consommation de substances ;
7. Pas de tentative antérieure d'arrêt, ou les tentatives antérieures en ambulatoire n'ont pas été suivies d'une abstinence dans la durée ;
8. Absence de tableau clinique psychiatrique évident ;
9. Au moins un non-usager est au courant et prêt à soutenir la tentative ;
10. Désir de suivre une cure de détoxification en ambulatoire.

La détoxification en hôpital est indiquée dans les cas suivants (De Jong et al, 2004) :

1. L'héroïne et/ou la méthadone est consommée depuis des années, et, au cours de l'année écoulée, la consommation dépasse 1 gramme d'héroïne ou 60 mg de méthadone par jour.
2. La consommation d'héroïne et/ou de méthadone a lieu tout au long de la journée, et la vie quotidienne tourne autour de l'acquisition de ces substances ;
3. La consommation est associée à celle d'une ou de plusieurs substances psychoactives ;
4. D'importants symptômes de sevrage se sont déjà manifestés antérieurement ;
5. La personne est en mauvais état général ou elle est enceinte ou présente une maladie physique qui devrait avoir ou a eu dans le passé une influence négative sur la détoxification ;
6. Les soins autonomes sont de mauvaise qualité ;
7. Après les détoxifications antérieures, la rechute s'est produite rapidement ; deux détoxifications antérieures ont échoué ; des détoxifications en hôpital ont présenté des difficultés ou ont été temporairement suspendues ;
8. Un tableau clinique psychiatrique devrait avoir ou a eu dans le passé une influence négative sur le résultat de la détoxification ;
9. Il existe peu de contacts avec des non-usagers ;
10. Désir d'une détoxification en milieu hospitalier.

Recommandation 30

La détoxification communautaire comprend normalement les éléments suivants :

- stabilisation préalable de la consommation d'opiacés par un traitement pharmacologique ;
 - coordination effective de la prise en charge par des spécialistes ou des médecins généralistes compétents ;
 - au besoin, interventions psychosociales au cours des phases de stabilisation et d'entretien.
- (consensus)

Argumentaire

Panel : Le Dossier Héroïne (Kinable & Verstuylf, 2010) décrit comme suit l'indication pour le traitement de maintenance par agoniste opiacé : « tout client dépendant des opiacés selon les critères DSM-IV ou ICD-10 avec dépendance physique et pour qui il n'y a pas de contre-indication particulière. Il doit toutefois être capable de donner son consentement au traitement en toute connaissance de cause, et, dans la plupart des pays, un âge minimum, allant de 18 à 25 ans, doit être respecté. »

Recommandation 31

La prudence est de rigueur pour la détoxification des femmes enceintes dépendantes des opiacés.

(consensus)

Argumentaire

Panel : Cette recommandation serait plus claire s'il y était précisé ce qu'on entend par « prudence ». À ce jour, aucune information scientifique n'a été trouvée à ce sujet.

Recommandation 32

Si les jeunes se présentant pour une détoxification des opiacés abusent aussi d'alcool, nous conseillons d'envisager les points suivants.

- Chez les jeunes qui n'ont pas développé de dépendance à l'alcool : essayer de prendre en charge l'abus d'alcool car la consommation d'alcool pourrait augmenter en réaction à l'apparition de symptômes de sevrage aux opiacés ou parce que l'alcool peut venir remplacer l'abus actuel d'opiacés.
- Chez les jeunes qui ont développé une dépendance à l'alcool : proposer une détoxification de l'alcool. Dans la communauté locale ou en prison, la détoxification de l'alcool est effectuée avant la détoxification des opiacés, mais en hôpital ou avec stabilisation dans la communauté locale, les deux détoxifications peuvent se dérouler en même temps.

(consensus)

Recommandation 33

Si un jeune qui se présente pour une détoxication des opiacés est également dépendant des benzodiazépines, nous conseillons d'envisager aussi la détoxication de ces dernières. Pour décider si la détoxication des benzodiazépines doit être entreprise en même temps ou séparément de celle des opiacés, les professionnels tiennent compte de la préférence du jeune et de la sévérité de la dépendance aux deux types de substances.

(consensus)

Argumentaire

Panel : Le choix de la simultanéité ou la succession des détoxications est laissé au patient.

Recommandation 34

Lors du traitement de la dépendance aux opiacés, proposer systématiquement un soutien psychosocial.

(GRADE 1B)

Argumentaire

Panel : Un point capital est que le soutien psychosocial est toujours nécessaire lors du traitement de la dépendance et que le traitement ne doit pas être uniquement pharmacologique. La phase de sevrage ne nécessite que des médicaments, mais ensuite le traitement devrait associer des médicaments et des interventions psychosociales ou consister uniquement en interventions psychosociales.

Recommandation 35

Proposer systématiquement un soutien psychosocial associé au traitement médicamenteux de la détoxication des opiacés.

(GRADE 1C)

Argumentaire

Panel : Le traitement de détoxication des opiacés peut ne comporter que des interventions psychosociales ou consister en l'association de médicaments et d'interventions psychosociales.

Quelle est la durée minimale du suivi des jeunes avec un abus de drogues ? En quoi ce suivi doit-il consister ?

Recommandation 36

Après la réussite de la détoxication des opiacés, proposer à tous les jeunes un traitement de suivi, un soutien et une surveillance dans le but de les aider à rester abstinents. Normalement, le suivi dure au moins six mois, indépendamment de l'établissement où s'est déroulée la détoxication.

(consensus)

Argumentaire

Panel : La rechute après la réussite du traitement est plutôt la règle que l'exception. La prise en charge post-thérapeutique semble avoir une influence positive sur le maintien des résultats obtenus avec le traitement en

hôpital, à savoir pour ce qui est de la réduction au minimum de la durée et de la gravité d'une rechute.
(Source : De Wildt et Verster, 2005)

La prise en charge post-thérapeutique est axée sur le maintien des effets thérapeutiques obtenus au cours de la phase précédente du traitement primaire (De Wildt et Verster, 2005), avec pour objectif la réintégration dans la société et l'autoresponsabilité. La prise en charge post-thérapeutique ne devrait pas tellement avoir pour but le maintien d'une abstinence continue, mais devrait viser à apprendre comment s'accommoder de périodes de consommation et comment retrouver la maîtrise de la consommation.

La forme et l'endroit ne semblent pas faire une grande différence : on n'a pas trouvé de différences entre les interventions se déroulant dans des cadres de références différents (par exemple prévention des rechutes et thérapie interpersonnelle), ni entre la prise en charge post-thérapeutique axée sur le groupe, la consultation par téléphone et la prise en charge post-thérapeutique individuelle. Les interventions de longue durée semblent plus efficaces que celles de courte durée. Une fréquence plus grande donne également de meilleurs résultats. Les interventions axées sur la stimulation des jeunes à poursuivre les activités de prise en charge post-thérapeutique peuvent donc être importantes. (De Wildt et Verster, 2005)

Pour l'abus d'opiacés, il est important que le suivi soit d'au moins six mois. Pour l'abus d'autres substances, telles que le cannabis, les choses peuvent se faire différemment car les efforts visent principalement à renforcer la famille pour soutenir l'utilisateur, de sorte qu'un suivi intensif par des professionnels est moins nécessaire.

Il est moins évident de proposer une prise en charge post-thérapeutique en ambulatoire aux jeunes qui ont été accompagnés en service résidentiel. Pendant leur séjour, ils ont établi une relation de confiance avec les intervenants. Pour ces jeunes, il ne va pas de soi de devoir de nouveau raconter leur histoire à d'autres intervenants avec qui ils devront établir une nouvelle relation de confiance. Un suivi en ambulatoire auprès des intervenants qu'ils connaissent déjà depuis leur hospitalisation n'est pas possible en Belgique du fait de l'organisation actuelle de la prise en charge des accoutumances.

Argumentaire

Acteurs : La plupart des jeunes interrogés seraient prêts à coopérer à un tel suivi après traitement.

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CRAFFT

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 (<http://ncpic.org.au/static/pdfs/cpq-a-s-final-1.pdf>)

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)

(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)

D'après: Legleye S, Karila L, Beck F, Reynaud M in J Subst Use 2007, 12(4), 233 – 242.

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 behaviour 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 ecstasy
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)

Other evidence is labeled level C. 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

How recommendations were made

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.

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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).

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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)

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

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

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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; O'Neill 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)

<i>Psychoeducation vs standard HIV education</i>		
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; O'Neill 1996; Siegal 1995; Sterk 2003; Wechsberg 2004)
<i>Psychoeducation vs self-help booklet</i>		
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)
<i>Standard education vs self-help booklet</i>		
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)
<i>Psychoeducation vs standard education for at-risk subgroup</i>		
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.

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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)

<i>Brief intervention vs control for stimulants or opioids</i>		
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
<i>Brief intervention vs control for cannabis</i>		
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
<i>Individual relapse-prevention CBT vs brief intervention</i>		
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
<i>Group relapse prevention CBT vs brief intervention</i>		
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)

<i>Brief intervention vs standard care for people who misuse drugs and/or alcohol</i>		
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)
<i>Brief intervention vs standard care for people undergoing cocaine detoxification</i>		
1 RCT, N=52, 35 yrs	moderate quality of evidence	Abstinent from cocaine after detox RR 1.44 (1.03 to 2.01)
<i>Brief intervention vs standard care for people undergoing MMT</i>		
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)
<i>Brief intervention vs standard care for people who primarily misuse stimulants or heroin</i>		
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.

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Evidence update

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

Barnett 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.

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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)

<i>Residential TC (therapeutic communities) vs day treatment TC</i>		
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)
<i>10 months residential + 2 months aftercare vs 6 months residential + 6 months aftercare</i>		
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)

<i>Residential treatment vs day treatment</i>		
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.

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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.

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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-step model 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.

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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)

<i>Methadone vs clonidine</i>		
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

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)

<i>Buprenorphine vs methadone</i>		
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
<i>Buprenorphine vs clonidine</i>		
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)

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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)

<i>Methadone: high dose (80-100 mg) vs moderate dose (40-50 mg)</i>		
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).

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

<i>Opioid antagonist-accelerated detoxification under minimal or light sedation</i>		
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)

<i>Rapid detoxification under moderate sedation</i>		
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; achieved 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)
<i>Ultra-rapid detoxification under general anaesthesia or deep (or heavy) sedation</i>		
<i>Ultra-rapid detoxification under general anaesthesia versus detoxification under light or minimal sedation</i>		
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.

		<p>84% vs 54%, RR=1.67 (0.88 to 3.18), N=270</p> <p>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</p> <p>Serious adverse events: RR 3.62 (1.36, 9.61), N=644</p> <p>(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</p>
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(For benefits, RR > 1 and negative SMD favour ultra-rapid detoxification. For adverse events, RR < 1 favours ultra-rapid.)

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- 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 (NICE, 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 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, Davoli M. 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.

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)

<i>Inpatient vs community-based detox</i>		
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 1.15, 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 methadone maintenance. *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.
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- 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.
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- 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, Davoli M. 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.