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This is the accepted manuscript.

This is the peer reviewed version of the following article:


which has been published in final form at http://www.dx.doi.org/10.1111/ajr.12361

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Exploring the use of drug trend data in the regional alcohol and other drug workforce

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Running title: Regional drug trends
Word count: 2,040 (not including participant quotations)
Acknowledgements: Funding for this project came from the Toowoomba Hospital Foundation Pure Land Learning College Research Scholarship.
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What is already known on this subject?

- Australia has a number of drug monitoring systems but none collect data in regional or rural areas.
- Those living in non-urban areas have risker patterns of substance use.

What does this study add?

- Law enforcement officials believe that they have access to good, current data on trends in substance use.
- Health workers want more data to assist in their roles.
- Collecting and collating data regarding trends in substance use and harm in non-urban areas may assist this workforce in policy development and planning.
Abstract

Objective: Drug trend data can inform appropriate policies to minimise drug-related harm, as well as assist in early detection and prevention. While Australia has a number of monitoring systems, none operate in regional areas. The aim of this study was to explore how drug trend and other data is used by the regional alcohol and other drug workforce.

Method: Twenty-one key experts from regional Queensland were interviewed between November 2014 and August 2015. KE worked in or had contact with the broader alcohol and other drugs (AOD) field in the Darling Downs area of Queensland. Interviews were analysed thematically.

Setting: Darling Downs, Queensland.

Results: Two themes emerged from the analysis. There were differences in workforce needs, with those in the law and criminal justice areas believing they had access to good, current data. Those in the health sector differed, though the majority indicated that there did appear to be a knowledge gap related to their location in a regional area.

Conclusions: Trends in the use of, and harms related to, substance use are well captured in urban areas, but less so in regional areas. This inhibits both our understanding of where substance use is changing, as well as how to best plan and respond.

Key words: drug trends; early warning; drug monitoring; regional health; workforce capacity
Introduction

The regular and systematic monitoring of trends in illicit drug markets allows for the documentation of emerging drug trends which may have significant public health implications (1). This data can inform appropriate policies to minimise drug-related harm, as well as assist in early detection and prevention. Australia has a number of systems designed to monitor trends in substance use and related harm (2). One of the key criticisms of these systems is their failure to describe trends outside of urban areas. Some of these criticisms are misplaced, as these systems were established to specifically monitor in these areas owing to earlier work showing that trends emerge in these areas before filtering out to other places (3). However, the lack of data in non-urban areas continues to be problematic.

Health outcomes for those in non-urban areas are lower than those living in urban areas (4), and these areas have riskier patterns of substance use (5). The recent focus upon increased methamphetamine use and related harm in Australia, in particular the crystalline form (‘crystal’ or ‘ice’), has shown that this increase has been driven in part due to a changing pattern of use in non-urban areas. Australia’s general population (“household”) survey found that those in remote and very remote areas were more likely than those in major cities to report methamphetamine use (6), while there has also been an increase in ambulance attendances in regional areas related to methamphetamine (7). This focus on methamphetamine use has served to highlight the dearth of information regarding substance use and harm in non-urban areas and the implications this has for engaging in earlier evidence-based practice, that being the process by which decisions are made based on evidence. In this instance, the household survey provided an important insight into where methamphetamine use was causing harm. Yet there is risk from relying on this survey to provide timely evidence to inform practice; it is limited in its capacity to provide detailed information regarding emerging trends or changes to trends in drug markets as it is conducted every three years. As Burns (8) notes, if monitoring does not occur, data from other sources, such as the tabloid media, become the key source of information, and the current debate surrounding increased use of methamphetamine in Australia has demonstrated this.
The criticisms of the focus of monitoring systems on urban areas assumes that this focus impedes policy, planning, or practice in non-urban areas; however no study has explored this. The aim of this study was to explore how drug trend and other data is used by the regional alcohol and other drug workforce.
Methods

Data for this study were collected from qualitative interviews from 21 key experts (KE) who worked in an area covering the Darling Downs Hospital and Health Service (DDHHS) area in Queensland, Australia. The DDHHS is responsible for providing services to a population of approximately 300,000 residents. The region consists of five local government areas spanning out over almost 90,000 square kilometres. Interviews occurred between November 2014 and August 2015. The eligibility criterion for KE participation was to work in or have contact with the broad alcohol and other drugs (AOD) field in the Darling Downs area. Participants were AOD workers/counsellors (n=6), prison and parole officers (n=6), police (n=4), care providers (n=3), general practitioners (GPs; n=2), and a clinical nurse (n=1). Snowball sampling, whereby a participant nominates another potential participant, was also utilised. Prior to contact with any participants, permission was sought from organisational heads and through research governance processes. Ethical approval to conduct the study was granted by the Darling Downs Hospital and Health Service Human Research Ethics Committee.

Participants were interviewed either in person or by telephone, according to the participant’s preference. Interviews were between 30-60 minutes in duration and were recorded, transcribed, and checked for accuracy by both authors. No new information emerged from later interviews at which point data saturation was reached and data sampling was considered complete. A semi-structured interview schedule was used. The questions included a uniform set of ‘prompts’; some were designed and used to build rapport with the participants (such as asking about their role in their organisation), while others were related to the study and its aims (such as asking whether their organisation collected data, how this was used). The analytic process began as soon as the data were collected. The transcripts were read and re-read in order to gain a comprehensive understanding of the content of the interviews. The transcripts were inductively analysed through a process of open coding, as advocated by Miles and Huberman (9). Themes were identified and then later refined, and were then grouped and categorised to enable comparison across themes and to ensure that minimal overlap was present. The presentation of the results in this paper includes representative quotes from the themes identified. These quotes are used to demonstrate the findings. To
maintain anonymity of the participants, all participants’ quotes are identified with a number.

Results

Two themes emerged from the analysis; these were 1) data type, need, and purpose, and 2) the knowledge gap.

Theme 1: Data type, need, and purpose
Not all participants used data to inform their work. Those in law enforcement – police, or prison and parole officers – were the exception, in that all reported using and having access to some type of data. Police referred to the intelligence that they had access to and were able to extract, and saw that as more useful and relevant to them when compared with other data sources that might be collected. They also stated that, because their data was related to arrests, it was more current and potentially more reflective of what was happening ‘on the ground’. One participant explained that through the number of arrests, they had a good sense of what was trending:

*We see an increase...like, it’s not hard for us to extract that data. Everybody has got a pretty good hold [on what is happening in the drug scene] ...that the majority of drug arrests, there is a big influx of ice or there is a big influx of amphetamines or cannabis...purely by the flow with the office of arrests. (Participant 4)*

Participants who were working in the health sector tended to state up front that they did not use data, collect data, or have a need for data. However, as the interviews progressed, participants started to vary or clarify their responses. For those in government agencies, data was collected – for instance, information from clients on intake into treatment – but that went to a central data manager; most participants acknowledged that they did not know how to access that data, or, even if they could, that there was a limitation to it. As Participant 6, who worked in the mental health field, clarified:

*A: We do collect it to a degree I suppose in the intake, but I think our data isn’t set up specifically for it. We might have young people present that may have a*
history of substance use, but that’s not really captured in the data because our data really only concentrates on the last three months. That might come up in conversation…I suppose you could pull the figure down from the last three months of our intake and collate that way, but it’s not very representative of what goes on. (Participant 6)

Q: Do you need that sort of information? Is there a reason you’re not using it or you are just not using it in your role?

A: I think we need that information. I mean, if it was available…especially for clinicians who, many of them are not trained in drug and alcohol counselling, so if they had some data that they could access every few months, just to see trends and know what is going on, to be able to help in the counselling sessions, I think that would be really important. (Participant 6)

For many, the discussion about the use of data caused them to reflect on what was missing from the data they did have access to, or what would be its ‘value add’. Several participants indicated that having a monitoring system focusing on regional areas would be useful because it would help confirm their own thoughts or experiences. As one AOD counsellor noted:

I mean some of the trends…I was thinking back to my experiences in intakes and that sort of thing and have noticed a bit of a trend, in my head, of particular age groups, what sort of drugs they were using and that sort of thing…I probably wouldn’t mind seeing if what I have worked out in my head is actually what is representative elsewhere as well. (Participant 6)

Others stated that it would help to contextualise the information that they were getting from less reliable sources, such as the media or the government. As Participant 18 stated:

The government started telling us that ice was big and I accessed a lot of illicit drug data to find out whether that really was the case to gel with my sense of it.
Theme 2: The knowledge gap

Participants discussed issues that were broadly related to a ‘knowledge gap’. For some, this gap came because they worked in a regional area. Some were able to access data for Queensland, or an area broadly related to where they worked, but were concerned that many people came into that geographical area to seek treatment and distance themselves from their old networks. A small number of participants had established networks to try and share this information; this, however, relied mostly on anecdotal evidence, and this was seen to be heavily influenced by the media.

_We have a teleconference about the illicit drug stuff…coordination between the different…specific health services in this area and really what we have got is anecdotal evidence which unfortunately in this case is anecdotal evidence as covered by medial portrayal which, you know, is problematic._ (Participant 18).

For others, they knew that other data existed, such as police data and data collected by various health agencies, and wanted that data to inform programs and provided targeted information.

_It would be very good if we had additional data from other sources, law enforcement or other areas of the community, you know, child safety and things like that, so that we could develop our health promotion sort of things and target that more to the substances being used in this region._ (Participant 11).

...good to know is what services people are accessing...it would be really good to know if they are being utilised or even what axillary services are being utilised, so particularly counselling services...or are there youth workers doing a lot of work around substances, you know, just incidental, it’s not really their direct role, but obviously they are meeting with young people and that comes up as a topic of discussion or is an issue in their lives...help us focus our attention or our efforts. (Participant 9)

Related to this was the idea that trends needed to be collected from those substance using populations who did not inject drugs. Some participants were aware of the existing monitoring systems, but they were too narrow for their purposes.
The biggest issue with the IDRS is, despite the fact that “I” at the beginning stands for illicit there really is injecting that’s their target group...it’s a fairly specific narrow focus market. And that leaves a lot of drug use unquestioned; a methodology would draw out non injecting drug users, people who would use drugs in a way that they would see not terribly different from drinking alcohol and smoking tobacco. That group would be nice to know about, because in many ways they are the largest group. (Participant 18)

Given the geographic location of the study site, many participants came into contact with Indigenous Australians, and many noted that they lacked data to be able to work effectively with this group. One participant, who worked in therapeutic services, noted that they collected some of their own data but it lacked this detail:

[The data we have lacks detail] because we have got the Indigenous community and also the non-Indigenous community, it sort of lacks in asking different question to different backgrounds, to get the different answer that we need. (Participant 1)
**Discussion**

The aim of this study was to explore how drug trend and other data is used by the regional alcohol and other drug workforce. The AOD workforce is not homogenous, and there were differences observed between those who worked in health and those who worked in law and criminal justice, with the latter believing they had access to good, current data. The majority who worked in the health sector indicated that there appeared to be a knowledge gap related to their location in a regional area. Given the recent focus on substance use in regional and rural areas, access to drug trend data in these areas may benefit not only policy and planning, it also may serve as an evidence base to counter tabloid media reports.

Those in the health sector wanted more data to assist in their roles. Some of those working in frontline health services believed that having drug trend data would help contextualise clients’ substance use, allowing clinicians to understand the types of substances clients may be using or may be exposed to. Others in the health sector felt that drug trend data would help frame what they were seeing in their services; if clinicians suspected that, for instance, they were seeing more people who were using a particular drug, they could use data to validate that suspicion. This in turn could inform how the service responded to changes in the drug market (and thus people seeking treatment for problematic use of different substances) but also help inform health promotion campaigns.

Despite wanting data for slightly different purposes, participants acknowledged the benefits of collecting data and monitoring trends over time. This is not surprising, as indicator data, such as the number of people entering treatment, has been demonstrated in Australia (10) to be extremely useful when attempting to place trends into context. Indicator data such as ambulance attendances, hospital admissions, and arrests for possession/use are used by many monitoring systems to triangulate with other data sources to provide a more accurate picture of the drug market. Identifying and accessing extant data sources is difficult (1, 11). A primary concern with using indicator data to monitor trends in the drug market is the acknowledged lag between the time a drug enters the market and when harms are observed from the use of that drug; caution is thus given when using this data to understand changes in drug patterns.
However, Mounteney and Haugland (12) have demonstrated the strategic role that a multi-indicator surveillance system can have in identifying emerging trends. There needs to be increased efforts not only in ensuring that good, accurate data is collected, but that it is easily accessible.

The idea of collecting information from substance using groups was raised in the interviews, though there was no consensus for how this would operate. Within the literature there is no one model for how a drug monitoring system should operate. Griffiths et al (13) championed what they termed an ‘integrated information system’ which gathered and evaluated data from different sources. The IDRS and EDRS are examples of systems which triangulate three data sources, with the acknowledgment that while each data source has its own strength, it also has its own weakness, which can be overcome by the strengths of the other two data sources (1). Other systems worldwide operate differently. The Illicit Drug Monitoring System (IDMS) in New Zealand interviews three different groups of frequent drug users (people who inject drugs, methamphetamine users, and ecstasy users) (14); the Bergen Early Warning System (BEWS) in Norway combines multiple drug indicator data with other sources such as school surveys of drug use, rapid assessments, media monitoring, and key informant panels (12); while the Drug Abuse Warning Network (DAWN) in the United States utilises drug-related emergency department visits (15). Including surveys of sentinel substance using groups has been a strength for those systems which include them, as data on use and harm may not only be more valid coming from those actively engaged in the drug market but also more timely (16). Attempting this in non-urban areas may be problematic. There may be an issue not only of recruiting large numbers of substances users, but also the impact of anonymity in these areas and how this may also impact on recruitment (17).

Limitations

There are limitations to the current study. The findings relate only to the Darling Downs area, and may not be generalizable beyond this area and the participants. Although efforts were made to include a range of stakeholders from the area, some chose not to participate. Of those who did provide their time, often their role, the function of the organisation, and how they were funded influenced the clientele seen;
this may impact on the types of drugs and drug related issues workers may perceive as being problematic for the community.

Conclusion

Trends in the use of and harms related to substance use are not well captured in non-urban areas. This inhibits not only our understanding of where substance use is changing, but also how to best plan and respond. Those in the regional AOD workforce do seek data to assist in policy and planning and there needs to be increased efforts to identify data that is both accurate and accessible.
References


