INITIAL APPRAISAL

Initial appraisal may be carried out immediately following detection of a drug or alcohol problem. The immediate objectives will be to:

- **Direct the immediate action plan, through a brief assessment of needs.**
- **Collect baseline information for the National Drug Treatment Monitoring System.**
- **Deliver harm-minimisation advice.**
- **Deliver a brief motivational intervention.**

Several decisions need to be made to direct immediate action:

- What is the stage of change of the patient (*see appendix 2*, page 116)?
- Is referral to specialist services indicated?
- Does the patient have any immediate prescribing needs to manage drug withdrawal?
- Are there any other urgent issues?

DIRECT THE IMMEDIATE ACTION PLAN

DECISION ONE:

How motivated is the client/what is their stage of change?

Motivation can be difficult to assess, and is largely a matter of clinical judgment. It is important to take a responsive approach; if the patient has presented requesting help of any kind then this probably represents a significant step for them. The 'Stages of Change' model (Prochaska & DiClemente 1992) describes a cycle of change through which the individual progresses in time (*appendix 2*, page 116). The actively using client who is not consciously motivated to seek help is in the pre-contemplation stage; contemplation of change then supervenes leading to preparation for change followed by action. The change in behaviour leads to the maintenance stage which is often followed by relapse thus completing the cycle. The immediate management of the client should be directed to an extent by the stage of change. The degree of treatment readiness may also be assessed by use of the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES; Miller & Tonigan, 1996). Clients who appear to be in the pre-contemplation or contemplation stage will usually be suitable for a brief motivational intervention (see Section A3, page 11), whereas those in the other phases may require more in-depth treatments such as prescribing or counselling.

DECISION TWO:

Is referral to specialist services indicated?

See Section A4, page 13.

DECISION THREE:

Does the patient have any immediate prescribing needs?

It is only rarely that a substance misuser will require a prescribing intervention on an immediate basis (unless they are already receiving a prescription).

1. Opiate dependency.

Opiate drug withdrawal is **not** life-threatening, apart from in very rare cases such as the elderly opiate user in heart failure. The only other presentation when an early prescribing intervention may be indicated is in pregnancy – opiate withdrawal may occasionally precipitate abortion or premature labour. **Neither** of these two scenarios (pregnancy & heart failure) indicate immediate prescribing in primary care, but rather indicate a referral to the medical or obstetric team via A&E if there is evidence of acute complications supervening.

2. Alcohol dependency.

In contrast to opiate dependency, alcohol withdrawal may occasionally present a risk to life. Delirium Tremens (characterised by acute confusion, disorientation, vivid visual hallucinations, paranoia, marked tremor and other symptoms and signs of alcohol withdrawal) may occur on acute withdrawal of alcohol in chronic alcohol dependency. Delirium Tremens is associated with a 10% mortality rate if left untreated and indicates an urgent medical admission. Alcohol withdrawal seizures may also present a risk to life and if observed should be treated with a bolus of parenteral or per rectal diazepam. The large majority of presentations by alcohol dependent patients should not lead to any

immediate prescribing; advice to cut down drinking slowly but surely will suffice to manage most acute presentations. Very occasionally, in the patient with a clear past history of withdrawal seizures who claims to have no access to alcohol supplies, it may be judged appropriate to commence a community detoxification with chlordiazepoxide on an immediate basis; this should be avoided whenever possible.

3. Benzodiazepine dependency.

As for alcohol dependency, the chronically benzodiazepine-dependent patient is at risk of withdrawal seizures. Very occasionally, in the patient with a clear past history of withdrawal seizures who claims to have no access to benzodiazepine supplies, it may be judged appropriate to commence a community detoxification with chlordiazepoxide on an immediate basis; this should be avoided whenever possible.

4. Other substances.

Withdrawal from the other common drugs of misuse is not associated with a threat to life, and there is **no** indication for immediate prescribing to manage withdrawal.

DECISION FOUR:

Are there any other urgent needs?

Heavy intoxication with most substances is associated with a degree of physical risk. Opiate intoxication can lead to respiratory depression and death; the intoxicated, unconscious opiate misuser should be dealt with as a medical emergency and administered parenteral naloxone if respiration or cardiac output is depressed. Severe intoxication with alcohol can similarly lead to coma and death. Heavy stimulant drug misuse (cocaine, amphetamine) can lead to arrythmias and intracerebral bleeding which may be fatal. Solvent use is particularly hazardous and can lead to fatalities related to intoxication.

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. If children are considered to be at possible risk, a referral should be made to social services.

NATIONAL DRUG TREATMENT MONITORING SYSTEM REPORTING

All illicit drug-using (but **not** alcohol-using) clients newly presenting for treatment or re-presenting after a gap of six months should be reported to the database. Clients who are referred to specialist services will be reported by the specialist service. Clients managed in primary care should be reported by the general practitioner.

DELIVER HARM-MINIMISATION ADVICE

Advice should be given regarding the effects of substances of misuse and how these may be minimised by reducing or ceasing use. The giving of such advice as a stand-alone measure has been clearly demonstrated to result in the reduction of alcohol and nicotine consumption in many individuals (Flemming M et al, 1997).

Injecting drug users should be advised of the local syringe exchange schemes available. The rationale for the provision of needle exchange is that of 'harm-minimisation', which is widely held to be responsible for the low prevalence of HIV infection in the UK as compared to other Western countries. Needle exchange, also offers an opportunity to come into contact with injecting drug users who might otherwise remain out-of-touch with services.

The main objectives of needle exchange are to provide easy access to free, sterile injecting equipment in a variety of settings, to provide a system for safe disposal of used injecting equipment, to provide free condoms, to provide harm-minimisation advice verbally and in the form of written material, and to act as a gateway to other services. It is essential for the success of schemes that confidentiality is maintained at all times.

MOTIVATION THROUGH ASSESSMENT

The style in which the assessment is delivered is essential in order to build rapport with the client and to motivate the client towards taking the next step in treatment. The FRAMES approach to counselling can be utilised to good effect in the short time available during a brief assessment. FRAMES stands for feedback, responsibility, advice, menu of options, empathy and self-efficacy. Further details are to be found above in Section A3 'Brief Interventions' and below in Section B2 'Basic Counselling Interventions'.