HEALTHIER COMMUNITIES SURVEY REPORT 2018

GRANITE BELT
NEIGHBOURHOOD CENTRE

Healthier Communities Survey Report 2018

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August 18th 2018

ACKNOWLEDGMENTS

The Granite Belt Neighbourhood Centre gratefully acknowledges assistance from the following people and organisations:

- Our partner agencies – Drug Arm Australasia and GBATSIC
- Our key stakeholders including: Southern Downs Regional Council, Churches of Christ, The Ministers Fellowship, Granite Belt Uniting Church, Mercy Family Services, St Vincent de Paul, Drawn Together & Southern Downs Health Practitioners
- The ADF Research Team

The Granite Belt Neighbourhood Centre gratefully acknowledges the cooperation and assistance of the following people and organisations in the marketing and distribution of this survey:

- St Joseph's Catholic School
- Domino's Pizza
- Stanthorpe Retailers
- TenFM
- Border Post
- Warwick Daily News
- Support Agencies across the Southern Downs
- Wallangarra residents for their time to attend a community forum
- Dalveen volunteers for the distribution of the survey via their local newsletter
- Local associations, groups and clubs
- GBNC staff and volunteers
- Wallangarra Store
- Free Range Kids
- Saint Martin de Porres

The Granite Belt Neighbourhood wishes to acknowledge and thank all students and residents who gave their time to complete the survey and provide feedback.

The darkest night is often the bridge to the brightest tomorrow
Jonathan Lockwood Huie

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1.1 PURPOSE

The Healthier Communities Survey was designed by the Granite Belt LDAT (Local Drug Action Team) for the purpose of

a) consulting with community and collecting evidence around community need

b) identifying strategies that minimise the risk of harm from alcohol and drugs

b) collecting data on alcohol and drug use, and age of exposure

c) seeking community feedback regarding risk and protective factors

d) to identify vulnerable and at risk groups

The survey was constructed in consultation with key stakeholders, health and AOD's clinicians and the ADF (Alcohol and Drug Foundation).

The survey was structured in two ways in order to reach both adult and youth demographics. For those under the age of 18years (and attending Secondary School) the survey focused on prevention strategies. Those over the age of 18years were asked questions about their lifetime and current use of alcohol, prescription pills, and illicit substances in addition to asking for their feedback around risk and protective factors.

Survey Monkey was utilised as a vehicle to harvest data and collate evidence.

Due to the nature of the survey and in consideration of ethical guidelines the survey was only released to young people who were attending Secondary School. Therefore, adolescents not in attendance at school were not included in this survey.

See Appendix 3 regarding ethical considerations

1.2 METHOD

The survey was distributed community wide across the Granite Belt using the methods listed below, and across the Southern Downs through newspaper, social media and inter-agency networks.

- Radio advertising
- Through newspaper editorials advertising the survey link
- Via local Council (SDRC) - social media and networks
- Through inter-agency networks
- By hardcopy letterbox drops
- Through face to face community forums
- Via email or face to face presentations to local groups including: Zonta, Rotary, Lions, Probus, Toastmasters, CWA and Chamber of Commerce
- Via email to local sports, music and recreation groups
- Via support agency workers and their direct contact with clients and families
- Via email and hardcopy surveys to Church networks
- Via distribution and promotion by local retailers
- By QR coded (business card sized) promotion cards

1.2.1 Survey Invitation Cards

A business sized invitation card was designed as a call to action inviting residents to participate in the survey via an advertised URL or QR code. This link or code took them to the opening consent page in Survey Monkey.

3,500 cards were printed and distributed across the Granite Belt, with the majority distributed by Domino's Pizza who attached the card to the front of takeaway pizza boxes. Retailers distributed cards at their checkouts and service desks, and cafes distributed cards in conjunction with customer purchases and by placement at dining tables.

See Appendix 1 to view a copy of the community poster promoting the survey
See Appendix 2 for a sample of the business sized survey invitation card
See Appendix 5 to see a snapshot of the opening intro page on Survey Monkey

The survey was open to residents for 3 weeks during the period of March 2018.

1.3 SCHOOL PROCEDURE

Principals of the two local High Schools were contacted with a request for permission to conduct the survey at their school. One High School was able to participate. The other High School had recently completed the ASSSAD survey so declined. The ASSSAD report is not due to be released until late 2018 so could not be referenced in this report.

Approval to survey students involved a research application to the Diocese of Toowoomba.

In order to meet ethical requirements schools required that parental consent be obtained before students participate in the study. The school concerned utilised their own methods to achieve parent consent. Due to tight timeframes and receipt of parent consent only approximately half of the students were able to participate. On a day agreed by the school, students accessed the survey electronically answering a total of five questions. The policy of the school determined the level of teacher support provided during surveying.

1.4 LOGIC

The survey contained inbuilt logic functions allowing us to map the survey in two pathways. One pathway for students of High School age and one for those 18 years and older.

High School aged students were asked just 5 questions including the consent question. Participants over the age of 18 years of age were asked 11 questions including the consent question, plus an additional two questions offering them the opportunity to participate in a prize draw.

See Appendix 4 for a copy of the survey logic.
See Appendix 6 for a copy of the survey questions (18yrs and over)
See Appendix 7 for a copy of the survey questions (12-17yrs of age)

All participants were provided privacy and confidentiality guarantees in the opening page of the survey, followed by an opening question seeking their consent to participate.

1.5 QUESTION CONTENT and KEY CONSIDERATIONS

i. Adult participants were asked questions about the following substances: alcohol, Marijuana, prescription pills, Ice/meth and inhalants. The key aim of the survey was to gather feedback on risk and protective factors, so with this in mind we did not delve deeper into the specifics of substance use. In addition to this we were aware that to do so may have resulted in a lower question completion rate.

ii. Community perceptions and social norms around drug and alcohol use became apparent during the rollout of this survey and reinforced our decision not to delve deeper into the specifics of substance use. The survey produced over a 70% completion rate.

iii. Stakeholders and health clinicians were involved in finalisation of the survey questions, and assisted in shaping the language used, to ensure everyday English replaced a natural desire to write in clinical terms.

iv. Questions regarding Marijuana use do not distinguish between hydroponic (hydro) and bush Cannabis.

v. The survey does not investigate use of the following substances: Cocaine, LSD, Ketamine, GHB, NPS (new psychoactive substances or Hallucinogens).

vi. Two key questions in the survey focused on current use and age of exposure. Participants were asked about their lifetime use (responses – never used, previously used, currently using, in-recovery) and their age of exposure by age grouping. (0-11, 12-17….)

vii. The funding for this project was insufficient to engage the services of a qualified statistician. In its place considerable research was undertaken in order to apply best practice in regards to data analysis and report writing. Guidance was also provided by the ADF research team.

viii. When reading the analysis of data by age or gender it is important to note the following:

a) Questions regarding 'risk' and 'protective' factors were presented early in the survey and were designed to be a soft entry. Questions following this ask about the respondents' individual experiences.

b) The words "When it comes to thinking of the world around you" were used in the opening of some questions to encourage participants to respond without feeling the question was targeting them individually, and was therefore open to interpretation. The 'world around you' could include: nuclear or extended family, social/peer group, their immediate neighbourhood, or the whole of community.

It is important to be careful with the analysis not to assume responses are about an individual's personal lived experience for example: where the 50+ age group identify 'experimentation' as one of the highest risk factors.

This could mean either

- that many 50+yr olds are experimenting OR

- that their opinion or perhaps what they are seeing and hearing in community is that this is a risk factor.

In this example their response to this question is weighted against their response to questions asking about individual drug use and exposure, which produced data indicating that the 2nd response to experimentation is more likely the more accurate one.

c) Percentages calculated are based on participants choosing a particular answer. Questions regarding 'risk' and 'protective' factors were multiple choice allowing participants to nominate between 11-13 answers and/or provide additional individual responses. This often produced 4-5 top responses from the group often with 70%+ weighting by respondents. Because of this all multiple choice questions have been presented in the report with both graphs and tables so readers can see the total number of respondents for each answer.

1.6 DATA ENTRY AND CLEANING

A small number of surveys were completed in hardcopy and entered manually into Survey Monkey and were signed and archived as evidence of this work.

Responses from open ended questions were collated by one individual in order to keep data collation clean. Responses that could not be read/deciphered or could not be understood were removed from the data set before final statistics were calculated.

1.7 SAMPLE SIZE

A total of 475 respondents opened the survey and 474 gave consent. Of those who answered the gender question, 344 Females and 117 Males completed the survey. 75 young people aged between 12-17 were surveyed and were attending High school at the time of the survey.

The following table provides a breakdown of the place of residence for participants

On the Granite Belt (Wallangarra to Dalveen)	69.57%	320
On the Southern Downs (Dalveen to Allora)	18.70%	86
Outside of this region	10.65%	49
Prefer not to respond	1.09%	5

Due the location of the Granite Belt in the Southern and South West corridor of Queensland, and its proximity to the NSW border, it is worth noting that the 10% of participants that indicated their place of residence was outside of the Southern Downs, may include those who live in New South Wales but are employed or conduct their daily business on the Granite Belt.

The following map provides the geographical location of key towns and borders.

Respondents spent on average 6 minutes completing the survey and were able to do this work on either a desktop or laptop computer, iPad or mobile phone, via a URL link or QR code. A small number of respondents chose to complete the survey in hard copy.

1.8 SURVEY INCENTIVE

A voluntary prize draw was included as an incentive to participate and required respondents to provide (with their consent) contact details.

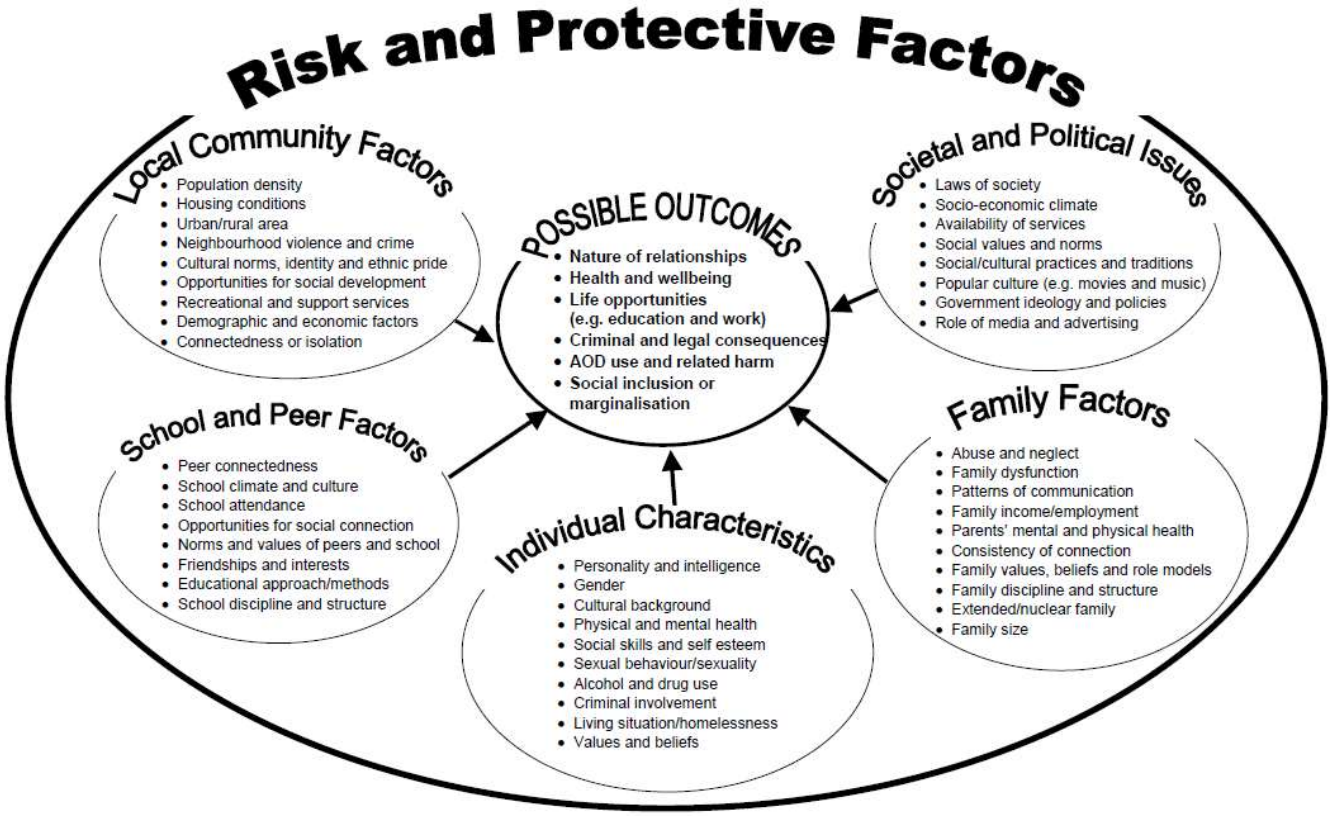
The prize draw provided a winning recipient the choice of a phone, coffee or pizza voucher. Recipient names were announced (with consent) in local newspapers alongside editorial articles publicising outcomes from this research project.

Interestingly only 116 respondents chose to participate in the prize draw; hopefully an indication that our marketing strategies (in particular our business sized survey marketing card) and the strength of our message proved highly effective in capturing the attention and participation of community.

1.9 WRITING THE REPORT

The diagram below by the Department of Health charts risk and protective factors that affect the health, wellbeing and prosperity of any individual.

Our greatest challenge is finding community inclusive strategies that increase protective factors and reduce risk factors in regards to exposure to alcohol and other drugs. Our survey directly asked participants and stakeholders about these factors. Their responses shape the following report and drive the development of an action plan.



http://www.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-front10-fa-toc~drugtreat-pubs-front10-fa-secb~drugtreat-pubs-front10-fa-secb-6~drugtreat-pubs-front10-fa-secb-6-1

We have attempted throughout the report to provide thoughtful questions to stimulate further exploration and discussion. It is our hope that these questions may also stimulate further research and collaboration. These questions are earmarked using the following drop capital: Q

2. Executive Summary

A total of 474 participants completed the survey. The following summary is based on the data collected from 406 participants who reside on the Granite Belt (320) or Southern Downs (86). The remaining 54 participants were either from outside of this region or chose not to provide this information.

One of the key purposes of this work was to obtain data around community need, as evidence to support future funding applications to deliver strategies to minimise risk of harm from alcohol and other drugs. The survey asked participants about the factors that influenced their alcohol and drug use (risk factors), and which factors helped keep them safe and well (protective factors).

Community response indicates that free mental health services, support programs and opportunities to connect and engage with community are key protective factors. Disconnection to community, peer pressure and mental health were highlighted as key risk factors contributing to exposure and/or use. It is evident from this data that the two sit in counter balance with each other and therefore benefit from a holistic approach.

Risk Factors

The 18-24yr age group produced the highest statistics for the following risk factors (for those aged under 50yrs of age) depression/anxiety, easy access to drugs and recreational use. The 35-49yr age group identified relationships that are violent or controlling (69.15%) as a significant risk factor. What is concerning is this same group scored the following risk factors highest (for those aged under 50yrs of age)- no one to provide healthy positive support or supervision, feeling like they don't belong, not wanting to be at home, and/or disengaged from family or community.

The 50-59yr age group reported the highest statistics for multiple risk factors including relationships that are violent or controlling, recreational use and pain management. They ranked peer pressure or social pressure higher than any other age group. Why is this? Is this their personal experience, or their observation of younger generations they care about?

The 60-69yr age group mirrored similar risk factors, but raised not going to school or work, or being able to find work as a top risk factor (69.09%).

The 70yrs+ age group ranked boredom/and or a lack of things to do in the community as a key risk factor (76.47%) in comparison to other age groups in the over 50 age group. Is this their personal experience, or their observation of younger generations they care about?

Interestingly the top 4 identified risk factors for those aged 50yrs and older mirror the same top risk factors for the under 50 age group. This provides evidence that overall age is not the most influential factor, gender is. For example, relationships that are violent or controlling ranked 72.85% by female respondents in comparison to 56.72% for male respondents, and 68.78% of female respondents indicated easy access to drugs as a risk factor in comparison to 58.21% for male respondents.

Protective Factors

The 18-24yr age group recognised access to courses such as anger management, resilience etc. as a top protective factor (76.47%), while those aged 25-34yrs strongly supported health and wellness programs (81.25%), and they ranked more free mental health support services as a top protective factor (68.75%).

The 35-49yr age group also supported more free mental health services (70.53%) however ranked easier and more affordable access to sports and recreational clubs as most important (71.58%).

Those aged 50-59yrs supported community activities that help link families to support (75.86%) as a top protective factor, while those in the 60-69yr age group ranked health and wellness programs highest (74.55%). Those 70yrs and older voiced support for programs for children and youth (76.47%).

Males

Males identified peer pressure or social pressure from friends, family, community or social media (76.12%), and experimentation (74.63%) as their greatest risk factors.

Males indicated that opportunities to be connected with community (65.67%) and easier and/or more affordable access to sports and recreational clubs (64.18% were key protective factors.

Females

In analysing the data by gender we see that unhealthy relationships rank in the top 4 risk factors for women (72.85%). Easy access to drugs, and boredom and/or a lack of things to do was strongly supported (68%) as a significant risk factor.

While males identified activities and sports and recreation as protective factors, females have identified overall health and wellness programs including mental health support as important protective factors.

This clearly demonstrates the need to think carefully about prevention and early intervention strategies that are gender inclusive and where possible promote a whole of community approach.

Exposure to alcohol and drugs:

65.67% of males and 45.29% of females are currently using alcohol

13.43% of males and 10.76% of females are using prescription pills

34.39% of females and 37.88% of males reported exposure to alcohol, weed or prescription pills at the age of 18-24yrs of age, and 28.96% of females and 34.85% of males reported exposure to these same substances at the age of 12-17yrs. This highlights an extreme period of vulnerability and risk and reiterates that early drug prevention strategies need to start before the age of twelve.

The following list highlights what is our call to action as a result of this survey.

a) A sense of belonging and feeling connected to family, and the greater community is key to strengthening protective factors

b) That any approach to drug prevention must consider mental health and peer pressure as two powerful influencing factors and therefore must plan holistically to address these

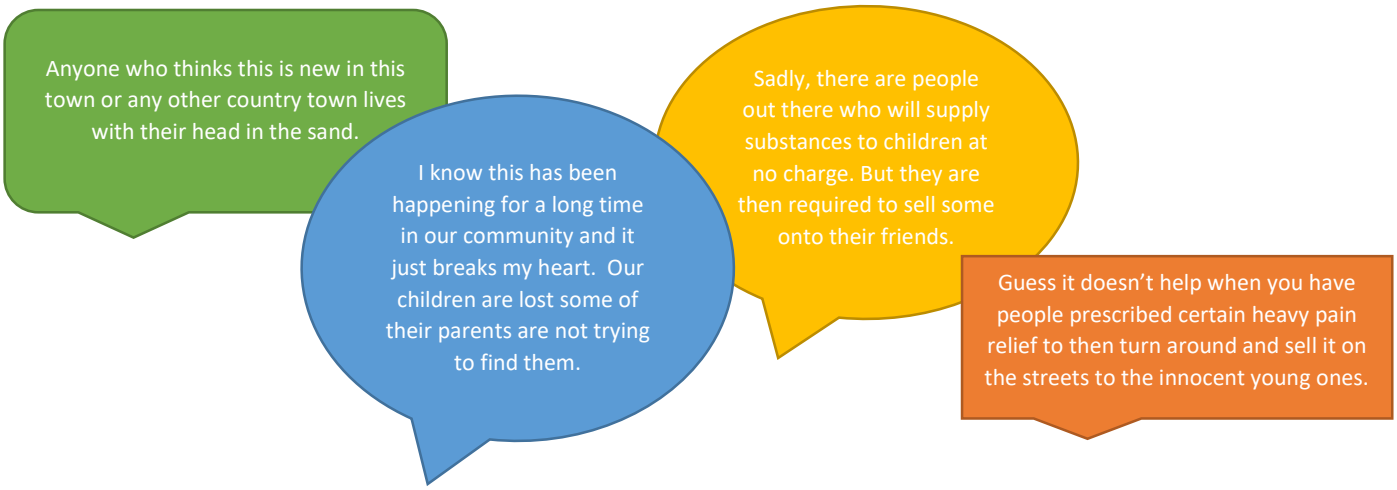
c) The public is asking for programs that support health and wellness, including programs that support children and youth. Most importantly they are seeking support from community to help families to reach out, connect and engage with activities and support services.

d) We must not fail to take into consideration current social norms and community stigma both of which can create a barrier to services for those vulnerable and in need.

We have attempted throughout the report to provide thoughtful questions to stimulate further exploration and discussion. A summary of these questions can be found on page 91 (Chapter 9 – Key Considerations).

We have consulted with community and just as importantly we have consulted those who support community. The summary on page 20 and page 22 draws a comparison between both and provides reassurance that a whole of community approach is the best strategy when it comes to prevention.

In August we released an early snapshot of survey results in a local newspaper that had previously assisted in promoting the research. Within a week community responses began pouring in. The comments harvested from this community feedback clearly indicates an awareness of local drug issues.



*examples of public comment in the Border Post newspaper. See Appendix 9 for further evidence.

On page 24 we discuss responses from youth and discover that their emphasis on sports and recreational activities, community support and local services as protective factors, matched responses from the older cohort.

Community are asking for more support services in the community and mental health/health sector. We are surely compelled to explore whether our future work in servicing these needs lies not in the 'who' but in the 'how'.

The survey results indicate support for strategies and programs that builds stronger community connection and perhaps in light of peer pressure, a need to nurture new social norms that sow a stronger desire for personal investment in self and in community.

A key aim of the project was to determine which demographic would benefit from early intervention, in order to design a work plan of strategies that would reduce risk factors and strengthen protective factors. Community stakeholders identified the following at risk/vulnerable groups that would benefit from early intervention programs including:

a) Students in the transition from Primary to High School
b) Those affected by mental health
c) Expectant Mums and those with young children
d) Those in unhealthy or controlling relationships

The challenge for agencies moving forward is how best to target these groups with evidence based, sustainable programs that will hand in hand reduce risk factors while strengthening protective factors.

Chapter 7 provides an insight into next steps and the work that is already underway around action plan development.

2.1. Community Feedback

This chapter of the report presents findings from open comment boxes in the survey. Participants (aged 18yrs and older) were asked to provide their feedback in regards to both protective factors and risk factors.

Protective Factors

269 Participants responded to the following question providing a total of 515 answers.

Q10 - In our communities there are things that can help us stay safe and well. We call these things protective factors. Examples of protective factors include health and wellbeing services, recreational activities, support services, and employment opportunities. Thinking about this community, what do you think are the protective factors?

Table 2.1.1: Protective Factors

Response	Number of Responses	Percentage
1. Sports and Recreational Activities (e.g. sporting clubs, healthy activities, dance schools, fitness centres, arts, music, choir, bands, scouts/girl guides, things for youth to do).	86	16.70
2. Community Organisations (e.g. CDS, AODs, Youth Services, CWA, St Vincent De Paul's)	81	15.73
3. Strong Community/ies linkages (e.g. supportive community, inclusion, identity, volunteer opportunities, activities and events, respectful of each other, confidentiality, talking about issues, encouraging people to seek help/ having someone to talk to/ role models)	79	15.34
4. Affordable Health Care/ Wellbeing (e.g. GP's, Hospital Care, Counsellors, Mental Health Services, Pain Management Help).	57	11.07
5. Employment (meaningful work), Employment Services	41	7.96
6. Nothing/Not Sure/ not a lot available	33	6.41
7. Strong Families/relationships- parental awareness of AOD issues/ education support for parents (in home help from birth) Support groups, strength from other members.	27	5.24
8. Education- Tafe, schools, tertiary support	26	5.05
9. Community Education (incl. guidance officers/school nurses)	17	3.30
10. Church/Chaplaincy	12	2.33
11. Nothing for youth to do	11	2.14
12. All of the Above	8	1.55
13. More Police Involvement/Engagement	7	1.36
14. Advertising of available services (social media, notice board)	6	1.17
15. Centrelink (more understanding- not just a handout)	6	1.17
16. Affordable, Safe and Secure Housing	5	0.97
17. Nature/Parks	4	0.78
18. Council/Politics	1	0.19
19. Identity	1	0.19
20. Discipline	1	0.19
21. Transport	1	0.19
22. Free venue hire needed	1	0.19
23. Indigenous connection services for child & family	1	0.19
24. Low cost of living	1	0.19
25. Anti-loitering music in town	1	0.19
26. Alleviation of poverty	1	0.19
Totals	515	100%

Protective Factors

The word cloud above summarizes the top 10 protective factors as identified by survey participants. This can be cross referenced against the list below collated by stakeholders including education, support and health workers who were also asked to identify key protective factors.

- Support programs for children and youth
- Parenting programs during pregnancy that discuss the risk of drug harm and where to go for help
- Health and wellness programs (including how to eat and stay well, be active and make friends)
- Pain management programs
- More support for students to stay in school
- Easier and/or more affordable access to sports and recreational clubs
- Community activities that help link families to support
- Access to courses (such as anger management, resilience and healthy relationship workshops)
- More free mental health support services
- Opportunities to be connected with community
- Community education around mental health to break down barriers

Comparison

Interestingly, sport and recreational activities, engagement with community, community support and health services (including mental health support) were highlighted as top protective factors by both survey participants and stakeholders. Education in schools and in community was also strongly supported by both groups. Overall there is a strong consensus about what works in this community. This list reinforces the vital role community organisations play in providing support pathways.

Employment and Employment Services were raised as important protective factors however interestingly they were ranked below strong community connections and affordable health care.

Participants recognise the importance of community connection, being engaged in work or education and the value of engagement in community activities and/or recreation. Their references to Police, Churches and other support agencies perhaps provides reassurance that a whole of community approach is the best strategy when it comes to prevention.

Risk Factors

284 Participants responded to this question providing a total of 656 answers.

Q11 - In our communities there are things that can increase the risk of harm from alcohol and other drugs. We call these things risk factors. Risk factors are the things that can sometimes lead to unhealthy behaviour or choices. Examples include: high unemployment, poor access to education, lack of support, and poor access to community activities etc. Thinking about this community, what do you think are the risk factors?

Table 2.1.2: Risk Factors

Response	Number of Responses	Percentages
1. High unemployment rate (jobs not responding, lack of, none for people with a disability)	130	19.82
2. Family cycle/family breakdown/DV/ no boundaries/poor parental involvement/role modelling/discipline/no support	58	8.84
3. Lack of community activities (affordable sports/recreation/ for all ages/ not all sport activities, community projects, boredom)	73	11.13
4. Lack of support services (that travel/ funding/ support services working together)	58	8.41
5. Easy access to drugs and alcohol (too much around/acceptance)	42	6.40
6. Nothing for youth/children to do.	29	4.42
7. Education- (incentive to stay, withdrawal from, more caring staff, access to tertiary Ed.	41	6.25
8. Financial stress- low socio-economic area/bills/poverty/low income	20	3.05
9. Peer pressure/ media influence	22	3.35
10. Judgemental communities/ stigma/small town/ denial/ fragmented community	19	2.90
11. Poor health and wellbeing care (e.g. mental health/rehab/pain management/ GP's)	19	2.90
12. Unwillingness to work/ no motivation to participate/ attitude/choice	17	2.59
13. No community education on alcohol & drugs, parental awareness	9	1.37
14. Low self-esteem/ self-worth/ take no responsibility/ see no future/ no confidence	15	2.29
15. Isolation	10	1.52
16. Mental health issues (e.g. depression)	9	1.37
17. Law enforcement (better police involvement, known criminals in area, drug testing)	12	1.83
18. No affordable transport/ lack of transport	11	1.68
19. All of the above	11	1.68
20. Government dependency (e.g. high number of Centrelink recipients)	8	1.22
21. Safe, secure & affordable housing/ homelessness	9	1.37
22. Advertising- community not knowing what services are available	3	0.46
23. Too many seasonal workers/ only seasonal work/farm work/ no community farming	6	0.91
24. Older demographic (volunteering = older people/ can't connect with younger generation)	2	0.30
25. Bullying (in person/cyber/from government/community)	4	0.61
26. Don't know/not sure/ none	3	0.46
27. Rebellion	2	0.30
28. Ignorance	1	0.15
29. Experimenting	2	0.30
30. Parents who don't value education	3	0.46
31. Business owners (getting richer)/ no support for	2	0.30
32. The employed used too	1	0.15
33. Crisis event	1	0.15
34. Poor decision making	1	0.15
35. Discipline	1	0.15
36. Youth pregnancy	1	0.15
37. Property values declining	1	0.15
Totals	656	100%

Protective Factors

The word cloud above summarizes the top key risk factors as identified by survey participants. This can be cross referenced against the list below collated by stakeholders including education, support and health workers who were also asked to identify key risk factors.

- Feeling like they don't belong. Not wanting to be at home. Disengaged from family or community
- Boredom and/or a lack of things to do in the community
- Not going to school or work or not being able to find work
- Relationships that are violent or controlling
- Easy access to drugs
- No one to provide positive healthy support or supervision
- Pain management
- Peer pressure or social pressure from friends, family, community or social media
- Experimentation
- Lack of awareness and knowledge of the risks of drug use
- Depression and/or anxiety
- Lack of community understanding to mental health issues feeling isolated and/or judged
- Recreational use

Comparison

Some of the top responses by participants align with the level of social disadvantage in this region; such as high unemployment, financial stress, lack of transport etc. While participants identify sports and recreation, job opportunities and health and support services as key protective factors it would appear that they are indicating there is not enough of them since they are being described as a deficit. While this is an external or economic factor it is interesting to note that community is also taking ownership of what is happening internally in community – family breakdown, easy access to drugs and peer pressure.

I believe it is also important to reference the following two risk factors which sit outside specific reference to mental health issues (16. in the table)

12. Unwillingness to work/no motivation to participate/attitude/choice
14. Low self-esteem/self-worth/take no responsibility/see no future/no confidence

- What does this say about dis-connection with community, and the need to find purpose? More importantly what does it tell us about the vision of the future as held by individuals?

- Do our young people describe the future as one of opportunity or as a tired repetition of social disadvantage? What message is our community transmitting about this?

Community stigma was identified as a risk factor and ranked 10th by participants.

10. Judgemental communities/stigma/small town/denial/fragmented community

Does the feeling of judgement have ties to mental health stigma or drug use stigma or are there other social norms at play here such as intergenerational stigma, or influence at play from small town networks and old boys networks?

Due to ethical considerations youth participants were asked only 5 questions. The first 4 questions covered consent, gender, location and age. The 5th question mirrored a question asked by our adult demographic and focused on protective factors as described below.

Protective Factors – (as identified by participants12-17yrs of age)

75 Participants responded to the following question which provided a free text box for individual comment.

Q5: Thinking about the world around you, what do you consider to be the most important things that help a person to stay safe, and well, and to feel healthy and happy? Think about your school and your home and what is available in your community (support services, community activities, sports and recreation etc.

The word cloud above summarizes the top key protective factors as identified by youth participants

Participants talked strongly of the necessity to have supportive friends and family, and of safety; feeling safe at home and in community and having someone they could trust. They spoke of the importance of being able to seek help, to be listened to and respected and to have someone they could talk to about their concerns.

An example of responses to this question include:

> "I think it's important to have a good support system of people who you can talk to and alert if you're feeling unsafe "

> "I think it requires self-care doing what makes you happy but also knowing that you don't have to do it alone"

What is interesting is that these young people showed an awareness of support avenues (internal and external in their world) all pointing to that common adage – a problem shared is a problem halved. It would appear from their responses that young people know where to seek help.

Their emphasis on sports and recreational activities, community support and local services as protective factors matched responses from the older cohort.

If young people know who to go to for support and survey participants are asking for more support services in the community and mental health/health sector, maybe our work lies not in the 'who' but in the 'how'?

Q How do we dissolve social stigma around support and challenge old and unproductive beliefs around the link between vulnerability and accepting assistance? How could we utilise social media to do this?

2.3 Summary – Total Group/All Respondents

The Data

This chapter provides an overall summary of key data from the total number of respondents, including risk and protective factors, current drug use statistics and age of exposure. We explore social norms, mental health stigma and the impact of our 'drinking culture'. The additional snapshot of community feedback supports the statements and findings provided.

Risk Factors

The top four **risk factors** as identified by respondents were

1. Peer pressure or social pressure from friends, family, community or social media 79.31%
2. Feeling like they don't belong. Not wanting to be at home. Disengaged from family or community 76.90%
3. Depression and/or anxiety 74.48%
4. Experimentation 72.07%

*risk factors as provided by respondents

As indicated experimentation was identified as a top risk factor (72.07%). This data is supported by outcomes from the National Drug Strategy Household Survey 2016 which indicates that curiosity and the fact that friends or family offered or were using illicit substances were the two main reasons for use.

In 2016, similar to 2013, the most common reason that an illicit substance was first used was curiosity (65%), followed by friends or family offered it or were using it (50%)[1]

Respondents indicated that high unemployment and a lack or affordability of community activities (including sports and recreation) were also significant risk factors. While these two factors are affected by economics, peer pressure and social media are factors that can be influenced within community, by community.

Q How can we influence social media in a way that positively impacts on sense of belonging, and depression and/or anxiety? (2 of the other key risk factors)

Q What role do our schools, Early Years providers, GP's, Sports & Rec groups, Councillors, Churches and support workers play in leading and facilitating this change? How could we facilitate a community wide response? Would a one-message campaign across community be effective?

The Queensland Alcohol and Other Drugs Action Plan 2015-2017 discusses the social impact of drug use:

For individuals, problematic drug use can lead to social isolation, stigma and discrimination leading to or compounding existing social disadvantage…. This stigma creates barriers to people seeking help to address problematic drug use and hinders their ability to find employment and reconnect with the community [2]

The Queensland Mental Health Commission has indicated it will undertake a project to research this issue and identify options that may be implemented to identify effective ways of reducing stigma and discrimination.

It is important to be mindful of social determinants for this rural region in particular evidence indicating homelessness, and the lack of affordable housing, in particular the seasonal migrant employment market affecting housing supply and demand.

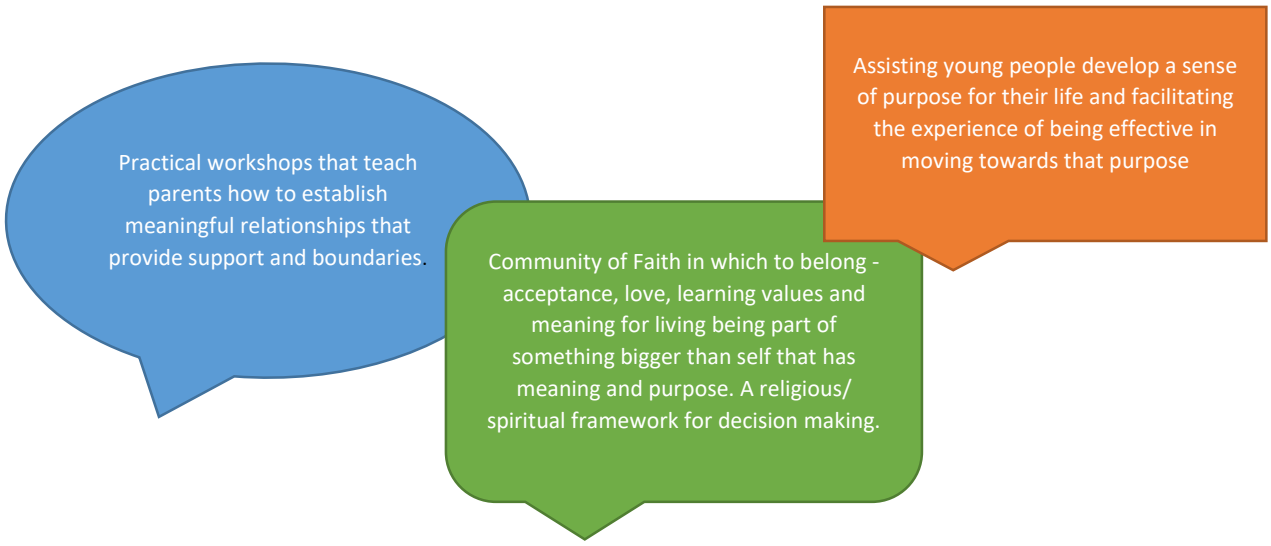
Detailed findings from the National Drug Strategy Household Survey 2016 indicate that,

People living in remote and very remote areas were more likely to smoke, drink at risky levels, and use cannabis and meth/amphetamines, but less likely to use illicit drugs such as Cocaine and Ecstasy compared with those in Major cities. [1]

Protective Factors

The top four **protective factors** as identified by participants were

1. Health and wellness programs (including how to eat and stay well, be active and make friends) 69.86%
2. Support programs for children and youth 69.18%
3. Community activities that help link families to support 66.78%
4. More free mental health support services 65.07%



*protective factors as provided by respondents

Support for Sports and Recreational clubs was highlighted by respondents (in the free text option of this survey question) with an emphasis on affordable access. In a rural region with high social disadvantage and no public transport the economics of this is an ongoing challenge. This is compounded by the spread of population, and local industry (such as Agriculture) which by its nature can result in isolation.

Health care including access to counsellors, mental health services and pain management was ranked highly by respondents. While we are fortunate to have bulk billing GPS on the Granite Belt, over 50% of survey participants identified the need for more free mental health services.

Over 50% of those aged 18-49, and over 60% of those aged 50years and older recognised opportunities to be connected with community as a key protective factor. This was described by participants as activities and events, support pathways and volunteer opportunities.

Q How can we better prepare the next generation with the tools for positive self-care (health), a stronger sense of purpose and value, and the desire and means to engage and contribute to community?

Drug and Alcohol Use

The following table provides statistics on the current alcohol and other drug use by 292 respondents.

Alcohol was identified as the most common currently used drug (49.66%) followed by prescription pills (11.64%). Approximately 25% of participants had previously used alcohol, and/or Marijuana and/or prescription pills. Of concern here is the percentage of other drug use and prescription pill use.

Table 2.3.1: Current substance use

Current Use	NEVER USED	PREVIOUSLY USED	CURRENTLY IN RECOVERY	CURRENTLY USING	PREFER NOT TO RESPOND	TOTAL
Alcohol	19.52% 57	26.03% 76	2.40% 7	49.66% 145	2.40% 7	292
Weed, Marijuana, Cannabis	70.89% 207	23.63% 69	0.68% 2	3.42% 10	1.37% 4	292
Prescription pills (pain killers, benzo's and stimulants)	59.93% 175	25.34% 74	1.71% 5	11.64% 34	1.37% 4	292
Ice, Meth	92.81% 271	4.79% 14	0.68% 2	1.03% 3	0.68% 2	292
Inhalants	95.21% 278	3.77% 11	0.34% 1	0.00% 0	0.68% 2	292
Other drugs	85.96% 251	10.27% 30	0.00% 0	1.71% 5	2.05% 6	292

Q How do we best equip those in the health and support sector to better understand illicit substances in our region including trends, and the influx of new substances? Are we currently doing enough?

*Britain is among the world's biggest cocaine users. 2.25% of those aged 16-59years in England and Wales consumed the drug, as recorded in the 2015/2016 Crime survey for England and Wales.[3]

Australia ranked in the top 10 countries in this same report for cocaine use.

Polydrug use is also an important key consideration; with an availability of research outlining the link between multiple substance use.

The National Drug Strategy Household Survey 2016 discusses polydrug use including alcohol and tobacco -

Among recent illicit drug users, cannabis was the drug most often used in addition to other illicit drugs in the previous 12 months, and use was particularly high among users of hallucinogens (88%), ecstasy (79%), synthetic cannabinoid (78%) and meth/amphetamines (74%). However, cannabis users and people who misused pharmaceuticals were the most likely to only use those substances in the same 12-month period and not use any other illicit drug, while users of other psychoactive substances had used at least 1 other illicit drug, with quite high usage among this group—over half had used cannabis, ecstasy and hallucinogens. Risky drinking (monthly risk of single occasion harm) was particularly prevalent among recent users of stimulants such as ecstasy (84%), cocaine (82%), hallucinogens (78%) and meth/amphetamines (73%). Among drug users, daily smoking was highest among recent users of meth/amphetamines (52%).[1]

Age of Exposure

Participants were asked: If you have had some experience with alcohol, weed, or prescription pills at what age did it start? 30% of participants indicated exposure began between the ages of 12-17yrs, and 36% indicated it began the age of 18-24yrs.

Respondents were asked the same question about exposure to meth, inhalants, or other drugs. 4.9% indicated exposure began between the ages of 12-17yrs, and 5.3% indicated it began the age of 18-24yrs.

Q How influential is social media, and print media on early exposure (12-17yrs of age) to alcohol and drugs?

Due to ethical considerations we were unable to survey those of high school age about exposure to drugs however the ASSSAD (Australian Secondary School Students' Alcohol and Drug Survey) report should provide further evidence relating to this region. The latest report is due for release in late 2018.

Social Norms

Survey participants were given the opportunity to provide their own feedback around risk and protective factors.

Some of the following comments may give us insight into community perceptions around alcohol and drug use.

"inter-generational use - believing its ok because your parents or other family members did it"

"Generational learned behaviours, Australia has a culture of drinking, just went along with mates."

"Learned behaviour from their family: cultural expectations of over indulgence of alcohol; lack of things to do that don't involve alcohol."

"…the biggest barrier is to get people to participate in programs being offered. It seems that an individual invitation has to be made before many people are willing to get involved"

"I think there is a breakdown in "community", the resources and recreation is there - just not appreciated."

"Sometimes people experiment with drugs & alcohol but not end up addicted because they don't have a huge vacuum in their lives that they believe D&A can fill. There is also a culture of the Drug world where they make young people think they are accepted and include, which meets their emotional need for acceptance. We need to teach parents to accept and love their children."

Interestingly we included 'lack of awareness and knowledge of the risks of drug use' as a suggested risk factor however it scored lowest of all suggested risk factors across all age groups. Does this indicate that current drug education is effective however risk of harm is not the highest consideration when weighted against risk factors such as peer pressure?

Feedback from those distributing the survey indicated that some of the population felt that the survey didn't apply to them.

Some of the reasons for this included:

'I don't have a drinking problem'

'There isn't a drug problem in our area',

'The people in our area are mostly working families or retired'

Some respondents indicated that social drinking precluded them from the survey because they didn't have a drinking problem.

Q What does this reveal about perceptions around alcohol and drug use, and quantity and potential harm? What do these comments reveal to us about social norms in this community? What does this tell us about our drinking culture?

Through conversation with support workers, clients and local Police it has been indicated that Ice/Meth is of concern to this community. This is further evidenced by the fact that participants cited easy access to drugs and alcohol as one of the top 5 risk factors in this community.

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Q How can we reduce the ease of access, disrupt the supply chain and local distribution, and challenge our 'no dob' culture? Suggested control measure are discussed in Chapter 7.

The National Drug Strategy Household Survey 2016 discusses the shift in people's perception of drugs,

In 2016, alcohol continued to be the most commonly mentioned drug that people thought caused the most deaths (35%) but excessive use of alcohol was no longer the drug people feel is of most concern to the general community (declining from 43% to 28%), with meth/amphetamine overtaking alcohol and more than doubling since 2013 (from 16.1% to 40%).

In 2016, there was a clear shift in people's perception of drugs, with meth/amphetamine nominated for the first time as the drug most likely to be associated with a 'drug problem' (the proportion more than doubled between 2013 and 2016, from 22% to 46%). People also considered meth/amphetamines to be more of a concern to the general community than any other drug (including alcohol) and the proportion who nominated it as a drug that caused the most deaths also increased in 2016[1]

Risk of harm

As presented in data from the DDHHS (Darling Downs Hospital and Health Service) in the period of 01 January 2016 - 28 February 2018 there were 506 alcohol and drug related presentations at Stanthorpe and Warwick Hospital.[4]

These figures have yet to be compared against wider regional data and require DDHHS assistance to achieve this. However, what we do know from The National Drug Strategy Household Survey 2016 -

In 2016, 2.8% of recent drinkers had been injured while under the influence of alcohol and required medical attention and 1.3% required admission to hospital for their injuries.

Requiring medical attention and/or hospitalisation because they were so intoxicated was reported by just 1.0% of drinkers…. Among recent illicit drugs users aged 14 or older, 1.1% reported that they had injured themselves while under the influence of illicit drugs and required medical attention and 0.4% said their injury was serious enough to require hospitalisation.[1]

Q Are alcohol and drug related admissions on the rise and do we have the resources to manage a growing demand for services?

Motivating Factors

Our report looks at identified risk factors for drug use by both age and gender and has compared and reported on the differences and trends. We have already referenced peer pressure and experimentation as key motivators.

The National Drug Strategy Household Survey 2016 discusses below their own research in regards to motivations/factors that influence decisions to use illicit drugs -

In 2016, similar to 2013, the most common reason that an illicit substance was first used was curiosity (65%), followed by friends or family offered it or were using it (50%) these were the main 2 reasons for both recent and ex-illicit drug users.

Among those who continued to use drugs:
• the most common reason for continuing drug use was that they wanted to enhance experiences (32%)
• more drug users continued to use illicit drugs to improve their mood or stop feeling unhappy (from 10.2% in 2013 to 15.3% in 2016)
• 14–19 year olds were more likely to be influenced by friends and family than those in other age groups. [1]

Mental Health

Depression and anxiety were highlighted in our survey as one of the top three risk factors for drug and alcohol use (74.5%) It scored highly as a risk factor across every age demographic. This was mirrored by the percentage of support for more free mental health services (70.40%) as a nominated protective factor.

I believe there is value in further research around access, affordability and use of mental health services. Do residents know enough about mental health services on offer and how to connect with them? Are we doing enough around education and awareness? Is the need for service outstripping current supply?

Q Which came first, the drug use or the mental health condition?

Research indicates a link between drug use and the onset of psychosis. Is there any link between drug use and anxiety and depression? Our survey does not set out to explore this however it is an important consideration.

Consideration should also be given to community stigma around drug use and any link to social dis-engagement, isolation and mental health. Interestingly, community stigma was one of the top 10 identified risk factors in our free answer section of the survey.

Therefore, do we need to change our questioning from a focus on awareness of mental health services to questions that explore community confidence to access services? In regards to engagement… how much of a factor is community stigma?

2.4 Summary – Male/Female comparison

The following chapter provides an analysis of data collected from both male and female respondents, and highlights the differences and similarities found.

Risk Factors

The number one risk factor identified by both male and female respondents was peer pressure or social pressure from friends, family community or social media. Feelings of not belonging, not wanting to be at home or feeling disengaged from family or community, and depression or anxiety were also ranked in the top 4 risk factors. Males ranked experimentation 74.63% and although it didn't make the top 4 for females it was closely followed at 71.49%.

Several interesting differences emerged between the male and female cohort.

1. Relationships that are violent or controlling ranked 72.85% by female respondents in comparison to 56.72% for male respondents
2. 68.78% of female respondents indicated easy access to drugs as a risk factor in comparison to 58.21% for male respondents
3. Both groups indicated depression or anxiety as a leading risk factor however while female respondents indicated that a lack of understanding to mental health issues was also a significant risk factor 61.99%, male respondents ranked this at 34.33%

The AIHW sheds some light on the link between alcohol and drugs and unhealthy relationships,

Family, domestic and sexual violence can be experienced across all age, socioeconomic and demographic groups. However, there are some common elements associated with raised levels of this type of violence. It is often associated with alcohol and drug use—in 2012, 56% of women who had been physically assaulted by a man reported that alcohol or drugs contributed to the most recent incident of assault (ABS 2013b).[5]

Men and women in controlling relationships may feel pressured into using drugs. The fear of violence or isolation may be a significant contributing factor. It is important to note that controlling relationships happen amongst peers and not always in households.

Top 4 Risk factors - Male

1. Peer pressure or social pressure from friends, family, community or social media 76.12%
2. Experimentation 74.63%
3. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 68.66%.
4. Depression or anxiety 62.69%

Top 4 Risk factors - Female

1. Peer pressure or social pressure from friends, family, community or social media 81.00%
2. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 80.09%.
3. Depression or anxiety 77.83%
4. Relationships that are violent or controlling 72.85%

Protective Factors

Support programs for children and youth, along with community activities that help link families to support were nominated by both groups as two of the top four protective factors. While access to sports and recreation factored in the top 4 for males, mental health was the focus for females.

Considering both groups had highlighted depression and anxiety as a key risk factor it is interesting to note that access to more free mental health support services was ranked higher for females (70.40%) than males (47.76%). Health and wellness programs were also ranked higher for females (73.54%) than males (58.21%).

Could community stigma around mental health have impacted the statistics for males?

Both groups nominated more support for students to stay in school (50%+) and females supported access to courses such as anger management, resilience etc. (68.16%) in comparison to males (46.27%).

Pain management programs received more support by females (47.98%) vs. males (40.30%)

Top 4 Protective factors - Male

1. Opportunities to be connected with community 65.67%
2. Easier and/or more affordable access to sports and recreational clubs 64.18%
3. Support programs for children and youth 62.69%
4. Community activities that help link families to support 61.19%

Top 4 Protective factors - Female

1. Health and wellness programs 73.54%
2. Support programs for children and youth 71.30%
3. More free mental health support services 70.40%
4. Community activities that help link families to support 68.61%

Use of alcohol and other drugs

95 Males and 309 Females completed the survey.

a) 65.67% of Males and 45.29% of Females are currently using Alcohol.
b) 2.99% of Males and 3.59% of Females are currently using Marijuana
c) 13.43% of Males and 10.76% of Females are using prescription pills.
d) 1.49% of Males and 0.90% of Females are using Ice/Meth
e) 4.48% of Males and 0.90% of Females are using other drugs

Use of alcohol and other drugs was higher for males in every category except Marijuana.

The AIHW reported on alcohol consumption reporting that - males aged 14 or older were almost twice as likely (7.6%) as females aged 14 or older (4.2%) to drink daily in 2016[-5]

These figures raise the question about the possible need for further research. In a rural community where the discussion around substance use focuses on Marijuana, Ice and prescriptions pills, we are seeing 'Other' drugs with a higher percentage of use than Ice/Meth. Neither group reported any current use of inhalants despite the male group reporting previous use of inhalants (7.46%) and the female group (2.69%).

A higher percentage of females had previously used alcohol, but both groups reported an equal percentage of previous Marijuana use. Previous use of prescription pills, Ice/Meth, inhalants and other drugs was higher for males than females.

A higher percentage of males were in recovery for alcohol and Marijuana than females.

Use of prescription pills is high. 13.43% of Males and 10.76% of Females are using prescription pills, however we do not have the breakdown of figures for non-medical use.

The AIHW discusses the rise in pharmaceuticals

The non-medical use of pharmaceuticals in 2016 was higher than all other illicit drugs, except cannabis (10.4%). Pharmaceuticals most commonly used for non-medical purposes were opioid analgesics and benzodiazepines. Recent non-medical use occurred more often than for most other illicit drugs, with 28% of people who misused them doing so daily or weekly. Prescriptions for opioid analgesics continue to rise.[6]

Age of exposure to alcohol and other drugs

34.39% of females and 37.88% of males reported exposure to alcohol, weed or prescription pills at the age of 18-24yrs of age. Exposure to these same substances at 12-17yrs of age dropped to 28.96% for females, and to 34.85% for males. Males reported little to no initial exposure in the 35+ age group in comparison to females who reported exposure into the 60+ age group.

4.61% of females reported exposure to Meth/Ice, inhalants or other drugs at the age of 18-24yrs of age and 3.23% at the age of 12.-17yrs.

Males reported 7.58% exposure at the age of 18-24yrs of age, and 10.61% at the age of 12-17 yrs. This raises the question as to why a greater percentage of males were exposed to 'other' drugs at the age of 12-17yrs than they were at the age of 18-24yrs and why their exposure at 12-17yrs was significantly higher than the female group. Perhaps the following explanation provides some insight.

The National Drug Strategy Household Survey 2016 reported that,

Males were about 1.4 times as likely to have recently used an illicit drug as females in 2016 (18.3% compared with 13.0%) and this ratio has remained fairly similar over time (since 2001)[1]

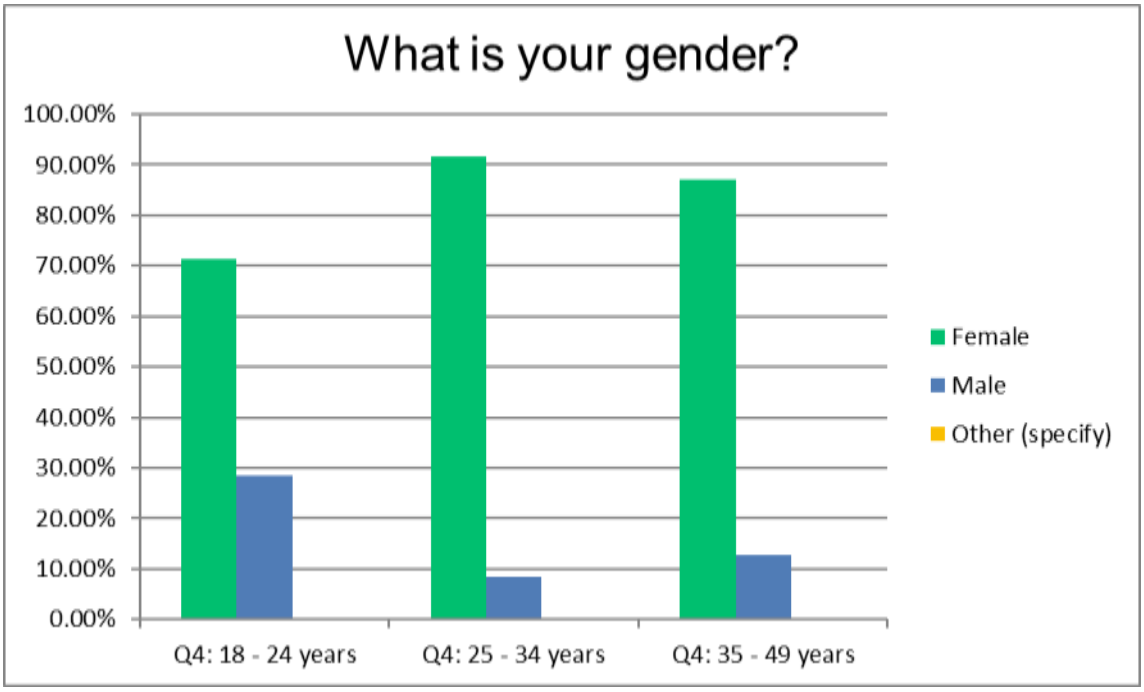
2.5. Summary – Age comparison under 50yrs

This chapter presents the data collated for 18-49 year olds; male and female. It highlights the differences between identified risk and protective factors in addition to presenting generational considerations influencing the age of exposure to alcohol and other drugs.

Risk Factors

The following is a summary of the whole group, followed by a breakdown of the 3 age groups; 18-24yrs, 25-34yrs and 35-49yrs of age.

Figure 2.5: Respondents by age group and gender



Summary - under 50 yrs. group

Risk Factors

Top 4 Risk factors – Under 50 age group

1. Peer pressure or social pressure from friends, family, community or social media 80.28%
2. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 76.06%.
3. Depression and/or anxiety 75.35%
4. Experimentation 72.54%

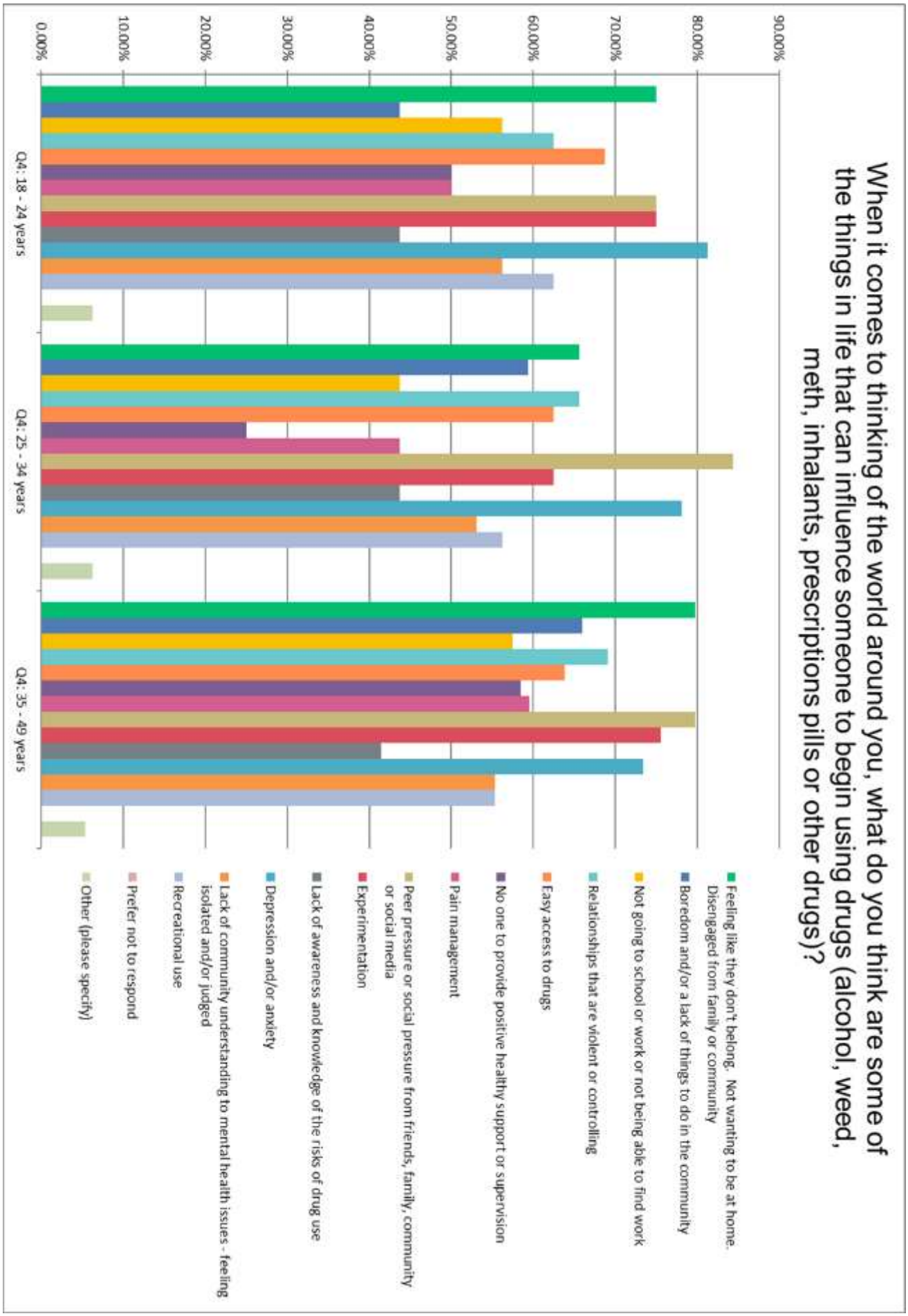


Figure 2.5.1: Risk factors by age group

Interestingly all 3 groups ranked lack of awareness and knowledge of the risks of drug use as the lowest risk factor. The same groups ranked easy access to drugs and relationships that are violent or controlling with a similar weight (63-69%). While these factors don't rank in the top 4 risk factors they should not be overlooked.

Q Is there a possible link here between access to drugs and relationships that are unhealthy? Which came first in an individual's personal experience - access to drugs that drew them into an unhealthy relationship (certainly a factor in the youth demographic) or an unhealthy relationship that led to drug use?

A lack of community understanding to mental health issues or of people with mental health issues was closely supported by all groups (53-56%)

Risk Factors by Age

18-24yrs

1. Depression/anxiety 81.25%
2. Peer pressure or social pressure from friends, family, community or social media 75%
3. Experimentation 75%
4. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 75%

The 18-24yr age group scored highest across the under 50 age group in the following 3 fields: Depression/anxiety, easy access to drugs and recreational use. Access to drugs surely warrants greater investigation? How is it so easy for young people to access drugs and how much of this access occurs in the home?

How much is a young person's depression and anxiety impacted by the feeling that they don't belong and don't have a family they want to be in? Connection with family is a protective factor on many levels. What messages are we giving within community that help strengthen a feeling of belonging and connection with others?

Q How can we disrupt the ease of access to drugs in our region?

Chapter 7 presents control measures relevant to this question.

The Ecstasy and Related Drugs Reporting System (EDRS) monitors the availability of ecstasy, amphetamines and other illicit drugs, and reported the following on access to these substances in Queensland.

The most common source person for purchasing either hydro Cannabis or bush Cannabis was a known dealer followed by a friend, and the most common location remained a private home for both forms[7]

Risk Factors by Age

25-34yrs

1. Peer pressure or social pressure from friends, family, community or social media 84.38%
2. Depression/anxiety 78.13%
3. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 65.63%
4. Relationships that are violent or controlling 65.63%

The 25-34yr age group ranked 'no one to provide positive healthy support or supervision' at just 25%, significantly lower than the 18-24yr age group, which could be attributed to an expectation of growing independence with age. However, what is interesting to note is that this percentage jumps from 25% to 58.51% in the 35-49yr age group. What has changed within family dynamics causing such an increase?

Recreational use and experimentation percentages dropped in the 25-34yr age group in comparison to the 18-24yr age group.

35-49yrs

1. Peer pressure or social pressure from friends, family, community or social media 79.79%
2. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 79.79%
3. Experimentation 75.53%
4. Depression/anxiety 73.40%

As a risk factor, relationships that are violent or controlling was ranked 69.15%, the highest percentage across these 3 age groups. What is concerning is this same group scored the following risk factors highest - no one to provide healthy positive support or supervision, feeling like they don't belong, not wanting to be at home, and/or disengaged from family or community. Are these risk factors linked to unhealthy relationships and if so, are they contributing to feelings of isolation and disconnection?

Were these participants referencing their own experiences or that of someone close to them, or were they merely giving an opinion?

As noted by the Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland report, alcohol and drug use is not a primary factor in predicting future violence, however it becomes a significant aggravating factor when it exists with other causes such as social norms about violence.[8]

Protective Factors

On average between the age groups there was a 15-20% difference in support for each protective factor, however, there was a general consensus across the following factors; (with data varying only by 5-6%) community education around mental health to break down barriers, opportunities to be connected with community, community activities that link families to support and more support for students to stay in school. Again and again we see disconnection and mental health as top risk factors and opportunities to link and engage with support and community as protective factors.

Summary - under 50 yrs. Group

Protective Factors

Top 4 Protective factors – Under 50 age group

1. Support programs for children and youth 68.06% and more free mental health support services 68.06%
2. Health and wellness programs 66.67%
3. Easier and/or more affordable access to sports and recreational clubs 65.97%
4. More support for students to stay in school 63.89%

Protective factors by Age

18-24yrs

1. Access to courses such as anger management, resilience etc. 76.47%
2. Health and wellness programs 70.59%
3. More support for students to stay in school 64.71%
   - Support programs for children and youth 64.17%
   -Community activities that help link families to support 64.17%
4. Easier and more affordable access to sports and recreational clubs 58.82%

Access to courses was ranked highest by this group as a protective factor. This group also ranked community activities that link families to support higher than both other age groups. Education and wellness are both key themes for this age demographic

We acknowledge the success of the Good Sports initiative supporting sports and recreational clubs to build a culture of responsible drinking, and the value of the Life Education program delivered across schools in this region.

The NDIA's research based guide for Parents, Educators and Community Leaders discusses the relevance of school based programs as a protective factor.

Prevention programs for middle or junior high and high school students should increase academic and social competence with the following skills (Botvin et al.1995; Scheier et al. 1999): • study habits and academic support; • communication; • peer relationships; • self-efficacy and assertiveness; • drug resistance skills; • reinforcement of antidrug attitudes; and • strengthening of personal commitments against drug abuse.[9]

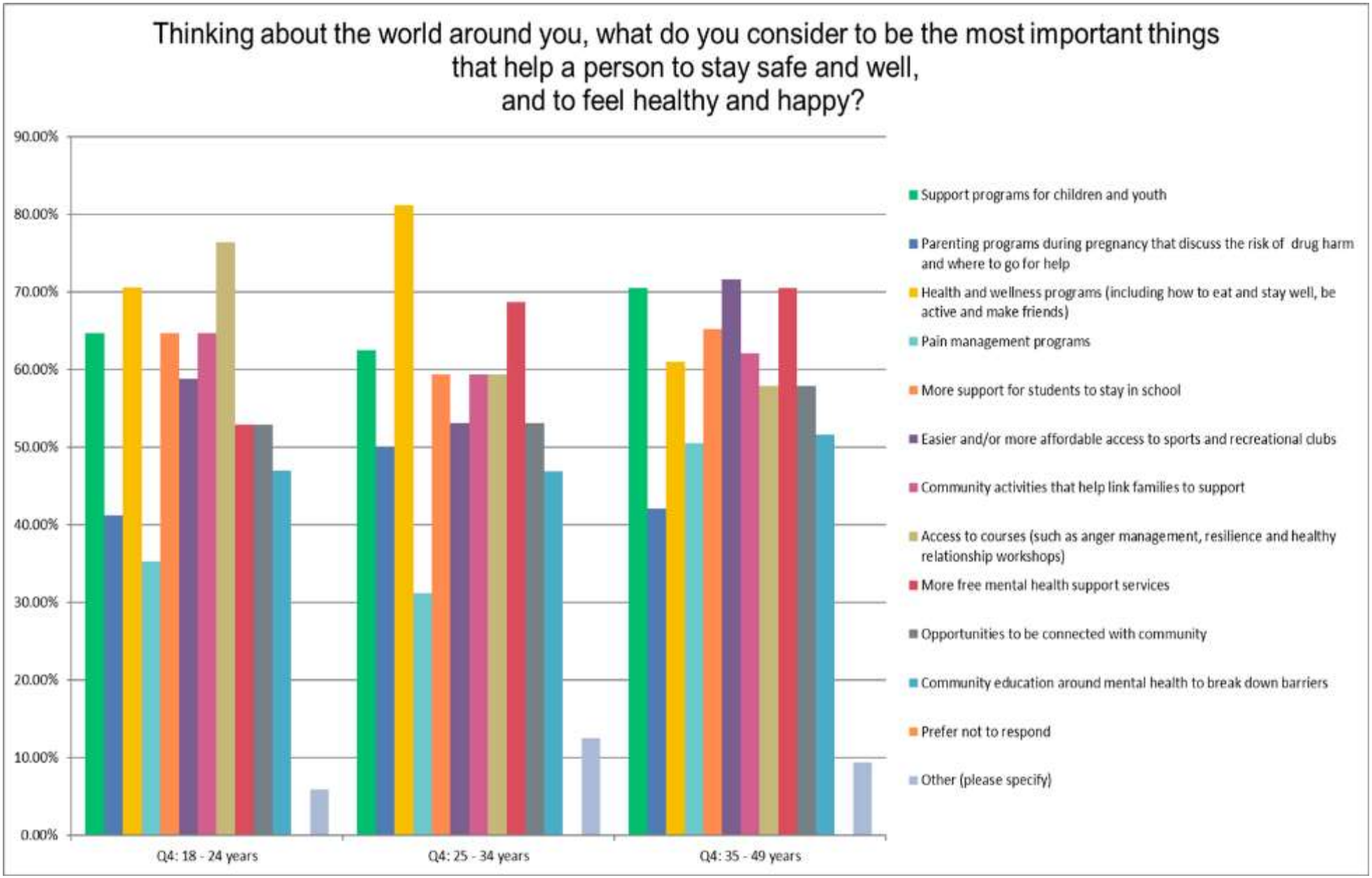


Figure 2.5.2: Protective factors by age group

Protective factors by Age

25-34yrs

1. Health and wellness programs 81.25%
2. More free mental health support services 68.75%
3. Support programs for children and youth 62.50%
4. Poor support for students to stay in school 59.38%
   -Community activities that help link families to support 59.38%
   -Access to courses such as anger management, resilience etc. 59.38%

Support for health and wellness programs was highest in this age group, along with support for parenting programs. Support for pain management programs was at its lowest with this age group. Support for mental health services jumped by 15% from the 18-24yr age group.

35-49yrs

1. Easier and more affordable access to sports and recreational clubs 71.58%
2. More free mental health support services 70.53%
3. Support programs for children and youth 70.53%
4. More support for students to stay in school 65.26%

.

Interestingly health and wellness programs scored lowest for this age group (61.05%) but support for pain management programs scored higher than for other age groups (50.53%) as did support for easier and or more affordable access to sports and recreational clubs. This group also ranked support of mental health services and support for community education around mental health higher than other age groups.

The National Drug Strategy Household Survey 2016 discusses the relevance of prescription pill use for this age group

Exposure to prescription pills varies according to age group and according to the NDSHS,

People who misused pharmaceuticals were older than illegal drug users; in 2016, their mean age was 45 compared with 34 for users of illegal drugs. As with illegal drugs, the average age of pharmaceutical misusers steadily increased between 2001 and 2013, from 39 to 43. Use of 'pain-killers/analgesics and opioids' was most common among those in their 40s (4.5%) and least common among those aged 14–19 (2.7%).[1]

Age of exposure to alcohol, Marijuana or prescription pills

While the majority of respondents (approx. 35%) across these 3 age groups indicated exposure to alcohol, Marijuana, or prescription pills began between the aged of 18-24yrs, 42.36% indicated it began between the age of 12-17yrs. The 35-49yr age group reported the largest spread of data across the 0-49yrs demographic, but also reported the lowest percentage of exposure in the 12-17yr age group at 35.79% in comparison to 50%+ in the other age groups. Exposure in the 12-17yr age group cannot be ignored. Even as a snapshot of community this data is alarming when compared to other research such as data from the NDSH survey:

The National Drug Strategy Household Survey 2016 outlines drug use among youth

Among people in their 20s, the only drug to significantly decline between 2013 and 2016 was recent use of meth/amphetamines (from 5.7% to 2.8%). Over the longer term, daily smoking, risky drinking, and recent use of cannabis and ecstasy were all significantly and considerably lower than for previous generations (when in their 20s). While this is positive for people in their 20s, use did not decline over the last 3 years and they are still far more likely to drink alcohol in risky quantities, and use cannabis, ecstasy or cocaine in the previous 12 months than any other age group.[1]

In regards to age of exposure they go on to say,

- The average age at which young people aged 14–24 first tried alcohol has steadily risen since 1998 from 14.4 to 16.1 in 2016

- The average age of initiation was similar for males and females aged 14–24, and between 2013 and 2016, increased for both sexes—from 15.7 to 16.2 for males and from 15.6 to 16.0 for females. Of all drinkers aged 14 or older, the age at which they first tried alcohol significantly increased in 2016 to 17.3 (from 17.2 in 2013)

They also discuss exposure to Cannabis,

For people aged 14 or older in Australia in 2016 35% (or 6.9 million) used cannabis in their lifetime 10.4% (or 2.1 million) used cannabis in the last 12 months 18.7 years was the average age people first tried cannabis.[1]

Age of exposure to Meth/Ice, inhalants or other drugs

I believe it's important to reference year of birth in regards to age of exposure. What social norms and environmental and external factors influence a generation? What was different about supply and demand and access to drugs? What trends and socio-economic factors influenced exposure?

18-24yrs of age – born between 1993-1999
25-34yrs of age – born between 1983-1992
35-49yrs of age – born between 1968-1982

Responses to our question about age of exposure dropped significantly in regards to this group of substances, with most respondents indicating the question was not applicable to them.

The National Drug Strategy Household Survey 2016 sheds a little light on generational trends.

People who were using drugs in their late 20s in 2001 would now be in their early 40s in 2016. In 2001, people in this cohort had high consumption of alcohol and use of illicit drugs. The increase now seen among people in their 40s in their consumption of alcohol and illicit drugs may be partly explained by a 'cohort' effect as the group has aged.[1]

What can be reported in regards exposure to Meth/Ice, Inhalants and other drugs is that

a) the 25-34yr age group reported the highest percentage of exposure in the years 18-24(15.63%) and
b) the 18-24yr age group reported the highest percentage of exposure in the years 12-17 (25%)
c) the 35-49yr age group reported the largest spread of data across 0-49years

These statistics warrant further consideration of the external influences at play in a particular generation.

The National Drug Strategy Household Survey 2016 provides further insight into age of exposure:

The average age of first use rose for cannabis, meth/amphetamines and hallucinogens with all these drugs showing an older age of first use in 2016. Among people aged 14–29, the age of initiation into illicit drug use remained stable at about 16.7 years (Table 5.12). More specifically, the age at which people first used cannabis rose from 16.9 years in 2013 to 17.3 years in 2016 but a younger average age of first use was reported by heroin and steroid users; however, these results should be interpreted with caution due to the wide margin of error.[1]

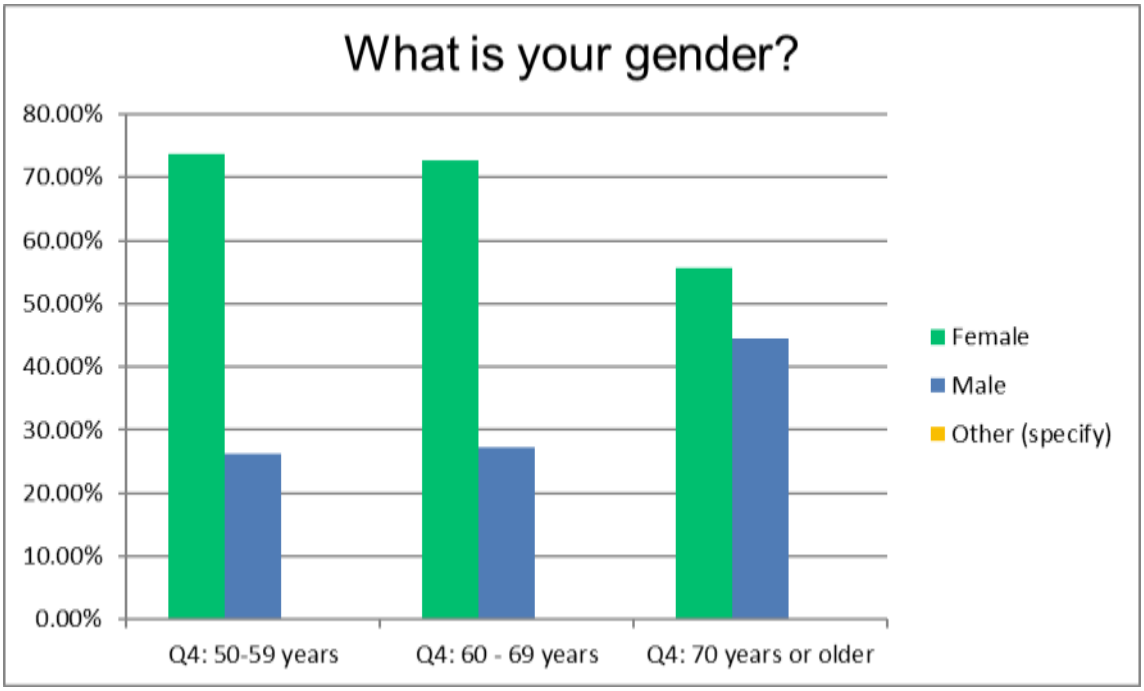
2.6. Summary – Age comparison 50yrs and older

The following chapter presents the data collated for respondents aged 50 years and over; male and female. We expose the differences in risk and protective factors and present key findings in relation to exposure to alcohol and other drugs.

Risk Factors

The following is a summary of the whole group, followed by a breakdown of the 3 age groups; 50-59yrs, 60-69yrs and 70+yrs.

Figure 2.6: Respondents by age group and gender



Summary - 50yrs+ age group

Risk Factors

Top 4 Risk factors – 50yrs of age and over

1. Peer pressure or social pressure from friends, family, community or social media 78.23%
2. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 77.55%.
3. Depression and/or anxiety 73.47%
4. Experimentation 72.11%

Interestingly the top 4 identified risk factors for this demographic mirror the same top risk factors for the under 50 age group. This provides evidence that overall age is not the most influential factor, gender is.

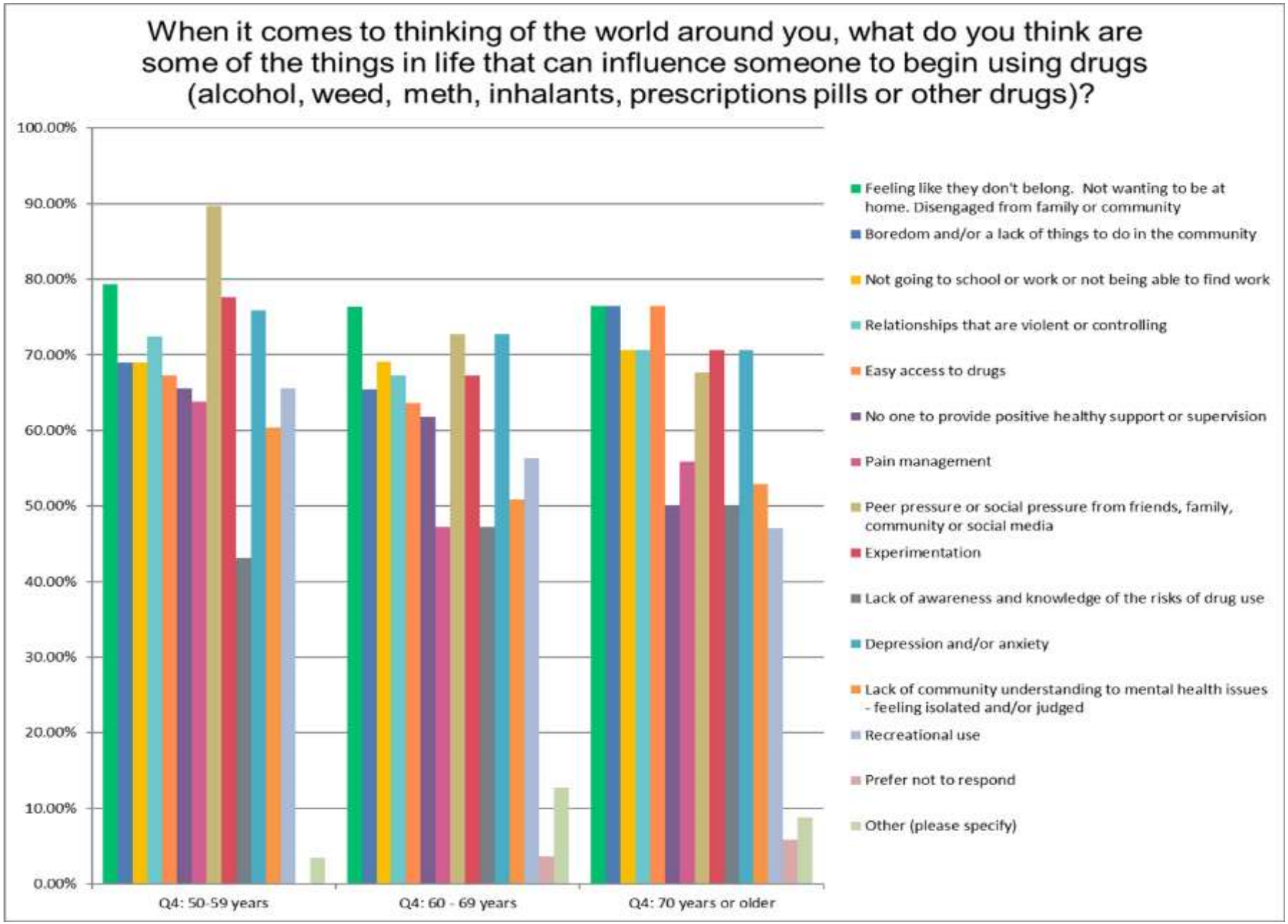


Figure 2.6.1: Risk factors by age group

While the strength of support for many risk factors varied by 10-20% between age groups, the following were strongly supported by all groups; (with only 2-3% difference) feeling like they don't belong, not wanting to be at home or disengaged from family or community, and not going to school or work or not being able to find work. A lack of awareness and knowledge of the risks of drug use was ranked lowest by all age groups.

Depression and/or anxiety was evenly supported by all age groups at between 71-76%. This statistic is lower than that of the under 50 age group at 75-81%.

Risk Factor by Age

50-59yrs

1. Peer pressure or social pressure from friends, family, community or social media 89.66%
2. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 79.31%
3. Experimentation 77.59%
4. Depression and/or anxiety 75.86%

The 50-59yr age group reported the highest percentage for multiple risk factors including relationships that are violent or controlling, recreational use and pain management

Q The 50-59 age group ranked peer pressure or social pressure higher than any other age group. Why is this? Is this their personal experience, or their observation of younger generations they care about?

60-69yrs

1. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 76.36%
2. Peer pressure or social pressure from friends, family, community or social media 72.73%
3. Depression and/or anxiety 72.73%
4. Not going to school or work, or being able to find work 69.09%

The defining difference for this age group was the support for employment and education. Experimentation as a suggested risk factor dropped to its lowest from 77.59% (50-59yr age group) to 67.27%.

This age group supported pain management least as a risk factor; dropping from 63.79% for 50-59yr olds to just 47.27%.

70+yrs

1. Feeling they don't belong. Not wanting to be at home. Disengaged from family/community 76.47%
   -Easy access to drugs 76.47%
   -Boredom and/or lack of things to do in the community 76.47%
2. Not going to school or work or not being able to find work, 70.59%
   -relationships that are violent or controlling 70.59%
   -experimentation 70.59%
   -depression and/or anxiety 70.59%
3. Peer pressure, or social pressure from friends, family or community, or social media 67.65%
4. Pain Management 55.88%

This group provided the highest rate of responses across every risk factor. They ranked boredom as a key risk factor at 76.47% in comparison to 65-68% for other age groups in the over 50 age group, and they ranked peer pressure below easy access to drugs. Recreational use as a risk factor was scored lower by this age group dropping to 47% from 65% in the 50-59yr age group. Why has this group identified easy access to drugs as a top risk factor? Is this related to what they know or hear from community networks/word of mouth, inter-generational knowledge or personal experience?

Q When both ends of the age spectrum are naming easy access to drugs as a top risk factor, why is this, and what can be done to disrupt supply?

Protective Factors

While the following protective factors were not ranked highest across the three groups they were ranked closest in regards to the difference in weighting between age groups (3-6%); Pain management programs, easier and/or more affordable access to sports and recreational clubs, and community education around mental health to break down barriers.

The following factors grew in strength with each age group; support programs for children and youth, parenting programs during pregnancy to discuss the risks of drug harm and where to go for help, and more support for students to stay in school.

Top 4 Protective factors – 50yrs+ age group

1. Health and wellness programs 66.67%
2. Community programs that help link families with support 71.43%
3. Support programs for children and youth 70.07%
4. Opportunities to be connected with community 66.67%

The importance of connection to community and support provision is raised again and again as a key protective factor by respondents.

Community prevention programs reaching populations in multiple settings—for example, schools, clubs, faith-based organizations, and the media—are most effective when they present consistent, community-wide messages in each setting (Chou et al. 1998)[9]

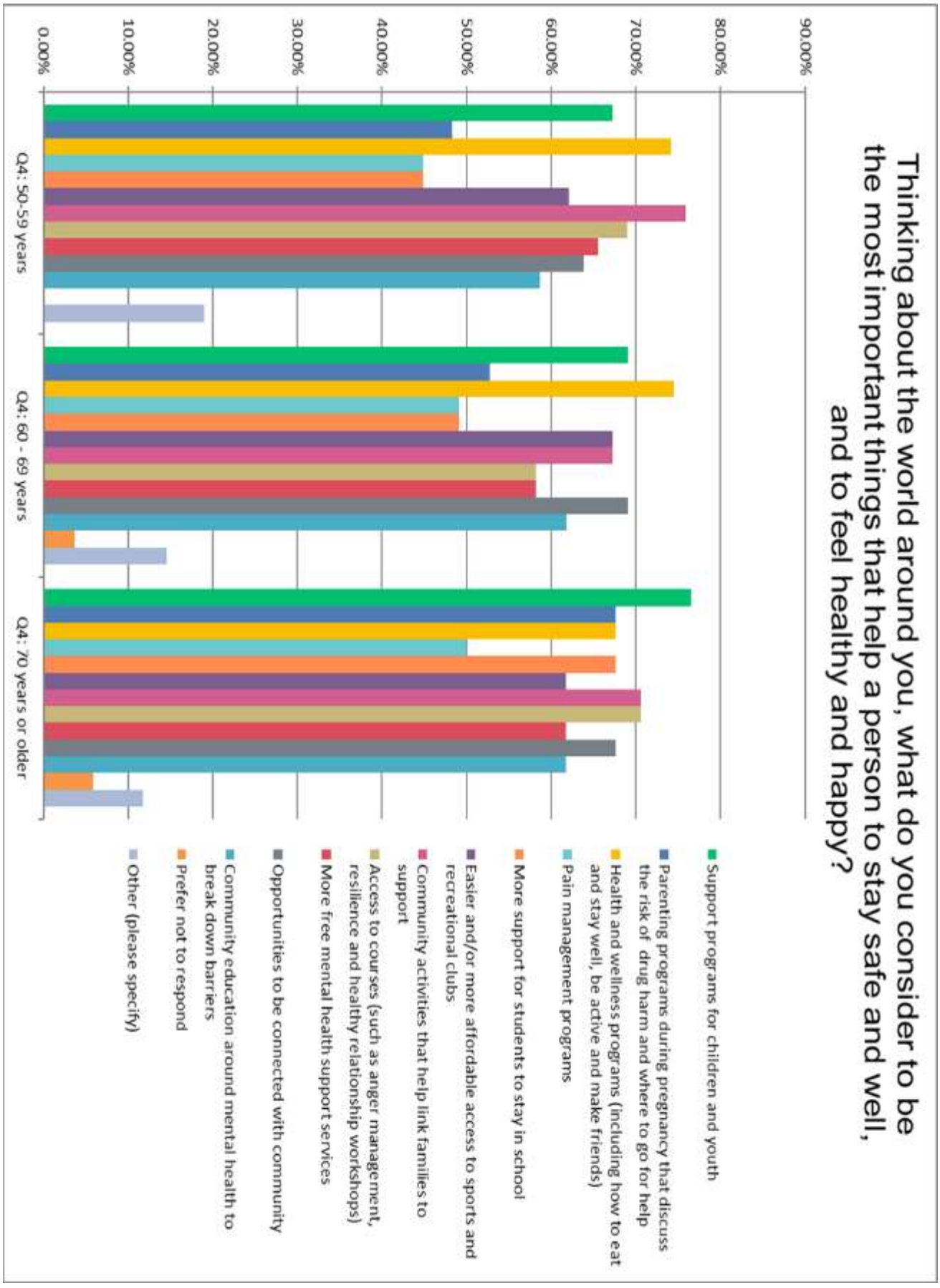


Figure 2.6.2: Protective factors by age group

Protective Factor by Age

50-59yrs

1. Community activities that help link families to support 75.86%
2. Health and wellness programs 74.14%
3. Access to courses such as anger management, resilience etc. 68.97%
4. Support programs for children and youth 67.24%

This 50-59year age group produced some interesting data. They supported the following factors least - support programs for children and youth, parenting programs during pregnancy, and support for students to stay in school, yet supported community activities that link families to support and more free mental health support services most.

60-69yrs

1. Health and wellness programs 74.55%
2. Opportunities to be connected with community 69.09%
3. Support programs for children and youth 69.09%
4. Community activities that link families to support, and easier and/or more affordable access to sports and recreational clubs 67.27%

Support for pain management as a risk factor is on the rise with this age group. They reported lower statistics for more free mental health support services in comparison to both other age groups, yet were the strongest supporter of opportunities to be connected with community.

Once again health and wellness and community programs factored highly as protective factors. In the progression through these 3 age groups the call to connect with community grows louder and louder.

70+yrs

1. Support programs for children and youth 76.47%
2. Community activities that link families to support 70.59%
3. Access to courses such as anger management, resilience etc. 70.59%
4. Opportunities to be connected with community, more support to stay in school, health and wellness programs, and parenting programs during pregnancy 67.65%

This age group ranked support programs for children and youth higher than any age group over 50yrs of age, along with parenting programs during pregnancy and more support for students to stay in school. They also reported the highest support for access to courses such as anger management and resilience.

This demographic are a huge contributing body to local volunteering from Lions, Rotary, Zonta and CWA to Menshed and local rural Fire Fighting brigades. These clubs and associations form powerful networks which in turn provide a living channel of shared information and wisdom. Is it this channel of wisdom that we see reflected in this data?

Q Should more time be given to consultation with this age group to draw on the collective wisdom of our long term residents and their experiences and networks?

Age of Exposure to alcohol, Marijuana or prescription pills

All 3 age groups reported exposure between the age of 12-59yrs of age. The 50-59yr old age group reported the highest percentage of exposure in the years 12-17(29.82%). Those in the 60-69yr old age group reported the highest percentage of exposure in the years 18-24(38.89%).

The National Drug Strategy Household Survey 2016 discusses alcohol and drug use by those of middle age and older.

- There were no significant differences in the proportion of people in their 40s and 50s drinking alcohol at risky levels (lifetime or single occasion risk) between 2013 and 2016, but consumption of 5 or more standard drinks at least once a month has been trending upwards since 2001.
- Those aged 70 or older continue to be the age group most likely to drink daily, for both males (19.5%) and females (8.7%)

In recent years, people in their 40s have shown an increase in illicit use of drugs and were the only age group to show a statistically significant increase in use between 2013 and 2016 (from 13.6% to 16.2%). Since 2001, recent use of any illicit drugs has increased by over a third for people in their 40s (was 11.8% in 2001). People in their 50s generally have some of the lowest rates of illicit drugs use but this cohort has shown the largest rise in illicit use of drugs since 2001 (from 6.7% to 11.7% in 2016), although there was little change between 2013 and 2016 (11.1% to 11.7%). The increase seems to be driven by an increase in both recent use of cannabis and misuse of pharmaceuticals (for both age groups)[1]

Age of Exposure to Meth/Ice, inhalants or other drugs

I believe it's important to reference year of birth in regards to age of exposure. What social norms and environmental factors influenced this generation? What was different about supply and demand and access to drugs? What trends and socio-economic factors influenced exposure?

The past five decades presents us with data on the Baby Boomers, Gen Xers and the Millennials and may unlock further insight into drug use and exposure by the over 50's.

50-59yrs of age – born between 1958-1967
60-69ys of age – born between 1948-1957
70+yrs – born before 1948

Responses to our question about age of exposure dropped significantly in regards to this group of substances, with most respondents indicating the question was not applicable to them.

What can be reported in regards to exposure to Ice/Meth, inhalants and other drugs is that

a) The 50-59yr age group reported the highest percentage of exposure in the years 12-17yr (8.93%) in comparison to 3.57% in the years 18-24, and 25-34years.
b) Data for the other age groups was not significant except a small percentage of exposure in the period 50-59yrs.

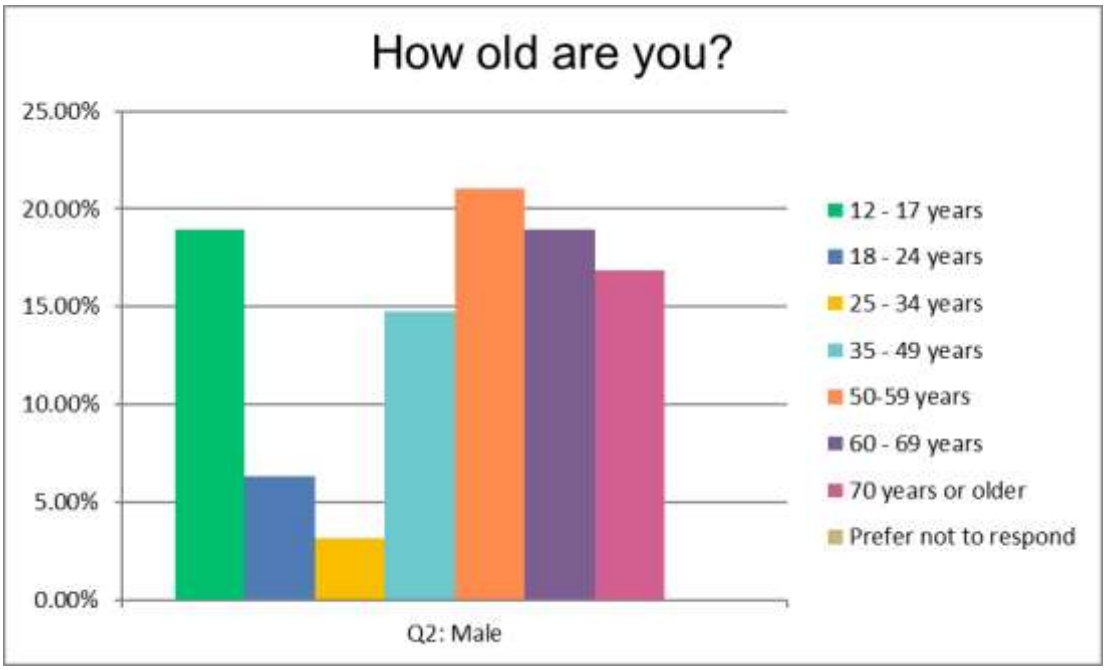
These statistics alone warrant further consideration of the external influences at play in a particular generation.

Introduction

This chapter presents data from male respondents aged 18 years and over. It includes data on identified protective and risk factors, alcohol and drug use, and age of exposure.

95 Male respondents aged 18 years and over completed the survey.
Respondents reside on the Granite Belt or Southern Downs.

Figure 3.1: Male respondents by age group



- 12-17yr old respondents did not complete the same questions as those 18yrs and older and are therefore not included in the following analysis

Summary

Respondents were asked to identify key protective and risk factors from a list, but were also provided a free text box to list other comments.

The following chapter provides tables and charts of the data surrounding risk and protective factors, drug use and age of exposure.

Risk Factors

The 4 highest risk factors for males were:

1. Peer pressure or social pressure from friends, family, community or social media 76.12%
2. Experimentation 74.63%
3. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 68.66%.
4. Depression or anxiety 62.69%

Are there any links between these 4 risk factors? Can we draw any link between feelings of disconnection and mental health? Or between social/peer pressure and experimentation?

Q If we could reduce unhealthy peer pressure would this in turn reduce the other 3 top risk factors?

While mental health issues are ranked highly by the female cohort, anxiety and depression is ranked 4th in the list of risk factors for males. Could this be due to stigma around mental health and the possibility that men are more hesitant to name it?

A lack of awareness and knowledge of the risks of drug use (34.33%) ranked lowest of all risk factors. Easy access to drugs dropped by 10% in the male cohort in comparison to the female cohort. What part does gender play in drug distribution?

Peer pressure and feeling like they don't belong were top risk factors by males and could also be considered risk factors for crime.

Queensland Police Service data for 2015-2016 provides drug offence data for males:

Approximately 74% of offenders for drug offences were male, with the majority aged between fifteen and twenty-four years. Females in the twenty to twenty-nine-year age bracket were also more likely to offend compared with those in other age groups. Unlike other offence categories, a sizeable proportion (31%) of offenders were aged over thirty-four years.[10]

Protective Factors

The following were ranked the highest protective factors

1. Opportunities to be connected with community 65.67%
2. Easier and/or more affordable access to sports and recreational clubs 64.18%
3. Support programs for children and youth 62.69%
4. Community activities that help link families to support 61.19%

Easy access to sports remains an important protective factor leading to better social connectedness and improved mental health. However, continued effort is required to challenge the association between our drinking culture and its impact on sports club culture. We acknowledge the Good Sports program for its work in this area.

Interestingly health and wellness programs followed these top 4 protective factors as identified by the male cohort. Males are not only referring to sports and recreation but opportunities to be connected with community. Could this include volunteering and other avenues for social service such as rural Fire Brigade, Horticulture clubs, local Show Society associations, Lions, Rotary etc.?

How much of a barrier is lack of transport and affordability, and is it the main reason for not engaging? How much pressure does this place on regional clubs and sports associations to mediate these factors in order to engage new members?

- How easy/comfortable is it for males to reach out and connect with volunteering opportunities? Are there any social norms, or possible stigma around this?

- What role does popular television play in breaking down/dissolving social stigmas? What impact are reality T.V shows like Masterchef, Australian Ninja, The Block etc. having on male stereotypes and mental health stigma?

Table 3.1: Percentage of support for risk factors by male demographic
* participants were able to select multiple answers in addition to adding comments in a free answer text box.

❍: When it comes to thinking of the world around you, what do you think are some of the things in life that can influence someone to begin using drugs (alcohol, weed, meth, inhalants, prescriptions pills or other drugs)?

Suggested risk factor	% of total responses/No. of respondents
Feeling like they don't belong. Not wanting to be at home. Disengaged from family or community	68.66%
	46
Boredom and/or a lack of things to do in the community	56.72%
	38
Not going to school or work or not being able to find work	61.19%
	41
Relationships that are violent or controlling	56.72%
	38
Easy access to drugs	58.21%
	39
No one to provide positive healthy support or supervision	46.27%
	31
Pain management	52.24%
	35
Peer pressure or social pressure from friends, family, community or social media	76.12%
	51
Experimentation	74.63%
	50
Lack of awareness and knowledge of the risks of drug use	34.33%
	23
Depression and/or anxiety	62.69%
	42
Lack of community understanding to mental health issues - feeling isolated and/or judged	34.33%
	23
Recreational use	59.70%
	40
Prefer not to respond	0.00%
	0
Other (please specify)	8.96%
	6
Total	100.00%
	67
Answered	67
Skipped	28

Figure 3.2: Percentage of support for risk factors by male demographic

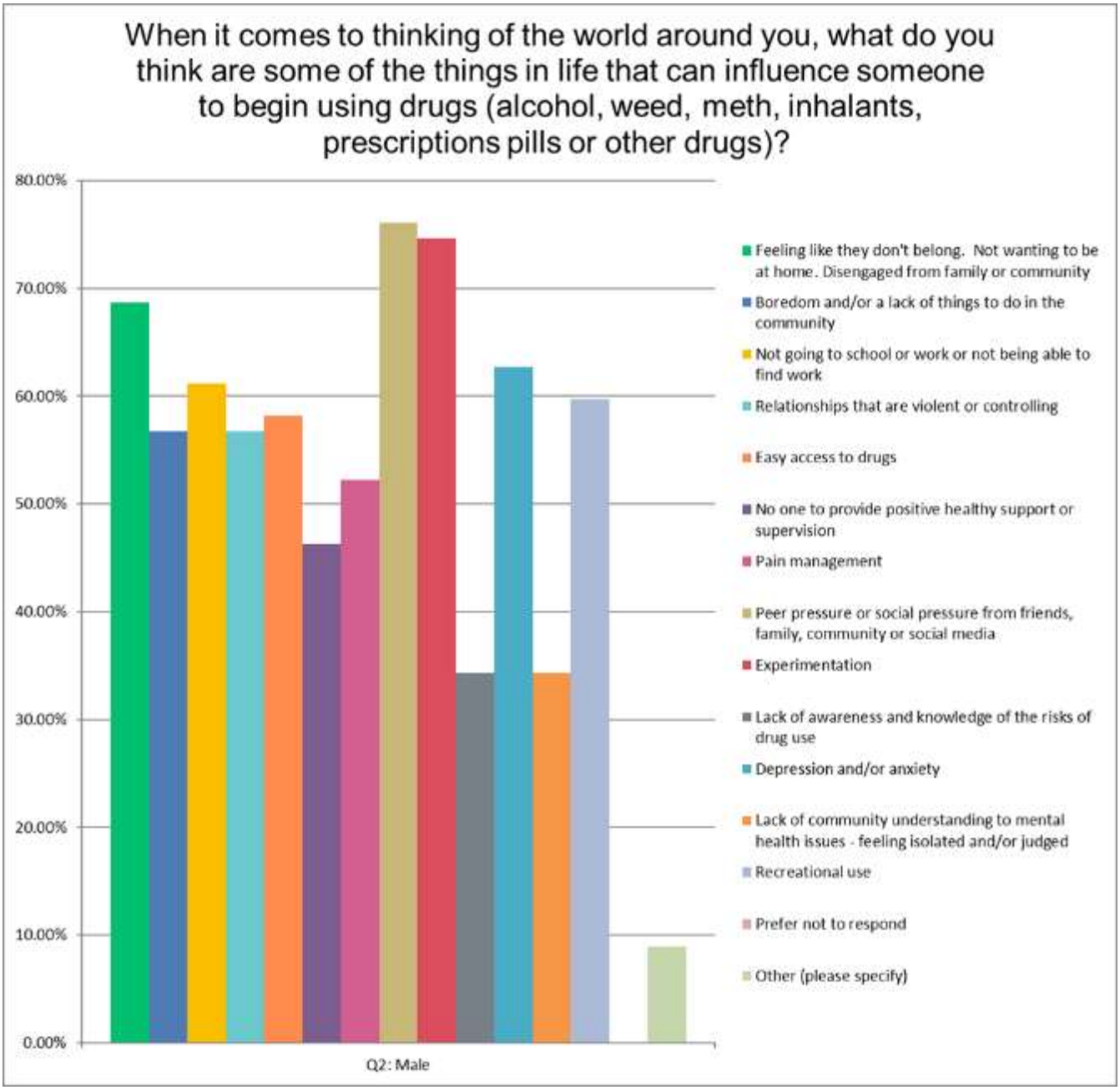


Table 3.2: Percentage of support for protective factors by male demographic
* participants were able to select multiple answers in addition to adding comments in a free answer text box

Q: Thinking about the world around you, what do you consider to be the most important things that help a person to stay safe and well, and to feel healthy and happy?

Suggested protective factor	% of total responses/No. of respondents
Support programs for children and youth	**62.69%**
	42
Parenting programs during pregnancy that discuss the risk of drug harm and where to go for help	41.79%
	28
Health and wellness programs (including how to eat and stay well, be active and make friends)	58.21%
	39
Pain management programs	40.30%
	27
More support for students to stay in school	53.73%
	36
Easier and/or more affordable access to sports and recreational clubs	64.18%
	43
Community activities that help link families to support	61.19%
	41
Access to courses (such as anger management, resilience and healthy relationship workshops)	46.27%
	31
More free mental health support services	47.76%
	32
Opportunities to be connected with community	65.67%
	44
Community education around mental health to break down barriers	49.25%
	33
Prefer not to respond	0.00%
	0
Other (please specify)	13.43%
	9
Total	100.00%
	67
Answered	67
Skipped	28

Figure 3.3: Percentage of support for protective factors by male demographic

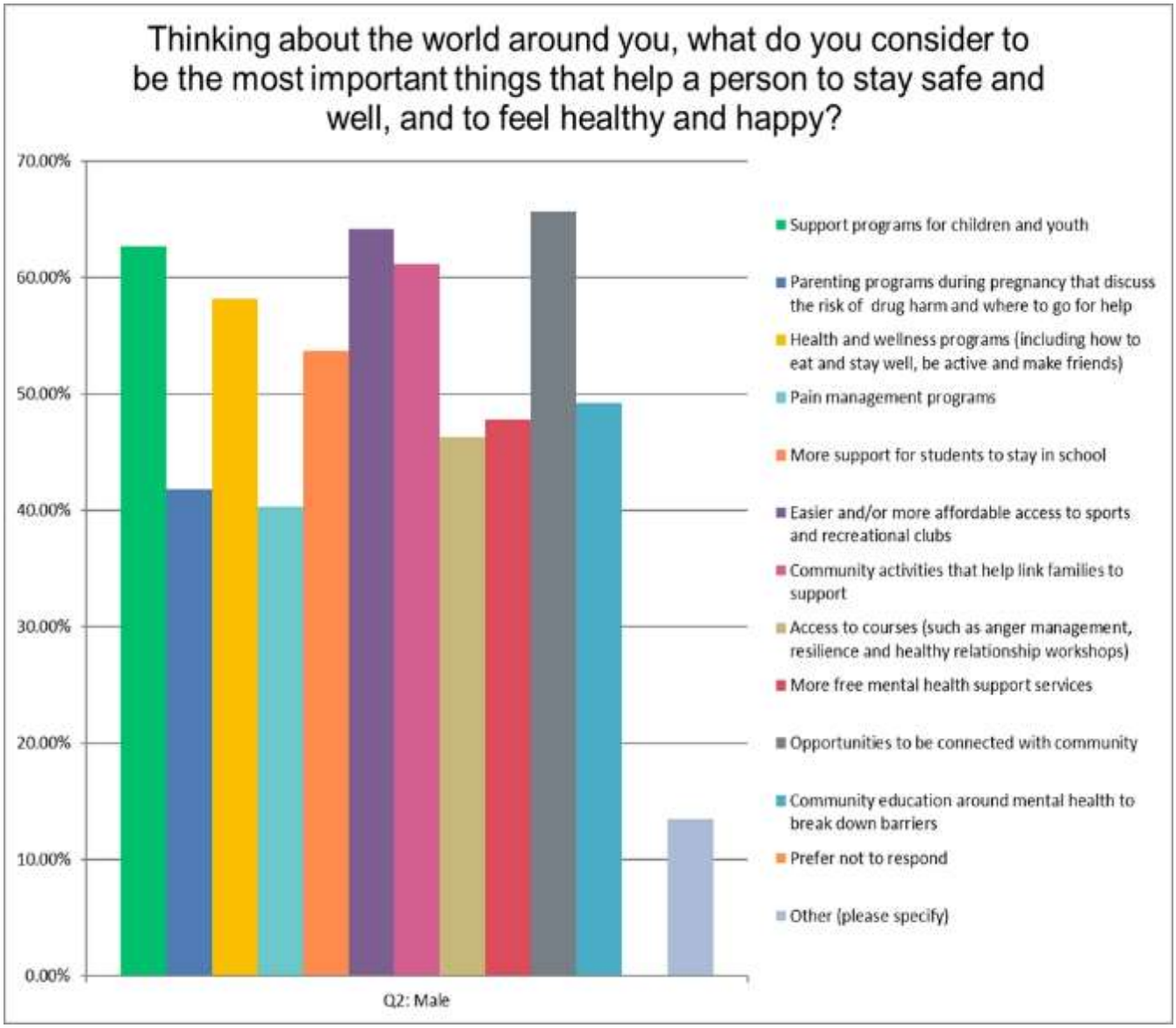


Table 3.3: Exposure to alcohol and other drugs by male demographic

Q: What is your experience with the following? Please use the drop down boxes to make your selections.												
Current Use												
	Never used		Previously used		Currently in recovery		Currently using		Prefer not to respond		Total	
Alcohol	8.96%	6	19.40%	13	4.48%	3	65.67%	44	1.49%	1	100.00%	67
Weed, Marijuana, Cannabis	68.66%	46	23.88%	16	1.49%	1	2.99%	2	2.99%	2	100.00%	67
Prescription pills (pain killers, benzo's and stimulants)	49.25%	33	34.33%	23	0.00%	0	13.43%	9	2.99%	2	100.00%	67
Ice, Meth	89.55%	60	7.46%	5	0.00%	0	1.49%	1	1.49%	1	100.00%	67
Inhalants	89.55%	60	7.46%	5	1.49%	1	0.00%	0	1.49%	1	100.00%	67
Other drugs	79.10%	53	13.43%	9	0.00%	0	4.48%	3	2.99%	2	100.00%	67
Total	100.00%	67	100.00%	67	100.00%	67	100.00%	67	100.00%	67	100.00%	67
											Answered	**67**
											Skipped	**28**

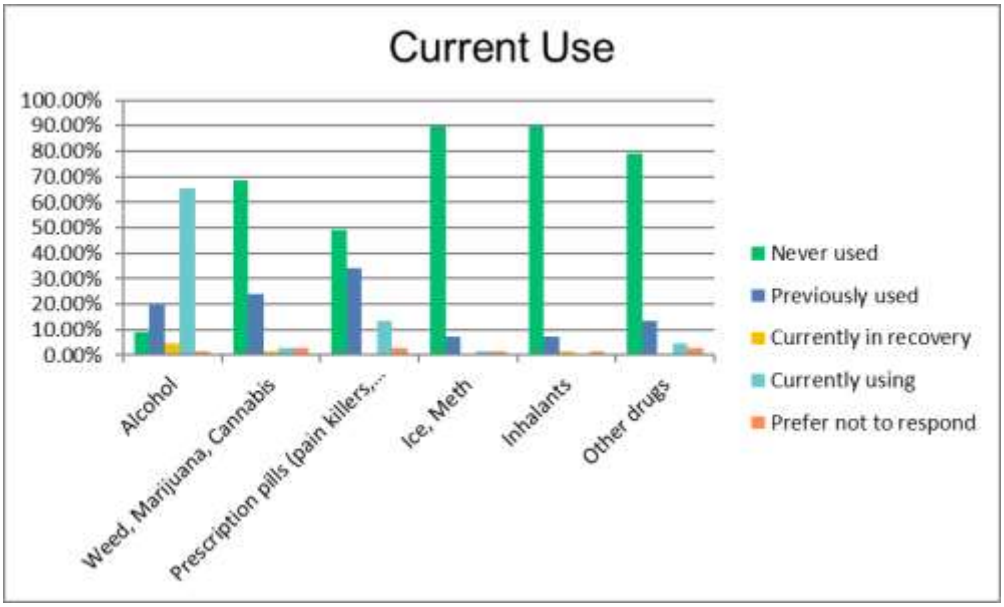
Alcohol and other drug exposure

65.67% of male respondents indicated they are currently using alcohol, 2.99%, Marijuana, 13.43% prescription pills, 1.49% Ice/Meth, 0% inhalants and 4.48% are using other drugs. The statistics for previous use by the male demographic is significantly higher than the female cohort. 19.40% of male respondents indicated having previously used alcohol, 23.88% Marijuana, 34.33% prescription pills and 7.46% Ice/Meth. 7.46% had used inhalants and 13.43% had used other drugs. Of particular concern is the level of 'other' drug use and prescription pill use.

The National Drug Strategy Household Survey 2016 draws comparisons between male and female alcohol consumption -

Males were twice as likely as females to drink at risky levels (24% and 9.5%, respectively). Males in their 40s (aged 40–49) were the most likely age group to drink at risky levels (29%)[1]

Figure 3.4: Percentage of respondents exposed to alcohol and other drugs by male demographic



Alcohol and other drug exposure

Table 3.4: Age of Exposure to alcohol, Marijuana or prescription pills by male demographic

Q: If you have had some experience with alcohol, weed, or prescription pills at what age did it start?																		
0 - 11 years		12 - 17 years		18 – 24 years		25 - 34 years		35 - 49 years		50 - 59 years		60 - 69 years		70 years or older		Prefer not to respond		Not applicable		Total	
0.00%	0	34.85%	23	37.88%	25	1.52%	1	0.00%	0	0.00%	0	1.52%	1	0.00%	0	3.03%	2	21.21%	14	100.00%	66
0.00%	0	34.85%	23	37.88%	25	1.52%	1	0.00%	0	0.00%	0	1.52%	1	0.00%	0	3.03%	2	21.21%	14	100.00%	66
																				Answered	**66**
																				Skipped	**29**

0% exposure reported under 11yrs of age.

While the majority of respondents indicated exposure to alcohol, Marijuana or prescription pills began between the ages of 18-24 years (37.88%), 34.85% indicated it began between the ages of 12-17. With so little difference between the statistics for these two age groups it is imperative we explore the messages absorbed by youth through visual marketing and social media channels. Furthermore, what do these statistics tell us about ease of access for 12-17year olds?

Table 3.5: Age of Exposure to Ice/Meth, inhalants or other drugs by male demographic

Q: If you have had some experience with meth, inhalants, or other drugs at what age did it start?																					
0 - 11 years		12 - 17 years		18 – 24 years		25 - 34 years		35 – 49years		50 – 59years		60 – 69 years		70 years or older		Prefer not to respond		Not applicable		Total	
0.00%	0	10.61%	7	7.58%	5	3.03%	2	0.00%	0	0.00%	0	0.00%	0	0.00%	0	1.52%	1	77.27%	51	100.00%	66
0.00%	0	10.61%	7	7.58%	5	3.03%	2	0.00%	0	0.00%	0	0.00%	0	0.00%	0	1.52%	1	77.27%	51	100.00%	66
																				Answered	**66**
																				Skipped	**29**

0% exposure reported under 11yrs of age
Approximately 79% of respondents chose not to respond or indicated the question was not applicable to them.

7.58% indicated exposure occurred between 18-24yrs of age, and 10.61% indicated it began between 12-17yrs of age. In comparison to the previous table a higher percentage of the male cohort were exposed to ice/meth, inhalants and other drugs and at a younger age than exposure to alcohol, Marijuana or prescription pills. Why is this?

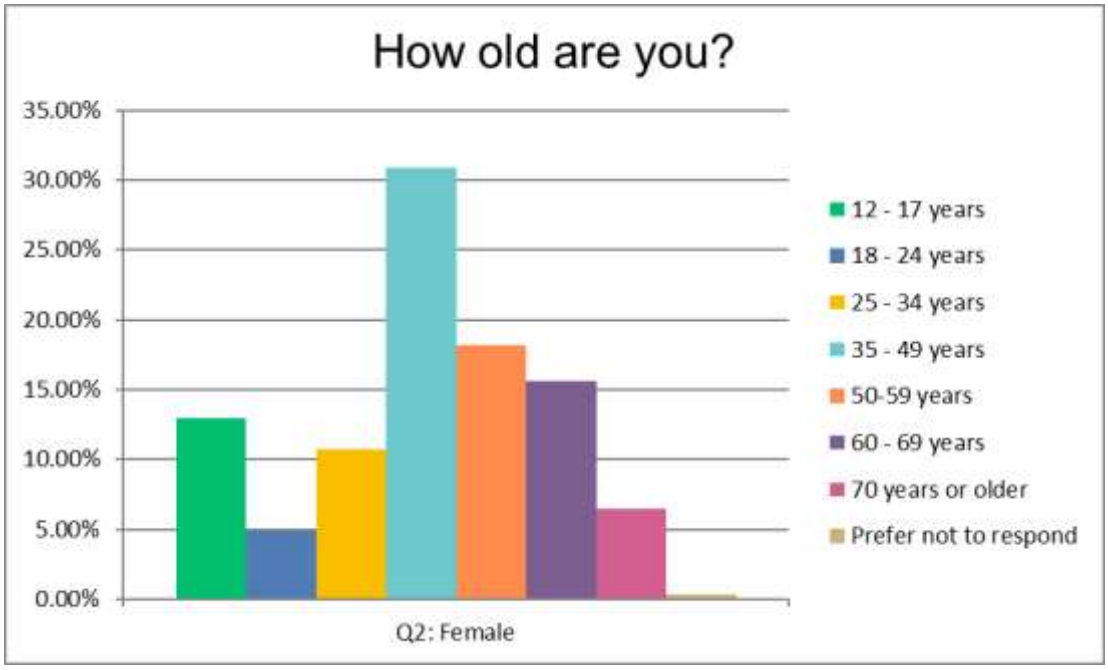
4. Female Respondents

Introduction

This chapter presents data from female respondents aged 18 years and over. It includes data on identified protective and risk factors, alcohol and drug use, and age of exposure.

309 Female respondents aged 18 years and older completed the survey.
Respondents reside on the Granite Belt or Southern Downs.

Figure 4.1: Female respondents by age group



- 12-17yr old respondents did not complete the same questions as those 18yrs and older and are therefore not included in the following analysis

Summary

Respondents were asked to identify key protective and risk factors from a list, but were also provided a free text box to list other comments.

The following chapter provides tables and charts of the data surrounding risk and protective factors, drug use and age of exposure.

Risk factors

The 4 highest risk factors for females were:

1. Peer pressure or social pressure from friends, family, community or social media 81.00%
2. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 80.09%.
3. Depression or anxiety 77.83%
4. Relationships that are violent or controlling 72.85%

In analysing the data by gender we see that unhealthy relationships jump to the top 4 risk factors for women (72.85%). Easy access to drugs, and boredom and/or a lack of things to do was strongly supported (68%) as a significant risk factor.

177 respondents out of a possible 221 identified peer pressure or social pressure as a risk factor. Further research may prove valuable in assessing the source of this pressure – does it occur in or out of home, does gender play a part, and which relationships in our social circles are most influential for women?

Young people are influenced by social media and peer pressure to partake in bullying, drugs and sexting and are frequently turning to online sources for information. Legislation to date has struggled to keep up with the evolving world of social media and its relevant harms. Drug research is identifying the 'dark web' as an avenue for illegal drug purchases.

There is an indication that physical violence between females is on the rise, particularly violence that happens in conjunction with alcohol and drugs.

Queensland Police Service data for 2015-2016 provides drug offence data for females -

Females in the twenty to twenty-nine-year age bracket were also more likely to offend compared with those in other age groups.[10]

Protective factors

Of 223 respondents the following were ranked the highest protective factors

1. Health and wellness programs 73.54%
2. Support programs for children and youth 71.30%
3. More free mental health support services 70.40%
4. Community activities that help link families to support 68.61%

One of the key differences between male and female respondents regarding protective factors, is the support by the female cohort for more free mental health support services.

While males identified activities and sports and recreation as protective factors, females have identified overall health and wellness programs including mental health support as important protective factors.

This clearly demonstrates the need to think carefully about prevention and early intervention strategies that are gender inclusive and where possible promote a whole of community approach.

Table 4.1: Percentage of support for risk factors by female demographic
* participants were able to select multiple answers in addition to adding comments in a free answer text box.

Q: When it comes to thinking of the world around you, what do you think are some of the things in life that can influence someone to begin using drugs (alcohol, weed, meth, inhalants, prescriptions pills or other drugs)?

Suggested risk factor	% of total responses/No. of respondents
Feeling like they don't belong. Not wanting to be at home. Disengaged from family or community	**80.09%**
	177
Boredom and/or a lack of things to do in the community	68.33%
	151
Not going to school or work or not being able to find work	62.90%
	139
Relationships that are violent or controlling	72.85%
	161
Easy access to drugs	68.78%
	152
No one to provide positive healthy support or supervision	58.82%
	130
Pain management	56.11%
	124
Peer pressure or social pressure from friends, family, community or social media	81.00%
	179
Experimentation	71.49%
	158
Lack of awareness and knowledge of the risks of drug use	47.51%
	105
Depression and/or anxiety	77.83%
	172
Lack of community understanding to mental health issues - feeling isolated and/or judged	61.99%
	137
Recreational use	56.11%
	124
Prefer not to respond	1.81%
	4
Other (please specify)	5.88%
	13
Total	100.00%
	221
Answered	**221**
Skipped	**88**

Figure 4.2: Percentage of support for risk factors by female demographic

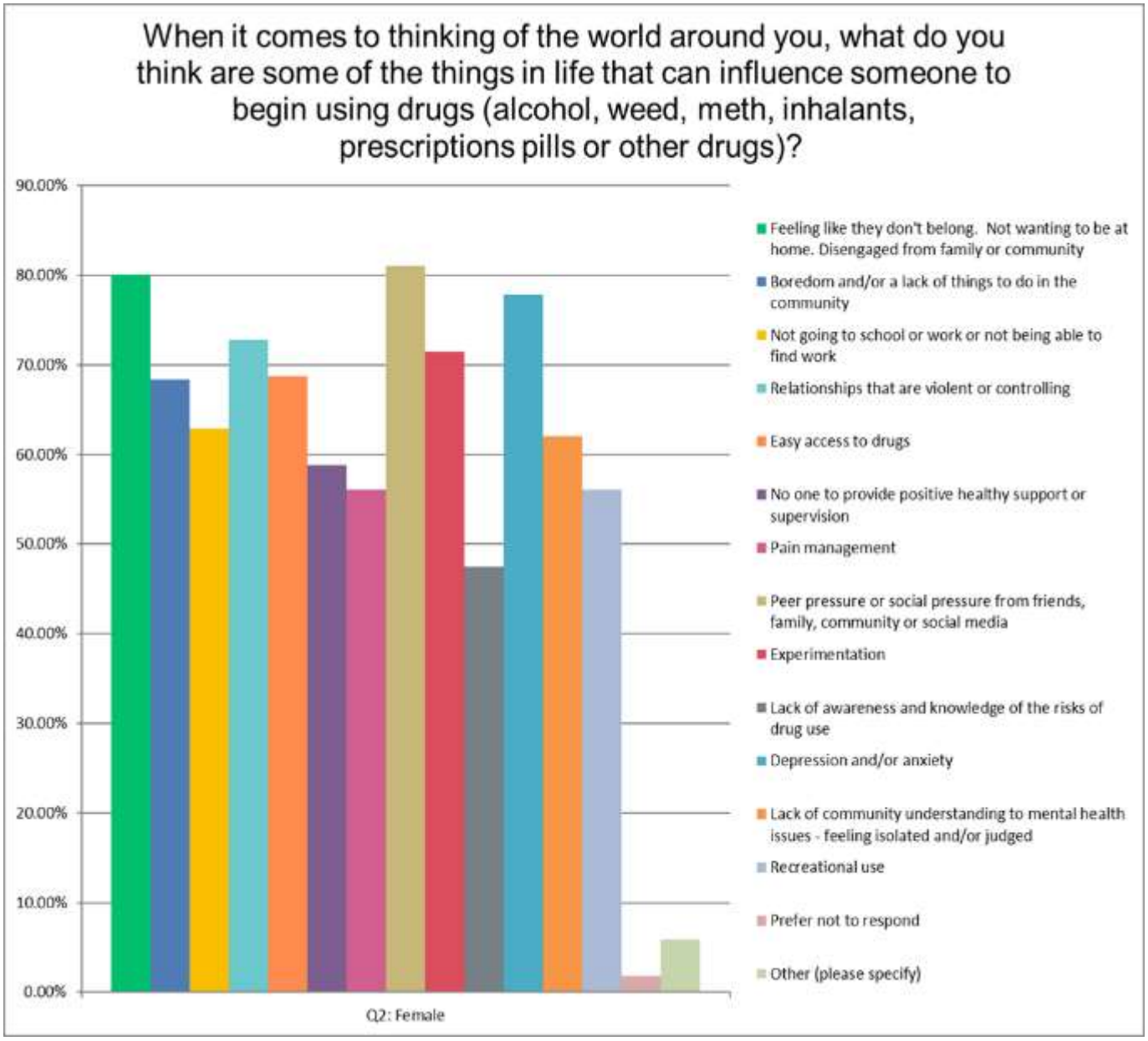


Table 4.2: Percentage of support for protective factors by female demographic
* participants were able to select multiple answers in addition to adding comments in a free answer text box

Q: Thinking about the world around you, what do you consider to be the most important things that help a person to stay safe and well, and to feel healthy and happy?

Suggested protective factor	% of total responses/No. of respondents
Support programs for children and youth	**71.30%**
	159
Parenting programs during pregnancy that discuss the risk of drug harm and where to go for help	52.02%
	116
Health and wellness programs (including how to eat and stay well, be active and make friends)	73.54%
	164
Pain management programs	47.98%
	107
More support for students to stay in school	59.19%
	132
Easier and/or more affordable access to sports and recreational clubs	65.47%
	146
Community activities that help link families to support	68.61%
	153
Access to courses (such as anger management, resilience and healthy relationship workshops)	68.16%
	152
More free mental health support services	70.40%
	157
Opportunities to be connected with community	60.54%
	135
Community education around mental health to break down barriers	57.40%
	128
Prefer not to respond	1.79%
	4
Other (please specify)	12.11%
	27
Total	100.00%
	223
Answered	**223**
Skipped	**86**

Figure 4.3: Percentage of support for protective factors by female demographic

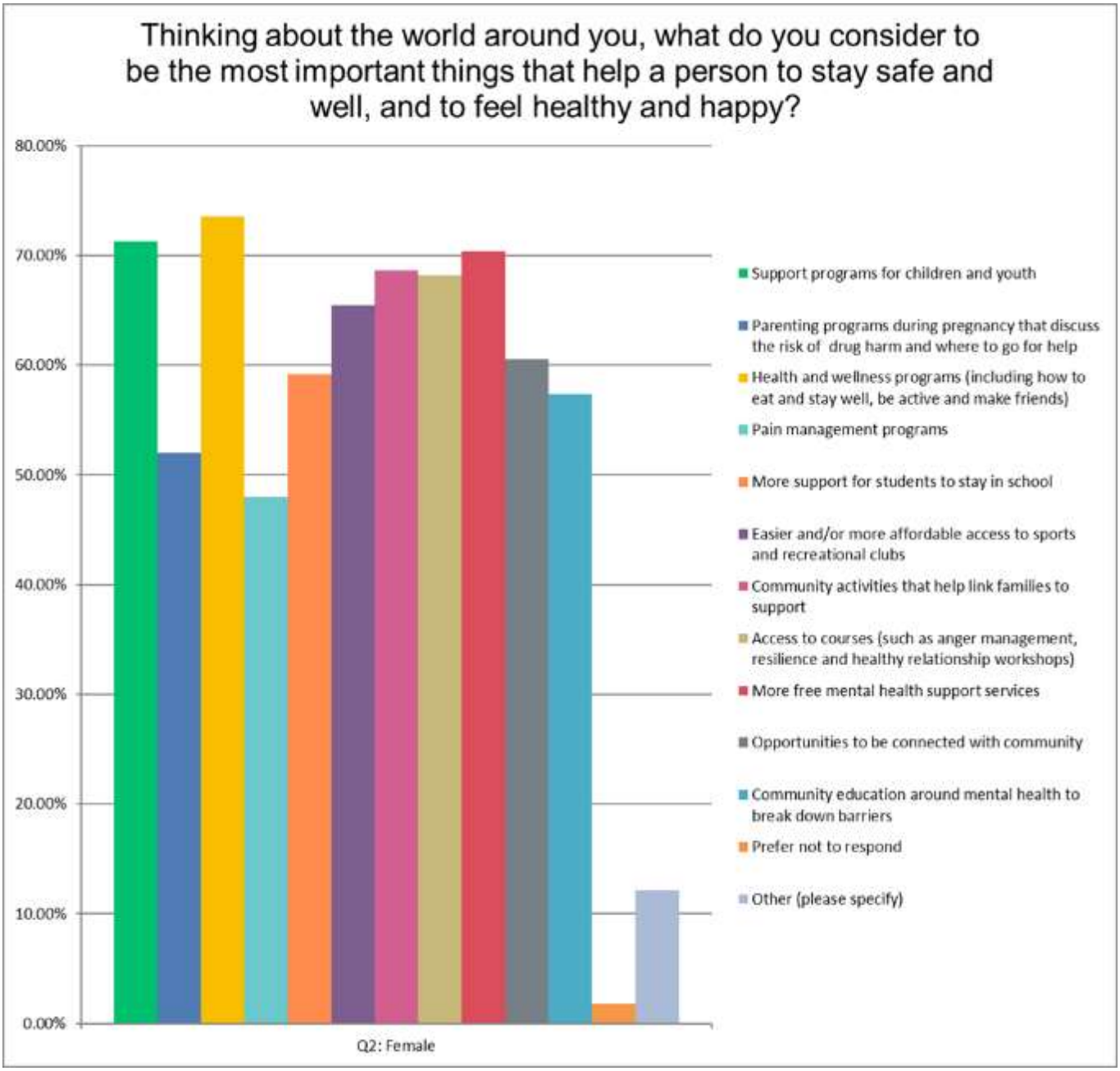


Table 4.3: Exposure to alcohol and other drugs by female demographic

Q: What is your experience with the following? Please use the drop down boxes to make your selections.												
Current Use												
	Never used		Previously used		Currently in recovery		Currently using		Prefer not to respond		Total	
Alcohol	22.42%	50	27.80%	62	1.79%	4	45.29%	101	2.69%	6	100.00%	223
Weed, Marijuana, Cannabis	71.75%	160	23.32%	52	0.45%	1	3.59%	8	0.90%	2	100.00%	223
Prescription pills (pain killers, benzo's and stimulants)	63.23%	141	22.87%	51	2.24%	5	10.76%	24	0.90%	2	100.00%	223
Ice, Meth	93.72%	209	4.04%	9	0.90%	2	0.90%	2	0.45%	1	100.00%	223
Inhalants	96.86%	216	2.69%	6	0.00%	0	0.00%	0	0.45%	1	100.00%	223
Other drugs	87.89%	196	9.42%	21	0.00%	0	0.90%	2	1.79%	4	100.00%	223
Total	100.00%	223	100.00%	223	100.00%	223	100.00%	223	100.00%	223	100.00%	223
											Answered	**223**
											Skipped	**86**

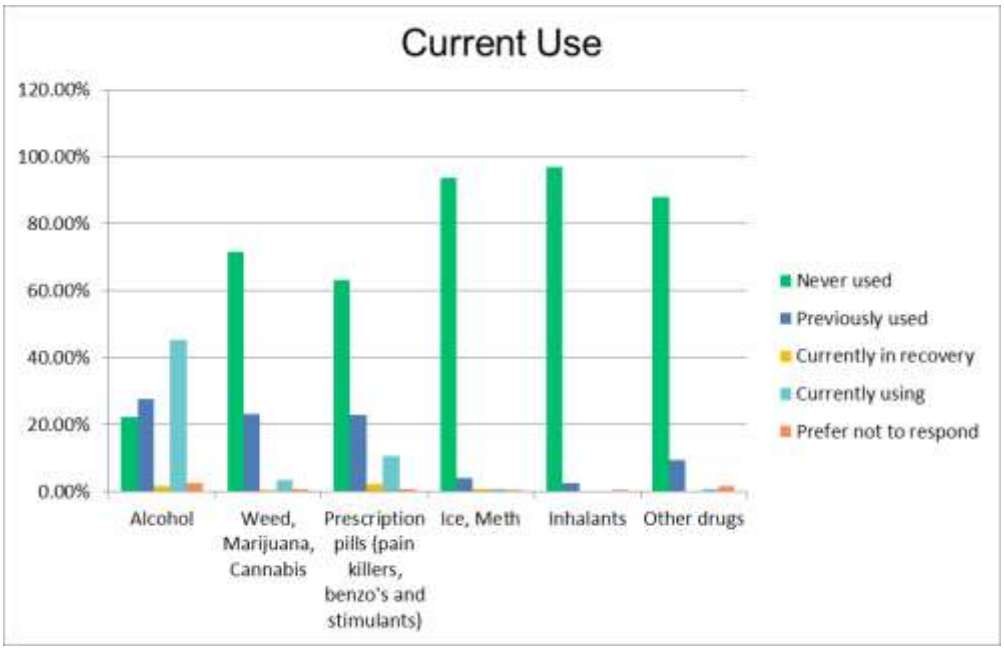
Alcohol and other drug exposure

45.29% of females indicated they are currently using alcohol, 3.59%, Marijuana, 10.76%, prescription pills, 0.9% Meth/Ice 0% using inhalants and .90% using other drugs. Approximately 23-27% of respondents indicated having used alcohol, Marijuana or prescription pills before. 4.04% had previously used Ice, 2.69% had used inhalants and 9.42% had used other drugs. 86 women skipped this question which raises the question why? Are social norms and acceptance around a drink with dinner leading us to believe that surveys like this are not relevant to us?

The National Drug Strategy Household Survey 2016 draws comparisons between male and female alcohol consumption -

Among females, those aged in their 50s (13.0%) are now the most likely to drink at risky levels, in place of those aged 18–24 (12.8%), who previously had the highest levels of risky drinking.[1]

Figure 4.4: Percentage of respondents exposed to alcohol and other drugs by female demographic



Alcohol and other drug exposure

It is important to draw attention to the percentage of prescription pill use.

Current alcohol use by males was 65%, significantly higher than for females (42.59%). It is important to consider social norms for women around alcohol consumption particularly around social drinking and the 'one drink before/with dinner' culture.

Table 4.4: Age of Exposure to alcohol, Marijuana or prescription pills by female demographic

Q: If you have had some experience with alcohol, weed, or prescription pills at what age did it start?																				
0-11years		12-17 years		18-24 years		25-34 years		35-49 years		50-59 years		60-69 years		70 yrs or older		Prefer not to respond		Not applicable		Total	
0.45%	1	28.96%	64	34.39%	76	5.88%	13	1.36%	3	1.36%	3	0.45%	1	0.00%	0	0.45%	1	26.70%	59	100.00%	221
0.45%	1	28.96%	64	34.39%	76	5.88%	13	1.36%	3	1.36%	3	0.45%	1	0.00%	0	0.45%	1	26.70%	59	100.00%	221
																				Answered	**221**
																				Skipped	**88**

While the majority of respondents indicated exposure to alcohol, weed or prescription pills began between the ages of 18-24 years (34.39%), 28.96% indicated it began between the ages of 12-17.

Table 4.5: Age of Exposure to Ice/Meth, inhalants or other drugs by female demographic

Q: If you have had some experience with meth, inhalants, or other drugs at what age did it start?																				
0 - 11 years		12 - 17 years		18 - 24 years		25 - 34 years		35 - 49 years		50 - 59 years		60 - 69 years		70 years or older		Prefer not to respond		Not applicable		Total	
0.92%	2	3.23%	7	4.61%	10	1.38%	3	1.38%	3	0.92%	2	0.00%	0	0.00%	0	1.38%	3	86.18%	187	100.00%	217
0.92%	2	3.23%	7	4.61%	10	1.38%	3	1.38%	3	0.92%	2	0.00%	0	0.00%	0	1.38%	3	86.18%	187	100.00%	217
																				Answered	**217**
																				Skipped	**92**

Approximately 87% of respondents chose not to respond or indicated the question was not applicable to them. 4.61% indicated exposure occurred between 18-24yrs of age, and 3.23% indicated it began between 12-17yrs of age. Exposure to these substances is lower for females in the 12-17yr age group than males (10.61%).

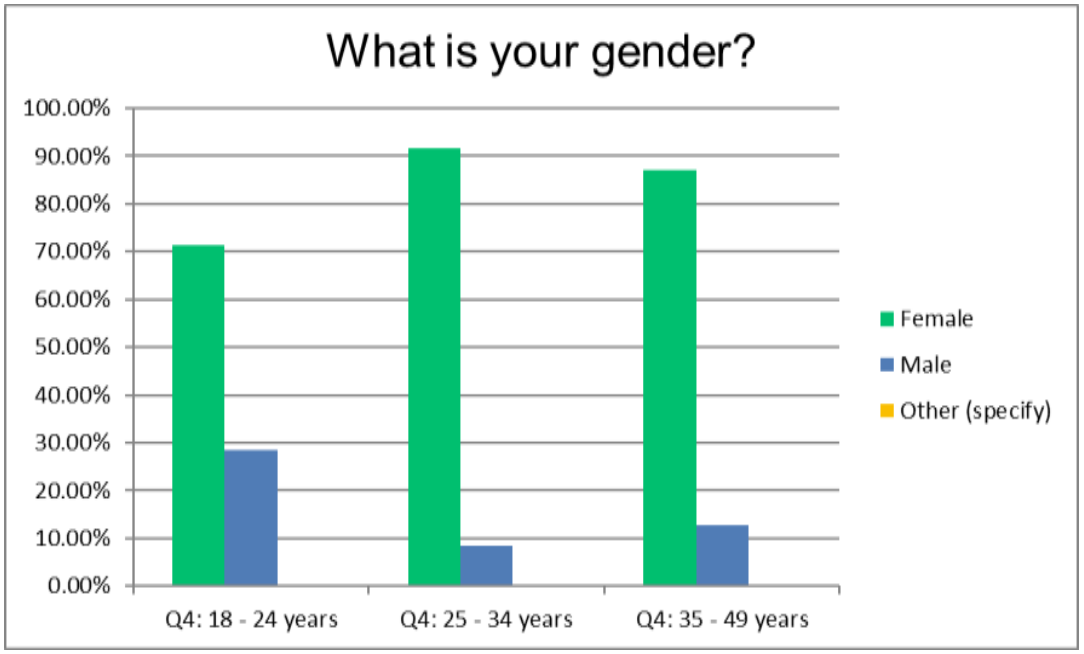
5. Under 50yrs age group

Introduction

This chapter presents key findings and comparisons from data collected on respondents aged 18 – 49 years of age. It includes data on identified protective and risk factors, alcohol and drug use and age of exposure.

167 participants (143 Female, 23 Male) aged between 18-49 years of age.
Respondents reside on the Granite Belt or Southern Downs.

Figure 5.1: Respondents by age group and gender



Summary

Respondents were asked to identify key protective and risk factors from a list, but were also provided a free text box to list other comments.

The following chapter provides tables and charts of the data surrounding risk and protective factors, drug use and age of exposure.

Risk factors

For the 18-49-year age group the 4 highest identified risk factors were

1. Peer pressure or social pressure from friends, family, community or social media 80.28%
2. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 76.06%.
3. Depression and/or anxiety 75.35%
4. Experimentation 72.54%

Easy access to drugs was also a significant factor at 64.08%. In fact, access to drugs and recreational use as risk factors was highest in the 18-24yr old cohort, dropping by 6% for the 35-49yr old age group. Interestingly it was the 35-49yr old respondents who ranked boredom and a lack of things to do, higher than other age groups. Is this a reflection of their own experience, or what they see for other family members, children/youth or extended family?

Q Is there a general consensus across community that there is not enough for youth to do? If so, is it about awareness and knowledge of available activities, affordable access or is it about youth culture?

It is a theme has been raised at youth network meetings by High School students.

Q Do clubs and groups need to upskill and provide greater access to information via digital means? Is there value in adopting smarter marketing strategies that appeal to this tech savvy generation?

Pain management as a risk factor rose in the 35-49year group. No one to provide positive healthy support and relationships that are violent or controlling were also ranked highest by this age group.

Protective factors

Respondents identified the following 4 highest protective factors

For the 18-49-year age group the 4 highest identified protective factors were

1. Support programs for children and youth 68.06% and more free mental health support services 68.06%
2. Health and wellness programs 66.67%
3. Easier and/or more affordable access to sports and recreational clubs 65.97%
4. More support for students to stay in school 63.89%

Those aged 18-24years ranked access to courses (such as anger management, resilience and healthy relationship workshops) highest, in comparison to the 25-34 age group who ranked health and wellness programs (including how to eat and stay well, be active and make friends) highest. Those in the 35-49 age group ranked easier and/or more affordable access to sports and recreational clubs, and support programs for children and youth as the most important protective factor.

Across these age groups opportunities for community connection received significant support (56-61%) and 50% of this group supported more community education around mental health to break down barriers.

Table 5.1: Percentage of support for risk factors by age group
* participants were able to select multiple answers in addition to adding comments in a free answer text box

Q: When it comes to thinking of the world around you, what do you think are some of the things in life that can influence someone to begin using drugs (alcohol, weed, meth, inhalants, prescriptions pills or other drugs)?

Suggested risk factor	% of total responses/No. of respondents			
	Q4: 18 - 24 years	**Q4: 25 - 34 years**	**Q4: 35 - 49 years**	**Total**
Feeling like they don't belong. Not wanting to be at home. Disengaged from family or community	75.00%	65.63%	79.79%	76.06%
	12	21	75	108
Boredom and/or a lack of things to do in the community	43.75%	59.38%	65.96%	61.97%
	7	19	62	88
Not going to school or work or not being able to find work	56.25%	43.75%	57.45%	54.23%
	9	14	54	77
Relationships that are violent or controlling	62.50%	65.63%	69.15%	67.61%
	10	21	65	96
Easy access to drugs	68.75%	62.50%	63.83%	64.08%
	11	20	60	91
No one to provide positive healthy support or supervision	50.00%	25.00%	58.51%	50.00%
	8	8	55	71
Pain management	50.00%	43.75%	59.57%	54.93%
	8	14	56	78
Peer pressure or social pressure from friends, family, community or social media	75.00%	84.38%	79.79%	80.28%
	12	27	75	114
Experimentation	75.00%	62.50%	75.53%	72.54%
	12	20	71	103
Lack of awareness and knowledge of the risks of drug use	43.75%	43.75%	41.49%	42.25%
	7	14	39	60
Depression and/or anxiety	81.25%	78.13%	73.40%	75.35%
	13	25	69	107
Lack of community understanding to mental health issues - feeling isolated and/or judged	56.25%	53.13%	55.32%	54.93%
	9	17	52	78
Recreational use	62.50%	56.25%	55.32%	56.34%
	10	18	52	80
Prefer not to respond	0.00%	0.00%	0.00%	0.00%
	0	0	0	0
Other (please specify)	6.25%	6.25%	5.32%	5.63%
	1	2	5	8
Total	11.27%	22.54%	66.20%	100.00%
	16	32	94	142
Answered				**142**
Skipped				**25**

Figure 5.2: Percentage of support for risk factors by age group

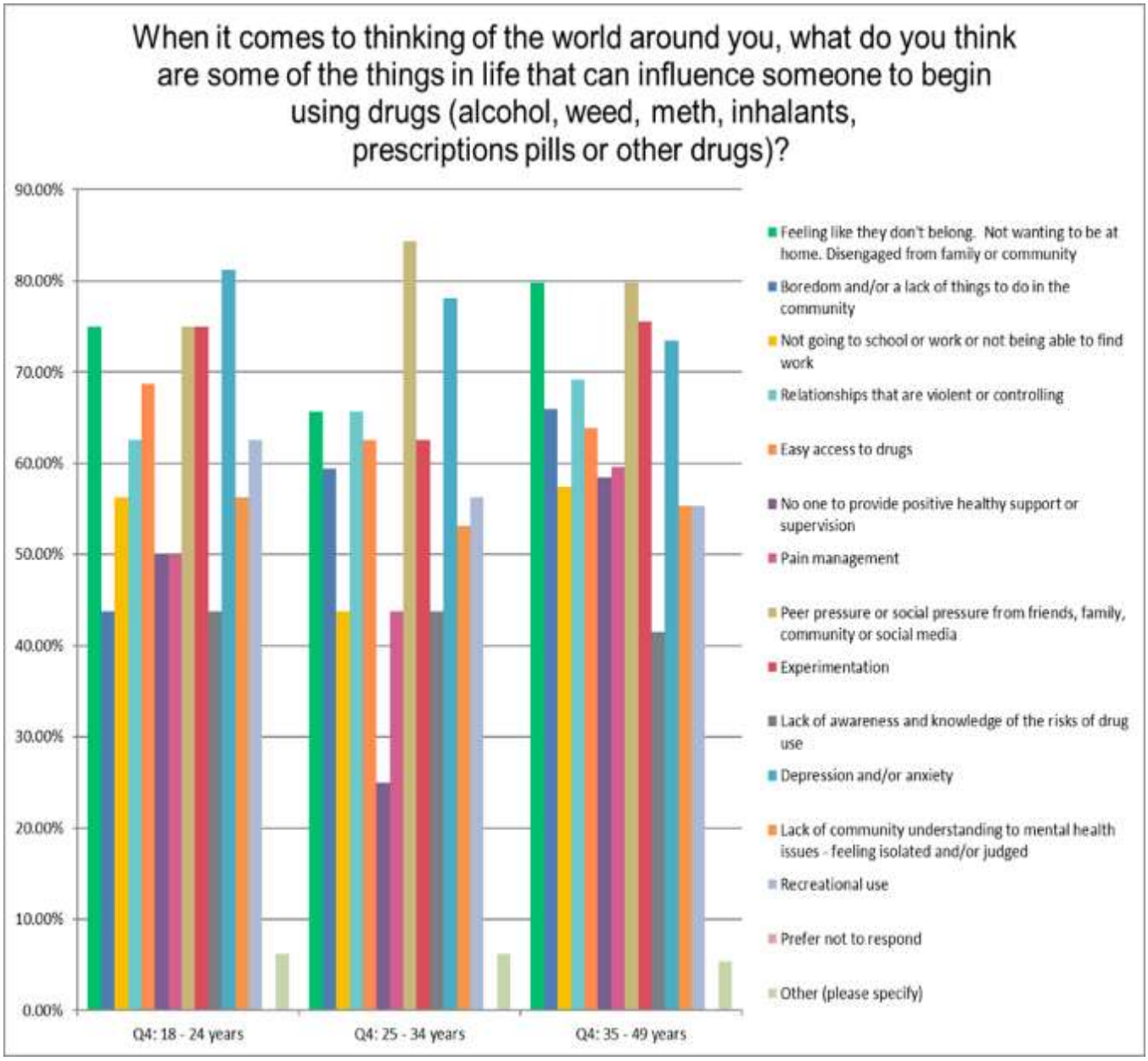


Table 5.2: Percentage of support for protective factors by age group
* participants were able to select multiple answers in addition to adding comments in a free answer text box

Q: Thinking about the world around you, what do you consider to be the most important things that help a person to stay safe and well, and to feel healthy and happy?

Suggested protective factor	% of total responses/No. of respondents			
	Q4: 18 - 24 years	Q4: 25 - 34 years	Q4: 35 - 49 years	Total
Support programs for children and youth	64.71%	62.50%	70.53%	68.06%
	11	20	67	98
Parenting programs during pregnancy that discuss the risk of drug harm and where to go for help	41.18%	50.00%	42.11%	43.75%
	7	16	40	63
Health and wellness programs (including how to eat and stay well, be active and make friends)	70.59%	81.25%	61.05%	66.67%
	12	26	58	96
Pain management programs	35.29%	31.25%	50.53%	44.44%
	6	10	48	64
More support for students to stay in school	64.71%	59.38%	65.26%	63.89%
	11	19	62	92
Easier and/or more affordable access to sports and recreational clubs	58.82%	53.13%	71.58%	65.97%
	10	17	68	95
Community activities that help link families to support	64.71%	59.38%	62.11%	61.81%
	11	19	59	89
Access to courses (such as anger management, resilience and healthy relationship workshops)	76.47%	59.38%	57.89%	60.42%
	13	19	55	87
More free mental health support services	52.94%	68.75%	70.53%	68.06%
	9	22	67	98
Opportunities to be connected with community	52.94%	53.13%	57.89%	56.25%
	9	17	55	81
Community education around mental health to break down barriers	47.06%	46.88%	51.58%	50.00%
	8	15	49	72
Prefer not to respond	0.00%	0.00%	0.00%	0.00%
	0	0	0	0
Other (please specify)	5.88%	12.50%	9.47%	9.72%
	1	4	9	14
Total	11.81%	22.22%	65.97%	100.00%
	17	32	95	144
Answered				144
Skipped				23

Figure 5.3: Percentage of support for protective factors by age group

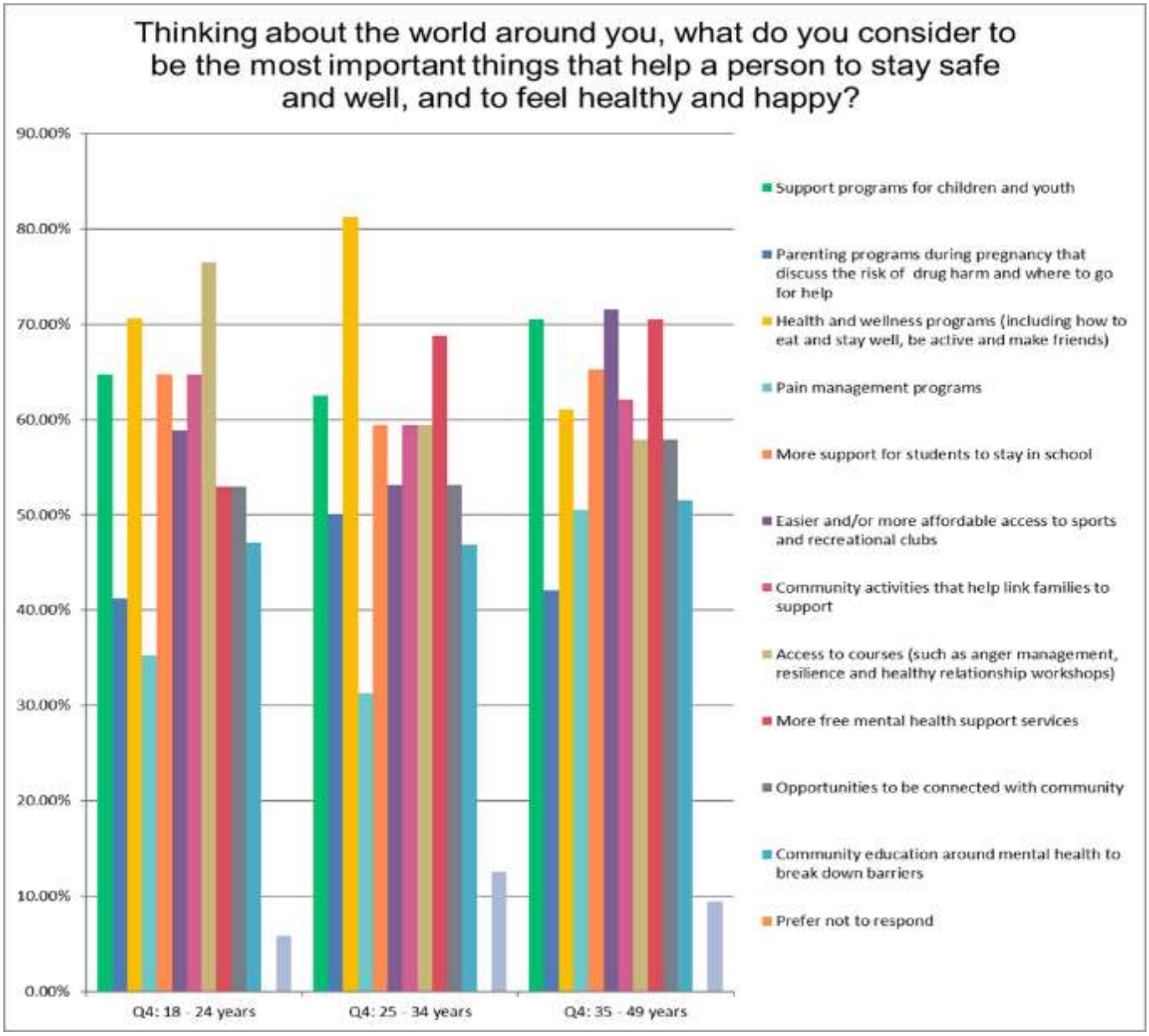


Table 5.3: Exposure to alcohol and other drugs by the 18-49yr age group

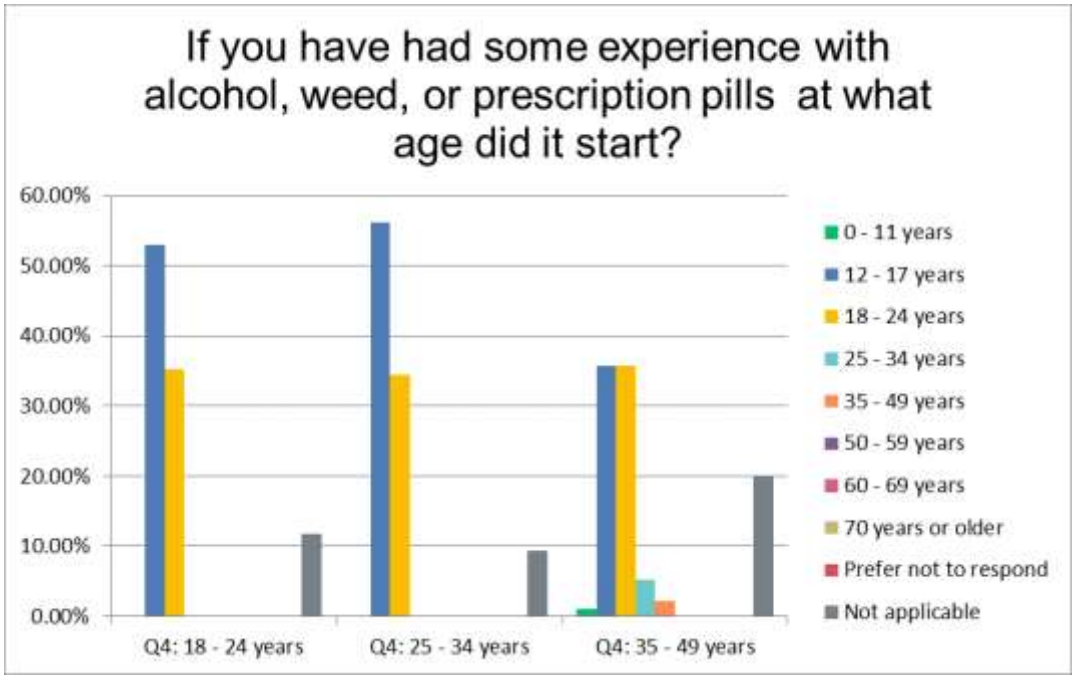
Q: What is your experience with the following? Please use the drop down boxes to make your selections.												
Current Use												
	Never used		Previously used		Currently in recovery		Currently using		Prefer not to respond		Total	
Alcohol	15.28%	22	31.94%	46	2.08%	3	49.31%	71	1.39%	2	100.00%	144
Weed, Marijuana, Cannabis	61.81%	89	31.94%	46	0.69%	1	5.56%	8	0.00%	0	100.00%	144
Prescription pills (pain killers, benzo's and stimulants)	58.33%	84	29.17%	42	2.08%	3	10.42%	15	0.00%	0	100.00%	144
Ice, Meth	89.58%	129	6.94%	10	1.39%	2	2.08%	3	0.00%	0	100.00%	144
Inhalants	97.22%	140	2.78%	4	0.00%	0	0.00%	0	0.00%	0	100.00%	144
Other drugs	84.03%	121	13.19%	19	0.00%	0	1.39%	2	1.39%	2	100.00%	144
Total	100.00%	144	100.00%	144	100.00%	144	100.00%	144	100.00%	144	100.00%	144
											Answered	**144**
											Skipped	**23**

Alcohol and other drug exposure

49.31% of those aged 18-49yrs indicated they are currently using alcohol, 5.56% Marijuana, 10.42% prescription pills, 2.08% Meth/Ice and 1.39% are using other drugs. 29-30% of respondents indicated having used alcohol, Marijuana or prescription pills before. 6.94% had previously used Meth/Ice, 2.78% had used inhalants and 13.19% had used other drugs.

The percentage of current alcohol use was similar to that of those over 50yrs of age (50.34%). However, while those over 50yrs of age reported a high use of prescription pills, this group reported a higher percentage of Marijuana use.

Figure 5.4: Percentage of respondents exposed to alcohol and other drugs by age group



Alcohol and other drug exposure

Table 5.4: Age of Exposure to alcohol, Marijuana or prescription pills by age group

Q: If you have had some experience with alcohol, weed, or prescription pills at what age did it start?																				
	0 - 11 years		12 - 17 years		18 - 24 years		25 - 34 years		35 - 49 years		50 - 59 years		60 - 69 years		70 years or older		Prefer not to respond		Not applicable		Total	
Q4: 18 - 24 years	0.00%	0	52.94%	9	35.29%	6	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	11.76%	2	11.81%	17
Q4: 25 - 34 years	0.00%	0	56.25%	18	34.38%	11	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	9.38%	3	22.22%	32
Q4: 35 - 49 years	1.05%	1	35.79%	34	35.79%	34	5.26%	5	2.11%	2	0.00%	0	0.00%	0	0.00%	0	0.00%	0	20.00%	19	65.97%	95
Total	0.69%	1	42.36%	61	35.42%	51	3.47%	5	1.39%	2	0.00%	0	0.00%	0	0.00%	0	0.00%	0	16.67%	24	100.00%	144
																					Answered	**144**
																					Skipped	**23**

While the majority of respondents indicated exposure to alcohol, weed or prescription pills began between the ages of 18-24 years (approx. 35%), 42.36% indicated it began between the ages of 12-17. Exposure in the 12-17year old period continues to drop from 52.94% to just 6% for those 70yrs and older. This indicates that youth of day are far more vulnerable and exposed to these substances that our grandparents were.

Table 5.5: Age of Exposure to Ice/Meth, inhalants or other drugs by age group

Q: If you have had some experience with meth, inhalants, or other drugs at what age did it start?																				
	0 - 11 years		12 - 17 years		18 - 24 years		25 - 34 years		35 - 49 years		50 - 59 years		60 - 69 years		70 years or older		Prefer not to respond		Not applicable		Total	
Q4: 18 - 24 years	0.00%	0	25.00%	4	6.25%	1	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	68.75%	11	11.27%	16
Q4: 25 - 34 years	0.00%	0	6.25%	2	15.63%	5	3.13%	1	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	75.00%	24	22.54%	32
Q4: 35 - 49 years	1.06%	1	3.19%	3	6.38%	6	2.13%	2	2.13%	2	0.00%	0	0.00%	0	0.00%	0	1.06%	1	84.04%	79	66.20%	94
Total	0.70%	1	6.34%	9	8.45%	12	2.11%	3	1.41%	2	0.00%	0	0.00%	0	0.00%	0	0.70%	1	80.28%	114	100.00%	142
																					Answered	**142**
																					Skipped	**25**

81% of respondents chose not to respond or indicated the question was not applicable to them. 8.45% indicated exposure occurred between 18-24yrs of age, and 6.34% indicated it began between 12-17yrs of age.

25% of the 18-24yr cohort indicated exposure began between 12-17yrs of age. 53% of this same age group reported that exposure to alcohol, Marijuana and prescription pills began in this same period. This highlights a period of vulnerability and risk and reiterates that early drug prevention strategies need to start before the age of twelve.

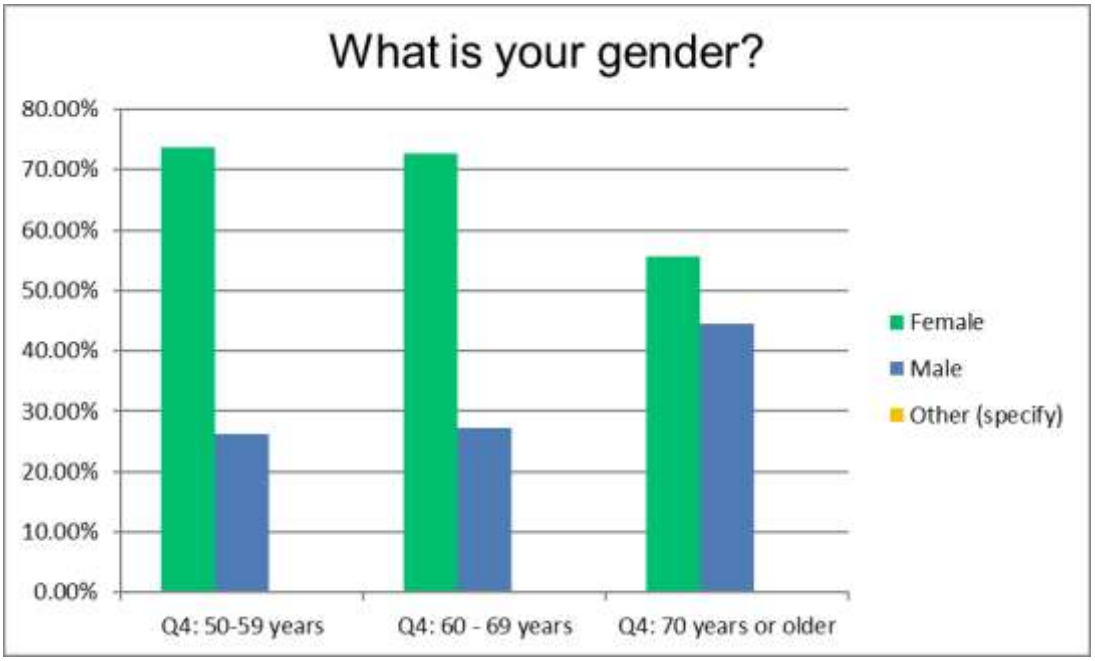
6. 50yrs and older age group

Introduction

This chapter presents key findings and comparisons from data collected on respondents aged 50 years of age and over. It includes data on identified protective and risk factors, alcohol and drug use and age of exposure.

179 participants (124 Female, 54 Male) aged 50yrs of age and older.
Respondents reside on the Granite Belt or Southern Downs.

Figure 6.1: Respondents by age group and gender



Summary

Respondents were asked to identify key protective and risk factors from a list, but were also provided a free text box to list other comments.

The following chapter provides tables and charts of the data surrounding risk and protective factors, drug use and age of exposure.

Risk factors

For the over 50yrs age group the 4 highest identified risk factors were

1. Peer pressure or social pressure from friends, family, community or social media 78.23%
2. Feeling like they don't belong, not wanting to be at home or disengaged from family or community 77.55%.
3. Depression and/or anxiety 73.47%
4. Experimentation 72.11%

These 4 risk factors were also mirrored by the under 50 age group with only a 2% difference in weighting. Easy access to drugs was a significant factor at 68.03%

In the 50-59yr age group peer pressure was ranked highest 89.66% (17-20% higher than the 2 other age groups). The 70+ age group ranked easy access to drugs, boredom and feeling like they don't belong equally high (76.47%). Yet they ranked depression and anxiety lower than other age groups at 70.59%. Again we must be mindful of what is lived experience and what is opinion when analysing these statistics.

Protective factors

Respondents identified the following 4 highest protective factors

For the 50+ year age group the 4 highest identified protective factors were

1. Health and wellness programs 72.79%
2. Community activities that help link families to support 71.43%
3. Support programs for children and youth 70.07%
4. Access to courses 65.31%

Responses across these 3 age groups were surprisingly consistent. The only significant difference came from the 70+ age group who in addition to the top 4 factors listed above gave more support for students to stay in school, and parenting programs during pregnancy. While health and wellness programs and support programs for children and youth were equally supported by the under 50 age group, the 50+ age group prioritized community activities that link families to support and access to courses.

Table 6.1: Percentage of support for risk factors by age group

* participants were able to select multiple answers in addition to adding comments in a free answer text box

Suggested risk factor	% of total responses/No. of respondents			
	Q4: 50-59 years	**Q4: 60 - 69 years**	**Q4: 70 years or older**	**Total**
Feeling like they don't belong. Not wanting to be at home. Disengaged from family or community	79.31%	76.36%	76.47%	77.55%
	46	42	26	114
Boredom and/or a lack of things to do in the community	68.97%	65.45%	76.47%	69.39%
	40	36	26	102
Not going to school or work or not being able to find work	68.97%	69.09%	70.59%	69.39%
	40	38	24	102
Relationships that are violent or controlling	72.41%	67.27%	70.59%	70.07%
	42	37	24	103
Easy access to drugs	67.24%	63.64%	76.47%	68.03%
	39	35	26	100
No one to provide positive healthy support or supervision	65.52%	61.82%	50.00%	60.54%
	38	34	17	89
Pain management	63.79%	47.27%	55.88%	55.78%
	37	26	19	82
Peer pressure or social pressure from friends, family, community or social media	89.66%	72.73%	67.65%	78.23%
	52	40	23	115
Experimentation	77.59%	67.27%	70.59%	72.11%
	45	37	24	106
Lack of awareness and knowledge of the risks of drug use	43.10%	47.27%	50.00%	46.26%
	25	26	17	68
Depression and/or anxiety	75.86%	72.73%	70.59%	73.47%
	44	40	24	108
Lack of community understanding to mental health issues - feeling isolated and/or judged	60.34%	50.91%	52.94%	55.10%
	35	28	18	81
Recreational use	65.52%	56.36%	47.06%	57.82%
	38	31	16	85
Prefer not to respond	0.00%	3.64%	5.88%	2.72%
	0	2	2	4
Other (please specify)	3.45%	12.73%	8.82%	8.16%
	2	7	3	12
Total	39.46%	37.41%	23.13%	100.00%
	58	55	34	147
Answered				**147**
Skipped				**32**

Figure 6.2: Percentage of support for risk factors by age group

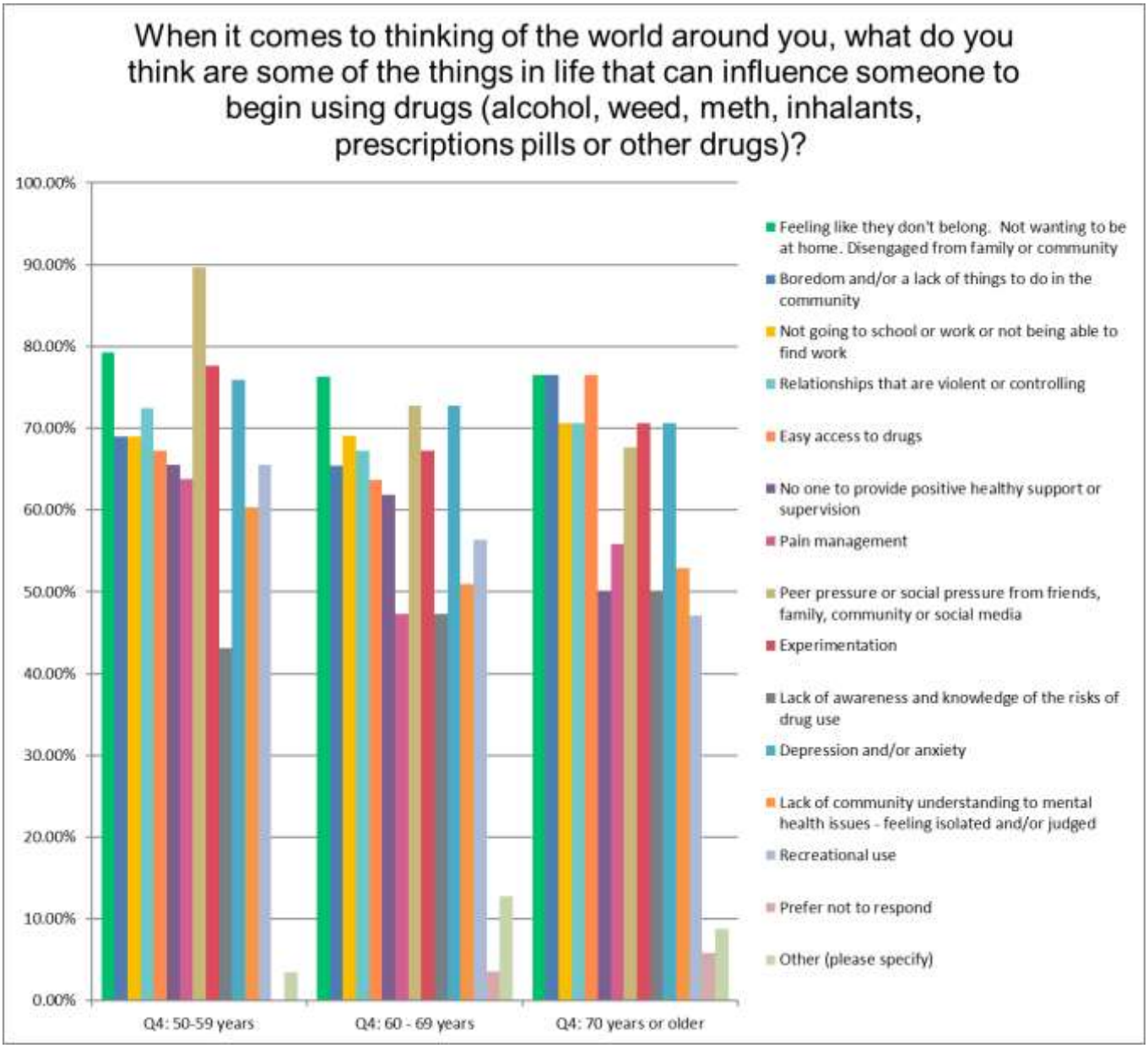


Table 6.2: Percentage of support for protective factors by age group

* participants were able to select multiple answers in addition to adding comments in a free answer text box

Suggested protective factor	% of total responses/No. of respondents			
	Q4: 50-59 years	**Q4: 60 - 69 years**	**Q4: 70 years or older**	**Total**
Support programs for children and youth	67.24%	69.09%	76.47%	70.07%
	39	38	26	103
Parenting programs during pregnancy that discuss the risk of drug harm and where to go for help	48.28%	52.73%	67.65%	54.42%
	28	29	23	80
Health and wellness programs (including how to eat and stay well, be active and make friends)	74.14%	74.55%	67.65%	72.79%
	43	41	23	107
Pain management programs	44.83%	49.09%	50.00%	47.62%
	26	27	17	70
More support for students to stay in school	44.83%	49.09%	67.65%	51.70%
	26	27	23	76
Easier and/or more affordable access to sports and recreational clubs	62.07%	67.27%	61.76%	63.95%
	36	37	21	94
Community activities that help link families to support	75.86%	67.27%	70.59%	71.43%
	44	37	24	105
Access to courses (such as anger management, resilience and healthy relationship workshops)	68.97%	58.18%	70.59%	65.31%
	40	32	24	96
More free mental health support services	65.52%	58.18%	61.76%	61.90%
	38	32	21	91
Opportunities to be connected with community	63.79%	69.09%	67.65%	66.67%
	37	38	23	98
Community education around mental health to break down barriers	58.62%	61.82%	61.76%	60.54%
	34	34	21	89
Prefer not to respond	0.00%	3.64%	5.88%	2.72%
	0	2	2	4
Other (please specify)	18.97%	14.55%	11.76%	15.65%
	11	8	4	23
Total	39.46%	37.41%	23.13%	100.00%
	58	55	34	147
Answered				**147**
Skipped				**32**

Figure 6.3: Percentage of support for protective factors by age group

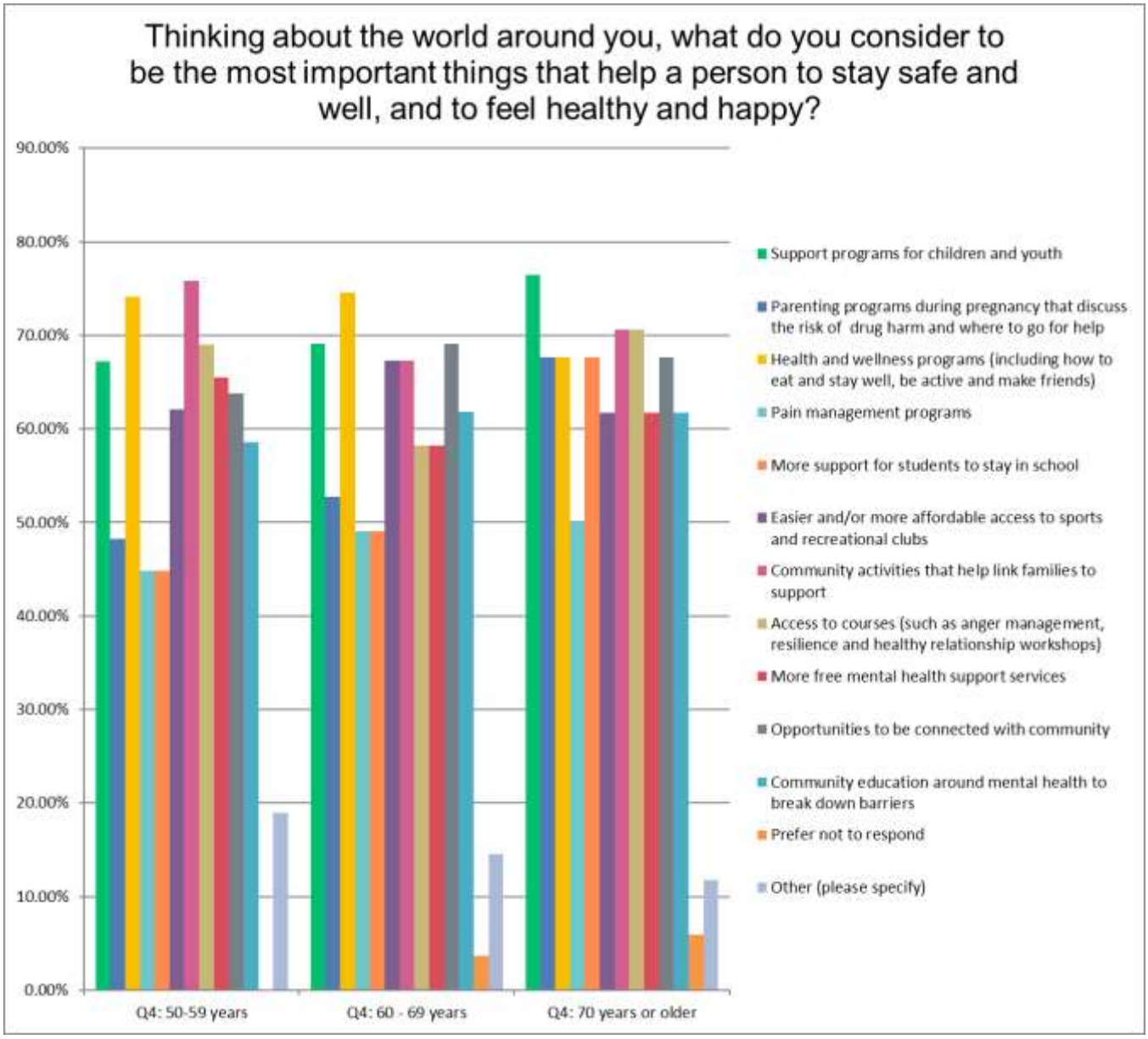


Table 6.3: Exposure to alcohol and other drugs by age group

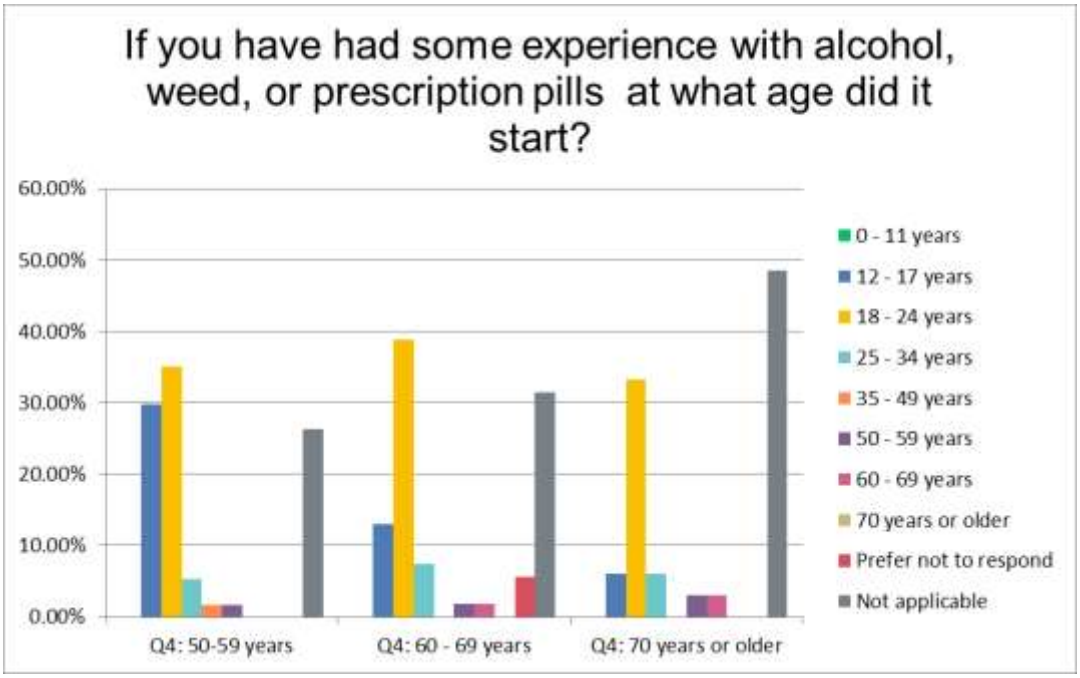
Q: What is your experience with the following? Please use the drop down boxes to make your selections.												
Current Use												
	Never used		Previously used		Currently in recovery		Currently using		Prefer not to respond		Total	
Alcohol	23.13%	34	20.41%	30	2.72%	4	50.34%	74	3.40%	5	100.00%	147
Weed, Marijuana, Cannabis	79.59%	117	15.65%	23	0.68%	1	1.36%	2	2.72%	4	100.00%	147
Prescription pills (pain killers, benzo's and stimulants)	61.22%	90	21.77%	32	1.36%	2	12.93%	19	2.72%	4	100.00%	147
Ice, Meth	95.92%	141	2.72%	4	0.00%	0	0.00%	0	1.36%	2	100.00%	147
Inhalants	93.20%	137	4.76%	7	0.68%	1	0.00%	0	1.36%	2	100.00%	147
Other drugs	87.76%	129	7.48%	11	0.00%	0	2.04%	3	2.72%	4	100.00%	147
Total	100.00%	147	100.00%	147	100.00%	147	100.00%	147	100.00%	147	100.00%	147
											Answered	**147**
											Skipped	**32**

Alcohol and other drug exposure

50.34% of those aged 50yrs and over indicated they are currently using alcohol, 1.36% Marijuana 12.93% prescription pills, 0% using Meth/Ice, 0% inhalants, and 2.04% are using other drugs. 20.41% of respondents indicated having used alcohol before 15.65% Marijuana and 21.77% had used prescription pills before. 2.72% had previously used Ice, 4.76% had used inhalants and 7.48% had used other drugs. The current and previous use of other drugs for all age groups is higher than that of Ice and warrants further research.

Current alcohol use by this age group is very close to those 18-49yrs of age.

Figure 6.4: Percentage of respondents exposed to alcohol and other drugs by age group



Alcohol and other drug exposure

Table 6.4: Age of Exposure to alcohol, Marijuana or prescription pills by age group

Q: If you have had some experience with alcohol, weed, or prescription pills at what age did it start?

	0 - 11 years		12 - 17 years		18 - 24 years		25 - 34 years		35 - 49 years		50 - 59 years		60 - 69 years		70 years or older		Prefer not to respond		Not applicable		Total	
Q4: 50-59 years	0.00%	0	29.82%	17	35.09%	20	5.26%	3	1.75%	1	1.75%	1	0.00%	0	0.00%	0	0.00%	0	26.32%	15	39.58%	57
Q4: 60 - 69 years	0.00%	0	12.96%	7	38.89%	21	7.41%	4	0.00%	0	1.85%	1	1.85%	1	0.00%	0	5.56%	3	31.48%	17	37.50%	54
Q4: 70 years or older	0.00%	0	6.06%	2	33.33%	11	6.06%	2	0.00%	0	3.03%	1	3.03%	1	0.00%	0	0.00%	0	48.48%	16	22.92%	33
Total	0.00%	0	18.06%	26	36.11%	52	6.25%	9	0.69%	1	2.08%	3	1.39%	2	0.00%	0	2.08%	3	33.33%	48	100.00%	144
																				Answered		**144**
																				Skipped		**35**

While the majority of respondents indicated exposure to alcohol, weed or prescription pills began between the ages of 18-24 years (36%). 18.06% indicated it began between the ages of 12-17. Although those in the 50-59 age group indicated exposure in the 12-17yr age group was 29.82%. This calls for a greater understanding of generational factors/influences as highlighted in earlier chapters.

Table 6.5: Age of Exposure to Ice/Meth, inhalants or other drugs by age group

Q:If you have had some experience with meth, inhalants, or other drugs at what age did it start?

	0 - 11 years		12 - 17 years		18 - 24 years		25 - 34 years		35 - 49 years		50 - 59 years		60 - 69 years		70 years or older		Prefer not to respond		Not applicable		Total	
Q4: 50-59 years	1.79%	1	8.93%	5	3.57%	2	3.57%	2	1.79%	1	0.00%	0	0.00%	0	0.00%	0	0.00%	0	80.36%	45	39.44%	56
Q4: 60 - 69 years	0.00%	0	0.00%	0	1.89%	1	0.00%	0	0.00%	0	1.89%	1	0.00%	0	0.00%	0	0.00%	0	96.23%	51	37.32%	53
Q4: 70 years or older	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	3.03%	1	0.00%	0	0.00%	0	9.09%	3	87.88%	29	23.24%	33
Total	0.70%	1	3.52%	5	2.11%	3	1.41%	2	0.70%	1	1.41%	2	0.00%	0	0.00%	0	2.11%	3	88.03%	125	100.00%	142
																					Answered	**142**
																					Skipped	**37**

90% of respondents chose not to respond or indicated the question was not applicable to them. 2.11% indicated exposure began between 18-24yrs of age and 3.52% at 12-17yrs of age. Exposure was lower in this group in comparison to the under 50 age group: at 18-24yrs (8.45%) and at 12-17yrs (6.34%).

7. Conclusion

The goal of our LDAT (Local Drug Action Team) project was to provide a vehicle for community consultation and to provide a comparison between community need as determined by those working in the community sector and that of everyday people. We developed and delivered this survey across the Granite Belt, and larger Southern Downs, inviting community to give feedback, ideas and recommendations around prevention strategies.

Information harvested from this survey has been analysed in order gain greater understanding about the specific needs of our community and has provided data not currently available in this region. It will drive decision making and future funding applications.

The survey results indicate support for strategies and programs that build stronger community connection and perhaps in light of peer pressure, a need to nurture new social norms that sow a stronger desire for personal investment in self and in community.

McMillan & Chavis wrote about membership as a key factor in creating a healthy community.

"To summarize, membership has five attributes: boundaries, emotional safety, a sense of belonging and identification, personal investment, and a common symbol system. These attributes work together and contribute to a sense of who is part of the community and who is not."[11]

Outcomes

This research project achieved the following outcomes

1. Provide a vehicle to create awareness and discussion and give community a voice
2. Put alcohol and drug misuse, and its impact on community, into the scope of community awareness
3. Challenge existing stigmas and perception about drug use
4. Strengthen the message of the power of an inclusive community approach
5. Utilise media platforms to advocate for funding and to also identify to community the work that is being done by locals to support locals
6. Harvest data that helps us better understand social norms and community perception, and to compare that with the thoughts and perceptions of local service providers
7. Collect data that is not currently available across key demographics in this region
8. Apply for future grants that fund our action plan for prevention reducing the risk of harm from alcohol and drugs
9. Identify vulnerable and at risk groups

Finding a Solution – creating an action plan

Using the Precede-Proceed model (a key tool for project development in both the health and community sector) we identified our target demographic, and drafted key strategies that would form the framework of a targeted prevention program. The following groups were identified as at-risk/vulnerable:

a) students in the transition to High School
b) those affected by mental health
c) expectant mums and those with young children
d) those in unhealthy or controlling relationships

See Appendix 8 for evidence of the Precede-Proceed model in use

It was decided we would focus on the development of an action plan for students in the transition to High School; Year 6 and Year 7. A 6 tier program plan (see Fig 7.1) was designed to complement existing transition programs, and strengthen work with parents and community.

The aim of the program is to foster a common thread of 'belonging' in community consciousness alongside our deep desire to nurture new social norms, that foster a united response to support parents and children in this rite of passage, and celebration of transition to adulthood.

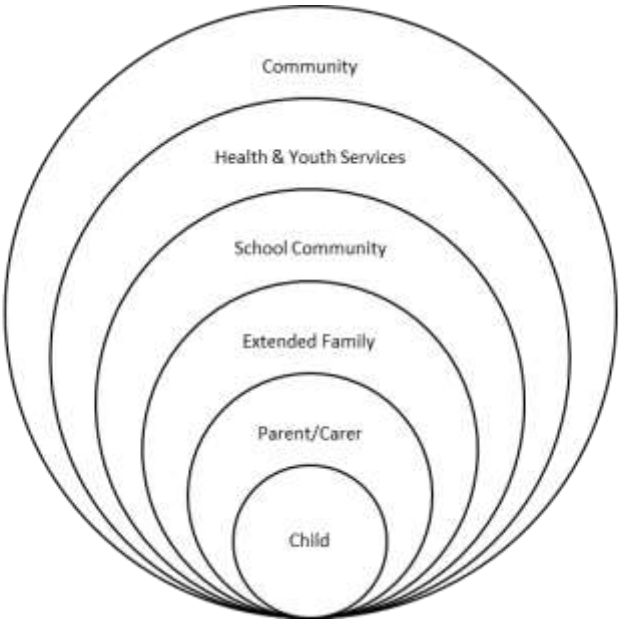


Figure 7.1: Community support model

The action plan details program delivery for each of the 6 areas of support listed in the model above.

Key Objectives of the Youth Action Plan

The following key objectives were formulated to address Education in Schools, Peer Support and Positive Parenting.

1. Increase attendance by students during their first term at High School by providing peer, teacher & community support throughout the last term of Year 6 & the first term of Year 7.

2. Increase an individual's sense of belonging and support during their transition to High School through peer, parent, school and community activities that provide knowledge, guidance and information, in addition to referral pathways for support and community engagement.

3. Increase the number of students participating in some form of internal or external sport/music/art or other activity by end of 1st term at High School through peer support activities that provide information and guidance on how to access available sport and recreation groups.

4. Create a greater sense of belonging and care from community for families during Term one, through the visual promotion/presence of the program in public spaces, and the rollout out of community based support activities.

5. Strengthen parenting skills through the provision of 11 workshops offering tools and strategies that support positive role modelling, conversations at home that support the young person's transition, and daily routine skills building to support school readiness.

6. Building the confidence and knowledge of parents/carers and their capacity to support their young person by increasing awareness of pathways for support at school and in community, and ensuring parents/carers know how to reach out for assistance.

Specific objectives were also established for parents and caregivers since they are central to the success of this transition.

1. To change up the energy around preparation for High School to build a sense of exuberant anticipation to embrace and to celebrate the rite of passage into young adulthood, through a visual community wide campaign/one message.

2. Increasing parents' knowledge of a young persons' developmental stages in conjunction with increased knowledge of peer and social pressure.

3. Strengthening parent-child relationships through the inclusiveness of the workshop journey and workshop content including a focus on 'positive conversations to have at home with your children during transition and beyond'.

4. Increasing awareness of pathways for support at school and in community, and ensuring parents/carers know how to reach out for assistance, and who to connect with within the school community.

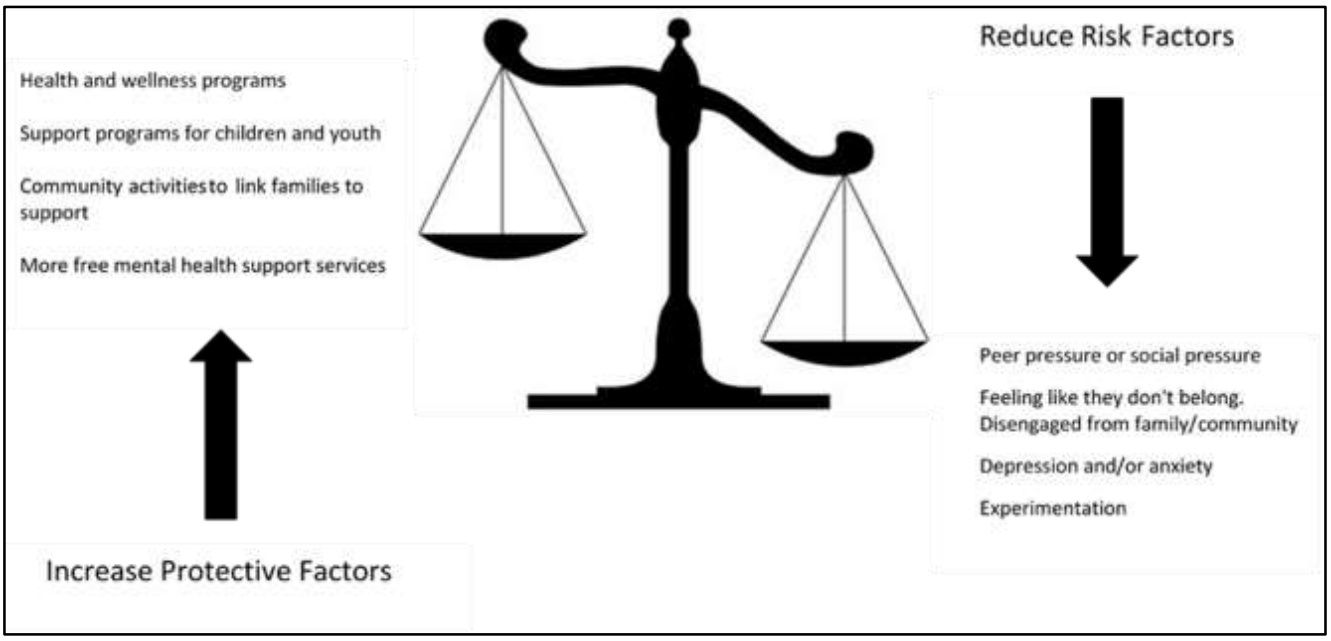
5. Providing a hook for parents by providing workshops that are just for them, and mirror the support provided for their children, and by providing a similar reward system that answers the question 'what's in it for me?'

This project requires funding to resource the work required. Implementation considerations require further exploration and in-depth consultation with all school and community stakeholders.

Other Considerations

We have talked a lot about protective factors and key strategies focused on engagement with community, health and wellness and other support programs, and the role of mental health support services. In balance with this we need to give consideration to reducing risk factors, in particular determining control measures relevant to this community.

Figure 7.2: Balancing Protective and Risk Factors



Finding Balance

Due consideration should be given to how we can reduce identified risk factors.

Using control measures that align with risk management models, we have identified strategies that reduce exposure, access and distribution of alcohol and drugs.

Consideration: Can we minimise access? Disrupt distribution?

Control Measure:

- Increased police campaigns stopping trucks and other traffic for drug testing and vehicle inspection, in order to disrupt distribution channels.
- Greater police presence in the main street. Undercover surveillance in public spaces
- Increased mobile security patrols in the community.
- Community walking patrols

Consideration: How can we isolate it from others?

Control Measure:

- Greater patrol of licensed premises to ensure alcohol isn't sold to under 18's
- Changes to liquor-licencing relating to trading hours and advertising
- Stronger campaigns for parents on drug awareness and in particular exposure at homes other than their own

Consideration: Can we reduce the risk through other controls?

Control Measure:

- Mass media efforts to enhance anti-drug messaging and pro-social behaviours
- Community wide awareness programs
- Changes to community surveillance and reporting
- Changes to neighbourhood watch
- Drug hotline so community can report dealers

Consideration: Can we reduce exposure through administrative or legislative actions?
Control Measure:

- Mandatory or incentivised parenting programs
- Changes to drug diversion that has offenders giving back to community
- Policy development and enforcement by local government
- Placement of information across community to provide greater awareness
- Enforce heavy penalties for any premises caught distributing Marijuana or other drugs

8. Next Steps

What's Next

The Granite Belt Neighbourhood Centre is committed to its work advocating for funding and supporting programs that reduce the risk of harm from alcohol and drugs. It is our intention to use this report to leverage support for future funding to continue this work in partnership with other local stakeholders.

In consideration of this regional community, mental health needs, drug use and social determinants, including the effects of housing supply and demand it is anticipated that this report may also be utilised to support funding applications across all of these areas of need.

Proposed next steps may include

- An invitation to community to explore and discuss questions arising from this report in addition to those provided in Chapter 9
- Presentation of the report at community forums, inter-agency meetings and Local Level Alliance meetings
- Invitations to other agencies or university bodies for further research
- Meetings with government and MP's to levy support for further funding
- Ongoing collaboration with local newspapers to keep this discussion alive and provide community with ongoing updates

We invite any interest or investment that would assist us to continue this journey.

Requests and enquiries concerning reproduction should be addressed to the Granite Belt Neighbourhood Centre by emailing admin@communityds.org.au

Please note that there is the potential for minor revisions to data in this report over its life.

9. Key Considerations

We have attempted throughout the report to provide thoughtful questions to stimulate further exploration and discussion. It is our hope that these questions may also stimulate further research and collaboration. The following is a summary of some of these key questions.

1. How can we better prepare the next generation with the tools for positive self-care (health), a stronger sense of purpose and value, and the desire and means to engage and contribute to community?

2. How do we best equip those in the health and support sector to better understand illicit substances in our region including trends, and the influx of new substances? Are we currently doing enough?

3. How influential is social media, and print media on early exposure (12-17yrs of age) to alcohol and drugs?

4. How can we reduce the ease of access, disrupt the supply chain and local distribution, and challenge our 'no dob' culture?

5. Which came first, the drug use or the mental health condition?

6. Do our young people describe the future as one of opportunity or as a tired repetition of social disadvantage? What message is our community transmitting about this?

7. How do we dissolve social stigma around support and challenge old and unproductive beliefs around the link between vulnerability and accepting assistance? How could we utilise social media to do this?

8. Is there a possible link between access to drugs and relationships that are unhealthy? Which came first in an individual's personal experience - access to drugs that drew them into an unhealthy relationship (certainly a factor in the youth demographic) or an unhealthy relationship that led to drug use?

9. How do we better resource consultation with our senior residents to draw on the collective wisdom of their longevity in our region and their experiences and networks?

10. How easy/comfortable is it for males to reach out and connect with volunteering opportunities? Are there any social norms, or possible stigma around this?

11. What role does popular television play in breaking down/dissolving social stigmas? What impact are reality T.V shows like MasterChef, Australian Ninja, The Block etc. having on male stereotypes and mental health stigma?

12. How can we improve drug education outside of the classroom in meaningful and engaging ways that are inclusive for community?

13. Is there a general consensus across community that there is not enough for youth to do? If so, is it about awareness and knowledge of available activities, affordable access or is it about youth culture?

Appendix 1 – Community poster

Welcome to our Healthier Communities Survey

Your input and ideas can help bring about great change, and it only takes 3mins!

- This research project invites community to give feedback, ideas and suggestions on how to strengthen our community and reduce and prevent harm from alcohol and other drugs.
- We are conducting a survey across this region in order to gather suggestions and assess needs. You may choose not to participate. If you decide to participate in this survey, you may withdraw at any time. This survey will take approx. 3 mins. Your responses will be confidential and we do not collect identifying information such as your IP address. All data is stored in a password protected electronic format. Please only complete the survey once.
- Personal contact details provided by participants will only be used for the purpose of a *prize draw* (if the participant is over 18yrs of age and chooses to participate in this) and will not be released to any third party.

You can complete the survey online using the following link:

https://www.surveymonkey.com/r/5HHMKVL

Survey closes Sunday March 25th

The results of this study will be publicly released by the Granite Belt Neighbourhood Centre as a needs analysis and shared with local agencies for the purpose of grant applications and improving services provided on the Granite Belt and greater Southern Downs.

This project has been funded by the Australian Government as part of the response to the Final Report of the National Ice Taskforce 2015 and the 2015 National Ice Action Strategy.
If you have any questions about the study, please contact Nicola, (LDAT Project Manager) on 46813777.

SCAN ME

Rounded corner business cards - standard matte: Reverse side

Ethical considerations

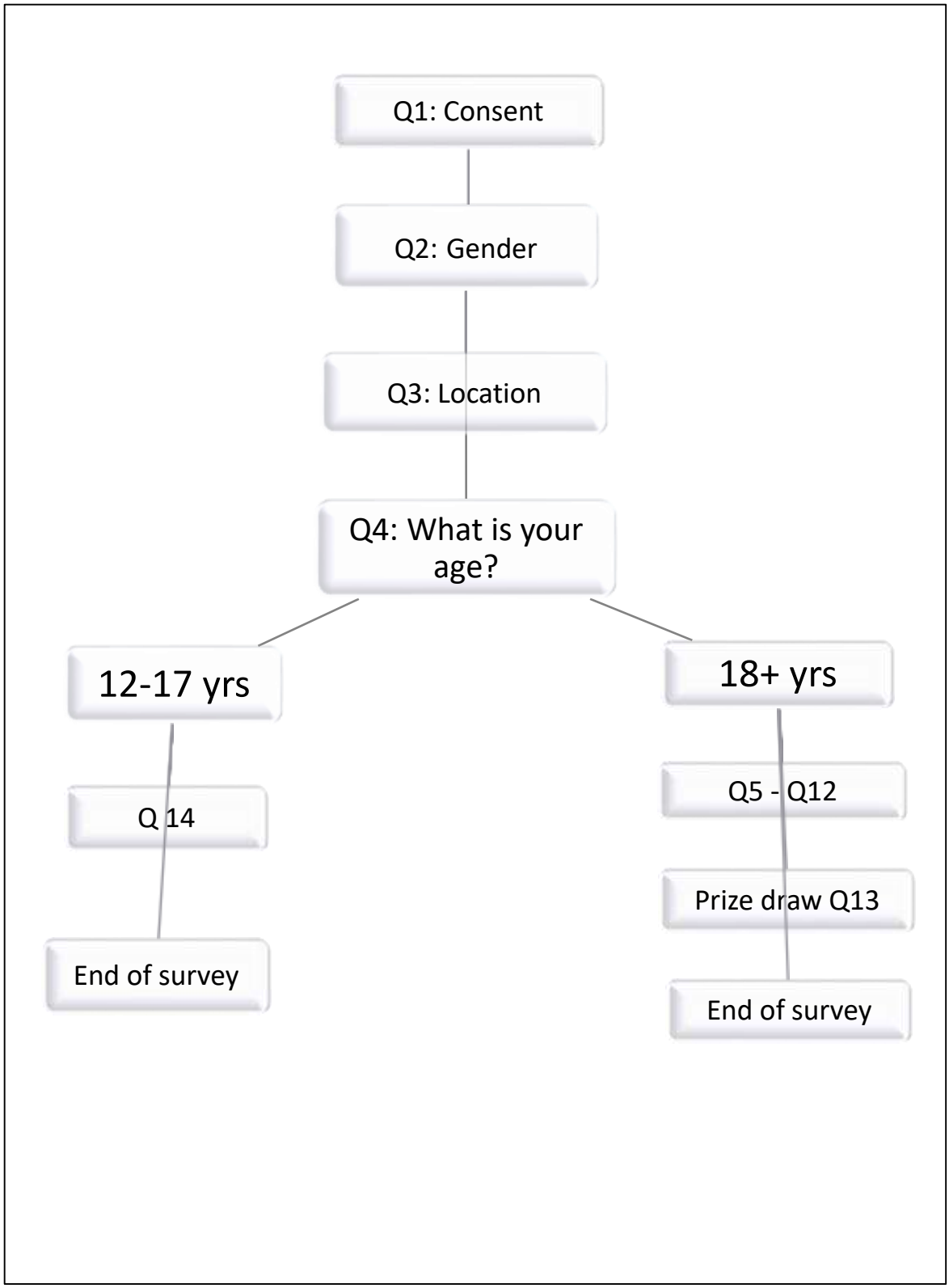
Consultation was conducted with the ADF (Alcohol and Drug Foundation) research team, clinical academics, the school community, and stakeholders, in addition to consideration of the National Medical & Research Councils guidelines on research with children.

The survey went thorough vigorous editing in light of the target demographic and to ensure the material was appropriate; language and age relevant.

Collaboration with our school community ensures there is parental/guardian consent for their children to participate in the survey; with an understanding that the surveys be conducted in the classroom with appropriate emotional support.

The following actions were also taken

1. Participants' notified in the opening consent question that this is a voluntary activity
2. Participants provided information as to the purpose and use of the survey, how information will be collected and stored and who it may be released to and for what purpose.
3. Survey encryption turned on in Survey Monkey to protect the security of their data in transit over the internet.
4. Participants notified that the IP address is not logged so all responses remain anonymous.
5. Participants notified about the confidentiality of their personal details and how this information is used.
6. Participants' provided the opportunity to exit the survey at the introduction and at any point during the survey.
7. Participants' are provided the ability not to respond to questions with a 'prefer not to respond' option provided.
8. The QR code on business cards is 'static' and does not track responses.
9. Consideration of the nature of the survey and its intended audience. In respect to the care of those under 18 years the survey requests information only about protective factors for young people. It does not make any reference to drugs or drug use or ask any questions in regards to their exposure or understanding of such.
10. The incentive prize draw is available only to those 18yrs and over and this is stated in both the introduction and on marketing material.
11. Participation in the prize draw is indicated as a voluntary option and participants must give consent before personal information is used to contact prize draw winners.
12. The online survey contains an applied logic function which separates adult questions from those directed at youth. The following flowchart outlines this transition


Q1: Consent
Q2: Gender
Q3: Location
Q4: What is your age?
12-17 yrs
18+ yrs
Q 14
Q5 - Q12
Prize draw Q13
End of survey
End of survey

Healthier Communities Survey
EXIT THIS SURVEY
Welcome,
We want to know what every day people have to say about important community issues and we need your help! Your voice can help bring about great change and it only takes 3mins!
This research project invites community to give feedback, ideas and suggestions on how to build positive communities and reduce and prevent harm from alcohol and other drugs.
You may choose not to participate. If you decide to participate in this survey, you may withdraw at any time. This survey will take approximately 3 minutes. Your responses will be confidential and we do not collect identifying information such as your IP address.
All data is stored on a password protected electronic format. Personal contact details provided by participants will only be used for the purpose of a prize draw (if the participant is over 18yrs of age and chooses to participate in this) and will not be released to any third party.
Please only complete the survey once.
The results of this study will be publicly released by the Granite Belt Neighbourhood Centre as a results analysis and shared with the ADF (Alcohol and Drug Foundation) and any other agencies for the purpose of grant applications and continuing services provided on the Granite Belt and greater Southern Downs.
This project has been funded by the Australian Government as part of the response to the Final Report of the National Ice Taskforce 2015 and the 2015 National Ice Action Strategy.

Healthier Communities Survey 0

Alcohol and Drug Foundation | Australian Government

Local Drug Action Team Program

Welcome to our Healthier Communities Survey

Your input and ideas can help bring about great change, and it only takes 3mins!

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- We are conducting a survey across this region in order to gather suggestions and assess needs. You may choose not to participate. If you decide to participate in this survey, you may withdraw at any time. This survey will take approximately 3 minutes. Your responses will be confidential and we do not collect identifying information such as your IP address. All data is stored in a password protected electronic format.
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We invite you to complete this survey online using the following link:

https://www.surveymonkey.com/r/5HHMKVL

Q1. Do you agree to the above? By ticking **Yes**, you are indicating: a) you have read the information above, b) you voluntarily agree to participate and c) you are over 18 years of age

Yes ☐ No ☐

Q2. What is your gender?

Female ☐ Male ☐ ☐ Other (please specify) _____

Q3. I live:

- ☐ On the Granite Belt (Wallangarra to Dalveen)
- ☐ On the Southern Downs (Dalveen to Allora)
- ☐ Outside of this region
- ☐ Prefer not to respond

Q4: How old are you?

- ☐ 18 - 24 years
- ☐ 25 - 34 years
- ☐ 35 - 49 years
- ☐ 50-59 years
- ☐ 60 - 69 years
- ☐ 70 years or older
- ☐ Prefer not to respond

Q5. When it comes to thinking of the world around you, what do you think are some of the things in life that can influence someone to begin using drugs (alcohol, weed, meth, inhalants, prescriptions pills or other drugs)? Please select all those answers that apply

- ☐ Feeling like they don't belong. Not wanting to be at home. Disengaged from family or community
- ☐ Boredom and/or a lack of things to do in the community
- ☐ Not going to school or work or not being able to find work
- ☐ Relationships that are violent or controlling
- ☐ Easy access to drugs
- ☐ No one to provide positive healthy support or supervision
- ☐ Pain management
- ☐ Peer pressure or social pressure from friends, family, community or social media
- ☐ Experimentation
- ☐ Lack of awareness and knowledge of the risks of drug use
- ☐ Depression and/or anxiety
- ☐ Lack of community understanding to mental health issues feeling isolated and/or judged
- ☐ Recreational use
- ☐ Prefer not to respond ☐ Other (please specify)_____

Q6. Thinking about the world around you, what do you consider to be the most important things that help a person to stay safe and well, and to feel healthy and happy? Please select all those answers that apply

- ☐ Support programs for children and youth
- ☐ Parenting programs during pregnancy that discuss the risk of drug harm and where to go for help
- ☐ Health and wellness programs (including how to eat and stay well, be active and make friends)
- ☐ Pain management programs
- ☐ More support for students to stay in school
- ☐ Easier and/or more affordable access to sports and recreational clubs
- ☐ Community activities that help link families to support
- ☐ Access to courses (such as anger management, resilience and healthy relationship workshops)
- ☐ More free mental health support services
- ☐ Opportunities to be connected with community
- ☐ Community education around mental health to break down barriers
- ☐ Prefer not to respond ☐ Other (please specify) _____

Q7. What is your experience with the following? Please tick the boxes to make your selections.

	Never Used	Previously Used	Currently in recovery	Currently Using	Prefer not to respond
Alcohol					
Weed, Marijuana, Cannabis					
Prescription pills (including pain killers, benzo's and stimulants)					
Ice, Meth					
Inhalants					
Other drugs					

Q8. If you have had some experience with ***alcohol, weed, or prescription pills***, at what age did it start?

- ☐ 0 - 11 years
- ☐ 12 – 17 years
- ☐ 18 - 24 years
- ☐ 25 - 34 years
- ☐ 35 - 49 years
- ☐ 50-59 years
- ☐ 60 - 69 years
- ☐ 70 years or older
- ☐ Prefer not to respond
- ☐ Not applicable

Q9. If you have had some experience with ***meth, inhalants, or other drugs*** at what age did it start?

- ☐ 0 - 11 years
- ☐ 12 – 17 years
- ☐ 18 - 24 years
- ☐ 25 - 34 years
- ☐ 35 - 49 years
- ☐ 50-59 years
- ☐ 60 - 69 years
- ☐ 70 years or older
- ☐ Prefer not to respond
- ☐ Not applicable

Q10. In our communities there are things that can help us stay *safe* and *well*. We call these things **protective** factors. Examples of protective factors include health and wellbeing services, recreational activities, support services, and employment opportunities. Thinking about this community, what do you think are the protective factors?

Q11. In our communities there are things that can increase the risk of harm from alcohol and other drugs. We call these things **risk** factors. Risk factors are the things that can sometimes lead to unhealthy behaviour or choices. Examples include: high unemployment, poor access to education, lack of support, and poor access to community activities etc. Thinking about this community, what do you think are the risk factors?

Q12. If you would like to go into a prize draw to win a $20 coffee voucher, phone card, pizza voucher or ITunes voucher please provide your contact initials and email address or phone number. This information will remain confidential and will only be used to contact you, if your name is drawn.

Name or initials: _____Email Address or Phone Number: _____

Q13. I give consent to being contacted about the thank you prize draw for participants?

- ☐ Yes
- ☐ No
- ☐ Not interested

Q1. Do you agree to the above? By clicking Yes, you are indicating a) you have read the information above b) you voluntarily agree to participate c) you are over 18 years of age or are completing the survey with parental/guardian consent, and under guidance by your school

Yes ☐ No ☐

Q2. What is your gender?

Female ☐ Male ☐ ☐ Other (please specify) _____

Q3. I live:

☐ On the Granite Belt (Wallangarra to Dalveen) ☐ On the Southern Downs (Dalveen to Allora)

☐ Outside of this region ☐ Prefer not to respond

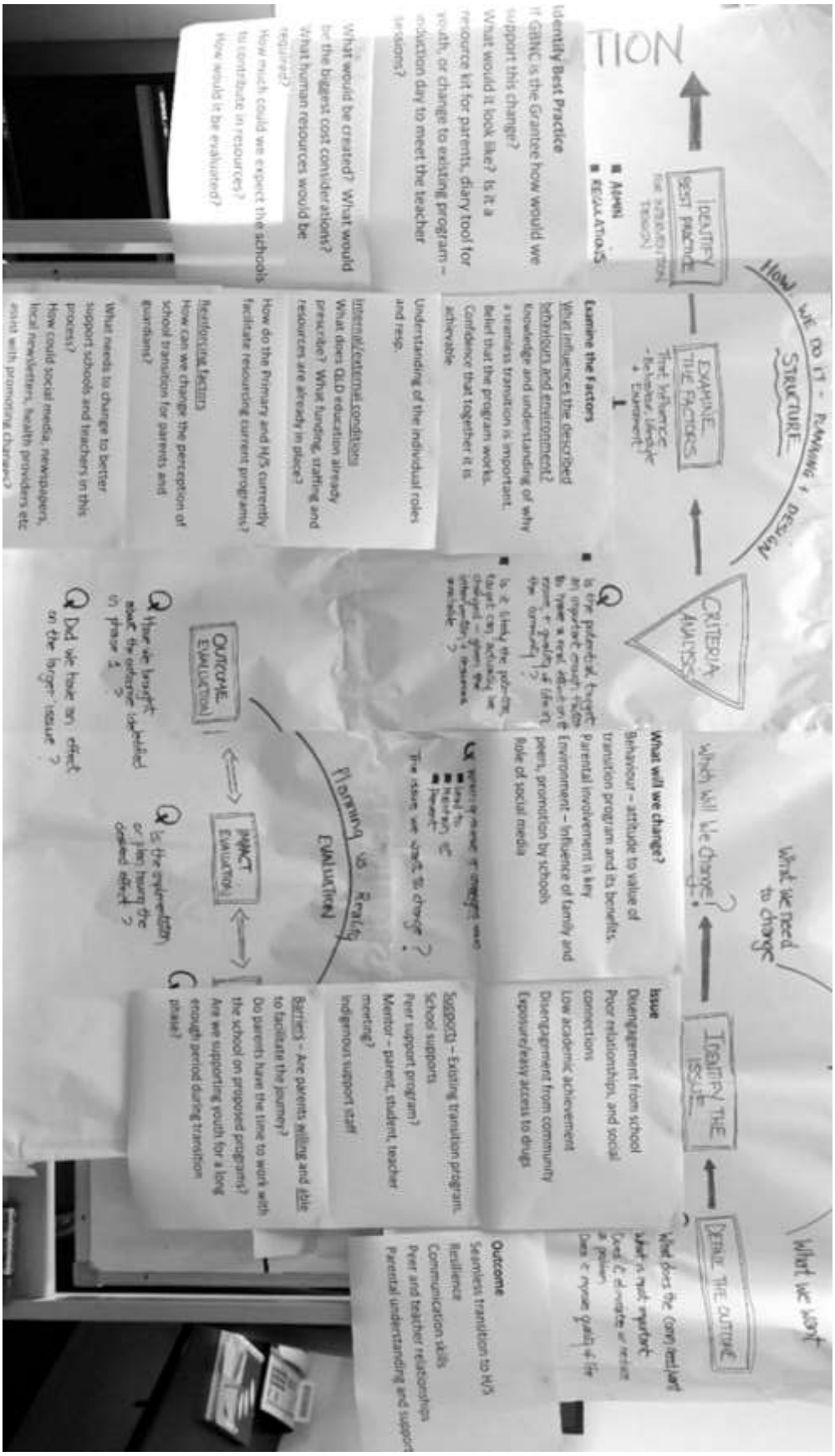
Q4: How old are you?

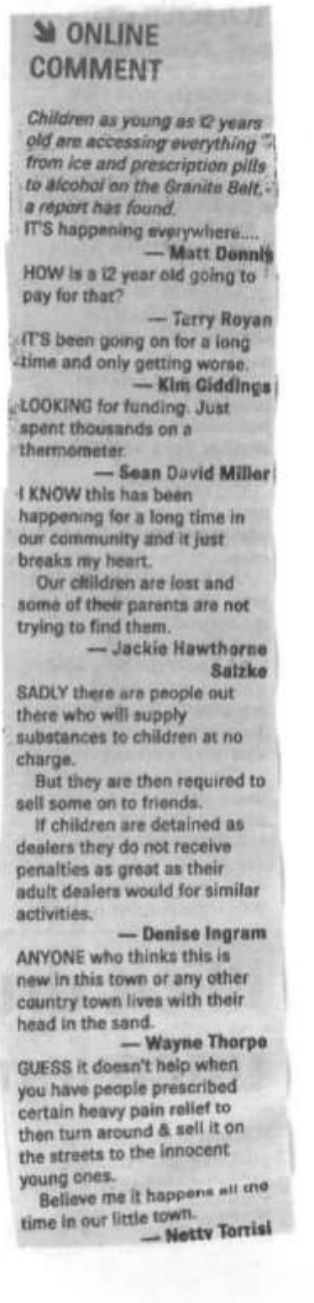
☐ 12 – 17 years ☐ 18 - 24 years ☐ 25 - 34 years ☐ 35 - 49 years

☐ 50-59 years ☐ 60 - 69 years ☐ 70 years or older ☐ Prefer not to respond

Q14: Thinking about the world around you, what do you consider to be the most important things that help a person to stay safe, and well, and to feel healthy and happy? Think about your school and your home and what is available in your community (support services, community activities, sports and recreation etc.

Appendix 8 – Precede-Proceed planning model in use





ONLINE COMMENT

Children as young as 12 years old are accessing everything from ice and prescription pills to alcohol on the Granite Belt, a report has found.
IT'S happening everywhere....
— **Matt Dennis**

HOW is a 12 year old going to pay for that?
— **Terry Royan**

IT'S been going on for a long time and only getting worse.
— **Kim Giddings**

LOOKING for funding. Just spent thousands on a thermometer.
— **Sean David Miller**

I KNOW this has been happening for a long time in our community and it just breaks my heart.

Our children are lost and some of their parents are not trying to find them.
— **Jackie Hawthorne Salzke**

SADLY there are people out there who will supply substances to children at no charge.

But they are then required to sell some on to friends.

If children are detained as dealers they do not receive penalties as great as their adult dealers would for similar activities.
— **Denise Ingram**

ANYONE who thinks this is new in this town or any other country town lives with their head in the sand.
— **Wayne Thorpe**

GUESS it doesn't help when you have people prescribed certain heavy pain relief to then turn around & sell it on the streets to the innocent young ones.

Believe me it happens all the time in our little town.
— **Netty Torrisi**

Border Post Newspaper – Facebook online comments. Printed on August 2nd 2018.

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