HOW TO USE THIS PROTOCOL

This screening and assessment protocol for polydrug abusers was written with the front-line worker in mind. It aims to facilitate the worker by providing an organized framework for information collection and assessment. This protocol in no way dictates what the worker should do because we understand that the client, the setting, and the rapport between the worker and the client can vary quite dramatically from case to case. We therefore expect that this protocol will be used with flexibility and in accordance with your individual or situational needs.

The **Annex Section** contains a lot of factual information. We understand that front-line workers come with varying degrees of experience and knowledge base, and the Annex Section would be a useful resource if the worker wants to update his/her knowledge in some aspects of substance abuse. The Annex Section will also come in handy if the worker wants to refer to some specific information in the process of screening and assessment. We therefore recommend that the worker should first scan through the Annex Section and read up information that are helpful to the screening and assessment procedures.

Next comes the **Screening Guideline**. Screening is used to ascertain whether the subject client is, or is not, having a substance abuse problem. The Guideline will be helpful to the worker in the course of collecting collateral information by enhancing their sensitivity to some of the salient risk factors. With the aid of the guideline, the worker will hopefully be able to conclude with a higher degree of confidence to which categories the target client belongs.

If you have a *bona fide* client of substance abuse (for example, through referral of self confession), the **Assessment Guideline** will help you collect and organize information in a more systematic manner. There are two domains pertinent to this section:

(1) History taking (information collection), and,
(2) Systematic assessment (including other medical examinations).

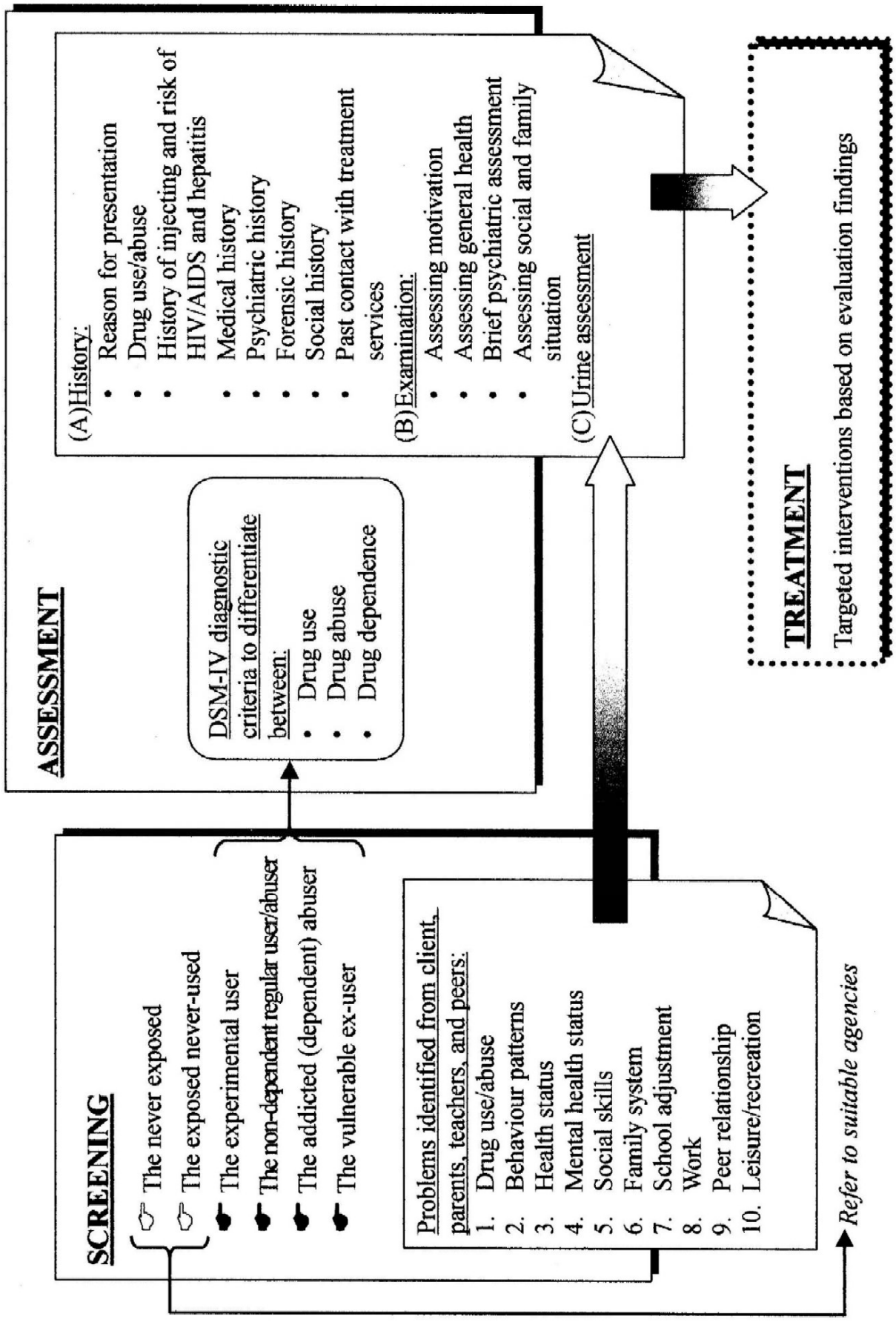
The first part suggests major areas of information collection, including personal history, family and social background, habits of abuse, and other relevant medical, psychiatric and forensic information.

The Examination part provides a guideline for more detailed questioning and investigation, often supplemented by questionnaires and checklists. We do not expect the worker to be able to, for example, make a definite psychiatric diagnosis. We only hope to increase the sensitivity of the workers on the presence of mood problems, cognitive deficits, and other psychiatric morbidity so that the worker knows when and who to refer to. Remember, we aim at collecting systematic and comprehensive information about the target client to help us to conceptualize the intensity and extent of his/her substance abuse so that we can arrange for a more appropriate services at later

stage.

In the process of information collection and examination, the worker should reassure the target client that all information collected would be treated with the strictest confidence. Workers are also reminded to adhere to their specific codes of professional ethics, and take every step to protect the client's personal data.

Finally, it should be reiterated that the protocol and guideline are meant to be used in a flexible way. The information so collected will hopefully be more comprehensive and systematic so that workers across organizations and services will be able to communicate with the same vocabulary and utilize the same data set in the course of their service provision.


SCREENING
The never exposed
The exposed never-used
The experimental user
The non-dependent regular user/abuser
The addicted (dependent) abuser
The vulnerable ex-user
ASSESSMENT
(A) History:
Reason for presentation
Drug use/abuse
History of injecting and risk of HIV/AIDS and hepatitis
Medical history
Psychiatric history
Forensic history
Social history
Past contact with treatment services
(B) Examination:
Assessing motivation
Assessing general health
Brief psychiatric assessment
Assessing social and family situation
(C) Urine assessment
DSM-IV diagnostic criteria to differentiate between:
Drug use
Drug abuse
Drug dependence
Problems identified from client, parents, teachers, and peers:
1. Drug use/abuse
2. Behaviour patterns
3. Health status
4. Mental health status
5. Social skills
6. Family system
7. School adjustment
8. Work
9. Peer relationship
10. Leisure/recreation
TREATMENT
Targeted interventions based on evaluation findings
Refer to suitable agencies