

SPECIAL SECTION: TRAINING AND WORK-FORCE DEVELOPMENT

The general practitioner's role in AOD issues: overcoming individual, professional and systemic barriers

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Abstract

General practitioners (GPs) and increasingly other medical practitioners are well placed to address alcohol and other drug (AOD) problems. Their involvement in this area of care, however, is assessed to be less than optimal. There is, however, a growing body of evidence for the potential efficacy of medical practitioner intervention at the primary care, emergency department and in-patient level. There is also considerably expanded scope to operate from an evidence-based perspective. However, key questions arise regarding what constitutes best practice in the translation of the growing AOD knowledge base into clinical practice behaviours. This paper explores possible contributory factors to the low level of engagement with AOD issues by GPs and examines a wide range of individual, structural and systemic issues that may be amenable to change. Strategies for the dissemination of research findings, changing professional practice behaviour and introducing sustainable structural reforms are also addressed. [Roche AM, Hotham ED, Richmond RL. The general practitioner's role in AOD issues: overcoming individual, professional and systemic barriers. *Drug Alcohol Rev* 2002;21:223–230]

Key words: AOD problems, efficacy of interventions, general practitioners, training, work-force development, work-place structure.

Introduction

There is a growing recognition of the extent, severity and sequelae of alcohol and other drug (AOD) problems. It is also recognized that health professionals, particularly general practitioners (GPs), are well placed to address these problems. However, general practitioners often pay little attention to AOD problems. This is in spite of convincing evidence that even brief interventions for alcohol or other drug use can be effective [1,2]. The potential for general practitioners to be involved in the management of alcohol and other drug problems is considerable but largely unrealized. A strong imperative exists therefore to support GPs in effective engagement with drug users. However, a range

of individual, professional and structural factors act as significant impediments.

It has been well documented that medical practitioners hold negative, stereotypical views about drug-using patients, especially those using illicit drugs [3–6]. Patients are variously regarded as 'hard work', unmotivated to change, not to be trusted and/or undeserving [4]. Moreover, interventions in this area are not always recognized as legitimate clinical business. These perceptions make it less likely that interventions with drug-using patients will occur. Even when doctors do intervene with drug-using patients they are often disappointed that patients do not cease drug use completely [7]. Interventions with AOD patients can indeed have low returns. For example, in a meta-

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analysis, Silagy *et al.* [8] determined that for every 44 smokers offered brief advice regarding cessation, one of these would be abstinent at 12 months compared with not offering any advice. While from a public health perspective, if large numbers of physicians offer advice the net effect on smoking rates could be substantial [8], this can be insufficient consolation for the acute care clinician.

Addressing the 'therapeutic nihilism' that exists in relation to drug-using patients remains a major challenge [9]. Much still needs to be done in terms of establishing realistic expectations of what can be achieved in the general practice context with its limited time and resources. None the less, in contrast to this negative perspective, there appears to be an increasing awareness that AOD problems form a significant part of the medical practitioner's work-load, that a duty of care exists to address these issues, and that much can be undertaken in a clinical setting to improve patient outcomes. The challenge is to overcome the individual, professional and systemic barriers that prevent or impede implementation of best clinical practice with regard to the AOD area.

The rationale for general practitioner involvement

Use and misuse of drugs

A substantial burden of morbidity and mortality is associated with use and misuse of both licit and illicit drugs [10]. In Australia, tobacco is responsible for a significant morbidity and the majority of drug-related deaths [10] and is implicated in much of the day-to-day clinical work-load of a GP. However, there is evidence that not all smokers are identified and advised to quit in general practice. Australian GPs identify two-thirds of their smoking patients but advise only half of these to quit [11]. Tobacco smoking among young people is also now seen in a new light with mounting evidence that it may act as a 'gateway' drug [12]. At the very least it is a strong predictor of illicit drug use among young people.

Alcohol is also a significant public health issue [13], with almost 70% of all alcohol consumed in a risky manner [14]. While consumption of alcohol among adults occurs in a lower-risk manner than previously, this is not the case for young people and particularly young women [15]. Risky drinking by young people is an area of growing concern for medical practitioners. Inappropriate use of pharmaceutical drugs, particularly psychotropic drugs and analgesics, is also of national and international concern [16], with costs to the Pharmaceutical Benefits Scheme of psychotropic drugs continuing to escalate [17].

In relation to illicit drugs, patterns of use and the characteristics of drug users have changed substantially

over the past decade. Illicit use is more prevalent, age of initiation has dropped, injecting drug use has increased and polydrug use is more common [16,18,19], with resulting social dysfunction and health problems. The types of drugs used are more diverse, readily available and affordable than ever before. Many of the harms experienced are of an acute and transient nature (e.g. sleep disorders, gastritis, infections, mood disorders, transient amphetamine-induced psychosis) and not the exclusive domain of an intractable dependence and commonly present at primary care settings.

In addition to the changing pattern of drug use, there is a high prevalence of co-occurring mental health disorders with almost 20% of those with a mental disorder exhibiting a co-morbidity for harmful substance use [20,21]. These co-existing disorders could be managed long term in general practice through a series of brief interventions [22] and good articulation with the secondary care system.

In view of these changing patterns, early and effective intervention for harmful AOD use by primary care providers and medical practitioners is a high priority in Australia.

Patient preference

Patients also often prefer to receive interventions and treatment for drug problems from their GPs. For instance, patients believe that they are more likely to succeed in quitting smoking if the GP advises them [23]. In addition, GP care has been seen by users of illicit drugs as the preferred option for detoxification or maintenance prescribing in the United Kingdom [24]. Primary care services were perceived as more accessible and responsive to their needs than hospital-based services [24]. However, where GPs are unsympathetic and unlikely to be responsive to repeated episodes of help-seeking, fewer than one-quarter of drug users reported in one study that they would return to their GP regarding their drug use; this contrasted with 91% who would return to an AOD agency [25].

Evidence for efficacy of interventions

There is considerable potential for medical practitioners to be involved in the prevention and management of AOD problems. Randomized controlled trials (RCTs) have demonstrated that advice and treatment by physicians and nurses reduce substance use and its associated morbidity and health care costs. At least 14 trials have demonstrated that advice by doctors and/or nurses to problem drinkers decreases alcohol consumption, emergency department visits and hospital admissions [26,27]. In addition, brief intervention by GPs for excessive drinkers has been shown to reduce the number of problems associated with their drinking [28].

Table 1. *Treatment outcome at 6 months*

Drug	Success rate (%) [*]	Range (%)
Alcohol	50	40–70
Opioids	60	50–80
Cocaine	55	50–60
Nicotine	30	20–40

^{*} Success defined as greater than 50% reduction in Addiction Severity Index [9].

Health-care costs, including hospital admissions, have been shown in randomized controlled trials to be reduced by up to one-third [29] and physicians who refer in-patients to a treatment programme can expect that up to 60% will accept the referral [30].

There have also been many RCTs of smoking interventions over the past two decades. US guidelines [31] recommend that all doctors should strongly advise every patient who smokes to quit and meta-analyses have revealed that there is a strong dose-response relation between the intensity of tobacco dependence counselling offered and its long-term effectiveness [31]. A review of general practice interventions in Australia, the United Kingdom, Canada and the United States also showed that a greater involvement of the doctor's time and a greater intensity of intervention were worthwhile in producing higher abstinence rates among smokers [32].

Medical practitioners, however, often perceive AOD interventions to have a low success rate [33]. In fact, success rates and cost-effectiveness of formal treatment compare favourably with treatment of other chronic disorders, as shown in Table 1.

In spite of the identified efficacy of medical practitioner intervention as measured against treatment, referral and economic criteria, it is known that doctors are often deficient in identifying alcohol problems [30,34,35], particularly in women and the elderly. There is also reluctance generally to tackle nicotine use [23], despite the finding, by meta-analyses, that if a clinician has a tobacco use status identification in place, the intervention rate and the success rate are doubled [31]. There is even less interest in relation to illicit drugs [33,36].

What, then, is needed to improve clinical performance in relation to AOD issues?

Capacity development and sustainability

Education and training

Training, support and remuneration have all been highlighted as needing improvement if engagement of

GPs with AOD users is to be enhanced, thereby taking advantage of the localized and widespread medical care offered by GPs [37]. Appropriate education and training can certainly be effective in enhancing practitioner response [38,39]. However, training has often largely been accepted without evaluation of its efficacy [40–42]. There is also concern about the potentially limited foci of some training: for instance, where a single treatment (such as methadone) might be highlighted rather than conveying a holistic understanding of drug use, addiction and addiction treatment [43,44].

Encouragingly, passive dissemination of information is giving way gradually to use of interactive case studies and clinical scenarios [45,46] reflecting national guidelines [47] and the experiences of practitioners already involved in AOD work [3,45]. Such design features are considered crucial in successful training and support schemes. For example, the recently launched UK Substance Misuse Management in General Practice Programme [48] utilizes initial face-to-face training with an interactive website for ongoing communication and information sharing. The course is designed on a 'constructivist alignment' model [49], with active learning and authentic tasks that build on existing knowledge and experience.

It has also been recognized that knowledge levels are easier to influence than performance, although there is evidence that in some AOD areas, training does impact positively on practitioner performance [39]. A review of methods used to disseminate tobacco and alcohol interventions [50] found that a multi-faceted approach in training was needed, and ideally included personal follow-up support by trainers. It is argued further that training should start at the undergraduate level [4,50] with reinforcement during intern and residency training. Without this early establishment of AOD issues on the agenda, it is more difficult to later enhance knowledge and skills. Although there is still too little offered in the way of AOD educational opportunities, opportunities are extending as learning materials are becoming increasingly web-based.

Promoting best practice

After initial education and training, medical practitioners, in common with professionals in many fields, are faced with the challenge of managing the expanding information available through not only traditional sources such as peer-reviewed journals but also electronically, for example via the internet [51]. These changes create special challenges for professionals and organizations in terms of the strategies required to filter, synthesize and absorb new knowledge [52]. Beyond the current emphasis on evidence-based practice is the concomitant need for an evidence-base to underpin promotion of knowledge uptake and best practice.

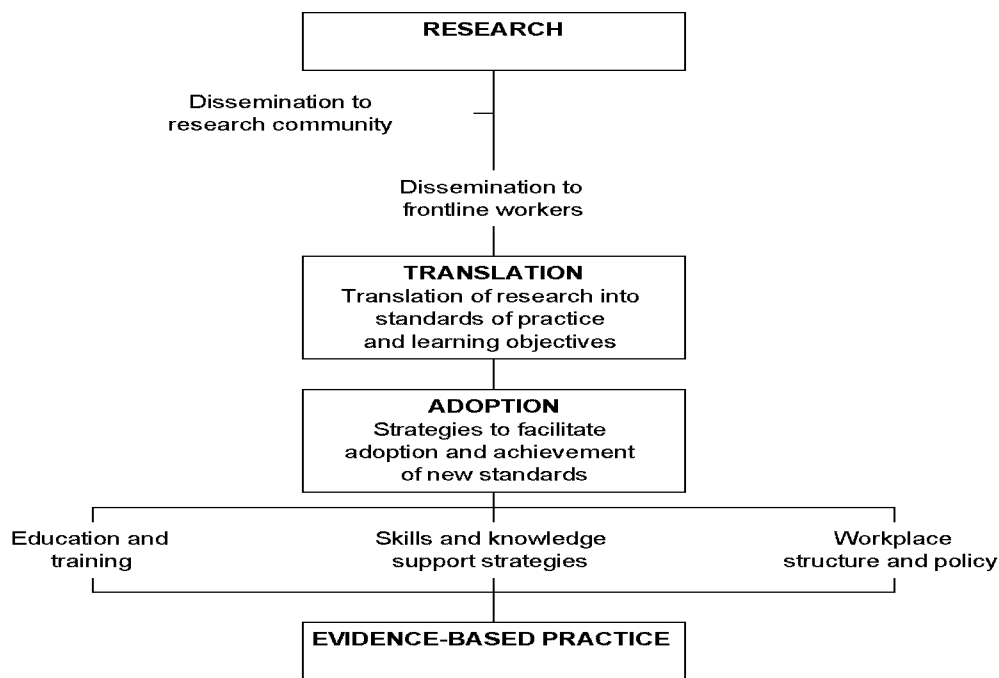


Figure 1. From research to practice: a model of change

Recent reviews of the impact of traditional education approaches on professional practice behaviour have often been disappointing [40,41,53,54]. It is unclear whether this is a weakness in the interventions, a failure to disseminate the interventions accurately and train the intervention agents adequately, or a problem at the implementation phase. For example, considerable effort has been directed at identifying interventions to modify life-style behaviours (especially those relating to drug use) but, despite some notable progress in the 1990s [38,55–57], methods to train health-care professionals in effective approaches to facilitate behaviour change in their patients are not well developed.

Bero *et al.* [58] have highlighted the fact that although many different types of interventions can be used to promote behavioural change among (health-care) professionals with respect to the implementation of research findings, there are very few good studies to guide decision making in this area. Bero and colleagues identified only 18 studies when they undertook a systematic review of the literature. Thus, seeking the evidence-base for ways to best disseminate current research findings and improve work-force practice is a challenging task. Bero *et al.*'s [58] review also indicated that most researchers in the AOD area fail to attempt to link their findings to theories of behaviour change. This deficit has been highlighted previously by Davis *et al.* [40], who noted that there was no consistent theory, or set of behaviour change theories, supported. Rather, findings were consistent with several different theories [51]. Clearly, there is a wide range of potential

theoretical perspectives from which practice behaviour change can be approached and, to date, no single theoretical perspective has been validated adequately by research to inform the choice of implementation strategies. This remains a largely untapped territory and warrants future research endeavours.

The multi-faceted and staged processes involved in translating research into practice behaviour are outlined in Fig. 1. Note that education and training comprise only a part of this model, taking equal place with support strategies and work-place structure and policy.

Work-place structures and policies

The strategies required to develop an adequate medical practitioner response to AOD problems extend well beyond the narrow traditional notion of training [51]. A major paradigm shift is required to refocus the emphasis away from an exclusive orientation on training to one which encapsulates factors such as organizational structures, evidence-based knowledge transfer and skills development [51]. Within the GP context, a range of important structural and policy factors need to be addressed. For example, perceptions of role legitimacy can impact on the likelihood of GP intervention with AOD patients [36,59,60] and doctors and nurses may be ready to intervene only when the patient's health is unequivocally influenced by their drug use rather than intervening opportunistically [59]. However, such practices are not only related directly to practitioner attitudes, skills and confidence in their ability to

intervene effectively but to a range of systemic issues within the work-place.

Isolation has also been identified as an important factor in dealing with substance-misusing patients [33,43], particularly with regard to engagement with users of illicit drugs. 'Burn-out', related partly to professional isolation and lack of support, may lead to practitioners ceasing to engage with substance-misusing patients [5]. Although isolation can obviously be exacerbated by a lack of knowledge and/or skills, organizational and financial issues are also identified as impediments to engagement with AOD users [33,61–63]. Disruption of clinic schedules may intensify further the perceived lack of remuneration for what may be regarded as impossible or 'hard to cure' patients [5].

Access to back-up by colleagues is seen as one means by which to address isolation. Shared-care models have been suggested for the management of patients with AOD-related disorders [64]. These models range from simple co-location in a practice with other GPs engaging with AOD users, to enhancement of networks, to more structured arrangements. Such arrangements can include employment of an AOD specialist by a GP practice for one or more sessions and a formalized, regular link between the GP and the AOD specialist, with the GP retaining primary responsibility for management [64]. A review [65] of Australian GP Divisions indicated that in 1998, several had instigated shared care programmes in the AOD area between GPs and both hospital and community health services. These programmes focused on early intervention, methadone prescribing and both out-patient and home-based detoxification [66].

The successful instigation of a comprehensive tobacco control programme in the US state of Massachusetts also highlighted the vital significance of organizational structures and networks in facilitating practitioner intervention [67]. Similarly, a Californian initiative related to domestic violence recognized that strong linkages with community agencies and the establishment of a practice environment conducive to physician involvement increased clinician screening and referral [68].

In terms of other forms of support, an Australian study [62] noted that the most frequent request by GPs was for 24-hour back-up from specialist services: this type of support was particularly preferred by those practitioners with less clinical experience. An example of this type of support in action is the local telephone consultancy incorporated into the highly effective model adopted by the Central Coast Area Health Service in New South Wales (Australia) [69] which was complemented later by peer networks. Similar models have also been adopted successfully elsewhere. In a recent clinical trial in the United States, for instance, involving patients without significant psychiatric co-

morbidity who had been on methadone maintenance for at least a year, clinician support included a 24-hour pager for clinical questions or concerns and monthly on-site reviews [70].

Another system trialled in the United Kingdom involved the use of a specialist AOD team led by a GP and including a nurse and an AOD worker [71]. This model received positive feedback in regard to direct treatment provision by the team, but tension was reported with respect to the training and consultative roles. Although affected possibly by shortcomings in the team's approach, this finding appeared to highlight further the reluctance of many primary care staff, especially GPs, to engage with patients regarding their AOD use [71].

Isolation can also be mitigated if practice partners are routinely sympathetic to practitioner involvement with AOD clients. 'Airing' sessions and regular staff support groups could be used to address conflicts, offset stress and prevent 'burn-out' [72]. The contribution of practice managers and reception staff is integral to the successful management of AOD patients and consideration also needs to be given to their training and support [73,74]. In an innovative Glasgow programme [75], partner agreement is necessary for practitioner accreditation in methadone provision and dedicated clinic sessions are utilized to provide adequate time and reduce conflict with other practice work. The Glasgow system [75] is based on the principle that AOD work should receive additional payment, as it is beyond the scope of general medical services.

While shared-care arrangements may help address the lack of time and resources available [59,62] issues related to appropriate remuneration also continue to be highlighted [61,62,76,77]. In Australia, the 'Better Outcomes in Mental Health Care' initiative, which commenced in January 2002, included treatment of alcohol and other drug disorders and has a number of key components to facilitate GP management of drug-using patients [78], including enhanced funding for GP education and training. The initiative funds specific items under the Medicare universal health insurance system for GP counselling and a separate item for psychiatrist participation in case-conferencing with GPs, especially in emergency situations. These arrangements will help to address concerns that the care of AOD patients, with its repeated and sometimes lengthy consultations, may lead to Health Insurance Commission over-servicing implications. However, the added financial incentive will not flow directly to salaried practitioners within a GP practice.

Work-force development

The need to address these broader work-force development issues is increasingly well understood and across

Australia and New Zealand a range of recent initiatives have emerged [79–81]. Similarly in Britain, a major effort is being directed currently to work-force reform as one strategy by which to salvage and revitalize the beleaguered National Health Service [82]. The need for such reform with regard to the provision of AOD services has been recognized for some years [83]. In Australia, the situation with respect to the AOD work-force generally, and GPs in particular, is strikingly similar with factors recognized in the United Kingdom [37] also identified here [33].

Conclusion

GPs are well placed to address the increasing morbidity associated with use and misuse of licit and illicit drugs in Australia. Tobacco and alcohol have been implicated in the daily clinical work-load of GPs for decades and changing patterns of drug availability and use are contributing to growing expectations for GP intervention with patients whose health problems are attributable to inappropriate use of pharmaceuticals, use of illicit drugs and polydrug use.

Negative health sequelae associated with drug use may present as an acute condition in either the GP surgery or in hospital emergency departments, or as a chronic problem. The high prevalence of co-occurring mental health disorders with harmful substance use brings further challenges to medical practitioners. Certain high-risk populations, the young, indigenous people [84] and prisoners also have specific needs that GPs are well placed to address.

There is good evidence that advice and treatment by GPs is not only efficacious but also generally well received by patients. However, reluctance to be involved is well documented, especially where use of illicit drugs is involved. This area of work is often seen as unrewarding, difficult and under-remunerated. Attitudes to drug users have usually been noted as negative and stereotypical, yet little effort has been directed to systematic and structural issues to actively change attitudes and professional behaviour. The dissemination of research findings into practice requires not only the transfer of knowledge to front-line workers such as GPs but also effective strategies to facilitate the adoption of new practices. Practitioners are being urged to incorporate the evidence base into their clinical practice. Concomitantly, there exists a pressing need for development of an evidence base to inform the selection of implementation strategies for new practice uptake.

Finally, it is recognized increasingly that the strategies required for facilitating GP engagement with patients with AOD problems extend beyond conventional notions of training. The structure of the practice environment, particularly the level of support from partners and ancillary staff, and wider organizational

and structural factors, impacts significantly on the likelihood of practitioner involvement in AOD issues. Shared-care models are an example of strategies that have been utilized to support the GP in the management of AOD patients and are designed to address the isolation reported by practitioners in this area.

Whatever the form of support taken, it is increasingly clear that overcoming barriers to GPs' involvement in patients' AOD problems will not be solved merely by the provision of education and training. A more sophisticated and broadly encompassing approach, such as that offered through a work-force development perspective, is needed. New approaches to work-force development are emerging and gaining attention [85] and they hold considerable relevance for the AOD field. In addition, initiatives such as globalization, technological advances and rapidly expanding knowledge all impact on the work-force and its evolving needs. Initiatives are required that will take this broad perspective and address systemic issues as well as individual factors.

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