Consultation paper:
Development of a whole-of-government Trauma Strategy for Queensland

Alcohol and other drug use, trauma, and trauma-informed care: *Re-establishing* a harm reduction approach for Queensland

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What is this research about

Problematic alcohol and drug (AOD) use persists as a major health issue in Australia, affecting both individuals and communities. It is closely tied to trauma and disproportionately affects certain demographics. By examining AOD use and trauma holistically within the systemic environment we can implement strategies that bring about meaningful change. Thus, this paper examines and, subsequently, *re-establishes* a clearer picture between AOD use, trauma, and what trauma-informed care (TIC) may look like as a holistic *harm reduction* approach. We present a narrative review of the literature, as well as recent findings drawn from a project investigating the Lived-Living Experience (LLE) of people who use drugs (PWUDs).

The context for this research

Drug 'Pleasures' and Harm Reduction

Throughout history, people have used drugs for various purposes, including spiritual, medicinal, cultural, and recreational reasons, often with no or minimal harm. However, our societal systems inadvertently encourage harm and trauma associated with drug use (Piatkowski, et al., 2023a; Valentine & Fraser, 2008). Further, recent scholarly perspectives have advocated for the role of *pleasure* in shaping discourses and practices surrounding drug use, revealing the complexities of regulating drug consumption (Race, 2017). Adopting this perspective offers insight into the technical strategies used by systems to '*manage*' drug effects and *control* 'users' in contexts where pleasure is often associated with '*illicit*' behaviour (Dennis & Farrugia, 2017). Given the '*illicit*' nature of drugs is intricately linked to perceptions of '*health*', the interconnectedness of drugs, *human rights*, and wellbeing is shaped by both systems and individuals (Seear, 2023). As a result, we seek to '*re-establish*' the framework surrounding AOD and trauma, acknowledging these perspectives.

Australia has adhered to a harm minimisation framework since 1985, comprising harm reduction, demand reduction, and supply reduction strategies (National Drug Strategy [NDS], 2017). This approach, recognised globally, guides health, law enforcement, and AOD policies (Queensland Mental Health Commission [QMHC], 2022; NDS, 2017). Of these pillars, *harm reduction* interventions have been demonstrated to the most effective at reducing AOD related harms as it does not stop AOD use, rather, provides options for safer use. This approach has been shown to be most effective at an individual and community level (Hope et al., 2023), and there is strong evidence to support interventions such as *drug checking services* (Maghsoudi et al., 2022; Piatkowski, et al., 2023b), *needle exchanges* (Harris, 2021), *supervised drug consumption facilities* (Levengood et al., 2021; Long et al., 2024), *naloxone distribution* (Conway et al., 2021; Kahn et al., 2022), and *peer-led approaches* (Piatkowski et al., 2022).

Prevalence

The majority of Australians over 14 years and older have consumed *alcohol* in the previous 12 months (Australian Institute of Health and Welfar [AIHW], 2024). The prevalence of risky alcohol use in Queensland highlights that 22% of the adult population exceeded lifetime risky drinking guidelines and 31% exceeded single occasion risky drinking levels at least once a month (Queensland Health, 2020). Men who live in regional or remote

Queensland are more likely to drink at risky levels than anyone else (QMHC, 2022). For secondary students aged 12-17, 52% had consumed alcohol in the previous 12 months and 32% had done so in the previous four weeks (Queensland Health, 2020). The prevalence of *smoking* has had a downward trend in Australia, between 2019 and 2022–2023, among people aged 14 and over, it dropped from 11.0% to 8.3%. (AIHW, 2024). Between 2019 and 2022–2023, e-cigarette usage surged across age groups [AIHW, 2024]: tripling among individuals aged 14 and over (from 2.5% to 7.0%), quadrupling among those aged 18–24 (from 5.3% to 21%), and increasing over five-fold among those aged 14–17 (from 1.8% to 9.7%). This is similar in Queensland as daily smoking has declined by 47% since 2002 (Queensland Health, 2020), with the largest declines seen in high socio-economic areas and younger age groups. However, 10% of adults still smoke daily, with 1 in 15 people vaping [AIHW, 2024]. Forty-two percent of Aboriginal and Torres Strait Islander adults smoked daily in 2018-2019, and 6.9% of school children aged 12-17 years smoked at least one cigarette in the past 7 days in 2017 (Queensland Health, 2020).

For illicit *drug use*, almost 1 in 2 (47%) of Australians had used illicit drugs at some point in their life, with almost 1 in 5 (17.5%) using an illicit drug in the previous 12 months in 2022-2023 (AIHW, 2024). The most common illicit drug used in the past 12 months was cannabis (11.5%), followed by cocaine (4.5%), ecstasy (2.1%), non-prescribed opioids (2.2%), and anabolic-androgenic steroids (0.2%). Within a Queensland context, 18.4% reported recent illicit drug use, 13% used cannabis, 4% cocaine, 2.6% Ecstasy, and 2.1% pain-relievers and opioids [AIHW, 2024].

Impact and Cost

Licit Drugs: For Australia, alcohol significantly causes the most overall harm (Bonomo et al., 2019), increasing the risk of hospitalisations whereby two thirds of the 135,000 drug-related hospitalisations were alcohol related and in 2022, was responsible for 1,742 deaths, and in 2017-2018 it was estimated to cost Australia $66.8 billion (AIHW, 2023). In Queensland, alcohol's impact including 45,000 hospitalisations and 146,200 patient days in 2015-2016 (Qld Health, 2020), is three times the combined effects of all illicit drugs and is a leading contributor to the burden of disease, preventable injury and death (Australian Burden of Disease Study [ABDS], 2018). Furthermore, Queenslanders were twice as likely to be a victim of alcohol-related incidents (21%) than drug-related incidents (9.2%; Qld Health, 2020). Due to alcohol's impact on others, the World Health Organisation (WHO; 2015) recommend quantifying the effects of alcohol on others in a similar fashion to the effects of passive smoking. Despite a decline in smoking rates, tobacco remains a significant public health challenge, costing $136.9 billion in 2015-2016 and being the highest contributor to the disease burden in Australia (AIHW, 2023).

Illicit Drugs: Illicit drug uses burden in Australia has increased 43% (2003-2015) with it being more common among younger populations (QMHC Consultation Report, 2022). From 2001 to 2021, Australia recorded 37,000 drug-induced deaths (Penington Institute, 2024). In the year 2021 alone, the country observed 1,675 deaths due to unintentional drug overdose, marking a significant rise of 70.7% compared to the national population growth of 32.9% over the same period (Penington Institute, 2024). Within a Queensland context, the state experienced 292 deaths from drug overdose in 2021, translating to an average of 5.6 deaths per 100,000 people (Penington Institute, 2024). Compounding these challenges are the significant rates of mental health conditions and increased criminal activity due to illicit drugs. In Queensland, it costs $500 million to administer its current drug policy and illicit drug use contributes to 11,200 hospitalisations (2015-2016). In addition, almost two-thirds of Queensland Magistrates Court drug cases are for use/possession, and around one-third of Queensland prisoners are chronic, low-harm offenders (QMHC, 2022).

Priority populations

Socio-structural determinants significantly contribute to problematic AOD use in Australia, including social exclusion, racism, poverty, and marginalisation (National Preventative Health Strategy, 2021). Certain populations, such as Aboriginal and Torres Strait Islander peoples, the homeless, rural or remote living, LGBTQ+ individuals, and those with mental health conditions, are at higher risk (AIHW, 2023). ***Aboriginal and Torres Strait Islander Peoples*** experience intergenerational trauma, negatively affecting their health, experience of lasting trauma that is connected to ongoing racism, colonisation, forced removal of children and families, land dispossession, discrimination, violence, and systematic state violence (Fomiatti et al., 2023; Reynolds et al., 2023). These systems have led to increasingly high rates of suicide, incarceration and juvenile detention, poor physical and mental health outcomes, family violence, and children being taken into care (Van der Kolk, 2014). Harmful AOD use, in particular, tobacco and alcohol are of particular concern among Aboriginal and Torres Strait Islander Australians, contributing heavily to this health disparity (Krakouer et al., 2022). Developing *culturally sensitive* approaches and understanding towards AOD issues is essential for enhancing the treatment experiences and outcomes for Aboriginal and Torres Strait Islander peoples (Heath et al., 2022; Krakouer et al., 2022). ***Regional barriers*** affect over half a million Australians, who cannot access the treatment they need for AOD use, due to limited resources, impacts of stigma, and large wait times for treatment in the public health system (Ritter et al., 2019; Rethink Addiction, 2022). Gaps in service impact isolated *rural* and *regional* communities the most (Rethink Addiction, 2022).

Trauma and trauma-informed care in the AOD context

Maté and Maté (2022) expand the concept beyond individual psychological processes, emphasising its interplay with relational, cultural, and societal factors, including systemic violence and the legacy of colonialism. Research has established strong evidence between the link of problematic AOD use and trauma (Mills, 2015; Phipps et al., 2019; Zhang et al., 2020). In Australia, 80% of people with problematic substance use have experienced a traumatic event with most experiencing multiple traumas (Dore et al., 2012). With the growing awareness of trauma and its impact, it has led to a significant increase in the development of *trauma-informed frameworks* (Blue Knot Foundation, 2024). Trauma Informed Care (TIC) in Australian AOD treatment settings is advocated due to the high prevalence of trauma among individuals seeking AOD treatment (Mills, 2015).

The key findings

In the process of understanding trauma, the voices of survivors who have been stigmatised, misdiagnosed, or mistreated for their mental health and social problems are indispensable (Gillece, 2012). Thus, qualitative insights are essential to understand the link between AOD use, trauma, and TIC. Drawing on the LLE of PWUDs in Queensland (*N*=30) we outline several key categories which draw together the complex relationship between trauma and AOD.

Trauma, AOD use, and Coping Mechanisms

People used drugs for a variety of reasons, Sebastian [Male, 49]: *"People use drugs for a million reasons… to stop their thoughts… thoughts of abuse that's happened to them or trauma… so, you'll do anything to stop those things."* Some report using substances as a means of coping with trauma. Participants spoke of seeking comfort, numbing pain, or escaping reality to cope with the aftermath of complex traumatic experiences, for example Clara [Female, 54]: *"I didn't pick up drugs until my daughter passed away and then I lost my husband as well in 11 months*

and I didn't pick up drugs until I was 33." Thus, substance use can represent different motivations for different people; a conscious choice as well as a survival strategy.

PWUDs saw this as a form of self-medication, seeking to alleviate the negative effects. However, this coping mechanism perpetuates a cycle of trauma as the consequences of AOD use, such as witnessing the deaths of peers due to overdose, contribute to further psychological distress and further trauma, for example, Adeline [Female, 38]: *"It comes back to coping mechanisms. Like you use so you don't have to think about all of the shit that's happened and then using on top of that as traumatic, and then people dying as traumatic."* This highlights the systemic nature of trauma within the context of AOD use, underscoring the urgent need for comprehensive support systems and interventions to address both substance use and the underlying traumas fuelling them.

We also underscore the agency and autonomy of PWUDs, emphasising their capacity to make decisions within the constraints of their circumstances. For instance, Abigail [Female, 47]: *"My mother was an alcoholic… I never saw my drug use as a coping mechanism… it's always been something I have chosen to do… drug use has always been a choice…That's something I want to be very clear on."* Their personal agency and external influences such as past experiences and social structures interact at this point – which we highlight is the point of potential intervention as a community. People make choices based on their circumstances and 'structures' – we emphasise a thought for the reader: *what are we doing to change the structures?*

Societal Impact, Stigma, and Re-traumatisation

Building on the systemic nature of trauma, PWUDs spoke of their perceived stigma and judgement, which exacerbated their isolation and hinder their recovery efforts. This stigma from others can then be internalised, affecting self-perception and the ability to seek help – we call this the 'stigma cycle'. For example, Scarlett [Female, 38]: *"It can be really harmful telling the story… be the stigma… be re-traumatisation…having to tell the story over and over again… that is what breeds self-stigma… that stops people from accessing [treatment]… it becomes internalised and then that self-stigma creates that identity and then that is perpetuated."*

This sentiment was echoed by other participants. Kai [Male, 42]: went on to say: *"When it comes to health workers and stuff… [they] have my file… I don't want to go over it over and over again. So 9 times out of 10 I try to avoid it… I just don't wanna repeat bad **** that I really would rather not have a part of my life."* Repeatedly speaking on traumatic experiences within organisations and healthcare workers could be triggering, so individuals avoid seeking help.

Some participants indicate the social isolation that can occur through frequent and problematic AOD use. Due to the mental health decline, the social relationship breakdowns, and the lack of support, it can be dangerous and detrimental for problematic AOD users. Adeline [Female, 38]: spoke out about their experience with a close friend: *"[friend] had been reaching out to a few people… I think because she was frightened for herself… using too much… having a really, really tough time with her mental health… she kind of burnt everybody out."*

Other participants highlighted that the criminal justice system, as it currently stands, in Queensland is difficult for successfully reintegrating into society. This stems from the vulnerability that problematic AOD users have, the coping strategies of drug use, the stigma and barriers they feel, which in turn, creates increased AOD use and further vulnerability. Aurora [Female, 38]: summed this vulnerability nexus up: *"It's a big transition… why people are vulnerable, cause… their coping strategy [is] to use drugs… they take them away from that drug. Don't give access to… evidence-based programs like Methadone or Subutex [Suboxone]… release you into a world where you're gonna face all this stigma and barriers at every corner… it's such as recipe for disaster and overdose."*

What does this research mean for policymakers

Drawing together the current literature and research findings we underscore the urgent need for policymakers to *address the systemic issues* contributing to trauma among people who use AOD in Queensland. Policies must prioritise the expansion of TIC frameworks throughout various points of contact for this demographic, considering their interaction with multiple systems and services due to existing disadvantages. Strengthening Queensland's current systems to address both problematic AOD use and underlying trauma, alongside improving social determinants, necessitates achieving and ensuring accountability for heightened levels of integration within services. Moreover, strategic priorities should focus on expanding access to evidence-based harm reduction interventions, recognising their effectiveness in mitigating a wide array of AOD-related harms, while ensuring sensitivity and effectiveness in engaging with this population. Furthermore, it is imperative to move beyond selective adoption of evidence-based practices and prioritise the *consistent implementation of best practices*, ensuring that *decisions are guided by evidence rather than political considerations*, to effectively address the needs of the community. We outline several recommendations which would facilitate these transitions.

Options for reform

If we do indeed seek to '*re-establish*' the framework surrounding AOD and trauma, the next logical step is to draw on research evidence which we have and look to *reform* systems and policies in Queensland. We provide several options:

1. **Investing** in the AOD sector where there is a critical need *for increased financial resources* to enhance support and address the multifaceted challenges faced by individuals and communities. This investment should be focused on implementation strategies based on current and emerging *research*.
2. **Shifting** towards a *human rights* approach means that change to *policy* is crucial. Moving away from punitive measures is an important step, and this includes *avoiding the criminalisation* of individuals which, in turn, can prevent trauma and exposure to further trauma experienced by individuals and their families. Therefore, comprehensive *system reform* is necessary to ensure equitable access to care and support for people using alcohol or other drugs, irrespective of their involvement with the criminal justice, youth justice, mental health or child safety system. Understanding the trajectory of individuals moving through various systems is crucial for comprehending the impact of *cross-system trauma* and *structural* issues. This approach necessitates a holistic understanding of how intersecting systems contribute to and perpetuate trauma, informing targeted interventions which distinguish between occasional and problematic substance use and, thus, tailoring interventions accordingly.
3. **Embedding** *culturally sensitive* approaches is imperative to address the needs of *Aboriginal and Torres Strait Islander* communities. For those in *rural* and *remote* areas, ensuring equitable access to care, particularly in *underserved regions*, is essential for individuals to receive timely and appropriate support wherever they may reside. Putting an end to the *stigmatisation* perpetuated by systems requires the launch of *campaigns* aimed at educating professionals working within these systems about the interconnectedness of trauma and AOD use. These campaigns must emphasise the detrimental effects of stigma and the criticality of seeking assistance.
4. **Ensuring** that measures in *training and workforce development* are targeted beyond the AOD system is essential. TIC training should be made available for all professionals working within healthcare, social services, justice, and education sectors. This training should be *Peer-led* and *co-produced*, focused on understanding the impact of trauma on individuals, recognising the signs and symptoms of trauma, and applying trauma-informed principles in their work.

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