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Practical tools to detect, counsel and treat patients with problematic psycho-active substance use in primary care

Summary
Problematic psycho-active substance use is highly prevalent in patients consulting in primary care. Although the use of substances is not always problematic, screening for problematic use is justified in the adolescent, adult and geriatric populations, considering the high prevalence, the existence of simple valid screening instruments and cost-effective interventions. Screening can be performed by simple questions or with standardized questionnaires.
When screening is positive, primary care physicians can promote health behaviour changes using brief interventions based on the 5 A's framework. Physicians play an important role in providing immediate and long term care to patients suffering from addiction, if needed in interdisciplinary collaboration.

Introduction
Primary care physicians have a very varied practice, including care for acute and chronic diseases as well as preventive activities. Prevention includes assessment and interventions for behaviour change, particularly regarding the use of psycho-active substances such as tobacco, alcohol, cannabis and other drugs.
Problematic substance use is highly prevalent among, probably, more than one third of primary care patients and directly influences health outcomes. According to the WHO annual report (2002), tobacco, alcohol and illicit drugs are in the top ten of preventable health problems [1].
From a social and health perspective, psychoactive substance use is not always problematic. It covers a spectrum from beneficial use (e.g. moderate use of coffee, a few units of wine per week, sacramental use of ayahuasca) to non-problematic use (e.g. non-excessive alcohol use), problematic use (e.g. alcohol binge drinking) and dependence.
Despite wide variations between regions, age groups and over time, estimated population prevalence in developed countries is over 25% for tobacco dependence, 20% for excessive alcohol use, 5% for alcohol dependence, 5–10% for benzodiazepines dependence (highest in elderly people), 2–5% for cannabis dependence (mostly adolescents and young adults), and less than 1–2% for cocaine/heroine dependence [2].
Primary care physicians face several barriers in addressing substance use during consultations. They include organisational issues such as time constraints and lack of financial compensation, or more individual issues such as lack of training on substance use, negative attitudes towards or personal/familial problems with substance use [3].
The aim of our article is to provide some practical tools for the primary care physicians to detect, counsel and treat patients with problematic psycho-active substance use. Join us to follow our patient, Joe, through different steps of his life.

Joe 15 years old
You have known Joe since he was 3 years old. He is a healthy boy, loving soccer and doing fine at school. Recently he consulted for bronchitis. This is the second appointment, three days later for a follow-up. Last time you asked him about substance use, he said that he uses alcohol and cannabis but not too much and has no problem with it.
Before this consultation the mother called to say she is worried, she thinks Joe smokes too much cannabis and his grades are dropping.

Comments
Experimenting with substances is part of the adolescent development process. Screening for substance use should aim to differentiate between occasional exploratory use and more regular use which may impact on adolescent's health and development.
Offering a safe and confidential environment to discuss these issues in the consultation is essential [4]. Problematic substance use should be suspected particularly if warning signs are present (table 1). A screening tool for adolescent substance use like Dep-ADO can help the physician assess multiple substance use frequency and psychosocial consequences. It can be used as an initial step (Assess) of 5A's brief intervention strategy.

Table 1
Unspecific warning signs of substance abuse in adolescents.

Decreased school/professional achievement
Isolation, lack of relationships
Violence, deviant behaviour
Recurrent physical/functional symptoms

Joe 35 years old
Joe finished school and obtained a degree in architecture. He started working as a private architect. He got married at 27 and had three children. He plays soccer every weekend and is active in local associations. Joe visits you at age 35, for increasing tiredness and dyspepsia. During the interview, he tells you that:
- *He currently smokes 1.5 packs of cigarettes/day with his 1st cigarette within 5 min after waking up; he started smoking when he was 16 then progressively increased his consumption; he never stopped despite a few attempts to reduce*
- *He drinks alcohol daily "like everyone": 2 glasses of wine at lunch & dinner & 2–3 beers; he gets drunk every 1–2 months in parties when he has 8–10 drinks*
- *Last year, he took cocaine 2 times in parties where it was easily accessible; he enjoyed it but wants to keep it occasional for fun*

Comments
The clinician can identify that Joe has 3 types of substance use:
- Recreational use of cocaine: occasional, minimally harmful use
- Excessive use of alcohol: regular, harmful consumption above the WHO limit for men of 21 alcoholic drinks/week or intake of more than 5 alcoholic drinks on one occasion [5]
- Tobacco dependence: daily, harmful and heavy consumption of cigarettes (30/day, 1st within 5 minutes after waking up); presence of at least 3 of the 6 criteria for dependence (table 2)

Primary care physicians can deliver brief interventions which are effective to promote behaviour change [6]. The 5 A's framework is a simple and structured tool including 5 counselling strategies to include brief interventions (table 3).

Table 2
ICD-10 criteria for dependence to psycho-active substances.

Presence of at least 3 of 6 criteria:
Strong desire to use a psycho-active substance
Difficulty to control use of a psycho-active substance
Withdrawal symptoms when stopping or reducing a psycho-active substance
Tolerance requiring higher doses of a psycho-active substance to obtain the same effect
Progressive loss of usual interests in favour of activities linked to a psycho-active substance
Continuing use of a psycho-active substance despite harmful effects

Table 3
The 5 A's counselling framework.

Assess	Assess behaviour, motivation to change, knowledge, beliefs
	Example: "How many drinks do you have daily? What do you think?"
	Use of questionnaires can be helpful (Dep-Ado for adolescents, ASSIST for all substances, AUDIT for alcohol)
Advise	Provide personalised infor mation on the behaviour
	Personalise information according to patient's concerns, health problems, experiences
	Example: "Tobacco and alcohol certainly cause your stomach pain and will improve if you reduce your consumption"
Agree	Agree on objectives & methods of change
	Select realistic and measurable objectives
	Example "We agree that you will reduce to 3 alcoholic drinks per day"
Assist	Provide support and information on resources
	Identify barriers to change and strategies to overcome
	Example: "I will help you to quit smoking and prescribe nicotine patches to reduce cravings"
Arrange	Organise follow-up for assessment & support
	Example: "We will meet regularly during the next months". Or "I propose we meet in 2 weeks to discuss….."

Joe 70 years

Joe stopped smoking with the help of his physician and nicotine replacement for 3 months. He relapsed once after 9 months, but quickly succeeded to stop again. He gained a few pounds but lost them when he took his bike instead of his car to go daily to his work. His children grew up and did fine. He retired at 64. His wife was diagnosed with Alzheimer disease, and died 5 years later.
When Joe is aged 70, his son comes to see you because he is worried about his father. Since his wife's death, he is living alone, is rarely going out, seems unstable when walking, and refuses to come for a medical consultation.

Comments
Possible signs and symptoms of harmful alcohol use in the elderly include unstable walking and falls, mood disorders, missed appointments and difficult control of chronic disorders (hypertension, diabetes). Of course, all these symptoms can be related to aging and increased frailty. Safe drinking behaviour in older age is difficult to define as WHO norms in normal adulthood do not necessarily apply, since elderly people have lower reserves and suffer higher alcohol toxicity. Current recommendations propose a maximum of 1 American standard drink (= 14 g), corresponding to one and a half Swiss standard drinks per day or a maximum of 10 Swiss standard drinks per week.
Harmful drinking is probably underdiagnosed in the elderly, as are cases of dependence. A third of these develop in older ages in association with specific conditions (retirement, isolation, death of partner) and 2/3 pursue younger patterns of addiction with increased health burdens [7, 8].
For assessment and brief interventions, the same recommendations as described above apply. In case of dependence, detoxification in inpatient settings should be preferred.

Conclusion

Use of psycho-active substances will be part of most of your patient's life and is not always problematic. Systematic screening for harmful use of substances during medical consultations is justified for adolescents, adults and elderly patients since prevalence is high. Assessment can be performed by using simple questions or a validated questionnaire. In case of positive screening, the 5 A's framework can guide further intervention.

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References

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Questionnaires:
- Dep-ado: www.risqtoxico.ca/risq/www/dep_ado.php
- ASSIST: http://www.who.int/substance_abuse/activities/assist/en/index.html with the questionnaire available in 5 languages, but also three documents: ASSIST: Guidelines for Use in Primary Care [pdf 244kb]
- Brief Intervention for Substance Use: A Manual for Use in Primary Care [pdf 164kb]
- Self-Help Strategies for Cutting Down or Stopping Substance Use: A Guide [pdf 424kb]
- AUDIT: http://www.who.int/substance_abuse/activities/sbi/en/index.html

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