INSIGHT: Alcohol and Other Drug Training and Education Unit

Induction Module 1
Big Picture
Alcohol & Other Drugs

Queensland Government
Australia

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Welcome to Alcohol and Other Drugs Sector Induction Material

Learning Material

This series of modules is designed to service health staff interested in addressing alcohol and other drug (AOD) issues with their clientele. The introductory material seeks to provide information to new workers in the alcohol and drug sector. The modules are based on best practice, and contain the most recent information available.

About InSight

InSight is a clinical support service that provides AOD clinical education and training, and clinical education services. Insight sits within the ADS which has a mission to minimise alcohol and other drug related harm and improve the health and well being of the Queensland people we serve.

Contact InSight

InSight can be contacted by phone or email if you have any queries or comments regarding this module, or for general information regarding training opportunities.

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How to use Module Materials

- The module is a study guide (PDF) that can be downloaded. Please be aware this is copyrighted material. If a colleague requests this module, direct them to the web page for their personal module download.
- There are suggested readings and references for further study which are located at the end of this module.
- There is no recommended text for this module.
- The module is designed as a 2 - 4 hour short course.
- A short multiple choice assessment can be submitted to InSight to enable us to forward your completion certificate.
- You may contact InSight regarding this module at any time.

Big Picture:
An Introduction

Aim

This module aims to provide an overview of alcohol and other drug (AOD) use in the community and highlight issues for practice.

Objectives

The objectives for this module are to:

- outline the difference between licit and illicit substances
- distinguish between prevalence, mortality, and morbidity of AOD use
- Identify the reasons why people use AOD's
- explain standard drinks information
- outline the three harm reduction objectives set out in the National Drug Strategy
- identify harm minimization initiatives for AOD use
- identify blood borne viruses and describe their association with AOD use
- recognise common myths and truths about drug use and treatment
- define the term "Dual Diagnosis" as used in the Alcohol and Drug sector.

This module provides an overview of alcohol and other drug (AOD) use in the community and highlights important issues for practice. When examining the major drug problems faced by communities, there is often a difference between the information portrayed in the media and empirical data. As a result of this discrepancy, a number of myths have emerged regarding drug use. For example, it is often perceived that illicit drugs (drugs which are illegal) are the main source of problematic drug use. Licit drugs (drugs which are legal) are infact causing the greatest social, economic and physical harm to the Australian population. As you complete this module, reflect on your own views and knowledge regarding AOD use and weigh them up against the evidence that is presented.

Prevalence of AOD use in Australia

Many adults in Australian have consumed either alcohol or other drugs during their lifetime. Psychoactive drugs are generally categorised into either licit or illicit drugs. Licit drugs include alcohol, tobacco, caffeine (found in tea, coffee, and cola drinks and some over the counter preparations), and prescription drugs such as tranquillisers, painkillers, and some amphetamine preparations. Illicit drugs include drugs such as heroin, cocaine (some restricted medical use is legal), cannabis, amphetamines, hallucinogens, and “designer” drugs such as ecstasy (MDMA), fantasy (gamma-hydroxybutyrate, GHB) and phencyclidine (PCP). The three most frequently used substances in order (excluding caffeine and some over-the-counter medications) are alcohol, tobacco, and cannabis. Figure 1 below indicates the prevalence of Australian AOD use in their lifetime (ever used), alongside recent use (within the past 12 months). This figure demonstrates that fewer people have used illicit substances than licit substances.

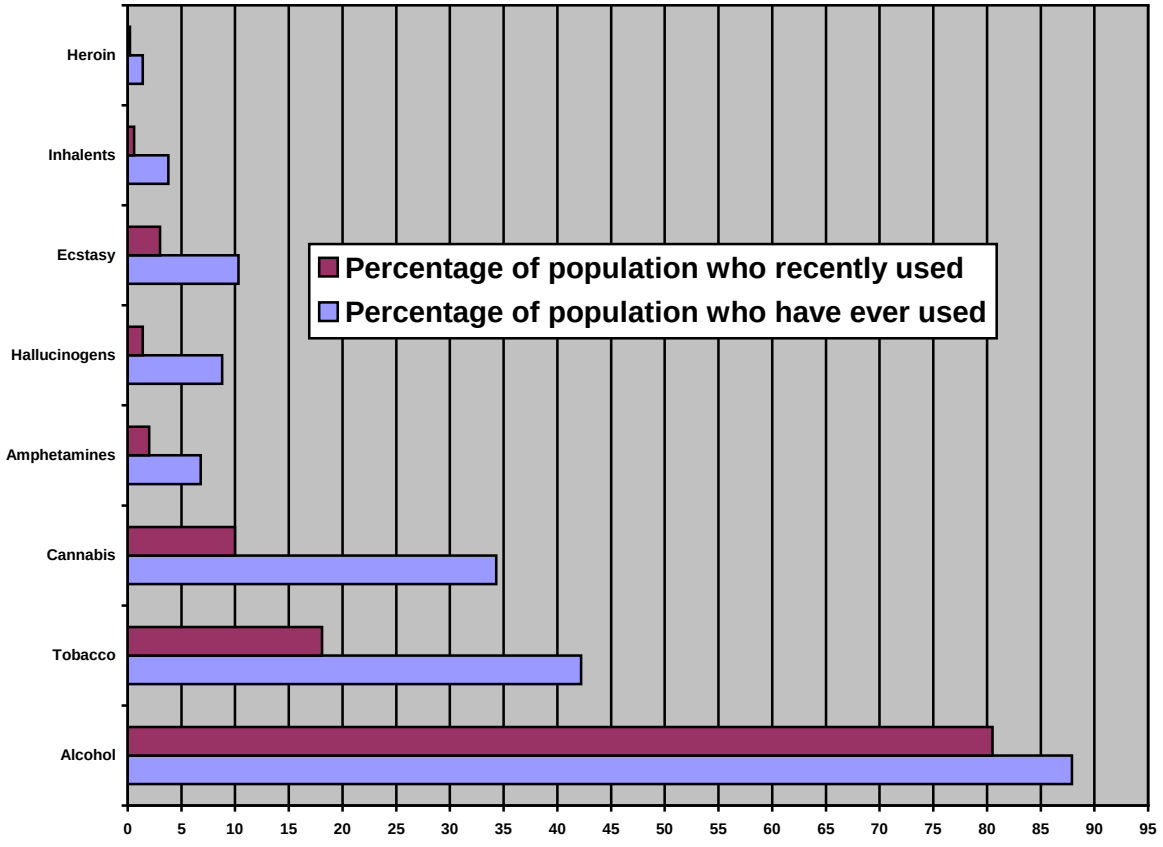

Figure 1: Australian AOD Use Prevalence 2010 (AIHW, 2011).

Alcohol Prevalence

The 2010 National Drug Strategy Household Survey (AIHW, 2011) has provided recent information about Australians' licit and illicit drug use. Approximately 87.9% of Australians over the age of 14 years reported they had tried alcohol at some time in their lives. In the previous 12 months, 80.5% of the population had consumed alcohol. The drinking patterns described in the survey indicated that 7.2% of the population (9.6% of males and 4.9% of females) drank alcohol on a daily basis, 39.5% drank weekly and 33.8% drank alcohol less than weekly. 12.1% of Australians had never consumed a full serve of alcohol, 7.4% were ex-drinkers, and 19.5% of the population had abstained from drinking alcohol in the past 12 months.

Different age groups showed different patterns of recent alcohol use. Daily drinking occurred more frequently in the 70+ age group, with weekly drinking likely to occur more frequently in persons aged between 20-59 years. Compared to other age groups, persons aged between 14-19 years (45.9%) were more likely to drink less than weekly, with 35.5% in this group indicating they had not consumed a full glass of alcohol in the past 12 months.

The **risk of alcohol-related harm** likely to be experienced by an individual is associated with their gender, and the frequency and quantity of alcohol they consume. The National Health and Medical Research Council (NHMRC, 2009) has outlined drinking guidelines to reduce the risk of alcohol related harm for both males and females. These guidelines provide information regarding drinking levels to reduce the overall risk of alcohol-related harm over a person's lifetime, with the aim of lowering the immediate risk of alcohol related harm. They provide universal guidance to healthy adults over 18 years of age, and include specific guidance to young people and children, and pregnant and breastfeeding women.

The four NHMRC 2009 drinking guidelines are as follows:

Guideline 1: Reducing the risk of alcohol related harm over a lifetime.

- The lifetime risk of harm from drinking alcohol increases with the amount consumed.
- For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.

Guideline 2: Reducing the risk of injury on a single occasion of drinking

- On a single occasion of drinking, the risk of alcohol-related injury increases with the amount consumed.
- For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.

Guideline 3: Children and young people under 18 years of age

- For children and young people less than 18 years of age, not drinking alcohol is the safest option.
  - **a)** Parents and carers should be advised that children under 15 years of age are at the greatest risk of harm from drinking and that for this age group, not drinking alcohol is especially important.
  - **b)** For young people aged 15−17 years, the safest option is to delay the initiation of drinking for as long as possible.

Guideline 4: Pregnancy and breastfeeding

- Maternal alcohol consumption can harm the developing foetus or breastfeeding baby.
  - **a)** For women who are pregnant or planning a pregnancy, not drinking is the safest option.
  - **b)** For women who are breastfeeding, not drinking is the safest option.

Tobacco Prevalence

The use of tobacco has declined over the past five years, with reports from over half the population (55.4%) that they had never smoked more than 100 cigarettes in their lifetime (AIHW, 2011). Just over 19% of Australians over the age of 14 years smoked tobacco regularly; 16.6% smoked daily; 1.3% of the population smoked weekly, and 1.5% used tobacco less than weekly. Overall, males were found to use tobacco more than females across smoking status groups. Additionally, higher levels of smoking were related to lower

socioeconomic status, rural and remote areas, and Aboriginal and Torres Strait Islander peoples.

Different patterns of tobacco use were noted across different age groups. Upward rates of regular tobacco use were noted for those aged between 20-49 years, which peaked at 40-49 years old, of whom 19.5% reported smoking daily. Weekly tobacco use was also more likely in persons between 20-29 years. The greatest percentage of ex-smokers (36.4%) was found in the 60 + years age group. Of those persons who had never smoked, the greatest percentage was reported by 14-19 year olds (88.1%).

Illicit Drug Prevalence

According to data from the 2010 National Drug Strategy Household Survey (AIHW, 2011), illicit drug use increased and was mainly due to an increase in the proportion of people who had used cannabis (from 9.1% to 10.3%), pharmaceuticals for non-medical purposes (3.7% to 4.2%), cocaine (1.6% to 2.1%) and hallucinogens (0.6% to 1.4%). While 39.8% had used an illicit drug at least once in their lifetime, only 14.7% had used an illicit drug at least once in the previous 12 months.

Overall, males (17.%) were more likely to have used an illicit substance in the previous 12 months than females (12.3%). Different age groups also indicated different use patterns whereby persons aged between 20-29 years were more likely to have used an illicit substance recently than any other age group.

Cannabis remains the most commonly used illicit drug, with 10.3% of the population having used in the previous 12 months (AIHW, 2011). The 30-39 year old group reported the highest lifetime cannabis use, whereas 18-29 year olds reported the most current use. Overall, males tended to use cannabis more frequently than females.

In the previous 12 months, **heroin, methadone and/or other opiates** (for non-maintenance, non-medical purposes) use was reported by 0.8% of the population, with **methamphetamine** use reported by 2.1% of Australians over 14 years of age (AIHW, 2011). Each of these drugs was used more by males than by females. Only 0.4% of Australians aged 14 years and older had injected an illicit drug in the previous 12 months. Of those, 27.1% had injected daily and 60.6% had injected once a week or less (AIHW, 2011). Males and people aged 20-39 years were more likely to use this method of drug administration.

Total Burden of Disease

To determine the effect of alcohol and other drug use on specific populations, researchers use different measures such as the 'disability-adjusted life year' (DALY). The DALY estimates the years of life lost due to premature death, coupled with years of 'healthy' life lost due to disability associated with certain factors such as alcohol and drug use. These measures are representative of the total burden of disease and injury imposed on populations by the identified factors, and assist in providing commentary on population mortality and morbidity data.

Mortality

Licit Substances

When deaths associated with tobacco, alcohol, and illicit drugs are compared, tobacco is responsible for the greatest portion of drug related deaths in Australia. Over 15,000 deaths were attributable to the use of tobacco in 2003 (Begg, et al., 2007). Tobacco use has also been identified as the "single most preventable cause of ill health and death in Australia" (AIHW, 2010, p.62). Alcohol use is another major cause of drug or alcohol related deaths in Australia. In 2003, approximately 3,400 deaths were attributable to the use of alcohol (Begg, et al., 2007).

Illicit Substances

Illicit drug use was associated with 1,705 deaths in Australia in 2003. Hepatitis C and Hepatitis B were the two major conditions for death attributable to illicit drug use, accounting for 759 and 329 deaths respectively (Begg, et al., 2007).

Morbidity

Licit Substances

The 'Burden of Disease and Injury in Australia 2003', estimated that 7.8 % of the total burden of disease was attributable to tobacco smoking. It was also estimated that almost 3.2% of the total burden of disease was attributable to alcohol consumption.

Illicit Substances

When combined with years lived with disability, illicit drug use is estimated to have accounted for almost 2% of the total burden of disease in Australia. A report evaluating the cost effectiveness of needle and syringe programs (NSPs) in Australia, estimated the population benefits of NSPs on Human Immunodeficiency Virus (HIV) and Hepatitis C virus (HCV) related outcomes among injecting drug users (IDUs) in Australia over the period from 2000 to 2009 (DoHA 2009). It has been reported that needle and syringe programs have directly averted 32,050 new Human Immunodeficiency Virus infections and 96,667 new Hepatitis C virus infections. From a financial perspective, every dollar invested in NSPs was found to return more than four dollars in healthcare cost-savings in the short-term (Department of Health and Ageing, 2009).

Blood borne viruses

Blood-borne viruses (BBVs) are viruses transmitted from the blood of one person to the blood of another person. The main blood-borne viruses are Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV).

Co-infection is the term used to describe when a person is infected with two or more BBVs at the same time. Treatment and management issues for people with co-infection are complex, particularly as the infections may interact and speed up disease progression (DoHA, 2008).

Hepatitis

Hepatitis is a condition where the inflammation of the liver has been a natural response to injury. There are many different causes of hepatitis, with viruses being the cause of viral hepatitis. In addition to HBV and HCV, there are other hepatitis viruses named A, D, and E. While each hepatitis viruses is different, they all target the liver. During the acute infection phase each one may also cause similar symptoms. When a person is infected with the hepatitis virus they may experience a severe illness with nausea, pain, abdominal discomfort and jaundice. In some cases, a person may not experience any symptoms at all. Some hepatitis viruses may clear naturally from the body (e.g. HAV), while others, including HBV and HCV, can cause a chronic infection. A chronic infection is described as an infection that is ongoing for a time period greater than six months (DoHA, 2008).

The **Hepatitis B Virus** is transferred through contact with infected blood or body fluids (including saliva, semen, vaginal secretions, and breast milk). Other HBV facts include:

- An acute infection may produce: loss of appetite; nausea; tiredness; jaundice; abdominal, muscle, or joint pain.
- Most adults (95%) recover completely from HBV, but progression to chronic infection is high when it is transmitted from mother to baby (90%), and intermediate for children aged 1-5 years (20-50%).
- Vaccination against HBV is available, inexpensive, and effective (95% of the population respond to vaccination).

The **Hepatitis C Virus** is transmitted through blood-to-blood contact and in Australia 90% of new infections result from sharing or re-using contaminated drug-injecting equipment. The remaining 10% result from other blood-to-blood contact such as tattooing and body piercing, needle stick injuries, and vertical transmission from mother to baby. Some other HCV facts include:

- A minority of people experience symptoms in the acute phase (approximately 10%), but symptoms may include nausea, jaundice, dark urine and abdominal discomfort.
- 25% of people contracting HCV will clear the infection naturally in the first 12 months.
- Chronic infection with HCV may lead to liver damage.
- There is no vaccination available for HCV.

Human Immunodeficiency Virus

Human Immunodeficiency Virus (HIV) is a fragile retrovirus (transmitted under specific conditions), that causes Acquired Immune Deficiency Syndrome (AIDS). Some other HIV facts include:

- HIV is transmitted in a number of ways (e.g. sexual intercourse with an infected partner, exposure to HIV-infected blood or blood products, or perinatal transmission during childbirth), where contact is made with (but not limited to) an infected individual's blood, semen, breast milk, and vaginal secretions.
- Seroconversion is the development of HIV specific antibodies, at which time some individuals may experience a flu-like syndrome of fever, swollen lymph glands, sore throat, headache, malaise, nausea, muscle and joint pain, and diarrhoea (Brown and Edwards, 2008). HIV acts by breaking down the ability of the body to fight infection by attacking the immune system, leaving infected individuals susceptible to opportunistic infections. (South Eastern Area Laboratory Services, 2009).

Why do People use Drugs?

Have you ever heard the comment “I don’t understand why people use drugs”? Interestingly, it is often thought that the reasons for using licit drugs are different to the reasons for using illicit drugs, yet this is often not the case. Apart from specific (targeted) prescription medication, many people use illicit drugs for the same reasons they use licit drugs. This is because most psychoactive drugs produce the effect of euphoria or a feeling of well being, even though the physical effect produced by each drug may be different.

The following table lists a number of different reasons why people use illicit drugs (you may notice similarities to some licit drug effects).

Reduce pain	Raise energy	Socialise	Relax	Increase libido
Go to sleep	To belong	Raise mood	Recover	Stay awake
Increase awareness	To dance (better)	Raise self esteem	To experience the effect	Chill out
Slow down	Drive further	Talk freely	The rush	Be creative
Out of body experience	Reduce withdrawals	Reduce medication side effects	To Lower inhibitions	Increase appetite
Become More intimate	To Lower stress	To laugh	Stop nausea	Dependence
Aphrodisiac	To forget	Get stoned	Be cool	To remember

Table 1. Some Reasons Why People Use Illicit Drugs.

Patterns of Drug Use

People vary in the patterns in which they use drugs. These patterns can be described as a spectrum that ranges from non-use to dependent drug use. People can move along the spectrum in any direction and stop at any one point. When a person uses more than one drug, each drug can be represented at a different point along the spectrum. For example, a client who uses both alcohol and cannabis may have a different pattern of use for each drug, such that they may be alcohol dependent, but smoke cannabis recreationally. The spectrum of drug use is illustrated below.

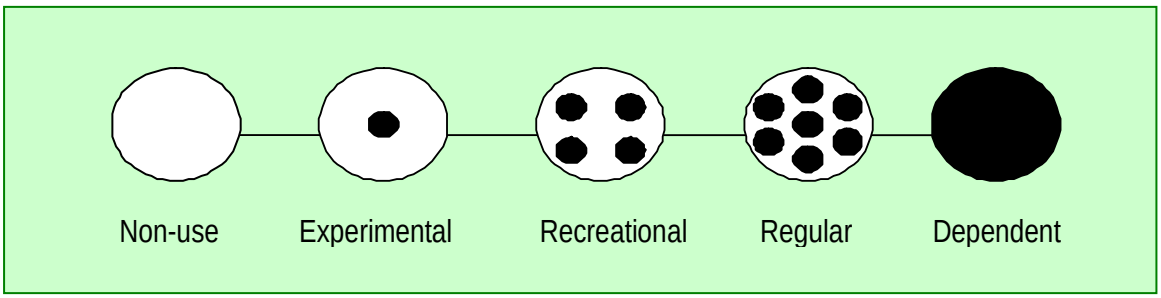

Figure 2. The Spectrum of Drug Use.

Each pattern of use along the spectrum of drug use is described as:

1. **Non-Use:** Some people choose not to use psychoactive substances for cultural, religious, or personal reasons. Non-use also includes individuals who may have used psychoactive substances at one time, but are now abstinent from AOD use.
2. **Experimentation:** People are often curious about drugs. They may have observed the effects in others and want to try it out for themselves. Experimentation is limited to only minimal use. After their curiosity has been satisfied, the person may either discontinue or progress to another pattern of use.
3. **Occasional/Recreational Use:** This pattern of use tends to be irregular or spasmodic. There is no established pattern of use evident.
4. **Regular Use**: This pattern of use is where a person consumes a drug on a regular basis and often there is a set pattern clearly identified. However, the individual may

use regularly under certain guidelines (e.g. maintaining recommended safe levels of alcohol consumption).

5. **Dependent Use**: The individual uses regularly and has developed a dependence on the drug.

The National Drug Strategic Framework

All public alcohol and other drug treatment agencies are guided by the National Drug Strategy 2010-2015 when designing and implementing treatments and services for their clients. The Ministerial Council on Drug Strategy (MCDS) approved the National Drug Strategy in 2011, and provides the following mission statement indicating the overarching aim of the strategy:

Mission

"To build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families, and communities" (MCDS, 2011, pp.6).

This strategy provides an important basis for treatment and it is described in some detail below.

Harm Minimisation

The overarching approach of the National Drug Strategy 2010-2015 is harm minimisation, which acknowledges that Australians use drugs and may continue to do so, despite the associated risks of harm to themselves or to the community. While alcohol and other drug-related harm cannot be prevented, it can be reduced.

A harm minimisation approach incorporates the three pillars of supply reduction, demand reduction, and harm reduction, and has guided the National Drug Strategy since its inception. Each of these pillars is of equal importance and incorporates prevention as an integral theme. They are described as follows:

1. Demand reduction strategies and actions focus on preventing the uptake and/or delaying the onset of alcohol, tobacco, and other drug use; reducing the misuse

of alcohol and the use of tobacco and other drugs in the community; and supporting an individual's recovery from dependence and reintegration into the community.

2. Supply reduction strategies and actions prevent, stop, disrupt, or reduce the production and supply of illicit drugs, as well as control, manage and regulate the availability of licit drugs.
3. Harm reduction strategies and actions reduce the adverse health, social and economic consequences of drug use experienced by both the individual and the community.

Objectives of the NDS

The National Drug Strategy 2010 – 2015 sets out the objectives of, and actions against, each of the three pillars of harm minimisation, while taking differences across drug type, disadvantaged populations, age and stage of life, and settings into consideration. These objectives and actions are aimed at reducing drug use and supply, and preventing and minimising harm caused by licit and illicit drugs. These objectives are:

Demand reduction

1. prevent uptake and delay onset of drug use
2. reduce use of drugs in the community
3. support people to recover from dependence and reconnect with the community
4. support efforts to promote social inclusion and resilient individuals, families, and communities.

Supply reduction

1. reduce the supply of illegal drugs (both current and emerging)
2. control and manage the supply of alcohol, tobacco, and other legal drugs.

Harm reduction

1. reduce harm to community safety and amenities
2. reduce harm to families
3. reduce harm to individuals.

(MCDS, 2011, pp. 4-5)

Most Australian alcohol and other drug services use harm reduction strategies to reduce harm and prevent problems associated with drug use. This does not mean that illicit drug use is condoned, but rather, a recognition that people use both licit and illicit drugs (and may continue to do so) despite the risks of harm associated with using. Therefore, while it is not possible to stop all drug use, it is possible to change the way in which drugs are used to reduce the risk of harm to individuals and communities. An example of this can be seen in the area of injecting drug use. While the use of illicit substances remains illegal, there is a highly effective health response to preventing transmission of disease through the operation of NSPs.

Harm Minimisation Initiatives

Below is a list of, local, state and nationally supported harm minimisation initiatives:

- low alcohol beer
- standard drinks promotion
- controlled drinking programs
- server intervention programs
- needle and syringe provision
- Methadone and Subutex® / Suboxone® provision
- tolerance rooms (safe injecting)
- police and court diversion programs
- ambulance overdose education
- blood testing
- relapse management
- public sharps bins
- public smoking restrictions
- nicotine replacement therapies
- booklets and information brochures. These include the following titles:
    - Safe partying
    - Rage safe
    - A user's guide to speed
    - A guide to safer injecting practices
    - An injecting drug users guide to benzos
    - Coping with drug use: A parent's guide
    - Heroin overdose: What to do

Harm Minimisation: Standard Drinks Information

Australian Standard Drink information (NHMRC, 2009), is used to help define or quantify the amount of alcohol consumed, and to estimate the subsequent risks associated with consumption. Each standard drink contains **10 grams** of alcohol. Examples of one standard drink are:

- 375ml of mid strength beer (3.5%) (can or stubby)
- 285ml of full strength beer (4.8%) (pot)
- 100ml of red wine (13.5%)
- 100ml of white wine (11.5%)
- 60ml of fortified wine (18%) (e.g. sherry)
- 30ml of spirit (40%).

In Australia, a standard drink often differs from a serving of alcohol. Through legislation all bottles, cans and casks that contain an alcoholic beverage must state the number of standard drinks they contain on the label. On average, one standard drink takes approximately **one hour to be eliminated from the body.** This rate of metabolism by the liver is relatively fixed, but is dependant on factors such as a person's liver size, their body mass and composition, their alcohol tolerance, and individual genetic variation in controlling the expression of enzymes that metabolise alcohol in the liver (NHMRC, 2009).

Attitudes towards AOD and AOD Users

We all have attitudes which encourage us to act positively or negatively towards another person, an object, a situation, or otherwise influence our values. Many of the attitudes that people have developed towards drug use may have been initially formed by hearing 'myths'. These 'myths' may have developed into a set of particular beliefs and attitudes that an individual has formed regarding AOD issues.

Attitudes towards AOD issues play a central role in influencing how a person might behave towards AOD users. Attitudes held towards AOD clients, licit and illicit drug use, and various treatment options can influence a client's experience of treatment, and may ultimately influence their treatment outcome. For example, a health worker's negative attitude towards opioid replacement treatment (ORT) may prevent the health worker referring their client for ORT. Given empirical evidence supports the notion that due to its harm reduction value, ORT is a very effective treatment for many people. The non-referral for treatment by the health worker in this example has the potential to limit and influence the client's treatment options and outcomes. Therefore, having an awareness of ones attitudes, and being guided by evidence based practice, is vital for people working with clients in the AOD field.

It can be beneficial for AOD workers to explore and reflect upon their own beliefs and attitudes surrounding AOD issues. In the next section some of the general myths surrounding AOD use are reviewed, and the truth about them revealed.

General Myths about AOD Use

You may already recognise some of the general myths surrounding AOD use in Australia as you read through the following:

Myth: 'Hard' drugs are more dangerous than 'soft' drugs.
Truth: Tobacco and alcohol are our biggest drug killers. Danger is determined by how a drug is used, and the harmful effects it has on an individual and community.

Myth: You only have to use ‘hard’ drugs once to become dependent.
Truth: It takes repeated use of a drug over a period of time to become dependent.

Myth: The use of cannabis or amphetamines leads to mental illness.
Truth: The quantity and frequency of the drug used may contribute to a drug induced psychotic episode. Cannabis or amphetamines may induce a psychotic episode in those persons who are predisposed to mental illness.

Myth: Only people in lower socio-economic groups use ‘hard’ drugs.
Truth: Illicit drugs such as amphetamines and heroin are used by persons from all socio-economic groups in our society.

Treatment Myths

There are also a number of myths held by Australians regarding treatment for AOD use. Some of these myths and the truth about them are listed as follows:

Myth: Going cold turkey is the only way to give up a drug.
Truth: There are many different and effective ways of addressing problematic drug use.

Myth: All you need is willpower to stop drug use.
Truth: Willpower is only one requirement to assist in stopping drug use.

Myth: Just say ‘no’, it’s easy!
Truth: It is not always easy to say ‘no’. Saying ’no’ can take considerable effort and a significant amount of practice.

Myth: Giving methadone to a heroin user is like giving beer to someone who is dependent on alcohol.
Truth: Methadone is a slow acting, long lasting drug that stops withdrawal symptoms and is not the drug of choice for a heroin user. Furthermore it assists in creating lifestyle stability.

Myth: Put them in gaol and they will stop using drugs.
Truth: Some people do stop using in gaol, however many do not.

Myth: Abstinence is the only mark of success in treatment.

Truth: In reality, treatment success is about achieving treatment goals. For example, getting into a detoxification program can be a successful milestone for a dependent person. Reducing one's drinking to the recommended 'low risk' guidelines and maintaining this drinking level is a treatment success for another person.

Impact of Negative Attitudes

Negative attitudes towards AOD issues can have a number of unfavourable effects that include the following:

- reinforce the client's negative self-image
- strengthen the client's feelings of hopelessness or powerlessness
- discourage a person's attempts to seek treatment
- block a healthy therapeutic alliance
- inhibit early problem recognition and diagnosis
- limit a client's choice and options
- reduce a helper's ability to separate the person from the behaviour.

Dual Diagnosis

Dual Diagnosis within the AOD sector refers to the co-occurrence of substance use and mental health problems. Within this context, Dual Diagnosis is also commonly referred to as ‘co-morbidity’, a general term that means having more than one diagnosed disorder at a time. An important document used by AOD clinicians is the Queensland Health Dual Diagnosis Clinical Guidelines 2010.

People with a dual diagnosis are the core business of mental health and AOD services. Often these clients have multiple and complex needs that require a high level of responsiveness throughout all phases of their treatment, based on their individual needs. Their treatment can also involve the use of different services within the community.

The Queensland Health Dual Diagnosis Strategic Plan (2003) identified the prevalence of co-occurring substance use and mental health problems within AOD services to be 40% generally, but as high as 80% in Dual Diagnosis within the AOD sector refers to the co-occurrence of substance use and mental health problems. Within this context, Dual Diagnosis is also commonly referred to as ‘co-morbidity’, a general term that means having more than one diagnosed disorder at a time.

The Queensland Health Dual Diagnosis Strategic Plan (2003) identified the prevalence of co-occurring substance use and mental dependent drug users. Within Mental Health Services (MHS), this co-occurrence of substance use and mental health problems was estimated to be between 50% - 70%. Some of the more common co-occurring disorders associated with substance use include mood disorders, social phobias and other anxiety disorders, psychoses, and personality disorders.

Gender differences have also been identified in the prevalence of co-occurring substance use and mental health disorders in adults. The Mental Health of Australians 2 (2009, pp 36) has illustrated these differences as shown in the following Figures 3 and 4. Males have marginally more co-occurring substance use and mental health disorders than females.

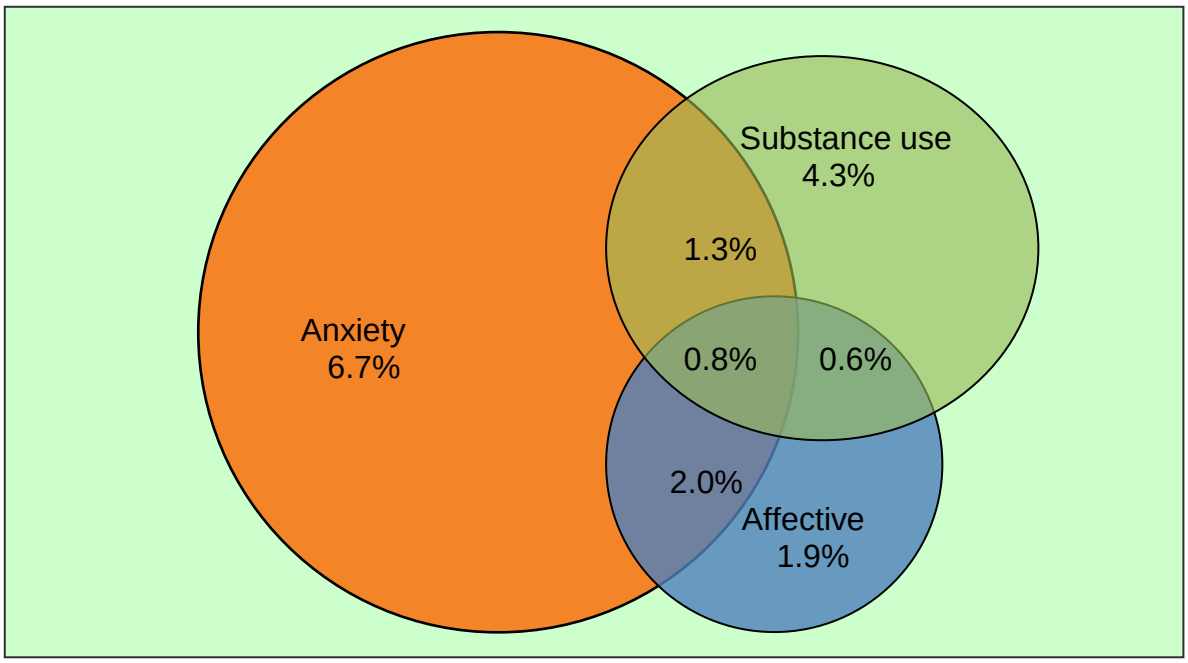

Figure 3: Prevalence of Single and Co-morbid Affective, Anxiety and Substance Use Disorders Amongst Australian Males (Slade et al, 2009).

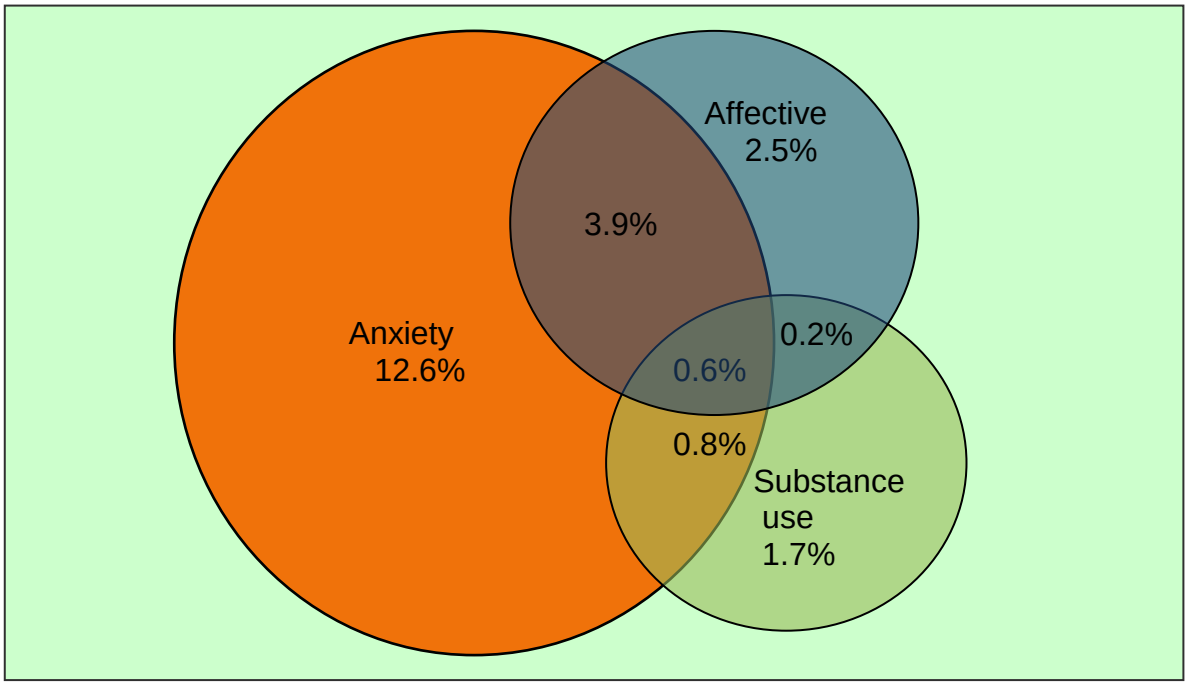

Figure 4: Prevalence of Single and Co-morbid Affective, Anxiety and Substance Use Disorders Amongst Australian Females (Slade et al, 2009).

The Impact of Dual Diagnosis

Clinicians in Mental Health Services (MHS), and Alcohol, Tobacco and Other Drug Services (ATODS), are presented with significant treatment issues when clients present with a co-morbid mental health and substance use problem. These clients often experience an increased severity of illness, have poorer treatment outcomes and higher service use compared to people experiencing a single disorder. People with a dual diagnosis also experience higher rates of physical problems, homelessness, financial difficulties, involvement in criminal behaviour and subsequent incarceration, admissions to acute mental health units, self harm, and suicide. Some of the complexities associated with dual diagnosis are illustrated in the following model (see Figure 5).

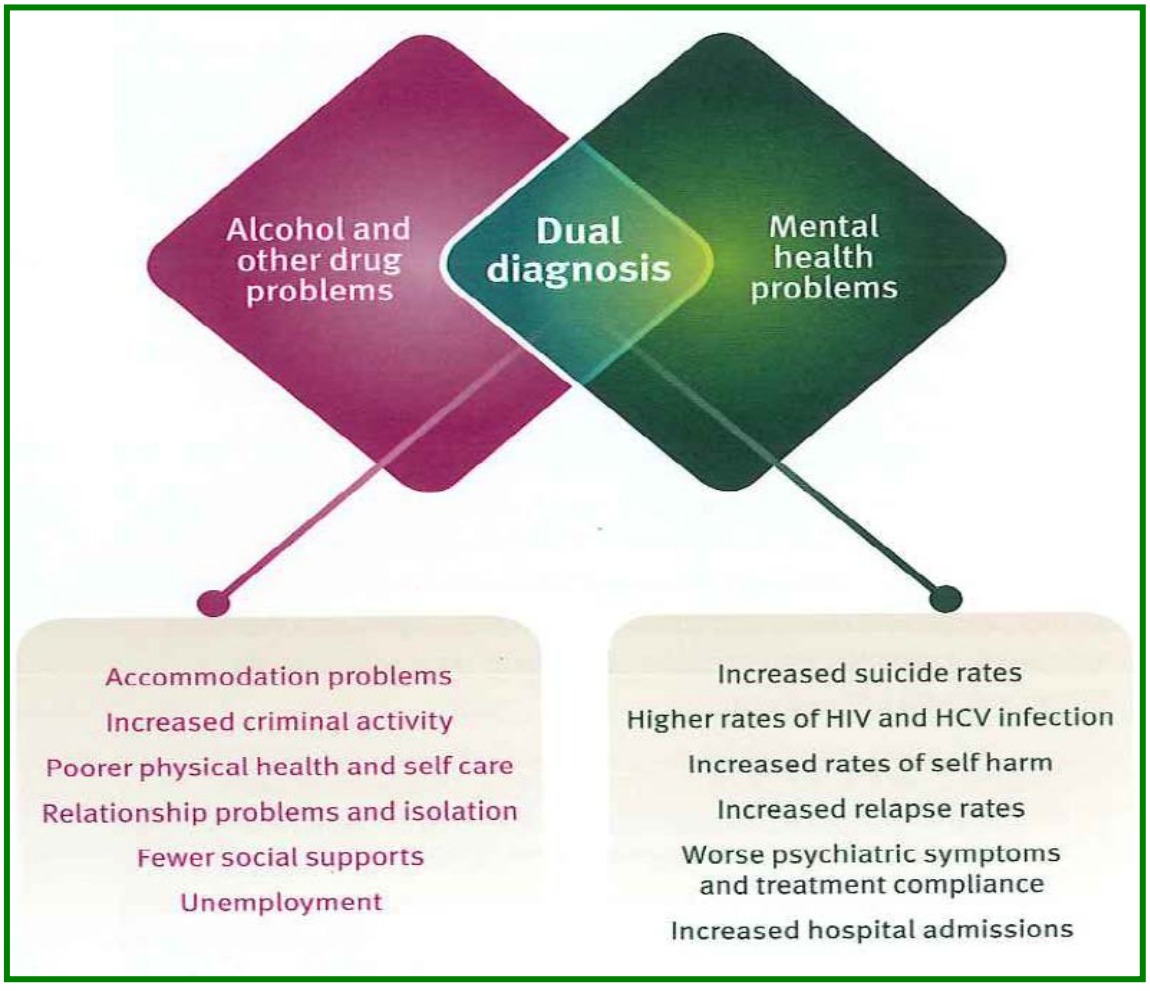

Figure 5: Impact of Dual Diagnosis (Queensland Health dual diagnosis clinical guidelines: Co-occurring mental health and alcohol and other drug problems, pp.12).

Models of Care

Historically, MH and AOD services operated from different philosophies and treatment models. The variation in care models has resulted in services operating side by side to manage the client's mental health or substance use problem in isolation. This approach has contributed to fragmented treatment (Queensland Health, 2010).

Treatment for co-occurring disorders can be provided by three different treatment models:

1. **Sequential** – the individual receives treatment for one disorder or problem first and is not eligible for referral to receive treatment for the other disorder until the first problem has been resolved or stabilised. This model relies on the premise that one disorder is primary and the secondary problem will resolve with the effective treatment of the primary disorder.
2. **Parallel** – both disorders are treated concurrently by two separate treatment services. This means the client has to attend separate services which may be independent of each other e.g. the client attends both the mental health service and the alcohol and drug service.
3. **Integrated Treatment** – refers to the provision of holistic care, addressing both mental health and AOD use by the same service provider or treatment team. Under this approach the client's dual diagnosis is treated at the same time in a co-ordinated approach either by one clinician or in collaboration with the other service in a seamless co-ordinated approach.

(Queensland Health, 2010)

The Queensland Health Dual Diagnosis Strategic Plan (2003) identified that the provision of integrated care would be essential to enabling the delivery of effective treatment for people with a dual diagnosis. At a service level this involves the provision of mental health and substance use services in a single setting where possible. When not possible, referral to other service agencies via agreed clinical pathways should occur.

The Quadrant Model (Minkoff, 2003) is a conceptual framework comprising of four domains which describe co-occurring disorders in terms of symptom severity as opposed to specific diagnoses, shown below in Figure 6. It provides guidance for the level of service coordination needed to improve client outcomes and is commonly used to inform the identification of treatment sector responsibility. Queensland Health promotes the application of this framework in line with international and Australian health service sectors.

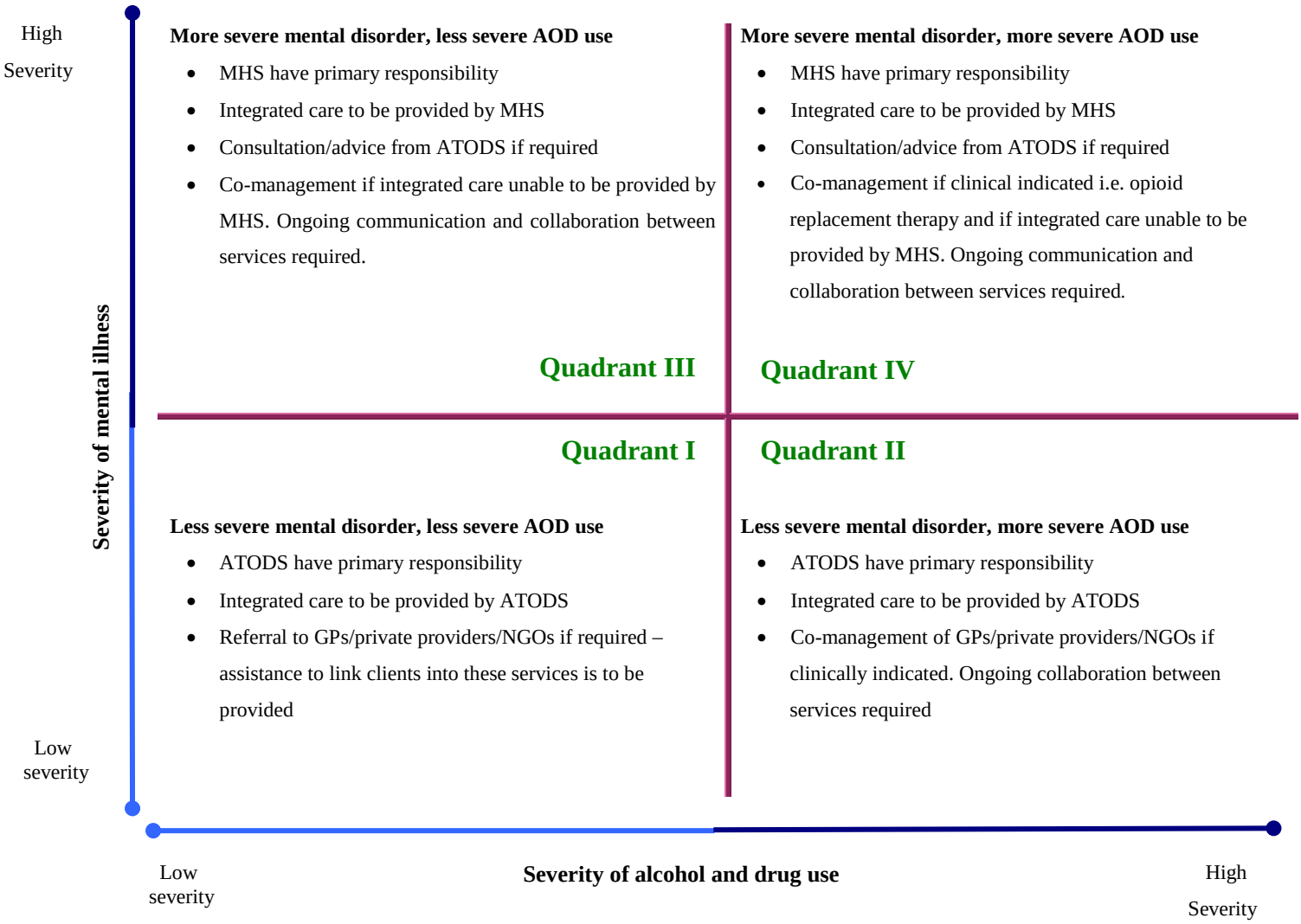

Figure 6: The Quadrant Model for Understanding Co-occurring Mental Health and Alcohol and Other Drug Use Disorders (Queensland Health 2010, pp.15).

PLEASE NOTE:

"It is critical that the application of the framework is flexible and adaptable to individual circumstances and not applied to exclude clients from services" (Queensland Health, 2010, pp.15).

No Wrong Door

The ‘no wrong door’ approach is a vital principle of care to ensure that clients with a dual diagnosis are provided with appropriate care. The ‘no wrong door’ approach requires MHS and AOD services to adequately assess and respond to a client’s individual needs through direct service provision or assertive referral to appropriate service providers, as opposed to redirecting the client to another service. This more comprehensive linkage aims to reduce the possibility of clients ‘falling through the gaps’ due to ineffective referral processes and the individual client’s reluctance to contact services independently, and acts as a mechanism to support the provision of safe and appropriate care.

Conclusion and Course Completion

This module has provided an overview of alcohol and other drug (AOD) use in the community and highlighted important issues for your practice. Clearly when examining the major drug problems faced by communities, there is often a difference between the information portrayed in the media and the actual empirical data. As a result of this discrepancy, a number of myths have emerged regarding drug use. It is important that we base our information on fact and the evidence based, much of which is covered in a number of important documents including the NDS and the Queensland Health Dual Diagnosis Guidelines.

Course Completion Certificate

To complete this module follow the link below to undertake a short quiz, then follow the quiz through to the evaluation. Your certificate will appear when you complete the evaluation. Don't forget to save or print your certificate.

Please note: QLD Health staff please ensure you are using the Firefox browser in order to complete this training online. You must complete the evaluation and enter your details in order to receive your certificate.

http://insightqld.org/big-picture/

BEGIN QUIZ

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