Drug and Alcohol REVIEW

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What do general practitioners want from specialist alcohol and other drug services? A qualitative study of New South Wales metropolitan general practitioners

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Abstract

Introduction. *Alcohol and other drug (AOD) use is common in Australia with significant health and community impacts. General practitioners (GP) often see people with AOD use; however, there is little research to understand how specialist AOD services could assist GPs in the management of patients with AOD issues.* ***Methods.*** *Thirty-five GPs working in general practice in a metropolitan area in Sydney in New South Wales, Australia, participated in one of three focus groups. The groups were recorded, transcribed and thematically analysed.* ***Results.*** *The five themes raised by participants were: GP personal agency and interest in AOD issues; GP education and training gaps; improving pathways between GP and specialist AOD services; easier access to AOD specialist advice; and improving access to collaborative care for patients with complex AOD presentations. Participants requested education on screening, assessing, managing AOD issues, focused on alcohol, stimulants and high-risk prescription medicines. They suggested better referral processes, discharge summaries and care planning for complex presentations. Participants wanted easy access to specialist advice and suggested collaborative care assisted by experienced AOD liaison nurses.* ***Discussion and Conclusions.*** *Australia has several existing programs; online referral pathways and specialist phone advice, that address some of the issues raised. Unfortunately, many participants were not aware of these. GP education must be supported by multiple processes, including durable referral pathways, ready access to local specialist advice, clear communication (including patient attendance and a treatment plan), care planning and written summaries.* [Wilson H, Schulz M, Rodgers C, Lintzeris N, Hall JJ, Harris-Roxas B. What do general practitioners want from specialist alcohol and other drug services? A qualitative study of New South Wales metropolitan general practitioners. *Drug Alcohol Rev* 2022]

Key words: primary health care, substance-related disorder, continuity of patient care, interdisciplinary communication, substance abuse treatment centre.

Introduction

Risky, problematic or dependent alcohol and other drug (AOD) use in Australia is common [1]. This use results in significant cost to individuals, their families and communities, due to physical and mental health comorbidities, mortality, family violence and negative social, economic and vocational outcomes [2–5]. There are effective treatments for AOD issues [6], but people may not seek treatment due to numerous structural and attitudinal barriers [7–9].

General practitioners (GP) are core to the Australian health-care system. They work in small to medium private businesses in a 'fee for service' model subsidised by federal government universal insurance (Medicare), often with patient co-payment [10]. This model is best suited to managing acute self-limited illnesses; however, GPs increasingly provide care for people with

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multiple complex and chronic conditions [11]. Every year, 86% of Australians see a GP [12] and, as a result, GPs often see people experiencing AOD problems. GP willingness and capacity to provide care for people with chronic AOD issues may be limited due to low levels of GP confidence and low AOD detection, complicated by poor remuneration and limited access to support services [13–15]. Formal referral by GPs to AOD services is low and the majority of patients access this care directly by self-referral [16]. As a result, GPs may be unaware and uninvolved in their patients' AOD treatment.

Australian public specialist AOD services are funded by state governments. They employ expert multidisciplinary teams and can play an important role in the management of people with chronic and complex AOD issues [16]. Unfortunately, these services have limited capacity to provide ongoing care [7] and are scarce or unavailable in regional and rural Australia [17]. Unlike GPs, they do not manage general health issues [18] and may have specific criteria limiting patient access and the services they provide may be invisible to GPs [19].

Care 'siloing' between AOD specialist services and primary care may delay access to treatment and limit relapse prevention support and aftercare [20,21]. Collaboration between AOD specialist services and primary care in the USA, Canada and Australia showed increased patient engagement in care, improved access and utilisation of treatment services, significant decrease in drug use and greater 6-month abstinence [22–28]. Unfortunately, short-term programs to encourage primary care to undertake care for patients with complex AOD needs tend to fail after specialist support is withdrawn [29].

Our study aimed to explore how specialist AOD services could better support GPs to address their patients' AOD issues. To do this, we sought to understand Australian GPs' expectations, perceptions and experience of collaboration with specialist AOD services and their views on what components could lead to more effective specialist AOD support and collaboration with GPs.

Methods

Thirty-five GPs (11–12 in each group) participated in three focus groups. The groups ran for two hours on a weekday evening, between August and September 2018, in one of the Primary Health Network (PHN) areas in metropolitan Sydney, Australia. PHNs are primary health-care support organisations, operated by non-government, not-for-profit companies with federal funding [30].

GPs were recruited via the online newsletter from the local PHN and all GPs working in general practice in this PHN were invited to attend. One author (M. S) from the specialist AOD service managed the recruitment process. To overcome the time and income loss reported as a barrier to GP engagement in research [31,32], participants were reimbursed for their time ($240, funded by the PHN). No GP who applied to attend was excluded from the study. Participant information and consent forms were forwarded via email prior to the groups and consent was checked at each group.

We collected demographic data on gender, cultural background, length of GP experience and Medication Assisted Treatment for Opioid Dependence (MATOD) prescribing during each focus group (see Table 1). Participants represented a diverse group with a range of ages, general practice experience and varied interest in assisting people with AOD issues.

The focus group format was used as group conversations can encourage contributions from multiple participants, help draw out diverse views and experiences, leading to debate and the expansion of ideas that may not occur in an individual interview format [33,34]. The participants discussed four case scenarios that covered patients presenting in general practice with issues related to alcohol, stimulants, prescription opioids and benzodiazepines (see Appendix S1, Supporting Information).

Group discussion was facilitated by three GPs with specialist addiction training who worked in the PHN (HW, CR and MC). The facilitators were aware of their insider status and the need for reflexivity and sought to ensure their views did not overshadow participants' experience [35].

The conversations were audio-recorded, verbatim transcriptions were generated by the first author and used to form the data for this study. The transcripts were imported into NVivo12 (https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home) and thematically analysed by the first author [36]. The analysis was reviewed by authors MS and CR. Data collection and analysis followed the consolidated criteria for reporting qualitative research (CORE-Q) guidelines to support analytical rigour and presentation of the findings [37] (see Appendix S2, Supporting Information).

The research was approved by South Eastern Sydney Local Health District Human Ethics Committee. HREC ref. no: 18/018(LNR/18/POWH/156). This project was undertaken as part of HW.'s PhD.

Results

We identified five themes from the focus group discussions: 'GP personal agency and interest in AOD

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Table 1. *Demographics of general practitioners (GP)*

	Focus group no.		
	FG1 (n = 12)	FG2 (n = 12)	FG3 (n = 11)
Gender			
Female = 23 (66%)	Female = 6	Female = 9	Female = 8
Male = 12 (32%)	Male = 6	Male = 3	Male = 3
Culturally and linguistically diverse background			
Yes = 12 (34%)	$n = 3$	$n = 5$	$n = 4$
No = 23 (66%)			
Length of GP experience			
GP Registrar = 7 (20%)	GP Registrar = 3	GP Registrar = 1	GP Registrar = 3
New Fellow[a] = 5 (14%)	New Fellow[a] = 1	New Fellow[a] = 3	New Fellow[a] = 1
Established GP = 23 (66%)	Established GP = 8	Established GP = 8	Established GP = 7
Prescribing MATOD			
Ever been MATOD prescriber = 5 (14%)	$n = 1$	$n = 3$	$n = 1$
Prescribing MATOD now = 3 (9%)	$n = 0$	$n = 2$	$n = 1$
Age (across all focus groups)	25–34 years = 9 (26%), 35–44 years = 14 (40%), 45–54 years = 3 (9%), 55+ years = 9 (26%)		

[a]New Fellow—within 5 years of graduation from GP training. MATOD, Medication Assisted Treatment of Opioid Dependence.

issues'; 'GP education and training gaps'; 'Improving pathways between GP and specialist AOD services'; 'Easier access to AOD specialist advice'; and 'Improving access to collaborative care for patients with complex AOD presentations' (see Figure 1).

The included quotes come from a wide range of participants. The themes were consistent across gender, cultural background and across the three focus groups. Early career GP participants sometimes reported different views and experiences of the themes compared to established GP participants.

GP personal agency and interest in AOD issues

Some established GP participants expressed limited interest in undertaking AOD work. They suggested a preference for referral to other services rather than managing AOD issues in their practice and reported that GPs needed to manage AOD issues regularly to maintain their skills.

> '*… I don't feel I can manage in my practice. So, I would prefer referral.*' (Female, established GP, FG3)

> '*… this is not our bread and butter you see. So you're not really, unless you're really starting to focus on it, … you're always a bit out of your comfort zone …*' (Male, established GP, FG3)

Participants with an interest in AOD expressed concern about the structural limitations imposed by the 'fee for service' funding in Australian general practice.

> '*I don't know how willing I'd be to take that on to be honest. Unless I've known that patient for a long time. Particularly in the bulk-billing setting…*' (Female, GP Registrar, FG3)

Early career GP participants expressed more interest in increasing their skills, suggesting that, with support, they would be willing to undertake the management of AOD issues in their GP setting. One suggested their ability to do this was limited by their GP supervisor.

> '*I'd love the challenge and trying to help someone … but … in my current practice, my supervisor would not be OK at all with me detoxing this patient.*' (Female, GP Registrar, FG3)

Participants reported that being able to choose who and what they saw in consultation was important.

> '*… I'm a GP at a more traditional GP … I tend not to want to see people with drug and alcohol.*' (Male, established GP, FG1)

GP education and training gaps

Participants, particularly early career GPs, described their need for continuing AOD education. Education including comprehensive assessment, safety and risk assessment, brief advice, motivational interviewing techniques, pharmacological management options and relapse prevention with a focus on alcohol, stimulants and prescribed medicines with addiction potential were suggested. Participants reported not always

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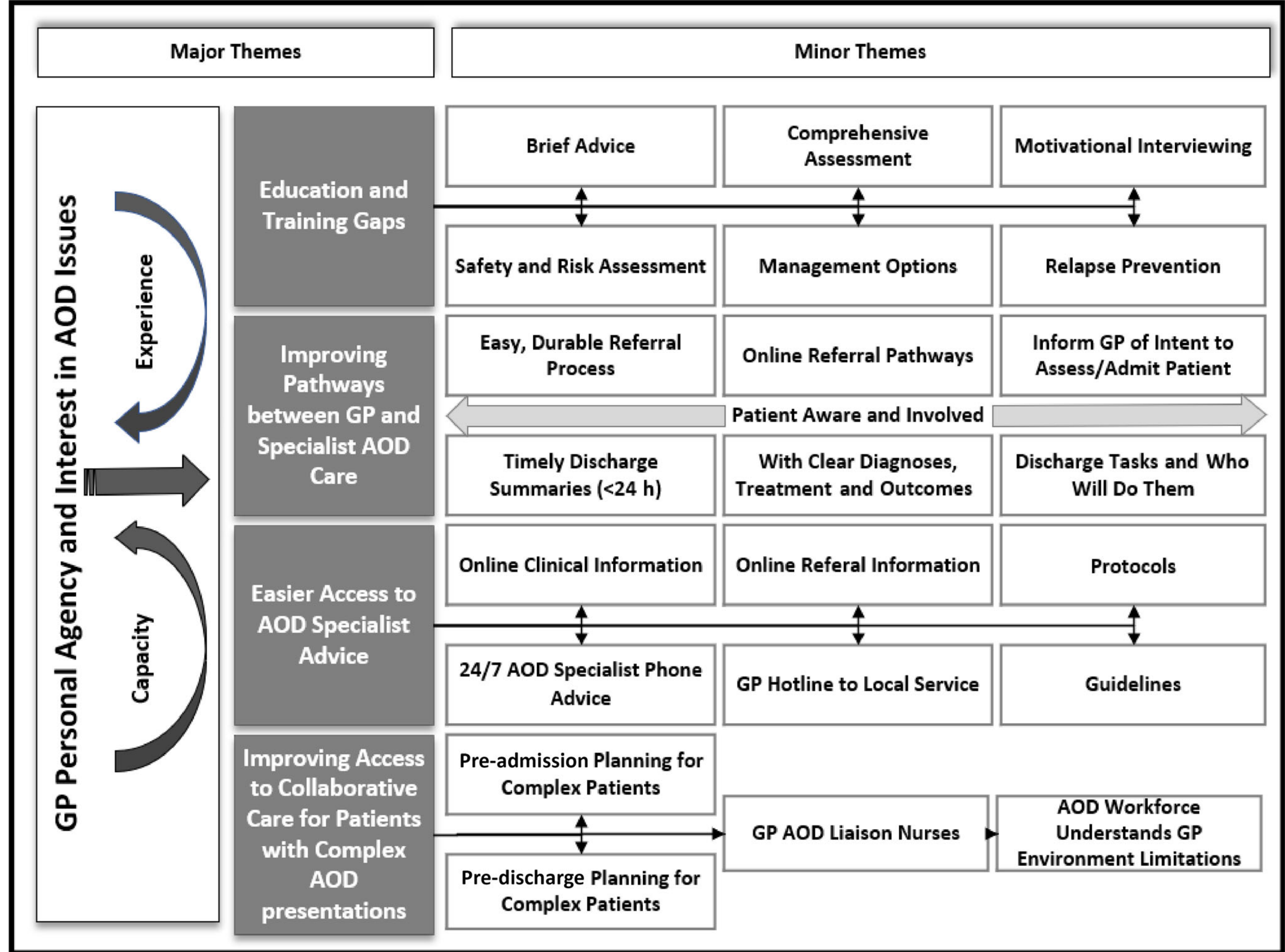

Figure 1. *What general practitioners (GP) want from specialist alcohol and other drug (AOD) services—major and minor themes.*

knowing when inpatient treatment for AODs was warranted and were keen to better match treatment to individual patient needs.

> '… *I've had a couple of patients who have very briefly gone off and very quickly been back on* [substances]. … *I just want to learn a little bit more about patient selection … a bit of an assessment about safety.*' (Female, established GP, FG1)

The participants reported a preference for education with experts in the field who understood the GP setting. They requested short, practical sessions with accompanying guidelines to help guide care, give certainty and flag clear treatment options for people with AOD issues. Online protocols and flow charts with scoring systems or checklists were suggested to support decision making.

> '… [a] *scoring system or some check-list you could go through and if it was OK, then that would mean they're suitable for [a] certain approach.*' (Female, GP Registrar, FG2)

Participants reported wanting practical skills they could use in their setting to screen, assess and make treatment decisions. They expressed a need for better understanding of referral routes to specialist AOD services. There were diverse views on the best format for education. Some preferred face-to-face evening sessions or all-day training sessions while others requested online webinars, web-based courses and pre-recorded sessions.

Improving pathways between GP and specialist AOD care

Many participants reported negative experiences trying to access specialist AOD care for their patients. There was confusion over what was available from public, non-government organisation and private AOD

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services. They reported finding AOD services hard to contact with opaque referral processes and described frustration when not informed of patient admission, treatment, outcomes or discharge.

> '… *it's hard to get through that door … then there's a sense that they just wander off into the wilderness and you might get a discharge summary down the track but also, I think that back end is really important too because the detox is an important step but as important, if not more important, is the ongoing support and rehab, integration. … So, there's the barrier getting in and then there's a disjointedness on the back-end as well*.' (Male, established GP, FG1)

> '*One of the things for me that I see, is that what happens in drug and alcohol is the person comes in and is cocooned in drug and alcohol and then they disappear*.' (Female, GP Registrar, FG2)

Participants requested improved communication, clear referral pathways and timely discharge summaries for all patients. In addition, it was suggested that a GPs ongoing management of patients with complex presentations would benefit from pre-discharge and transfer of care planning. Participants reported wanting to refer to AOD services, but found writing detailed referral letters time consuming. More guidance regarding relevant referral information was suggested; this could be assisted by an online referral form. Ideally, this would download into GP software and auto-populate with patient details to make completion quicker and easier.

> '*I'm sure I could write a decent referral, but it would take me a long time and I'd try to think about what you might want to know from me and my history taking. But to know exactly what you want or need on a referral to facilitate that connection would be helpful*.' (Female, established GP, FG2)

Participants suggested that online information to assist patient management in their setting would be helpful. Some reported wanting clinical 'red flags' to be highlighted. Some verbalised a need for simple information, while others reported wanting more detailed information to improve their expertise and management skills.

> '… *one of the challenges is … confident assessment and risk management. Maybe just some simple pathways for people who don't feel as comfortable with that process*.' (Female, established GP, FG1)

Following referral, participants reported wanting to know the outcome of their referral. This included notification of non-attendance and the specialist service's treatment plan after assessment. They wanted to know that their referral resulted in the AOD service taking responsibility for patient management.

> '… *when I'm contacting them* [AOD services], *it's usually because I want to facilitate some form of transfer and I think … that the sense is there's some degree of certainty related to that process … I know what it is at the end of the day, the patient knows what the plan is and at least I have a sense that the facility has taken some ownership*.' (Male, established GP, FG1)

Participants reported wanting a clear understanding of their role in the ongoing care of the patient and feedback, including the management plan, was important. Some suggested that sometimes their preferred management plan was not followed and that they would like to know why it had been altered. For example, why outpatient withdrawal management was planned when the GP had referred the patient for inpatient admission.

Participants reported that they would like a written summary at patient discharge for both inpatient and outpatient AOD services. This summary needed to be legible and timely, arriving before the patient returned for follow up. A standardised discharge summary needed to clearly state diagnosis, completed treatment, ongoing treatment and follow-up plans, including the role and actions to be undertaken by the GP. It was suggested this summary was a powerful learning tool for GPs.

> '… *a really simple, practical thing that could be done would be a kind of standardised discharge summary … a really clear simple plan. "Oh these, I've seen these summaries before. I know what they look like, I know that they're going to tell me to do this in a week and this in a month and this in three months and maybe the patient will be seen in six months" … I think that would be really a simple, not high-tech thing to do but a really simple sort of way of giving you the confidence of OK, this person has come out of detox … and also it would be a powerful learning tool. Because after you've seen 10 discharge summaries like that, you sort of recognise the pattern and that's really good for your learning*.' (Male, GP New Fellow, FG3)

Participants reported little experience prescribing medications used in the specialist AOD setting, including anti-craving medications. More information on the medicines prescribed to patients on discharge would increase confidence to continue prescribing.

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'*... what we have to do and what drugs they're discharged on, any information about the drugs ... I don't think it's fair to assume that all GPs just know, sure we've all heard of them, but I haven't had to prescribe them myself and I'd be happy to, I'd be happy to kind of take it on, but I need that information*'. (Female, GP New Fellow, FG3)

The importance of patient engagement and understanding of the discharge plan was flagged by participants. The discharge document needed to explain what the patient had been told.

'[the patient] *had no idea what to do and if he hadn't brought it* [to me] *... he wouldn't have gone anywhere. I think the patient really understanding what they're supposed to do and the importance of why they're supposed to do it and why you're actually going to your GP is* [important].' (Female, GP New Fellow, FG1)

Easier access to AOD specialist advice

Many participants described difficulties contacting AOD services for information and advice. They reported that they could not find the right phone number and when they did, either the call went unanswered or the person taking the call was not helpful. Timely advice was important and a hotline to provide information about services was suggested. New South Wales (NSW) already has a state-wide 24/7 AOD specialist advice phone line (Drug and Alcohol Specialist Advisory Service; svhs.org.au). Some participants had used this service and described high degrees of satisfaction with the advice and support given, while others had not heard of it.

'*what is also essential for my service is good pathways into* [specialist AOD services] *... and if I want specialist advice, I'd call,* [Drug and Alcohol Specialist Advisory Service] *is excellent*.' (Male, established GP, FG1)

Many participants expressed a keenness to have access to local specialist AOD advice to help them make clinical decisions for specific patients. Specialist addiction physicians were described as inaccessible; too busy, and too few in number in the PHN area to make it possible for them to answer GPs calls. There were concerns that GPs would appear 'silly', that their level of expertise in addiction would make them sound 'stupid' to a specialist medical colleague. Addiction medicine trainees were reported to often have limited knowledge and only be able to assist if the person needed hospital admission.

'*I don't think you'd call the registrar unless it's someone who is quite acute. Someone that might need some kind of intervention. You're asking them "do they need to come and see you or not?". Whereas if there was someone more like a shared care person who, you know, would also be happy to give you the advice about the patient you're seeing because if, say, the registrar said "no, they don't sound that bad, it's only like four times a week rather than six times a week", you know, it's in that grey area, then they'd be like, talk to community services. So, it would be better if it could be someone who could give you long-term information or "yeah, they need to go to the ward"...*' (Female, New Fellow GP, FG3)

Participants suggested nurses were more approachable and more likely to have the broad knowledge needed for all presentations and treatment options. Some participants recalled good interactions with antenatal share-care service nurses and suggested that the nurse could become a regular point of contact to discuss patients currently undertaking treatment in the AOD setting, keeping them informed of patient progress.

'*a CNC* [Clinical Nurse Consultant] *over the drug and alcohol registrar. So, it depends on their level of training. The CNCs have been there for a while. They know much more usually, and they know the services. I'm aiming for, 'tell me where do I send this person, what else is available?' . They're quite familiar with the services*.' (Female, established GP, FG1)

Improving access to collaborative care for patients with complex AOD presentations

Participants flagged the importance of GP and AOD collaborative care to assist patients with complex multimorbidity. The GP was seen to be integral to this care, but this also required the specialist AOD service to understand how to work with GPs within the structure of Australian general practice.

'*... it needs to be wrap-around and there needs to be ongoing liaison. I think the GP's in an ideal role is to manage that with support ... the primary care is the hub to the spokes ... I think once you get to that level of things, a specialist service could do very well to arrange or suggest for a GP to arrange a case conference which is booked into an appointment slot, there's my 15 minute or half hour slot and I'm going to have a conversation with drug and alcohol specialists, CNCs, psychologists, whoever is involved, can be billed reasonably favourably in comparison to a standard consultation, have all the*

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team members in and can be repeated regularly. It starts to get to the complexity of the social matters that are going on and I think that needs to be a real key.' (Male, established GP, FG1)

A small group of participants in this study reported regularly undertaking care for people with complex chronic AOD issues and they stressed the need for stronger durable links to assist them to provide care. Other participants expressed concern about their ability to manage alcohol withdrawal, stimulant use, poly-substance use, de-prescribing prescription opioids and opioid use disorder in their setting. The logistics of alcohol withdrawal were difficult due to the need for daily review. Some of the participants reported working part time, while others had full appointment books for weeks ahead and as a result were not available on a daily basis to support patients going through alcohol withdrawal. A nurse led AOD program that could work more closely with GPs managing acute alcohol withdrawal to provide dosing and other support throughout the withdrawal period was suggested. This was seen to be a conceptual leap for AOD services, but with protocols and dosing procedures, AOD services supporting GP management of acute alcohol withdrawal could work and help to build GP capacity to undertake alcohol withdrawal with their patients.

'… *if I could just get them to turn up there* [at the AOD service] *and just get their diazepam, that would be wonderful. I know that it would be a conceptual leap for the service, but that practical leap wouldn't be that big a deal if you knew the regime was a standard detox*.' (Male, established GP, FG1)

The participants suggested advantages in a specialist AOD nurse seeing their patients with AOD issues in their surgery, as it was more convenient and less stigmatising for patients than attending the AOD setting. This needed to be readily available and free to low-income patients. Some flagged that it may not be a good use of resources and specific and agreed role definition was needed to ensure appropriate use of the role.

A number of participants expressed caution about involving themselves in the treatment of opioid use disorder with MATOD, reporting that the complexities of treating opioid use disorder in their setting made this work seem too risky. They suggested a liaison to assist them with referral and requested specialist management for this patient group. One GP suggested that they would be happy to take this on with AOD specialist support. Most expressed no wish to be involved in MATOD. A small number of participants were current authorised MATOD prescribers and voiced little desire to increase MATOD patient numbers.

Discussion

By increasing our understanding of the perspectives and experiences of GPs, this study can improve the interactions between GPs and specialist AOD services and assist patient care. The main findings from this study include the need for:

- improved access to AOD treatment information, communication with AOD services, including referral pathways, discharge planning and discharge summaries and GPs' awareness of existing services provided by specialist AOD services;
- collaborative models of care between GPs and AOD services for patients with complex AOD presentations;
- GP education and training gaps; and
- accounting for varying GP personal agency to manage AOD presentations throughout their career.

Easy access to information, referral and discharge processes are key. Online AOD clinical information and referral pathways are already accessible in NSW and Australia via free web-based portals recently introduced by PHNs; 'HealthPathways' [38]. Specialist AOD phone advice is available 24/7 to all health practitioners throughout NSW through the Drug and Alcohol Specialist Advisory Service and throughout Australia with comparable state-based services. Consistent with previous research [39–41], participants had limited knowledge and experience of existing phone advice, referral and treatment options. Increasing awareness and use of these programs could boost GPs' level of engagement in management of AOD issues. Timely discharge summaries are integral to ongoing care for patients in general practice. Essential components of discharge summaries have been described elsewhere [42] and this is consistent with the approach suggested by the participants in our research.

Collaborative care models that assist treatment planning for patients with complex presentations and chronic illness, throughout the patient journey, will assist GPs to engage in the person's ongoing care. Creating strong professional alliances and support for GPs who manage complex chronic AOD conditions is likely to support and strengthen these GPs' capacities to continue to provide this care.

Participants suggested a strong need for specialist support. The preference for a nurse contact is driven by experiences of successful nurse-led programs and this is supported by the literature [43]. Nurses are seen to have a wide knowledge of both clinical and service

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issues and to be approachable, while medical registrars may not have the required skills and specialist doctors are less approachable. Nurses supporting GPs with local knowledge and advice, as well as case management and patient support could dovetail with medical advice from addiction specialists to provide a level of support not currently experienced by most GPs.

Knowledge is important and participants identified a broad range of education and skills needed to assist them to manage AOD issues in the GP setting; however, knowledge alone is not enough [44] and must be supported by the other solutions suggested by the GP participants in this research.

GP participants expressed diverse levels of interest in providing AOD care. Early career GPs reported higher levels of willingness to treat AOD issues, increased use of online and telephone supports, and this is supported by previous research [40,45]. It is important to understand that this group may frequently move practices through their GP training and may have limited capacity to manage chronic AOD issues or influence their workplace's approach to AOD work.

Strengths and limitations

This study was undertaken within one PHN area in metropolitan Sydney; however, Australian general practice and specialist AOD services have similar structures Australia wide and, as a result, the issues may be applicable across Australia. Non-metropolitan GPs may face additional barriers to metropolitan GPs and further research could better understand this.

It can be estimated that only 3–5% of GPs in Australia prescribe MATOD [46,47] and MATOD prescribers are overrepresented in this group at 9%. This may indicate this group is more open to engaging with AOD care than other GPs. There were however several GPs who clearly stated they had little interest in providing AOD care. Two of the participants who had previously undertaken MATOD prescribing, no longer undertake this work. This is consistent with recent research showing a net deficit in Australian MATOD prescribers working in NSW, with more ceasing prescribing than taking this up [48].

GPs researching GPs have a shared language and experience and this is both a potential strength and weakness. Response bias may influence participants as they seek to impress and match their colleagues and the GP facilitators. In our research, a wide range of views were expressed and debated, and we believe the focus groups created a safe environment where all views and ideas were welcomed.

This study does not address whether specialist AOD services are ready, willing, or able to change their current practices and workflows to better support and work successfully with GPs. Further research could investigate specialist AOD services' capacity and willingness to work with GPs and implementation of the solutions suggested in this paper.

Conclusions

It is important to understand GP perspectives. GPs want advice, education, streamlined referral and timely discharge processes. They want to be involved and aware of care planning for people with complex needs throughout the patient specialist AOD service journey. State-based phone advice services and online management/referral pathways are already in place or being developed. Improving GP awareness and use of these may be easy wins.

Improving GP and AOD service engagement and collaboration may encourage early intervention, referral, engagement in treatment and follow up, which may lead to better health outcomes for patients and improved clinician and patient experiences.

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Conflict of Interest

None of the authors have any connections with the tobacco, alcohol or gaming industry. HW has received funding for consultancies and/or expert advisory panels with Indivior, Lundbeck, Seqirus, Mundipharma and Pfizer. NL has been received funding for research studies, consultancies and/or expert advisory panels with Indivior, Braeburn and Mundipharma. All other authors have nothing to declare.

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Supporting Information

Additional Supporting Information may be found in the online version of this article at the publisher's website:

Appendix S1. Scenarios for focus groups – all patients present to the general practitioner in their practice.
Appendix S2. CORE-Q Consolidated Criteria for Reporting Qualitative Studies.

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