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Hi Team

Thank you for the opportunity to provide feedback on the Queensland Government's consultation paper, *Options to improve the Queensland opioid dependence treatment (ODT) system*. The Queensland Network of Alcohol and other Drugs Agencies (QNADA) submission is attached.

QNADA represents a dynamic and broad-reaching specialist network within the non-government alcohol and other drug (NGO AOD) sector across Queensland. We have more than 55 member organisations, representing the majority of specialist NGO AOD providers. This submission is made following consultation with QNADA members.

QNADA is pleased to provide further information or discuss any aspect of this submission. Please don't hesitate to contact me at Rebecca.Lang@qnada.org.au or by calling 0408 669 590.

Yours sincerely



Rebecca Lang

CEO



Submission to the
**Consultation Paper - Options
to improve the Queensland
opioid dependence
treatment (ODT) system**

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This submission has been prepared by the Queensland Network of Alcohol and Other Drug Agencies (QNADA), with the Queensland Alliance for Mental Health (QAMH) providing content related to psychosocial interventions. Its content is informed by consultation with QNADA member organisations providing alcohol and other drug treatment and harm reduction services across Queensland, as well as a review of relevant research and reports.

This submission responds to the issues raised within *Queensland Health's Consultation Paper - Options to improve the Queensland opioid dependence treatment (ODT) system*. Substantial issues with the current ODT system and redesign options to improve the ODT system have been identified with respect to:

- The need to resolve significant institutionalised stigma.
- Undue restrictions on clients decision-making capacity and self-management around choice and control in medication and administration options.
- Issues with the use of QScript within the ODT program.
- Access to Queensland's ODT program.
- The breaches of the Qld Human Rights Act with respect to ODT and harm reduction within prisons and watchhouses.
- A lack of effective mechanisms for oversight and monitoring.
- The proposed positioning of ODT as separate from both the broader AOD treatment system as well as from other forms of health care.

We welcome the opportunity to provide input into the much-needed reform of the ODT program. Many of the issues raised in this submission have been raised previously with Queensland Health and are likely to continue to escalate unless immediate action is taken.

Stigma

As outlined our position paper [Stigma and Discrimination](#), there is an established understanding that experiences of stigma and discrimination are a common occurrence in the lives of people who experience problematic alcohol and other drugs use which impedes treatment seeking as well as the effectiveness of treatment where it is accessed. Specifically, research shows that experiences of stigma and discrimination are common for people receiving ODT in Queensland which negatively effects treatment¹.

The way in the program is implemented and operationalised reproduces certain stereotypes about people who use drugs². This manifests in the paternalistic, highly protocolised, and restrictive nature of ODT treatment delivery in Queensland which frames clients as people in need of management and supervision incapable of making choices for themselves, contradicting what we know works in this space - independence and self-determination¹.

A key issue which hinders ODT clients' ability to develop independence is the restrictive prescribing of take-home doses. The Queensland Opioid Dependence Treatment Guidelines are highly prescriptive in this regard and restrict client's ability to exercise choice and control over treatment. ODT clients consistently report that they are not given access to sufficient takeaway doses, which limits their ability to lead a normal life and disrupts employment, education, family life, and other daily activities. This is compounded by specific practices from some GPs and clinics. QNADA is aware that some clinics

¹ Hall, N. Y., Le, L., Abimanyi-Ochom, J., Teesson, M., & Mihalopoulos, C. (2023). Identifying the most common barriers to opioid agonist treatment in an Australian setting. *Australian journal of primary health*, 29(5), 445–454

² Robin Room et al., "Cross-Cultural Views on Stigma, Valuation, Parity, and Societal Values Towards Disability," in *Disability and Culture: Universalism and Diversity*, ed. Faculty of Social Sciences Stockholm University, Centre for Social Research on Alcohol and Drugs (SoRAD) (Seattle: Hogrefe & Huber Publishers, 2001).

make receiving take-away doses contingent on arbitrary 'goals' such as gaining full time employment, despite the obvious difficulty of achieving this while also accessing daily dosing.

Our members also raised issues around the narrowing of choice of pharmacotherapy options. Queensland's ODT Guidelines encourage long-acting injectable buprenorphine without sufficient consideration of some illicit opioid user's preference for short acting injectables. Clients should be able to exercise some control over their choice of medication. Current practices are at odds with the body of evidence which demonstrates that increasing takeaway doses improves compliance, retention, and treatment uptake as well as relationships between providers and clients and, unsurprisingly, a client's ability to work³.

To address this ODT practices should be aligned with of the Qld Human Rights Act to support self-determination, cultural safety, and conform with the principles of good practice in health service delivery, including:

- Increasing the takeaway doses allowed for both buprenorphine and methadone.
- Allowing for higher numbers again for those travelling interstate or overseas.
- Removing caps on the number of takeaway doses permitted.
- Increasing patient self-determination by giving clients control over the type (long-acting vs short-acting) of medication, as recommended by the Pennington Institute⁴.
- Engaging people with lived-experience (through QuIVAA) when reviewing the current Queensland Opioid Treatment Guidelines.

ODT clients also consistently report judgmental and stigmatising attitudes of pharmacists and other health care practitioners associated with opioid use and treatment. Concerningly, this is a recurrent issue in the research literature⁴. People who use alcohol and other drugs consistently report feeling unsafe to talk about substance use in primary care settings, which limits ODT service availability in primary care⁵. This stigma is reinforced by the need for GPs to undertake specific training to deliver these services, contributing to fears that offering ODT is 'professionally risky'. These issues are further compounded for regional and remote clients, as well as for people from First Nations, Refugee, and Migrant communities⁶. These experiences of stigma will inevitably deter individuals from seeking help or adhering to their treatment plan due to concerns about confidentiality and social judgment.

The Queensland Mental Health Commission's [Don't Judge, And Listen](#) and [Changing Attitudes, Changing Lives](#) reports found that stigma is best addressed by:

- building the capacity of social sector workforces to recognise and reduce stigma and discrimination.
- focusing on evidence-based information sharing.
- strengthening engagement with people with a lived experience.
- promotion of inclusive, rights based, health care responses.

To push back against this stigma, we believe anti-stigma training should be compulsory across staff working in public ODT programs, including systems management and policy positions to ensure ODT

³ Hall, N. Y., Le, L., Abimanyi-Ochom, J., Teesson, M., & Mihalopoulos, C. (2023). Identifying the most common barriers to opioid agonist treatment in an Australian setting. *Australian journal of primary health*, 29(5), 445–454

⁴ Pennington Institute (2023). Opioid pharmacotherapy at the crossroads: enduring barriers and new opportunities. Melbourne: Pennington Institute.

⁵ Michala Kowalski & Liz Barrett, (2020) "Engaging General Practice and General Practitioners in Alcohol and Other Drug Treatment," in Drug Policy Modelling Program Monograph. University of New South Wales.

⁶ Opie, C. A., Wood, P., Haines, H. M., & Franklin, R. C. (2021). "Here Comes the Junkies," Opioid Replacement Therapy in Rural Australia. *Journal of addictions nursing*, 32(1), E1–E10.

client safety and facilitate de-stigmatised information sharing. Particular attention should be paid to rural and remote clients and people that are experiencing multiple intersections of vulnerability. This information should be peer-developed and delivered by people with lived experience and be locally oriented.

QScript

Considering the stigma faced by ODT clients, it is crucial that reforms be implemented in the least intrusive way possible in a way that seeks to uphold the right to privacy and reputation included in the [Queensland Human Rights Act 2019](#). It is concerning that the consultation paper attached to this reform lauds QScript as a strength considering the evidence that prescription drug monitoring programs carry a range of documented harms, including increased stigma and discrimination, untreated pain and mental illness, and a denial of appropriate health care for those identified as ‘high risk’⁷.

As outlined in our submission to the review of QScript in 2023, this process leads to reduced privacy and confidentiality for ODT clients as well as further restriction of people’s decision-making capacity and self-management around choice and control – which are often already limited. Our member services have raised concerns that QScript negatively effects ODT client’s ability to receive equitable healthcare. We have heard concerning stories of GPs being reluctant to prescribe pain medication or benzodiazepines to those on ODT and those who were previously on ODT, driving clients to either relapse back to illicit opioids or suffer unnecessary distress and pain.

The language associated with prescription monitoring also serves to perpetuate stigma and discrimination. Conceptualising people who are currently or have previously been registered on the Queensland Opioid Treatment Program as ‘high-risk clinical scenarios’ within the Monitored Medication Standards only serves to perpetuate stigma; as is the inclusion of a requirement for prescribers or dispensers to document where they have prescribed monitored medicine ‘under duress.’ It is recommended that QScript shifts from a risk-based framework to one that focuses on achieving optimal clinical outcomes an associated reframing of the current language and terminology. Queensland Health should reframe the language and terminology associated with ODT and QScript and strengthen communication in relation to the reasons why someone may need further clinical attention and support if they have been identified through QScript We recommend that Queensland Health cease the use of QScript in ODT settings – or at a minimum review and reengineer the use of QScript within ODT. As outlined in our previous submission to QScript, shifting to a voluntary system may help to mitigate some of these concerns.

QScript is also compounds the foremost challenge for ODT in Queensland – access⁸. Under the QScript regime, OST providers appear to be most at risk of being audited, and most likely to attract restrictions to their practice¹³. The current system also perpetuates a professional perception that ODT is too risky and burdensome to participate in, further impacting on the number of prescribers and limiting access to appropriate health care for people who use drugs despite these substances being clinically safer than other opioids commonly prescribed by practitioners. Queensland is facing a public health emergency with a number of ODT providers having restrictions placed on their scope of practice as part of this enhanced monitoring and regulatory regimen. This has led to a substantial reduction in the availability of prescribers for people accessing ODT.

⁷ Haines, S., Savic, M., Nielsen, S. & Carter, A. (2022) Key considerations for the implementation of clinically focused Prescription Drug Monitoring Programs to avoid unintended consequences, *International Journal of Drug Policy*.

⁸ Penington Institute (2023). *Opioid pharmacotherapy at the crossroads: enduring barriers and new opportunities*. Melbourne: Penington Institute.

Access / Prescribing

Research by the Pennington Institute estimates that current ODT regimes are meeting roughly half of demand and that there are tens of thousands of people who need, but cannot access, ODT¹². The current system relies heavily on a small number of high volume, mostly private sector, prescribers to treat the majority of clients⁹, while new prescribers are not being retained¹⁰. This is due to the treatment of ODT as uniquely ‘high risk’ and separate from other prescription medications. Lengthy approval processes for prescriber permits, additional prescriber training, and burdensome reporting requirements serve as significant barriers to health practitioners becoming OST prescribers¹¹. These requirements also feed a perception that being an OST prescriber is professionally risky. A 2022 survey of Queensland GPs found that the increased scrutiny and reporting requirements associated with ODT made doctors fearful of losing their licence and directly informed decisions not to prescribe¹².

To resolve the prescriber deficit, ODT must be moved into the mainstream and treated as a mainstream health service – no different to the multitude other substances which GPs prescribe. The regulatory burden on GPs who prescribe ODT needs to be reduced. GPs should be allowed to prescribe ODT without additional training or undue monitoring as is current practice for many other prescriptions. Treatment numbers should not be capped, instead high treatment numbers should indicate to system managers to promote support systems for prescribers and/or dispensers such as sharing information of ADCAS, harm reduction services, and psychosocial referral pathways. We would welcome any attempts to lessen the regulatory burden on ODT prescribers. Moving ODT onto the PBS provides an opportunity to reframe the program as business as usual for GPs.

Considering that over 70% of current ODT prescribers are private, more support is needed to encourage uptake within public sector¹³. State funding for provision at public clinics has not maintained pace as demand grows⁹. Queensland Health needs to increase incentives for the prescribing of ODT and should consider the recommendations within the Pennington Report:

- Establish a program offering GPs per-patient incentive payments for active opioid replacement prescribing, structured to retain patients in care throughout the initiation and stabilisation period
- QH should encourage the activation of newly trained prescribers by funding professional mentoring and support networks

Prisons and Watchhouses

There are significant issues around access to ODT in Queensland prisons and watchhouses. It is concerning that Queensland’s current approach clearly prioritises operational requirements of correctional centres over the right to equivalent health services in the community – in contradiction with the [Queensland Human Rights Act 2019](#). Per The Act, the provision of equal access to healthcare for prisoners is an essential human right, however Queensland watchhouses and prisons remain the settings most in need of access to ODT and other harm reduction services. Whilst in theory ODT access has been available across Queensland prisons since 2023, in practice we see barriers and restrictions

⁹ Australian Institute of Health and Welfare. National Opioid Pharmacotherapy Statistics Annual Data Collection. Canberra: Australian Institute of Health and Welfare, 2023.

¹⁰ Jones NR, Nielsen S, Farrell M, Ali R, Gill A, Larney S, Degenhardt L. Retention of opioid agonist treatment prescribers across New South Wales, Australia, 2001-2018: Implications for treatment systems and potential impact on client outcomes. *Drug Alcohol Depend.* 2021 Feb 1;219:108464.

¹¹ Prathivadi, P. & Sturgiss, E.A. (2021) When will opioid agonist therapy become a normal part of comprehensive health care? *The Medical Journal of Australia*

¹² Kowalski M; Barrett L, 2020, Engaging general practice and General Practitioners in alcohol and other drug treatment, UNSW Social Policy Research Centre, Sydney, <http://dx.doi.org/10.26190/5f4def2515991>

¹³ Dietze, P., Kinner, S., Kirwan, A., Ritter, A., Stooze, M. (2019). Queensland Prison OST Evaluation. Centre for research Excellence into Injecting Drug Use.

placed on prisoners at correctional centres across Queensland and resistance to ODT and harm reduction still runs deep amongst staff. The majority of watchhouses in Queensland currently do not provide ODT dosing – even to those stabilised on ODT. This can lead to a range of unnecessary outcomes including:

- Overdose upon arrival at prison or on release to the community due to a reduced opioid tolerance.
- Difficulties re-registration with prescribers after missing dose for 3 days whilst in the watch house.
- Increased risk of high-risk drug taking in prison (to allay withdrawal).
- Increased risk of contracting blood born viruses.
- Increased risk of re-incarceration, due to the person being in involuntary withdrawal upon release, often being de-registered from ODT.

We are also concerned about the choice of options for ODT clients within these settings. Our member services have consistently raised concerns about the restriction of ODT pharmacotherapy options within prisons and watchhouses. ODT is a health service and must – in line with the Queensland Human Rights Act – provide equivalent health service, including equivalent choice. A key recommendation of QCS’s OST Evaluation Report was to “...ensure that all evidence-based OST medications are available at all sites to ensure equivalence of prison health care”¹⁴.

In order to harmonise policy with the right to equivalent health service, we also recommend introducing NSPs within correctional settings. There is a wealth of evidence which shows that NSPs within prisons lead to a marked reduction in the transmission of blood-borne viruses, reduce risk behaviours, reduce death, improve prison safety, and reduce rates of reoffending while there is no evidence to suggest that these programs have unintended negative consequences¹⁵. Queensland Health must, as a matter of priority, work with QPS and QCS to ensure people in Queensland Watch Houses and Prisons have immediate access to ODT, needle exchange programs, as well as the full complement of harm reduction services.

Settings and models of service and care

These barriers underscore the need for increased flexibility in facilitating access. Effective responses to drug use, like other health interventions, should be flexible, realistic and culturally responsive, matched to the needs of individuals based on the level of harm experienced and intensity of use, as outlined in our position paper [Effective Responses](#). Improving the flexibility of service delivery will go a long way to improving the effectiveness and accessibility of ODT in Queensland. Queensland Health should consider other models of delivery to bridge this divide, such as expanding the use of telehealth across ODT settings.

The NGO sector is also ideally placed to deliver additional ODT capacity, including in in-home settings. We recommend further investment to service settings in the NGO sector to provide a suitable setting for either induction or tapering off. Residential rehabilitation services should be utilised to accommodate ongoing maintenance, stabilisation, and other treatments where appropriate. In NSW, WHOS provide a modified Therapeutic Communities model offering residential treatment for stabilisation of opioid dependence (RTOD program), as well as a day program for ODT clients. These

¹⁴ Dietze, P., Kinner, S., Kirwan, A., Ritter, A., Stoove, M. (2019). Queensland Prison OST Evaluation. Centre for research Excellence into Injecting Drug Use.

¹⁵ Rutter, S., Dolan, K., Wodak, A., & Heilpern, H. (2001). Prison-based syringe exchange. A review of international research and programme development. NDARC Technical Report No. 112.

programs, funded and supported by Commonwealth DOHAC and NSW Ministry of Health, offer dosing on site in a safe environment alongside access to a range of medical, mental health, and peer supports.

We also see potential in the proposal to integrate ODT into harm reduction spaces and/or community housing to reducing siloing and enhance access. This should not, however, extend to collaborative models with health hubs or GP super-clinics. We are concerned that this was included as a proposal considering the evidence that these arrangements are fundamentally unsafe or accessible to someone seeking ODT and harm reduction supports¹⁶.

The consultation paper also includes an erroneous assumption that harm reduction services are accessible, which is patently false – particularly for rural and remote Queensland¹⁷. Any efforts to increase ODT accessibility must also consider the concomitant need to increase access to harm reduction services. We welcome efforts to increase access to NSPs, needle and naloxone vending machines, take-home naloxone, as well as the full suite of harm reduction services.

Workforce

Maintaining and growing a skilled AOD workforce is vital for the quality and accessibility of ODT in Queensland. While we support the proposed options to establish graduate rotation positions within AOD services, increases to workforce support, and developments such as communities of practice, there are broader systemic challenges that must be addressed to improve ODT delivery. As outlined in [Achieving Balance](#), growing a skilled and culturally-capable workforce is critical to a well-functioning treatment system. However, there are significant workforce challenges to be addressed including an ageing workforce, insufficient specialist training, challenges in attracting and retaining Aboriginal and Torres Strait Islander workers, negative perceptions deterring new entrants, and staffing shortages in rural and remote areas¹⁸. We recommend that QLD Health design and implement an AOD workforce plan that provides a strategic, coordinated approach for AOD workforce development.

Participation and engagement of people with lived-living experience (PWLE)

Improving engagement with people with lived-living experience (PWLE) must be central to reforms. PWLE should be involved in decisions about the design, implementation and evaluation of health policies, programs and services¹⁹. To facilitate this QLD health should increase engagement with people with lived-living experience, in partnership with QuIVAA, to maximise collaboration with people seeking support across providers and sectors. We recommend that QLD health increase funding for AOD lived-living experience workers to be embedded in clinical spaces where people face the most stigma, particularly in regional and rural areas. There should also be an increased focus on peer support groups in the regional and rural areas.

Policy and planning

We are also concerned that the reforms proposed by the consultation paper appear to frame ODT as a siloed intervention separate from other AOD treatment and harm reduction as well as to other forms of health care more broadly. According to the Pennington report, prescribers are segregated from other clinicians and services as well as to other health care elements, particularly AOD treatment and

¹⁶ Lane, Riki, et al. "When colocation is not enough: a case study of general practitioner super clinics in Australia." *Australian Journal of Primary Health* 23.2 (2017): 107-113.

¹⁷ Opie, C. A., Wood, P., Haines, H. M., & Franklin, R. C. (2021). "Here Comes the Junkies," *Opioid Replacement Therapy in Rural Australia*. *Journal of Addictions Nursing*, 32(1), E1–E10.

¹⁸ Michala Kowalski & Liz Barrett, (2020) "Engaging General Practice and General Practitioners in Alcohol and Other Drug Treatment," in *Drug Policy Modelling Program Monograph*. University of New South Wales.

¹⁹ Australian Commission on Safety and Quality in Health Care (2011). *Patient-centred care: improving quality and safety through partnerships with patients and consumers*.

mental health services at the detriment of service delivery. This dichotomy is directly informed by stigmatised attitudes to ODT according to the report²⁰. ODT should be re-positioned as part of an integrated system across AOD treatment, prevention, and harm reduction, the aim of which is to minimise the harms associated with problematic drug use.

Another core issue with the Queensland ODT model, is a lack of effective monitoring and a concomitant poor understanding of treatment availability and patient outcomes. There is an urgent need to improve the monitoring, and evaluation capability of ODT through improved data collection. Queensland's NOPSAD collection is incomplete – noting that there are significant gaps (2020-2022) where data were missing. Considering the impact of this program, such oversights are unacceptable. To improve this capacity, government should engage with the stakeholders at the nexus of this system; QNADA, QAIHC, QuIVAA, as well as established service providers.

We recommend that Queensland Health introduces statewide data mapping for all AOD services includes both public and private providers, as well as peer sourced data from peak bodies. ODT data capacity, along with data collection for other treatment types should be improved. We also recommend that Queensland Health establish a statewide communication structure across the whole AOD system, which meets at regular intervals, and which provides a holistic, connected approach to ODT in Queensland.

To ensure adequate accountability, complaints mechanisms also need to be reformed. The current process is ineffective and unsafe, placing onus on those facing the injustice – potentially undermining their treatment. We recommend that Queensland Health consider further investment to capture and manage complaints and feedback. Queensland Health should consider further investment into PeerQnect, delivered by QuIVAA, as an independent vehicle to capture and manage complaints and feedback for the ODT system.

Psychosocial supports

Psychosocial support can improve the psychological health, quality of life and social environments and functioning of people accessing opioid dependence treatment (ODT)²¹. QNADA and QAMH agree that the combination of psychosocial interventions and pharmacotherapy can improve therapeutic outcomes, such as retention in treatment, reduced substance use, and less risky injecting behaviours.

Effective AOD treatment services are person-centred and ensure that appropriate screening and assessment is undertaken to develop options and interventions to suit people's individual needs, in collaboration with them. QNADA and QAMH believe psychosocial support must be available within communities but accessed voluntarily, not as a mandatory condition of participation in clinically-led ODT programs. Crucially, program participants must be provided with comprehensive, high-quality information about the benefits and availability of psychosocial support options. This information empowers individuals to make informed decisions about their care. As such, maximising people's choice and control through the provision of this information and support to evaluate options needs to be a key feature of ODT program design. In a space where people are routinely denied the right to self-determination and treatment programs have historically been punitive rather than empowering, this emphasis on informed, voluntary participation is especially important.

While psychosocial supports have significant potential to assist individuals experiencing problematic use of alcohol and other drugs in addressing multiple social determinants impacting their wellbeing,

²⁰ Penington Institute (2023). Opioid pharmacotherapy at the crossroads: enduring barriers and new opportunities. Melbourne: Penington Institute.

²¹ Dugosh, K., Abraham, A., Seymour, B., McLoyd, K., Chalk, M., and Festinger, D., (2016). *A Systematic Review on the Use of Psychosocial Interventions in Conjunction with Medications for the Treatment of Opioid Addiction*. Published online Pub Med Central <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4795974/>

these services remain underutilised and difficult to access. This is largely due to a lack of awareness and limited availability. In Queensland, as in other parts of Australia, funding structures continue to heavily favour clinical access points, acute care provision, and costly biomedical solutions. Conversely, community-managed mental health non-government organisations - which are ideally positioned to respond to human distress earlier, more effectively, and at a lower cost - remain critically underfunded. This imbalance creates significant challenges for the delivery of psychosocial support within ODT programs in Queensland.

For ODT programs, it's crucial that psychosocial support be offered as a voluntary option within community settings, rather than as a mandatory requirement in clinical environments. This approach respects individual choice while offering a more holistic, less stigmatising support system. While Head to Health (now known as Medicare Mental Health Centres) services offer a centralised pathway for support, they aren't suitable entry points for ODT programs due to the specialised training required.

To improve access to voluntary, community-based psychosocial supports for ODT participants, we recommend:

- Ensuring ODT participants are well-informed about available community-based psychosocial support options.
- Enabling easy self-referral to a broad range of Community Mental Health and Wellbeing Sector services, reducing reliance on medical pathways.
- Encouraging referrals from primary care and ODT clinicians to these voluntary, community-based services, promoting a social prescribing approach.

These expanded, community-focused referral pathways could facilitate early intervention for those who choose it, potentially reducing the need for acute care among ODT participants experiencing mental health challenges, while respecting their autonomy.