# Discussion paper to inform the development of a statewide Alcohol and Other Drug Action Plan

Prepared for the Queensland Mental Health Commission

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# Acronyms and abbreviations

AA	Alcoholics Anonymous
ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
АСТ	Australian Capital Territory
ADIS	Alcohol and Drug Information Service
ANCD	Australian National Council on Drugs
AODTS-NMDS	Alcohol and Other Drug Treatment Services – National Minimum Data Set
AOD	Alcohol and Other Drugs
ATODS	Alcohol Tobacco and Other Drugs Services
CALD	Culturally and Linguistically diverse
СВТ	Cognitive Behavioural Therapy
DALY	disability-adjusted life years
DETE	Department of Education and Training (Queensland)
DJAG	Department of Justice and Attorney General (Queensland)
DoH	Department of Health (Australian Government)
DUMA	Drug Use Monitoring in Australia
FARE	Foundation for Alcohol Research and Education
FAS	Foetal Alcohol Syndrome
FASD	Foetal Alcohol Spectrum Disorders
HCV	Hepatitis C Virus
IDRS	Illicit Drugs Reporting System
IGCD	Intergovernmental Committee on Drugs
IRA	Immediate Risk Assessment
LGBT	Lesbian Gay Bisexual, Transgender
LGBTI	Lesbian Gay Bisexual, Transgender, Intersex
MAST	Michigan Alcoholism Screening Test (MAST)
MCDS	Ministerial Council on Drug Strategy
MHAOD	Mental Health Alcohol and Other Drugs
MRT	Moral Reconation Therapy
NCETA	National Centre for Education and Training on Addiction
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NGO	non-government organisation
NHMRC	National Health and Medical Research Council
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NPS	novel psychoactive substance
NSP	Needle and Syringe Program
NSW	New South Wales
NT	Northern Territory



OESR	Office of Economic and Statistical Research
OST	opioid substitution treatment
PIED	Performance and Image Enhancing Drug
PWID	people who inject drugs
QAIHC	Queensland Aboriginal and Torres Strait Islander Health Council
QCS	Queensland Corrective Services
QIADP	Queensland Indigenous Alcohol Diversion Program
QIDDI	Queensland Illicit Drug Diversion Initiative
QLD	Queensland
QMERIT	Queensland Magistrates Early Referral into Treatment Program
<b>QMHC</b>	Queensland Mental Health Commission
QPS	Queensland Police Service
QuIHN	Queensland Injectors Health Network
ROGS	Report on Government Services
SA	South Australia
TAS	Tasmania
тс	Therapeutic Community
VIC	Victoria
WA	Western Australia

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# Discussion paper to inform the development of a Statewide Alcohol and Other Drug Action Plan

# May 2015

## **Section 1 Introduction**

## 1.1 The Queensland Mental Health Drug and Alcohol Strategic Plan 2014-2019

The Queensland Mental Health Commission (QMHC or Commission) was established to drive reform towards a more integrated, evidence-based, recovery-oriented mental health and alcohol and other drugs system.

To guide reform, the Commission in partnership with other government and non-government stakeholders has developed the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019* (the Strategic Plan) (QMHC 2014) which aims to improve the mental health and wellbeing of Queenslanders.

The Strategic Plan is the culmination of a process of consultation and deliberation led by the Commission. The Strategic Plan provides a shared vision for:

A healthy and inclusive community, where people experiencing mental health difficulties or issues related to substance use have a life with purpose and access to quality care and support focused on wellness and recovery, in an understanding, empathic and compassionate society.

QMHC 2014, p 5

The Strategic Plan aims to improve the mental health and wellbeing of Queenslanders by working towards six long term outcomes. They are:

- 1. a population with good mental health and wellbeing
- 2. reduced stigma and discrimination
- 3. reduced avoidable harm
- 4. improved life expectancy
- 5. improved physical and oral health for people living with mental health difficulties or issues related to substance use
- 6. people living with mental illness and substance use disorders have positive experiences of their support, care and treatment.

The Strategic Plan includes a Shared Commitment to Action to prevent and reduce the adverse impacts of drugs and alcohol on the health and wellbeing of Queenslanders. It is a stage one priority within Shared Commitment 3 - Priority area actions.

Shared Commitment 3 aims to improve the mental health and wellbeing of Queenslanders by achieving:

- better outcomes and wellbeing for individuals and communities who may be more vulnerable to experiencing poor mental health and wellbeing
- tailored effective responses to meet the unique cultural, social and developmental needs of priority groups
- improved access to integrated and innovative health and social services to meet the needs of individuals and communities in more holistic ways.



The Commission will work with key stakeholders from across government, from the non-government sector, private providers, service users and their families to develop an Alcohol and Drug Action Plan.

## 1.2 Purpose and scope of the Discussion Paper

The Discussion Paper sets out the key issues relating to harmful drug use in Queensland and provides an overview of the services system to reduce demand and harm. It guided discussion at a Roundtable of key stakeholders in May 2015. It will also inform a broader public consultation on the draft Action Plan. The final Action Plan will be publicly released by the Commission later in 2015.

The Action Plan will encompass harm, supply and demand reduction actions in line with the three program areas or 'pillars' in the current *National Drug Strategy 2010–2015: A framework for action on alcohol, tobacco and other drugs* (NDS) (Ministerial Council on Drug Strategy 2010) across drug types, and interventions from prevention and early intervention through to tertiary clinical responses and continuing care. This comprehensive approach is designed to delay the uptake of drugs, and address the needs of people in the early stages of problematic drug use through to those living with drug use disorders.

## Terminology

This Discussion Paper focuses on health and broader social issues related to alcohol and other drug use problems. The following terms and definitions, outlined in the NDS, have been adopted throughout this Discussion Paper:

**Drug:** The term 'drug' includes alcohol, tobacco, illegal (also known as 'illicit') drugs, pharmaceuticals and other substances that alter brain function, resulting in changes in perception, mood, consciousness, cognition and behaviour.

The term 'alcohol and other drugs' (AOD) is also used. The term 'substance use' is also used as an umbrella term inclusive of alcohol, drugs (legal and illegal) and other substances.

**Illegal drug:** A drug that is prohibited from manufacture, sale or possession — for example, cannabis, cocaine, heroin and amphetamine type stimulants (ecstasy, meth/amphetamines).

**Pharmaceutical drugs:** A drug that is available from a pharmacy, over-the-counter or by prescription, which may be subject to non-medical use — for example, opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine and steroids.

**Other substances:** Other psychoactive substances – for example, inhalants, kava and new synthetic chemicals or herbal products that have emerged to mimic the effects of illegal or legal drugs.

#### 1.3 Content and structure of this Discussion Paper

**Section 1 Introduction** presents the background to the development of the drug Position Paper and Action Plan, and describes the purpose and scope of the Discussion Paper.

**Section 2 Drug policy context** summarises the national and Queensland approach and key issues in drug related policies.

**Section 3 Effective drug harm, supply and reduction strategies** provides an overview of interventions to reduce drug related harms, supply of drugs and demand for drugs.

**Section 4 Drug prevalence of use and harms** analyses of publicly available Queensland and national data to identify alcohol and other drug use and harms at the whole population level in Queensland and those affecting vulnerable groups.

Section 5 The Queensland drug service system presents a snapshot of information on the drug service system in Queensland.



## Section 2 Drug policy context

Since 1985, the objective of Australia's coordinated national drug policy has been to minimise alcohol, tobacco and other drug related health, social and economic harms among individuals, families and communities. Australia has earned a high international reputation for its progressive, balanced and comprehensive approach to dealing with the problems posed by the harmful use of drugs in the community. The Queensland Government is enjoined in the implementation of the NDS through its representation on the IGCD and through its policies, actions and services.<sup>12</sup>

Key elements of the NDS include:

- a focus on harm minimisation through three program areas (harm, supply and demand reduction)
- enshrining a comprehensive partnership approach
- a joint Commonwealth and state strategy.

Under the current phase of the NDS framework (2010-2015), state and territory governments continue to have responsibility for leadership, policy development, implementation and evaluation, and the delivery of police, health and education services to reduce drug related harm within their respective jurisdictions.

In the last 30 years of monitoring and development under the NDS, governments, service providers, universities and communities have invested in dissemination of evidence informed information and practices, evaluation and other research, monitoring drug-use trends and developing workforces and systems.

#### 2.1 A comprehensive partnership approach

In Australia, a comprehensive partnership approach to minimising drug related harms is spelled out in the NDS:

The National Drug Strategy, a cooperative venture between Australian, state and territory governments and the non-government sector, is aimed at improving health, social and economic outcomes for Australians by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in our society.

Australian Government website 2014<sup>3</sup>

The NDS has adopted a comprehensive approach to drugs, including tobacco and substances which may be legal or illegal that potentially could be used in a harmful way, for example ecstasy, cocaine, cannabis, alcohol, petrol, paint or glue, pharmaceuticals.

It is well understood that drug use and harms are "complex multi-determined social problem[s]" (Ritter *et al* 2014). This means that effective interventions should take into account the interaction between individual health and wellbeing, the substance itself and individuals, their families and communities including their social, physical, cultural, legal and economic circumstances (Wilkes *et al* 2014, Gray & Wilkes 2010, Ministerial Council on Drug Strategy [MCDS] 2006).

In practice, the partnership approach means that interventions that address the complexity of drug problems involve input from multiple organisations to deliver broad based (universal) and targeted

<sup>&</sup>lt;sup>3</sup> http://www.nationaldrugstrategy.gov.au/



<sup>&</sup>lt;sup>1</sup> See Section 5 below for a snapshot of the Queensland alcohol and other drug service system.

<sup>&</sup>lt;sup>2</sup> The Intergovernmental Committee on Drugs (IGCD) is responsible for the implementation of the NDS framework. The IGCD comprises senior officers representing health and law enforcement and education agencies in each Australian jurisdiction and New Zealand. It also includes and representatives of the Australian Government Department of Education, Employment and Workplace Relations.

promotion and prevention activities (campaigns, law enforcement, emergency services, information and education about drug use and harms).

Partnerships are crucial to coordinated service provision for individuals, families and communities. For some organisations this will involve leadership to support change in organisation culture and processes (Battams & Roche 2011, FARE 2015). At a system and provider level, partnered coordinated service provision should be designed to "[improve] access to integrated and innovative health and social services to meet the needs of individuals and communities in more holistic ways" (QMHC 2014 p 20). At the individual level this approach translates into access to a tailored service response delivered through multi-organisation/agency work across sectors including police and ambulance services (often the first responders); health services; child, youth and family services; domestic violence services; child care providers; justice services; employment and education services; supported accommodation services; maternal and child health services, disability and aged care services, mental health services and child protection services.

As the mainstay of Australia's AOD system, contemporary primary health care and specialist AOD services (screening, assessment, brief intervention and treatment for individuals experiencing problems) include partnerships across providers to deliver strengths-based models of culturally competent multidisciplinary care similar to those available for other chronic conditions (eg cancer, mental illness) and decrease stigma associated with addictions. These models of care are designed to provide services across a continuum of care including:

- pathways from social services and self-referral or police/court diversion to primary care intervention and support to specialist services
- engagement in treatment
- joint client plans
- case management
- care coordination and support
- protocols for information sharing and referral
- an appropriately skilled and qualified personnel to deliver the model of care in culturally competent ways.<sup>4</sup>

## 2.2 Demand, supply and harm reduction

Since the first phase of the NDS in 1986, Australia's overarching approach has been one of harm minimisation. Under the NDS harm minimisation is operationalised through Australian Government and state and territory governments' evidence-based policies and programs which aim to *reduce* drug related harm.

## Harm minimisation

Harm minimisation is achieved under the NDS framework through three program areas or "pillars":

- 1. harm reduction
- 2. supply reduction
- 3. demand reduction (MCDS 2010).

It is important to acknowledge that the three 'pillars' do not operate independently and apply to all drug types.

<sup>&</sup>lt;sup>4</sup> See Appendix 1 below for a matrix showing possible services and workforce across an AOD continuum of interventions



The three pillars apply across all drug types but in different ways, for example, depending on whether the drugs being used are legal or illegal. The approaches in the three pillars will be applied with sensitivity to age and stage of life, disadvantaged populations, and settings of use and intervention.

MCDS 2010, p ii

In 2006, Ritter and colleagues produced a monograph which discussed the difficulty of classifying interventions across the pillars.

## 2.3 Policy influences and emerging issues

A number of significant factors have influenced policy, programs and practice in the last 30 years of monitoring under the NDS. These factors include changing social attitudes towards drug use and an evolving approach to 'recovery'.

The National Drug Strategy Household Survey (NDSHS) data on changing social attitudes and beliefs about drug policy shows that the Australian population continues to be misinformed about the relative effectiveness of the various interventions available for dealing with drug problems. The population considers that drug education interventions should receive more resources than drug treatment interventions. (AIHW 2014a, p 118).

This overview of the findings of Roxburgh and colleagues (2013) with additional material from the 2013 NDSHS show that in Australia incrementally:

- The number of people taking up smoking has decreased incrementally and steadily in the last 10 years (Roxburgh et al 2013).
- Younger people are choosing to abstain from alcohol, with abstaining levels increasing in the 12-17 age group in the last 3 years (AIHW 2014a).
- The percentage of people drinking at risky levels declined between 2010 and 2013 (AIHW 2014a).
- Media coverage on "king hits" or "coward punches", and other forms of public and domestic alcohol related violence increased along with studies and interventions to reduce supply and harms (e.g. reviews of licensing, policing, sobering up facilities, women's refuges for women and children) (Miller *et al* 2014).
- The use of meth/amphetamines as powder and pills etc. has halved and the use of crystal meth/amphetamine has doubled possibly because crystal meth/amphetamine is a more popular, available and potent form (Roxburgh *et al* 2013, AIHW 2014 a).
- In general, there were no significant changes in daily smoking or use of illegal drugs among Aboriginal and Torres Strait Islander Australians between 2010 and 2013 but there was a decline in the proportion exceeding the lifetime risk guidelines for alcohol (AIHW 2014a).
- In 2013, people living in rural and remote regions were more likely to smoke, drink alcohol at risky levels, use cannabis and meth/amphetamines (AIHW 2014a).
- Women reporting alcohol use during pregnancy declined in the period 2010 to 2013 (AIHW 2014a).
- In the period 2010 to 2013, the proportion of Queenslanders smoking daily declined from 17.7% to 15.7%, which was not significant; and the proportion using illicit drug slightly increased from 15.1% to 15.5% but again this was not significant (AIHW 2014a).

In addition a number of studies have noted an increase in the percentage of people who have recently used a pharmaceutical drug for a non-medical purpose.



Attention needs to be given to special population groups in the development of any comprehensive drug policy and implementation program. A number of national policies and strategies acknowledge the role of drugs as risk factors for specific population groups including women, young people and children, Aboriginal and Torres Strait Islander Australians, people living in rural and remote locations.

## Children and young people

These policies and strategies draw on the data and evidence produced under the NDS (e.g. the NDSHS and monographs developed by the Australian National Council on Drugs (ANCD) and the national drug research centres). These policies and strategies include the:

- National Plan to Reduce Violence Against Women and their Children 2010 2022
- Protecting Children is Everybody's Business National Framework for Protecting Children 2009-2020.

The ANCD research paper entitled: *From Policy to implementation: child and family sensitive practice in the alcohol and other drugs sector* (Roche *et al* 2014) highlighted the international and national focus on parental support and protection of children. It provided examples of child and family sensitive policy and practice initiatives within the alcohol and drugs sector in Australian states and territories. Roche and colleagues (2014) found that the "...ability of the alcohol and other drugs sector to respond to the needs of clients' children and families was compromised by a lack of consistency in development and implementation of child and family sensitive policy at both national and state/territory levels" (Roche *et al* 2014 p x).

No current national policy exists to guide approaches to evidence based drug education in schools. Recently, Lee and colleagues (2014) at the National Centre for Education and Training on Addiction (NCETA) reviewed the evidence for effectiveness in the publication *Alcohol education for schools: What are the most effective programs?* Their research suggested that only a small number of programs had enough evidence to support their use in schools and a larger number had minimal or insufficient evidence to conclude that they were effective in delivering outcomes for students. "...effective programs included: accurate evidence based information about alcohol; a focus on social norms; an interactive presentation style; clear, achievable and measureable goals and objectives; teacher training and support; and a whole of school approach." (Lee *et al* 2014, p iii).

#### Aboriginal and Torres Strait Islander peoples

The policy framework adopted in Australia particularly focuses on the needs of Aboriginal peoples and Torres Strait Islanders. The *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* adopts a focus on social and emotional wellbeing. It highlights the need to consider holistic approaches which recognise the importance of land, spirituality, ancestry, family and community. It acknowledges that:

Social and emotional wellbeing can be affected by the social determinants of health including homelessness, education and unemployment and a broader range of problems resulting from grief and loss, trauma and abuse, violence, removal from family and cultural dislocation, substance misuse, racism and discrimination and social disadvantage. It is important that policy approaches recognise the legacy of intergenerational trauma on social and emotional wellbeing.

#### Australian Government 2013, p 21

The current NDS framework speaks to the issues for Aboriginal and Torres Strait Islander Australians. The NDS included the *National Drug Strategy Aboriginal and Torres Strait Islander People's Complementary Action Plan 2003-2009* (CAP) to guide drug service and treatment for Aboriginal and Torres Strait Islander communities with a strong focus on a holistic, community-controlled approach to health services.



More recently, the Commonwealth of Australia published the second edition of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* to guide approaches to substance use and mental health problems amongst Aboriginal and Torres Strait Islander Australians (Dudgeon *et al* 2014). The principles echo those set out in the *Second National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013*, and the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. In addition, Dudgeon and colleagues (2014) discuss how the effective implementation and integration of the National Standards for the Mental Health Services 2010 and practitioner/workforce standards can ensure the provision of culturally competent mental health services (including services for comorbid mental health and substance use problems (Dudgeon *et al* 2014).

Since 2008, governments have been working in partnership with Aboriginal and Torres Strait Islander Australians and organisations to develop and implement the policies, frameworks, strategies, state and territory partnership agreements and plans as part of the *Closing the gap in Indigenous life expectancy* strategy and the national campaign to address disadvantage between Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians. The gap, targets and other health and early childhood development performance indicators and initiatives are included in the Council of Australian Governments national partnership agreements, signed by the Queensland Government. The Indigenous Health Outcome National Partnership Agreement focuses on the following shared commitments:

- tackling smoking
- healthy transition to adulthood
- making Aboriginal and Torres Strait Islander Australian's health everyone's business
- primary health care services that can deliver
- fixing the (service) gaps and improving the patient journey.<sup>5</sup>

## Rural and remote communities

Geography and a dispersed regional rural and remote population as well as the cultural diversity of communities present as challenges to the delivery of AOD services in Queensland. The *National Strategic Framework for Rural and Remote Health* (Australian Health Ministers' Conference Standing Council on Health 2011) focuses on the planning, design and delivery of health services in rural and remote communities. It highlights:

- The challenges associated with availability and access to current and local information about rural and regional services and programs, and the difficulty achieving the economies of scale available in more densely populated areas which have better access to infrastructure and shorter distances between services.
- Telehealth is one way of addressing access to services, the isolation of rural services and their workforces, accessing continuing professional education and patient education.

Grants to substance use treatment organisations and youth services have been provided by governments to address issues of equity of access and ensure delivery health promotion, services, and training and education of health professionals in rural and remote areas. In addition, the Australian Government funded improvements to primary care infrastructure and rebates on remote medical consultations and case conferencing using telehealth.

<sup>&</sup>lt;sup>5</sup> Queensland Government website updated 2013 <u>http://www.health.qld.gov.au/atsihealth/close\_gap.asp</u>



## Recovery

There are similarities and differences in the concept of recovery as it applies in mental health and addiction. In mental health the recovery movement began in the 1970s as a movement aimed at restoring the human rights and full social inclusion of people with mental health issues. Recoveryoriented approaches are sensitive to the uniqueness and needs of each individual. It supports individuals to make their own choices and set their own goals, and gives opportunities for living a meaningful, satisfying and purposeful life as a contributing member of the community. In addiction recovery has its roots in the American abstinence movement, in American religiosity and in the personal responsibility focus that is so strong in American culture (el-Guebaly 2012). In addiction and mental health, recovery approaches have been viewed as alternatives to the medical model with its emphasis on pathology, deficits and dependency (AHMAC 2013).

Historically, the concept of recovery in the addiction field has had downsides. These include:

- the difficulty in finding an agreed-upon definition of 'recovery' and ways of operationalising the definition
- the difficulty in quantifying 'recovery' and building monitoring and evaluation processes to assess what works in this area,
- its history of a heavy emphasis derived from its roots in Alcoholics Anonymous (AA) on abstinence from all psychoactive substances.

Based on recent (2010-2012) initiatives of the UK Government, British and Australian observers are concerned that the 'new recovery' movement could precipitate a shift of resources away from the treatment and harm reduction interventions for which there is a sound evidence base (e.g. medication to treat cravings and/or withdrawal) (AIVL 2012, ANEX 2012). No justification exists for reducing evidence-informed treatment and rehabilitation services (nor harm reduction services) in the name of a move towards a recovery framework. A sounder approach is to (1) strengthen treatment and rehabilitation, (2) better link the people it serves with continuing care that focuses on long-term recovery, and (3) for the drugs sector to pursue improved links with community services such as employment, housing and social supports that are crucial to long-term recovery.

In the addiction field, a strength of the 'new recovery' movement is that it frames substance use problems, especially dependence, as chronic conditions, with the implication that many people need long-term supports after they finish their period of active treatment (el-Guebaly 2012, SAMHSA 2011, Best *et al* 2010).

In 2015, a network of representatives of government and NGO drug treatment agencies in Queensland circulated a *Queensland Alcohol and other Drug Treatment Service Delivery Framework* which included a definition of 'recovery' for drug treatment settings:

In the context of Queensland AOD treatment, the term 'Recovery' is used to describe any approach that seeks to identify and achieve goals that are meaningful to the client, which may include safer using practices, reduced use or abstinence. For many people, recovery describes a holistic approach that offers greater opportunity for positive engagement with families, friends and communities.

MacBean et al 2015, p 7

#### Stigma and discrimination

The NDS notes that people with drug problems experience stigma and discrimination. The effect of it is a reduction in seeking help and access to services. Social rejection based on the belief that an individual who belongs to a particular social group is separate from the 'norm' is referred to as 'stigma'. Essentially, stigmatisation is the application of negative stereotypes to a group of individuals. It can lead to conscious or unconscious personal, family, community or institutional discrimination, exclusion or rejection.



According to the World Health Organisation (WHO), illegal drug dependence is the most stigmatised health condition in the world (Kelly & Westerhoff 2010). Research suggests that stigmatisation of clients of drug treatment and justice service systems is institutionalised and widespread, particularly for people who inject drugs (PWID) (AIVL 2011, Adlaf *et al* 2009, Corrigan *et al* 2009). Drug treatment itself and the drug treatment providers may also experience stigmatisation. Lancaster and colleagues (2014) found that PWIDs' experience of stigmatisation and discrimination created barriers to PWIDs accessing what they knew to be effective interventions (Lancaster *et* al 2014). Further, drug user experience of stigmatisation and discrimination has been found to engender or add to poor mental health and social outcomes (AIVL 2011, Link & Phelan 2010).

## 2.4 The Queensland drug policy context

The former *Queensland Drug Strategy 2006-2010* aimed to reduce the harm associated with drug use. The achievements of the Strategy — including the results and findings of evaluations of the targeted education and information campaigns and some initiatives — were summarised in the *Queensland Drug Strategy 2006-2010: End point implementation report* (Queensland Health 2011).

The Queensland Government continued to build on the progress of the whole-of-government Strategy in the 2011–2012 Queensland Drug Action Plan. The Action Plan included five priority areas for action:

- alcohol related violence and injury
- smoking and heavy drinking
- reducing harms for families
- tobacco, alcohol and cannabis use amongst Aboriginal and Torres Strait Islander Australians
- pharmaceutical and illegal drugs.

The Mental Health Alcohol and Other Drugs (MHAOD) Branch within the Department of Health (DoH) is responsible for setting the Queensland AOD treatment services policy and investment framework. The Branch also sets targets and collects data on public health AOD Treatment provision and administers funding of non-government organisation (NGO) AOD services.

Harm, demand and supply reduction strategies and programs have been developed and/or contributed to by a range of Queensland Government agencies, including the:

- Department of Justice and Attorney General (DJAG) (supply and harm reduction Liquor Licensing and court diversion)
- Department of Communities, Child Safety and Disability Services (harm reduction families, women, young people children, people with a disability and the elderly)
- Queensland Police Service (QPS) (demand, supply and harm reduction services including police diversion)
- Department of Aboriginal and Torres Strait Islander Partnerships (demand, supply and harm reduction Alcohol Management Plans in discrete Aboriginal and Torres Strait Islander communities)
- Department of Health (harm, supply and demand reduction drug health promotion, regulating access to prescription pharmaceuticals, prevention, early intervention and treatment services).

In Section 5, a snapshot of the publicly available information on Queensland drug programs and services is provided, including partnership initiatives involving Queensland government departments and agencies, NGO and private sector service providers and the Aboriginal Community Controlled Organisation sector.



Current whole-of-government activity, the NGO sector and the private healthcare sector provide important foundations for the development of a Queensland Position Paper and Action Plan. The Queensland Aboriginal and Torres Strait Islander Health Council (QAIHC), the Queensland Network of Alcohol and Drug Agencies, the Queensland Injecting Drug Users Network, and Dovetail (to name a few) have been involved in many joint projects, partnerships, collaborations and initiatives with organisations in Queensland and nationally. For example, the AOD NGO sector has recently developed the *Queensland Alcohol and Other Drug Treatment Service Delivery Framework* (March 2015) to guide implementation of common and good practice across alcohol and other drug treatment providers across Queensland.

The following reports highlight the importance of enhancing partnership approaches across sectors and agencies, including child safety, domestic violence, the crime and justice system, un/employment and education.

 Queensland Child Protection Commission of Inquiry report – Taking responsibility: a road map for Queensland Child protection (Carmody 2013) reports that in 47 per cent of all households with substantiated child protection issues one or both parents had a current or previous drug and/or alcohol problem. The Queensland Government's response to the report has included the establishment of the Queensland Family and Child Commission to oversee the child protection system and report directly to the Premier of Queensland. For full details of the government response see:

<u>http://www.communities.qld.gov.au/resources/reform-renewal/qg-response-child-protection-inquiry.pdf</u>

Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland (2015) is a report prepared by a special Taskforce established by the Premier of Queensland in September 2014. Alcohol and drug use is not considered to be a primary factor in predicting future perpetration of violence. However, the Taskforce identified alcohol and drug use as a significant aggravating factor when it coexists with other complex causal factors such as an unequal distribution of power and resources between men and women, rigid or narrow gender roles and stereotypes, and a culture and attitudes that support violence. The report recognised that alcohol in domestic violence is an issue within Aboriginal and Torres Strait Islander communities with the risk of an Aboriginal and/or Torres Strait Islander person becoming a victim of domestic or family violence increasing with high risk alcohol use. One of the report's recommendations is the design of a common risk assessment framework that can be used as part of an integrated response to domestic violence, incorporating the role of generalist services such as health, mental health and drug and alcohol service providers. The Queensland government has not yet released its response to the report (as at April 2015).

#### **Queensland Government policies and frameworks**

A number of current Queensland Government policies and frameworks acknowledge the role of drugs as risk factors for specific population groups. Some include commitments to enhance drug initiatives by providing additional support to these groups. These related strategies<sup>6</sup> include the:

- Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019 (QHMC, 2014)
- Better Health for the Bush: A plan for safe, applicable healthcare for rural and remote Queensland (Queensland Health 2014)
- Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033 (Queensland Health, 2010a)

<sup>&</sup>lt;sup>6</sup> There may be other current policies or frameworks that could not be found in the public domain in February and March 2015.



- Queensland Health 2010: Making tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033 – policy and accountability framework (Queensland Health, 2010b)
- Queensland Aboriginal and Torres Strait Islander Economic Participation Framework (Department of Aboriginal and Torres Strait Islander and Multicultural Affairs 2013)
- Queensland Health Policy: Service delivery for people with dual diagnosis (co-occurring mental health and drug problems) (Queensland Health, 2008).
- Queensland Youth Strategy connecting young Queenslanders 2013 (Queensland Government, Department of Communities, Child Safety and Disability Services 2013)
- Supporting Student Health and Wellbeing Policy Statement (Department of Education, Training and Employment) updated February 2015 at: <u>http://education.qld.gov.au/schools/healthy/student-health-wellbeing-policy-statement.html</u>

The Department of Education, Training and Employment, in conjunction with the Queensland Curriculum and Assessment Authority, has developed the *Alcohol and other drugs education program* for Queensland schools. It can be found at:

http://www.education.qld.gov.au/curriculum/safe-night-out/

#### Summary

Problematic substance use can be thought about as a health and wellbeing problem, a cultural problem, a problem of criminal behaviour, or a combination of these. For example, there are many ways to think about intoxication with drugs and its consequences for individuals, families, communities and society including: interpersonal violence, physical and mental illness, loss of productivity and social isolation.

Under the NDS:

- Significant achievements have been made nationally and in Queensland in policy development, the number and range of relevant evidence based programs and services available, the data available to inform patterns of drug use and harm over time, and people's attitudes to problematic drug use and interventions to respond to it.
- Effective interventions should take into account the interaction between individual health and wellbeing, the drug itself and individuals, their families and communities including their social, physical, cultural, legal and economic circumstances.
- Partnership approaches are used because of the complexity of harmful drug use, its determinants and consequences.
- In Queensland significant whole of government work has been undertaken to address the impacts of drug problems on communities, families and individuals. This has been achieved through partnership approaches across sectors and agencies, including health, child safety, domestic violence, the crime and justice system, un/employment and education.
- In Queensland, there is no current whole of government drug strategy.
- The treatment sector (across government, NGO and Aboriginal Community Controlled Organisations) have recently developed a framework to guide to development of the sector.



## Section 3 Effective drug harm, supply and demand reduction strategies

Specific programs and policies can be located in each of the pillars. In practice, programs often combine different types of interventions across the three pillars (MCDS 2010). The NDS sets out many examples of interventions for legal and illegal drugs for which there is evidence for effectiveness under the three pillars. It may also be helpful to also think about effective interventions using categories from Babor and colleagues (2010). Babor and colleagues from around the globe presented the research on strategies and interventions for reducing illegal drug use and related harm, organising the evidence into the following categories: preventing illegal drug use by young people, health and social services for drug users, supply control, criminalisation and decriminalisation of drug use possession, prescription regimes and other measures to control harmful use of psychopharmaceuticals.

Effective interventions should be tailored to meet the local area's needs. An appropriately skilled and qualified workforce is required to deliver them as intended. A comprehensive tailored approach to address social, community and individual drug problems requires multi-organisation/agency work across sectors including child, youth and family services; domestic violence services; child care providers; justice services; employment; health and education services; supported accommodation services; maternal and child health services, disability and aged care services, mental health services and child protection services.

It is important to note that there is more evidence for the effectiveness of some interventions than others. Often the absence of evidence in these areas reflects an absence of sound research (including evaluation research) rather than the fact that particular interventions are not effective or cost-effective. This is particularly the case for prevention interventions and some types of harm reduction interventions.

#### 3.1 Harm reduction

*Harm reduction* refers to strategies and action which *reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.* 

Interventions to reduce drug related harm include a wide range of activities, initiatives and services. Broadly these interventions can be categorised as promotion and prevention activities; and drug treatment services. Population wide and targeted information and education and treatment services for individuals with drug problems and their families are also a *key demand reduction strategy*. In the section on demand reduction below, a number of interventions are briefly described.

Examples of harm reduction interventions include: drink driving prevention; responsible service of alcohol; interventions to improve public amenity and transport from entertainment hubs at night; brief interventions, treatment for drug dependence including aftercare; services to reduce the impact of family conflict and violence; smoking bans, needle and syringe programs (NSP); sobering up spaces; information and emergency medical services at events; diversion from the criminal justice system (e.g. Magistrates Early Referral Into Treatment (MERIT) is a pre-court/sentencing program available in most Local Courts in New South Wales that provides the opportunity for adult defendants with substance abuse problems to work, on a voluntary basis, towards rehabilitation as part of the bail process, and have their treatment outcomes taken into account by the magistrate when their case is heard in court).

Police powers and public intoxication laws are generally harm reduction strategies in the sense that they provide police with the authority to move on intoxicated people as a way of intervening in potentially violent situations before significant harms occur, or being able to restrain people in watch-houses to protect the community and the individuals themselves. Court appearances and sentencing options, on the other hand, can be seen as demand reduction strategies in the sense that they, at least in part, seek to deter future offenders as well as responding to a previous offence. In



terms of sentencing options, the recently passed 'one-punch' alcohol laws in the NSW Parliament include mandatory eight-year prison terms for anyone who, while under the influence of drugs and/or alcohol, fatally punches someone and two years for seriously injuring someone.

## 3.2 Supply reduction

**Supply reduction** refers to strategies and action which prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.

Supply reduction generally refers to legislative or regulatory frameworks that determine the extent to which drugs are available (generically referred to as liquor licensing) or crop eradication programs or precursor chemicals controls, community and third party policing. This may include drug law enforcement activities undertaken by police and customs agencies to disrupt the possession, supply, production and trafficking of these types of substances. Project STOP is an example of a supply reduction measure focused on reducing the availability of the key precursor, pseudoephedrine, for diversion to the illegal production of meth/amphetamines. Examples of supply reduction strategies for legal drugs include regulations controlling access to medicines such as the *Health (Drugs and Poisons) Regulation 1996*, which outlines Queensland Health's role in regulating access to prescription pharmaceuticals such as opioid analgesics and benzodiazepines, and the responsibilities of doctors, pharmacists and other practitioners in controlling access to these medications.

Liquor licensing in Australia is designed and implemented in each state and territory to manage the local problems of harms from alcohol supply and "night time economy". They attempt to address problems of intoxication, public safety and amenity, and adverse effects on a person's health. In the context of alcohol related violence, the aim is to limit availability of alcohol at those times that are high-risk for alcohol related violence. Examples include banning the sale of high alcohol drinks and shots after a set time and control of premises where alcohol is sold, such as opening hours, compliance with responsible service of alcohol and time of entry to licensed premises.

#### **3.3 Demand reduction**

**Demand reduction** refers to strategies and action which prevent the uptake of harmful drug use and/or delay the onset of use; reduce harmful drug use; and support people to recover from dependence and reintegrate with the community.

These strategies can be broad based to raise awareness across whole communities or populations, or they can aim to change the behaviour of high-risk individuals to modify their demand for excessive drug consumption (e.g. treatment).

Governments fund a range of prevention, education and community action initiatives including websites with information and resources to assist the community (people using drugs and alcohol, concerned family members and friends as well as health care professionals) to make informed decisions about drug and alcohol use, its harms and ways to minimise harm. Other examples of demand reduction strategies include, alcohol and tobacco taxation and pricing; brief interventions and treatment.

#### Community information and education

It is generally accepted that public health and justice information and education for the younger generation can effectively shift community attitudes to drug and alcohol intoxication, such as those focused on changing the heavy drinking culture in Australia (MCDS 2009). Drug and alcohol prevention in schools targets young people by using the school setting and community to support awareness, knowledge and skills about drugs and alcohol use among young people and to influence their behaviour in relation to drugs and alcohol (Lee *et al* 2014, Meyer & Cahill 2004). Promotion and prevention activities target the whole population and/or specific population groups. They include



information and education, self-help resources, school/event based and family support programs in a range of settings (e.g. schools, social media and entertainment precincts).

These activities seek to educate, influence future behaviour and change current behaviour. Motivation to change behaviour can be increased by emphasising high benefits and low costs of the behaviour change. Research also suggests that formative research to gain a deep understanding of the target audience, specifically what motivates and deters individuals from changing their behaviour is important. It is important to understand what and how personal characteristics affect how a message is received; these include gender, age, experience feelings of vulnerability and whether they have previously been predisposed to the message. Finally, continuous monitoring and revision of a social marketing campaign is necessary, to maintain the interest and motivation of the target audience (Siggins Miller 2014 citing McGuire 1974 and Miller & Ware 1989). It is important to consider that research has suggested "that the collective value of school, family, and community prevention programs is appraised differently by different stakeholders" (Strang *et al* 2012).

The use of social marketing has increased as an educational tool and as a way of disseminating information. Evidence suggests that a variety of strategies used in combination are more likely to be effective in increasing awareness and knowledge of health risks and in changing health related behaviours. This may include advertising, public relations, printed materials, promotional items, signage, special events and displays, face-to-face selling and entertainment media to communicate with the target audience.

Controlling the locations in which legal drugs can be consumed and the extent to which alcohol and tobacco products can be advertised is also likely to reduce demand for these products in Australia. The advertising code for tobacco products is mandatory and multifaceted. Currently the advertising code for alcohol products is voluntary, meaning that there are no mandatory limitations on alcohol advertising, although there is a standards review panel that examines the content and acceptability of alcohol advertising against a set of agreed criteria.

Examples of reviews of the effectiveness of demand reduction interventions include:

- Munro and Ramsden (2013) have reviewed the evidence for mass communication interventions (social marketing, media advocacy and new social media) in raising awareness of drug and alcohol related issues (e.g. HIV-AIDS, tobacco smoking, drink driving, binge drinking). They found that even if the mass media campaign is successful in terms of reach and coverage of the target groups, it should be seen as only one part of a multi-component program which includes for example, legislative change and education. The effectiveness of mass marketing in changing "entrenched" behaviours can be affected by access to skills, resources and services.
- Wagenaar and colleagues (2009) found that public policies that raise alcohol prices by increasing the tax on alcohol products can reduce average alcohol consumption of both heavy and light drinkers. Cobiac and colleagues (2009) found that in Australia, a volumetric tax is the most cost-effective strategy available for reducing average consumption. A more recent analysis, however, suggests that taxation may not be the most efficient way to reduce binge drinking, because drinkers in Australia are likely to have fewer days on which they drink at all in order to save enough money to continue to binge drink (Byrnes *et al* 2013).

#### Drug treatment services

Individual services are only one part of larger interdependent system of AOD and other health and welfare services (Lubman *et al* 2014). A local system of AOD programs and services includes, community education and information as well as treatment and support for individuals and families.

Appendix 1 presents a matrix showing levels types of services across the continuum for harm reduction, health promotion and harm prevention, treatment, and extended and continuing care;



service types; service settings; and the staff types to deliver the services. It is important to note that a single treatment model does not apply to alcohol, tobacco and other drugs.

Evidence for the effectiveness of treatment by drug type is reflected in national and state clinical guidelines. Evidence based drug treatment services include a number of interventions (screening, assessment, early intervention, intensive treatment and after care/relapse prevention) tailored for individuals at risk of harm and treatment for those who are dependent on drugs or are recovering from dependence.

- Brief interventions involve activities that identify and limit problematic substance use by applying a variety of strategies that aim to influence or change behaviour and includes screening and assessment and counselling services
- Residential and non-residential treatment including detoxification and withdrawal support, and relapse prevention medications to address issues of dependence and established patterns of harmful or dependent drug use
- After care/continuing care that focuses on relapse prevention and recovery, in recognition that like other chronic diseased drug dependence is a relapsing and remitting condition.

The term 'brief intervention' refers to clinical interventions implemented by health professionals that typically include:

- 1. screening and assessment
- 2. individualised information and advice that are individually designed to achieve a reduction in the person's risky AOD use and related problems.

The continuum of effective treatment interventions is organised based on the individual and their circumstances as well as the outcomes sought (e.g. harm reduction and demand reduction) as well as the nature and severity of individual's problem/s. Treatment services within a harm and demand reduction framework, may be delivered in a range of settings and include residential and non-residential services, telephone based interventions and the use of the combination of face-to-face and internet/telephone/telehealth infrastructure to support clients in regional areas and staff who require specialist assistance in the management of clients with complex health and medical needs.

Treatment is most effective when it is supported by a formal network of service providers who work together to deliver a pathway of care, and share the referral mechanisms and information exchange protocols to support the pathway. Case planning, case management and case coordination are important features of effective implementation of a suite of evidence based interventions matched to an individual client's needs.

#### **3.4 Specific population groups**

Some population groups are at greater risk of experiencing drug related harm and have differing needs including: young people, Aboriginal and Torres Strait Islander Australians, women, elderly people, people from culturally and linguistically diverse backgrounds (CALD), lesbian, gay, bisexual, transgender people and people in the justice system (Wilkes *et al* 2014, King *et al* 2013, MCDS 2010).

King and colleagues (2013) summarised the literature and evidence on differences in drug related harm in specific populations in Australia. They examined drug patterns of use (e.g. "binge drinking", dependent use), and other factors which combine to place specific populations at higher risk of drug related harm, including factors such as:

• socioeconomic disadvantage and social problems (e.g. violence, social disorder, family and other relationship breakdown, child neglect, unemployment, lack of education, homelessness, loss of income, imprisonment)



- personal problems (stress, grief, loss, trauma, marginalisation, discrimination, vulnerability to harmful risk behaviours)
- health problems (comorbid chronic disease and mental health problems, infections, injury and disability)

These groups have limited access to prevention and treatment services for a variety of reasons including that they may:

- experience prejudice and stigmatisation based on beliefs that these groups are the only ones with drug problems
- be offered inappropriate interventions
- lack information and education that effectively communicates drug use risks
- feel disengaged from the service system
- have had negative experiences with culturally insensitive and unsafe services
- have had difficulty seeking help and/or navigating the service system (King *et al* 2013).

#### Aboriginal and Torres Strait Islander Australians

While it has long been acknowledged that treatment services (particularly residential treatment services) for Aboriginal and Torres Strait Islander Australians may need to have different features from mainstream services, the issues of quality and return on investment remain important (Wilkes *et al* 2014, Gray & Wilkes 2010). Dudgeon and colleagues (2014) have affirmed the concept of holistic health and described the Aboriginal and Torres Strait Islander holistic view of social and emotional wellbeing approach to mental health and substance use — a perspective which incorporates the physical, social emotional and cultural wellbeing of individuals and their communities. In practice it means that services and programs should be designed and delivered by taking into account the importance of strong culture and spirituality in relation to social and emotional wellbeing and "the importance of accessing traditional and contemporary healing models, and programs and training developed by Aboriginal and Torres Strait Islander people themselves" (Dudgeon *et al* 2014 p xxv).

The holistic view of health of Aboriginal Australians is evident in their capacity to sustain self and community in the face of historically hostile and imposed culture. Unique protective factors contained within Indigenous cultures and communities have been sources of strength and healing when the effects of colonisation and what many regard as oppressive legislation have resulted in grief, loss and trauma.

Dudgeon et al 2014, p xxv

New information has emerged about clinical management and, particularly important considering earlier resistance to pharmacotherapy, on the processes and outcomes of implementing this modality in Aboriginal and Torres Strait Islander health settings (Brown *et al* 2008). The importance of Aboriginal and Torres Strait Islander-sensitive, culturally safe services within mainstream drug treatment settings continues to be highlighted and has been demonstrated in evaluation research (Teasdale *et al* 2008).

#### Children and young people

The development of preventive and therapeutic interventions for adolescents is another priority area. It is useful to apply a developmental perspective to problem identification and resolution, acknowledging that different adolescents are at different points on the spectrum of drug use and problems. The aetiology of substance use among young people is now relatively well known (National Institute on Drug Abuse 2003) and the principles of engaging adolescents in screening and treatment have been documented (Latt *et al* 2009, 6; Kang *et al* 2005). Although the brief



interventions discussed above have promise, evidence continues to emerge about the importance of intensive levels of care for optimising the treatment outcomes of adolescents (Knudsen 2009). Dovetail has produced a *framework for youth alcohol and other drug practice*, a youth alcohol and drug good practice guide. It identifies service availability and service design issues which should be considered and addressed from a specific population group's perspective to maximise attractiveness and client engagement:

- geographic location, including accessibility by public transport and privacy considerations
- hours of operation
- entry criteria (for example, requiring photo ID)
- worker characteristics (for example, gender, ethnicity, professional background)
- access for people with special needs (for example, mobility or sensory impairment)
- cultural appropriateness
- the overall level of service appeal or 'look and feel' (Crane *et al* 2013).

Crane and colleagues' work to outline the issues for young people is relevant to other specific needs populations. These features of good drug treatment practice can be applied based on cultural understanding and competency in providing services for cross cultural groups with an emphasis on support to access information, seek help, engage with services and navigate the service system.

## People in the criminal justice system

In 2007, the ANCD published a research paper providing evidence for the effectiveness of mandatory treatment for drug problems. This was followed in 2013 by a study of injecting rates in prison (Fetherston *et al* 2013), and in 2014 by a position statement on mandatory treatment. Mandatory treatment included responses to drug use by non-offenders as well as offenders. Mandatory treatment includes detoxification, counselling, education, residential rehabilitation or a combination of these. Mandatory treatment was defined as "...court ordered treatment as part of sentencing orders, and civil commitment, in which interventions occur without the consent of those receiving them." (ANCD 2014 p 1). It did not include voluntary diversion. The Paper notes that: "...the empirical evidence demonstrating the effectiveness or otherwise of responding to [drug use and crime] is both limited and inconclusive. Nevertheless mandatory treatment has been shown to be effective in reducing drug use and crime for some people, and completion of diversion programs, especially drug court programs, has been associated in Australia with reductions in both recidivism and drug use." (ANCD 2014 p 6, citing Pritchard *et al* 2007 and others).

There are no prison based NSPs in Australia (Rodas *et al* 2012). A number of research studies have shown that the provision of sterile needles through prison based NSPs is not associated with an increase in the injection of drugs or the use of injecting equipment (Jurgens *et al* 2009). Rather, a review of prison based NSPs internationally has suggested that the implementation of NSPs is associated with a significant decrease both in the sharing of injecting equipment and in new incidences of HIV and hepatitis infections among prisoners (Jurgens *et al* 2009). Prison-based NSPs have also been found to be effective in reducing the number of overdoses and abscesses as well as increasing referral to treatment services.

Australian researchers have reviewed evidence for four interventions for drug-dependent prisoners: detoxification, drug-free units, TCs, and opioid substitution treatment (OST) (Larney *et al* 2007). They found that more thorough studies of these options implemented in the prison context, particularly in view of the relatively poor access prisoners have to evidence based treatments and after care post prison release, compared to drug treatment patients outside the prison system.



Vandevelde *et al* (2004) conducted a study to examine the similarities of these two models in a correction setting, noting that both:

- highlighted the power of the client peer group and avoided extreme professionalism
- emphasised social learning as a key concept
- utilised free and equal communication
- considered motivation to undergo treatment as crucial.

In recent years, a number of comprehensive prison and juvenile justice centre based drug treatment interventions have been developed and implemented. These include the cognitive behavioural therapy (CBT) based Wanberg/Milkman approach (Wanberg & Milkman 2008) and SMART Recovery (<u>http://www.smartrecoveryaustralia.com.au</u>), along with Moral Reconation Therapy (MRT) (<u>http://www.moral-reconation-therapy.com</u>). Drug-free therapeutic communities (TC) on prison campuses have also been developed. All have been found useful in addressing detainees' substance use problems, and in reducing post-release substance use and reoffending (AIC 2011).

In Queensland prisons, women can access OST if they have been on the program prior to imprisonment. Pregnant women can commence treatment while in prison. In other jurisdictions men also have access to OST. All jurisdictions currently provide harm reduction education programs to prisoners, hepatitis vaccinations and testing for blood-borne viruses. Queensland and the Northern Territory governments have continued to provide compulsory testing for human immunodeficiency virus (HIV). Research has shown that providing PWIDs with disinfectants and bleach in prison can be effective. The extent of its effectiveness in prisons where it is provided has not been assessed. In 2011, disinfectants and bleach in prison were being provided in all jurisdictions expect WA, Tasmania and NT (Rodas *et al* 2011).

Rates of HIV and hepatitis C Infection are known to be significantly higher for the prison population than those of the general population. The prison setting is a high-risk environment for the transmission of blood-borne viruses such as hepatitis C and HIV, due to prisoner engagement in high risk activities such as the sharing of contaminated injecting equipment, tattooing, body piercing and barbering (AIHW 2013). It is well accepted that NSPs in the community and prison systems globally indicate that NSPs are an effective and safe method of reducing the risk of blood-borne virus transmission among prisoners, staff and the community.

Other populations with special needs deserving attention in planning include women (especially those who are pregnant or planning to become pregnant, victims of domestic and sexual violence, carers), elderly people, disadvantaged populations, adults and juveniles in detention, migrants and refugees, and health professionals experiencing substance abuse problems or dependence (Latt *et al* 2009, King *et al* 2013).



#### Summary

There is evidence for the effectiveness and cost effectiveness of AOD interventions. Effective interventions should take into account the interaction between harm reduction, supply reduction and demand reduction strategies. They should be designed based on an understanding of:

- the evidence for effectiveness of interventions
- supply issues
- community family and individual needs including their social, physical, developmental cultural, legal and economic circumstances individual health and wellbeing, the drug type/s
- local services systems.

A local systems approach would mean that effective interventions would be selected to meet community and individual needs across the three pillars.

Promotion, prevention, assessment, early intervention and treatment programs and services can be designed to contribute to both reduction of harm and demand. They may:

- target all or specific drug types (alcohol, tobacco, illegal drugs, pharmaceutical and/or other substances)
- be designed for specific settings and at risk groups
- be tailored for the local service system and levels and types of need.



## Section 4 Drug prevalence, harms and treatment service use

## 4.1 Introduction

The Queensland population is similar to the national population on key characteristics (age, gender, socio-economic status, proportion of Aboriginal and Torres Strait Islander people). Most importantly, for planning purposes, is that the age distribution in Queensland is similar to that of Australia as a whole, for both Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians (OESR 2015). These similarities, mean that data on key national indicators such as drug use and dependence prevalence, and alcohol and drug related burden of disease (illness and death rankings), treatment seeking and service use can be applied to Queensland, albeit with caution because of both the limitations of the data collections themselves and local variation.

Queensland's population growth rate has been relatively high but recent ABS census data online report (April 2015) show that this is no longer the case because of a reduction in interstate migration to Queensland.

## Data sources indicating community prevalence and the need for treatment

Community prevalence and the need for treatment and trends over time can be further understood by using a combination of data such as the:

- NDSHS
- Alcohol and Other Drug Treatment Services-National Minimum Data Set (AODTS-NMDS)
- Illicit Drugs Reporting System (IDRS)
- National Needle and Syringe Program Survey
- Drug Use Monitoring in Australia (DUMA) program
- National Prisoner Health Census.

These data sources all provide valuable information about specific groups of users of illegal drugs, but none is useful for assessing the extent and nature of *service needs* at the population level.

For this section a number of publicly available data sources were used to examine the nature and extent of drug use and related harms in Queensland. The data sets analysed include AOD data from AIHW for the years 2012-13 or 2013, and population data from the Australian Bureau of Statistics (ABS). The main sources of data are the:

- NDSHS (AIHW 2007, 2011, 2014a)
- National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection (AIHW 2014b)
- Alcohol and Other Drug Treatment Services National Minimum data set (AODTS-NMDS) (AIHW 2013)
- Alcohol and other drug treatment and diversion from the Australian criminal justice system (AIHW 2014c)
- Health of Australia's prisoners (AIHW 2013).

In addition, the following government data sources were drawn upon:

- Overcoming Indigenous Disadvantage Productivity Commission 2014 Report (SCRGSP 2014)
- Report on Government Services (2015).

The data analyses are presented in this section to provide an overall picture of:

- the prevalence and patterns of AOD use
- risky levels of alcohol consumption



- AOD related harms
- AOD treatment service demand.

A summary of the nature and limitations of these data can be found at Appendix 2. In line with the data definitions and terminology used in the national data sources, in this Section we use the terms Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians unless the term Indigenous is part of the name of a policy or program or a direct quotation.

## 4.2 Drug use and community perceptions

Legal drugs- Tobacco and alcohol

## Prevalence of tobacco smoking

a) yearly

In the 2013 NDSHS (AIHW 2014a), 17.4% of Queensland respondents aged 14 years and over reported that they had smoked tobacco in the year before the survey, compared with 19.7% in the 2010 NDSHS (AIHW, 2010). Though the Queensland rate has decreased it is still greater than the national tobacco smoking rate of 15.8%.

In Queensland, 16.8% of males reported that they had smoked tobacco in the past year compared to 13.3% of females.

b) daily

The rate of daily tobacco smoking in Queensland in the year before the NDSHS 2013 was 15%, compared to the national rate of 12.8%. The Queensland (QLD) daily rate was greater than New South Wales (NSW), Victoria (VIC), Western Australia (WA), South Australia (SA) and the Australian Capital Territory (ACT), but less than the Northern Territory (NT) and Tasmania (TAS).

The average age when young people first smoked tobacco was 15.9 years compared to 1995 when the age of uptake was 14.2 years (AIHW 2014a).

The reduction in tobacco smoking in the general population has not been seen among Aboriginal and Torres Strait Islander Australians population (King *et al* 2013). According to the Productivity Commission's *Overcoming Indigenous Disadvantage* 2014 Report, in 2013 44% of Aboriginal and Torres Strait Islander Australians were daily smokers compared to approximately 18% of non-Indigenous Australians (SCRGSP 2014). Though the rate was high, it had declined from 2011 (51%), and:

- There was no significant difference between males and females a similar proportion of Aboriginal and Torres Strait Islander men and women smoked daily in 2013 (40.9% and 39.6% respectively).
- Of the 3636 Aboriginal and Torres Strait Islander women who were pregnant during 2013, nearly half reported that they had smoked during their pregnancy.
- Aboriginal and Torres Strait Islander Australians aged between 25-35 years had the highest rate of tobacco smoking (50.2%) compared to other age brackets.
- There was a large difference in daily tobacco smoking prevalence rates between Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians aged between 15-17 years 1 in 6 Aboriginal and Torres Strait Islander Australians aged 15-17 years were current daily smokers compared to 1 in 25 of non-Indigenous Australians.
- More of the Aboriginal and Torres Strait Islander Australian population in remote and very remote locations engaged in tobacco smoking (52.2% and 50.3% respectively) compared to major cities which had the lowest rate of 41.7% (SCRGSP 2014).



In 2013 compared to heterosexual populations, the Australian lesbian, gay, bisexual and transgender (LGBT) population had a higher prevalence of tobacco use, and were more likely to smoke tobacco daily (AIHW 2014a).

## Prevalence of alcohol use

a) yearly

In Queensland 80.4% of respondents aged 14 years and over reported that they had consumed alcohol in the year before the survey compared to 83.2% of respondents in 2010 (NDSHS; AIHW 2014a, 2011). The national rate of alcohol consumption from the NDSHS 2013 was 78.2%.

b) daily

In QLD the rate of daily drinking in 2013 was 7.4%, higher than the national rate of 6.5% and is ranked the second highest rate behind the NT. In QLD a greater proportion of males reported that they consumed alcohol daily (9.6%) compared to females (5.3%).

Between 2010 and 2013, daily drinking rates for men and women have significantly decreased (from 7.2% to 6.5%) and has been at its lowest level since 1991.

## Risky levels of alcohol consumption

There are two types of alcohol consumption classified by the Australian Drinking Guidelines (2009) as 'risky': first, increased *lifetime risk* from alcohol, defined as the consumption of more than two standard drinks per day; secondly, *increased risk* on a single drinking occasion, defined as the consumption of more than 4 standard drinks on one occasion (NHMRC 2009).

A critical point to note about the prevalence of risky drinking is that a much higher proportion of the QLD population who drink at risky levels are at risk from *single occasion drinking* rather than lifetime risk (approximately twice as many: 40.6% single occasion compared to 20.2% lifetime risk).

Single occasion risky drinkers are at high risk of accidents and injuries from falls, assaults and other accidents while they are intoxicated. Services that aim to provide some protection for those who are vulnerable to such harms have been developed precisely because they target the most prevalent type of risky drinkers.

## Lifetime risk

In QLD, an estimated 20.2% of persons aged 14 years and over reported consuming alcohol at this level of risk. Lifetime risk has reduced in the period 2010 to 2013. Men (28.2%) were approximately twice as likely to consume alcohol at this level of risk compared to women (12.2%).

In terms of age related risk, in QLD the highest proportion of risky drinkers were aged 40-49 years (26.5%), followed by those aged 20-29 years (25%) (AIHW 2014a). These QLD data were not available by age group, gender and location.

Nationally, the highest proportion drinkers at risk of alcohol related harm over a lifetime were aged between 40-49 years (22.5%) followed by those aged 18-24 (21.3%). For those aged 18-24, a higher proportion of men were at risk of alcohol related harm over a lifetime compared to females (27.6% and 14.6% respectively). The pattern was similar for males and females aged 40-49 (31.7% and 13.5% respectively).

#### Single occasion risk

The percentage of people in QLD who drank at this level of risk in 2013 was 40.6%, compared with 37.8% nationally. NSW had the lowest percentage (34.5%) and NT had the highest (51.9%). Nationally, men (48.2%) were almost twice as likely as women (27.6%) to consume alcohol at this level of risk (AIHW 2014a). In terms of age related risk, the highest proportion of risky single occasion drinkers were aged 20-29 years (43%), followed by those aged 30-39 years (33.7%) (AIHW 2014a).



National level data show that young people aged 15-24 years were more at risk of experiencing harm from alcohol related accidents or injury compared to those aged 25 and above who were most likely to be harmed by alcohol related diseases. The fact that these data indicate that young people were more at risk of having alcohol related accidents than people aged 25 and above may be associated with the high rate of binge drinking (drinking more than 4 standard drinks in a single occasion) amongst young people (AIHW 2014a).

Nationally, the average age at which young people started drinking alcohol was 15.7 years in 2013 compared to 14.8 years in 1995. As shown in Figure 1, the age of first alcohol consumption in Australia steadily increased since 1998. State and territory level data was not available.



Figure 1: National age of initiation to alcohol



Nationally, 47% of respondents aged 18-24 years drank at a risky level (consumed more than 4 standard drinks) in a single occasion at least once a month. This was a significant decrease from 2010 where the national rate was 54%. As summarised in Figure 2, 50.3% of QLD respondents aged 18-24 years reported having more than 4 standard drinks on a single occasion at least once a month which was close to the national rate of 47% (AIHW 2014a). QLD had the fourth highest rate of single occasion risky drinking in Australia. TAS had the highest. Prevalence data of single occasion risky drinking were not published at state/territory level in the NDSHS prior to 2013.

Figure 2: Prevalence of risky monthly single occasion alcohol consumption by 18-24 year olds



Data Source: NDSHS 2013 (AIHW 2014a)



The 2014 NDSHS report did not provide analyses of geographical remoteness, however the 2010 NDSHS data showed that people living in rural and remote areas had consumed alcohol at levels associated with higher lifetime and single occasion risks (AIHW 2011).

Data from the *Overcoming Indigenous Disadvantage Productivity Commission 2014 Report* are used (SCRGSP 2014) are presented for alcohol:

Based on self-report by Aboriginal and Torres Strait Islander adults in 2012-13:

- 22.7 per cent reported not consuming alcohol in the previous 12 months (after adjusting for differences in population age structures, this was 1.6 times the rate for non-Indigenous adults)
- 19.7 per cent reported exceeding lifetime alcohol risk guidelines, similar to 2004-05 (after adjusting for differences in population age structures, this was similar to the proportion for non-Indigenous adults in 2011-12)
- 57.0 per cent reported exceeding single occasion risk guidelines in the previous 12 months (after adjusting for differences in population age structures, this was 1.1 times the rate for non-Indigenous adults).

SCRGSP 2014, p 2881

Compared with non-Indigenous Australians, fewer Aboriginal and Torres Strait Islander Australians drink alcohol but those who do drink at more harmful levels (King *et al* 2014).

Research suggests that the proportion of Aboriginal and Torres Strait Islander Australians consuming alcohol at risky levels may be at least double that of the general population (Wilson *et al* 2010 cited in King *et al* 2013).

In 2013 compared to heterosexual populations, the Australian LGBT population had a higher prevalence of alcohol use, and were more likely to consume alcohol at risky levels (AIHW 2014a).

Despite potential dangers to children's health, drinking by pregnant women is fairly common in Anglo-Saxon countries such as Australia (WHO 2012). Approximately half of pregnant women self-report drinking alcohol during their pregnancy. Since 2007 there has been an increase in the number of women in Australia abstaining from drinking alcohol whilst pregnant. According to the NDSHS 2013, 52.8% of pregnant respondents reported that they had not consumed alcohol whilst they were pregnant compared to 40% in 2007 (AIHW 2014a, 2008). Of the 46% of women who reported that they had consumed alcohol whilst pregnant the majority (77.9%) drank monthly or less and usually consumed 1-2 standard drinks (95.8%). Only 2.4% had consumed alcohol more than four times a week during their pregnant and 26.1% continued to consume alcohol after they knew they were pregnant (AIHW 2014a).

#### Illegal drug use

Queenslanders aged between 18-24 years had the highest rate of recent use of any illegal drug (28.5%) compared to those aged below 18 or above 24 (AIHW 2014a).

Nationally from 2010 to 2013, there was an increase in the number of people aged 50-59 who reported using illegal drugs in the 12 months prior to the NDSHS survey (10.5% in 2010 to 11.1% in 2013). A similar trend was suggested in the data for those aged 60 years and over. In 2010 5.5% of respondents aged 60 years and over reported recent use of illegal drugs. In 2013 this rate increased to 6.4% (AIHW 2014a).



## Prevalence of meth/amphetamine use<sup>7</sup>

In the 2013 NDSHS (AIHW 2014a), 2.3% of QLD respondents aged 14 years and over reported that they had used meth/amphetamines in the year before the survey, the national rate was 2.1%. The QLD rate was more than NT, NSW, SA, VIC and the ACT however less than WA and TAS.

The NDSHS also looked at the use of meth/amphetamine in the year before the survey by forms of meth/amphetamine (powder, liquid, ice/crystal, paste/base/pure, tablet, prescription, capsules).

In QLD as in Australia as a whole, the major trend between 2010 and 2013 was *a significant decline in the use of powder and an equally significant increase in the use of ice/crystal.* From 2010 to 2013 the use of powder in QLD halved from 41.6% to 21.2%. In comparison the use of ice/crystal doubled from 19.9% to 45.5%. A similar trend was seen nationally (AIHW 2014a).

Prevalence of meth/amphetamines use among Aboriginal and Torres Strait Islander Australians was about twice that of non-indigenous Australians (Wilkes *et al* 2014).

In 2013 compared to heterosexual populations, the Australian LGBT population were 4.5 times more likely to use meth/amphetamines (AIHW 2014a).

#### Prevalence of cannabis use

For respondents aged 14 years and over, 10.2% reported that they had used cannabis in the year before the NDSHS 2013 compared to 11.1% in QLD (AIHW 2014a). The QLD rate was greater than NSW, VIC, SA and ACT but less than WA, TAS and NT. Nationally a greater proportion of males reported that they had recently used cannabis (12.8%) compared to females (7.6%). This was similar in QLD (males 14.3% and females 8.1%).

Prevalence of cannabis use among Aboriginal and Torres Strait Islander Australians was about twice that of non-indigenous Australians (Wilkes *et al* 2014).

In 2013, compared to heterosexual populations, the Australian LGBT population was 2.9 times more likely to use cannabis in the previous 12 months (AIHW 2014a).

#### Prevalence of cocaine use

In Australia the rate of cocaine use in the year prior to the NDSHS 2013 was 2.1% compared to the QLD rate of 2.0%. The QLD rate was greater than WA, SA and TAS and less than NSW, ACT and NT. VIC and QLD had the same prevalence rate. More males were recent users of cocaine compared to females both nationally (2.9% and 1.4% respectively) and in QLD (males 2.9% and females 1. 1%).

There were no data on the prevalence of use of cocaine among Aboriginal and Torres Strait Islander Australians.

In 2013, compared to heterosexual populations, the Australian LGBT population was 2.8 times more likely to use cocaine in the previous 12 months (AIHW 2014a).

#### Prevalence of ecstasy use

In the 2013 NDSHS, 2.5% of respondents reported that they had used ecstasy in the 12 months prior to the survey. In QLD this rate was similar at 2.4%. The QLD rate was the same as NSW and VIC and less than the rate of WA, SA, TAS, ACT and the NT. More males reported that they had recently used ecstasy compared to females for both Australia (3.2% and 1.8% respectively) and QLD (3.0% and 1.7% respectively) (AIHW 2014a).

There were no data on the prevalence of use of ecstasy among Aboriginal and Torres Strait Islander Australians.

<sup>&</sup>lt;sup>7</sup> In the NDSHS 2013 meth/amphetamines relate to methamphetamines and amphetamines used for non-medical purposes. More specifically meth/amphetamines in the following forms: powder, liquid, crystal/ice, base/paste/pure, tablet, prescription amphetamines, capsules and 'other'.



In 2013, compared to heterosexual populations, the Australian LGBT population was 5.8 times more likely to use ecstasy in the previous 12 months (AIHW 2014a).

## Prevalence of pharmaceutical for non-medical purposes

In Australia 4.7% of respondents aged 14 years and over reported that they had consumed pharmaceuticals for non-medical purposes in the 12 months before the NDSHS 2013 and in QLD this rate was 4.8%. The QLD rate was greater than NSW, SA, TAS and the ACT but less than NT and WA. Victoria had the same rate as QLD.

Nationally, 5.1% of males and 4.4% of females reported recent pharmaceutical use for non-medical purposes compared to 6.0% of males and 3.7% of females in QLD (AIHW, 2014a)

The prevalence of use of pharmaceuticals for non-medical use among Aboriginal and Torres Strait Islander Australians was about twice that of non-Indigenous Australians (Wilkes *et al* 2014).

In 2013, use of pharmaceuticals for non-medical purposes was more common for LGBT people than for heterosexual people (AIHW 2014a).

#### Prevalence of opioid use

#### Heroin

The prevalence rates for heroin have remained low (less than 1%) over the past decade. According to the NDSHS 2013 there was a decline in heroin use from 2010 to 2013. In 2013, 0.1% of respondents aged 14 years or older reported using heroin in the 12 months prior to the survey compared to 0.2% in 2010 (AIHW 2014a, 2011). The AIHW reported that the state and territory prevalence rates for heroin were obtained however they were not appropriate for use (AIHW 2014a).

#### All opioids

NDSHS data were not available for the prevalence of use of all opioids. It is likely that a number of the pharmaceuticals used for non-medical purposes were opioid analgesics. The data on treatment rates and the research on estimating the prevalence of use are included here to provide some insights into the level of use in Australia, as follows:

- In 2013, there were 47,422 clients receiving OST in Australia on a snapshot day (AIHW 2014b). Of these 6,093 clients received their treatment in QLD.
- In the last few years, researchers have estimated that:
  - The number of people in receipt of OST on any one day represents approximately half the total number of Australians who are opioid dependent (Chalmers and Ritter 2012).
  - Degenhardt and colleagues (2014) estimated the number of dependent users of opioids in Australia in 2010 to be approximately 93,000.

#### Prevalence trends Queensland and Australia

Alcohol consumption had the highest rate of prevalence followed by tobacco smoking and cannabis use in both QLD and Australia. (AIHW 2011, 2014a). Prevalence rates for ecstasy, pharmaceuticals, cocaine and meth/amphetamines in QLD were similar to the national rates. Although the prevalence rate for heroin remains relatively low at less than 1%, the risks associated with its use are high. That is, while tobacco causes the most ill health and premature death out of any drug, it is closely followed by opioid related deaths which continue to out-number deaths for any other illegal drugs (Roxburgh *et al* 2013). See burden of disease section for further detail on burden of disease rankings.



Figure 3 summarises the NDSHS prevalence of use data in QLD and illustrates changes in drug prevalence rates over time, and shows that the prevalence of use and trends in the last 10 years were similar for QLD and Australia.



Figure 3: Australian and Queensland drug prevalence rates NDSHS data 2003-2013

Data sources: NDSHS 2004, 2007, 2010, 2013 (AIHW 2005 2008 2011 2014)

#### Australian community views about alcohol and other drug use

The inconsistency between perceptions and evidence was further highlighted in how the public perceived certain drugs to be linked to drug issues.

Figure 4 below summarises changing Australian community views about drug use. In 2007, the community was most concerned about excessive alcohol consumption (AIHW 2014a). This concern spiked in 2010 and remained at that level in 2013. From 2010 to 2013, community concern about meth/amphetamine use increased and by 2013 it was the second greatest concern to the general community. Levels of concern about tobacco smoking and heroin use have been steady since 2007.





Figure 4: Form of drug use of most serious concern to the general community

Data sources: NDSHS 2007, 2010 and 2013

According to the 2013 NDSHS report the majority of respondents perceived that alcohol was associated with most drug related deaths in Australia however in reality it was tobacco (AIHW 2007, 2014a, 2015). Furthermore the majority of Australians listed heroin as the drug they first associated with 'a drug problem' however a very small proportion of the population (about 0.1%) actually used heroin (AIHW 2014a, 2014b).

## Emerging drug use trends

There are currently no published data on the 'new' or novel psychoactive substances (NPS) use among the general population in Australia (Roxburgh *et al* 2013), but among the Ecstasy and Related Drugs (EDRS) population just under half of the national sample reported recent use of NPSs in 2013 – a slight increase from 2012. It is expected that NPSs will become part of the NDSHS collections in the future.

No data were found on the prevalence of use of performance and image enhancing drugs (PIED) such as steroids although Australian information resources have been produced (eg by Drug Aware) and the issue of use has been covered in mass media. However, the Queensland Crime and Corruption Commission website has information about the PIED 'marketplace', which indicates an increase in the importation of PIEDs and an increase in their use by younger people as well as their use and supply through sources which include the internet.<sup>8</sup>

## Estimating numbers needing treatment for alcohol related problems

The 2013 NDSHS (AIHW 2014) showed that, in the QLD sample, 80.4% of the population aged 14 years and above had consumed alcohol in the year before the survey ('recent drinkers'), compared with 78.2% nationally. Some 7.4% reported drinking alcohol daily, prevalence higher than the national rate of 6.5%. The QLD prevalence of daily drinking among males was 9.6% and among females 5.3%. Some 20.2% of recent drinkers in QLD consumed alcohol at a level at which they were at risk of life-time alcohol related harm, which was greater than the national rate of 18.2%. The single drinking occasion level of risky drinking was 40.6% including 50.6% of male drinkers and 30.6% of female drinkers.

<sup>&</sup>lt;sup>8</sup> http://www.ccc.qld.gov.au/crime/results/drug-market-profiles/performance-and-image-enhancing-drugs-pieds



Converting these proportions to numbers of QLD residents in 2013 produces the following:

- at risk of alcohol related harm over the lifetime 953,934 people
- at risk of alcohol related harm from single-occasion drinking 1,917,313 people.

It is widely accepted among epidemiologists that approximately 5% of adult drinkers will develop alcohol dependence (Latt *et al* 2009 p 27). Applying this proportion to the QLD population indicates that some 236,000 Queenslanders may be alcohol dependent and therefore needing treatment services. It is unclear, at this stage, what proportion may need residential treatment.

#### Estimating numbers needing treatment for illegal drug related problems or dependence

The prevalence of recent use of illegal drugs in QLD, as revealed through the NDSHS 2013, was 15.5% (15.1% in 2010) (some 732,000 people), a figure just a little higher than the national proportion of 15.0% (AIHW 2014a).

The proportion of QLD respondents who reported recent use of cannabis was 11.1% (11.0% in 2010) compared with 10.2% nationally. This means that approximately 519,000 Queenslanders used cannabis in the year prior to the survey. It is estimated that some 15% of recent cannabis users are dependent on the drug (n=78,000), indicating a high level of need, and potential demand, for early intervention and active treatment services addressing cannabis.

Of Queenslanders, 2.4% (2.7% in 2010) said that they are recent users of ecstasy compared with 2.5% nationally, representing some 113,000 people in QLD. Some 2.3% (1.9% in 2010) reported recent use of meth/amphetamine (2.1% nationally), representing approximately 109,000 people. The natural history of ecstasy and other psychostimulant use in Australia is not well known, but some estimate that approximately 10% of recent users (in QLD 11,300 ecstasy users and 10,900 meth/amphetamine users) become dependent on these drugs.

Recent use of painkillers for non-medical purposes was reported by 3.3% (3.1% in 2010) of Queenslanders (some 156,000 people), the same proportion as the national figure of 3.3%.

As the NDSHS is not an appropriate instrument for estimating treatment demand for problem use of drugs with a low prevalence of use, other sources are needed. Less than 1% (0.2%) of Australians reported past year heroin use in 2010 (Roxburgh *et al* 2013).<sup>9</sup> Findings from the IDRS showed that amongst PWIDs, heroin use in the previous six months has decreased at a constant rate of approximately 0.7% each year from 2001 to 2013. The daily rate of heroin use amongst those users significantly increased in this time (Stafford & Burns 2014, Roxburgh *et al* 2013). The number of people receiving OST increased between 2001 and 2012, particularly among Australians aged 50 years and over, with a decline in people aged 30 years and under. In 2013, 6,093 people (4,637 in 2007) were recorded as receiving pharmacotherapy for opioid dependence in QLD (AIHW 2014b). The total number of dependent opioid users in QLD can be estimated to be twice the number of people in treatment (Degenhardt *et al* 2014). This provides some indication of unmet needs for treatment among opioid users.

Non-medical use of pharmaceutical opioids (heroin, and harmful use and diversion of prescribed opioids (such as morphine, buprenorphine, methadone, fentanyl and oxycodone) are associated with a range of mild to severe health and social problems) has remained low among the general population at less than 1% in 2010 (Roxburgh *et al* 2013). Injecting use of morphine among IDRS participants, in the past six month period, declined significantly between 2006 and 2013. Conversely, the proportion of IDRS participants injecting Oxycodone<sup>®</sup> increased by approximately 1.2% each year from 2005 to 2013 (Stafford & Burns 2014, Roxburgh *et al* 2013). In 2013, 7% of people who regularly

<sup>&</sup>lt;sup>9</sup> Please note that the figures for the prevalence of heroin use are very unstable and as such vary across reporting years. In 2013 it was 0.1%



inject drugs surveyed for the IDRS reported recent use of licit oxycodone, and 32% reported recent use of illegal oxycodone (Stafford & Burns 2014). Recent use of morphine and oxycodone was reported by about a third of participants (38% and 36% respectively). Morphine was the pharmaceutical most commonly injected (35%) followed closely by oxycodone (31%). Almost half (48%) of the survey participants reported recent use of methadone (any form, legal and/or illegal).

## 4.3 Drug related harms

As noted in Section 2, drug use affects health, families, the economy and the criminal justice system. Harms vary according to the substance used or consumed and the degree of use. Poly-drug use (concurrent use of more than one type of drug) can multiply the effects of each drug and therefore increase the risk of harm.

Broadly, for individuals these harms include: mental and physical health related issues, blood-borne virus transmission, and overdose deaths, criminality, antisocial behaviour trauma, violence, and social exclusion. For the family and the community harms include injury, trauma, social disruption (including homelessness and family and relationship issues) workplace problems, and property and vehicle damage. Costs to society include lost productivity, justice system costs (police, courts, prisons, child protection and family support services) costs associated with drug related hospitalisation, insurance administration and other organisations associated with addressing the consequences of property and vehicle damage (Dietze *et al* 2013, Manning *et al* 2013).

Some types of harm have been easier to measure as the casual relationship is more linear, and systems exist that measure this type of information (e.g. deaths from drug overdoses, hospitalisations for drug related injury and illness and arrests for alcohol and drug offences). "However other types of harm, including social disruption (including family and relationship issues), violence and workplace problems have proven to be much more difficult to examine." (Dietze *et al* 2013, p 84).

Laslett and colleagues (2015) reviewed the available national and state and territory data on drug related domestic violence and alcohol involvement in child protection cases. They found that alcohol related domestic violence incidents were not consistently recorded across states, and no recent figures were available for QLD, SA, ACT and TAS. There were no recent national state and territory estimates of how many substantiated child protection cases involved alcohol use by a carer. Queensland data from the then Department of Communities in 2007 indicated that:

Substantiated cases in 2007: 47 per cent involved alcohol or drugs, 51 per cent of these cases involved alcohol only (i.e. 24 per cent of all cases). Parental/carer alcohol misuse was most commonly found in neglect cases in 2007, (24%) of all substantiated cases of child maltreatment involved alcohol.

Laslett et al 2015, p 83

#### Burden of disease and drug related injuries

In QLD, as in other states and territories in Australia, tobacco and alcohol are the drugs responsible for the most harm to individuals, families and communities (Begg *et al* 2007). Drug use can cause illness, injury and early death. While QLD specific data on the burden of disease and injury are not published, the 2007 study of the burden of disease nationally is informative (Gao *et al* 2014, Begg *et al* 2007).<sup>10</sup> <sup>11</sup> It identifies the top 14 risk factors and their percentage contribution to the total individual and joint burden of disease and injury, expressed in disability-adjusted life years (DALYs).

<sup>&</sup>lt;sup>11</sup> "Burden of disease is a measure used to assess and compare the relative impact of different diseases and injuries on populations by quantifying health loss due to disease and injury that remains after treatment, rehabilitation or prevention efforts of the health system and society generally." (AIHW 2014)



<sup>&</sup>lt;sup>10</sup> The most recent study on burden of disease and injury in Australia uses 2003 data.

It reveals that tobacco use is the risk factor that contributed most to Australia's disease burden (7.8% of the total burden).

Of all drug related deaths, 85% were attributed to tobacco, 9% to illegal drugs and 6% to alcohol. Around two thirds (65%) of drug related DALYs were attributed to tobacco, 19% to alcohol and 16% to illegal drugs. In addition:

- Alcohol accounted for 2.6% of all deaths nationally and 3.2% of the DALYs. The net impact, after adjusting for the protective effects of alcohol consumption, was 0.8% of the deaths and 2.3% of the DALYs. The diagnostic category 'alcohol abuse' accounted for 56% of the alcohol related DALYs, followed by alcohol related suicide and self-inflicted injuries at 20% and alcohol related road traffic crashes at 18%.
- Tobacco accounted for 11.7% of all deaths nationally and 7.8% of the DALYs. Lung cancer accounted for 35% of the tobacco related DALYs, with chronic obstructive pulmonary disease accounting for an additional 27%.
- Illegal drugs accounted for 1.3% of all deaths nationally and 2.0% of the DALYs.

We note that the AIHW is currently working to update Australia's burden of disease estimates, building on the Begg *et al* (2007) burden of disease study and disease monitoring work. The AIHW aims to "identify the extent and distribution of health problems in Australia and to quantify the contribution of key health risks" for all Australians. The AIHW also pays particular attention to the health and wellbeing of Aboriginal and Torres Strait Islander Australians. The results are expected to be published in late 2015.

## Drug related mortality and morbidity

Each year, alcohol and drug use in QLD accounts for an estimated 4,300 deaths and over 55,000 hospital admissions.<sup>12</sup> Detailed QLD data for emergency department presentations, hospital and mental health unit admissions and ambulance attendances at overdose incidents were not publicly available. The Queensland Ambulance Service (QAS) is currently participating in a project led by Turning Point (Victoria) to improve the data on non-fatal drug related events attended by ambulance paramedics.

The Queensland IDRS Study (McIlwraith *et al* 2014) analysed the findings of the IDRS for Queensland. They presented QAS data on the number of overdose cases attended by the QAS where the primary substance was recorded. The authors point out that the data are not definitive of the actual number of overdose cases attended because the data do not include formal diagnoses, and the drug type field is optional because it is sometimes not possible for the paramedic to ascertain. Mindful of the limitations of these data, McIlwraith and colleagues (2014) note that the data show a pattern over four years whereby alcohol was the drug identified in just under half the overdose cases attended by the QAS. The authors also presented ABS causes of deaths data for overdoses in QLD, and noted that the "data for accidental opioid overdose deaths continues to trend upward" (McIlwraith *et al* 2014 p 52).

The ABS deaths data provide information on the underpinning causes of death by state and territory. For example, in 2013, the deaths from mental and behavioural disorders associated with psychoactive substance use were mostly attributed to alcohol with 214 people in QLD dying from alcoholic liver disease. The data also cover death from intentional and accidental poisonings from alcohol.

Alcohol during pregnancy

<sup>&</sup>lt;sup>12</sup> Queensland Government website updated 2014 <u>http://www.qld.gov.au/health/staying-healthy/atods/drug-abuse/index.html</u>



Alcohol exposure in pregnancy is a risk factor for poor pregnancy and child outcomes (Peadon *et al* 2010). It can cause low birth weight and a range of physical and neurodevelopmental problems (National Indigenous Drug and Alcohol Committee 2012, National Health and Medical and Medical Research Council 2009). High-level or frequent intake of alcohol in pregnancy increases the risk of miscarriage, stillbirth and premature birth, and alcohol related birth defects and neurological problems described in the literature since 1968 under the umbrella of Foetal Alcohol Syndrome (FAS), and more recently Foetal Alcohol Spectrum Disorder (FASD) (National Indigenous Drug and Alcohol Committee 2012, Parliament of the Commonwealth of Australia 2012, Peadon *et al* 2011, National Health and Medical Research Council 2009, O'Leary *et al* 2009). FASD describes a "cluster of permanent birth defects caused by maternal consumption of alcohol during pregnancy" (Lee *et al* 2013, National Health and Medical Research Council 2009).

In recent years a greater understanding of foetal alcohol spectrum disorder and related conditions (Kelly *et al* 2013, 2008) has developed, particularly among disadvantaged women. The most effective mechanism for reducing alcohol consumption among pregnant women or women planning a pregnancy has been thought to be antenatal care that addresses alcohol consumption during pregnancy.

## Aboriginal and Torres Strait Islander Australians risk of harm

Aboriginal and Torres Strait Islander Australians are more at risk of experiencing harm from alcohol related accidents, injury and alcohol related diseases. Combined with high rates of socio-economic disadvantage, drug use among Aboriginal and Torres Strait Islander Australians results in a high disease burden (SCRGSP 2014, King *et al 2013,* Gray *et al* 2010). Data from the *Overcoming Indigenous Disadvantage Productivity Commission 2014 Report* highlights the following:

In 2012-13, ..., the most common type of alcohol related hospitalisation for Aboriginal and Torres Strait Islander Australians was for acute intoxication around 12 times the rate for non-Indigenous Australians... .. The hospitalisation rate for acute intoxication for Aboriginal and Torres Strait Islander Australians in remote and very remote areas was double the rate in major cities... .

SCRGSP 2014, p 2885

...for NSW, QLD, WA, SA and the NT combined, the alcohol induced death rate for Aboriginal and Torres Strait Islander Australians was around 5 times the rate for non-Indigenous Australians.....

SCRGSP 2014, p 2886

From 2003–2007 to 2008–2012, ..., for NSW, QLD, WA, SA and the NT combined, the druginduced death rate for Aboriginal and Torres Strait Islander Australians was consistently around 1.5 times the rate for non-Indigenous Australians... .

SCRGSP 2014, p 2894

#### Mental health comorbidity with drug use

Those who experience co-existing mental health and substance use issues also face a range of health and social challenges, including increased risks of health problems (infections, injuries, chronic disease) homelessness and imprisonment compared to those who only have a mental disorder or a substance use disorder (National Mental health Commission 2013).

The Queensland IDRS study of 100 PWID from the South East Queensland region notes the link between injecting drug use and mental health (McIlwraith *et al* 2012).<sup>13</sup> Over half of the participants in the survey (n=56, 56%) self-reported a mental health problem and reported high or very high levels of psychological distress (n=59, 59%). Participants' scores on the SF-12 health survey suggest

<sup>&</sup>lt;sup>13</sup> It is not possible to make statistically reliable comparisons between the IDRS sample of PWID and larger population studies due to the size and nature of the sample.



that the participants also had below average mental and physical health (McIllwraith *et al* 2012). Other contributing factors such as unemployment rate, physical health and criminal history were also examined in the Queensland IDRS study.

These findings align with those published in the National Mental Health Commission's A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention which suggest that a large proportion of people with mental health issues will use substances at some stage, and vice versa (National Mental Health Commission 2013). In fact, almost 340,000 Australians will have both a mental illness and a substance use disorder in a year (ABS 2013).

## Alcohol and other drug related crime

The use of drugs has been correlated with various types of criminal offending, particularly with property crime, violent offences, and assault (AIC 2012). Analysis of DUMA program data in 2009-10, demonstrated that substance use is more prevalent among those convicted of crimes than in the general population, with an estimated two in every three (66%) offenders detained by police across Australia testing positive for at least one drug, not including alcohol (Gaffney *et al* 2010). Further, nearly half (45%) of all police detainees indicated that substance use had contributed to their current offences (Gaffney *et al* 2010).

The ABS national level data on the number of incidents of drug related crime in 2012-13 are publicly available (ABS 2014). In 2012-13, a large proportion of victims of physical assault believed that alcohol and/or other drugs contributed to their most recent assault incident (67% of males and 62% of females). Drug related assaults were most likely to occur in the victim's home (25.3%), followed by their work/place of study (24.8%), entertainment/recreation area (14.9%) and the street or footpath (14.6%). Almost half (42%) of all victims of drug related assaults were aged between 18 and 34 years.

Eighty-seven per cent of victims of physical assault and 75% of victims of face-to-face threatened assault whose most recently experienced incident occurred at a place of entertainment or recreation (licensed or unlicensed) believed alcohol and/or any other substance contributed to the most recent incident. This was statistically significantly higher than the overall proportion of victims who believed that alcohol and/or any other substance contributed to their most recent incident (59% for physical assault and 55% for face-to-face threatened assault respectively). Seventy-nine per cent of victims of physical assault whose most recent incident occurred in another person's home and 81% of victims whose most recent incident occurred at a train station, bus stop or interchange also believed alcohol and/or any other substance contributed to the incident...

#### ABS 201314

In a recent nation-wide study into "king-hit" deaths in Australia, Pilgrim *et al* (2014) established that alcohol was a major contributing factor to violent fatalities, and not necessarily in combination with use of other drugs. Out of the 90 cases studied across the 12 year period (2000 -2012), 28 deaths occurred in NSW, followed by VIC and QLD which had 24 cases each. The study also showed that alcohol intoxication increased not just aggressive offending but also vulnerability to victimisation. "In the case of violent assaults, alcohol consumption is the more urgent contributing issue." (Pilgrim *et al* 2014).

#### Drug use related crime in QLD

The rates of AOD use related crime in QLD per 100,000 population dropped by 11.2% from December 2010 (4,577) to December 2013 (4,064). These crime rates were for offences where police

<sup>&</sup>lt;sup>14</sup> <u>http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/BCACA21A9BA3E8CBCA257B16000E0B73?opendocument</u>

officers determined that the offence was related to AOD use. AOD use related crimes for QLD in 2013 are presented in Table 1 below. It shows the rates and numbers of AOD related offences for different offence types, the proportion of AOD use related offences deemed alcohol related, and the proportion of all offences. It should be noted that these data are for reported incidents only, and do not account for offences that are *not* reported to police. These data were not categorised by geography (e.g. Local Government Areas) or by location (e.g. domestic, public space, or licenced premises). Meth/amphetamine-type stimulants were not distinguished in the dataset.

Offence type	Rate of offences per 100,000 (number)*	% of AOD offence type deemed alcohol related	% of all offence type deemed AOD related
Assault	133 (6,159)	90.6	32.8
Damage to property	68 (3,201)	88.6	8.1
Steal from retail store	14 (694)	63.3	4.3
Steal from motor vehicle	7 (294)	74.5	1.0
Break and enter dwelling	6 (288)	77.1	1.1
Motor vehicle theft	4 (157)	78.3	1.3
Break and enter non-dwelling	3 (189)	66.1	1.3
Robbery	2 (136)	72.8	7.7

Table 1. Rates of AOD use related crime in QLD in 2013

Data source: Data set provided by the QPS specifically for this Discussion Paper

\*Note that it may be difficult for police to make a determination about the involvement of AOD in a criminal incident if the identity of the offender is not known. This is common for many property offences and these data should therefore be interpreted with caution.

Data from the DUMA program showed that in 2009-10, detainees who were charged with violent, property, drug, drink, traffic, disorder or breach offences, as their most serious offence, were more likely to test positive for cannabis than any other illegal drug (Sweeney *et al* 2012). Another study which analysed DUMA data for the same year showed that although cannabis was the most detected substance, the majority of interviewees attributed their offending behaviour to alcohol (Payne & Gaffney 2012).

The number of national illegal drug arrests totalled 101,749 in 2012-13, representing a 27.2% increase since 2003-04.<sup>15</sup> Cannabis continued to account for the greatest proportion of illegal drug arrests in Australia in 2012-13 (61.0%), followed by amphetamine-type stimulants (21.8%), other and unknown drugs (13.5%), heroin and other opioids (2.4%), and cocaine (1.3%) (Stafford *et al* 2013). Nationally, the number of cannabis-related arrests has risen by approximately 3% each year since 2007 (ACC 2014). A record number of national steroid, hallucinogen, cocaine, other and unknown drug arrests were also reported in 2012-13, and national heroin and other opioid arrests decreased by one-third in the 10 years to 2012-13 (Stafford *et al* 2013).<sup>16</sup>

<sup>&</sup>lt;sup>16</sup> These data (numbers and percentages of the total population in a given year) were used to calculate rates per 100,000 based on the June 2004 and June 2013 Office of Economic and Statistical Research Data (OESR) population statistics for Queensland and Australia. Using the rate means that the issue of population growth is removed as a factor and the rates can be compared.



<sup>&</sup>lt;sup>15</sup> For the purposes of the ACC illicit drug data collection, the term 'arrests' relates to law enforcement action for "suspected unlawful involvement in illicit drugs" and includes arrests, summons, diversion programs, cannabis explation notice, simple cannabis offence notice, drug infringement notice and notice to appear. Even the ACC has tried to separate arrests and seizures in the data, it notes that some overlap is likely.

Table 2 below summarises data on the rates of illegal drug use arrests trends in QLD and Australia in 2003-04 and 2012-13.

	Arrest rates per 100,000*			
Drug Type	QLD		Australia	
	2003-04	2012-13	2003-04	2012-13
Cannabis	568	405	253	269
Amphetamine Type Stimulants	77	106	48	96
Heroin and other opioids	9	6	18	11
Cocaine	1	5	2	6

Table 2: Illegal drug use arrest rates in 2003-04 and 2012-13 in QLD and Australia

Data source: Data source: 2003-04 and 2012-13 Illicit Drug Data Reports (ACC 2005, 2014)

Using the rates in Table 2 illegal drug use arrests trends can be compared for QLD and Australia as a whole. The trend in QLD is similar to that found nationally, where (with the exception of heroin and other opioids) the arrest rate for each drug type increased from 2003-04 to 2012-13:

- QLD drug arrest rates increased in the period 2003-04 to 2012-13 for both amphetamine type stimulants and cocaine, but not for cannabis and heroin and other opioids.
- Cannabis arrest rates were higher in QLD than nationally for cannabis arrests in 2012-13, with a rate of 405 per 100,000, compared with Australia as a whole, where the rate was significantly lower at 269 per 100,000.

These data should be interpreted with caution because rates would be affected by factors such as increased policing, and alternatives to arrest (police diversion programs), particularly for cannabis (Payne *et al* 2008).

A record number of national illegal drug seizures and arrests were reported in Australia in 2012-13 (ACC 2014).<sup>17</sup> Table 3 below summarises data on the rates of illicit and regulated drug seizure trends in QLD and Australia in 2003-04 and 2012-13.

	Arrest rates per 100,000*			
Drug Type	QLD		Australia	
	2003-04	2012-13	2003-04	2012-13
Cannabis	433	387	200	234
Amphetamine Type Stimulants	61	90	40	91
Cocaine	2	5	4	9
Heroin	7	4	8	7
Steroids	0.6	1	0.2	1
Other Opiates	0.3	0.3	0.5	0.4

Table 3: Illegal and regulated drug seizures in 2003-04 and 2012-13 in QLD and Australia

Data source: 2003-04 and 2012-13 Illicit Drug Data Reports (ACC 2005, 2014)

Seizure rates by drug type can be compared for QLD and Australia as a whole using the rates per 100,000 presented in Table 3.  $^{\rm 18\ 19}$ 

<sup>&</sup>lt;sup>17</sup> For the purposes of the ACC illicit drug data collection, the term 'seizure' refers to, "the confiscation of an illicit drug whether or not an arrest is being made in conjunction with that confiscation".



The following trends are particularly noteworthy:

- Seizures rates for amphetamine-type stimulants, cocaine and steroids increased in QLD and Australia from 2003-04 to 2012-13.
- Heroin seizure rates in QLD and Australia decreased in the period 2003-04 and 2012-13.
- Cannabis seizure rates were significantly higher in QLD than in Australia in both 2003-04 and 2012-13.
- QLD seizure rates for cannabis decreased from 2003-04 to 2012-13 (433 per 100,000 to 387 per 100,000) whereas national seizure rates for cannabis increased from 200 per 100,000 to 234 per 100,000 between 2003-04 and 2012-13.

It is important to note that there may be some overlap between the drug seizure and arrest data as some AOD related arrests may have been made in conjunction with the confiscation of illicit and regulated drugs.

#### 4.4 Drug treatment service use

Alcohol and other drug specific service utilisation data are drawn from the AODTS-NMDS (AIHW 2014). The AODTS-NMDS data were converted to rates per 100,000 as part of the analysis in order to compare QLD and national data. QLD had a total of 30,564 treatment episodes, equivalent to a rate of 656 per 100,000, which was marginally less than the rate of 703 per 100,000 for Australia as a whole.<sup>20</sup> The AODTS-NMDS provides data on several dimensions of treatment service utilisation (by number of treatment episodes), namely: referral source; type of treatment; main drug of concern to the person seeking treatment; treatment settings; cessation of treatment; reason for cessation. See Appendix 2 for more information on the nature and limitations of this data source.

#### **Referral sources**

QLD has a higher proportion of clients being referred to drug interventions from diversion programs than nationally and a lower proportion of self or family referral than nationally, although self or family referral remains the most common source in QLD.

Source of referral	QLD %	Australia %	Rate ratio <sup>21</sup>
Self or family	34	41	0.8
Health service	22	24	0.9
Corrections	9	9	1
Diversion	30	17	1.8
Other	6	8	0.8

#### Table 4: Referral source in QLD compared to Australia

<sup>21</sup>Note: a rate ratio is a difference measure used to compare the incidence rates of two different events at any one time. For instance, in Table 4 referral from corrections occurs at the same rate in QLD as it does nationally.



<sup>&</sup>lt;sup>18</sup> These data (numbers and percentages of the total population in a given year) were used to calculate rates per 100,000 based on the June 2004 and June 2013 OESR population statistics for Queensland and Australia. Using the rate means the issue of population growth is removed as a factor and the rates can be compared.

<sup>&</sup>lt;sup>19</sup> The seizure data presented in Table 3 were calculated by adding data from Australian Federal Police and state police operations. These data should be interpreted with caution as the ACC notes that seizures resulting from joint operations between the federal police and state police services were not taken into consideration.

<sup>&</sup>lt;sup>20</sup> These data include services delivered by government (community health not hospitals) and NGO service providers only. They do not include drug treatment and support services provided by general practitioners, nurses, psychologists, pharmacists and specialists in the private sector.

## Type of treatment

The proportion of clients receiving 'information and education only' treatment in QLD is almost four times the national level. The most common type of treatment is counselling, although this is below national level. QLD is also below national level for withdrawal management, assessment only, support and case management only and rehabilitation. This pattern is indicative of a gap in the service system for "actual treatment", which is defined as involving drug and alcohol dependence assessment, assessment of risk-taking behaviours, information on harm minimisation and motivational intervention in a 2-hour session (AIHW 2015).

In QLD, treatment provided to clients whom are referred via police or court diversion programs is commonly recorded as 'information and education only' (AIHW 2015).

A high proportion of 'information and education only' treatments were delivered to clients referred from police and court diversion programs in QLD (87%). Such programs include the Queensland Courts Referral (QCR) program and the Queensland Illicit Drug Diversion Initiative (QIDDI). The comparatively large proportion of clients that are referred/diverted by the courts or police to treatment programs compared to national level accounts for the high level of 'information and education only' treatment in QLD.

Type of treatment	QLD %	Australia %	Rate ratio
Counselling	33	41	0.8
Withdrawal management	10	16	0.6
Assessment only	16	18	0.9
Support and case management only	6	9	0.7
Rehabilitation	3	5	0.6
Information and education only	31	8	3.9
Other	2	3	0.7

## Table 5: Treatment types in QLD compared to Australia

#### Treatment settings

The proportion of treatment episodes in QLD and nationally that were non-residential was comparable. Table 6 below shows that in QLD the proportion of drug treatment episodes that were provided to clients in residential settings was half the proportion at the national level. The proportion of treatment episodes that were delivered in outreach or 'other' settings was above the national level.

Treatment setting	QLD %	Australia %	Rate ratio
Non-residential	66	68	~1
Residential	7	14	0.5
Outreach	17	10	1.7
Home	1	2	0.5
Other	9	6	1.5

#### Table 6: Treatment settings in QLD compared to Australia

#### **Treatment cessation**

Overall, the proportion of QLD treatment episodes that were closed due to 'treatment completed' was 28% of total episodes in QLD, which was half the national level. QLD was on par with TAS (23%



of treatment episodes completed), but well below completion levels in other states/territories, which ranged from 47% in WA to 65% in SA.

It is noteworthy that the proportion of treatment episodes that 'ceased to participate at expiation' was 26% in QLD, almost four times the national rate. Of treatments that 'ceased to participate at expiation', 92% were information and education only treatments. This result reflects the relatively high proportion of 'information and education only' treatments that were referred from police and court diversion programs in QLD (87%).<sup>22</sup>

Reason for cessation	QLD %	Australia %	Rate ratio
Treatment completed	28	53	0.5
Ceased to participate at expiation	26	7	3.7
Ceased to participate without notice	20	15	1.3

#### Table 7: Reason for treatment cessation in QLD compared to Australia

In QLD, the proportion of completed treatment episodes varied by treatment type, as outlined in Table 8 below.

Type of treatment episode completed	QLD %	Australia %	Rate ratio
Counselling	29	53	0.5
Withdrawal management	45	67	0.7
Assessment only	32	56	0.6
Support and case management only	44	59	0.7
Rehabilitation	28	35	0.8
Information and education only	16	36	0.4
Other	17	51	0.3

#### Table 8: Type of treatment episodes completed in QLD compared to Australia

Counselling treatment episodes completed

For counselling treatment episodes completed, the QLD proportion was half that for Australia. The proportion of counselling treatment episodes that were closed due to 'ceased to participate without notice' was 36% in QLD compared to 15% nationally.

Table 8 below shows state and territory data for closed counselling episodes, the proportion of these completed in the three main settings, and the proportion of these that were 'completed counselling episodes' and 'ceased to participate without notice' closed counselling episodes.<sup>23, 24</sup>

<sup>&</sup>lt;sup>24</sup> Data for 'home' treatment setting has not been included in Table 9.



<sup>&</sup>lt;sup>22</sup> Diversion sessions for police and court diversion are closed as 'ceased to participate at explation'.

<sup>&</sup>lt;sup>23</sup> Some low frequency reasons for treatment closure not included in Table 7 including: 'ceased to participate at expiation', 'ceased to participate by mutual agreement', 'ceased to participate against advice', 'ceased to participate due to non-compliance', 'change in main treatment type', 'change in delivery setting', 'change in principal drug of concern', 'transferred to another service provider', 'drug court or sanctioned by court diversion service', 'imprisoned (other than drug court sanctioned)', 'died', and 'other'.

	Counselling episodes by setting %			Main reason for counselling episode closure %		
State/territory	Residential treatment	Non-residential treatment	Outreach & other treatment		Episodes completed	Episodes 'ceased to participate without notice'
QLD	2	81	1	4	29	36
NSW	2	97	3	3	50	29
VIC	<1	99	(	)	69	12
WA	<1	77	1	9	42	25
SA	<1	85	1	0	36	36
NT	10	75	1	3	41	32
ACT	5	91	2	1	59	22
TAS	<1	86	1	2	24	28

Table 9: State and territory closed counselling episodes by setting and reason for closure

The analysis in Table 9 highlights that, compared with other states and territories, QLD:

- completed a lower proportion of its counselling episodes with the exception of TAS
- had the highest proportion of counselling episodes closed due to 'ceased to participate without notice', together with SA
- was the only state with a lower proportion of counselling episodes completed than episodes closed due to 'ceased to participate without notice', with the exception of TAS
- had a higher proportion of counselling treatment delivered in non-residential settings compared to NSW, VIC, SA, ACT and TAS, but a smaller proportion than WA and NT
- had a smaller proportion of counselling treatment delivered in residential settings compared to NT and ACT
- had a higher proportion of treatment delivered in 'outreach' and 'other' settings compared to NSW, VIC and SA, but a smaller proportion than WA.

## Drug of concern

Data from QLD's 133 publically-funded alcohol and other drug treatment agencies show that alcohol was the most common principal drug of concern (37%) for which clients sought treatment, followed by cannabis (34%), amphetamines (11%), nicotine (4%) and heroin (4%) (AIHW 2015). QLD is above the national level with respect to the proportion of treatment episodes that are for cannabis (34% in QLD compared to 24% nationally) and nicotine (4% in QLD compared to 2% nationally). These results reflect the relatively high levels of police and court diversion sessions. QLD is below the national level for alcohol (37% compared to 41% nationally), amphetamines (14% nationally) and heroin (8% nationally).

Principal drug of concern	QLD %	Australia %	Rate ratio
Alcohol	37	41	0.9
Cannabis	34	24	1.4
Amphetamines	11	14	0.8
Nicotine	4	2	2
Heroin	4	8	0.5

#### Table 10: Principal drug of concern in QLD compared to Australia



Furthermore, in 63% of closed treatment episodes, QLD clients sought treatment for drugs of concern in addition to their nominated principal drug of concern. Nicotine was the most common additional drug of concern (21%), followed by cannabis (20%) and alcohol (17%). When both principal and additional are considered, both alcohol and cannabis were the most common drugs of concern (both 54% in QLD), followed by nicotine (25%) (AIHW 2015).

When identifying service utilisation data across the drug treatment sector in relationship to (principal) drug and treatment type, it is possible to see the same effect with regard to a higher proportion of information and education only treatment in QLD compared to Australia-wide.

Alcohol: QLD high on 'information and education only' and similar for other treatments

- Counselling QLD 41%, Aust 45%, rate ratio 0.9
- Withdrawal management QLD 15%, Aust 19%, rate ratio 0.8
- Assessment only QLD 19%, Aust 17%, rate ratio 1.1
- Information and education only QLD 10%, Aust 4%, rate ratio 2.5

Cannabis: QLD very high on 'information and education only' and very low on counselling

- Counselling QLD 23%, Aust 40%, rate ratio 0.6
- Withdrawal management QLD 4%, Aust 11%, rate ratio 0.4
- Assessment only QLD 9%, Aust 14%, rate ratio 0.6
- Information and education only QLD 59%, Aust 19%, rate ratio 3.1

Amphetamines: QLD very high on 'information and education only' and low on counselling

- Counselling QLD 40%, Aust 45%, rate ratio 0.9
- Withdrawal management QLD 9%, Aust 12%, rate ratio 0.8
- Assessment only QLD 21%, Aust 21%, rate ratio 1
- Information and education only QLD 15%, Aust 4%, rate ratio 3.8.



#### Summary

**Drug use** among the general population and specific population groups in Queensland Is similar to that for Australia. In Australia:

- The number of people taking up smoking has decreased incrementally and steadily in the last 10 years.
- The percentage of people drinking at risky levels declined between 2010 and 2013.
- In 2013, people living in rural and remote regions were more likely to smoke, drink alcohol at risky levels, use cannabis and meth/amphetamines.
- The use of meth/amphetamines as powder and pills etc. has halved and the use of crystal meth/amphetamine has doubled possibly because crystal meth/amphetamine is a more popular, available and potent form. There was therefore no significant change in the number of people using meth/amphetamines, but a change to the more potent form of the drug.
- Younger people are choosing to abstain from alcohol, with abstaining levels increasing in the 12-17 age group in the last 3 years.
- LGBTI populations have higher rates of illegal drug use than heterosexuals (meth/amphetamines, cannabis, cocaine and ecstasy). Compared to heterosexual populations LGBTI people have high rates of tobacco use, are more likely to smoke daily and have a higher use of alcohol and alcohol consumption at risky levels.
- In general, there were no significant changes in prevalence of daily smoking or use of illegal drugs among Aboriginal and Torres Strait Islander Australians.
- Between 2010 and 2013 but there was a decline in the proportion of people 14 years and over exceeding the lifetime risk guidelines for alcohol.
- Women reporting drinking alcohol during pregnancy declined in the period 2010 to 2013.

National data are in development on emerging drug use trends, particularly on use of NPSs and PIEDs.

Data on *drug related harms* hospitalisations, deaths and crime were drawn from national reports which only provide an indication of what is happening in Queensland. Nationally alcohol related hospitalisations have increased over time. The rate of AOD related crime in QLD per 100,000 population dropped by 11.2% from December 2010 (4,577) to December 2013 (4,064). The highest rate was for AOD related assault.

The Queensland rates of *drug treatment service use* (excluding private providers and public hospital treatment) is similar to that of Australia per 100,000 of the population. Importantly, the Queensland picture differs from that for Australia on three main ways:

- 1. Most common referral source the QLD clients were referred from police and court diversion at almost twice the national rate.
- **2. Type of treatment episode** the QLD rate of information and education only treatment was almost four times the national rate. A large proportion of diversion clients received information and education only.
- **3. Treatment episodes that closed due to treatment completion** the rate for QLD treatment episodes that closed due to 'ceased to participate at explainon' was almost four times the national rate
- 4. Counselling treatment episodes closed due to ceased to participate without notice 'Ceased to participate without notice' was the reason for treatment closure in a high proportion of QLD counselling treatment episodes relative to national level data.

In addition, Queensland had a rate higher than the national rate for treatment episodes delivered in 'outreach' and 'other' settings. Roundtable participants noted that these data suggest that a large proportion of treatment capacity is directed to diversion clientele, outreach and individual information and education sessions for which there may be poor evidence for effectiveness.



## Section 5 The drug service system in Queensland

In this section a snapshot of publicly available information on Queensland drug programs and services is provided. It includes partnership initiatives involving Queensland government departments and agencies, the non-government and private sector service providers and the Aboriginal Community Controlled Organisation sector. The alcohol, tobacco and other drugs services provided by a range of organisations and sectors in Queensland play a crucial role in reducing harms, supply and demand.

The alcohol tobacco and other drugs services provided by a range of organisations and sectors in Queensland play a crucial role in reducing drug harms, supply and demand.

## 5.1 Prevention and early intervention

The Queensland Government provides information about the locations of services through its online health service directory, by telephoning the Alcohol and Drug Information Service (ADIS) or 13 HEALTH. QFinder, a directory of Queensland health and community services, is also available on the Queensland Health website and can assist clients in searching for AOD services. The Queensland Network of Alcohol and Drug Agencies website also provides an AOD NGO service finder function. The rural and regional Australia website provides place-based information that will allow consumers, providers and planners, including Medicare Locals in regional Australia, to search for information about Commonwealth health programs and services.

Further information about alcohol and other drug issues policies, programs and services, both Queensland and Australia-wide, is available to the public via clearinghouses for drug information and services. Such clearinghouses include the Australian Indigenous Alcohol and Other Drugs Knowledge Centre (which provides information in categories which distinguish between "Indigenous", "general", and "possibility of indigenous content"), and DrugInfo.

National online and telephone support and information services are also available to Queensland clients, including Quitline, Counselling Online, Cannabis Information and Helpline, Family Drug Support, Kids Help Line, Lifeline and the Australian Drug Foundation's Drug Info website.

#### 5.2 Partnership approach to reducing drug harm supply and demand

The Safe Night Out Strategy, legislated in Queensland on 26 August, 2014, contains a number of provisions in a partnership approach aimed at reducing drug-fuelled violence and anti-social behaviour. It is modelled to some extent on a similar program in NSW. The Strategy is consistent with the NDS principle of harm minimisation, with specific provisions supporting the three harm minimisation principles of supply reduction, demand reduction and harm reduction, as outlined below. Some measures that have been included in the Strategy apply to the principles in combination.

#### Demand Reduction

Several provisions of the strategy are designed to reduce consumer demand for drugs and alcohol, and by extension aim to reduce drug- and alcohol related violence. Such provisions include the following:

- Culture change
- New penalties.

#### Harm Reduction

The various harm reduction measures outlined in the strategy make up the third core principle: "safe and supportive environments" (State of Queensland 2014). Such measures include the following:

• Safe Night Precincts



- User pays Sober Safe Centre
- Rest and recovery services
- High visibility rapid response policing in Safe Night Out Precincts
- ID Scanners (not yet implemented).

#### Supply Reduction

The Safe Night Out Strategy included a number of changes to the *Liquor Act 1992*, to ensure licensees are compliant and consistent in providing a safe environment for their patrons. With regards to reducing the supply of alcohol, the Queensland Government will amend the definition of "unduly intoxicated", so action can be taken against licensees whom provide alcohol to an intoxicated person, regardless of the cause of intoxication (State of Queensland 2014).

Other examples of supply reduction strategies that have been implemented in Queensland include the Alcohol Management Plans in some Aboriginal and Torres Strait Islander communities. Many of these include a combination of supply and harm reduction measures. Queensland Health regulates access to prescription pharmaceuticals such as opioid analgesics and community pharmacies have role in reducing the availability of S3 pseudoephedrine for diversion to the illegal production of meth/amphetamines.

## 5.3 Criminal justice system

#### Diversion to treatment

The criminal justice system provides a number of programs, including:

- The Drug and Alcohol Assessment Referral (DAAR) that is part of the Safe Night Out Strategy
- QIDDI (court diversion assessment and early intervention for first time offenders 12 years and over)
  - Police Diversion Program (drug assessment and education for adults cannabis only)
  - Queensland Illicit Drugs Court Diversion Program (drug assessment and education for adults).

The QIDDI Program provides assessment and education sessions (early brief intervention) to clients 12 years and over who are diverted/referred by the courts or police for minor illegal drug offences.

The Queensland Magistrates early Referral into Treatment (QMERIT) operates in Maroochydore and Redcliffe Magistrates Courts to engage defendants charged with illegal drug related offences with drug rehabilitation services as part of their conditions of bail. It combined structured treatment intervention opportunities and support services which aim to improve defendants' health and wellbeing and reduce their offending behaviour. It was in the process of being evaluated in 2011 (Queensland Government 2011).

The Queensland Indigenous Alcohol Diversion Program (QIADP) was a whole of government initiative involving Queensland Government departments and agencies including Queensland health, and Corrective Services. It was a pre-sentence bail-based court diversion program which commenced on 1 July 2007. The QPS was involved in the criminal justice stream of QIADP through its Specialist Courts and Diversion, Legal Services Branch. The program ceased in 2012. It was a voluntary treatment program for Aboriginal and Torres Strait Islander defendants charged with offences where alcohol was a factor, and Aboriginal and Torres Strait Islander parents involved in the child protection system who had an alcohol problem. The program was available in Cairns and Yarrabah, Townsville and Palm Island, and Rockhampton and Woorabinda. People were able to voluntarily withdraw or be terminated from the program. Factors identified during the assessment process which prevented clients from entering the program included mental health issues, other



addictions which outweighed any alcohol dependency and the commission of further and more serious offences before the person was endorsed into the program. The Queensland Police conducted and published a QIADP Recidivism Study in 2010. It found that QIADP had a number of positive elements, but had encountered implementation difficulties, including slow uptake (Queensland Police Service 2010).

## Drug programs and services in prisons<sup>25</sup>

The *Corrective Services Act 2006* makes it an offence for a prisoner to deal with or consume illegal drugs or prescription medication not prescribed to them. Prisoners are subject to drug testing on both a random and targeted basis. Prisoners who fail to provide a sample without a reasonable excuse will be deemed to have returned a positive test result which may be dealt with as a breach of discipline.

Each year, Queensland Corrective Services (QCS) conducts up to 10,000 random and targeted tests of prisoners in correctional centres and more than 20,000 urinalysis drug tests of offenders in the community.<sup>26</sup> Drug testing in the community is not conducted for all offenders and is dependent on order type, order conditions and identified risks. QCS uses instant testing technology, which gives an immediate indicative drug detection result. Indicative positive samples are forwarded to the Queensland Health Forensic and Scientific Services laboratory for confirmatory testing.

For prisoners entering custody, the Immediate Risk Needs Assessment (IRNA) identifies any risks or needs relating to a prisoner upon admission that require immediate action. In 2013-14, approximately 23% of adult prisoners who were admitted to Queensland custody identified an immediate substance use need during their initial assessment. This included the prisoner reporting that they had suffered withdrawal symptoms during the past week. The percentage was slightly higher for females (approx. 26%) than males (approx. 23%).

For offenders supervised in the community, an Immediate Risk Assessment (IRA) is used to provide a "snapshot" of immediate risk factors for the offender and details of any issues requiring immediate intervention. The IRA must be administered to all offenders at the first physical contact between the offender and the Probation and Parole District Office where possible. In 2013-14, approximately 8% of offenders were identified as having an immediate substance use issue during their initial assessment. This percentage was consistent for both males and females.

Additionally, for offenders supervised by Probation and Parole who have an eligible level of service, a Benchmark Assessment is completed which identifies an offender's risk factors, criminogenic and non-criminogenic needs and protective factors at the point of admission to the correctional episode. This assessment is generally completed within five weeks of admission to the episode. One factor assessed by the Benchmark is substance use. The substance use factor provides a holistic picture of the offender's history of drug, alcohol and/or other substance use, including age of commencement, methods of substance use and its impacts.

In 2013-14, nearly 60% of offenders (approx. 58% for women, 60% for men) who completed this assessment had scores that indicated they had a high level of risk and/or need on this factor. Summary scores are used to inform the offender's dynamic supervision and planning.

QCS offers a range of intervention programs which address specific behaviours such as violence, substance use and sexual offending. Intervention programs are delivered in correctional centres and at probation and parole offices. The programs are delivered consistent with sound, research based principles and offenders are assessed for their program suitability by trained staff.

<sup>&</sup>lt;sup>26</sup> Information on drug testing of prisoners and prisoner drug risk identification was provided by the Queensland Department of Corrective Services on 16 March 2015, specifically for this consultancy project.



<sup>&</sup>lt;sup>25</sup> Information on drug programs and services for Queensland prisoners was provided by the Queensland Department of Corrective Services on 16 March 2015, specifically for this consultancy project.

Substance related offending programs and services are delivered both in prison and in the community to address substance use problems and stop the cycle of reoffending. Intervention programs currently delivered or funded by QCS include:

- Pathways: High Intensity Substance Abuse Program: 126 Hours in Duration: Pathways is a High Intensity Substance Abuse Program using CBT to change antisocial thinking and behaviour associated with offending and substance abuse. The program targets cognitive, emotional and behavioural skills which are known to reduce future offending and substance abuse. (The program is custodial only and not delivered at Lotus Glen Correctional Centre.)
- Positive Futures: Anger, Violence and Substance Abuse Program: 36 hours: The Positive Futures Program is a culturally sensitive 'strength based program' targeting anger and violence, alcohol and drug abuse, power and control, jealousy, trust and fear, family and community and parenting. The program has been specifically developed for Aboriginal and Torres Strait Islander men. (This program is delivered in the community and in custody)
- *LISI: Low Intensity Substance Interventions*: 16 through 24 hours: The Low Intensity Substance Abuse Program is based on CBT and aimed at providing offenders the skills to manage their substance abuse. (Delivered in community and Custody)
- *SAMI: Substance Abuse Maintenance Intervention*: 16-24 hours: The SAMI is a substance abuse program designed to build on and strengthen offender's cognitive, emotional and behavioural skills linked to substance abuse. (Delivered in Community and Custody)

QCS also partners with a number of community agencies to break the cycle of addiction. Some services are contracted and others operate on a voluntary basis. AA partners with QCS to coordinate support groups within correctional centres across Queensland.

## 5.4 Treatment services

## Treatment services

The recently completed *Queensland Alcohol and Drug Treatment Service Delivery Framework* (2015) "...reflects a consensus across AOD treatment providers — both government and non-government — on common and accepted good practice." (MacBean *et al* 2015, p 2). The document identifies the AOD treatment sector in Queensland and sets out the key AOD treatment types delivered across the continuum from prevention and early intervention (harm has not yet occurred) through to intervention (harm has occurred) and maintenance/aftercare (mitigating further harm).

Treatment services are provided in local communities by Queensland Hospital and Health Services (public health Mental Health and Alcohol, Tobacco and Other Drug Services and public hospitals), non-government, Aboriginal Community Controlled Health Services and private organisations (e.g. general practice, addiction specialists).

Some agencies provide services across the spectrum needs, from prevention and early intervention (such as education and telephone/email advice lines), screening, assessment and treatment (such as case management, NSPs, rehabilitation and hospital detox) and maintenance/aftercare (such as peer support programs, supported housing and education) (MacBean *et al* 2015).

Specifically, services currently provided by the Queensland system include:

- standalone client advocacy
- information and education (individual or group)
- links to national online and telephone information and counselling (Counselling Online, Cannabis Information and Helpline, Quitline – 13 QUIT, Family Drug Support, Kids Help Line, Lifeline Drug info website)



- assessment only, brief intervention, intake and screening and consultation and liaison
- treatment planning and review
- pharmacotherapy (including nicotine or nicotine-receptor-agonists, opioid replacement therapy and treatment for alcohol dependence)
- detoxification (ambulatory/out-client/home-based or inpatient/residential withdrawal management and support)
- Residential withdrawal, rehabilitation centres including seven TCs and five Aboriginal and Torres Strait Islander community controlled residential rehabilitation centres)
- medical interventions (including blood-borne virus screening and hepatitis vaccination)
- NSPs (both primary and secondary levels of support)
- discharge planning and aftercare
- community support (including mentoring programs, peer support groups and therapeutic groups) (MacBean *et al* 2015, Queensland Government website updated 2015)

#### Outreach treatment models

As noted in the *Queensland Alcohol and Drug Treatment Framework* (2015), many drug treatment services utilise assertive outreach approaches. Outreach is not a treatment in and of itself, but a method for locating clients, providing information about treatment and support services, as follows:

- Assertive Street Work (looking in public spaces such as streets, malls, parks, etc. for individuals not currently in AOD treatment)
- Assertive Community Outreach (looking in health, social and accommodation services such as boarding houses, hospitals and Centrelink offices for individuals not currently in AOD treatment)
- Clinical Outreach (structured AOD work with clients in other service settings, such as community centres or hospitals)
- Detached/Mobile Outreach (structured AOD work the client's home, workplace or other agreed setting) (MacBean *et al* 2015).

#### Summary

Services are committed to working in partnership across sectors (health, education, courts, police corrections) to deliver the best possible outcomes for their clients in common with drug problems.

Important work in partnership across treatment service providers has fed into the development of a Queensland Framework - the recently finalised *Queensland Alcohol and Other Drug Treatment Service Delivery Framework* (MacBean *et al* 2015). It sets out the key AOD treatment types delivered across the continuum from prevention and early intervention (harm has not yet occurred) through to intervention (harm has occurred) and maintenance/aftercare (mitigating further harm).



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## Appendix 1 Possible services and workforce across a continuum of AOD interventions

Matrix developed by Siggins Miller for this Discussion Paper

SERVICE L	EVEL	SERVICE TYPE	SERVICE SETTING	WORKFORCE	POPULATION FOCUS
LEVEL 1	HARM REDUCTION	Needle and syringe program Brief intervention - information and education	Needle and syringe centre Community based health centre Health, welfare and homelessness service Youth service Aboriginal Medical Service Schools Community events	Health education officer Community development officer Welfare / youth worker Drug and alcohol worker / counsellor Aboriginal health worker	Individuals, families and communities Pre and contemplative, experimental and regular drug use Injecting drug use
LEVEL 2	HEALTH PROMOTION AND HARM PREVENTION	Health promotion and prevention - information and education / community development	Specialist drug and alcohol service – out-client Community based health centre Health, welfare and homelessness service Youth service Aboriginal Medical Service Schools Community events Social media	Drug and alcohol specialist knowledge and skills required. Health education officer Community development officer Welfare / youth worker Drug and alcohol worker / counsellor Aboriginal health worker	As above + Problematic drug use. At risk individuals and groups
LEVEL 3	TREATMENT	Case management Psychosocial counselling Withdrawal management Rehabilitation day program Residential rehabilitation Opioid treatment program	Specialist drug and alcohol service: - Out-client - Out-reach - Residential detox - Residential	Drug and alcohol specialist knowledge and skills required. Drug and alcohol worker / counsellor Aboriginal health worker Mental health worker / counsellor Psychologist Social Worker Nurse General / medical practitioner	Individuals and families. Problematic or dependent drug use. At risk individuals and groups
LEVEL 4	TREATMENT +	As above + Specialist programs, including: - Residential family - Residential women with dependent children - Indigenous - Residential pharmacotherapy stabilisation or reduction	As above	As above	As above + High complex health and social needs: - Women and parents with children - Coexisting mental health issues - Cognitive impairment - Acute physical health issues - Criminal justice connection - Trauma histories
LEVEL 5	EXTENDED AND CONTINUING CARE	Case management Psychosocial counselling Supported living / transitional housing program	Specialist drug and alcohol service – out-client and out-reach Supported living / transitional housing	Drug and alcohol specialist knowledge and skills required. Drug and alcohol worker / counsellor Aboriginal health worker Mental health worker / counsellor Psychologist Social Worker	Individuals and families Problematic or dependent drug use At risk individuals and groups



#### Appendix 2 Nature and limitations of the data

Where Queensland and national data are available within the same data set we present both. All data sets contain caveats to do with under-reporting which is known to be a feature of self-report survey methods such as those used in the NDSHS and the *Overcoming Indigenous Disadvantage Productivity Commission 2014 Report* (SCRGSP 2014).

If no data were available from the reports on the major drugs data sets, an alternative data source was used if available.

Data from the *Overcoming Indigenous Disadvantage Productivity Commission 2014 Report* (SCRGSP 2014) are presented for tobacco, alcohol and other substance use. These data were gathered using a self-report survey method. "The three yearly NDSHS has a small Indigenous Australians sample (461 respondents in the 2013 survey), and is not designed to make robust comparisons between Indigenous and non-Indigenous Australians" (SCRGSP 2014 p 2888). As such it provides only a broad impression of Indigenous drug use. (King *et al* 2014). The AIHW is working on improving Aboriginal and Torres Strait Islander Australian coverage in this survey.

Daily and yearly rates are available for alcohol consumption and tobacco smoking. Yearly rates are available for other drug use. The NDSHS data parameters for alcohol are based on the National Alcohol Guidelines (2009), regarding number of drinks recommended for men and women, lifetime and single occasion risk. Survey items for tobacco and alcohol include questions on yearly and daily use. The NDSHS provides data on the prevalence of alcohol consumption during pregnancy (AIHW, 2014a). However, no data are available on advice given to pregnant women with regards to alcohol consumption, or where pregnant women obtain information on alcohol consumption during pregnancy (AIHW, 2014c). Items for illegal drugs do not ask about yearly use. Data on meth/amphetamines includes all types and forms. Some data for specific population groups for specific illegal drugs were available. No data were available on Aboriginal and Torres Strait Islander use of cocaine. In addition, data on meth/amphetamines includes all types and forms.

The Overcoming Indigenous Disadvantage Productivity Commission 2014 Report national level analyses of data from a number of sources including data from 2012-13 for people 18 years and over, and combined data (NSW, QLD, WA, SA and NT only) on AOD. These analyses detail levels and types of harms associated with AOD use (e.g. drug related hospitalisation rates, death rates including overdose deaths, and accidents and homicides from the unpublished AIHW hospital morbidity data base and the unpublished ABS Causes of Death Australia, Cat. No. 3303.0) (SCRGSP 2014).

QPS drug related crime data were provided specifically for this Discussion Paper. They were analysed and used to indicate the extent of drug related harm. The Project Reference Group advised that many crimes and injuries resulting from alcohol and illicit drug intoxication are not reported to police, and the majority of those who are injured as a consequence of alcohol and/or illicit drug use do not seek medical attention .

The AODTS-NMDS 2012-13 (AIHW 2015), the QLD drug treatment use data can be compared with national data. Using the AODTS-NMDS data and ABS data on population for QLD and Australia in 2013, the number of treatment episodes per 100,000 of population is compared and summarised later in this section.

Not all treatment agencies submitted data to the AODTS-NMDS. All 133 specialist drug treatment agencies in QLD in 2012-13 were publically funded or funded by a combination of government funding, user pays and donations (56 government agencies and 77 NGOs). Of the 133 agencies in QLD, 121 submitted data to the 2012-13 AODTS NMDS collection (AIHW 2014). The data do not include AOD specific episodes of care delivered in public hospital settings or the private sector (e.g. by addiction or mental health specialists and general practitioners).



These service use data can be used as a proxy measure for treatment seeking and service demand (Roxburgh *et al* 2013). However, it is important to keep in mind that service use data may underestimate actual service demand because geographic, economic and cultural barriers; stigma and discrimination; and service availability constraints may prevent some people from accessing the services they require.



## Appendix 3 Trends in public opinion and perceptions of drug use and harms 2007 – 2013

Source NDSHS 2007, 2010, 2013

Year	NDSHS results		
NDSHS item: Drugs perceived to be associated with a Drug Problem			
2007	Heroin (30.3% of respondents; 29.7% male, 30.9% female)		
	Cannabis (25.2% of respondents; 25.8% male, 24.6% female)		
	Meth/amphetamines (16.4% of respondents)		
2010	Heroin (31% of respondents; 30.7% males; 31.4% females)		
	Cannabis (23.9% of respondents; 23.9% males; 23.9% females)		
	Meth/amphetamine (16% of respondents)		
2013	Heroin (26%; no sex data available)		
	Cannabis (approx 23%; no sex data available)		
	Meth/amphetamines (22% of respondents)		
Trends	<ul> <li>In 2013 <i>fewer</i> people (26%) perceived that heroin was the drug most likely to be related to a drug problem compared to 2010 (31%).</li> <li>However, heroin is still the drug most commonly perceived to be associated with a drug problem</li> </ul>		
	• The perception of cannabis has remained <i>stable</i> .		
	<ul> <li>In 2013 more people (22%) perceived that meth/amphetamine was the drug most likely to be related to a drug problem compared to 2010 (16%).</li> </ul>		
	<ul> <li>Males and females had similar in their perceptions.</li> </ul>		
	• Aboriginal and Torres Strait Islander Australians viewed Marijuana as most associated with a 'drug problem' whereas non-indigenous Australians viewed Heroin as the drug most associated with a 'drug problem.'		
NDSHS item: Form of Drug use perceived to be most serious concern for the general community			
2007	Excessive alcohol consumption (32.3% of respondents; 30.5% males, 34.0% females)		
	Tobacco smoking (17.2% of respondents; 18.2% males, 16.3% females)		
	Meth/amphetamines (16.4% of respondents; 17.2% males, 15.7% females)		
	Heroin (10.5% of respondents; 10.8% males, 10.5% females)		
2010	Excessive alcohol consumption (42.1% of respondents; 39.6% males, 44.5% females)		



Year	NDSHS results			
	Tobacco smoking (15.4% of respondents; 16.7% males, 14.2% females)			
	Meth/amphetamines (9.4% of respondents; no sex data available)			
	Heroin (11.4% of respondents; no sex data available)			
2013	Excessive alcohol consumption (43% of respondents; 41% males; 44% females)			
	Tobacco smoking (15% of respondents; 16% of males; 13% females)			
	Meth/amphetamines (17% of respondents; no sex data available)			
	Heroin (11% of respondents; no sex data available)			
Trends	• Excessive alcohol consumption was perceived as the most serious concern for the general community. The proportion of people who perceived that excessive alcohol was a concern for the community increased in the period 2007-2013. Excessive alcohol consumption remained as the most serious concern in all three NDSHS reports.			
	<ul> <li>Excessive alconol consumption was viewed as the most serious concern for the community by both Aboriginal and Torres Strait Islander Australians and non-indigenous Australians.</li> </ul>			
	• More females than males perceived that excessive alcohol consumption was a serious concern for the community.			
	<ul> <li>In 2013 fewer people (15%) perceived that tobacco smoking was a serious concern for the general community compared to 2007 (17.2%) and 2010 (15.4%).</li> </ul>			
	More males than females perceived that tobacco smoking was a serious concern for the community.			
	• The proportion of people who perceived meth/amphetamines to be a serious concern for the general community <i>increased</i> from 2010 (9.4%) to 2013 (17%).			
	• The proportion of respondents who perceived heroin to be the drug of most serious concern for general community remained <i>stable</i> between 2007 and 2013.			
NDSHS item: Drug	s perceived to be associated with mortality (death)			
2007	Tobacco (40.6% of respondents; 40.6% male. 37.4% female)			
	Alcohol (29.4% of respondents; 29.4% male, 29.3% female)			
	Opiates/opioids such as heroin (9% of respondents; 9.8% male, 10.7% female)			
	Meth/amphetamines (5.3% of respondents; 4.8% males; 5.7% females)			
2010	Tobacco (35.9% of respondents; 38.4% males, 33.4% females)			
	Alcohol (29.56% of respondents; 29.3% males, 29.8% females)			



Year	NDSHS results
	Heroin (15.7% of respondents; 15.1% males, 16.3% females)
	Meth/amphetamines (4.6% of respondents; 4.6% males, 4.6% females)
2013	Tobacco (32% of respondents; 35% males, 29% females)
	Alcohol (34% of respondents; no sex data available)
	Heroin (14.1% of respondents; no sex data available)
	Meth/amphetamines (8.7% of respondents; no sex data available)
Trends	• In 2013 fewer people (32%) perceived that tobacco was associated with mortality compared to 2007 (40.6%) and 2010 (35.9%).
	Males associated tobacco with mortality more than females did.
	• In 2013 more people perceived alcohol to be associated with mortality compared to tobacco which was the opposite of the results in
	2007 and 2010.
	• More people perceived meth/amphetamines to be associated with mortality in 2013 compared to 2007 and 2010.
	Females associated heroin with mortality more than males did.

