Evaluation of The Opiate Program

TOP

"We need to accept that the illegal nature [of drug use]..... also makes field research, harm reduction measures and education all the more difficult."
A. Byrne 2002, **Addiction**.

A report by the ACT Division of General Practice
August 2003

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Executive Summary

The TOP service

- The TOP service was instigated to fill a gap in the management of opiate dependent patients in general practice. In its first year, TOP has succeeded in improving access to treatment for opiate-dependent people in the community, and assisted GPs in the seamless management of opiate dependent patients in general practice. Sixty three percent of TOP patients were not in current drug and alcohol treatment when they first engaged with TOP.
- GP knowledge and confidence has improved with the presence of TOP nurses in general practice. TOP nurses value add for the GP by spending time with patients, performing a detailed assessment which includes drug and alcohol use, risk-taking behaviour, treatment history, physical health, and psychological adjustment, together with suicide risk screening. The detailed assessment results in a range of options for a treatment plan and goal setting. The GP TOP nurse and patient then review and discuss treatment options and goals and the TOP nurse maintains contact with the patient and GP throughout the treatment plan.
- The TOP service has effectively engaged pharmacists in the management of opiate dependent patients. Pharmacists from a range of Canberra pharmacies have actively and enthusiastically collaborated with TOP nurses to provide a range of dosing options for TOP patients.
- TOP is attractive to patients because visiting the TOP nurse is free. This is a useful counterbalance to the low number of GPs who are able to bulk bill. Patients are encouraged to maintain contact with their GP, but sharing care with the TOP nurse reduces patients' costs and affirms continuity of care with the patient's GP.
- A TOP nurse assisting a GP with the management of an opiate patient encourages the patient to attend one general practice, therefore reducing the likelihood for doctor shopping.
- The characteristics of the TOP mainstream and TOP Winnunga services are quite different. TOP mainstream has more female patients, TOP Winnunga more male. The average ages of mainstream (32.4 years) contrasts with the average age of Winnunga (24.8 years). TOP Winnunga treatment interventions are focused on the continuing support of these patients, who remain with the program and are actively followed by the TOP Winnunga nurse. Treatment interventions are similar for both programs, with methadone maintenance and community opiate withdrawal both appearing in the top three types of service for both arms of TOP. TOP Winnunga patients have a higher prison rate (78%) than TOP mainstream (20%). Winnunga patients have a higher prevalence of intravenous drug use (91%) compared to mainstream (53%). These comparisons indicate that the TOP team has been able to successfully and simultaneously deliver two distinct variations of the TOP service. This demonstrates a service that is adaptable, patient orientated and culturally responsive.
- A TOP Advisory Committee has ably advised the TOP service since its inception (see Appendix 1 for membership). The TOP Advisory Committee is particularly relevant to the success of TOP because its membership includes practicing General Practitioners (GPS), a consumer representative, and community representation. The members of the TOP Advisory Committee have supported and promoted the TOP service in its infancy and growth. We warmly regard the work they have contributed and the role they have played in the success of TOP. In particular, the inclusion of a consumer and community representative in the advisory committee is an indication of the intent of the TOP service to be inclusive and responsive to the needs of patients and families.

TOP mainstream demographics and treatment interventions

- TOP has enrolled and engaged with 46 patients in its first fifteen months, this exceeds the estimated patient numbers (n=30) for its first year of service.
- The evaluation of the TOP service in its first fifteen months of operation has identified the TOP service as a specialist drug and alcohol service in general practice, which particularly suits the needs of women. Fifty eight percent of TOP patients are female, and 48% of these patients have children.
- The main functions of the TOP service in its first year has been brief interventions (33%), methadone maintenance (22%) and community opiate detoxification (15%).
- The mean age of a TOP patient in the evaluation period was 32.4 years. TOP patients range in age from 18 to 55 years, with the bulk (34%) of TOP patients falling within the 36-45 year old age group.
- Forty seven percent of TOP patients used heroin in the past month, and 28% had used opiates other than heroin. Ninety four percent of TOP patients are polydrug users; the most frequently used drugs (after opiates) were tobacco (81%); cannabis (44%); tranquilisers (41%) and amphetamine (18%).
- Fifty three percent of TOP patients are intravenous drug users (IDUs), and fifty percent of this group were estimated by TOP to be at increased risk of contracting or spreading Human Immunodeficiency Virus (HIV) via poor injecting practice.
- TOP patients have an 8% non-attendance rate, which is very low in comparison to other drug and alcohol agencies' attendance rates. This is a result of frequent telephone communication with TOP nurses and confirmation of GP appointments with patients. TOP patients are more likely to attend appointments with GPs and TOP nurses because of the convenience of TOP interventions in the patient's local general practice or pharmacy.
- Fifteen percent of TOP patients are long-term patients, having been with the program for a minimum of 6 months. Overall, 10% of TOP patients have engaged in a long-term opiate reduction, either from Methadone, MS Contin, Endone or Oxycontin. The TOP program is the only program that offers long-term opiate withdrawal in the community.
- Sixty one percent (n=31) of TOP patients completed their TOP intervention. Of those who have not completed their treatment, 86% are current patients.
- TOP has made 17 referrals to the Alcohol and Drug Program (ADP), 2 to mental health services and 13 referrals to non-government organisations. This represents a total referral rate of 32 referrals for 42 patients, giving an overall referral rate of 69%.
- Significant proportions of TOP patients demonstrated psychopathology for anxiety (39%) and somatic symptoms (34%) at their first TOP visit. Nineteen percent of TOP patients were identified as depressed at their first visit, and 4% were suffering from social dysfunction. These results indicate that co-morbidity of mental health with drug and alcohol problems is a substantial factor in the TOP patient demographic.
- TOP GPs are predominantly female (65%), and half of all TOP GPs are aged between 35 and 45 years.
- The range of experience of TOP GPs in general practice was 1 to 42 years. Most GPs (75%) had 25 years or less experience.
- TOP GPs worked in a range of practices from a single person practice to one containing 12 GPs. The most common type of practice using TOP was a 3-person practice (this included the TOP-using GP).

TOP Winnunga demographics and treatment interventions

- TOP Winnunga has enrolled 46 patients in its first twelve months of service and its growth has increased at a steady rate.
- Once engaged with the TOP Winnunga service, these patients and their families are actively followed-up by the TOP Winnunga nurse. TOP Winnunga patients stay with the service for the duration of their association with Winnunga Aboriginal Health Service.
- Seventy eight percent of TOP Winnunga patients are current patients, the remainder are either incarcerated interstate; in a residential rehabilitation centre interstate or have moved interstate.
- The age range of TOP Winnunga patients is 18-36 years, with an average age of 24.8 years.
- Sixty five percent of Winnunga patients are male, and most of these fall into the 18-25 year old age group.
- Seventy eight percent of TOP Winnunga patients had ever been in prison.
- Ninety one percent of TOP Winnunga patients are intravenous drug users, preferring to use heroin rather than amphetamines.
- The most common type of treatment for TOP Winnunga patients is "ongoing support" (100%), followed by community opiate withdrawal (65%) and methadone maintenance (30%).
- Sixty one percent of TOP Winnunga patients were referred to other drug and alcohol or mental health treatment agencies. Most referrals were for either methadone or Buprenorphine initiation.
- Forty six percent of TOP Winnunga patients completed their TOP Intervention.

Conclusions

- The TOP service, with its large female patient demographic provides a unique community drug and alcohol service tailored to primary health care.
- The costs of providing drug and alcohol treatment interventions "are significantly offset by the savings associated with its outcomes" (Addy et.al., 2000). A community based primary healthcare service such as TOP is more cost effective than a tertiary healthcare service.
- The high rate of TOP patients completing treatments paired with a low non-attendance rate of TOP patients makes TOP a cost-effective program.
- The Key Principles and Practices (Clinical Treatment Guidelines for Alcohol and Drug Clinicians, 2000), quotes The Ministerial Council on Drug Strategy (1998) as emphasizing the increased involvement of general practitioners in the management of drug and alcohol patients. The TOP service is the only service in the ACT that assists GPs in the management of these patients.
- The development of clinical pathways for the referral of methadone patients between the Opioid Treatment Service and TOP is in progress. Preliminary negotiations are underway with the Alcohol and Drug Program (ADP).
- TOP mainstream has had recruitment problems complicated by staff attrition; this is despite a reasonably steady growth in patient numbers. Within the current staffing levels (two TOP staff), TOP is nearing its maximum potential for growth.

Recommendations and Future Directions

- Peer support and education is widely recognised in the drug and alcohol sector as a legitimate resource and service for users. Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) is the local peer organisation that would benefit from sessional TOP consultations with a TOP nurse and a GP.
- Future iterations of TOP should include either drug and alcohol nurses with mental health qualifications, or a mental health nurse to assist TOP nurses and GPs with the care of co-morbid patients.

- Locating TOP in a general practice would enhance the emphasis of primary health care in the delivery of the TOP service.
- TOP nurses co-located with GPs in general practice would afford more opportunity for GPs to opportunistically use drug and alcohol services with patients who have immediate drug and alcohol issues.
- TOP is unique in the drug and alcohol treatment sector because it only addresses the issues surrounding opiate dependency. The gradual diversification of the TOP service into other 'drug' areas, commencing with benzodiazepine dependencies and amphetamine dependencies would help to address these two areas, which are problematic within general practice. Alcohol misuse would follow soon after.
- TOP Winnunga has steadily grown in its first year, and clearly requires the current TOP nurse position to be upgraded to 1FTE in order to permit increased growth.
- Expansion of the TOP service to include a mental health nurse would alleviate the difficulty with maintaining the current patient load, but not solve the drug and alcohol specialist nurse recruitment problem.
- Recognition of TOP nurses as Level 3 Clinical Nurse Consultants would acknowledge the level of skill required to work with GPs in general practice and would make TOP more attractive for recruitment purposes.

Introduction

This report documents the successful initiation and establishment of a specialist drug and alcohol clinical service designed specifically to assist General Practitioners (GPs) with the management of opiate dependent patients. The Opiate Program (TOP) was established under a purchaser provider agreement between the ACT Division of General Practice (ACTDGP) and ACT Health. Funding for TOP was sourced from part of the funds allocated to the Safe Injecting Place Trial, which was delayed in 2000. As a result of the source of this funding, the successful ACTDGP proposal for what later became TOP was targeted at illicit and licit opiate users.

The aim of the TOP service is to provide an improved system of multidisciplinary healthcare for opiate dependent people in the ACT utilising the unique role of the GP in partnership with the client. TOP has a focus on primary health care for the opiate dependent patient, and encourages patients to seek comprehensive care with one general practitioner. The implementation of the service required the engagement of specialist drug and alcohol nurses who provide detailed assessment of patients, information, advice and resources for treatment interventions, ongoing support to GPs and patients, and referral to other drug and alcohol agencies. This translates into a collaborative system of care that is patient centred, addresses the bio/psycho/social needs of the patient, supports GPs and does not replicate existing services. Within this framework, the ACTDGP via TOP broadly supports the principles of the current ACT Drug Strategy.

The TOP team have also successfully gained ethical approval from the ACT Health and Community Care Ethics Committee for the conduct of the evaluation of the TOP service. All TOP patients sign an approved consent form before participating in TOP. This also requires a full explanation of the TOP service, the type of information we collect and the types of treatment interventions available. All information collected from TOP patients for the purposes of evaluation is de-identified. TOP has also been included in the Epidemiological Studies (Confidentiality) Act 1992. This means that TOP patient data and information is protected by statute.

The purchaser provider agreement between ACTDGP and ACT Health contains specific performance indicators, which have been used to evaluate the effectiveness of the program. An action research methodology was utilised to implement and evaluate TOP in its first 15 months. The results of this research are presented with respect to each of the quantitative and qualitative outcome measures identified below:

Quantitative Performance Indicators

- Numbers of participating GPs/practices;
- Numbers of patients participating in the program;
- Key non identifying data collected at each patient contact by the drug and alcohol nurses;
- Changes in the waiting time for methadone initiation in the public clinic;
- Numbers of newly stabilised Methadone patients being treated in the community;
- Tracking the use of EPC item numbers for Methadone patients and for other patients using illicit drugs not currently in treatment;
- Occurrence and outcome of any adverse events;
- Numbers of GPs attending the education sessions.

Qualitative Performance Indicators

- GP satisfaction levels with the services provided by the drug and alcohol nurses in the practice;
- Client satisfaction levels with the services provided by the GPs and drug and alcohol nurses;
- Changes in GP confidence levels in the management of opiate dependency;
- Changes in collaboration levels between GPs and other service providers;
- GP satisfaction levels with the multidisciplinary services available for their patients.
- Satisfaction with the education and training provided for GPs and practice staff;
- Satisfaction levels of the drug and alcohol nurses with the program;
- Satisfaction of other service providers with the program.

What is the TOP service?

TOP facilitates a team-based approach to the management of individuals with opiate dependency problems. The program acknowledges psychosocial and physical needs, emphasising the placement of the patient at the centre of the decision making process. TOP provides a comprehensive system of individual patient care that supports GPs in a practice setting. TOP is available to all ACT GP's who wish to utilise the service.

The TOP service began a two-month pilot in February 2002 and commenced full operations in April 2002. The Winnunga arm of the TOP service commenced in May 2002. This report embraces the results from the pilot study and TOP mainstream, together with TOP Winnunga until the end of May 2003.

The TOP Advisory Committee

A contractual requirement of the TOP program has been an advisory group, which would oversee the project. The inaugural TOP Advisory Committee was held in December 2001. The TOP Advisory Committee has met bi-monthly ever since and has remained consistent and vigilant in their advice, support and assistance. The designated constituency of the committee is stated below, with the corresponding TOP Advisory Committee member named alongside the contractually required position.

- A GP chairman; Associate Professor Nicholas Glasgow
- 3 other GPs; Dr Rosie Yuille, Dr David Barton, Dr Peter Sharpe
- 2 consumer representatives from non-government agencies; Mr John Ley (Friends and Family for Drug Law Reform), Mr Peter Parkes (until October 200) and Ms Nicole Wiggins, Managers Canberra Alliance for Harm Minimisation and Advocacy.
- Representative from Winnunga Nimmityjah; Dr Peter Sharpe
- A representative from the ACT Drug and Alcohol Program; Ms Sally Pink, Director ADP
- A pharmacist; Mr Ben Gilbert
- The project team leader; Ms Jodie Fisher (until Jan 2003) then Mr Simon Mirfin

Section 1 The TOP pilot

The pilot of the TOP service was undertaken so that the TOP team could refine the procedures for engaging GPs and patients; and apply the techniques we developed for patient assessment and service evaluation. A summary of the pilot process is presented in the following section while more detailed results are presented in Appendix 2.

Evaluation of the TOP pilot

Background

At the time of the commencement of TOP, there were about 124 general practices in the ACT and roughly 350 general practitioners registered with the ACTDGP. Within this group, there were 27 general practitioners who were methadone prescribers, located at 17 different practices. The ACTDGP membership database contained a subgroup of 19 general practitioners who had indicated a general interest in drug and alcohol issues. Four of these were also methadone prescribers. During the pilot phase of TOP, we targeted methadone prescribers and the drug and alcohol 'interest group' as potential participants.

In November 2001, there were about 600 community methadone patients in the ACT. Of these, about 155 were on methadone maintenance treatment (MMT) where the patient's own GP prescribed methadone and it was dispensed to the patient in a community pharmacy. Two MMT patients were located at the Winnunga-Nimmityjah Aboriginal Health Service.

A distribution of ACT methadone prescribers by location of general practice surgery identified a concentration of prescribers in one practice (n=7). Otherwise the distribution of prescribers in general practice was fairly evenly spread. A cluster of prescribers (n=5) was evident at practices situated around the Woden Town Centre area and Civic (n=4). In consideration of the known concentration of opiate users in the Civic and Woden regions, we decided to undertake the pilot with a focus on practices in these two geographic regions.

The selection procedure for pilot practices can be found in Appendix 2.
It is standard practice to run a pilot phase with a group or groups who will not be in the main study. However, for the TOP pilot participants, we continued with the delivery of the service after the end of the pilot phase and persisted with data collection from these surgeries during the evaluation period.

For the evaluation of TOP, the amount of data collected form pilot practices was small enough to allow its inclusion in the whole analysis without the risk of bias.

Pilot GPs and pilot practices

The pilot commenced on in February 2002 after the ACT Health and Community Care Ethics Committee approval had been received.

Letters were sent to a total of six practices, inviting 8 GPs to participate in the Pilot. By the end of February, all practices had responded to the pilot invitation. Of these, one Practice containing two prescribers (7%) declined to participate, and 5 practices (n=6 GPs) were pre-tested. Thus, we had a pretest response rate of 75% for (GPs) and 83% for (Practices).

Exclusion from the pilot

While TOP is a service intervention, not a study, pilot testing the service on a group that could be big users of the service before the intervention is rolled out would seriously skew the results.

There were two general practices that together contributed to 51% of the total number of methadone clients in the ACT (n=155). In consultation with Associate Professor Nick Glasgow, we decided not invite these practices to participate in the pilot study because we felt they could contribute a significant bias to the results of the pilot and the final evaluation. However, both practices were encouraged to participate in TOP at the end of the pilot phase.

Inclusion in the pilot

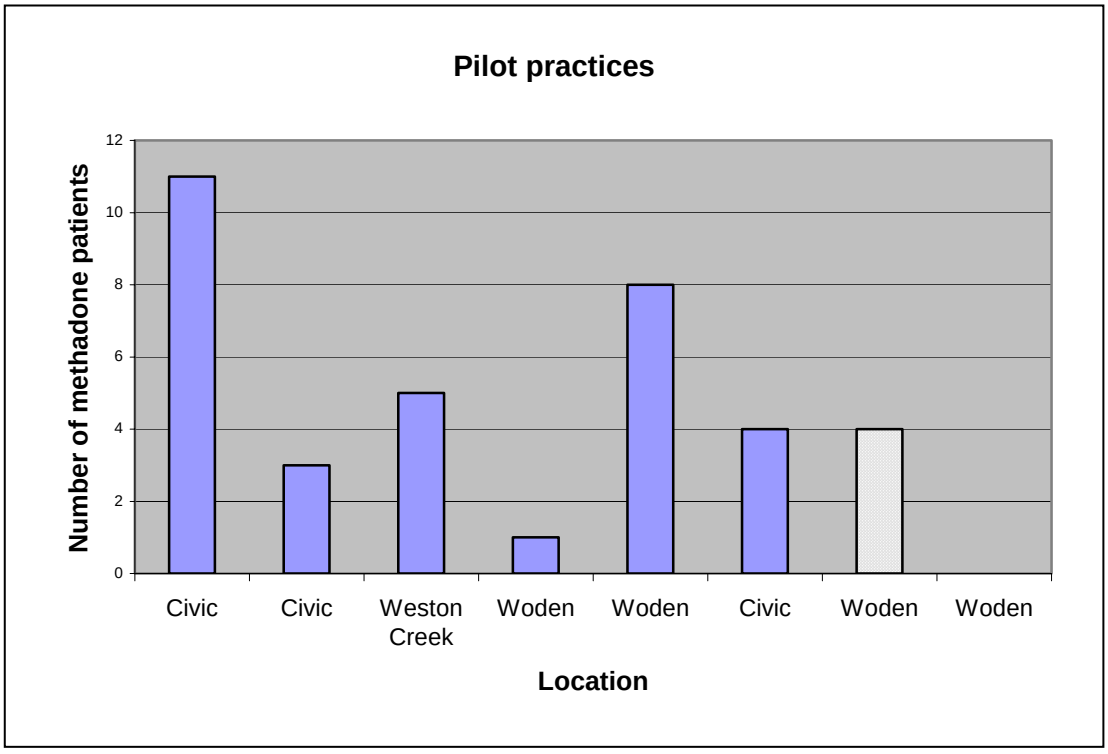
Practices with middle-ranging numbers of opiate users were invited to participate. Figure 1 gives a graphical representation of the spread of methadone clients per prescriber and location. The patterned bar and empty space represents the two GPS who declined to participate in the pilot.

In terms of location of practices and numbers of registered methadone patients, we believe the pilot practices represent a reasonable cross-section of 'ordinary' practices. We note that non-methadone using clients would also be included in the program, so these figures represent a minimum number of opiate users.

During the invitation phase, another GP contacted TOP to discuss treatment of a methadone patient. During the course of this discussion, the GP was invited to participate in the pilot program.

With the inclusion of another GP and practice, the pilot now covered 37 potential methadone patients, representing 24% of the known methadone population in the GP community. The eight GPs invited to participate in the pilot represented 27% of methadone prescribers in the ACT at that time.

Figure 1 Pilot practices comparing prescribers, locations, and self-reported numbers of methadone patients.



General Practice issues that resulted from the pilot

Appointments were made with GPS for TOP team members to discuss the TOP service and its availability and to administer the GP Needs Analysis Questionnaire and Practice Staff Needs Analysis Questionnaires. Visits were also used as a means of allowing GPs and practice staff to literally see the TOP nurses, so they may be identified at the next visit. The TOP team also left business cards and pamphlets at each practice, with the TOP contact number. Each participating GP was contacted by mail and telephoned to alert him/her to the immediate availability of the TOP service.

GPs

Some themes developed during the visiting of the six pilot practices. Most GPs stated that they did not want to increase their numbers of methadone clients; two GPs (both female) agreed to consider accepting more clients in the future, but not at present. Most GPs stated that they felt their stable clients would not benefit from the TOP service. Three GPs had patients they could think of that would be immediate candidates for the TOP service. One GP talked about a non-methadone prescribing colleague's difficult patient.

GPs were also concerned about TOP nurses accessing their patient notes, but were very happy with summary sheets for filing. The TOP consent form contains a specific section where the TOP patient can permit or deny TOP nurses access to their doctor's notes.

All GPs were eager to have pamphlets available for patient information and general TOP information. All GPs referred to their practice as a business in one form or another. It

was clear both overtly and covertly that D&A patients were very time consuming and one of the benefits from TOP would be the filtering process performed by the TOP nurse prior to GP consultations. This was evident in the very first patient seen by TOP.

Practice staff

Practice staff were a significant factor in TOP's ability to gain access to GPs. Practice staff were not enthusiastic about the type of patient that TOP might attract to the practice, and were suspicious of TOP nurses.

Practice staff also appeared to find the prospect of dealing with more D&A patients unpalatable, this impression was confirmed when some practice staff refused to fill in questionnaires. As a result, the TOP team organized a practice staff forum on managing difficult behaviours. The meeting was held in March 2002 and was attended by 38 practice staff. The large attendance was emphasized by a clear need amongst practice staff to discuss the management of difficult behaviour, to recognise that it is a common occurrence in general practice and to establish more formal techniques and supports for managing difficult patients. The meeting allowed the TOP team to showcase their expertise and publicize the TOP service in a less stressful environment.

GP estimation of methadone maintenance clients

GPs were asked to nominate how many of their patients were on methadone maintenance treatment. The GPs estimated that they treated between 3 and 15 Methadone patients, which gave an average number of estimated methadone patients as 5.6. One GP did not answer the question.

This estimation differed from our sources (ADP Opioid Treatment Services, ACTDGP database), which had the pilot GPs treating a range of 1 to 11 methadone patients, giving a practice average of 4.5. GPs generally said they had more methadone patients than the ADP had recorded, both for November 2001 and in comparison with records in March 2002 (Table 1). The apparent over-estimation of MMT patients by GPs indicates that there could be many more people on methadone in the community than we anticipated.

Table 1 GP estimates of clients, February 2002

GP number	GP estimate	ADP record
1	15	11
2	3	3
3	6	4
4	4	1
5	Not completed	7

Capitation

GPs were asked if they would consider a system of capitation payments. This has been an ongoing issue in general practice for a long time. Methadone prescribers in NSW receive capitation payments. Three GP respondents indicated that they either needed more details or 'would consider', one said yes and one did not answer.

Satisfaction with service delivery in terms of case scenarios

GPs were presented with four case scenarios and asked to outline the management of these patients. The results from this exercise are included in Appendix 2.

From the four patient scenarios, GPs were asked to rate their satisfaction with current services in managing each patient. GPs were generally satisfied with services available to stable and community methadone patients. Three out of 5 GPs were either neutral or satisfied with services available for new methadone patients; one GP was dissatisfied with these services. Three GPs were dissatisfied and one neutral with the services available for someone who has abruptly stopped taking a medium-sized dose of methadone. One GP did not answer any of the scenario questions.

This exercise, together with the results of the GP utilisation of services indicated that TOP pilot GPs were not fully aware of all the drug and alcohol services available in the ACT, and were not satisfied with the resources available to assist with patients who had abruptly stopped using methadone.

Summary of GP expectations of the TOP program

GPS were asked to list their expectations of TOP.

- Overall, GPs appeared to be more concerned with what the TOP program could do for their patients rather than what TOP could do for them.
- 3/5 were more concerned about patient referral, education and information
- 2/5 were interested in networking or referral
- 1/5 was interested in developing personal knowledge [about D&A issues]

Number of patients included in the TOP pilot

At the end of the pilot, the TOP team had interviewed 4 patients from 9 appointments. Two patients did not arrive for scheduled appointments. One GP phoned for a telephone consultation, and four practices used TOP services. Two referrals were made to other D&A services (one to a non-government drug and alcohol organisation, and one to ADP).

Lessons learned from the pilot

The pilot exercise made it clear to the TOP team that some GPs and many practice staff were not interested in attracting drug and alcohol patients to their general practices. This response has continued in the first year of the TOP service. TOP recognises that it is not a service for all general practices, and we do not expect every GP in the ACT to use the TOP service. However, we are available to any GP who wishes to use TOP, and we continue to promote TOP at every available opportunity.

In addition, TOP staff now concentrate upon actively engaging with practice staff in their roles as gatekeepers, participants in our service, and as people exposed to drug-using patients.

In addition to the pamphlets, the TOP team have developed an information folder for GPs, and TOP stickers for practice staff. TOP nurses wear identification badges, and telephone to confirm all bookings for TOP patients. This has proven to be reassuring for practice staff and has ensured patient cancellations are reduced.

In an operational sense, the TOP team decided after the pilot that we would use hard copy versions of the OTI rather than enter the data on laptop computers. The TOP nurses found that the laptop interfered with patient interaction and broke everyone's concentration. Preliminary results from the pre and post testing of GPs indicated that no difference was demonstrated in GP knowledge between the pre and post tests. We decided to cease post-testing. GPs were also unhappy with the length of the GP Needs Analysis questionnaire. Many did not complete the case scenarios, so we removed these from pre-testing.

Section 2 The TOP mainstream project

The TOP mainstream service began at the end of April 2002. The term TOP mainstream refers to the TOP service, which is directed at all general practices in the ACT and Queanbeyan, with the exception of the Winnunga-Nimmytijah Aboriginal Medical Service (Winnunga). Winnunga commenced with its own arm of the TOP service (TOP Winnunga) in May 2002 with the appointment of a 0.5FTE specialist drug and alcohol nurse. Winnunga provides funding for the remaining 0.5FTE of this position, so that there is a fulltime designated drug and alcohol nurse at Winnunga.

The remainder of this report is divided into two sections; these are TOP mainstream, followed by TOP Winnunga. The TOP mainstream report specifically addresses the Performance Indicators for TOP that were named in the purchaser provider contract with ACT Health.

Project design

Intervention study

This project aimed to improve the management of opiate users in community general practice surgeries. The measures of success were improved collaborative care (measured by satisfaction of GPs, A&D nurses and clients); improved management of opiate users; improved psycho/bio/social management of clients with the client at the centre of the decision-making process; and improved knowledge and skills for GPs. The TOP service itself is an intervention. Any GP or patient that invites the participation of a TOP nurse in their care will experience a TOP intervention. TOP interventions commence with a full and detailed assessment of the patient using the Opiate Treatment Index (OTI), and a discussion with the patient of immediate goals and priorities for their health care. The patient, TOP nurse and GP then have a consultation to decide on the immediate most favorable plan of care for the patient.

Sampling

TOP is available to all GPs in the ACT, the sampling frame for this project was self-selected general practices or GPs who had an interest in drug and alcohol issues. From this convenience sample, there has been a convenience sample of D&A clients invited to enroll in the intervention. Access to the TOP service is by referral form GP, referral form another drug and alcohol or related agency (government or non-government) and self-referral.

This sampling process is inherently biased because both GPs and patients are self-selected. This means, in a scientific sense, that the results of the TOP evaluation are not generaliseable to the population. However, the results of this evaluation may be generally applicable to D&A clients of GPs in the ACT at this time.

Evaluation

The nature of TOP is that it is an intervention study, and it is unique. In order to estimate the impact of the TOP service, we decided to test the drug and alcohol knowledge, acceptance of drug and alcohol patients and utilisation of drug and alcohol services by participating practices before they experienced the TOP service. We have called this pre-testing. The tools used for pre-testing are validated and reliable tools that were chosen because they measured the kinds of performance indicators that we were striving to achieve via the new TOP program.

Pre testing was conducted using a validated questionnaire, the Shortened Drug and Drug Problems Perception Questionnaire (SDDPPQ). In addition, the G.P. Needs Analysis Questionnaire was used to identify practice and training needs. These questionnaires were used in the Inner City Project (ref).

The OTI was used to assess each TOP patient at the first visit. The eight sections of the OTI were generally administered, unless the patient was unable to complete the OTI, or if the patient refused to complete all or part of the OTI. It is valid to use sub-sections of the OTI, and these were occasionally re-administered to evaluate general health or social functioning. Most of the patient data presented in this document is data collected from the OTI.

Patient satisfaction questionnaires were also administered after three visits.
All of these questionnaires, and those in Appendix 5 have been selected so that they may address the performance indicators identified in the contract.

Entry to the TOP service

The following is the policy used by TOP to screen potential patients.

Patient inclusion criteria

- Patients eligible to be enrolled in TOP will be;
- Aged 18yrs or over and consent to being registered on the program
- Opioid dependent or are considered to be at risk of opioid dependency
- Currently enrolled as a methadone client.
- Underage patients will be assessed on an individual basis then given age-appropriate referral.

Patient exclusion criteria

- Patients will not qualify for the TOP service if they;
- Are aged under 18 years (see above)
- Are unable or unwilling to give informed consent to participate in TOP
- (Included in the group unable or unwilling to give consent would be those;
- Who have an unstable psychiatric illness, or whose consent is not considered voluntary.)
- Are not opioid dependent, or not at risk of opioid dependency
- Are intoxicated at the time of presentation;
- Are regular 'no shows' for TOP appointments. This may be considered as missing 3 or more consecutive appointments;
- Exhibit threatening behaviour; patients who regularly exhibit threatening behaviour may be withdrawn from TOP.
- Have an acute medical condition, which precludes immediate management of the drug problem.
- Negotiation for re-entry to the program will be undertaken between the patient, GP and TOP nurse.

Practice inclusion criteria

- All ACT practices will be eligible to call for the services of a TOP nurse.
- All practices must participate in pre–testing for the purposes of evaluation.
- All practices will receive a practice visit and information pack. The information pack will be explained and will include guidelines for participation in TOP.
- Formal acknowledgement and acceptance of TOP guidelines is required.

Practice exclusion criteria

- If a practice is unwilling to recognise the policies and procedures of TOP the practice will be excluded from the TOP service.

Section 3 TOP Mainstream Performance Indicators: Quantitative

The following sections detail the quantitative performance indicators, which are outlined in the contract between ACTDGP and ACT Health. The results for each of the performance indicators are discussed under each sub-heading. Appendix 2 summarises the evaluation tools used in the TOP service.

Numbers of participating GPs/practices

TOP initially targeted methadone prescribers, as a group that would be willing to treat opiate dependent patients, but any GP who declared and interest or referred a patient to TOP was included.

Twenty-two general practitioners used TOP in its first 15 months of service (including the pilot). Of these, 16 (73%) of GPs were methadone prescribers.

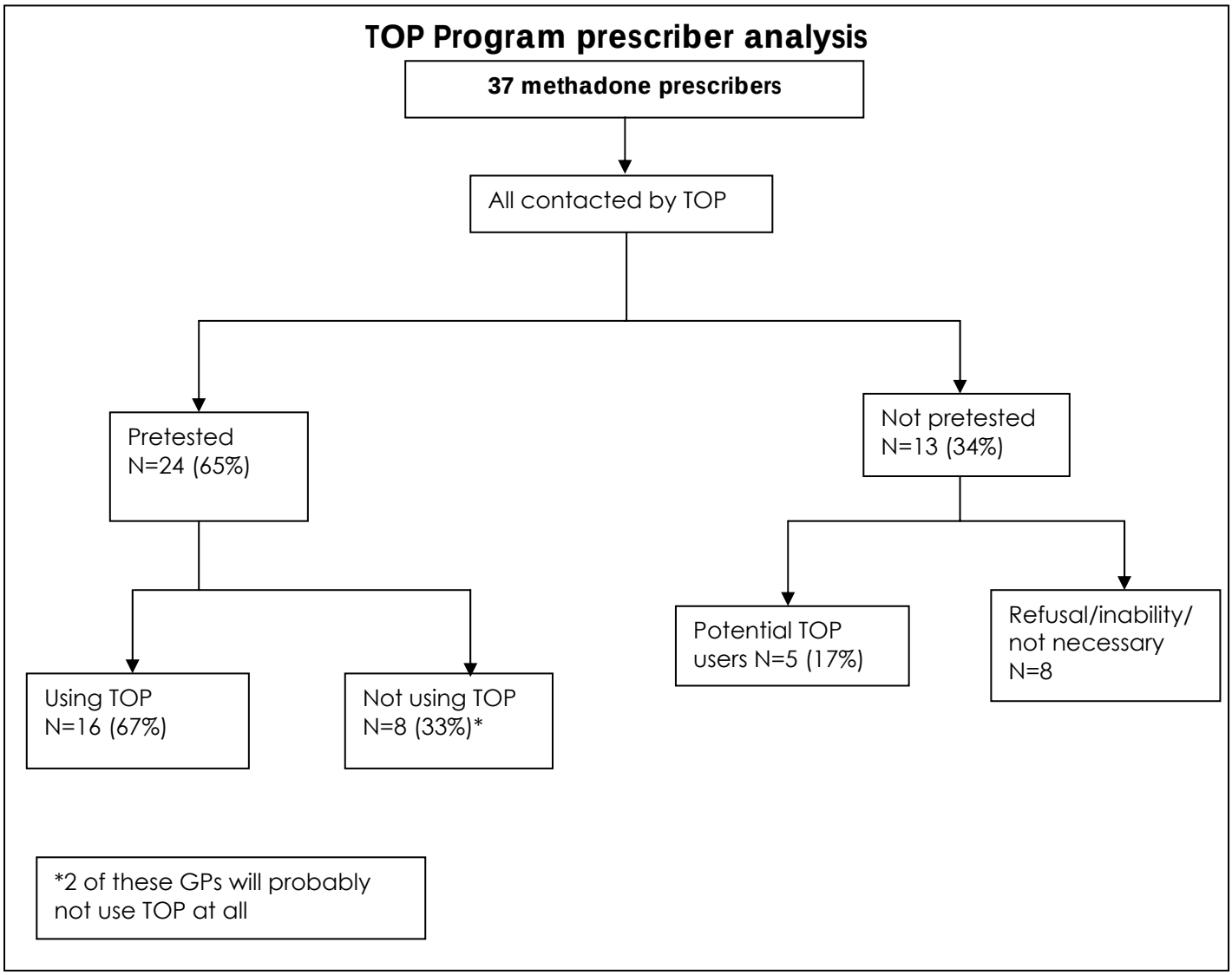
Until the end of May 2003, TOP had pre-tested 24 general practices, constituting 48 GPs. Within this group, 23 (48%) were not methadone prescribers.

Our records indicated that there were 37 methadone prescribers in the ACT in March 2003. TOP made written contact with all of these prescribers, and had pre-tested 24 (65%) of them. Of the 24 methadone prescribers that were pre-tested, 16 (67%) of these had used TOP, 8 (33%) had not (see Figure 2).

Thirteen (34%) prescribers had not been pre-tested (by the end of May 2003), 8 of these would not use TOP for a variety of reasons; 3 had refused, one did not meet the inclusion criteria; one prescriber worked after hours, thus not coinciding with TOP operating hours; three did not need the services of TOP.

Of the 10 who have been pre-tested and not used TOP, we believe 2 will never use TOP. This left a total of 13 (35%) methadone prescribers in the ACT who did not use TOP. This divided into 5 to pre-test, and 8 pre-tested people to follow-up in the next year of the service.

Figure 2 Schematic view of ACT methadone prescribers and TOP access and use



Demographics of General Practitioners who participated in TOP

The TOP team have collected data from 20 GPs who returned the pre-test questionnaires. This represents a response rate of 42%. GPs were not enthusiastic about completing the Short Drug Problems Perception Questionnaire and the GP Needs Analysis questionnaire. The questionnaire was too long, and clearly took too much time to complete. The maintenance phase of TOP has trimmed the questionnaire into a two-page questionnaire divided into GP demographic information and GP linkages (ie drug and alcohol and related services used by the GP). This new, smaller questionnaire will be used to collect GP demographics and identify service utilisation from the beginning of June 2003.

Of the GPs who returned questionnaires for analysis, 65% were females. The age range of GPs who completed questionnaires and who used TOP was 35-73 years, within this group 50% were aged between 35 and 45 years, and 80% of these were females. Fifteen percent (n=3) of TOP GPs had 1 year's experience as a GP, 30% of TOP GPs had 10 year's or less experience. The range of experience in general practice was 1 to 42 years. Most GPs (75%) had 25 years or less experience.

TOP GPs worked in a range of practices from a single person practice to one containing 12 GPs. The type of practice that was most common was a 3-person practice (this included the TOP-using GP). Two other TOP GPs came from 6 and 12 person-practices. This may reflect the tendency of GPs in the same practice to talk to each other about TOP and encourage their colleagues to participate, or it may reflect patients using one practice, but not necessarily a specific GP in that practice.

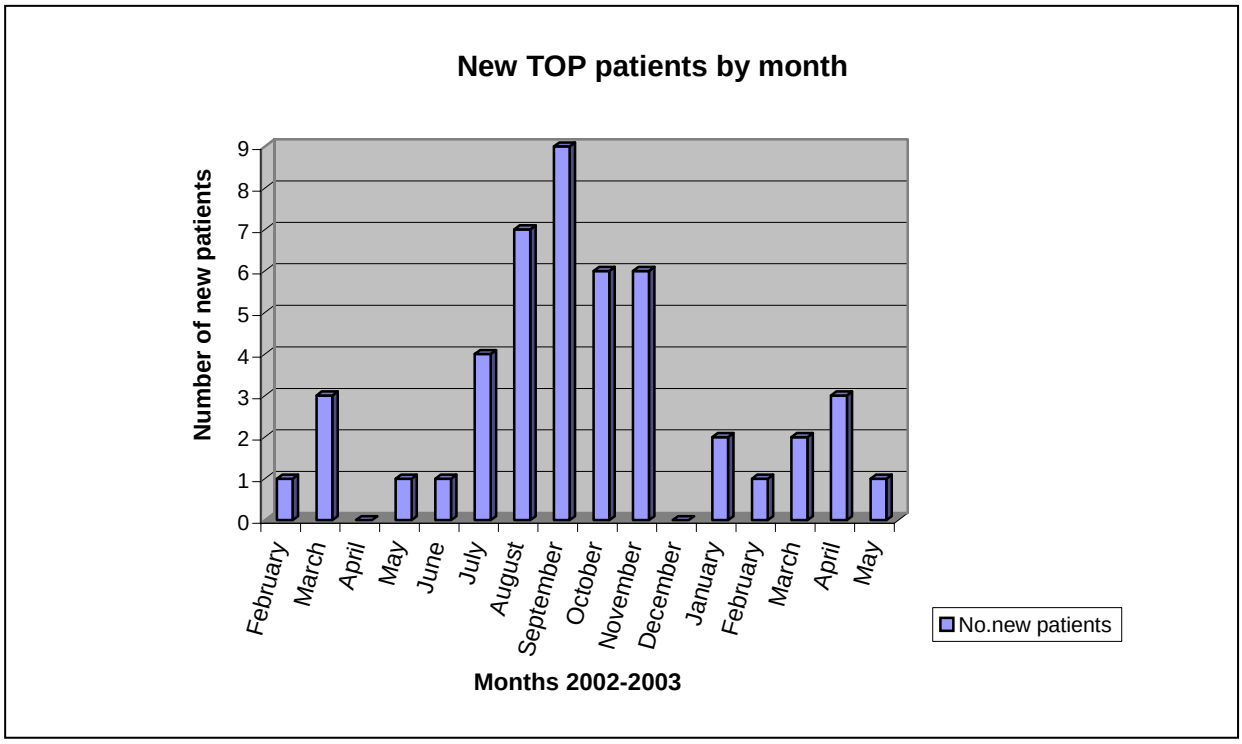
Once the pilot results were considered, it became obvious that the number of sessions the GPs worked each week would be important data to collect. Preliminary data from the ACTDGP Workforce Survey (December, 2002) indicated that more GPs are working part-time, and female GPs are more likely to work part time. The TOP questionnaires were altered to include a question on the number of sessions worked per week and the number of sessions worked at the practice in which they completed their questionnaire. Sixty percent (n=12) of the GPs who returned questionnaires did not answer this question, 8 of these were pilot GPs. Only 20% (n=4) who were asked the question did not answer it. Of the remainder, the range of sessions worked each week by GPs was 2-10. The distribution of GPs across numbers of sessions was fairly even, as was the gender distribution. These results indicate that TOP GPs fall within the normal working patterns of ACT GPs.

Numbers of patients participating in the program

The total number of patients participating in the TOP program unit the end of May 2003 was 46. In the TOP Interim Report, we conservatively estimated that TOP should see 40 patients in its first year of service. This was based upon the number of methadone patients in the community (n~100), and an estimated capture rate of 50%, with a 20% 'no show' rate built into the equation. By the end of May 2003, TOP had seen 46 new patients, exceeding the anticipated number of estimated patients by 6. Further, TOP nurses currently see 16 patients on a regular basis, constituting 35% of the total number of patients using TOP.

The following figure describes the pattern of engagement of new patients into the TOP program. Throughout D&A services there is a reduction in patients accessing treatment during the Christmas and holiday season, the TOP numbers reflect this. It is too early in the life of TOP to speculate about seasonality or other patterns of patient presentation rates for treatment.

Figure 3 Number of new TOP mainstream patients by month; 2002-2003



Engagement in the TOP program occurred through GP referral, self-referral and referral from other agencies. During the pilot and early phases of TOP, referral was predominantly by GP, where the referring GP identified a problematic patient that they felt would benefit from a TOP intervention. As the service grew, and as the Patient Information Leaflets (see Appendix 3) were distributed throughout government and non-government agencies, we found that potential clients would telephone the TOP team and self-refer. Figure 3 demonstrates a cluster of self-referrals, by word of mouth in August through to November 2002. The TOP team were able to identify word-of-mouth referrals during TOP triage assessment (see Appendix 4).

Key non identifying data collected at each patient contact by the drug and alcohol nurses

The main instrument used for patient data collection was the Opiate Treatment Index (OTI). Not all patients (n=6) were capable of completing an OTI assessment with the TOP nurse; three of these patients did not qualify in terms of their drug use. Overall, we collected 41 de-identified OTI records, which are presented in this document as the patient group. Among those who did not complete the OTI, the gender distribution was equal.

TOP patient demographics

The TOP service is unique in the drug and alcohol sector because it is attractive to female patients. TOP patients were predominantly female (58%), with the age group 18-25 years containing most female patients and the 36-40 year old age group containing most males. For patients who completed the OTI with a TOP nurse, the age groups ranged from 18 to 55 years. Table 2 describes the age groups of TOP patients in the first 15 months of service, and identifies the 36-45 year old age group as the group

responsible for the largest group (34%) of TOP patients. The mean age of a TOP patient was 32.4 years.

Table 2 Distribution of ages of TOP patients by gender

Age	Female	Male	Total
18-25yrs (%)	8 (73%)	3 (27%)	11 (100%)
26-35yrs	7 (54%)	6 (46%)	13 (100%)
36-45yrs	6 (43%)	8 (57%)	14 (100%)
46-55yrs	3 (100%)	0 (0%)	3 (100%)
Number of pts	24 (58%)	17 (42%)	41 (100%)

- Thirty nine percent of TOP patients had completed year 10 and 24% had completed senior secondary school. Most of the group who had completed senior school was female (69%). Most TOP patients had not pursued further education, but 42% had gained technical, trade or university qualifications. Within the group of people who had gained further qualifications, 59% were males.
- Most TOP patients (61 %) were unemployed; 27% were employed fulltime, part-time or casually employed and 11% classified themselves as 'home duties'.
- Twenty percent of TOP patients had been in prison, 87% of these were male. Thirty percent of TOP patients reported having committed a crime or crimes in the last thirty days.
- Of TOP patients who elected to complete the section on injecting behaviour in the OTI (n=19), 53% of these were injecting drug users.

It is tenuous to compare TOP patients with patients from other drug and alcohol services because TOP is unique to general practice and TOP only services those with opiate dependency. However, for the purposes of making a comparison, we have used information from local intravenous drug users and a national sample of those seeking treatment so that we may have a broad picture of the types of people who use TOP.

- A comparison of TOP patient demographics with ACT intravenous drug users from the most recent report of the Illicit Drugs Reporting System (IDRS) (Rushforth, 2003) indicates that TOP patients compare with IDRS results in terms of age (mean of 32.4 years) and schooling (IDRS participants had an average of 10.7 years of schooling).
- TOP patients differ in terms of employment, gender, current drug and alcohol treatment, and prison history. Specifically, IDRS demographics showed 77% of their sample (n=100) was unemployed, whereas 66% of TOP patients were unemployed.
- Sixty three percent of TOP patients were not in treatment at the time of their first TOP intervention, while 45% of IDRS informants were not in current treatment.
- Forty five percent of the IDRS sample had been in prison, while only 20% of TOP clients had a prison history.
- Gender, however represents the greatest difference, with 58% of TOP patients being female, while the IDRS reported that 66% of their sample was male.
- Another comparison of TOP patients can be made with the most recently available National Minimum Data Set (NMDS) results (2000-01). The first results of the NMDS indicate that most people who register for treatment are males (64%); most clients fell into the 20-29 year old age group; and 58% had injected drugs.
- Again, a comparison of TOP patients with this national group indicates that TOP is particularly suited to females and has the ability to access groups in the community that don't usually access traditional drug and alcohol treatment agencies.

TOP has been identified as the type of service that attracts females; is attractive to those who are more likely to have not been in current treatment; and to those with a more stable lifestyle.

TOP Treatment interventions 2002-2003

The most common form of treatment intervention performed by the TOP team was Brief Intervention (BI). This is a structured treatment strategy, which incorporates Motivational Interviewing. This is used to increase the patient's readiness to change; encourage change and enable positive change with regard to harmful drug use (Addy, 2000). The Motivational Interviewing technique is situated within the Stages of Change Model, and administered within the framework of Harm Minimisation.

The TOP nurses take at least an hour to administer the OTI, which forms part of the assessment. This is followed by a discussion with the patient where a plan is agreed; the GP consultation with the patient and TOP nurse then follows. Clearly, a brief intervention by a TOP nurse and GP is not really brief in terms of time taken to assess and plan treatment, or to inform and support the patient.

In terms of treatment options, 33% of TOP patients had a brief intervention, 22% were on methadone maintenance and 15% used TOP for a community opiate withdrawal. These were the main functions of TOP in its first year of service. By gender, 67% of the brief interventions were female; 80% of those on methadone maintenance were female and males undertook 57% of TOP opiate withdrawal regimes.

Table 3 identifies the types of treatment offered by the TOP service in its first year and the proportions of patients who undertook these treatments. This table includes all TOP patients (n=46), and identifies the types of TOP interventions preferred by females. For women, the TOP program appeared to be very useful in assisting with methadone maintenance and methadone withdrawal regimes. The population sample of 46 patients for the first year of the TOP service is not large enough to make any firm statements about the range and popularity of TOP interventions.

Table 3 Type of TOP treatment intervention, frequency of patients using this intervention, and proportion of females using this intervention

Type of treatment	Number of patients	Proportion female
Brief intervention	15 (33%)	67%
Methadone maintenance	10 (22%)	80%
Community opiate withdrawal (heroin detox)	7 (15%)	43%
Opiate maintenance	3 (6%)	0%
Methadone withdrawal	2 (4%)	100%
Prescribed opiate reduction	2 (4%)	50%
Brief intervention/ Alcohol withdrawal	1 (2%)	0%
Benzodiazepines withdrawal/ heroin maintenance	1 (2%)	0%
Alcohol withdrawal	1 (2%)	0%
Benzodiazepines withdrawal/ opiate reduction	1 (2%)	0%
Community opiate withdrawal/ongoing support	1 (2%)	100%
Community opiate withdrawal x 2(twice)	1 (2%)	100%
Community opiate withdrawal x 2(twice) /methadone maintenance	1 (2%)	100%
Total	46 (100%)	

Those patients who completed an OTI questionnaire with the TOP nurses gave information about current and previous drug and alcohol treatments. This group (n=41) consisted of 37% who were currently on methadone treatment and 63% who were not currently in any type of drug and alcohol treatment. While almost two thirds (63%) of TOP interventions were on people who were not currently in treatment for their opiate problem, 68% of patients had previously received treatment for their opiate dependence before engaging with the TOP service.

Another factor that became significant to the TOP service was patients who had pain. These were patients with chronic pain, who were prescribed opiates and who had become tolerant to ever increasing doses of opiates. TOP nurses provide long-term community opiate reduction programs to assist these patients to reduce their opiate intake. Long-term reduction programs are individualized to patient needs; patient directed and performed in consultation with the prescribing GP and pharmacist. These programs have been very successful, with no current failures in the long-term reduction program. Thirty five percent (n=16) of TOP patients had chronic pain, 56% (n=9) of these were female. There were 8 patients still undertaking a long-term reduction at the end of the evaluation period. A further eight had successfully completed their long-term reduction.

Completion rates

Sixty one percent (n=31) of TOP patients completed their TOP intervention. Of those who have not completed their treatment, 86% are current patients. Overall, 15% of TOP patients did not complete their treatment interventions with TOP. We believe this is a low failure rate for a drug and alcohol intervention.

TOP patient drug use and primary health care issues

A total of 47% of TOP patients had used heroin in the past month, and 28% of patients had used opiates other than heroin (e.g. street methadone, morphine). Alcohol was

used by 3% of TOP patients; cannabis by 44%; amphetamines by 18%; cocaine by 3%; 41% used tranquilisers; 81% smoked tobacco and no-one used barbiturates, hallucinogens or inhalants.

Overall, 94% of TOP patients were polydrug users. This compares with the most recent IDRS survey, which found that "polydrug use was universal" (Rushforth, 2003). The ubiquity of polydrug use is another argument for the diversification of TOP into the general drug and alcohol sector.

Of all TOP patients, 45% had reported injecting-related problems in the past month. This includes overdoses (9%), dirty hits (12%), vein scarring or bruising (28%) and difficulty injecting (31%). This information is collected from the OTI, and as these details emerge during the assessment, TOP nurses inspect injecting sites and provide immediate assistance and advice on infection, bruising and safe use. Interventions for injecting problems are discussed with the GP and included in the patient's plan of care. In the case of a patient disclosing a recent overdose, the TOP nurse discusses safety issues and harm minimisation.

Risk taking behaviour

As mentioned in the demographic section, 53%(n=19) of TOP patients were IDUs. This group represents those who chose to complete the section on injecting and sexual practices in the OTI. Within this group, a further 50% (n=18) were identified as at increased risk of contracting or spreading the Human Immunodeficiency Virus (HIV) via injecting practice, while 64% (n=23) were identified as at increased HIV risk via sexual practices. Just over half (55%) of TOP patients reported having only one partner in the past month, and 22% reported never using condoms.

Clearly, when TOP nurses collect this data in general practice, any intravenous or blood borne virus risk taking behaviour is discussed with the patient in a supportive, non-judgmental and professional manner. TOP patients are encouraged to undergo regular testing for HIV and hepatitis B and C; and supported with pre and post test counseling. Immunisation status for hepatitis B is also discussed with all relevant patients.

General Health Questionnaire (GHQ) scores

The GHQ constitutes section seven of the OTI. It has four sub-sections: depression; somatic symptoms; anxiety and social dysfunction. TOP nurses usually required patients to complete this part of the OTI themselves. Each subsection has a possible maximum score of 7, with a total maximum score for the GHQ being 28. Patients may score as a 'case' in one or more of the four components.

TOP patients scored between 0 and the maximum of 7 for the depression component. Darke (et.al.,1991) states that "the cut-off point for cases of psychopathology is 4/5." Using a cut-off point of 4 (i.e. caseness began at a score of 5), TOP patients were analysed for the presence of mental health issues under the four GHQ categories. Table 4 presents the prevalence of TOP patients who scored as cases in each of the four components of the GHQ at their first visit with a TOP nurse. This information clearly demonstrates two points: firstly, that TOP patients clearly perceive that they are in crisis when they first access the TOP service via their GP, and secondly, that there is a high rate of dual diagnosis in TOP patients. These data accord with existing evidence on the high prevalence of co-morbid drug and alcohol misuse with mental health problems.

Table 4 TOP patients' 'caseness' for psychopathology at first TOP assessment

General Health Questionnaire section	Percentage (number)
depression	19% (n=8)
somatic symptoms	34% (n=15)
anxiety	39% (n=17)
social dysfunction	41% (n=19)

The GHQ was re-administered to some TOP patients 3 months after the commencement of a TOP intervention, or earlier, if the TOP nurse was concerned about the patient's well being. These patients all demonstrated improved scores after a TOP intervention. One example of this improvement is presented in Table 5. This patient scored a worrying 20 out of 21 for the depression scale. Regular (weekly) meetings with the TOP nurse and GP, and second daily phone calls, together with a reduction regime produced a score of 8 three weeks later. While this score still represents caseness, it is clear that the GP and TOP nurse were able to make significant improvements in this patient within 3-4 weeks.

Table 5 Original score and re-administration score of section VII of the OTI to a patient with signs of depression and social dysfunction

Sect VII-OTI	**15/7/02**	**1/08/02**
Q1-7 Somatic	13	9
Q8-14 Anxiety	15	7
Q15-21 Social Dysfunction	16	0
Q22-28 Depression	20	8
Total	**64**	**24**

Changes in the waiting time for methadone initiation in the public clinic

The ability to change waiting times for methadone initiation in the public clinic was beyond the scope of TOP and was considered to be questionable performance criterion. The direct impact of TOP on such waiting times would be difficult to demonstrate and would require a study of very complex methods. Although changes in waiting time for methadone initiation is a performance indicator in this contract, it would be a very difficult change to demonstrate in terms of attributing waiting times to TOP. TOP team members and patients have both experienced extended delays (up to 7 weeks waiting time) when the senior medical officer from ADP was on extended leave. We know there are fluctuations in waiting times for the ADP Opioid Treatment Service, which are related to staffing and patient demand. The Director of ADP has provided information to TOP team members for the purposes of this report, which identify monthly averaged waiting times ranging between 1 and 15 days for the period Sept 2002-April 2003 (Pink, personal communication).

There has been progress between the ACTDGP and ACTCC in terms of improvement of liaison, communication and access to both services. Current achievements include a Framework Document of key principles, a flow chart of services unique to, and common to, both organisations. In addition, TOP staff now access the medicated withdrawal unit on a weekly basis to speak to inpatient opioid users about TOP services.

Numbers of newly stabilised Methadone patients being treated in the community

The quantification of this outcome is beyond the scope of TOP and it is questionable whether this should have been a performance criterion. The latest findings from the Illicit Drug Reporting System (Rushforth, 2003) indicate that there was an average of 630 methadone maintenance patients per quarter in 2001-2002. The proportion of community-to-ADP dosing was 60:40.

TOP has engaged with 13 methadone maintenance patients, this represents 28% of our patient population. Eight of these patients are current TOP patients.

The TOP team have referred 4 patients to the Opioid Treatment Services at ADP for methadone maintenance induction. This represents a referral rate of 9% from TOP to the ADP for methadone maintenance treatment. Three of these patients were from one practice, and none of the four have been returned to the TOP program.

Tracking the use of EPC item numbers for Methadone patients and for other patients using illicit drugs not currently in treatment

TOP nurses have produced 7 Enhanced Primary Care (EPC) care plans for 47 patients. This is a completion rate of 15%. TOP patients are more likely to have a formal care plan prepared if they remain with TOP for one month or more, because these are the patients who are most likely to engage in a medium or long term treatment intervention. Of this group, 33% of TOP patients who have stayed with the program for one month have had an EPC submitted to their GP; 15% of those who have been retained for 6 months have had an EPC submitted to their GP and 15% of those who have been retained for 1 year have had an EPC submitted to their GP.

The submission of EPC items between GPs and the Health Insurance Commission are not possible for TOP to quantify. Medicare EPC item groups collected by Division of General Practice show that for the December quarter in 2002, the ACT had a 28% uptake rate. The overall uptake rate of 15% for the TOP program indicates a lower level of submission of EPC plans for those with dependency as a diagnosis. However, we know that most EPC items are related to aged care patients, rather than patients with chronic conditions.

The experience of the TOP team indicates that EPC care plans are not attractive to GPs, but GPs who use TOP do use patient care plans that have been created in collaboration with the patient, TOP nurse and GP.

Occurrence and outcome of any adverse events

For the purposes of reporting, the TOP team have defined adverse events as those that cause patient morbidity or mortality while the patient is a current TOP patient. Under these circumstances, TOP had one patient who serially consumed large doses (about 26 tabs daily) of Panadol over a period of approximately three days as a result of awful domestic circumstances. This patient presented for a scheduled TOP appointment with a TOP nurse, the condition was immediately identified, and the patient referred to the Emergency Room (ER) at The Canberra Hospital (TCH). The TOP nurse phoned ahead to identify the patient and the situation to the ER staff. The patient was successfully treated and sent home.

One TOP patient experienced self-harm and another experienced auditory hallucinations with paranoia, both as a result of treatment received from another health service organisation. The GP caring for these patients was advised immediately,

and together with the TOP nurses these situations were remedied by contact with the services in question, and altered use of the services by these patients. Both patients have remained with TOP and have successfully continued with their TOP interventions. In another instance, a new TOP patient was being prescribed methadone from a GP who did not have adequate authorisation. TOP liaised with the chief pharmacist to remedy this situation, and the patient was immediately referred to the Opioid Treatment Service at the ADP to continue with methadone treatment.

There were no other adverse events related to TOP or TOP patients during the first year of service.

In anticipation of adverse events, the TOP team have devised policies on emergency situations; needle stick injuries; and working with apparent unsafe practice. We have constructed a Nurses Code of Ethics specific to TOP and we have an incident report form. The TOP Advisory Committee has approved these policies.

Numbers of GPs attending the education sessions

TOP has conducted a total of five GP education sessions, and participated in two methadone and Buprenorphine training sessions, which were organised in partnership with ADP.

The October 2002 methadone training session was attended by six GPs; the pain management seminar (19/09/02) was attended by 19 GPs; the managing of opiate dependency in the family seminar was attended by 2 GPs; and the amphetamines seminar (21/11/03) was attended by 10 GPs; a scheduled seminar in May 2002 on the results of the National Evaluation on Pharmacotherapies in Opiate Dependence (NEPOD) was cancelled due to insufficient GP responses, as was a seminar on Tobacco in May 2003. The attendance numbers were enhanced by the presence of individuals from non-government organisations and community groups at each seminar. Numbers were bolstered by 12 (family seminar); 13 for the amphetamines seminar; and 10 for the pain seminar. TOP education seminars became valued for the networking and intersectorial linkage opportunities that they provided.

Section 4 TOP Mainstream Performance Indicators: Qualitative

The following sections detail the qualitative performance indicators, which are outlined in the contract between ACTDGP and ACT Health. The results for each of the performance indicators are discussed under each sub-heading. Appendix 5 summarises the evaluation tools used in the TOP service. An example of some of the satisfaction questionnaires is included in Appendix 8.

GP satisfaction levels with the services provided by the drug and alcohol nurses in the practice

TOP has been well received by every GP that has used the service. There has been an average of four different practices using TOP each month for the duration of the project, with a core group of about 8 surgeries (out of the 26 that have been pre-tested), that regularly use TOP. The GPs in these surgeries have actively engaged with the TOP service after having their first patient successfully managed. In most of these cases, GPs have then pursued TOP services for additional patients with good results. TOP nurses assist with the management of most of one GP's opiate-using patients. Comments obtained from GPs about TOP include;

'TOP is very responsive and available'
'Very happy with the TOP service. I would like all my opiate dependent patients to be reviewed by TOP'
The types of surgery that use TOP are mostly generalist practices, although TOP is also working very well in collaboration with a specialist D&A general practice. The TOP service believes that consistent use of TOP by 8 practices is a good proxy for satisfaction, as is regular use by a specialist D&A practice. TOP has proven to be equally useful to GPs who are not methadone prescribers (n=6) as well as prescribers (n=16). An additional measure of satisfaction with TOP was a letter of commendation sent by a TOP-using GP to the ACTDGP monthly newsletter. This letter is appended to this report (Appendix 6).

The GP satisfaction with D&A nurses questionnaire (see Appendix 8) was used to measure GP satisfaction. Four questionnaires were submitted to GPs at four different practices. These were all returned, and all GPs were satisfied or very satisfied with TOP nurses when asked to rate their satisfaction level from very unsatisfied over five rankings to very satisfied. GPs were also very happy with their consultations with TOP nurses (75%) while 25% were neither happy nor unhappy. All the GPs felt that the TOP nurses understood and appreciated what the GP does, and all the GPs felt the TOP nurses cooperated with the doctors.

During the first 15 months of TOP, there has not been one complaint about the TOP service to the ACTDGP, or to TOP team members, and we are unaware of any complaints to other agencies.

Client satisfaction levels with the services provided by the GPs and drug and alcohol nurses

Client satisfaction was formally measured by using the Patient Consultation Satisfaction with D&A Nurse Questionnaire (see Appendix 8a). TOP nurses distributed 12 satisfaction questionnaires to TOP patients. The response rate to this questionnaire was very low (17%), but this was expected because of the nature of the client group. We did not actively pursue TOP clients to complete satisfaction a questionnaire because we felt that attention to their treatment intervention was took precedence. Only two patients returned this questionnaire, and both patients 'strongly agreed' when asked if they

were "totally satisfied with my visit to this drug and alcohol nurse". In addition both TOP patients reported that they felt the TOP nurses were interested in them as people, and listened carefully to what the patient had to say. Both also reported that the TOP nurses had helped them to understand their illness much better and the TOP nurses had spent enough time with them.

TOP nurses have reported regularly receiving positive comments directly from patients. Another proxy for satisfaction could be length of time spent with the program and completion rates for TOP interventions. Most TOP patients (67%) completed the TOP intervention that they had received. Among those who haven't completed their intervention, 86% are current patients. By the end of the first 15 months of TOP, 15% (n=7) patients had remained with the program for 6 months, and 4% (n=2) had remained with the program for 12 months.

Changes in GP confidence levels in the management of opiate dependency

The GP Needs Analysis Questionnaire was used to identify effectiveness, confidence and knowledge regarding treatment of patients with drug and alcohol problems. The results from the information collected with regard to illicit drug use are presented in this report.

Twenty GPs completed this questionnaire in the first 15 months of the project. In terms of confidence, GPs were asked: "How confident do you feel in working with the following aspects of drug and alcohol problem?"
The responses were categorised into very confident, relatively confident, not very confident and not confident at all. Most GPs (65%) felt relatively confident or very confident in their ability to assess illicit drug users. Only 30% of GPs felt confident about detoxing a patient, but 55% were confident about counselling an illicit drug user. Most GPs (80%) were confident about referring an illicit drug using patient and 50% were confident about their ability to undertake a brief intervention with their illicit drug using patients.
These results indicate that most GPs who returned their questionnaire are confident in their management of illicit drug users. TOP team members have noticed that GPs are very confident about their abilities to treat drug users, but usually need information on withdrawal protocols for managing detoxification or long-term withdrawal regimes.
In contrast to this, 25% of GPs felt they were effective or very effective at helping patients to achieve change in reducing their illicit drug use.

Changes in collaboration levels between GPs and other service providers

We believe that collaboration levels between GPs and drug and alcohol service providers have improved since the inception of TOP because GPs did not have community alcohol and drug resources prior to TOP. TOP has improved collaboration between GPs and other drug and alcohol services through its day-to-day management. TOP has made 17 referrals to the ADP, 2 to mental health services and 13 referrals to non-government organisations. This represents a total referral rate of 32 referrals for 42 patients, giving an overall referral rate of 69%. TOP referrals are generally made in consultation with the GP, and always made in agreement with the patient. Consultations between patients, GPs and TOP nurses allow TOP nurses to discuss potential referral pathways, while identifying other drug and alcohol and related services for the patient and GP.

The TOP team gathered information on service utilisation by GPs by asking each GP to place a tick next to the local drug and alcohol services he/she had used in the past twelve months. The following table indicates the proportion of GPs who had used local drug and alcohol services for their patients. Table 6 also identifies the low utilisation of these resources by GPs, and demonstrates the need for TOP nurses in general practice,

both as information resources and as vital links between general practice and specialist drug and alcohol agencies.

The information gathered from GPs also identifies a propensity for GPs to contact other medical practitioners for information and assistance. While this maintains links between medical practitioners, it does not foster collaboration between paramedical services. Continued use of the services utilisation questions will demonstrate that TOP has improved GPs' knowledge of local drug and alcohol services through assistance with the management of opiate dependent patients in general practice.

Table 6 ACT Drug and Alcohol Service utilisation

Local Drug and Alcohol or related service	Proportion of GPs who had used the service (n=20)
Community Care Alcohol and Drug Program	
Case-management	15% (n=3)
MMT (clinic)	40% (n=8)
Specialist doctor services (ADP specialists)	60% (n=12)
ADP 24hour help line number	45% (n=9)
Court Alcohol and Drug Assessment Service (CADAS) or Drugs of Dependency Assessment (DODA)	5% (n=1)
Withdrawal services	40% (n=8)
ADDInc	
DIRECTIONS	35% (n=7)
Arcadia House	20% (n=4)
Late-night DRIC	0%
Karralika	10% (n=2)
DRIC at College	0%
Families in Action	0%
Needle and Syringe Exchange	5% (n=1)
TOORA	
WIREDD (Women's Information Referral and Education on Drug Dependency	25% (n=5)
TOORA Wimmin's Shelter	25% (n=5)
Ted Noff's PALM ACT	5% (n=1)
Salvation Army	
Mancare	0%
Oasis	0%
Other GPs	20% (n=4)
Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)	0%
Family and Friends for Drug Law Reform (FFDLR)	0%
Drugs in the Family	0%
Family Drug Support	0%
Other resources	Private psychologist 5% (n=1)
Belconnen Remand Centre	15% (n=3)
Periodic Detention Centre	5% (n=1)

GP satisfaction levels with the multidisciplinary services available for their patients

GPs were asked to identify gaps in the local drug and alcohol sector as a proxy for satisfaction with multidisciplinary services. This information should be considered in tandem with the information on GPs' utilisation of local drug and alcohol services in the

previous section. We have already identified a limited use of local services for dependent patients, and this limited use of services may inform the GPs' perceptions of gaps.

Table 7 summarises the results of the question related to gaps identifies a diverse range of views from GPs, but also indicates that 40% (n=8) GPs had no comment to make and 10% (n=2) were unsure. The remainder were concerned about waiting times for detoxification facilities (GPs did not differentiate between medicated and unmedicated withdrawal facilities), and a cluster of other issues (e.g. meeting with pharmacists; better collaboration with methadone clinic and exposure to other organisations) which could be summarised as a needed for improved communication with other groups involved in the treatment of dependent patients.

Table 7 Summary of GPs perceived 'gaps in the system' for their alcohol and drug patients

Identified gap	Number of GPs commenting
Meeting with dispensing pharmacists	2
Better collaboration with the Methadone Clinic	2
Exposure to other organisations (i.e. D&A services)	2
Access to Buprenorphine in the community (maintenance & detox)	1
Knowing other GPS who support drug users	1
Assistance for women with children	1
Family support and education	1
Detox facilities (including waiting times)	3
Rehab facilities	1
Outreach services (including more)	1
Prescription heroin	1
Ongoing counselling	2
Unsure	2
Difficulty getting appointments	1
Emergency detox for young people	1
Generally under-resourced	1
No comment	8

It is clear from the information received from the 'gaps' question together with the information collected from GPs on service utilisation that busy GPs do not use a wide range of services, and have not had the opportunity to discover the wide range of drug and alcohol services available in the ACT. The presence of a specialist drug and alcohol nurse in general practice provides GPS with an information resource for GPs, which allows them a wider range of services for their patients. The TOP nurses also facilitate an improvement in liaison between pharmacists and GPs, particularly with the prescription of opioids. These are key features of the strength of the program.

Satisfaction with the education and training provided for GPs and practice staff

Each of the five GP education sessions hosted by TOP was assessed using existing ACTDGP evaluation forms (see Appendix 7). These are presented to all GPs who attend education sessions organised through ACTDGP.

Generally, GPs were happy with the educational content of the seminars, according to the evaluation form results. Results of TOP education fora indicated that GPs were universally able to relate three clinical aspects of each seminar that they found useful. On a 5-item Likert scale all GPs ranked the attainment of learning objectives as 'very well' or 'extremely well' attained. In a qualitative sense, GPs remarked that the seminars

were "very appropriate", "interesting and informative"; "very comprehensive" or "very beneficial and well organised".

GPS were asked for a preferred time for seminars; all GPs (n=20) opted for weekday nights. TOP seminars were duly conducted on weekday nights. There were a few complaints, which were directed at quality and amount of food, room heating and the venue, in general. The ACTDGP now uses a different venue.

Satisfaction levels of the drug and alcohol nurses with the program

There were three TOP nurses (2.0FTE) for the duration of the evaluation period. One half time position was located at Winnunga. The remaining 1.5FTE were with TOP mainstream. Both TOP mainstream nurses were actively involved with the development and establishment of the program. A flexible clinical approach was utilised by both TOP nurses as the optimum style for service delivery. Close involvement with the development of TOP and the opportunity to be flexible in service delivery contributed to high levels of satisfaction for both TOP nurses. Nurses also gained a sense of satisfaction when they received positive feedback from clients and GPs. The Winnunga nurse also developed her own style of service delivery, which was culturally specific to her client group needs and their family. As a result, the TOP Winnunga nurse also felt very satisfied with clinical service delivery and received positive reinforcement from her Winnunga clients, families and colleagues.

Satisfaction of other service providers with the program

TOP has not actively surveyed other services for their degree of satisfaction with the TOP program. However, in January 2003, a GP conducted a "Survey of Methadone Prescribers", which included questions specific to the role and functions of TOP. The survey was sent to 21 methadone prescribers whose names were provided to the GP by the ADP. This survey was undertaken without the knowledge of the ACTDGP. An Advisory Committee member presented the results of the survey to the February TOP Advisory Committee. The results of the 18 replies to the survey showed that TOP was known to 100% of these prescribers. Within that group, 6 (33%) prescribers had used TOP.

Section 5 TOP Winnunga Performance indicators: Quantitative

The Winnunga-Nimmityjah Aboriginal Medical Service (AMS) has a 0.5FTE TOP nurse who is funded by Winnunga for the remaining 0.5FTE, so that they have a fulltime drug and alcohol nurse available to all Winnunga patients. The TOP Winnunga position has been in place since May 2002, so the results presented here are for the first 12 months of the Winnunga-TOP service.

There are five Winnunga GPs who work with the TOP Winnunga nurse, but one senior GP does the majority of the drug and alcohol consultations with the Winnunga nurse. All TOP Winnunga patients are Aboriginal. The TOP Winnunga nurse has a completely different modus operandi within the policies and procedures of the TOP program, in that the Winnunga clients require a service adapted to their cultural needs and expectations. Specifically, this requires family support and involvement in patient interventions, which requires a very social and time-consuming methodology.

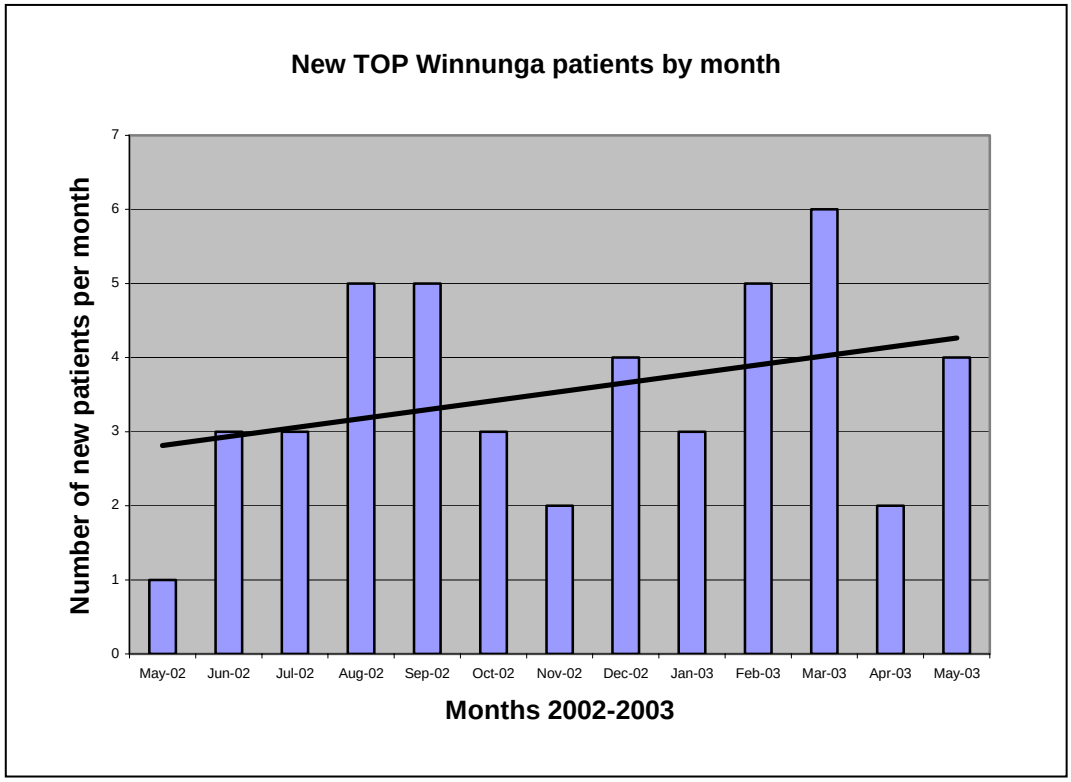
A further difference between TOP Winnunga and TOP mainstream patients is that TOP Winnunga patients become engaged with the program and stay with the TOP nurse for the duration of their association (and their family's) with Winnunga. The TOP Winnunga nurse also works in close collaboration with the Winnunga Substance Misuse Workers who have made a substantial contribution to the success of the TOP Winnunga program.

Numbers of patients participating in the program

The total number of patients participating in the TOP Winnunga program from May 2002 to May 2003 was 46. Figure 4 indicates a steady rate of new patients per month for the TOP Winnunga nurse. Once the TOP Winnunga nurse arrived at the Winnunga AHS, referrals to the program began. A steady growth of new patients has gradually increased in the first year of TOP Winnunga; the trend line in figure 4 visually demonstrates this. This figure also reinforces the need for additional staff in the TOP Winnunga arm of the service.

Engagement in the TOP Winnunga program was more direct with TOP Winnunga patients because the holistic healthcare style of Winnunga means that drug and alcohol services are already on site for easy access by patients. Once engaged with the TOP program, Winnunga patients and their families are actively followed-up by the TOP Winnunga nurse.

Figure 4 Number of new TOP Winnunga patients by month; 2002-2003



TOP Winnunga patient demographics

Winnunga patients were not comfortable completing the OTI with the TOP Winnunga nurse. Sharing information with healthcare workers or government officials is not well accepted among Aboriginal people for historical reasons, and this is recognised in practice at the Winnunga AMS. Many Winnunga patients were also participating in a concurrent National Health and Medical Research Council project, which involved the administration of the OTI. The Winnunga nurse felt that the collection of data was obstructing access to Winnunga drug and alcohol patients, so the TOP team compromised on subtle information gathering, and restricted information collection to basic demographic and drug use information.

The age range of TOP Winnunga patients is 18-36 years, with a mean age of 24.8years. Table 8 identifies the 18-25 year age group as the predominant age group for TOP Winnunga patients.

Table 8 Distribution of ages of TOP Winnunga patients by gender

Age	Female	Male	Total
18-25yrs (%)	10 (36%)	18 (64%)	28
26-35yrs	6 (35%)	11 (65%)	17
36-45yrs	0 (0%)	1 (100%)	1
46-55yrs	0 (0%)	0 (0%)	0
Number of pts	16	30	46

Sixty five percent (n=30) of TOP Winnunga patients are male. This demographic is similar to the comparison data from the NMDS and IDRS presented earlier. When distributed by age and gender, 60% of males (n=18) fall into the 18-25 year age group.

Most (67%) TOP Winnunga patients had children, and by gender, most parents were males (64%). All of the TOP Winnunga patients are unemployed.

TOP Winnunga treatment options

TOP Winnunga patients differed from TOP mainstream patients in that all the Winnunga patients stayed with the program for ongoing support. This was also maintained if the patient was incarcerated in the ACT. The TOP Winnunga nurse also visited patients in the Belconnen Remand Centre, City Watch House and Symonston Temporary Remand Centre. Seventy eight percent (n=36) of TOP Winnunga patients had ever been in prison, 78% (n=28) of these are males.

TOP Winnunga has 36 (78%) current patients; the remainder is either incarcerated interstate, in a residential rehabilitation centre interstate or has moved away from the ACT. Some also return to their extended families interstate for periods of time, but usually come back to the ACT and reconnect with Winnunga.

The most common type of treatment intervention for TOP Winnunga patients is "ongoing support" (100%), followed by community opiate withdrawal (65%; n=30) and then methadone maintenance (30%; n=14). Within the community opiate withdrawal group, 22% (n=10) had more than one attempt at withdrawal.

TOP Winnunga patients differ from mainstream patients in that 26% (n=26) have been managed through an amphetamine withdrawal and six patients (13%) are on Buprenorphine. No mainstream TOP patients have had an amphetamine withdrawal or are taking Buprenorphine.

Forty six percent (n=21) of TOP Winnunga patients completed their treatment intervention, and 28%(n=13) ceased their treatment before it had been completed. These numbers do not add up to 100% because 98% (n=45) of TOP Winnunga patients have undertaken multiple TOP interventions.

No TOP Winnunga patients had EPC care plans prepared, although treatment plans were negotiated between the patient, TOP nurse and GP at Winnunga.

TOP Winnunga patient drug use and primary health care issues

A total of 91% (n=42) of TOP Winnunga patients are IV drug users. Their drug of preference is heroin, although many use amphetamines because 26% (n=12) were treated for amphetamine withdrawal.

The information we collect on pain for TOP patients is for physical pain of a pathological nature. In this category, 37% (n=17) of TOP Winnunga patients had pain as a factor in their drug use. However, all of the Aboriginal patients seen by the TOP Winnunga nurse assert that they suffer from psychological pain, including shame. This factor also explains the need for continued ongoing support by the TOP Winnunga nurse, which contrasts with the more transient nature of TOP mainstream patients.

The Aboriginal patients at TOP Winnunga also have a high rate of 'pre-contemplative' behaviour. This is a recognised behaviour in the Stages of Change model used in the drug and alcohol sector. Pre-contemplation means that patients are thinking about behaviour change related to their dependence or misuse, or they will accept information on drug misuse, but they are not yet at a stage where they feel motivated to do anything about their drug problem. Thirty percent (n=14) of TOP Winnunga patients were in this phase of change. This contrasts with 4% of TOP mainstream patients at this stage of change. The high rate of pre-contemplation in TOP Winnunga patients

also informs the high number of treatment options that these patients have undertaken, and the high non-completion rates.

Most TOP Winnunga patients (61%; n=28) were referred to other agencies for alcohol and drug or mental health treatment. In most cases this was either for methadone maintenance treatment or Buprenorphine treatment. Winnunga has its own psychiatrist who deals with most mental health problems on site.

Section 6 Planning and Policy Implications for TOP

Conclusions

The TOP service sets itself apart from other general drug and alcohol services because 58% of its clientele are female. The TOP team have recognised the importance of marketing this as an issue to women-specific services, and have already commenced promoting TOP in this sector.

TOP is attractive to patients because it is flexible in its treatment options; it is genuinely patient-orientated; it is easy to access at the patient's local general practice; the service is discreet and confidential; it is not costly to patients; and it attends to all the patients healthcare needs.

TOP emphasises the role of primary health care of opiate dependent people in general practice. A clinical drug and alcohol service in primary health care is more cost effective than a tertiary inpatient service.

TOP patients have a high completion rate (61%), for TOP interventions. Of the remaining patients who have not completed their treatments, 85% are current TOP patients. Fifteen percent of TOP patients do not complete their treatment. We believe this is a low failure rate for drug and alcohol services, and it makes TOP a cost-effective service.

Another service unique to TOP is the long-term community opiate withdrawal (for prescribed opiates). TOP's high completion rate, together with a low 'no show' rate (8%), make TOP the ideal service to use for this treatment.

Twenty two percent of TOP patients are on a methadone maintenance program. The TOP team and GP also manage their general health care including screening for blood borne viruses and immunisation. TOP is ideally placed in the community to monitor methadone initiation and Buprenorphine maintenance.

TOP has had no communication or professional complaints from GPs or patients about the delivery of the TOP clinical service. A recent methadone prescriber survey demonstrated that TOP was universally recognised. The TOP service has pre-tested 65% of methadone prescribers and most of these (67%) were using TOP at the end of May 2003.

Generally, the experience of the TOP team in the first year of TOP has been rewarding and fulfilling in terms of patient care, and in the development of successful professional relationships with GPs. There have been difficulties with managing a service where there are very few specialist drug and alcohol nurses available in the sector. This has had a major impact on the ability of TOP to recruit staff, a factor that has been formally recognised by the TOP Advisory Committee.

Recommendations

Locating TOP in a general practice would enhance the emphasis of primary health care in the delivery of the TOP service. TOP nurses co-located with GPs in general practice would afford more opportunity for GPs to opportunistically use drug and alcohol services with patients who have immediate drug and alcohol issues. Brief interventions make up about one third of TOP interventions.

Future iterations of TOP should include either drug and alcohol nurses with mental health qualifications, or a mental health nurse to assist TOP nurses and GPs with the care of co-morbid patients. A significant proportion of TOP patients had depression (19%) and anxiety (39%) at levels of psychopathology.

A principle of Drug and Alcohol Treatment is to offer integrated treatment to patients with co-morbidity. The co-location of TOP in general practice would facilitate this integration.

TOP is unique in the drug and alcohol treatment sector because its main focus addresses the issues surrounding opiate dependency. The TOP team recommend gradual diversification into the other 'drug' areas, commencing with benzodiazepine dependencies, and amphetamine dependencies. These are two areas, which are problematic within general practice. Alcohol misuse would follow soon after.

The TOP team recognise the importance of peer support and peer education and intend to organise sessional TOP consultations with a TOP nurse and a GP at the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA).

The TOP team is keen to pursue the development of clinical pathways for the referral of methadone patients into the community from the Opioid Treatment Service. Preliminary negotiations are underway with the Alcohol and Drug Program (ADP). Methadone maintenance accounts for 22% of clinical service delivery.

TOP nurses provide consultation, information, support and ongoing assistance and monitoring of general practice patients. This fulfils the job description for a registered nurse level 3 (i.e. a clinical nurse consultant). TOP nurses have been employed as RN level 2s which has also contributed to the recruiting problem. Upgrading the position of TOP nurses to Level 3 RNs may be more attractive to potential applicants.

Further, the experiences of the past year have strongly impressed upon the TOP team that a clinical service requires management by a person with a clinical background, and the availability of regular professional mentorship. TOP has advertised for a GP advisor to assist with clinical advice and professional mentoring. This process is en train.

Specific Winnunga recommendations

Specific recommendations arise out of the TOP Winnunga data. TOP Winnunga has the same patient load as TOP mainstream, but with a 0.5FTE TOP-funded nurse. The high numbers (78%) of patients requiring ongoing support from TOP strongly support the recommendation that the TOP Winnunga funding be increased to 1.0FTE.

One third of TOP Winnunga patients were encouraged to commence on methadone and 13% are on Buprenorphine. There is a methadone prescriber at Winnunga, but this GP is not able to initiate patients onto methadone or Buprenorphine. Winnunga AMS with the presence of the TOP Winnunga nurse is eager to be placed in the situation

where they could initiate Methadone and monitor Buprenorphine dosing in the community. This treatment forms a significant part of the TOP Winnunga service and would allow Aboriginal patients access to a local and familiar outlet for their opioid treatment, therefore improving compliance rates.

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Appendix 1 TOP Advisory Committee

Chair: Associate Professor Nicholas Glasgow
Dr Rosie Yuille, GP Advisor
Dr David Barton, GP Advisor
Dr Peter Sharpe, GP Advisor
Mr John Ley, Families and Friends for Drug Law Reform
Ms Nichole Wiggins, Canberra Alliance for Harm Minimisation and Advocacy
Ms Sally Pink, Director Alcohol and Drug Program
Mr Ben Gilbert, Pharmacist

TOP Team
Simon Mirfin, TOP Team Leader and TOP nurse
Jane Lynch, TOP nurse, Winnunga
Robyn Davies, Research Officer & TOP nurse from June 2003
Fiona DeLacy, TOP nurse (until June 2003)
Jodie Fisher, Team Leader (until January 2003)

Appendix 2 TOP Pilot information and results

Selection of pilot practices

As part of the selection process for pilot practices, in addition to the number of prescribers, we cross-referenced general practitioners (GPs) with methadone patients. This was achieved by a collaborative effort with the coordinator of the Opioid Dependent Persons Treatment Service.
We recognised that different practices would have varying proportions of opiate users that they treat each week. Some practices would have very few opiate users (including those on prescribed methadone), some would have a moderate number of opiate using patients and other practices would see a large number of opiate users. A significant factor in opiate patient load should be the number of methadone prescribers in the practice, but this may not necessarily be the case in the clinical setting. We considered GPs in the Civic and Woden area and looked at what may be a moderate number of methadone clients in those practices.

TOP pilot results

Pilot demographics-GPs

Three female and three male GPs participated in the pilot.
Ages ranged from 40-54 years of age, representing 1-28 years of general practice experience. The pilot GPs practiced in surgeries ranging in size from a single practitioner up to practices containing 6 other GPs.

Practices

Three practices were located in Civic, one in the Woden Town Centre and one in the Weston Creek area.
One GP estimated seeing 0-50 general practice patients per week, two saw between 51 and 100 patients, one saw between 1 and 150 patients per week in the practice and one could not estimate. The mix of full-time and part-time practitioners was not known, although two of the female GPs mentioned during the pre-test interview that they worked part-time.

Practice staff

A total of 12 practice staff were provided with the pilot questionnaires. All of the staff were female, and they included 2 practice managers; 2 practice nurses and 4 receptionists. Three staff from one practice refused to complete the pre-test questionnaires (two receptionists and one office manager), and one person from another practice did not complete the questionnaire. The designation of this person was not known.

Needs Analysis: GPs

Service utilisation

All GPs (n=5) reported using the ADP specialist medical services. Three GPs had used the ADP Withdrawal service and Drug Referral Information Centre (DRIC; now DIRECTIONS). Two GPs had used the Opioid treatment service, the ADP 24 hour hotline, WIREDD and the Toora Wimmins Shelter.
One GP reported using other GPs for support. Only one GP (a different individual) had used/worked with the Belconnen Remand Centre (BRC), and one GP had used the Karralika therapeutic community.

None of the GPs used the ADP Court treatment and referral services; late night DRIC; DRIC at college; Families in Action; the NSP outlets; Ted Noffs (neither rehab nor withdrawal services); The Salvation Army; CIN; FFDLR; Drugs in the Family; Family Drug Support and PDC.
In terms of referrals, one GP referred patients once or twice a week, 3 GPs referred 1-2 times per month and one referred 3-4 times a year.

Table 9 Service utilisation

Service (ranked)	GP1	GP2	GP3	GP4	GP5
N=5	ADP Specialist Medical Services	ADP Specialist Medical Services	ADP Specialist Medical Services	ADP Specialist Medical Services	ADP Specialist Medical Services
N=3	Withdrawal services		Withdrawal services	Withdrawal services	
N=3	DRIC	DRIC		DRIC	
N=2	Opioid treatment service	Opioid treatment service			
N=2		ADP Hotline		ADP Hotline	
N=2	Arcadia	Arcadia			
N=2		WIREDD		WIREDD	
N=2		TOORA Wimmins shelter	TOORA Wimmins shelter		
N=1	Other GPs				
N=1				BRC	
N=1		Karralika			

Scenarios

Four patient scenarios were presented to GPs for comment. They were asked to describe the management, referral and follow-up of these patients. The qualitative data is summarised below:

Summary scenario 1; heroin user wanting MMT

- 4/5 GPs refer to ADP
- 4/5 mention or allude to methadone treatment
- 3/5 screen for BBV and follow-up that screening
- 2/5 provide D&A specific assessment
- 2/5 referred to other AOD agencies
- 2/5 discussed pros and cons of MMT
- 1/5 suggested alternative (doloxene)

Summary scenario 2; stable methadone patient

- 4/5 considered social difficulties
- 4/5 reviewed current status of treatment
- 3/5 reviewed drug use
- 3/5 did a physical review
- 2/5 reviewed HepC status
- 1/5 referred if problematic

- 1/5 followed-up if HepC+
- 1/5 discussed possibility of cessation
- 0/5 reviewed safety /status of take-aways and
- 0/5 considered a dental review.

Summary scenario 3; abrupt withdrawal from methadone

- 4/5 discussed withdrawal services
- 3/5 offered GP assisted (home) withdrawal services
- 2/5 referred to ADP for inpatient or outpatient withdrawal services
- 2/5 considered stigma of being on methadone
- 2/5 talked about alternative treatment
- 1/5 offered follow-up for home withdrawal services
- 1/5 connected with methadone clinic
- 1/5 explored previous history for withdrawal services and quitting
- 1/5 talked about reduction
- 1/5 warned about relapse

Summary scenario 4; community methadone management

- 4/5 reviewed relationship between urine testing and take-aways
- 2/5 reviewed drug use and top-ups
- 2/5 referred to methadone clinic
- 1/5 explored the difficulties
- 2/5 negotiated take-aways
- 2/5 acknowledged GP control over situation and suggest compliance
- 1/5 asked D&A specialist

GP Resources and education preferences

GPs were asked to nominate their top three preferences for educational resources; these are presented below. All five GPs nominated weekday evenings as the most convenient time for workshops.

Table 10 GP preferred learning resources, ranked 1-3

Resource	*Number of GPs*	*Ranking 1-3*
Local D&A Consultancy	*3*	*1*
Self-learning IT package	*2*	*2*
	1	*3*
Information on patient referral	*1*	*2*
GP training workshop	*1*	*2*
Literature for patients	*1*	*1*
	1	*3*
Literature for GPs	*1*	*3*
Video resources	*1*	*3*
No answer	*1*	*1,2,3*

Needs Analysis: General Practice Staff

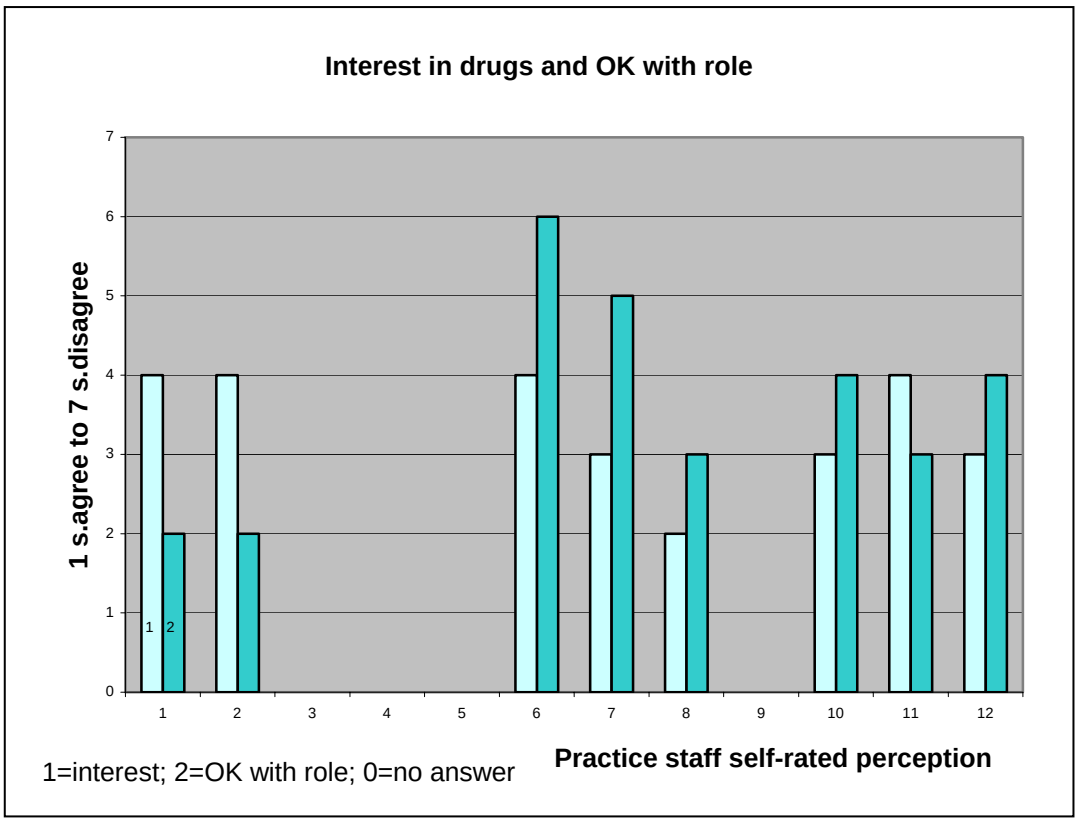
There were 12 staff who returned questionnaires. Four of these were refusals.

Summary of practice staff estimation of gaps in D&A services

- 4/12 did not answer the questionnaire
- 3/12 did not answer this question
- 2/12 did not know what the service gaps were
- 1/12 identified a general lack of services
- 1/12 was unsure about the sector
- 1/12 identified the need for safe injecting areas, more shared care, drug trials and public education

In comparison with this response, we found that 4 practice staff were neither interested nor disinterested in drug-related problems (Figure 5, column 1) and two were interested in drug-related problems. In addition, 6 staff felt they knew enough about drug problems to carry out their roles, while two acknowledged they did not know enough. The comparison of interest and comfort with role was a stark contrast to their ability to comment upon the gap in local D&A services. Figure 5 also records the four practice staff who did not answer that question.

Figure 5 Comparison of practice staff interest in drug-related problems and their self-perceived comfort with their role



Appendix 3 TOP leaflets (patient and GP)

Appendix 4 Intake form for TOP clients

Date……../2002……TOP initial…….
Name…… Call back arrangement……..
GPs……
……
……
Surgery……Tel……..
Age……M…….F…… Contact number……

1. Reason for calling/why
   ……
   ……
   ……
   ……
   …….
2. Current treatment/previous treatment
   ……
   ……
3. **Current and recent drug use (last 30 days)**

	Alcohol	**Amphetamines**	**Benzos**	**Cannabis**	**Opiates (licit)**	**Opiates (Illicit)**	**Other**
Frequency							
Amount							
Duration of use							
Route							
Last used							

4. History of seizures: alcohol/ benzo /epileptic (circle)……
5. Pregnant……..
6. CPR :Current plan……..
   Prior history…… ……..
   Resources……..
   Crisis team number 1800 629 354
7. Current mental health treatment……
8. Medical risk factors……
9. Preferred (treatment/other) option
   ……
   ……
10. Referral from ……
11. Referral to ……..
12. Appointment made (date/time)……..
13. Appointment with (circle)
    GP……TOP……
    ADP……NGO……
14. Follow-up and
    Comments……..

Appendix 5 Evaluation tools used in TOP

Pre-test evaluation	Prospective evaluation	Post-test evaluation	Program descriptive statistics
GPs			
Short Drug Problems Perception Questionnaire (Gorman and Cartwright, 1991)		Short Drug Problems Perception Questionnaire (Gorman and Cartwright, 1991)	Numbers of participating GPs and practices
GP Needs Analysis (Turning Point)		GP Needs Analysis (Turning Point)	Changes in GP confidence in treating drug users
Part B: GP Service Utilisation (Checklist)		GP Service Utilisation (Checklist)	Changed use of NGO and Govt services by GPs
Part C: Case scenarios		Part C: Case scenarios	
GP satisfaction with multidisciplinary services available (Included in case scenarios)		GP satisfaction with multidisciplinary services available (Included in case scenarios)	
	GP satisfaction with education and training sessions (ACTDGP Evaluation Forms)		Numbers of GPs attending education sessions
	GP satisfaction with D&A nurses (after Poulton, 1996 and Burnard, 1999)	GP satisfaction with D&A nurses (after Poulton, 1996 and Burnard, 1999)	
Patients			
OTI sections I-VII if able (Darke, et.al, 1991)	OTI sections II, III, IV*, VI, VII (Darke, et.al, 1991)	OTI sections I, II, III, IV*, VI, VII (Darke, et.al, 1991)	Numbers of patients participating in the program
	Nurse's Drug and Alcohol assessment forms		Numbers of new community methadone patients
Consultation Satisfaction Questionnaire, with GPs and Nurses (Poulton, 1996)		Consultation Satisfaction Questionnaire, with GPs and Nurses (Poulton, 1996)	
TOP Nurses			
	Nurse satisfaction with GP (after Poulton, 1996 and Burnard, 1999)	Nurse satisfaction with GP (after Poulton, 1996 and Burnard, 1999)	
	Nurse satisfaction with the TOP program	Nurse satisfaction with the TOP program	

	(Semi-structured interview)	(Semi-structured interview)	
Practice Staff			
Staff Needs Analysis (After Gorman and Cartwright, 1991)		Staff Needs Analysis (After Gorman and Cartwright, 1991)	Changes in staff confidence in treating drug users
	Staff satisfaction with education and training sessions (ACTDGP Evaluation Forms)		Numbers of staff attending education sessions
Other service providers			
	Satisfaction with the program (ACTDGP Evaluation Forms)	Satisfaction with the program (ACTDGP Evaluation Forms)	

*Section IV: Social Functioning of the OTI is designed to measure functioning over the past six months. The results from the pilot study will assist with the decision to administer section IV more frequently.

Appendix 6 Letter of commendation from a GP who uses TOP

(Published in the February ACTDGP Newsletter, 2003)

A GP on TOP

"I've referred 5 people to TOP. Three stand out successes reflect the diversity and professionalism the service offers to general practice. All were long term patients I knew very well—each had a complement of emotional and pain problems. The crucial aspect in their success was one daily contact with either Simon or Fiona to get them through difficult early days. The problems included dependence on MS Contin, Panadeine Forte and Benzodiazepines. In all cases, mental health service and Drug and Alcohol services had turned them away for being "too unwell"- yet all had attempted suicide at some stage. They were high risk patients who were prepared for the difficult road of reducing their opiate use; Thought their efforts, assisted by TOP service the outcomes include reductions of 600 mg of Codeine daily to 240 mg; 100 mg of Benzodiazepines to 40 mg; 400 mg of Ms Contin to 120 mg daily.

All patients respect the TOP team enormously and are very empowered by their achievements and I feel that involvement with TOP has provided the personal support that allowed then to achieve far more than I (or previous services they had tried) could have done. A real benefit was the close link between TOP, the dispensing pharmacists, Peter Holder and Andrew Brown and myself. This created a very co-operative and responsive service."

Appendix 7 TOP Education and Training Session Evaluation Form


ACT Division of General Practice

The Opiate Program TOP Seminar

Evaluation

Learning Objectives

- Increased understanding of the principles underlying management of acute pain in people who are dependent on opiates.
- Increased understanding of applying the criteria for selecting patients for long term management of chronic pain so that the risk of iatrogenic analgesic dependence is minimised.
- Increased understanding of choices regarding the drug, its route of administration and the frequency and level of dose when using narcotics to manage chronic pain.

1. How well were these learning objectives met? *(Please circle)*

Poor	average	well	very well	extremely well
1	2	3	4	5

2. How relevant was the information presented to general practice? (Please circle)

Poor	average	well	very well	extremely well
1	2	3	4	5

3. Briefly describe the criteria for selecting patients for long term management of chronic pain

_____

_____

_____

4. Name three clinical aspects of this seminar you found the most useful.

_____

_____

_____

Please rate the following (Please circle)

Quality of presenter

Poor	average	well	very well	extremely well
1	2	3	4	5

Quality of Venue

Poor	average	well	very well	extremely well
1	2	3	4	5

Comments: _____

_____

_____

Thankyou for Completing this Evaluation

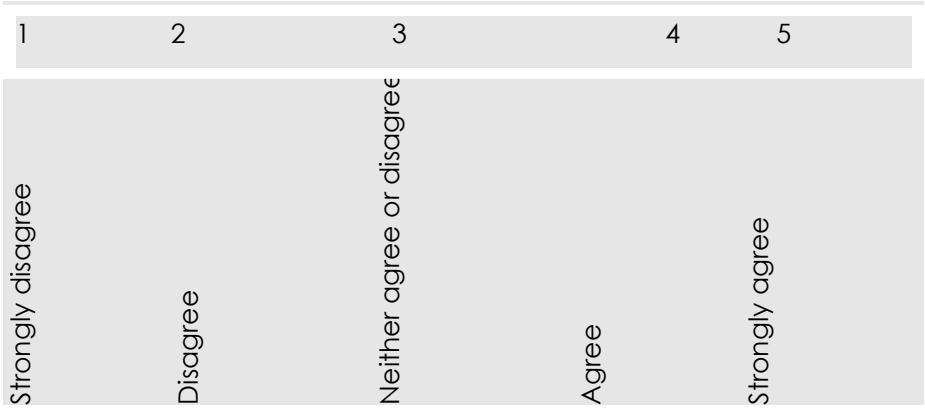
Appendix 8 GP Satisfaction with D&A Nurse Questionnaire

Questionnaire _300_____
Practice Number_____
GP number_____

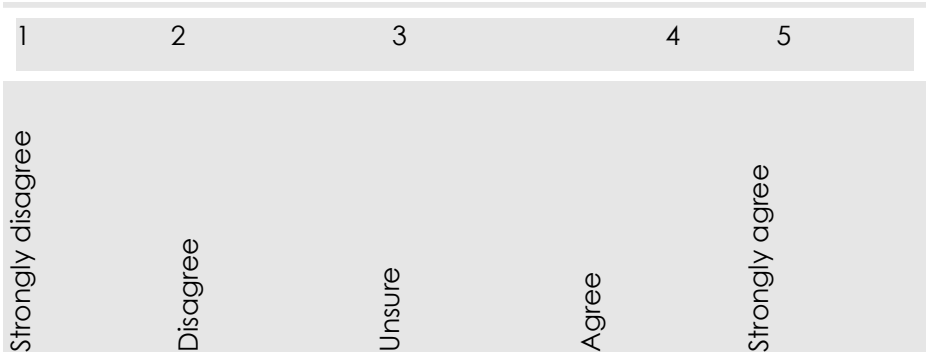
1. I am totally satisfied with the service provided by the D&A nurses

2. Some things about the consultations between the doctor and the D&A nurses could have been better

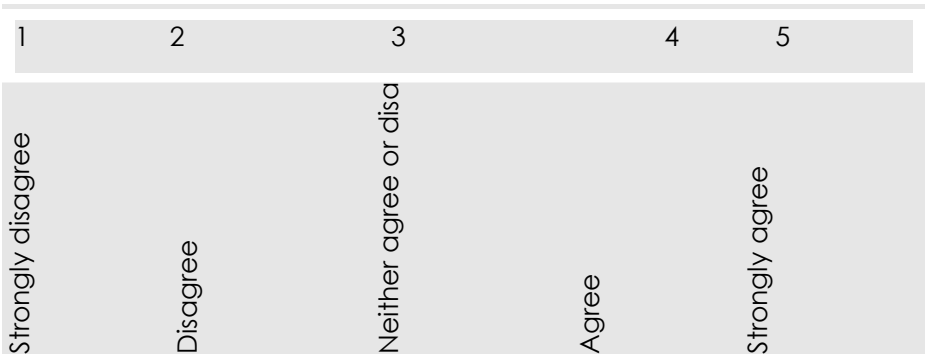
3. I am not completely satisfied with the service provided by the D&A nurses



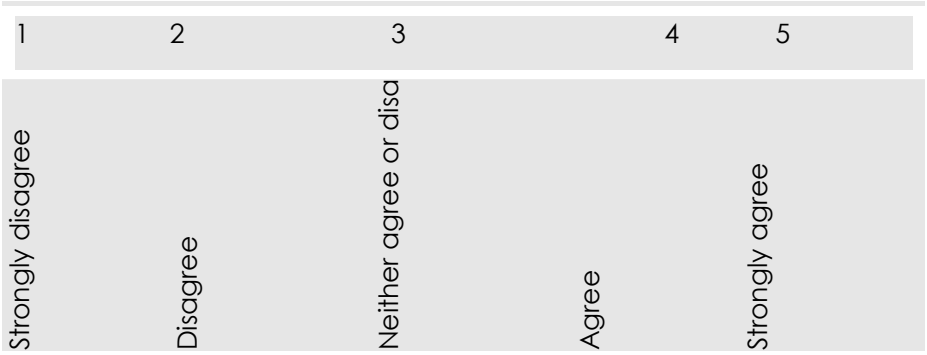
4. There is a lot of teamwork between doctors and nurses in this practice



5. The TOP nurses generally understand and appreciate what the doctor does



6. TOP nurses in general don't cooperate with the doctors here



Appendix 8a Patient Consultation Satisfaction with D&A Nurse Questionnaire

Questionnaire _600_____
Practice Number_____
Patient number_____

1. I am totally satisfied with my visit to this drug & alcohol nurse

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disa	Agree	Strongly agree

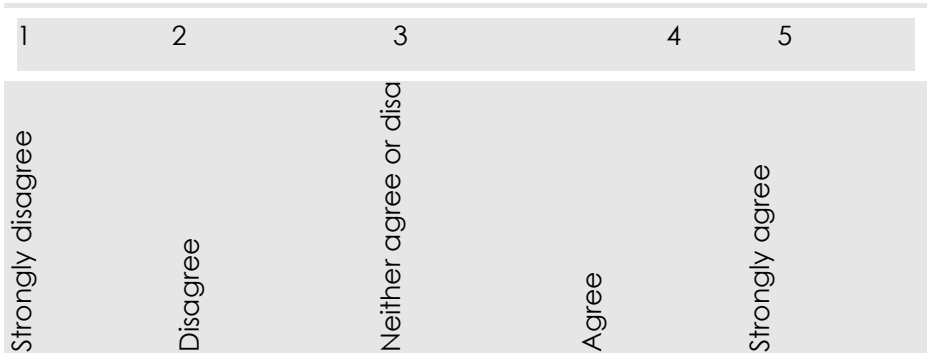
2. This drug & alcohol nurse was very careful to check everything when examining me/carrying out my care/discussing my family's health

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disa	Agree	Strongly agree

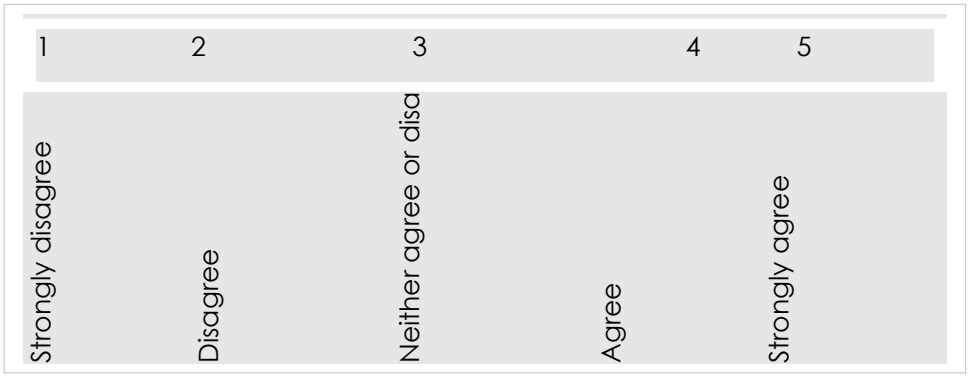
3. I will follow this drug & alcohol nurse's advice because I think he/she is absolutely right

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disa	Agree	Strongly agree

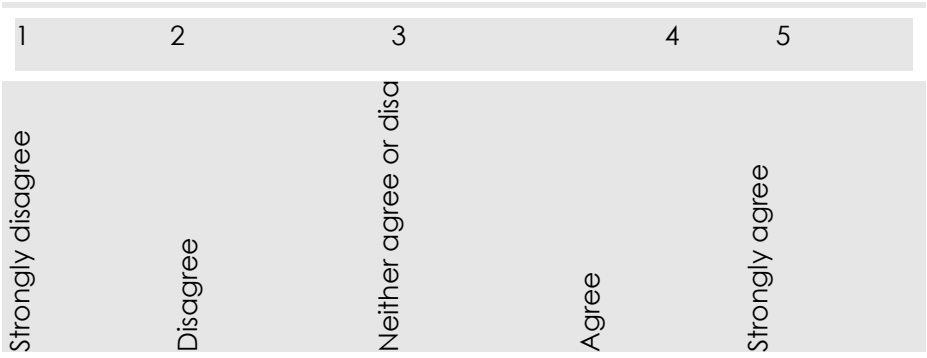
4. I felt able to tell this drug & alcohol nurse about very personal things



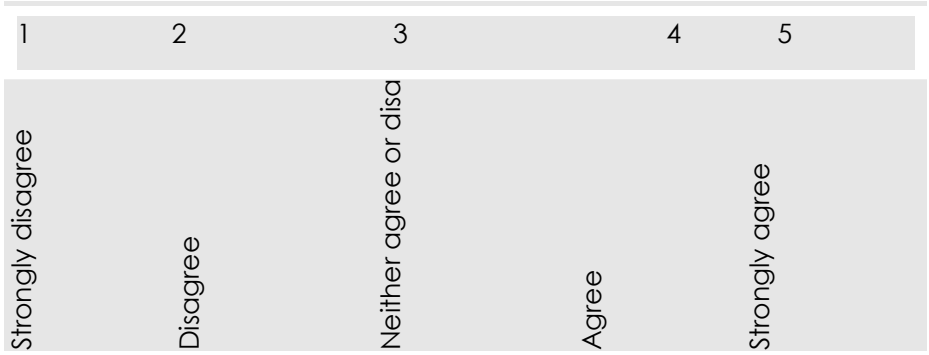
5. The time I was able to spend with this drug & alcohol nurse was a bit too short



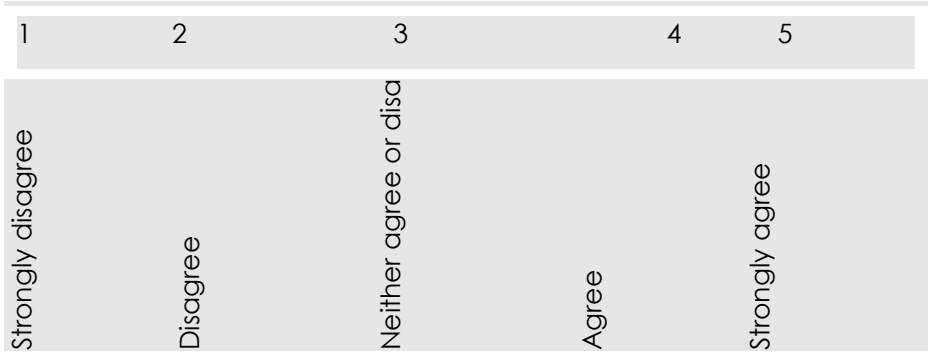
6. The drug & alcohol nurse told me everything about my treatment/care and explained the reasons for the advice given



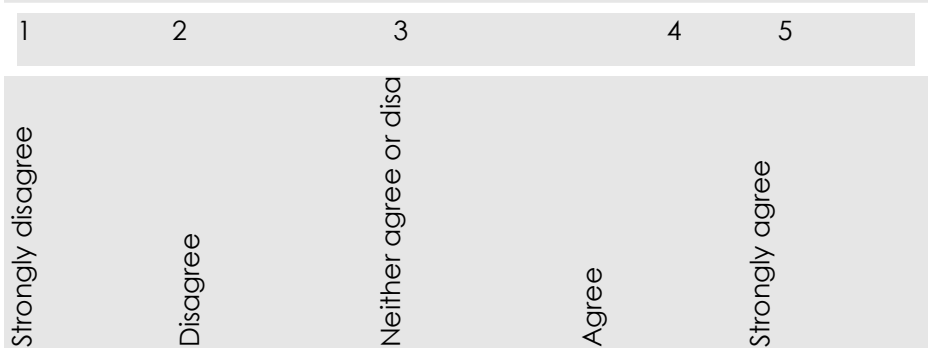
7. Some things about the consultation with the drug & alcohol nurse could have been better



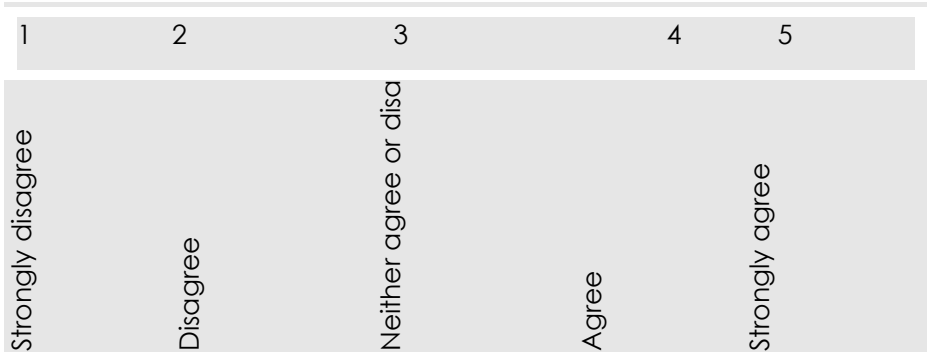
8. There are some things this drug & alcohol nurse does not know about me



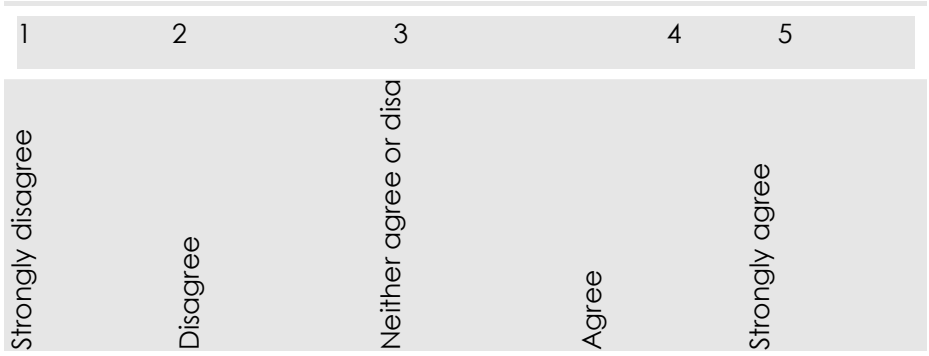
9. The drug & alcohol nurse listened very carefully to what I had to say



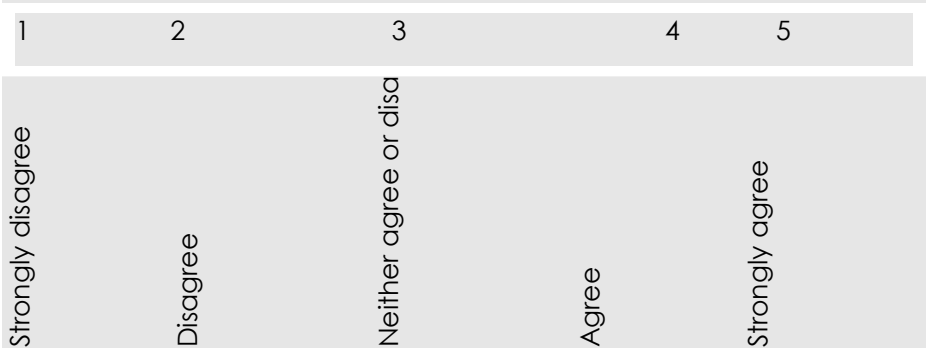
10. I thought this drug & alcohol nurse took notice of me as a person



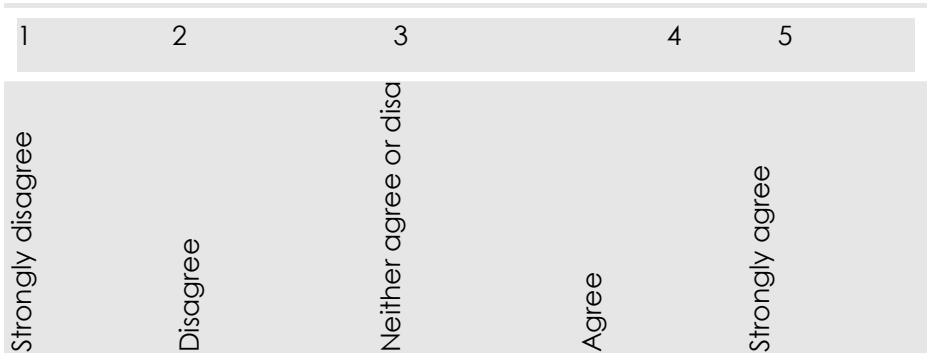
11. The time I was able to spend with this drug & alcohol nurse was not long enough to deal with everything I wanted



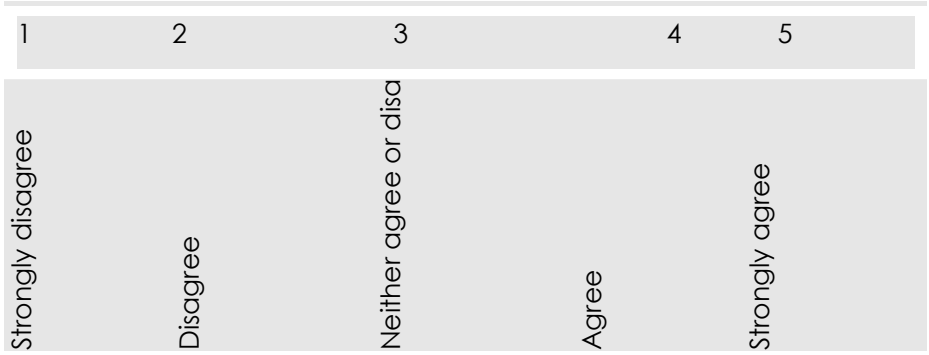
12. I understand my illness /about my family's health much better after seeing this drug & alcohol nurse



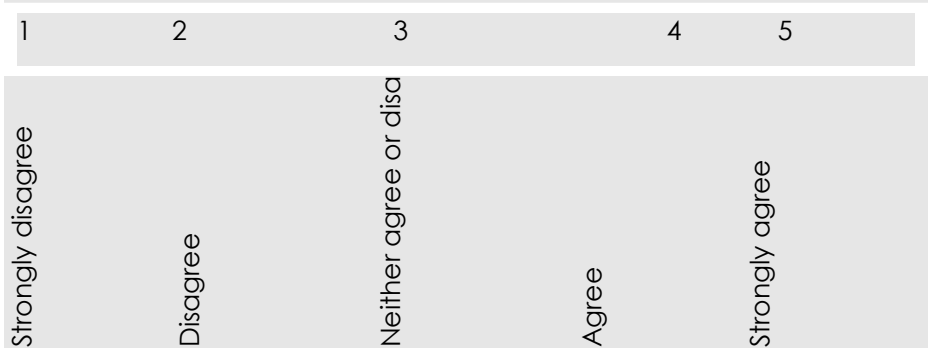
13. This drug & alcohol nurse was interested in me as a person not just my illness/interested in the health of my whole family



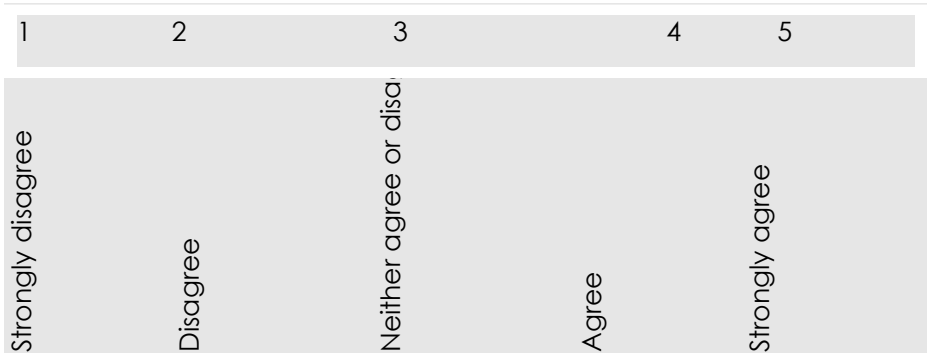
14. This drug & alcohol nurse knows all about me



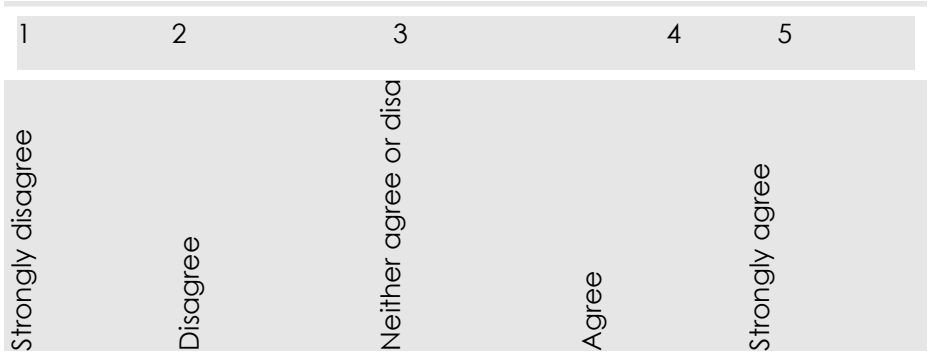
15. I felt this drug & alcohol nurse really knew what I was thinking



16. I wish it had been possible to spend a little longer with this drug & alcohol nurse



17. I am not completely satisfied with my visit to this drug & alcohol nurse



18. I would find it difficult to tell this drug & alcohol nurse about some private things