

Appendices & Glossary

NHMRC ALCOHOL GUIDELINES – SHORT- AND LONG-TERM RISK

Table A-1
Risk of harm in the short term

	Low Risk <i>minimal risk, potential health benefits</i>	Risky <i>regularly drinking to intoxication</i>	High Risk <i>sustaining moderate to high levels of drinking over time</i>
Males (on any one day)	up to 6 standard drinks on any one day, no more than 3 days per week	7–10 standard drinks on any one day	11 or more standard drinks on any one day
Females (on any one day)	up to 4 standard drinks on any one day, no more than 3 days per week	5–6 standard drinks on any one day	7 or more standard drinks on any one day
		HIGH RISK OF HARM FROM INTOXICATION	

Source: NHMRC (National Health and Medical Research Council) 2001, *Australian Alcohol Guidelines: Health risks and benefits*, National Health and Medical Research Council, Canberra.

Table A-2
Risk of harm in the long term

	Low Risk <i>minimal risk, potential health benefits</i>	Risky <i>regularly drinking to intoxication</i>	High Risk <i>sustaining moderate to high levels of drinking over time</i>
Males (on an average day)	up to 4 standard drinks per day	5–6 standard drinks per day	7 or more standard drinks on any one day
Males (overall weekly level)	up to 28 standard drinks per week	29–42 standard drinks per week HAZARDOUS	43 or more standard drinks per week HARMFUL
Females (on an average day)	up to 2 standard drinks per day	3–4 standard drinks on any one day	5 or more standard drinks on any one day
Females (overall weekly level)	up to 14 standard drinks per week	15–28 standard drinks per week HAZARDOUS	29 or more standard drinks per week HARMFUL

Source: NHMRC (National Health and Medical Research Council) 2001, *Australian Alcohol Guidelines: Health risks and benefits*, National Health and Medical Research Council, Canberra.

Appendix A

LABORATORY MARKERS FOR ALCOHOL-RELATED DAMAGE

Test	Advantages	Disadvantages
<p>(GGT) Serum Gamma-Glutamyl Transferase</p> <p>(enzyme in liver, blood and brain)</p>	<ul style="list-style-type: none"> • non-specific indicator of liver disease • sensitivity 20–50% for consumption of 40g alcohol per day or more • raised before AST and ALT • has half-life of 14–26 days 	<ul style="list-style-type: none"> • low sensitivity — GGT may be elevated by medications, non-alcoholic liver disease, diabetes, obesity. A standard measure of liver function
<p>AST/SGOT (Aspartate aminoTransferase)</p> <p>ALT/SGPT Alanine aminoTransferase</p>	<ul style="list-style-type: none"> • reflects overall liver health • can be routinely obtained using standard laboratory measures 	<ul style="list-style-type: none"> • like GGT, elevation in one of these measures alone may not necessarily be due to alcohol consumption
<p>(CDT) Carbohydrate Deficient Transferrin</p> <p>(variant of the protein that transports iron)</p>	<ul style="list-style-type: none"> • sensitivity is 60–70%; specificity 95% (few false positives) • elevated levels specifically associated with the metabolism of alcohol and dependent on quantity consumed (detected at > 60g per day) • returns to normal on reduction of consumption (half-life of 15 days) 	<ul style="list-style-type: none"> • need to exclude uncommon liver disease e.g. primary biliary cirrhosis <p>(note: this test is not routinely available in clinical practice)</p>
<p>(MCV) Mean red Cell Volume</p>	<ul style="list-style-type: none"> • supportive diagnostic tool when used with LFTs 	<ul style="list-style-type: none"> • less sensitive than GGT – can be elevated by medications e.g. valproate, azathioprine, folate and Vit B 12 deficiency, liver disease, hypothyroidism, smoking
<p>Other laboratory measures</p> <p>Thrombocytopenia, elevated bilirubin, low albumin and a prolonged INR all indicate significant organ damage related to high alcohol intake (Dawe et al., 2002).</p>		

REFERENCES

Dawe, S., Loxton, N.J., Hides, L., Kavanagh, D.J. & Mattick, R.P. 2002, *Review of Diagnostic Screening Instruments for Alcohol and Other Drug Use and Other Psychiatric Disorders*, 2nd edn., Commonwealth Department of Health and Ageing, Canberra.

AUDIT – INTERVIEW VERSION

The Alcohol Use Disorders Identification Test: Interview Version

<p>1. How often do you have a drink containing alcohol?</p> <p>(0) Never [skip to questions 9–10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week</p> <input type="text"/>	<p>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <input type="text"/>
<p>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <p>(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8 or 9 (4) 10 or more</p> <input type="text"/>	<p>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <input type="text"/>
<p>3. How often do you have six or more drinks on one occasion?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <input type="text"/> <p>Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0</p>	<p>8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <input type="text"/>
<p>4. How often during the last year have you found that you were not able to stop drinking once you had started?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <input type="text"/>	<p>9. Have you or someone else been injured as a result of your drinking?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p> <input type="text"/>
<p>5. How often during the last year have you failed to do what was normally expected from you because of drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <input type="text"/>	<p>10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p> <input type="text"/>
<p style="text-align: right;">Record total of specific items here</p> <p style="text-align: center;">If total is greater than recommended cut-off, consult User's Manual</p> <input type="text"/>	

Source: Babor, T., Higgins-Biddle, J.C., Saunders, J. & Monteiro, M.G. 2001, *The Alcohol Use Disorders Identification Test (AUDIT): Guidelines for Use in Primary Care* (2nd edn.) WHO, Department of Mental Health and Substance Dependence, Geneva, www.stir.ac.uk/departments/humansciences/appsocsci/audit/DRUGS.

Appendix C

AUDIT – SELF-REPORT VERSION

Scoring instructions: Each response is scored using the numbers at the top of each response column. Write the appropriate number associated with each answer in the column at the right. Then add all numbers in that column to obtain the total score.

The Questionnaire appears overleaf.

The Alcohol Use Disorders Identification Test: Self-report Version

GP: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	never	monthly or less	2–4 times a month	2–3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	never	less than monthly	monthly	weekly	daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	never	less than monthly	monthly	weekly	daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	never	less than monthly	monthly	weekly	daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	never	less than monthly	monthly	weekly	daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	never	less than monthly	monthly	weekly	daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	never	less than monthly	monthly	weekly	daily or almost daily	
9. Have you or someone else been injured because of your drinking?	no		yes, but not in the last year		yes, during the last year	
10. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	no		yes, but not in the last year		yes, during the last year	
Total						

Source: Babor, T., Higgins-Biddle, J.C., Saunders, J. & Monteiro, M.G. 2001, *The Alcohol Use Disorders Identification Test (AUDIT): Guidelines for Use in Primary Care* (2nd edn.) WHO, Department of Mental Health and Substance Dependence, Geneva, www.stir.ac.uk/departments/humansciences/appsocsci/audit/DRUGS, pp. 30-31.

TIP SHEET FOR REDUCING ALCOHOL CONSUMPTION

- Drink slowly, sip, don't gulp, take smaller mouthfuls.
- Place glass on the table between each sip.
Drink slowly, and concentrate on each mouthful.
- Alternate alcoholic drinks with non-alcoholic spacers.
- If thirsty, quench thirst with water, then have an alcoholic drink.
- Ensure there are plenty of non-alcohol or low-alcohol drinks available for yourself and your friends.
- Eat when, or before you drink as it helps to slow down the rate of absorption.
- Avoid drinking in rounds, or keeping up with your mates.
Alternatively, buy the first round then opt out and buy your own drinks from then on.
- Plan your drinking time — begin drinking later and go home earlier.
- Drink a full glass each time and say no to top-ups.
This makes it easier to count your drinks.
- Avoid salty snacks, no matter how tempting.
- Limit the number of drinks and money for each drinking occasion.
Ensure you have enough food to eat, and taxi money to get home.

Source: adapted from WAADA, 1995; NSW Health, 2000

REFERENCES

NSW Health 2000, *Alcohol and Other Drugs Nursing Policy for Nursing Practice in NSW: Clinical Guidelines 2000–2003*, NSW Health Department, Gladesville, NSW, www.health.nsw.gov.au.

WAADA 1995, *The Drinker's Guide to Cutting Down or Cutting Out*, Drug and Alcohol Services Council (DASC), Adelaide.

ALCOHOL WITHDRAWAL ASSESSMENT SCALE (CIWA-AR)

<p>Nausea and vomiting</p> <p>Ask ‘Do you feel sick in the stomach? Have you vomited?’ Observation:</p> <ul style="list-style-type: none"> (0) No nausea and no vomiting (1) Mild nausea with vomiting (2) (3) (4) Intermittent nausea, with dry retching (5) (6) (7) Constant nausea, frequent dry retching and vomiting 	<p>Tactile disturbances</p> <p>Ask ‘Have you any itching, pins and needles sensations, any burning, any numbness or do you feel bugs crawling on or under your skin?’ Observation:</p> <ul style="list-style-type: none"> (0) None (1) Very mild itching, pins and needles, burning or numbness (2) Mild itching, pins and needles, burning or numbness (3) Moderate itching, pins and needles, burning or numbness (4) Moderately severe hallucinations (5) Severe hallucinations (6) Extremely severe hallucinations (7) Continuous hallucinations
<p>Tremor</p> <p>Arms extended, elbows slightly flexed and fingers spread. Observation:</p> <ul style="list-style-type: none"> (0) No tremor (1) Not visible, but can be felt fingertip to fingertip (2) (3) (4) Moderate (5) (6) (7) Severe, even with arms not extended 	<p>Auditory disturbances</p> <p>Ask ‘Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?’ Observation:</p> <ul style="list-style-type: none"> (0) Not present (1) Very mild sensitivity (2) Mild sensitivity (3) Moderate sensitivity (4) Moderately severe hallucinations (5) Severe hallucinations (6) Extremely severe hallucinations (7) Continuous hallucinations
<p>Paroxysmal sweats</p> <p>Observation:</p> <ul style="list-style-type: none"> (0) No sweat visible (1) Barely perceptible sweating, palms moist (2) (3) (4) Beads of sweat obvious on forehead (5) (6) (7) Drenching sweats 	<p>Visual disturbances</p> <p>Ask ‘Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing things you know are not there?’ Observation:</p> <ul style="list-style-type: none"> (0) Not present (1) Very mild sensitivity (2) Mild sensitivity (3) Moderate sensitivity (4) Moderately severe hallucinations (5) Severe hallucinations (6) Extremely severe hallucinations (7) Continuous hallucinations

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ALCOHOL WITHDRAWAL ASSESSMENT SCALE (CIWA-AR) (CONTINUED)

<p>Anxiety</p> <p>Ask '<i>Do you feel nervous?</i>' Observation:</p> <ul style="list-style-type: none"> (0) No anxiety, at ease (1) Mildly anxious (2) (3) (4) Moderately anxious or guarded so anxiety is inferred (5) (6) (7) Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions 	<p>Headache, fullness in the head</p> <p>Ask '<i>Does your head feel different? Does it feel as though there is a band around your head?</i>' Do not rate for dizziness or light headedness. Otherwise rate severity.</p> <ul style="list-style-type: none"> (0) Not present (1) Very mild (2) Mild (3) Moderate (4) Moderately severe (5) Severe (6) Very severe (7) Extremely severe
<p>Agitation</p> <p>Observation:</p> <ul style="list-style-type: none"> (0) Normal activity (1) Somewhat more than normal activity (2) (3) (4) Moderately fidgety and restless (5) (6) (7) Paces back and forth during most of the interview or constantly thrashes about 	<p>Orientation and clouding of sensorium</p> <p>Ask '<i>What day is this? Where are you? Who am I?</i>' Observation:</p> <ul style="list-style-type: none"> (0) Oriented and can do serial additions Ask person to perform serial addition of 3s up to 30 e.g. 3, 6, 9... (1) Cannot do serial addition or is uncertain about date (2) Disoriented for date by no more than 2 calendar days (3) Disoriented for date by more than 2 calendar days (4) Disoriented for place and/or person

ALCOHOL WITHDRAWAL OBSERVATION CHART

Observations

Surname	First name	Age
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	Date								
	Time								
Breath alcohol reading									
Blood glucose reading									
Temperature (per axilla)									
Pulse									
Respiration rate									
Blood pressure									

Alcohol Withdrawal Assessment Score

Nausea and vomiting									
Tremor									
Paroxysmal sweats									
Anxiety									
Agitation									
Tactile disturbances									
Auditory disturbances									
Visual disturbances									
Headache, fullness in head									
Orientation and clouding of sensorium									
Total score									

Nursing Management:

- Nurse in a quiet, evenly lit environment
- Provide reassurance and explanation
- Re-orientate the person if confused
- Ensure adequate hydration

Vitamin Administration

- thiamine 100 mg and multivitamins daily
- give thiamine orally unless parenteral administration indicated (e.g. malnutrition, acute Wernicke's Syndrome)
- persons receiving intravenous dextrose or glucose should first receive parenteral thiamine to prevent acute Wernicke's Syndrome.

Medical Management of Acute Alcohol Withdrawal

When significant withdrawal is predicted preferred drug treatment is:

- diazepam 20 mg orally 2 hourly by weight (i.e. total 60 mg if weight < 75 kg; total 80 mg if weight 75–90 kg; total 100 mg if weight > 90 kg). Thereafter diazepam 20 mg orally by 2 hourly until Alcohol Withdrawal Scale (AWS) score is 10 or less
- further medical assessment is required for doses beyond 120 mg
- if AWS score rises to 15 or more recommence diazepam loading after further medical assessment

Withdrawal Convulsion Prophylaxis

- preferred drug treatment is:
 - Day 0 diazepam by weight related loading to a minimum of 75 mg (i.e. if < 75 kg, additional 15 mg 2 hours after last dose)
 - Day 1, 2 diazepam 10 mg orally b.d.
 - Day 3 diazepam 5 mg orally b.d.
- Note: If high AWS scores occur during the Day 0 loading phase, doses should be continued 2 hourly until the score is 10 or less. Ensure that a minimum total of 75 mg diazepam has been given on Day 0 unless the patient is excessively drowsy.

Combined Alcohol and Benzodiazepine Withdrawal

- where a combined alcohol and benzodiazepine dependence exists, the minimum dose of diazepam given during Day 0 should be equivalent to the stated dose of benzodiazepine intake, to a maximum of 80 mg. This dose should be given at a rate of 20 mg per 2 hours until the total first day dose has been given
- in the initial stages, more diazepam may be required to manage acute alcohol withdrawal symptoms or to prevent withdrawal convulsions. This should be given at a rate of 20 mg per 2 hours until the score has settled
- during subsequent days, inpatient clients will require a continuous, gradual diazepam withdrawal regime in accordance with the recommended guidelines (see *Guidelines II: Drugs: Hospital Management of Intoxication & Withdrawal*)
- such regimes feature QID doses of diazepam with the total daily dose decreasing by 5–10 mg per day over a period of 7–14 days.

General

- symptomatic treatment (e.g. paracetamol for headache, metoclopramide for nausea or vomiting) may be useful

THE FIVE ‘A’s

1. Ask

Which of these best describes you?

- Smoker Thinking of quitting
- Smoker Not thinking of quitting
- Ex-smoker Quit in the last 6 months
- Ex-smoker Quit for more than 6 months
- Never smoked

Intervention Level: Brief; Moderate (Mod.); Intensive (Intens.)

2. Assess

Not Interested in Quitting		Interested in Quitting		Recently Quit	
Brief	“How do you feel about your smoking right now?” “Have you considered quitting?”	Brief	“How important is quitting for you right now?”	Brief	“Any slips, even one puff?”
Mod.	Explore difficulties and what would be the hardest thing about quitting.	Mod.	Experience from past quit attempts: “What worked?” “What didn’t?” Explore motivation and confidence (use scale 1–10). Assess nicotine dependence.	Mod.	Check how they are managing. “Any benefits or problems?”
Intens.	Systematically explore likes and dislikes; e.g. decisional balance.	Intens.	Assess high-risk situations.	Intens.	Explore high-risk situations.

3. Advise					
Not Interested in Quitting		Interested in Quitting		Recently Quit	
Brief	State importance of considering quitting and acknowledge their right to choose, handle reactivity.	Brief	Set quit date. Support decision to quit.	Brief	Affirm decision: "That's great, it's the most important thing that you could do for your health."
Mod./ Intens.	Provide personalised feedback on any objective adverse health effects.	Mod./ Intens.	Brainstorm solutions: "What has worked?" "What didn't work?" "What tipped you back?" "How can I help?"	Mod./ Intens.	Summarise benefits accrued to date.

4. Assist					
Not Interested in Quitting		Interested in Quitting		Recently Quit	
Brief	Express interest: "I'm interested in your long term health and I'm here to help if you need it."	Brief	Offer Quitbook and Quitline Card.	Brief	Offer support e.g. Quitbook and Quitline Card.
Mod.	Mention Quitbook and Quitline card.	Mod./ Intens.	Develop a plan and quit date. Review dealing with nicotine withdrawal, triggers, social support, habit, negative emotions and social situations. Discuss pharmacotherapy e.g. NRT, Zyban, covering type, side effects, dosage, monitoring.	Mod.	Express ongoing interest: "I'll make a note to see how you are getting along."
Intens.	Discuss options e.g. Quitline, Pharmacotherapy (NRT, Zyban). Offer Quitbook and Quitline card. Acknowledge difficulties, most smokers take 5–6 attempts to quit.			Intens.	Help with specific situations e.g. weight gain, withdrawal, negative moods, and stress. Assist with high-risk situations.

5. Arrange					
Not Interested in Quitting		Interested in Quitting		Recently Quit	
Brief	Offer help in future.	Brief	Suggest follow-up appointment, ideally in the next seven days.	Brief	Offer follow-up appointment if there is a likelihood (or occurrence) of relapse.
Mod.		Mod.		Mod.	
Intens.		Intens.		Intens.	
	Offer appointment and explain how you can help.		Discuss a plan highlighting the value of follow-up appointments. Discuss Quitline 12 week support program.		

CREATE

- C** **Coordinated** — is there a clear plan, identified role and allocated responsibilities?
- R** **Receptive** — what will stimulate interest in doing this e.g. feedback, incentives, benefits greater than costs
- E** **Effective** — are evidence based strategies for implementation being used e.g. reminder systems?
- A** **Ability** — is there adequate knowledge, appropriate skills, sufficient resources and time?
- T** **Targeted** — can all smokers be identified especially those who are interested in quitting?
- E** **Efficient** — what steps have been taken to make the process a part of routine practice?

Appendix I

PROFORMA FOR DECISION BALANCE WORKSHEET

	Like (benefit)	Dislike (cost)
Smoke		
Quit		

Appendix J

HEPATITIS C REFERRAL CHECKLIST

Date: / /

To Doctor: _____

Referring Medical Officer

Name: _____

Surgery: _____

Provider No: _____

Patient Details

Name: _____

Address: _____

Date of Birth: _____

The following laboratory results accompany this referral:

- HCV Antibody (confirmed +ve)
- ALT (3 abnormal results over 6 months)
- LFTs
- Prothrombin Time
- FBC
- Alpha feto protein baseline
- TSH
- HBV serology including
 - HbsAg
 - HbsAb
 - HbcAb
- HAV IgG
- HIV Ab
- Fe studies
- EUC
- Past Liver Biopsy results

Comments:

Signature:

Source: Northern Rivers Area Health Service

Appendix K

A TO Z DRUG GLOSSARY

This has been compiled from a number of Australian and international sources. It is focussed on the AOD sector with emphasis on those concepts and terms that may be of specific interest to health professionals.

QUICK LISTING

A

AA
abstinence
abstinence syndrome
addict
addiction
ADIN
ADIS
administration – routes of
agonist
alcohol
amphetamines
ANCD
antagonist
anticraving agents
assessment
AUDIT
aversion therapy

B

barbiturates
behaviour change
benzodiazepines
binge
brain function
brief intervention
brief motivational interviewing
buprenorphine

C

cannabis
CBT
CDSR
chroming
cocaine
Cochrane Library
communication style
comorbidity or dual diagnosis
controlled use
classes of psychoactive drugs
cravings

D

dependence – DSM–IV & ICD–10
depressants
detox/detoxification
'doctor shopping'
drug abuse
drug interactions
drug-related behaviours and harms
drug states

E

'E' or ecstasy
education (community focus)
education (patient focus)
education (schools)
effectiveness
efficacy
Evidence Based Practice (EBP)

F

FLAGS
follow-up
FRAMES

G

GABA
GHB
gold standards

H

half-life
hallucinogens
harm minimisation
harm reduction

I

illicit drugs
inhalants
interventions
intoxication

K

ketamines

L

LAAM
lapse/lapse-relapse cycle
licit drugs

M

maintenance
maintenance pharmacotherapy
methadone
models of drug use
motivational interviewing
mesolimbic dopamine system/reward
centre of the brain

N

National Drug Strategy (NDS)
National Drug Strategy Household Survey
(NDSHS)
NEPOD
neuro-adaptation
neurotransmitters

O

opioids/opiates
overdose

P

party drugs
patient-centred approach
patient information
patterns of drug use
pharmacotherapies
polydrug use
pregnancy and drugs
prevention – primary, secondary & tertiary
psychoactive drugs

R

relapse/relapse prevention
risk/ 'at risk' groups

S

salience
screening tools
serotonin
setting limits
shared care
social rehabilitation
stages of change
stimulants
street language/names
supply reduction

T

THC
Therapeutic Community (TC)
tolerance
treatment options/modalities

U

unsanctioned drug use

W

withdrawal syndrome

Y

youth

Z

zero tolerance

GLOSSARY

A

AA

Alcoholics Anonymous is a voluntary, anonymous self-help organisation which promotes abstinence as a goal. Abstinence is achieved by commitment to a 12-step program, requiring active involvement and regular attendance at meetings. AA is not affiliated with any particular religion but is spiritually based.

abstinence

Refraining from using drugs.

abstinence syndrome

See [withdrawal syndrome](#)

addict

A term arising from the disease model of addiction. Generally considered judgmental as it stereotypes or labels a person. 'Addict' doesn't provide useful information regarding a person's pattern of AOD use (i.e. high risk, low risk). Alternatives: he/she has problems related to their drug use; she/he uses drugs.

addiction

Physical and psychological craving for a drug or drugs and related behaviours. The process of addiction is progressive and chronic. Addiction is more commonly referred to as psychological and physical dependence.

ADIN

Australian Drug Information Network

This provides a central point of access to quality Internet-based alcohol and drug information provided by prominent Australian and international organisations. It is funded by the Australian Government Department of Health and Ageing under the National Illicit Drug Strategy – 'Tough on Drugs'



www.adin.com.au

ADIN's large collection of quality assessed websites and databases enables organisations and individuals to search and share relevant information on licit and illicit drug issues. Info on conference events, latest publications and links to AOD services.

ADIS

Alcohol and Drug Information Services

Each state provides AOD assessment, referral or advisory/counselling services. Resources include printed information for people experiencing AOD related harms, and their friends, families and carers. Some states offer access to experienced clinicians on specific clinical matters; e.g. withdrawal and maintenance therapies. Generally operate a 24-hour service.

ACT	02 6205 4545	SA	1300 131 340 (Adelaide)
NSW	02 9361 8000 (Sydney) 1800 422 599 (NSW)	TAS	1800 811 994
NT	08 8981 8030 (Darwin) 1800 629 683 (NT)	VIC	13 15 70
QLD	07 3236 2414 (Brisbane) 1800 177 833 (QLD)	WA	08 9442 5000 (Perth) 1800 198 024 (WA) 1800 198 024 (WA)

administration – routes of

Important information when taking a patient history since the way a drug (or drugs) enters the body will affect how quickly the drug has an effect, how the drug is metabolised and potential harms. Changing from one route to another may be a useful stepping stone to cutting down and quitting. Methods of administration include oral, nasal, smoked, rectal and injected.

agonist

A drug that 'mimics' naturally occurring chemicals which stimulate receptors in the brain and CNS periphery (endogenous agonists). Agonists bind to and activate receptor sites. Their effect depends upon the drug's affinity for the receptor site and its concentration at the site.

See also [antagonist](#), [pharmacotherapies](#)

alcohol

Classified as a sedative/hypnotic drug. Ethanol (ethyl alcohol C₂H₅OH) is the main *psychoactive* ingredient in alcoholic beverages. Alcohol is second to tobacco in its effect on morbidity, mortality and health care costs from drugs. Routinely asking about patterns of alcohol (&OD) use assists GPs to identify alcohol-related harms or risky patterns of drinking and provides opportunities for intervention. Screening tools for alcohol use, can be self-administered, such as the *AUDIT* have good reliability and validity.

Alcohol is commonly called *grog*, *piss* and *booze*.

amphetamines

A category of CNS stimulants that include amphetamine (commonly known as 'speed'), methamphetamine (speed, crystal, meth, ice) as well as *d*-amphetamine and prescription drugs; e.g. Ritalin. Effects include wakefulness, perceived increases in awareness and greater energy. Other effects may include dilation of the pupils, tachycardia, elevated blood pressure, sweating, chills, loss of appetite, nausea or vomiting. *Exaggerated behaviours associated with use include aggression, agitation and impaired judgement. Chronic use can result in permanent personality and behavioural changes (WHO, 1994).*

Commonly called *go-ey, speed, go-fast, crystal, amphetts, ox blood* (mixed with iodine), *dexies, uppers, pep pills, quick, fast, ice*.

ANCD

Australian National Council on Drugs

Key advisory body established by the Prime Minister that supports the Ministerial Council on Drug Strategy (MCDS). ANCD has broad representation from volunteer and community organisations and law enforcement, education, health and social welfare interests.



www.ancd.org.au

The ANCD website contains information about national projects, research publications including evidence supporting treatment, funding opportunities, drug use information and links to AOD related sites.

antagonist

A drug that can bind with a receptor site in the brain, producing no pharmacological response but inhibiting the actions of agonists for that receptor

Examples: naltrexone at opioid receptors; buprenorphine, an opioid antagonist and a partial opioid agonist.

See also [agonist](#), [pharmacotherapies](#)

anticraving agents

Pharmacotherapeutic medications that reduce craving for a drug, thus promoting abstinence.

Examples: Acamprosate [Campral] suppresses alcohol craving by facilitating **GABA** transmission and reducing glutamate so that a balance is restored.

See also [pharmacotherapies](#)

assessment

Taking a good history, opportunistic communication, observations and investigations and the use of appropriate screening tools are generic assessment strategies. Assessment of AOD problems includes:

- history of drug use and treatment, medical and psychiatric problems, psychosocial factors,
- physical examination and where needed laboratory tests to confirm drug use/investigate abnormalities and/or screen for illnesses predisposed by the drugs used.
- create opportunities for harm reduction (injecting behaviour, sexual behaviour, immunisation).

AUDIT

Alcohol Use Disorders Identification Test, a ten item validated questionnaire that takes approximately 2-5 minutes to complete. See Appendices C & D.

See also screening tools

aversion therapy

Therapy based on the use of aversive stimuli, such as electrical shock linked with drug related behaviour so that the patient is unwilling to continue certain behaviours.

B

barbiturates

A sedative–hypnotic group of drugs that are now rarely seen in Australia. Increasing dosage produces progressive CNS depression, ranging from mild sedation to anaesthesia. *Very narrow margin between therapeutic and lethal dose, especially with presence of tolerance, hence dangerous in overdose.*

behaviour change

A response to a specific behaviour (adoption/quitting). Behaviour change is influenced by beliefs and prior knowledge of the behaviour, attitudes and subjective norms surrounding the behaviour, exposure to the behaviour (weighing up the pros and cons) and the perceived ability to adopt the new behaviour.

See also stages of change motivational interviewing

benzodiazepines

Introduced as safer alternatives to barbiturates. They are used as anti-anxiety medications, anti-epileptics and muscle relaxants. They are classified according to speed of onset and duration of effects. *Have significant potential for dependence in a relatively short time (2–4 weeks).* Commonly called *rohies, serras, vals, moggies, sleepers, footballs, tamazies, tranx.*

Examples: *Valium, Librium, Halcion, Xanax, Ativan, Serax, and Klonopin*

Enhances inhibitory neurotransmitter GABA at post-synaptic receptors by 'bending' the receptor so that GABA molecules attach to and activate their receptors more effectively and more often. They do not act directly to open chloride ion channels, and as such are not as lethal in overdose but alcohol and benzos is potentially fatal, as ethanol opens this channel and adds synergistically to generalised depressant effects.



www.dasc.sa.gov.au/site/page.cfm?site_page_id=88

Benzodiazepines GP Handbook (21 pages) covering who needs help to stop? Management of withdrawal, referral, prevention of dependence – pdf 726kb. Patient resources 'Benzodiazepines 1: Reasons to Stop' and 'Benzodiazepines 2: Stopping Use' OR try the links, *Publications & Resources, Professional* from:



www.dasc.sa.gov.au/site/page.cfm

See also [doctor shopping](#)

binge

An episode of intense (concentrated) or excessive alcohol or drug use. A prolonged binge is called a bender. Heavy drug use over a limited time period that can result in intoxication and sometimes overdose.

brain function

Studies on psychoactive drugs indicate common patterns of altered brain function across all addictive substances; e.g. drug induced activation of particular brain pathways and regions; persistent changes in brain function even after prolonged abstinence; and the brain's memory of the drug experience, triggered by exposure to environmental cues that induce drug-craving and drug-seeking behaviour.

See also [mesolimbic dopamine system/reward centre of the brain](#) [neuro-adaptation](#)

brief intervention (BI)

'any intervention that involves a minimum of professional time in an attempt to change drug use ... requiring a total of between five minutes and two hours' (Heather, 1990). BI provides GPs with a unique opportunity to reduce and prevent problematic use of AOD as part of their continuing and holistic care, especially for patients with low levels of problem severity and low levels of dependence. It is an effective, realistic, efficient and flexible treatment option in a primary care setting.

Examples: brief assessment, self-help materials, information on safe levels of consumption (alcohol), [harm reduction](#), [relapse prevention](#), assessment of readiness to change including [brief motivational interviewing](#), brief counselling including problem solving and goal setting, follow-up.

brief motivational interviewing

A technique developed for time limited (less than 5 minutes) and opportunistic interventions. Two central concepts are determining:

- the *importance* to the patient about changing their drug use behaviour and
- *confidence* about their ability to do so.

The technique consists of using scaling questions, exploring importance, summarising, building confidence, exchanging information, reducing resistance and summarising and inviting action.

See also [motivational interviewing](#) [patient centred approach](#) [stages of change](#)

buprenorphine

A synthetic partial opioid agonist and antagonist; blocks the effects of other opioids and has demonstrated effectiveness in opioid maintenance and withdrawal. Duration of action is dose dependent, 24–48 hours at higher doses making it useful as a maintenance treatment for opioid dependence. Withdrawal from short acting opioids (e.g. heroin) can be managed using short duration (5–7days) treatment. Withdrawal from buprenorphine is milder and the overdose risk is lower than with other opioid agonists such as methadone.

State and territory regulations restrict prescribing to accredited medical practitioners with specific training.

See also [pharmacotherapies](#)

C**cannabis**

A generic term for the various [psychoactive](#) preparations of the marijuana plant, *Cannabis sativa*. Cannabis is both a depressant (at low doses), and a hallucinogen (at high doses). The principal psychoactive constituent is delta-9-tetra-hydrocannabinol (THC). Acute effects may include relaxation, euphoria, disinhibition, heightened visual and auditory perceptions, increased appetite, altered time perception and difficulties with concentration. Other effects may include anxiety and panic, paranoia, visual or auditory hallucinations, impaired coordination, short-term memory loss, tachycardia and supraventricular arrhythmia.

Cannabis is the most prevalent illicit drug used today (AIHW, 2001).

Commonly called *pot*, *mull*, *gunja*, *kiff*, *hooch*, *THC*, *heads*, *dope*, *grass*, *yarndi*

CBT

Cognitive Behaviour Therapy. A broad array of therapeutic interventions that aim to provide patients with coping and living skills to function in their environment. Specific techniques include social skills training, anger management, and behavioural self-management. After-care or ongoing follow-up sessions are likely components of such a program.

CDSR

See [Cochrane Library](#)

chroming

The practice of inhaling vapours from spray paint. Also sometimes refers to sniffing volatile substances. Other modes of administration are huffing (saturated material is held against the mouth or nose) and bagging (vapours inhaled from a plastic or paper bag held over the nose or mouth). Both methods increase vapour concentration and euphoric effects.

See also [inhalants](#)

cocaine

A central nervous system stimulant, derived from the South American coca plant. It produces euphoria, increased confidence and feelings of control, energy, reduces the need for sleep and suppresses appetite. Cocaine blocks the reuptake of dopamine, noradrenaline and serotonin at presynaptic locations, thereby increasing these neurotransmitters at postsynaptic receptor sites. Tolerance to the rewarding effects of cocaine develops extremely quickly because of rapid [neuro-adaptation](#). Crack (purest and most potent form of cocaine) is obtained by heating cocaine salt combined with baking soda (freebasing). Cocaine is snorted, usually smoked (crack) or injected intravenously. The most common clinical problems associated with cocaine use are anxiety, temporary psychosis and cardiovascular problems.

Commonly called *coke*, *snow*, *C.flake*, *stardust*, *white lady*, *crack*

Cochrane Library

A regularly updated electronic library of databases and a register. It includes **CDSR**, **Cochrane Database of Systematic Reviews**, a collection of regularly updated health care reviews by an international network of experts, (named the Cochrane Collaboration). Its aim is to produce, maintain and disseminate systematic reviews of the evidence about the prevention and treatment/control of health problems.



www.cochrane.org.au

The **Australasian Cochrane Centre** website.
Email: cochrane@med.monash.edu.au.



www.cochrane.org/cochrane/revabstr/g360index.htm

The Drugs and Alcohol Review group listing.

communication style

A communication style which is open and empathetic and non-judgmental facilitates effective responses to drug problems. In attempting to bring about behaviour change, active listening and guidance rather than prescriptions are known to be effective.

See also [motivational interviewing](#)

comorbidity or dual diagnosis

Refers to a person who has a substance use problem(s) and a mental health problem(s) (e.g. depression or anxiety) at the same time. Interaction between the two can have serious consequences for a person's health and wellbeing; therefore appropriate diagnosis is essential in the management of comorbidity. Comorbid problems generally require long-term management approaches and an *integrated approach with other services*.



www.health.gov.au/pubhlth/nds/new/comorbidity.htm

Describes the 1st phase of the National Comorbidity Project and provides discussion papers in PDF format. Includes a General Practice perspective, what comorbidity is, how common, prevention and treatment.



som.flinders.edu.au/FUSA/PARC/toolkitcomorbidresource

Treatment principles guide for GPs.



som.flinders.edu.au/FUSA/PARC/Publications

Also in PDF format on the PARC website.



www.ceida.net.au/training_forum/website/midasc.htm

Provides a set of info slides for trainers & GPs including comorbidity; i.e. which comes first, approaches to dealing with dual disorder, what frontline staff need to learn, treatment goals.

See also [shared care](#)

controlled use

Treatment goal of moderation (cut down) as opposed to abstinence.

classes of psychoactive drugs

Psychoactive drugs affect moods, thoughts and behaviours. Despite the range of drugs commonly used, broad groupings (depressant, stimulant or hallucinogenic) can assist health professionals to identify or anticipate problems related to drug type. Table G-1 lists the major effects.

Table G-1
Major effects of psychoactive drugs

Depressants	Stimulants	Hallucinogens
decrease consciousness, awareness & coordination; cause relaxation & euphoria, respiratory depression, lowered HR, BP, slower reactions e.g. alcohol, barbiturates, benzodiazepines, opioids, solvents	increase alertness, activity, confidence, heart rate, anorexia e.g. amphetamines, nicotine, cocaine, caffeine, volatile nitrites	distort perceptions and subjective awareness e.g. LSD, psilocybin

NOTE: Some of the limitations of classifying drugs in this way include: many drugs produce different effects with different dosages, or when combined with other drugs; individuals vary in their response to a drug(s).

cravings

A strong desire or urge to use drugs, most apparent during drug withdrawal and may persist long after cessation of drug use. Symptoms are both psychological and physiological. Cravings may be triggered by a number of cues; e.g. seeing a dealer, music/object association such as walking past a pub.

See also anticraving agents

D

dependence

A person a strong desire to take a drug or drugs and cannot control their use despite harmful effects. Using the DSM-IV or ICD-10 diagnostic criteria assists diagnosis of dependence. Physical dependence is referred to as neuro-adaptation. The criteria appear overleaf.

Dependence is characterised by three (or more) of the following occurring at any time in the same 12-month period.

1. Tolerance – the need for markedly increased amounts of the substance to achieve intoxication or desired effect or a markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal – the characteristic withdrawal syndrome for the substance or where the same (or a 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 was intended
4. There is a persistent desire or unsuccessful attempts to cut down or control substance use
5. A great deal of time is spent in activities necessary to obtain the substance or to recover from its effects
6. Social, occupational or recreational activities are given up or reduced
7. Substance use is continued despite awareness of recurrent problems associated with use.

NOTE: The World Health Organization International Classification of Diseases, 10th Edition (ICD–10) suggests that the person must possess a strong desire to take the substance and is consuming it (Proudfoot & Teesson, 2000).

dependence (continued)

DSM–IV Diagnostic and Statistical Manual of Mental Disorders (4th edn) of the American Psychiatric Association. Provides a widely used definition for dependence. See Table G–2.

See Table G–3 for the **ICD–10** International Classification of Diseases, 10th edition definition of dependence.

depressants

Describes a group of psychoactive drugs which effect the CNS by suppressing functions resulting in decreased consciousness, awareness and coordination. High levels of intoxication may result in stupor or coma. Included in this category is alcohol, benzodiazepines, barbiturates, small doses of cannabis, opiates (i.e. codeine, methadone).

detox/detoxification

Is synonymous with and more commonly termed withdrawal. Usually it refers to supervised withdrawal for a person who is dependent. It may or may not involve medication.

‘doctor shopping’

Common term for describing the practice of visiting many doctors over a period of time in order to obtain larger quantities of prescription drugs.

The HIC (Health Insurance Commission) defines a ‘doctor shopper’ as someone who in one year sees 15 or more different GPs, has 30 or more Medicare consults, and obtains more PBS prescriptions than appears to be clinically necessary.

drug abuse

Although substance abuse is a DSM–IV diagnosis the term ‘drug abuse’ is subjective and often has little relative meaning. It is probably more useful to look at patterns of use and problems of use. Alternatives: this person experiences AOD related harm; has risky patterns of use, is a dependent user etc.

See also models of drug use

Table G–3
ICD - 10 definition of dependence

Dependence is characterised by three (or more) of the following occurring at any time in the same 12-month period.

1. Tolerance – evidence, such that increased doses of the substance are required to achieve the same effects originally produced by lower doses.
2. Withdrawal – physiological state when substance use has reduced/ ceased, evidenced by the characteristic withdrawal syndrome for the substance or use of the same substance with the intention of relieving/ avoiding withdrawal symptoms.
3. Compulsion to use – strong desire or compulsion to take the substance
4. Difficulties controlling use – difficulties in controlling substance behaviour, such as onset, termination and levels of use.
5. Substance use prioritised – neglect of other interests due to substance use (increased amount of time obtaining, using and recovering).
6. Continued use despite harmful consequences – persisting with substance use despite evidence of harmful consequences. Efforts should be taken to determine that the user was actually, or could be expected to be, aware of the extent of harm.

drug interactions

Two or more psychoactive drugs interact with each other in one of three ways:

- *antagonism*, one drug cancels out the effects of the other, see [antagonist](#);
- *potentiation*, combined effects that exaggerate and increase the effects of each drug; e.g. alcohol and benzodiazepines enhance sedation;
- *interference*, one drug disrupts the action of the other; e.g. disulfiram prevents the metabolism of alcohol beyond acetaldehyde.

drug-related behaviours and harms

This has been described in various models (e.g. Thorley's model – intoxication, regular use, and dependence). It can also be viewed temporally as a cycle of drug-related behaviour that starts with the acquisition of drugs and moves through administration of drugs, drug affected behaviour, recovering from drug use and withdrawal.

See also [patterns of drug use](#)

drug states

Conditions induced by drug use that may impact on physical, cognitive and social/emotional functioning. Drug states – [intoxication](#), [overdose](#), [dependence/tolerance](#) and [withdrawal](#) require consideration when working with people who have drug-related issues. Some patients will exhibit multiple states over a period of time.

E

'E' or ecstasy

The street name generally used for 3,4-methylenedioxymethamphetamine (MDMA). However other drugs may be sold as 'ecstasy', and 'ecstasy' tablets often contain a range of drugs such as amphetamine, amphetamine derivatives, caffeine, aspirin, paracetamol, ketamine in addition to, or in place of MDMA. It is usually sold as a tablet or capsule, typically with a symbol impressed on the surface.

Commonly called *white doves*, *love hearts*, *ecstasy*, *Adam*, *XTC*

education (community focus)

The National Illicit Drug Strategy stresses the importance of increased education, counselling and referral services through community based programs as well as augmenting existing community wide education and information campaigns on illicit drugs. One of the community initiatives can be accessed at the following web address. The Community Partnerships Kit web site is a resource for groups wishing to undertake community action to prevent harms related to illicit drug use. It uses an action research model: Look, Think, Act & Reflect.



www.communitypartnerships.health.gov.au/

education (patient focus)

GPs are well placed to provide information to patients so that they are better informed about their condition and can make an informed choice about what to do. Educating patients implies being an active listener and responding to gaps in a patient's knowledge and skill base. This exchange of information can be reinforced and extended by providing published patient information.

education (schools)

There is a range of State and National drug strategy initiatives from Reception to Year 12 (R–12). These include teacher support materials, learning activities for students and take-home activities to involve parents and other adults in the learning process as well as early intervention approaches.

effectiveness

The degree to which an intervention produces desired outcomes under everyday, normal conditions in contrast to efficacy, i.e. interventions under 'ideal' conditions. To search for evidence regarding effectiveness, try the following databases: CDSR (Cochrane Database of Systematic Reviews), DARE (Database of Abstracts of Reviews of Effectiveness), EMBASE and MEDLINE.

efficacy

The degree to which an intervention produces desired outcomes under optimal or ideal conditions such as those carried out in a research setting with high levels of resourcing. Caution should be exercised in interpreting the relevancy of the results to a GP's setting, to the local population or service.

Evidence Based Practice (EBP)

Evidence Based Practice integrates and reviews the best available research evidence, with professional expertise and practical wisdom, to apply it to decision-making practices. It promotes the explicit, conscientious and judicious use of the best, most up-to-date research evidence to guide health care decisions.



www.cochrane.org/cochrane/revabstr/g360index.htm

For the most up-to-date listing of Drugs and Alcohol Reviews and protocols go to the Cochrane website.

See also gold standards

F

FLAGS

A treatment model in relation to AOD patients. The model consists of five steps:

Feedback (give results of screening)

Listen to patient's concerns

Advise patients about continued use of drugs

Goals of treatment should be defined

Strategies for treatment are discussed, implemented and monitored.

See also [FRAMES](#)

follow-up

An essential process in monitoring the outcomes of treatment, providing ongoing psychological/social support and adapting treatment plans according to patient needs.

FRAMES

A treatment model (Miller & Sanchez, 1993) with six therapeutic steps that are common to successful brief interventions:

Feedback

Responsibility

Advice

Menu

Empathy

Self-efficiency

G

GABA

Gamma-aminobutyric acid is the most important inhibitory neurotransmitter in the CNS. By gating negative chloride (Cl⁻) ions into the interior of nerve cells, GABA inhibits the presynaptic release of neurotransmitters due to a positive voltage polarization pulse. GABA receptors can be found at 60–80% of CNS neurons. Benzodiazepines enhance the effect of GABA at post-synaptic receptors, hence their depressant action.

GHB

Gamma hydroxybutyric acid (GHB) is a naturally occurring short-chain fatty acid metabolite of gamma amino butyric acid ([GABA](#)). It is found in all body tissues, the highest concentration being in the brain where (unlike GABA) it crosses the blood–brain barrier to affect the

activity and levels of neurotransmitters. It is involved in the regulation of GABA, dopamine, 5-hydroxytryptamine, acetylcholine and affects the rate of serotonin metabolism. Research indicates that GHB produces deep reversible depression of cerebral metabolism, increases dopamine concentrations and induces hypothermia.

GHB is used as a 'party drug' and a 'drug-rape' drug. It comes in a liquid form, is easy to manufacture (recipes are available on websites), has no colour or smell, and can be easily slipped into drinks and food. It has been described as 'like alcohol without the hangover'. There is a narrow margin of safety with overdose being common. It is typically taken with other drugs (ecstasy, alcohol, amphetamines, cannabis).

Common names include *Fantasy*, *Grievous Bodily Harm*, *GHB*, *Liquid ecstasy*, *Liquid E*, *Liquid X*.



[ndarc.med.unsw.edu.au/
ndarc.nsf/website/
DrugInfo.resprojfactsheet](http://ndarc.med.unsw.edu.au/ndarc.nsf/website/DrugInfo.resprojfactsheet)

GHB use, patterns and associated harms (2001) based on interviews with 76 GBH users OR try 'Drug Info, Research Project Sheets' link:



[ndarc.med.unsw.edu.au/
ndarc.nsf/website/home](http://ndarc.med.unsw.edu.au/ndarc.nsf/website/home)

gold standards

The gold standard demonstrates a high level of confidence that the result will re-occur. A 'gold standard' is said to have the highest quality and validity at the present time and become accepted as such by the medical community.

Examples: AUDIT as a screening tool to assess alcohol risk
Methadone as a pharmacotherapy for opiate dependent patients

H

half-life

The time it takes for the concentration of a drug in the blood to be reduced by 50%. Drugs with a short half-life and short duration of action are commonly used (e.g. heroin) because of their 'peak effects' than drugs with a longer duration of action and longer half-lives.

hallucinogens

Substances that interact with the CNS affecting state of consciousness, and producing disturbances in thought and perception (e.g. illusions, and occasionally hallucinations).

Examples: LSD, Psilocybin (Magic Mushrooms)

harm minimisation

Underpinned the National Drug Strategy and aims to promote better health, social and economic outcomes for the community and individual. Harm minimisation includes preventing anticipated harm and reducing actual harm from licit and illicit drugs. It is a comprehensive approach to drug-related harm, involving *demand reduction*, *supply reduction* and *harm reduction* strategies. It takes into account three interacting factors: the individual, the environment/ setting and the drug(s).

harm reduction

Aims to reduce the impact of drug-related harm within society, at an individual and community level. It includes reducing the physical and social harms associated with drug use, encompassing the prevention of disease, death, incarceration and isolation. It acknowledges that drug use exists and will continue to, and therefore it focuses on promoting harm reduction methods.

Examples: clean needles and syringe programs, methadone as a treatment option for opioid dependency, experimental, supervised injecting facilities, brief advice, info pamphlets

I**illicit drugs**

A drug whose production, sale or possession is prohibited. An alternative term is 'illegal drug'. Classification of legal status varies over time according to societal attitudes and legislation.

inhalants

A group of psychoactive substances which are CNS depressants, rapidly changing from a liquid or semisolid state to vapour when exposed to air. The most commonly used inhalants include petrol, lacquers and varnishes containing benzene and adhesives, spray paint, glue and paint thinners containing toluene. Alternatively called solvents or volatile substances. Their appeal is linked to being inexpensive, readily obtainable, easy concealment and rapid intoxication with accompanying rapid resolution of intoxication.

interventions

A set of sequenced and planned actions designed to reduce risky behaviours in society. Intervention often targets a specific group (*risk group*) in order to reduce the adoption of potentially harmful behaviours (such as drug use). In the GP setting interventions are synonymous with treatment plan activities, which are negotiated with the patient.

intoxication

The acute effects of a drug when taken on a single occasion that produce behavioural and/or physical changes. When intoxicated the amount of a drug(s) exceeds the individual's tolerance. The capacity to think and act within a normal range of ability diminishes.

See also [drug-related behaviours and harms](#)

K**ketamines**

Fast-acting dissociative anaesthetics commonly used as animal tranquillisers. They interfere with pain pathways, leaving the respiratory and circulatory functions intact. The effects are rapid and usually last from 45–90 minutes. Low doses produce stimulant effects; medium to high doses a powerful paralysing psychedelic – and possible out-of-body or near death experiences at high doses. Ketamine is synthetically produced by the pharmaceutical industry in liquid form; however it is easy to convert into powder form by heating and grinding. It comes in liquid, pill, powder and tablet form. Injecting ketamines may cause immediate loss of consciousness.

Commonly called *special k*, *kitkat*, *vitamin k*, 'k' and *ket*.



www.thegooddrugsguide.com/ketamine/effects.htm

A consumer-oriented information site on ketamine and other drugs.

L**LAAM**

Levo-alpha-acetyl-methadol, an opioid agonist used for the management of opiate dependence. LAAM has duration of action of 48–72 hours, considerably longer than other opioids such as methadone. Currently (2003) not available in Australia.

lapse/lapse–relapse cycle

The first use of drugs after a period of abstinence. A relapse refers to a return to uncontrolled use or use at levels similar to those prior to abstinence. It is important to recognise that lapse/relapse is not 'failure' but a step towards behaviour change. Research indicates that the absence of coping skills and certain belief systems (e.g. 'I'm an addict and can't stop') are major predictors of relapse risk.

See also [relapse](#)

licit drugs

A drug whose production, sale or possession is not prohibited. 'Legal' drug is an alternative term.

Examples: Alcohol, tobacco, benzodiazepines, some inhalants

M

maintenance

A stage of behaviour change, in which a dependent user actively tries to remain abstinent.

maintenance pharmacotherapy/drug substitution

A drug (e.g. methadone or buprenorphine) is prescribed on a long-term basis to provide pharmacological stability (i.e. relief from withdrawal/intoxication), allowing the patient to make lifestyle changes.

See also [relapse/relapse prevention](#)

methadone

A synthetic opioid agonist predominantly used in maintenance therapy with patients who are dependent on opioids. Methadone liquid is usually administered once daily as the effects last 24 hours with regular dosing. It may also be used short-term (5–30 days) to relieve heroin withdrawal discomfort. GPs can become methadone prescribers by completing a nationally accredited methadone prescribers' course.

models of drug use

Frameworks to assist in understanding different perspectives about drug use at an individual and community level.

Examples: *Thorley's model* identifies drug-related problems/harms, derived from three interactive and overlapping areas of drug use – dependence (being 'STUCK'), regular use (DRIP, DRIP) and intoxication.

Zinberg's model (based on Social Learning Theory) considers three interactive factors – the drug itself, the person, and the social setting or environment in which drug usage occurs. Zinberg's model suggests that drug use is functional with both positive and negative consequences, it is learned (therefore can be 'unlearned') and the social setting is important. Controlled use is possible.

The Medical model emphasises drug use (addiction) as a disease due to genetic/biological causes and the physiological and psychological effects that are induced by drug taking. This model stresses the importance of pharmacotherapy in treating drug use problems.

models of drug use (continued)

www.sociology101.net/system/page2ofcrack



www.bali3000.com/drugnet/models/-20k-

motivational interviewing

This is a counselling technique developed by Miller and Rollnick. It assists GPs to work with ambivalence in their patients and explore their patient's reasons to change drug use – the patient is encouraged to argue for change (not the GP) and to provide their own solutions with support from the GP.

Examples of motivational interviewing activities – exploring positive and negative consequences of drug use, exploring patient's concerns, using reflective listening and summarising to communicate understanding, eliciting self-motivational statements (e.g. *'what are the things you like and dislike about your cannabis use?'*) helping the patient to decide whether to change (e.g. *'where does this leave you now?'*).

See also [brief motivational interviewing stages of change](#)

mesolimbic dopamine system/reward centre of the brain

A pathway in the brain comprising the ventral tegmental area (VTA), nucleus accumbens and the prefrontal cortex. It is activated by natural rewards such as sexual activity as well as psychoactive substances. The intense feeling from activation of the reward or pleasure experienced previously leads to a desire for or repetition of the behaviour. In chronic substance users this can lead to chronic and intense cravings which may be activated by anticipatory dopamine release in response to cues; e.g. drug use implements.

National Drug Strategy (NDS)

Refers to a framework of policies and programs aimed at reducing drug-related harm in the community. The NDS aims to prevent and reduce the uptake of harmful drug use and minimise the harmful effects of licit and illicit drug use in Australian society. The NDS adopts a comprehensive approach, which encompasses the use of both licit and illicit drugs.



www.health.gov.au/pubhlth/strateg/drugs/nds/index.htm

Describes the National Drug Strategy 1998–99 to 2002–03. PDF file, 393 Kb.



www.health.gov.au/pubhlth/strateg/drugs/illicit/index.htm

Describes the National Illicit Drug Strategy 1998–99 to 2002–03

National Drug Strategy Household Survey (NDSHS)

This is the most current and comprehensive survey concerning licit and illicit drug use undertaken in Australia. The 2001 survey gathered information from almost 27,000 persons aged 14 years and over. Previous surveys were conducted in 1998, 1995, 1993, 1991, 1988 and 1985.

2001 National Drug Strategy Household Survey: First Results is published by the Institute of Health and Welfare and can be found on their website



www.aihw.gov.au/

Summary of drug use: proportion of the population aged 14 years and over, and mean age of initiation, Australia, 1998, 2001 OR try 'Fact Sheets' link from:



[ndarc.med.unsw.edu.au/
ndarc.nsf/website/
DrugInfo.factsheets](http://ndarc.med.unsw.edu.au/ndarc.nsf/website/DrugInfo.factsheets)



[ndarc.med.unsw.edu.au/
ndarc.nsf/website/home](http://ndarc.med.unsw.edu.au/ndarc.nsf/website/home)

NEPOD (1998–2000)

National Evaluation of Pharmacotherapies for Opiate Dependence.

A three-year clinical trial (1998–2000) which monitored the effectiveness of treatment options for opiate (heroin) users. Thirteen studies were conducted which investigated detox/withdrawal treatments and maintenance treatments. It found that all maintenance treatments provided benefits and that methadone was the most cost-effective; buprenorphine, because of its unique properties should also be considered.

neuro-adaptation

The process whereby the brain adapts to the presence of a drug. The brain becomes relatively insensitive to normal levels of neurotransmitters by a number of postulated mechanisms. This is one explanation for craving. The drug user may experience under-stimulation (without drugs), a reduction in euphoria/pleasure and need to increase the dose to maintain the drug's euphoric effects.

neurotransmitters

Chemical messengers that are released by neurones to communicate across synapses. They bind to particular receptor sites, exciting or inhibiting an action. Psychoactive drug molecules can behave like neurotransmitters, binding to a particular receptor site and occupying the neurotransmitter's position. The interaction between the drug molecule and the receptor site involves two types of action:

Agonist The drug's shape may be similar to the neurotransmitter molecule. The drug molecule will therefore occupy the receptor site and imitate the neurotransmitter's action.

Antagonist The drug's shape may resemble the shape of the neurotransmitter molecule, and occupy the receptor site, but not imitate its actions. The drug prevents the neurotransmitter from exerting its action.

O

opioids/opiates

A class of substances with morphine-like effects that can be reversed by the specific antagonist naloxone. Morphine is derived from the opium poppy; others are semi-synthetic; e.g. heroin or synthetic; e.g. pethidine; they are mostly used as analgesics for pain. Opioids stimulate opioid receptors, producing drowsiness, reduced pain perception and euphoria (highly reinforcing). Regular use leads to tolerance accompanied by craving for the drug and physical dependence with accompanying strong withdrawal syndrome on cessation of use. Potential adverse effects include respiratory depression and arrest, nausea, confusion, constipation, sedation, unconsciousness, coma; tolerance and dependence.

Examples: opium, heroin, morphine, codeine, fentanyl, methadone, buprenorphine, pethidine, diconal, palfium

overdose

Results from the ingestion of a drug(s) that exceeds a person's tolerance. The result may include acute psychosis (e.g. amphetamines) or potentially life threatening effects; e.g. respiratory depression with opiates.

Table G-4
Overdose categories of concern

<p>Drugs that depress vital functions</p> <p>heroin, benzodiazepines + alcohol</p>	<p>Drugs that have toxic effects</p> <p>alcohol or analgesics e.g. paracetamol</p>	<p>Drugs that cause stress on internal organs</p> <p>stimulants which cause organs and systems to work harder</p>
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P

party drugs

A term that loosely groups drugs used in the pub, club, party or rave scenes. Includes stimulants.

Examples: amphetamines, MDMA (Ecstasy), GHB, ketamine

Individuals who use party drugs often take other drugs; e.g. alcohol, antidepressants, benzodiazepines, cannabis.

patient centred approach

This is recommended in order to encourage a good therapeutic relationship and trust with the patient. It includes regarding the person's behaviour as their choice, expressing empathy, encouraging the person to decide how much of a problem they have, avoiding arguments/confrontation, encouraging discrepancy and reevaluation of substance use. These strategies have been empirically demonstrated to enhance the quality of support to drug users and enhance the likelihood of behaviour change.

See also [motivational interviewing stages of change](#)

patient information

Refers to effective strategies in providing patients with relevant information. Information can be provided in passive (pamphlets, posters, booklets) and active (consultation with physician) forms. Passive patient information is usually free or of minimal cost and needs to be provided in different languages to cater for the broad community.

See also [ADIS](#)

patterns of drug use

This model suggests drug use exists as a continuum and that most drug use is experimental or occasional. Some people gradually move up the 'scale' and progress towards dependent patterns of use.



pharmacotherapies

Involves the use of medications in responding to problem drug dependence. Medication can be used to alleviate withdrawal discomfort, as maintenance substitution; e.g. methadone or to reduce craving; e.g. naltrexone. Pharmacotherapies are best used as part of a comprehensive treatment plan that includes psychosocial therapies and support.

polydrug use

The simultaneous or sequential non-medical use of more than one drug.

pregnancy and drugs

Drug and alcohol use throughout pregnancy is associated with a range of adverse effects.

- Examples:
- Increased incidence of premature labour, risk of spontaneous abortion (miscarriage) and stillbirth
 - Reduced birth size and weight, often leads to breathing difficulties and vulnerability to infection
 - Neonatal Abstinence Syndrome (NAS)
 - Fetal Alcohol Syndrome (FAS)

Assessment includes questions about history of alcohol and other drug use from the date of the woman’s last menstrual period and whether or not substance use is continuing. Management strategies include providing patient information about the effects of drug and alcohol use during pregnancy and exploring a range of choices for action.

prevention

Interventions that are designed to stop or delay the uptake of drugs or reduce further problems among those using drugs. Interventions can be categorised as primary, secondary or tertiary.

Table G-5

TYPE AND TARGET	FOCUS
<p>Primary</p> <p>Individuals who are likely to – or who have already begun experimenting with drugs</p>	<p>Educate about drug-related harm, and aims to prevent uptake of drug use or reduce frequency of use</p>
<p>Secondary</p> <p>Individuals who are already using drugs</p>	<p>Increase awareness about the risks involved, in order to reduce the amount of drug-related harm</p>
<p>Tertiary</p> <p>Individuals who are dependent or heavy substance users.</p>	<p>Treat and rehabilitate</p>

psychoactive drugs

Refers to any chemical substance which when taken into the body, alters mood, cognition and behaviour. The term ‘drug’ usually includes tobacco, alcohol, pharmaceutical drugs and illicit drugs. It also refers to other substances that have psychoactive effects; e.g. solvents.

R

relapse/relapse prevention

Relapse is a commonly described feature of those patients who are drug-dependent. It takes time for anyone to change their behaviour. Encourage patients to view relapse as just another step in a journey, not as a failure.

Relapse prevention describes a set of strategies that aim to equip patients to cope with high-risk situations that may lead to previous patterns of drug use.

See also [motivational interviewing](#)

risk/'at-risk' of AOD related harms

Surveys, reviews and epidemiological data indicate that certain groups in society are potentially at greater risk of harm through intended/actual drug use, relative to the general population. These 'at-risk' groups include outpatient groups, youth, gay, lesbian, bisexual, transgender and intersex groups, Aboriginal and Torres Strait Islanders and health professionals.

S

saliency

A preoccupation with substance use, or seeking the substance. It dominates the user's thoughts or actions.

screening tools

Questionnaires that assist in screening for drug use and related harms. They provide useful information and facilitate further discussion between the patient and GP. Screening tools are not designed to replace a good history but are complementary to, and time saving.

Examples AUDIT, FAST (based on the AUDIT) & CAGE for alcohol use
 SDS for psychological dependence
 ASSIST for alcohol and other drug use

serotonin (5 hydroxytryptamine)

A phenolic amine neurotransmitter that has a prominent role in sleep regulation and mood. Serotonin is affected by a number of psychoactive substances. Its synaptic concentration is increased by stimulants, especially MDMA. Its release is inhibited by opioid receptors. Many antidepressants act via their effects on serotonin; e.g. inhibition of reuptake.

setting limits

Setting limits can have benefit for both GPs and patients. Consequences are clear and there is less room for feeling compromised or used. The basic principles are being clear, concrete and 'up front' in what you say, mean what you say and say what you mean, and follow through with what you say.

shared care

An integrated approach to provide effective, planned delivery of care for patients with chronic or complex conditions. The AOD shared care model focuses on joint provision of clinical services by GPs and specialist AOD agencies to those patients with AOD problems and ongoing education and training for GPs.

social rehabilitation

An intervention to integrate clients into society through education, work or housing. Traditionally social rehab was provided after completion of a treatment program but it is increasingly viewed as an intervention that can be used at any stage throughout the treatment process.



[www.emcdda.org/
responses/themes/
social_reintegration.shtm](http://www.emcdda.org/responses/themes/social_reintegration.shtm)

The European Monitoring Centre for Drugs & Drug Addiction website describes social rehabilitation, an in-depth study on social reintegration facilities and has an evaluation instruments bank that can be downloaded; European Union focus.

stages of change

Prochaska and DiClemente described a model with five distinct stages to behaviour change:

Pre-contemplation – the individual may not have recognised they have a problem

Contemplation – the individual is beginning to question the behaviour (weigh up pros and cons).

Action – the individual is at the stage where they want to do something about the behaviour. They become actively involved in attempting to change their behaviour.

Maintenance – the individual attempts to maintain their progress by replacing the behaviour with an alternative one.

Relapse

See also [motivational interviewing patient centred approach](#)

stimulants

Any drugs that activate, enhance or increase neural activity of the CNS. Includes the amphetamines, caffeine, cocaine, nicotine and synthetic appetite-suppressants. Some other drugs such as antidepressants and certain opioids have stimulant effects in high doses or after chronic use.

street language/names

There are good listings of street language and their meanings in a number of publications. It is recommended that GPs use medical terminology since this is standard, less subject to change and is less likely to result in misunderstanding.

supply reduction

Activities that aim to disrupt the production and supply of illicit drugs. It may also be used to impose limits on access to and the availability of licit drugs such as legislation regulating the sale of alcohol and tobacco to people under the age of 18.

T**THC**

Delta-9-tetrahydrocannabinol, the primary psychoactive constituent in cannabis.

Therapeutic Community (TC)

'A structured residential environment in which people live whilst undergoing drug treatment' (National Drug Strategic Framework, 1998). Therapeutic communities are long-term residential programs (often at least 3 months) that provide a holistic approach to therapy via counselling, group therapy, and other self-help strategies.

tolerance

A state in which continued use of a drug results in a decreased response to the drug dose. Increased doses are required to achieve the same level of effect previously produced by a lower dosage.

treatment options/modalities

The choice of treatment option(s) depends upon the nature and severity of the drug problem/habit, the social and environmental context in which the patient lives and the resources that exist within and outside the GP setting. There is a range of treatment options.

U**unsanctioned drug use**

Drug use that is proscribed by law, school authorities or school policies and/or guidelines. It includes illicit, social and prescription drugs.

W

withdrawal syndrome

Describes a range of physical and psychological symptoms that occur when a person stops or substantially reduces substance use if they have been using for a long period or/and at high doses. Generally, signs and symptoms are opposite of the acute effects of the drug. The course of the withdrawal depends upon the level of tolerance developed, other illnesses and the psychosocial environment.

Y

Youth

Youth are a high-risk group for drug-related harms. GPs are viewed as credible information sources and are in a good position to deliver information on illicit/licit drug use to youth, parents and/or carers. Although young people have access to illicit drug information (especially on the Internet) they need information on the health consequences associated with illicit drug use, especially the long-term health effects.



www.ysas.org.au/

Youth Substance Abuse Service, Victoria

See also [patterns of drug use](#)

Z

zero tolerance

A policy that promotes the idea that 'no drugs', 'no drug use' is the aim of education and intervention activities. This contrasts with the policy of [harm minimisation](#).

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