Chapter 6

Initial Assessment of Drug Abuse Patients by Family Doctors

Scope of clients
It is clinically helpful when assessing patients to use a spectrum that includes use, misuse, abuse, and dependence. The latter two terms represent formal diagnostic categories. Use of a substance may or may not be clinically significant. If use of a substance is thought to be potentially clinically significant but does not meet diagnostic criteria for abuse or dependence, it may be characterized as “misuse,” although this is not a formal diagnostic category. Even when functional impairment is absent or limited, substance misuse can be an early indicator of an individual’s vulnerability to developing a chronic substance use disorder.

Brief early interventions can effectively reduce this progression [1-3], although follow-up reinforcement appears necessary for sustained utility. Most individuals presenting or referred for treatment of a substance use disorder, however, have been unable to stop using substances on their own. They often exhibit functional impairments across many categories (e.g., health, social and family, occupational, financial, and legal) and have a history of chronic or relapsing episodes of problematic substance use. This practice guideline refers primarily to the care of such individuals.

Scope of assessment
Individuals with substance use disorders are heterogeneous with regard to a number of clinically important features [4]:

1. The number and type of substances used
2. The individual’s genetic vulnerability for developing a substance use disorder(s)
3. The severity of the disorder, the rapidity with which it develops, and the degree of associated functional impairment(s)
4. The individual’s awareness of the substance use disorder as a problem
5. The individual’s readiness for change and motivation to enter into treatment for the purpose of change
6. The associated general medical and psychiatric conditions (either co-occurring or induced by substance use)
7. The individual’s strengths (protective and resiliency factors) and vulnerabilities
8. The social, environmental, and cultural context in which the individual lives and will be treated.

Assessment procedures
The assessment includes [4]:

1. A detailed history of the patient’s past and present substance use and the effects of substance use on the patient’s cognitive, psychological, behavioural, and physiological functioning
2. A general medical and psychiatric history and examination
3. A history of psychiatric treatments and outcomes
4. A family and social history
5. Screening of blood, breath, or urine for substance used
6. Other laboratory tests to help confirm the presence or absence of conditions that frequently co-occur with substance use disorders
7. With the patient’s permission, contacting a significant other for additional information.

Substance-related disorders are divided into two groups:
1. Substance use disorders, which include substance dependence and substance abuse
2. Substance-induced disorders which include substance intoxication, substance withdrawal, substance-induced delirium, substance-induced persisting dementia, substance-induced persisting amnestic disorder, substance-induced psychotic disorder, substance-induced mood disorder, substance-induced anxiety disorder, substance-induced sexual dysfunction, and substance-induced sleep disorder.

This section of the guideline focuses on the first group, substance use disorders.

Substance dependence
1. Cognitive signs and symptoms
2. Behavioural signs and symptoms
3. Physiological signs and symptoms indicating ongoing substance use despite significant problems associated with such use.

Usually this continuous use will result in tolerance, withdrawal and a pattern of compulsive use.

Substance abuse
1. Has not experienced signs or symptoms of withdrawal or tolerance or met the criteria for compulsive substance use required for a diagnosis of substance dependence
2. Has shown a maladaptive pattern of substance use that is associated with significant recurring adverse consequences.

With DSM-IV-TR criteria, patients may be classified as currently manifesting a pattern of abuse or dependence, or as being in remission. Those in remission can be divided into six subtypes—full, early partial, sustained full, sustained partial, on agonist therapy, and in a controlled environment—on the basis of whether any of the criteria for abuse or dependence have been met and over what time frame. Patients receiving agonist therapy (e.g. methadone maintenance) or living in a controlled substance-free environment are also categorised as being in remission, with the corresponding diagnostic modifier used to denote the circumstances of remission.

Clinical features: cross-sectional
The clinical picture varies with the substance used, the dosage, the duration of action, the time elapsed since the last dose, the presence or absence of tolerance, and co-occurring psychiatric or general medical conditions. The expectations of the patient, his or her style of responding to states of intoxication or physical discomfort, and the setting in which intoxication or withdrawal is taking place also play a role.

Patients experiencing substance-induced intoxication manifest changes in mood, cognition, and/or behaviour. Mood-related changes range from euphoria to depression, with considerable lability in response to or independent of external events. Cognitive changes include shortened attention span, impaired concentration, and disturbances in thinking (e.g. delusions) and/or perceptions (e.g. hallucinations). Behavioural changes include wakefulness or somnolence and lethargy or hyperactivity. Impairment in social and occupational functioning is also common in intoxicated individuals.

Other cross-sectional diagnostic features include those related to any co-morbid psychiatric or general medical disorders that may be present. Psychiatric disorders include conduct disorder (particularly the aggressive subtype) in children and adolescents [6-8], depression, bipolar disorder, schizophrenia, anxiety disorders, eating disorders, pathological gambling, antisocial personality disorder, and other personality disorders [7,9-19]. Co-morbid general medical disorders include cardiac toxicity resulting from acute cocaine intoxication, respiratory depression and coma in severe opioid overdose, and hepatic cirrhosis after prolonged heavy drinking [20]. General medical conditions frequently associated with opioid-dependent individuals who administer opioids by injection include subacute bacterial endocarditis, HIV infection, and hepatitis. Patients whose substance use disorder
is accompanied by diminished self-care and/or high levels of risk-taking behaviour are at increased risk of experiencing malnutrition, physical trauma, and HIV infection [21,22].

**Clinical features: longitudinal**

Patients with substance use disorders frequently present with a long history of repeated episodes of intoxication and withdrawal, interspersed with attempts to cease use of the substance. Substance-dependent patients presenting for treatment often have profound psychological, social, general medical, legal, and financial problems. These may include disrupted interpersonal (particularly family) relationships, absenteeism, job loss, criminal behaviour, poor academic or work performance, failure to develop adaptive coping skills, and a general constriction of normal life activities. Peer relationships often focus extensively on obtaining and using illicit substances or alcohol. The risk of accidents, violence, and suicide is significantly greater for these individuals than for the general population [23,24].

**Street names of some illicit drugs**

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Street Names</th>
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<tbody>
<tr>
<td>Heroin</td>
<td>no. 3 三仔, no. 4 四仔</td>
</tr>
<tr>
<td>Cannabis</td>
<td>草, Hashish 大麻精, Hash oil 大麻油</td>
</tr>
<tr>
<td>Lysergic acid diethylamide (LSD)</td>
<td>迷幻藥, 方糖, 郵票, 黑芝麻</td>
</tr>
<tr>
<td>Phencyclidine (PCP)</td>
<td>angel dust, 天使塵</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>大力丸, methylamphetamine 氰</td>
</tr>
<tr>
<td>Methylene-dioxy-methylamphetamine (MDMA)</td>
<td>芬陀, E 仔, 忘我, 狂喜, designer's drug</td>
</tr>
<tr>
<td>Cocaine</td>
<td>C, coke, 可卡因, crack, 可樂, 霹靂</td>
</tr>
<tr>
<td>Chlordiazepoxide (Librium)</td>
<td>綠豆仔</td>
</tr>
<tr>
<td>Nimetazepam</td>
<td>五仔</td>
</tr>
<tr>
<td>Flunitrazepam (Rohypnol)</td>
<td>十字架</td>
</tr>
<tr>
<td>Midazolam (Dormicum)</td>
<td>羅氏藍精靈</td>
</tr>
<tr>
<td>Triazolam (Halcion)</td>
<td>藍精靈, 藍瓜子</td>
</tr>
<tr>
<td>Nitrazepam (Mogadon)</td>
<td>魔鬼黨, 睡覺幫</td>
</tr>
<tr>
<td>Zolpiclone (Imovane)</td>
<td>白瓜子</td>
</tr>
<tr>
<td>Zolpidem (Stilnox)</td>
<td>思諾施</td>
</tr>
<tr>
<td>Mandrex</td>
<td>忽得, MX, 賽仔</td>
</tr>
<tr>
<td>Ketamine</td>
<td>K 仔</td>
</tr>
<tr>
<td>Gamma hydroxybutyrate (GHB)</td>
<td>G 水, 迷姦水, X 水</td>
</tr>
<tr>
<td>Dextromethorphan (Romila)</td>
<td>O 仔</td>
</tr>
</tbody>
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**Retrospective assessment of drug use**

[25-28]

1. Timeline Follow Back (TLFB)
2. Interview technique to assist patients in recalling past drug use
3. Greater validity than simple questions about usual quantity and frequency of drug use
4. Includes a calendar to help people to provide a retrospective estimate of their daily drug use.
Memory aids for TLFB
1. Daily calendar
2. Key dates: holidays, birthdays, etc
3. Black and White days: periods of time of abstinence or using drugs in a very patterned manner
4. Discrete events and anchor points: specific events, like hospitalisation, illness, treatment participation
5. Drug use boundaries: greatest and least amounts of drug consumption
6. Exaggeration technique.

Psychoactive drug history questionnaire [29]
1. Drug category
2. Ever used
3. Total years used
4. Year last used
5. Frequency of use in past 6 months.

Screening test: WHO ASSIST
ASSIST is the Alcohol, Smoking and Substance Involvement Screening Test [30]. It is a brief screening questionnaire to find out about a person’s use of psychoactive substances. It was developed for the World Health Organization (WHO) by an international group of substance abuse researchers to detect and manage substance use and related problems in primary and general medical care settings. Version 3.0 consists of eight questions. Questions one to seven ask about use and problems related to tobacco, alcohol, cannabis, cocaine, ATS, inhalants, sedatives or sleeping pills, hallucinogens, and opioids. Taken together these questions provide indications of hazardous and harmful substance use, and dependence. Scores in the mid range on the ASSIST are likely to indicate hazardous or harmful substance use. Question eight is focused on injecting and asks whether the patient has ever injected any drug. Injection is treated separately because it is a particularly high-risk activity associated with increased risk of dependence, blood-borne viruses such as HIV and hepatitis C and with higher levels of other drug-related problems.

Assessment of readiness for change
Motivational interview [31] is a client-centred, semi-directive method of engaging intrinsic motivation to change behaviour by developing discrepancy and exploring and resolving ambivalence within the client. Motivation as defined by Motivational Theory can be classified into: reliable stage, predictable stage, and well-defined stage.

The therapist identifies the stage the patient is in and applies the stage-appropriate counselling approaches to get the best results. It is non-judgmental, non-confrontational, and non-adversarial. The therapist targets to diminish client resistance, resolve ambivalence with empathy and differential reinforcement of client speech, and finally to increase client change talk. Family doctors can do that with training as an effective time-limited counselling approach. If not responsive, family doctors may refer to a specialist for more specialised treatment.

Conclusion
Family physicians have important roles to play in early identification, assessment and brief intervention of youth illicit drug use. Early intervention in a non-stigmatising setting addresses a gap in service. It serves as a gateway to help the clients to quit substance abuse. Liaison by family doctors with family members, community carers, and other professional service-providers at different institution-based and community treatment settings provides a stepped-care multidisciplinary approach to manage this pertinent youth health problem in our society.
References


