30 September 2015

Dr Lesley van Schoubroeck
Mental Health Commissioner
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By email: commissioner@qmhc.qld.gov.au

Dear Commissioner

Re: Response to ‘Reducing Alcohol and Other Drug Impacts in Queensland’

The Queensland Branch of the Faculty of Addiction Psychiatry of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to respond to the Queensland Mental Health Commission’s ‘Reducing Alcohol and Other Drug Impacts in Queensland’ discussion paper.

The RANZCP Faculty of Addiction Psychiatry has been recently upgraded from a Section and the Queensland Branch of the Faculty of Addiction Psychiatry has recently formed. Its members are a core group of psychiatrists with sub-specialty interest and experience in addictions. RANZCP Fellows have clinical leadership roles within private and public sector clinical services across Queensland, and work in conjunction with other medical specialists, general practitioners, and health professionals from other disciplines. As a broad group they have particular expertise in both pharmacology and psychotherapy, and altogether have a great capacity to enhance alcohol and other drugs (AOD) service delivery.

The RANZCP recognises that addictions and harmful use of substances are causes of significant morbidity and mortality, with associated impairment and other psychosocial consequences for both individuals and their families and their wider communities, and that consequently these disorders are associated with public stigma and exclusion, adding to the impairments experienced.

There continues to be a very significant gap between clinical need and provision of evidence-based services in relation to AOD problems. To continue efforts to bridge this gap, the RANZCP believes that ongoing action is required to enhance both prevention and treatment of substance use disorders. Addressing these challenges will require many cultural and attitudinal shifts, workforce developments and service integration driven forward by new policy frameworks aimed at prevention and promotion and improved treatment, management and rehabilitation with a recovery focus.

The RANZCP believes there is an urgent need to challenge the low expectations within health services and the service fragmentation that have frequently influenced the treatment experiences of people with severe substance use disorders, which are serious mental illnesses in their own right. This has been the case in their interactions with specialist services for substance use disorders and with other mental and physical health care services in all settings, which have usually been very separate to specialist AOD services.
The RANZCP recognises that past medical and other health discipline training in relation to substance use and substance related health problems has often been very limited and fragmented and that the separation of services has been a contributing factor. All psychiatrists receive training in and have expertise in assessment and management of substance use disorders and addictions and develop this further in their own specialist practices, however the historical separation of AOD services in Queensland over recent decades has contributed to many psychiatrists not receiving training in dedicated AOD services, since often these services were not under the purview of RANZCP training services. The RANZCP has long encouraged re-integration of AOD and other specialised mental health services.

General practitioners do recognise treatment of alcohol and other drug problems as their clinical responsibility however they often perceive themselves to lack skills and experience in substance use disorders and to lack of specialised support. The RANZCP believes that within clinical settings the ongoing focus should be on secondary prevention at primary care level, with appropriate support from specialist services in assessment and treatment of patients with more severe or disabling substance use disorders (SUDs). Enhancing secondary prevention in primary care will require identification of requisite knowledge and skills of the existing workforce and the provision of increased training opportunities.

Recognising the clear community need, the RANZCP has increased its focus on enhancing the treatment of people with SUDs, providing more specific training in SUDs for all psychiatrists and establishing advanced training in addiction psychiatry. Queensland’s mental health services have taken a lead in developing such training positions. The RANZCP believes that the recent Queensland reintegration of AOD and other mental health services will support improved training for psychiatrists in substance use disorders and addictions to meet the challenges they pose to individuals and to community well-being. This is vital since psychiatrists working outside specialist addiction psychiatry settings nevertheless bring great additional expertise across various populations and clinical settings and practices with potential relevance to future improvements in AOD service delivery, including particularly the perinatal period, childhood and adolescence, forensic psychiatry, consultation liaison psychiatry, old age psychiatry, acute adult psychiatry and psychotherapy.

The recognition of the harmful use of substances and addictions as a core component of all medical and particularly psychiatric practice is an important step towards de-stigmatisation and improving prevention and treatment. Support of psychiatrists, including in all the above sub-specialty areas, to enhance their focus on substance use disorders in their ongoing practice has the potential to significantly enhance and extend service capacity. Further encouragement and support of their clinical and training focus to consider relevant substance use disorders will have benefits in wider populations of health service providers, including psychiatrists, medical generalists and other medical and health practitioners. The RANZCP believes Queensland’s health services are well placed to make the necessary changes in these areas.

Queensland’s AOD sector has limited research capacity, which is recognised as an important component of delivering effective services, and enabling ongoing development of services and ensuring evidence based service provision. The RANZCP believes that collaboration between policy makers, law enforcement, substance users and people with addictions,
clinicians and researchers is vital to preventing harms due to AOD use and behavioural addictions and improving service delivery to substance users and people with addictions.

The RANZCP has prepared specific responses to the questions posed by the discussion paper which are provided overleaf, and would also like to refer the Commission to other RANZCP publications which they may find of use, ‘Position Statement 82 - Recognising and addressing the harmful mental health impacts of methamphetamine use’, and the RANZCP’s submission to the National Ice Taskforce. Both are attached to this submission.

For further information please do not hesitate to contact the RANZCP Queensland Branch on (07) 3852 2977 or via ranzcp.qld@ranzcp.org.

Yours sincerely

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working with the community
There is a significant gap between clinical need and provision of evidence based services in relation to alcohol and other drugs (AOD) problems. The RANZCP believes that enhanced prevention and treatment of substance use disorders will require new service delivery and policy frameworks, challenging existing low expectations and service fragmentation.

As a broad group psychiatrists have a great capacity to enhance AOD service delivery in Queensland. The Queensland Branch of the RANZCP Faculty of Addiction Psychiatry have clinical leadership roles within services across Queensland, working in conjunction with other health professionals from various disciplines.

The RANZCP believes that Queensland should concentrate on developing evidence-based AOD service models which involve collaboration between policy makers, law enforcement, substance users and people with addictions, clinicians and researchers.

There is a need to improve the training of psychiatrists, mental health professionals and other health professionals in the area of substance use disorders and addictions and related health problems, in primary and preventative health care.

AOD services should be better connected and work with shared service models, including non-government organisations, public and private sector health services, and community organisations. All of these AOD services need to be better connected to health and mental health services, which will also help provide opportunities for early intervention and preventative approaches.

Focus is required on particular vulnerable groups in Queensland including: people with other mental illnesses, people of Aboriginal and Torres Strait Islander origin, and people in regional and remote settings.

Health and support services addressing the acute and continuing needs of people with substance use disorders must be resourced at a level commensurate with the level of need in the community. This includes proper resourcing for Queensland Ambulance and Police Services, acute inpatient psychiatric units, emergency departments, acute care teams of mental health services and specialised AOD services.

Emergency departments have increasingly become the first option for disturbed behaviour associated with AOD intoxication. Alternative models to current management of aggressive behaviours occurring while patients are intoxicated should be actively considered.

Psychiatrists in Queensland have identified that the group known as ‘frequent presenters’ to emergency departments have very high proportions of people with substance use disorders. Initiatives such as court diversion programs into AOD treatment and rehabilitation services are strongly supported by the RANZCP, particularly for young offenders and those with substance use disorders who would not otherwise engage in criminal activity.

There are relatively low rates of help-seeking for substance use disorders. To address this in Queensland’s geographically decentralised populations requires innovation such as, local community focussed solutions supported by technology.

The RANZCP endorses support to educational authorities in implementing evidence-based whole-of-school education policies and programs addressing substance use and behavioural addictions.
Overarching Questions

1. **What priorities should the Action Plan address?**

   a) A continuing emphasis on primary and preventive health care is essential, with a focus on indicated and secondary prevention in addition to universal primary prevention initiatives.

   b) Comprehensive networks of AOD specialist services should be established. These should have a coordinating role to assist services to assume a population based perspective and should enable clear linkages between services, including at primary care level and with NGOs, regardless of funding source and models and ensure that a comprehensive array of linked services are available to the identified population base.

   c) Services within these networks should work closely together to respond to need identified at both individual and community levels and to support development and implementation of alternative multi-disciplinary and multi-service models for support of people with substance use disorders, including in community settings and regional and remote areas.

   d) Clear and specific models of care should be developed and implemented by all AOD specialist services to facilitate the above linkages and networking. These should include specific approaches targeting the identified high need populations, including in regional and remote Queensland and particularly remote Aboriginal and Torres Strait Islander communities.

   e) Increased support for generalist health and other service providers in provision of substance use disorders supported by training and by clear pathways to specialist and, where appropriate, sub-specialist services is also vital. Addressing substance use disorders requires a clear understanding of the delineation of various clinical roles and close consultation with these groups as necessary. Specialist public sector drug and alcohol services in Queensland have in general not optimised their links with the primary health sector and although this is changing rapidly, the monitoring of such linkages should be prioritised as an important quality or performance indicator.

   f) A specific focus on selected vulnerable groups. Each of the groups highlighted in the discussion paper are of great importance however the RANZCP would particularly emphasise the following groups of Queenslanders: people with other mental illnesses, people of Aboriginal and Torres Strait Islander origin, people in regional and remote settings. Each of these groups has high levels of co-morbid substance use and associated impairment and disability. We believe also that pregnancy is a time of particular opportunity for intervention and high risk of generational consequence if substance use disorder is not detected and effectively treated.

   g) Queensland’s public sector health services should ensure that changes to clinical documentation in electronic health records such as in the existing databases, iEMR and CIMHA, address substance use comprehensively, and include the needs of specialist drug and alcohol services. The RANZCP supports the existing plans to review the AOD public sector clinical ATODS-IS database which is not meeting existing service needs, including via facilitation of communication with general practitioners and other service providers. This should be linked with improved transparency and accountability through improved and more consistent data collection across the recommended health networks. This will enable better targeting of service delivery.

   h) Health and support services addressing the acute and continuing service needs of people with substance use disorders must be resourced at a level commensurate with the level of need in the community so as to be able to respond effectively to the health effects of acute intoxication and
withdrawal, including aggressive and suicidal behaviours, in particular from alcohol and methamphetamine use. This includes Queensland Ambulance and Police Services, acute inpatient psychiatric units, emergency departments, acute care teams of mental health services and specialised alcohol and other drug services. These and other frontline services require support in the form of training, resources and supervision to enable them to manage alcohol and methamphetamine-related challenging behaviours safely and to avoid adverse effects on staff.

i) Emergency departments appear to have increasingly become the first option for disturbed behaviour associated with intoxication. Health services recognise that at a wider social policy level this is part of an effective strategy to reduce harm by diverting responses from a criminal and judicial approach. This approach may also often be of assistance to police in managing possible health related risks which they are not equipped to assess. In the past and in some other jurisdictions internationally this risk has been effectively and appropriately managed via models of care involving forensic medical officer attendance on people in watch houses, however this seems to have become less available. This approach does come at an opportunity cost to health services and practitioners, particularly in emergency departments and acute mental health services as noted above. Alternative models to current management of aggressive behaviours occurring while patients are intoxicated should be actively considered. The recommended networks could take a lead in considering alternative models of care in defined geographical areas, since it is clear that a “one size fits all” model to address such behaviours will not be geographically viable in Queensland.

j) Psychiatrists report that in some situations there is a reluctance on behalf of health practitioners, health services systems and police to charge people who have committed offences while intoxicated, sometimes apparently due to a view that the person was not aware of their actions or their consequences or that they will not be convicted or penalised. Health services and the Queensland Police Service should ensure that people who commit criminal offences while intoxicated are consistently charged for these offences. The criminal justice system has processes to consider mitigating factors such as intoxication however psychiatrists have a concern that an apparent reluctance to appropriately charge and contain intoxicated offenders does contribute to some of the challenging violent behaviours which create problems for emergency departments and acute mental health units.

k) Specialised AOD services in Queensland currently have limited to no capacity to provide extended hours acute assessment. Acute Care Teams (ACTs) of mental health services provide an extended hours crisis response which includes high proportions of presentations of people with substance use disorders, particularly to emergency departments. Although creating an extended hours capacity to provide assessment and initiate treatment for urgent AOD presentations is important, this is likely to be more accessible and efficient across Queensland if it is provided by less highly specialised existing clinical staff. Emergency department clinicians and ACTs are best placed and most appropriate to perform this task and are already doing so in many cases, though sometimes without clear pathways and with a lack of confidence in their skills and knowledge. This should be a clear expectation of ACTs, emergency departments and their clinicians. This will require consideration and provision of the required resources using a stepped screening, brief intervention and referral to treatment (SBIRT) model and the requisite training. The Drug and Alcohol Brief Intervention Team (DABIT) model (expanded on below) could provide a template for this. Ideally, this would include a dedicated capacity to manage acutely intoxicated people within emergency departments, including supporting them in management of toxicity during short term admissions with protocols for sedation shared between emergency physicians and psychiatrists to maximal extent possible. Psychiatrists in Queensland have also identified, through clinical audit and observation, that the group known as
“Frequent presenters” to emergency departments have very high proportions of people with substance use disorders.

l) In situations where substance use has significantly contributed to offending behaviours, the criminal justice, correctional and health and social service systems should be active in working together, through the above recommended networks, to ensure more seamless linkages to appropriate treatment options for offenders with substance use disorders and addictions. Initiatives such as court diversion programs into alcohol and other drug treatment and rehabilitation services are strongly supported by the RANZCP, particularly for young offenders and those with substance use disorders who would not otherwise engage in criminal activity.

m) The RANZCP strongly endorses the existing proposal to create a Queensland state-wide capacity to initiate and maintain opioid substitution therapy within correctional settings. There is considerable evidence of efficacy of such programs and that along with other substance use treatment within prisons, this program is likely to be cost saving in the longer term. They have been successful over extended periods in NSW and Victoria. It endorses active consideration of how to extend the protective effects of such therapy into the immediate period after release from prison, including preventive treatment of harms associated with overdose through appropriately targeted routine prescription of naloxone, an opioid antagonist which can prevent death from overdose, and behavioural strategies to ensure linkage to community based treatment programs.

n) Behavioural addictions, including problem gambling and gambling addiction and some forms of problematic internet and smartphone use, should be considered as an integral part of the response to addictions and substance use disorders. Health services should ensure that a stepped screening, brief intervention and referral to treatment (SBIRT) approach is implemented in relation to gambling and problematic internet and smartphone use. Such screening should be consistently linked with substance use assessment. Adoption of some very successful overseas interventions such as those in South Korea for smartphone and gaming addiction, should be considered.

o) It is vital that key sectors of the AOD workforce are supported in further professional development. Implementation of the above priority actions will require an enhanced focus on training of clinicians and other staff working with people with alcohol and other drug problems and substance use and addictions. This includes training to prepare health care providers to work in primary and preventive care and also in specialised alcohol and other drug services and other mental health services. Clinicians working in the two latter types of specialist services should be trained to enable ready bridging of existing gaps between these two. This will require further consideration of requirements for ongoing professional development and up-skilling of existing staff, addressing barriers to workforce flexibility. It will also require consideration of how to ensure that clinical training in mental health across disciplines in future addresses substance use assessment and treatment and vice versa. Continuing efforts should be maintained to up-skill the current AOD medical workforce to the level of addiction specialists via appropriate negotiations with the specialist colleges involved. This will require more than just academic courses but also the necessary supervised clinical rotations as outlined by specialist college training in addictions.

p) The RANZCP believes that research into AOD use across Queensland and into specific populations, supported by enhancements in clinical systems identifying patterns of service delivery, is essential to inform policy, planning and workforce development. Victoria has a publicly accessible resource (available at www.aodstats.org.au) that provides free public access to multiple AOD-related variables that can be accessed by health services and local governments. Queensland should be seeking to provide similar data to support research and in turn policy and planning.
2. What actions are currently being taken that would support preventing and reducing the adverse impact of drugs and alcohol and how might they be improved?

A number of steps have been taken to initiate many aspects of the above within Queensland. In 2008 Queensland’s Mental Health Alcohol and Other Drug Branch released the Dual Diagnosis Guidelines (please see attached) which supported a seamless, holistic approach to substance use disorders and other mental health disorders. This was associated with creation of dual diagnosis co-ordinators which have provided training to clinicians and a clinical support function for consumers in both AOD services and other mental health services. It also included among its principles a “No wrong door system of care”.

The Mental Health Commission and the Department of Health, primarily though not solely through the Mental Health Alcohol and Other Drugs Branch, should consider how to best influence HHS Boards, Primary Health Networks and non-governmental AOD service providers, to be actively involved in supporting the networks proposed.

a) A disconnect between AOD and mental health services has been regularly identified across Australia as an impediment to effective referral and holistic treatment. This has prevented coherent service planning and training of a capable multi-disciplinary workforce. The recent integration of Queensland’s public sector AOD and Mental Health Services, now uniform across all 16 HHSs, has been an important step which has the potential to enable significant improvements in clinical service delivery and training over coming years. It has enabled a number of HHSs to adopt innovative approaches to service development and governance, such as Metro South HHS which has created an Addiction and Mental Health Services Program under the leadership of Professor David Crompton, Executive Director, which includes amongst its Academic Clinical Units an Addiction Services Academic Clinical Unit, directed by Linda Hipper. Such examples of a focus on addictions within wider mental health services provide a catalyst for further improvements in AOD service delivery.

b) The creation of the Dual Diagnosis Co-ordinator roles has been effective in focusing attention on co-morbid substance use and other mental illness, however greater consistency of approach in this model of care would be of benefit. This could be considered in future models.

c) The existing focus of the RANZCP and the Clinical Collaborative (see later) on the physical health of people with severe mental illness, including the central importance of active treatment of nicotine addiction, should be extended into all AOD service delivery.

3. What other actions should be taken?

The historical gap between AOD and other specialist mental health services has contributed to significant shortages in the addiction psychiatry workforce. This and other workforce supply and capacity issues must be addressed in order to enhance the capacity of mental health services to treat substance use disorders and to support the AOD sector in better addressing other mental health issues. This is essential given the high frequency of substance dependence and other mental health issue comorbidity. Enhanced training opportunities for undergraduate and postgraduate trainees from medical and other clinical disciplines to work in AOD programs are required, with funding for addiction trainee and specialist consultant positions to support these.

Specific actions in relation to training could be implemented within Queensland, where the integrated mental health services and training organisations could take a lead, include the following:
Responses to Discussion Paper Questions

a) Augment consumer and carer input into AOD service delivery which are strong in some services but patchy state-wide. Mental health services will be able to support greater consistency with National Standards for Mental Health Services and National Safety and Quality Standards for Health Services.

b) Increasing capacity of specialist clinicians, currently working in services focused on mental health or ATODS, to treat and care for people with substance use and other mental health disorders. This is consistent with the Dual Diagnosis Guidelines.

i) All mental health clinicians, including psychiatry trainees and nurses and allied health clinicians transitioning to independent practice, should be expected and given opportunity to gain experience in AOD problems and disorders, similar to other high prevalence disorders, including in identification and treatment of substance use disorder co-morbidity with other mental illnesses. Flexible rotations from other health and mental health services should be supported to enable hands on experience.

ii) Acute care teams and their clinicians should be identified as a particular group requiring training and support to broaden their expertise in AOD since they provide an extended hours crisis response which includes high proportions of presentations of people with substance use disorders.

iii) Trainee psychiatrists in Queensland should have specific AOD placement experiences during basic training (first three years). This could occur on a sessional basis within adult and/or consultation-liaison psychiatry rotations, which usually include high rates of primary and co-morbid substance use disorders.

iv) All AOD clinicians, including psychiatry trainees and nurses and allied health clinicians transitioning to independent practice, should gain experience in other mental health problems and disorders, including in relation to identification and treatment of other mental illnesses co-morbidity with substance use disorders.

v) Consultation-liaison services for AOD and Psychiatry should be combined, with a focus on their commonality rather than differences. This will ensure provision of a more efficient and comprehensive service in a clinical area with significant co-morbidity and enhance training opportunities, including ensuring a specific AOD experience for all psychiatry trainees, supported where necessary by upskilling in addictions of psychiatrists specialising in consultation-liaison psychiatry. Such mergers have occurred in recent years in several large Queensland hospitals including the Gold Coast and Townsville. Where necessary and appropriate, specialised consultation-liaison AOD training rotations should include other mental health disorders to the maximal degree possible.

c) Reduce the barriers that currently exist to general practitioners and other services taking on the treatment of alcohol & other drug problems. Examples of such barriers include existing restrictions on prescribing of opioids within the Queensland Opioid Treatment Program.

i) Permit prescribing of buprenorphine/naloxone (Suboxone) to limited numbers of stable patients on transfer from an existing opioid prescriber without the requirement of completing additional Opioid Prescriber training – e.g. for general practitioners or psychiatrists in homeless mental health teams.
ii) Facilitate training of medical staff, such as RMOs rotating through AOD and other mental health services by allowing them to prescribe opioids on an Opioid Treatment Program under supervision without completion of Opioid Prescriber training.

d) Promotion of shared care models of treatment for patients with substance use problems between specialist and general practice settings.

e) Increase capacity of public and private specialist pain services with access to specialist alcohol & other drug expertise in recognition of the increasing prevalence of therapeutic opioid dependence. This will require increased capacity in chronic pain services as well as increased access to AOD expertise for these pain services.

Demand Reduction

4. What improvements could be made on the current mix of demand reduction activities in Queensland?

The RANZCP endorses an active focus on developing and implementing treatment and family-support strategies involving all members of the proposed networks. These do have the potential to prevent AOD use and to change intergenerational patterns. Increased linkages of AOD with child and adolescent and perinatal mental health services may assist in providing capacity to support such work and in identifying at least some children at high risk and in need of such strategies. Initiatives such as headspace, with its focus on the 12-25 year age group and early intervention in mental health and substance use disorders, should be a core part of the proposed networks and should be encouraged and worked with cooperatively across all of Queensland.

5. What are some innovative ways that prevention and early intervention activities can be promoted and access improved?

Innovative strategies to prevent cigarette smoking and other substance use by Aboriginal and Torres Strait Islander people have been trialled and rolled out in various settings in Queensland and in other states, with active leadership from Aboriginal and Torres Strait Islander communities and specifically their leaders and elders. These should be reviewed and implemented by the communities themselves with the necessary support from other services across Government levels and departments. This will require support in developing clear processes and identifying specific intended outcomes.

The RANZCP recognises that there are relatively low rates of help-seeking for substance use disorders and that addressing these in Queensland’s geographically decentralised populations does require innovation. The recommended networks would have capacity to develop local community focussed solutions, supported by technology, including on-line and smartphone interventions. Services in larger population centres should consider options for extending availability of service beyond standard hours.

6. Are there any examples of good practice in demand reduction?

Education Queensland supports an evidence based approach to education in schools and provides relevant materials for this purpose. The RANZCP endorses further support to educational authorities in implementing evidence-based whole-of-school education policies and programs addressing substance use and behavioural addictions.
The RANZCP believes that health provider contacts provide opportunities for intervention both with individuals and their social support networks to provide brief interventions. There are some good examples of this such as the Drug and Alcohol Brief Intervention Team (DABIT) at Metro North Mental Health Service. DABITs were initiated in three sites as a pilot project but not continued in some of the trial locations. It would be timely to consider the extension of such a program but as recommended above to link it with ACTs in emergency departments in order to ensure sustainability and extended hours coverage.

There are many excellent examples of stand-alone programs targeted at AOD problems however generalisation to larger populations is often difficult at present.

The work undertaken and continuing by the Mental Health Alcohol and Other Drugs Branch to scope AOD service needs, delineate best practice AOD models of service and to inform the development of a Mental Health Alcohol and Other Drugs Plan is of high quality and will create a solid base for further service enhancements.

Despite publicity suggesting the opposite, interventions aimed at binge drinking have been successful with a general decrease in youth binge drinking now being reported across Australia. Such improvements highlight the importance of prevention efforts.

Supply Reduction

7. **Are there improvements that could be made on the current supply reduction activities in Queensland?**

The RANZCP has previously released shared policy with recommendations relating to supply reduction for cigarette smoking, alcohol and pharmaceutical drugs. It anticipates the release shortly of a revised alcohol policy, developed with the Royal Australasian College of Physicians and other specialist medical colleges. It contains a number of specific recommendations relating to supply reduction.

In relation to illicit drug supply reduction, legal and policing approaches are central, however appropriate linkages, including legal and ethical communication between police and correctional services and health and other social services need to be considered, particularly at local levels such as in remote communities and prisons, where the sharing of information may be of direct benefit for clinical care.

8. **Are there any examples of good practice in supply reduction?**

There are many specific examples of good practice in relation to cigarette smoking and alcohol availability referred to in previously mentioned RANZCP policy documents. It is clear that the introduction of supply reduction solutions is an effective strategy in reducing overall legal substance related harms but that any such implementation needs to be thoughtfully considered at the appropriate population level. The evidence is much less clear in regard to illicit substances.
9. Are there improvements that could be made to harm reduction strategies in Queensland?

a) An enhanced focus on child and family sensitive practice in Queensland’s AOD treatment services with better links and integrated approaches with child and youth mental health service and with family and child welfare services.

b) Further development of coordinated measures to prevent, diagnose and manage foetal alcohol spectrum disorders and ensure the provision of appropriate supports to affected children and families.

c) Further enhance preventive approaches to tobacco, alcohol and other drug use during pregnancy, including via community and targeted education. Queensland has taken significant steps in this direction via both population and targeted education campaigns however further indicated prevention steps would still be of benefit.

d) Introduce consistent approaches to efforts to prevent drug overdose including the prescription of naloxone for use in case of opioid overdose. Although there are programs of this kind in Queensland they have not been consistently introduced. As noted previously, their introduction for prisoners, particularly but not only in the pre-release period, should be actively considered.

e) Support increased availability and use across Queensland of opioid substitution therapies, substance withdrawal treatment and other pharmacotherapies.

f) Increase the focus on identification and specific treatment of people with co-morbid substance use disorders in Queensland’s health services including across generic mental health services. The very high prevalence of such co-morbidity in people with other serious mental illnesses requires a continued focus on this area.

g) Distance-based interventions such as real-time online and smartphone and other telephone-based interventions may offer effective solutions for substance users and also for the support networks of substance users, who themselves often require guidance. These need to be considered with a particular focus on regional and remote service users. The creation of the recommended networks would facilitate a focus on this issue with a sharing of concerns and possible solutions.

h) Improved systems for monitoring prescribing of drugs associated with dependence with particular emphasis on opioid analgesics and benzodiazepines. This should include advocating for national integration of systems that would provide real-time information to prescribers as well as targeted education programmes for prescribers and communities.

10. Are there any examples of good practice in harm reduction that you can identify in Queensland and elsewhere?

The Queensland Adult Mental Health Clinical Collaborative, chaired by Dr Brett Emmerson, Executive Director, Metro North Mental Health Service, has been effective at improving practice in the several specific clinical areas which it has targeted. It has engaged all of Queensland’s Mental Health Services to participate in a collaborative approach targeting specific actions with very significant practice improvements in other domains. The Collaborative has recently taken up as its focus concerns about identification and treatment of smoking among people receiving treatment for mental illness within
mental health services. If consistent with previous choices of focus it can be expected that this will lead to significant improvements in the agreed targets.

In Victoria, telephone-based structured interventions have been trialled and found to be effective in engaging and treating those new to treatment who are reluctant or who cannot access face-to-face AOD services.

Vulnerable Population Groups

11. How can people experiencing problematic alcohol and drug use be supported to participate in the economy through education, training and employment and in the community?

The RANZCP believes that such functional outcomes are a vital goal and intended endpoint for all treatment efforts, and that achievement and maintenance of occupation and meaningful activity are central to maintaining recovery from substance use disorders. An important first step towards such goals must be engagement in effective treatment. The proposed networks would have a broad overview of health and social support services, including services dedicated to education and training and employment, and would be well placed to encourage and support linkages between services to facilitate engagement in treatment and in achieving functional goals. This should include strategies found to be effective in other mental health service settings. These include NGOs dedicated to employment of people with mental illness and mental health workforce support workers embedded within teams to provide that support engagement in education/training/work.

The RANZCP supports provision of increased NGO sector support for people using substances to continue to be engaged or to re engage both into treatment and into the wider community.

12. What should be the main priorities to prevent and reduce the adverse impact of drugs and alcohol for groups who are at greater risk of alcohol and drug related harms including:

- people experiencing disadvantage such as unemployment and homelessness
- Aboriginal and Torres Strait Islander peoples
- people living in rural and remote communities
- children and young people
- pregnant and parenting women
- people living with co-occurring problematic drug use and mental health issues
- people from culturally and linguistically diverse backgrounds
- people in contact with the criminal justice and youth justice systems
- lesbian, gay, bisexual and transgender people.

All of these groups have been considered either specifically or in general in the above responses to the overarching questions.

However, for children and young people demand reduction interventions should include a developmental approach at each stage of child and adolescent development, that reinforces positive protective factors such as good housing, education and employment and promoting early intervention for risk factors predictive of later AOD use. This could be facilitated by increasing potential links with child and adolescent mental health services.