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Diagnostic dilemmas in substance disorders

Substance disorders include specific complex conditions such as substance abuse, dependence, or addiction and diagnosis can be a complex process.

A researcher may use a classification system when investigating discrete aspects of a defined disorder or condition applied to a population cohort. The processes of diagnosis and implementation of a treatment plan in a specific clinical situation makes very different demands of a classification system. To be of maximal use in the clinical setting, it is important that defining diagnostic criteria are presented in such a way as to allow clinicians to:

- discriminate conditions that require different management approaches, and
- recognise patients for whom special risks or more variable outcomes might be anticipated.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),[1] and Manual of the International Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines (ICD-10),[2] are the most widely used diagnostic aids. Despite the widespread availability and use of these manuals, it is arguable how useful they are for clinicians in assessing the often complex presentations of individual patients with substance related problems.

The DSM-IV criteria for substance abuse and substance dependence are shown in *Table 1*. However, particularly in the primary care setting, patients with potential problems related to illicit drugs or prescription analgesics or sedatives do not neatly fit into these categories. Such presentations may include:

- the patient with chronic pain who has been prescribed narcotic analgesics and requires increased amounts
- the patient who has been prescribed benzodiazepines (BZD) for insomnia or anxiety and experiences withdrawal or return of symptoms on attempted cessation
- the 'prescription shopper'.

As Monheit's article in this issue of *Australian Family Physician* illustrates,[3] the problems of managing patient requests for analgesics and BZD in particular, have become more prominent and are a disturbingly frequent cause of both patient and doctor distress in clinical encounters. My own impression in rural clinical practice in the substance related area over 25 years, is that patient 'drug seeking' presentations have become more sophisticated over the past decade. 'Surrogate seekers' and 'deceptive diverters' can be difficult to spot and include partners, parents, and even grandparents of the ultimate consumer of the Schedule 8 opioid or BZD. This trend, particularly prominent in rural areas, appears to be related to the significant (and sometimes appropriate) increased use of opioid medication in the treatment of chronic nonmalignant pain. It can, however, be equally driven by the well recognised advantages opioid dependent patients gain from using 'prescribed' opioids, compared with a range of disadvantages of using illicit heroin including cost, availability, risk and legal issues.

Doctors generally, but general practitioners in particular, have a critical role in either appropriately prescribing or withholding psychoactive medication in patients with substance related problems. Both patient and prescriber can be placed significantly at risk if the clinician doesn't have a clinically relevant framework for assessing the individual patient. There is an argument for making a distinction between 'dependence', which could be defined as experiencing psychological or physical withdrawal symptoms, and 'addiction', defined as a set of cognitions and/or behaviours associated with loss of control (self regulation). Such features would include manipulative behaviours, deceit (including of self: 'I can stop any time') and drug seeking behaviours.

In the primary care setting 'dependent', 'nonaddictive' use of medications, specifically opioids and BZD, are more commonly encountered than in specialist drug and alcohol settings or other tertiary care settings. This distinction is extremely important because a patient with dependence on prescription medication, but not addiction, requires a different management plan to one who displays evidence of manipulative and drug seeking behaviour. Characteristically, dependent, nonaddicted patients are more likely to respond positively and cooperatively to explanations about the real nature and cause of their withdrawal symptoms or tolerance. The nonaddicted patient may demonstrate some increased use of medication (increased dose and/or frequency), which may be related simply to their increasing tolerance or withdrawal symptoms, rather than to drug seeking behaviour. The nonaddicted patient will characteristically be happy to discuss their management and ways to reduce/cease their medication and will more readily accept alternative medications or treatments, if indicated, to assist with their management.

It is always safer and never inappropriate practice, particularly where the patient is previously unknown to your practice, to exercise universal prescribing principles,[4] particularly when prescribing opioids[5] and BZD, until the absence or otherwise of addiction becomes apparent. It is also increasingly important professionally for GPs to prescribe carefully, having recognised a patient as being addicted. Not only are these patients at increased risk of overdose, but prescribing to an addicted patient inappropriately may result in scrutiny of the treating doctor's prescribing practices by jurisdictional regulatory authorities.

It is clinically more useful to use an assessment model, such as the Personal Drug Assessment (PDA), which broadens the current DSM-IV classification for substance abuse and dependence to reflect three critical clinical elements:

- **P**attern of recent (eg. last month) drug use for

each relevant psychoactive substance used with any regularity. The pattern of use (ie. when last used, used alone or in company, why used, how used) is arguably more useful in the general practice setting than concentrating on a precise frequency/quantity history

- **D**ependence – defined specifically as evidence of psychological and/or physical withdrawal symptoms
- **A**ddiction – defined as a set of cognitions and/or behaviours associated with loss of control (self regulation) such as manipulative or drug seeking behaviours. Often secondary sources such as the patient's spouse, parent, past GP or pharmacist can provide critical information, as can resources such as the Drugs & Poisons Regulation Group or the Prescription Shopping Program.

It is important to note that neither 'dependence' nor 'addiction', as defined above, are fixed entities that always apply to a particular person over time or a particular type of presentation. They are appropriately viewed as cardinal substance related symptom clusters. The patient's psychological state, social circumstances and a host of other factors act to influence the degree to which these are experienced at any point in time.

The value of assessing individual patients using this PDA framework is that when combined with simple questions about readiness to change, the patients social circumstances and psychological risk factors (eg. mental health disorders or suicidality), it can assist in clarifying important diagnostic and management decisions.

With a PDA, information simple advice can be tailored to the patient's:

- readiness for change. For example, a patient may be ready to accept advice about how to manage their withdrawal or reduce consumption, but not be ready to deal with long term addictive behaviour
- presenting complaints, such as symptoms of withdrawal. The need for prescribed treatment can be assessed against risk of withdrawal or need for symptom relief. Patients with dependence often will not require specific medicated treatment in the primary care setting. Anxiety is a very frequent symptom/sign of almost all substance withdrawals. However, BZD are only specifically indicated in managing significant or complex alcohol or BZD withdrawal
- identified substance related complications such as addiction. The need for tailored restrictions on their access to prescribed drugs with potential for abuse can be more readily appreciated and managed.

The key role GPs have in responsible prescribing and prescription management is dependent on effective diagnosis and assessment. Using the PDA framework for assessment of individual patients can assist in addressing clinical and ethical management issues and reducing the significant adverse clinical, public health and social consequences which can so easily flow from inadequately and ineffectively addressing substance use disorders.

Table 1. Substance abuse and dependence criteria[6]

DSM-IV substance abuse criteria

Substance abuse is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following, occurring within a 12 month period:

1. Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home
2. Recurrent substance use in situations in which it is physically hazardous
3. Recurrent substance related legal problems
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

Note: The symptoms for abuse have never met the criteria for dependence for this class of substance. According to the DSM-IV, a person can be abusing a substance or dependent on a substance but not both at the same time

DSM-IV substance dependence criteria

Substance dependence is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12 month period:

1. Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of the substance to achieve intoxication or the desired effect or (b) markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal, as manifested by either of the following: (a) the characteristic withdrawal syndrome for the substance or (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms
3. The substance is often taken in larger amounts or over a longer period than intended
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
6. Important social, occupational, or recreational activities are given up or reduced because of substance use
7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance

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