Appendix IV

Medical Practitioners

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

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

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

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

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

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

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

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

Appendix IV. **SEVEN UNDERPINNING EDUCATIONAL PRECEPTS OF TRAINING PROGRAMS**

1. Principles of Evidence-Based Practice	**The course content, as with the program overall, are based on the principles of evidence-based practice. That is, aetiology, assessment and intervention strategies reflect current state-of-the-art knowledge and best practice.**
2. Adult Learning Principles	**Education and training principles appropriate for experienced professionals. Key factors which define quality education programs and which facilitate the transfer of knowledge and skills into practice include:** • Basing methods on adult learning principles ▪ The use of experiential and participative learning strategies ▪ Linking course content with trainees' previous experience, learning and skills and with their usual work role ▪ Ensuring practice is underpinned by theory ▪ Using methods which encourage trainees to be responsible for their own learning and which will enable them to translate new knowledge and skills into practice ▪ Providing post-training support, supervision and practice ▪ Linking education to support in the form of leadership and championship which legitimises the practice of new knowledge and skills in the work setting. ▪ Rewarding course participation (e.g. accreditation) ▪ Capitalising on strategic opportunities (e.g. the interest of key change agents). ▪ High quality and well resourced programs (in terms of staff and materials) ▪ Offering content which is under-pinned by the best available evidence (i.e. based on empirical data of consensus about quality practice) ▪ Relating the program to accepted standards ▪ Making it relevant to the job role of participants ▪ Providing flexible delivery strategies to enhance access ▪ Ensuring provision of post-training support and supervision.
3. Skills Development Orientation	**Course are often oriented towards skill development. It is noted that an important criticism levelled against much drug education and training is insufficient attention directed towards skills development.**
4. Delivery Mode	**Evidence supports use of several different delivery modes packaged in a variety of formats to allow for different delivery formats. The three main delivery formats are:** **1. Face-to-face delivery** 2. **Self directed learning using a paper based instructional modules and optional tutors,** 3. **Electronic delivery using a web based package.**

5. Training Tailored by Specialty and Context	**Selected training experiences for practitioners working in different settings and with different professional backgrounds and primarily designed to cater for the needs of a given group. Such programs need to be flexibly structured so that different components of a program can be tailored to groups' needs.**
6. Tiered options	**The training packages often comprise a series of modules. Modules will form self contained and independent learning units, which can articulate with other modules in the package. Modules are often categorised as** **a) core,** **b) optional or** **c) technical speciality**
7. Ongoing education and training	**It is an accepted educational principle that one-off or short term training experiences that lack options for reinforcement, consolidation of learning and options for ongoing training and support are likely to be less successful than more integrated training experiences. In order to be effective, training packages need to be backed up with access to consultancy/supervision as learners are putting their knowledge into action. Strategies and options to maximise the impact of the short training courses include:** • **Ongoing support systems** • **Consultancy service** • **Further integrated training experiences** • **Establishment of networks and mentoring schemes** • **Network newsletters and updates.**