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Engaging general practice and General Practitioners in alcohol and other drug treatment

Drug Policy Modelling Program
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DPMP Drug Policy Modelling Program

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The Drug Policy Modelling Program

This monograph forms part of the Drug Policy Modelling Program (DPMP) Monograph Series.

Drugs are a major social problem and are inextricably linked to the major socio-economic issues of our time. Our current drug policies are inadequate, and governments are not getting the best returns on their investment. There are a number of reasons why:

- there is a lack of evidence upon which to base policies
- the evidence that does exist is not necessarily analysed and used in policy decision-making
- we do not have adequate approaches or models to help policy-makers make good decisions about dealing with drug problems, and
- drug policy is a highly complicated and politicised arena.

The aim of the DPMP is to create valuable new drug policy insights, ideas and interventions that will allow Australia to respond with alacrity and success to illicit drug use. DPMP addresses drug policy using a comprehensive approach that includes consideration of law enforcement, prevention, treatment and harm reduction. The dynamic interaction between policy options is an essential component in understanding best investment in drug policy.

DPMP conducts rigorous research that provides independent, balanced, non-partisan policy analysis. The areas of work include:

- developing the evidence-base for policy
- developing, implementing and evaluating dynamic policy-relevant models of drug issues, and
- studying policy-making processes in Australia.

Monographs in the series are listed and available to download from the DPMP website.

DPMP strives to generate new policies, new ways of making policy and new policy activity and evaluation. Ultimately our program of work aims to generate effective new illicit drug policy in Australia. I hope this Monograph contributes to Australian drug policy and that you find it informative and useful.

Professor Alison Ritter, Director, DPMP

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Abbreviations

ADCAS	Alcohol & Drug Clinical Advisory Service
ADIS	Alcohol & Drug Information Service
AOD	Alcohol and Other Drugs
CoPs	Communities of Practice
DPMP	Drug Policy Modelling Program
GLAD	GP liaison in alcohol and other drugs
GP	General Practitioner
GPLO	General Practice Liaison Officer
MBS	Medicare Benefits Schedule
OTP	Opioid Treatment Program
PCLO	Primary Care Liaison Officer
PHN	Primary Health Network
PN	Practice Nurse
QNADA	Queensland Network of Alcohol and Other Drugs Agencies
RACGP	Royal Australian College of General Practitioners

Executive summary

QNADA commissioned the Drug Policy Modelling Program (DPMP) at the start of 2019 to undertake research that could identify practical recommendations and initiatives Brisbane North Primary Health Network (PHN) could undertake in order to improve General Practitioners (GPs) engagement with people around alcohol and other drug (AOD) problems.

The approach we took deviated from previous studies in this area as it considered the many different contact points a patient might have with a general practice. GPs and other practitioners, namely Practice Nurses, were approached to participate in our study, as well as administrative staff including receptionists and Practice Managers. This study also included the voices of people who use AOD in order to explore the types of practice that would encourage them to engage with GPs around their AOD use.

Our study found a range of experience and practice across Brisbane North PHN in relation to GP engagement of people with AOD use - both good and bad - that broadly fell under one of six themes:

1. Innovations, positive experiences and successful engagement
2. Getting in to see a GP
3. Quality of general healthcare provided to patients
4. Quality of AOD care provided
5. Referrals and links to specialist services; and
6. Broader structural issues in healthcare.

In engaging with both Brisbane North PHN staff and practitioners across the region it became apparent during the course of this project that Brisbane North PHN are already undertaking an enormous amount of work and devoting significant resources to this space. Clear policy leadership and objectives have been developed, and best-practice evidence used to develop a number of initiatives that address many of the themes and issues of engagement discovered during our project.

In developing recommendations, this project has sought to only focus on those areas not addressed by current initiatives. While they have been drafted in response to perceived need in the Brisbane North PHN region, it is acknowledged that many of these recommendations are likely to be applicable to any PHNs in Australia seeking to improve engagement of GPs with people experiencing problematic AOD use.

Recommendations

Recommendation 1	QNADA consider facilitating visits by specialist AOD services to local general practices
Recommendation 2	Brisbane North PHN consider creating a new AOD GPLO position
Recommendation 3	Brisbane North PHN explore initiatives to improve the use of Practice Nurses in the management and care of people experiencing problematic AOD use
Recommendation 4	Brisbane North PHN develop and distribute a resource for GPs on MBS items that can be used to support clients experiencing problems with their AOD use
Recommendation 5	Brisbane North PHN AOD community of practice to consider expanding membership to include GPs, practice nurses and other specialist AOD allied health professionals
Recommendation 6	QNADA to consider working with Brisbane North PHN and Qld Health to develop opportunities for GPs to visit and/or undertake short placements in AOD services
Recommendation 7	Brisbane North PHN to work with relevant stakeholders for the greater promotion of ADCAS and ADIS among GPs
Recommendation 8	Expand localised AOD pathways on the HealthPathways referral tool to include ADIS and ADCAS, specialist AOD services in Brisbane North PHN and pathways for existing MBS items
Recommendation 9	Amend the Brisbane North PHN website so that AOD resources are more visible and accessible to health professionals
Recommendation 10	Brisbane North PHN to commission evaluations of models of integrated care they fund in the region
Recommendation 11	Brisbane North PHN to consider funding one or more of the following models of integrated care: • Rotations of AOD specialist practitioners in GP practices • Rotation of GPs into AOD services • Care coordinators/specialist liaison officers
Recommendation 12	Brisbane North PHN offer AOD ‘clinical audits’ to general practices
Recommendation 13	Brisbane North PHN to commission resources for general practice that support a safe and inclusive work environment for staff and patients including: • Development of occupational risk assessment and management plans • Provision of guidelines on appropriate evidence-based strategies for dealing with aggressive behaviours • Training for administrative staff on de-escalation techniques

Recommendation 14	Brisbane North PHN to commission anti-stigma training and AOD training for other general practice staff including Practice Managers, administrative staff and Practice Nurses
Recommendation 15	Brisbane North PHN consider working with RACGP and Insight to implement follow-up for practitioners who engage in AOD-related training

Background

General Practitioners are critical in both the prevention and treatment of problematic AOD use (Allan 2010). GPs are well-placed to address AOD issues as they are the first point of contact with the medical system for most people (Teesson, Baillie et al. 2006). They are therefore in an ideal position to intervene early and manage problematic AOD use so that future or further alcohol and drug-related disease and injury can be avoided (Roche and Freeman 2004, Lubman, Manning et al. 2014). The majority of Australians see a GP at least once in any given year (Degenhardt, Knox et al. 2005) and GPs already have a role in linking patients into other specialised treatments and managing a person's ongoing treatment (National Centre for Education and Training on Addiction 2004, Degenhardt, Knox et al. 2005). However, a range of barriers prevent people with problematic AOD use from receiving quality and prompt health care in general practice, resulting in increased complications, emergency department presentations and preventable deaths (Bywood, Katterl et al. 2011).

The importance of primary health care, and GPs in particular, in the identification and treatment of problematic AOD use has been recognised by a range of Commonwealth government inquiries, reports and policy documents relevant to Brisbane North PHN (Department of Prime Minister and Cabinet 2015, COAG Health Council 2017, Department of Health 2017, Department of Health 2018, Department of Health 2019). A number of initiatives related to improving AOD treatment and patient engagement are already underway in Brisbane North PHN, to meet objectives set out in *Planning for Wellbeing 2018-2023: A draft regional plan for North Brisbane and Moreton Bay focusing on the mental health, suicide prevention and alcohol and other drug treatment services 2018-2023*. An implementation plan has been developed by the Alcohol and Drug Partnership Group, a group convened by Brisbane North PHN that includes stakeholders across specialist service providers, peak bodies and Queensland Health (Qld Health). Many of these initiatives seek to engage GPs and therefore have relevance to this project. In light of the many initiatives underway, the work herein has focused on strategies to complement existing initiatives.

The majority of literature on barriers to accessing GPs and GP treatment by people who use AOD focused on stigma and discrimination (Treloar, Abelson et al. 2004, Lloyd 2013, van Boekel, Brouwers et al. 2013, de Crespigny, Grønkjær et al. 2015, Brener, Cama et al. 2019). There is a very strong evidence base for the use of education and training in reducing stigma (Corrigan, Morris et al. 2012). As a result, most of the literature investigated this as a means of increasing access and quality of GP services for people who use AOD. In the past 10 years, there has been increasing advocacy, particularly from the National Centre for Education and Training on Addiction (NCETA), to move beyond education and training and look at broader organisational initiatives that can improve patient experiences and outcomes (Bywood, Lunnay et al. 2008, Skinner, Roche et al. 2009, Roche and Nicholas 2017), and to tackle the broader structural causes of stigma (Lancaster, Seear et al. 2018).

Aside from stigma, the literature found other GP barriers to be related to lack of practitioner knowledge and/or confidence about management of AOD issues or referrals to specialist services (Roche, Hotham et al. 2002, Moriarty, Stubbe et al. 2012), lack of time and funding, structural issues such as waiting lists (Moriarty, Stubbe et al. 2012, Miller, Ramsey et al. 2016), and the adequacy of Medicare in treating chronic conditions (Biggs 2017). There were more limited studies focusing on barriers from a patient perspective although stigma was the most common reoccurring theme that prevented patients from accessing services (Treloar, Abelson et al. 2004). Structural barriers such as transport costs and the difficulty of appointment-only systems were mentioned as additional barriers for patients in accessing primary health services through a GP (Lewer, Freer et al. 2019).

A great deal of research on improving outcomes for people who use AOD examined the influence of GP screening, brief intervention (BI) and motivational interviewing on patient behaviours, particularly with regards to alcohol and tobacco use (Roche and Freeman 2004, Kaner, Dickinson et al. 2009, Humeniuk, Newcombe et al. 2018). There is general agreement in the literature that even brief conversations about AOD use in the GP setting can deliver cost-effective reductions in risky use (Navarro, Shakeshaft et al. 2011). However, there is some evidence that Australian GPs are not taking up opportunities to screen for or discuss AOD issues with clients in practice (Roche, Hotham et al. 2002, Swan, Sciacchitano et al. 2008, Mules, Taylor et al. 2012), but are more confident discussing alcohol use than 'other drugs' (Miller, Ramsey et al. 2016). As a result, a number of tools have been created for GPs to assist with screening and BI of AOD use with the Commonwealth, RACGP and Qld Health encouraging use of the Alcohol Use Disorders Test (AUDIT) and AUDIT-C (created by the World Health Organisation) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (Tam, Zwar et al. 2013, Queensland Health 2015, Department of Health 2017, Humeniuk, Newcombe et al. 2018).

In terms of the focus of literature on general practice (also referred to here as doctors surgeries or surgeries), most studies tended to only include GPs in the research unless Practice Nurses (PNs) were part of implementing a pilot program, or the study investigated barriers to healthcare more broadly for people who use AOD. This is despite PNs being present in the majority of Australian general practices (Heywood and Laurence 2018) (key informants estimated PNs to be in 90% of Brisbane North PHN practices). Studies that included people who use AOD frequently mentioned the role of reception and administration staff as a key facilitator or barrier to health services (Treloar, Abelson et al. 2004, Hargraves 2015, Duncombe 2017). However, there were no GP and AOD Australian studies that included administration staff and also limited international literature to draw from. Therefore, the project reported herein provides an important addition to the existing knowledge base by examining all of the contact points that people who use AOD may have when engaging or attempting to engage with a GP. It should be noted that while this project focused solely on Brisbane North PHN, the findings and recommendations are likely to have relevance for Primary Health Networks across Australia.

Project aims

This project aimed to examine current barriers to increased GP engagement with people with problematic AOD use within the catchment area of the Brisbane North PHN. The goal was to deliver practical recommendations and interventions that Brisbane North PHN can undertake with GPs to improve GP engagement with people with problematic AOD use. More specifically, the aims were to:

- Study local barriers that are currently preventing GPs engaging with clients on their AOD use
- Identify what the preferred types and models of engagement from GPs are for people with problematic AOD use in the catchment area
- Identify relevant interventions, models, projects or strategies that improve GP engagement with people with problematic AOD use, and
- Produce practical recommendations for improving GP engagement with people with problematic AOD use specifically tailored for Brisbane North PHN.

Project methods

Literature review

A literature review took place during 2019 and early 2020 with an initial search in February and March 2019. The websites of government departments and peak bodies including Brisbane North PHN and the RACGP were searched for relevant policy, funding and regulatory frameworks as well as data on GP and AOD service provision and use. Targeted searches were conducted during these times using PubMed, Informit, Scopus, Cochrane, Psychinfo, Google Scholar and the UNSW library database. A combination of terms was used to identify articles on general practice, practice concerning people who use AOD, barriers to treatment and initiatives to improve practice.

Terms to identify articles about general practice and roles within it included: 'GP', 'General Practitioner', 'doctor', 'nurse practitioner', 'practice nurses', 'primary health', 'primary care', 'allied health', 'healthcare' 'Medicare', 'receptionist', 'GP receptionists', 'practice manager', 'administrative staff', 'general practice' and 'waiting room'. These were combined with terms for barriers such as 'barriers', 'gatekeeping', 'gatekeepers', 'access' and/or 'attitudes'; and a range of terms for AOD including 'AOD, 'alcohol', 'illicit drugs', 'addiction' and individual drugs such as 'cannabis'. Searches were also conducted that included 'treatment', 'intervention', 'models', 'pilots' and 'engagement'. The reference lists of key documents were reviewed to ensure that all relevant literature had been captured.

At the start of the review only Australian and New Zealand research was considered, with exceptions given to systematic reviews that drew from a range of international literature but included at least one study from Australia or New Zealand. Certain parts of the review were expanded to consider international literature when limited local literature could be found – this was specifically the case for research on administrative staff and general practice receptionists. Where international literature has been used, it is highlighted in the text.

Finally, a separate literature review was undertaken during November and December 2019 and early 2020 to explore initiatives to address GP barriers that had been mentioned during interviews with key informants and others but that had not been found during the initial literature review. Additional searches were conducted using the terms: 'shared care', 'chronic disease management', 'screening', 'brief intervention', 'integrated care' and 'communities of practice'. In addition, the website of other Primary Health Networks were searched to identify initiatives being piloted in other locations.

Qualitative study

We conducted a qualitative study focusing on past and present experiences of GP engagement with people who are experiencing problems with their alcohol or other drug use, as well as

studying what type of engagement participants would like to see in the future. Recruitment started in August of 2019 with collection commencing in September of 2019 and concluding in January 2020. MK conducted six semi-structured phone interviews with GPs averaging 30 minutes each, one 45 minute semi-structured phone interview with a practice nurse, four face-to-face focus groups with people who are currently or have experienced problems with their alcohol or other drug use (n=23), which ran for 75 to 90 minutes and one 90 minute remotely accessed (ZOOM) focus group with practice managers and reception staff at GP surgeries (n=3). Additionally, MK and LB conducted nine semi-structured phone interviews with Brisbane North PHN staff, averaging 30 minutes per interview.

Recruitment of GPs was challenging and note that our original project outline aimed for a larger cohort of GP interviews (n=18). We had initially planned to recruit primarily through Brisbane North PHN direct emails out to general practice members. However, upon discovering this was not possible, Brisbane North PHN assisted in rolling out new strategies including recruitment via Primary Care Liaison Officer (PCLOs), distribution of materials and information at Clinician's Advisory Groups and placements of advertisements in Brisbane North PHN newsletters. QNADA additionally reached out to organisations and networks. In early 2020 we discovered that KPMG had undertaken a similar research project in Brisbane North PHN during 2019 and were recruiting GPs in the region at the same time as our project. We believe that this also had an impact on response and recruitment rates. Despite these challenges, we reviewed the data we had collected over 6 months, the number of participants in total, and the saturation and triangulation of the data and decided our dataset was rich enough to close recruitment.

All the GP participants are currently practicing medicine in the Brisbane North PHN catchment area, between them they have 157 years' experience practicing medicine, 116.5 of which were spent practicing in the PHN catchment area. All six were male, ranging in age from 31 to 65 years of age and with between 4 and 43 years' experience in medicine. All the GPs were practicing in multiple doctor surgeries, ranging from small 2–3 person GP private practices to large corporate practice. All participants saw patients with chronic conditions, with a stable population of repeat patients. Medical interests included paediatrics, chronic conditions, HIV and sexual health, internal care and orthopaedics. Two of the GPs offered bulkbilling with the other four offering mixed billing.

All patient participants were currently receiving care for primary care health services in the Brisbane North PHN catchment area. Participants age ranged from 18 to mid-to-late 60s. Eight participants were female; 15 participants were male. Patient participants were interviewed across four focus groups which were constructed around the type of drug they were using or had experienced problems with. Groups were split into alcohol use, injecting drug use, use of amphetamine-type substances and poly drug use. Some of our participants may have experienced additional barriers engaging with the healthcare or AOD treatment system due to the following: two male participants identified as Indigenous, four participants disclosed a history of incarceration, and two male participants spoke of a history of child sexual abuse. Seven participants (four female participants and three male) spoke about being parents.

The practice nurse was female, with many years' experience in nursing, the majority of which was spent practicing in the catchment area. All the administrative staff were female and worked at multi doctor general practice surgeries in the PHN catchment area. All the PHN staff who

were interviewed are current staff members of the PHN who either work in the drug and alcohol team at the PHN or on the PHN's engagement with GPs in one capacity or other. Two of the staff members were male, the rest were female.

All collection activities were digitally audio recorded and professionally transcribed. MK conducted a thematic analysis of the data as described by Braun and Clarke (Clarke and Braun 2013) in NVivo 12 which involved two readings of the dataset in its entirety; analytical discussions with LB; two rounds of coding: first an inductive open coding of each data set followed by axial coding; construction of candidate themes; review of all data coded to the themes and construction of final themes and writing of the results.

All participant names have been replaced with pseudonyms in order to protect participants' confidentiality. Quotes have been edited for clarity (i.e. word repetitions have been removed). Ethics was granted by UNSW's HREAP B: Arts, Humanities & Law, HC190523.

Results

GPs worked with patients across the gamut of treatment, from initial contact, through to management of patient's health and AOD needs, through to referral out to specialists and other services. Our GP and nurse participants identified having more experience working with patients experiencing problems with alcohol than any other drug. Next in reported prevalence were patients experiencing problems with prescription medication, followed by illicit drug use, but not necessarily harmful illicit drug use, and people currently in the methadone program. It is also worth noting that in our interviews and focus groups we used the term 'alcohol and other drugs'. While participants who were clients or patients were comfortable with this terminology, our participants who are practitioners often commented on the terminology used and explained that in their experience they see a divide between alcohol and other drugs.

We constructed the following six themes relating to engaging GPs in AOD treatment in our study:

1. Innovations, positive experiences and successful engagement
2. Getting in to see a GP
3. Quality of general healthcare provided to patients
4. Quality of AOD care provided
5. Referrals and links to specialist services; and
6. Broader structural issues in healthcare.

Innovations, positive experiences and successful engagement

We found many examples of best practice, innovative care and careful and successful engagement with patients around their problems with AOD, as well as preferred models of care raised by participants.

Positive experiences

When things worked in this space, they worked well. At least one patient participant from each group reported that they had good ongoing care relationships with their primary care provider that resulted in them getting the ongoing care that they needed, as well as referrals into more intensive levels of care such as residential rehabilitation services:

> The GP I have now doesn't discriminate. He takes you on face value. If you're telling him bullshit, he'll call you out on it. So, you just be straight up with him. And if you're straight up with him, he'll be straight up with you. - *John, patient participant*

Nancy is one of the participants who described a supportive primary care provider who worked with her on her medical health symptoms, accommodated her mental health needs and arranged the level of support necessary for her:

> And it was pretty much once we started getting the ball rolling with scans and ultrasounds and coming down for MRIs, and it got to the stage with her, because my anxiety was through the roof as well, and every appointment it was like the first appointment there. Whatever day it was, if there was an appointment already booked, she would make sure that my name went before it because I'd be there and see her in the door. And when I was coming back and forward from Brisbane, back up north doing the tilt train and stuff, and with the anxiety, yeah, I had a really good rapport, it was, 'phone me when you get back. Let me know you got back. Phone the office and make sure the girls know. If you need to come in, just let them know and they'll schedule an appointment.' So yeah, that was a really good experience. - *Nancy*

Successful engagement

The type of accommodations to scheduling that Nancy described above were also described by our GP participants and practice manager participants as types of practice that they engage in, where possible, in order to accommodate their patients' needs. This often involves scheduling special times to see their patient, limiting waiting times and making sure that the patient is able to schedule an appointment for the time of day that they are at their most functional. This serves two purposes: making sure the patient can reap the most benefit from their appointment and ensuring that the appointment goes smoothly from an administrative point of view:

> For me the experience that I've had, which stands out, is one of our patients is quite severely alcoholic, I should say, and he tends to sort of come in late, is quite dishevelled, the admin team actually is a little bit apprehensive of him coming in, but he does need to come in to see the doctor. So, they actually brought it to my attention. So, we've had to put some measures in place where we've spoken to the doctor and the doctor said 'look if he comes and sees me first appointment then he's generally very good. Whereas if he comes later during the day then he's had a couple of drinks and its' quite difficult to communicate with him.' So, we've got a few of those measures in place for him. - *Marian, practice manager*

Innovations

We found many examples of innovations in this space in our study. In our interviews with staff from the PHN it became clear that the PHN had developed the role of Primary Care Liaison Officer (PCLO) in order to better engage GPs practicing in the catchment area. In addition to performing a conduit role of funnelling information, PCLOs are also able to offer GPs an array of support from the PHN as per their needs.

We also found examples of AOD treatment services and harm reduction services co-located on the same premises as a primary care service, and other services that had partnerships with primary care services, where for instance a visiting GP was available at a certain time each week at a harm reduction service. Many of the patient participants who had experience with these models of care described them as ideal, and even patient participants who didn't have direct experience with it modelled their own ideal primary care service model as a co-located hub:

> It would be like one big hub where you have GPs, you have registered nurses. You'd just about have everything. And they've got it down at [location]. They've got these massive, big hubs that cover everything. They've got nothing like this out here, you know what I mean? Yeah, everything kind of under one roof… And have more GPs instead of having one or two… For me, that's what I think. And that's my idea of a massive big hub, like huge big hub, three, four storeys. Each section has its own sections. - *Nancy, patient participant*

Getting in to see a GP

Our study found that the first, and most significant barrier to accessing GP care that patient participants reported, was actually getting in to see a GP. There were a range of reasons that patients were not able to get into a GP, with significant barriers found to be practices refusing to provide appointments for certain clients (including those with known AOD use problems), issues with navigating appointment-based systems, the 'blacklisting' of aggressive, anti-social and disadvantaged clients (not necessarily AOD-related), the 'blacklisting' of clients seeking schedule-8 drugs, discouraging people who are seeking prescriptions for schedule-8 drugs from approaching practice with the use of signs, and patients avoiding GPs due to previous negative experiences.

General Practice refusing and/or administration staff being instructed to not make appointments for patients with known AOD use

Not all of our patient participants could successfully schedule appointments with their GP or surgery of choice. Many of our participants described their experiences with being refused to be taken on as a new patient because they were in a rehabilitation program, being blacklisted by a surgery, or being told to cease attending. One PHN staff member recounted being approached to assist in finding a GP for a patient (with the patient's consent), due to the difficulties both the patient and service had in locating a GP willing to take on the patient:

> The patient really desperately needed to link in with a doctor to help them through that rehab process, and they had some other health issues and needed some monitoring around their medication for their alcohol use. And so, they were quite vulnerable at the time, and so the service contacted the PHN and then someone from our drug and alcohol team contacted me and said, "Look, this is what's happening and we need to try and locate a doctor that will be sensitive to this person, so they need to know some of the details." Yeah, so that's how it happened that I was the person to phone them. And I literally phoned every practice in my region and one practice said that they would be happy to take that patient, given the person wanted the doctor to be sensitive to what their needs were... It was really disheartening, to be honest, to hear some of the responses.

Administration staff had experience of being instructed to not allow patients to make an appointment with a GP although they were often not told why a GP does not want to see the patient and reported that they often do not know what health issues a patient has. Some had experience with being asked to obfuscate by informing the patient that there were no appointments available, instead of telling the patient that the doctor will not be accepting them into care:

> We always have to tell the patient, "Oh sorry, the doctor's not here." And then they ask to book for another day and it's like, "No, sorry, the doctor's not here." And personally, I would prefer them to either turn round and say, "Yes, we'll see the patient," or just let them know that they're not going to see that patient anymore. - *Sally, receptionist*

Staff described this as an impossible situation in which they are compassionate towards the patient and the doctor, and stuck between both:

> I tend to get in trouble quite a lot because I do show quite a bit of empathy for some of them and the doctors are really strict on who they see and who they don't. And it could be a drug shopper and they don't want to see them at all, but it could be a regular patient. But because that patient maybe has come from another surgery and isn't identified as a drug shopper and may just be sick or unwell, I feel that they should be able to see a doctor. - *Sally, receptionist*

Other times it was clear to administrative staff that patients were being refused access to GPs because of their AOD use:

> We have a patient who's a long-term alcoholic and he's an older gentleman and has lots of falls. He presented at the practice and one of the doctors said, "Oh, no. I won't be seeing him." And it was quite awful because he just wanted to just send him off to the hospital and have him dealt there. But yeah, they just seem to label them, not all of them, but some. - *Michelle*

Patient participants also reported problems booking appointments at GPs when they were sick or being accommodated as a walk-in:

> And the receptionists, yeah, they can be very judgemental. When I was prescribed Oxys, I went in there, I forgot to make an appointment and I know that they squeeze people in there. And I see them talking amongst themselves about being on opiates and that and they had a way not to fit me in, things like that. The simple things, where they would make arrangements to fit anyone else in if they weren't on that drug or they're a bit more cliquey with the surgery. - *Dan, patient*

Difficulties of appointments-based system

In our study this was the first barrier to care that many of our patient participants reported experiencing, as well as a site of friction and risk management as described by the practice managers, reception staff and GPs. Expected schedule disruptions were cited as the biggest concern of administration staff with regards to servicing people experiencing problematic AOD use. Schedule disruptions take the form of missed appointments, late arrivals, and booking the wrong length of appointment, i.e. booking a short consult instead of long consult. Many of the practices who participated in our study reported operating within limited financial margins and that these disruptions were costly to the practice as they affect revenue negatively:

> The worst thing is just constantly making appointments and not turning up, from our point of view. And then you have the ones that come in and are quite adamant to see the doctor. - *Sally, receptionist*

Conversely, patients described having to schedule appointments weeks in advance and how this acted as a barrier when there were other events in their lives that they were managing.

'Blacklisting' patients due to aggressive and anti-social behaviour

Administrative staff described experiences of dealing with antisocial behaviour of patients in the waiting room spanning psychosis, agitated, nervous, disruptive, heightened, disrespectful and aggressive behaviour, although it should be noted this was a general comment and not necessarily related to AOD use:

> I have also had one patient that came in that was having an episode of psychosis and the doctors were both in their rooms, in their consult rooms, and I was dealing with her at the front and I got the nurse to come and help me. That was actually quite hard for me because, well I tried to stay calm, but she was all over the place in-out, in-out. She wasn't aggressive. I just felt incredibly sorry for her. - *Sally, receptionist*

Antisocial behaviour was described as particularly concerning as the practices in our study reported that they did not have security on site and described how it is often up to the female reception and nursing staff to manage these behaviours:

> We had a patient who came into the treatment room because he was very abusive at the front counter. We took him through to the treatment rooms where the nurses were, where one female nurse was. He was in there and I rang the other practice where he said he had been to get some information about a patient summary or medical history and they said that he was no longer welcome there because he often had a knife in his backpack. So, we did alert the doctor straightaway and there was that knife there. - *Michelle, Practice Manager*

Strategies that worked in diffusing situations where clients were aggressive included PNs escorting patients displaying antisocial behaviours into an available treatment room, but it was noted this strategy relies on spare rooms and nurses being available. Others discussed working together with GPs in order to best accommodate the needs of patients. Furthermore, GP participants and administrative participants reported working together as a practice in order to accommodate the needs of patients who are experiencing problems with alcohol and other drugs, as well as the needs of staff, as per Marian's (Practice Manager), experience described in the section regarding successful engagement.

'Blacklisting' of patients was reported as a very difficult space to navigate for the administrative staff. Only one of the participating surgeries had a protocol in place for this, in which a patient who has been blacklisted is taken to sit down with the practice owner face to face, who tells them that their behaviour has been unacceptable and they are no longer welcome to attend. Where staff had undertaken training on managing behaviours, they spoke highly of it, with others expressing enthusiasm for doing similar training, and wanting training on specific conditions in order to foster greater empathy and understanding for the client. It was noted that although training on de-escalation and behaviour management techniques was provided by Brisbane North PHN, this was infrequent and often over-subscribed.

Administrative staff and PHN staff participants reported that a common site of tension resulted from inappropriate referrals into GPs. Surgeries located within walking distance of job agencies reported that those services sent clients over with forms to exempt them from mutual obligation requirements, without consulting the GP surgeries ahead of time. After multiple encounters that did not go well with clients the Practice Manager went down to the job agencies and explained

to them that patients need to get those forms filled out by their regular GPs who have access to a patient's entire medical history and that getting the form filled out was not a tick box exercise. This demonstrates some tensions between requirements put on people, predominantly welfare recipients, by other government agencies (Centrelink), and the actual purpose and role of GPs and general practice.

Discouraging clients who are seeking prescriptions for schedule-8 drugs with the use of signs

All of the administrative staff reported that the only visible content regarding alcohol and other drugs in the surgeries they work in are signs detailing that schedule-8 prescriptions are not available to new clients:

> Well, the only thing we have is 'Schedule eight drugs will not be issued without a thorough patient health history and not on the first consult.' That's about all we've got in our surgery. Yeah that's about all. - *Sally*

Michelle described that at the practice she works at, the sign is hung on the door and acts both as a deterrent to patients entering and as a tool staff use while discussing what type of care may be available on site:

> I must say, we have had people walk up to the door, see the sign, and then walk away. But we do direct them to the sign and say, I'm sorry if you just understand that we won't give scripts to new patients for these drugs, and that we need a full patient history. That's when things turn sour generally.

This form of spatial signalling was linked to the likelihood that a patient would disclose their AOD status and care needs by Nicole, practice nurse:

> I can't speak for every practice, but I have moved around quite a bit, and having an environment where patients feel safe, safe to express themselves, does come down to the displays that you have in the waiting room.

Participants also reported how AOD related material factored into their experience at a surgery:

> Mine was good. I mean, even in a doctor's office he had pamphlets and everything "Do you have a problem with alcohol and drugs? Or anything else, domestic abuse or anything". You can go and pick up that pamphlet and read it and ask your doctor about it. That's what they're there for. - *Catherine*

Avoidance of help-seeking due to prior negative experiences

GP participants and PHN staff voiced concerns over patients disengaging from the healthcare system due to prior negative experiences. This was indeed reported by a few of our participants.

> *Lisa:* I will say I'm 10 years clean. I did it with two lateral breaks in my rib. Not much help except a good longstanding drug and alcohol doctor prior, and I disengaged from those systems. I spent many nights in emergencies with no help. I got clean. Because I do disengage medical people, but unfortunately, I don't mean to. But I wore my empowerment, I wore my belief in myself, and I wore my self-respect.
>
> *Gary:* I really don't go to the GP anymore because of just some of the experience I've had out here. I'd rather go straight to the emergency ward and go to hospital.

This disengagement can also cause generational disengagement, with one of our participants describing his first appointment with a general practitioner ever as part of his court mandated drug treatment program. His father had experienced problems with heavy drug use.

> *Shaun:* Basically, we moved here to get away from everything. Because my family grew up [overseas]. So yeah, came up here and my dad ended up choosing drugs overlooking after his own kids… Yeah, this was the first time I've been to one. Been to see even a doctor in general, this is the first time.
>
> *Michala:* Okay. So, you've never gone to see a doctor?
>
> *Shaun:* Yeah, no.
>
> *Michala:* When you're sick or anything?
>
> *Shaun:* No. It would just be the same old story from my dad, "Harden the fuck up. Go sleep it off. Go walk it off."

Quality of general healthcare provided to patients

The quality of general healthcare described as provided to patients was mixed, with some patient participants reporting receiving excellent care from their GPs while others reported harrowing experiences with the local health care system. Factors impacting on the quality of healthcare provided to patients in general practice included 'diagnostic dismissal' (the misdiagnosis of symptoms due a presumption of drug-seeking), the use of judgemental or non-judgemental practice, patient privacy, the general practice environment and the practice of GPs in prescribing medications.

Diagnostic dismissal

Failure to investigate medical symptoms, and help-seeking being written off as drug-seeking was reported by multiple patient participants both at the local hospital and with their local GPs. Experiences cited spanned failure to investigate epilepsy, shingles, pleurisy and genetic conditions to not investigating what turned out to be fatal stage 4 liver cancer that was eventually diagnosed by the doctors when the patient only had weeks left to live and choosing to die at home.

> *Millie:* My best friend, she was Eddy's partner for 40 years and my best friend, we nursed her at home, and she died of stage four liver cancer, which is a bad death.
>
> *Eddy:* Yeah, it wasn't nice.
>
> *Millie:* She had been with Eddy, going to this same GP, to whom I sent this letter, every two weeks complaining of bad pain in the side. It was like take your breath away pain. Did he send her for an ultrasound, did he send for anything investigative, blood tests? Sweet fuck all.
>
> *Eddy:* Nothing.
>
> *Millie:* And that's how it got to be stage four. And by the time she was diagnosed, she had weeks to live. How could he, sitting there at the computer? "Here's your script." Out the door.
>
> *Eddy:* Yeah. But with one visit to [named place]

Millie: It was negligent. It was negligent.

Eddy: With one visit to here with [GP], she was sent around to get an ultrasound at [specialist].

Jack: Yeah, [GP] would have been all over it.

Eddy: By the time we got back, he said, "Take this letter back to your GP now." By the time we got back here, there was a bed ready for her at the hospital. We had to wait a couple of hours actually, but there was a bed ready for her at the hospital. She had to be admitted.

Patient privacy & disengaging from patients

All the GP participants and many of the PHN staff members who participated in our study stressed the need for patients to come forward and disclose their AOD status to their practitioner as a first step in getting assistance. However, some patients described a reluctance to disclose their AOD use for fear of privacy and stigma, and how this might impact their lives and relationships. This reluctance was described as ongoing throughout their patient and AOD journey. One client related how his medical history was subpoenaed in a custody court case and he was concerned that admitting to problems with alcohol use would lead to him losing access to his child. He cited this as his motivation to not seek treatment early:

> Because the one I'm with is going through actually in the custody case, and they've subpoenaed all of my GP's consultations. So, they've got all my medical history. So, if I'd gone to see him sooner, then they would've known. So, my theory was, yes, that's going to go against me trying to see my son. Obviously, it's too late now. It's got to the point where it's got too bad now and I've ended up in rehab. But I was terrified to go and have that on my permanent record, and that was why, basically. - *Chris*

For other clients, concerns that their family GP would disclose their alcohol or other drug use to their family members, other members of staff at the surgery or even fellow mums at their children's school were described:

> Like, I lied to my family about it. You think you're this high functioning person getting away with what you do in secret, and the last thing you're going to go and do is admit it to your family doctor, who's potentially going to see Nana the next day. I know they're not supposed to say anything, but it would just be the first bit of -. - *Jen*

Fears around judgement were described as magnified when it concerned disclosure to a GP the patient had known their entire life:

> It's like if you're seeing a family doctor all your life, and they've seen you since you were a young kid and then now you're this teenager and then you rock on with a bad crowd and you started smoking drugs and what not, you're probably not going to want to tell them because they still see you as that innocent kid. So, it's probably harder to talk to a GP that you've seen for a while. - *William*

Practice managers and reception participants reported not knowing client's AOD status in order to protect their confidentiality however, clients reported that this was not always the case:

> I think it's so much more prominent amongst doctors and workers dealing with people in drug and alcohol to break confidentiality and mark people as troublemakers. [They] talk too much. - *Lisa*

Although the diagnostic dismissals described in the section above were reported as isolated incidents, all the patient participants reported experiencing some form of disengagement from at least one GP when they disclosed their alcohol or other drug use status. Patient participants also described distancing physical behaviours such as failing to make eye contact, or never touching the patient without gloves, if at all. Some participants had no choice regarding whether or not to disclose their AOD status:

> The same thing, I get judged, they look at the track marks on my arms, which are pretty extensive, and as soon as they see that when they go to do me blood pressure, so I can't hide it, they see them and you instantly see the demeanour change. - *Patrick*

Multiple patient participants cited the desire for non-judgemental and compassionate practice from GPs. Patient participants, PHN staff, practice managers and receptionist participants and GP and nurse participants all reported that engaging primary care in the treatment of people with alcohol and other drug use problems has to involve the entire practice. Care worked best when the entire team was dedicated to creating an inclusive and caring environment, offering wrap around services and multiple care options.

Prescription practice

Several patient participants described concerns they had regarding being overmedicated by GPs who did not communicate effectively with them. These patients were predominantly experiencing problems with alcohol or pharmaceutical drugs, and they described being diagnosed by their GP with anxiety or other mental health disorders and being prescribed selective serotonin reuptake inhibitors (SSRIs) that they did not feel they needed or were good for them:

> I find the area I was from was just too easy to get medication. You come here, you get Endone and you go on anti-depressants and you get Zoloft and you get Xanax if you really put it on. And some of these doctors from where I'm from, out at Deception Bay, you just stick your hand up and go, "Right, I'm not feeling this. I've got a sore back. Can I get some Endone?" "Oh yeah, not a problem." - *Gary*

Patients also reported having had practitioners who failed to accommodate for their lifestyle, for instance by providing multiple scripts in advance to the patient directly (instead of at the pharmacy for example), leaving the patient at a loose end when they inevitably lost their scripts:

> I've lost a few repeats in the past and they won't prescribe them again until the date has expired. Yeah, they just won't, like no matter if I need them or not. I think I've been on antidepressants, like started, stopped, and started again, and stopped again because I've lost my scripts in the past, like three or four times. - *Kitty*

Quality of AOD-specific care provided

Though a few of the participants (both patients and PHN staff) questioned whether GPs should have an increased role in the provision of AOD treatment, many participants saw GPs as ideally situated to provide in-house treatment and care for patients experiencing problems with their alcohol or other drug use. This was largely due to their holistic knowledge of a patients' life history and existing behavioural change skillset. However, patients described a number of barriers to receiving better AOD treatment and support through their GP including

limited experience/knowledge of the GP of in-house treatment options, a focus on abstinence, inappropriate questioning or advice, a lack of GP Opioid Treatment Program (OTP) prescribers in the region and whether or not they were able to participate in treatment planning. For GPs, barriers to becoming more engaged in AOD-specific treatment included a lack of knowledge, a risk of burnout and becoming overwhelmed, and a lack of soft-skills.

Current screening practices

GP participants, PHN staff participants and our nurse participant all discussed current screening for alcohol and smoking practices in place at surgeries across the PHN. Patients are asked about their alcohol and intake and smoking status when they are new to a practice as part of their new patient documentation. The PHN has also made the collection of this data an indicator of care that they collect from practices and as such records are constantly being updated.

All of the GP participants discussed a desire to improve screening practices for problems with AOD across the board. Despite this, they articulated different scenarios in which they thought a brief intervention might be appropriate with a patient; namely clinical relevance and indications that the patient might be experiencing problems with their alcohol or other drug use:

> *Stephen, GP participant:* But otherwise they might present something else. So, they might present, for example, an alcoholic might present with gout. Now, gout is not [inaudible], say, from too much alcohol. So, they present with a complication, and if you dive in the history, then you find they do have alcohol as one of the co-factors there.
>
> *Michala:* Yep. Okay. And what are the kind of interventions that GPs are able to offer for alcohol or other drug problems?
>
> *Stephen:* Well, there's firstly to try and screen for it. And, I mean, that's what we don't do well, do screening for alcoholics. That's a big deficiency. We kind of have a problem screening for everything. I mean, you'll go mad if you screen the patient with things that they don't need to be screened for. So, you just couldn't do it. Not enough time in a consultation. But, I suppose, you've got target screening. So, the first thing is to screen for it, find it, identify it, talk to the patient about it, explain the issue, explain the problems with alcohol, and then intervene.

Limited experience/knowledge of AOD treatment options

Patients in our study described treatment options offered through GPs as being quite limited and abstinence focused. Two participating doctors had direct experience in conducting supervised alcohol withdrawals, and one doctor spoke about their experience prescribing medications used to curb addiction, although they also stated that these have not been successful. The only participants who spoke about harm reduction were staff members of the PHN and the practice nurse we interviewed.

The reported focus on abstinence resonated in the reports of patient participants who relayed experiences of being told that they're 'doing their recovery wrong', or in one case, being advised to stop attending his prescribing GP's office because his urine drug test did not come out clean. Some felt they were offered assistance and treatment that was not a good fit for them due to the GP's own personal preference for abstinence-based models:

> When I go to a doctor and their belief is, "Oh, but NA [Narcotics Anonymous] has done wonderful," or VNA model. Who are you to decide? I'm not a Christian. This is a guilt-based model. This does not work for me… And if I say anything, it's almost like I'm going to an acupuncturist. And it's not done in such a way somebody's sort of like, "Oh, I'm going to see a faith healer" or looking gently and politely. It's, "No, this is what you're meant to do. Now, make up your mind." - *Lisa*

Many participants also reported that they are unable to find a 'good' GP who can both care for their health and their alcohol and other drug needs, and therefore see two or more practitioners at a time, one for their AOD and another for everything else:

> I have two GPs. One is the old family doctor, and it's not because I'm doctor shopping, it's not like that, he was my parents' doctor. He's in his 90s, and he knows full family history, all that kind of things. Anything genetic, he'd pick up on it, kind of thing. And the other one is a doctor I have here at QuIHN with whom I can be completely honest. About six years ago, I came off of 20 years on methadone. And as close as the old family doctor got to that would be, "Are you still on that stuff?" He couldn't even say the word 'methadone'. It was outrageous. - *Millie*

Lack of GP OTP prescribers

Our participant GPs also confirmed that they regularly see patients who go elsewhere for their opioid treatment needs. We found that there may be a shortage of GP OTP prescribers in the catchment area, with key informants reporting that they know of between 0–2 in each Brisbane North PHN subregion. Key informants also recounted GPs requesting resources with regards to who they can send patients to, and patients' reliance on programs like QuIHN to be linked in with OTP prescribers. None of the known OTP prescribers working in the Brisbane North PHN catchment area participated in this study. Our GP participants did however cite a number of reasons that they chose not to become OTP, namely because AOD is not their chosen area of interest, because the practice they work at does not want to attract patients who are part of the OTP program, fear of losing their licence and because of the complexity involved.

Inappropriate consultations

We also found that there is a disconnect between our patient participants and our GP participants regarding what is 'in scope' or appropriate within a consult regarding the patients' alcohol or other drug use. This revolved particularly around a focus on legalities rather than medical manifestations such as the participant who reported that their family GP asked extensively about his court charges:

> Mine asked me about my recent charges and stuff, but I don't know, I didn't want to tell him anything. He asked me how many I had, and I just felt like - It was just the tone of his voice, even. It just sounded like he was judging me a bit. He was asking what drugs I got caught with and all that kind of stuff. Yeah, I just didn't want it going back to my mum and my dad. The way he looks at my whole family would be a problem in general. - *Nathan*

GP burnout

GPs who do take on patients who are experiencing problems with AOD use were described by PHN staff and patient participants as at higher risk of burn out, and prone to becoming

desensitised to their patients. A lack of support for these practitioners was also described by practice manager participants who reported that these practitioners often cannot find fellow GPs who will care for their clients while they are away or shoulder the burden at the surgery:

> We actually had one of our doctors' present at one of the team meetings and he had to ask all of the other doctors to help. He said, "Help me. How do I help these patients?" So, a lot of the other doctors gave him strategies and ideas, but then all of them turned around and said, "While you're away, we will not see these patients." So, it was a catch-22 for him. - *Marian*

Burnout was associated both with this described lack of support but also with the sheer volume of work involved. PHN staff, GPs Practice Managers and patients all reported that successful provision of in-house care and treatment for problematic AOD use requires extensive resources and planning, time, effort and paperwork. This can include scheduling frequent appointments and phone calls with patients, constant reinforcement of the program and maintaining an open door, all activities described by participants as time consuming.

GP behavioural change skills

Working with clients on the management of their AOD use was reported to rely heavily on behavioural change skills and motivational interviewing skills. One of our GP participants recalled a patient, who, without consistent reinforcement, regressed back into heavy use despite the GP believing there had been a clear improvement in his patient's quality of life following a period of reduced use/abstinence:

> She recently went to hospital and, partly as a result of being an inpatient for a while and partly carrying that forward for a little bit, when she got home was able, I think, to make some really good progress with the legs as well as seeming a lot better in herself by stopping drinking for maybe a month. And I'm happy to talk about that and encourage her to continue and make it clear exactly how beneficial that was for her in so many ways, including the chronic leg issues that kind of plague her and are painful and require so much input from so many people and cause so much discomfort and limitation to her. And I sort of thought that that was so clear cut how well she was doing. That that would be enough to drive the ongoing abstinence. But it turned out not to be. Next time I met her; she was drinking again in the same way. - *Mark*

Patient participation in treatment planning

GP and patient participants also spoke about the importance of patient participation in creating plans and deciding on treatment pathways. Many of the GPs spoke about the need for motivation for treatment to come from the patient, both as a condition of success of the treatment, as well as a barrier to engaging further with patients about their alcohol and other drug problems:

> The main barrier I find that the treatment is the patient's willingness to confront their problem or the motivation. And you've just got to be persistent without driving them away. - *Darryl*

Patient participants however, described the experience of being left out of their healthcare plans, having trouble obtaining a second opinion about the mental health care plan they have been assigned, or unsure of why they have been diagnosed with anxiety and prescribed SSRIs.

Some of our patient participants who reported being heavily stigmatised for injecting drug use, also described that their years of lived experience of drug use and any medical knowledge they had, was often ignored by practitioners. These participants expressed a desire to be involved in the decisions regarding their healthcare instead of having all their decisions made for them:

> The other thing I wanted to say is that as well as not being judged, I also want to be consulted and play a part in my treatment. Because I'm 53 years old and I've done all of this training... And so, I'm pretty restricted in what I do. But I have all this knowledge. - *Patrick*

Referrals and links to specialist services

Many of our GP and patient participants focused on the importance of GPs capabilities to refer patients to appropriate specialists and dedicated services, as often GPs are best able to offer the coordination of other modes of care. The biggest challenges to fulfilling this aspect of their role that our participants discussed were the current gaps in the provision of specialist services and referral knowledge and resources.

Service gaps

GP participants voiced their concerns regarding the overloading of the system and the gaps in care available to support patients after they have completed withdrawal. There was a particular concern among GPs about a perceived lack of bulkbilling AOD-specialist psychiatrists across the region, or at the very least a lack of knowledge about where to find these psychiatrists:

> I find the main issue with that is ongoing support once they've actually detoxed. So, actually getting psychiatrists for these people that have a low socioeconomic status, some of them have prison histories, a lot of them do have forensic histories as well. Then they come out and they've got a lot of psychiatric kind of comorbidity as well. - *Paul, GP*

Referral knowledge and resources

Many of our GP participants also emphasised that they would greatly appreciate a resource of suitable specialists and services that they can refer patients to or into, as all of our GPs stated that they were relying on personal relationships or institutional knowledge at the surgery that they practiced at in order to refer patients into care.

Broader structural issues in healthcare

Participants raised a number of issues that are useful to consider with regards to current capacities in the local medical system and systemic issues that also impact the delivery and quality of GP engagement with people who use AOD in the Brisbane North PHN catchment area including: lack of AOD specific items & software incompatibility, corporatisation of primary care and GP risk management and liability.

Lack of AOD specific items & software incompatibility

Good quality data concerning AOD use in general, and problematic use specifically is foundational to successful engagement in this space. In Brisbane North PHN current data quality around AOD use is reportedly limited to smoking and alcohol status, and many

participants had reservations regarding the accuracy of these figures. With regards to other drug use, participants felt that data quality was poor to non-existent due to patients not disclosing use, GPs not investigating use and informational systems which are not set up to record information regarding 'other drug' use, or problematic use. To a large extent the 'institutional knowledge' is reliant on client notes, the Medicines Regulation and Quality list of people who are experiencing problems with pharmaceutical drugs (often labelled "doctor shoppers" or "drug shoppers") and the working memories of staff across the surgeries and PHN. The PHN is currently engaged in improving the data quality in GP surgeries across the board however, they have yet to focus Quality Improvement (QI) activities on alcohol and other drugs.

GP participants and PHN staff reported that there are no specific item numbers for drugs and alcohol counselling (with patients able to access MBS funded supports through a range of different items including Chronic Disease Health Plans and Mental Health Care Plans). The lack of dedicated item numbers limits the depth of data analysis the PHN can provide surgeries in this space. While the PHN data project reportedly collects roughly 300 data points, such as information regarding diabetes and hypertension, the only AOD data collected for these records is the number and percentage of patients over or equal to 18 years with alcohol consumption recorded.

Another effect of the lack of specific item numbers is that this type of care needs to be billed as part of a different consultation:

> Well as far as I know, there's no specific item number for it from the MBS. They'd be needing to do it as part of a usual consultation. Or if the patient does have those issues then, say the patient had diabetes and was drinking to excess, then that could be addressed as part of that process. - *PHN staff member*

Furthermore, the clinical software at many surgeries reportedly does not allow for information regarding alcohol consumption to be lodged for anyone under the age of 18:

> Their clinical software impairs their ability to record that information accurately as well. Yeah, so some of that might have to just be written into their software. I mean into their clinical notes, the progress notes. - *PHN staff member*

Corporatisation of primary care and budgetary issues

Participants across the study described how the shift away from small GP-owned practices towards larger, often corporate practices combined with budget cuts has affected their work environment, their financial operational environment, the quality of care they're able to offer and the quality of care received. Both GPs and administrative staff described practices operating within limited financial margins.

Cited as an effect of continuous cuts to rebates, practices have opted to offer what they refer to as the 10-minute consult, during which they need to attend to as many of the patient's health concerns as possible. One of the effects of the 10-minute consult described by Nicole, practice nurse, is that when alcohol or other drug issues are raised during a consult practitioners are out of time to address the issue at hand; instead commissioning health checks and scheduling patients in for another appointment three months down the line, and offering an appointment with a psychologist in the interim which patients are often not interested in.

Furthermore, participants described working in a system operating without enough slack to allow for missed appointments and compassionate billing, both of which were cited as problems pertaining to clients experiencing problems with alcohol and other drugs.

The financial environment was also described as attributing to a focus on revenue driven activities leaving (indirect) value-adding exercises such as training and upskilling by the wayside:

> Our practice avoids auditing. They don't like it because it exposes our weaknesses. That's how the corporate looks at it. I am saying we should do the clinical audits to expose what we can improve. But a corporate is like that, because a corporate sees it as a deficiency in their corporate structure… Corporates are very defensive. They don't want to see it that their practices are deficient. If they do an audit, they might find out that we're not up to scratch in certain areas compared to the average practice. That could be information that can held against them. So, they're very defensive about directing information. And they want to give as little information away as possible. So, once you collect information, it's liable to be disseminated. So, a corporate would try and defend itself by not having that information found. They're not interested in patient care, as you might think. They're more interested in making profits. - *Stephen*

The described resistance to clinical auditing amongst corporate practices for its potential to rank a practice is of particular interest given this is the current model in place at the PHN for delivering intensive training modules devoted to upskilling.

Risk management and liability

GP and administrative participants described fears around risk management and liability, including loss of licence as a reason for being cautious to register as an OPT prescriber. It was perceived that increased scrutiny and reporting requirements by Medicare on opiate prescriptions had increased this risk:

> I can tell you I sent a letter to the Drugs of Dependency Unit in Queensland requesting permission to continue supplying a general one of Targin, because he's had spinal surgery, he's been seen by the chronic pain service, he's on a stable strength of Targin. I checked the guidelines, 'If you want to prescribe long term, unless you were to withdraw it, the patient would suffer harm.' So, I sent them that letter. They told me I didn't need to send it. I said, "I'm sending it anyway." I sent the request through and they denied the request because the patient wasn't drug dependent. But I could tell you that they'd be sending me a letter going, "Why did you prescribe this medication if the gentleman abuses it?" Even though I don't think he will, they'd still be pointing the finger at me. So, that's kind of one of those ones where, for my personal liability and stress levels, I barely prescribe any pain relief, strong pain relief, opioid pain relief. I think he's the only patient that I supply with regular pain relief in terms of Benzodiazepines as well. I very rarely will prescribe that medication just because it's not worth it. - *Paul, GP*

Discussion and recommendations

This project has revealed the difficult environment within which GPs and their practice staff are working, and the flow-on that this has to people experiencing problematic AOD use. Numerous barriers exist, both for GPs to provide greater support to people who use AOD, and for people to access GP services in order to address their general healthcare needs and their AOD use. The challenge is, having identified the barriers to engagement, how can Brisbane North PHN use their resources to support GPs and respond to these barriers?

Brisbane North PHN have already advanced significant work in improving access to primary healthcare and AOD services for people in the region. Objectives have been created to support this work under *Planning for Wellbeing 2018–2023* (Brisbane North PHN 2018) and an implementation plan developed by the Alcohol and Drug Partnership Group (a group convened by Brisbane North PHN that includes stakeholders across specialist service providers, peak bodies and Qld Health) is well underway with a range of best-practice initiatives being strengthened or rolled out in the area. For instance the AOD Partnership Group has developed destigmatising language guides for healthcare and the NGO AOD sector, established a group of people with lived experience to assist in the development of materials and facilitated addiction medicine specialist workshops between Lives Lived Well and GPs (Brisbane North PHN 2019).

In addition to Brisbane North PHN initiatives, there are also a number of programs and supports available to GPs funded by Medicare which aim to assist with the management of people presenting with problematic AOD use, but these appear to be underutilised. An additional consideration then, is how to best support GPs in accessing existing resources.

This report was commissioned by QNADA to examine initiatives that could be undertaken by Brisbane North PHN. During the course of the project, a number of barriers were identified that straddle multiple strata of government and governance. While we have attempted to focus only on those areas that are in Brisbane North PHNs domain, we have also included opportunities for QNADA to assist in creating a system of greater support and connection of both people who use AOD and general practitioners.

The following recommendations fall into three categories:

1. Initiatives to improve knowledge of, and linkages, to existing supports and services for GPs
2. New models of care and/or expansion of existing models of care, and
3. Addressing gaps in guidelines, policy and training.

Initiatives to improve knowledge of, and linkages to, existing supports and services for GPs

Recommendation 1: QNADA consider facilitating visits by specialist AOD services to local general practices

It is clear through our research that GPs often have little understanding or are unclear of the specialist AOD sector and what it provides, a factor not unique to Brisbane North PHN and found in the literature and other PHNs (Marel and Mills 2018). Promotion of the AOD specialist system is needed to bridge this gap, however, a common comment that arose in our research was the difficulty in transferring knowledge to GPs when they have so many conflicting priorities and when AOD may not be an area of interest to them.

The importance of service knowledge, personal networks and relationships in assisting referrals has been well documented in health and mental health literature (Forrest, Nutting et al. 2002, Hackl, Hummer et al. 2015). Outreach by specialist AOD services to improve community knowledge and connectedness is common, and has been used to great effect, especially in Aboriginal communities, for instance, where AOD workers attend events and other services and have informal conversations with people about their service and what they do (Allan and Campbell 2011).

In the Queensland AOD sector outreach is undertaken regularly across four modalities – street level assertive community outreach (in areas where people who many benefit from services may be present such as hospital emergency departments), clinical outreach (involving structured, planned work with a client in another venue such as a health service), and detached/mobile outreach (planned work with clients in their own home or another agreed setting) (Department of Health 2018).

Both community and clinical outreach, as defined above, could be deployed effectively in GP practices. While many forms of outreach are aimed at the community in community settings, it is also a useful tool for engaging primary health practitioners. In the GP setting, outreach by a specialist AOD service could involve a designated outreach worker from a service vising their local GPs, meeting with the GP to introduce themselves and the service, seeing if there were any clients who need extra social support that they can assist with (such as linking them in with legal aid), talking to administration staff and potentially interacting with clients as they wait for appointments. Similar models have been used in the past to increase linkages between GPs and specialist services and supports for people with hepatitis C (World Health Organization 2012).

More formalised versions of the above exist through shared care models and hiring of specialist care coordinators (explored in recommendation 11). However, an informal process more aligned with community outreach with an aim of network building is an achievable first step to improving relationships between the two sectors. It is therefore recommended that QNADA explore options for facilitating AOD services to arrange visits to their local GPs.

Recommendation 2: Brisbane North PHN consider creating a new AOD GPLO position

GP Liaison Officers (GPLO) in Brisbane North PHN work across a range of services and hospitals, assist services by enhancing appropriate clinical pathways between settings, improve

clinical handover and discharge from hospitals, drive GP engagement and also facilitate GP education (Brisbane North PHN 2017). GPLOs have been used to support the expansion of new models of care available to GPs under the GPs with a Special Interest (GPwSI)-led initiatives for instance in musculoskeletal health through the Healthy Spines Service (Brisbane North PHN 2018).

Currently there are no GPLOs with an AOD specialisation. Given that GPLOs provide linkages between primary health and specialist services, and are involved in GP engagement and education, we would recommend Brisbane North PHN consider hiring an additional GPLO with an AOD specialist interest. Many of the following recommendations would benefit from the support of this role.

Recommendation 3: Brisbane North PHN explore initiatives to improve the use of Practice Nurses in the management and care of people experiencing problematic AOD use

A range of incentives introduced by the Commonwealth since 2001 has seen the employment of PNs in general practice grow, with an estimated 63% of practices in Australia employing PNs (Heywood and Laurence 2018). Key informants estimated this number to be closer to 90% across Brisbane North PHN. The current Practice Nurse Incentive Program (PNIP) provides incentive payments to accredited practices for the employment of nurses and other allied health professionals working in general practice, particularly in preventative health and education, and chronic disease management and care coordination (Department of Human Services 2017).

The 2015 RACGP smoking, nutrition, alcohol and physical activity (SNAP) guidelines notes there are a number of key roles for practice nurses when implementing SNAP interventions including identification of at-risk patients, providing education and information to patients individually or in groups, following-up with patients, scheduling support visits, ensuring the practice has appropriate tools available for health assessments and management, liaising and follow-up of referrals with local health service providers and providing a link with self-help and other community organisations (Royal Australian College of General Practitioners 2015).

This broad range of roles allows nurses to take over functions that GPs, key informants and administrative staff noted were burdensome and a barrier for GPs in 'taking on' patients experiencing problematic AOD use. It should be noted that key informants did perceive that PNs were well utilised in, and often the primary staff member responsible for, undertaking general health assessments (that include some questions about drinking and smoking) and initial client assessments. However, it appears from our study that PNs are underutilised in the broader range of activities that support the management of AOD use, and for clients experiencing chronic, complex problems (that might, for instance, cause them to miss appointments and need follow-up).

It appears that the new AOD training developed by RACGP does not include information for GPs on how PNs may be better utilised in managing patients who use AOD and have other complex needs (Royal Australian College of General Practitioners 2019). Brisbane North PHN may want to consider if and how extra training may be of benefit, as well as how greater communication about practice nurses can be integrated into existing channels, for instance, information on the website and review of the use of practice nurses through clinical audit (see recommendation 12). An AOD GPLO would be in an ideal position to liaise with GPs on these issues.

Recommendation 4: Brisbane North PHN develop and distribute a resource for GPs on MBS items that can be used to support clients experiencing problems with their AOD use

This project found that many GPs and other practitioners are unaware of existing supports funded by Medicare for people experiencing problematic AOD use. For instance GPs reported that patients were not able to access bulk-billing (AOD-specialist) psychiatrists in region as a barrier for patients accessing assistance, so it may be that a lack of knowledge around eligibility for a range of MBS items may be preventing GPs from gaining access to existing supports.

While there may be no specific items for AOD use under the MBS, a number of existing programs can be utilised by GPs to assist clients experiencing problematic AOD use. This includes mental health care plans, chronic disease care plans, Aboriginal Health Assessments and Case Conferences. For instance, under the *Better Access to Psychiatrists, Psychologists and General Practitioners* program, a GP can refer a patient to a psychiatrist for assessment and creation of a management plan, with psychiatrists able to claim payment under item 291 of the MBS (Department of Health 2019). The management plan is then provided to the GP who provides advice on ongoing treatment and management of the presenting disorder (Department of Health 2019).

Another program funded under Medicare since 2004 is the Chronic Disease Management (CDM) program that provides rebates to GPs for managing chronic and complex care needs by creating, reviewing and coordinating a GP Management Plan or Team Care Arrangements (Department of Health 2014). The CDM program gives patients with complex or chronic disease access to up to five allied health consultations per year through Medicare (Cant and Foster 2011). There is no list of eligible conditions, but Medicare guidelines consider a chronic disease to be one that is present for 6 months or longer and require help from multidisciplinary teams of two or more health care providers (Department of Health 2014). Patients experiencing problematic AOD use are also eligible to access Mental Health Care Plans (South Western Sydney PHN 2018) through which they can receive 10 Medicare-subsidised visits to an allied mental health service such as a psychologist or psychiatrist, and 10 separate visits to a group therapy service (Department of Health 2019). After the plan has been created, GPs can claim funding under the MBS for ongoing management, consultation and plan review.

Guides for GPs on existing MBS items and eligibility criteria are a tool commonly produced by PHNs to assist GPs for a broad and disparate range of health issues. Brisbane North produce and distribute resources to GPs in the region on MBS items including the *MBS Quick Guide* and the *Desktop Guide to Frequently Used MBS Items in General Practice* (Brisbane North PHN 2019, Australian Doctor 2020). However, what is missing from these resources is a clear articulation of who is eligible for these range of supports. For instance, the *MBS Quick Guide* notes what items can be claimed under the headings 'chronic disease/complex care management' and 'mental health', but if GPs are unaware that people experiencing problematic AOD use are eligible for these items, then it will not assist in patients with AOD needs accessing these arrangements.

South West Sydney PHN has produced a 2-page tool specifically to assist GPs in optimising the delivery of Medicare-funded health care to patients experiencing drug and alcohol issues (see Appendix A). It is therefore recommended that Brisbane North PHN adapt this tool or create a

similar tool that can be shared with GPs in the region both by distributing via PCLOs and making it available online; and ensure that the information is integrated with HealthPathways (See recommendation 8). Should an AOD GPLO position be created, they would also be in a good position to share and promote this tool among GPs and GP networks.

Secondly, it should be noted that Medicare supports Practice Nurses to be involved in many of these items. While PNs are not able to claim items from Medicare directly they are able to contribute to the formation and monitoring of GP Management Plans, Team Care Arrangements and multidisciplinary care plans, and provide follow-up services to Aboriginal and Torres Strait Islander people who have received a health check (Health Victoria 2016). We therefore suggest that a useful secondary tool would be a separate 2-page document explaining how Practice Nurses can be used to assist in the creation and management of these plans.

Recommendation 5: Brisbane North PHN AOD community of practice to consider expanding membership to include GPs, practice nurses and other specialist AOD allied health professionals

In healthcare, communities of practice (CoPs) are used as a means of sharing knowledge (usually between specialist practice areas), building networks and improving organisational performance (Wenger, McDermott et al. 2002). Research on the effectiveness of CoPs supports them as a tool to improve clinical practice, implement innovative practice and processes and break down professional, geographical and organisational barriers (Ranmuthugala, Plumb et al. 2011).

In areas of health that deal with problematic AOD use and/or other comorbidities and complexities, CoPs have been used to increase integration and networks across different specialist treatment and social services (such as homelessness services) (Whiteford and Byrne 2014) and to improve networks and relationships (Cornes and Manthorpe 2013). In mental health, the establishment of CoPs among GPs and workers in the field such as social workers and psychologists has helped to foster greater collaboration and self-sustained clinical networks (Eagar, Pirkis et al. 2005).

Brisbane North PHN revived CoP during 2018 and have implemented a number of actions to strengthen and develop the networks. It is worth noting that CoPs are also being used in other PHNs (such as Nepean Blue Mountain) as an alternative method to raising awareness and knowledge of AOD treatment among GPs and as a vehicle for interested GPs to engage with other AOD experts and each other (Nepean Blue Mountains PHN 2020).

Possibly a reflection of being in the early stages of implementation, the CoP in Brisbane North PHN is currently limited to specialist AOD services. Broadening the membership to include GPs with a specialisation or interest in AOD as well as other interested allied health professionals such as psychologists could lead to better links between different services, as well as providing a forum for GPs to tap into a shared knowledge network. CoPs could also provide opportunities for peer support for GPs who work with people who use AOD and are therefore one means to address the burnout and lack of support found in this study (Goodyer 2012). An AOD GPLO would be perfectly positioned to assist with bringing in GPs to this group.

Recommendation 6: QNADA to consider working with Brisbane North PHN and Qld Health to develop opportunities for GPs to visit and/or undertake short placements in AOD services

Opportunities for placements of registrars in AOD services are well evidenced as a way to create knowledge in GPs of the specialist AOD sector and improve GP practice, build links between services, provide healthcare to people who attend specialist AOD services and reduce demands on local GPs (Allan 2010, Allan 2011).

Visits and shorter-term placements by GPs of a few hours in specialist services have also been used to improve services. For example, the Mid-North Coast Division of General Practice trialled a program called *We Can Do Better* where 18 GPs undertook 4-hour clinical placements in both Drug and Alcohol and Mental Health Services (General Practice NSW 2010). The project was found to improve referrals and communication between GPs and specialist services and improved GP knowledge, confidence and skill in identifying and treating comorbidity (General Practice NSW 2010).

QNADA may want to consider developing opportunities for formal visits and short placements for interested GPs and assist in building supportive infrastructure such as rosters and guiding program goals and policies. An AOD GPLO would be ideally placed to assist with this initiative on behalf of Brisbane North PHN and to help facilitate connections with general practices. In the absence of an AOD GPLO role being created, Brisbane North should consider what other staff could assist in working with QNADA to develop placement opportunities and connect interested health professionals.

We acknowledge that it may be difficult to attract GPs to attend even short placements without other incentives. Other (more formal and extensive models) that require extra resourcing are explored further in recommendation 11.

Recommendation 7: Brisbane North PHN to work with relevant stakeholders for the greater promotion of ADCAS and ADIS among GPs

We understand from key informant interviews, that promotion of ADIS among GPs has previously taken place in Brisbane North PHN. However, continued, or greater promotion of both ADCAS and ADIS would be of benefit to practitioners and patients. ADCAS is staffed by AOD specialist medical practitioners and provides clinical advice to other practitioners regarding the management of patients with AOD concerns and provides information on local services that GPs can refer to. ADIS is a service that GPs can refer clients to in order for them to find greater information and support and be assisted with self-referral into different programs. ADIS and ADCAS therefore fill an identified gap for practitioners who may not know how to respond to patients experiencing problematic AOD use.

As a state government initiative, responsibility for the promotion of ADCAS and ADIS falls to Qld Health. However, there are clear benefits for GPs practicing in the Brisbane North PHN catchment area to have greater knowledge of and access to both services. Ensuring that there are clear links to ADCAS and ADIS on the Brisbane North PHN website and that it is promoted in other Brisbane North PHN AOD materials is a good first step.

QNADA's Systems Navigation program provides a good template for other initiatives Brisbane North PHN may wish to commission in order to increase promotion of ADIS and ADCAS. Under

this program QNADA rolled out a social media campaign and worked with GPs in four regional areas of Queensland in order to address inequality of access to AOD services and build GP capacity to respond to problematic AOD use (QNADA 2019). Evaluation of the program found that calls to ADIS increased 28% and hits to the ADIS website increased 552% following the social media campaign (QNADA 2019).

Longer term, Brisbane North PHN should work with Qld Health on greater promotion of both ADIS and ADCAS within general practices, including promotional flyers and materials being made available to clients in the waiting room.

Recommendation 8: Expand localised AOD pathways on the HealthPathways referral tool to include ADIS and ADCAS, specialist AOD services in Brisbane North PHN and pathways for existing MBS items

Referral pathways and good referral tools are essential for achieving improved integration of services and linkages between primary and specialist health services (Moriarty, Stubbe et al. 2009, Bywood, Brown et al. 2015). Research has found that referral tools, and the referral tool HealthPathways in particular, can improve knowledge of local services, provide GPs with easy access to referral pathways and therefore have the potential to improve patient management and health outcomes (McGeoch, McGeoch et al. 2015, Gill, Mansfield et al. 2019).

Brisbane North PHN have devoted significant resources to enhance referral tools in the region through the implementation of HealthPathways. HealthPathways is a web-based referral tool that provides GPs with information on local pathways for a range of chronic conditions as well as assistance with patient assessment and management (Brisbane North PHN 2019). At time of writing, the only localised pathways for AOD-related issues are under mental health and for “alcohol intervention and withdrawal”, and for “codeine- chronic use and deprescribing” (Brisbane North PHN 2020). By comparison HealthPathways Melbourne has direct access to all PHN-funded local AOD services which allows direct referral into services, as well as access to pathways for low risk AOD treatment and assessment, and high risk AOD treatment and assessment (North Western Melbourne PHN 2019).

While we understand that there are changes being made to other GP referral tools in the mental health space i.e. through the Brisbane MIND Plus EReferral tool, we note that, at time of writing, this was also lacking information or capacity to refer to AOD specialist services. Given that HealthPathways has been promoted extensively, and as we understand it, adopted by many GPs in Brisbane North PHN, we for therefore recommend including ADIS and ADCAS as pathways in the tool.

We note too the work that the AOD Partnerships Group has undertaken in assisting ADIS to establish referral pathways between themselves and all specialised AOD treatment services in Brisbane Metro North and South (Brisbane North PHN 2019). However, we also recommend considering including all local pathways for specialist AOD services into the HealthPathways referral tool, starting with those services funded by Brisbane North PHN. This then provides options for GPs to direct patients for self-referral through ADIS, speak to a specialist for advice and guidance on the best treatment pathways for their patients in ADCAS; or if they are more confident, assist with referrals themselves. It also meets the needs of GP participants in our study who emphasized the need for a resource with information on suitable specialists and services in their area that they can refer to.

In addition, we recommend that all MBS items that can currently be used to assist people who use AOD (described above in recommendation 5) are also integrated in the HealthPathways tool. In undertaking this work Brisbane North PHN may wish to adapt pathways that have been devised in other PHNs across the country.

Recommendation 9: Amend the Brisbane North PHN website so that AOD resources are more visible and accessible to health professionals

Navigation to AOD resources on the Brisbane North PHN website is tricky as it requires a few steps. First 'mental health' must be selected in the drop-down list 'health professionals', and then AOD must be located on the sidebar of the new page. To make navigation easier to this part of the website, in the first instance it is suggested that AOD is presented as an independent heading in the 'health professionals' drop-down list.

It is also suggested that the AOD page is used to clearly promote tools for GPs prominently at the top of the page, including ADCAS and links to resources produced by Brisbane North PHN to assist GPs in this area such as the AOD quick guide for GPs (Brisbane North PHN 2018). For comparison, North Sydney PHN provides links to webinars and training resources for GPs (Northern Sydney PHN 2020) and South West Sydney PHN includes links to a range of resources including information on opioid prescription, brochures they've produced on specialist AOD services (similar to Brisbane North PHN's AOD quick guide for GPs) and screening and BI tools (South Western Sydney PHN 2019).

Initiatives that involve new models or greater expansion of existing models in Brisbane North PHN to provide additional support to GPs and/or people who use AOD

Recommendation 10: Brisbane North PHN to commission evaluations of models of integrated care they fund in the region

Brisbane North PHN fund a number of AOD specialist services in the region and different models of integrated care. Ensuring funding for evaluations is included in program funding means that any learnings from those programs can be applied elsewhere and projects that have scalability can be identified.

For instance, Lives Lived Well, a service that provides withdrawal and rehabilitation services, is co-located with the Morayfield Health Hub at Caboolture and was well regarded by the client participants in our research. While there are other mental health hubs funded by Brisbane North PHN, co-locating with specialist AOD services is an innovative approach that has potential to be utilised elsewhere in the region.

Existing evidence into co-located services that include specialist AOD services and primary health care services have been found to be important in reducing practical barriers to accessing services and improving referral pathways (Savic, Best et al. 2017), with some evidence that such models also improve patient outcomes (Day, Islam et al. 2011, Berends and Lubman 2013) and are considered an important strategy for integration (Bywood, Brown et al. 2015).

Research on improving integration of AOD, mental health and primary health services suggests that to be of most use to future policy makers and funders, evaluations of integrated and co-located services must occur (Savic, Best et al. 2017) and include both qualitative and quantitative methods, evaluation of the clinical processes as well as client outcomes including program effectiveness and cost effectiveness (Bywood, Brown et al. 2015). Evidence collected can then be used to form the basis of considerations for expanding models into other subregions of the Brisbane North PHN.

Recommendation 11: Brisbane North PHN to consider funding one or more of the following models of integrated care:

- **Rotations of AOD specialist practitioners in GP practices**
- **Rotation of GPs into AOD services**
- **Care coordinators/specialist liaison officers**

Integrated care attempts to address the multidimensional causes of poor health by integrating healthcare and other service delivery to individuals (Zonneveld, Driessen et al. 2018), including a range of non-health and social issues such as housing, education and employment services (Bywood, Brown et al. 2015). The desire to improve outcomes for people with chronic and complex issues has resulted in a number of different models of integrated care including the use of multidisciplinary teams, co-located services, specialist rotations, shared care and consultation/liaison models (Davies, Perkins et al. 2009, Fuller, Perkins et al. 2009, Mitchell, Burridge et al. 2015).

Evidence suggests that a number of these initiatives can and should be employed concurrently in order to improve linkages between primary and specialist services in order to improve outcomes for clients (Fuller, Perkins et al. 2009, Savic, Best et al. 2017), although the heterogeneity in outcomes and models means that no one uniform approach can be identified as superior (Mitchell, Burridge et al. 2015). Ensuring that adequate funding is available to whatever models of integrated care are chosen is the most critical factor for success (Savic, Best et al. 2017). The models of integrated care suggested here represent the best fit for the needs of the Brisbane North PHN.

Any one of these models offers a solution to multiple issues raised by participants in our study. Aside from increased linkages such models provide additional or alternative staff to ease the extensive resourcing, planning, referral and follow-up work needed for people accessing specialist services outside of MBS funded initiatives (Henderson, Valenti et al. 2016). All models also offer greater support to GPs by providing easy access to expert knowledge with some initiatives also providing opportunities for mentoring, inhouse training and clinical supervision.

The rotation of AOD practitioners in GP practices across the region

One option to address both the difficulties for some patients experiencing problematic AOD use from accessing GPs, is to provide AOD workers within general practices on a regular and ongoing basis as ‘visiting specialists’. There are many different models to draw from in terms of how such visiting specialists are integrated into practice with the most relevant for AOD specialists likely to involve either a ‘replacement model’ (where the specialist becomes the primary contact for some patients), a ‘consultation model’ (where treatment is mediated through the GP), or the ‘liaison attachment model’ where specialists form part of a team of visiting services (Gruen, Weeramanthri et al. 2004).

In Australia, the latter model is commonly used in rural/regional general practices and in Aboriginal community-controlled health organisations (ACCHOs) where access to permanent specialist services is not available, and specialists visit regions/services on a rotational basis (National Rural Health Alliance 2004, Gruen, Bailie et al. 2006, Clifford and Shakeshaft 2011). Such placements and outreach models including workers from specialist AOD services have been found to increase patient access to services, patient satisfaction and improve health outcomes (Gruen, Weeramanthri et al. 2004, Berends 2010).

As well as increasing access to services, it is argued that people with AOD and mental health needs particularly benefit from provision of specialist services within general practice, partly because it has been found to increase engagement between primary and specialist providers (Bartels, Coakley et al. 2004, Krantz and Mehler 2004, Berends and Lubman 2013). Other benefits include the potential for visiting AOD workers to also provide upskilling and knowledge to staff for managing and referral of patients (Allan 2011).

However, placing AOD workers in general practice does not necessarily change the way that GPs and AOD services work with each other (Gruen, Weeramanthri et al. 2004). In Australia, issues with implementation of rural rotations of AOD workers have stemmed from lack of planning and notice to providers around visits and lack of consideration of local demands (Allan 2010). A Cochrane review of literature found that integration and interaction between practitioners was found to be greatest when placements where part of a complex multi-faceted intervention including joint care planning and management and education and training opportunities (Gruen, Weeramanthri et al. 2004). Other critical success factors include ensuring the programs are have sufficient funding and contribute to local capacity building and infrastructure (National Rural Health Alliance 2004).

A pilot scheme in the UK in the early 2000s involved a care nurse position that was paid by, and based in a specialist AOD service, providing outreach clinics in GP surgeries (Smith and Mistral 2003). GPs could refer clients to the nurse who then took over management of the client and advised the GP on methadone prescriptions. An evaluation of the program found a reduction in workload on the GPs, and that GPs were happy to be relieved of the job of methadone prescription although, some GPs were reticent to join the pilot scheme because they did not want methadone using patients at their practice (Smith and Mistral 2003).

Wariness of pilot schemes from practitioners is a challenge for any potential new model, as some studies have found that GPs are worried that projects will evaporate, leaving them with a new complex cohort of clients to manage without support (Smith and Mistral 2003, Wilson 2017). However, evidence suggests first piloting AOD integration strategies before scaling them up (Savic, Best et al. 2017). Potentially, long-term commitments to any new initiative as well as a clear plan for GPs on what happens to clients in the event the pilot ends, may encourage uptake. Larger practices and community health centres may also be more amenable to this initiative. An alternative is to instead place GPs in AOD services, discussed below.

The rotation of GPs into AOD services

Given the difficulties for clients exiting rehabilitation and withdrawal services to find a GP, another option for rotations of workers is to provide GP services directly at specialist AOD services for a designated number of hours per week. A benefit of this model is to rebuild links between people who use AOD and general practice for those who have disengaged due to prior

bad experiences. Incentivisation for GPs will likely have to occur, but there are a number of tools that Brisbane North PHN can use, including direct payment of GPs and provision of more formal shared care arrangements with AOD services.

For instance, Northern Sydney PHN have funded an AOD shared care model aimed at GPs already supporting clients with AOD use, or who have an interest in this area and are willing to accept referrals from the local health district (Northern Sydney PHN 2018). This model requires GPs to become an OST prescriber and participate in case conferencing and care planning with Northern Sydney PHN commissioned AOD services. The model provides incentives for GPs to participate in the form of special remuneration from the PHN, clinical supervision from drug and alcohol specialists at the Royal North Shore Hospital and mentoring from other AOD specialist GPs, guidance on the use of Medicare items such as Better Access, and access to specialist AOD nurses who can assist in the management of patients (Northern Sydney PHN 2018).

A shared care model like the Northern Sydney PHN one above, additionally offers a method of increasing OST prescribers (aside from increased training opportunities through the Queensland Opioid Treatment Program Prescriber course run by Insight (Insight 2020)) which was identified as a need in our project. GPs and other informants described factors such as fear of being overwhelmed, lack of support, and complexities and license worries of OST prescription as barriers to becoming a prescriber, so linking prescriber training in with a range of other supports and structured care planning that can ameliorate those concerns, as well as providing a financial incentive, is likely to be more successful than simply offering a financial incentive alone.

Models of shared care have long been suggested as a means of improving outcomes for people who use AOD and managing their overall health (Copeland 1998). 'Shared care' models that look to improve links between primary health and specialist AOD services generally involve formal agreements between specialist services and GPs or the hiring of specialist liaison officers who then take on management of a patient and refers between specialist services and GPs as necessary (Copeland 1998).

Some shared care projects have previously been trialled in Brisbane (albeit outside of the Brisbane North PHN area). For instance, a small shared care project between a clinical nurse and local GPs operated at South Brisbane's Peel Street clinic in the early 2000s. This project identified clients who used pharmacotherapy and their GPs and with the clients' consent asked the GP if they'd consider writing pharmacotherapy scripts as part of their care (Goodyer 2012). Queensland's medicines regulatory unit provided authorisation for GPs to write scripts as part of a shared care model. As a result, 15 clients moved from the clinic to their GP for primary healthcare management, although the project closed when funding ran out (Goodyer 2012).

Care coordinators/specialist AOD liaison officers

Clinical care coordinators and/or specialist liaison officers are commonly hired to bridge the gap between specialist services, other social/welfare services and primary health care services (Gruen, Weeramanthri et al. 2004). They have been used widely in mental health in Australia, for instance through the Mental Health Nurse Incentive program (Happell and Platania-Phung 2019). While both an AOD GPLO position and care coordinator could assist GPs with information and linkages to AOD services, a care coordinator is capable of directly assisting patients and also providing ongoing support to GPs in the management of their patients.

Brisbane North PHN previously funded a model of clinical care coordination for people with severe mental health and complex health issues through the 'Mental Health Nursing in Brisbane North' (MHNiB) (Brisbane North PHN 2019). The MHNiB program supported GPs (and community based psychiatrists) via a specialised mental health nurse (MHN) who could case manage consult and collaborate with GPs in the management of patients' mental health needs, formation of a mental health treatment plan, referral to specialist services, coordination of different social services and client follow-up (Brisbane North PHN 2019). They also maintained contact with a person in order to monitor their wellbeing and progress and can administer medication (Brisbane North PHN 2019).

Other models have involved the hiring of specialist liaison officers who then take on management of a patient and refer the patient between specialist services and GPs as necessary. There is some evidence internationally that the involvement of primary healthcare liaison officers can significantly improve the management of people who use drugs, particularly for people who use opiates (Dey, Roaf et al. 2002).

A number of other PHNs are currently supporting specialist AOD liaison and coordinator roles that provide good examples for how a similar program could run in Brisbane North PHN. In Central and Eastern Sydney PHN, the GP liaison in alcohol and other drugs (GLAD) project is a new collaboration with AOD services in 3 local health districts in Central and Eastern Sydney PHN (CESPHN) including South East Sydney Local Health District (SESLHD), Sydney Local Health District (SLHD); and St Vincent's Health Network (SVNH) and is funded by CESPHN. GLAD employs AOD GPs and nurses who provide the following to GPs: advice, support and information, referral, opportunities for shared care, consultation clinics, and education including the running of in-clinic information sessions and training (Central and Eastern Sydney PHN 2018). It should be noted that these roles are in addition to case managers in AOD services that work with people already in AOD treatment.

GLAD in CESPHN also funds nurses who are part of the SESLHD Shared Care Nurses Program that work in the community and support GPs responding to patients experiencing problematic AOD use. The program began as a means to address many of the same barriers found in this project – difficulties in accessing OST, GPs unwilling to take on people who use AOD, people who use AOD unable to access care for their general health, and a lack of GP knowledge of the specialist AOD sector and referrals into it (Wilson 2017).

With seed funding, the shared care program employed nurses based in a GP practice in the local area who liaised with the PHN and local GPs to identify practices with high and low caseloads of AOD clients. The nurses provide case management, assessments of AOD and mental health, referrals (both from AOD services into GPs and from GPs into specialist services), care planning including assistance with other services such as housing, employment, work in relapse prevention and relationship building across different sectors (Wilson 2017). A limited evaluation (that was funded along with the initial start-up of the project) suggested the program had improved socio-economic outcomes of patients, created 20 new GP prescribers in the area and therefore decreased waiting times for an OST and improved primary drug use issues, and was widely regarded positively by patients (Wilson 2017).

The project found that elements of program sustainability included taking a long-term view in regards to funding, with importance of the program not being a pilot, time spent engaging GPs

and considering them part of the team, acting on what GPs tell them they need, focusing on high case load practices, finding champions and creating ease of referrals for both GPs and specialist services (Wilson 2017).

Addressing gaps in policy, guidelines and training

Recommendation 12: Brisbane North PHN offer AOD 'clinical audits' to general practices

Clinical audits are a common tool used for assessing current practice in a particular area, and identifying areas for quality improvement (Johnston, Crombie et al. 2000, Amoroso, Proudfoot et al. 2007) and are already offered to general practices by Brisbane North PHN, currently in the areas of diabetes and chronic kidney disease (Brisbane North PHN 2020). It should be noted however, that our research found that the term 'clinical audit' is anathema for many practices who believe 'auditing' is a negative process that potentially uncovers weaknesses and exposes them to risks. We therefore suggest that the term 'clinical audit' is avoided and replaced with positive language focused on skills building and the support that Brisbane North PHN can offer. It is also worth noting that participants in this study raised problems with clinical audits in their current format, particularly with regards to corporate practices. Therefore, we suggest culturally adapting clinical audits to fit better into corporate culture, perhaps by measuring improvement against the practice's baseline as opposed to against their peers.

The literature suggests that reviews or audits of primary health practice include a risk analysis to ensure that the operating environment meets standards of safety and amenity for clients to reduce stigma and discrimination for people who use AOD (Queensland Mental Health Commission 2018). Such audits could include undertaking an organisational needs analysis in order to identify areas for specific focus as suggested by the National Centre for Education and Training on Addiction (NECTA) (Roche, Pidd et al. 2009, Roche and Nicholas 2017). Reviewing and/or assisting in the establishment of clear service objectives or mission statements, development of relevant anti-stigma metrics and targets, and Key Performance Indicators are also service-level initiatives with some evidence for improving quality of care for people who use AOD in primary healthcare (Berends and Lubman 2013, Roche and Nicholas 2017, Lancaster, Seear et al. 2018).

An AOD 'clinical audit' that addresses organisational factors found in this project could also include:

- Audit of existing processes for how general practice deals with clients with AOD needs and other complex, chronic illnesses
- Review of how practice nurses are used, and may be more effectively used to assist GPs in the management of clients with AOD needs and other complex, chronic illnesses
- Assistance in development of service objectives, mission statements and service goals or milestones
- Review use of screening, motivational interviewing and brief intervention and provision of additional assistance in skills building if necessary
- Development of support plan for general practice in the management of complex clients including appointment systems and people seeking schedule-8 prescriptions

- Review of practice in relation to access to healthcare as a human right (as set out in 12(1) of the International Covenant on Economic, Social and Cultural Rights)
- Development of plan to support patient participation in treatment planning
- Assessment of the general practice environment included the resources available for clients in waiting rooms.

As an alternative to, or in addition to Brisbane North PHN offering clinical audits, Brisbane North PHN may want to consider commissioning a 'clinical audit' tool for GP practices to use themselves. We note that the Insight Centre for Alcohol and Other Drug Training and Workforce Development (Insight) have already produced a number of toolkits to assist general practices in their delivery of services to people who use AOD (Insight 2020). Insight may therefore be best placed to assist in development of an AOD clinical audit toolkit.

Recommendation 13: Brisbane North PHN to commission resources for general practice that support a safe and inclusive work environment for staff and patients including:

- **Development of occupational risk assessment and management plans**
- **Provision of guidelines on appropriate evidence-based strategies for dealing with aggressive behaviours**
- **Training for administrative staff on de-escalation techniques**

Aggressive client behaviour was an issue raised by administrative staff and patient participants and is a phenomenon common across general practice in Australia, particularly verbal abuse (Forrest, Herath et al. 2011). It should be noted that staff did not draw a direct link between AOD use and aggressive behaviour but talked about aggressive clients in more general discussions about issues they face in general practice. Indeed, research shows that AOD use may be one of several risk factors for aggression in health settings (Sim, Wain et al. 2011) although others argue that clinical practice factors such as excessive wait times or a feeling of being unfairly treated are the more common triggers for aggression (Secker, Benson et al. 2004, Wand and Coulson 2006).

All workplaces in Queensland have a responsibility to ensure the health and safety of their workforce (Workplace Health and Safety Queensland 2019) and it is of concern that some administration staff are dealing with aggressive behaviours without guidance, training or support from other staff members. It is also of concern that patients are being 'blacklisted' from general practice in the absence of behaviour management strategies as research suggests that aggressive behaviour in the general practice setting can be managed and de-escalated through the use of good communication skills (Department of Health 2004, Sim, Wain et al. 2011).

It is recommended that the Brisbane North PHN team responsible for clinical audits also offer and conduct risk assessments with general practices that include a review of their processes and strategies for dealing with aggressive behaviours, and then work with practices to implement best-practice processes.

Secondly, we recommend that Brisbane North PHN either promote existing guidelines or commission the development of their own guidelines in regard to risk management. A number of tools have been developed to assist health providers in the creation of risk management

plans and appropriate intervention strategies including guidelines produced by Workplace Health and Safety Queensland (Workplace Health and Safety Queensland 2019) and the RACGP (Royal Australasian College of General Practitioners 2016). It would preferable for guidelines produced by Brisbane North PHN to include suggestions of which staff members should have roles and responsibilities for communicating with patients where they have been 'blacklisted' as well as acknowledging that the 'blacklisting' of clients should be a last resort after mitigation techniques have been employed.

Research suggests that 'blacklisting' can be avoided altogether by recognising early warning signals and using appropriate de-escalation techniques as violence rarely suddenly erupts (Wand and Coulson 2006). Proven de-escalation techniques focus on calming a patient down and often includes a 'verbal loop' acknowledging a patient's position while directing the patient to what they should do (Raveel and Schoenmakers 2019). Guidance on de-escalation should be provided in guidelines, and training should also be offered to staff. Administration staff spoke highly of previous opportunities provided by Brisbane North PHN to engage in training on dealing with aggressive behaviours in practice. We recommend that Brisbane North PHN consider commissioning extra training in this area.

Recommendation 14: Brisbane North PHN to commission anti-stigma training and AOD training for other general practice staff including Practice Managers, administrative staff and Practice Nurses

One gap that was identified in the course of our research was the lack of AOD education and training available for staff in general practice who are GPs, namely administrative staff, Practice Managers and Practice Nurses. Administrative staff expressed their desire for additional training in this area, and it was clear from patients that negative experiences were possible during every contact with a general practice, regardless of staff position. Expanded training options for all general practice staff is also supported by people consulted for *Planning for Wellbeing* who proposed that:

> all staff with a consumer contact role in human services irrespective of the role or field in which they are employed, should have basic knowledge about alcohol and other drug use (Brisbane North PHN 2018).

Education and training around AOD use has been found to improve practice and decrease discrimination where general ignorance about AOD is a contributor to stigma, or where a lack of knowledge, confidence or experience in AOD contributes to a reluctance to engage and treat people who are experiencing problems with AOD (Roche, Pidd et al. 2009, Beaulieu, Patten et al. 2017, Lancaster, Seear et al. 2018).

Commissioned training should then continue to be offered on an ongoing basis to ensure that all staff have opportunities to engage, as well as providing opportunities for staff to refresh their knowledge. In addition, all training should include follow-up for participants (see below).

Recommendation 15: Brisbane North PHN consider working with RACGP and Insight to implement follow-up for practitioners who engage in AOD-related training

In order to cement learnings from professional trainings, evidence suggests that systems of follow-up or reminders are used (Bywood, Lunnay et al. 2008). One model that had some limited

success in increasing screening and BI for alcohol use in Aboriginal Community Controlled Health Services (ACCHSs) was a program that involved both training and a one day visit to each ACCHS by a local drug and alcohol clinician 6 months after training (Clifford, Shakeshaft et al. 2013). The added potential benefit of using a local AOD clinician for follow-up is to build links between the practitioner and the GP. It is therefore recommended that Brisbane North PHN consider commissioning follow-up for GPs who undertake AOD-related training in coordination with training providers RACGP and Insight. This is in addition to new anti-stigma training that may be commissioned by Brisbane North PHN.

Appendix A

Copy of South West Sydney PHN 'Optimising MBS items for patients with drug and alcohol issues' tool for GPs

The following is an excerpt from the tool created by South West Sydney PHN for GPs to assist in applying MBS items to patients arriving at practice for issues relating to AOD use. For the full resource, please visit: https://sydneynorthhealthnetwork.org.au/wp-content/uploads/2018/03/Optimising-MBS-items-for-drug-and-alcohol-patients-FINAL.pdf

phn SOUTH WESTERN SYDNEY
An Australian Government Initiative

Optimising MBS items for patients with drug and alcohol issues

The following MBS item number descriptor has been put together to help GPs optimise the delivery of health care to patients with drug and alcohol issues. Whilst there are no specific addiction medicine MBS items available for general practice, there are other items that can be used to support patient management. Examples have been provided to help GPs understand how these item numbers can be used in general practice setting.

Chronic Disease Care plans			
721	GP Management Plan (GPMP)	$144.25	• For use to enhance care when one or more chronic disease present ie Cirrhosis of the liver from alcohol use disorder • Requires care from multidisciplinary team • Co-claiming of GP consultation items (ie 3,4,23,24 etc) with CDM items 721, 723 or 732 is not permitted for the same patient on the same day. • 721/723 minimum claim period – 12 months • 729-732 minimum claim period – 3months
723	Team Care Arrangement (TCA) …	$114.30	
732	Review of GPMP/TCA	$72.05	
10997	Service to patient with GPMP/TCA by a PN or Aboriginal health practitioner	$12.00	• Not more than 5, per patient, per year
GP Mental Health Treatment Items			
• All substance use disorders and alcohol use disorders are included in the list of mental disorders that can be incorporated into a GP MHCP			

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