Evidence-based best practice interventions for the treatment of drug and alcohol abuse: Annotated Information Package

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The AIP was prepared by Sarah Hancock (NZHTA Researcher). It should be read in conjunction with the appended Information Package prepared by Susan Bidwell (NZHTA Information Specialist).

WHAT IS AN ANNOTATED INFORMATION PACKAGE?

Annotated Information Packages (AIPs), prepared by a NZHTA Reviewer, are overviews of an appended Information Package (IP). The IP provides a folder of printed material relating to a specific topic area identified from a systematic search strategy of electronic databases and website resources. The materials include lists of abstracts, key full text papers (where readily available from local resources), and website resources.

The AIP is aimed at giving the client an informed "guided tour" of their IP to increase its usefulness. The AIP report outlines the contents of the IP, highlights information of particular interest and relevance, summarises key articles, and comments on the stage and extent of the research base. It also makes suggestions for publications that the client may wish to have retrieved, and comments on the potential of the topic for evidence-based reviews, such as NZHTA Technical Brief or Systematic Review outputs. AIPs do not involve systematic processes for the critical appraisal of identified research. Another significant limitation is that full text articles of key interest are not retrieved unless freely obtainable from local resources. As a consequence of this, comments and summaries in the AIP may be based on abstracts rather than full text papers.

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Title – Evidence-based practice interventions for the treatment of drug and alcohol abuse: an Annotated Information Package

RESEARCH QUESTION

Are there any guidelines pertaining to interventions for substance abuse, in particular abuse of drugs and alcohol?

BACKGROUND AND SCOPE OF TOPIC

Intervention

The interventions under study for this AIP are all interventions for the treatment of drug and alcohol abuse. In particular, guidelines for interventions will be examined to evaluate the level of the evidence for effectiveness.

Client/population group and condition

The population group of interest are people who present for treatment of a substance abuse disorder, specifically the abuse of drugs and alcohol within primary or secondary health settings. Drug and alcohol consumption continues to increase with consequent adverse effects on physical, psychological and social (including community) well-being. Best practice guidelines for interventions across different age groups, including adults over 18 years of age, older adults (over 60 years) and children and adolescents are presented. Where available, information was included regarding special populations, for example, pregnant or breastfeeding women.

This AIP is one of a series of five reports presenting the best practice recommendations for the treatment of common mental health disorders. The other reports present recommendations for interventions treating mood disorders, schizophrenia/psychotic disorders, anxiety disorders and adjustment disorders. Co-morbid disorders are not specifically examined but are discussed in some guidelines.

Outcomes

The principal outcomes of interest for this AIP are those relating to morbidity, mortality, hospitalisations and episodes of care. In addition, other outcomes such as abstinence from using drugs or alcohol and maintenance of treatment may also be presented.

METHODOLOGY

Search strategy

The search covered systematic reviews and guidelines from 2000 onwards in English. Sources included the Cochrane Database of Systematic Reviews, the Database of Abstracts of Reviews of Effects (DARE), BMJ Clinical Evidence reviews, and the Health Technology Assessment database. Guidelines websites were also searched.

A search of the bibliographic databases Medline, PubMed (added in last 60 days), Embase and PsychInfo were searched for systematic reviews on treatment for drug and alcohol abuse and linked with validated filters for systematic reviews or relevant keywords where no filters were available. The search was completed on July 23 2007.

Full details of the sources searched and the strategies used are given in the attached Information Package.

Methods

The author (SH) carefully considered the contents of the appended IP. An overview of its contents was provided, highlighting information of particular interest and relevance. Clinical guidelines and articles of key interest, where freely obtainable from local resources, were retrieved and summarised. Summary versions of those not available in full text were used to abstract relevant information. Based on the research identified in the IP, a description of the stage and extent of the research base was prepared. Finally, a recommendation was made on whether there was potential for appraisal and evidence-based review of the topic (i.e., as a NZHTA Technical Brief or Systematic Review).

OVERVIEW OF FINDINGS – DRUG ABUSE

A number of recent, high quality guidelines were available which presented best practice recommendations for the treatment of substance misuse disorders. Those that are particularly relevant or thorough are summarised in some detail below. Additional relevant systematic reviews which were not included in the guidelines or were published subsequent to them are also summarised in brief. A list of other reviews which were not summarised in this report appears at the end of this section.

In addition, a number of other guidelines were identified and retrieved, including a number from the United States Substance and Mental Health Services Administration (SAMHSA). Given the large volume of guidelines identified, and also that a recent (June 2007) guideline from the United Kingdom Department of Health covered the subject areas of the SAMHSA guidelines, they have not been reviewed in this AIP. However, executive summary information and instructions for retrieval of these guidelines and other identified guidelines and reviews are provided in the Information Package.

SUMMARY OF KEY RESEARCH

Clinical Guidelines and Standards

United Kingdom Department of Health: Drug misuse and dependence – guidelines on clinical management: CONSULTATION DRAFT JUNE 2007.

(Department of Health 2007)

Commissioned by: DoH (England), and supported by Department of Health, Social Services and Public Safety (Northern Ireland), Scottish Executive Health, and the Welsh Assembly Government
Published: June 2007
The final version of these updates will be[1] available at the web sites of the UK health departments at
www.dh.gov.uk (England)
www.dhsspsni.gov.uk (Northern Ireland)
www.scottishexecutive.gov.uk (Scotland)
Http://new.wales.gov.uk/?lang=en (Wales)

These guidelines provide guidance on treatment of drug misuse in the UK, based on current evidence and professional consensus on how to provide drug treatment for the majority of patients in most instances. They do not provide rigid protocols on how clinicians must provide drug treatment for all drug misusers. The guidance does not override the individual responsibility of clinicians to make

[1] As of end of September it appeared the final version had still not been released.

appropriate decisions in the circumstances of the individual patient in consultation with the patient and/or carer or guardian.

The current report is a draft update on previous guidelines on clinical management of drug misuse which were last revised in 1999. The 1999 guidelines were based on a number of sources for effectiveness including research reviews, evidence from expert committee reports and the clinical experience of respected authorities. In 2004 the National Institute for Health and Clinical Excellence (NICE) was charged with developing a suite of guidelines and technology appraisals on various aspects of the treatment and care of people who misuse drugs.

In updating the guidelines, a working group (consisting of 21 experts, five service users, six carers, and 10 observers) commissioned a series of reviews of the evidence on specific aspects of drug misuse treatment. The working group, by a process of consensus, came to a view of the best available evidence from whatever source. The Update was developed concurrently with the NICE suite of guidance on drug misuse treatment and NICE had observer status on the working group. The NICE guidance incorporates reviews of effectiveness, economic evaluations of interventions and stakeholder comment. The following related NICE guidance reports are available as follows:

Drug misuse: psychosocial interventions. NICE clinical guideline 51 Available from www.nice.org.uk/CG051 (NICE 2007c)

Drug misuse: opiod detoxification. NICE clinical guideline 52 (2007). Available from: http://www.nice.org.uk/CG052#documents (NICE 2007b)

Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. NICE Public Health Intervention Guidance 4 . Available from www.nice.org.uk/PHI004 (NICE 2007a)

Methadone and buprenorphine for the management of opioid dependence. NICE technology appraisal guidance 114 (2007). Available from www.nice.org.uk/TA114 (NICE 2007d)

Naltrexone for the management of opioid dependence. NICE technology appraisal guidance 115 (2007). Available from www.nice.org.uk/TA115 (NICE) 2007e)

The topics on which reviews were commissioned were:

- Drug testing in treatment
- Methadone and buprenorphine dose induction
- Drug treatment for young people
- Drugs and driving
- Drug treatment in prisons
- Cardiac assessment and monitoring
- Treatment of substance use in pregnancy
- Injectable opioid treatment
- Drug testing technology

The guidelines themselves were developed using the best available evidence and can be regarded as a reliable source of information.

The working group considered draft NICE guidelines and final NICE technology appraisals in drafting the update. This update interprets and incorporates the NICE suite of guidance where appropriate but the management and treatment of drug misusers is covered in a more wide-ranging manner than the NICE suite of guidance.

A summary of the principal recommendations from each of the chapters is outlined at the beginning of each chapter in this order

- Clinical governance (principles, training, non-medical prescribing, drugs and driving, involvement of carers)
- Essential elements of treatment provision (assessment, care planning and treatment, treatment delivery, drug testing and general health assessments)

- Psychological interventions (principles, models and evidence, interventions and different substances of misuse, competencies to deliver psychosocial interventions)
- Pharmacological interventions including methadone and buprenophine (common issues, opioid maintenance prescribing, opioid detoxification, naltrexone for relapse prevention, benzodiazepines and prescribing for users of stimulants and hallucinogens)
- Health considerations (blood-borne viruses, prevention of drug-related deaths, drinking and drug misuse)
- Clinical situations (criminal justice, prisons, pregnancy and neonatal care, mental health, treatment for young people, older current and ex-drug users, pain management in drug users and admission to and discharge from hospital)

Final sections of the report provide a set of annexes outlining

- Cardiac assessment and monitoring for methadone prescribing
- Writing of prescriptions
- Interactions of other medications with opioids
- Marketing authorisations
- Licensing of medications and in particular, consideration for use with young people
- Child protection in Scotland with guidance on inter-agency co-operation
- Contacts for drug treatment monitoring systems
- Other useful documents including NICE technology appraisals and guidelines relevant to drug misuse, other drug misuse guidelines and service guidance

Special Populations/Settings

Royal College of General Practitioners: Guidance for working with cocaine and crack users in primary care. RCGP Drug and Alcohol misuse training programme and RCGP Sex, Drugs and HIV task group.(Royal College of General Practitioners 2004)

For review: 2006 (update not yet available)

Guideline Scope

Target population and health care settings
These guidelines have been compiled by the RCGP with support from the RCGP drug training programme, RCGP Sex Drugs and HIV Task group, the Conference on Crack and Cocaine (COCA), Trafasi, the Alliance and Black Poppy.

This guidance is for general practitioners and other primary care workers for the management of users of cocaine and particularly crack cocaine. High-dose users of cocaine especially of crack are likely to need treatment for a large range of physical and psychological problems.

The authors of the guidelines state that the recommendations in the guidelines are underpinned as far as possible by the published clinical evidence base. The experience of drug users and the pooled experience of experts in the field of cocaine abuse (including a range of practitioners from different treatment and healthcare backgrounds) were also used in the production of the guidance. The available published research (cited through the guidance document) is primarily from the United States, but relies on experience gained in the UK. There is no critical appraisal or evaluation of the evidence by the authors of the guidelines from which the recommendations are produced.

A substantial amount of information is provided on cocaine itself, and categories of users (recreational users, binge or problematic users and chronic high-dose users). The principal guidelines outlined relate to:

- Caring for the user in the general practice surgery (presentation, assessment for first presentation, screening and notification)
- Treatment options in the surgery

- Sharing care outside the surgery (including psychological interventions and complementary and alternative therapies, formal drug treatment settings)
- Group specific issues (primary crack users, methadone and buprenorphine users who also use crack, heroin and crack users and "speedballing", users of crack and alcohol together, users of crack and cannabis, use of other drugs such as ketamine and sildenafil)
- Different types of user communities (black and minority ethnic groups, young people, women, pregnancy and child protection issues, the sex industry, and cocaine and the criminal justice system).

Final sections of the report
These contain appendices relating to cocaine and health, prescribing, harm reduction, the development of protocols for shared care, patient information and sources of additional reading, organisations and websites for further information.

National Institute for Health and Clinical Excellence (NICE): Community-based interventions to reduce substance misuse among vulnerable and disadvantaged young people. (NICE 2007a)

Published: March 2007

Target population
The guideline offers the Institute's formal guidance on community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people aged less than 25 years. This group includes

- Those whose family members abuse substances
- Those with behavioural, mental health and social problems
- Those excluded from school and truants
- Young offenders
- Looked after children
- Those who are homeless
- Those involved in commercial sex work
- Those from some black and minority ethnic groups

Health care settings:
The guidance is for NHS and non-NHS practitioners and others who have a direct or indirect role in and responsibility for reducing substance misuse. This includes those working in local authorities and the education, voluntary, community social care, youth and criminal justice sectors. The community-based interventions on which the guidelines have been developed are defined as interventions or small-scale programmes delivered in community settings, such as schools and youth services. The aims of these interventions are to change the risks factors for the target population.

Versions of the guidelines available:
The main guideline is referred to most in the current report as it contains definitive summaries of best practice recommendations based on the best available evidence. This guideline was in turn created by the Public Health Interventions Advisory Committee who considered a systematic review of effectiveness, an economic appraisal, a set of stakeholder comments and the results of fieldwork in developing a set of recommendations. The systematic review of effectiveness was completed by the National Collaborating Centre for Drug Prevention (NCCDP) at Liverpool John Moores University. The economic appraisal was also undertaken by Matrix Research and Consulting Ltd. In addition, fieldwork was also carried out by the NCCDP in conjunction with a Merseyside-based training and health promotion organisation.

The systematic review of effectiveness included detailed appraisals of the studies identified by comprehensive searches for available evidence. Study types included were meta-analyses and systematic reviews of RCTs, individual RCT reports, non-randomised trials, case-control studies, cohort studies, controlled before and after studies, interrupted time series studies and correlation studies, case series, and case reports. The interventions were assessed for their applicability to the UK and graded on an A (highly applicable across a broad range of settings and populations) to D

(applicable to only the setting and population under study in the particular report). The review data was summarised at five intervals

- Immediate term (up to and including seven days)
- Very short term (up to and including one month)
- Short term (one to six months)
- Medium term (six months to one year)
- Long term (one year or more).

Field work was undertaken to evaluate the relevance and usefulness of NICE guidance for practitioners and the feasibility of implementation. This was conducted with commissioners and practitioners who provided services for vulnerable and disadvantaged children and young people.

The review of effectiveness, the economic evaluation and the issues arising from the fieldwork are available on the NICE website
www.nice.org/PHI004

Main priority recommendations for implementation:
A set of five principal recommendations are outlined, for different groups within the target population of vulnerable and disadvantaged people aged less than 25 years, and for different groups charged with implementing programmes.

Recommendation 1
For any child under the age of 25 who is vulnerable and disadvantaged: local strategic partnerships should develop and implement a strategy to reduce substance misuse among vulnerable and disadvantaged people as part of a local area agreement. This strategy should be based on a local profile of the target population developed in conjunction with the regional public health observatory, and supported by a local service model defining the role of local agencies and practitioners, the referral pathways and referral criteria.

Recommendation 2:
For any child under the age of 25 who is vulnerable and disadvantaged: practitioners and others who work with this group in the health, education, voluntary social care, youth and criminal justice sectors should use existing screening and assessment tools to identify young people in this group who are misusing or at risk of misusing substances. The tools should include the Common Assessment Framework and those available from the National Treatment Agency. Children and young people should be referred as appropriate to other services based on a mutually agreed plan.

Recommendation 3
For vulnerable and disadvantaged children and young people aged 11-16 and assessed to be at high risk of substance misuse: practitioners and others who work with this group in the health, education voluntary social care, youth and criminal justice sectors should offer a family-based programme of structured support (drawn up with the parents or carers of the child or young person) over two or more years. The programme should:

- Include at least three motivational interviews aimed at the parents/carers
- Assess family interaction
- Offer parental skills training
- Encourage parents and carers to monitor children's behaviour and academic performance
- Include feedback
- Continue even if the child or young person moves schools.

Recommendation 4:
For children aged 10-12 who are persistently aggressive or disruptive and assessed to be at high risk of substance misuse (and their parents or carers): appropriately trained practitioners should offer the children group-based behavioural therapy over 1-2 years, before and during their transition to secondary school. The sessions should take place once or twice per month and involve focus on coping mechanisms, development of the child's organisational and problem-solving skills and involve goal setting. The parents or carers should be offered group-based training in parental skills, which should take place on a monthly basis over the same time period. The sessions should focus on stress management, communication skills, and how to help develop the child's social-cognitive and problem-

solving skills. In addition, advice should be provided on how to set targets for behaviour and establish age-related rules and expectations for their children.

The rest of the guideline outlines considerations accounted for in compiling the recommendations and issues for the implementation of the recommendations. A section on related NICE guidance is also included. Evidence statements underpinning the recommendations are also given as are scores for the quality of the evidence given.

Gaps in the evidence are also identified as these include:

- Little long term evidence of the effectiveness of the interventions to reduce problematic substance abuse
- Few UK-based evaluations of community-based interventions
- Few studies of the relative effectiveness of different practitioners working in differing settings to deliver interventions
- Specific components that make an intervention effective
- Little information on precisely which factors make particular at-risk groups vulnerable or susceptible to substance misuse
- Possible iatrogenic effects of interventions i.e. increasing awareness may encourage rather than discourage drug use
- Effect of interventions on parents or carers
- Little evidence on the impact of substance misuse on wider outcomes, e.g. greater personal and social independence.

Royal Pharmaceutical Society of Great Britain for the National Treatment Agency for Substance Misuse (NHS): Best practice guidance for commissioners and providers of pharmaceutical services for drug users. (Royal Pharmaceutical Society of Great Britain and NHS National Treatment Agency for Substance Misuse 2006)

Published: February 2006
Next expected update: Ongoing

Target population:
The guideline offers best practice guidance for commissioners and providers on the development of service specification for pharmacists providing services to adult drug users (aged 18 years and over). The guideline is focussed principally on the provision of needle exchange and supervised consumption of prescribed medicines.

Health care settings:
The service specifications are intended for the purchase of pharmaceutical services for adult drug users, which form the basis for providing pharmaceutical services to drug users within the community in which they reside or work.

Included/excluded diagnoses:
The guideline specifically examines:

- Pharmacy-based needle exchange and harm reduction
- Dispensing and supervised consumption of substitute medication (e.g. methadone and buprenophine) by pharmacists involved in shared care
- Clarification of current and future roles for pharmacists in the provision of services to substance users

Summary
The guideline is an adjunct to *Models of Care: Update 2005 (NTA 2005)* in which the primary focus was adult drug misuse treatment, including harm reduction initiatives.
There are few evidence-based citations in this guideline for each of the recommended steps. This guideline principally outlines the wide range of services available from pharmacists and community pharmacies and the applicability of these service specifications to substance-abuse treatment services.

Additional reviews not included in the NICE or Clinical Evidence Guidelines but relevant for special populations or alternative treatments

Pharmacotherapy

McCarthy et al (2005) Treatment for methaqualone dependence in adults (Cochrane Review)
Objective: To compare the effectiveness of any type of pharmacological or behavioural treatment administered in either an inpatient or out-patient setting compared with either a placebo or no treatment or to a waiting list or with another form of treatment in an in-patient or out-patient setting. No studies were found that met the criteria for inclusion.(McCarthy et al. 2005)

Srisurapanont et al (2001) Treatment for amphetamine dependence and abuse (Cochrane Review)
Objective: To investigate risks, benefits and costs of a variety of treatments for the treatment of amphetamine dependence or abuse. Fluoxetine, amlodipine, imipramine and desipramine have been investigated in four randomised controlled trials. In comparison to placebo, short-term treatment of fluoxetine (40mg/day) significantly decreased craving. In comparison to imipramine 10 mg/day, medium term use of imipramine 150 mg/day significantly increased the duration of adherence to treatment. All four drugs had no benefits on a variety of other outcomes including amphetamine use.
Clinical implications: Fluoxetine, amlodipine, imipramine and desipramine have very limited benefits for amphetamine dependence and abuse. This limited evidence suggests that no treatment has been demonstrated to be effective for the treatment of amphetamine dependence and abuse. Although there are a large number of people with amphetamine dependence worldwide, very few controlled trials in this area have been conducted.(Srisurapanont et al. 2001a)

Srisurapanont et al (2001) Treatment for amphetamine withdrawal (Cochrane Review)
Objective: To search and determine risks, benefits and costs of a variety of treatments for the management of amphetamine withdrawal. All relevant RCTs and controlled clinical trials were to be included. Two studies were identified, the results of which showed some benefits of amineptine in the treatment of amphetamine withdrawal in respect of discontinuation rate and global state, as measured by Clinical Global Impression Scale. No direct benefit on withdrawal symptoms or craving was shown.
Clinical implications: No available treatment has been demonstrated to be effective in the treatment of amphetamine withdrawal. Although amineptine has limited benefits, it has been withdrawn from the market due to reports of amineptine abuse.(Srisurapanont et al. 2001b)

Srisurapanont et al (2001) Treatment for amphetamine psychosis (Cochrane Review)
Objective: To search and determine risks, benefits and costs of a variety of treatments for amphetamine psychosis. All relevant randomised controlled trials and clinical trials were included. Comprehensive searches found no controlled trials of treatment for amphetamine psychosis meeting the criteria for considering studies for inclusion. The results of two studies in amphetamine users showed that agitation and some psychotic symptoms may be abated within an hour after antipsychotic injection. (Srisurapanont et al. 2001c)

Ferri et al (2005) Heroin maintenance for chronic heroin dependents (Cochrane Review)
Objective: To assess the efficacy and acceptability of heroin maintenance versus methadone or other substitution treatment for opioid dependence, in retaining patients in treatment, reducing the use of illicit substances, and improving health and social functioning.
Main findings: Four trials involving 577 people were included for analysis. For the outcome of retention in treatment there was no difference found in two group studies. Relapse to illegal heroin use (self-reported): in one study people using heroin in treatment was 64% (heroin group) compared to 59% (methadone group); in the other study the risk of using heroin was 0.33 (95%CI 0.15 to 0.72) favouring heroin, compared to methadone.
The authors suggested that no definite conclusions about the overall effectiveness of heroin prescription were possible. Results favouring heroin treatment come from studies conducted in countries where easily accessible methadone maintenance treatment is available. In those studies heroin prescription was addressed to patients who had failed previous methadone treatments.(Ferri et al. 2005)

Gowing et al (2004) Substitution treatment of injecting opioid users for prevention of HIV (Cochrane Review)
Objective: To assess the effect of oral substitution treatment for opioid dependent injecting drug users on rates of HIV infections and high risk behaviours.
Main findings: All types of original studies were considered for inclusion. A total of 28 studies with 7900 participants were included, the majority of which were not RCTs and there were problems of confounding and bias. The level of quantitative analysis was limited because of reporting of study results. Oral substitution treatment was associated with statistically significant reductions in illicit opioid use, injecting use and sharing of injecting equipment. It was also associated with reductions in the proportion of injecting drug users reporting multiple sex partners or exchanges of sex for drugs or money, but had little effect on condom use. It appears that the reductions in risk behaviours related to drug use translate into reductions in cases of HIV infection.
The lack of data from RCTs limits the strength of the evidence presented in this review.(Gowing et al. 2004b)

Clark et al (2002) LAAM maintenance versus methadone maintenance for heroin dependence (Cochrane review)
Objective: To compare the efficacy and acceptability of levomethadyl acetate hydrochloride (LAAM) with methadone maintenance in the treatment of heroin dependence. All RCTs, controlled clinical trials and controlled prospective studies comparing LAAM to methadone maintenance were included.
Main findings: Eighteen studies (including 15 RCTs) were included. Cessation of allocated medication (11 studies, 1473 participants) was greater with LAAM than with methadone (RR1.36, 95%CI 1.07-1.73, p=0.001, NNT=7.7). Non-abstinence was less with LAAM (five studies, 983 participants, RR 0.81, 95%CI 0.72-0.91, p=0.0003, NNT=9.1).
LAAM appears to be more effective than methadone at reducing heroin use. More LAAM patients than methadone patients ceased their allocated medication during the studies but many transferred to methadone so the significance of this is unclear. There were no differences in the safety profiles of the interventions, although there was not enough evidence reported in the original studies to comment on adverse events.(Clark et al. 2002)

Soares et al (2003) Dopamine agonists for cocaine dependence (Cochrane review)
Objective: To evaluate the efficacy and acceptability of dopamine agonists for treating cocaine dependence.
Main findings: Seventeen studies were included with 1224 participants. Amantadine, bromocriptine and pergolide were the drugs evaluated. The principal outcome measures were positive urine samples for cocaine metabolites, for efficacy, and retention in treatment as an acceptability measure. There were no significant differences between interventions. Current evidence does not support the clinical use of dopamine agonists in the treatment of cocaine dependence, and given the high rate of dropouts in this population, clinicians should consider adding other supportive measures aiming to keep patients in treatment.(Soares et al. 2003)

Lima et al (2003) Antidepressants for cocaine dependence (Cochrane Review)
Objective:To conduct a systematic review of all RCTs in the use of treating cocaine dependence with anti-depressants.
Main findings: Eighteen studies of 1177 participants were included in the review. Positive urine sample for cocaine metabolites was the main efficacy outcome, but no significant results were obtained, regardless of anti-depressant type. One single trial showed imipramine performed better than placebo in terms of clinical response according to patient's self-report. Results from another trial suggest fluoxetine patients on SSRIs are less likely to drop out of treatment. Similar results were obtained for trials where patients had additional diagnoses of opioid dependence and/or were in methadone treatment. Although there is no current evidence supporting the clinical use of antidepressants in the treatment of cocaine dependence, clinicians may consider adding psychotherapeutic supportive measures aiming to keep patients in treatment.(Lima et al. 2003)

Lima Reisser et al (2002) Carbamazepine for cocaine dependence (Cochrane Review)
Objective: To determine whether carbamazepine is effective for the treatment of cocaine dependence.
Main findings: Five studies with a total of 455 participants were included. There were no differences between carbamazepine and placebo in positive urine samples. Scores on the Spielberg State Anxiety Inventory slightly favoured carbamazepine, though not significantly. Dropouts were high in both

groups. There is no current evidence supporting the clinical use of carbamazepine in the treatment of cocaine dependence. (Lima Reisser et al. 2002)

Other treatment

Smith et al (2006) Therapeutic communities for substance-related disorder (Cochrane Review)
Objective: To determine the effectiveness of therapeutic communities versus other treatments for substance dependents, and to investigate whether effectiveness is modified by client or treatment characteristics.
Main findings: Seven studies were included. The intervention of therapeutic communities was compared with the following: residential care, enhanced abbreviated therapeutic communities, and programmes of varying duration (e.g. six months versus 12 months), as well as therapeutic communities within prison settings. There is little evidence that therapeutic communities offer significant benefits in comparison with other residential treatment or that one type of therapeutic community is better than another. Therapeutic communities within prison may be better than prison on its own or mental health treatment programmes to prevent re-offending post-release for inmates. Methodological limitations in the included studies may have introduced bias and firm conclusions cannot be drawn due to the limitations of the existing evidence.(Smith et al. 2006)

Gates et al (2006) Auricular acupuncture for cocaine dependence (Cochrane Review)
Objective: To determine whether auricular acupuncture is an effective treatment for cocaine dependence and to investigate whether its effectiveness is influenced by the treatment regimen.
Main findings: Seven studies with a total of 1433 participants were included. The quality of the included studies was generally low. There were no differences found between acupuncture and sham acupuncture or between acupuncture and no acupuncture. There is currently no evidence that auricular acupuncture is effective for the treatment of cocaine dependence.(Gates et al. 2006)

Day et al (2005) Inpatient versus other settings for detoxification for opioid dependence (Cochrane Review)
Objective: To evaluate the effectiveness of any opioid detoxification programme when compared with all other time-limited detoxification programmes on the level of completion of detoxification, the intensity and duration of withdrawal symptoms the nature and incidence of adverse effects, the level of engagement in further treatment post-detoxification and the rates of relapse post-detoxification.
Main findings: Only one study met the inclusion criteria. The number of participants in each group was not explicitly reported, but the published data showed that 7 out of 10 (70%) in the inpatients detoxification group were opioid-free on discharge compared with 11 out of 30 (37%) in the outpatient group. There was very limited data about the other outcomes of interest.(Day et al. 2005)

Additional reviews

The summary pages for these reviews are included in the AIP and instructions for their retrieval from the Cochrane Collaboration website are detailed in the appended Information Pckage.

Included in NICE or Clinical Evidence Guidelines:

Pharmacotherapy
Faggiano et al.(2003) Methadone maintenance at different dosages for opioid dependence (Cochrane Review)
Amato et al. (2005) Methadone at tapered doses for the management of opioid withdrawal (Cochrane Review)
Gowing et al. (2006c) Opioid antagonists with minimal sedation for opioid withdrawal (Cochrane Review)
Gowing et al. (2006b) Opioid antagonists under heavy sedation or anaesthesia for opioid withdrawal (Cochrane Review)
Denis et al. (2006a) Pharmacological interventions for benzodiazepine mono-dependence management in outpatient settings (Cochrane Review)
Minozzi et al. (2006) Oral naltrexone maintenance treatment for opioid dependence (Cochrane Review)
Mattick et al. (2003) Buprenorpine maintenance versus placebo or methadone maintenance for opioid dependence (Cochrane Review)
Gowing et al. (2006a) Buprenorphine for the management of opioid withdrawal (Cochrane Review)

Gowing et al. (2004a) Alpha2 adrenergic agonists for the management of opioid withdrawal (Cochrane Review)

Psychological Treatment

Denis et al. (2006b) Psychotherapeutic interventions for cannabis abuse and/or dependence in outpatient settings (Cochrane Review)

Mayet et al. (2004) Psychosocial treatment for opiate abuse and dependence (Cochrane Review)

Amato et al. (2004) Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence (Cochrane Review)

OVERVIEW OF FINDINGS – ALCOHOL ABUSE

A number of recent, high quality guidelines were available which presented best practice recommendations for the treatment of alcohol misuse disorders. Those that are particularly relevant or thorough are summarised in some detail below. Additional relevant systematic reviews which were not included in the guidelines or were published subsequent to them are also summarised in brief. A number of additional documents identified in the search but not summarised in the AIP are included with their executive summaries (where available and links to the full text given in the Information Package.

SUMMARY OF KEY RESEARCH

Clinical Guidelines and Standards

Scottish Intercollegiate Guidelines Network (SIGN): the management of harmful drinking and alcohol dependence in primary care; a national clinical guideline.(Scottish Intercollegiate Guidelines Network (SIGN) 2003)

Published: 2003. The guideline will be considered for review as new evidence becomes available.

Target population

This guideline pertains to patients with alcohol dependence, hazardous or harmful drinking in primary care (general practice and community nursing) and among those attending, but not admitted from accident and emergency departments.

The guideline does not address some specific situations:

- Patients already in specialist care
- Patients admitted to general or psychiatric hospitals
- Driving
- Drinking related to vocational or professional issues e.g. for van drivers, surgeons or teachers with alcohol problems
- Adolescents with an alcohol problem
- Child safety
- The management of alcohol-related organ damage
- Treatment of carers and family members of patients with an alcohol problem

A Health Technology Assessment has been performed by NHS Quality Improvement Scotland on the prevention of relapse in alcohol dependence in specialist settings which complements this guideline.

The guideline report provides a key to evidence statements provided in support of the recommendations made in the guideline. The levels of evidence from which the evidence statements are generated are rated on a 1++ to a 4 scale. The scales are defined as follows:

- "1++" representing "high quality meta-analyses, systematic review of randomised controlled trials or RCTs with a very low risk of bias"
- 1+: well conducted meta-analyses, systematic reviews of RCTs or RCTs with a high risk of bias

- 2++: High quality systematic reviews of case control or cohort studies or high quality case-control or cohort studies with a very low risk of confounding or bias and a moderate probability that the relationship is causal
- 2+: well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.
- 2-: case control studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
- 3: non-analytic studies e.g. case reports or case series
- 4: representing "expert opinion".

The recommendations are graded according to the levels of evidence supporting each recommendation. A recommendation graded "A" would denote a recommendation supported by a body of evidence consistently principally of studies rated as "1+" or "1++", directly applicable to the target population and demonstrating overall consistency of results or at least one meta-analysis, systematic review of RCTs or RCT rated as "1++" and directly applicable to the target population. The lowest grade was "D" representing evidence from levels of evidence rated as from 3-4.

Main recommendations

The guideline report is divided into chapters of the following aspects of alcohol abuse management: outlining detection and assessment, brief interventions for hazardous drinking, detoxification, referral and follow-up, advising families, and information for discussion with patients and carers.

The principal recommendations, with the corresponding grades were as follows:

- Clinical history: Primary care workers should be alerted by certain presentations and physical signs, to the possibility that alcohol is a contributing factor and should ask about alcohol consumption (D)
- Screening for alcohol dependence and those at risk:
    - Abbreviated forms of Alcohol Use Disorders Identification Test (AUDIT) or CAGE plus two consumption questions, should be used in primary care when alcohol is a possible contributory factor (B)
    - In A& E, the Fast Alcohol Screening Test (FAST) or the Paddington Alcohol Test (PAT) should be used for people with an alcohol-related injury (C)
    - TWEAK and T-ACE (or shortened versions of AUDIT) should be used in antenatal and preconception consultations (B)
    - (All of the above tests are found in the annexes in the guideline report).

- Biological markers of alcohol problems: Biological tests are useful when there is reason to believe that self-reporting may be inaccurate (B)
- Brief interventions for hazardous and harmful drinking:
    - General practitioners and other primary health professionals should opportunistically identify hazardous and harmful drinkers and deliver a brief (10 minute) intervention (A)
    - The intervention should, wherever possible, relate to the patient's presenting problem and should help the patient weigh up any benefits as perceived by the patient, versus the disadvantages of the current drinking pattern (A)
    - Training for GPs practice nurses, community nurses and health visitors in the identification of hazardous drinkers and delivery of a brief intervention should be available (D)
    - Routine antenatal care provides a useful opportunity to deliver a brief intervention for reducing alcohol consumption (B)
    - Motivational interviewing techniques should be considered when delivering brief interventions for harmful drinking in primary care (B)

- Detoxification:
    - When medication to manage withdrawal is not needed, patients should be informed that at the start of detoxification they may feel nervous or anxious for several days, with difficulty in going to sleep for several nights (D)
    - Benzodiazepines should be used in primary care to manage withdrawal symptoms in alcohol detoxification but for a maximum period of seven days (A)

  - For patients managed in the community, chlordiazepoxide is the preferred benzodiazepine (D)
  - Provided attention is paid to any acute or physical illness, elderly patients should be managed the same way as younger patients (C)
  - Anti-epileptic medication should not be used as the sole medication for alcohol detoxification in primary care (B)
  - Antipsychotic drugs should not be used as first line treatment for alcohol detoxification (B)
  - Patients with any sign of Wernicke-Korsakov syndrome should receive Pabrinex in a setting with normal resuscitation facilities. The treatment should be according to British national formulary recommendations and should continue over several days, ideally in an inpatient setting (D)
  - Local protocols for admitting patients with delirium tremens should be in place (B)

- Referral and follow up
  - Access to relapse prevention treatments of established efficacy should be facilitated for alcohol dependent patients (A)
  - When a patient has an alcohol-related physical disorder, the alcohol treatment agency should have close links with the medical and primary care team (B)
  - Primary care teams should maintain contact over the long term with patients previously treated by specialist services for alcohol dependence (B)
  - Acamprosate is recommended in newly detoxified dependent patients as an adjunct to psychosocial interventions (B)
  - Patients with an alcohol problem and anxiety or depression should be treated for the alcohol problem first (B)
  - If depressive symptoms persist for more than two weeks following treatment for alcohol dependence, consideration should be given to using an SSRI or referring for counselling or specialist psychological treatment along with relapse prevention treatment (B)
  - Patients with psychotic disorder and alcohol dependence should be encouraged to address their alcohol use and may benefit for motivational, cognitive behavioural, family and non-confrontational approaches (B)

- Advising families: the primary care team should help family members use behavioural methods which will reinforce reduction of drinking and increase the likelihood that the drinker will seek help (B)

Final sections of the report

The final sections of the guideline report comprise a chapter on the development of the guideline and a set of annexes. These include summaries of the alcohol content of some beverages, clinical presentations where the role of alcohol should be considered, diagnostic tests for hazardous drinking, advice to patients withdrawing from alcohol at home. There is also a set of NHS Quality Improvement Scotland recommendations on the prevention of relapse in alcohol dependence.

Health Technology Board of Scotland: Prevention of relapse in alcohol dependence. (National Technology Board for Scotland (NTBS) 2005)

Published: 2002, and complements the advice given in the SIGN document reviewed above.

Target Population

This guideline is the outcome of a Health Technology Assessment (HTA) by the Health Technology Board of Scotland of interventions to prevent relapse in people with alcohol dependence.

This HTA was based on the critical appraisal and analysis of evidence published in scientific literature; evidence submitted by experts, professional groups, patient groups, manufacturers and other interested parties. The assessment process, evidence base, methodology, results, an economic evaluation and recommendations for implementation are described in this particularly comprehensive and very detailed report of 344 pages. The full report is not included in this AIP as it contains very detailed information about the generation of each recommendation. It does however demonstrate that the guidelines themselves were developed using the best available evidence and can be regarded as a

reliable source of information. It is available in full text from the NHS Quality Improvement Scotland website (formerly Health Technology Board of Scotland) website at http://www.nhshealthquality.org and instructions for its retrieval are included in relevant section of the Information Package.

Each recommendation outlined in the guideline is referenced back to the section of the HTA containing the evidence for the recommendation. However, the actual studies on which these recommendations are based were not included in the guideline. In terms of best practice, it is probably sufficient to rely on the guideline and refer to the complete report only if detailed information about particular studies or sources of evidence is required. There is also a summary of the guideline included in this AIP, which contains the general recommendations and the grade of evidence upon which each was based.

Main priority recommendations for implementation:

- The HTBS advises that the following psychosocial interventions should be available to all people with alcohol dependence who have undergone detoxification and are newly abstinent: Coping/Social skills training, behavioural self-control training, motivational enhancement therapy, and marital/family therapy.
- Two pharmacological interventions, acamprosate and supervised oral disulfiram, are recommended as treatment options for use in conjunction with psychosocial interventions.
- The recommended psychosocial interventions should be administered by appropriately trained and competent professionals using standardised protocols.
- Other psychosocial interventions are not recommended as their clinical effectiveness is unproven for alcohol dependence.
- Naltrexone is recommended for routine use in alcohol dependence in NHS Scotland.
- Health professionals should carefully consider the choice of treatments on an individual patient basis following discussion with patients about their needs, preferences and circumstances. These should be supported by information about the range of interventions.
- NHS specialist services should contact people who drop out of treatment to offer another appointment and make provision for continuing care
- NHS specialist services should be aware of mutual help (Alcoholics Anonymous and non-statutory agencies) operating in their area. Introduction to AA and non-statutory agencies should be part of the overall strategy.
- Long term audit data should be collected for all psychosocial and pharmacological interventions to evaluate patient outcomes and resource consequences of using the therapies in various Scottish settings

All HTBS documents are available in a variety of formats on request and from the NHS Quality Improvement Scotland website.

Update: December 2005

This update resulted in the inclusion of data from nine recent randomised controlled trials into the meta-analysis previously published in Health Technology Assessment Report 3 (2003). As a result of the analysis, naltrexone and acamprosate were both considered effective as adjuncts to psychosocial interventions in the treatment of alcohol dependence. Limited evidence also suggests that naltrexone treatment may be useful in cases where the availability of psychosocial interventions is restricted.

Special Populations

British Medical Association Board of Science: Foetal alcohol spectrum disorders – a guide for healthcare professionals. (British Medical Association (BMA) 2007)

Published: June 2007
Next expected update: December 2008

Target population:
The guideline focuses on the adverse health impacts of alcohol consumption by women during pregnancy and in particular the problem of foetal alcohol spectrum disorders. The guide also aims to

raise awareness of FASD by examining the incidence, cause and outcomes of the range of disorders associated with alcohol intake during pregnancy. Recommendations are provided detailing the responsibilities of healthcare professionals and the wider medical community in managing and reducing the incidence of these disorders.

Health care settings:
It covers the care provided by primary, community and secondary health care professionals who have direct contact with and make decisions concerning the care of pregnant women and the diagnosis, referral and management of babies with manifestations of FASD.

Versions of the guidelines available:
The main guideline contains definitive summaries of best practice recommendations based on the best available evidence. This guide for healthcare professionals was prepared under the auspices of the Board of Science of the British Medical Association. Recommendations are also provided for healthcare professionals (for the provision of advice to pregnant women on alcohol consumption during pregnancy) and UK health departments including:

- data collection and FASD,
- implementation of training for healthcare professionals on prevention, diagnosis and management of FASD
- production of specific guidance on referral pathways for pregnant women or women considering becoming pregnant
- production of specific guidance on targeted interventions and referral to specialist alcohol services.

The guideline from which the recommendations for the diagnosis and management are generated is very detailed. However there is no information about the quality and strength of evidence obtained for each of the recommendations, including appraisals of contributing studies and the results obtained. It does however demonstrate that the guidelines themselves were developed using the best available evidence and can be regarded as a reliable source of information. In terms of best practice, it is probably sufficient to rely on the guideline.

The report also contains a detailed section of organisations and sources of information.

Additional reviews

Gillman et al (2007). Psychotropic analgesic nitrous oxide for alcoholic withdrawal states. (Cochrane review)
Objective: To assess the effects of psychotropic analgesic nitrous oxide (PAN) for treating alcohol withdrawal states.
Main results: Five studies with a total of 212 participants were included. PAN was compared to oxygen and/or benzodiazepine regimens.
PAN showed improvement of symptoms, of the amount and duration of sedative medication and of psychomotor function. At one hour post-intervention, there were no significant differences found for depression and anxiety. There were no adverse effects of any treatment.
Clinical implications: Results indicated that PAN might be an effective treatment of the mild to moderate alcohol withdrawal state. The rapid effect of PAN therapy coupled with the minimal sedative requirements may enable patients to enter the psychological treatment phase more quickly than those on sedative regimens which may accelerate recovery. The review does not provide particularly strong evidence due to the small sample size of the enrolled trials. (Gillman et al. 2007)

Ferri et al (2006) Alcoholics Anonymous and other 12 step programmes for alcohol dependence (Cochrane Review)
Objective: To assess the effectiveness of Alcoholics Anonymous (AA) or twelve-step programmes compared to other psychosocial interventions in reducing alcohol intake, achieving abstinence, maintaining abstinence, improving the quality of life of affected people and their families, and reducing alcohol-associated accidents and health problems.
Main results: Eight trials involving 3417 people were included. AA may help patients accept treatment and keep patients in treatment more than alternative treatments, although the evidence for this is from one small study that combined AA with other interventions and should not be regarded as conclusive.

Other studies reported similar retention rates regardless of treatment group. Three studies compared AA combined with other treatments and found few differences in the amount of drinks and percentage of drinking days. Severity of addiction and drinking consequences did not seem to be differentially influenced by twelve-step facilitation programmes versus comparison treatment interventions and no conclusive differences in treatment dropout rates were reported. Included studies did not allow a conclusive assessment of the effect of twelve-step programmes in promoting complete abstinence.
Clinical implications: No experimental studies unequivocally demonstrated the effectiveness of AA or twelve-step facilitation programmes for reducing alcohol dependence or problems. One large study focussed on the prognostic factors associated with interventions that were assumed to be successful rather than on the effectiveness of the interventions themselves.(Ferri et al. 2006)

Kanet et al (2007). Effectiveness of brief alcohol interventions in primary care populations (Cochrane review).
Objective: To assess the effectiveness of brief interventions, delivered in general practice or based in primary care to reduce alcohol consumption.
Main results: A total of 21 RCTs were included of 7286 participants. Participants receiving brief interventions reduced their alcohol consumption compared to the control group, although there was substantial heterogeneity between the trials. Sub-group analysis confirmed the benefit of a brief intervention for men, but not in women. Meta-regression showed a non-significant trend of an increased reduction in alcohol consumption for each extra minute of treatment exposure but no relationship between the reduction in consumption and the efficacy score of the trial. Extended intervention compared with the brief intervention was associated with a non-significantly greater reduction in alcohol consumption.
Clinical implications: Brief interventions consistently produced reductions in alcohol consumption. When data were available by gender, the effect was clear in men at one year of follow up but unproven in women. The lack of differences in outcomes between efficacy and effectiveness trials suggests that the current literature had clear relevance to routine primary care.(Kaner et al. 2007)

Polycarpou et al (2005). Anticonvulsants for alcohol withdrawal (Cochrane review)
Objective: To evaluate the effectiveness and safety of anticonvulsants in the treatment of alcohol withdrawal.
Main findings: A total of 48 studies of 3610 participants were included for analysis. There was a variety of outcomes and of different rating scales that led to a limited quantitative synthesis of data. For the anticonvulsant versus placebo comparison, therapeutic success tended to be more common among the anticonvulsant-treated patients and anticonvulsant medication tended to show a protective effect against seizures. None of the effects reached statistical significance. The authors of the review stated that it was not possible to draw definite conclusions about the safety of anticonvulsants in alcohol withdrawal, because of the heterogeneity of the trials both in interventions and the assessment of outcomes. (Polycarpou et al. 2005)

Ntais et al (2005). Benzodiazepines for alcohol withdrawal (Cochrane review)
Objective: To evaluate the effectiveness and safety of benzodiazepines in alcohol withdrawal
Main findings: Fifty-seven trials with a total of 4051 people were included. Benzodiazepines offered a large benefit against alcohol withdrawal seizures compared to placebo. Benzodiazepines also had similar success rates as other drugs or anticonvulsants in particular and offered a significant benefit for seizure control against non-anticonvulsants but not against anticonvulsants. Data on other comparisons were very limited, making quantitative synthesis for various outcomes not very informative.
Clinical implications: Benzodiazepines are effective against alcohol withdrawal symptoms, in particular against seizures when compared to placebo. It was not possible to draw definite conclusions about the relative effectiveness and safety of benzodiazepines against other drugs in alcohol withdrawal because of the large heterogeneity of the trials both in interventions and assessment of outcomes but the available data do not show prominent differences between benzodiazepines and other drugs in success rates.(Ntais et al. 2005)

OTHER GUIDELINES IDENTIFIED AND RETRIEVED IN THE SEARCH BUT NOT SUMMARISED

Other guidelines identified in the search but not summarised in the AIP are listed in the attached Information Package. Executive summaries, where available, are included in a separate section following the print copies of the summarised documents. Refer to the *Location Information for Documents* for a full listing and links to the text.

CONCLUDING COMMENTS

Research base and stage

The research base on drug and alcohol abuse was in general of very high quality and several guidelines as well as Cochrane Collaboration reviews were identified and retrieved. In particular, several high-quality systematic reviews underpin the NICE guidance from which the recent UK Department of Health guidelines are derived. There are, however, some shortcomings in the literature as there are few studies with long term follow-up, making it difficult to draw firm conclusions about long term outcomes of most interventions. This limits the evidence base and therefore the recommendations of the guidelines in many cases. In general there is more high-quality, robust evidence available for pharmacological interventions than for psychological or the combination of psychological and pharmacological interventions.

Potential for Technical Brief or Systematic Review

There is a plethora of information on interventions for drug and alcohol abuse. The guidelines identified and reviewed briefly are underpinned by recent comprehensive, high quality systematic reviews of evidence. The information provided in this AIP may be sufficient for the needs of the Nelson-Marlborough DHB, given the availability of relevant documents that have been produced recently by well respected groups.

REFERENCES

Amato, L., Davoli, M., Minozzi, S., Ali, R., & Ferri, M. (2005). Methadone at tapered doses for the management of opioid withdrawal. *Cochrane Database of Systematic Reviews*, 3.

Amato, L., Minozzi, S., Davoli, M., Vecchi, S., Ferri, M., & Mayet, S. (2004). Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence *Cochrane Database of Systematic Reviews*, 4.

British Medical Association (BMA) (2007). *Fetal alcohol spectrum disorders: a guide for healthcare professionals* London: BMA.

Clark, N., Lintzeris, N., Gijsbers, A., Whelan, G., Dunlop, A., Ritter, A., & Ling, W. (2002). LAAM maintenance vs methadone maintenance for heroin dependence. *Cochrane Database of Systematic Reviews*, 2.

Day, E., Ison, J., & Strang, J. (2005). Inpatient versus other settings for detoxification for opioid dependence. *Cochrane Database of Systematic Reviews*, 2.

Denis, C., Fatseas, M., Lavie, E., & Auriacombe, M. (2006a). Pharmacological interventions for benzodiazepine mono-dependence management in outpatient settings. *Cochrane Database of Systematic Reviews*, 3.

Denis, C., Lavie, E., Fatseas, M., & Auriacombe, M. (2006b). Psychotherapeutic interventions for cannabis abuse and/or dependence in outpatient settings. *Cochrane Database of Systematic Reviews*, 3.

Department of Health (2007). *Drug misuse and dependence –guidelines on clinical management: CONSULTATION DRAFT JUNE 2007.* London: Department of Health. Available from: http://www.scotland.gov.uk/Resource/Doc/179705/0051089.pdf Accessed 27.9.07

Faggiano, F., Vigna-Taglianti, F., Versino, E., & Lemma, P. (2003). Methadone maintenance at different dosages for opiod dependence. *Cochrane Database of Systematic Reviews*, 3.

Ferri, M., Amato, L., & Davoli, M. (2006). Alcoholics Anonymous and other 12-step programmes for alcohol dependence. *Cochrane Database of Systematic Reviews*, 3.

Ferri, M., Davoli, M., & Perucci, C. A. (2005). Heroin maintenance for chronic heroin dependents. *Cochrane Database of Systematic Reviews*, 2.

Gates, S., Smith, L. A., & Foxcroft, D. R. (2006). Auricular acupuncture for cocaine dependence. *Cochrane Database of Systematic Reviews*, 1.

Gillman, M. A., Lichtigfeld, F. J., & Young, T. N. (2007). Psychotropic analgesic nitrous oxide for alcoholic withdrawal states. *Cochrane Database of Systematic Reviews*, 2.

Gowing, L., Ali, R., & White, J. (2006a). Buprenorphine for the management of opioid withdrawal. *Cochrane Database of Systematic Reviews*, 2.

Gowing, L., Ali, R., & White, J. (2006b). Opioid antagonists under heavy sedation or anaesthesia for opioid withdrawal. *Cochrane Database of Systematic Reviews*, 2.

Gowing, L., Ali, R., & White, J. (2006c). Opioid antagonists with minimal sedation for opioid withdrawal. *Cochrane Database of Systematic Reviews*, 1.

Gowing, L., Farrell, M., Ali, R., & White, J. (2004a). Alpha2 adrenergic agonists for the management of opioid withdrawal. *Cochrane Database of Systematic Reviews*, 4.

Gowing, L., Farrell, M., Bornemann, R., & Ali, R. (2004b). Substitution treatment of injecting opioid users for prevention of HIV infection. *Cochrane Database of Systematic Reviews*, 4.

Kaner, E. F. S., Beyer, F., Dickinson, H. O., Pienaar, E., Campbell, F., Schlesinger, C., Heather, N., Saunders, J., & Burnand, B. (2007). Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews*, 2.

Lima, M. S., Reisser Lima, A. A. P., Soares, B. G. O., & Farrell, M. (2003). Antidepressants for cocaine dependence. *Cochrane Database of Systematic Reviews*, 2.

Lima Reisser, A., Lima, M. S., Soares, B. G. O., & Farrell, M. (2002). Carbamazepine for cocaine dependence. *Cochrane Database of Systematic Reviews*, 2.

Mattick, R. P., Kimber, J., Breen, C., & Davoli, M. (2003). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database of Systematic Reviews*, 2.

Mayet, S., Farrell, M., Ferri, M., Amato, L., & Davoli, M. (2004). Psychosocial treatment for opiate abuse and dependence. *Cochrane Database of Systematic Reviews*, 4.

McCarthy, G., Myers, B., & Siegfried, N. (2005). Treatment for methaqualone dependence in adults. *Cochrane Database of Systematic Reviews*, 2.

Minozzi, S., Amato, L., Vecchi, S., Davoli, M., Kirchmayer, U., & Verster, A. (2006). Oral naltrexone maintenance treatment for opioid dependence. *Cochrane Database of Systematic Reviews*, 1.

National Institute of Clinical Excellence (NICE) (2007a). *Community based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people* London: NICE.

National Institute of Clinical Excellence (NICE) (2007b). *Drug misuse: opiod detoxification*. London: NICE.

National Institute of Clinical Excellence (NICE) (2007c). *Drug misuse: psychosocial interventions*. London: NICE.

National Institute of Clinical Excellence (NICE) (2007d). *Methadone and buprenorphine for the management of opioid dependence* London: NICE.

National Institute of Clinical Excellence (NICE) (2007e). *Naltrexone for the management of opioid dependence*. London: NICE.

National Technology Board for Scotland (NTBS) (2005). *Prevention of relapse in alcohol dependence*. Glasgow: NTBS.

Ntais, C., Pakos, E., Kyzas, P., & Ioannidis, J. P. A. (2005). Benzodiazepines for alcohol withdrawal. *Cochrane Database of Systematic Reviews*, 3.

Polycarpou, A., Papanikolaou, P., Ioannidis, J. P. A., & Contopoulos-Ioannidis, D. G. (2005). Anticonvulsants for alcohol withdrawal. *Cochrane Database of Systematic Reviews*, 3.

Royal College of General Practitioners (2004). *Guidance for working with cocaine and crack users in primary care* London: The College. Available from: http://www.rcgp.org.uk/PDF/drug_cocaine.pdf Accessed 27.9.07

Royal Pharmaceutical Society of Great Britain, & NHS National Treatment Agency for Substance Misuse (2006). *Best practice guidance for commissioners and providers of pharmaceutical services for drug users*

Scottish Intercollegiate Guidelines Network (SIGN) (2003). *The management of harmful drinking and alcohol dependence in primary care. SIGN guideline No. 74* Edinburgh: SIGN.

Smith, L. A., Gates, S., & Foxcroft, D. (2006). Therapeutic communities for substance related disorder. *Cochrane Database of Systematic Reviews*, 1.

Soares, B. G. O., Lima, M. S., Lima Reisser, A., & Farrell, M. (2003). Dopamine agonists for cocaine dependence. *Cochrane Database of Systematic Reviews*, 2.

Srisurapanont, M., Jarusuraisin, N., & Kittirattanapaiboon, P. (2001a). Treatment for amphetamine dependence and abuse. *Cochrane Database of Systematic Reviews*, 4.

Srisurapanont, M., Jarusuraisin, N., & Kittirattanapaiboon, P. (2001b). Treatment for amphetamine withdrawal. *Cochrane Database of Systematic Reviews*, 4.

Srisurapanont, M., Kittiratanapaiboon, P., & Jarusuraisin, N. (2001c). Treatment for amphetamine psychosis. *Cochrane Database of Systematic Reviews*, 4.