

August 2015

REDUCING ALCOHOL AND OTHER DRUG IMPACTS IN QUEENSLAND

Discussion Paper



Purpose

This discussion paper seeks the views of Queenslanders and key stakeholders on actions to be taken as part of the whole-of-government *Queensland Alcohol and Other Drug Action Plan 2015–2017* (the Action Plan). It outlines the themes arising from consultations held to date and evidence about what works to prevent and reduce the adverse impact of alcohol and other drugs on the health and wellbeing of Queenslanders.

About the Action Plan

Queensland has committed to implementing actions to prevent and reduce the adverse impacts of alcohol and drugs on the health and wellbeing of Queenslanders through the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* (the Strategic Plan).

The Queensland Mental Health Commission (the Commission) is leading this work and is partnering with government, non-government agencies, people who have experience of problems related to alcohol and drug use, their families and support people to develop the Action Plan. The Action Plan aims to prevent and reduce the adverse impact of drugs and alcohol on the health and wellbeing of Queenslanders.

The Action Plan will support the Strategic Plan's six outcomes:

1. A population with good mental health and wellbeing
2. Reduced stigma and discrimination
3. Reduced avoidable harm
4. People living with mental health difficulties or issues related to substance use have lives with purpose
5. People living with mental illness and substance use disorders have better physical and oral health and live longer

6. People living with mental illness and substance use disorders have positive experiences of their support, care and treatment.

This Action Plan supports other initiatives taken to implement the Strategic Plan including:

- actions to improve consumer, family and carer engagement and leadership
- the Queensland Suicide Prevention Action Plan
- the Queensland Mental Health Awareness, Prevention and Early Intervention Action Plan
- a new mental health, drug and alcohol services plan
- the Queensland Rural and Remote Mental Health and Wellbeing Action Plan, and
- the Queensland Aboriginal and Torres Strait Islander Action Plan.

The Action Plan will align with the National Drug Strategyⁱ and reflect its overarching policy approach of harm minimisation. The National Drug Strategy is currently being reviewed by the Australian Government in partnership with States and Territories.

The Action Plan will initially be in place for 18 months although actions may be implemented over a longer period. To ensure continual improvement, the Action Plan will be reviewed and updated by the Commission in consultation with a broad range of stakeholders after 12 months. This will provide the Action Plan with the flexibility to adjust to new or emerging issues and take into account progress being made.

The Action Plan will be publicly released later in 2015.



Developing the Action Plan so far

In early 2015 the Commission engaged Siggins Miller consultants to prepare two evidence-based papers and facilitate a Roundtable held on 12 May 2015 with key stakeholders including service providers and service users to inform the development of the Action Plan. Copies of the research papers and the roundtable communicate are available on the Commission's website.

The key themes from this work are outlined throughout this discussion paper and include the need to ensure:

1. **Do no harm** — Alcohol and drug planning, policy, programs and service delivery should 'do no harm' to clients, their families and support persons. Actions should enhance individual and community life; and support individual, significant others and communities to achieve their goals. Approaches should seek to minimise the health and social harms caused by problematic substance use.
2. **A balanced approach** — A balanced approach to investment is needed across the harm minimisation approach i.e. harm reduction, supply reduction and demand reduction actions.
3. **Supports other government priorities** — Harm minimisation approaches will support the Queensland Government to address other social policy areas such as child protection, domestic and family violence and homelessness.

A Project Reference Group was established by the Commission to oversee the Action Plan's development and comprised of representatives from the Queensland Mental Health and Drug Advisory Council; the Queensland Network of Alcohol and Other Drugs Agencies; Dovetail; the Queensland Injectors Health Network; the Queensland Indigenous Substance Misuse Council, Queensland Aboriginal and Torres Strait Islander Health Council; the Department of Health; the Gold Coast Hospital and Health Service; the Queensland Police Service; the Public Safety Business Agency; the Department of Education and Training; the Department of Communities, Child Safety and Disability Services; and the Department of Justice and Attorney-General.

Continuing the Action Plan's development

The Commission is continuing consultation with alcohol and drug service users and service providers, government and non-government agencies and the broader community during August and September 2015.

This includes consultations in regional Queensland to be jointly led by the Commission and the Queensland Network of Alcohol and other Drugs Agencies (QNADA) to seek the views of front line service providers, service users, their families and support persons.

Share your views and experiences

You are invited to consider the questions outlined below and provide feedback to aodactionplan@qmhc.qld.gov.au by 30 September 2015.

All feedback will be considered and inform the development of the final Action Plan.

Overarching questions

1. What priorities should the Action Plan address?
2. What actions are currently being taken that would support preventing and reducing the adverse impact of drugs and alcohol and how might they be improved?
3. What other actions should be taken?

Demand reduction

4. What improvements could be made on the current mix of demand reduction activities in Queensland?
5. What are some innovative ways that prevention and early intervention activities can be promoted and access improved?
6. Are there any examples of good practice in demand reduction?

Supply reduction

7. Are there improvements that could be made on the current supply reduction activities in Queensland?
8. Are there any examples of good practice in supply reduction?

Harm reduction

9. Are there improvements that could be made to harm reduction strategies in Queensland?
10. Are there any examples of good practice in harm reduction that you can identify in Queensland and elsewhere?

Vulnerable population groups

11. How can people experiencing problematic alcohol and drug use be supported to participate in the

economy through education, training and employment and in the community?

12. What should be the main priorities to prevent and reduce the adverse impact of drugs and alcohol for groups who are at greater risk of alcohol and drug related harms including:

- people experiencing disadvantage such as unemployment and homelessness
- Aboriginal and Torres Strait Islander peoples
- people living in rural and remote communities
- children and young people
- pregnant and parenting women
- people living with co-occurring problematic drug use and mental health issues
- people from culturally and linguistically diverse backgrounds
- people in contact with the criminal justice and youth justice systems
- lesbian, gay, bisexual and transgender people.

Background

National approach to reducing drug related harm

The *National Drug Strategy 2010–2015* (the National Strategy) provides a national framework for action to minimise the harms to individuals, families and communities from alcohol, tobacco and other drugs. It sets out a nationally agreed harm minimisation approach to reducing the harmful effects of licit and illicit drugs in Australia. The strategy aims to improve health, social and economic outcomes for Australians by preventing harmful alcohol and other drug use and reducing their harms on society. The current Strategy is under review.

The National Strategy included the *National Drug Strategy Aboriginal and Torres Strait Islander People's Complementary Action Plan 2003–2009* which, despite having lapsed, continues to provide a relevant framework to guide nationally coordinated and integrated approaches to reducing drug-related harm among Aboriginal and Torres Strait Islander peoples.

Implementation of the National Strategy will be primarily through Australian and State Government policies and programs under the three pillars of harm minimisation.

The pillars of harm minimisation²

Demand reduction: refers to strategies and actions which prevent the uptake of alcohol and other drugs use and/or delay the onset of use; reduce misuse; and support people to recover from dependence and reintegrate with the community.

Harm reduction: refers to strategies and actions that reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

Supply reduction: refers to strategies and actions 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.

Importantly the three 'pillars' do not operate independently and apply to all drug types.

What do we mean by the term 'drug'?

The Action Plan and this discussion paper adopts the definition of 'drug' used in the National Strategy. The term 'drug' means more than an illegal substance and includes alcohol and prescription medication as follows:

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.

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

Pharmaceutical drug: A drug that is available from a pharmacy, over-the-counter or by prescription, which may be subject to misuse — 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 chemical or herbal products that have emerged to mimic the effects of illegal or legal drugs.

What is the current level of drug use in Queensland?

The *National Drug Strategy Household Survey* (the 2013 Household Survey)³ is conducted triennially and provides

information about drug use and patterns of use over time nationally and on a State by State basis. Overall, alcohol consumption had the highest prevalence followed by tobacco smoking and cannabis use in both Queensland and Australia. Other forms of illicit drug use have been decreasing or remained stable.

The 2013 Household Survey report indicates that people aged 14 years and over reported that in the previous 12 months:

Alcohol use

- Alcohol was the most widely used drug in Australia and in Queensland
- More Queenslanders drink alcohol than the national average, with 80.4 per cent of Queenslanders consuming alcohol compared to 78.2 per cent nationally
- More Queenslanders also drink alcohol on a daily basis with 7.4 per cent indicating they drank daily compared to 6.5 per cent nationally
- A recent decline in young people consuming alcohol.

Tobacco

- Although there has been a decrease in smoking uptake in the last 10 years, 15 per cent of Queenslanders smoke tobacco daily.

Illicit drug use

- The proportion of people in Australia having used any illicit drug has remained relatively stable over the last decade with 15 per cent of Australians reporting use of at least one illicit drug.
- Queensland's level of illicit drug use is similar to the national average with 15.5 per cent of Queenslanders having used at least one illicit drug.
- Eleven per cent of Queenslanders have used cannabis compared to 10.2 per cent nationally. Cannabis use has declined significantly over the past 10 years both in Queensland and across Australia.
- There was no increase in meth/amphetamine use in 2013 (from 2010) with use levels remaining stable at around 2.3 per cent in Queensland compared to 2 per cent nationally.
- The type of meth/amphetamines used has changed among meth/amphetamine users. The use of powder fell between 2010 and 2013 from 41.6 per cent in Queensland (50 per cent nationally) to 21.2 per cent in Queensland (29 per cent nationally).

- The use of crystal methamphetamine (ice), as opposed to other forms of meth/amphetamines, more than doubled amongst current meth/amphetamine users, from 22 per cent to 50 per cent (19.9 per cent to 45.5 per cent in Queensland) over the same period.
- The use of ecstasy, heroin and GHB has been decreasing nationally.

Pharmaceuticals

- Nationally, the misuse of pharmaceuticals has increased from 4.2 per cent to 4.7 per cent.

Other drugs

- Nationally, 1.2 per cent had used synthetic cannabis.

What are some of the harms?

Alcohol and other drug use affect individuals, families and communities. Harms vary according to the substance used and the degree and frequency of use. For example while a small number of Queenslanders use drugs such as crystal methamphetamine ('ice'), the impact and harms can be significant.

The harms broadly include harm to physical and mental health and wellbeing, and social, family and community harms.

Physical and mental health

Problematic drug use can impact a person's physical wellbeing through illness, injury and in some cases lead to early death. For some people, problematic drug use can lead to mental illness. It also impacts on broader mental health and wellbeing; that is, a person's ability to cope with the stresses of life and realise their full potential.

Each year, around 4,300 Queenslanders die and more than 65,000 are admitted to hospitals where alcohol, tobacco and other drug use is involved⁴.

Suicide is complex and multiple factors contribute to a person taking their own life. Harmful use of alcohol and drugs has been recognised as a risk factor. In Queensland:

- problematic alcohol use was reported in 18.3 per cent of all suicide cases without significant difference by gender
- over one quarter (27.2 per cent) of people who died by suicide were reported to have had some pattern of illicit drug use (including occasional and past users); and this was significantly more frequent in males than females

- problematic alcohol use was more frequent in the age group 25–64 years and illicit drug use declined with age⁵.

Tobacco and alcohol are the drugs responsible for the most harm to individuals, families and communities⁶. Alcohol has a significant role in Australian society with the majority of Australians and Queenslanders reporting that they drink alcohol. Many do so at levels that have few harmful effects. However there are a substantial number of people who drink at levels that increase the risk of short and/or long term harm.

To provide guidance on safe levels of alcohol use, the Australian Government, through the National Health and Medical Research Council, has issued *Australian Guidelines to reduce health risks from drinking* (the guidelines)⁷. The guidelines indicate that drinking no more than two standard drinks on any day reduces the life-time risk of harm from alcohol-related disease or injury. More than this amount is considered to be 'life time risky drinking'. Drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion. Drinking more than this amount is considered to be 'single occasion risky drinking'.

In Queensland in 2013:

- An estimated 20.2 per cent of Queenslanders aged 14 years and over drank at life time risky drinking levels. This has reduced since 2010⁸
- 40.6 per cent of Queenslanders aged 14 years and over drank at risky levels on single occasions compared to 37.8 per cent nationally⁹
- The underlying cause of death from mental and behavioural disorders associated with psychoactive substance use were mainly attributed to alcohol (53 out of 61 persons)
- 214 people in Queensland died from alcoholic liver disease (159 males, 55 females) and accidental poisoning by exposure to alcohol and resulted in 17 deaths¹⁰.

The health risks associated with tobacco smoking are well known and accepted including increased risk of cancers, respiratory disease and heart disease. Smoking is recognised by Queensland's Chief Health Officer as one of the greatest risk factors on health outcomes and is a leading cause of preventable death¹¹.

- Smoking accounts for one in seven deaths in Queensland with 3,700 Queenslanders dying annually from tobacco-related conditions¹².

- Two-thirds of deaths in current smokers can be directly attributed to smoking¹³
- In 2013 emphysema was the cause of death for 137 Queenslanders¹⁴.

Other harms from alcohol and other drugs include overdose. The Queensland Illicit Drug Reporting System (IDRS) study in 2014 indicates that between 2009–10 and 2012–13 Queensland ambulance officers reported an increasing number of overdose cases from 8,376 in 2009–10 to 9,616 in 2012–13. In just under half of these calls ambulance officers reported alcohol as being the primary drug with 4,151 calls relating to alcohol in 2012–13. Other medications accounted for 1,026 with antidepressants at 720 calls. Amphetamines (282), cannabis (251), heroin (217) accounted for far fewer callouts¹⁵.

Harm associated from other drugs also includes higher risks of developing physical illness and mental health problems. For example unsafe injecting drug use is a major driver of the transmission of blood-borne viruses such as hepatitis C and HIV.

The emergence of novel or new psychoactive substances presents a significant challenge for treatment services and law enforcement agencies. New synthetic and herbal products are broadly covered under the *Drugs Misuse Act 1986* definition of a dangerous drug listed in section 4 of the Act. Any substance that is substantially chemically similar, has a substantially similar psychoactive effect or intends to 'mimic' other legal or dangerous drugs is an illegal drug in Queensland.

The physical and psychological effects of these new substances are largely unknown and unpredictable. The lack of research on their effects, and the unprecedented rate of drug development contribute to heightened level of potential harm.

Social and community harms

There is also a range of social and community harms associated with problematic drug use including victimisation and violence, criminal behaviour, anti-social behaviour, stigma and discrimination, unemployment and involvement in the child protection and criminal justice systems.

For families harm can include family breakdown, domestic and family violence, child abuse and neglect, and housing issues. For example the analysis undertaken by the Department of Child Safety in 2007 and reported in the *Taking Responsibility: A Roadmap for Queensland Child Protection*¹⁶ found that 47 per cent of all

substantiated child protection notifications involve one or both parents experiencing a current drug and/or alcohol problem.

Alcohol and drug problems are linked to family and domestic violence. However, as noted by the *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* report, alcohol and drug use is not a primary factor in predicting future violence and only becomes a significant aggravating factor when it exists with other causes such as social norms about violence¹⁷.

Alcohol was found to be a major contributor to 'king-hit' deaths in Australia with 24 people dying in Queensland between 2000 and 2012. Alcohol intoxication can also lead to increased vulnerability to violence.

More broadly for the community there are costs associated with lost productivity, justice system administration (for example police, courts, community corrections and prisons, and victim support services), road accidents, hospital and health expenses associated with alcohol and drug-related hospital presentations. For detailed discussion about drug related harms including burden of disease data see the background paper prepared by Siggins Miller *Discussion paper to inform the development of a statewide Alcohol and Other Drug Action Plan* available on the Commission's website at www.qmhc.qld.gov.au.

The levels of harm related to the use of specific drugs are not always proportionate to the levels of prevalence. For example heroin use has remained relatively low over the last decade, at less than one per cent of the population; however the risks associated with its use are high.

Methamphetamine (including 'ice') is used by a relatively small proportion of the population (around 2 per cent) however overuse can cause psychosis with some people exhibiting aggressive and violent behaviour. These behaviours can have dramatic impacts on the individual, families and the broader public.

Poly-drug use (concurrent use of more than one type of drug) can increase the risk of harm. Nationally in treatment episodes 54 per cent of clients reported more than one drug of concern. Nicotine and cannabis were the most common additional drugs of concern¹⁸.

Many people who experience problematic drug use access a wide range of services including health services and are significantly represented in the criminal justice and child protection systems. The Australian Institute of

Criminology indicated that a conservative estimate of the cost of alcohol misuse alone is \$14.352 billion nationally. This includes costs to the health system, the criminal justice system, lost productivity and costs relating to alcohol-related road accidents¹⁹.

Stigma and discrimination

Problematic drug use is associated with social isolation and experiences of stigma and discrimination. The World Health Organisation indicates that illicit drug dependence is the most stigmatised health condition in the world and dependence on alcohol is ranked as the fourth most stigmatised condition²⁰. Stigma and discrimination create barriers to people seeking help in the form of effective interventions to reduce harm. This in turn can lead to poor mental health and social outcomes. Injecting drug users are particularly vulnerable to stigma and discrimination.

Questions for consideration

What priorities should the Action Plan address?

What actions are currently being taken that would support preventing and reducing the adverse impact of drugs and alcohol and how might they be improved?

What other actions should be taken?

Groups experiencing higher levels of harm

Some Queenslanders experience higher levels of alcohol and drug use and associated harms, requiring tailored approaches and responses. The following section highlights some of the key population groups requiring specific attention.

Disadvantaged Queenslanders broadly

The National Strategy notes that problematic use of alcohol and other drugs can contribute to and reinforce social disadvantage experienced by individuals, families and communities. There is strong evidence of an association between social determinants such as unemployment, homelessness, family breakdown and drug use.

Unemployment is a major risk factor for problematic drug use and the development of substance-use disorders. Problematic drug use can reduce a person's employment prospects, both by reducing productivity and by decreasing the chance of getting and keeping a job²¹.

According to the 2013 Household Survey unemployed people are:

- 1.7 times more likely to have smoke daily
- 1.6 times more likely to have used cannabis
- 2.4 times more likely to have used meth/amphetamines
- 1.8 times more likely to have used ecstasy
- 1.6 times more likely to have misused pharmaceuticals
- 1.4 times more likely to have used cocaine.

Aboriginal and Torres Strait Islander peoples

Problematic alcohol and drug use has a very significant impact on life outcomes for Aboriginal and Torres Strait Islander people and is a significant factor in reduced life expectancy.

According to the *Overcoming Indigenous Disadvantage: Key Indicators 2014* report, tobacco is the leading risk factor contributing to disease and death in Aboriginal and Torres Strait Islander communities. While there has been a marked decrease in the proportion of Aboriginal and Torres Strait Islander people who smoke daily from 51 per cent to 44 per cent between 2001 and 2012–13, the current level of smoking is significantly greater than for non-Indigenous people.

While more Indigenous people abstain from drinking alcohol, with 23 per cent reporting not having consumed alcohol in the previous 12 months, rates of risky drinking are greater than for non-Indigenous adults. In 2012–13, 20 per cent reported exceeding lifetime alcohol risk guidelines, a similar proportion to that in 2004–2005. Over half (57 per cent) reported exceeding single occasion risk guidelines in the previous 12 months²².

The 2014 Report on Government Services reported that in 2012–13 the most common type of alcohol-related hospitalisation for Aboriginal and Torres Strait Islanders was for acute intoxication around 12 times the rate for non-Indigenous Australians²³.

According to self-reported substance use by Aboriginal and Torres Strait Islander adults in 2012–13 around half (47 per cent) of adults living outside of remote areas reported having never used illicit drugs. Just under one quarter (23 per cent) of Aboriginal and Torres Strait Islander people reported having used an illicit drug in the preceding 12 months²⁴.

Rural and remote communities

According to the 2013 Household Survey people living in remote and very remote areas were two times more likely to smoke daily, drink alcohol in risky quantities and use meth/amphetamine in the previous 12 months than those living in major cities.

Lung cancer rates were also 1.3 times the rate than in major cities. The continuing high levels of tobacco smoking are likely to see this situation continue. Importantly there was no reduction nationally in the proportion of people who smoke daily in inner regional, outer regional and remote and very remote areas between 2010 and 2013.

Illicit drug use was also higher in remote and very remote communities however the type of drug used varied. For example, nationally cannabis was more commonly used by people living in outer regional (12 per cent) and remote and very remote communities (13.6 per cent) than people living in major cities. Similarly, people living in remote and very remote communities were twice as likely to have used meth/amphetamine as people in major cities (4.4 per cent compared to 2.1 per cent).

Cocaine and ecstasy was less likely to be used by people living in remote and very remote communities than in major cities²⁵.

Children and young people

Children and young people, including infants, are at greater risk of experiencing the health and social consequences of problematic alcohol and drug use. There is increasing evidence that early onset drinking during childhood and the teenage years can interrupt normal development of the brain.

The 2013 Household Survey indicates that fewer young people are taking up smoking with 95 per cent of people nationally aged between 12 and 17 having never smoked. In 2013, 3.4 per cent of teenagers smoked tobacco daily.

Young people are also abstaining from alcohol with the proportion of 12 to 17 year olds abstaining increasing between 2010 and 2013 from 64 per cent to 72 per cent. However people in their late teens and twenties are more likely to consume alcohol considered to be at a very high risk, that is 11 or more standard drinks on a single occasion with about one third reporting they had done so in the past year. Over half of all serious alcohol-related road injuries occur among those aged 15 to 24 years.

The Queensland Crime and Corruption Commission reports²⁶ a growth in the use of performance and image enhancing drugs such as steroids, human growth hormone, insulin and melanotan by younger people, particularly male adolescents who are motivated to use the substances by body image rather than sports performance enhancement.

Women and infants

Maternal alcohol consumption can harm the developing foetus or breastfeeding baby. It can cause low birth weight and a range of physical and neurodevelopmental problems including foetal alcohol spectrum disorders. Foetal Alcohol Spectrum Disorder (FASD) is a term used for a spectrum of conditions caused by foetal alcohol exposure. Each condition and its diagnosis is based on the presentation of characteristic features which are unique to the individual and may be physical, developmental and/ or neurobehavioural. High level or frequent consumption of alcohol during pregnancy increases the risk of miscarriage, still birth and premature birth. The Australian drinking guidelines recommend that it is safest not to drink during pregnancy. A 2010 study reported that approximately 20 per cent of Australian women fully abstained from alcohol during their pregnancy, 60 per cent consumed up to seven drinks in a week and 20 per cent were consuming more than that amount²⁷.

The 2013 Household survey reports that nationally 50 per cent of pregnant women consumed alcohol before they knew they were pregnant and 25 per cent continued to drink after they knew they were pregnant.

About 17 per cent of preterm births in Queensland were associated with smoking after 20 weeks gestation, combined with non-completion of recommended antenatal care visits. Indigenous Queenslanders infants were 1.7 times more likely to be born preterm than non-Indigenous infants, leading to greater risk of perinatal death²⁸.

People living with mental illness

People living with mental illness have higher rates of alcohol and drug use than other Queenslanders. The 2015 Report on Government Services indicates that in 2011–12 Queensland 25.7 per cent of people who live with mental or behavioural conditions were daily smokers compared to 15.8 per cent for other Queenslanders. It also indicated that 20.4 per cent were drinking alcohol at levels which represent a risk for long-term harm compared to 19.8 per cent of other Queenslanders²⁹.

These issues contribute significantly to the physical and oral health of people living with mental illness and contribute to reduced life expectancy.

People from culturally and linguistically diverse backgrounds

Data indicates that people from culturally and linguistically diverse backgrounds do not report high levels of drug and alcohol use. However, research also indicates that this may represent a significant under-representation. This may be due to negative cultural and religious attitudes to drug and alcohol use³⁰. It is important to note however that newly arrived migrants experience many of the risk factors associated with problematic alcohol and drug use, for example being disconnected from the broader community due to language and cultural differences. Refugees and asylum seekers are also likely to have experienced trauma³¹.

There is considerable evidence which suggests that different approaches are needed which adopt a more culturally appropriate approach. In 2015, the Queensland Network of Alcohol and other Drug Agencies published the *Helping asylum seeker and refugee background communities with problematic alcohol and other drug use: A guide for community support and AOD workers*. It was developed in partnership with the Ethnic Communities Council of Queensland, the Queensland Program of Assistance to Survivors of Torture and Trauma, the Multicultural Development Association and the Mater Integrated Refugee Health Services. The guide provides information:

- For workers supporting people from refugee background across the general health and community services sector who may not have specific training or experience in alcohol and other drugs service provision
- For those working in the alcohol and other drugs sector to support effective treatment³².

Prisoners

For prisoners entering custody, the Immediate Risk Needs Assessment (IRNA) identifies any risks or needs relating to a prisoner upon admission that requires immediate action. In 2013–14, approximately 23 per cent of adult prisoners who were admitted to Queensland custody identified an immediate substance use issue 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 (approximately 26 per cent) than males (approximately 23 per cent).

The Department of Justice and the Attorney-General reports that in excess of 50 per cent of released prisoners in Australia return to custody with re-offending strongly linked to drug and/or alcohol dependency and social disadvantage.

The 2012 *Health of Australia's Prisoners* report indicated 50 per cent of prisoners drank alcohol at risky levels prior to incarceration with three in five being Aboriginal and Torres Strait Islander people. Further, 70 per cent of prisoners used illicit substances prior to incarceration with the main drugs used being cannabis and methamphetamine. The report also indicated that 50–90 per cent of injecting drug users had been incarcerated, with 90 per cent sharing equipment in custody. Prisons are risky environments for the transmission of blood-borne viruses such as hepatitis C due to prisoner engagement in high risk activities such as sharing injecting equipment, unsafe sexual practices, tattooing, body piercing and barbering. There are currently no prison based needle and syringe programs in Australia.

In Queensland prisons, women can access opioid substitution treatment (OST) if they have been on the program prior to imprisonment. Pregnant women can commence treatment while in prison. There are currently two male centres where OST is being provided to a small number of prisoners.

After release from prison, relapse to risky alcohol and drug use is common and associated with poor outcomes including non-fatal overdoses, hospitalisation, return to custody and death.

Queensland Corrective Services provides a range of intervention programs delivered both in prison and in the community to address alcohol and drug use problems and stop the cycle of reoffending.

Lesbian, gay, bisexual and transgender people

Compared to heterosexual populations lesbian, gay, bisexual and transgender (LGBT) people have higher rates of tobacco and alcohol use, and are more likely to smoke daily and have a higher use of alcohol and consume alcohol at risky levels. They also report higher rates of illicit drug use (meth/amphetamines, cannabis, cocaine and ecstasy) than the general population³³. The Queensland Association for Healthy Communities reports that some of the major reasons LGBT people use alcohol, tobacco and other drugs include isolation, loneliness, homophobia, internalised homophobia, family rejection, violence and abuse³⁴.

Questions for consideration

How can people experiencing problematic alcohol and drug use be supported to participate in the economy through education, training and employment and in the community?

What should be the main priorities to prevent and reduce the adverse impact of drugs and alcohol for groups who are at greater risk of alcohol and drug related harms including:

- people experiencing disadvantage such as unemployment and homelessness
- Aboriginal and Torres Strait Islander peoples
- people living in rural and remote communities
- children and young people
- pregnant and parenting women
- people living with co-occurring problematic drug use and mental health issues
- people from culturally and linguistically diverse backgrounds
- people in contact with the criminal justice and youth justice systems
- lesbian, gay, bisexual and transgender people.

Priorities for Action

The Action Plan's priorities for action mirror the three pillars of harm minimisation and their objectives under the National Strategy. Current Queensland services and initiatives, levels of access and effectiveness, as well as areas for reform are outlined below.

Importantly those consulted at the Alcohol and Other Drug Roundtable held in May 2015 indicated that there was a need for:

- greater integration and collaboration between health services and with other areas of service delivery including child protection, education and employment services
- a flexible and responsive service system is needed to provide individualised care that considers individual need according to levels and type of drug and alcohol use
- a strengthened focus on awareness, early intervention and prevention activities, including

whole-of-population initiatives as well as those targeted to groups with greater or specific needs

- a focus on vulnerable groups
- improved transparency and accountability through improved and more consistent data collection.

Queensland’s alcohol and other drug treatment sector works across both demand and harm reduction. The sector’s mission statement highlights its role in harm reduction activities:

“The provision of effective, evidence-informed prevention, treatment and harm-reduction responses that build a Queensland community with the lowest possible levels of alcohol, tobacco and other drug related harm.”³⁵

Key treatment types work across a continuum from prevention and early intervention (harm has not yet occurred) to intervention (harm is occurring) to maintenance/aftercare (mitigating further harm). Services provide a range of supports and interventions such as needle and syringe programs, sobering up spaces, information and emergency medical services at events, brief interventions and other forms of treatment.

Outlined below is the approach taken under three priority areas which seek to build on evidence-based practice and services, while improving the system by focusing on better integration; tailored approaches for vulnerable groups; and improved transparency and accountability.

1

Demand reduction

The National Strategy defines demand reduction as strategies aimed to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the problematic use of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate into the community. It includes three objectives under this pillar which will inform the Action Plan’s actions:

- Prevention the uptake and delay use of alcohol, tobacco and other drugs
- Reducing the use of drugs in the community
- Support people to recover from dependence and reconnect with the community.

Preventing the uptake and delay use of alcohol, tobacco and other drugs

Central to preventing the uptake and delaying drug use is providing information and education and raising community awareness. Prevention is widely accepted as being more cost-effective than treating problematic drug use related problems. It can reduce future harms and represent a significant cost saving to government not only in health costs but also reduce demand on other government services such as the child protection and criminal justice systems.

Participants at the Roundtable strongly supported strengthening the focus in Queensland on awareness, prevention and early intervention. They indicated that whole-of-community evidence-based awareness-raising activities are needed with key messages about alcohol and drug use and harms, reducing stigma and promoting the availability of treatment services.

There was agreement that different approaches and strategies are needed for people of different ages, backgrounds and geographical locations.

Reducing the use of drugs

Treatment services are provided in local communities by Hospital and Health Services, the non-government sector³⁶, Aboriginal Community Controlled Health Services and the private sector including General Practitioners who work to reduce problematic alcohol and drug use.

In Queensland, 141 publicly funded alcohol and other drug treatment agencies provided 36,093 treatment episodes in 2013–14 to an estimated 29,207 clients. This has doubled over the 10 years from 2003–04. The location of these services are: 65 in major cities; 30 in inner regional communities; 30 in outer regional communities; eight in remote and nine in very remote communities.

Alcohol is the most common drug people are seeking treatment for however treatment for use of amphetamines is increasing.

The Australian Institute of Health and Welfare reports that nearly all (97 per cent) clients in Queensland in 2013–14 were receiving treatment for their own drug use and most (70 per cent) were male. The reverse was true for clients receiving treatment for someone else’s drug use (70 per cent were for females). In Queensland in 2013–14, just over one in seven clients were Indigenous Australians (15 per cent). These results are consistent with the national picture.

Drug	2003-04	2013-14
Alcohol	4,716	13,188
Cannabis	7,079	11,796
Amphetamines	1,844	4,362
Nicotine	795	1,065
Heroin	1,367	1,198

Table 1 – Closed episodes provided for own drug use by principal drug of concern, Queensland 2003–04 to 2013–14³⁷

The Queensland rate of drug treatment service utilisation (excluding private providers and public hospital treatment) is similar to that of Australia per 100,000 of the population. However some significant differences are apparent. Data indicates:

- A high proportion of referrals to drug interventions are from criminal justice diversion initiatives
- The proportion of ‘information and education only’ sessions delivered is almost four times the national average
- Compared to the national rate Queensland has high rates of people recorded as not completing treatment.

High proportion of referrals to drug interventions are from diversion initiatives

The most common source of referrals in Queensland is by ‘self or family’ referrals, however this pathway is below the national rate. Notably there are a significantly higher proportion of clients referred to drug interventions from criminal justice diversions compared to national rates. See Table 2.

This data and participants at the Roundtable indicated that the criminal justice system, through police and court diversion programs, is a significant entry point for people accessing alcohol and drug treatment services. While this is important and should be maintained, Roundtable participants suggested that other referral pathways and

Source of referral	Queensland (%)	Australia (%)
Self or family	34	41
Health service	22	24
Corrections	9	9
Diversion	30	17
Other	6	8

Table 2 – Referral source to treatment services in Queensland compared to Australia

entry points need to be strengthened and expanded, for example through the child protection and housing service systems.

Greater service integration (that is services working more closely together) was identified at the Roundtable as an area requiring attention. Improved collaboration between services will mean that fewer clients will fall through the gaps, and issues such as privacy will not act as a barrier to appropriate information sharing. This is particularly important for clients experiencing multiple issues and accessing services from multiple organisations.

The proportion of ‘information and education only’ sessions delivered is almost four times the national average

Counselling is the most common type of treatment being provided in Queensland which was consistent nationally. Importantly, the proportion of clients receiving ‘information and education only’ treatment in Queensland is almost four times the national level. As treatment provided to people diverted to services by police and the courts is recorded as ‘information and education only’ this may be reflective of the high number of people referred to treatment from police and court diversion programs in Queensland.

Type of treatment	Queensland (%)	Australia (%)
Counselling	33	41
Withdrawal management	10	16
Assessment only	16	18
Support and case management only	6	9
Rehabilitation	3	5
Information and education only	31	8
Other	2	3

Table 3 – Treatment types in Queensland compared to Australia

Treatment involves a two hour treatment session that includes assessments to determine dependence and risk-taking behaviours as well as the provision of advice and information on harm minimisation and provision of referrals.

Queensland is below the national level for withdrawal management, assessment only, support and case management only and rehabilitation.

Compared to the national rate Queensland has high rates of people not completing treatment

Statistics indicated that Queensland clients had lower rates of treatment completion compared to national rates. The Queensland rate of treatment episodes closed due to ‘ceased to participate at expiation’ was almost four times the national rate. This may reflect the high number of people diverted to treatment through police and court diversion programs.

Reason for cessation	Queensland (%)	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 4 – Reason for treatment cessation in Queensland compared to Australia

**Diversion sessions for police and court diversion are closed as ‘ceased to participate at expiation’*

Supporting people to recover from dependence and reconnect with the community

In 2015, a network of representatives of government and non-government drug treatment agencies in Queensland circulated a *Queensland Alcohol and other Drug Treatment Service Delivery Framework*³⁸. It proposes 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.

Evidence suggests that continuing care is effective in supporting people to recover. This involves providing a full continuum of care and supporting people through transition points for example between agencies as well as types of treatment services such as detoxification and rehabilitation services.

Importantly, reconnection to community is often impacted by stigma and discrimination which can lead to lower levels of employment and social exclusion. This can impact on a person’s ability to recover and reconnect with their community.

There is also a need to tailor service delivery to meet the unique circumstances and needs of vulnerable groups, for example a focus on social and emotional wellbeing is more likely to result in better long-term outcomes for Aboriginal and Torres Strait Islander people. Similarly a different approach is needed for children and young people. Dovetail have released a series of good practice guides to support Queensland’s youth alcohol and drug sector including a guide focused on working with Aboriginal and Torres Strait Islander young people³⁹.

People living in rural and remote communities may need increased access to services through methods such as telehealth and targeted promotion and early intervention approaches.

Questions for consideration

What improvements could be made on the current mix of demand reduction activities in Queensland?

What are some innovative ways that prevention and early intervention activities can be promoted and access improved?

Are there any examples of good practice in demand reduction?

2 Supply reduction

Supply reduction strategies seek to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs and control, manage and/or regulate the availability of legal drugs. The National Strategy highlights the need for a collaborative effort from all levels of government including law enforcement, the health sector, industry and regulatory authorities to ensure effective application of supply reduction strategies for licit and illicit drugs.

The National Strategy includes two objectives that will inform the action plan:

- Reduce the supply of illegal drugs (both current and emerging)

- Control and manage the supply of alcohol, tobacco and other legal drugs.

In Queensland the following agencies are principally responsible for supply reduction strategies:

- the Queensland Police Service
- the Office of Liquor and Gaming Regulation, Department of Justice and Attorney-General in relation to alcohol
- the Department of Health in relation to prescription pharmaceuticals such as opioid analgesics and other medications.

The Queensland Police Service has a primary enforcement role for the *Drugs Misuse Act 1986* Queensland. The Queensland Police Service works collaboratively with the community, industry and interstate Commonwealth law enforcement and government agencies to target the organised importation, distribution and manufacture of illicit drugs in Queensland. The Queensland Police Service, in partnership with other agencies, is also involved in reducing availability of licit drugs such as pharmaceuticals that are misused or otherwise diverted for unlawful purposes.

The Office of Liquor and Gaming Regulation issues liquor licences and permits in accordance with the *Liquor Act 1992 (Qld)*. The Act aims to regulate the liquor industry and areas in the vicinity of licensed premises to minimise (section 3):

- harm, and the potential for harm, from alcohol abuse and misuse and associated violence
- adverse effects on the health and safety of members of the public
- adverse effects on the amenity of the community.

Part of the decision making process to approve a liquor licence involves a community impact statement which requires the Commissioner for Liquor and Gaming to give greater weight to the impact the licence may have on the surrounding community⁴⁰.

The Queensland Police Service and the Office of Liquor and Gaming Regulation enforce compliance with liquor legislation. Non-compliance can result in on-the-spot fines or criminal sanctions.

According to the annual *Liquor and Gaming Report 2012–13*, there were 6,925 issued liquor licenses operating throughout Queensland representing 20.2 per 10,000

adults aged 18 years and over. The report’s trend analysis indicates that liquor licences have increased between 2011–12 and 2012–13 and that there has been a decrease in post 3am trading licences. The Office of Liquor and Gaming Regulation regularly undertakes inspections to ensure compliance with liquor licencing conditions and investigates complaints made by the public including police.

The Department of Health regulates drugs access to medicines under the *Health (Drugs and Poisons) Regulation 1996*. The Act outlines the Department’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.

Drug seizures

The Australian Crime Commission (ACC) reported a record number of illegal drug seizures and arrests in Australia in 2012–13⁴¹.

While this data should be treated with caution, it reveals the following trends:

- The rate of seizures for amphetamine-type stimulants, cocaine and steroids increased in Queensland and Australia from 2003–04 to 2012–13
- Heroin seizure rates in Queensland and Australia decreased in the period 2003–04 and 2012–13
- Cannabis seizure rates were significantly higher in Queensland than in Australia in both 2003–04 and 2012–13
- Queensland 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.

Questions for consideration

Are there improvements that could be made on the current supply reduction activities in Queensland?

Are there any examples of good practice in supply reduction?

3

Harm reduction

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

The National Strategy includes three objectives:

- Reduce harms to community safety and amenity
- Reduce harms to families
- Reduce harms to individuals.

This pillar includes providing support to people who have a family member, loved one or significant other who is using drugs.

The types of harm reduction work to reduce drug related harm includes a wide range of activities, initiatives and services.

Primary health care plays an important role in providing brief interventions and harm reduction information. For example, regular and timely antenatal care that addresses alcohol consumption during pregnancy has been considered one of the most effective ways to reduce alcohol consumption among pregnant women or women planning a pregnancy.

Diversion from the criminal justice system, police powers and public intoxication laws can also be considered harm reduction strategies in that they can be used to intervene in circumstances where intoxicated people can be moved on before violent situations escalate are more significant harms occur. The Queensland Police Service's efforts to prevent drink driving and reduce the incidence of alcohol-related road accidents have been a key harm reduction approach.

The National Strategy calls for enhanced child and family sensitive practice in alcohol and other drug treatment services and build links and integrated approaches with community, family and child safety services.

Innovative methods of harm reduction which are not currently practiced in Queensland include medically supervised injecting centres, pill testing screening in entertainment precincts, widespread provision of Naloxone for reversing opiate-overdoses, peer-based education and support programs and public anti-discrimination campaigns.

For individuals, reducing harm should focus on evidence-based education, targeted broadly as well as initiatives customised for particular vulnerable groups and life stages.

Sharing knowledge and information

Improved methods for sharing information across government agencies (including police) may enable early warning of specific drug related harms and allow agencies to develop effective responses under the

demand, supply and harm reduction pillars. Information does not need to be identifiable, simply monitoring for changes in usage patterns, associated harms and availability of drugs.

Questions for consideration

Are there improvements that could be made to harm reduction strategies in Queensland?

Are there any examples of good practice in harm reduction that you can identify in Queensland and elsewhere?

Monitoring and governance of the Action Plan

A governance group will be established by the Commission to provide oversight of the finalisation and implementation of the Action Plan. Membership of the group will comprise of government and non-government representatives. The governance group will monitor levels of risky drinking and drug use in Queensland.

The Action Plan will be reviewed after 12 months in consultation with key stakeholders.

The Commission will report on the progress of the Action Plan as part of its annual report on the implementation of the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019*.

Further information

Phone 1300 855 945
 Web www.qmhc.qld.gov.au
 Email info@qmhc.qld.gov.au
 Mail PO Box 13027, George Street Brisbane QLD 4003

References

- ¹ Ministerial Council on Drug Strategy (2010). National Drug Strategy 2010–2015: A Framework for Action on Alcohol, Tobacco and Other Drugs. Commonwealth of Australia. Canberra.
- ² Ibid.
- ³ Australian Institute of Health and Welfare (2014a). National Drug Strategy Household Survey detailed report 2013. Drug statistics series no. 28. Cat. No. PHE 183. Canberra: AIHW.
- ⁴ Queensland Government 2015, 'Drug use: help and treatment', retrieved 5 August 2015, <<http://www.qld.gov.au/health/staying-healthy/atods/drug-abuse/help/index.html>>
- ⁵ Kolves, K., Potts, B. & De Leo, D. (2015). Suicides in Queensland 2002–11. Australian Institute for Suicide Research and Prevention. Brisbane.
- ⁶ Siggins Miller (2014). Discussion paper to inform the development of a statewide Alcohol and Other Drug Action Plan. Brisbane.
- ⁷ National Health and Medical Research Council 2009, 'Australian Guidelines to Reduce Health Risks from Drinking Alcohol', retrieved 20 July 2015, <<http://www.nhmrc.gov.au/health-topics/alcohol-guidelines>>
- ⁸ Australian Institute of Health and Welfare (2014a), op cit
- ⁹ Ibid.
- ¹⁰ Australian Bureau of Statistics (2013). 3303.0 Causes of Death, Australia, 2013.
- ¹¹ Queensland Health 2014. The health of Queenslanders 2014. Fifth report of the Chief Health Officer Queensland. Queensland Government. Brisbane.
- ¹² Ibid.
- ¹³ Ibid.
- ¹⁴ Australian Bureau of Statistics (2013), op cit
- ¹⁵ McIlwraith, F, Alati, R, 'Queensland Drug Trends 2014: Findings from the Illicit Drug Reporting System', retrieved 20 July 2015, <https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/QLD_IDRS_2014.pdf>
- ¹⁶ Queensland Child Protection Commission of Inquiry (2013). Taking Responsibility: A Roadmap for Queensland Child Protection. Queensland Child Protection Commission of Inquiry, Brisbane.
- ¹⁷ The Special Taskforce on Domestic and Family Violence in Queensland (2015). 'Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland'. The Special Taskforce on Domestic and Family Violence in Queensland, Brisbane.
- ¹⁸ Australian Institute of Health and Welfare 2015. Alcohol and other drug treatment services in Australia 2013–14. Drug treatment series no. 25. Cat. no. HSE 158. Canberra: AIHW.
- ¹⁹ Australian institute of Criminology 2013. Trends and issues in crime and criminal justice: The society costs of alcohol misuse in Australia, retrieved on 20 July 2015, <http://www.aic.gov.au/media_library/publications/tandif/tandif454.pdf>
- ²⁰ Kelly JF, Westerhoff, CM. Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. International Journal of Drug Policy. 2010; 21(3): 202–207.
- ²¹ Australian Institute of Health and Welfare (2014a), op cit.
- ²² Steering Committee for the Review of Government Service Provision (2014). Overcoming Indigenous Disadvantage: Key Indicators 2014. Productivity Commission, Canberra.
- ²³ Steering Committee for the Review of Government Service Provision (2015), Report on Government Services. Productivity Commission. Canberra.
- ²⁴ Ibid.
- ²⁵ Ibid.
- ²⁶ Crime and Corruption Commission Queensland 2012, 'Performance and image enhancing drugs (PIEDs)', retrieved 4 August 2015, <<http://www.ccc.qld.gov.au/crime/results/drug-market-profiles/performance-and-image-enhancing-drugs-pieds>>
- ²⁷ Powers JR, Loxton DJ, Burns LA, Shakeshaft A, Elliott EJ, Dunlop AJ. Assessing pregnant women's compliance with different alcohol guidelines: an 11-year prospective study. The Medical Journal of Australia 2010; 192:690-693.
- ²⁸ Queensland Health 2014, op cit.
- ²⁹ Steering Committee for the Review of Government Service Provision (2015). Report on Government Services. Productivity Commission. Canberra.
- ³⁰ Drug Info Clearinghouse 2010, 'Prevention of alcohol and other drug problems in culturally and linguistically diverse communities', retrieved on 4 August 2015, <<http://www.druginfo.adf.org.au/newsletters/newsletters-drug-prevention-in-culturally-and-linguistically-diverse-communities-2010>>
- ³¹ Ibid.
- ³² Pont B, Jaworski A (2015), Helping asylum seeker and refugee background communities with problematic alcohol and other drug use: A guide for community support and AOD workers, Queensland Network of Alcohol and other Drug Agencies Ltd, Brisbane.
- ³³ Queensland Association for Healthy Communities (2010). States of Mind: Mental health and wellbeing and alcohol, tobacco and other drugs use in Queensland lesbian, gay bisexual and transgender (LGBT) communities – a community needs analysis. Brisbane: Queensland Association for Healthy Communities.
- ³⁴ Ibid.
- ³⁵ MacBean R, Hipper L, Buckley J, Fewings E, Podevin K, Tatow D (2015). Queensland Alcohol and other drug treatment service delivery framework. Brisbane. Available at <http://dovetail.org.au/media/103784/qldaodtreatmentframework_march2015finalpdf.pdf>
- ³⁶ Ibid.
- ³⁷ Australian Institute of Health and Welfare 2015, op cit.
- ³⁸ MacBean R, Hipper L, Buckley J, Fewings E, Podevin K, Tatow D (2015), op cit.
- ³⁹ Dovetail 2014, 'Learning from Each Other: Working with Aboriginal and Torres Strait Islander Young People good

practice guide', <<http://www.dovetail.org.au/i-want-to/open-the-good-practice-toolkit.aspx>>

⁴⁰ Office of Liquor and Gaming 2014, 'Guidelines 38: Community Impact Statement', retrieved 20 July 2015, <<https://publications.qld.gov.au/storage/f/2014-06-16T04%3A24%3A06.283Z/liquor-guideline-38-community-impact-statement.pdf>>

⁴¹ Australian Crime Commission (2014). 2012–13 Illicit Drug Data Report. Canberra: Australian Crime Commission.