phn BRISBANE SOUTH
An Australian Government Initiative

QUALITY IMPROVEMENT TOOLKIT FOR GENERAL PRACTICE

Mental health

Alcohol, tobacco and other drugs MODULE

Version 2

March 2022

Introduction

The Quality Improvement (QI) toolkit

This QI toolkit is made up of modules that are **designed to support your practice to make easy, measurable and sustainable improvements to provide best practice care for your patients.** The toolkit will help your practice complete QI activities using the Model For Improvement (MFI).

Throughout the modules, you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the MFI.

The MFI uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- A simple approach that anyone can apply.
- Reduced risk by starting small.
- It can be used to help plan, develop and implement change that is highly effective.

The MFI helps you break down your change into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and that minimal effort is wasted. There is an example of increasing alcohol status recorded on patients using the MFI at the end of this module.

If you would like additional support in relation to QI in your practice please contact Brisbane South PHN on support@bsphn.org.au.

This icon indicates that the information relates to the ten Practice Incentive Program Quality Improvement (PIP QI) measures.

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Brisbane South PHN if you have any feedback regarding the content of this document.

Alcohol, tobacco and other drugs QI toolkit goals and objectives

This toolkit is to be used in general practice to:

- identify those patients in your practice experiencing problematic substance use and/or dependency
- develop a register of patients experiencing problematic substance use and/or dependency to facilitate better continuity of care
- better manage the physical health and comorbidities of patients experiencing problematic substance use and/or dependency
- identify patients eligible for MBS item numbers and other funding streams.

How to use this toolkit

There are checklists included below that will guide you and your practice to:

- identify a sample group of patients by reviewing data measures from your practice population
- set yourselves timelines to achieve your goals
- consider potential internal or external factors that could impact the activity and factor these into your planning e.g. accreditation preparation, staff leave (planned or unplanned), global pandemic, influenza vaccination season
- review your progress regularly
- review your process and start again if you find your process is not working and you are not seeing improvements.

For more support

support@bsphn.org.au

1300 467 265

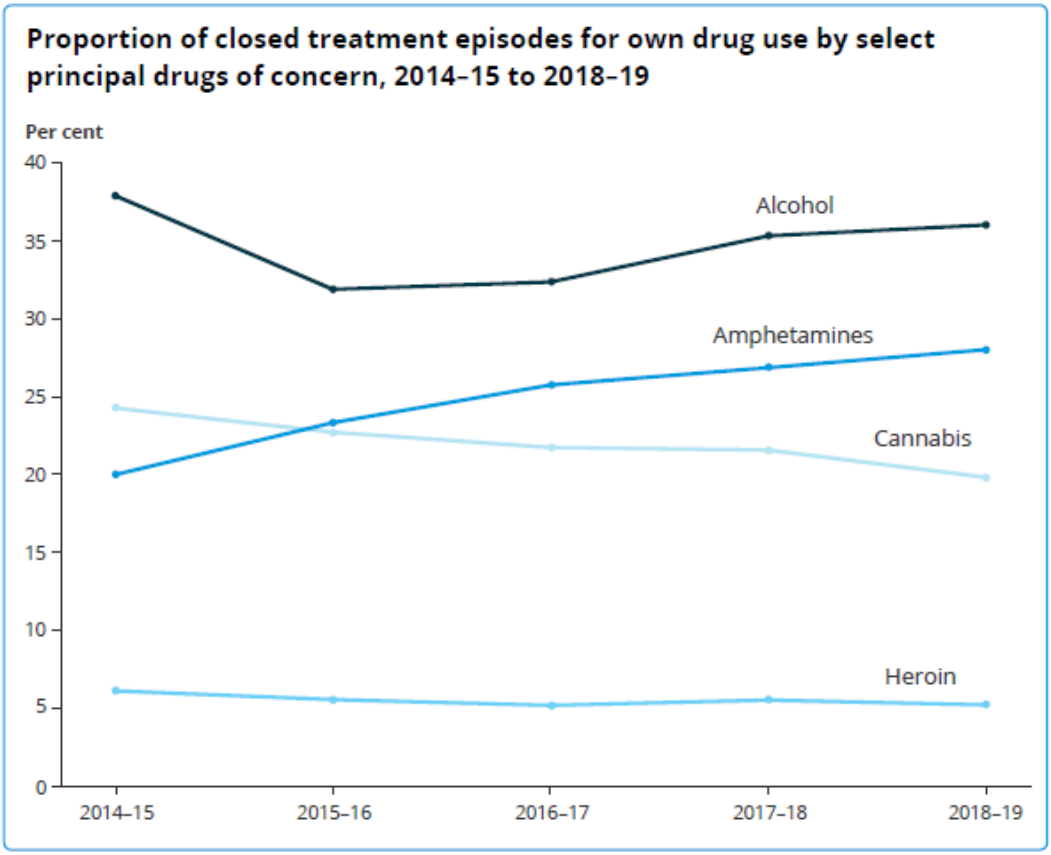
Contents

Alcohol, tobacco and other drugs

The consumption of alcohol, tobacco and other drugs is a major cause of preventable disease and illness in Australia.

Tobacco, alcohol and illicit drug use can place a heavy burden on individuals, families and society. The health, social and economic effects are diverse and substantial, and include disease and injury, mental health conditions, road accidents, family and domestic violence, and other crime.[1]

Research shows that patients expect GPs to assess their alcohol and other drugs (AOD) use, within a GP setting. Patients in general trust their GP, so it's imperative that the development of a positive therapeutic relationship is developed by focussing on the patient's concerns. Asking questions in a non-judgemental manner and avoiding stigmatising language all contribute to the development of trusted and maintained relationships, encouraging patients to come back. Statistics show that AOD use is prevalent in Australia, which means that asking patients about AOD use can no longer be problematic. It's important to incorporate AOD screening into the patient agenda, and not as a stand-alone or 'tacked on' side-assessment. There are plenty of opportunities to do so in everyday practice, such as when a patient presents with common symptoms like hypertension, falls, anxiety, gastro-oesophageal reflux disease, pregnancy, respiratory difficulties, pain, etc. These symptoms all have potential links to AOD use and permit an entry point to screen for AOD as part of a holistic and person-centred approach.[2] Other triggers for AOD screening could include requestions for regular time off work, recent conflict or injury, loss of drivers licence, financial difficulties. Clinically, if there are abnormal pathology results e.g. unexplained elevated MCV and GGT or medication requests for diazepam, opioids or if there is a significant family history of dependence on alcohol/drugs or trauma.



[3]

[1] https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/contents/summary
[2] https://www1.racgp.org.au/newsgp/professional/doctor-patient-relationship-the-most-effective-too
[3] https://www.aihw.gov.au/reports/australias-health/australias-health-2020-in-brief/contents/pdf-table-of-contents

Alcohol, tobacco and other drug use is common

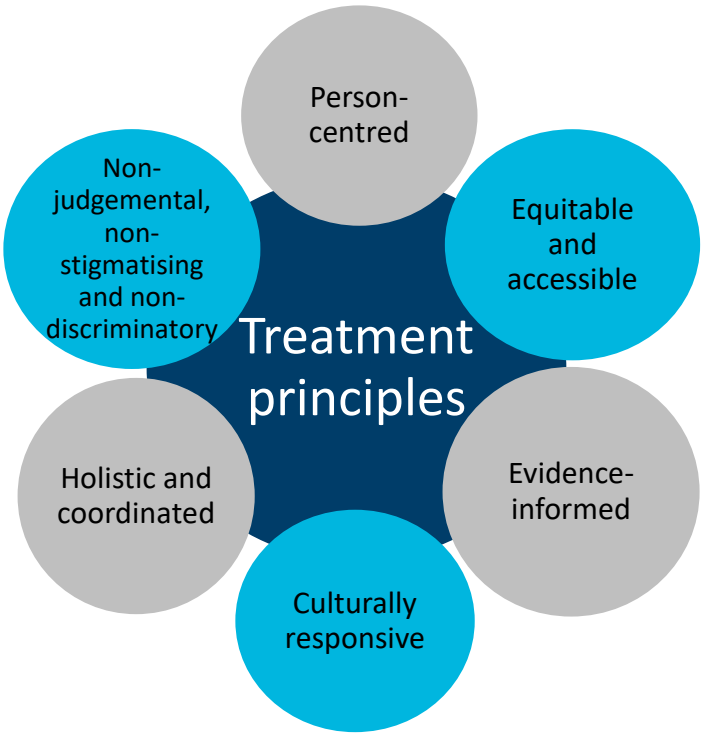
According to the Australian Institute of Welfare (AiHW) national drug strategy household survey 2019 – Queensland, for people aged 14 and over:

- 1 in 7 smoked tobacco daily
- 1 in 4 consumed 5 or more drinks in one sitting (at least monthly)
- 1 in 6 used an illicit drug in the past 12 months.

The report presents key results including:

- Fewer Australians are smoking tobacco
- Roll-your-own and e-cigarettes use is increasing
- More Australians are giving up or reducing their alcohol intake, driven by health concerns
- More than 2 in 5 Australians have used an illicit drug in their lifetime, and recent cannabis use has increased
- Rates of substance use are falling among younger generations
- Cocaine use is at its highest level in almost 2 decades
- Non-medical pharmaceutical use is down, driven by a fall in use of pain-killers
- Fewer Indigenous Australians are smoking or drinking at risky levels
- Smoking rates increase with socioeconomic disadvantage, but illicit drug use is highest is the most advantaged areas
- Smoking and drinking rates are down among gay, lesbian and bisexual people[4]

Six treatment principles



These principles should be implemented in all aspects of treatment, including policies and procedures, practice approaches, models of care, treatment pathways, training and quality improvement activities. The principles are based on human rights, the right to healthcare, and the philosophy of harm minimisation.[5]

[4] https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/contents/summary
[5] https://www.health.gov.au/resources/publications/national-framework-for-alcohol-tobacco-and-other-drug-treatment-2019-29

Not everyone who drinks alcohol or uses other substances will develop problems

Some people use substances without experiencing any significant short or long-term harm. However, there is a proportion of the population who require treatment, care and support to reduce harm from their alcohol, tobacco, prescribed medication, and illicit drug use.

There are some groups in the community that are more at risk than others

Problems with alcohol, tobacco, prescription medication and illicit drugs can affect anybody. People who experience marginalisation and trauma are more at risk of developing problems, especially people who experience socio-economic disadvantage.

Aboriginal and Torres Strait Islander peoples have been impacted by government policy, societal values and exclusion from opportunities that have resulted in disconnection from culture, major disruption to families, unresolved trauma and poverty. People with co-occurring mental health conditions, young people, older people, people in contact with the criminal justice system, culturally and linguistically diverse populations, and people identifying as gay, lesbian, bisexual, transgender or intersex.

Problems with substances are health problems

Problems with substances are health problems that can be treated, and treatment is generally more effective if initiated early. Historically in Australia, much alcohol and other drug treatment was provided outside the healthcare system. Much of the treatment was focussed solely on abstinence, and notions of coordinated holistic or individualised care were absent. Now, alcohol and other drug treatment is seen as part of the healthcare system, the person receiving care drives the goals and outcomes, and there is a continuum between harm reduction and abstinence-based services.

Treatment experiences vary depending on individual circumstance

For some people with alcohol and other drug problems, treatment will be required over the course of their life (consistent with dependence being a chronic condition, like asthma or diabetes). In many cases, ongoing support to achieve long-term change is crucial in helping people achieve a more enduring set of life changes. For other people, support and treatment early on will be sufficient to prevent alcohol and other drug problems into the future, and others may access treatment intermittently as required. Some people will independently receive support through mutual aid services, such as SMART recovery. And for others, the problems associated with substances will subside over time without the need for any formal intervention.

Alcohol or other drug treatment is only part of what a person might need

People who seek or receive alcohol or other drug treatment may have social, psychological or other health care needs that they consider more, or as pressing, as their alcohol or other drug problems. This may include social issues (e.g., housing, family and domestic violence, employment, welfare, child protection, legal problems), and other medical and health needs (e.g., co-occurring mental health conditions, liver disease, chronic obstructive pulmonary disease, blood borne viruses).

Stigma and discrimination are barriers to seeking treatment

There is significant stigma and discrimination against people who experience problems because of their substance use. Stigma and discrimination against people exist in most settings: in the workplace, in healthcare services, in social welfare services, and in the broader community. It creates a serious barrier to seeking and receiving help. [6]

[6] https://www.health.gov.au/sites/default/files/documents/2020/01/national-framework-for-alcohol-tobacco-and-other-drug-treatment-2019-29.pdf

Linkages between trauma and substance use

For some people, problematic substance use can be linked to trauma in childhood such as abuse, neglect and violence. Adverse experiences in formative years can increase the risk of problematic substance use and other behavioural/psychological addictions including overwork, compulsive shopping, eating disorders, sex addiction, gambling, gaming and sport addiction. Some addictions are more socially acceptable than others, but all can be understood in the context of underlying trauma. For some people, substance use or other coping mechanisms may assist them to manage and process extreme early stress and may be protective initially. However, when coping strategies become problematic, they can negatively affect the person and their wellbeing over the course of their life.[7]

Other Brisbane South PHN mental health QI toolkits

Brisbane South PHN has a number of other mental health QI toolkits available. These include:

- Mental health overview
- Anxiety and depression
- Eating disorders
- Improving physical health of people living with a mental illness
- Trauma informed care.

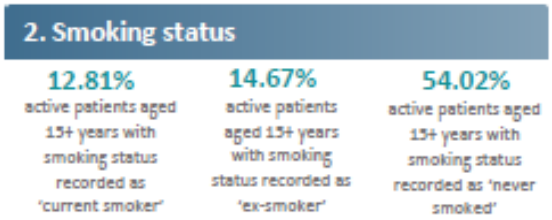
[7] https://professionals.blueknot.org.au/

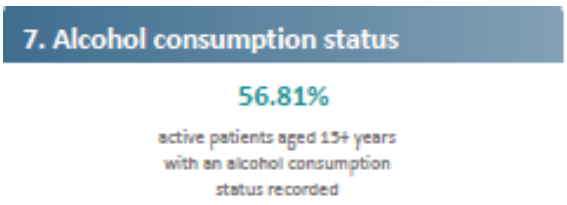
Activity 1 – Introduction to understanding your patient alcohol, tobacco and other drugs profile

Activity 1.1 – Data collection from CAT4

The aim of this activity is to collect data to identify the recording of patients' alcohol, smoking and other drug status from your practice software.

Complete the below table by collecting data from your PIP QI measures from your monthly benchmark report provided to your practice by Brisbane South PHN. You can also collect information from CAT4 – Smoking status **or** Alcohol status **or** Medication **or** Conditions or Active patients.





	Description	Total number of active patients as per RACGP criteria (3 visits in 2 years)	Total number of active patients
1.1a	Number of active patient population		
1.1b	Number of patients aged 15+ years with smoking status recorded as current smoker PIP QI		
1.1c	Number of patients aged 15+ years with an alcohol consumption status recorded PIP QI		
1.1d	Number of patients diagnosed with a drug abuse disorder or dependency		
1.1e	Number of patients prescribed Naloxone (*this search may bring up patients who do not have alcohol, tobacco or other drug dependencies)*		
1.1f	Number of patients prescribed narcotics/opiods (*this search may bring up patients who do not have alcohol, tobacco or other drug dependencies)*		
1.1g	Number of patients prescribed benzodiazepines(*this search may bring up patients who do not have alcohol, tobacco or other drug dependencies)*		

Please note: if a patient has not had the above items marked in their past history, they will not display in the results. More information on coding is available in activity 5.

Advance searches on Best Practice or Medical Director

You may wish to do an advanced search on your practice software looking at past history via the search option. Some of the past history categories include: drug abuse, drug addict, drug addiction, drug dependence, alcohol abuse, alcohol addiction, alcohol dependence, alcohol misuse, alcohol overuse, alcoholic, alcoholism, cannabis abuse/dependency, opioid dependence. Please note that the terms outlined are not in alignment with contemporary language in regards to substance use.[8]

Activity 1.2 – Reviewing your alcohol, tobacco and other drug profile

Complete the checklist below to review your practice's alcohol, tobacco and other drug patient profiles.

Description	Status	Action to be taken
After completing **activity 1.1**, are there any unexpected results with your practice's alcohol, smoking or other drugs profile?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients who currently smoke tobacco than expected.)* How will this information be communicated to the practice team?
After reviewing your benchmark report, under the data quality and accreditation section are there any unexpected results when comparing your data with other practices in the Brisbane South PHN region?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. lower number of patients with alcohol status recorded than other practices.)* How will this information be communicated to the practice team?
Do all clinicians know how to enter alcohol and smoking status in your practice's clinical software?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to instructions on how to enter into Best Practice or MedicalDirector.
 After reviewing your practice's alcohol, smoking or other drugs profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals**. ☐ No: you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

[8] https://adf.org.au/resources/power-words/

Activity 2 - Understanding the risk factors of your patients experiencing problematic substance use and/or dependence

What is problematic substance use and/or dependence?

Problematic or harmful substance use and/or dependence is basically a compulsion to use a substance or substances in order to feel good (or sometimes to stop feeling really bad). Therefore, GPs play an important role in the prevention, early detection and management of harmful substance use, dependence and behavioural addictions. GPs are a trusted and credible source of advice, and international research has shown that people experiencing problematic substance use and/or dependence may prefer to engage with their GPs, rather than attending outpatient drug dependency services. [9]Problematic substance use falls into two main categories: physical and psychological.

Physical dependence

This is when the body becomes dependent on one or more substances. It can also mean an increased tolerance for the substances with a need to consume more of the substance to feel the effects. If a person is experiencing problematic substance use and/or a physical dependence, they may experience symptoms of withdrawal when they try to reduce consumption or abstain.

Psychological addiction

This is when a person psychologically craves a substance or a behaviour comes from an emotional or psychological desire, rather than from a physical dependence. The brain is so powerful that it can produce physical symptoms like those of withdrawal, including cravings, irritability and insomnia. Examples of psychological addictions include gambling, gaming, exercise, internet use, shopping, sex and overeating.

Signs of problematic substance use

A number of generic signs may indicate that a person is addicted to a substance or behaviour:

- increased intake and/or frequency of use of a substance
- previous unsuccessful attempts to quit
- increased symptoms of anxiety and/or depression
- withdrawal from family and friends
- problems with school or work[10]

Problematic substance use and the effects on families

Support from family and other important people can contribute positively to a person seeking treatment. However, supporting a person navigating their problematic substance use and/or dependence can be challenging and confronting.

Ways in which a family can be affected include:

- disruption of usual family routines
- uncertainty
- stress and anxiety
- financial hardship
- difficulties with relationships and social life

Family members can experience stress-related physical and psychological symptoms that can be severe and long lasting. It is important to link families and supporters to services that can assist them. [11]

[9] https://ama.com.au/position-statement/harmful-substance-use-dependence-and-behavioural-addiction-addiction-2017
[10] https://au.reachout.com/articles/what-is-addiction
[11] http://www.sharc.org.au/wp-content/uploads/2018/11/The-Role-of-the-Family-in-AOD-Treatment.pdf

Alcohol consumption

Drinking more than 4 standard drinks a day can seriously affect the health of individuals over their lifetime[12].

Long-term effects include:

- increased symptoms of mental health issues
- family trauma e.g. fights, family breakdown, accidents, legal and court matters
- increased risk of suicide
- problematic use — people may become dependent or addicted to alcohol, especially if they have depression or anxiety
- increased risk of diabetes and weight gain
- cancers such as stomach, bowel, breast, mouth, throat, oesophageal and liver
- impotence and other problems with sexual performance
- fertility issues such as reduced sperm count and reduced testosterone levels in men
- brain damage and brain-related conditions such as stroke and dementia
- heart issues such as high blood pressure, heart damage and heart attacks
- cirrhosis of the liver and liver failure.[13]

Drugs of dependence

Witnessing the growing problem of prescription drug deaths in Australia is confronting for people dedicated to good health outcomes for patients.

The Royal Australian College of General Practitioners (RACGP) is determined to take a proactive role in addressing this problem and has developed four guidelines as a starting place for general practice to be a solution to problematic prescription drug use.

- Prescribing drugs of dependence in general practice - Part A - Clinical Governance Framework

  Prescription drug harm and death touches the lives of people of all ages and all demographics.
- Prescribing drugs of dependence in general practice - Part B: Benzodiazepines

  This guide represents a synthesis of the best available evidence for benzodiazepine use in the primary care setting.
- Prescribing drugs of dependence in general practice - Part C1: Opioids

  Almost three million Australians received at least one Pharmaceutical Benefit Scheme (PBS) listed opioid analgesic.
- Prescribing drugs of dependence in general practice - Part C2: The role of opioids in pain management

  Key to effective pain management is understanding the significant difference between acute and chronic pain with regard to definition, aetiology and complexity.

Mental health assessments

There are a number of assessments available to assist with identifying diagnoses.

Assessment name	Description
Mental state examination (MSE)	The MSE is used to gain an understanding of the patient's psychological functioning at a particular point in time in order to direct care appropriately.

[12] https://www.health.gov.au/health-topics/alcohol/about-alcohol/how-much-alcohol-is-safe-to-drink
[13] https://www.health.gov.au/health-topics/alcohol/about-alcohol/what-are-the-effects-of-alcohol

Assessment name	Description
Mini mental state examination (MMSE)	The MMSE was designed as a screening test for the purpose of evaluating cognitive impairment in older adults
Psychosis screener	The Psychosis Screener is an interview-style questionnaire to assess the presence of characteristic psychotic symptoms.
PsyCheck	The PsyCheck manual includes training on how to administer, score and interpret the results of each section, and the subsequent steps to take according to the screening results.
Kessler (K10)	The Kessler 10 consists of ten questions that are answered using a five-point Scale.
Depression, Anxiety and Stress Scale 21 (DASS 21)	The DASS 21 has been shown to be a valid and reliable screening tool to measure depression, anxiety and stress and can be used to measure such states over time.
Primary Care PTSD Screen (PC-PTSD)	The PC-PTSD is a brief screen which has been validated for post-traumatic stress disorder in people experiencing problematic substance use.
Assist and Assist-Lite	The ASSIST and the ASSIST-Lite are available in electronic format. The eASSIST and the eASSIST-Lite are web based versions that can be used on a personal computer.The ASSIST Checkup and ASSIST Checkup Lite are downloadable apps for completion on any smartphone or tablet.
Aboriginal and Torres Strait Islander Risk Impact Screen (IRIS)	The IRIS is a statistically validated tool effective in the early identification of alcohol use and mental health risks for Aboriginal and Torres Strait Islander peoples.
Alcohol Use Disorders Identification Test (AUDIT)	The AUDIT can be self or clinician administered and scored without specific training.
Severity of Dependence Scale (SDS)	The SDS contains five items, takes less than one minute to complete and one minute to score.
DrugCheck Problem List	The DrugCheck Problem List can be used as a screening instrument, or as part of a motivational interview.
Fagerstrom Test for Nicotine Dependence	The Fagerstrom Test for Nicotine Dependence comprises six items that measure smoking related behaviours.
Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES-D)	The SOCRATES-D (Personal drug use questionnaire) is available in pencil-and-paper self-administered format and can be administered in approximately three minutes. No special training is required for the administration of this instrument.
Recovery Attitudes Questionnaire (RAQ-7)	The RAQ was designed to measure respondents' attitudes about the supposition that people can recover from mental illness.

Activity 2.1 – Review your practices assessment awareness and use

The aim of this activity is to review the availability of assessments in your practice.

Description	Status	Action to be taken
Do you know where to access assessment templates to assist with identifying diagnosis?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Refer to adult mental health assessment template.
Do relevant team members know where to access some of the mental health assessments in your practice software?	☐ Yes: continue with activity**.** ☐ No: **see action to be taken**.	Refer to information from Best Practice and MedicalDirector.
Do any team members require additional training in completing assessments?	☐ Yes: continue with activity**.** ☐ No: **see action to be taken**.	Refer to training from General Practice Mental Health Standards Collaboration.
After reviewing your practice team's access to assessment templates, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see action to be taken to help set your goals.** ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

Real time reporting of monitored medications

Queensland has a prescription drug monitoring program that captures a comprehensive list of medicines that have a recognised therapeutic use but may also present a high risk of physical, mental and social harms. QScript is Queensland's real-time prescription monitoring system.

From commencement of the *Medicines and Poisons Act 2019*, relevant health practitioners will be required to check the patient's QScript record before:

- prescribing a monitored medicine
- dispensing a monitored medicine
- giving a treatment dose of a monitored medicine.

The program aims to provide prescribers, pharmacists and dispensing medical practitioners with a real-time reporting ICT solution to enable safer decision-making when prescribing and dispensing certain high-risk medications ('monitored medicines').

To register for QScript:

- click the QScript registration link sent to the AHRPA registered email address
- refer to the QScript registration portal.

Prescription shopping program

The Australian government has a prescription shopping program (PSP) which identifies patients who may get more PBS subsidised medicines than they need.

Patients meet the PSP criteria if, in any 3-month period, they received:

- any PBS items prescribed by 6 or more different prescribers
- a total of 25 or more PBS target items
- a total of 50 or more items. This includes PBS items both target and non-target, supplied to the patient.

The program uses PBS data, updated in the last 24 hours, to know when patients receive PBS medicine from an approved pharmacy.

Activity 3 – Substance use and other health conditions

Mental illness, smoking, alcohol and other drugs

There is a complex relationship between mental health and substance use; however, the two can be mutually exclusive. A mental illness may increase a person's vulnerability for engaging in substance use.[14] Smoking and alcohol use are significant contributors to the poorer physical health outcomes experienced by people with mental illness.

In Australia, while the prevalence of smoking is declining in the general community, it remains high among people living with a mental illness. Compared with the general population, people living with mental illness have higher smoking rates, higher levels of nicotine dependence, and a disproportionate health and financial burden from smoking.[15]

Alcohol can also have a major impact on mental and physical health. Studies suggest people who exceed the recommended alcohol intake may experience increased levels of psychological distress and/or mental illness. [16]

It is important to identify those with mental illness who use tobacco or consume more than the recommended daily intake of alcohol in order to be able to help with smoking cessation and alcohol reduction. This can lead to both improved mental and physical health.

Alcohol and drug use affect the chemical messaging processes in the brain, so it's difficult to predict how people respond to them. Everyone is different. Every drug is different. [17]

Mental illness and substance use - dual diagnosis

Dual diagnosis is a term used to describe when a person is experiencing both mental illness and substance use. It is also commonly referred to as co-morbidity and co-occurring mental health and substance use.

Examples of a dual diagnosis might include:

- a mental health problem or disorder leading to or associated with problematic substance use
- substance use leading to or associated with a mental diagnosis
- alcohol and/or other drug use worsening or altering the course of a person's mental illness.[18]

Please note, mental health and substance use can be mutually exclusive, and should be discussed with patients in alignment with the provision of patient centred care.

Considerations for dual diagnosis

A range of factors should be considered when screening, treating and managing people with dual diagnosis:

- young people with a dual diagnosis are particularly at risk of experiencing poor outcomes. Their age means that their stage of physical, neurological, psychological and social development makes young people more vulnerable
- dual diagnosis presents specific challenges for Aboriginal and Torres Strait Island people, who may experience lower healthcare outcomes and higher vulnerabilities in relation to substance use
- substance use among older people can have accentuated and profound impacts because of ageing physiology and reduced social interaction
- as well as differences across ages, the type and pattern of drug and alcohol use varies with culture, gender, peer group and social setting.

[14] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions
[15] https://www.tobaccoinaustralia.org.au/chapter-7-cessation/7-12-smoking-and-mental-health
[16] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions
[17] https://www.beyondblue.org.au/the-facts/drugs-alcohol-and-mental-health
[18] https://adf.org.au/insights/understanding-dual-diagnosis/

Activity 3.1 – Data collection from clinical software

The aim of this activity is to review your practice's database to identify patients with a mental illness and problematic substance use and/dependence.

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

Note - instructions on how to extract the data is available from: condition or smoking or alcohol

	Description	Number
3.1a	Number of active patients with a mental illness and alcohol status as drinker *(please note, this may produce a large list of patients. You could choose to search in your clinical software for patients with a mental illness and alcohol use or dependence)*	
3.1b	Number of active patients with a mental illness and drug use	
3.1c	Number of active patients with a mental illness and smoking status as daily smoker	

Please note: if a patient has not had the above items marked in their past history, they will not display in the results. More information on coding is available in activity 5.

Activity 3.2 – Reviewing your patients with a mental illness and alcohol, tobacco or other drug dependence

Complete the checklist below to review your practice's patients with a mental illness and alcohol, tobacco and other drug dependence profiles.

Description	Status	Action to be taken
After completing **activity 3.1**, are there any unexpected results with your practice's mental illness and alcohol, smoking or other drugs profile?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. lower number of patients with a mental illness and tobacco dependence than expected.)* How will this information be communicated to the practice team?
 After reviewing your practice's mental illness and alcohol, smoking or other drugs profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes**, see actions to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

Alcohol and Other Drugs – physical complications

Alcohol, tobacco and other drugs can affect short and long-term health outcomes. Some of these health outcomes can be serious, and possibly irreversible.

Drug use can also result in long-term health outcomes that include:

- damage to the throat, stomach, lungs, liver, pancreas, heart, brain, nervous system
- cancer (such as lung cancer from inhaling drugs)
- infectious disease, from sharing contaminated injecting equipment and increased incidence of risk-taking behaviours
- higher risk of mental illness, depression, suicide and death.[19]

Blood borne viruses and people who inject drugs

- 4% of Australians who currently or recently injected drugs are living with chronic hepatitis B. [20]
- The risk of acquiring HIV for people who inject drugs was 22 times higher than for people who do not inject drugs.[21]
- 1.6% of the Australian population has injected drugs at some time
- The number of people with a history of injecting drug use living with chronic hepatitis B is about 13,600.

Hepatitis C

- Approximately 83% of hepatitis C virus (HCV) infections have resulted from unsafe injecting practices.
- In Australia in 2006 it was estimated that approximately 264,000 people had been exposed to HCV and had HCV antibodies
- At the end of 2019, an estimated 121 560 people had chronic hepatitis C infection in Australia.[22] The estimated number of new cases of HCV infection has declined from 16,000 per annum in 2001 to 10,000 in 2005.
- 65% of people with HCV are aged between 20 and 39 years, and 35% of national notifications of HCV are in women.[23]
- A total of 93,130 individuals have initiated direct acting antiviral (DAA) treatment for chronic hepatitis C virus (HCV) infection in Australia, including 88,790 individuals through Pharmaceutical Benefits Scheme (PBS) during 2016 to 2020.[24]
- It is estimated 49% of the people living with chronic HCV infection in Australia in 2015 have initiated Direct Acting Antiviral (DAA) treatment[25]

Treatment is now more than 95% effective at curing hepatitis C. Most people can get a prescription from their GP or Nurse Practitioner, and people who have a Medicare Card can access treatment at a low cost.[26] Additionally, those eligible for the Closing the Gap PS Co-payment program who would normally pay the full PBS co-payment will pay the concessional rate and those eligible patients who would normally pay the concessional rate receive their PBS medicines without being required to pay a PBS co-payment.[27]

Alcohol worsens HCV outcomes and increases the likelihood of cirrhosis.

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[19] https://www.betterhealth.vic.gov.au/health/HealthyLiving/How-drugs-affect-your-body
[20] https://www.hepatitisb.org.au/prevalence-and-epidemiology-of-hepatitis-b/#:~:text=The%20most%20recent%20evidence%20suggests%20that%204%25%20of%20Australians%20who,living%20with%20CHB%20(39).
[21] https://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf
[22] https://burnet.edu.au/system/asset/file/4532/2020-progress-towards-hepatitis-c-elim-report.pdf
[2323] https://www1.health.gov.au/internet/publications/publishing.nsf/Content/illicit-pubs-needle-frame-toc~illicit-pubs-needle-frame-bac~illicit-pubs-needle-frame-bac-blo
[24] https://kirby.unsw.edu.au/report/monitoring-hepatitis-c-treatment-uptake-australia-issue-11-july-2021
[25] https://kirby.unsw.edu.au/report/monitoring-hepatitis-c-treatment-uptake-australia-issue-11-july-2021
[26] https://www.hepatitisaustralia.com/hepatitis-c-cures
[27] https://www.pbs.gov.au/info/publication/factsheets/closing-the-gap-pbs-co-payment-measure

Assistance for General Practitioners and Nurse Practitioners wishing to prescribe hepatitis C DAA treatment

As hepatitis C DAAs are s85 medications when prescribed in the community, any GP or NP can prescribe if they feel confident to do so. Free training is available for those interested in learning more about hepatitis C prescribing, and resources are available to assist those who do not have experience prescribing. See education and resources listed below.

Resources:

- A 2-page Decision Making in Hepatitis C tool has been developed to assist healthcare providers make decisions for their patients
- General Practitioners and Nurse Practitioners who are wishing to prescribe hepatitis C treatment but do not feel confident to do so can access the REACH-C online form to receive a response from a specialist within 48 hours to indicate whether they should treat, and what treatment options are available for their patient.

Free hepatitis C education for healthcare providers:

- On-demand online learning module for Hepatitis C in Primary Care and Drug and Alcohol Settings. Note that those accessing will be prompted to create a free login.
- Facilitated education is available by ASHM.

Activity 3.3 – Data collection from clinical software

The aim of this activity is to review your practice's database to identify patients with existing liver disease.

You will need to search for patients from CAT4. Instructions are available here *(search for conditions under other)*.

	Description	Number
3.3a	Number of active patients experiencing alcohol or drug dependence and hepatitis B	
3.3b	Number of active patients experiencing alcohol or drug dependence/abuse and hepatitis C	
3.3c	Number of active patients experiencing alcohol or drug dependence/abuse and HIV	
3.3d	Number of active patients experiencing alcohol or drug dependence/abuse and liver disease	
3.3e	Number of active patients with lung cancer and a smoker	
3.3f	Number of active patients with lung cancer who are an ex-smoker	

Please note: if a patient has not had the above items marked in their past history, they will not display in the results. More information on coding is available in activity 5.

Activity 3.4 – Reviewing your patients experiencing problematic substance use and/or dependency and liver disease and lung cancer

Complete the checklist below.

Description	Status	Action to be taken
After completing **activity 3.3**, are there any unexpected results with your practice's patients experiencing problematic substance use and/or dependence, liver or lung disease?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients with hepatitis B than expected.)* How will this information be communicated to the practice team?
After reviewing your practice's patients from **activity 3.3**, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes**, see actions to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

Activity 4 –Monitoring patients at risk of problematic substance use and/or dependence

Increased Risk

There is a higher risk associated with people who have consumed alcohol and other drugs for example, according to the 2016 NDSHS:

- almost 1 in 6 (17.4%) people identified as "recent drinkers" aged 14 and over put themselves or others at risk of harm while under the influence of alcohol in the previous 12 months
- risky alcohol use (lifetime and single occasion) increases the likelihood of engaging in harmful activities than low-risk drinkers.

Family, domestic and sexual violence

Data shows that incidents of family, domestic or sexual violence often occurs in contexts where substance use was present. For example, the 2016 Personal Safety Survey showed that of women who have experienced physical or sexual violence in the past 10 years, around half reported that substance use may have been a factor related to their experience.

Data from the 2016 NDSHS showed that 22% of Australians had reported experiencing verbal or physical violence, or felt threatened by someone under the influence of alcohol. Females were more likely than males to report experiencing violence from a current or former spouse or partner while males were more likely to report experiencing violence from a stranger.[28]

Alcohol, tobacco, other drugs and suicide risk factors

Suicide is a leading cause of death among people who use drugs and alcohol. The annual prevalence of attempted suicide among people experiencing problematic alcohol, tobacco or other drug use and/or dependence is equivalent to the lifetime prevalence in the general population. Clearly, suicide presents crucial clinical challenges for people experiencing problematic alcohol, tobacco or other drug use and/or dependence.

Research has identified a number of risk factors for suicide and established that individuals experiencing problematic alcohol, tobacco or other drug use and/or dependence have a very high prevalence of these risk factors. As suicide risk is a dynamic phenomenon it needs to be assessed continuously throughout treatment.[29]

It is important to be aware of risk factors for suicide and evaluate the risk of suicide through the following steps:

- enquiring into the extent of suicidal thinking and intent. This includes assessing the following; suicidal thinking (if present, how frequent and how persistent?), plan (if present how detailed and realistic is it?), lethality (what method has been chosen and how lethal is it?), means (does the person have the means to carry out the method?), past history (has the person ever planned or attempted suicide?), history of suicide of family member or peer
- also consider; risk and protective factors, mental state (e.g. hopelessness, despair, psychosis, agitation, shame, anger, guilt, impulsivity), substance use, strengths and supports
- for all people with suicidal ideation, enquiry should be made about preparatory activities e.g. making a plan, obtaining the resources required to carry out the plan, putting affairs in order, giving away possessions, preparing a note, etc.
- in young people the HEADS tool has questions that can assist in assessing suicide risk.

The Victorian overdose deaths 2011-2020 report provides some interesting information regarding combinations of drugs (monitored and unmonitored) and illegal/legal drugs.

[28] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impacts/social-impacts
[29] https://ndarc.med.unsw.edu.au/resource/suicide-risk-assessment-and-intervention-strategies-current-practices-australian

Responding to suicide risk

It is important that clinicians are equipped to discuss and develop a suicide safety plan. Safety planning has been shown to reduce suicide risk and increase engagement with health services when used in combination with evidence-based therapy. It is important to involve the patient in treatment planning and to have a recovery-oriented focus. For people at a high and immediate risk of suicide it is important that GPs and practice staff are aware of where to access immediate assistance if required. This may involve the local hospital or acute mental health service. Occasionally for those at immediate danger to themselves or others this may require calling 000 and using the Mental Health Act.

More information about training options can be found on the Think GP website.

Activity 4.1 – Reviewing patients experiencing problematic alcohol, tobacco or other drug use and/or dependence

Complete the checklist below to review the management of patients at your practice with alcohol, tobacco or other drug dependence.

Description	Status	Action to be taken
Do you know where to find assistance and services available for people experiencing problematic alcohol, tobacco or other drug use and/or dependence in the Brisbane south region?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to Alcohol and Drug Support or MSH AOD or SpotOnHealth HealthPathways.
Do you have a system for ensuring regular monitoring and reminders are in place for people experiencing problematic alcohol, tobacco or other drug use and/or dependence?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to recall and reminders section.
Do you have a system for ensuring regular blood tests and monitoring is occurring for people with alcohol and drug abuse or dependency and physical co-morbidities (e.g. liver disease)?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to recall and reminders section.
Do relevant team members understand their role in completing assessments for patients experiencing problematic alcohol, tobacco or other drug use and/or dependence?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to activity 4.2 – Identify roles for supporting people experiencing problematic alcohol, tobacco or other drug use and/or dependence.
Do relevant team members know how to set-up a Topbar prompt to improve recording of data in patient's medical records?	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	See Topbar instructions.

Description	Status	Action to be taken
 After reviewing your practice's system for managing patients experiencing problematic alcohol, tobacco or other drug use and/or dependence, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes**, see actions to be taken to help set your goals.** ☐ No: you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

Activity 4.2 - Identify roles for physical health screening and monitoring for people experiencing problematic substance use and/or dependence

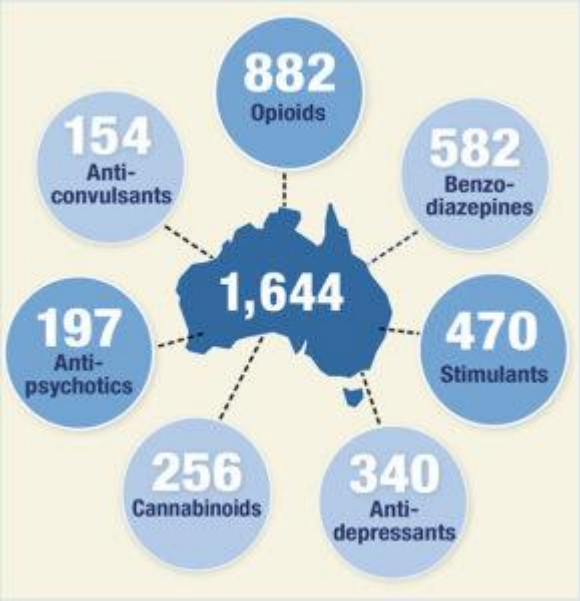
Consider how best to use your practice staff to provide optimum care.

Activity	Nurse	GP	Admin
Organise investigations (as appropriate)			
Monitor blood pressure			
Height, weight & BMI			
Complete cardiovascular risk assessment (if appropriate)			
Complete ECG (particularly for those on antipsychotics, mood stabilisers and certain antidepressants) (if appropriate)			
Update patient reminders for regular monitoring			
Review diet/healthy eating			
Review physical activity and exercise tolerance			
Review smoking and offer cessation support and discuss harm reduction strategies			
Review alcohol use and discuss harm reduction strategies			
Review substance use (include licit and illicit substances) and discuss harm reduction strategies			
Assess support from family, carers or other support people			
Offer treatment referral pathways and support services			
Provide self-care education			
Mental health assessment			
Consider comorbidities (liver disease, hepatitis C, HIV, mental health conditions, lung cancer)			
Review medications and drug use interactions			
Complete mental health treatment plan and review			
Home Medication Review (if appropriate)			

Activity	Nurse	GP	Admin
Assess need for referral to other mental health providers			
Consider advanced care planning			
Complete risk assessments			
Consider GP Management Plan and Team Care Arrangement (if eligible)			

Opioid deaths in Australia

The Annual Overdose Report 2021 found:



- 1,644 Australians died of unintentional overdose in 2019.
- The majority of opioid-induced fatalities resulted from unintentional overdoses in middle-aged males and involved the use of pharmaceutical opioids, often in the presence of other substances.
- Aboriginal & Torres Strait Islander people were almost four times likely to die from an unintentional drug-induced death.

Opioid related harm, including mortality, is a serious public health issue both in Australia and internationally.

- Of the 1,740 registered drug-induced deaths in 2018, opioids were present in close to two thirds (1,123 deaths, 64.5%).
- Pharmaceutical opioids are present in over 70% of opioid-induced deaths. The rate of opioid-induced deaths with synthetic opioids present has increased significantly over the last decade.
- There were 438 heroin-induced deaths in 2018. This is the highest number of heroin-induced deaths since the year 2000, with the increase being significant over the last 5 years.[30]

Opioid overdose treatment on the PBS

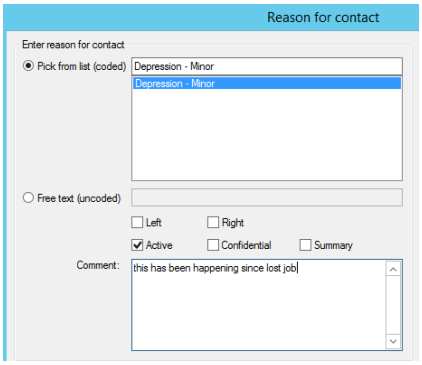
A new nasal spray form of naloxone – a life-saving antidote medicine used to treat a narcotic overdose in an emergency situation – was added to the Pharmaceutical Benefits Scheme (PBS) on 1 November 2019.

Previously, Naloxone was required to be injected to reverse the side effects of an overdose. The PBS listing of the nasal spray Nyxoid® will provide easier administration of this overdose antidote for people suffering an overdose and first responders, which could help save more Australian lives.

- Every day in Australia three people die from drug-induced deaths involving opioid use, and nearly 150 hospitalisations and 14 emergency department admissions involve opioid harm.
- More than 110,000 Australians are currently experiencing opioid dependence with increasing deaths from overdose: 1119 deaths in 2016.
- Prescription opioids are now responsible for more deaths and hospitalisations in Australia than illicit opioids such as heroin.

[30] https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2018~Main%20Features~Opioid-induced%20deaths%20in%20Australia~10000

Activity 5 – Building your practice register



Coding is simply a process of using an agreed standardised descriptor to store data as a series of numbers or letters. There are multiple ways clinical staff may enter a patient's diagnosis in practice software. Some will type this information directly into the patient progress notes or enter this information as free text in the 'reason for encounter' or 'diagnosis field'. This process is called free texting or un-coded diagnosis. Free text is not easily searchable in any database by the clinical software or third-party software (e.g. extraction tools).

If GPs require further information to describe the clinical condition, then include this in a descriptor field. If a particular coded diagnosis is not available, contact your software provider (see example image).

The recommended process is to use a diagnosis from the drop-down boxes provided in the clinical software. This is a coded diagnosis. If all clinical staff within the practice use the same codes to identify a diagnosis then it is easier to search for particular conditions.

It is important to ensure your coding is consistent and agreed upon by all clinical staff in the practice, and diagnostic criteria for alcohol, tobacco and other drugs are uniform.

Advantages and disadvantages of labelling patients with conditions

If someone is experiencing problematic substance use and/or dependence it is important it is recorded correctly so that the treating team are aware for safety and to allow correct treatment. Any diagnosis should be discussed with the person. Just as we would record a physical health diagnosis, problematic substance use and/or dependence should be recorded if it has been identified. If preferred, it may be marked as confidential, or inactive if no longer of concern, and the patient may choose not to upload it to My Health Record if desired.

Activity 5.1 – Determine terms of consistent coding

The aim of this activity is for the clinical team to agree on consistent coding to be used within the practice.

Description	Status	Action to be taken
Are relevant practice team members aware of the importance of quality data including using consistent coding (avoiding free text)?	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Organise a practice team meeting to discuss how to develop a clinical coding policy for your practice. This may be a specific area that the practice is working on, to make the task easier.
Have you agreed on accepted terminology for alcohol, tobacco or other drugs from the drop-down lists in your practice software? (*Remember, the language that you use could impact treatment seeking and treatment engagement).*[31]	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Source list of clinical codes already available in current clinical software. Develop and agree on clinical codes for AOD to be used within practice.
Are practice team members aware of how to enter diagnoses in clinical software using agreed mental health conditions?	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Refer to instructions for Best Practice or MedicalDirector.

[31] https://adf.org.au/resources/power-words/

Description	Status	Action to be taken
After reviewing your practice's clinical coding guidelines, are there any changes you would like to implement in the practice, to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals.** ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

Activity 5.2 – Marking condition as active/inactive

It is important when completing each patient's progress notes, to mark the consult with an appropriate condition. PLEASE NOTE: if condition/diagnosis is marked as 'active' the patient will be included in any appropriate reports produced on CAT4. If the condition is marked 'inactive', they may not be included in CAT4 reports.

The aim of this activity is to ensure all the clinical team within the practice understand the importance of marking conditions as active or inactive.

Description	Status	Action to be taken
Are relevant practice team members aware of the importance of marking conditions or reason for visits as active or inactive?	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Include in the next clinical team meeting/s the importance of marking patient's history and/or reason for visit as active or inactive.
Are relevant practice team members aware that they can mark sensitive information as confidential?	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Include in the next clinical team meeting/s some information on marking patient's history and/or reason for visit as confidential. This is generally only done for very sensitive information.
Are practice team members aware of how to enter active/inactive in your practice's clinical software?	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Refer to instructions from Best Practice or MedicalDirector.
Are practice team members aware of what conditions, if marked inactive, are not included in CAT4 searches?	☐ Yes: continue with activity. ☐ No, **see action to be taken.**	Refer to information from CAT4.
After reviewing your practice's active/inactive conditions processes are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes**, see actions to be taken to help set your goals.** ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

Practice decision point

It is recommended that you have a practice meeting to review the data collection table results and determine any action that needs to be taken.

Activity 6 – Medicare item numbers, alcohol, tobacco and other drugs

The aim of this activity is to outline some of the Medicare item numbers that you may use in general practice for eligible patients.

Patients experiencing problematic alcohol, tobacco, other drug use and/or dependence or liver disease ***may be eligible*** to access item numbers within the Medicare Benefit Schedule (MBS). These are dependent on patient age, ethnicity and co-morbidities. Conditions apply to each item number; please ensure the GP understands these prior to claiming the item number/s. Brisbane South PHN has a comprehensive toolkit looking at MBS items, however, a summary of the items are below:

MBS items

- Mental health consultations (item 2713)
- Mental health treatment plan & review
- GPMP & TCA
- Aboriginal and Torres Strait Islander health assessment
- Health assessment
- MBS telehealth fact sheet

TIP: GPs are required to make sure each patient meets the MBS criteria prior to claiming each item number.

Can you claim a mental health plan and a chronic disease plan on the same patient?

The CDM Medicare items continue to be available for patients with chronic medical conditions, including patients needing multidisciplinary care.

Patients with a mental illness only, who require a treatment plan to be prepared, should be managed under the GP mental health treatment items (MBS items 2700, 2701, 2712, 2713, 2715 and 2717).

Where a patient has a mental illness as well as significant co-morbidities and complex needs requiring team-based care, the GP is able use both the CDM items (for team-based care) and the GP mental health treatment items. [32]

Please note: GPs should always ensure they fully understand the criteria from Medicare before claiming the item number.

[32] https://www1.health.gov.au/internet/main/publishing.nsf/Content/pacd-gp-mental-health-care-pdf-qa#7_1

Activity 6.1 – Data Collection from CAT4

The aim of this activity is to review your practices claiming of MBS item numbers for patients with AOD use or liver disease.

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

Note - Instructions on how to extract the data is available from: MBS attendance items or Management plan or condition.

	Description	Number of eligible patients	Number of MBS items claimed
6.1a	Number of patients with an alcohol consumption status recorded as drinker and a mental health treatment plan completed in the past 12 months		
6.1b	Number of patients with drug abuse recorded and a mental health treatment plan completed in the past 12 months		
6.1c	Number of patients with liver disease and AOD who have had a GP management plan claimed in the past 12 months		
6.1d	Number of patients with hepatitis C who have had a GP management plan claimed in the past 12 months		
6.1e	Number of patients with HIV who have had a GP management plan claimed in the past 12 months		
6.1f	Number of patients who are daily smokers and have a health assessment claimed in the past 12 months *(please note: patient must meet the criteria for the health assessment)*		
6.1g	Number of patients with drug or alcohol abuse recorded and an Aboriginal and Torres Strait Islander health assessment claimed in the past 12 months *(please note: patient must meet the criteria for the health assessment)*		
6.1h	Number of patients with daily smoker recorded and an Aboriginal and Torres Strait Islander health assessment claimed in the past 12 months *(please note: patient must meet the criteria for the health assessment)*		

Activity 6.2 – Checklist for reflection on MBS claiming

Complete the checklist below to review your practice's MBS claiming for patients with a dependence or liver disease

Description	Status	Action to be taken
After completing **activity 6.1** are there any unexpected results with your practice's MBS claiming?	☐ Yes, **see action to be taken.** ☐ No, continue with activity.	Please explain:

Description	Status	Action to be taken
		What action will you take?
Are there any patients with dependence who would benefit from a GPMP? *(note: not all patients are eligible for a GP management plan).*	☐ Yes, **see action to be taken.** ☐ No, continue with activity.	Please explain: What action will you take? How will you use this information to increase the number of management plans completed?
Have you created a Topbar prompt on all patients who may be eligible for a GPMP?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Follow the instructions to complete this.
Do you know the contact details for any MBS related questions?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Email: askMBS@health.gov.au Provider enquiry line - 13 21 50.
Do relevant staff know that Medicare provides online training modules?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	More information can be obtained from Medicare Australia e-learning modules.
 After reviewing the MBS claiming for patients experiencing problematic substance use and/or dependence, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes**, see actions to be taken to help set your goals.** ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

Activity 7 – Recall and reminders

As part of the RACGP accreditation standards, it is a requirement that practices provide health promotion, illness prevention, preventive care and a reminder system based on patient need and best available evidence. Brisbane South PHN have a comprehensive toolkit to assist you to review your practice recall and reminder systems, however, the aim of this activity is to assist with dependency specific recall and reminders. You can also access other QI tools via medical software modules that will assist your practice to merge duplicate recall/reminder lists in your practice's clinical software. Access these modules via DiscoverPHN.

- Module 7 – Recalls, Reminders and Screening using MedicalDirector
- Module 8 – Recalls, Reminders and Screening using Best Practice.

Activity 7.1 – Reminder system

The aim of this activity is to review the practice's reminder system.

Question to consider	Status	Action to be taken
Does your practice have a routine reminder for appropriate follow up of physical health checks for people with mental illness (e.g. cancer screening, diabetes review, blood tests, depot injection etc)?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Refer to instructions from Best Practice or MedicalDirector.
Do clinicians know how to initiate a patient reminder within clinical software?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	Clinician education on setting up patient reminders.
Is there a system for ensuring patients recently diagnosed with an alcohol or drug dependence/abuse are incorporated into the reminder system?	☐ Yes, policy is working. ☐ Yes, policy is not working, see action to be taken. ☐ No policy, **see action to be taken.**	Revise policy. Practice policy on reminders to be implemented.
Does the recall and reminder system take into consideration patients with low English proficiency?	☐ Yes, policy is working. ☐ Yes, policy is not working, **see action to be taken**. ☐ No policy, **see action to be taken.**	Revise or implement practice policy. Letters and voice phone messages can be confusing for patients with limited or no English. Using the Translating and Interpreting Service to call the patient or sending text messages can be more effective. Consider using the online Appointment Reminder Translation Tool.
After reviewing your practice recall and reminder system, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes**, see actions to be taken to help set your goals.** ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

Activity 8. Referral pathways

The aim of this activity is to ensure that practice staff have access to the relevant information and understand pathways for referral of patients to specialists and allied health staff as deemed clinically appropriate.

Engaging other medical services (e.g. diagnostic services; hospitals and consultants; allied health; social, disability, financial, housing, training, supported employment, alcohol and drug treatment and community services) assists the practice in providing optimal care to patients whose health needs require integration with other services.

Multidisciplinary teams provide many benefits to both service users and the mental health professionals working as part of the team, such as continuity of care, the ability to take a comprehensive, holistic view of the service user's needs, the availability of a range of skills, and mutual support and education.[33]

Potential members of the multidisciplinary mental health team

33 https://www.researchgate.net/publication/260125071_Interdisciplinary_Care_to_Enhance_Mental_Health_and_Social_and_Emotional_Wellbeing

Essential referral information for alcohol, tobacco or other drug treatment

Metro South 24-hour phone support

The Metro South community can access local mental health services for information and assistance in times of mental health crisis, 24 hours a day, via a centralised phone number: 1300 MH CALL (1300 64 22 55)

Refer Your Patient

Metro South Health is the major provider of public health services, and health education and research, in the Brisbane south side, Logan, Redlands and Scenic Rim regions. Refer Your Patient assists health professionals to access public health services for patients. It provides a single point of entry for all new referrals.

On the website, it outlines available health professionals, criteria to access appointments with the health professionals, expected wait times plus all the information that is required in the referral.

Metro South Addiction and Mental Health services

Metro South Addiction and Mental Health services also provide a community-based Addiction (Alcohol and Drug) Service for individuals, families and communities impacted by substance use. The service provides counselling, treatment and specialty services, primarily in a community setting. It deals with any kind of substance use including alcohol, tobacco, illicit drugs, prescription drugs, inhalants and over the counter preparations.

Urgent referrals

Referrers can contact the Alcohol and Drug Assessment Unit directly on (07) 3176 5191 in cases where a higher level of urgency is considered (e.g. assessment for detoxification at the state-wide Hospital Alcohol and Drug Service (HADS) at the Royal Brisbane and Women's Hospital, or where the patient has just recently been detoxified and needs an outpatient program).

Alcohol and drug information service

General practitioners can contact and refer a patient to ADIS via their website. Patients seeking information can be directed to ADIS 24 hours a day on 1800 177 833 for counselling, information and referral to treatment services.

Alcohol and Drug Clinical Advisory Service

The Alcohol and Drug Clinical Advisory Service (ADCAS) is a specialist telephone support service for health professionals in Queensland, providing clinical advice regarding the management of patients with alcohol and other drug concerns. This free service is available from 8.00am-11.00pm, 7 days a week. Please note that this service is for **health professionals only**.

SpotOnHealth HealthPathways

SpotOnHealth HealthPathways provides clinicians in the greater Brisbane south catchment with web-based information outlining the assessment, management and referral to other clinicians for over 550 conditions. It is designed to be used at point of care primarily by general practitioners but is also available to specialists, nurses, allied health and other health professionals.

Mental Health, Suicide Prevention, Alcohol and Other Drugs

Brisbane South PHN commissions mental health, suicide prevention and alcohol and other drug services designed to provide flexible support that is best suited to an individual's needs. There are three sub-regions:

- Brisbane (Princess Alexandra Hospital catchment area),
- Logan/Beaudesert (Logan Hospital catchment area) and
- Redlands (Redlands Hospital catchment area).

Information for GPs on how to link to Brisbane South PHN commissioned mental health services.

Other services

If you can't find a service that suits your needs, these links may help:

- Ask Izzy
- Head to Health
- Lifeline
- Metro South Health
- Suicide Call Back Service.

Activity 8.1 – Referral Pathways

This activity is designed to raise your awareness of local referral options available for you and your patients to facilitate co-ordinated and therefore optimal care.

Description	Status	Action to be taken
Do all GPs and nurses have login details for SpotOnHealth HealthPathways?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Obtain access.
Do all GPs and nurses know how to access SpotOnHealth HealthPathways via Topbar?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	See instructions, or contact BSPHN Digital Health Team via email: ehealth@bsphn.org.au.
Do all GPs and nurses know how to refer to Brisbane South PHN commissioned mental health, suicide prevention and alcohol and other drug services?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Refer to Brisbane South PHN website.
Are all relevant team members aware of referral pathways via ADIS?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Refer to referral information from ADIS.
Do all GPs use the Alcohol and Drug Clinical Advisory Service (ADCAS) for seeking advice on the management of patients with alcohol and other drug concerns?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Refer to ADCAS for more information.
How will you communicate information so clinicians know where to access details on referring a patient to specialist services?	What is the practice plan for communicating referral information?	
Do all relevant team members know how to contact Brisbane South PHN Program Coordinators – Mental Health, Suicide Prevention, Alcohol and Other Drugs?	☐ Yes, continue with activity. ☐ No, see **action to be taken.**	Submit an enquiry online.
After reviewing your practice referral system, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes**, see actions to be taken to help set your goals.** ☐ No, you have completed this activity.	Complete the MFI template in the Practice Plan portal on DiscoverPHN for your practice. Refer to the example MFI at the end of this document.

Activity 9 – Resources

Resources for health professionals

- Alcohol and Drug Foundation – Indigenous resources
- Assist – Digital screening tools
- Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) - Free facilitated education sessions for hepatitis C, hepatitis B, HIV, and sexual health
- ASHM – Free on-demand online learning modules (free registration required)
- ASHM – Decision Making in Hepatitis C
- ASHM – REACH-C form to receive specialist approval if GP or NP are not confident to prescribe hepatitis C DAA treatment [A collaboration between ASHM and the Kirby Institute]
- ASHM – Viral Hepatitis Mapping report
- Brisbane South PHN – First Nations Health Focus
- Brisbane South PHN - GP Psychiatry support line
- Brisbane South PHN - Primary Mental Health & Wellbeing initiatives
- EC Australia – Practice Software Instruction Sheets to optimise the use of medical practice software (hepatitis C focused)
- Dovetail Good Practice Guides for working with youth around AOD use
- Faculty of Pain Medicine - Opioid Calculator
- Faculty of Pain Medicine - Opioid Dose Equivalence Chart
- Hep Drug Interactions checker
- Hepatitis Australia
- Hepatitis Queensland
- Homeless health outreach team
- Insight training modules – "The Starter Pack" for Primary Care Staff
- National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-2029
- NPS – medicine line
- NPS - Over-the-counter Codeine: Changes to Supply
- NPS - Recommendations for Deprescribing or Tapering Opioids
- Positive choices – drug and alcohol information for Aboriginal and Torres Strait Islander people
- Queensland centre for mental health learning
- Queensland Government - Drug Dependent Person
- Queensland Health - Alcohol and Drug Clinical Advisory Service
- Queensland Health - Queensland Opioid Treatment Program: Clinical Guidelines 2012
- Queensland Health - Queensland Regulatory Requirements for Medical Practitioners Prescribing Schedule 8 Medicines (S8s)
- Queensland Health - Queensland Alcohol and Drug Withdrawal Clinical Practice Guidelines
- Queensland Health - Regulatory Requirements and Resources
- QNADA – Harm reduction resources for health professionals
- RACGP – AOD education program for GPs
- RACGP - Prescribing Drugs of Dependence in General Practice, Part A: Legislative Requirements
- RACGP - Prescribing Drugs of Dependence in General Practice, Part C1: Opioids

- RACGP - Prescribing Drugs of Dependence in General Practice, Part C2: The Role of Opioids in Pain Management
- RACGP – Supporting smoking cessation in general practice
- Therapeutic Goods Administration –Tips for Talking About Codeine: Guidance for Health Professionals with Prescribing Authority.

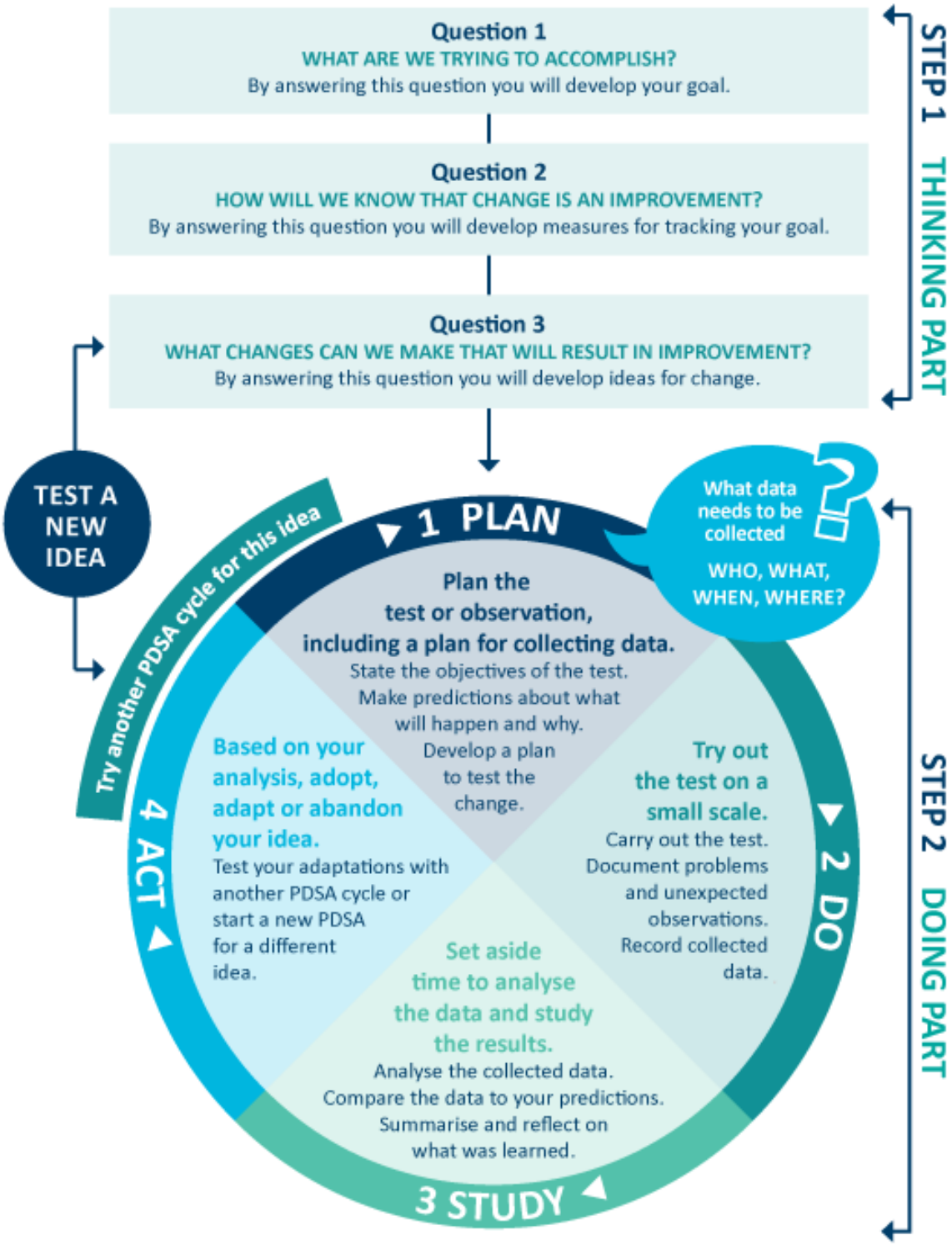
Resources for patients

- DrugArm
- Hepatitis Australia
- Lives lived well
- Queensland Injector Health Network (QuIHN)
- Anglicare
- CHAMP at Home, part of CHAMP Clinic
- Alcohol and Drug Information Service (ADIS)
- Alcoholics Anonymous (AA)
- Narcotics anonymous Australia
- Queensland Network of Alcohol and Other Drug Agencies
- QuitCoach
- Quitline
- Smart Recovery Australia
- Beyond Blue
- Brisbane City Council – homelessness
- Mission Australia.

Family support resources

- Breakthrough for Families QLD
- Family drug support
- Lives lived well
- Adis resources
- Al-Anon Family Groups Australia
- The first stop.

Model for Improvement diagram



Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

MFI and PDSA template EXAMPLE

Step 1: The thinking part - The 3 fundamental questions

Practice name:	**Date:**
Team members:	

Q1. What are we trying to accomplish? (Goal)

By answering this question, you will develop your GOAL for improvement.
Record this as a S.M.A.R.T. goal (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime bound).

Increase the percentage of alcohol consumption recorded on all active patients aged 15 years and older, by 10% by 31 July.

Q2. How will I know that a change is an improvement? (Measure)

By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g. CAT4 reports, patient surveys etc). Record and track your baseline measurement to allow for later comparison.

We will measure the percentage of active patients who have their alcohol consumption recorded. To do this we will:

A) Identify the number of active patients aged 15 years and older.

B) Identify the number of active patients aged 15 years and older who have had their alcohol consumption recorded.

B divided by A x 100 produces the percentage of patients who have had their alcohol consumption recorded.

Q3. What changes could we make that will lead to an improvement? (List your IDEAS)

By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.MA.R.T. goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.

IDEA: Identify active patients aged 15 years and older who have not had alcohol consumption recorded.

IDEA: Identify patients eligible for 45-49 year old health assessment and review their alcohol consumption status.

IDEA: Run an awareness campaign for alcohol consumption.

Note: Each new GOAL (1st Fundamental Question) will require a new MFI plan.
Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

MFI and PDSA template

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the 3rd fundamental question in step 1. You will use this template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

IDEA	Record the change idea you are testing
Which idea are you going to test? *(Refer to Q3, step 1 above)*	
Identify active patients aged 15 years and older who have not had their alcohol consumption recorded.	
PLAN	**Record the details of how you will test your change idea**
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (if applicable); the data to be collected; and predictions about the outcome.
WHAT: Mary will conduct searches on CAT4 to identify patients aged 15 years and old who do not have their alcohol consumption recorded. A Topbar prompt will be created to ensure next time patients attend the practice who have not had an alcohol assessment completed, the health professional will be prompted to do so. WHO/WHEN/WHERE: Who: Receptionist (Mary) When: Begin 20 May Where: at the practice in Dr Brown's room DATA TO BE COLLECTED: Number of active patients 15 years and older and the number of active patients 15 years and older who have not had an alcohol consumption recorded. PREDICTIONS: 40% of the active patient population aged 15 years and older will have an alcohol consumption recorded.	
DO	**Run the test, then record your actions, observations and data**
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).
Mary the receptionist conducted searches on CAT4 to identify patients aged 15 years and older who did not have their alcohol consumption recorded. A Topbar prompt was created to notify relevant team members when the patient presented at the practice next. This report did create a large list of patients, so the team decided to focus on patients aged 15 to 45 years with no alcohol status recorded.	
STUDY	**Analyse the data and your observations**
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.
Completed 20 May – the receptionist contacted Brisbane South PHN for support with the CAT4 search and the export function. The data search was conducted very quickly, with the receptionist being upskilled to conduct further relevant searches. A total of 327 active patients (37%) 15 years and older have had their alcohol consumption recorded = 3% lower than predicted. *Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.*	

ACT	Record what you will do next
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. *ADOPT: record what you will do next to support making this change business as usual*; ADAPT: *record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.*

ADOPT:

ADAPT:

ABANDON:

Repeat step 2 to re-test your adapted plan or to test a new change idea

Acknowledgements

We would like to acknowledge that some material contained in this toolkit has been extracted from organisations including the Institute for Healthcare Improvement; the Royal Australian College of General Practitioners (RACGP); the Australian Government Department of Health; Best Practice; MedicalDirector, CAT4; and Train IT. These organisations retain copyright over their original work and we have abided by licence terms. Referencing of material is provided throughout.

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First floor, Building 20, Garden City Office Park, 2404 Logan Road, Eight Mile Plains QLD 4113
PO Box 6435, Upper Mt Gravatt QLD 4122 T: 3864 7555 or 1300 467 265 | F: 3864 7599
bsphn.org.au | ABN 53 151 707 765

phn BRISBANE SOUTH
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