RACP
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EDUCATE ADVOCATE INNOVATE

Prioritising Health

2020 Queensland election statement

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,000 physicians and 8,500 trainee physicians across Australia and New Zealand, including 1770 physicians and 1016 trainee physicians in Queensland (QLD).[1] The College represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, addiction medicine, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, and rehabilitation medicine.[2]

The RACP acknowledges the traditional owners and custodians of the land on which our members practise, live, and teach. We extend our respect to all Aboriginal, Torres Strait Islander, and Māori people and value the importance of their ongoing connection to land, sea, sky, and community. We pay our deepest respect to Elders past, present, and emerging. And together we re-state our shared commitment to advancing Aboriginal, Torres Strait Islander, and Māori health and education as core business of the College.

Overview

The RACP and its Queensland Regional Committee are committed to working with all political parties on the development of health policies that are based on evidence, informed by specialist expertise and experience, and focused on ensuring the provision of high quality healthcare accessible to all, and integrated across primary, secondary, and tertiary services, as well as across the public and private sectors.

Beyond the drive for medical excellence, the RACP is committed to developing policies, programs, and initiatives which will improve the health of communities and address the inequities that underpin so many poor health outcomes. Patients should have access to an integrated and well-coordinated health system. Governments should take a whole-of-government approach to improve health, including addressing the social determinants of health.

The RACP is committed to advancing Aboriginal and Torres Strait Islander health and education as core business of the College, implemented via a comprehensive Indigenous Strategic Framework. We are a founding member of the Close the Gap Campaign for equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030, and we advocate strongly in conjunction with valued partners including Indigenous peak health organisations.

Queensland has made real gains in recent years that we applaud and want to see maintained. These include a strong response to accelerated silicosis, and legislation to ensure each Hospital and Health Service has both a strategy for achieving health equity for Aboriginal people and Torres Strait Islander people, and one or more Aboriginal and/or Torres Strait Islander people as board members.[3]

This statement sets out our advocacy priorities for the coming years.

The Impact of COVID-19

The next parliament, and the government in office after this election, will faces challenges like never before.

Due to the epidemiology of the novel coronavirus that causes COVID-19 and the need, at times, for a very nimble public health response, we are not making specific recommendations about it in this statement except in respect to physician and trainee wellbeing. However, as the sole accredited provider of specialist medical education for public health physicians, infectious diseases physicians, and respiratory physicians and paediatricians (among other specialties), we seek and expect appropriate input into Queensland's ongoing management and response to COVID-19.

In addition to death, suffering, grief, societal disruption, and social distancing around the world, the COVID-19 pandemic poses a high-stakes set of tests for the next QLD government and the specialist medical community alike. Simultaneously, the pressure to mitigate and combat the novel coronavirus has brought about real collaboration and ingenuity, which the incoming government should support and foster. This is a pivotal moment for the health and healthcare needs of Queenslanders. The foundation of innovation must be a stable, well run, and well resourced hospital system. Now is not the time for belt tightening, especially in the areas of general medicine which carry the load of routine, day in day out physician care.

Lessons can be learned from the effective approach taken by Aboriginal and Torres Strait Islander public health practitioners and researchers in Queensland and nationally to combat the impact of COVID-19. This approach has been pivotal in identifying the issues, setting priorities, and proposing solutions for culturally informed strategies relating to the COVID-19 response, including in remote communities. Self-determination has been fundamental to the outcomes, as has a consistent equity lens.

Our priorities

We have identified six priority areas for 2020 and beyond, each with specific recommendations for the incoming government. These priorities reflect the clinical expertise and professional experience of our members, as well as the opportunities for improvement that we and our physician and trainee colleagues across the state encounter in the course of our work. These priority areas have been selected because we see clear potential benefits to overall health and improved patient outcomes.

Over and above these priority areas, we seek a continued cooperative and productive relationship with the government in the next term, noting that the RACP routinely makes important contributions and submissions to parliamentary (and other) inquiries, taskforces, panels, and reviews. As the professional organisation for physicians and paediatricians, the RACP is a key source of advice and expertise across specialist medicine, health, hospitals, and health systems. To enable us to provide that advice we consult internally each and every time, which means we have not always been able to meet very short deadlines given to us. We respectfully request 4-6 weeks minimum for all but the most urgent matters, and always when we are invited to contribute to parliamentary committee work or routine Queensland Health consultations.

Our objective is to provide advice on improving and optimising the Queensland health system so it continues to operate at a world-class level, delivering good health outcomes in a sustainable way that works well for patients and physicians alike. This will require innovation, increased efficiency and effectiveness, and a focus on integrated high quality, high value specialist care.

1. Wellbeing of the specialist and trainee specialist workforce

Doctors' health and wellbeing is a growing concern within the RACP, and within the medical profession and the community more generally, prompted by several tragic early deaths of doctors in training. A steadily increasing literature, and a profession-wide consensus supports wellbeing being taken appropriately seriously.

We have long known that junior doctors report high rates of burnout, emotional exhaustion, and cynicism,[4] and our members see this phenomenon first-hand. All RACP's Queensland trainees, like most junior doctors, are simultaneously engaged in postgraduate specialist medical training and work in the state's health system in over 60 accredited training locations statewide.

The RACP recognises that high quality specialist training is demanding and that there are intrinsic pressures and stressors within medical workplaces that are not always avoidable. Specialist training is a shared responsibility, and we believe that improving the health and wellbeing of trainees requires the cooperation of government, hospitals, health services, specialist colleges, training supervisors, doctors' own doctors, and doctors themselves.

The RACP has previously joined the New South Wales Government, other colleges, educators, and regulators in endorsing the NSW Health *Statement of Agreed Principles on a Respectful Culture in Medicine,* which recognises that "past practices and behaviours have not always met the accreditation standards required to provide a safe, inclusive and respectful environment." We encourage the adoption or development of a comparable Statement of Agreed Principles in Queensland.

The RACP is determined to take an active role in shaping a healthier training culture for doctors. While recent improvements to working hours and culture in medicine are a good start, more needs to be done to address the untenable working hours and unacceptable behaviour in some hospitals and training sites.

As indicated in our new accreditation standards, our expectation is that all training sites provide a safe, respectful working and learning environment and address any behaviour that undermines self-confidence or professional confidence as soon as it is evident.

The RACP seeks a continuing commitment from all political parties to work in partnership with the College finding ways to combat discrimination, bullying, harassment, and racism. This includes taking proactive steps to enable, normalize, and accommodate safe work arrangements and practices, and to support all aspects of a physician's work including leadership, training, and career development opportunities in a way that is appropriately mindful of family and other care responsibilities.

Bullying or harassment of any kind is totally unacceptable—to or from Fellows, trainees (of the RACP or other colleges), non-trainee junior doctors, other health practitioners, or anybody. The RACP has zero tolerance for such behaviour.[5]

While working conditions are improving for junior doctors, albeit gradually, there are also areas of improvement for senior doctors. At present, many physicians and paediatricians have only enough time for clinical duties. The RACP would like the government in office after the election to explore measures that

support senior doctors' ongoing professional development, and flexibility to conduct research. These are key to maintaining Queensland as an international leader in health care and medical research.

The RACP also invites all parties to commit the post-election Queensland Government to signing our Health Benefits of Good Work principles, an initiative from the RACP's Australasian Faculty of Occupational and Environmental Medicine (AFOEM).

Our recommendations reflect the RACP's strong support for building a safe and respectful culture of training for junior doctors, and high-quality specialist care for patients.

The RACP recommends the incoming Government:

- Prioritise and commit to improving trainee and physician health and wellbeing, to providing a positive workplace culture and working conditions for trainees and physicians.
- Commit to workplaces and workforce models that support high quality specialty training.
- Work collaboratively with the RACP and other stakeholders to eliminate bullying and harassment.
- Adopt the NSW Statement of Agreed Principles on a Respectful Culture in Medicine, or develop a comparable one in Queensland.
- Become a signatory to the AFOEM Health Benefits of Good Work Principles to further champion health and wellbeing and supportive workplace culture in the health sector.

2. Doctors' wellbeing during a pandemic

Over and above morbidity and mortality from COVID-19's physical affects, published literature attests to higher rates of anxiety, distress, insomnia, and symptoms of depression among doctors and nurses in fever clinics and wards for patients with the disease.[6]

In addition, there is established literature examining the effects on healthcare workers of previous novel infectious diseases including Severe Acute Respiratory Syndrome (SARS) patients. For example, in 2003, Toronto healthcare workers caring for SARS patients reported higher levels of burnout, psychological distress, and post-traumatic stress compared to a control group nearby. [7]

Another study of SARS in Taiwan indicates that, in addition to readily conceivable reasons for emotional distress such as fear of contagion, concern for family members, stigma, and interpersonal isolation, "conscription of non-specialists into infectious disease work" was associated with the presence of significant emotional distress.[8] It is important that health systems and the governments that run them take active steps to minimize the psychological impact which we know can result from such work.

A rapid review and meta-analysis conducted by Queensland researchers in early 2020 examined the psychological impact on healthcare workers who worked during viral epidemics such as SARS (2003), H1N1 Influenza (2009), Middle East Respiratory Syndrome (2012), H7N9 Influenza (2013), and Ebola virus disease (2014):

> *[F]actors for psychological distress included being younger, being more junior, being the parents of dependent children, or having an infected family member. Longer quarantine, lack of practical support, and stigma also contributed.*[9]

The meta-analysis found the following factors to be protective for psychological wellbeing:

- Frequent short breaks
- Adequate time off work

- Family support
- Clear communication between hospital and staff
- Faith in infection control measures
- Access to psychological support services[10]
- Development of staff support protocols
- Access to adequate PPE
- Seeing infected colleagues getting better
- A general drop in disease transmission
- Age and experience was correlated to lower stress.

While the quality of findings varies, it is clear that psychological support and a range of practical measures can make a difference in reducing psychological morbidity among healthcare workers. While the epidemiology of COVID-19 is different to previous viral epidemics, these findings may point to potential strategies the Queensland Government can institute, promote and encourage.

Media and medical literature have reported deaths by suicide among healthcare workers in multiple countries. While noting that many deaths by suicide are multi-factoral, the burden of treating patients who are unable to have visitors falls on hospital staff. Doubtless an emotional toll falls on those who provide end of life care to patients who die of COVID-19 while unable to see their loved ones.

The Queensland Government should generate a state-specific healthcare worker wellbeing strategy that is dedicated to the mental health and wellbeing of Queensland healthcare workers and other essential workers (such as aged care staff), based on the National Mental Health and Wellbeing Pandemic Response Plan. That national plan correctly identifies that:

> *There is a particular risk of deterioration in the mental health of frontline and health workers who are actively involved in responding to the COVID-19 pandemic in the short and long term. The physical experience of providing safe care, heightened physical isolation from loved ones, hypervigilance, higher demands in work, and reduced capacity to access social support all heighten the risks for these essential workers. Research from previous pandemics confirms this, demonstrating increased rates of PTSD among these workers.*

This National Plan has been supported by National Cabinet and was developed with the leadership of other jurisdictions (New South Wales, Victoria, and the Commonwealth).

It is a Queensland Government responsibility to deliver on the important and specific immediate actions which the Plan carefully outlines and “encourage[s]” – in other words, this will take a political decision to implement its recommendations in Queensland.

The potential for widespread COVID-19 infections in Queensland generally has detrimental effects on doctors’ wellbeing, even aside from the potential for direct effect from contracting COVID-19 in their workplaces. We know this has been the case in previous viral outbreaks.[11] Indeed, there is some evidence that while small case numbers are obviously desirable overall, the impact may be worse for the particular health care workers who care for one patient only.[12]

The incoming government has a duty to develop robust arrangements to provide continuity of care for patients (including for non-COVID-19 related healthcare) while maximising policy settings, actions, and activities that most effectively support doctors’ wellbeing. The incoming government should bear in mind that the unique stressors and risks for healthcare workers exist on top of the widespread stressors and risks that are being experienced by the general public, such as family members’ unemployment, isolation, and fear.

In relation to doctors' wellbeing during the pandemic, the RACP recommends the incoming government:

- Swiftly develop detailed plans to minimise the infection risk to healthcare workers likely to be at elevated risk of coronavirus infection.
- Develop arrangements to address issues including but not limited to:
    - PPE supply and availability
    - PPE training and fit-testing
    - backfilling of staff on sick leave or in precautionary isolation
    - the risk to physicians' families and the burden that risk causes on healthcare workers
    - job instability
    - confidential psychological support services
- Support wellbeing research.
- Implement protective measures in a way that permits accurate evaluation and refinement over time.
- Ensure support for health services to continue training and assessment for medical specialist trainees in this pandemic. This requires rostering and resourcing to enable participation in education, study leave, and exam preparation and attendance.

In relation to PPE,[13] the RACP is on the record urging all governments to:

- Commit to a target of zero occupationally acquired healthcare worker COVID-19 infections.
- Ensure frontline health care workers have access to necessary PPE (in public and private hospitals as well as residential aged care settings).
- Ensure physicians and paediatricians working in private practice in the community can access the National Medical Stockpile for their PPE requirements.
- Provide transparent information about reserves in the National Medical Stockpile, including by jurisdiction.
- Report nationally, and by jurisdiction, on health care workers testing positive to COVID-19 by jurisdiction, age group, occupation, primary workplace, and whether the infection was occupationally acquired.
- Extend PPE requirement for the use of N95 masks to aged care facilities.

3. Geriatric and related services

Queensland has good geriatric service availability in many areas, but expanding access beyond metropolitan Queensland remains a challenge. The availability of geriatric medical and psychogeriatric services should be expanded, including by outreach and telehealth.[14] Combined with the aging population, gaps in service coverage means Queensland requires a range of measures designed to support the quality of life of all people in Queensland.

As the RACP said in our submission to the Royal Commission into Aged Care Quality and Safety, residential aged care facilities (RACFs) have their services precariously stretched in an operating environment that has

seen state government funding reductions to other providers of related services. There is constant pressure to discharge patients from acute care facilities back to residential care, and the funding of residential care tends to underfund higher care patients. Moreover, the level of resources is too narrow given its span of responsibility across residential aged care. RACFs must currently provide the full breadth of highly specialised services to younger and older patients which include:

- Acting as a specialist dementia service managing the full range of 'difficult to manage' behaviours.
- Providing high quality medical and nursing care to older people with highly complex care needs.
- Administering hospice care for the dying, bearing in mind the average life expectancy in RACFs is just over two years, meaning that 30% of residents die each year. Most would like to die among family and friends, but RACFs often lack the physical environments or the trained staff to facilitate good end of life care.
- Delivering medical, nursing and behavioural management for younger people with brain injury and other neurodegenerative diseases.
- Being a mental health service for older people with chronic cognitive and psychogeriatric problems, given that at least 60% of residents have dementia, many of whom have challenging behaviours which cannot be managed in physically unsuitable environments by staff with very limited training.
- Providing a rehabilitation unit for people discharged from hospital with delirium or deconditioning resulting from acute illness. [15]

Queensland should fund and facilitate the development of community situated services that promote healthy aging, such as community transport for older people, and should ensure adequate funding to build up community services for geriatric evaluation and home-based rehabilitation.

While we acknowledge that RACFs are predominately a Commonwealth responsibility, we see a role for Queensland in improving the interface between hospital and residential care sectors, especially with regard to people experiencing additional layers of complexity, such as commonly caused by mental illness; dementia; physical and/or mental disability; behavioural issues; and people requiring residential care facilities who are not yet in the age brackets for which aged care is normally designed.

We are concerned that some patients may remain in hospital for lack of appropriate accommodation or suitable disability or behavioural services – in some cases, for many months. Some people's discharge is delayed for non-clinical reasons; in other cases discharge occurs but to facilities that are suboptimal and not designed to meet the patient's needs. For example, it takes too long to provide post-hospital discharge care and accommodation for people who have intellectual disabilities with significant behavioural issues. These people end up spending prolonged periods in acute hospitals with large resources being required to ensure the safety of the person and other inpatients and staff.

Acknowledging the complex interplay of clinical decision-making, bureaucratic processes, and paucity of options, having people linger in acute care settings often serves the patients poorly, in addition to being a poor use of resource-intensive acute hospital services.

Queensland needs to provide or facilitate appropriate residential and care services to people under 65, including young and middle-aged adults, whose condition means they are currently accommodated in facilities not designed or suitable for them.

The RACP calls on the incoming government to:

- Commit to incorporating the recommendations of the Aged Care Royal Commission, where relevant and implementable by the Queensland government.
- Commit to developing a long-term statewide strategy for the provision of geriatric and related services in Queensland, mapped to need and estimated future need, covering hospital and community settings.
    - This should involve appropriate input from disability advocacy organisations, consumers, carers, medical specialists, other health and care professionals, and the Queensland Public Advocate.
    - This strategy should aim at the creation of a properly funded network of facilities and services, designed by consumers, people with a disability, geriatricians, psychiatrists, and other medical specialists (including psychiatrists), allied health practitioners, and other support professionals.

- Support hospital based general medicine services where the bulk of acute medical care is carried out with inpatient frameworks for managing patients with Behaviours and Psychiatric Syndromes of Dementia.
- Ensure there is sufficient funding to meet the needs in ambulatory and community settings (including residential aged care facilities) for appropriately qualified palliative medicine, geriatric medicine and other physicians and advanced trainees.
- Fund and facilitate the development of community situated services that promote healthy aging, such as community transport for older people

- Ensure adequate funding to build up community services for geriatric evaluation and home-based rehabilitation.

- Commit to working with the Federal government to provide appropriate (and age-appropriate) accommodation and care services for non-geriatric patients, including addressing differing needs of:

    - People with intellectual disabilities.

    - People with dementia and related diseases.

4. Drug and alcohol strategy and services (including detox facilities), especially in regional areas

Substance use disorders are a health issue, and governments should move away from the dominant paradigm of criminality as the means to deal with individuals who use alcohol and other drugs. The incoming government should instead adopt an increased focus on health and wellbeing to improve outcomes for individuals and communities more broadly.[16]

Alcohol

Despite ongoing and concerted advocacy from public health experts, including the RACP, alcohol remains one of the most harmful drugs in Australia and a leading contributor to disease. Alcohol is responsible for 4.6 percent of the total disease burden across Australia and is a factor in over 30 diseases and injuries.

While the prevalence of Fetal Alcohol Spectrum Disorders (FASD) in Queensland – and in Australia – is unknown, it is believed that nationally alcohol is the most common preventable cause of neurodevelopmental disability. Qualitative reporting shows that many children who had been exposed to prenatal alcohol are experiencing learning and emotional difficulties, and that a considerable number of affected young people are coming into contact with the juvenile justice system.[17]

Alcohol-related harms create enormous social and economic costs to Australian society, with estimates putting the figure at between $15 billion and $36 billion annually.[18] This is a cost of between $604 and $1450 per person per year.

The RACP's Alcohol Policy, developed jointly with the Royal Australian and New Zealand College of Psychiatry, provides an in-depth review of the evidence and provides recommendations on effective policies to reduce the harms of alcohol.[19]

As well as addressing harmful consumption, the RACP is calling for an increase in the availability and range of treatment services for those with alcohol addiction.

Evidence shows that a coordinated public health approach to reducing alcohol consumption is required to comprehensively tackle the harms associated with alcohol – this must involve all levels of government. The incoming government must demonstrate leadership in pro-actively working across jurisdictions to help instigate and support a national approach to addressing drug and alcohol issues.

Using price signals and targeted investment to amplify harm minimisation
Recommended actions:

- Introduce minimum unit pricing.

- Invest in alcohol and other drug treatment sector reform through access to a multidisciplinary workforce and increasing workforce capacity through professional development, investment in physical infrastructure, addressing unmet demand for treatment and providing for a range of treatment models.

- Increase funding for prevention services to reduce the incidence of alcohol and other drug misuse.

Improving data collection to ensure targeted and evidence-based policy
Recommended actions:

- Put in place appropriate infrastructure and data collection systems for alcohol-related medical consultations, ambulance call outs, emergency department presentations and hospital admissions, and for other key issues such as family violence.

- Introduce a system for ongoing monitoring of alcohol-related harm, including harm to others, especially within the hospital sector, and for monitoring and analysis of assessments and diagnoses of FASD.

Reducing the rates of FASD and other alcohol-related physical and psychological health outcomes connected to alcohol use in pregnancy and breastfeeding
Recommended actions:

- Educate communities, particularly high-risk communities, on the harms of alcohol use in pregnancy and breastfeeding.

- Support the national rollout of the warning labelling scheme for alcohol products in pregnancy.

- Ensure appropriate dissemination of the new national NHMRC guideline on alcohol use in pregnancy and breastfeeding (once finalised) to health professionals and the public and encourage health professionals to talk about alcohol consumption during pregnancy with women who are pregnant or seeking to fall pregnant.

- Provide routine screening and early interventions for women of reproductive age who use alcohol or have alcohol dependency.

Strengthening licensing provisions

- Improve monitoring of and compliance with the existing and upcoming regulations for licensed venues and off-licence liquor sales premises, especially in relation to online sales and home delivery.

Drug and alcohol services

Drug and alcohol services in Australia are chronically underfunded and consistently overstretched. This has been clearly shown by the work undertaken on the *Drug and Alcohol Service Planning Model* (DASP) and the *Drug and Alcohol Clinical Care and Prevention Project* (DACCP), developed by a project team with representation from Commonwealth and state governments, health care providers and consumers. These are valuable tools available to governments to determine the level of need for drug and alcohol treatment across Australia.

Every year approximately 200,000 Australians access drug and alcohol treatment. However, it is estimated that an *additional* 200,000 to 500,000 Australians annually are not able to access the treatment they need. Even on an economic analysis, increased treatment is a good investment: one estimate is that for every dollar invested in treatment for substance use disorder is associated with a monetary benefit to society of $7, primarily because of reduced costs of crime and increased employment earnings.[20]

Specific alcohol treatment services include helplines, detoxification, withdrawal management, and counselling delivered by government, non-government and private providers in a range of settings such as hospitals, general practices and residential programs.

The availability of drug and alcohol services can be made more equitable, bearing in mind geography, rurality, ability to meet out of pocket cost, and other factors. Noting that an appropriate mix of these (and other) services is needed to cover the range of patient needs, we recommend specifically that publicly available

detoxification beds need to be more accessible to people in Queensland. Currently, the Hospital Alcohol and Drug Service (HADS) is the only public specialist detox unit in the state, and is Brisbane-based. We recommend the allocation of funds (set-up and recurrent) to increase inpatient detoxification beds.

The RACP and its Australasian Chapter of Addiction Medicine support the principles of real-time prescription monitoring. However, we are concerned that due to the acute shortages of health professionals with the required expertise (especially Addiction Medicine Physicians), appropriate treatment will not be available for the cohort of individuals in need of them who will be identified through the introduction of QScript.

The incoming government should:

- Increase funding for drug and alcohol treatment services, including supporting appropriate workforce development, to address the unmet need.
- Increase investment in prevention services to reduce the incidence of illicit drug use and alcohol use disorders.
- Invest in and support initiatives to reduce the inappropriate and harmful use of prescription drugs.
- Prioritise specialist addiction workforce development so that the availability of specialist treatment is commensurate with the identified need.
- Commit to exploring a pain-focused telehealth facility dedicated to supporting general practitioners in their management of rural pain patients, particularly those at risk from problematic use of opioid analgesics.

5. Raising the age of criminal responsibility

The RACP, along with the Australian Medical Association[21] and the Australian Indigenous Doctors' Association[22], recommends that the minimum age of criminal responsibility be raised to at least 14 years of age in all Australian jurisdictions. It is inappropriate for 10 to 13 year olds to be in the youth justice system.

Children aged 10 to 13 years old in the youth justice system are physically and neurodevelopmentally vulnerable. Most children in the youth justice system have significant additional neurodevelopmental delays.

Children aged 10 to 13 years old in juvenile detention have higher rates of pre-existing psycho-social trauma which demands a different response to behavioural issues than older children.[23]

A range of problematic behaviours in 10 to 13 year old age children that are currently criminal under existing Australian law are better understood as behaviours within the expected range in the typical neurodevelopment of 10 to 13 year olds with significant trauma histories (typically actions that reflect poor impulse control, poorly developed capacity to plan and foresee consequences such as minor shoplifting or accepting transport in a stolen vehicle).[24]

Given the high rate of neurodevelopmental delay experienced by children in juvenile detention, including conditions such as Fetal Alcohol Spectrum Disorder (FASD) and delayed language development, these behaviours often reflect the developmental age of the child, which may be several years below their chronological age. Determining criminal responsibility on the basis of a chronological age is inappropriate for children who may have a much lower developmental age due to a number of medical and developmental conditions.

Young children who exhibit problematic behaviour as a result of their neurodevelopmental conditions, and their families, need appropriate healthcare and protection. Involvement in the youth justice system is not an appropriate response to addressing problematic behaviour that stems from these conditions. It further damages and disadvantages already traumatised and vulnerable children.

The RACP position statement on the Health and Wellbeing of Incarcerated Adolescents provides further detail on the health issues of young people in contact with the criminal justice system.

The incoming government should:

- Raise the minimum age of criminal responsibility to 14.
- Support raising the age at meetings of the Council of Attorneys General.
- Commit to reducing the high rates of incarceration of Indigenous young people.
- Commit to housing zero young people in adult facilities, both before and after the age of criminal responsibility is raised.

6. Urgent action to address accelerated silicosis

Silicosis, or fibrosis of the lungs due to inhalation of crystalline silica dust at work, is a disease that was thought to be declining in Australia until recent years. However, there has been a concerning resurgence in cases of accelerated silicosis in Queensland which has resulted in young workers developing severe progressive lung disease and disablement.

While silicosis is not a new disease, the information that has already been collected on the accelerated silicosis epidemic that has emerged since 2018 indicates that this new form of the disease is different. It develops with a lower level of exposure to silica dust; progresses much more rapidly; and is frequently much more severe than previously reported cases of silicosis.

Use of artificial stone is widespread throughout Australia. The accelerated silicosis cases have been identified in workers and stonemasons using artificial stone (also known as engineered, reconstituted or manufactured stone, and quartz conglomerate), which contains very high levels (often at least 90%) of crystalline silica. Engineered stone is used to make bench tops in kitchens, bathrooms and laundries, often in new developments during the housing boom. Due to the rapidly progressive nature of this type of silicosis, there is a high burden of disablement and distress and no effective treatment.

We welcome the significant steps the Queensland Government has taken to tackle this epidemic of accelerated silicosis amongst engineered stone workers, including a commitment to the National Dust Disease Taskforce, the implementation of a comprehensive health screening program for workers exposed to respirable crystalline silica, compliance auditing of workplaces, a legally enforceable “Code of Practice” for “Managing respirable crystalline silica dust exposure in the stone benchtop industry,” and mandatory reporting once a dust lung disease is diagnosed.

We commend the Queensland Government’s Office of Industrial Relations (OIR) for the development of the OIR Guideline to assist clinicians who are assessing workers exposed to silica dust generated from engineered stone. This guideline was developed in consultation with the Practitioner Reference Group which includes representation from the RACP’s Australasian Faculty of Occupational and Environmental Medicine (AFOEM) and the Thoracic Society of Australia and New Zealand (TSANZ) as well as other medical specialist groups.

There are potential major costs to public hospitals arising from the management of this preventable disease. These diseases are difficult to diagnose and require expert respiratory diagnostic services and surgical expertise for lung biopsy. The cost of lung transplantation is borne by state and territory governments, albeit partially federally funded through the COAG Agreements, as are the significant disability and medical costs. Consequently, prevention and identification of silicosis in its early stages will likely reduce demands on the public hospital system.

This situation requires a national response centred around the urgent establishment of a national occupational lung diseases registry to map cases in similar industries across Queensland, as well as action from state and territory governments nationwide.

The RACP calls on the incoming Queensland government to:

- Continue to enforce the prohibition on uncontrolled dry cutting techniques.
- Collaborate with the Federal and other state and territory Governments as this is a national problem. An effective response requires the collaboration of all stakeholders.
- Establish the best possible disease notification and data and information systems to provide the necessary information about Queensland cases in a national registry.
- Ensure these systems are designed and continue to operate robustly, with advice from all relevant medical and health professionals involved in the diagnosis and treatment of accelerated silicosis, including occupational and respiratory physicians, radiologists, and occupational hygienists.
- Initiate appropriately scaled public and industry-specific education/awareness campaigns, informed by the best evidence about how they can affect industry behaviour and worker safety.

The Way Forward

High quality and local training of junior doctors, including physician trainees, is crucial to ensuring the availability of a competent specialist workforce to meet current and future healthcare needs.

The incoming government must be cognisant of, support, and value the contribution made by physicians to training junior doctors within the Queensland health system. Direct clinical care is the ultimate role of most specialist medical practitioners, but their duties to that end include indispensable non-clinical activities such as supervision, research, mentoring, and management.

The incoming government should acknowledge that these activities constitute an essential investment in Queensland's future specialist workforce, including in specialties with relatively few practitioners in the state, and:

- Recognise that the training of physicians is an integral part of the delivery of healthcare services, and commit to services having adequate physical resources and sufficient protected time for teaching, supervision, and research.
- Support the health and wellbeing of physicians and physician trainees, and collaborate with sector partners in improving training environments and medical professional culture.
- Continue to work with the Commonwealth and other states and territories in undertaking workforce planning.
- Ensure that any post-election new directions in clinical workforce are only developed and implemented with appropriate consultation with, and appropriate input and leadership from, physicians and the RACP.

The RACP calls on all political parties and candidates to make a commitment to the health of all people in Queensland extending beyond the election cycle, and to engage and work with key health stakeholders to deliver effective evidence-based and expert-informed health policies. Foundational to this is adequate time for consultation, which we have not always been given.

Developing relationships with government in support of RACP advocacy priorities is both a commitment of the RACP Board[25] and a priority for the Queensland Regional Committee.

We therefore look forward to working collaboratively with the incoming government, as well as all successful candidates, to improve the health of all people in Queensland.

To provide us with a response to these election priorities or to seek more information about the RACP and the Queensland Regional Committee, please contact Ms Tracey Handley, Senior Executive Officer, by emailing RACPQLD@racp.edu.au.

[1] As of 30 June, 2019.
[2] For a diagram showing the diversity of RACP medical specialities, training programs, and qualifications, see of the RACP Strategic Plan 2019-2021, p. 25.
[3] See RACP submission to the Queensland Health Equity consultation, May 2020.
[4] National Mental Health Survey of Doctors and Medical Students (beyondblue, 2013, dataset and executive summary available by request).
[5] See Respectful Behavior in College Training Programs, and Statement on Safe and Respectful working environment (7 February 2019).
[6] Lai J, Ma S, Wang Y, et al. Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019. *JAMA Netw Open.* 2020;3(3):e203976.
[7] For example, see Maunder R, Lancee W, Balderson K, Bennett J, Borgundvaag B, Evans S et al. Long-term Psychological and Occupational Effects of Providing Hospital Healthcare during SARS Outbreak. Emerging Infectious Diseases. 2006; 12(12):1924-32;doi 10.3201/eid1212.060584.
[8] Chen CS, Wu HY, Yang P, Yen CF Psychological distress of nurses in Taiwan who worked during the outbreak of SARS. Psychiatr Serv. 2005;56:76–9 10.1176/appi.ps.56.1.76
[9] Occurrence, prevention, and management of the psychological effects of emerging virus outbreaks on healthcare workers: rapid review and meta-analysis, BMJ 2020;369:m1642, *BMJ 2020; 369 doi: https://doi.org/10.1136/bmj.m1642.*
[10] It is possible that access to psychological support services is a protective measure indepently of whether those services are utilized. Further investigation of this point would potentially be warranted.
[11] Lin C, Peng Y, Wu Y, Chang J, Chan C, Yang D. The psychological effect of severe acute respiratory syndrome on emergency department staff. Emergency Medicine Journal. 2007;24(1):12-7;doi 10.1136/emj.2006.035089.
[12] See Styra, Rima et al. "Impact on health care workers employed in high-risk areas during the Toronto SARS outbreak." *Journal of psychosomatic research* vol. 64,2 (2008): 177-83. doi:10.1016/j.jpsychores.2007.07.015, including this finding: "[t]he level of contact (number of patients with SARS treated) has an important mediating effect on the degree of PTSS experienced. Data showed that caring for only one patient with SARS is significantly more stressful than caring for none or caring for two or more patients with SARS."
[13] The RACP recently conducted a survey of Australian members on PPE. A precis of results is available here, from which the report is also downloadable, along with a selection of international media coverage and a summary of our call to governments:
[14] We note here the joint statement of the Faculty of Psychiatry of Old Age of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australian and New Zealand Society for Geriatric Medicine (ANZSGM), "Relationships between old age psychiatry and geriatric medicine."
[15] RACP submission to the Royal Commission into Aged Care Quality and Safety (December 2019), p. 41.
[16] See RACP submission to the Victorian Parliament Law Reform, Road and Community Safety Committee Inquiry into Drug Law Reform, March 2017 for more detail on our approach to drug and alcohol use and harm minimization.
[17] https://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/7232/1/DOH_FASD_Strategy_Web.pdf
[18] The Royal Australasian College of Physicians. Alcohol Policy, p 1.
[19] The Royal Australasian College of Physicians. Alcohol Policy.
[20] Ettner, S., Huang, D., Evans, E., et al. (2006). Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"? Health Services Research, 41(1), 192-213.
[21] https://ama.com.au/gp-network-news/ama-calls-age-criminal-responsibility-be-raised
[22] https://www.aida.org.au/wp-content/uploads/2018/03/20171121-JOINT-MEDIA-RELEASE-Rasie-the-age-PR_PDF.pdf
[23] Abram KM, Teplin LA, et al. *Posttraumatic Stress Disorder and trauma in youth in juvenile detention*. Archives of General Psychiatry, 2004. 61. 403–410
[24] Johnson, Sara B. et al. Adolescent Maturity and the Brain: T*he Promise and Pitfalls of Neuroscience Research in Adolescent Health Policy* Journal of Adolescent Health, Volume 45, Issue 3, 216 - 221
[25] See Goal 5, Advocacy & Influence, of the RACP Strategic Plan 2019-2021, p. 20.