phn
CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

Central Queensland Wide bay Sunshine Coast PHN: Alcohol and Other Drugs Health and Service Needs Analysis

15 November 2021

Contents

Acronyms

ABS	Australian Bureau of Statistics
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other drugs
AODTS	Alcohol and Other Drug Treatment Services
ASR	Age Standardised Rates
CHO	Chief Health Officer
CQ	Central Queensland
CQHHS	Central Queensland Hospital and Health Service
CQWBSCPHN	Central Queensland Wide Bay Sunshine Coast Primary Health Network
DoH	Department of Health
ED	Emergency Department
ERDS	Ecstasy and Related Drug Reporting System
HHS	Hospital and Health Service
HNA	Health Needs Assessment
HWQ	Health Workforce Queensland
LGA	Local Government Area
MBS	Medicare Benefit Scheme
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NDSHS	National Drug Strategy Household Survey
NHMP	National Homicide Monitoring Program
NMDS	National Minimum Data Set
NGO	Non-Government Organisations
PBS	Pharmaceutical Benefit Scheme
PHN	Primary Health Network
QNADA	Queensland network of Alcohol and Other Drug Agencies
QSAS	Queensland Survey Analytics System
RPBS	Repatriation Pharmaceutical Benefit Scheme
SA3	Statistical Area Level 3
SC	Sunshine Coast
SCHHS	Sunshine Coast Hospital and Health Service
QGSO	Queensland Government Statistician Office
QH	Queensland Health
WB	Wide Bay
WBHHS	Wide Bay Hospital and Health Service

1. Overview

The consumption of alcohol, tobacco and other drugs is a major cause of preventable disease, illness and death in Australia. Similarly, in the Central Queensland Wide Bay Sunshine Coast PHN (the PHN), located within Queensland, people experience poorer health outcomes associated with alcohol and other drugs (AoD) use in certain areas. Recognition of significant health and service needs related to AoD in the region has led the PHN to commission activities that address some of the prioritised concerns. The PHN has expanded current service provider to deliver residential drug and alcohol rehabilitation programs by offering funding for counselling, withdrawal management, case management, care planning and co-ordination. In addition, investment in the sector has included workforce development, capacity building, information and education for health professionals. Construction has started at Yamba Road Parkhurst for the Rockhampton Residential Rehabilitation and Withdrawal Management Services which will provide much needed support and build capacity in the region.

Whilst the PHN is working towards achieving eventual goal of commission equitable health services, the purpose of this health needs assessment (HNA) report is to identify and inform priority areas for investment so that services commissioned by the PHN are tailored to the local needs. This needs assessment, that is built on previous understanding of the needs and options for action, also provides some evidence to guide effective approaches to improving AoD related services as and where required. The information in this report is derived from various publicly available datasets, peer reviewed publications and reports and anecdotal information received from the PHN staff members. While this HNA is informed by a wide range of national, state, and local data sources (CHO report, ABS, AIHW, MBS etc); such data is limited in its ability to fully inform the health status and service needs due to a lack of available data presented at a local level.

Other data is presented here is from the consultation that was undertaken by the PHN from Nov 2020 to Feb 2021. The consultation was undertaken in the form of surveys and conversations with the community. Three separate surveys were implemented and the detailed results of these will be published by the PHN on the website at a later point.

- A survey to seek inputs from Aboriginal and Torres Strait Islander people (the ‘Have a yarn about health Community Health Survey’). There were 603 survey responses for this survey.(1)
- A survey to seek input from stakeholders within the PHN (general practitioners, NGOs, allied health practitioners etc) that received 240 completed responses.(2)
- A survey to consult all community members across the PHN that received 620 completed responses.(3)

The PHN also commissioned Health Workforce Queensland (Oct 2020-May 2021) to undertake a service mapping project to understand the distribution of health services across the PHN region. A positive response from around 2,265 service providers (around 6,167 health professionals) was identified and used in mapping the type of service that were delivered within the region. Some limitations to this mapping apply as not all the service providers could be engaged however the data provides details regarding the services within the PHN that was not available from other resources.(4)

2. Health Needs Analysis

Prevention is an important part of a comprehensive harm reduction approach to reduce alcohol and other drug (AOD) harms. Primary prevention strategies aim to shift the focus 'upstream' by helping people to avoid, reduce or modify drug use; rather than reacting to a subsequent 'downstream' problem that requires acute treatment, and often an emergency response. For example, encouraging people to avoid early or heavy alcohol and other drug use can help reduce personal and social dysfunction, mental and physical health problems and the need for complex interventions through the health, legal and justice systems. By strengthening and supporting personal and social protective factors the likelihood that people, particularly young people, will engage in problematic AOD use is reduced, thus promoting mental and physical health and improving their life chances.

The National Alcohol Strategy 2019-2028 (5) aims at preventing and minimising alcohol-related harms among individuals, families and communities by (i) identifying agreed national priority areas of focus and policy options; (ii) promoting and facilitating collaboration, partnership and commitment from the government and non-government sectors; and, (iii) targeting a 10% reduction in harmful alcohol consumption. Similarly, the National Drug Strategy 2017-2026 aims to build safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related health, social, cultural and economic harms among individuals, families and communities. (6).

It is acknowledged widely that certain risk factors can increase the likelihood of a person using alcohol and other drugs or experiencing harm from alcohol and other drug use. Personal and family circumstances such as parental illness, unemployment, conflict or absence, and abuse or neglect can impact a person's development. As a person reaches adolescence and adulthood, other factors such as listed below also contribute to health and wellbeing outcomes(7),

- educational attainment
- the strength of the economy and opportunities for employment
- age and the experience of ageism
- the accessibility of family planning
- interpersonal relationships (such as experiencing family violence).
- parental supervision and communication(8)
- social and emotional competence(9)

There is a strong evidence for certain modifiable factors that increase the risk of alcohol and other drug use.

Examples of these risk factors are:

- living in a household or community where alcohol or other drugs are readily available(10)
- favourable parental attitudes toward substance use (11)
- family dysfunction (11)
- associating with peers who have favourable attitudes toward alcohol and other drugs (12)
- school failure (12)
- People with AOD issues, mental health conditions, or a dual diagnosis have a higher risk of cardiovascular disease (13) and may also have heavier rates of:
    a. alcohol consumption(14)
    b. diabetes(15)
    c. poor diet and obesity (16)
    d. physical inactivity (17)

Some protective factors interact with risk factors in complex ways. They may moderate the influence of risk factors to reduce the likelihood of AOD use in young people or reduce harm should young people engage in AOD use(9).

In summary, socio-demographic factors are strongly associated with harmful use of alcohol and other drugs. It is also established that the burden of disease due to this harmful use is very high in Australians including young people and is associated with avoidable morbidity and mortality. Certain population groups are at higher risk of harmful use of AoD (e.g., young people, Aboriginal and Torres Straits Islander people, LGBTIQ+ community) and are a focus of targeted policies and interventions across Australia. The details of these are discussed in the sections below.

The section below provides key findings from data and consultations regarding the risk factors associated with AOD use, prevalence of alcohol and other drug use within the PHN, associated co-morbidities, hospital presentations and mortality. It also presents specific findings for priority population groups with respect to AOD use and harms.

Note: The details of the demography including population distribution and characteristics are detailed in the General HNA and relevant summary is included in this AOD HNA.

2.1. Socio-demographic factors and use of AoD

Social determinants of health are linked to higher AOD use, including geographic and social isolation and higher rates of socio-economic disadvantage. Specific risk factors that are associated with harmful use of AoD and on which the data is available are presented in Table 1 and summarised here.

- In 2016, 8.8% of the population in the PHN catchment was in the least disadvantaged quintile, while 27.1% was in the most disadvantaged quintile (QLD 20%)(18).The LGAs with high proportions of population in the most disadvantaged quintile were: Woorabinda in CQ (100% of population), Fraser Coast in WB (59%), North Burnett in WB (57%), Bundaberg in WB (50%), Gympie in SC (46%) and Rockhampton in CQ (39%).
- In 2016, the majority of the PHN population (58% or 476,000 people) lived in inner regional areas, 33% lived in major cities and the remaining 9% (73,000 people) lived in outer regional, remote or very remote areas. However, four of the 12 LGAs in the PHN catchment had 100% of their populations living in outer regional or remote/very remote areas: Woorabinda, Central Highlands, Banana and North Burnet.
- As of June 2019, there were 876,789 people within the PHN with almost equal distribution of men (n= 432,181,49.3%) and women (n=444,608, 50.7%) within the PHN.
- There are around 22% (n=194,559) young people aged between 15-34 years in the PHN with highest % of young people living in the LGAs of Woorabinda, Rockhampton, Central Highlands, and Gladstone (18).
- Older people make up a considerable proportion of the PHN population (20.6% compared to Qld 15.7%). In 2019, over 1 in 5 people were aged 65 and over and the number and proportion of older Australians is expected to continue to grow (18).
- The PHN includes the Aboriginal Community, Woorabinda LGA (number of Aboriginal and Torres Strait Islander people =908, 94.4%). Two other LGAs , Rockhampton (n=5,874, 7.4%) and North Burnett (n=678, 6.5%), have higher percentage of Aboriginal and Torres Strait Islander people compared to Queensland (4.0%) . (18).

Table 1: Identifying LGAs with highest socio-economic disadvantage based on multiple risk factors for harmful use and outcomes of AOD, by LGAs within the PHN[1]

	Indigenous people		Outer regional, remote, or very remote areas		People living in areas defined as low SEIFA		Young people (15 to 29 years)		Older people (>60 years)		Total Ranking	Overall Ranking(most disadvantage)
	%	Ranking	%	Ranking	%	Ranking	%	Ranking	%	Ranking	Total	Ranking
Banana (S)	4	8	100	1	17.2	8	16.6	6	21.0	9	32	8
Central Highlands (R)	4.3	5	100	1	14	10	18.1	4	13.6	3	23	3
Livingstone (S)	4.4	4	5.4	3	16.5	9	16.3	8	26.1	8	32	8
Rockhampton (R)	7.4	2	2.4	6	39.1	6	21.1	2	20.6	10	26	4
Woorabinda (S)	94.4	1	100	1	100	1	27.7	1	8.5	12	16	1
Bundaberg (R)	4	8	4.4	4	49.5	4	16.5	7	31.2	6	29	6
North Burnett (R)	6.5	3	100	1	57.1	3	15.6	9	31.6	3	19	2
Fraser Coast (R)	4.2	6	0.4	7	59.4	2	13.8	11	35.7	1	27	5
Gladstone (R)	4.1	7	13.8	2	21.5	7	18.3	3	17.2	11	30	7
Sunshine Coast (R)	1.9	11	0	8	9.1	11	17.1	5	26.7	7	42	11
Noosa (S)	1.5	12	0	8	5.8	12	13.3	12	33.5	2	46	12
Gympie (R)	3.6	10	4.3	5	46.1	5	14.6	10	31.5	5	35	10

Source: Queensland Government Statistician's Office, *Queensland Regional Profiles: Resident Profile for Custom region*. 2018, Queensland Treasury. And QGSO regional profile created on the 28th July 2021

- Ranking from 1 to 12 based on 12 LGAs in the regions
- Same % has ranked equally with the next ranking skipping one point on the scale (e.g. two LGAs with 4% of Indigenous people have ranked 8 and next ranking being 10 instead of 9)
- For all 5 indicators: highest is marked lowest (1 on the scale)
- Lowest total ranking indicates highest disadvantage indicated by 1 in overall ranking.

[1] Queensland Government Statistician's Office, *Queensland Regional Profiles: Resident Profile for Custom region*. 2018, Queensland Treasury.

2.1.1. Socio-economic disadvantage

According to the Australia's health (2016) the disparity in illicit drug use compared with the general population was greatest amongst populations with socio-economic disadvantages, including Aboriginal and Torres Strait Islander people, people who were unemployed, single people with dependent children and people with a mental illness. (19) Harmful alcohol intake and use of illicit drugs show different patterns between population groups across Australia.

For example,

- In 2019, exceeding lifetime alcohol risk guidelines was more commonly reported by people living in outer regional and remote and very remote areas, people whose main language spoken at home is English, people living in the highest socioeconomic area and people who are employed (20)
- A 2016 report indicates that compared to the general population, methamphetamine use was 2.7 times higher among unemployed people, 6.1 times higher among people with a mental illness, and 2.4 times higher among single people with dependent children (19). Table 2 summarises the PHN data across the 12 LGAs in combination with rate for mental health concerns and rate of offences.
- People in the lowest socio-economic group were 1.8 times as likely to have recently used opioids for illicit or non-medical purposes as those in the highest (21).

2.1.2. Remoteness

Findings from AIHW's report on AOD use in regional and remote Australia indicates that people living in remote and very remote areas continued to be more likely than people in major cities to drink alcohol at risky levels (8% vs 5% daily alcohol consumption: 21% vs 15.4% lifetime risk)(22).

Additionally, in 2016-17:

- In remote areas the ***burden of disease attributable to alcohol use*** was twice that of major cities
- The ***rate of drug-induced deaths*** in regional and remote areas had increased 41% since 2008, compared to 16% for major cities (22).
- ***amphetamine-related treatment episodes*** had increased from 24% to 26% in regional and remote areas between 2003-04 and 2012-13 (19).
- People living in Regional and remote areas of Australia were more likely than people living in Major cities to have consumed alcohol at quantities that placed them at risk of harm from an alcohol-related disease or injury.
- Results from the 2016 National Drug Strategy Household Survey (NDSHS) showed that people aged 14 or older living in Regional and remote areas were significantly more likely than people living in Major cities to:
- consume alcohol daily (8.0% compared with 5.0%)
- drink in excess of the lifetime risk guideline (21% compared with 15.4%) and of the single
- occasion risk guideline (at least monthly) (29% compared with 24%).
- Levels of recent drug use were similar between remoteness areas, however the type of illicit drug used varied. The burden of drug and alcohol use increases with remoteness. Remote and Very remote areas experienced 2.1 and 2.7 times, respectively, the burden of disease attributable to alcohol use, compared with Major cities in 2011. The rate of burden due to Illicit drug use increased as remoteness increased, for Suicide and self-inflicted injuries, Chronic liver disease and Road traffic injuries—motor vehicle occupant. The rate of drug-induced deaths was higher in Regional and remote areas than in Major cities between 2012 and 2016.(23)
- The remoteness status of the regions within the PHN is included in Table 1 above and more details are also found in general part of the HNA

Table 2: The PHN regions with high socio-economic disadvantage and mental health concerns as predictive factors for harmful AoD use, by LGAs

Geography	SEIFA (% living in most disadvantaged quintile), 2016	Unemployment, March 2021		Total families with parent (children <15 years) not employed,2016		Single Parent Families, 2016		People with mental and behavioural problems, 2017-18*		Crime and Justice (Total Offences), 2019-20	
	%	N	%	N	%	N	%	N	ASR per 100	N	Rate per 100,000
Queensland	20.0	197,575	7.3	66,139	13.8	201,308	16.5	1,089,817	22.7	537,798	10,386
the PHN	27.1	33,233	7.7	12,593	15.8	35,405	16.1	n/a	n/a	80,105	9,002
Central Queensland Area	26.2	7,706	6.1	3,414	14.5	8809	15.6	n/a	n/a	28,197	12,459
Banana (S)	17.2	297	3.5	110	7.4	385	10.6	2,906	20.8	1,309	9,333
Central Highlands (R)	14	717	4.2	240	7.5	729	11.1	5,617	20.9	2,746	9,546
Gladstone (R)	21.5	2,567	7.3	1,036	14.7	2,250	14	14,839	24.1	7,102	11,121
Livingstone (S)	16.5	971	4.8	428	12.5	1,303	13.7	8,195	22.3	2,714	7,044
Rockhampton (R)	39.1	3,111	7.1	1,516	18.3	4,032	19.9	20,960	26.5	13,573	16,558
Woorabinda (S)	100	43	7.3	84	59.6	110	53.4	n/a	n/a	753	73,320
Wide Bay Area	54.8	9,915	11.1	4,258	23.8	9,519	17.2	n/a	n/a	20,204	9,709
Bundaberg (R)	49.5	4,334	10.3	1,919	22.9	4,366	17.3	23,530	24.8	8,910	9,240
Fraser Coast (R)	59.4	5,227	12.6	2,185	25.2	4,826	17.4	25,437	24.4	10,660	9,873
North Burnett (R)	57.1	354	6.7	154	17.6	327	12.6	2,583	24.1	634	5,996
Sunshine Coast Area	13.3	15,612	7.3	4,921	12.9	17,077	15.7	n/a	n/a	31,704	7,777
Gympie (R)	46.1	2,330	10.5	1,116	24.8	2,363	17.8	13,330	25.9	4,761	8,930
Noosa (S)	5.8	1,904	7.0	565	12.2	2,267	15.4	11,494	20.7	4,101	7,272
Sunshine Coast (R)	9.1	11,378	6.9	3,240	11.2	12,447	15.5	66,001	21.3	22,842	6,778

*Source: Modelled Estimates, Public Health Information Development Unit (PHIDU), Social Health Atlas of Australia: Data by LGA, PHIDU, Sep, 2020; Table: Estimates_chronic_disease
Other SES data source: Queensland Government Statistician's Office, *Queensland Regional Profiles* created on the 28th July 2021

2.1.3. Gender

There is evidence that drinking per se and high-volume drinking were consistently more prevalent among men than among women. Among drinkers, the prevalence of high-frequency drinking seems to be consistently greatest in the oldest age group, particularly among men (24). However, women are just as likely as men to develop a substance use disorder. In addition, women may be more susceptible to craving and relapse which ***demands attentions to differences in the AOD service needs for women*** (25)**.** There is also an indication that girls aged 12 to 20 have slightly higher rates of alcohol misuse and binge drinking than their male counterparts. ***For both sexes, marijuana use disorder is associated with an increased risk of at least one other mental health condition***, such as depression or anxiety however women who are addicted to marijuana have more panic attacks and anxiety disorders (25).

In the PHN***, the prevalence rate of alcohol lifetime risk in males was three times that of females*** and almost double that of Queensland overall.(26) In 2017-18, ***Twice as many AOD services were provided to male clients (68%) as female clients (32%) across*** the PHN and this was comparable to overall Australian proportions(27).

The gender difference between seeking AoD services is still being understood. In 2006, it was indicated that women are more likely than men to face multiple barriers to accessing substance abuse treatment and are less likely to seek treatment. Women also tend to seek care in mental health or primary care settings rather than in specialised treatment programs.(28) For most women, the threat of losing custody of their children is an essential barrier to treatment, they report social stigma in private as well as professional contexts as a barrier to treatment. (29)

AIHW data on ***AOD treatment services*** indicated that across the PHN in 2017-18 (25):

- Of the 5,992 closed episodes of AOD treatment services that were provided to a total of 5,025 clients, twice as many services were provided to male clients (68%) compared to female clients (32%) and this was comparable to overall Australian proportions.

AODTS data 2018-19 for the PHN indicates (30):

- Distribution by gender for closed AOD treatment episodes across the PHN (63% males, 36% females) similar to Australia
- higher-than-average proportion of cannabinoid treatment episodes for males in the PHN (69% males, 31% females) and a lower-than-average proportion of opioid episodes for males (58% males, 42% females)
- Smoking followed by ingestion are the most common methods of principal drug use for both males and females (males: smoking 46% of all closed treatment episodes, ingestion 29%; females: smoking 40%, ingestion 35%).
- Table 3 shows the number of closed episodes of treatment by gender within the PHN.

The Queensland Government's Queensland Survey Analytics System (QSAS) data 2019-20 (26) showed that across the PHN:

- The prevalence rate of ***alcohol lifetime risk in males (40%) was three times that of females*** (13%), and almost double that of Queensland overall (22%).

Data for 2018 in Australia's annual overdose report 2020 (31) indicated that in 2014-18:

- In Australia, males were almost three times as likely as females to suffer an unintentional drug-induced death in 2018, accounting for 71.5% of deaths.

2.1.4. Young age

Experimentation with alcohol and other drugs use among young people remains concerning as these age groups are susceptible to permanent damage from alcohol and other drug use as their brains are still developing, which also makes them a vulnerable population. The details on patterns of use of AoD clearly

highlight the need to focus on the young people for whole of the population approaches to reduce harmful use of AoD.(32)

- AIHW data on *AOD treatment services* (27) indicated that across the PHN in 2017-18, of the 5,992 closed episodes of AOD treatment services provided to a total of 5,025 clients:
- The proportion of people receiving AoD services in the PHN was highest in young people aged 20–29 years (27%), followed by age groups 30–39-year (23%), 10-19 year (19%), 40-49 year (17%), 50-59 year (9%) and those 60 years and over (5%).
- The PHN had a higher proportion of young people aged 10-19 year receiving AOD treatment services (19%) than the rest of Australia (12%).

More recent Queensland Health AODTS data 2018-19 for the PHN (30) indicates:

- A distribution by age for ***closed AOD treatment episodes*** across the PHN (young people aged 20–29-year 27%, 30-39 year 26%, 40-49 year 18%, 10-19 year 16%, >50 year 9%)
- Compared to Queensland (14%) the proportion of closed AoD treatment episodes for young people aged 10–19-year was highest in Sunshine Coast HHS (25%) followed by Central Queensland HHS (14%) and Wide Bay HHS (10%)
- ***Cannabinoid use*** was related to 85% of all closed treatment episodes for the young people aged 10-19 year in the PHN, far higher than the overall proportion of treatment episodes relating to cannabinoids for all ages in the PHN (39%). The next highest proportion for cannabinoid use was in young people aged 20-29 year (46%).
- Although ***methamphetamine*** represented only a small proportion of close treatment episodes in young people aged 10-19 year (9%), this was far higher in age groups: 20-29 year (35%) and 30-39 year (39%).

The Queensland Government's Queensland Survey Analytics System (QSAS) regional detailed data (2019-20) showed (26):

- Young people 18-29 years of age had the highest ***rates of alcohol lifetime risk*** (33%) of all groups in the PHN, and this rate was higher than the rate for young people in all other Queensland PHNs and Queensland overall (24%).

These findings are consistent with findings from the National Drug Strategy Household Survey 2019 (33) which found that in Australia for young adults aged 18–24-year:

- 41% ***exceeded the single occasion risk guidelines*** by consuming on average more than 4 standard drinks on one occasion***.***
- 14.6% consumed more than 11 ***standard drinks on one occasion*** at least monthly.
- ***continue to be the most likely age group to use*** cannabis (also most widely used drug of choice for this age group***)*** with 25% having used cannabis in the past 12 months
- Use of meth/amphetamine among younger people has declined over time.

The AIHW ***Burden of Disease*** Study (33) found that in young people aged 15-24 years:

- Alcohol and illicit drug use were the leading causes of the total burden of disease in males
- Alcohol and illicit drug use were the second and third leading causes (respectively) of disease burden in females
- Males experienced nearly twice the burden from alcohol use and nearly twice the burden from illicit drug use, compared with females

- Non-fatal burden was the main contributor to alcohol-attributed burden of disease (AIHW 2019).

The 2019 National Drug Strategy Household Survey (33) indicated that ***younger people across Australia are also more likely to be victims of alcohol-related incidents***, with 1 in 3 (34%) people aged 18–24 having been the victim of any alcohol-related in the previous 12 months.

Data for 2018 in Australia's annual overdose report 2020 (31) indicated that in 2014-18:

- In Australia, people aged 30 years and older account for over 90% of unintentional drug-induced deaths.

This is consistent with findings from the ABS Causes of Death statistics 2017 (33) which indicate that:

- For both males and females, drug induced deaths were lowest for those aged 15–19 years
- Males aged 20–24 are the only age group to have an illicit drug (rather than a pharmaceutical drug) as the most common substance present in drug induced deaths, with heroin being present in 1.6 deaths per 100,00 males.

2.1.5. Older people

Older people make up a considerable proportion of the PHN population (20.6% compared to Qld 15.7%). In 2019, over 1 in 5 people were aged 65 and over and the number and proportion of older Australians is expected to continue to grow (18). Multiple factors impact older people's health including pain, co-morbidities, and social circumstances such as isolation. These factors are important to consider in the context of alcohol and other drug use. Reports from 2019 indicate that (33):

- People in older age groups are more likely to be ex-drinkers than younger people, but people in their 50s (21%) and 60s (17.4%) are also ***more likely to exceed lifetime risk guidelines*** than the general population aged 14 and over (16.8%).
- Compared with people aged 14 and over (4.4%), people in their 50s (6.8%) and 60s (5.7%) were more likely ***to exceed single occasion risk guidelines*** most days or every day.
- From 2001 to 2019, ***recent illicit drug use has nearly doubled*** among both males (from 8.1% to 16.0%) and females (from 5.2% to 10.3%) in their 50s.
- ***Recent use of any illicit drug*** has also become more common among people aged 60 and over (from 3.9% in 2001 to 7.2% in 2019).
- There has been an ***increase in drug-induced deaths*** among older people since 1999.
- Table 4 shows the number of closed episodes of treatment by age groups within the PHN.

2.1.6. Aboriginal and Torres Strait Islander people

The Australian Burden of Disease Study identified that Aboriginal or Torres Strait Islander people experience a burden of disease that is 2.3 times the rate of non-Indigenous Australians (34). The gap in the disease burden is due to a range of factors including disconnection to culture, traditions and country, social exclusion, discrimination and isolation, trauma, poverty, and lack of adequate access to services. Along with these factor tobacco, alcohol, and other drugs are key risk factors contributing to the health gap between Indigenous and non-Indigenous Australians (34).

Key findings of the 2021 report (33) indicates:

- While the ***proportion of Indigenous people who consume alcohol at levels that exceed lifetime risk guidelines*** has decreased overall since 2008, this proportion increased from 14.7% in 2014 to 18.4% in 2018–19.

- In 2019, just under 1 in 4 (23%) Indigenous Australians had ***used an illicit drug*** in the last 12 months. This was 1.4 times higher than for non-Indigenous Australians (16.6%).
- In 2019, 15.5% of Indigenous Australians reported ***recent use of cannabis*** and 7.7% reported recent use of pharmaceuticals for non-medical purposes.
- In 2019–20, 17% of clients seeking alcohol and other drug treatment services aged 10 and over were Indigenous Australians.

Indigenous Australians (3,580 per 100,000 population) were 7 times as likely to receive ***AOD treatment services*** than non-Indigenous Australians (515 per 100,000 population) (33). In 2018–19, where the principal drug of concern was:

- amphetamines—1,014 per 100,000 population for Indigenous Australians compared with 141 per 100,000 population for non-Indigenous Australians
- heroin—172 per 100,000 population for Indigenous Australians compared with 26 per 100,000 population for non-Indigenous Australians
- cannabis—927 per 100,000 population for Indigenous Australians compared with 116 per 100,000 population for non-Indigenous Australians
- alcohol—1,249 per 100,000 population for Indigenous Australians compared with 173 per 100,000 population for non-Indigenous Australians

Travel time for Indigenous clients

- In 2016–17, ***Indigenous clients travelled 1 hour or longer to their treatment service in about 1 in 4 (26%) closed treatment episodes.*** About 1 in 8 (13%) closed treatment episodes for non-Indigenous clients had a travel time of 1 hour or longer (33).
- ***Indigenous clients who sought treatment in Regional and remote areas*** travelled 1 hour or longer to the treatment service in 37% of closed treatment episodes, compared with 13% of closed treatment episodes for Indigenous clients in Major cities (33).

AIHW data on ***AOD treatment services*** (27) indicated that across the PHN in 2017-18, of the 5,992 closed episodes of AOD treatment services provided to a total of 5,025 clients. The majority of services were provided to non-Indigenous people (83%), similar to Australian figures (80%). Aboriginal and Torres Strait Islander people received 13% of services, and 4% were provided to people who did not state their background.

AODTS data 2018-19 for the PHN (30) indicates:

- 14% of ***closed treatment episodes*** in 2018-19 were provided to Aboriginal and/or Torres Strait Islander people across the PHN, and this was slightly less than the Queensland proportion (16%)
- At an area level, a higher proportion of closed treatment episodes were for Aboriginal and Torres Strait Islander people in CQ (20%) than the PHN or Queensland overall, and much lower in SC (6%) (WB 13%)
- Cannabinoids and amphetamines each accounted for 39% of closed treatment episodes for Aboriginal and Torres Strait Islander people across the PHN, followed by alcohol (21%).

The NDSHS 2018-19 (33) indicates that in Australia:

- Between 2010 and 2019, the proportion who ***drank at a risky level on a single occasion*** at least monthly fell from 46% to 34%, as did the proportion who exceeded the lifetime risk guideline, from 32% to 19%

- ***Rates of illicit drug use*** remained fairly stable among Aboriginal and Torres Strait Islander Australians but rose for non-Indigenous Australians.
- The proportion of Aboriginal and Torres Strait Australians who consumed 11 or more drinks at least once a month has declined from 18.8% in 2016 to 10.6% in 2019 (noting that for non-Indigenous Australians, this figure remained stable (6.8% and 6.4%).

The National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2018-19 (33) found that

- 50% of Indigenous Australians aged 15 and over ***exceeded the single occasion risk guidelines for alcohol consumption***, which is an increase since 2002 (35%).
- Over one quarter (28.3%) of Aboriginal and Torres Strait Islanders Australians aged 15 and over had ***used illicit substances*** in the last 12 months.
- Males were substantially more likely than females to have used illicit substances (36.7% compared with 21.1%).
- Those aged 45 years and over were less likely to report that they had used substances in the last 12 months (21.2% compared with 32.9% for those aged 15–29 years and 31% for those aged 30–44 years).

Data for 2018 in Australia's annual overdose report 2020 (31) indicated that:

- In Australia, Aboriginal and Torres Strait Islander people were almost three times as likely to die from an unintentional drug-induced death in 2018, with a rate of deaths of 17.3 per 100,000 population, compared with 6.0 deaths per 100,000 population for non-Indigenous people
- The rate of unintentional drug-induced deaths among Aboriginal and Torres Strait Islander Australians has increased between 2001 and 2018 (from 9.5 to 17.3 deaths per 100,000).
- Stimulants account for a much higher proportion of all deaths for Aboriginal people: in 2017, 33.0% of all drug-induced deaths involved stimulants for Aboriginal people, compared with 19.1% among all non-Aboriginal people (31).
- Table 5 shows the number of closed episodes of treatment by gender within the PHN.

Identified Issues

- *Socio-economic disadvantages, including people who are unemployed, single people with dependent children and people with a mental illness are at higher risk of harmful AOD use. The PHN data indicates that the LGAs of Bundaberg, Fraser Coast and Gympie show disadvantage on two or more of these indicators.*
- *People living in remote and very remote areas continued to be more likely than people in major cities to drink alcohol at risky levels, have higher burden of disease attributable to alcohol use, have higher rate of drug-induced deaths (steady increase) and have increased episodes of amphetamine-related treatment. Within the PHN, 100% population of 4 LGAs , Banana, Woorabinda, North Burnett and Central Highlands lives in outer regional, remote or very remote areas.*
- *Although data indicates higher proportion of men drinking alcohol at risky levels and using drugs, the impacts of harmful AOD use are different on men and women therefore requires attention while commissioning services. Women seek services at the lower rate compared to men due to stigma associated.*
- *Young adults under 29 years of age are at higher risk of harmful use of AOD. LGAs with highest % of young people (15-34 years) are Woorabinda, Rockhampton, Central Highlands, and Gladstone.*

- *People in older age groups (≥50 years) are more likely to exceed lifetime risk guidelines, exceed single occasion risk guidelines most days or every day. Recent illicit drug use has nearly doubled among both males and females and there is an increase in drug-induced deaths among older people since 1999. High % older people (>60 years) within the PHN is in the LGAs of : Bundaberg, Fraser Coast, North Burnett, Noosa and Gympie.*
- *Various socio-economic and historical reasons have impacted on harmful use of AOD in Indigenous Australians. This impact extends from high prevalence of harmful use of AOD, higher morbidity associated with it along with higher mortality.*
- *Use of ranking that triangulates some socio-demographic information (Table 1 above) indicates that 5 LGAs with highest disadvantages within the PHN are Woorabinda followed by North Burnett, Central Highlands, Rockhampton, and Fraser coast. This analysis considers five risk factors that are associated with harmful use of AOD: being Aboriginal and/or Torres Straits Islander, living in remote areas, living in areas identified as most disadvantaged (lowest SEIFA score), % of younger people (15 to 29 years) in the area and % of older people (>60 years) in the area.*

Table 3: Number of closed treatment episodes by gender and region, 2018-19

Gender	Central Queensland		Sunshine Coast		Wide Bay		The PHN		QLD	
	N	%	N	%	N	%	N	%	N	%
Male	899	64%	1,240	64%	1,245	63%	3,384	63%	27,462	65%
Female	501	36%	706	36%	735	37%	1,942	36%	14,430	34%
Other	0	0%	1	0%	0	0%	1	0%	21	0%
Not stated	1	0%	3	0%	0	0%	4	0%	22	0%
Grand Total	1,401	100%	1,950	100%	1,980	100%	5,331	100%	41,935	100%

Source: Queensland Health: Alcohol and Other Drug Treatment Services (AODTS) National Minimum Data Set (NMDS) 2018-19
https://www.data.qld.gov.au/dataset/alcohol-and-other-drug-treatment-services-aodts-national-minimum-data-set-nmds

Table 4: Number of closed treatment episodes by age and region, 2018-19

Age Group	Central Queensland		Sunshine Coast		Wide Bay		The PHN		QLD	
	N	%	N	%	N	%	N	%	N	%
10-19	194	14%	479	25%	196	10%	869	16%	6,075	14%
20-29	430	31%	517	27%	496	25%	1,443	27%	11,294	27%
30-39	414	30%	417	21%	558	28%	1,389	26%	10,450	25%
40-49	225	16%	311	16%	419	21%	955	18%	7,794	19%
50-59	111	8%	153	8%	184	9%	448	8%	3,789	9%
60+	25	2%	73	4%	124	6%	222	4%	2,474	6%
Unknown	2	0%	0	0%	3	0%	5	0%	59	0%
Grand Total	1,401	100%	1,950	100%	1,980	100%	5,331	100%	41,935	100%

Source: Queensland Health: Alcohol and Other Drug Treatment Services (AODTS) National Minimum Data Set (NMDS) 2018-19
https://www.data.qld.gov.au/dataset/alcohol-and-other-drug-treatment-services-aodts-national-minimum-data-set-nmds

Table 5: Number of closed treatment episodes by Indigenous status and region, 2018-19

Indigenous status	Central Queensland		Sunshine Coast		Wide Bay		The PHN		QLD	
	N	%	N	%	N	%	N	%	N	%
Aboriginal but not Torres Strait Islander	277	20%	122	6%	260	13%	659	12%	5,813	14%
Torres Strait Islander but not Aboriginal	12	1%	10	1%	9	0%	31	1%	363	1%
Both Aboriginal and Torres Strait Islander	20	1%	13	1%	12	1%	45	1%	597	1%
Neither Aboriginal nor Torres Strait Islander	1,064	76%	1,695	87%	1,647	83%	4,406	83%	33,278	79%
Not stated	28	2%	110	6%	52	3%	190	4%	1,884	4%
Grand Total	1,401	100%	1,950	100%	1,980	100%	5,331	100%	41,935	100%

Source: Queensland Health: Alcohol and Other Drug Treatment Services (AODTS) National Minimum Data Set (NMDS) 2018-19
https://www.data.qld.gov.au/dataset/alcohol-and-other-drug-treatment-services-aodts-national-minimum-data-set-nmds

2.2. Prevalence of alcohol and other drug use

The consumption of alcohol, tobacco and other drugs is a major cause of preventable disease, illness and death in Australia. This section presents the most recent information on the availability and consumption of alcohol, tobacco and other drugs in the PHN where possible otherwise presents data on state or national level. It also includes related impacts, harms and treatment data. Number of closed episodes of treatment and principle drug of concern statistics are used as a proxy for use of alcohol and other drugs (prevalence) across the region and nationally.

2.2.1. Illicit drug use

The 2019 National Drug Strategy Household Survey Queensland data (33) showed that in 2019, about 1 in 6 (16.9%) people in Queensland had used an illicit drug in the past 12 months, a similar proportion to 2016 (16.8%). Between 2016 and 2019, the recent use of cocaine increased (from 2.1% to 3.6%) and the recent use of pain-killers and opioids for non-medical purposes decreased (from 4.1% to 2.7%).

Cannabis is the most commonly used illicit drug in Queensland (12.8% of people) and this has not changed over time.

- **Cannabis:** AODTS data for 2018-19 (25) showed that for both Queensland and the PHN, cannabis and cannabinoids remained the principal drug of concern (34% closed treatment episodes in the PHN, and 30% QLD). Cannabinoids were a principal drug of concern in all PHN regions. However, there was regional variation across the PHN, with Sunshine Coast having the highest number and proportion of closed treatment episodes for cannabinoids: CQ 34%, 476 closed treatment episodes; SC 41%, 803 episodes; WB 27%, 539 episodes.
- **Methamphetamine**: AODTS data for 2018-19 (25) identified that amphetamines were the principal drug of concern in the PHN in a slightly higher proportion of closed treatment episodes than for Queensland overall (27% PHN, 24% QLD). There were similar proportions of methamphetamine closed treatment episodes across the PHN regions: CQ (29%, 407 episodes) followed by WB (27%, 536 episodes) and SC (26%, 504 episodes) (30)
- **Opioid:** In 2016, ***opioid deaths accounted for 62% of all drug-induced deaths in Australia*** (21). From 2007 to 2016, after adjusting for differences in the age structure of the population, the rate of opioid deaths increased by 62%, from 2.9 to 4.7 deaths per 100,000 population. The increase was driven by an increase in accidental opioid deaths and in pharmaceutical opioid deaths. Across Australia, legal or pharmaceutical opioids (including codeine and oxycodone) are responsible for far more deaths and poisoning hospitalisations than illegal opioids (such as heroin) (33).

2.2.2. Principal drug of concern

Data on the ***principal drug(s) of concern for the PHN*** (AIHW AOD treatment services data (24) indicate that of 5,886 closed treatment episodes across the PHN in 2017-18:

- ***Cannabis remained the principal drug of concern*** across the PHN. Despite dropping from 48% of treatment episodes in 2013-14 to 40% in 2017-18, this was much higher than the proportion of treatment episodes for cannabis in Australia overall (22%).
- ***Alcohol remained the second principal drug of concern*** for the PHN (26% compared to Australia 35%), although this has decreased steadily from 41% of all treatment episodes in 2013-14.
- ***Amphetamine is the third principal drug of concern***, and use has increased since 2013-14 to now represent 21% of all treatment episodes, still lower than 27% in Australia overall.

PHN data from the Queensland Health 2018-19 AODTS NMDS (25) indicate that :

- the proportion of ***closed AOD treatment episodes related to cannabis across the PHN*** has continued to fall (to 34% in 2018-19), although it still remains the principal drug of concern across the PHN.
- Harmful alcohol intake has also reduced slightly to 24% but amphetamines, including methamphetamine, have increased to 27% or second highest principal drug of concern. The high proportions of cannabis treatment episodes were largely influenced by police and illicit drug court diversion programs operating in the state of Queensland (25).

Analysis of HHS areas within the PHN (2018-19) (25) indicates similar ***patterns of principal drug use*** at a regional level, with Sunshine Coast continuing to have the highest proportion of treatment episodes relating to cannabinoids (41%):

- CQHHS: Cannabinoids were the top principal drug of concern (34% of closed episodes), followed by amphetamines (29%) and alcohol (25%)
- WBHHS: Cannabinoids, alcohol and amphetamines each represented 27% of closed treatment episodes
- SCHHS: Cannabinoids were the top principal drug of concern (41% of closed episodes), followed by amphetamines (26%) and alcohol (21%).

Table 6: Number and % closed treatment episodes by region and principal drug of concern (selected), 2018-19

	Opioid		Alcohol		Total amphetamines		Cannabinoids		Total treatment episodes	
	N	%	N	%	N	%	N	%	N	%
Central Queensland	27	1.9%	348	24.8%	407	29.1%	476	34.0%	1,401	89.8%
Sunshine Coast	7	0.4%	408	20.9%	504	25.8%	803	41.2%	1,950	88.3%
Wide Bay	35	1.8%	532	26.9%	536	27.1%	539	27.2%	1,980	82.9%
PHN total	69	1.3%	1,288	24.2%	1,447	27.1%	1,818	34.1%	5,331	86.7%
QLD	527	1.3%	12,558	30.5%	9,704	23.6%	12,172	29.6%	41,165	84.9%

Source: Queensland Health: Alcohol and Other Drug Treatment Services (AODTS) National Minimum Data Set (NMDS) 2018-19 https://www.data.qld.gov.au/dataset/alcohol-and-other-drug-treatment-services-aodts-national-minimum-data-set-nmds

2.2.3. Alcohol use

Overall, the proportion of ***people drinking daily in Queensland*** in 2019 was higher than the national average (6.5% compared with 5.4%) (35). Alcohol-related risk is defined as follows: lifetime risk for alcohol consumption of more than 2 standard drinks per day. single occasion risk for alcohol consumption of more than 4 standard drinks at a single occasion. (36)The proportion of people in Queensland exceeding the lifetime risk guidelines was also higher than the national average (20% compared with 16.8%) There has been little change in these proportions in Queensland since 2007 (33). Nationally, the proportion of people exceeding the single occasion risk and lifetime risk has also remained stable in recent years, although it improved since the NHMRC Guidelines to Reduce Health Risks from Drinking Alcohol were introduced in 2009 (37).

Within the PHN, the Queensland Government's Queensland Survey Analytics System (QSAS) regional detailed data (2019-20) (27) showed:

- The PHN catchment had a higher prevalence of alcohol lifetime risk (25.9%) than Queensland overall (22.5%). Regional rates were higher in SC (28.0%) than WB (23.7%) and CQ (23.7%).

- Male rates were three times those of females (40% vs. 13%) across the PHN, with similar disparities across the three geographical areas.
- Young people 18-29 years of age showed the highest rates of alcohol lifetime risk (33%) of all groups in the PHN, and this rate was higher than the rate for young people in all other Queensland PHNs and Queensland overall (24%).
- Of note, this rate has remained stagnant since 2011-12.

2.2.4. Impact of AOD on the society and community

Alcohol, tobacco and other drug use is associated with a range of adverse health, social and economic impacts. Adverse health impacts are described above. However, the social impacts of AOD are far reaching too. They are pervasive, and include criminal activity and engagement with the criminal justice system, victimisation and road trauma (33).

Risky behaviours and criminal activity

Beyond the illegality of drug use in Australia, the consumption of alcohol and other drugs may influence people to engage in risky or criminal activities such as driving a motor vehicle intoxicated, offensive conduct and verbal or physical violence.

- The most recently available data from the National Drug Strategy Household Survey (NDSHS) is from 2016 and showed that of people aged 14 and over (33):
- Driving a motor vehicle whilst under the influence of alcohol and other drugs significantly increases the risk of an accident. 1 in 10 (9.9%) recent drinkers reporting driving a motor vehicle
- almost 1 in 6 (17.4%) recent drinkers put themselves or others at risk of harm while under the influence of alcohol in the previous 12 months
- risky drinkers (lifetime and single occasion) were far more likely to engage in risky behaviours or harmful activities than low-risk drinkers
- people who recently used illicit drugs were more likely than recent drinkers to engage in criminal behaviour, however criminal activity is generally declining
- 0.6% of people who recently used illicit drugs physically abused someone (down from 2.4% in 2007)
- In 2020, around one-third (33%) of participants in the national Ecstasy and Related Drugs Reporting System (EDRS) reported engaging in some form of criminal activity in the month prior to interview.
- Similarly, 2 in 5 (40%) participants in the 2020 Illicit Drug Reporting System (IDRS) reported engaging in any form of criminal activity in the month prior to interview (38).
- Among participants in the 2017 IDRS who reported recently driving a vehicle, three-quarters (75%) drove within 3 hours of using an illicit or illicitly obtained drug on a median of 24 occasions (39).

Family, domestic and sexual violence

Data shows that incidents of family, domestic or sexual violence often occur in the context of alcohol and other drug use.

- Data from the 2019 NDSHS showed that 21% of Australians aged 14 and over had ever been verbally or physically abused or put in fear by someone under the influence of alcohol. (33)
- Females were more likely than males to report their abuser being a current or former spouse or partner, while males were more likely to report their abuser was a stranger. (33)

- Respondents of a study who reported the use of illicit drugs in the previous 12 months were 3 times as likely to report experiencing violence over the same period and the frequency of violent incidents was 6 times higher. The risk of injury doubled when respondents reported that the most recent incident involved drug use. (40)

Illicit drug use within families

Parental drug use and conflict with parents are family factors that can increase the risk of drug use among younger people. Wave 17 of the Household, Income and Labour Dynamics in Australia (HILDA) Survey data collection for all family members allows the inter-relationship of illicit drug use among family members to be explored. Only findings for cannabis use have been reported and indicate that ***31% of respondents whose mother reported a lifetime history of cannabis use had used an illicit drug in the previous 12 months***. This was 2.5 times higher than those whose mother reported no history of cannabis use (12.7%). Findings were similar when comparing results based on the history of cannabis use for fathers (41).

Homicide

The Australian Institute of Criminology's (AIC) National Homicide Monitoring Program (NHMP) showed that there were 224 homicide incidents recorded in Australia in 2018-19. In 2018–19 in the 194 incidents where the relationship between the victim and offender was known, 5.7% were motivated by an alcohol-related argument and 3.1% were related to drugs.(42)

In 2018–19 (42):

- Victims had consumed alcohol in over one-quarter (27%) of homicide incidents, down from 30% in 2017–18.
- Victims had used illicit drugs (including non-therapeutic levels of pharmaceutical drugs) in around 1 in 5 (21%) of incidents, down from 27% in 2017–18.
- Offenders were recorded as having consumed alcohol in over one-quarter (28%) of homicide incidents, up from 25% in 2017–18.
- Offenders had used illicit drugs in over 1 in 10 (12%) incidents, similar to 2017–18 (13% of incidents)

Victimisation

The 2019 NDSHS showed that (33):

- more than 1 in 5 (21%) Australians aged 14 and over had been a victim of an alcohol-related incident, although this proportion has declined from 30% in 2007.
- just over 1 in 10 people (10.5%) had been a victim of an illicit drug-related incident, up from 9.2% in 2016
- verbal abuse was the most frequently reported incident overall (7.9%) and a significantly greater proportion of people in their 50s reported being verbally abused by someone under the influence of illicit drugs (increasing from 8.0% in 2016 to 9.8% in 2019)
- people in their 20s were most likely to experience an incident caused by someone under the influence of illicit drugs (13.3%), with 2.9% physically abused and 9.8% put in fear

Economic Impacts of harmful use of AOD

The harmful use of alcohol and other drugs has not only above impacts on the society overall but have a number of economic impacts relating to healthcare and law enforcement costs, as follows (43):

- The social costs of alcohol misuse in Australia in 2010 was estimated to be $14.35 billion. The highest costs were associated with productivity losses (42.1%), traffic accidents (25.5%) and cost to the criminal justice system (20.6%).

- Opioid use, including the use of any illegal opioids and the use of pharmaceutical opioids not as prescribed, was estimated to cost $15.76 billion in 2015–16. Premature mortality, criminal justice and other health care were the leading sources of costs.
- The social cost of cannabis use was estimated to be $4.5 billion in 2015–16. More than half (54%, or $2.4 billion) of this cost was related to the criminal justice system, including imprisonment, administering community supervision orders and the impact on victims of crime.
- The estimated social cost attributable to methamphetamine use in 2013–14 was just over $5 billion dollars. This included cost associated with a range of domains including prevention, harm reduction and treatment; health care; premature mortality; crime; child maltreatment and protection; workplace accidents and productivity.

2.2.5. AoD related mortality

Opioids (including both pharmaceutical opioids and heroin) continue to be the primary drug group associated with unintentional drug-induced deaths, though there have been significant changes in the types of opioids since 2001. While deaths involving pharmaceutical opioids have continued to rise, and comprise the largest proportion of deaths involving opioids, there have been dramatic rises in deaths involving heroin since 2012. “There has been a sharp rise in deaths involving stimulants (including methamphetamine) in Australia since 2012, which is seen in both regional and urban areas” (31).

In the PHN, total rates of drug related deaths increased to 11 per 100,000 (2014-2018), from 9.8 per 100,000 (2009-2013), with the accidental drug related death rate increasing slightly to 8.0 per 100,000 (2014-2018), from 7.7 per 100,000 (2009-2013) (31) . This equated to a total of 103 drug-induced deaths across the PHN in 2018, including 72 accidental drug induced deaths.

Data for 2018 in Australia’s annual overdose report 2020 indicated that in 2014-18 in Australia (31):

- Queensland had the highest increase of any state or territory in unintentional drug-induced deaths caused by benzodiazepines (3.9 times greater than 2004-08 rate), stimulants (7.7x 2004-08 rate) and opioids (4.2x 2004-08 rate).
- Almost three quarters of drug-induced deaths in 2018 were unintentional.
- Opioids continued to be the most commonly identified drug group in unintentional drug-induced deaths.
- In every state and territory across Australia, the rate of unintentional drug-induced deaths was higher outside the capital city in 2018.
- People aged 30 years and older account for over 90% of unintentional drug-induced deaths.
- Males were almost three times as likely as females to suffer an unintentional drug-induced death in 2018, accounting for 71.5% of deaths
- Aboriginal and Torres Strait Islander people were almost three times as likely to die from an unintentional drug-induced death in 2018, with a rate of deaths of 17.3 per 100,000 population, compared with 6.0 deaths per 100,000 population for non-Aboriginal people.

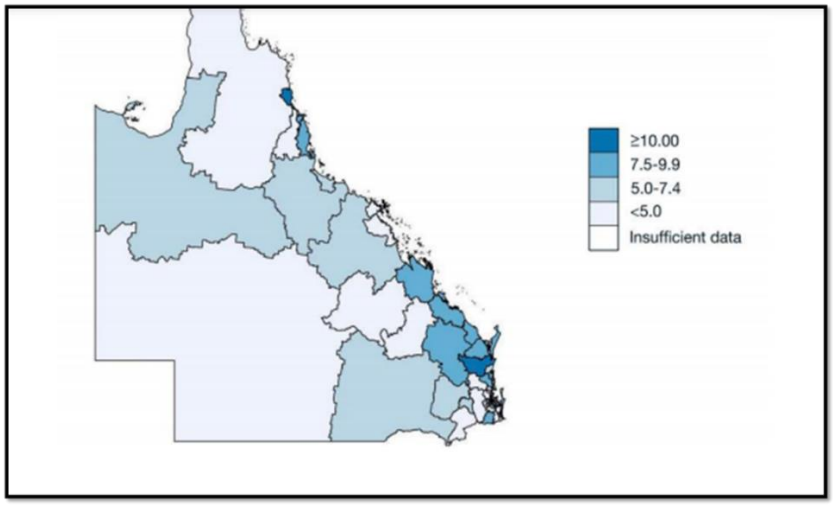
Specifically, within the PHN Burnett SA3 continues to show very high (≥10 per 100,000) unintentional drug-induced deaths in 2013-2017. WB: Bundaberg, Hervey Bay

- CQ: Rockhampton
- SC: Gympie – Cooloola, Nambour, and Sunshine Coast Hinterland (44).

Unintentional drug-induced death (2014-2018) within the PHN are represented in the map below by SA3 regions.

Note: The 2020 report state on p65 that for Queensland data the section does not include data as a rate per 100,000 for different drug types, because relatively low numbers in some drug groups for regional and rural Queensland makes calculation of rates less reliable. Therefore, 2019 data is used for SA3 regions.

Figure 1: Unintentional drug-induced deaths 2014-2018 (Statistical Area 3), rate per 100,000 population



Source: Penington Institute (2020). Australia's Annual Overdose Report 2020. Melbourne: Penington Institute. Page 80.

2.2.6. Alcohol and Other Drug Use during COVID

The data is available on how pattern of usage of AoD changed during COVID pandemic. It also summarises the impact on treatment during this period. It is gathered and published by AIHW. (45)

- In May 2020, 27% of ANUPoll respondents reported having decreased their alcohol consumption since the spread of COVID-19 and 20% had increased.
- 37% of Ecstasy and Related Drugs Reporting System participants used a different main drug during COVID-19.
- 49% of Illicit Drug Reporting System participants had a disruption to their drug treatment since COVID-19.
- 12% of IDRS participants had difficulties accessing sterile needles & syringes and 5% had difficulties safely disposing of used needles & syringes.
- alcohol and cannabis were the most common drugs where people said their use increased while meth/amphetamine and MDMA were the most common drugs where people said their use decreased
- 1 in 2 (52%) of EDRS participants reported a decrease in frequency of use of ecstasy and related drugs between February 2020 and April–July 2020

While how this change has impacted overall mental and physical health is unclear, the association on increase in alcohol or drug use and other impacts on the society are also yet to emerge.

Identified Issues

- *Principle Drug Use*
  - *Based on closed episodes data 2018-19: cannabis (34%) remains the principle drug of concern followed by Methamphetamine (27%) and alcohol (24%) within the PHN*
  - *Treatment episodes of principle drug use distribution in HHSs: Cannabinoids (CQ 34%, WB 27%, SC 41%), alcohol (CQ 25%, WB 27%, SC 21%) and amphetamines (CQ 25%, WB 24%, SC 23%)*
- *Alcohol Use*
  - *Highest proportion of alcohol lifetime risk was in SC (28% Qld=22%)*
  - *Men, young people (18-29 years) were at higher risk of drinking alcohol over lifetime risk levels*

- *Opioids*
    - *The rate of opioid prescribing in the PHN was well above the national average in 2016-17, with only 4 of the 16 PHN SA3 regions being below the Queensland average age-sex standardised rate of 67 opioid medicine prescriptions per 100 population (Buderim, Central Highlands, Noosa, Biloela).*
    - *Maryborough, Hervey Bay and Gympie-Cooloola were in the highest 10% of age-standardised dispensing rates for opioids nationally*
- *AOD associated impacts on society*
    - *AOD, domestic violence, and assault and rape offences in the PHN had increased from 23,054 in 2014-15 to 25,631 in 2016-17. This represented an average annual growth of 5.4%.*
    - *Sharp decrease observed in alcohol related offences was offset by increases in drug related offences and domestic violence.*
    - *Highest rates associated with alcohol related offences were observed in Woorabinda and Banana LGAs, while the lowest rates were recorded in Bundaberg LGA*
    - *Highest rates for drug related offences were observed in Woorabinda & Rockhampton LGAs, while the lowest rates were in Noosa LGA*
- *AOD related mortality*
    - *Total rates of drug related deaths increased within the PHN from 2009-13 to 2014-18.*
    - *Opioids continued to be the most commonly identified drug group in unintentional drug-induced deaths.*
    - *Risk of higher rate of unintentional drug-induced deaths increased in people living outside the capital cities, in men, in people aged over 30 years and over and/or in Aboriginal and Torres Straits Islander people*
    - *High rate of unintentional drug induced deaths in 2013-2017 within the PHN was reported in Bundaberg, Hervey Bay, Rockhampton, Gympie – Cooloola, Nambour, and Sunshine Coast Hinterland*

Impacts of harmful use of AOD are far reaching and include criminal activity, abuse, homicide, domestic violence, and road trauma. The social and economic impacts affect families, relationships, children, and elderly over lifetime and a lifecourse approach is required to address this complex issue.

2.2.7. Selected priority population groups

Certain population subgroups are at higher risk of AoD use because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with gender. The section covers key AoD issues and barriers specific to various population sub-groups that require more targeted and tailored approach to address the issues.

There is a strong association between problematic AOD use and priority populations identified below (33):

- ***Homeless people***: Around one in ten clients of specialist homelessness services reported problematic drug or alcohol use
- ***People in contact with criminal justice system:*** AOD consumption was more prevalent among people in contact with the criminal justice system; around two thirds of prison entrants smoke tobacco daily, and around two thirds report illicit drug use in 12 months prior to incarceration
- ***LGBTIQ community:*** People identifying as lesbian, gay or bisexual have relatively high rates of substance use compared with heterosexual people, though daily smoking and risky alcohol consumption have declined; however, there is a lack of comprehensive data available on the associated harms for this population group
- ***People with mental health concerns:*** Among people with self-reported mental health conditions and high or very high levels of psychological distress, drug use has varied over time. Between 2016 and 2019, recent cocaine use increased for both groups and use of pain-killers/pain relievers and opioids decreased.

Homeless People

There is a strong association between problematic AOD use and experiences of homelessness. Within the PHN there are 3,049 homeless people (2016 data). The highest numbers are on Sunshine Coast (1,184) followed by Wide Bay (933) and Central Queensland (932), with the highest rate per 100,000 in Woorabinda (652) followed by North Burnette (63) (Qld 45.6 per 100,000). Fraser Coast (456), Bundaberg (408) and Rockhampton (372) LGAs have the highest number of homeless people (18).

The data on national level indicates that in 2019-20 (33):

- one in ten (10%) clients of specialist homelessness services (SHS) reported having problematic drug and/or alcohol use.
- 6% of SHS clients sought assistance for problematic drug use or substance use, and 3% sought assistance for problematic alcohol use.
- 44% of SHS clients with problematic drug and/or alcohol use also reported a current mental health issue.
- Roughly, applying these proportions to the overall PHN data (3,049 homeless people),
- 304 homeless people having problematic drug and/or alcohol use
- 183 requiring assistance for problematic drug use or substance use, and 91 requiring assistance for problematic alcohol use.
- Around 1,340 homeless people with problematic drug and/or alcohol use require help for a current mental health issue.

People having an association with criminal justice system

People in prison usually come from disadvantaged backgrounds, with poorer physical and mental health compared to the general population. They are less likely to have accessed health care services, and more likely to have a history of risk behaviours (46) .

- The risky consumption of alcohol has been found to be strongly associated with adverse outcomes including criminal offending (47). Alcohol consumption was common among police detainees, with data from 2019 showing that 31% of police detainees reported consuming alcohol in the 48 hours prior to their detention.
- A link between the use of illicit drugs and involvement in the criminal justice system is established in the literature. In 2019, 78 % (n=676) of detainees tested positive to at least one type of drug, and 44 % (n=382) tested positive to more than one drug type. Methamphetamine had the highest test positive rate of any drug (51%, n=444), and was also described as the most readily available (48). Cannabis (46%) accounted for the greatest proportion of national illicit drug arrests in 2018–19 (49)
- The Health of Australia's Prisoners 2018 (46) reports that overall, two-thirds (65%) of prison entrants reported using illicit drugs in the 12 months before incarceration, with the most common drug being methamphetamine (43%) followed by cannabis (40%).
- Based on available 2020 data (50) , there were 13,656 drug related offences reported by police within the PHN. Highest rate of drug related offences was in Woorabinda shire (8,179.2 per 100,000) followed by Rockhampton Shire (2,939.9) and Gladstone regional council (2,104.4). (See Table 7 below)
- Based on available 2020 data (50) , there were 5,265 drink driving offences reported by police within the PHN. Highest rate of drink driving offences was in Woorabinda shire (1,071.1 per 100,000) followed by Banana Shire (1,005.3) and Gladstone regional council (892.5).

Table 7: Police Records 2018 to 2020 showing numbers of drug offences and drink driving offences

	Number of drug offences			Number of drink driving offences		
Year	**2018**	**2019**	**2020**	**2018**	**2019**	**2020**
Banana Shire Council	180	302	256	122	169	141
Bundaberg Regional Council	1,450	1,534	1,702	684	637	690
Central Highlands Regional Council	815	556	447	247	321	203
Fraser Coast Regional Council	1,359	1,680	1,451	518	535	560
Gladstone Regional Council	1,047	1,150	1,344	435	535	570
Gympie Regional Council	966	823	941	362	354	324
Livingstone Shire Council	273	497	433	178	165	188
Noosa Shire Council	704	922	880	364	419	404
North Burnett Regional Council	150	257	92	92	95	57
Rockhampton Regional Council	1,876	1,937	2,410	619	586	544
Sunshine Coast Regional Council	4,008	3,834	3,616	2,202	2,018	1,573
Woorabinda Shire Council	85	54	84	13	10	11
Total for the PHN	12,913	13,546	13,656	5,836	5,844	5,265

Source: https://www.police.qld.gov.au/maps-and-statistics

With nearly 80,000 offences within the PHN during 2019-20 (18) it is critical to understand the number of offences associated with harmful AOD use to assess the need of required services in the areas with high

offences. In 2016-17, the highest rates were observed in Woorabinda and Banana, both in CQ, while the lowest rates were recorded in Bundaberg WB (51). The highest rates for drug related offences were also observed in CQ (Woorabinda & Rockhampton LGAs), while the lowest rate was in Noosa (SC).

LGBTIQ community

There is a lack of publicly available and comprehensive data examining the use of alcohol and other drugs by people identifying as LGBTIQ (33).

The NDSHS has consistently shown high rates of substance use among people who identify as gay, lesbian or bisexual relative to the heterosexual Australian population (33). These proportions have declined for smoking and alcohol use but remain relatively stable for illicit drug use. After adjusting for differences in age, people who were homosexual or bisexual were still far more likely than others to smoke daily, consume alcohol in risky quantities, use illicit drugs and use pharmaceuticals non-medically in 2019 (33).

The NDSHS 2018-19 (33) indicated that after adjusting for age differences, compared with people who identified as heterosexual, people who identify as homosexual or bisexual were:

- 1.5 times as likely to exceed the alcohol lifetime risk guidelines (25% compared with 16.9%)
- 1.4 times as likely to exceed the alcohol single occasion risk guidelines at least monthly (35% compared with 26%)
- 9.0 times as likely to have recently used inhalants (9.9% compared with 1.1%)
- 3.9 times as likely to have recently used meth/amphetamine (5.1% compared with 1.3%)
- 3.5 times as likely to have recently used hallucinogens (4.9% compared with 1.4%)
- 2.6 times as likely to have recently used ecstasy (7.4% compared with 2.9%).

2.2.8. PHN Stakeholder Survey Input

The ***PHN Stakeholder HNA Survey*** (2021) consultation indicates that, of 240 respondents across the PHN, AOD was ranked in the top three community health concerns for the following LGAs, all in Central Queensland (noting that the three highest ranked health concerns across the PHN overall were mental health and suicide, chronic health conditions, and social factors):

- AOD was ranked as the second highest health concern in Woorabinda (n=10, 15.9% of respondents) and Rockhampton (n=17, 11.6% of respondents)
- AOD was ranked as the third highest health concern in Livingstone (n=9, 12.5% of respondents).

The ***PHN Indigenous Community Health Survey*** (2020-21) found that of 621 respondents:

- AOD was the 2nd highest rated urgent community health concern for Aboriginal and Torres Strait Islander people in the PHN, indicated by 62% of respondents (behind mental health, 65%)
- Males ranked AOD the highest urgent community health concern, and females ranked it 2nd
- All age groups ranked AOD the 2nd highest community health concern, except those 64+ years who ranked it 4th
- Amongst LGBTIQ Aboriginal and Torres Strait Islander people (23 responses), AOD was ranked the 3rd highest community health concern behind mental health and chronic health conditions.

The ***PHN Community Health Survey*** (February 2021) found that, of 612 respondents across the PHN:

- 89.5% indicated that was important or very important to them that people of all ages do not binge drink or abuse drugs, and only 7.8% were satisfied with the current state

- A need to reduce AOD use particularly amongst young people, and improve access to AOD services and supports, was indicated as a key area for change across LGAs in each of the three PHN regions (specifically Banana in CQ, Bundaberg and Fraser Coast in WB, and Sunshine Coast in SC).

Identified Issues

- *There are at least 1,340 homeless people within the PHN requiring support for various AOD and/or mental health services (total 3,049 homeless people within the PHN)*
- *Within the PHN there are high rates of drug related and drink driving offences. These offences vary within the PHN however Woorabinda and Gladstone LGAs consistently show higher rates. The close association between AOD harmful use and contact with criminal justice system requires the health and CJS to work together towards a solution-oriented approach.*
- *The reasons such as stigma and higher mental health concerns in LGBTIQ+ community might also mean that these populations are far more likely than others to smoke daily, consume alcohol in risky quantities, use illicit drugs and use pharmaceuticals non-medically. The socio-demographic factors in such communities require attention while addressing AOD concerns.*
- *People with mental health conditions and high or very high levels of psychological distress continue to be more likely to smoke and consume alcohol and illicit drugs than people without these conditions.*
- *The consultation indicates:*
    - *AOD ranked in the top three community health concerns for the many LGAs within the PHN.*
    - *AoD is the 2nd highest rated urgent community health concern for Aboriginal and Torres Strait Islander people in the PHN*
    - *AoD is ranked by males as the highest urgent community health concern, and females ranked it 2nd highest*
    - *AoD is one of the top three health concerns for LGBTIQ Aboriginal and Torres Strait Islander people*
    - *There is a need to reduce harmful AOD use particularly amongst young people, and*
    - *Need to improve access to AOD services and supports was indicated as a key area for change across LGAs in each of the three PHN regions (specifically Banana in CQ, Bundaberg and Fraser Coast in WB, and Sunshine Coast in SC).*

3. Service Needs Analysis

Alcohol and other drug treatment services help people to address their own drug use and provide support to their family and friends. Good AOD public policy involves a balance between reducing the supply of drugs (through regulation and law enforcement), reducing the demand for drugs (through prevention and treatment) and reducing the harmful consequences of use (through harm reduction interventions). Treatment objectives can include reducing or stopping drug use and improving social and personal functioning. Treatment services include detoxification, rehabilitation, counselling and pharmacotherapy, and are delivered in residential and non-residential settings. Overseas evidence and reflections from Australian service providers suggest that social stability factors (52) — such as employment, positive family relationships and stable housing — are crucial determinants of drug use patterns. Alongside AOD treatment, effective responses can resource integrated services that support people to achieve their AOD treatment goals.

This section provides key findings from data and consultations regarding the volume and types of AOD treatment and other related services provided in the PHN, with comparison both within the PHN and with Queensland and national data to identify areas of service need.

The rate of closed treatment episodes for the PHN in 2018-19 ranked 20th (864.27 per 100,000) from the top (3328 per 100,000 highest number of episodes for Northern Territory PHN) amongst the 31 PHN across Australia while the rate of number of clients ranked 17th (697.12 per 100,000) highest nationally. (highest 1771.25 per 100,000 for the Western Queensland PHN) (53). This might indicate lack of access to AoD treatment within the region as rate of people accessing the services ranks higher than closed treatment episodes.

3.1. Alcohol and other drug treatment services

3.1.1. AOD services and service delivery

Volume and type of services

Queensland Health AODTS data (30) for 2018-19 indicates that:

- In 2018-19, a total of 5,331 treatment episodes were delivered across the PHN, higher than the 4,996 services delivered in 2017-18.
- 37% of these treatment episodes were each delivered in Wide Bay (1,980 episodes) and Sunshine Coast (1,950 episodes), and 26% of episodes were delivered in Central Queensland (1,401)
- AOD treatment services were delivered at a rate of 608 AOD treatment episodes per 100,000 population across the PHN (20, 54) (Queensland rate of 823 episodes per 100,000)
- Wide Bay had the highest rate of treatment episodes (929 per 100,000), above the Queensland rate, followed by Central Queensland (618) and Sunshine Coast (446), both well below the Queensland rate. The low rate of treatment episodes in Central Queensland is important, given that people living in remote and very remote areas are more likely than people in major cities to drink alcohol at risky levels (22).

Types of AOD services delivered in the PHN are also indicated by Queensland Health AODTS data for 2018-19 (30):

- The majority of AOD main treatment episodes in the PHN during 2018-19 were for counselling (51%), well above the proportion of episodes for counselling in Queensland overall (34%); CQ had the highest proportion of treatment episodes with counselling as the main treatment type (65%), followed by WB (49%) and SC (42%)
- The second most frequently provided AOD main treatment type was provision of information and education, in the same proportions as Queensland (27%) (note that in the AODTS NMDS, police and

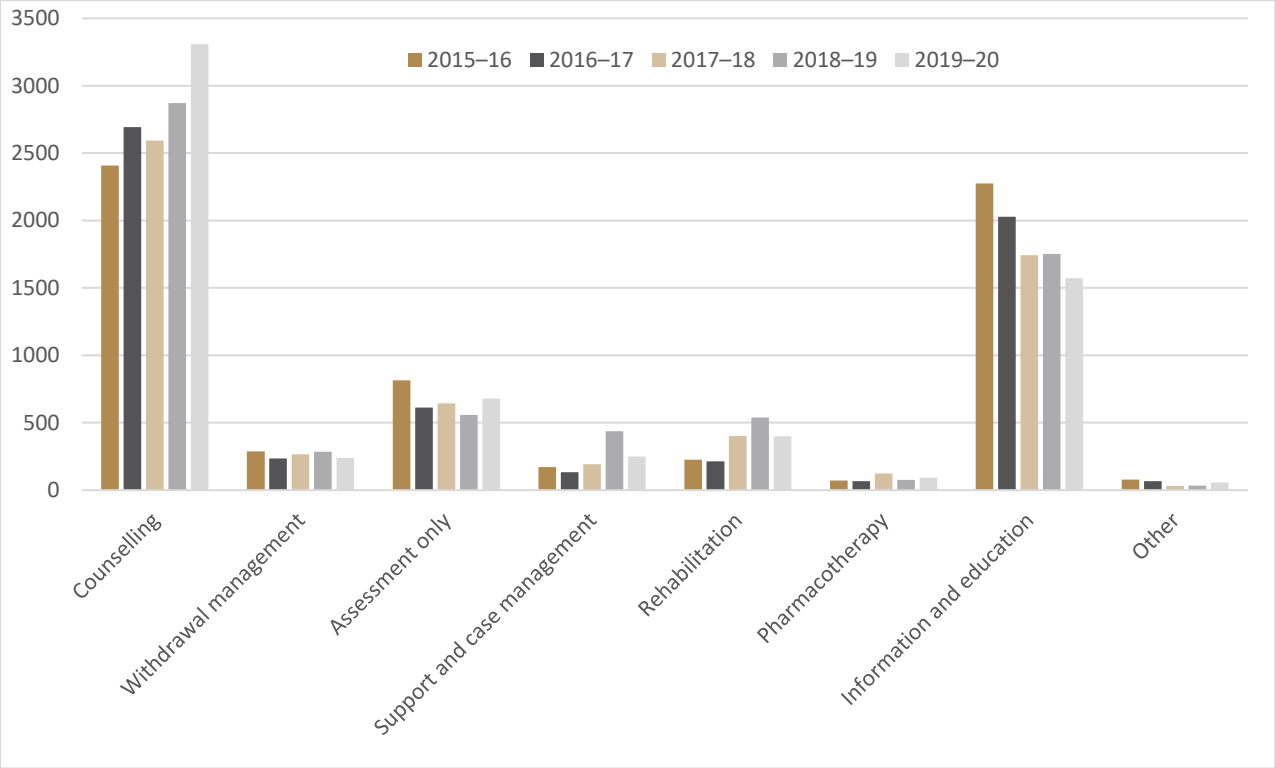
court diversion client treatment is recorded under 'information and education', and these treatment sessions also include assessment); SC had the highest proportion of treatment episodes with information and education as the main treatment type (39%), followed by CQ (23%) then WB (19%)

- Although a slightly higher proportion of main treatment episodes in the PHN were for rehabilitation than Queensland overall (8% vs 6%), this varied across the regions; the number and proportion of rehabilitation treatment episodes was negligible in CQ (n=6 of 1401 episodes, 0%) and highest in WB (15% of episodes)
- The proportion of PHN AOD treatment episodes for assessment only (5%) and withdrawal management (2%) were well below the proportions of AOD episodes for these services in Queensland overall (13% and 10% respectively); in both CQ and SC, only 10 treatment episodes in total for withdrawal management as the main treatment type were provided during 2018-19 (1% of total episodes in each region).

Note that different data sets show different numbers for closed treatment episodes e.g., for 2017-18: AIHW AODTS in Australia: PHN Analysis = 5,992 while Qld Governments AODTS NMDS shows PHN = 4,996. The data is referenced accordingly as available.

More recent data from AIHW (2019-20) presents number of treatment episode on the PHN level.(55) The figure below shows the distribution of treatment episodes by treatment type overtime. *Most of episodes of care were delivered as counselling services, the pattern that is not changed much overtime. Reduction in information and educational services is also visible.*

Graph 1: Number of closed treatment episodes by main treatment type, the PHN, 2015-2016 to 2019-20



Source: https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/data

3.1.2. Opioid Prescribing

Opioids can be an effective component of the management of acute and cancer-related pain. However, the evidence shows that for most people with chronic non-cancer pain, opioids do not provide clinically important improvement in pain or function compared with placebo. Opioids carry significant risk of harm, even when used as prescribed. These risks can range from nausea, constipation and hyperalgesia through to addiction, respiratory depression, coma and death. Over the past decade, Australians have experienced a significant

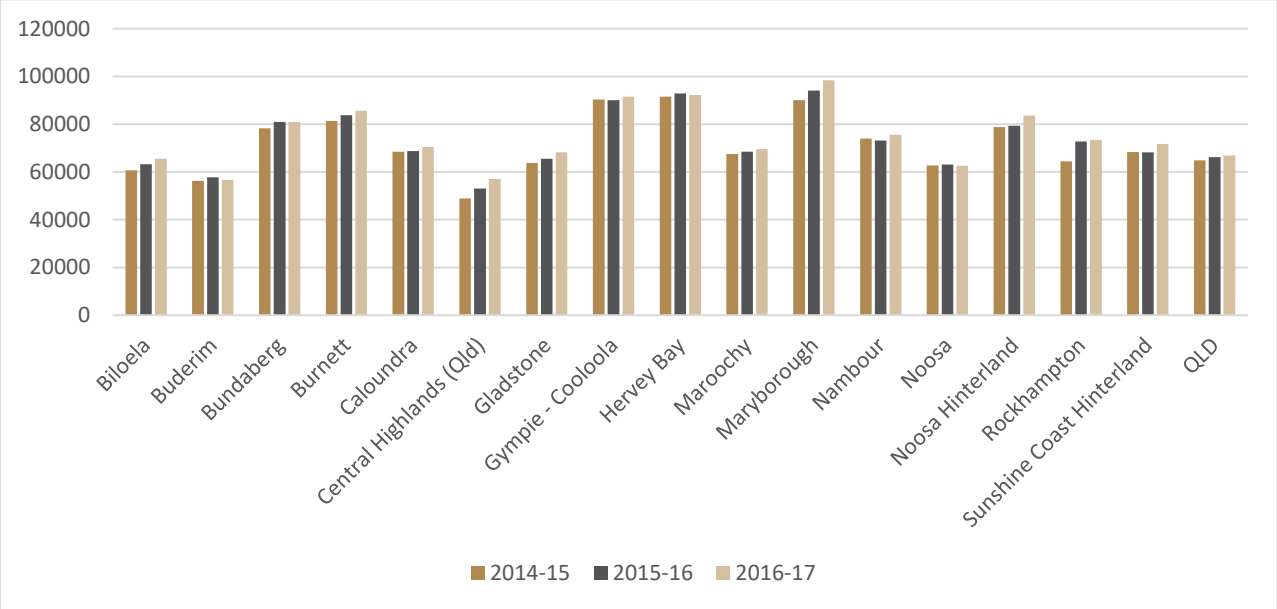
increase in the level of harm and deaths arising from the use of pharmaceutical opioids. Every day in Australia, nearly 150 hospitalisations and 14 emergency department admissions involve issues relating to opioid use, and three people die from the harm that results. (56)

The rate of opioid prescribing in the PHN was well above the average in 2016-17 (44), with only 4 of the 16 PHN SA3 regions being below the Queensland average age-sex standardised rate of 67 opioid medicine prescriptions per 100 population (Buderim, Central Highlands, Noosa, Biloela), and only 2 below the Australian average of 59 per 100 (Buderim and Central Highlands).

- Specifically:
- More than 700,000 prescriptions for opioid medicines were dispensed across the PHN in 2016-17, translating to a crude rate of almost 87 scripts per 100 people, much higher than QLD (71) and Australia (64).
- The highest age-sex standardised rates of PBS/RPBS prescriptions dispensed for opioid medicines per 100 people in the PHN were observed in:
  - WB: Maryborough (98), Hervey Bay (92), Burnett (86) and Bundaberg (81) SA3s
  - SC: Gympie-Cooloola (91), Noosa Hinterland (84), Nambour (76), and Sunshine Coast Hinterland (72) SA3s
  - CQ: Rockhampton (73) SA3.

Maryborough, Hervey Bay and Gympie-Cooloola were in the highest 10% of age-standardised dispensing rates for opioids nationally (44).

Graph 2: Number of PBS/RPBS prescriptions dispensed for opioid medicines per 100,000 population, SA3 regions within the PHN, overtime form 2014-15 to 2016–17



Source: Australian Commission on Safety and Quality in Health Care (ACSQHC). *The Third Atlas of Healthcare Variation 2018: 5.7.4 Data file – Opioid medicines dispensing 2016-17* https://www.safetyandquality.gov.au/publications-and-resources/resource-library/third-atlas-healthcare-variation-2018-data-sets

Who accesses services?

Queensland Health AODTS data at a regional level within the PHN (2018-19)(30), indicate the following regarding AOD treatment service users:

- Approximately two thirds of clients in the PHN were male, a pattern evident across areas and aligned to state ratio
- Nearly half (47%) of clients in the PHN were aged 10 to 29 years, slightly higher than the Queensland rate of 43%
- A high proportion of treatment services were provided to older clients in Wide Bay, with nearly half of clients aged 30-49 years (WB 49%; CQ 46%; SC 37%; QLD 44%)
- The majority of clients accessing AOD services in the PHN were non-Indigenous (83%), slightly higher than the Queensland rate (79%)
- A higher proportion of treatment services were provided to clients of Aboriginal and/or Torres Strait Islander background in Central Queensland (20%) (WB 13%, SC 6% Qld 21%)
- Within the PHN, 98.5% of clients accessed services in relation to their own AOD use, and 1.5% for others' AOD use.

Who delivers services?

AIHW identified 25 organisations providing publicly funded AOD treatment services in 2017-18 across the PHN (22). These included 16 non-government and 9 government agencies, and include services commissioned by the PHN.

Queensland Health AODTS data for 2018-19 indicates that of 5,331 total closed treatment episodes in the PHN (30):

- 57% were delivered by private (non-government) agencies and 43% by public (government) agencies (compared to a 50:50 split across Queensland overall)
- Wide Bay had the highest proportion of services delivered by private (non-government) agencies (73% of 1,980 services) and Central Queensland the least (42% of 1,401 services) (SC 51% of 1,950).
- The proportion of AOD treatment services delivered by the private (non-government) sector has increased from 45% in 2017-18 to 57% in 2018-19 in the PHN. This sharp increase is reflective of the 30% decrease in the number of services delivered by the public sector since 2015-16 (3,395 treatment episodes in 2015-16 to 2,763 in 2017-18, then to 2,306 in 2018-19) (30).

Clients who are in an opioid pharmacotherapy program are not included in the AODTS NMDS dataset (30). Opioid pharmacotherapy is prescribed by medical personnel in each state and territory who have undergone requisite training and are authorised to prescribe opioid pharmacotherapy to clients (57). National opioid pharmacotherapy statistics annual data (NOPSAD) 2020 indicates that (55):

- In Queensland there were 292 registered opioid prescribers in 2020, and all were registered to prescribe more than one type of drug
- Based on a snapshot day, 41% worked in the private sector (compared with 82% across Australia) and 40% worked in the public sector (13% nationally).

Where are services provided?

Queensland Health AODTS data (30) for 2018-19 indicates that:

- The proportion of closed treatment episodes delivered in a non-residential setting was far higher in the PHN than in Queensland overall (82% the PHN compared with 58% QLD), and the proportion of outreach services was lower in the PHN (13% the PHN, 28% QLD)

- Only 3% of treatment episodes were delivered in residential treatment facilities in the PHN compared with 9% in Queensland overall, with this rate being highest for Sunshine Coast (SC 7%, CQ 1%, WB 0%)
- Wide Bay had the highest proportion of services provided in non-residential settings (92%), with 6% via outreach and only 2 episodes (0%) in residential facilities.

Note that COVID-19 impacted how AOD treatment services were delivered across Australia during 2020. Based on a survey conducted in May-June 2020 by the State and Territory Alcohol and Other Drugs Peaks Network, nearly 4 in 5 AOD treatment providers indicated that they had moved from face-to-face delivery to telehealth (online or telephone) as a result of the pandemic, with the majority indicating that they would consider continuing these changes post pandemic. This shift particularly applied to delivery of non-residential services.(58)

3.1.3. Screening services

Queensland Health AODTS data for 2018-19 indicates that:(30)

- Assessment-only treatment episodes were delivered at much lower rates per 100,000 population in the PHN (31 per 100,000) than Queensland (111 per 100,000) and were similar across PHN areas (CQ 27; SC 29; WB 39)
- Assessment-only main treatment episodes comprise a lower proportion of total treatment episodes within the PHN (5%) compared to Queensland overall (13%), and these figures are similar across the 3 PHN areas
- Although the proportion of assessment-only episodes was similar in 2017-18 within the PHN (6%), the actual number fell from 309 episodes across the PHN in 2017-18 to 270 in 2018-19
- The majority of assessment-only episodes in the PHN are provided by government organisations (71%), and in non-residential delivery settings (83%), with 15% provided via outreach.

Findings from the ***PHN Stakeholder HNA Survey*** support that in the general practice setting, GPs may be unwilling to take on the care of patients with substance use disorders.

3.1.4. Counselling services

Queensland Health AODTS data for 2018-19 indicates that (30):

- Counselling episodes were delivered at slightly higher rates per 100,000 population in the PHN (308 per 100,000) than Queensland (283 per 100,000) and varied across PHN areas with Sunshine Coast having the lowest rate (CQ 400; SC 186; WB 460)
- 51% of main treatment episodes in the PHN were for AOD counselling in 2018-19, and this was higher than the proportion of episodes for counselling in Queensland (34%)
- Central Queensland has the highest proportion of episodes for counselling (65%), almost double Queensland proportions, with much lower proportions than Queensland in assessment-only, rehabilitation and withdrawal management services
- The proportion and actual number of main treatment episodes for counselling have risen since 2017-18 within the PHN (n=2,366, 47% in 2017-18; n=2,700, 51% in 2018-19)
- The majority of AOD counselling episodes in the PHN are provided by private (non-government) organisations (58%), and in non-residential delivery settings (77%), with 20% provided via outreach.

3.1.5. Withdrawal management services

Queensland Health AODTS data for 2018-19 (20) indicates that:

- Withdrawal management main treatment episodes were delivered at much lower rates per 100,000 population in the PHN (15 per 100,000) than Queensland (81 per 100,000), with Sunshine Coast and Central Queensland having even lower rates (SC 2 per 100,000; CQ 4; WB 52)
- Only 2% of main treatment episodes in the PHN were for AOD withdrawal management in 2018-19, which is low compared with the proportion of episodes for withdrawal management in Queensland (10%)

- Wide Bay has the highest number and proportion of episodes for withdrawal management (n=110, 6%), with Central Queensland and Sunshine Coast each having only 10 episodes in 2018-19 (1%)
- The actual number of main treatment episodes for withdrawal management have risen since 2017-18 within the PHN although proportions remain the same (n=94, 2% in 2017-18; n=130, 2% in 2018-19)
- The majority of AOD withdrawal management treatment episodes in the PHN are provided by private (non-government) organisations (57%), and in non-residential delivery settings (92%).

A 2019 evaluation of a local withdrawal nurse program explored 450 clients over three years (59). The report identified a growing proportion of clients citing their principal drug of concern as methamphetamine (ice) – greater than the state average – which aligns with state and national trends. They also highlight the protracted and complex nature of methamphetamine withdrawal, with symptoms lasting weeks to months, and a high prevalence of complications. Queensland Health Clinical Practice Guidelines (60) for Alcohol and Drug Withdrawal notes that withdrawal from psychostimulants is not medically dangerous and can often be managed in an ambulatory treatment setting, whilst more severe cases who experience psychosis, may need to be managed in a psychiatric inpatient setting. This difference in withdrawal management requirements will need to be factored into service planning in areas of high methamphetamine use.

Findings from the ***PHN Stakeholder HNA Survey*** support that there are current gaps in availability and access to detox services across all areas of the PHN.

3.1.6. AOD rehabilitation services

AIHW data for 2017-18 indicated that 7% of AODTS episodes (401 episodes) were for rehabilitation, aligned to 6% nationally (58).

Queensland Health AODTS data for 2018-19 indicates that of the 5,331 treatment episodes in that period (30):

- Rehabilitation main treatment episodes were delivered at the same rate per 100,000 in the PHN as Queensland overall (50 and 52 per 100,000 respectively)
- However, rehabilitation treatment episode rates varied across the 3 PHN areas, with the rate in Central Queensland being extremely low (3 per 100,000) and the rate in Wide Bay (142 per 100,000) being higher than the Queensland rate of 52 per 100,000 (SC 30 per 100,000)
- 8% of main treatment episodes in the PHN were for AOD rehabilitation in 2018-19, slightly higher than Queensland overall (6%)
- Wide Bay has the highest number and proportion of episodes for rehabilitation (n=303, 15%), with Central Queensland recording negligible rehabilitation episodes (n=6, 0%) in 2018-19, and Sunshine Coast in line with Queensland overall (n=131, 7%)
- The actual number of main treatment episodes for rehabilitation in the PHN have risen by 75% from 252 in 2017-18 to 440 in 2018-19, although proportion of treatment services for which rehabilitation is the primary treatment type have fallen from 10% to 8% in that period
- Almost all AOD rehabilitation treatment episodes in the PHN are provided by private (non-government) organisations (97%), with 66% delivered in non-residential settings and 29% in residential settings.

The low number of rehabilitation episodes reported in Central Queensland may reflect different reporting practices or service models rather than availability or provision of rehabilitation services.

Findings from the ***PHN Stakeholder HNA Survey*** indicate that there are current gaps in availability and access to rehabilitation services at local areas across the PHN.

3.1.7. Support and case management

AIHW data for 2017-18 indicated that 3% of AODTS episodes (192 episodes) were for support and case management, compared to 14% nationally (46).

Queensland Health AODTS data for 2018-19 (20) indicates that of the 5,331 treatment episodes in that period:

- Main treatment episodes for support and case management were delivered at half the rate per 100,000 in the PHN as Queensland overall (28 and 56 per 100,000 respectively), with only slight variation in rates across the 3 PHN areas (CQ 34; SC 24; WB 30)
- 5% of main treatment episodes in the PHN were for AOD support and case management in 2018-19, similar to the Queensland rate of 7% and with little variation across the PHN areas
- The actual number of main treatment episodes for case management and support in the PHN have risen by 50% from 164 in 2017-18 to 247 in 2018-19, although proportion of treatment services for which case management and support are the primary treatment type have fallen from 10% to 8% in that period
- Increases in number of case management and support treatment episodes occurred in Sunshine Coast and Wide Bay since 2017-18, but number of episodes has decreased by 30% in Central Queensland in 2018-19 (from 109 to 77 treatment episodes)
- Around two-thirds of AOD case management and support episodes in the PHN are provided by private (non-government) organisations (65%), and 89% are delivered in non-residential settings.

3.1.8. After-hours and outreach AOD services

Queensland Health AODTS data (30) for 2018-19 indicates that:

- The proportion of closed treatment episodes delivered in an outreach setting in the PHN (13%) is less than half that in Queensland (28%), with the lowest proportion being in Wide Bay (6%)
- 79% of all outreach services are for counselling.

In 2016, only two organisations – one in WB and one in CQ – were delivering AOD services 24/7. Although there were 8 AOD providers offering outreach AOD services in the PHN catchment, the capacity to deliver services was rather constrained (47).

The summary of AoD treatment services across the PHN based on the Queensland Health's 2018-19 ATODS data is provided below.

Table 8: Summary of AOD treatment episodes across the PHN,2018-19

	Qld	The PHN	CQ	WB	SC
Population based on 2019 data	5,094,510	876,789	226,875	213,167	436,747
Prevalence of lifetime risky use of alcohol	22.5%	25.9%	23.7%	23.7%	28.0%
Prevalence of harmful drug use: Cannabis related closed episodes	30%	34%	34%	27%	41%
Prevalence of harmful drug use: Methamphetamine related closed episodes	24%	27%	29%	27%	26%
Prevalence of harmful drug use: Opioid related closed episodes per 100 people (crude rate)	71	87	NA	NA	NA
Total number of treatment episodes associated with AoD	41,935	5,331	1,401	1,980	1,950
Rate of treatment episodes per 100,000 population	823	608	618	929	446
% of AOD treatment episodes delivered to people aged 30 and below	41%	43%	45%	35%	52%
% of treatment episodes with counselling as treatment type	34%	51%	65%	49%	42%

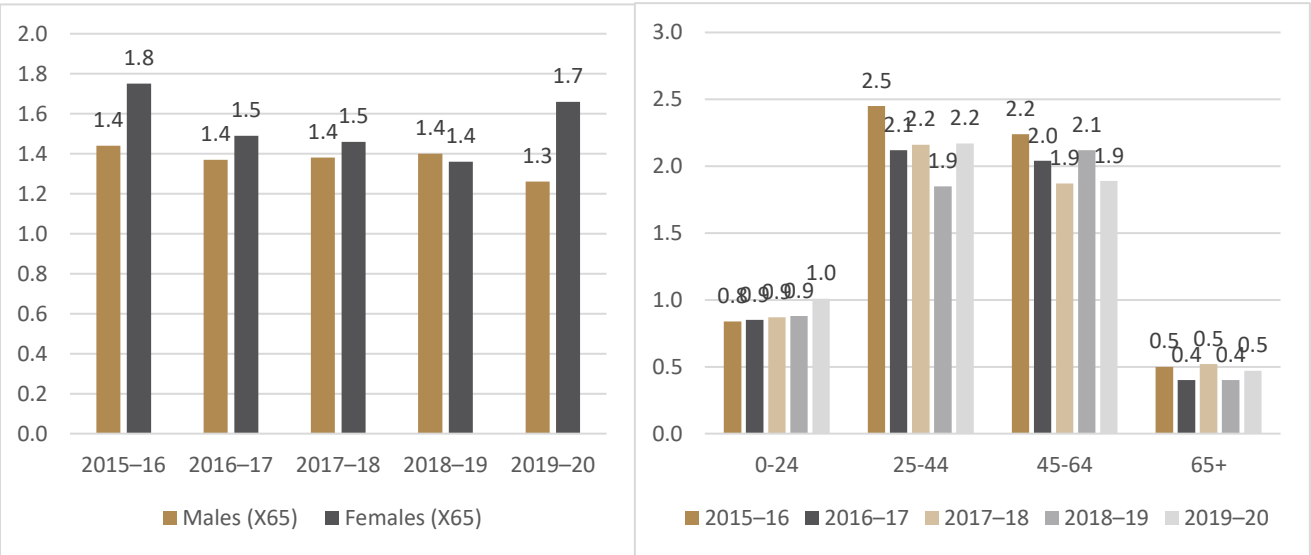
	Qld	The PHN	CQ	WB	SC
Rate of treatment episodes with counselling as treatment type per 100,000 population	83	308	400	460	186
% of treatment episodes with rehabilitation as treatment type	6%	8%	0%	15%	7%
Rate of treatment episodes with rehabilitation as treatment type per 100,000 population	52	50	3	142	30
% of treatment episodes with assessment only as treatment type	13%	5%	5%	5%	5%
Rate of treatment episodes with assessment only as treatment type per 100,000 population	111	31	27	39	29
% of treatment episodes with withdrawal management as treatment type	10%	2%	1%	6%	1%
Rate of treatment episodes with withdrawal management as treatment type per 100,000 population	81	15	4	52	2
% of treatment episodes with support and case management as treatment type	7%	5%	5%	3%	5%
Rate of treatment episodes with support and case management as treatment type per 100,000 population	56	28	34	30	24
% of treatment episodes with information and education as treatment type	27%	27%	23%	19%	39%
% of closed treatment episodes delivered in a non-residential setting	58%	82%	72%	92%	78%
% of treatment episodes delivered as outreach services*	28%	13%	23%	6%	13%
% of treatment episodes delivered in residential treatment facilities	9%	3%	1%	0%	7%

Source: Queensland Health: Alcohol and Other Drug Treatment Services (AODTS) National Minimum Data Set (NMDS) https://www.data.qld.gov.au/dataset/alcohol-and-other-drug-treatment-services-aodts-national-minimum-data-set-nmds

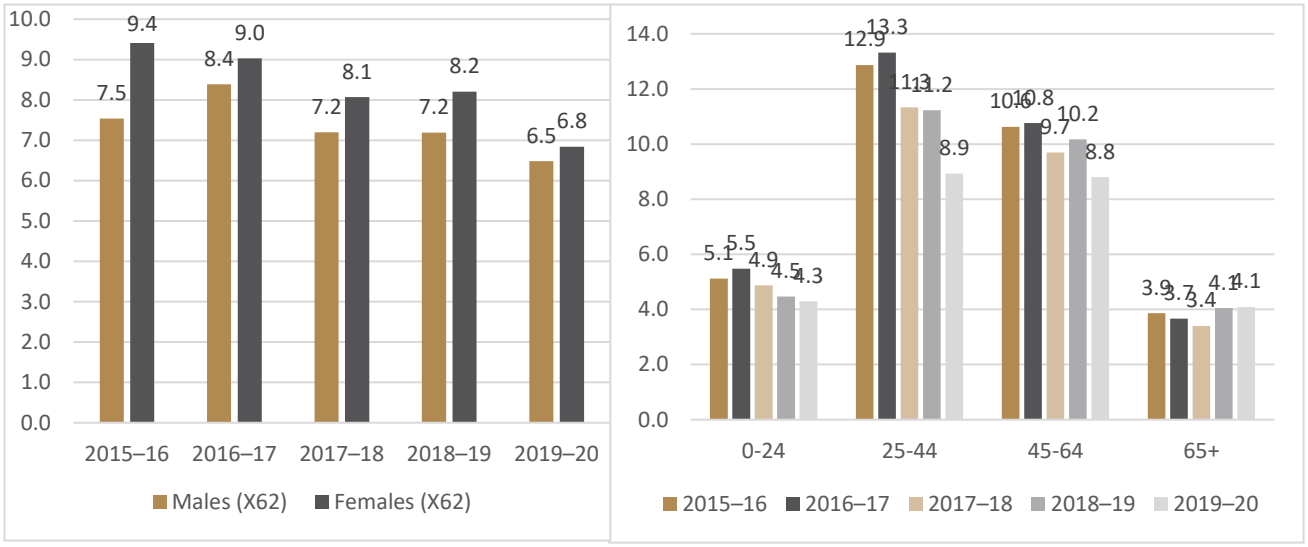
3.1.9. AOD related hospitalisations

For 2015-16, the ASR per 10,000 people of overnight hospitalisations due to AOD misuse across the PHN was 14 (61). This is well below the observed national (ASR 20 per 10,000) and across regional areas (ASR 21 per 10,000). The ASR across the PHN remained similar to the previous year (2014-15), contrasting with the increasing national trend over the same period. (53) Across the PHN around a third (32.2%) of all these hospitalisations took place in specialised care. This was lower than the national average (42.7%) and the regional rate of 39.2%. (53) This was in line with earlier findings in regard to the relatively large numbers of mental health hospitalisations in general hospitals, particularly in rural areas. (53). In the absence of most recent data available on the PHN, the figures below show the rates of intentional harm hospitalisations associated with alcohol and 'narcotics and psychodysleptics (X62)' across Australia. 'Narcotics and psychodysleptics' includes use of cannabis (derivatives), cocaine, codeine, heroin, lysergide [LSD], mescaline, methadone morphine and opium (alkaloids). The table below summaries the rates across Australia overtime.

Graph 3: Intentional self-harm hospitalisations associated with alcohol intake (X65) National rate per 100,000, by age groups, gender and overtime, 2015-16 to 2019-20



Graph 4: Intentional self-harm hospitalisations associated with 'narcotics and psychodysleptics (X62) intake, National rate per 100,000, by gender, age groups and change overtime, 2015-16 to 2019-20



Source: AIHW, 2021. Suicide and Self-Harm. National Hospital Mortality Database. https://www.aihw.gov.au/suicide-self-harm-monitoring/data/data-downloads

3.1.10. Consultation findings from surveys on AOD service gaps

The PHN consultations

Of the 240 respondents to the ***PHN Stakeholder Survey***, only 15% agreed or strongly agreed that there were adequate numbers of drug and alcohol services to meet demand across the regional areas in which their organisation provided services, with lowest proportion of services in Banana, Central Highlands, Gladstone, Woorabinda and North Burnett.

Respondents were also asked to indicate in which areas of health service provision they had come across gaps or needs when working with clients or community. Respondents from the following LGAs indicated alcohol and other drug service gaps as one of their top 3 areas:

- Rockhampton in Central Queensland
- Bundaberg and North Burnett in Wide Bay
- Noosa and Sunshine Coast in Sunshine Coast.

Over half of the survey respondents ***(53%) felt that there were gaps in alcohol and other drug health service provision.*** Service gaps and opportunities most commonly identified across the PHN included a need for:

- Increased in-patient or community-based detox services
- Increased rehabilitation services
- Improved waiting times for public services
- Increased availability of addiction specialists
- Improved culturally appropriate services
- Increased prevention and early intervention services.

Analysis of free text survey responses by LGA provided additional useful detail regarding existing gaps in AOD services in each of the PHN areas, summarised below.

Central Queensland

- **Workforce gaps** – Central Queensland does not currently have an Addictions Medicine Specialist; more access needed to AOD counsellors, psychologists, psychiatrists
- **Specific service gaps** – Lack of funded **rehabilitation services** including for methadone, with residential rehabilitation plans reportedly underway but progressing very slowly; lack of **outreach services**, particularly for youth, and opportunity to consider outreach programs with government and non-government organisations to improve access; **poor communication** between services and regions; recent increase in service provision to 2 days per week ('Bridges') still to be evaluated; lack of local services in small communities (e.g. in Central Highlands)
- **Service appropriateness** – Many AOD services reported to be not culturally appropriate; inadequate training of disability services support staff to support people with AOD issues.

Sunshine Coast

- **Workforce gaps** – Reluctance of GPs to see clients with AOD issues; more access needed to AOD bulk-billing counsellors, psychologists, psychiatrists; funding for more case managers and peer workers
- **Specific service gaps** – Lack of local **detox and rehabilitation services**, including residential services and services for youth; lack of specialist AOD services for people with **comorbidities** e.g. mental health; lack of **outpatient programs and mobile services** to the community; **service fragmentation** between specialist AOD assessment, withdrawal inpatient/outpatient and community counselling services
- **Service appropriateness** – Many AOD services reported to be not culturally appropriate and require greater funding for more reach

Wide Bay

- **Workforce gaps** – Particular need noted for more early intervention providers
- **Specific service gaps** – Lack of local **detox and rehabilitation services**, including residential services and services for youth; lack of **outreach services**, particularly for youth, and opportunity to consider outreach programs with government and non-government organisations to improve access; need for additional **preventive and educational programs**
- **Service appropriateness** – Many AOD services reported to be not culturally appropriate.

Surveys undertaken by Health Workforce Queensland

Health Workforce Queensland gathers data via surveys from general practitioners (GPs), health service/practice managers, primary health care nurses/midwives, Aboriginal and Torres Strait Islander health workers/practitioners and allied health professionals to undertake the HWQ HNA. The total number of survey participants (2020-21) from the PHN were 211, which consisted of 91 general practitioners, 63 practice managers, 43 allied health practitioners/others and 14 nurses/midwives. The HWQ ranking on the scale of 1 to 100 indicated substantial service gaps if the mean score is ≥ 60. There were 11 service gap means of 60 or more in the PHN region, with the highest gaps being for mental health, alcohol and other drugs and community-based rehabilitation services. ***All three areas within the PHN have shown need for AOD and community-based rehabilitation services.***

The main service gap themes were centred around insufficiency in availability of mental health/ alcohol and other drug (AOD) and dental services. Access and affordability of these services was problematic. There were other comments highlighting specific issues such as a lack of acute services, and poor transport facilities.

Identified Issues

- *A very low proportion of hospitalised clients receive care in specialised psychiatric units with many being treated in general hospitals.*
- *Areas with high need like Gympie-Cooloola and Gladstone-Biloela SA3s showed some of the lowest AOD hospitalisation rates in the region*
- *The PHN has higher rate of people who use AOD at harmful levels however have lower rate of AOD related episodes of care compared to Qld, this requires to be investigated in specifically targeted areas that have higher risk of harmful use of AOD due to social gradient, higher prevalence of drinking alcohol at harmful levels, low episodes of AOD services however high rates of clients.*
- *Very small proportion of withdrawal management services and rehabilitation services might relate to higher rates of relapse*
- *Young people (aged 10 to 29 years) and middle-aged people (30-49 years) are at higher risk of harmful use of AOD*
- *Majority of the treatment episodes provided within the PHN were for counselling services and information/education only services followed by assessment only and rehabilitation services.*
- *Taking into consideration the differences in salaries, working conditions, recruitment, retention issues and organisational culture across both sectors, the growing share of the NGO sector had important implications for future workforce development in the region.*
- *A move from face-to-face delivery to telehealth (online or telephone) as a result of the pandemic, with the majority indicating that they would consider continuing these changes post pandemic. This shift particularly applied to delivery of non-residential services and offers future opportunities for greater reach in rural/remote areas of the PHN*
- *Stakeholder surveys clearly identify service gaps as:*
    - *Need for detox services, addiction specialist services, rehabilitation services, mobile or telehealth services, after-hours and outreach AOD services*
    - *Need of culturally appropriate services*
    - *Improved communication requiring between services was suggested*
    - *General practices sometimes unwilling to provide care for patients with substance use disorders*
    - *Such gaps are mainly identified in the following LGAs: Rockhampton, Bundaberg, North-Burnette, Noosa and Sunshine Coast*

3.2. AoD services for specific population groups

3.2.1. Youth

The PHN has been delivering increasing number of services through Headspace for young people.

Year	# young people for all service types	# episodes of care for all service types	# young people for AOD worker	# episodes of care for AOD worker
2017/18	3663	14969	67	128
2018/19	4445	16701	75	195
2019/20	5467	20537	69	170
2020/21	5476	21753	39	117

Note that episodes of care # do not include episodes where clients did not attend

Queensland Health AODTS data (30) for 2018-19 indicates that:

- Close to half (43%) of AOD services across the PHN in 2018-19 were delivered to people under 30 years of age, similar to the 41% observed in Queensland
- The proportion of services delivered to people under 30 years of age was highest in Sunshine Coast (52%) followed by Central Queensland (45%), with Wide Bay (35%) below Queensland figures (41%)
- For 10-19 year olds, the most commonly delivered treatment services were information and education (67%) followed by counselling (23%), and cannabinoids were the principal drug of concern in 85% of treatment episodes
- For 20-29 year olds, these proportions had reversed, with the most commonly delivered treatment services being counselling (49%) followed by information and education (31%), and cannabinoids now being the principal drug of concern in less than half of treatment episodes (46%) (followed by amphetamines 39% and alcohol 15%)
- 10-19 year olds had the highest proportion of treatment services provided via outreach (22%), with majority provided in non-residential settings (76%) as in all age groups.

For the 49 respondents to the ***PHN Stakeholder HNA Survey*** who specified that their organisations support youth, only 9 felt that there were adequate numbers of drug and alcohol services to meet demand, and 27 felt that there were gaps in provision of AOD services. Key gaps listed by respondents were:

- Insufficient withdrawal and rehabilitation services, including residential options
- Fragmented service system, particularly for those with dual diagnoses (e.g., mental health, disability).

3.2.2. Aboriginal and Torres Strait Islander populations

Queensland Health AODTS data (20) for 2018-19 indicates that:

- 13% of AOD service episodes across the PHN in 2018-19 were delivered to Aboriginal and/or Torres Strait Islanders, similar to the 16% observed in Queensland
- The proportion of services delivered to Aboriginal and/or Torres Strait Islanders was highest in Central Queensland (22%) followed by Wide Bay (14%), with Sunshine Coast (8%) only half the Queensland figures (16%)
- The split of treatment delivery settings for AOD treatment services for Aboriginal and Torres Strait Islander people (non-residential settings 78%, followed by outreach services 16%) was similar to overall treatment services across the PHN (non-residential settings 82% and outreach 13%), but with a much lower proportion of outreach services than Queensland overall (28%).

The lower proportion of outreach services in the PHN becomes important in light of AIHW data indicating that Aboriginal and Torres Strait Islander clients travelled one hour or longer to their treatment service in about 1 in 4 (26%) closed treatment episodes, compared to about 1 in 8 (13%) closed treatment episodes for non-Indigenous clients (33).

The ***PHN Aboriginal and Torres Strait Islander community survey 2020*** informs that in the last 12 months, 46 of 603 respondents (8%) felt that they needed to see someone about an alcohol or drug related issue but did not go. Key reasons for not attending an appointment included:

- Too busy
- Did not know where to go
- Could not get an appointment when needed.

For the 30 respondents to the ***PHN Stakeholder Survey*** who specified that their organisations support Aboriginal and Torres Strait Islander people, only 7 felt that there were adequate numbers of drug and alcohol services to meet demand, and 16 indicated gaps in provision of alcohol and other drugs' services. Key gaps listed by respondents were:

- Lack of local services, particularly rehabilitation
- Lack of qualified staff and clinicians willing to work in the sector
- Lack of timely interventions
- Insufficient services for youth
- Services not always culturally appropriate.

Identified Issues

- *Higher rates of AOD harmful use in young people are evident and indicates need for readily available withdrawal and rehabilitation services, including residential options*
- *Reduction in fragmentation of services, particularly for those with dual diagnoses (e.g. mental health, disability) are required*
- *Culturally appropriate services that meet the demand for AOD services delivered to Aboriginal and Torres Straits Islander people are required*

3.3. AoD workforce and gaps

3.3.1. AOD workforce

There was limited information available on the profile of our specialist AOD workforce and the implications of local issues such as the relative share of NGO vs. government sectors and changing patterns in AOD use. Current best-practice in workforce development strategies emphasises a multi-faceted approach with a strong system focus targeting individual, organisational and structural factors impacting workforce in general.

In 2017, the PHN commissioned NCETA to undertake workforce development needs assessment consultations to inform regional strategy and determine priority areas for future action, including assembling the required data. Key issues include:

- Difficulty in sourcing local level MHAOD workforce data and information
- Limited availability of suitable workforces in rural and remote areas
- Ageing cohort of MH and AOD workforces
- Short term funding arrangements
- Rapid growth of the NGO sector in service provision (62).

These concerns still remain. Staff feedback from the PHN also highlighted the need for GPs to have more comprehensive education in AOD prevention, management, and literacy.

3.3.2. AOD service coordination

According to Health Workforce Queensland's 2020 survey (63), alcohol and other drug services had one of the greatest perceived primary care service gap ratings (68.2) for services in remote, rural and regional QLD.

Feedback to QNADA (64) from state-wide NGO AOD service providers identified the need to:

- Improve coordination of AOD and related services between sectors.
- Coordinate with existing services to avoid overlap and expand capacity to accommodate all individuals in need of treatment.
- Co-locate mental health and AOD services as a strategy to improve coordination.

Identified Issues

Workforce development has been identified as a critical gap for effective scale-up of services in the PHN, although limited evidence exists on current gaps and best strategies to address these gaps.

3.4. Triangulation

A holistic view to build safe, healthy and resilient Australian communities requires preventing and minimising alcohol and other drug-related harm by addressing health, social, cultural and economic factors that are responsible for this harmful use among individuals, families and communities. It is established that AOD harmful use has a social gradient and factors such as age being between age of 15-29 years), gender (male) , Indigenous status (being an Aboriginal and/or Torres Straits Islander Australian) , being in contact with criminal justice system, living outside major cities, and socioeconomic status (living in most disadvantaged area) are all associated with harmful use of AOD.

Young Individuals at risk of AoD harmful use:

It is clear that young individuals from LGAs such as Woorabinda, North Burnett, Central highlands, Rockhampton, Gladstone and Fraser Coast are at higher risk of harmful use of AOD as they have more than one risk factors listed below:

- Aboriginal and Torres Straits Background: Due to many disadvantages discussed previously including feeling of loss of identity and culture, young Indigenous people are at higher risk of harmful AoD use. Most of the Aboriginal and Torres Straits Islander people live in rural/remote, low socio-economic areas and communities that have unstable health workforce due to issues with recruitment and retention of health workers. (highest proportions are Woorabinda, Rockhampton, North-Burnett)
- There are four LGAs (Woorabinda, Banana, Central Highlands, and North Burnett) that are 100% outer regional/rural or remote. Australian's living in rural/remote areas have higher rates of AoD use, higher burden of disease associated with harmful use of AoD and higher mortality due to drug-induced deaths. (23)
- There are four LGAs (Woorabinda, Fraser Coast, North Burnett, Bundaberg) where ≥ 50% of the people are most disadvantaged quintile of SEIFA. Low socio-economic status is associated with higher burden of disease associated with harmful use of AoD. (65)
- There are four LGAs with around 20% of population aged 15-29 years (Woorabinda, Rockhampton, Central Highlands, and Gladstone). The life-course approach dictates that experiences, education and health in young age predicts the long-term health outcomes. These issues are further compounded by the prevalence of stigma associated with substance use, which can in turn become a barrier to someone seeking early intervention and treatment.

The evidence underpinning different interventions, programs and campaigns is available and will be considered while designing the options for action for the young people. (32)

Gender difference in treatment seeking

While the prevalence of AoD harmful use and treatments is higher in men compared to women, the gender difference between seeking AoD services is still being understood. Women are less likely to seek treatment and tend to seek care in mental health or primary care settings rather than in specialised treatment programs.(28) For most women, the threat of losing custody of their children is an essential barrier to treatment, they report social stigma in private as well as professional contexts as a barrier to treatment. (29). It is also established that nationally intentional self-harm hospitalisations occur at higher rate in women than men. Noting the differences in the harmful use and impact of the AoD on gender, it is critical that in the future commissioning of services the PHN should consider : (1) improving care for women who seek help in primary care or mental health settings, (2) increasing the referral of women to specialised addiction treatment, (3) identifying subgroups of women and men who would benefit from gender-specific interventions, and (4) addressing gender-specific risk factors for reduced treatment initiation, continuation, and treatment outcomes.(28) The PHN seeks to consider different approaches that are required to address the gender difference in treatment seeking behaviour.

Mental health and other co-morbid conditions

People with mental health conditions and high or very high levels of psychological distress continue to be more likely to smoke and consume alcohol and illicit drugs than people without these conditions. The PHN has high mental health concerns in the LGAS such as North Burnett, Rockhampton, Fraser Coast, Gladstone, Bundaberg and Gympie. These areas also have socio-economic disadvantage. Some of these areas also show high rates of unintentional drug induced deaths (Bundaberg, Hervey Bay, Rockhampton, Gympie – Cooloola, Nambour, and Sunshine Coast Hinterland SA3). Along with this the rate of opioid prescribing is well above the national average in Maryborough, Hervey Bay and Gympie-Cooloola SA3.

This evidence indicates the need for addressing multiple health concerns simultaneously such that there is improved care-coordination, communication and integration of the treatment pathways.

General lack of AoD services

Overall, all the qualitative and quantitave data points towards insufficient AoD treatment services within the PHN region. It is possible that a very small proportion of withdrawal management services and rehabilitation services might relate to higher rates of relapse and higher unintentional harm. A strong need for detox services, addiction specialist services, rehabilitation services, mobile or telehealth services, after-hours and outreach AOD services including a need of culturally appropriate services was identified and requires further deep dives to seek further understanding. It is possible that a move from face-to-face delivery to telehealth (online or telephone) as a result of the pandemic, with the majority indicating that they would consider continuing these changes post pandemic might be helpful in reducing some of the gaps in service delivery. This shift particularly applied to delivery of non-residential services can offers future opportunities for greater reach in rural/remote areas of the PHN

It is clear that a linear relationship often does not exist between social determinants (such as SES), patterns of alcohol consumption and related harms. Instead, risky consumption and harms appear as ‘clusters of problems’, affecting different groups in different ways. As a result, the best available evidence should be used to implement a blend of measures appropriate for particular groups and settings.(65)

Therefore, to address the identified health and service needs, the PHN will ensure a system-wide and local attention to:

***Early identification and management*:** Strengthening and developing strategic collaborations to support identification and management of harmful use of AOD with a focus on vulnerable groups and priority populations

Improved collaboration, communication, and integration: There is an intrinsic link between harmful use of AOD, socio-economic issues and underpinning good health. Recognising the need to address harm minimisation must include attention to physical, spiritual, cultural, emotional and social wellbeing, capacity and governance at family, community and individual levels. The growth of AOD focused health workforce will assist in addressing this process. This also includes factors such as local decision-making, working in partnerships and help building the capacity of health services to ensure sustainability.

***Improved management of mental health and other comorbid conditions*:** Assessment and support regarding emotional wellbeing for patients with and without chronic conditions to avoid associated hospitalisations and unintentional deaths.

Ensuring commissioning of culturally appropriate services: Improved care-coordination and providing culturally appropriate services. Care-coordination and referrals data to ensure recording of brief interventions (such as advice or referrals for physical activity and quit smoking programs) and linkages with chronic disease treatments.

3.5. Opportunities, Priorities and Options

The opportunities, priorities and options for AOD interventions have been suggested based on the needs and priorities identified through triangulation exercise. Recognition of significant health and service needs related to AoD in the region has led the PHN to expand current providers residential drug and alcohol rehabilitation programs through providing funding for counselling, withdrawal management, case management, care planning and co-ordination. In addition, investment in the sector has included workforce development, capacity building, information and education for health professionals.

Key priority areas suggested were also explored against visions and priority areas of the national and regional AOD strategies and programs for consistency and alignment. However, actual implementation of these interventions depends on various factors such as ability to tailor it to local conditions, careful consideration of opportunity cost, and implementation feasibility. It requires close consultation and collaboration with PHN stakeholders. Similar to approach promoted on addressing mental health issues, AOD strategies and interventions also require whole-of-person, whole-of-community and whole-of-government approach taking into consideration issues beyond health including social support, education, employment, and other related social factors.

Key strategic documents explored include the following:

National Drug Strategy 2017-2026: The Strategy aims to build safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related health, social, cultural and economic harms among individuals, families and communities (66). The Strategy proposes a balanced approach across the three pillars of harm minimisation: ***demand reduction; supply reduction; and harm reduction***. The priority actions include the following:

- Enhance access to evidence-informed, effective and affordable treatment
- Develop and share data and research, measure performance and outcomes
- Develop new and innovative responses to prevent uptake, delay first use and reduce alcohol, tobacco and other drug problems
- Increase participatory processes
- Reduce adverse consequences
- Restrict and/or regulate availability
- Improve national coordination

National Framework for Alcohol, Tobacco and other Drug Treatment 2019-2029 provides overarching guide to national response and focusses on treatment interventions, addressing how harms from alcohol, tobacco, prescribed medications or illicit drugs are reduced based on individual needs and goals (67).

Improving mental health and wellbeing: Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019: The vision articulated by the Plan by the Queensland Mental Health Commission will continue serve as a direction for the PHN AOD plan as it emphasizes holistic approach and promotes “healthy and inclusive community, where people experiencing mental health difficulties or issues related to substance use have a life with purpose and access to quality care and support focused on wellness and recovery, in an understanding, empathic and compassionate society” (68).

Joint Regional Plan 2020-2025 on Mental health, suicide prevention and alcohol and other drugs: The plan sets out an important initiative towards the provision of mental health, suicide, alcohol and other drugs services for the communities in the region. It combines the resources and knowledge of CQWBSC-PHN, three regional Hospital and Health Services (Wide Bay HHS, Central Queensland HHS and Sunshine Coast HHS), non-government organisations, private health providers and consumer representatives (69). AOD specific strategies include i) developing targeted services focused on the needs of people who have problems with alcohol and other drugs; ii) developing AOD workforce through staff retention programs and recruitment and

building capacity to support expanded rehabilitation and withdrawal services; and iii) implementing collaborative governance and planning through a continuing role of the Regional Mental Health, Alcohol and Other Drugs Council.

The Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018-2023: It sets the five-year direction for a whole-of-person, whole-of-community and whole-of-government approach to improving the mental health and wellbeing of Queenslanders. Strategic priorities include strengthening coordination between clinical mental health, AOD, physical health, psychosocial, housing, disability and employment supports and services, across public, private and non-government sectors; supporting the workforce and strengthening human right protections in implementing AOD interventions (70).

Connecting care to recovery 2016-2021: A plan for Queensland's state-funded mental health, alcohol, and other drug services. Five priority areas include the following (71):

- Priority 1: Access to appropriate services as close to home as practicable and at the optimal time
- Priority 2: Workforce development and optimisation of skills and scope
- Priority 3: Better use of ICT to enhance clinical practice, information sharing, data collection and performance reporting
- Priority 4: Early identification and intervention in response to suicide risk
- Priority 5: Strengthening patient's rights Mental Health Act 2016

Central Queensland Wide Bay Sunshine Coast PHN-Strategic Plan 2021-25: One of the key priorities in the plan is to improve mental health and wellbeing and the PHN is implementing Mental Health, Suicide Prevention and Alcohol and Other Drugs Joint Regional Plan to enhance innovative, integrated and co-designed models of care (72).

The PHN Primary Mental Health Care Activity Work Plan (AWP 2020/21-2022/23): AOD specific key priority areas include:

- Youth mental health services including AoD
- Aboriginal and Torres Strait Islander mental health services: Aim of this activity is to provide tailored and culturally appropriate treatment for Aboriginal and Torres Strait Islander people
- Stepped care approach: The PHN partners with Regional Mental Health and Alcohol and Other Drug Council and local service integration networks to facilitate a regional and local level stepped care approach

Numerous evidence also suggests that successful AOD interventions have certain attributes (73) and these were largely embedded in the interventions proposed by the national and regional strategies above. These are:

- harm minimisation principles are incorporated into the culture, attitudes, and values
- there is an adequate skill mix, with senior level clinical expertise and knowledge being demonstrated by the majority of staff.
- staff are provided with adequate professional support and training
- individuals, their family and significant others, and other service providers are involved in all aspects of care
- strong internal and external partnerships are established and maintained; and
- there is participation in research and evaluation to promote service quality and innovation

Our priorities and approaches for providing AOD services closely align with national and regional mental health and AOD focus areas and strategies. We have identified the following priority areas based on the HNA findings, consultation with relevant strategies/plans and key stakeholders. The PHN focus to commission AOD initiatives will need to ensure the following key areas are supported and implemented successfully. These include:

Priority area 1: Early Identification and Management: this includes delivery of safe, high quality, integrated, and evidence driven AOD care

Priority area 2: Improve collaboration, communication, and service integration: this includes establishing effective service partnerships, improving knowledge, and understanding of AOD and related services and how to access and navigate through AOD services

Priority area 3: Improved management of AOD harm and other co-morbid conditions

Priority area 4: Ensure informed and supported AOD workforce in place: this includes ensuring culturally appropriate AOD service commissioning

Priority	Possible Options	Expected Outcome	Potential Lead
There are socio-economic gradients linked with the AOD use. Age, gender, Indigenous status, being in prison, living in a rural area, and socio-economic status (SES) are all associated with variability in harmful use of AOD. These will need to be carefully considered in AOD service planning.			
Priority area 1: Early Identification and Management			
Key issues and needs: High prevalence and harm associated with AOD use especially among young people, Aboriginal and/or Torres Strait Islander people and people living in low socio-economic areas **Priority Area:** Alcohol and Other Drugs **Priority sub-categories:** Early Intervention and Prevention	Establish collaborations with organisations that influence a young person's life that includes family, social activities, and school to provide education and information in preventing harmful use of AOD (74) Work with the organisations that support development throughout the life course (for example, support for families in raising children, structures for youth development, and support for adolescents and adults in achieving success in education and employment)(75) Continue supporting Rockhampton Residential Rehabilitation and Withdrawal Management Services that will provide much needed support and build capacity in the region. Develop innovative responses to prevent uptake, delay first use and reduce AOD use (65)	Increased number of collaborative interventions More services that provide holistic care to high-priority populations including young people Reduction in unintentional/intentional harm associated with AoD Reduction in AOD use prevalence among high-priority populations	PHN, CJS, Headspace, GPs

Key issues and needs: Lack of gender specific AOD services Priority Area: Alcohol and Other Drugs Priority sub-category: Other: Gender specific AoD service	Commission gender specific services to ensure women feel supported going through treatments and have holistic approch of addressing trauma, stigma and parental-care related concerns (28)	Increased gender specific access to AOD service and treatments	PHN will lead in conjunction with service providers and other stakeholders in the region
Key issues and needs: Lack of knowledge and understanding on early identification services among service providers Lack of health seeking behavior and knowledge among clients Priority Area: Alcohol and Other Drugs Priority sub-category: Care coordination	Support GPs, other primary health care providers and support services to understand referral pathways for PHN-commissioned and other available AOD prevention and management services in the region Improve community understanding and knowledge in regard to seeking appropriate AoD services	Improvement in providing AOD service among high-risk populations Reduced stigma around seeking treatments and improved help seeking behaviour	PHN will lead in conjunction with service providers and other stakeholders in the region
Priority area 2: Improved management of AOD harm and other co-morbid conditions			
Key issues and needs: Need for managing complex clients with harmful use of AOD and comorbidity **Priority Area:** Alcohol and Other Drugs **Priority Subcategory:** Multi-Disciplinary Care	Work with MHAOD providers to improve dual diagnosis and the delivery of integrated multidisciplinary care. Identify GPs with an interest in AOD across the PHN and engage them as champions to facilitate GP education on AOD	Improved dual diagnosis rates for MH & AOD clients More integrated and coordinated care for AOD clients	PHN, HHS

Key issues and needs: Fragmentation of services. Lack of integration and coordination of care between levels of care **Priority Area:** Alcohol and Other Drugs **Priority Subcategory:** Care Coordination	Sector Engagement and Strategy Development in the context of the established regional plan for MHAOD services Work collaboratively with HHSs, QNADA, specialist drug and alcohol treatment providers in the region, Aboriginal and Torres Strait Islander organisations and service providers, consumers, other government agencies and welfare organisations to further develop a comprehensive regional plan	PHN uses ATODS data to further identify levels of services required, gaps and priority populations and locations	PHN and HHS
Priority area 3: Improved collaboration, communication, and service integration			
Key issues and needs: Lack of integration between the mental health sector, AOD sector and other relevant health and support services Need for a region-wide, better integrated care to deliver AoD services **Priority Area:** Alcohol and Other Drugs **Priority Subcategory:** Access	Develop targeted and culturally appropriate approaches to high prevalence population groups and regions at increased risk of exposure to and harm from AOD Increase access to transitional rehabilitation to community services, particularly in rural/remote areas(23) Ensure availability of peer-based community support, brief interventions in primary care and hospital services through more intensive specialist treatment services.	Improved access to AOD services, especially in rural areas	PHN

	Ensure a range of services and agencies are appropriately connected through established referral pathways.		
Key issues and needs: Lack of locally available withdrawal management services **Priority Area:** Alcohol and Other Drugs **Priority Subcategory:** Care Coordination	Support people to recover from dependence through evidence-based treatment Increase local availability of withdrawal management and support services Engage further with local AOD service providers regarding opportunities and barriers to increasing local or home-based withdrawal management and support services Commission appropriate withdrawal management and support services within the PHN region	Increased uptake of withdrawal management services in the PHN catchment	PHN, NGOs, HHS

Key issues and needs: Need for a comprehensive monitoring and evaluation framework for MH, SP, AOD, social and emotional wellbeing (SEWB) and psychosocial services **Priority Area:** Alcohol and Other Drugs **Priority Subcategory:** System integration	Identify areas with higher AOD related concerns based on the healthcare data within the PHN Monitor and evaluate AOD services data on regular basis Engage with GPs,AOD services and other stakeholders to identify harmful use of AOD Work with the HHSs and undertake data analysis to measure impacts of primary prevention activities	Increased identification of harmful use in primary care Lessons of what works/does not work and has impact on services is understood and integrated into future planning and decision-making PHN AOD program improvements	PHN,HHS and QPS PHN will lead in conjunction with service providers and other stakeholders in the region
Key issues and needs: Availability and quality of the local MHAOD workforce **Priority Area:** Alcohol and Other Drugs **Priority sub-categories:** Workforce	Ensure availability of peer-based community support, brief interventions in primary care and hospital services through more intensive specialist treatment services. Ensure a range of services and agencies are appropriately connected through established referral pathways. As part of the Joint Regional Plan (2020-25) implementation, work with public/private providers to regularly map the region's service needs and support regional planning for AOD service development	Improved MHAOD service mapping in the region to effectively guide regional MHAOD service planning Regional workforce development strategy developed in consultation with the MHAOD Strategic Collaborative, service providers and Clinical and Community Advisory Councils. A workforce development strategy is developed and aligned with the Queensland Health's MHAOD Workforce Development Framework	PHN Regional MHAOD Strategic Collaborative (Members: QH, PHN, HHS) Service providers, consumers and carers

	Implement regional workforce development framework aligned with the Queensland Health's MHAOD Workforce Development Framework Develop a workforce development strategy with a strong system focus that is tailored to the PHN		
Priority area 4: Ensuring Commissioning of culturally appropriate services			
Key issues and needs: Need for building the skills and knowledge of the MHAOD workforce **Priority Area:** Alcohol and Other Drugs **Priority sub-categories:** Practice support	Develop a workforce development strategy with a strong system focus that is tailored to the PHN. Provide regular training opportunities to the staff members working in the field of AOD including cultural training, holistic approach of addressing trauma, stigma and parental-care related concerns Build GP capacity and support to help expand the skills and resources for GPs to identify and care for high-risk clients	Increased cultural competency of AOD workforce, including primary care providers. Increased Aboriginal and Torres Strait Islander AOD workforce in the region. Improved capacity and skills of GP, family, carers and peer support Training and support provided in line with the workforce development strategy	PHN, relevant GPs, HHS, local training institutions, such as Universities.

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