What is it?

**Addiction**
According to the Canadian Society of Addiction Medicine, addiction is defined as a primary, chronic disease characterized by impaired control over the use of substance(s) and/or behaviour(s). Clinically, manifestations occur along four dimensions—biological, psychological, social and spiritual.

Common symptoms include change in mood; relief from negative emotions; provision of pleasure; preoccupation with the use of substance(s) or ritualistic behaviour(s); and continued use of the substance(s) and/or engagement in behaviour(s) despite adverse physical, psychological and/or social consequences. Like other chronic diseases, it can be progressive, relapsing and fatal. Often, there are physical and psychological (e.g., emotional, mental, spiritual) complications such as liver disease, neurological problems, anxiety, depression, cognitive distortions, anhedonia, and loss of connectedness or meaning in life.

**Addiction medicine assessments**
A comprehensive addiction medicine assessment addresses complications along all four dimensions identified above. This definition of assessment differs from that in the Essentials of ... Assessment in that only physicians have the necessary medical training to assess client complications along the biological dimension. The physician assessment is necessary for the physical examination, review of medications, assessment of co-morbidity and ordering of urine and blood tests.

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) distinguishes between individuals who abuse substances and individuals who are substance dependent. That differentiation can drive treatment choices and decisions.

**How does a comprehensive addiction medicine assessment work?**

Physicians work with other health care providers who assess complications in the psychological, social and spiritual dimensions. A thorough addiction assessment considers the readiness of the patient/client to change and documents severity and acuity as a guide for treatment.

The psychological assessment must include cognitive (i.e., thinking) and affective (i.e., emotional) distortions that may be difficult for the individual to articulate (such as rationalization, minimization, fear, anger and shame), as well as defence mechanisms such as grandiosity, avoidance and projection.

The social assessment must include a development history in the context of family and friends who have had and currently have a major influence on the individual’s life routines, rituals and priorities.

The spiritual assessment must identify the things that provide meaning and purpose in the individual’s life, together with the values they endorse. Behaviours may or may not be congruent with these values; hence, dissonance and related emotional turmoil must be explored. The presence or lack of religious affiliation or cultural traditions is not as significant as the exploration of the individual’s belief system, since a belief system can
contribute to the psychosocial instability and can be helpful in establishing balance and direction in recovery.

The physician conducting the assessment may have training and qualifications in addiction medicine (known as an addictionist) or may be a family physician with a special interest in addiction medicine or the basic concepts of the disease of addiction. A psychiatrist may be included in the assessment team for individuals with more severe mental illnesses that can occur as a complication of addiction or can be concurrent with addiction. Studies have shown that up to 50 percent of people with substance disorders have a concurrent psychiatric illness.

A thorough assessment is critical for providing the most appropriate treatment, which may include pharmacotherapy in addition to educational, behavioural and psychotherapeutic interventions provided through individual/group work and peer support.

The assessment is conducted in a clinical setting where the various members of the interdisciplinary team can attend to the individual's treatment needs in one location. The collaborative enhances the continuity of care. In rural or remote areas with a solo practitioner with limited expertise or resources, the health care provider should be familiar with other providers in the vicinity for mutual support. The provider may also need to establish and use telecommunication with specialists in urban centres for more expert guidance. In some cases, the client and the family may need to travel to access comprehensive assessment resources and more treatment options.

The following areas are investigated and documented in addiction medicine assessments:

- In addition to individual self-reports, collateral information from caring family members and friends with appropriate confidentiality boundaries and consents.
- A complete history of past injuries, surgeries, serious medical illnesses or psychological/psychiatric problems, especially noting any past history of suicide attempts, medications that may have been prescribed and adverse effects/allergies.
- A systematic history of alcohol, tobacco and other drug use, including age of first use, patterns of use over the years and related complications for each drug category, such as stimulants, depressants, opioids, hallucinogens or inhalants (even though a client may identify only one particular drug as a problem).
- Other addictive behaviours such as gambling, sex and eating disorders.
- Consequences or problems related to relationships, family, education, work, finances or legal matters.
- Family violence, sexual abuse and other trauma.

In addition, physical assessments are necessary. These can include:

- Drug testing as an essential element of objective documentation.
- Bloodwork, including:
  - A complete blood count (platelets, red blood cell count, mean corpuscular volume, white blood cell count and differential); liver profile (AST, ALT, GGT, ALP); kidney function (creatinine, BUN); and thyroid stimulation hormone level. These indices provide a general evaluation of any gross complications due to alcohol/drug use.
• Possibly cholesterol and triglycerides testing, as excessive alcohol use adversely impacts these indices.

• A physical examination to document any evidence of liver disease, neurological issues (transient or irreversible) or needle use and related complications of infections.

When a mental health issue is suspected, a psychiatric screening is sought to ensure more specialized concurrent assessment and care. This screening assesses a range of possible disorders, with particular attention to trauma, anxiety, mood instability or psychotic disorders that affect thought content and structure.

As an aid to assessment, health care providers in urban or rural settings should become familiar with resources and tools for screening, brief intervention and referral for treatment (SBIR). SBIR is a comprehensive, integrated, public health approach to deliver early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing them. Primary care centers, hospital emergency rooms, trauma centres and other community social services settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

The Canadian Centre on Substance Abuse developed a professional toolkit on **SBIR for Alcohol Use** that can be helpful to health care providers and other professionals.

Some standard instruments and related documentation that can be helpful in assessing substance use problems include:

- Substance Use Disorder Diagnostic Schedule (SUDDS) and/or the Comprehensive Addictions and Psychological Evaluation (CAAPE), available through [www.changecompanies.net](http://www.changecompanies.net).
- Patient Placement Criteria (PPC), now in its second revised edition (2R) and available through [www.asam.org](http://www.asam.org). The PPC-2R provides two sets of guidelines—one for adults and one for adolescents—and five broad levels of care for each group.

Further information and resources are also available in the professional toolkits on **Screening** and **Assessment**.

**What are the implications for health care providers?**

It is essential that results from standardized instruments, interviews and examinations be considered in the individual’s context to formulate appropriate working diagnoses. Health care providers must work together to distinguish between individuals who abuse substances and individuals who are substance dependent to ensure treatment that matches their needs. Gathering information about physical, psychological, social and spiritual symptoms requires a coordinated effort, often by many individuals involved with the client. Information about medical and/or psychiatric co-morbidities or concurrent illnesses, for instance, becomes critical in determining assessment recommendations and treatment options.
Accurate and comprehensive diagnoses are also essential for facilitating client engagement in assessment and related actions directed at treatment.

The Stages of Change model has proven to be a useful approach to engaging clients in the screening and assessment process. The model matches the recommended clinical approach with a patient's/client's specific level of motivation to change in the following ways:

- **Pre-contemplation** (client suggests that there is no problem): A helper validates lack of readiness; clarifies that treatment decision belongs to the client; encourages re-evaluation of current behaviour, encourages self exploration (not action), and explains and personalizes the risk; and identifies any potential ambivalence. (A helper is anyone assisting the individual to deal with the issues; this could be a counsellor, doctor, friend or family member.)

- **Contemplation** (client acknowledges there may be a problem but is not completely convinced): A helper validates the lack of readiness; clarifies that the decision is still the individual’s to make; encourages evaluation of the pros and cons of behaviour change and developed ambivalence; and identifies and promotes new positive outcome expectations.

- **Preparation** (client has made changes before and is getting ready to try again): A helper identifies and assists in problem solving obstacles; helps the client identify social support; verifies that the client has underlying skills for behavioural change; and encourages small, concrete, initial steps.

- **Action** (client is making and practicing new behavioural changes): A helper assists patient/client to focus on restructuring thoughts; assists with feelings management, cues and social support; assists the client to build self-efficacy for dealing with challenges; and helps the client face feelings of loss and hopelessness by focusing on long-term benefits of change.

- **Maintenance** (client is working a recovery program on a regular basis): A helper provides follow-up support; reinforces internal rewards of change; and discusses how to cope with relapse.

- **Relapse** (client resumes some or all old behaviours, often by returning to use): A helper explores early signs of relapse; reassesses motivation and challenges; and collaborates with the client to increase and improve coping strategies and supports.

Readers are encouraged to review the professional toolkit **Motivational Interviewing** for further assistance on approaching patients/clients with substance abuse problems.

Treatment must be tailored to where the individual is, based on Stages of Change model, rather than the client conforming to a program. The options can vary from outpatient, intensive outpatient, day patient, short-term residential, long-term residential or therapeutic community. A thorough discussion with the client and/or the family will assist health care providers in determining the best approach, given the individual’s circumstances, to achieving the best outcome.

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References


