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

**Prepared for the Queensland Mental Health Commission**

**June 2015**

# Contents

**Acronyms and abbreviations**

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| **AA** | Alcoholics Anonymous |
| **ABS** | Australian Bureau of Statistics |
| **AODTS-NMDS** | Alcohol and Other Drug Treatment Services – National Minimum Data Set |
| **AOD** | Alcohol and Other Drugs |
| **ATODS** | Alcohol Tobacco and Other Drugs Services |
| **HCV** | Hepatitis C Virus |
| **LGBT** | Lesbian Gay Bisexual, Transgender |
| **LGBTI** | Lesbian Gay Bisexual, Transgender, Intersex |
| **MCDS** | Ministerial Council on Drug Strategy |
| **NDS** | National Drug Strategy |
| **NDSHS** | National Drug Strategy Household Survey |
| **NGO** | non-government organisation |
| **NPS** | novel psychoactive substance |
| **PIED** | Performance and Image Enhancing Drug |

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

## June 2015

## Section 1 Introduction

This Position Paper is designed to inform community consultations on actions that could be taken in Queensland to prevent and reduce the adverse impacts of alcohol and other drugs on the health and wellbeing of Queenslanders.

The development of a Queensland Alcohol and other Drugs Action Plan 2015-2017 (Action Plan) forms an important part of the State's efforts to prevent and reduce the harms associated with AOD use and improve the mental health and wellbeing of Queenslanders under the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019*. The Action Plan development is being led by the Queensland Mental Health Commission (the Commission) in consultation with government and non-government agencies, the private sector and alcohol and other drug service users.

The Commission established an Alcohol and Other Drug Project Reference Group (AOD PRG) to guide the development of *the Statewide Alcohol and Other Drug Discussion Paper* and this Position Paper, both prepared by Siggins Miller Consultants. The AOD PRG includes representatives of agencies including the Queensland Injectors Health Network; Dovetail; the Queensland Indigenous Substance Misuse Council, Queensland Aboriginal and Torres Strait Islander Health Council; the Queensland Network of Alcohol and other Drug Agencies; the Department of Health; the Queensland Police Service; the Public Safety Business Agency; the Department of Communities, Child Safety and Disability Services; the Department of Education and Training; and the Department of Justice and Attorney-General. It also includes representation from the Queensland Mental Health and Drug Advisory Council. These organisations are responsible for delivering services, developing policy and practice and providing advice to government on effective approaches to reducing harms associated with problem substance use.

A broader range of stakeholders was also engaged in the development of this Position Paper. On 12 May 2015 the Commission hosted an Alcohol and other Drugs Roundtable facilitated by Professor Mel Miller (Siggins Miller consultants) and Professor Michael Farrell (National Drug and Alcohol Research Centre). The Roundtable participants discussed the information and issues raised in the Discussion Paper and provided advice to inform this Position Paper.

### 1.1 Background

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, Australian Government 2013, Gray & Wilkes 2010, Ministerial Council on Drug Strategy [MCDS] 2006).

The term 'drug' is used in national and international policy to mean alcohol, tobacco, illegal (also known as illicit) drugs, pharmaceuticals and other substances (which may be subject to misuse) that alter brain function resulting in changes to perception, mood, consciousness, cognition and behaviour. Throughout this Paper the terms 'alcohol and other drugs' and 'substance use' are also used. This Position Paper includes actions across the National Drug Strategy's three pillars – demand reduction, supply reduction and harm reduction.

In Queensland, services are committed to working in partnership with government and non-government agencies, the private sector and alcohol and other drug service users, and across sectors

(e.g. health, housing, education, courts, police, corrections) to deliver the best possible outcomes for people who have alcohol and drug problems, their families and communities, for example:

- prevention and early intervention services (e.g. media campaigns, drink driving policing, needle and syringe programs)

- AOD treatment services (community, residential, hospital, ambulance)

- safe night precincts

- school drug education[1]

- police and court diversion to treatment

- prisoner testing and treatment programs.

King and colleagues (2013) summarised the literature and evidence on differences in AOD related harm in specific populations in Australia. They examined AOD 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).

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

- the number and sophistication of strategies to change people's attitudes to problem drug use and to interventions to respond to it (e.g. national advertising campaigns).

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[1] See Section 2.3 of the Discussion Paper for information about the evidence for effectiveness of school AOD education programs drawing on research by Lee and colleagues (2014) for the National Centre for Training and Education on Addiction (NCETA). 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…; 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).

## Section 2 Policy and practice context

In Australia, AOD problems of individuals, families and communities are considered to be a health and wellbeing problem, a cultural problem, a problem of criminal behaviour, or a combination of these.

Alcohol and other drug related harms include:

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

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*.

MCDS 2010, p ii[2]

Key elements of the NDS include:

- a focus on harm minimisation through the three 'pillars' or program areas
    1. harm reduction
    2. supply reduction
    3. demand reduction
- enshrining a comprehensive partnership approach
- a joint Commonwealth and state strategy.

*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 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.

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

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[2] Ministerial Council on Drug Strategy (MCDS) (2010). *National Drug Strategy 2010-2015: A Framework for Action on Alcohol, Tobacco and Other Drugs.* Canberra: Commonwealth of Australia.

- be tailored for the local service system and levels and types of need.

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

In practice, the partnership approach means that interventions that address the complexity of AOD problems involve input from multiple organisations. Under the NDS, governments are responsible for leadership, policy development, implementation and evaluation as well as the delivery of justice, police, health and education services to reduce drug related harm in their respective jurisdictions.

**2. 1 Policy influences and emerging issues**

A strong commitment to evidence based harm minimisation rather than zero tolerance approach has characterised the last 30 years of drug policy in Australia. Even so there have been periods during which advocacy for zero tolerance approaches have held sway relative to illicit drug consumption.

In the last 30 years of monitoring progress against indicators under the NDS:

- Social attitudes towards drug use have matured and changed.

- Media coverage has increased on "king hits" or "coward punches", and other forms of public and domestic alcohol-related violence, along with studies and interventions to reduce harm, supply and demand (e.g. reviews of licensing, policing, sobering up facilities, refuges for women and children); there is a perception that more recently media coverage on illegal drugs is greater than the relatively non-sensational portrayal of harms associated with alcohol.

- The Australian population (including professional groups) lack information about community AOD use, harms, as well as the need for and effectiveness of the various evidence based interventions available for dealing with AOD problems.[3]

- A 'recovery' approach has evolved in the treatment sector, (making available the range of mixture of evidence based pharmacological and medical and psychosocial treatments matched to individual needs) in line with the principle of harm minimisation and individualised rather than one-size-fits-all approaches.

- Progress has been made towards a data and information framework to drive the system forward even though there is more progress to be made (see section on data issues below for areas for improvement such as, accident and emergency data).

- A range of medications has been designed to assist clients to manage cravings as part of treatment for nicotine and opioid dependence.

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[3] See Section 4 of the Discussion Paper for summary analyses of current data on drug use, and harms and community perceptions of use and effectiveness of treatment.

**Section 3 The Queensland Alcohol and Other Drug system**

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, 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.

Within Queensland, the partnership approach is demonstrated in the significant whole-of-government, non-government, private sector work that has been undertaken to address the impacts of problem AOD use on communities, families and individuals. This has been achieved through partnership approaches across agencies, including:

- health
- housing
- child safety
- domestic violence
- drug user organisations
- youth
- Aboriginal and Torres Strait Islander peoples
- liquor licencing
- crime and justice
- employment
- school education
- researchers and evaluators.

The role of AOD as a risk factor for specific population groups including women, young people and children, Aboriginal and Torres Strait Islander peoples, people living in rural and remote locations is acknowledged in number of current Queensland Government policies, strategies and reports, for example:

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

The lesbian, gay, bisexual, transgender, intersex (LGBTI) group is vulnerable to the risks of harms associated with AOD use. Issues for LGBTI people are outlined in *Improving the Lives of LGBT*

*Queenslanders: a call to action* – a paper published online by the Queensland Association for Healthy Communities in 2010.[4] [5]

Examples of Queensland Government agency harm, supply and demand reduction strategies include:

- 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, harm and supply reduction — drug health promotion, prevention, early intervention and treatment services).

- The Department of Health also sets targets and collects data on public health AOD Treatment provision and administers funding of non-government organisation (NGO) AOD services.

In 2015 the Queensland AOD treatment sector jointly developed the Queensland Alcohol and Other Drug Treatment Service Delivery Framework (2015) (Framework) to guide development of the AOD treatment sector. The Framework reaffirms:

- the national and policy and funding commitment to evidence informed and cost effective harm minimisation through harm reduction, supply reduction and demand reduction interventions

- the principles underpinning the *National Drug Strategy Aboriginal and Torres Strait Islander People's Complementary Action Plan 2003 – 2009*

The principles highlight the importance of non-government treatment services. The Complementary Action Plan highlights the need for:

- enhanced capacity

- a whole-of-government commitment

- improved access [to services]

- holistic approaches

- workforce initiatives

- sustainable partnerships.

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[4] http://communitydoor.org.au/sites/default/files/Improving%20the%20Lives%20of%20LGBT%20Queenslanders.pdf

[5] Section 4 of the Discussion Paper for summary analyses of current data on drug use, and harms and community perceptions of use and effectiveness of treatment

## Section 4 Summary of AOD use, harms and treatment use in Queensland

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

These similarities mean that data on key national indicators such as drug use and dependence prevalence, and AOD related burden of disease (illness and death), 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.

Governments in South Australia, Victoria, Western Australia and the Australian Capital Territory have committed to monitoring progress on their AOD priority areas and actions through a number of linked indicator measures.

The issue of the differences in risk of AOD harm are noted in the section below on the burden of disease data. It is important to provide the public with data and information on the extent of the harms from AOD use. For instance, when it comes to alcohol suppliers note that ABS data indicate that alcohol consumption is at the lowest level in 50 years – but the harms levels are not. 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.

### 4.1 Prevalence of use

In 2013, alcohol consumption had the highest rate of prevalence of use (including the number of those who consume alcohol at risky levels) followed by tobacco smoking and cannabis use in both QLD and Australia. National data for the general population on emerging drug use trends, particularly NPSs and PIEDs are in development.

The prevalence of use and trends in the last 10 years were similar for Queensland and Australia, they and in 2013, AOD use among the general population and specific population groups in Queensland was similar to that for Australia.[6] Studies and the analyses included in the Discussion Paper indicate:

- a national decrease in smoking uptake in the last 10 years

  In 2013, the rate of daily tobacco smoking in Queensland 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).

- a national increase in the age at which younger people had their first cigarette

  In 2013, the average age when Queensland's young people first smoked tobacco was 15.9 years compared to 1995 when the age of uptake was 14.2 years

- nationally no significant changes in daily smoking or use of illegal drugs among Aboriginal and Torres Strait Islander Australians

- The reduction in tobacco smoking in the general population has not been seen among Aboriginal and Torres Strait Islander Australians. According to the Productivity Commission's

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[6] See Section 4 of the Discussion Paper for the summary of information on AOD prevalence of use, harms, and treatment service use and community perceptions of these.

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. Although the rate was high, it had declined from 2011 (51%)

- a national increase in the age at which younger people had their first alcoholic drink

- a national increase in the proportion of younger people choosing to abstain from alcohol

- a national reduction in the percentage of people drinking alcohol at risky levels

- nationally the proportion of women reporting alcohol use during pregnancy declined in the last three years

- a greater likelihood nationally that people living in rural and remote regions smoked, drank alcohol at risky levels, and used cannabis and meth/amphetamines

- in Queensland in 2013, prevalence of use rates for ecstasy, pharmaceuticals, cocaine and meth/amphetamines in were similar to the national rates

- lesbian, gay, bisexual, transgender and intersex populations nationally had higher rates of drug use (alcohol, tobacco, meth/amphetamines, cannabis, cocaine and ecstasy) and alcohol consumption at risky levels, compared to heterosexual populations

- a national doubling in the use of the more potent form, crystal meth/amphetamine also known as 'ice', set against halving in the use of meth/amphetamines (powder, pills etc)[7]

- a national increase in the percentage of people who have recently used a pharmaceutical drug for a non-medical purpose, particularly in older adults.

**4.2 AOD related harms in Queensland**

*Burden of disease and drug related injuries*

In Queensland, as in other states and territories in Australia, tobacco and alcohol are the drugs responsible for the most harm to individuals, families and communities. Drug use can cause illness, injury and early death.

Due to the lack of availability of current Queensland specific data on AOD-related hospitalisations, the data on deaths can be drawn from national reports even though they provide only an indication of what is happening in Queensland. Although national levels of AOD consumption have remained flat, hospitalisations have increased.

While QLD specific data on the burden of disease and injury are not published, the Australian Institute of Health and Welfare 2007 study of the burden of disease nationally is informative.[8] [9] 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). It reveals that tobacco use is the risk factor that contributed most to Australia's disease burden (7.8% of the total burden).

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[7] 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.

[8] "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)

[9] The most recent study on burden of disease and injury in Australia uses 2003 data. The Australian Institute of Health and Welfare 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 (based on 2011 data) are expected to be published in late 2015.

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.

Queensland specific data made available for the Discussion Paper (May 2015) by law enforcement Theses data suggested that the rate of AOD related crime in Queensland 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.[10]

The number of national illegal drug arrests totalled 101,749 in 2012-13, representing a 27.2% increase since 2003-04.[11] 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.[12]

***Key gaps in publicly available Queensland AOD related harm data***

No current (2013 - 2015) Queensland data were publicly available on the following key indicators of AOD related harm:

- the number of alcohol and drug caused deaths

- alcohol related hospitalisation (admissions/separations and emergency department presentations)

- other drug-related hospitalisation (admissions and emergency department presentations)

Other data (already collected or which may be collected in the future) may be of interest for the purposes of monitoring outcomes of a plan, for example:

- proportion of ambulance attendances for alcohol or drug overdose

- prevalence of HIV and Hep C among injecting drug users

- number of liquor infringement notices issued

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[10] See Table 1 Section 4.3 Drug Related Harms Table 1 for rates of AOD use related crime in Queensland

[11] 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 expiation 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.

[12] 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.

- number of arrests for trafficking

- number of people diverted from the criminal justice system to brief interventions and treatment

- number and weight of illegal drug seizures.

Queensland Ambulance Service is a partner in a national project led by Turning Point to develop a standard data set (e.g. ambulance attendances for alcohol overdose; proportion of ambulance attendances for alcohol related injury).

## 4.3 Alcohol and Other Drug treatment utilisation

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:

- 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.

Whilst Queensland has a higher rate of treatment episodes delivered in 'outreach' and 'other' settings, this could be related to how the data definitions are interpreted by staff. Discussion among key treatment provider stakeholders may assist with interpretation of the analyses. Due to the relationship between diversion referral and the high rate of 'ceased to participate at expiation' treatment episodes, the nature and efficacy of 'information and education only' episodes could be investigated further, particularly considering its prevalence in Queensland.

## Section 5 Effective interventions

National and international policy and priority setting is underpinned by research evidence on the effectiveness and cost effectiveness of interventions, and implementing evidence based AOD interventions. The NDS enjoins Australian governments at federal, state and local levels in continuously monitoring progress, as well as understanding and considering:

- patterns and trends in AOD use and harms (and costs) associated with problem AOD use
- the interactions between harm reduction, supply reduction and demand reduction strategies across drug types.

Effective interventions should be implemented as intended by an appropriately skilled and qualified workforce (including where appropriate the skilled and qualified AOD peer workforce). They should be tailored to meet individual and local community needs and form part of a local balanced, comprehensive approach to addressing:

- community, family and individual needs including their social, physical, developmental, cultural, legal and economic circumstances, individual health and wellbeing (i.e. the health and social determinants of problem AOD use)
- supply issues
- how the local services system can better tailor its approaches to maximise capacity to address AOD problems.

*A local systems approach* would mean that effective interventions would be selected to meet community and individual needs across the three pillars. It is important to balance and tailor efforts across the different substances and different demographic groups. For example, understanding where opiate substitution treatment services will be needed in the future – the different age groups, and the networks people will be willing to use – and altering services to better address the needs of perhaps older people who are opioid dependent.

### 5.1 Continuum of evidence informed AOD interventions

Evidence based AOD interventions span a 'continuum' from promotion and prevention through to early intervention and individualised treatment and support:

- broad based (universal) and targeted promotion and prevention activities (campaigns, information and education about drug use and harms)
- individual interventions (screening, assessment, brief intervention and treatment). [13]

### 5.2 Balance of interventions across harm, supply and demand reduction programs

The NDS sets out, under the three program areas ('pillars'), many examples of interventions for which there is evidence for effectiveness, for example: court and police diversion to AOD treatment, liquor licensing, regulation of supply of prescription medications, needle and syringe programs, brief intervention assessment and treatment, including counselling, detoxification, drug replacement therapies/medication assisted treatment (e.g. nicotine replacement and opioid substitution treatment). In practice, programs often combine different types of interventions across the three pillars from multiple organisations, agencies and personnel. [14]

In practice, the partnership approach means that interventions that address the complexity of drug problems involve input from multiple organisations. Partnerships are crucial to coordinated service

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[13] See Appendix 1 in the Discussion Paper for a matrix showing possible services and workforce across a continuum of AOD interventions

[14] See Appendix 1 for more information about types of interventions designed to reduce AOD harm, supply and demand

provision for individuals, families and communities. For some organisations this will involve leadership to support change in organisation culture and processes:

- At the community level this approach translates to community engagement through, information and education about drug use and harms, involvement in campaigns, law enforcement, emergency services, information and education about drug use and harms (eg the liquor accords in place in Queensland, policing of illicit drug manufacturing and importation, school drug education, 'safe night out' precincts.

- At the individual level this approach translates to 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 (including specialist AOD treatment services); child, youth and family services; domestic violence services; child care providers; justice services; correctional 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 (i.e. screening, assessment, brief intervention and treatment) 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 AOD dependence.

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.

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 assumption that particular interventions are not effective or cost-effective. This is particularly the case for prevention and harm reduction interventions, the effectiveness of which has not yet been studied.

The Framework and the Roundtable deliberations across sectors involved in providing promotion, prevention, early intervention and treatment on 12 May 2015 highlight that:

- A proportion of the population will require specialist support ranging from brief, one-off assistance to complex, long term treatment.

- Current guidelines exist that inform service providers about implementing AOD treatment and support services in line with evidence for effectiveness and cost effectiveness, but not all AOD treatment services being delivered in Queensland are not based on the guidelines.

- Training programs exist to upskill primary care and community service organisations to support people to access specialist services.

- Ongoing planning and review of existing services is required to better meet need, ensure infrastructure and workforce capacity is adequate, work to minimise sector fragmentation and barriers to treatment.

## Section 6 Key Issues and priority areas for consideration

This section presents a high level overview of the current situation and issues for consideration in the development of the Action Plan. It also summarises and of a summary of key priority areas identified through the research conducted to develop the Discussion Paper, the Roundtable and the AOD PRG

### 6.1 High level overview of the current situation and issues in Queensland

In Queensland and Australia as a whole, significant whole-of-government work has been undertaken to address the impacts of problem alcohol and drug use on communities, families and individuals. This has been achieved through partnership approaches across sectors and agencies, including health, child safety, domestic violence, youth, Aboriginal and Torres Strait Islander, consumers; and the crime and justice, un/employment and school education systems; as well as universities, to improve and inform the evidence base and evaluate the effectiveness of services. It is a matter of:

- maintaining and improving the workforce, funding and collaboration to achieve the right interventions delivered at the right intensity at societal, community and individual levels

- monitoring and improving access, equity, effectiveness and return on investment.

It is therefore important to understand the best available research on the effectiveness and cost effectiveness of AOD programs and initiatives and draw on the collective expertise of practitioners, communities (including individuals with AOD problems and their families) to better understand and prioritise actions based on:

- community level and whole of population needs

- local service system capacity and engagement

- cost effective and appropriate initiatives, across the pillars and the continuum of care from will make a positive difference to health and wellbeing outcomes for individuals, families and the local community.

The key system level issues highlighted by Roundtable participants were:

- 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 form the political, bureaucratic, community through to evidence based practice at the family and individual level.

They thought that to maintain a sustainable AOD system, Queensland should work to develop a functioning *integrated* system where people are able to get the right service no matter where they come into the system (i.e. no wrong door and a holistic, client needs focused approaches). The sustainability of the system could be affected by imbalances in investment, different drug types and/or across supply, harm and demand reduction strategies.

A key issue was the need for Queensland to develop multiple entry points to prevention, early intervention and treatment services – making AOD everybody's business – and the workforce capacity across services and sector to deliver evidence based prevention (information and education), early intervention and referral to treatment. This entails maintaining the quality of treatment and increasing early intervention capacity in a range of sectors where people with early stage AOD problems present.

Other key issues to address in order to build on current strategies entailed:

- better use of resources through better justice and health triage to an appropriate level of prevention, early intervention or treatment and support

- clarifying AOD pathways from prevention into early intervention and, where appropriate, to more intensive support and treatment services, and supporting people to seek help and access services

- better use of health and human services workforce and infrastructure resources

- upskilling of the health and human services workforce to broaden the capacity of staff and organisations to provide evidence based AOD education information and appropriate referral

- re-examination of the current *ad hoc* approach by drug type (tobacco, alcohol, ICE etc.) creates a reactive and potentially media driven single substance crisis approach to prevention

- improvement in the quality of existing services by:

    - ensuring that the services provide evidence based interventions

    - working to reduce stigma and build strengths based approaches

- engagement of families and communities about AOD issues

- community information about the Queensland AOD burden of disease and injury.

In line with the overarching principle of harm minimisation, the Roundtable highlighted the importance of ensuring that this commitment includes doing no further harm. This implies work to continuously monitor policy and programs to identify and address/manage any unintended negative consequences. Other principles which could be appropriately adopted be based on work to date included working in ways which:

- enhance capacity (individual, family, community, service provider, system)

- affirm the role/s Aboriginal and Torres Strait Islander community controlled organisations

- demonstrate and develop a whole-of-government commitment

- deliver improved access, equity and affordability of services

- demonstrate and develop holistic approaches

- provide for workforce development

- demonstrate sustainable partnerships.[15] [16]

**6.2 Key priority areas for consideration**

Priority areas included:

1. Build community awareness and knowledge about AOD use, harms and treatment.

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[15] Ministerial Council on Drug Strategy (MCDS) (2006). *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009*. Canberra: Commonwealth of Australia.

[16] MacBean R, Hipper L, Buckley J, Fewings E, Podevin K, Tatow D (2015). *Queensland Alcohol and other drug treatment service delivery framework*.

2. Increase community access to data about AOD use, harms, and treatment that is online, mobile phone based, readily accessible website with information and data about how regions and the state is tracking and information about service options.

3. Develop an AOD governance structure and high level leadership to support a collaborative approach, access to a basic AOD data set as well as appropriate consumer and carer involvement.

4. *Design collaborative local service systems and programs and allocate existing resources efficiently.*

5. *Build the workforce capacity needed to provide evidence based AOD services.*

**Section 7 Action areas recommended for consideration**

This section presents key action areas proposed to address the key issues and priorities outlined in Section 6 above. They are based on Siggins Miller's *Discussion paper to inform the development of a statewide Alcohol and Other Drug Action Plan* (May 2015), and the deliberations of experts on priorities for the future through the Roundtable and the Queensland AOD PRG, and are presented here for consideration during broader consultations to develop the Action Plan.

The action areas recommended for consideration are designed to sustain and improve current efforts in Queensland to prevent and reduce the adverse impact of alcohol and other drugs (AOD) on the wellbeing of Queenslanders. They are set out under each of the pillars of reform in the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019*. Some of the recommended actions relate to more than one of the pillars of reform.

*Pillar 1 - Better services for those who need them, when and where they are required*

**Action 1**

Identify existing best practice integrated treatment and support cross agency case management approaches and widely disseminate information about these practices.

**Action 2**

Develop and document local and regional AOD models of care tailored to increase the integration of AOD and other services (including police, court, hospital, mental health, chronic disease, child and family, youth). The models of care should describe:

- pathways from social services and self-referral or police/court diversion to primary care intervention and support to specialist services
- roles of the generalist health and human services workforce in AOD problem identification, early intervention and referral (e.g. best local use of the police, paramedic, emergency, health worker, allied health, nursing, GP and specialist workforce to support community and home based care)
- use of mobile phone self-management, tele-monitoring and telehealth technologies
- 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.

**Action 3**

Address key system level factors underpinning sustainability of AOD services, by supporting and evaluating a suite of demonstration projects such as:

- increasing the capacity of the generalist health and human services workforce in AOD problem identification, early intervention and referral
- maintaining availability of a specialist AOD workforce

- enhancing the links between and the capacity of services to refer and act as entry points to the specialist AOD services

- developing care facilitator/coordinator/patient navigator roles to promote Aboriginal and Torres Strait Islander family and community empowerment and a holistic approach to health care

- designing and implementing workforce development and training programs for generalist and specialist workers whose clients have AOD problems, for example:

- including addiction studies as a core part of the range of professional curricula across the health and human services disciplines

- providing generalist and specialist staff of health and human services with rotations into AOD services) supervision, mentoring and access to secondary consultation

- developing and evaluating innovative approaches to community education and information (e.g. development of a function similar to the 'My School website' which is updated with information each year, use of mobile phone apps to engage people in campaigns to increase awareness and help seeking)

- developing telehealth based connections that allow specialist advice and support from major regional centres to rural service providers, convening of multidisciplinary care team meetings virtually

- better utilising scarce resources by maximising the use of technology and other clinical infrastructures in settings where general practice and mental health services already exist where better integration would create efficiencies (e.g. in regional and remote areas, general hospitals, prisons and youth services).

### Pillar 2 - Better awareness, prevention and early intervention initiatives

#### Action 4

Increase the emphasis in community education and awareness activities of risky alcohol consumption and smoking, particularly for those from groups at higher risk of AOD related harm[17]

#### Action 5

Develop ways to identify the needs of culturally and linguistically diverse groups, such as refugees and asylum seekers and developing particular actions to address those needs.

#### Action 6

Identify and build the capacity of the service system to provide more early intervention service modalities (mobile phone applications etc.) before people require specialist treatment.

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[17] See Section 3.4, Discussion Paper for examples from the literature of AOD factors which combine to place specific populations at higher risk of AOD related harm. 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, socioeconomically disadvantaged populations, women (especially those who are pregnant or planning to become pregnant, victims of domestic and sexual violence, carers), elderly people, people from culturally and linguistically diverse backgrounds, lesbian, gay, bisexual, transgender, intersex people, people in the justice system, migrants and refugees, people from rural and remote communities, and health professionals experiencing substance abuse problems or dependence.

**Action 7**

Identify and document best practice already in place and disseminate it widely (e.g. brief interventions as expressed in the current DABIT model

**Action 8**

Work to improve the capacity (knowledge, skills and confidence) of a broad range of health and human services organisations' case workers to provide to their clients prevention and early intervention in the form of AOD information and education, screening and brief intervention and referral.

**Acton 9**

Work with court system and other service providers to achieve more appropriate triage to early intervention/low intensity strategies.

*Better engagement and collaboration*

**Action 10**

Develop the role of multi-agency state-wide services in support for people with AOD problems (e.g. requiring cultural capability, stigma reduction and capacity to appropriately support and referral of people with AOD problems).

**Action 11**

Provide better targeted and integrated AOD training and education for health and human service provider workforces at all levels, including in undergraduates.

**Action 12**

Improve processes for gaining client permission to share data across service providers.

**Action 13**

Establish and support consumer involvement in AOD governance processes.

*Pillar 4 - Better transparency and accountability*

**Action 14**

Develop indicators and measures for monitoring harm including ways to better understand the extent and nature of harms from new substances (and deliver the data to inform and engage all stakeholders about the prevalence of problem AOD use in the Queensland community, and the harms associated with it).

Action 15

Improve data systems across health and human services so that AOD issues and outcomes are included in a systematic way and staff are skilled and supported to code data accordingly.

**Action 16**

Establish a way of measuring/monitoring and feeding back to all stakeholders including the community on the effectiveness of the Action Plan at the local level and across all parts of the system to inform future actions, intervention design, and continuous improvement and improvements.

**Action 17**

Clearly define the roles and responsibilities of agencies and local, state and federal government and their commitment to the provision of AOD services.

**Action 18**

Integrate data collected across the various systems to report against the indicator set (e.g. corrections, prisons, treatment system etc.) to deliver a baseline for monitoring and reporting to the community about how the situation changes.

**Action 19**

Continue to provide and further develop information for communities about what they can expect from the AOD service system in Queensland.

**Appendix 1 Examples of evidence based harm, supply and demand reduction strategies**

*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 use; and support people to recover from dependence and reintegrate with the community.

**Harm reduction**

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. the 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 AOD 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).

**Supply reduction**

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.

**Demand reduction**

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.