Alcohol and Other Drug Action Plan Project

Roundtable summary

May 2015

SIGGINS MILLER

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Acronyms and abbreviations

ABS	Australian Bureau of Statistics
AOD	alcohol and other drugs
LGBTI	lesbian, gay, bisexual, transgender, intersex
MCDS	Ministerial Council on Drug Strategy
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NGO	non-government organisation
NPS	novel psychoactive substance
PIED	performance and image enhancing drug
PWID	people who inject drugs
QMHC	Queensland Mental Health Commission

Alcohol and Other Drugs Action Plan Project

Roundtable Summary, May 2015

Section 1 Introduction

1.1 The Queensland Mental Health Drug and Alcohol Strategic Plan 2014-2019

The Queensland Mental Health Commission (QMHC or Commission) was established to drive reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system.

To guide reform the Commission has developed, in partnership with other government and non-government stakeholders, the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019* (the Strategic Plan) (QMHC 2014) which aims to improve the mental health and wellbeing of Queenslanders.

The Strategic Plan is the culmination of a process of consultation and deliberation led by the Commission. The Strategic Plan provides a shared vision for:

> *A healthy and inclusive community, where people experiencing mental health difficulties or issues related to substance use have a life with purpose and access to quality care and support focused on wellness and recovery, in an understanding, empathic and compassionate society.*
>
> QMHC 2014, p 5

The Strategic Plan includes a Shared Commitment to Action to prevent and reduce the adverse impacts of drugs and alcohol on the health and wellbeing of Queenslanders.

The Commission is working with key stakeholders from across government, from the non-government sector, private providers, service users and their families to develop an Alcohol and Drug Action Plan. The Commission convened a Project Reference Group to guide the development of a draft Alcohol and Other Drug Discussion Paper. Siggins Miller Consultants developed the draft Discussion Paper and facilitated a Roundtable to inform the development of a Position Paper and a draft Action Plan.

The draft Discussion Paper was used to support the deliberations of Queensland alcohol and other drug experts at the Roundtable meeting held in Brisbane on Tuesday 12 May 2015.

This report summarises the draft Discussion Paper, and the deliberations of the Roundtable participants including:

- High level issues raised in response to the draft Discussion Paper
- Issues, priorities and recommendations for actions under each of the four 'pillars of reform' in the Strategic Plan, namely:
  - *Better services for those who need them, when and where they are required*
  - *Better awareness, prevention and early intervention initiatives to maintain wellbeing, prevent onset and minimise the severity and duration of problems*
  - *Better engagement and collaboration to improve responsiveness to individual and community needs*
  - *Better transparency and accountability so the system works as intended and in the most effective and efficient way possible.*

Section 2 Draft Discussion Paper summary

Australia has earned a high international reputation for its progressive, balanced and comprehensive approach to dealing with the problems posed by the harmful use of drugs in the community. In Australia, problematic substance use is considered to be a health and wellbeing problem, a cultural problem, a problem of criminal behaviour, or a combination of these. Drug related harms include:

- interpersonal violence
- physical and mental illness
- loss of productivity
- social isolation.

Effective interventions take into account the interaction between the drug itself and individuals, their families and communities including their social, physical, cultural, legal and economic circumstances.

In Queensland, significant whole of government work has been undertaken to address the impacts of drug problems on communities, families and individuals. This has been achieved through partnership approaches across sectors and agencies, including health, child safety, domestic violence, youth, Aboriginal and Torres Strait Islander; and the crime and justice, un/employment and school education systems; as well as universities, to improve and inform the evidence base and evaluate the effectiveness of services.

2.1 The National Drug Strategy 2010 – 2015

Australia's coordinated national drug policy is founded on the *National Drug Strategy 2010-2015* (NDS) which aims to:

- build safe and healthy communities by minimising alcohol, tobacco and other drug related health, social and economic harms among individuals, families and communities
- improve health, social and economic outcomes for Australians
- prevent the uptake of harmful drug use
- reduce the harmful effects of legal and illegal drugs in Australian society.

The NDS adopts a *comprehensive partnership* approach to *minimising drug related harms* because of the complexity of harmful drug use, its determinants and consequences.

Key elements of the NDS include:

- a focus on harm minimisation through the three pillars or program areas
- enshrining a comprehensive partnership approach
- a joint Commonwealth and state strategy.

The key to the success Australia has had and the uniqueness of the Australian approach that other countries have picked up, has been the harm minimisation approach.

Harm minimisation is achieved under the NDS through three program areas or "pillars" – demand reduction, supply reduction and harm reduction – which are applied together to minimise harm. *Prevention* is an integral theme across the three pillars.

While the rhetoric over the years has changed depending on the policy stance of elected governments (e.g. zero tolerance rhetoric), the harm reduction practice and ideological stance has not. In Australia there is widespread professional, political and community acceptance of:

- harm reduction initiatives, along with supply and demand reduction (e.g. in the alcohol area things like the Safe Night Out Strategy, Needle and Syringe Program and the Opioid Substitution Treatment program; as well as court and police diversion)
- the increasing importance of addressing the social determinants of health and wellbeing.

2.2 Harm, supply and demand reduction

Harm reduction refers to strategies and action which reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

Supply reduction refers to strategies and action which prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.

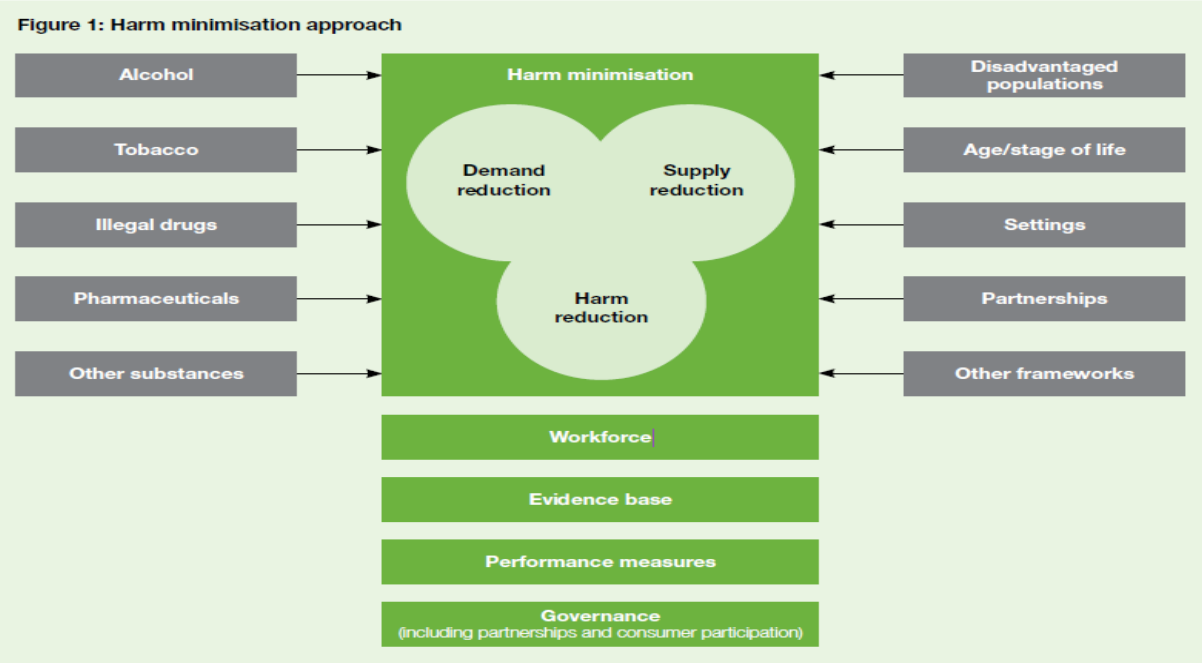
Demand reduction refers to strategies and action which prevent the uptake of harmful drug use and/or delay the onset of use; reduce drug misuse; and support people to recover from dependence and reintegrate with the community.

Promotion, prevention, assessment, early intervention and treatment programs and services can be designed to contribute to both reduction of harm and demand. They may:

- target all or specific drug types (alcohol, tobacco, illegal drugs, pharmaceutical and/or other substances)
- be designed for specific settings and at risk groups
- be tailored for the local service system and levels and types of need.

Australia's drug harm minimisation framework (NDS 2010 – 2015)

Figure 1: Harm minimisation approach



Australia's drug policy has been characterised by strong partnerships across health, justice, law enforcement as well as education and the other human service sectors.

Governments are responsible for leadership, policy development, implementation and evaluation as well as the delivery of justice, police, health and education services to reduce drug related harm in their respective jurisdictions.

In practice, the partnership approach means that interventions that address the complexity of drug problems involve input from multiple organisations to deliver broad based (universal) and targeted promotion and prevention activities (campaigns, information and education about drug use and harms). For screening, assessment, brief intervention and treatment for individuals experiencing problems, multi-organisation input includes access to appropriately skilled and qualified personnel and secondary consultation, referral and support to access specialist services joint plans, joint case management, case coordination, protocols for information sharing and referral.

The comprehensive approach includes alcohol, tobacco, illegal (also known as illicit) drugs, pharmaceuticals and other substances (which may be subject to misuse) that alter brain function resulting in perception, mood, consciousness, cognition and behaviour. It includes actions across the three pillars – demand reduction, supply reduction and harm reduction.

In practice, a comprehensive and tailored approach to addressing a person's drug problems requires multi-organisation/agency work across sectors including police and ambulance services (often the first responders); health services; child, youth and family services; domestic violence services; child care providers; justice services; employment and education services; supported accommodation services; maternal and child health services, disability and aged care services, mental health services and child protection services.

2.3 Drug Policy achievements

Significant achievements have been made nationally and in Queensland in:

- the number and range of relevant evidence-based policy, policies, programs and services available
- the data available to monitor patterns of drug use and harms over time
- strategies to change people's attitudes to problematic drug use and interventions to respond to it. These have grown in their numbers and sophistication.

The whole-of-government Queensland Drug Strategy 2006 – 2010 prioritised actions to address:

- alcohol related violence and injury
- smoking and heavy drinking
- reducing harms for families
- tobacco, alcohol and cannabis use amongst Aboriginal and Torres Strait Islander Australians
- pharmaceutical and illegal drugs.

2.4 Other current Queensland frameworks

A number of national and state policies and strategies acknowledge the role of drugs as risk factors for specific population groups including women, young people and children, Aboriginal and Torres Strait Islander peoples, people living in rural and remote locations.

A number of current Queensland Government policies, strategies and reports refer to the determinants of problematic drug use, e.g. the:

- *Taking Responsibility: a road map for Queensland child protection* (Carmody 2013)
- *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* (Special Taskforce On Domestic and Family Violence 2015)
- *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 - 2033*

- *Supporting student Health and Wellbeing Policy Statement* (Department of Education Training and Employment 2015).

2.5 Queensland Government agency harm, supply and demand reduction strategies:

Department of Justice and Attorney-General (supply and harm reduction — Liquor Licensing and court diversion)

- Department of Communities, Child Safety and Disability Services (harm reduction — families, women, young people children, people with a disability and the elderly)
- Queensland Police Service (coordinated demand, supply and harm reduction services including police diversion)
- Department of Aboriginal and Torres Strait Islander Partnerships (demand, supply and harm reduction Alcohol Management Plans in discrete Aboriginal and Torres Strait Islander communities)
- Department of Health and the drug treatment sector more broadly (demand and harm reduction — drug health promotion, prevention, early intervention and treatment services)
- The Department of Health also sets targets and collects data on public health AOD Treatment provision and administers funding of non-government organisation (NGO) AOD services
- The treatment sector (across Government, NGO and Aboriginal Community Controlled Organisations) has recently developed a framework to guide to development of the sector.

The development of this Statewide Alcohol and Drug Action Plan under the *Queensland Mental Health Drug and Alcohol Strategic Plan 2014-2019* has the potential to position Queensland to influence the development of the next NDS (which is currently underway).

2.6 Policy influences and emerging issues

In the last 30 years of monitoring progress against indicators under the NDS:

- Social attitudes towards drug use have changed into a more mature perspective. However, one caveat to this is that when there isn't alarm around drug policy it slips down the agenda. It's as if the AOD sector needs a crisis to receive the attention it requires. We are caught between being pragmatists and drama queens.
- A 'recovery' approach has evolved in the treatment sector. However, there is also an issue with the dialogue around recovery, harm minimisation, and longstanding abstinence and pharmacotherapy services. A contemporary approach looks at the mixture of pharmacological and medical and psychosocial treatments, and looking to see that we're using the evidence to get the mix right.
- There is room for improvement and there is a need for continued work on data and frameworks for action. The correct information framework is not yet available nationally to provide leverage in the system to drive it forward.
- The Australian population (including professional groups) continues to be misinformed about the relative effectiveness of the various interventions available for dealing with drug problems. The challenge is shifting this attitude to identify where there are clear opportunities, and where those opportunities need to implemented in various parts of the system – not just the drug and alcohol sector.
- Telehealth is one way of addressing access to services, the isolation of rural services and their workforces, accessing continuing professional education and patient education.

- Grants to substance use treatment organisations and youth services have been provided by governments to address issues of equity of access and ensure delivery health promotion, services, and training and education of health professionals in rural and remote areas.
- It is not currently clear how Ice National Taskforce will feed into the NDS. However, it probably makes the NDS all the more important in terms of getting a balance across the different substances and sectors. If anything, we want to make sure that we keep the focus on demand reduction, harm reduction and treatment, and that we think in a clear and coherent way about investment into parts that are currently underinvested and can provide real help for people.

Studies drawing on the results of the 2013 National Drug Strategy Household Survey (NDSHS) note the following national trends:

- a decrease in smoking uptake in the last 10 years
- clear causal links between reduction in smoking uptake in the last 10 years and drug policy
- an increase in the age of younger people having their first drink (i.e. age of first drink is older than before)
- a reduction in the percentage of people drinking alcohol at risky levels
- an increase in the proportion of younger people choosing to abstain from alcohol
- increase in the proportion of younger people choosing to abstain from alcohol and the increase in the age of first drink are changes in behaviour that we need to look at closely in the next few years
- lesbian, gay, bisexual, transgender and intersex (LGBTI) populations have higher rates of illegal drug use (meth/amphetamines, cannabis, cocaine and ecstasy) than heterosexual populations
- LGBTI populations have higher rates of tobacco use, are more likely to smoke daily and have a higher use of alcohol and alcohol consumption at risky levels than heterosexual populations
- no significant changes in daily smoking or use of illegal drugs among Aboriginal and Torres Strait Islander Australians. This is a social equity issue
- halving in the use of meth/amphetamines (powder, pills etc.) and doubling in the use of crystal meth/amphetamine
- no significant change in the number of people using meth/amphetamines, but a change to the more potent form of the drug which is attributed to crystal meth/amphetamine (ICE) being a more popular, available and potent form[1]
- increase in the percentage of people who have recently used a pharmaceutical drug for a non-medical purpose, particularly older adults
- people living in rural and remote regions were more likely to smoke, drink alcohol at risky levels, use cannabis and meth/amphetamines
- women reporting alcohol use during pregnancy declined in the last three years.

In addition, media coverage has increased on “king hits” or “coward punches”, and other forms of public and domestic alcohol related violence increased along with studies and interventions to

[1] the scale of the crystal meth/amphetamine problem is difficult to understand (although it is clear that use has increased

reduce supply and harms (e.g. reviews of licensing, policing, sobering up facilities, women's refuges for women and children) (Miller *et al* 2014).

National data for the general population on emerging drug use trends, particularly the so called new psychoactive substances (NPS) and performance and image enhancing drugs (PIED) are in development.

Highlights from the data on Queensland drug use prevalence and harm

The Queensland population is similar to the national population on key characteristics (age, gender, socio-economic status, proportion of Aboriginal and Torres Strait Islander people). Most importantly, for planning purposes, is that the age distribution in Queensland is similar to that of Australia as a whole, for both Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians (OESR 2015). These similarities mean that data on key national indicators such as drug use and dependence prevalence, and alcohol and drug related burden of disease (illness and death), treatment seeking and service use can be applied to Queensland, albeit with caution because of both the limitations of the data collections themselves and local variation.

Prevalence of alcohol and other drugs use

Queensland's population growth rate has been relatively high but recent the ABS census data online report (April 2015) show that this is no longer the case because of a reduction in interstate migration to Queensland.

In Queensland in 2013:

- Drug use among the general population and specific population groups in Queensland Is similar to that for Australia.
- Alcohol consumption had the highest rate of prevalence followed by tobacco smoking and cannabis use in both Queensland and Australia.
- Prevalence rates for ecstasy, pharmaceuticals, cocaine and meth/amphetamines in Queensland were similar to the national rates.
- Although the prevalence rate for heroin remains relatively low at less than 1%, the risks associated with its use are high. That is, while tobacco causes the most ill health and premature death out of any drug, it is closely followed by opioid related deaths which continue to out-number deaths for any other illegal drugs.
- The prevalence of use and trends in the last 10 years were similar for Queensland and Australia.
- From 2010 to 2013, the proportion of Queenslanders smoking daily, declined from 17.7% to 15.7%, which was not significant; however, this may be slightly higher than the national rate of smoking prevalence at 13.5%. The proportion using illicit drug slightly increased from 15.1% to 15.5% but again this was not significant.

Drug related harms

- Due to the lack of availability of current Queensland specific data on AOD related hospitalisations, deaths have been drawn from national reports which only provide an indication of what is happening in Queensland.
- Nationally, alcohol related hospitalisations have increased over time.
- The Queensland specific data available from law enforcement suggests that the rate of AOD related crime in Queensland per 100,000 population dropped by 11.2% from December 2010 (4,577) to December 2013 (4,064). The highest rate was for AOD related assault.

The fact that the data is limited is important when it comes to alcohol issues. Brewers are now saying that they want to drop the restrictions on advertising because the ABS reported that alcohol consumption is at the lowest level in 50 years – but the harms levels are not, so good Queensland and local level data are needed on this. Although levels of consumption have remained flat, hospitalisations have increased.

The following limitations of the publicly available data may mean that the action plan may need to have some emphasis on obtaining more adequate data at state and regional levels within Queensland. Locally tailored responses should be based on needs data. Data are also needed as a starting point for (and an important part ongoing) for partnerships and a community engagement strategy.

There was no current Queensland data available to this project regarding:

- the number of alcohol and drug caused deaths
- smoking rates for target populations
- alcohol related hospitalisation (admissions/separations and emergency department presentations)
- other drug related hospitalisation (admissions and emergency department presentations).

Data on people with substance use disorders using health services were limited to data collected for the NDMS (i.e. some community based AOD services). Other data which may be of interest to inform indicator measures could include:

- uptake rates of drug treatment services by priority populations
- rate of hospitalisation related to alcohol and illegal drug use
- number of juvenile and adult drug offenders diverted by police or courts to treatment types.

Other data may be of interest for the purposes of monitoring outcomes of a plan which aims to maintain and improve efforts to prevent and reduce the adverse impacts of drugs and alcohol on the health and wellbeing of Queenslanders , for example:

- proportion of ambulance attendances for alcohol or drug overdose
- prevalence of Human Immunodeficiency virus (HIV) and Hepatitis C infection among injecting drug users
- Number of liquor infringement notices issued
- Number and weight of illegal drug seizures
- Number of arrests for trafficking
- Number of people diverted to brief interventions and treatment
- Number and weight of illegal drug seizures.

Highlights from the data on Queensland drug treatment use

The Queensland rate of drug treatment service use (excluding private providers and public hospital treatment) is similar to that of Australia per 100,000 of the population. However:

- Queensland had almost double the rate of clients being referred from police and court diversion.
- The Queensland rate of information and education only treatment was almost four times the national rate, and a large proportion of diversion clients received information and education only.

- The Queensland rate of treatment episodes closed due to 'ceased to participate at expiation' was almost four times the national rate.
- 'Ceased to participate without notice' was the reason for treatment closure was higher in Queensland for counselling treatment episodes compared to Australia.

Whilst Queensland had a higher rate of treatment episodes delivered in 'outreach' and 'other' settings, this could be the result of staff misinterpretation of data definitions. Discussion among key treatment provider stakeholders may shed further light on the differences between Queensland and national rates. The relationship between 'diversion' referrals and the high rate of 'ceased to participate at expiation' treatment episodes, and the nature and efficacy of 'information and education only' could be investigated further, particularly considering the high rate of 'information and education' in Queensland.

2.7 Effective drug harm, supply and demand reduction strategies

The NDS sets out, under the three pillars, many examples of interventions for legal and illegal drugs for which there is evidence for effectiveness. In practice, programs often combine different types of interventions across the three pillars.

It is important to note that there is more evidence for the effectiveness of some interventions than others. Often the absence of evidence in these areas reflects an absence of sound research (including evaluation research) rather than the fact that particular interventions are not effective or cost-effective. This is particularly the case for prevention interventions and some types of harm reduction interventions. Thus, it is important to gather and draw on the collective expertise of practitioners and policy to make good recommendations from the best available evidence.

Effective interventions should be tailored to meet the local area's needs. An appropriately skilled and qualified workforce is required to deliver them as intended. A comprehensive tailored approach to address social, community and individual drug problems requires multi-organisation/agency work across sectors including child, youth and family services; domestic violence services; child care providers; justice services; employment; health and education services; supported accommodation services; maternal and child health services, disability and aged care services, mental health services and child protection services.

System level determinants of effectiveness

At a systems level, the determinants of effectiveness of strategies and interventions are:

- inter-sectoral planning and collaboration during all phases of implementation
- strong commitment to monitoring and evaluation
- openness to continuous review and improvement
- strong community engagement
- accessible high quality treatment services
- strong commitment at all levels form the political, bureaucratic, community through to evidence based practice at the family and individual level (MCDS 2010).

Effective interventions should take into account the interaction between harm reduction, supply reduction and demand reduction strategies. They should be designed based on an understanding of:

- the evidence of effectiveness of treatment interventions
- supply issues

- community, family and individual needs including their social, physical, developmental, cultural, legal and economic circumstances, individual health and wellbeing and the drug type/s
- local services systems.

A local systems approach would mean that effective interventions would be selected to meet community and individual needs across the three pillars. It is important to balance and tailor efforts across the different substances and different demographic groups. For example, understanding where opiate substitution treatment services will be needed in the future – the different age groups, and the networks they are willing to use – and altering our services to deal with the needs of perhaps older people who are opioid dependent.

2.8 The drug service system in Queensland

Services are committed to working in partnership across sectors (health, education, courts, police and corrections) to deliver the best possible outcomes for their clients in common with drug problems, for example:

- AOD treatment services (community, residential, hospital, ambulance)
- safe night precincts
- Alcohol Management Plans
- school drug education
- police and court diversion to treatment
- prisoner testing and treatment programs
- prevention and early intervention services.

Recent work in partnership across treatment service providers has fed into the development of a Queensland Framework - the recently finalised *Queensland Alcohol and Other Drug Treatment Service Delivery Framework* (MacBean *et al* 2015). It sets out the key AOD treatment types delivered across the continuum from prevention and early intervention (harm has not yet occurred) through to intervention (harm has occurred) and maintenance/aftercare (mitigating further harm).

Section 3 High level issues arising from the draft Discussion Paper

Following the presentation of the draft Discussion Paper, Siggins Miller invited the participants in the Roundtable to provide comments and questions for clarification. The following high level issues and actions were noted:

- Research and thirty years of experience with implementing and monitoring the NDS tells us that Australia and Queensland have successfully prevented and reduced harm, supply and demand for drugs. Now it is a matter of:
    - maintaining it
    - having enough resource base workforce and funding to achieve the right dose effect of it at societal and individual levels.
- Acknowledge the strong role Queensland Health plays in supply reduction
- Improve clarity about the places and priorities of treatment within the system by:
    - Identifying actions to decrease the emphasis on entry points via criminal justice system
    - Acknowledging that not all AOD use requires treatment
    - Increasing the emphasis on smoking and mental health, particularly for disadvantaged groups and rural and remote areas
    - Making early intervention a priority
    - Maintaining availability, quality, and presence of the specialist AOD workforce.
- Develop ways to measure the needs of culturally and linguistically diverse groups, such as refugees and asylum seekers and have particular actions to address those needs.
- Include trauma as a determinant of AOD misuse.
- Include social disadvantage as a determinant of AOD use.
- Include an overarching principle is to “do no further harm” and be prepared to address any unintended negative consequences.
- Include workplaces as a key setting for action across all four pillars.
- Ongoing research and evaluation should be built into everything that is done to ensure continuous improvement and provide a basis for disinvesting in things when we find they are not as effective.
- Give domestic violence and child abuse a higher profile and prominence in the draft Action Plan.
- Focus both on individual family, carer and community level perspectives and action.
- Make sure that training and continuing professional development and specialist/generalist drug and alcohol capacity is maintained in primary, secondary and tertiary parts of system
- the principles in Australia’s National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan are still current and can be used to guide the development of the AOD Action Plan in Queensland
- Consider what actions promote transparency and accountability in each of the areas and understanding that there is a need to consult with purpose.

Section 4 Issues, priorities and actions under the pillars of reform

This section summarises the deliberations of the Roundtable participants as issues, priorities and actions to maintain and improve Queensland's efforts to prevent and reduce the adverse impacts of drugs and alcohol on the health and wellbeing of Queenslanders.

Some actions relate to more than one of the four pillars of reform.

Pillar 1 – Better services for those who need them, when and where they are required

Key issues

- sustainability
- accessibility of prevention, early intervention and treatment – entry points
- investment required to achieve evidence based, effective services
  - not doing enough treatment but what's currently done is done well
  - AOD is under-resourced – it is therefore not a matter of shifting investment – there is a need for additional funding to create early intervention capacity in a range of sectors where people with early stage AOD problems present
  - both the AOD and the mental health sectors are underinvested which makes it difficult to simply roll them together
  - managing resources through better justice and health triage to an appropriate level of treatment
- Maintaining a balance between not causing harm with criminal conviction but also satisfying community expectations (e.g. education)
- Court system works well to detect people in the early stages
- Increasing capacity for non-court opportunistic intervention (eg looking for opportunities to identify people who are affected quite young (e.g. via school education, entertainment precincts) and consider where there are teachable moments in people's lives that can offer them a pathway into the service system
- follow-up capacity
- threshold of referral to specialist treatment
- innovation/outcomes
- better use of technology
- models of care tailored to increase the integration of AOD and other services (including police, court, hospital, mental health, chronic disease, child and family, youth) describe:
  - pathways from social services and self-referral or police/court diversion to primary care intervention and support to specialist services
  - engagement in treatment
  - joint client plans
  - case management
  - care coordination and support

- protocols for information sharing and referral
- an appropriately skilled and qualified personnel to deliver the model of care in culturally competent ways
- establishing pathways, being clear about what is being provided to whom at different levels of service (using communication technology more innovatively).

Key priorities

- model of service delivery
- better early intervention
- AOD and mental health integration
- Data systems to support understanding of AOD harm
- addiction specialists
- innovation: apps and technology.

Key actions

This plan will contribute to achieving "better services…" by working to:

1. Develop region-wide client pathways within evidence-based models of care that ensure care is provided as close to home as possible and the team structures (including expanded scopes of practice) and ICT to support them are in place.
2. Develop agreed guidelines for role and service redesign at the local level.
3. Explore the best local use of the police, paramedic, emergency, health worker, allied health, nursing, GP and specialist workforce to support health services and community and home based care.
4. Develop telehealth based connections that allow specialist advice and support from major regional centres to rural service providers, convening of multidisciplinary care team meetings virtually.
5. Develop care facilitator/coordinator/patient navigator roles to promote Aboriginal and Torres Strait Islander family and community empowerment and a holistic approach to health care.
6. Raise awareness of and capacity for self-care in the community, use of mobile phone self-management, tele-monitoring and telehealth technologies.
7. Educate staff and the community about the quality and safety of, and the need for new roles and respectful, culturally competent ways of working with individuals, families and communities with substance use problems.
8. Design and implement workforce development and training programs for generalist and specialist workers whose clients have AOD problems, for example:
    - Include addiction studies as a core part of the range of professional curricula across the health and human services disciplines
    - Provide generalist and specialist staff of health and human services with rotations into AOD services) supervision, mentoring and access to secondary consultation
    - Define the role of multi-agency state-wide services in system capacity building (e.g. requiring cultural capability, stigma reduction and capacity to appropriately support and refer people with AOD problems.

9. Improve data systems across health and human services so that AOD issues and outcomes are included in a systematic way and staff are skilled and supported to code data accordingly.
10. Adopt innovative technology for service delivery – use of eHealth and web programs, and apps.
11. Identify best practice already in place, for example:
    - brief interventions (i.e. as expressed in the current DABIT model) and work to improve screening and brief intervention provision as a low intensity intervention which could be delivered by a range of workers
    - triaging some referrals to group information and education sessions
    - justice reinvestment strategies (Mick Gooda[2])
    - sober up centres provide safe place from emergency departments but no mental health issues
    - recognise 'readiness' of people to engage with services and maintain treatment. Need range of options, to cater for need/readiness
    - range of models – rehab, spiritual etc.
    - local based medical detoxification centres/programs.

Pillar 2 – Better awareness, prevention and early intervention initiatives to maintain wellbeing, prevent onset and minimise the severity and duration of problems

Key issues

- The current approach to prevention and early intervention is not working.
- Awareness of the whole community about use and harms, as well as how effective treatment is.
- Current *ad hoc* approach by drug type (tobacco, alcohol, ICE etc.) creates a reactive and potentially media driven single substance crisis approach to prevention.
- Navigation of pathways are unclear for some people - from prevention into early intervention and, where appropriate, to more intensive support and treatment services.
- Reduce stigma and build strengths approaches.
- Increase engagement of families and communities about AOD issues.
- Increase community information about the Queensland AOD burden of disease and injury.

Key priorities

- life course approach – early prevention (e.g. drinking and smoking during pregnancy, university students just starting to drink)
- mechanisms for learning from and building on what services are doing already, maintaining this and moving forward instead of starting from scratch – long term focus with capacity for regular review and reset

[2] https://www.humanrights.gov.au/news/speeches/justice-reinvestment-new-solution-problem-indigenous-over-representation-criminal

Key actions

This plan will contribute to achieving "better awareness, prevention and early intervention" by working to:

1. Build community level data (like the "my school" website) that is online, mobile phone based, readily accessible website with information and data about how regions and the state is tracking and information about service options.

   Also relates to Pillar 3

2. Identify and build the capacity of the service system to provide more early intervention service modalities (mobile phone applications etc.) before people require specialist treatment for example, work with court system to get more appropriate triage to early intervention/low intensity strategies.

Pillar 3 – Better engagement and collaboration to improve responsiveness to individual and community needs

Key issues

There are two levels of engagement and collaboration 1) with people with substance use problems, their families and communities across a range of ages, cultures and settings, 2) between service providers.

- Current AOD services are not providing for people with AOD related cognitive impairments resulting in intellectual disability.
- Flexibility is important and continuity of relationships between services and clients through the system are important (maintaining the relationships). Complex patients – mobile, some may not be ready to change.
- Some settings/communities have a combative approach (risk management in workplace) rather than strategies to keep in workplace (supportive)
- Workplace health and safety legislation is important and employers need AOD policies and procedures that can translate into human resource management skills and processes as well as workplace culture about substance use, risk and addiction
- Need for connected services – integration
  - common goals re AOD problems
  - common understanding
  - cultural and attitudinal competencies and behaviours should become part of induction training and performance management processes
- Clarity of roles for government services (federal, state and local)
- Leadership from top of the health bureaucracy critical (e.g. permission to participate in collaborative case management and client information sharing across agencies as happens in multidisciplinary services for other conditions)
- Governance structures are very important ways to influence actions.

Key priorities

- Identify existing best practice treatment and support collaborative cross agency case management approaches

- Examine justice reinvestment strategies
- Right people in right place - gender/cultural appropriateness and competency in service design and workforce
- Women in prison with very high rates of abuse (as children and adults) → drug and alcohol use → need for collaborative responses to bring the requisite expertise in
- Leadership from top of bureaucracy is critical to progressing the capacity to address substance use problems
- Governance structure for a collaborative approach with access to a basic AOD data set as well as appropriate consumer and carer advice is very important to influence decisions and actions.

Key Actions

This plan will contribute to achieving "better engagement and collaboration …" by working to:

1. Improve processes for gaining client permission to share data across service providers.
2. Improve collaboration/integration between services and agencies (generalist and specialists across sectors) who have clients in common.
3. Examine ways for AOD to be collaboratively led at all levels of governance.

Pillar 4 - Better transparency and accountability so the system works as intended and in the best way possible

Key issues

- no transparency or accountability with the way the system works
- no support in the minimum data set – need ongoing regular training around definitions
- data system not working well in:
  - emergency rooms
  - demand side of data and service outcomes data eg not just episodes of care but also pathway approach
- no system for monitoring non-fatal overdose in all the ways it can be discovered → need this to monitor harm → early warning system
  - increase staff capacity to collect routine data (e.g. Victoria has a good system for this
  - need to monitor poly drug/"co-drug"
- drug problems in Queensland are different to other states & our data would show this
- Many data sets but poor linkage – need to join the data sets up → better evidence base
- research resources should be steered towards areas of treatment and practice improvement
- system transparency: → it should work as a functioning *integrated* system people should be able to get the right service no matter where they come into the system (i.e. no wrong door and a client needs focused model)
- supply reduction is over-invested when compared with demand reduction and harm reduction.

Key priorities

- Fund local service system planning roles that problem solve local service issues and get services working together
- Engender local level accountability
- Develop mechanisms to get broad 'user' voice input but ensure that safety and anonymity is maintained
- Develop mechanisms and processes to provide accountability to community and service users
    - statement about what they can expect from services
    - description of treatment his is what treatment is
- Work to see more early intervention than criminal justice referral to the intensive end of the treatment system (e.g. AOD use related risk of eviction from public housing).

  Also relates to pillar 2
- Human Rights bill could provide a platform to force government to act in the best interests of people with mental health and substance use issues.
- Each portfolio and department needs to have a commitment and some capacity/resources to respond to the AOD needs of their own clients:
    - Ministers' letters and charters of goals must include a response around AOD
    - Different parts of the system must be able to inform/talk to each other on an ongoing basis, understanding what responses, at a minimum, one part of the system can reasonably expect from responses in another part of the system
    - All sectors need to respond to the wellbeing agenda, including mental health sector
    - System change is best achieved incrementally → get all parts of the system headed in the right direction.
- Establish a way of measuring/monitoring the effectiveness of all parts of the system to inform design and system expectations→ explore unintended consequences and learn from what is happening → to tweak system strategy and intervention design – continuous improvement
    - Review the system of supply, harm and demand reduction and document what worked or did not work → to design future system responses
    - Hold treatment centres accountable – whether funded or not
    - Treatment models that do not work should not be a referral point.
- Close some jails and redirect funds to treatment and community support.

  Also related to pillar 2

Key actions

1. Develop indicators and measures for monitoring harm including ways to better understand the extent and nature of harms from new substances.

   Also relates to pillar 3

2. Integrate data collected across the various systems to report against the indicator set (e.g. corrections, prisons, treatment system etc.) to deliver a baseline for monitoring and reporting to the community about how the situation changes.
3. Review and rebalance investment across the system.
4. Continue to provide and further develop information for communities about what they can expect from the AOD service system in Queensland.

   Relates to pillar 3
5. Continue to provide and further develop information for communities about AOD related harm, supply and demand in Queensland.

   Also relates to pillar 3
6. Clearly define the roles and responsibilities of agencies and local, state and federal government and their commitment to the provision of AOD services.