Complete Summary

GUIDELINE TITLE

Screening for illicit drug use: U.S. Preventive Services Task Force recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Screening for illicit drug use: U.S. Preventive Services Task Force recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Jan. 7 p. [15 references]

GUIDELINE STATUS

This is the current release of the guideline.

This version updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 53, Screening for drug abuse. p. 583-95. [80 references]

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Illicit drug use

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Nursing
Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the U.S. Preventive Services Task Force (USPSTF) recommendations and supporting scientific evidence on screening for illicit drug use
- To update the 1996 USPSTF recommendations on screening for illicit drug use

TARGET POPULATION

Asymptomatic adolescents, adults, and pregnant women

INTERVENTIONS AND PRACTICES CONSIDERED

Note: The following was considered but not recommended:

Routine screening for illicit drug use using standardized questionnaires or toxicologic tests of blood or urine

MAJOR OUTCOMES CONSIDERED

Key Question 1: Is there direct evidence that screening for drug misuse reduces morbidity and/or mortality?

Key Question 2: Do screening tests accurately detect drug misuse?

Key Question 3: Does screening for drug misuse result in adverse effects?

Key Question 4: Does treatment for drug misuse among individuals identified through screening improve morbidity and/or mortality?

Key Question 5: Does treatment for drug misuse among individuals identified through screening result in decreased drug misuse?

Key Question 5a: Does treatment for drug misuse reduce risk behaviors or improve social and legal outcomes?

Key Question 6: Does treatment for drug misuse result in adverse effects?

Key Question 7: Is decreased use or abstinence following drug misuse reliably associated with reduced morbidity and mortality?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A staged review of the literature was prepared by Oregon Evidence-based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF). Following this, AHRQ staff conducted a separate review of recent literature on the accuracy, reliability, and clinical utility of instruments designed to screen for drug use among adolescents, adults and pregnant women (see the "Availability of Companion Documents" field).

Staged Systematic Review

To update this topic, EPC staff utilized an analytic framework (see Figure 1 in the Evidence Synthesis [see the "Availability of Companion Documents" field]) with eight Key Questions (KQs) (see "Major Outcomes Considered" field).

For this report, EPC staff used a staged review approach that focused first on the evidence for the following five critical key questions (KQ 1, 4, 5, 5a, and 7) oriented toward the health benefits of treatment and on an overarching question determining whether there is direct evidence of benefit from screening patients for treatment.

In the logic of the staged review, if the evidence for these critical key questions is insufficient to establish the links between drug misuse identification through screening, treatment, and clinically-meaningful health benefits, further systematic review to include the other key questions in the analytic framework is unwarranted. Insufficiency of evidence for these critical key questions indicates that the overall body of evidence is insufficient for a USPSTF recommendation for drug misuse screening as a clinical preventive service in primary care. Indication of sufficient evidence for critical key questions 4, 5, 5a, and 7 indicates that a full systematic review of all key questions would be warranted.

Literature Search and Strategy

This staged review is intended to update the previous USPSTF report on drug misuse, which was based on an authoritative, but non-systematic, research

review. Consequently, EPC staff conducted literature searches to systematically locate relevant literature for their critical key questions as follows (see Appendix A–Search Strategies in the original guideline document).

For KQ 1, Ovid MEDLINE for the time period 1994-April 2006 was searched. Randomized controlled trials (RCTs), controlled clinical trials, and longitudinal cohort studies were included. No relevant articles were identified for this key question.

For KQs 4, 5, and 5a, EPC staff conducted a two-stage literature search to locate high-quality, relevant systematic reviews, supplemented by bridge searches as necessary. They also retrieved all potentially relevant treatment research or trials cited in the previous 1996 USPSTF report. Relevant systematic reviews were identified from four distinct searches of Ovid MEDLINE, the Cochrane Database of Systematic Reviews (CDSR), the Database of Abstracts of Reviews of Effectiveness (DARE), and PsycINFO for the time frame 1994-January 2006. They identified 14 high-quality systematic reviews that addressed treatment for one or more of the illicit drugs addressed in this report (heroin, cocaine, marijuana, multiple drugs). Those systematic reviews were used as sources of relevant trials for this review, supplemented by two additional searches for randomized or controlled clinical trials in Ovid MEDLINE and PsycINFO from 2001-April 2006. Additional articles were obtained from comparing reference lists of related reviews, studies, editorials, reports, websites, and by consulting experts. Seventeen relevant articles were identified for these key questions.

For KQ 7, Ovid MEDLINE was searched for the time period 1994-April 2006. RCTs, controlled clinical trials, and longitudinal, cohort studies were included. All potentially relevant articles cited in the 1996 USPSTF report were also retrieved. Eleven relevant articles were identified for this key question.

All studies were managed in an electronic database (Reference Manager®).

Inclusion and Exclusion Criteria

Two investigators reviewed identified abstracts for potential relevance to all critical key questions and determined eligibility by applying inclusion and exclusion criteria specific to each critical key question (see Appendix B–Inclusion and Exclusion Criteria in the Evidence Synthesis [see "Availability of Companion Documents" field]). Full-text articles for included abstracts, articles from the previous USPSTF report, and articles located from existing systematic reviews were examined for relevance. Eligible studies provided data relevant to the critical key questions for marijuana, cocaine, opiates, or multiple substances, and were English-language, primary care feasible or referable (defined in Appendix B in the Evidence Synthesis [see "Availability of Companion Documents" field), conducted in the U.S. (or applicable country), and examined adolescents/teens ages 12-17, young adults ages 18-25, adults ages 26+, or pregnant women. Studies of detoxification/withdrawal, comparative treatment effectiveness, and animal studies were not included.

For KQ 1, RCTs, controlled clinical trials, and longitudinal cohort studies were included. For KQs 4, 5, and 5a, RCTs and controlled clinical trials were included.

For KQ7, RCTs, controlled clinical trials, and longitudinal cohort studies were included.

Supplemental Review: Assessment of Screening Instruments

Literature Search

AHRQ undertook a systematic review of documents identified as of August 2006, from a number of databases. The aim was to identify appropriate, validated screening instruments for the detection of drug misuse among asymptomatic patients seen in ambulatory general medical settings.

Inclusion/Exclusion Criteria

AHRQ staff first searched the Substance Abuse Screening and Assessment Instruments database (http://lib.adai.washington.edu/instruments/) maintained by the University of Washington's Alcohol and Drug Abuse Institute. Information on each questionnaire in the database was examined and questionnaires were eliminated from further consideration using the following exclusion criteria:

1. Instrument is designed to detect misuse of alcohol only, or of a single drug.
2. Instrument is designed primarily for diagnostic purposes or for assessment of those already known to have a substance abuse problem.
3. Instrument is not available to the public (not yet published, or subject to a fee for reproduction or downloading)
4. Instrument requires specific training to administer or to score/interpret results.
5. Instrument contains more than 20 items or takes more than 5 minutes to administer and score.

Using the title or acronym of each remaining questionnaire (i.e., those not excluded using the above criteria), AHRQ staff searched Ovid Medline and PsychINFO, for the period from 1980 through August 2006, for published evidence in English of the instrument's validity, reliability, and clinical utility. Abstracts of identified articles were screened and rejected if they met the following exclusion criteria:

1. Not a study of the specified screening instrument
2. Editorial, letter, or other opinion piece
3. Study conducted using only a non-English version of the instrument
4. Study that examined use of the instrument for a purpose other than screening

Results

After exclusion criteria were applied to all instruments described in the SASAI database, nine instruments were identified as potentially useful for screening for drug misuse in primary care practice settings:

- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

- Cut down, Annoyed, Guilty, Eye-opener - Adapted to Include Drugs (CAGE-AID)
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)
- Drug Abuse Screening Test (DAST)
- Drug Use Disorders Identification Test (DUDIT)
- Relax, Alone, Forget, Friends, Trouble (RAFFT)
- Reduce, Annoyed, Guilty, Start (RAGS)
- Rapid Drug Problems Screen (RDPS)
- Simple Screening Instrument for Substance Abuse (SSI-SA)

NUMBER OF SOURCE DOCUMENTS

Staged Systematic Review

Key Question 1: No relevant articles were identified.

Key Questions 4, 5, and 5a: 17 relevant articles were identified.

Key Question 7: 11 relevant articles were identified.

Supplemental Review: Assessment of Screening Instruments

The abstracts of a total of 340 articles, identified from literature searches conducted for each of the nine instruments, were reviewed for relevance using the screening criteria noted above. Of these, 37 citations were selected for review of full-text articles. Most of the excluded abstracts were not studies of the specified screening instrument (e.g., the instrument shared its acronym with some other entity). After full-text articles were reviewed, 16 studies were ultimately included that addressed the validity, reliability or clinical utility of the screening instrument. Of these, 2 evaluated ASSIST, 3 evaluated CAGE-AID, 4 evaluated CRAFFT, 4 evaluated DAST, 2 evaluated RAFFT, and 1 evaluated SSI-SA. No studies reporting on assessments of DUDIT, RAGS or RDPS met the criteria for inclusion.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A staged review of the literature was prepared by the Oregon Evidence-Based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF). Following this,

AHRQ staff conducted a separate review of recent literature on the accuracy, reliability, and clinical utility of instruments designed to screen for drug use among adolescents, adults and pregnant women (see the "Availability of Companion Documents" field).

Staged Systematic Review

Data Abstraction and Critical Appraisal

Data were extracted from each paper, entered into evidence tables, and, for key questions 4, 5, and 5a, the main findings were highlighted in a summary table, with trials categorized by population, drug, and treatment type. Information abstracted in an evidence table for trials of drug treatment included: target population, whether the population was screened/not screened in primary care, total number of patients, patient inclusion/exclusion criteria, type of drug(s) treated, treatment and control conditions, treatment duration and longest follow-up, results (by key question), whether results differed at short follow-up(s), and reviewer comment. For key question 7, the following information was abstracted: study design, target population, whether the population was screened or not screened in primary care, total number of patients, inclusion criteria and sample description, exclusion criteria, type of drug(s), groups analyzed, length of follow-up(s), type of data analysis, outcome(s), results, and reviewer comment. A second investigator reviewed or abstracted studies if the initial investigator required confirmation of exclusion or inclusion criteria or data abstraction elements.

The quality of studies, including systematic reviews, was rated using design-specific criteria developed by the USPSTF and others (see Appendices C, D, and E in the Evidence Synthesis [see "Availability of Companion Documents" field]). Each study's overall rating is a combination of internal and external validity ratings. Throughout the literature review and data abstraction process, when reviewers disagreed, a final rating was reached through consensus.

Literature Synthesis

Since this staged review's primary purpose was to determine evidence sufficiency, EPC staff did not undertake quantitative data synthesis such as meta-analysis. These techniques are used to provide summary effect sizes or explore heterogeneity in systematic reviews of treatment. Instead, they qualitatively summarized the findings, with an emphasis on the best available evidence for each critical key question and the overall coherence of the evidence. This level of synthesis was appropriate to the decision being made by the USPSTF using this review.

Supplemental Review: Assessment of Screening Instruments

Data Abstraction

Full text articles of non-excluded studies were examined and critically appraised. When available, the following data were extracted from each study:

1. Type of patient population
2. Sample size
3. Reference standard used
4. Sensitivity
5. Specificity
6. Positive predictive value
7. Negative predictive value
8. Internal consistency (alpha score)
9. Test-retest coefficients (kappa values)

It was also noted if the instrument measured recent use or lifetime use, and if it had been evaluated for feasibility and/or clinical utility. ARHQ staff asked if assessment studies were conducted in primary care practice settings.

Critical Appraisal

Studies were rated using previously published USPSTF grading scales. Studies were considered of good quality if they used a credible reference standard, interpreted the reference standard independently of the questionnaire, and included more than 100 patients with and without a drug use problem, some of whom were from a general clinic population.

Studies were considered of fair quality if they used a reasonable, although not the best possible, reference standard, interpreted the reference standard independently of the questionnaire, and included a sample size of 50-100.

Studies were considered of poor quality if an inappropriate reference standard was used, there was a potentially biased ascertainment of the reference standard, or the study included a small (<50) sample size.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to "balance sheets") are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the

preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive service affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive at a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make the trade-off of benefits and harms a "close-call," then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.

Grade	Grade Definitions	Suggestions for Practice
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • the number, size, or quality of individual studies; • inconsistency of findings across individual studies; • limited generalizability of findings to routine primary care practice; or

Level of Certainty	Description
	• lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • the limited number or size of studies; • important flaws in study design or methods; • inconsistency of findings across individual studies • gaps in the chain of evidence; • findings not generalizable to routine primary care practice; or • a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force makes its final determinations about recommendations on a given preventive service, the Evidence-Based Practice Center and the Agency for Healthcare Research and Quality send a draft evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendation statements are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the final recommendations are confirmed.

Comparison with Guidelines from Other Groups. Recommendations for screening from the following groups were discussed: American Academy of Pediatrics, the

American Medical Association, the Bright Futures initiative, and the American College of Obstetrics and Gynecology.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the Levels of Certainty regarding Net Benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendations and Evidence

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use. (This is an **I statement**)

Clinical Considerations

Patient Population Under Consideration: While the rate of illicit drug use in the U.S. is highest between the ages of 18-20 years, more than 10% of adolescents aged 12-17 are known to use illicit drugs. The percentage of adults who regularly use illicit drugs decreases steadily with age. About 5% of pregnant women report using illicit drugs within the past month.

Patterns of Drug Use: Marijuana is the most commonly used illicit drug in the U.S., with around 6% of the population age 12 and older admitting to use within the past month. While cocaine is the second most commonly used illicit drug, it is used by less than 1% of the population. Only a small minority of Americans use hallucinogens, inhalants, heroin, or illicitly manufactured methamphetamine, although the potential for abuse of, or dependence on, these substances is high. Illicit (non-medical) use of prescription-type drugs, categorized as pain relievers, tranquilizers, stimulants, and sedatives, is a growing health problem in the U.S.

Screening Tests: While clinicians should be alert to the signs and symptoms of illicit drug use in patients, the added benefit of screening asymptomatic patients in primary care practice remains unclear. Toxicologic tests of blood or urine can provide objective evidence of drug use, but such tests do not distinguish between occasional users and those who are impaired by drug use. A few brief, standardized questionnaires have been shown to be valid and reliable in screening adolescent and adult patients for drug use/misuse. However, the clinical utility of these questionnaires is uncertain. The reported positive predictive values are variable and at best 83% when the questionnaires are applied in a general medical clinic. Moreover, the feasibility of routinely incorporating the questionnaires into busy primary care practices has yet to be assessed. The validity, reliability and clinical utility of standardized questionnaires in screening for illicit drug use during pregnancy have not been adequately evaluated.

Treatment: Although drug-specific pharmacotherapy (e.g., buprenorphine for opiate abuse) and/or behavioral interventions (e.g., brief motivational counseling

for cannabis misuse) have been proven effective in reducing short term illicit drug use, the longer term effects of treatment on morbidity and mortality have been inadequately evaluated. Moreover, these treatments have been studied almost exclusively in individuals who have already developed medical, social, or legal problems due to drug use, and their effectiveness in individuals identified through screening remains unclear. In all but one trial, treatment was delivered outside the primary care setting, often in specialized treatment facilities. More evidence is needed on the effectiveness of office-based treatments for illicit drug use/dependence.

Other Approaches to Prevention: While interventions to prevent or reduce illicit drug use have been proposed for use in schools and sites of employment, evidence assessing preventive measures delivered in settings other than primary care practice was outside the scope of the USPSTF review. However, the Centers for Disease Control and Prevention's (CDC's) Task Force on Community Preventive Services has announced plans to assess the effectiveness of selected population-based interventions for preventing or reducing abuse of drugs (other than tobacco and alcohol) and to make recommendations based on these findings.

Definitions:

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of

Grade	Grade Definitions	Suggestions for Practice
	benefits and harms cannot be determined.	benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • the number, size, or quality of individual studies; • inconsistency of findings across individual studies; • limited generalizability of findings to routine primary care practice; or • lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • the limited number or size of studies; • important flaws in study design or methods; • inconsistency of findings across individual studies • gaps in the chain of evidence; • findings not generalizable to routine primary care practice; or • a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.

CLINICAL ALGORITHM(S)

None available

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Benefits of Detection and Early Treatment

There is good evidence that various treatments are effective in reducing short term illicit drug use. Evidence is insufficient, however, either to demonstrate that treatment reliably improves social and legal outcomes for patients or to link treatment directly to longer term improvements in morbidity or mortality. Since all but one published clinical trial of treatment interventions involved individuals who had already developed problems due to their drug use, the generalizability of findings to asymptomatic individuals whose illicit drug use is detected through screening is unknown. There is fair evidence that, regardless of the patient's history of treatment, reducing or stopping drug use is associated with improvement in some health outcomes.

POTENTIAL HARMS

Harms of Detection and Early Treatment

There is little evidence of harms associated with either screening for illicit drug use or behavioral interventions used in treatment. Several clinical trials of pharmacotherapy for drug misuse have reported mild to serious adverse events, although some of these events were likely related to underlying drug use. The specific adverse events noted to occur more frequently in the treatment arm of trials (compared to placebo) have been previously recognized as potential side effects of the treatment medication and cited on its product label.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.
- Recommendations are based on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.
- The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policy-makers should understand the evidence but individualize decision making to the specific patient or situation.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards
Tool Kits

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Screening for illicit drug use: U.S. Preventive Services Task Force recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Jan. 7 p. [15 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2008)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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**Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to* www.ahrq.gov/clinic/uspstfab.htm.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have a significant financial, professional/business, or intellectual conflict for each topic being

discussed. Task Force members with conflicts may be recused from discussing or voting on recommendations about the topic in question.

GUIDELINE STATUS

This is the current release of the guideline.

This version updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 53, Screening for drug abuse. p. 583-95. [80 references]

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Polen MR, Whitlock EP, Wisdom JP, Nygren P, Bougatsos C. Screening in Primary Care Settings for Illicit Drug Use: Staged Systematic Review for the U.S. Preventive Services Task Force. Evidence Synthesis No. 58. Part 1. (Prepared by the Oregon Evidence-based Practice Center under Contract No. 290-02-0024.) AHRQ Publication No. 08-05108-EF-1. Rockville, MD, Agency for Healthcare Research and Quality, 2008 Jan. Available in Portable Document Format (PDF) from the U.S. Preventive Services Task Force (USPSTF) Web site.
- Lanier D, Lo S. Screening in primary care settings for illicit drug use: assessment of screening instruments - A supplemental evidence update for the U.S. Preventive Services Task Force. Evidence Synthesis No. 58, Part 2. AHRQ Publication No. 08-05108-EF-2. Rockville, MD, Agency for Healthcare Research and Quality, 2008 Jan. Available in Portable Document Format (PDF) from the U.S. Preventive Services Task Force (USPSTF) Web site

Background Articles:

- Barton M et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. Ann Intern Med. 2007;147:123-127.
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. Ann Intern Med. 2007;147:117-122. [2 references]

- Sawaya GF et al., Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Rockville (MD): Agency for Healthcare Research and Quality, 2007 Dec.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

Electronic copies: Available from U.S. Preventive Services Task Force (USPSTF) Web site.

The following is also available:

- The guide to clinical preventive services, 2007 Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2007. 256 p. Electronic copies available from the AHRQ Web site.
- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2002 May. 189 p. Electronic copies available from the AHRQ Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Electronic Preventive Services Selector (ePSS), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following are available:

- Men: Stay Healthy at Any Age – Checklist for Your Next Checkup. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP006-A. February 2007. Electronic copies: Available from the USPSTF Web site.
- Women: Stay Healthy at Any Age – Checklist for Your Net Checkup. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP005-A. February 2007. Electronic copies: Available from the USPSTF Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical

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NGC STATUS

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