FULL NEEDS ASSESSMENT

Following triage assessment by specialist services a full needs assessment will be carried out by the specialist team if on-going working with the client is indicated. Where the patient is to be treated under a shared-care arrangement, then the specialist team will undertake a full assessment and feed this back to the general practitioner. In all cases, it remains the joint responsibility of all professionals involved in the on-going care of the client to ensure that an adequate assessment has been undertaken before on-going management commences; this is especially the case where prescribing interventions are involved.

THE AIMS OF ASSESSMENT

Assuming triage assessment has been completed, the remaining objectives of full needs assessment will be as follows:

- **Detail the current and past history of substance misuse.**
- **Identify and assess complications of substance misuse.**
- **Identify and assess the presence of complex needs.**
- **Confirm active substance misuse objectively.**
- **Collect other information necessary to determine the appropriate immediate, medium and long-term management plan.**
- **Engage the client with treatment –** **(*see Section E10,* page 104, Poor Concordance).**

- Reason for presentation.
- Current and past substance misuse/ substance misuse treatment history.
- Current and past injecting drug misuse.
- Family, social and forensic history.
- Psychiatric history and current mental state.
- Medical history and physical examination.
- Risk assessment.
- Assessment of motivation.
- Special investigations.
- Formulation of needs (bio-psycho-social).
- Formulation of care plan to meet needs.

REASON FOR PRESENTATION

This is always likely to impact directly on the eventual management plan. The reasons given for presentation may be accurate or inaccurate, realistic or unrealistic. The very large majority of requests for help will be honestly motivated – the drug user who presents purely to supplement income through unnecessary prescribing and subsequent diversion is rare. However, preconceptions regarding 'what it is necessary to say' in order to receive treatment are rife and may lead to inaccurate statements of need. For example, it is common-place for heroin misusers to present requesting a methadone reduction prescription, when in fact they both desire and may be better served by a methadone maintenance prescription. Equally, unrealistic expectations of treatment are quite common and important to identify, so that the client can be guided in a more appropriate direction. Examples include the heroin user who expects a large methadone prescription immediately, or the heavily dependent alcoholic who wishes to plan for controlled drinking rather than abstinence. Presentations related to impending court appearances should lead the clinician to question the likely longevity of the client's motivation to engage.

Where the reason given is realistic and appears accurate, it is usually wise to follow the patient's lead in terms of delivering interventions; imposing unwanted treatments is likely to lead to resistance and poor compliance.

The reason given for presentation may be useful in judging motivation, stage of change, and for indicating the overall direction of the management plan.

CURRENT AND PAST SUBSTANCE MISUSE

It is important to obtain an accurate history of **recent** drug and alcohol use for several reasons:

- Determination of level of use – higher levels are likely to be associated with physical dependence and physical complications, and give an indication of likely prescribing needs, of costs to the user and need for crime.
- Determination of route of use – association with route-dependent physical complications, indicator of severity of misuse.
- Determination of pattern of misuse – bingeing use as opposed to regular use of a drug is less likely to be associated with physical dependence but may be associated with marked complications of a biological, psychological or social nature.
- Number of substances used – poly-drug/alcohol misuse indicates a poorer prognosis and the need for a referral to specialist services in most cases.
- Reaction to withdrawal of access to substances – physical withdrawal may indicate the need for substitute prescribing or detoxification (see below), craving during abstinence may indicate the need for relapse prevention measures including both pharmacological and psychological interventions.

A reasonably detailed past history of substance misuse and past treatment episodes is of use in indicating prognosis and the likely response to future management interventions:

- Age of first illicit drug misuse – if below 14 years indicates a poor prognosis.
- Past history of injecting drug misuse – indicates need for specific harm-minimisation advice, hepatitis and HIV screening.
- Past history and duration of clean/dry periods – examine the reasons for onset and termination of clean periods and associated life-events; previous clean periods indicate a good prognosis.
- Past treatment episodes – examine the reasons for success, failure, compliance and non-compliance with previous treatments – take into account in formulation of current management plan.
- Past history of accidental opiate overdose – deliver harm-minimisation advice.

CURRENT AND PAST INJECTING DRUG MISUSE

- Need for testing, immunisation and/or treatment of viral hepatitis and HIV.
- Need for testing, immunisation and/or treatment of viral hepatitis and HIV in sexual partners and those who have shared needles.
- Need for education regarding risks of injecting and safest techniques for injecting.
- Need for referral to needle exchange scheme or/and specialist services.

FAMILY, SOCIAL AND FORENSIC HISTORY

- Positive family history indicates possible genetic loading with prognostic implications.
- Personal history may reveal background leading to generalised vulnerability to substance misuse.
- History of childhood behavioural disorder is associated with poor prognosis regarding current adult substance misuse.
- Current social instability in terms of relationships, occupation, accommodation and finances is directly related to poor prognosis and indicates specific psycho-social interventions in management plan.
- Intensity of forensic history is related to prognosis.

PSYCHIATRIC HISTORY AND CURRENT MENTAL STATE

The psychiatric history can reveal clues regarding the underlying cause of the substance disorder as well as its prognosis. Additionally, identification of concurrent psychiatric disorder is of particular importance, as effective management of such disorder may lead to a marked improvement in the prognosis for the substance disorder.

Behavioural disorder in childhood (as distinct from simple delinquency), dissocial personality disorder and social phobia are linked to a predisposition to development of substance misuse; social phobia is especially important to identify as it may be amenable to psychiatric treatment leading to alleviation of substance misuse.

Anxiety and depression are commonly linked with substance misuse and are in general more likely to be a result of rather than a cause of substance misuse. While the primary intervention for management of (mild) depressive and anxiety disorders occurring in this context will be treatment of the associated substance misuse, it is important to educate the client regarding the likely cause of their symptoms.

Drug-induced psychosis usually occurs following stimulant drug misuse, and generally has a good prognosis if the underlying substance misuse can be treated.

Severe, chronic psychiatric disorder is also over-represented in substance-misusing populations; patients co-morbid for severe psychiatric disorder and substance misuse pose special challenges for effective management and should usually be managed by specialist psychiatric services with support from specialist substance misuse services.

Substance misuse is also a prominent risk factor for suicide and violence. Threats of suicide should always be taken seriously and followed-up appropriately by urgent referral to psychiatric services if the risk is judged as acute and serious. Threats of violence should be assessed as to their likelihood, seriousness and acuteness; if there may be a risk of serious harm or death to others, then confidentiality should be broken and the police and individuals at risk informed. A formalised risk assessment should be undertaken routinely (see Section E2, page 62).

In conclusion, as well as analysis of past psychiatric history, there should be an examination of current behaviour, mood, suicidal and violence risk and for psychotic symptoms.

MEDICAL HISTORY AND PHYSICAL EXAMINATION

There are multiple physical complications of substance misuse, some of which are listed in *appendix 4,* page 119. Solvents and alcohol are probably the most toxic substances in themselves, whilst severe physical complications occurring with other substances are usually related as much to the route of misuse as to the substance itself. Generally there is a greater prevalence of certain illnesses amongst the chronic drug misusing population including viral hepatitis, bacterial endocarditis, HIV, tuberculosis, septicaemia, pneumonia, deep vein thrombosis, pulmonary emboli and dental disease.

Occasionally, the onset of substance misuse may be associated with pain control, either formally treated or self-medicated. Such cases are usually best mangaged by assessment from specialist services, in conjunction with pain control specialists.

Physical examination is important to confirm the history (e.g. signs of intoxication or withdrawal, signs of injecting drug misuse such as track marks and abscesses), and to diagnose complications of substance misuse. Feedback regarding the risk of physical complications acts as a powerful motivator in some clients.

ASSESSING MOTIVATION

The assessment of motivation is largely a matter of clinical judgment. Firstly it is important to answer the question: Motivated for what? Is the motivation for abstinence or stabilisation? Is the motivation for a period of intensive treatment or for a low-key, 'low threshold' approach? If the client is not immediately

motivated to make changes in their substance misuse behaviour, are they motivated to make changes in other aspects of their behaviour such as work, accommodation and personal relationships?

The client's stated reason for seeking treatment balanced against other factors elicited in the history may give an indication of the true motivation. For example, the client who presents requesting detoxification from alcohol but who also says that if he stops drinking he will lose a valued escape from depression probably remains ambivalent in his true objective. Equally, the patient who presents requesting a methadone reduction, but has a history of several failed such treatments in the recent past, may well be more motivated for and more suitable for a period of maintenance prescribing. This is of course a simplification, as ambivalence is characteristic of dependency and mirrors the conflict between the rational acceptance that harm is occurring and the subconscious addictive drive to continue misuse of the substance regardless.

The general manner and behaviour of the client during assessment may also reveal clues as to their motivation and likely compliance with treatment. More often than not, the client who is consistently blaming others for her problems will fail to engage successfully, as will the poor attender.

Motivation can change in time and this is expressed in the 'Stages of Change' model (Prochaska & DiClemente, 1992) (*see appendix 2,* page 116). Clients in the pre-contemplation stage probably have little to gain from common forms of treatment, and in the absence of complex needs such as pregnancy or severe dual diagnosis should probably be managed in a primary care setting utilising a 'brief intervention' approach (Section A3, page 11), aimed at improving their motivation. Alternatively they may make use of low threshold engaging specialist services. Clients at other stages in the cycle may be treated effectively by more rigorous interventions.

SPECIAL INVESTIGATIONS

a) Outcome monitoring.

The assessment procedure should form part of a system of monitoring outcome. It is suggested that the Maudsely Addiction Profile (MAP) (Marsden J et al, 1998) is adopted as the main means of measuring outcome in view of its comprehensive validation and widespread use in the UK (potential for benchmarking).

b) Biological investigations.

Baseline blood tests should be performed as part of a full needs assessment, to aid in the identification of physical complications of substance misuse. Full Blood Count (FBC), Clotting Screen, Urea & Electrolytes (U&Es), Liver Function Tests (LFTs), Gamma Glutaryl Transferase (GGT), Thyroid Function Tests (TFTs) and a Random Blood Sugar (BS) will together form a comprehensive baseline screen. Urine drugs of misuse screen should be performed as standard. Chest X-ray (CXR) will frequently be indicated. More specialist tests should be performed as indicated below (see Section E7, page 79).

FORMULATION OF NEEDS

The care plan should formulate the immediate, medium and long-term biological, psychological and social needs of the client. This is dealt with in more detail below in Section E3, page 63: Care Planning & Care Coordination.

FORMULATION OF CARE PLAN

The care plan summarises the immediate, medium and long-term interventions which are to provided in an attempt to address the needs of the client. This is dealt with in more detail below in Section E3, page 63: Care Planning & Care Coordination.