Appendix III

Medical Practitioners

The recommendation by Single and Rohl (1997) to train mainstream health professionals (amongst others) to minimise drug-related harm effectively has been widely implemented in Australian medical schools. However, the notion that training GPs will automatically lead to a significant increase in the provision of treatment to people with substance use disorders is both superficial and naïve. Whilst it is true that many GPs have limited knowledge, skills and confidence to assess and intervene appropriately, there are a number of other barriers which need to be addressed:

- De-skilling of GPs has occurred a result of centralised controls and the perception that statewide specialist drug and alcohol agencies were the monopoly providers of treatment.
- Payment structures for the longer consultations required for substance use disorder treatment have been a major disincentive for GPs.
- The isolated nature of many general practices has led to difficulties in the distribution of information resources for GPs and patients and to difficulties in the development of relationships between GPs and specialist Drug and Alcohol services. Activities such as “doctor shopping’ and perceptions of threatening behaviour towards doctors have reinforced negative stereotypical attitudes towards substance users amongst GPs and practice staff.
- Treatment of substance use disorder by GPs has often been idiosyncratic, without particular reference to evidence-based recommendations

The difficulties experienced in most states in recruiting GP methadone prescribers are testimony to the barriers described above. However, the engagement of the general practice sector is vital as the specialist services are expensive and are clearly unable to provide the quantity of treatment required. The expansion in the range of maintenance opioid pharmacotherapies and the introduction of drugs to treat alcohol dependence represent additional opportunities for GPs to take a greater role in alcohol and drug dependence treatment.

Apart from training and education, the steps required for the realisation of the dream of GP involvement include:

- The development of links and networks between specialist services and the divisions of general practice and GPs.
  A high-level commitment to such networks is essential, as is the provision of both tangible and intangible support. The role of divisions is crucial as they possess the mechanisms for information distribution, coordination and promotion of continuing medical education programs and management of special divisional projects.
- Improved quality of GP interventions.
  Training and education should be supported by the development of clinical practice guidelines, which are evidence-based. The NHMRC has published a guide for the development of such guidelines. Quality Use of Medicines grant funding may assist the development of guidelines for the alcohol and drug field. Review of GPs’ practice has been recognised by the RACGP as an important component of quality improvement. This has led to the development of clinical audit modules, which generally include a review of current practice, feedback and

a post-feedback review. Incentives are available, through the Practice Improvement Program, to pay GPs to undertake clinical audits related to Quality Prescribing Initiatives offered through NPS.

- Removal of financial disincentives to offer alcohol and drug treatment.
  Current fee schedules favour short consultations and do not allow adequate payment for GPs performing longer tasks, such as methadone assessments or counselling. The newer schedule fee items for Care Plans and Case Conferencing have been favourably regarded by GPs, who are actively involved in treatment provision for alcohol and drug use disorders. Further recognition of the time demands that this segment of medical care requires would encourage much greater GP involvement.
- Make it simple for GPs
  Paper-based screening tools, assessment formats, intervention resources, referral information, etc are soon lost in the idiosyncratic filing and storage systems adopted by many GPs. The time has come for this material to be incorporated into the medical software programs becoming increasingly used by GPs. Software applications could ensure that prompts, reminders, cautions, etc are available to GPs and should encourage a higher rate of alcohol and drug history taking.

The recommendation by Drew led to the appointment of coordinators of alcohol and drug education in medical schools throughout Australia. It is time for state Alcohol and Drug funding bodies to show a similar commitment to community medicine. Agreement to create stronger links should be reached between specialist services and divisions of general practice. Staff resources should be dedicated to improving the capacity of GPs to offer quality alcohol and drug use disorder treatment. A recognition that GP uptake will evolve gradually, rather than suddenly, will necessitate a longer-term commitment.