

Queensland alcohol and other drugs plan

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Structure of this presentation

- Drug policy context
- Effective drug harm, supply and demand strategies
- Drug prevalence harms and service use
- The drug service system in Queensland



Drug policy context

In Australia, problematic substance use is considered to be a health and wellbeing problem, a cultural problem, a problem of criminal behaviour, or a combination of these. Drug related harms include:

- interpersonal violence
- physical and mental illness
- loss of productivity
- social isolation.

Effective interventions take into account the interaction between the drug itself and individuals, their families and communities including their social, physical, cultural, legal and economic circumstances.



The National Drug Strategy 2010-2015

Australia's coordinated national drug policy is founded on the *National Drug Strategy 2010-2015* (NDS) which aims to:

- Build safe and healthy communities by minimising alcohol, tobacco and other drug related health, social and economic harms among individuals, families and communities
- Improve health, social and economic outcomes for Australians
- Prevent the uptake of harmful drug use
- Reduce the harmful effects of legal and illegal drugs in Australian society.

The NDS adopts a *comprehensive partnership* approach to *minimising drug related harms* are used because of the complexity of harmful drug use, its determinants and consequences.

Harm minimisation is achieved under the NDS through three program areas or “pillars” – demand reduction, supply reduction and harm reduction – which are applied together to minimise harm. *Prevention* is an integral theme across the three pillars.



The three pillars

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.*

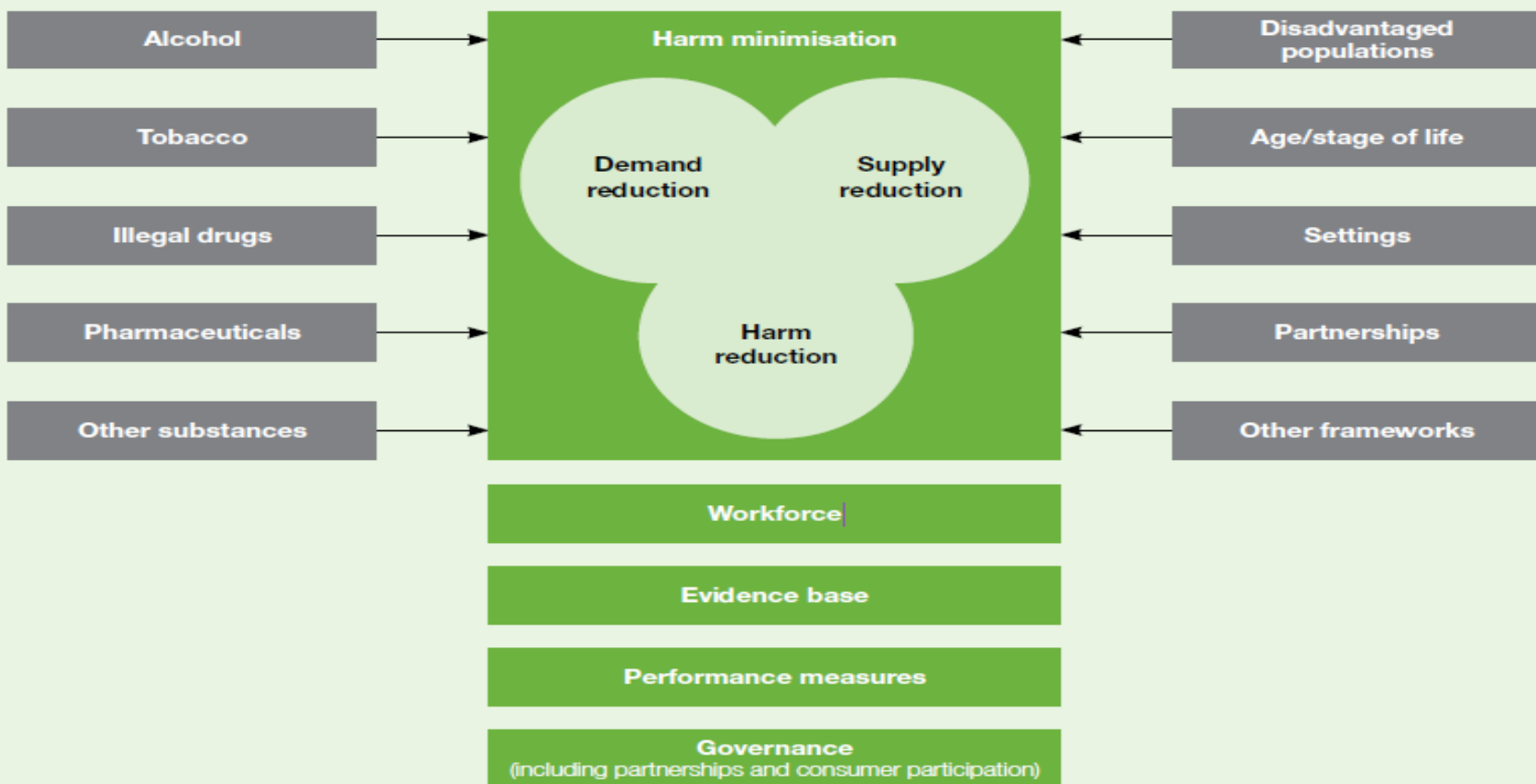
Supply reduction refers to strategies and action which *prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.*

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



Australia's drug harm minimisation framework (NDS 2010 – 2015)

Figure 1: Harm minimisation approach



Drug Policy achievements

Significant achievements have been made nationally and in Queensland in:

- the number and range of relevant evidence-based policy, policies, programs and services available
- the data available to monitor patterns of drug use and harms over time
- strategies to change people's attitudes to problematic drug use and interventions to respond to it.



Other current Queensland frameworks

- *Taking Responsibility: a road map for Queensland child protection* (Carmody 2013)
- *Not Now, Not Ever: Putting and End to Domestic and Family Violence in Queensland* (Special Taskforce On Domestic and Family Violence 2015)
- *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 - 2033*
- *Supporting Student Health and Wellbeing Policy Statement* (Department of Education Training and Employment 2015)



Queensland Government agency harm supply and demand reduction strategies:

- Department of Justice and Attorney-General (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 (coordinated 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 and the drug treatment sector more broadly (demand, supply and harm reduction — drug health promotion, prevention, regulation, early intervention and treatment services).



Policy influences and emerging issues

Monitoring progress against indicators under the NDS in the last 30 years:

- changing social attitudes towards drug use have changed
- a 'recovery' approach has evolved in the treatment sector
- the Australian population continues to be misinformed about the relative effectiveness of the various interventions available for dealing with drug problems.



Policy influences and emerging issues (cont.)

- a decrease in smoking uptake in the last 10 years
- an increase in the proportion of younger people choosing to abstain from alcohol
- a reduction in the percentage of people drinking alcohol at risky levels
- no significant changes in daily smoking or use of illegal drugs among Aboriginal and Torres Strait Islander Australians
- halving in the use of meth/amphetamines (powder, pills etc) and doubling in the use of crystal meth/amphetamine
- increase in the percentage of people who have recently used a pharmaceutical drug for a non-medical purpose
- people living in rural and remote regions were more likely to smoke, drink alcohol at risky levels, use cannabis and meth/amphetamines
- women reporting alcohol use during pregnancy declined in the last three years



Effective drug harm, supply and demand reduction strategies

- The NDS sets out, under the three pillars, many examples of interventions for legal and illegal drugs for which there is evidence for effectiveness.
- 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.



Effective strategies

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.



System level determinants of effectiveness

- inter-sectoral planning and collaboration during all phases of implementation
- strong commitment to monitoring and evaluation
- openness to continuous review and improvement
- strong community engagement
- accessible high quality treatment services
- strong commitment at all levels from the political, bureaucratic, community through to evidence based practice at the family and individual level.



Highlights from the data on prevalence and harm

Drug use among the general population and specific population groups in Queensland is similar to that for Australia. The prevalence of use and trends in the last 10 years were similar for Queensland and Australia.

- Alcohol consumption had the highest rate of prevalence followed by tobacco smoking and cannabis use in both QLD and Australia.
- 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.
- From 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.



Drug related harms

- Due to the lack of availability of current Queensland specific data on AOD-related hospitalisations, deaths have been drawn from national reports which only provide an indication of what is happening in Queensland.
- Nationally, alcohol-related hospitalisations have increased over time.
- The Queensland specific data available from law enforcement suggests that 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.



Drug treatment use

The Queensland rate of drug treatment service use (excluding private providers and public hospital treatment) is similar to that of Australia per 100,000 of the population. However:

- QLD had almost double the rate of clients being referred from police and court diversion
- 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.
- The QLD rate of treatment episodes closed due to 'ceased to participate at expiation' was almost four times the national rate.
- 'Ceased to participate without notice' was the reason for treatment closure was higher in QLD for counselling treatment episodes compared to Australia.



A snapshot of the drug service system in Queensland

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, for example:

- 'safe night out' precincts
- Alcohol Management Plans
- school drug education
- police and court diversion to treatment
- prisoner testing and treatment programs
- prevention and early intervention services
- AOD treatment services (community, residential, hospital, ambulance)



Pillars of reform

Queensland Mental health, Drug and Alcohol Strategic Plan 2014 - 2019

1. Better services for those who need them, when and where they are required
2. Better promotion, prevention and early intervention initiatives to maintain wellbeing, prevent onset, and minimise the severity and duration of problems
3. Better engagement and collaboration to improve responsiveness to individual and community needs
4. Better transparency and accountability so the system works as intended and in the best way possible

