
General Practice Victoria (GPV) is the State-Based Organisation (SBO) for Victorian divisions of general practice. It works at the state level to support Victorian divisions of general practice. Divisions build capacity in general practice, working at the local level towards a skilled, viable and effective general practice sector to improve the health and well-being of Victorian communities. Divisions provide the organisational interface between government and other stakeholders and general practice because they provide broad representation of general practice, have an effective role in GP education for systems' and practice change, and have a role in the coordination and provisions of vital services.

This submission is in response to the Australian Government consultation process to develop the next National Drug Strategy. Comments are based on GPV's past and current work with divisions of general practice, in addressing alcohol and drug (AOD) issues. We have framed our key messages specifically on: *Where efforts should be focussed over the coming five years to increase the capacity of the generalist health workforce to identify and respond to substance use problems?*

This submission has been discussed with the **Victorian Alcohol and Drug Association (VAADA)** and **the Australian Needle Exchange (ANEX)**. While this submission is not formally endorsed by these two organisations, GPV's comments were perceived as aligning with their viewpoints on where efforts should be focussed over the coming years.

Overall the National Drug Strategy needs to acknowledge and strengthen the roles, contribution and capacity of general practice, via divisions of general practice, in addressing AOD issues. The role of general practice is well established in the provision of AOD services, as GPs are usually the first point of contact with the health care system; patients expect to receive advice from GPs regarding matters affecting their health; GPs are in an ideal position to motivate patients around prevention and offer brief interventions as part of comprehensive, continuing and holistic care; and support and motivate patients requiring rehabilitation^{1,2,3,4}. The Australian Needle Exchange (ANEX) further pointed out to GPV and hence to the National Drug Strategy that for people with entrenched drug problems, the Needle Syringe Program is often the only point of contact with the health care system.

- ***GPV supports a coordinated integrated approach to addressing AOD issues, where the role and contribution of general practice is supported within a national integrated systematic strategy across providers, government, non-government and the community.***

GPV also recommends that the National Drug Strategy needs to recognise that the increase in chronic disease and the ageing population has meant that multiple morbidities are the most common reasons for presentation to primary care⁵. Within general practice three in ten people, and one in four Australians overall, have multi-morbidity, so that GPs and other health care professionals need to work with and treat people with 'Dual Diagnosis' or 'Comorbidities' (ie people with AOD problems and mental health

¹ Moriarty et al (2009) Opportunity for drug and other advice in the GP consultation, University of Otago.

² RACGP National Preventive & Community Medicine Committee (1998)

<http://www.racgp.org.au/AM/Template.cfm?Section=VicDacResources&Template=/CM/ContentDisplay.cfm&ContentID=32040>

³ <http://www.health.vic.gov.au/drugservices/downloads/blueprintdisc.pdf>

⁴ <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-publhlth-strateg-comorbidity-index.htm>

⁵ Fortin M, Lapointe L, Hudon C, Vanasse A. *Canadian Family Physician* 2005; 51: 244-245.

problems). The next National Drug Strategy must provide for this prevalence and these patterns of care⁶.

- ***GPV advocates that the National Drug Strategy needs to have a ‘Comorbidity Platform’ as comorbidity is becoming the norm and is a ‘best practice’ approach.***

Given that within Australia, general practice is experiencing substantial serious **workforce capacity challenges**, including recruitment, retention, quality assurance, supervision, and training, which are all crucial elements of a sustainable workforce, GPV believes that the National Drug Strategy needs to focus efforts on **four key priority areas**:

1. ***Facilitating general practitioner (GP) engagement with AOD services by a) continuing funding for the National Primary Health Care Comorbidity Network at the state level and b) to improve funding for dedicated AOD workers in the divisions Network locally***

Across Australia Commonwealth-funded successful models for addressing AOD issues are being implemented via the Australian General Practice Network to strengthen general practice’s capacity to identify and care for people with AOD issues. In 2009 the Australian Government Department of Health and Ageing via its *National Comorbidity Initiative*, funded the **Primary Health Care Comorbidity Network**⁷ to provide resources to improve the role of primary health care in the promotion, coordination and delivery of quality mental health and substance use programs at the local level via 26 general practice networks across Australia. Examples of successful models in Victoria are⁸:

- **Knox Division of General Practice** – conducts the *Linking General Practice with Eastern Mental Health/Drug and Alcohol Services: Supervised Clinical Attachments for GPs* project, which is designed to improve GP skills and knowledge in working with AOD services.
- **Albury Wodonga Regional GP Network** – conducts the *Border Comorbidity Collaboration* project which is designed to identify and promote the use of evidence-based screening tools, GP visual aids, AOD services, pathways of care for patients, and a platform for education for GPs and clinicians.

Anecdotal evidence suggests that the PHC Comorbidity Network⁹ has developed a high level of willingness and capacity within divisions of general practice to address AOD issues, and has improved the linkages and relationships between GPs and AOD services. Currently funding for the PHC Comorbidity Network ends March 2010, with no ongoing funding for AOD workers within divisions of general practice and no practice-level incentives for GPs and practice nurses to address AOD issues.

A Victorian division of general practice also pointed out that the current **Australian Better Health Initiative (ABHI)**¹⁰ is an example of a new model of integration that could be used to improve general practice infrastructure to develop AOD/Mental Health Clinics in general practice.

The development of effective linkages between general practice and the AOD sector is particularly important because GPs see 85% of the population in any given year. Therefore they are well placed to detect people’s difficulties with alcohol and drug issues. However GPs are reluctant to probe into such

⁶ Britt et al (2008). *Medical Journal of Australia*, 189(2): 72-77

⁷ <http://www.agpn.com.au/media-centre/newsletters/mental-health-newsletters/agpn-newsletter20/new-articles/primary-health-care-comorbidity-network>

⁸ <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-comorbidity-index.htm>

⁹ For further information contact GPV’s Comorbidity Consultant, Tung Le, t.le@gpv.org.au

¹⁰ For further information contact GPV’s ABHI Consultant Merrian Oliver-Weymouth, GPV Primary Care Integration Program, m.oliver-weymouth@gpv.org.au

issues because of patients' sensitivities about AOD use and GPs do not necessarily have the skills or access to expertise or referral networks required if they do uncover problems. Improving the linkages with specialist services will give GPs access to up-skilling and support and so will make them more likely to explore these issues. GPs also report that they need to be supported to link and work with AOD services, so that GPs can assist home detoxification, and in-hospital detoxification. Interestingly, the recent Victorian Parliament Drugs and Crime Prevention Committee's *Inquiry¹¹ into the misuse/abuse of Benzodiazepines and other Pharmaceutical drugs* put forward many recommendations relating to GPs, but failed to note the importance of increasing linkages between GPs and AOD services.

2. Increasing investment in general practice workforce training opportunities at the undergraduate, postgraduate, vocational education and continuous professional development level, to improve the effectiveness of general practice care for people with AOD issues

Evidence exists about the effectiveness of interventions and benefits of treatment that GPs and nurses can provide to people with AOD issues^{3,4,5,6}. These include: screening; assessment; information and advice; brief interventions for tobacco, alcohol and to a lesser extent cannabis; detoxification, including home detoxification; pharmacotherapy for tobacco, alcohol and opioid dependence; counselling, including motivational interviewing, and relapse prevention; referral to clinicians with specialist skills in drug and alcohol; and follow-up monitoring and care coordination.

The 2007 Victorian *Towards a New Blueprint for Alcohol And Other Drug (AOD) Treatment Services¹²* emphasised the need for increased attention within the education and training continuum of GP and PHC professionals. The 2008 review of AOD, mental health and comorbidity training opportunities in Australia¹³ also recommended that "...a national comorbidity workforce development strategy be developed that includes training as a key component" (p7). Similarly, a review of the delivery of alcohol and other drug brief interventions (AOD BIs) across Victorian primary care settings by Turning Point in 2008¹⁴ recommended that significant attention was needed to increase the uptake of AOD BI across the primary care sector. This should occur through workforce development, awareness raising activities, and system- and organisation-level support for AOD BI delivery. Current evidence¹⁵ and GPV's work with divisions also highlights that training packages and guidelines in isolation are not sufficient to facilitate change at the individual or organisational level.

The Australian Government Department of Health and Ageing National Comorbidity Initiative, has also funded the development of the **Can Do Initiative¹⁶: Managing Mental Health and Substance Use in General Practice** - a training package developed for general practice to meet the challenge of mental health and substance use with community health teams engaged in AOD service, community pharmacy and mental health service delivery. In Victoria, basic Comorbidity (AOD & MH) training also occurs via the **Victorian Dual Diagnosis Initiative**. Anecdotal evidence suggests that the Can-Do and Victorian Dual Diagnosis Initiatives have improved knowledge amongst general practice and community health teams and improved the linkages and relationships between GPs and AOD services. However, there is no ongoing funding for the delivery of these programs to general practice. In addition it is important to be able to offer local level training in general motivational interviewing which has been well received by GPs and practice nurses and is a good precursor to brief intervention training.

¹¹ <http://www.parliament.vic.gov.au/dcpc/inquiries/pharmaceuticalmisuse/>

¹² <http://www.health.vic.gov.au/drugservices/downloads/blueprintdisc.pdf>

¹³ Roche et al (2008) Alcohol & Other Drugs, Mental Health & Comorbidity: a training review, NCETA

¹⁴ http://www.turningpoint.org.au/library/Brief_Interventions_in_Primary_Care_Final_Report.pdf

¹⁵ Huang, N & Menzies, D (2005). Referral options for GPs in lifestyle interventions: a review of the evidence. Kinect Australia.

¹⁶ <http://www.agpn.com.au/media-centre/newsletters/mental-health-newsletters/agpn-newsletter20/new-articles/primary-health-care-comorbidity-network>

3. Increasing investment in practice level infrastructure, particularly e-health systems to support screening, recording, assessment and treatment within general practice of people with AOD issues

GPV's work with divisions has revealed that current medical software within general practice (eg Medical Director) does not enable patient AOD information to be identified and recorded. At a strategic level GPV and our national peak organisation, Australian General Practice Network AGPN), are well placed to bring these issues to the forefront through our work and collaboration with the National E-Health Transition Authority (NEHTA)¹⁷. At an operational level, this will require working with medical software vendors to ensure e-health systems support screening, recording, assessment and treatment of people with AOD issues. Many divisions currently have a detailed working knowledge of the medical software vendors and products that are in use by their GPs and will be able to advise on the best mechanisms to progress this work. Furthermore, GPV's work with divisions has highlighted that any system to define the practice population with AOD issues needs to be complemented with practice level methodologies (eg Australian Primary Care Collaboratives) and the use of tools (eg PEN Clinical Audit Tool) to support the GP's role in: identifying patients at risk of AOD abuse within general practice; delivering, coordinating or referring patients to evidence based services and managing their patients in conjunction with specialist services. The Australian Needle Exchange (ANEX) further pointed out to GPV and hence to the National Drug Strategy that Commonwealth (general practice) and State funded (AOD services) data collection systems need to be aligned via the work of NEHTA.

4. Developing models within general practice to address the reported increase in the misuse of the prescribing of pharmaceutical drugs by GPs to people with AOD issues

The 2007 Victorian Parliament Drugs and Crime Prevention Committee's *Inquiry into the misuse/abuse of Benzodiazepines and other Pharmaceutical drugs* clearly signalled that **the misuse of the prescribing of pharmaceutical drugs by GPs** is a key priority area.¹⁸ However, to date no formal models exist to address this issue. Informally organised models exist within Victoria, where local GPs have agreed to work together to standardise recommendations for prescribing pharmaceutical drugs to people with AOD issues. The Victorian Alcohol and Drug Association (VAADA) further emphasised the need to standardise prescribing of pharmaceutical drugs across all patients and not only people with AOD issues

GPV's consultation both within GPV and with Victorian divisions of general practice also highlighted several other key areas the National Drug Strategy needs to focus on, including:

- **Indigenous Communities:** GPV's work with indigenous communities¹⁹, strongly reinforces and suggests that the National Drug Strategy should include strategies, activities and funding which are relevant to the indigenous community, within the overall strategy. It is not appropriate to have a single separate drug strategy for the indigenous community, but to design interventions to meet the needs of local communities which vary greatly over Australia. The strategies and activities funded for the indigenous community should also be culturally appropriate and designed and delivered in partnership with local communities and indigenous organisations such as the National Aboriginal Community Controlled Health Organisations (NACCHO) and its affiliates.
- **Hepatitis C:** With a prevalence of approximately 1% and association with significant morbidity and mortality, chronic hepatitis C infection is an important public health issue for Australia. The vast majority (approximately 90%) of infections occur in injecting drug users. Despite the availability of effective treatment, reimbursed under the highly specialised drugs scheme (s100 schedule), only 1-2% of chronically infected people access HCV therapy. This disparity is partially explained by a hospital/specialist-centric model of care. In order to address this area of unmet need,

¹⁷ <http://www.nehta.gov.au/>

¹⁸ <http://www.parliament.vic.gov.au/dcpc/inquiries/pharmaceuticalmisuse/>

¹⁹ For further information contact Lesley Czulowski, GPV Program Consultant Nursing in General Practice and Aboriginal Health, l.czulowski@gpv.org.au

the development of a new model of care with a focus on service delivery in a primary care setting is urgently required. Community-based pharmacotherapy providers already provide services to those most likely to be at risk of contracting or being infected with hepatitis C. Therefore, these health care providers are ideally situated to provide hepatitis C treatment. GPV's experience through working within the Sexual Health, HIV and Hepatitis Education (sh³ed) Program²⁰ strongly supports this conclusion. In this context, GPV recommends that the next National Drug Strategy integrate the relevant aspects from the National Hepatitis C Strategy²¹ which is currently available in draft form at www.ashm.org.au.

- **People with AOD issues and potential service use patterns:** The National Drug Strategy needs to also focus on potential service use patterns by people with AOD issues such as: models to manage doctor-shopping by people with AOD issues; the misuse of prescription medicines by people with AOD issues; and the poor attendance by people with AOD issues
- **General Practice Payment Systems:** The National Drug Strategy needs to also recognise that the current Medicare Benefits Schedule (MBS) fee-for-service payment system penalises GPs for patient 'no-shows' and that there is a need for either new MBS items for non-face-to-face follow-up or dedicated GP sessions for people with AOD issues.

²⁰ For further information contact sh³ed program consultant, Soenke Tremper, s.tremper@gpv.org.au. Sh³ed is delivered by GPV in collaboration with the Alfred Hospital's Infectious Diseases Unit and the Australasian Society for HIV Medicine (ASHM).

²¹ <http://www.health.vic.gov.au/hiv aids/hepatitisc.pdf>