Substance Use Disorders

in South Asian population

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Substance Use Disorders

SOCIAL

HARMFUL

DEPENDENCE

POLY SUBSTANCE

Epidemiology & Impact

- 1 in 4 Canadians will experience Substance use/mental illness during lifetime
- Costs Canada $32 billion/yr (Single, 1996)
- 79% of general population drink alcohol
- 14% use cannabis (CAS 2004)
- 80%+ of Grade 12 students drink & about half report hazardous drinking (Adlaf, 2005)
- Daily cannabis use increasing significantly and 1 in 5 students report driving after use (Adlaf, 2005)

Table 1: Rates of selected mental or substance use disorders, lifetime and 12 month, Canada, household population 15 and older, 2012

	Lifetime	12-month
	percent	
Mental or substance use disorders[1]	**33.1**	**10.1**
Substance use disorder[2]	21.6	4.4
Alcohol abuse or dependence	18.1	3.2
Cannabis abuse or dependence	6.8	1.3
Other drug abuse or dependence (excluding Cannabis)	4.0	0.7
Mood disorder[3]	12.6	5.4
Major Depressive Episode	11.3	4.7
Bipolar Disorder	2.6	1.5
Generalized Anxiety Disorder	8.7	2.6

1. **Mental or substance use disorders** is comprised of: substance use disorders, mood disorders and general anxiety disorder. However, these three disorders cannot be added to create this rate because these three categories are not mutually exclusive, meaning that people may have a profile consistent with one or more of these disorders.
2. **Substance use disorder** includes alcohol abuse or dependence, cannabis abuse or dependence and other drug abuse or dependence.
3. **Mood disorder** includes depression (major depressive episode) and bipolar disorder.

Source: Statistics Canada, Canadian Community Health Survey – Mental Health, 2012.

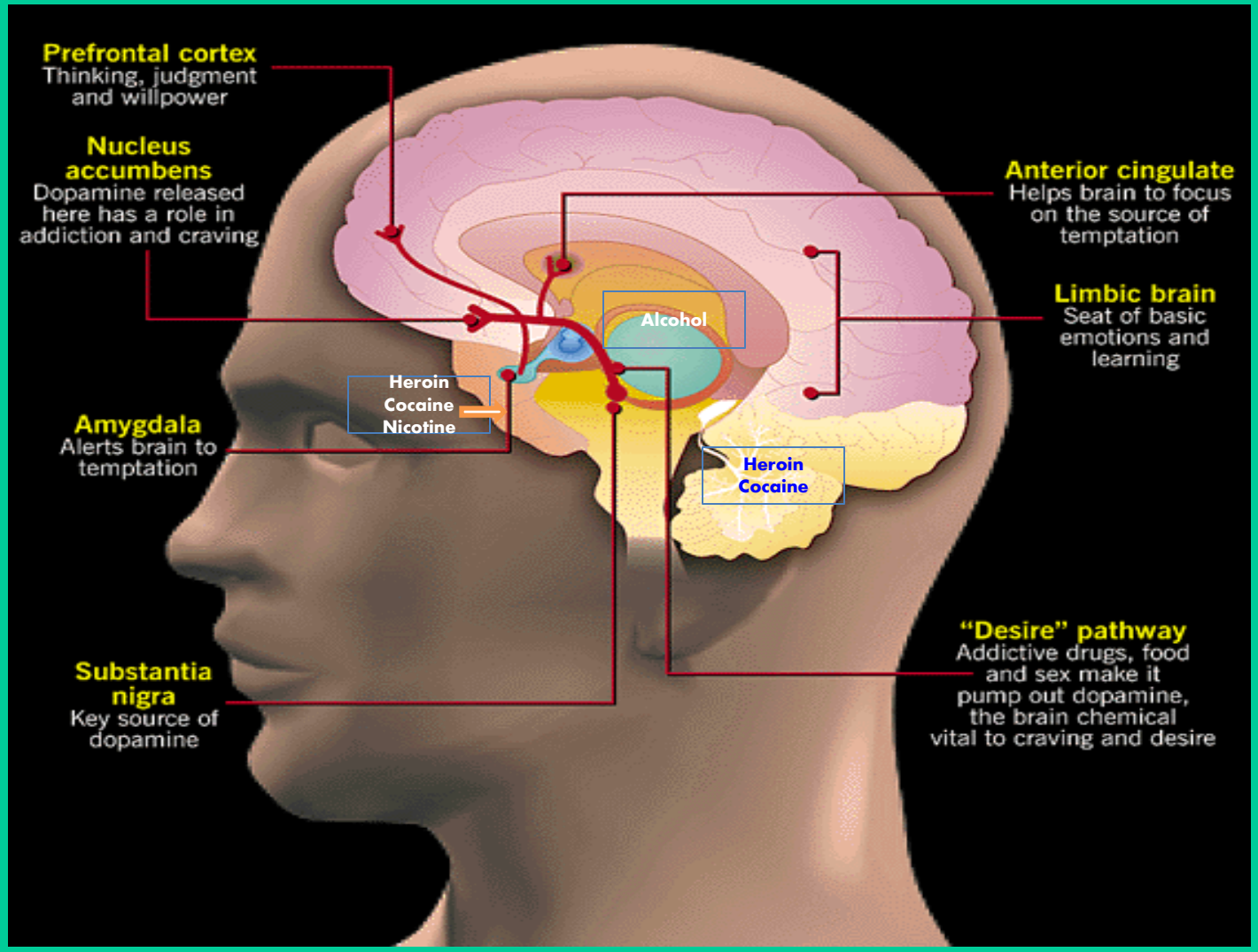
Substance Use in south asians

- Substance rising in India
- National Household survey, 2001
  - Alcohol 21.4%
  - Cannabis 3.0%
  - Heroin 0.2%
  - Opium 0.4%
- ICD, UN Survey, 2011 (Punjab)
  - 2nd highest prevalence
  - 67% use 1+ substance
  - 66% of school children take Gutka or Tobacco
  - 7/10 college students use more than one substance

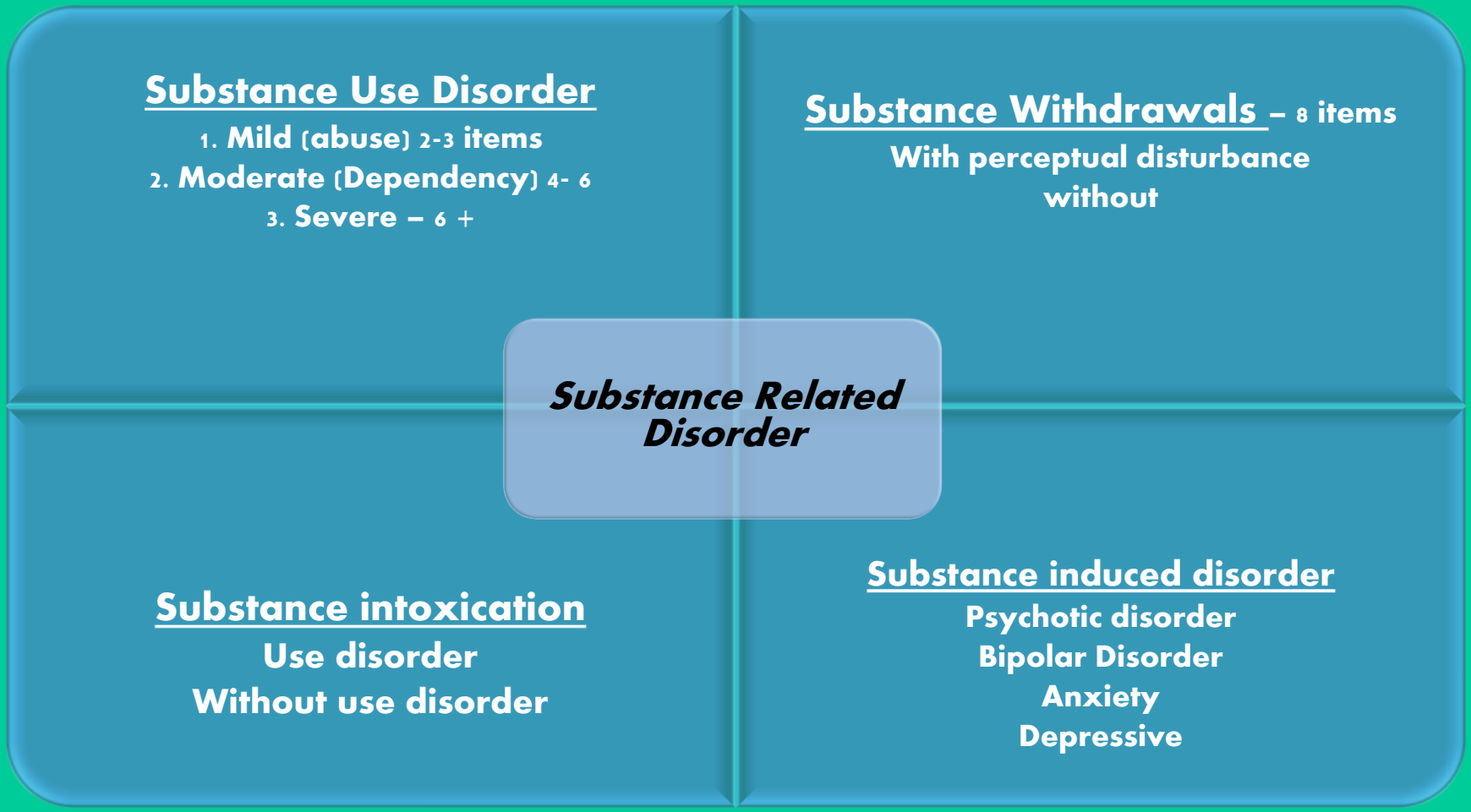
Substance Use in south asians

- Limited Canadian data
- 57% of South Asians use alcohol regularly (Sivia et al, 2009)
- Pattern of substance use in South Asians similar to general population (NDA, UK, 2007)
- Binge drinking more prevalent in Sikhs, particularly spirits (Gosh & Nayak 1984)
- Substance use increasing among young

Mechanism of Addiction: Reward Pathway



DSM-5


Substance Use Disorder
1. Mild (abuse) 2-3 items
2. Moderate (Dependency) 4- 6
3. Severe – 6 +
Substance Withdrawals – 8 items
With perceptual disturbance
without
Substance Related Disorder
Substance intoxication
Use disorder
Without use disorder
Substance induced disorder
Psychotic disorder
Bipolar Disorder
Anxiety
Depressive

Best Practice, Policies & Current Service Models

- **National Drug Strategy, $210M strategy** (Gov't of Canada, 1987)
- **Canada's Drug Strategy, 1992, $270M strategy to reaffirm the NDS**
- **Best Practices: Substance Abuse Treatment and Rehabilitation** (Health Canada, 1999)
- **Changing Directions, Changing Lives: The Mental Health Strategy for Canada** (Mental Health Commission, 2012)
- **Targeted areas such as education, public and school awareness campaigns, DARE, Crime prevention and National Native Alcohol Program, Harm reduction** (MMT, NE & Outreach programs, supervised injection sites etc.)
- **Need ethno cultural specific policy...??**

Factors influencing Substance Use

in South Asians

Cultural factors (Bhugra et al 2004)

Post migration factors

- Culture shock
- Culture conflict
- Acculturation
- Discrepancy in aspiration & achievement
- Language

Resiliency factors

- Positive cultural identity
- Role of Spirituality/ Adherence to religious values
- Social support
- Socio economic advantage

Barriers to Treatment

- Lack of awareness of treatment options
- Lack of appropriate services
- Language and literacy
- Stigma/ Shame
- Confidentiality policy and practice
- Unwilling to seek help outside immediate family or close friendship network
- Cultural ties
- Negative beliefs
- Gender
- Emphasis on medical model and hence less engagement with other therapies

Where do we go from here?

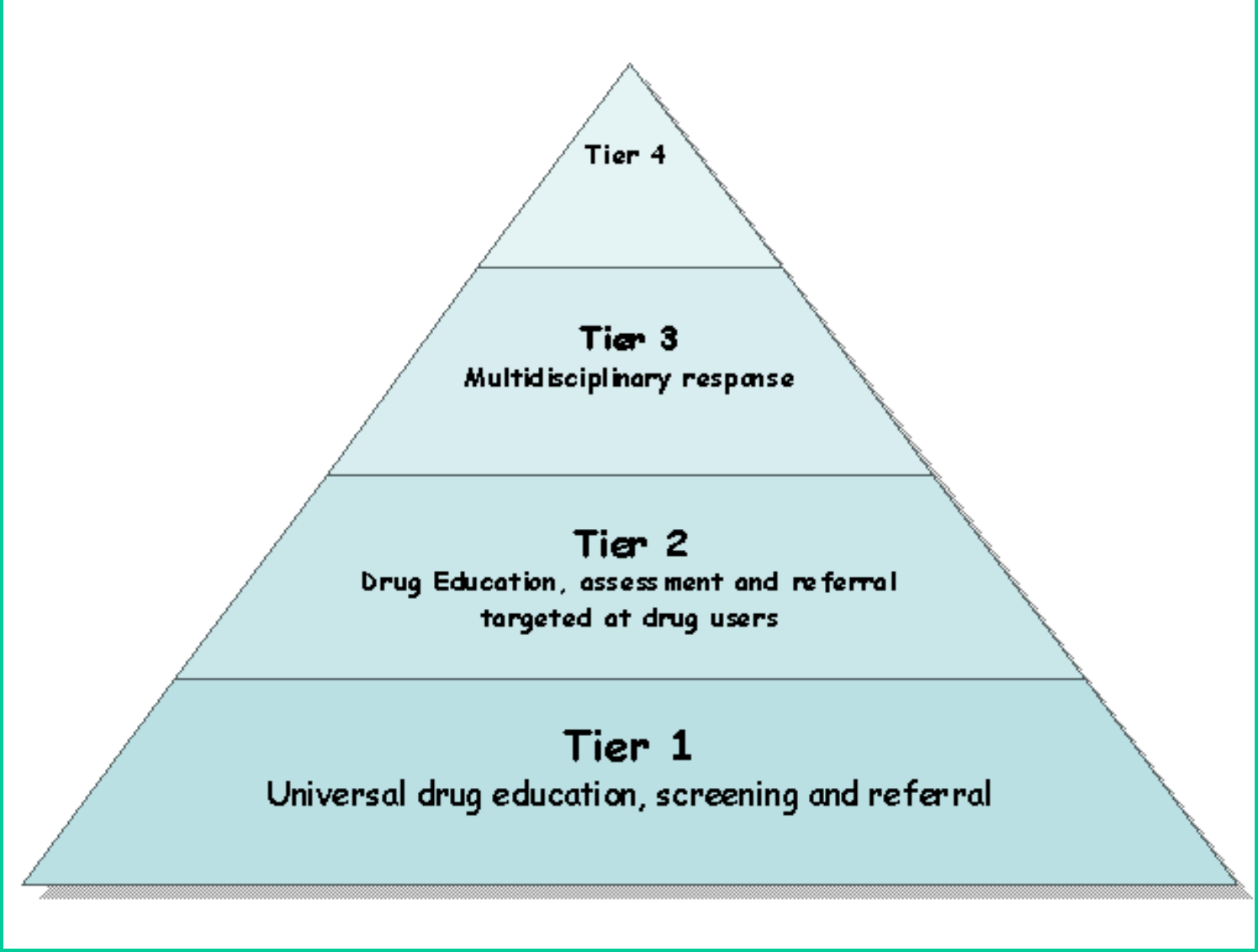
ntegrated Culture Competent Model (ICCM)

- **Underpins NIDA's principle of treatment**
  - **No single treatment appropriate for everyone**
  - **Treatment needs to be readily available**
  - **Treatment must attend to multiple needs of the individual not just the drug use**
  - **Multiple courses of treatment may be required for success**
  - **Remaining in period for a adequate period of time may be critical for success**
- **In addition, need to provide appropriate, timely and effective service for diverse groups**

Integrated Culture Competent Model (ICCM)

- **Health promotion & education at all levels**
  (taboo, awareness, confidentiality, early intervention & prevention)
- **Culturally competence/ appropriate services**
  (Services need to cater around people not people around services)
- **Specialist outreach workers:**
  - **work with family**
  - **work with the community**
- **Integrate with Police & Criminal Justice system**
- **Residential rehabilitation**
- **Transcultural counseling**
- **Medical management**

Required Service Model



Opportunities & Research

- **Heterogeneity of South Asians necessitates further local research**
- **Most alcohol consumption use instruments are European-based – need for culturally & linguistically appropriate tools for South Asians**
- **Given the large # of immigrants coming to Canada (≈250,000 annually), effective service delivery that meets varied need is important**
- **Development & Implementation of federal & provincial health policies (ie, 5-year Action Plan, Delivering Race Equality in Mental Health)**

Where do we go from here?

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Key messages (for reference only)

- Heterogeneity (NDA for substance use, university of Lancashire)
- Cultural Competence: recognizing difference between the south Asian communities – what works for one does not work for other
- Engaging the south Asian communities while doing service or strategy planning

- Struggle with insufficient knowledge
- Existing services are unaware of the needs of the SA communities and how to meet them
- Drug services lacks capacity to provide support

- Most IMPORTANT is the drug related information about the drugs and services
- The SA communities trust in the cultural competence of drug services must be built up
- Engagement between SA communities and local drug service planners is essential
- Adaptations and flexibility are required to overcome the barriers for access