phn
BRISBANE SOUTH
An Australian Government Initiative

QUALITY IMPROVEMENT TOOLKIT
FOR GENERAL PRACTICE

Mental health

Alcohol, tobacco and other drugs MODULE

Version 1

Introduction

The Quality Improvement Toolkit

This Quality Improvement (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 Quality Improvement (QI) activities using the Model for Improvement.

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 Model for Improvement.

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

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

The Model for Improvement 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 alcohol status recorded using the Model for Improvement and a blank template for you to complete at the end of this module.

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

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

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; Medical Director, 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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Brisbane South PHN, 2020

Contents

Alcohol, tobacco and other drugs

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.[1]

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

Many Queenslanders, from all walks of life, regularly use alcohol, tobacco and other licit and illicit drugs. The 2016 National Drug Strategy Household Survey indicates the following proportions of Queenslanders aged 14 years and over had used alcohol and other drugs in the previous 12 months:

- 19.5% drank alcohol at lifetime risky drinking levels
- 15.6% drank alcohol at risky levels on single occasions at least weekly (had more than 4 standard drinks at least once a week)
- 14.8% smoke tobacco daily
- 16.8% used at least one illicit drug
- 11.9% used cannabis
- 1.5% had used meth/amphetamine. [2]

While not everyone who uses alcohol and other drugs experiences harm, when harm occurs it can have a significant impact on the health and wellbeing of the individual, their family and the broader community. The type of harm can also vary from immediate risk of physical injury to long-term disability, and in some cases death. Harm also includes social isolation, stigma and discrimination. Many people experiencing problematic substance use also experience other complex social needs.

They may also experience issues such as, but not limited to:

- homelessness
- mental health problems
- conditions such as hepatitis C and HIV/AIDS
- involvement with the criminal justice and/or child protection systems. [3]

[1] https://www1.racgp.org.au/newsgp/professional/doctor-patient-relationship-the-most-effective-too

[2] https://www.qmhc.qld.gov.au/sites/default/files/downloads/changing_attitudes_changing_lives_options_to_reduce_stigma_and_discrimination_for_people_experiencing_problematic_alcohol_and_other_drug_use.pdf

[3] https://www.qmhc.qld.gov.au/documents/changingattitudeschanginglives

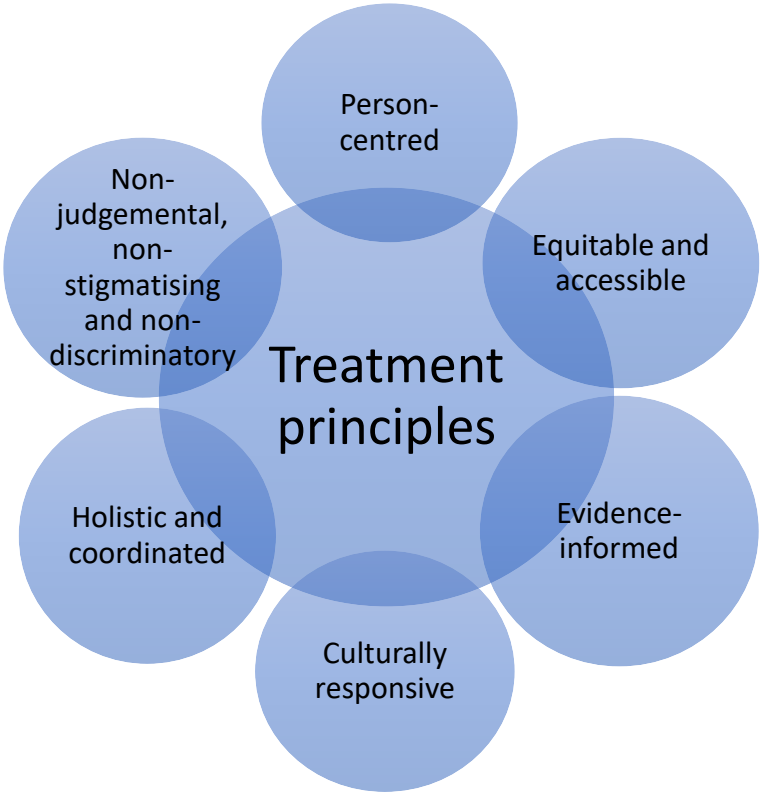
Role of general practice in alcohol, tobacco and other drugs

GPs are often the first point of contact as trusted healthcare advisors and have an important role to play in creating safe spaces that encourage treatment-seeking.

The strengths of general practitioners — knowledge of patients and their families, continuity of care, good communication skills, empathy, listening, quiet determination, setting boundaries, knowledge of the community and relationship building — are all key when treating patients with problematic substance use. [4] These principles can enable problematic substance use to be treated as any other chronic disease such as diabetes, with early implementation of known cost-effective treatments and patient follow-up by a primary care team. As with other chronic diseases, the aim is careful long-term management and support, not cure.

Respect for human rights is fundamental to supporting harm reduction and change processes for people experiencing problems with alcohol and other drugs. Six treatment principles should underpin all alcohol and other drug treatment interventions in Australia.

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] McCormick R. Primary care special interests. Addiction medicine. *N Z Fam Physician* 2008; 35: 82-83.

[5] https://www.health.gov.au/resources/publications/national-framework-for-alcohol-tobacco-and-other-drug-treatment-2019-29

Alcohol, tobacco and other drug use is common

Around 8 in 10 Australians consume alcohol each year and 12% of the Australian population smoke tobacco daily. About 1 in 8 Australians have used at least one illegal substance in the last year, the most common of which is cannabis (10.4%). The use of other illegal drugs such as ecstasy, methamphetamine, and cocaine, occur in around 2% of the population, and the use of legal, prescribed medication not as intended occurs for around 5% of the Australian population.

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

Alcohol, tobacco and other drug statistics

According to the Australian Institute of Welfare Alcohol and other drug treatment services in Australia 2016–17 the top four drugs that led people to seek treatment were:

- alcohol (32% of all treatment episodes)
- amphetamines (26%)
- cannabis (22%)
- heroin (5%).

Brisbane south statistics

- In 2017-18, 15.7% of adults in the Brisbane south region consumed alcohol at a level that exceeded that recommended by the National Health and Medical Research Council (NHMRC) (National rate = 16.0%).
- In 2015, tobacco was the leading cause of cancer in Australia (contributing 22% of cancer burden).
- There has been a long-term downward trend in daily tobacco smoking since 1991 (24% to 12% in 2016).
- 13.8% of adults in the Brisbane south region were current daily smokers in 2017-18 (National rate = 14.0%).
- 2019 wastewater data analysis indicates that methamphetamine remains the highest consumed illicit drug monitored by the program.
- Death rate involving meth/amphetamine was 4 times higher in 2017 than in 1999.
- In 2016, the recreational or non-prescribed use of pharmaceuticals was perceived to be acceptable by 28% of Australians. [7]

Tobacco smoking

Tobacco smoking is the leading cause of preventable disease burden in Australia. It is linked with many chronic diseases and is the leading cause of cancer in Australia.[8]

According to the 2016 NDSHS estimates, people who reported daily tobacco smoking were:

- more than twice as likely to have high/very high levels of psychological distress compared with people who had never smoked (22% compared with 9.7%)
- nearly 2.5 times as likely to have been diagnosed with, or treated for, a mental health condition as those who had never smoked (29% compared with 12.4%).

Alcohol consumption

The association between alcohol use and psychological distress and the diagnosis or treatment of a mental health condition is less marked than for tobacco and illicit drugs. The 2016 NDSHS findings showed that:

- people who exceeded the single occasion risk guidelines at least weekly were more likely to have high or very high levels of psychological distress (16.0%) than people drinking at low-risk levels for a single occasion (9.3%)
- the diagnosis of or treatment for a mental health condition was about 1.2–1.3 times higher among those drinking at risky levels (for both lifetime and single occasion risk) than those drinking at low-risk levels or abstaining from alcohol.

[7] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/data
[8] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/drug-types/tobacco

Illicit drugs

There is a strong association between illicit drug use and mental health issues. Estimates for the 2016 NDSHS indicate that the proportion of people self-identifying as being diagnosed with, or treated for, a mental illness significantly increased among recent users of cannabis, ecstasy, meth/amphetamines and cocaine between 2013 and 2016.

- The most noticeable increase was among recent users of ecstasy (from 18% to 27%), followed by recent users of meth/amphetamines (from 29% to 42%).
- People using meth/amphetamines in the past 12 months were more likely than any other drug users to report being diagnosed with or treated for a mental illness, and their rate was 3 times as high as the non-illicit drug using population (42% compared with 14%).

Pharmaceutical drugs

Pharmaceutical drugs are subject to recreational or non-prescribed use.

The non-medical use of pharmaceutical drugs is an increasing public health problem in Australia, with evidence suggesting increasing prevalence of problematic pharmaceutical drug use and associated harms including mortality. The Annual Overdose Report 2019 found that 1,612 Australians died of unintentional overdose in 2017 equating to one death every 5.4 hours; for comparison, 1,246 people died on our roads nationwide in the same year.

- The rate of dispensed prescriptions for pharmaceutical opioids has been climbing—up 11% between 2012–13 and 2016–17.
- In 2016, 1 in 20 (4.8%) Australians aged 14 and over reported using a pharmaceutical drug recreationally in the previous 12 months.
- Pharmaceutical opioids are the most commonly used pharmaceutical (3.6%), followed by tranquilisers/sleeping pills (1.6%).
- Between 2008 and 2018, the number of deaths where benzodiazepines were present rose by 120%.
- Aboriginal and Torres Strait Islander persons were 2.3 times as likely to use pharmaceutical drugs recreationally as non-Indigenous people were in the previous 12 months.
- The use of pharmaceuticals is perceived to be acceptable by 28% of Australians, which is higher than the perceived level of acceptability for the use of other drugs, such as tobacco and cannabis.
- People who reported recent recreational use of pharmaceuticals were more likely to report living with mental illness (29%) or chronic pain (16%).
- Between 2013–14 and 2017–18, benzodiazepines and other sedatives and hypnotics (excluding alcohol) continued to result in more drug-related hospital separations than opioids.[9]

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. 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.[10]

[9] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/drug-types/non-medical-use-of-pharmaceutical-drugs

[10] https://www.blueknot.org.au/Resources/Newsletters/Breaking-Free-Newsletter/Breaking-Free-May-2019

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.

Other Brisbane South PHN mental health QI toolkits

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

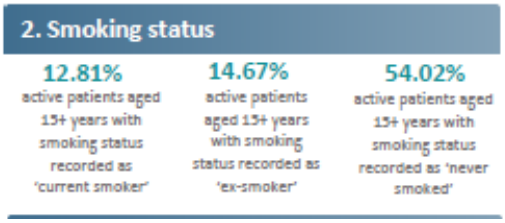
- Mental health overview
- Anxiety and depression
- Eating disorders
- Improving physical health of people living with a mental illness

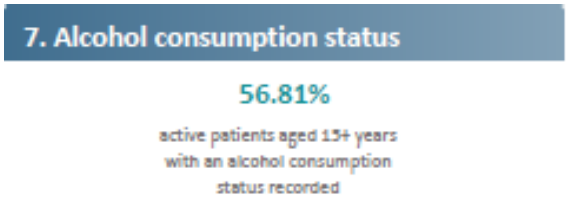
Activity 1 – Introduction to understanding your patient alcohol, tobacco and other drugs profile

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 practice monthly benchmark report. You can also collect information from CAT4 – Smoking status **or** Alcohol status **or** Medication or Conditions





	Description	Total number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
1.1a	Number of active patient population		
1.1b	Number of active patients (i.e.: 3 x visits in 2 years) **Identify active patients with at least 3 visits in the last 2 years**		
1.1c	Number of patients aged 15+ years with smoking status recorded as current smoker PIP QI		
1.1d	Number of patients aged 15+ years with an alcohol consumption status recorded PIP QI		
1.1e	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)*		

	Description	Total number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
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: *the RACGP defines active as 3 x visits in 2 years. This search criteria does not capture those patients who may come in for screening every 2 years, or twice in 2 years e.g. flu vaccine, hence the option to look at all active patients.*

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.[11]

Reflection on Activity 1.1:

Practice name:	Date:
Team member:	

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

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.

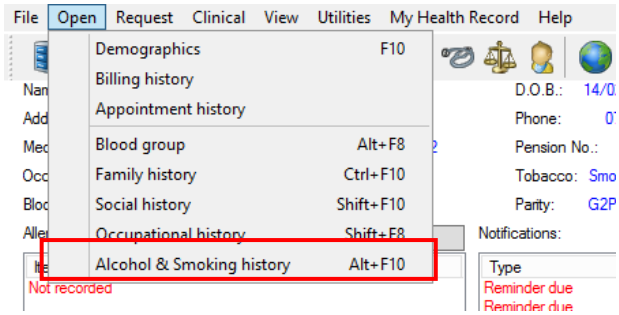
Description	Status	Action to be taken
After completing activity 1.1, are there any unexpected results with your practice's alcohol, smoking or other drugs profile?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients who are currently smoke 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 actions 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.**	See instructions on how to enter into Best Practice or Medical Director.
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 actions to be taken.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

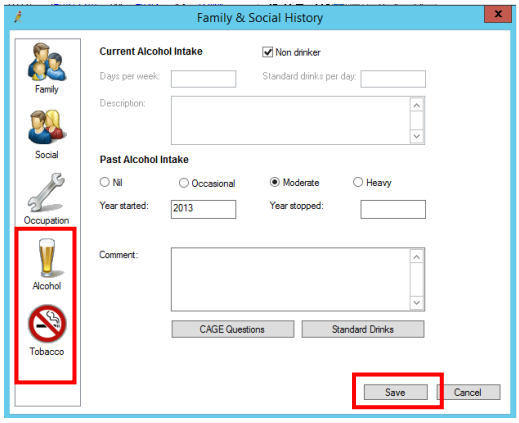
Reflection on Activity 1.2**:**

Practice name:	Date:
Team member:	

Instructions for entering alcohol and smoking status in Best Practice

1. Open the patient file, then select **Open** and **alcohol & smoking history.**

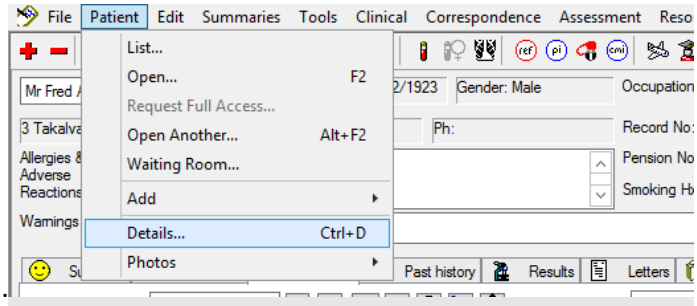




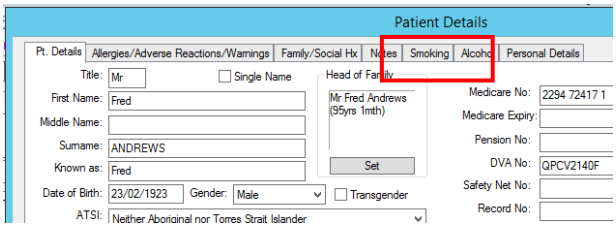
2. Select **Tobacco** on the left-hand side menu.
3. Once you have entered the information, select **alcohol.**
4. Select **Save** to complete.

Instructions on entering alcohol and smoking status into Medical Director

1. Open the patient file.



2. From the '**patient'** menu select '**details**'.
3. This will open a screen where you can enter patient details, allergy/reactions, family/social history, smoking, alcohol and personal details.
4. Select **Smoking**



5. Once you have entered the details, select **Alcohol.**
6. Once all details have been completed, select **save**.

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. [12]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. Two examples of physical addiction are drug and alcohol dependence, including cigarettes and non-medical prescription opioid dependence.

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[13]

[1212] https://ama.com.au/position-statement/harmful-substance-use-dependence-and-behavioural-addiction-addiction-2017

[13] https://au.reachout.com/articles/what-is-addiction

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. [14]

Alcohol consumption

Drinking more than 4 standard drinks a day can seriously affect the health of individuals over their lifetime[15].

Long-term effects include:

- increased symptoms of mental health issues
- 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.[16]

[14] http://www.sharc.org.au/wp-content/uploads/2018/11/The-Role-of-the-Family-in-AOD-Treatment.pdf
[15] https://www.health.gov.au/health-topics/alcohol/about-alcohol/how-much-alcohol-is-safe-to-drink
[16] https://www.health.gov.au/health-topics/alcohol/about-alcohol/what-are-the-effects-of-alcohol

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.

Activity 2.1 – Advanced search on practice database

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

You will need to search for patients from your clinical software package. Instructions are available from Best Practice **or** Medical Director

	Description	Number
2.1a	Number of active patients with a past history of alcohol dependency	
2.1b	Number of active patients with a past history of alcohol abuse	
2.1c	Number of active patients with a past history of drug abuse	
2.1d	Number of active patients with a past history of drug addiction	
2.1e	Number of active patients with a past history of illicit drug use referral	
2.1f	Number of active patients with a past history of tobacco dependence	

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 3.

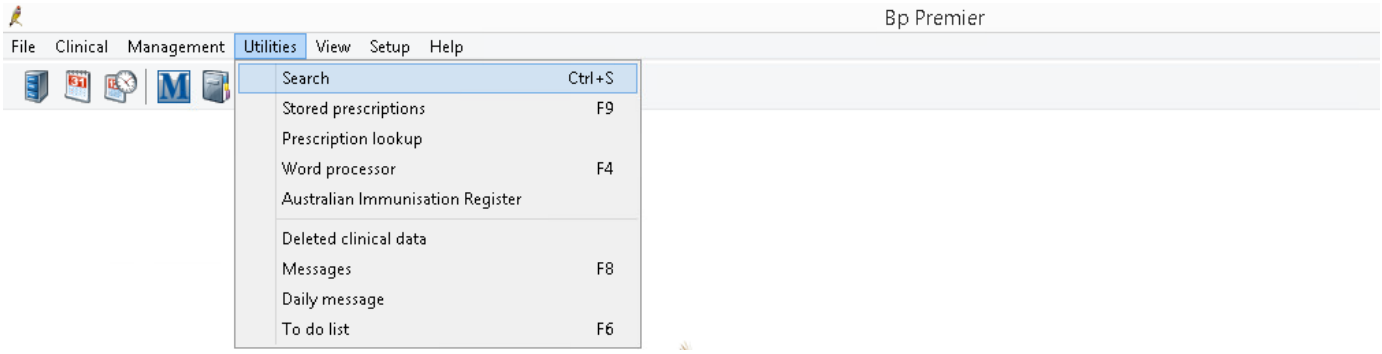
Reflection on Activity 2.1:

Practice name:	Date:
Team member:	

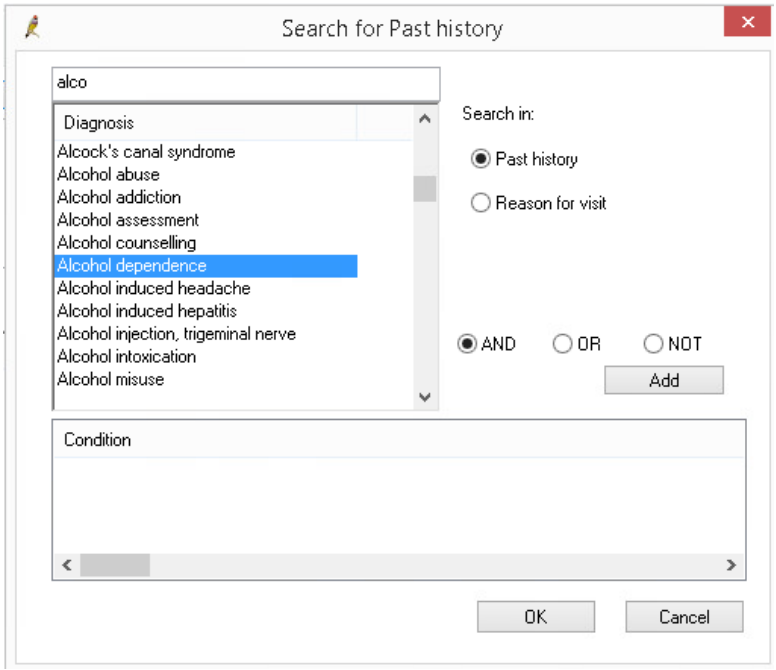
Instructions for searching patient database in Best Practice

To conduct a search of patients with a condition marked in their past history, in Best Practice:

1. From the Best Practice screen, select **Utilities** & **Search.**



2. From the **Setup search** menu, select **Conditions.**
3. A search for past history screen will appear.
4. In the **Diagnosis** box, enter the diagnosis you want to search for and select **Past history** or **Reason for visit.**
5. Select **Add.**



6. Select **OK.**
7. Select **Run Query** and your list of patients with the specific diagnosis will appear.

8. To search for a new diagnosis, select **New query** and repeat steps 4 to 7.

Activity 2.2 – Reviewing your patient addiction's profile

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

Description	Status	Action to be taken
After completing activities 2.1, are there any unexpected results with your practice's alcohol, smoking or other drug use patient profile?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients with alcohol dependency than expected.)* How will this information be communicated to the practice team?
After reviewing your practice's alcohol, smoking or other drug use 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.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 2.2:

Practice name:	Date:
Team member:	

Real time reporting of monitored medications

Queensland has a prescription drug monitoring program that collects dispensed schedule 8 (S8) prescription drug information on a weekly basis and provides a telephone enquiry service for doctors. However, the data isn't available in real-time or automatically accessible to clinicians. In response to this, Queensland Health has implemented a program of work on monitored medicines.

The program of work 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'). The proposed real-time reporting system will:

- contain prescription data about monitored medicines which has been uploaded automatically at the point of dispensing, in real-time
- be directly accessible by Queensland prescribers, pharmacists and dispensing medical practitioners, to inform their clinical decision-making.

Prescription Shopping Programme

The Australian government has a Prescription Shopping Programme (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.

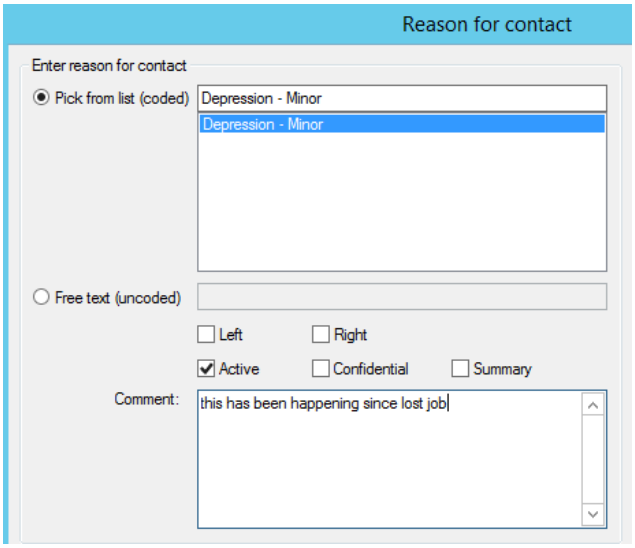
The program uses PBS data, updated in the last 24 hours, to know when patients receive PBS medicine from an approved pharmacy.

More information on the prescription shopping programme is available on the Services Australia website.

Activity 3 – 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. The following activity will guide you through this process.

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 3.1 – 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 this 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.

Description	Status	Action to be taken
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).*[17]	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Source list of clinical codes already available in current clinical software. Source list of clinical codes from CAT4 clinical audit tool. From these two lists agree on clinical codes to be used within the practice. _____ _____ _____ _____
Have your agreed clinical codes been included in your practice policy?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Record agreed clinical codes in practice policy manual.
Are practice team members aware of how to enter diagnoses in clinical software using agreed mental health conditions?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	See instructions for Best Practice users. See instructions for Medical Director users.
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 actions to be taken to help set your goals.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

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

Reflection on Activity 3.1:

Practice name:	Date:
Team member:	

Activity 3.2 – 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 clinical team should understand the importance of marking conditions as active or inactive.

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 this 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 this 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.
Does your practice policy and procedure manual include a section on marking patient past history and/or conditions as active or inactive?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Update policy and procedure manual.

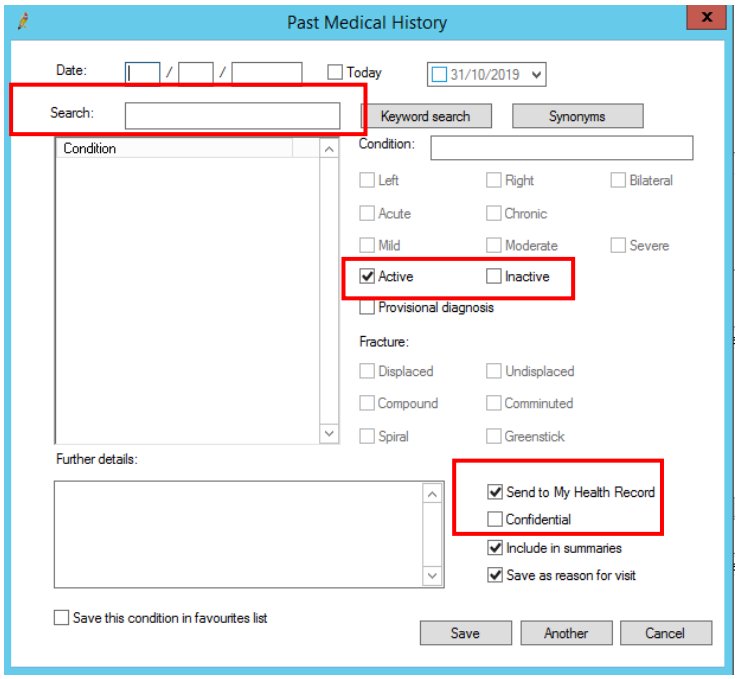
Description	Status	Action to be taken
Are practice team members aware of how to enter active/inactive in your practice's clinical software?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	See instructions for Best Practice users. See instructions for Medical Director users.
Are practice team members aware of what conditions, if marked inactive, are not included in CAT4 searches?	☐ Yes: continue with this 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.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 3.2:

Practice name:	Date:
Team member:	

Instructions for adding active, inactive or confidential to Best Practice notes

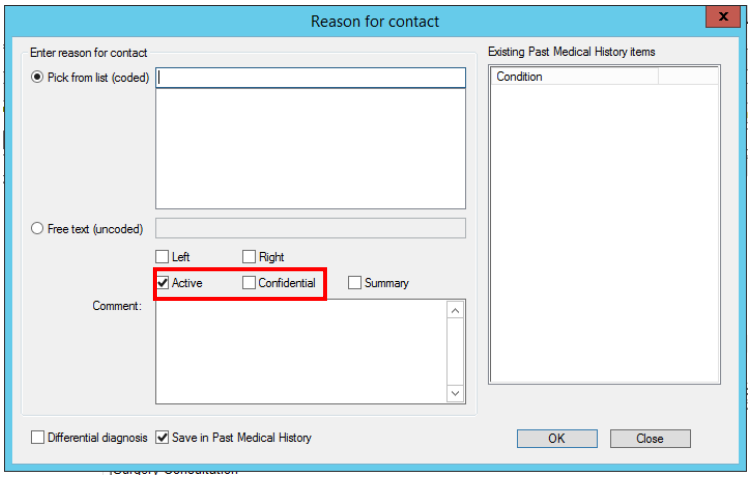
1. In the **past medical history** screen, select the condition in the **search** field.
2. Then tick either **Active** or **Inactive.**
3. You may wish to remove from sending to **My Health Record.**
4. Mark item as **Confidential** if extremely sensitive.
5. Select **Save** to complete.

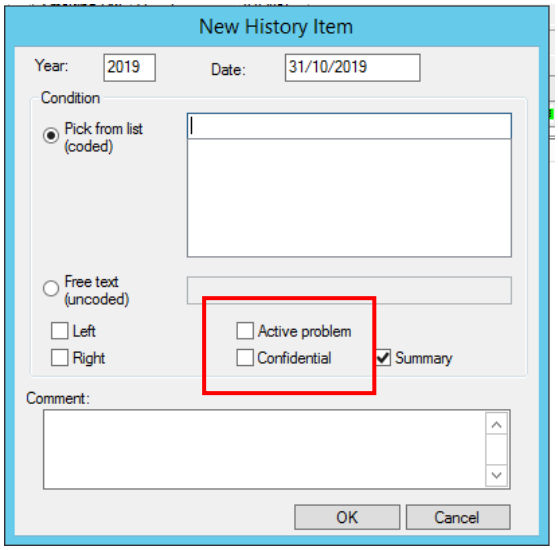


The 'Confidential' box marks history items as confidential and these will not appear in materials such as Referral Letters and Reports. This feature is intended for very sensitive personal health information only.

Instructions for adding active, inactive or confidential to Medical Director notes

1. In the **reason for contact** or **new history item** screen, select the condition in the **pick from list** field.
2. Then tick **Active** if relevant.
3. In the reason for contact screen, you can choose to save in past medical history for significant problems.
4. Mark item as **Confidential** if extremely sensitive.
5. Select **ok** to complete.





By default, the procedure is marked as Active. To change this, clear the **Active** check box

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. The table below will help guide you through this process.

Activity 3.3 – Distribute list of patients with alcohol, tobacco or other drug addictions to individual GPs

Description	Action to be taken	
After completing activity 2.1, note how many active patients have addictions &/or dependencies.	Number: _____	
Is there an explanation for this result?	(*e.g. practice is located in low socio-economic area):* _____ _____ _____	
Have you distributed lists to individual GPs for review and update of their diagnosis?	☐ Yes Ensure you follow up in a week's time to receive the reviewed reports back from the GP. You have completed this activity.	☐ No Follow the instructions to complete this.

Please note: CAT 4 assigns providers in the following ways:

Best Practice: Best Practice uses the 'Usual Doctor' field in the patient demographics as the patient's assigned provider. Where a 'Usual Doctor' is not selected, patients will be assigned to the active provider who saw them for the highest number of consultations in the previous 18 months.

Medical Director: Where there is more than one provider in the practice, patients will be assigned to the provider who saw them for the highest number of consultations in the previous 18 months. Providers that are active will be given priority over providers that have been made inactive.

Reflection on Activity 3.3:

Practice name:	Date:
Team member:	

Activity 4 – 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.[18] 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.[19]

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. [20] 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. [21]

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.[22]

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. [23]

[18] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions
[19] https://www.tobaccoinaustralia.org.au/chapter-7-cessation/7-12-smoking-and-mental-health
[20] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions
[21] https://www.beyondblue.org.au/the-facts/drugs-alcohol-and-mental-health
[22] https://adf.org.au/insights/what-is-dual-diagnosis/

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.

Activity 4.1 – 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
4.1a	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)*	
4.1b	Number of active patients with a mental illness and drug use	
4.1c	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 3.

Reflection on Activity 4.1:

Practice name:	Date:
Team member:	

Activity 4.2 – 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 activities 4.1, are there any unexpected results with your practice's mental illness and alcohol, smoking or other drugs profile?	☐ Yes: **see actions 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.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 4.2**:**

Practice name:	Date:
Team member:	

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:

- harm to organs and systems in your body, such as your throat, stomach, lungs, liver, pancreas, heart, brain, nervous system
- cancer (such as lung cancer from inhaling drugs)
- infectious disease, from shared injecting equipment and increased incidence of risk-taking behaviours
- higher risk of mental illness, depression, suicide and death.[24]

Hepatitis B and people who inject drugs

The most recent evidence suggests that 4% of Australians who currently or recently injected drugs are living with chronic hepatitis B. Given that about 1.6% of the Australian population has injected drugs at some time, a conservative estimate of 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. Transmission rates can be minimised by discussing safe injecting practices in alignment with the principles of harm reduction. In Australia in 2006 it was estimated that approximately 264,000 people had been exposed to HCV and had HCV antibodies with around 197,000 living with chronic hepatitis C. The estimated number of new cases of HCV infection has declined from 16,000 per annum in 2001 to 10,000 in 2005. The majority (65%) of people with HCV are aged between 20 and 39 years, and 35% of national notifications of HCV are in women.[25]

Treatment is now more than 95% effective at curing hepatitis C. Most people can get a prescription from their GP, and people who have a Medicare Card can access treatment at a low cost.[26]

Alcohol worsens HCV outcomes and increases the likelihood of cirrhosis.

[24] https://www.betterhealth.vic.gov.au/health/HealthyLiving/How-drugs-affect-your-body

[2525] 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

[26] https://www.hepatitisaustralia.com/hepatitis-c-cures

Activity 4.3 – Data collection from clinical software

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

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

	Description	Number
4.3a	Number of active patients experiencing alcohol or drug dependence and hepatitis B	
4.3b	Number of active patients experiencing alcohol or drug dependence/abuse and hepatitis C	
4.3c	Number of active patients experiencing alcohol or drug dependence/abuse and HIV	
4.3d	Number of active patients experiencing alcohol or drug dependence/abuse and liver disease	
4.3e	Number of active patients with lung cancer and a smoker	
4.3f	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 3.

Reflection on Activity 4.3:

Practice name:	Date:
Team member:	

Activity 4.4 – Reviewing your patients experiencing problematic substance use and/or dependency and liver disease and lung cancer

Complete the checklist below to review your practice's patients experiencing problematic substance use and/or dependence and liver disease and lung disease.

Description	Status	Action to be taken
After completing activity 4.3, are there any unexpected results with your practice's patients experiencing problematic substance use and/or dependence, liver or lung disease?	☐ Yes: **see actions 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 4.3, 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.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 4.4:

Practice name:	Date:
Team member:	

Activity 5 –Monitoring patients at risk of problematic substance use and/or dependence

GPs and other primary care professionals such as practice nurses and mental health workers, operating in multidisciplinary care teams, have a key role to play in prevention, early detection and management of problematic substance use and/or dependence. More than 80% of patients visit a GP at least once a year. GPs are looked to for credible and reliable health and harm reduction advice, and specialist treatment referral pathways. GPs have an important role to play for people seeking advice and treatment as frontline responders, so it is paramount that GPs are represented as positive health advisors committed to stigma reduction and non-discriminatory treatment of people who use alcohol and drugs. For the most part, it is reported that patients' attitudes towards lifestyle enquiry and interventions by GPs are positive.[27]

Social impacts

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).[28]

The social impacts of substance use are pervasive, and include criminal activity and engagement with the criminal justice system, victimisation and road trauma.

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.[29]

[27] https://www.mja.com.au/journal/2008/189/2/addiction-and-addiction-medicine-exploring-opportunities-general-practitioner

[28] https://www.health.gov.au/resources/publications/national-framework-for-alcohol-tobacco-and-other-drug-treatment-2019-29

[29] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impacts/social-impacts

Alcohol, tobacco, other drugs and suicide risk factors

GP involvement in suicide assessment

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.[30]

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.

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.

[30] https://ndarc.med.unsw.edu.au/resource/suicide-risk-assessment-and-intervention-strategies-current-practices-australian

Activity 5.1 – 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 5.2 – Identify roles for supporting people experiencing problematic alcohol, tobacco or other drug use and/or dependence.

Description	Status	Action to be taken
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.
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.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 5.1:

Practice name:	Date:
Team member:	

Activity 5.2 - 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
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		
Complete mental health treatment plan and review		
Home Medication Review (if appropriate)		
Assess need for referral to other mental health providers		
Consider advanced care planning		
Complete risk assessments		

Activity	Nurse	GP
Consider GP Management Plan and Team Care Arrangement (if eligible)		

Reflection on Activity 5.2:

Practice name:	Date:
Team member:	

Opioid deaths in Australia

The Annual Overdose Report 2019 found that 1,612 Australians died of unintentional overdose in 2017, equating to one death every 5.4 hours. Comparatively, 1,246 people died on Australian roads nationwide in the same year. 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.

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%). Opioid-induced mortality in 2018 was slightly lower than in 2017, with a per capita rate of 4.6 per 100,000 people compared with 4.8 the previous year.
- 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. In 2018, there was a decrease in the number of deaths with naturally derived and semi-synthetic opioids present compared with 2017.
- 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.[31]

New 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.

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

- 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.

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

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.

Mental health consultation (item 2713)

The GP mental health treatment consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental illness, including for a patient being managed under a GP Mental Health Treatment Plan. This item may be used for ongoing management of a patient with a mental health condition. This item should not be used for the development of a GP Mental Health Treatment Plan.

Mental Health treatment plan (MBS item 2700, 2701, 2715 or 2717)

GPs providing mental health treatment plans, and who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration, have access to items 2715 and 2717.

More information is available at Education guide for Mental Health Care

Mental health treatment plan review (MBS item 2712)

The mental health treatment plan review item is a key component for assessing and managing the patient's progress once a GP mental health treatment plan has been prepared, along with ongoing management through the GP mental health treatment consultation item and/or standard consultation items. A patient's GP mental health treatment plan should be reviewed at least once.

Temporary mental health telehealth item numbers

During the COVID-19 outbreak, the Australian Government has provided temporary item numbers to manage patients with a mental illness. These numbers are available from March 2020 to September 2020. More information is available on the MBS fact sheet.

Service	Existing Items *face to face*	Telehealth items *via video-conference*	Telephone items – *for when video-conferencing is not available*
Mental Health Services			
GP without mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes	2700	92112	92124

Service	Existing Items *face to face*	Telehealth items *via video-conference*	Telephone items – *for when video-conferencing is not available*
GP without mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes	2701	92113	92125
Review of a GP mental health treatment plan or Psychiatrist Assessment and Management Plan	2712	92114	92126
Mental health treatment consultation, at least 20 minutes	2713	92115	92127
GP with mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes	2715	92116	92128
GP with mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes	2717	92117	92129

Chronic disease management plans (MBS items 721, 723 or 732)

Holistic team-based care of both physical and mental health is critical to achieve the best possible outcomes for people experiencing problematic substance use and/or dependence.

There are two types of plans that can be prepared by the patient's regular General Practitioner (GP) for Chronic Disease Management (CDM): GP Management Plans (GPMP); and Team Care Arrangements (TCAs)

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

The Chronic Disease Management (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

Temporary chronic disease telehealth item numbers

During the COVID-19 outbreak, the Australian Government has provided temporary item numbers to manage patients. These numbers are available from March 2020 to September 2020. More information is available on the MBS fact sheet.

Service	Existing Items *face to face*	Telehealth items *via video-conference*	Telephone items – *for when video-conferencing is not available*
Chronic disease management			
Preparation of a GP management plan (GPMP)	721	92024	92068
Coordination of Team Care Arrangements (TCAs)	723	92025	92069
Contribution to a Multidisciplinary Care Plan, or to a review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729	92026	92070
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731	92027	92071
Review of a GPMP or Coordination of a Review of TCAs	732	92028	92072

Aboriginal and Torres Strait Islander Health Peoples Assessment (MBS 715) (if relevant)

Aboriginal and Torres Strait Islander peoples are estimated to have ten years lower life expectancy than other Australians. Tobacco, alcohol and other drugs are key risk factors contributing to the health gap between Indigenous and non-Indigenous Australians.[33] Conducting a health assessment provides an opportunity to ensure a thorough health check is completed and a holistic treatment plan is developed.

The Aboriginal and Torres Strait Islander Peoples Health Assessment is available to:

- children between ages of 0 and 14 years,
- adults between the ages of 15 and 54 years,
- older people over the age of 55 years.

See MBS descriptor for more information

[33] https://www.aihw.gov.au/getmedia/9844cefb-7745-4dd8-9ee2-f4d1c3d6a727/19787-AH16.pdf.aspx

Temporary telehealth health assessment item numbers

During the COVID-19 outbreak, the Australian Government has provided temporary item numbers to manage patients. These numbers are available from March 2020 to September 2020. More information is available on the MBS fact sheet.

Service	Existing Items *face to face*	Telehealth items *via video-conference*	Telephone items – *for when video-conferencing is not available*
Health Assessment for people of Aboriginal or Torres Strait Islander descent			
Health assessment	715	92004	92016

Patients experiencing problematic substance use and/or dependence and health assessments (MBS item 701-707)

Some patients experiencing problematic substance use and/or dependence *may be* eligible for a health assessment. A health assessment is the evaluation of an eligible patient's health and wellbeing. General practitioners use it to help decide if a patient needs:

- preventive health care
- education, to improve their health and wellbeing
- appropriate interventions

There are time-based MBS health assessment items: **701 (brief), 703 (standard), 705 (long)** and **707 (prolonged)**. If you are a non-vocationally registered GP, the following item numbers can be claimed**: 224 (brief), 225 (standard), 226(long)** and **227 (prolonged)**.

More information available from MBS online here.

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 dependence 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)*		

Reflection on Activity 6.1:

Practice name:	Date:
Team member:	

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 the activity.	Please explain: What action will you take?
Are there any patients with dependence who would benefit from a GP management plan? *(note: not all patients are eligible for a GP management plan)*	☐ Yes, **see action to be taken.** ☐ No, continue with the 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 GP management plan?	☐ Yes: continue with activity. ☐ No: **see actions to be taken.**	Follow the instructions to complete this.
Do relevant staff know what the criteria is for completing Mental Health treatment plans and Health Assessments through Medicare?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Refer to MBS criteria at: Mental Health treatment plans Health Assessments
Does the practice have a system for tracking Medicare item number claiming?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Do GP's have access to their day sheets to identify MBS item numbers claimed? Does the practice nurse check that any assessments completed have the correct billing? Are item numbers checked against appointment diary prior to batching?

Description	Status	Action to be taken
Do you know the contact details for any MBS related questions?	☐ Yes, continue with the activity. ☐ No, **see actions 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 the activity. ☐ No, **see actions 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.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 6.2:

Practice name:	Date:
Team member:	

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.

Reminders, recalls and prompts (flags)

Reminders are used to initiate prevention, before or during the patient visit. They can be either opportunistic or proactive. Recalls are a proactive way to follow up after a preventive or clinical activity. Prompts are usually computer generated, and designed to opportunistically draw attention to a prevention or clinical activity needed by the patient during the consultation. Using a recall system can seem complex, but there are three steps you can take:

- be clear about when and how you want to use these flags
- explore systems used by other practices, your PHN, and information technology specialists to ensure you get the correct system
- identify all the people who need to be recalled and place them in a practice register, to ensure that the recall process is both systematic and complete
- ensure that patient consent is obtained prior to including them in the practice reminder system.

Some examples specific to mental illness may include review of GP mental health plan due, medication monitoring due, depot injection due etc.

Train IT Medical – Recall and reminder resources for Medical Director

Train IT Medical have a number of resources available for practices to use to assist managing their recall and reminder systems. These include:

- Sample Recall Management Protocol/Flowchart
- MedicalDirector learning resources
- Sample Quality Improvement Activity
- Train IT Medical 'Recalls, Reminders & Screening' using MD Presentation
- Read our MedicalDirector Clinical Top 5 'Recalls & Reminders' Tips

Train IT Medical – Recall and reminder resources for Best Practice

Train IT Medical have a number of resources available for practices to use to assist managing their recall and reminder systems. These include:

- Reminders quick reference guide
- Creating a reminder template
- Sending SMS reminders to patients
- Recall & reminders – why it's so hard

Activity 7.1 – Reminder system

	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 is due etc)?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**		Instructions on creating a reminder in Best Practice. Instructions on creating a reminder in Medical Director.
Is consent obtained from patients, family members or carers to be included in the practices reminder system?	☐ Yes, how is this done? ☐ No, **see action to be taken.**		Include a section on New patient information sheet about consent to participate in reminder system. Clinicians ask patients prior to placing them on reminder system.
How does the practice record if a patient **DOES NOT** wish to be contacted offering reminder appointments?			
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.
How regularly are reminder lists generated for each doctor/nurse?	Doctor	Practice nurse	Create a practice policy for frequency of generating lists Nominate a practice member to generate reminder lists
Is there a system for reviewing and actioning reminder lists? i.e. • all posted • all telephoned • wait for patient to attend • GPs review lists and classifies reminders.	☐ Yes, continue with activity. ☐ No, **see action to be taken.**		Create policy for activating reminders due. Nominate a practice member to activate reminders due.
Is there a system to identify in the appointment book when a patient is coming in for a reminder appointment?	☐ Yes, continue with activity. ☐ No, **see action to be taken.**		Use of a symbol in the appointment book to identify type of appointment.

	Status	Action to be taken
Is there a process for acting on or removing outstanding reminders? E.g. patients fail to attend, reminder no longer needed.	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	GP education on removing reminders. Document practice process on removing reminders.
Is there a practice policy on how reminders are to be implemented? E.g. *entering all reminders for the upcoming 12 months to ensure all tests are performed*?	☐ 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.
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.
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.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

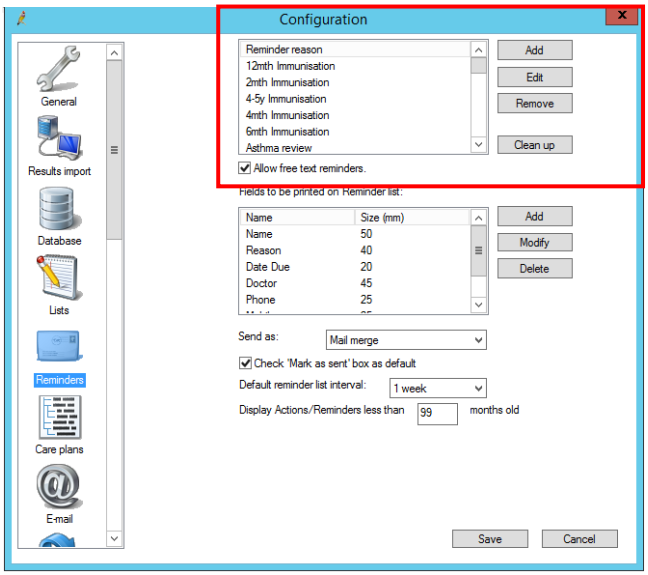
Reflection on Activity 7.1:

Practice name:	Date:
Team member:	

Creating reminder category for monitoring in Best Practice

To create a reminder category for monitoring patients with mental health in Best Practice: (*please note: always check the reminder list prior to creating a category as it may already be included.)*

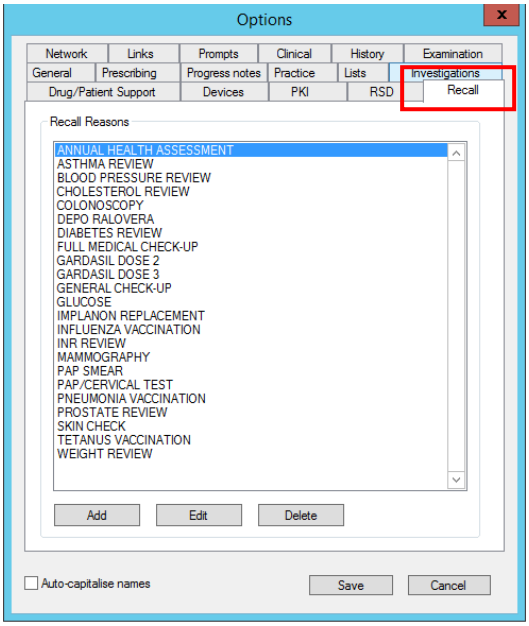
1. Select **Setup>Configuration** from the main Best Practice screen.
2. Scroll down on the left-hand side to find the Reminders icon.
3. The top section of the screen shows the Reminder Reason list- this is the full list of reminder reasons available when reminders are being created within the patient record.
4. Choose **Add.**



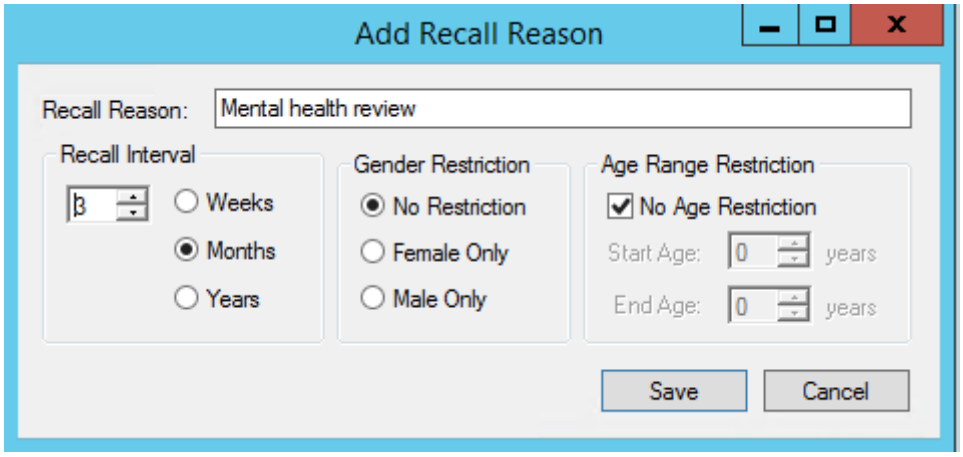
5. Type in the reason as appropriate (for e.g. Mental health review) and then the interval.
6. Click Save and Save.

Creating reminder category for monitoring in Medical Director

To create a reminder category for monitoring mental health patients in Medical Director: (*please note: always check the reminder list prior to creating a category as it may already be included.)*



1. Select **Tools > Options**. Medical Director options appears.
2. Select the **Recall tab**. The list of recall reasons is presented.
3. Select **Add.**
4. Enter a **name/description** for the recall reason you wish to add.
5. Modify other settings as desired, note that these settings are simply the defaults for this recall reason, which can be overridden when you go to create a new recall for the patient.



- **Recall Interval:** How often the recall should occur, when it is used for recurring recalls (as opposed to once-off recalls).
- **Gender Restriction**: Whether the recall reason's availability is limited to a specific gender.
- **Age Range Restriction:** Whether the recall reason's availability is limited to a specific age group.

6. Click **Save** to confirm. You will be returned to the **Recall tab**, where your new recall reason is now listed.

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.[34]

Potential members of the multidisciplinary mental health team

34 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).

More information about referral criteria can be found from Metro South Health

Alcohol and drug information 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**.** Patients seeking information should be directed to Adis 24/7 Alcohol and Drug Support on 1800 177 833 for counselling, information and referral to treatment services.

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.

To access SpotOnHealth HealthPathways you will need to log in.

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).

More information can be found on the Brisbane South PHN website.

Information for GPs on how to link to Brisbane South PHN commissioned mental health services can found on the GP information page.

Health Services Directory

Health Services Directory is a joint initiative of all Australian governments, delivered by HealthDirect Australia, to enable health professionals and consumers access to reliable and consistent information about health services.

My Community Directory

My Community Directory lists organisations that provide free or subsidised services to the public in thousands of locations across Australia. These services are organised into Community Directories.

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

Complete the checklist below in relation to 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.

	Status	Action to be taken
Do all GPs and nurses have login details for SpotOnHealth HealthPathways?	☐ Yes, continue with the activity. ☐ No, see **Action to be taken.**	Register on the login page to request access.

	Status	Action to be taken
Do all GPs and nurses know how to access SpotOnHealth HealthPathways via Topbar?	☐ Yes, continue with the 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 the activity. ☐ No, see **Action to be taken.**	Refer to Brisbane South PHN website. Refer to the FAQs page.
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?	
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.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 8.1:

Practice name:	Date:
Team member:	

Activity 9 – Resources

Resources for health professionals

- Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine
- Brisbane South PHN Primary Mental Health & Wellbeing initiatives
- Faculty of Pain Medicine - Opioid Calculator
- Faculty of Pain Medicine - Opioid Dose Equivalence Chart
- Hepatitis Australia
- Hepatitis Queensland
- Homeless health outreach team
- 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
- Queensland centre for mental health learning
- Queensland Government - Drug Dependent Person
- Queensland Health - Alcohol and Drug Clinical Advisory Service
- Queensland Health - Alcohol and drug support
- 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

- Alcohol and Drug Information Service (ADIS)
- Alcoholics Anonymous (AA)
- Beyond Blue
- Brisbane City Council - homelessness
- DrugArm
- Lives lived well
- Mission Australia
- Narcotics anonymous Australia
- Needle syringe program (NSP)
- Queensland Injector Health Network (QuIHN)
- Queensland Network of Alcohol and Other Drug Agencies
- QuitCoach
- Quitline
- Smart Recovery Australia

Family support resources

- Al-Anon Family Groups Australia
- Family drug support
- Lives lived well
- The first stop

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.
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.

Assessment name	Description
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.
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.
WHO Quality of Life Scale (WHOQoL-BREF)	WHOQOL-BREF is a self-report questionnaire which assesses 4 domains of quality of life (QOL): physical health, psychological health, social relationships, and environment, this validated screening tool is available in 19 different languages.
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.

Quality improvement activities using the model for improvement and PDSA

After completing any of the workbook activities above you may identify areas for improvement in the management of patients with an alcohol, tobacco or other drug dependence. Follow these steps to conduct a Quality Improvement Activity using The Model for Improvement and PDSA. The model consists of two parts that are of equal importance.

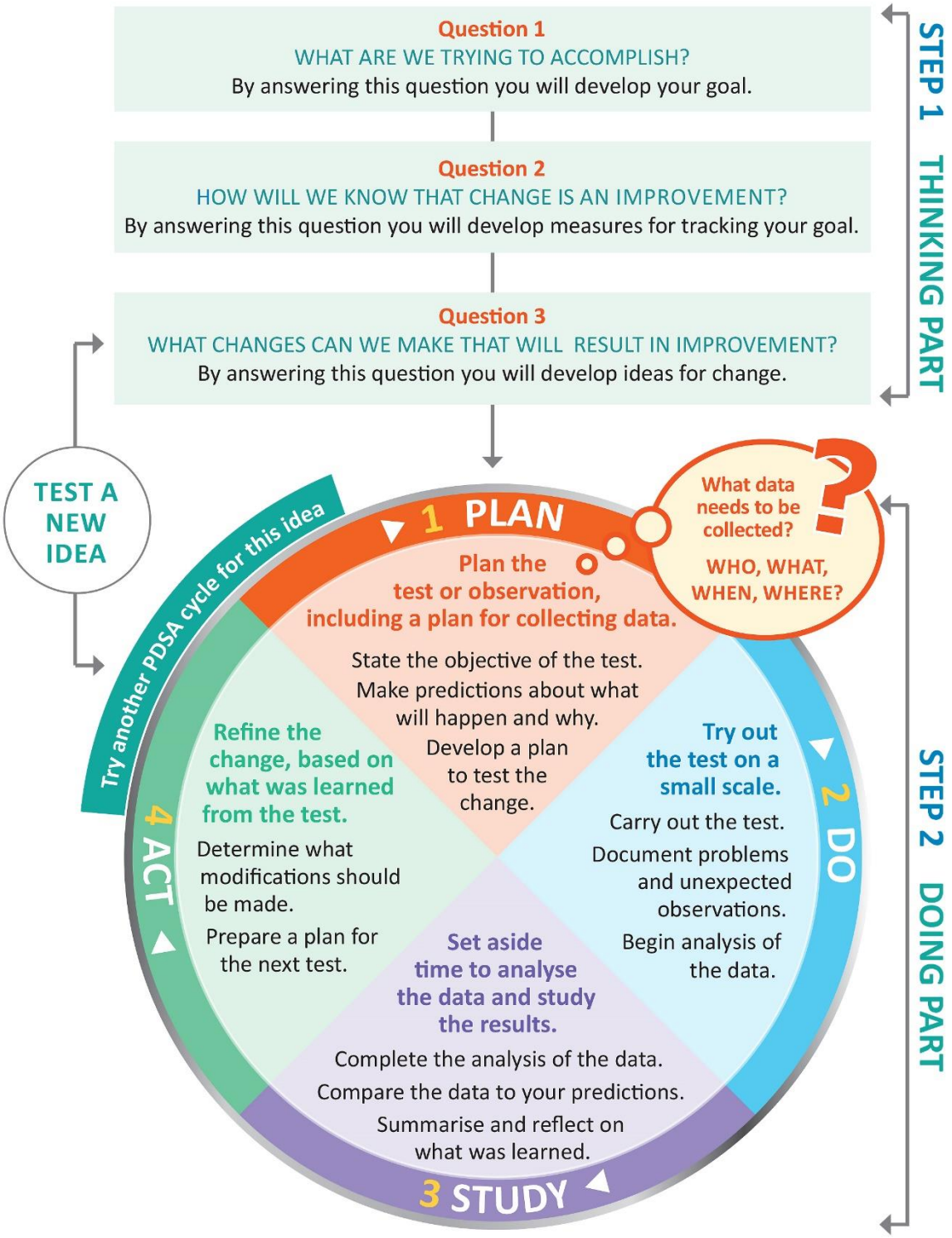
Step 1: The **'thinking'** part consists of three fundamental questions that are essential for guiding improvement work:

- What are we trying to accomplish?
- How will we know that the proposed change will be an improvement?
- What changes can we make that will lead to an improvement?

Step 2: The **'doing'** part is made up of Plan, Do, Study, Act (PDSA) cycles that will help to bring about rapid change. These include:

- helping you test the ideas
- helping you assess whether you are achieving your desired objectives
- enabling you to confirm which changes you want to adopt permanently.

The model for improvement diagram



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

Model for Improvement and PDSA worksheet EXAMPLE

Step 1: The Thinking Part - The 3 Fundamental Questions

Practice name:	Date:
Team member:	

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

By answering this question, you will develop your goal for improvement.

Our goal is to:

- Ensure all active patients age 15+ have their alcohol consumption recorded.

This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.

So, for this example, a better goal statement would be:

Our S.M.A.R.T. goal is to:

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

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

By answering this question, you will develop MEASURES to track the achievement of your goal.
E.g. Track baseline measurement and compare results at the end of the improvement.

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 develop the IDEAS that you can test to achieve your CHANGE goal.
You may wish to BRAINSTORM ideas with members of our Practice Team.

Our ideas for change:

1. Using CAT4, identify active patients aged 15 years and older who have not had alcohol consumption recorded.
2. Identify patients from list exported from CAT4 and create a Topbar prompt.
3. Source and provide endorsed patient education resources (in waiting rooms, etc).

The team selects one idea to begin testing with a PDSA cycle.

Note: Each new GOAL (1st Fundamental Question) will require a new Model for Improvement Guide

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

Model for Improvement and PDSA worksheet EXAMPLE

Step 2: The Doing Part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1
You will use this sheet to test an idea.

PLAN	Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data.	*What exactly will you do? Include what, who, when, where, predictions and data to be collected.*

Idea: Using CAT4, identify active patients aged 15 years and older who have not had their alcohol consumption recorded.
What: Mary will conduct a search on CAT4.
Who: Receptionist (Mary)
When: Begin 20 May
Where: at the practice in Dr Brown's room
Prediction: 40% of the active patient population aged 15 years and older will have an alcohol consumption recorded.
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.

DO	**Who is going to do what? (Action)**
Run the test on a small scale	*How will you measure the outcome of your change?*

Completed 20 May – the receptionist contacted Brisbane South PHN for support with the PenCS CAT4 search and the export function. The data search was conducted very quickly, with the receptionist being upskilled to conduct further relevant searches.

STUDY	**Does the data show a change? (Reflection)**
Analyse the results and compare them to your predictions	*Was the plan executed successfully?* *Did you encounter any problems or difficulty?*

A total of 327 active patients (37%) 15 years and older have had their alcohol consumption recorded = 3% lower than predicted.

ACT	**Do you need to make changes to your original plan? (What next)** **OR Did everything go well?**
Based on what you learned from the test, plan for your next step	*If this idea was successful you may like to implement this change on a larger scale or try something new.* *If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.*

1. Create a PenCS Topbar prompt to ensure all patients aged 15 years and older have alcohol consumption recorded. Review this by 31 July (in 2 months' time) to determine if there has been an increase in the % of patients recorded.
2. Ensure the clinical team know how to enter alcohol consumption in the medical software.
3. Remind the whole team that this is an area of focus for the practice.

Repeat Step 2 for other ideas – What idea will you test next?

Model for Improvement and PDSA worksheet template

Step 1: The Thinking Part - The 3 Fundamental Questions

Practice name:	Date:
Team member:	

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

By answering this question, you will develop your GOAL for improvement.

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

By answering this question, you will develop MEASURES to track the achievement of your goal.

E.g. Track baseline measurement and compare results at the end of the improvement.

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

By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal.

You may wish to BRAINSTORM ideas with members of our Practice Team.

Idea:

Idea:

Idea:

Idea:

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

Model for Improvement and PDSA worksheet template

Step 2: The Doing Part - Plan, Do, Study, Act cycle

You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1
You will use this sheet to test an idea.

PLAN	Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data.	*What exactly will you do? Include what, who, when, where, predictions and data to be collected.*
DO	**Who is going to do what? (Action)**
Run the test on a small scale.	*How will you measure the outcome of your change?*
STUDY	**Does the data show a change? (Reflection)**
Analyse the results and compare them to your predictions.	*Was the plan executed successfully?* *Did you encounter any problems or difficulty?*
ACT	**Do you need to make changes to your original plan? (What next)** **OR Did everything go well?**
Based on what you learned from the test, plan for your next step.	*If this idea was successful you may like to implement this change on a larger scale or try something new.* *If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.*

Repeat Step 2 for other ideas - What idea will you test next?

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