GUIDELINES

for Management of **Inhalant** Abuse in Primary Care

Alcohol and Substance Unit,
MoSVIPP Sector,
Non-Communicable Disease Section

with collaboration
World Health Organisation,
Kuala Lumpur

2013

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CONTENT

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PREFACE

Director General of Health, Ministry of Health Malaysia

I would like to congratulate the Non-Communicable Disease Section of the Disease Control Division, Ministry of Health and the Inhalant Abuse Technical Working group for their strenuous and hard effort to produce the National Guideline for Management of Inhalant Abuse in Primary Care.

I would also like to take this opportunity to sincerely thank and appreciate the support and financial assistance given by World Health Organization (WHO) in making the production of this Guideline a success.

The publication of this document is very timely since at present there is no national guidelines on the management of Inhalant Abuse especially at Primary Care level which is the front liner for those who wish to seek help. The aim of producing this Guideline is to assist health care providers at primary level to offer assistance and interventions needed for those with Inhalant Abuse problems and dependence.

Studies showed that Inhalant Abuser is more common among youth especially those in the 12-18 years of age. They tend to start at early age, more commoner among boys, higher in school drop-outs and history of broken families. The most common type of Inhalant abuse in the country is glue sniffing.

Chronic Inhalant abusers pose serious complications and grievious consequences such as brain damage and retardation apart from permanent damage to the central nervous system, liver and kidney. Sudden Sniffing Death Syndrome (SSDS) can also occur with first timers as a result of cardiac arrhythmias or died of asphyxia due to suffocation. They were also commonly involved in crime and anti-social behaviours.

Interventions need to be given early and prompt to avoid further damages. This National Guidelines is also the first attempt to educate and empower health care providers at primary care level to detect early and provide the necessary interventions for Inhalant abuse cases.

I sincerely hope this National Guideline will be very useful and beneficial to all health providers.

YBhg. Datuk Dr Noor Hisham bin Abdullah
Director General of Health.

GUIDELINE FOR MANAGEMENT OF INHALANT ABUSE IN PRIMARY CARE

CHAPTER ONE: INTRODUCTION

1.1 WORLD WIDE OVERVIEW OF INHALANT ABUSE

National Household Survey on Drug Abuse (NHSDA), 2001 revealed approximately 2 million youth 12 to 17 years of age ever use inhalants meanwhile 18 million people had use inhalant.

National Survey on Drug Use and Health, US (2010) showed 68.4% of 793,000 respondents that use inhalants for the first time were those between 12 to 18 years.

Studied by Monitoring the Future (MTF), US (2011) on inhalants use contributing factors are lower socioeconomic background, history of childhood abuse, low academic achievement and school drop-out. From ethnic perspective, Hispanics were the highest inhalant abuser as compared to the Blacks and Whites.

1.2 MALAYSIAN OVERVIEW OF INHALANT ABUSE

Studied by Haslina Hashim et al (2009) involving 127 youth (122 males and 5 females) in Kuching, Sarawak found majority of respondents started to abuse inhalants at the age of 11 to 15 years.

118 respondents (95%) preferred glued as compared to other inhalants (petrol, thinner and correction pen) since it is highly accessible and easy to keep. Average frequency of usage is 9 times to a maximum of 28 times per week.

CHAPTER TWO: BACKGROUND INFORMATION

2.1 WHAT IS INHALANT?

Inhalant are volatile substances that produce chemical vapors that can be inhaled to induce a psychoactive, or mind-altering, effect

2.2 TYPES OF INHALANT

i. Volatile solvents:
These are liquids or semi-solids such as petrol, glue or paint thinner that vaporize at room temperature.

ii. Aerosols:
Propellant gazes and solvents contained in spray-cans are known collectively as aerosol such as spray paints, deodorants and hairsprays.

iii. Gases:
The most commonly used substance in this category is nitrous oxide.

iv. Nitrites:
Often are considered a special class of inhalants. Nitrites include cyclohexyl nitrite, isoamyl (amyl) nitrite and isobutyl (butyl) nitrite.

2.3 MODE OF INHALANT ABUSE

- "Sniffing"
- "Snorting" fumes from containers.
- Spraying aerosol directly into the nose or mouth.
- "Bagging"-sniffing or inhaling fumes from substance sprayed or deposited inside a plastic or plastic paper.
- "Huffing" from an inhalant-soaked rag stuffed in the mouth.
- Inhaling from balloons filled with nitrous oxide.

2.4 HIGH RISK GROUP

- Youth
- Low socioeconomic
- History of childhood abuse.
- Poor grades and drop out from school.

2.5 EFFECT OF INHALANT ABUSE

i. Immediate effect and the danger of Sudden Sniffing Death Syndrome (SSDS)
ii. Short term effect
iii. Long term effect
iv. Social effect

2.5.1 IMMEDIATE EFFECT

i. Euphoria
ii. Excitation
iii. Wheezing
iv. Sneezing
v. Coughing
vi. Palpitation
vii. Nausea and Vomiting
viii. Hallucination

Sudden Sniffing Death Syndrome (SSDS)

- This is due to a sudden and unexpected disturbance of the heart's rhythm (arrhythmia).
- Could occur with first timer and all types of Inhalants.
- Asphyxia due to suffocation of the plastic bag used during sniffing.
- Vomitus aspiration
- Injury, drowning and accidents.

2.5.2 SHORT TERM EFFECT

i. Rapid intoxication and recovery
ii. Hallucination
iii. Loss of inhibition
iv. Loss of muscular coordination
v. Slurred speech and blurred vision
vi. Feelings of invulnerability / invincibility

vii. Drowsiness
viii. Dizziness
ix. Confusion and incoherence
x. Aggression
xi. Increase risk taking behaviours

2.5.3 LONG TERM EFFECT

Some of the harms from longer-term or chronic use include:

i. Organic brain damage
   - Psychosis
   - Dementia

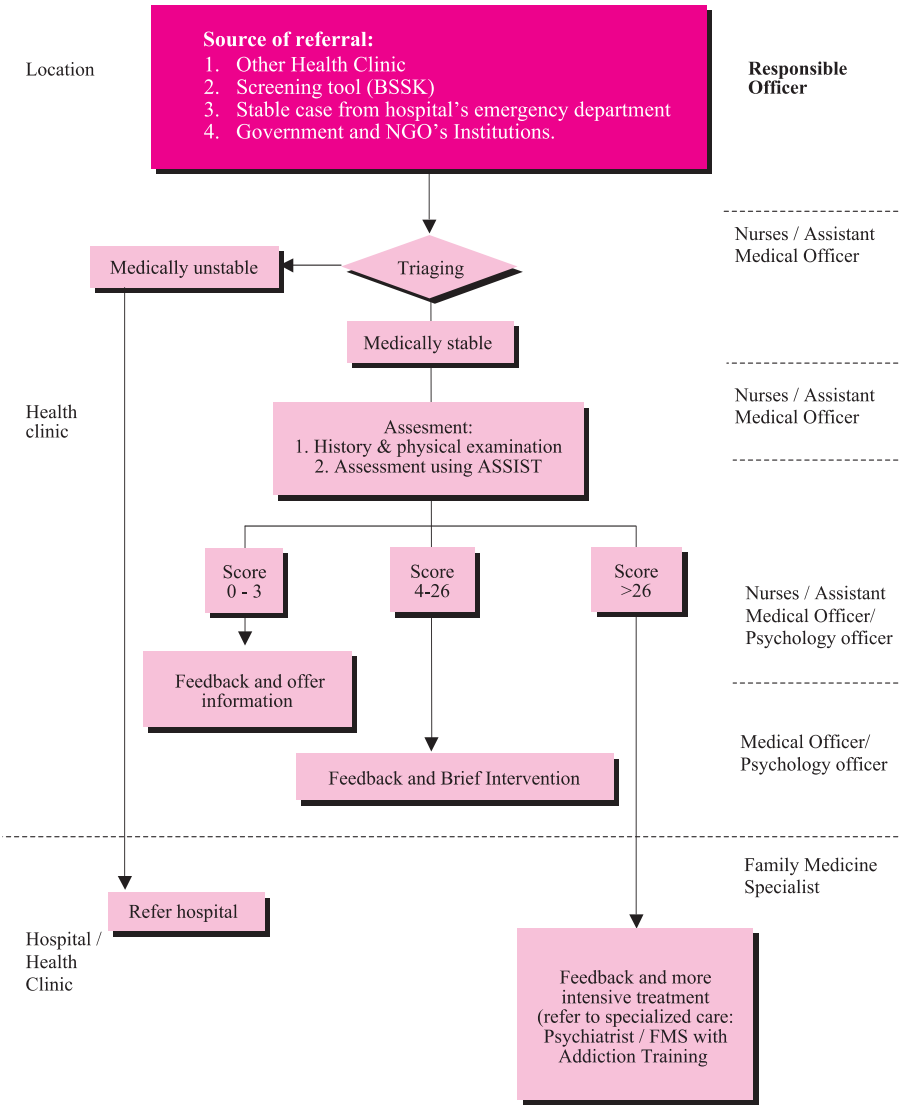
ii. Permanent damage to nervous system, liver, muscle, bone marrow and kidneys
iii. Diminished cognitive function (eg memory loss)
iv. Recurrent nose bleeds
v. Oran and nasal ulceration
vi. Sinusitis
vii. Lethargy
viii. Indigestion
ix. Conjunctivitis and blood-shot eyes
x. Chronic or frequent cough
xi. Tinnitus

2.5.4 SOCIAL EFFECT

i. School absenteeism
ii. Poor academic achievement
iii. Broken homes
iv. Juvenile crimes
v. Antisocial behavoiur

CHAPTER THREE: TRIAGING, DETECTION AND ASSESSMENT

FLOW CHART FOR MANAGEMENT OF INHALANT ABUSE IN PRIMARY HEALTH CARE



3.1 SOURCE & PATIENT IDENTIFICATION

PATIENT	SOURCE OF IDENTIFICATION
Walk in	Patient itself / family/ friends
Patients in Medication Assisted Therapy program	Referral from Methadone clinic
Government agencies and NGO such as school, NADA / PDRM (Narcotic)	People accompanied patient.
Recently stable discharge patient	Referral letter
Out Patient	Referral letter

3.2 TRIAGING

Triaging process is to identify any acute medical, surgical or psychiatric conditions. Assessments include examinations of:

CONDITION	NEXT STEP
Conscious level • GCS score (see appendix A) • Identify seizure	GCS: - Scoring 12 and below; refer to casualty. Refer to medical team at hospital
Physical condition: • Hydration status • Vital sign; BP, PR, SPO2, • Appearance such as unpleasant odors smell, traces of paint on their faces and clothes, tremors, slurred speech. • ECG (if needed)	Refer to casualty if patient is not stable. Further assessment using ASSIST

CONDITION	NEXT STEP
Mental state • Delusion and/or Hallucination which is not dangerous to patient and other people.	Refer to FMS
• Delusion and/or Hallucination in acute condition • Agitation • Restlessness • Cognitive condition / confusion • suicidal intent	Refer to psychiatrist

NOTE: Patients who are acutely ill will be stabilized accordingly and referred to the hospital. Stable patients will be further assessed.

3.3 DETECTION.

We should identify the symptom/sign of inhalant abuse.

CLINICAL SYMPTOMS	NEXT STEP
a. Initial: • Euphoria • Excitation • Sneeze, cough, and wheeze • Heart palpitations • Nausea, vomiting, diarrhea b. Chronic: • Bloodshot eyes • Chronic nosebleed • Low energy and motivation • Reduced appetite • Increased salivation and spitting • Sores in the nose and mouth • Dry throat	1. Staff Nurses / Assistant Medical Officer to perform ASSIST - The next is depending on the ASSIST score. 2. Medical officer/Psychology officer - Psychosocial support.
Central Nervous System (CNS) depression • Slurred speech • Delusions • Disorientation • Confusion • Tremor	1. Family Medicine Specialist (FMS) 2. Psychiatrist (if FMS not available) 3. Neuropsychological assessment: The signs and symptoms to look out for include: • Memory problems

CLINICAL SYMPTOMS	NEXT STEP
• Hallucinations	• Co-ordination problems in the absence of intoxication • Poor problem-solving capacity • Sensory problems like vision and hearing problems.
Further CNS depression • Poor balance, ataxia, staggering, stupor, Seizures.	A&E (hospital) & for further specialize care.

3.4 ASSESSMENT

3.4.1 INTRODUCTION.

Basically there are three methods can be used to assess patient condition before appropriate further treatment given, these assessment are:

a. ASSIST screening tool
The aim of the ASSIST (Appendix B) is to gather some information quickly and simply to understand current inhalant use and the potential risks for the purpose of immediate intervention or referral and also to determine the severity of use.

b. Full history

c. Physical examinations

} Appendix C

During assessment, there are some suggested tools /forms that can be used by us to additional information such in appendix C (History And Physical Examination), Appendix D (Brief Mental Health Assessment), appendix E, F and G (checklist for intervention).

Beside that, we have to familiar with behavioural clues of possibility inhalant user. This can be:

- Monotonous voice
- Poor eye contact
- Unpleasant body movement

CHAPTER 4: STRATEGY AND APPROACH.

4.1 INTRODUCTION

There are four strategies recommended when dealing with patient having issues with inhalants and each one tailored to a particular goal.

STRATEGY	GOAL	APPROACH
Deferrence	Prevention of inhalant use in the setting.	The aim of deterrence strategies is to make inhalant use more difficult and less desirable. Deterrence relies on establishing consistent rules and operatives that are known from the outset, with known consequences.
Dealing with intoxication and acute effects	Safety of person abusing inhalants	These strategies list the specific courses of action required when a person is acutely affected by inhaled substances. These outline the immediate medical and psychological strategies for intervening in acute circumstances, including life-threatening emergencies.
Short-term behavioural management strategies	Safety, behaviour management, cessation of use	These behavioural management strategies are concerned with assisting a person who is currently engaged in inhalant use. These strategies are aimed at immediate behavioural intervention.
Long-term behavioural maintenance strategies	Addressing maintaining factors of inhalant use, long term cessation	These strategies are long-term and focus on a range of factors that are maintaining inhalant use. They are aimed at longer-term behaviour change by individual and broader community intervention.

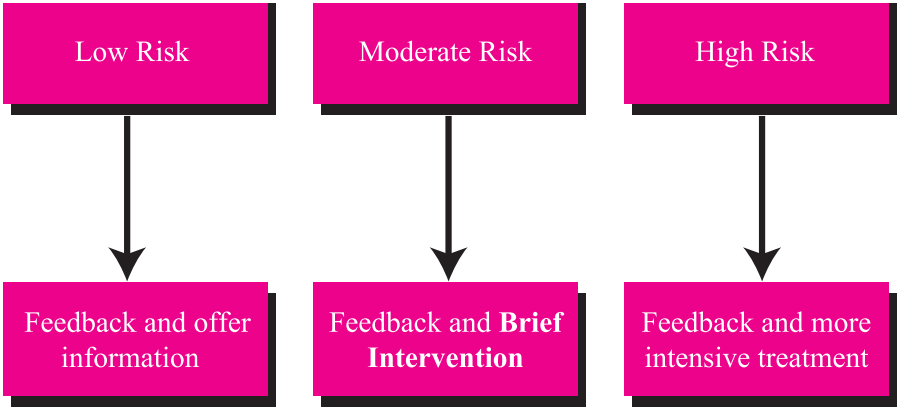
4.2 ASSIST ASSESSMENT & INTERVENTION:

Management for inhalant use in primary care setting mainly involves the psychological approach. The approach will depend on the severity of use measured by ASSIST screening tool. Adolescent age 18 yrs old and below is preferred to be accompanied by parents during clinic visits.

a. ASSIST scoring 0-3 : mild use (Low risk)
b. ASSIST scoring 4-26 : moderate use (Moderate risk)
c. ASSIST scoring > 26 : severe use (High risk)

In general, each ASSIST score is link to certain appropriate intervention as shown in Figure 1 below:

FIGURE 1: LINKING ASSIST SCORE TO APPROPRIATE INTERVENTION



All patients screened using the ASSIST should receive feedback regarding their scores and level of risk and be offered information or advice about the substances they use. This is the minimum level of intervention for all patients.

4.2.1 Brief Intervention (BI)

a) Aims of BI

i. to identify current or potential problems with substance use
ii. motivate those at risk to change their substance use behavior.

Brief interventions should be personalised and offered in a supportive, non judgemental manner. There is strong evidence for the effectiveness of brief interventions in primary care settings for substance users.

b) Components of BI

Components of brief interventions that work can be summarized using the acronym **FRAMES**:-

- Feedback
- Responsibility
- Advice
- Menu of options
- Empathy
- Self efficacy (confidence for change)

4.2.2 ASSIST Score

Subsequently, they should be approached according to their score using specific steps.

a) ASSIST scoring 0-3 : mild use (Low risk)

- Suitable for either first time users or known regular users.
- Should be repeated a number of times unless the behaviour escalates.

Those with low risk score do not need any intervention to change their inhalants use. However, provision of general information about inhalants to low risk users is appropriate.

Steps to be taken with patients whose ASSIST scores indicate they are at low risk:

1. Provide feedback about their ASSIST scores and risk level.
2. Ask if they would like any additional information about drugs for themselves or their family. Give the patient pamphlets or education materials about inhalants to take home.
3. Reinforce that what they are doing is responsible and encourage them to continue their current low risk substance use patterns.
4. This approach should be used for at least 3 months to see the improvement. During follow ups, ASSIST assessment should be used and intervene accordingly.

b) ASSIST scoring 4-26 - moderate use

Those with moderate use should be offered a brief intervention. It should be flexible and take account of the patient's level of risk, specific problems, and readiness to change.

The main components of a brief intervention as stated above should be considered:

1. Discuss the meaning of the results and link to the specific problems listed on pages 2-4 of the Report Card.
2. Provide clear advice (FRAMES) that the best way to reduce the risk of substance related problems is to cut down or stop substance use. It is important to emphasis that the patient is responsible (FRAMES) for their own substance use behaviour.
3. Provide them with a Model Of Behavior Change for understanding of how people change their behavior

This approach should be used for **at least monthly** to see the improvement. During follow ups, ASSIST assessment should be used and intervene accordingly.

NOTE: The brief intervention approach is based on the Motivational Interviewing Principals.

c) ASSIST scoring more than 26 – severe use

Elements of the brief intervention may be used to motivate patients who are not willing to accept intensive treatment (see appendix *).

Review and monitor all patients according to follow up schedule or whenever they return to see us. If unsuccessful, refer to specialized care (Psychiatrist / FMS with Addiction Training).

This approach should be used for **at least two weekly** to see the improvement. During follow ups, ASSIST assessment should be used and intervene accordingly.

4.3 FOLLOW UP

Below is recommended follow up schedule:

ASSIST score	Follow up interval
0-3	3 monthly
4-26	monthly
> 26	2 weekly

4.4 MANAGEMENT APPROACH OF ACUTE INHALANT INTOXICATION IN PRIMARY CARE

Goal: Safety of person abusing inhalants

If a young person appears intoxicated, assess their need for immediate medical attention. The young person's safety is the highest priority.

1. **If conscious** and not in need of immediate first aid:
   - Confiscate substance if it is safe to do so.
   - Reduce any immediate risks to the young person or surrounding people by:
     i. opening doors and windows if in an enclosed area (staff to be mindful of impact on themselves if they are in a vapour-filled room).
     ii. remove matches and do not permit smoking.
     iii. call police if appropriate
   - Reduce stimulation by:
     i. removing to a safe location with low stimulus, or
     ii. making the immediate environment low stimulus by removing spectators. Over stimulating environments for an intoxicated person could result in an acute physiological reaction such as shock or sudden death.
     iii. Keep calm, reassure the person, speak softly.

2. If unconscious:
   - Start "ABC" procedure: Check airways, breathing and circulation. If not breathing/no pulse, start EAR/CPR. Use standard first aid procedures – put the person on their side, loosen clothing, keep warm.
   - Call ambulance for immediate referral.
   - Segregate: If possible remove to safe space or remove other people from the area.
   - Remove paraphernalia: Retain for identification at hospital if required.
   - Keep calm.

- Reduce any immediate risks to the young person or surrounding people by:
  i. opening doors and windows if in an enclosed area
  ii. remove matches and no smoking
  iii. defuse/debrief other young people and other witnesses.
- Stay with young person until effects have worn off.
- When recovered, check and ask: What happened? Which drugs have been taken? How? How long ago? Is anybody else involved who might need help?

NOTE: An ambulance also needed when the person is:

- Having difficulty in breathing
- Not breathing
- Pulseless
- Troubled breathing (audible wheeze/crackle)
- Altered conscious state
- Cyanosed – blue skin, clammy skin, hot, red, dry skin
- A history of breathing problems such as asthma
- Recent undiagnosed psychotic symptoms

APPENDICES

A4 GLASGOW COMA SCALE

The Glasgow Coma Scale (GCS) evaluates eye opening, verbal and motor responses, and brainstem reflex function.

- It is considered one of the best indicators of clinical outcome

- 15 is normal
- 13-14 is associated with mild head injury
- 8-12 is associated with moderate head injury
- <8 is associated with severe head injury

	Adult	1-5 years*	0-1 years**
Eye Opening			
4	spontaneously	spontaneously	spontaneously
3	to command	to command	to shout
2	to pain	to pain	to pain
1	no response	no response	no response
Best Verbal Response			
5	oriented	appropriate words, phrases	coos, babbles, smiles
4	confused	inappropriate words	cries
3	inappropriate words	cries, screams	inappropriate cries, screams
2	incomprehensible	grunts	grunts
1	no response	no response	no response
Best Motor Response			
6	obeys commands	spontaneous	spontaneous
5	localizes pain	localizes pain	localizes pain
4	withdraws from pain	flexion withdrawal	flexion withdrawal
3	abnormal flexion	abnormal flexion	abnormal flexion
2	extension	extension	extension
1	no response	no response	no response

*age 2-5 for verbal response
**age 0-2 for verbal response

ASSISST SCREENING QUESTIONAIRE

ASSIST v3.1 BM (A)/2011

Ujian Saringan Keterlibatan Alkohol, Merokok dan Dadah - ASSIST v3.1

Nama Penemuduga:		Negeri:		Tempat:	
		Daerah		Tarikh:	
Nama Pelanggan:				ID:	
Alamat:				No Tel:	

Pengenalan ***(Sila baca kepada pelanggan. Sila sesuaikan mengikut keadaan setempat)***

Soalan berikut adalah berkenaan pengalaman anda tentang pengambilan arak, tembakau dan bahan-bahan lain seumur hidup anda dan tiga bulan kebelakangan ini. Bahan-bahan ini mungkin diambil dengan cara merokok, menelan, menyedut, menghidu atau menyuntik *(tunjuk **Kad Maklumat Maklumbalas ASSIST v3.1**)*.

Sebahagian daripada bahan yang disenaraikan mungkin diberi oleh doktor (contohnya amfetamin, ubat pelali, ubat penahan sakit). Dalam temuduga ini, ubat-ubatan yang **diberi oleh doktor tidak diambil kira**. Namun begitu, anda diminta untuk memberitahu penemuduga sekiranya anda menggunakan ubat-ubatan tersebut untuk tujuan lain **selain daripada** yang diarahkan oleh doktor, atau mengambilnya lebih kerap atau melebihi dos yang ditetapkan oleh doktor.

Pihak kami akan memastikan bahawa maklumat peribadi yang kami perolehi daripada anda berkenaan penggunaan bahan-bahan tersebut dirahsiakan daripada pengetahuan umum.

*Sebelum memulakan sesi temuduga, sila berikan **Kad Maklumat Maklumbalas ASSIST v3.1** kepada pelanggan. Seterusnya sila berikan penerangan ringkas berkenaan maklumbalas tersebut.*

SOALAN 1: Daripada senarai berikut, seumur hidup anda, bahan yang mana yang pernah anda ambil selain daripada tujuan perubatan?		
a. Bahan berasaskan tembakau (rokok, mengunyah tembakau, cerut dsb.)	Tidak	Ya
b. Minuman keras/arak (bir, wain, samsu, spirit dsb.)	Tidak	Ya
c. Kanabis (ganja, marijuana dsb.)	Tidak	Ya
d. Kokain (koka, “crack” dsb.)	Tidak	Ya
e. Perangsang jenis amfetamin (ATS, ekstasi, “speed”, pil kuda, syabu dsb.)	Tidak	Ya
f. Inhalan/bahan yang dihidu (gam, petrol, pelarut cat/“thinner” dsb.)	Tidak	Ya
g. Ubat pelali atau pil tidur (Valium, Roche dsb.)	Tidak	Ya
h. Halusinogen (ketamin, pil ubat batuk, Eramine-5, LSD dsb.)	Tidak	Ya
i. Opioid (heroin, morfin, metadon, kodein, candu, Subutex/Subuxon, daun ketum dsb.)	Tidak	Ya
j. Lain-lain (contohnya DF118). Sila nyatakan: _____	Tidak	Ya
Sekiranya semua jawapan adalah tidak, sila buat kepastian dengan bertanya: "Langsung tidak pernah? Walaupun semasa anda masih bersekolah?" *Sekiranya "Tidak" untuk semua bahan, temuduga boleh ditamatkan.* *Sekiranya "Ya" untuk salah satu daripada bahan di atas, sila teruskan dengan SOALAN 2.*		

SOALAN 2: Dalam ***tiga bulan kebelakangan*** ini, berapa kerapkah anda mengambil _____ (bahan pertama, kedua dan seterusnya yang dinyatakan oleh pelanggan)?	Tidak pernah	Sekali atau dua kali	Bulanan	Minggua n	Setiap hari atau hampir setiap hari
a. Bahan berasaskan tembakau (rokok, mengunyah tembakau, cerut dsb.)	0	2	3	4	6
b. Minuman keras/arak (bir, wain, samsu, spirit dsb.)	0	2	3	4	6
c. Kanabis (ganja, marijuana dsb.)	0	2	3	4	6
d. Kokain (koka, "crack" dsb.)	0	2	3	4	6
e. Perangsang jenis amfetamin (ATS, ekstasi, "speed", pil kuda, syabu dsb.)	0	2	3	4	6
f. Inhalan/bahan yang dihidu (gam, petrol, pelarut cat/"thinner" dsb.)	0	2	3	4	6
g. Ubat pelali atau pil tidur (Valium, Roche dsb.)	0	2	3	4	6
h. Halusinogen (ketamin, pil ubat batuk, Eramine-5, LSD dsb.)	0	2	3	4	6
i. Opioid (heroin, morfin, metadon, kodein, candu, Subutex/Subuxon, daun ketum dsb.)	0	2	3	4	6
j. Lain-lain (contohnya DF118). Sila nyatakan: _____	0	2	3	4	6
Sekiranya "Tidak pernah" untuk semua bahan bagi SOALAN 2, terus ke SOALAN 6. *Sekiranya salah satu daripada bahan dalam senarai SOALAN 2 pernah diambil* ***dalam tiga bulan kebelakangan*** *ini, teruskan dengan SOALAN 3, 4 & 5 bagi setiap bahan yang diambil.*					

SOALAN 3: Dalam ***tiga bulan kebelakangan*** ini, berapa kerapkah anda mempunyai keinginan yang kuat atau berasa gian untuk mengambil _____ (bahan pertama, kedua dll.)?	Tidak pernah	Sekali atau dua kali	Bulanan	Minggua n	Setiap hari atau hampir setiap hari
a. Bahan berasaskan tembakau (rokok, mengunyah tembakau, cerut dsb.)	0	3	4	5	6
b. Minuman keras/arak (bir, wain, samsu, spirit dsb.)	0	3	4	5	6
c. Kanabis (ganja, marijuana dsb.)	0	3	4	5	6
d. Kokain (koka, "crack" dsb.)	0	3	4	5	6
e. Perangsang jenis amfetamin (ATS, ekstasi, "speed", pil kuda, syabu dsb.)	0	3	4	5	6
f. Inhalan/bahan yang dihidu (gam, petrol, pelarut cat/"thinner" dsb.)	0	3	4	5	6
g. Ubat pelali atau pil tidur (Valium, Roche dsb.)	0	3	4	5	6
h. Halusinogen (ketamin, pil ubat batuk, Eramine-5, LSD dsb.)	0	3	4	5	6
i. Opioid (heroin, morfin, metadon, kodein, candu, Subutex/Subuxon, daun ketum dsb.)	0	3	4	5	6
j. Lain-lain (contohnya DF118). Sila nyatakan: _____	0	3	4	5	6

SOALAN 4: Dalam ***tiga bulan kebelakangan*** ini, berapa kerapkah anda menghadapi masalah kesihatan, sosial, perundangan atau kewangan berpunca daripada pengambilan _____ (bahan pertama, kedua dll.)?	Tidak pernah	Sekali atau dua kali	Bulanan	Minggua n	Setiap hari atau hampir setiap hari
a. Bahan berasaskan tembakau (rokok, mengunyah tembakau, cerut dsb.)	0	3	4	5	6
b. Minuman keras/arak (bir, wain, samsu, spirit dsb.)	0	3	4	5	6
c. Kanabis (ganja, marijuana dsb.)	0	3	4	5	6
d. Kokain (koka, "crack" dsb.)	0	3	4	5	6
e. Perangsang jenis amfetamin (ATS, ekstasi, "speed", pil kuda, syabu dsb.)	0	3	4	5	6
f. Inhalan/bahan yang dihidu (gam, petrol, pelarut cat/"thinner" dsb.)	0	3	4	5	6
g. Ubat pelali atau pil tidur (Valium, Roche dsb.)	0	3	4	5	6
h. Halusinogen (ketamin, pil ubat batuk, Eramine-5, LSD dsb.)	0	3	4	5	6
i. Opioid (heroin, morfin, metadon, kodein, candu, Subutex/Subuxon, daun ketum dsb.)	0	3	4	5	6
j. Lain-lain (contohnya DF118). Sila nyatakan: _____	0	3	4	5	6

SOALAN 5: Dalam ***tiga bulan kebelakangan*** ini, berapa kerapkah anda **tidak dapat melakukan** perkara yang biasanya anda dapat lakukan (contohnya pekerjaan, aktiviti harian dsb.) berpunca daripada pengambilan _____ (bahan pertama, kedua dll.)?	Tidak pernah	Sekali atau dua kali	Bulanan	Minggua n	Setiap hari atau hampir setiap hari
a. Bahan berasaskan tembakau (rokok, mengunyah tembakau, cerut dsb.)					
b. Minuman keras/arak (bir, wain, samsu, spirit dsb.)	0	5	6	7	8
c. Kanabis (ganja, marijuana dsb.)	0	5	6	7	8
d. Kokain (koka, "crack" dsb.)	0	5	6	7	8
e. Perangsang jenis amfetamin (ATS, ekstasi, "speed", pil kuda, syabu dsb.)	0	5	6	7	8
f. Inhalan/bahan yang dihidu (gam, petrol, pelarut cat/"thinner" dsb.)	0	5	6	7	8
g. Ubat pelali atau pil tidur (Valium, Roche dsb.)	0	5	6	7	8
h. Halusinogen (ketamin, pil ubat batuk, Eramine-5, LSD dsb.)	0	5	6	7	8
i. Opioid (heroin, morfin, metadon, kodein, candu, Subutex/Subuxon, daun ketum dsb.)	0	5	6	7	8
j. Lain-lain (contohnya DF118). Sila nyatakan: _____	0	5	6	7	8
*Teruskan dengan SOALAN 6 & 7 bagi semua bahan yang **pernah digunakan seumur hidup** (berdasarkan SOALAN 1)*					

SOALAN 6: Pernahkah rakan anda, saudara-mara anda atau orang lain mengambil kisah tentang masalah penggunaan _____ (bahan pertama, kedua dll.)?	Tidak pernah	Ya, dalam 3 bulan kebelakangan ini	Ya, tetapi bukan dalam 3 bulan kebelakangan ini
a. Bahan berasaskan tembakau (rokok, mengunyah tembakau, cerut dsb.)	0	6	3
b. Minuman keras/arak (bir, wain, samsu, spirit dsb.)	0	6	3
c. Kanabis (ganja, marijuana dsb.)	0	6	3
d. Kokain (koka, "crack" dsb.)	0	6	3
e. Perangsang jenis amfetamin (ATS, ekstasi, "speed", pil kuda, syabu dsb.)	0	6	3
f. Inhalan/bahan yang dihidu (gam, petrol, pelarut cat/"thinner" dsb.)	0	6	3
g. Ubat pelali atau pil tidur (Valium, Roche dsb.)	0	6	3
h. Halusinogen (ketamin, pil ubat batuk, Eramine-5, LSD dsb.)	0	6	3
i. Opioid (heroin, morfin, metadon, kodein, candu, Subutex/Subuxon, daun ketum dsb.)	0	6	3
j. Lain-lain (contohnya DF118). Sila nyatakan: _____	0	6	3
*Peringatan: Sila tanya SOALAN 6 & 7 bagi semua bahan yang **pernah digunakan seumur hidup** (berdasarkan SOALAN 1)*			

SOALAN 7: Pernahkah anda gagal dalam cubaan untuk mengurangkan pengambilan _____ (bahan pertama, kedua dll)?	Tidak pernah gagal (berjaya)/ Tidak pernah mencuba	Ya, gagal, dalam 3 bulan kebelakangan ini	Ya, gagal, tetapi bukan dalam 3 bulan kebelakangan ini
a. Bahan berasaskan tembakau (rokok, mengunyah tembakau, cerut dsb.)	0	6	3
b. Minuman keras/arak (bir, wain, samsu, spirit dsb.)	0	6	3
c. Kanabis (ganja, marijuana dsb.)	0	6	3
d. Kokain (koka, "crack" dsb.)	0	6	3
e. Perangsang jenis amfetamin (ATS, ekstasi, "speed", pil kuda, syabu dsb.)	0	6	3
f. Inhalan/bahan yang dihidu (gam, petrol, pelarut cat/"thinner" dsb.)	0	6	3
g. Ubat pelali atau pil tidur (Valium, Roche dsb.)	0	6	3
h. Halusinogen (ketamin, pil ubat batuk, Eramine-5, LSD dsb.)	0	6	3
i. Opioid (heroin, morfin, metadon, kodein, candu, Subutex/Subuxon, daun ketum dsb.)	0	6	3
j. Lain-lain (contohnya DF118). Sila nyatakan: _____	0	6	3
*Peringatan: Sila tanya SOALAN 6 & 7 bagi semua bahan yang **pernah digunakan seumur hidup** (berdasarkan SOALAN 1)*			

SOALAN 8: Pernahkah anda mengambil dadah dengan cara suntikan selain daripada tujuan perubatan?	Tidak pernah	Ya, dalam 3 bulan kebelakangan ini	Ya, tetapi bukan dalam 3 bulan kebelakangan ini
(Tandakan kotak yang berkenaan)			

PERHATIAN
Pelanggan yang pernah mengambil dadah dengan cara suntikan dalam 3 bulan kebelakangan ini, perlu ditanya berkenaan corak suntikan sepanjang jangka waktu tersebut. Hal ini perlu bagi menentukan tahap risiko dan intervensi terbaik untuk menangani masalah pelanggan tersebut.

Corak pengambilan secara suntikan		**Panduan intervensi**
Purata 4 hari atau kurang dalam sebulan untuk jangkamasa 3 bulan kebelakangan ini	–	Intervensi singkat termasuk **Maklumat Risiko Suntikan ASSIST v3.1**
Secara purata, lebih daripada 4 hari dalam sebulan untuk jangkamasa 3 bulan kebelakangan ini	–	Penilaian lanjut dan rawatan yang lebih intensif (rujukan kepada pakar atau AADK)

Panduan pengiraan skor keterlibatan bahan khusus.

Bagi setiap bahan (yang dilabel 'a' hingga 'j'), jumlahkan skor yang diperolehi bagi **SOALAN 2 hingga 7**. SOALAN 1 dan 8 tidak diambil kira dalam penjumlahan skor. Sebagai contoh, skor khusus bagi pengambilan kanabis ialah: *SOALAN 2c + SOALAN 3c + SOALAN 4c + SOALAN 5c + SOALAN 6c + SOALAN 7c*.

Bagi **SOALAN 5**, skor untuk **tembakau** tidak dikodkan. Oleh itu pengiraan adalah seperti berikut: *SOALAN 2a + SOALAN 3a + SOALAN 4a + SOALAN 6a + SOALAN 7a*.

Jenis intervensi adalah berdasarkan skor keterlibatan bahan khusus				
	Rekodkan skor bagi bahan khusus	Tidak perlu intervensi	Perlu intervensi singkat	Perlu rawatan intensif
a. Tembakau		0 - 3	4 - 26	27+
b. Arak		0 - 10	11 - 26	27+
c. Kanabis		0 - 3	4 - 26	27+
d. Kokain		0 - 3	4 - 26	27+
e. ATS		0 - 3	4 - 26	27+
f. Inhalan		0 - 3	4 - 26	27+
g. Ubat pelali		0 - 3	4 - 26	27+
h. Halusinogen		0 - 3	4 - 26	27+
i. Opioid		0 - 3	4 - 26	27+
j. Lain-lain		0 - 3	4 - 26	27+
*Sekarang gunakan **Laporan Maklumbalas ASSIST v3.1** sebagai intervensi singkat untuk pelanggan.*				

HISTORY AND PHYSICAL EXAMINATION

Worker _____

Date of first contact __ __ / __ __ / __ __

Name : _____

Date of birth : _____

Gender (circle one) : M / F

Address : _____

Urine Drugs Screen : (to identify other substance use)

Contact Person

1. Name : _____
   Contact No : _____
   Relationchip : _____

2. Name : _____
   Contact No : _____
   Relationchip : _____

3. Name : _____
   Contact No : _____
   Relationchip : _____

Presenting issues

What are the key issues for this person? Immediate needs? Why have they contacted this agency now (eg Voluntary or mandated client)?, *what is the client's understanding of the problem? What are the perceived consequences of their use.*

_____

_____

_____

_____

_____

_____

_____

Type of substance(s) used (list in order of preference)			
Frequency of use			
Context of use (eg With whom, where, when)			
Mode of administration			
Reason(s) for use			

Risk factors

List any specific risks identified for this person

Past History

Identify previous medical problems, admissions to hospital, institutions.

Family

Explore the nature of this person's involvement with family members
(eg Identify supports. What do they think about patient's substance use? Do they use substances?)

Mother/Caregiver/Siblings

Statutory issues *(For young person)*

Current legal guardian *(where relevant)*

Current orders *(eg Protective, Juvenile Justice, Community Based Corrections, include dates)*

Immediate legal commitments *(eg Court, signing on at police station)*

Social Issues

Accommodation

Accommodation issues *(eg Stable, unstable, short/medium/long term, supportive, rental, homeless/at risk of homelessness, substance use in household)*

With whom does this young person live?

Age first left home *(Include reason for leaving)*

_____

_____

Relationships

Explore relationships - which are important/significant to the young person at this time?
(eg Which relationships are supportive, conflictual?)

_____

_____

_____

_____

_____

_____

Is there anyone (parents, partner, friend) whom the person would like to involve in this process?

_____

_____

_____

Other family relationships *(eg Grandparents, relatives, partner, parent's defacto)*

_____

_____

_____

Is this person married or in a defacto relationship? Y / N

Does this person have children? Y / N If yes, number of children
Age(s) of children _____, _____, _____, _____ .
Do the children live with this person? Y / N

Problematic family issues

(eg Traumatic events, separation/divorce, death/loss, abuse, other AOD use, mental illness)

_____

PHYSICAL EXAMINATION

General
Inspect for paint or other stains on face, hands or clothes
Chemical odors on breath or clothing
Drunk or or disoriented appearance
Slurred speech
Nuritional status
Weight and height
Vital signs (BP, PR, RR, SPO2)

Cardiovascular system
Look for arrhythmia, signs of failure

Respiratory
Look for rhonci, crepitations

Abdomen
Look for hepatomegaly

CNS
Look for cerebellar signs

1. Have you ever been hospitalised for emotional or psychiatric problems?
   Yes / No

   If yes, please provide details _____

2. Are things so bad at the moment that you have considered hurting yourself or others?
   Yes / No

   If yes, please specify _____

If there is intent, means and a plan, immediately refer to mental health services for an
Assessment

3. Has anyone in your immediate family ever had a mental illness?
   Yes / No

   If yes, please specify _____

4. Has anyone in your immediate family attempted or contemplated suicide?
   Yes / No

   If yes, please specify _____

5. Are you currently seeing a GP/Psychiatrist/Counsellor for any emotional or health reasons?
   Yes /No

   If yes, please specify_____

6. Do you ever hear or see things that other people cannot hear or see?
   Yes/ No

   If yes, please specify_____

7. Have there been times that you thought anything strange or unexplainable was going on?
   Yes/ No

   If yes, please specify_____

Mild (Score: 0-3) Simple contracting

- suitable for either first time users or known regular users.
- should be repeated a number of times unless the behaviour escalates

1. Confiscate: Request that the young person hand over the substance.

2. Explain consequences: Describe what you will do and why, based on the rules. Explain the consequences that may be applied.

3. Express concern.

4. Educate: Indicate the harms that may result from inhalant use.

5. Distract: Attempt to engage the child or young person in another activity eg eating, physical activity, games.

6. Simple Contract: Get assurance from the client that they will cease inhalant use.

7. Seek secondary consultation: Contact local Addiction specialist and discuss management options and a potential care plan, including potential respite options if behaviour escalates in the future.

8. Repeat these steps if inhalant use continues.

9. Escalate consequences to contingency management when behaviour intensifies or simple contracting is not effective in reducing or eliminating use.

10. Continue to assess the physical state of the client throughout this intervention and take appropriate action such as refer to specialist.

Moderate (Score: 4-25) Contingency management

- suitable when simple contracting response fails to provide satisfactory results in a reasonable time frame (3 months) or for regular and chronic users or behaviour escalates.
- should be repeated unless it fails to provide satisfactory results after a number of episodes or the behaviour escalates.

1. Confiscate: Request that the young person hand over the substance.
2. Explain consequences: Describe what you will do and why.
3. Express concern.
4. Educate: Indicate the harms that may result from inhalant use.
5. Distract: Attempt to engage the client in another activity eg eating, physical activity, games.
6. Develop an individual contingency management plan:
   - negative consequences for continued inhalant use (eg loss of, or reduced pocket money) or
   - positive consequences for cessation (eg additional outings or activities).
   - At each cycle through the contigency level response, increase the level of consequences if necessary, explaining why.
   - An outline of the principles and practice of contingency planning is in **Appendix G**.
7. Review assessment and case management plan.
8. Refer: to local specialist substance use services for full assessment.
9. Assess motivation to change: Undertake strategies to increase motivation to change. Motivational interviewing strategies have been successfully used with young people for a range of issues, including substance use.
10. Repeat these steps if inhalant use continues. Escalate consequences to intensive management when behaviour intensifies or repeated attempts at second level response are not effective in reducing or eliminating use
11. Continue to assess the physical state of the client throughout this intervention and take appropriate action.

ASSIST scoring more than 26 – severe use

- Provide feedback of ASSIST results and risk levels (page 1 of *"The ASSIST Feedback Report Card"*). Discuss the meaning of the results and link to the specific problems listed on pages 2-4 of the Report Card (and the *"Risks of Injecting"* card if relevant).

- Provide clear advice that the best way to reduce the risk of substance related problems and to manage existing problems is to cut down or stop substance use. If the patient has tried unsuccessfully to cut down or stop their substance use in the past, discuss these past attempts. This may help the patient understand that they may need treatment to change their substance use.

- Link the results to specific problems the patient is already experiencing.

- Take a brief history of drug use over the past week.

- Encourage the patient to weigh up the positives and negatives. You can use the decision balance or the table of benefits and costs on page 7 to help the patient think about this. Asking open ended questions is also an effective technique;
  - "Tell me about the good things about using (substance)."
  - "Can you tell me about some of the less good things about using (substance)?"

- Encourage the patient to consider both long term and short term consequences.

- Refer back to the problems listed on pages 2-4 of the ASSIST report card.

- Discuss the patient's level of concern about their drug use. You can use the importance ruler on page 9 to help the patient show you how important they believe it is to change their substance use.

- Provide information about what is involved in treatment and how to access treatment.

- Provide encouragement and reassurance about the effectiveness of treatment.

- Provide written materials on problem substances and strategies for reducing use.

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