RACGP
Royal Australian College of General Practitioners

Alcohol and Other Drugs GP Education Program

Final report – Part B

Alcohol and Other Drugs GP Education Program
Final report – Part B

Disclaimer

The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular patients or circumstances. Nor is this publication exhaustive of the subject matter. Persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular circumstances when so doing. Compliance with any recommendations cannot of itself guarantee discharge of the duty of care owed to patients and others coming into contact with the health professional and the premises from which the health professional operates.

Accordingly, The Royal Australian College of General Practitioners Ltd (RACGP) and its employees and agents shall have no liability (including without limitation liability by reason of negligence) to any users of the information contained in this publication for any loss or damage (consequential or otherwise), cost or expense incurred or arising by reason of any person using or relying on the information contained in this publication and whether caused by reason of any error, negligent act, omission or misrepresentation in the information.

Recommended citation

The Royal Australian College of General Practitioners. Alcohol and Other Drugs GP Education Program. Final Report – Part B. East Melbourne, Vic: RACGP, 2023.

The Royal Australian College of General Practitioners Ltd
100 Wellington Parade
East Melbourne, Victoria 3002
Wurundjeri Country

Tel 03 8699 0414
Fax 03 8699 0400
www.racgp.org.au

ABN: 34 000 223 807
ISBN: 978-0-86906-615-7

Published February 2023

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

ID-3968

Contents

List of tables

List of figures

Program overview

Project title	Education Package and Training Grants for GPs in Alcohol and Drug Addiction
Organisation	The Royal Australian College of General Practitioners (RACGP)
Key RACGP personnel	Rob LoPresti, Chief Education Officer Tess Joseph, National Education Strategy and Development Manager Leigh Williams, AOD Program Lead Dr Bryce Brickley, AOD Program Evaluation Coordinator Lizette Fox-Miller, AOD Program Content Coordinator
Project contact	Leigh Williams, AOD Program Lead AOD@racgp.org.au (03) 8699 0531
Total funding	$7,991,200 (GST exclusive)

Project description	The Education Package and Training Grants for GPs in AOD aim to improve support and increase resources available to GPs to treat alcohol and other drug misuse. The RACGP will: • Develop and deliver a training package to strengthen a GP's capacity to address drug and alcohol addiction in their community. Training material will be made available to all members of the RACGP and access not to be restricted to participants or fellowed GPs. • Develop an Education Package that includes: 1. Face-to-face (subsequently live online) workshops 2. Online webinars 3. A professional development schema that provides options to explore specific elements of AOD dependence in detail. • Ensure training: – includes content on case studies demonstrating appropriate responses to a range of scenarios, such as healthcare of Aboriginal and Torres Strait Islander people and other at-risk groups – builds on existing education modules and information already developed by the Grantee as well as incorporation of new content – includes a scan of currently available resources to ensure there is no overlap with material being developed – includes an online database to direct users to particular programs that already exist – is guided by GPs and integrates advice from the Royal – Australasian College of Physicians Chapter of Addiction Medicine and RACGP Education Services, ensuring training packages comply with differing legislative requirements in each state – is contextualised to the locality of the GPs and the local services as well as issues in different communities and settings – has an emphasis on best practice in the care of individual population levels.

Project description (continued)	The training should incorporate the following elements: • be tailored to the unique needs of RACGP members • canvass a range of issues particular to members' local contexts (for example, rural and remote, and socially disadvantaged communities) • identify the precursors of drug and alcohol addiction • include content on the 5 A's (ask, assess, advise, assist and arrange) of brief intervention from the RACGP SNAP guide • provide detail on Opioid Substitution Therapy (OST) including relevant State and Territory legislation • outline key psychological and cultural issues • address contemporary issues in treatment • describe the effects of drug and alcohol addiction across the life cycle, including to family and community • discuss management of drug and alcohol withdrawal and treatment • assist with identification of at-risk patients • encourage collaboration with other services involved in care • outline the ongoing role for GPs in supporting treatment, recovery, relapse prevention • encourage the development of a checklist of appropriate contacts and resources in the GP's locality, including local referral options • include a course evaluation.
Project activities	The training grant delivery activities are: • develop Program Guidelines which outline funding allocation and incentives according to level of participant engagement. The Program Guidelines should also prioritise a GP's access to the training. Highest priority should be given to those doctors who are providing services to patient groups with the highest rates of drug and alcohol addiction, e.g. Aboriginal and Torres Strait Islander communities, areas of social disadvantage. These guidelines will be submitted to the Department for approval before commencement of the program • manage funding allocation and incentive payments as per the developed Program Guidelines to ensure: – The grant is only accessed once by each GP – The participant is incentivised according to their level of participation. • deliver training for up to 1100 members of the Grantee's organisation • deliver workshops at locations across the country giving focus to rural/remote areas of highest need which are customised to each communities'/region's priorities • if appropriate, collaborate with the other GP College in delivery of the training to their members in certain locations, such as remote communities, where GP numbers are low, and to ensure GPs can only access the grant once through either college • collaborate with Primary Health Networks (PHNs) who will have a role in the promotion and advertising of the training package to GPs and practices.

AOD Program staff/authors

Dr Bryce Brickley (PhD), Evaluation Coordinator

Lizette FoxMiller, Content Coordinator

Dr Paul Grinzi, Medical Educator

Tess Joseph, Head of Education Governance and Development

Susanna Kelaart, Project Officer

Emily Lindsay, Project Officer

Rob LoPresti, Chief Education Officer

Dr Shani Macaulay, Medical Educator

Mimi Naghoor, Project Officer

Dr Simon Slota-Kan, Medical Educator

Leigh Williams, Program Lead, AOD GP Education Program

AOD Program Reference Group

Dr Mary Belfrage, RACGP Aboriginal and Torres Strait Islander Health

Dr Chris Davis, Addiction Medicine Network

Dr Paul Grinzi, Addiction Medicine Network

Dr Rodney Omond, Rural Council

Dr Hester Wilson, Addiction Medicine Network

Acknowledgements

The RACGP acknowledges the contributions of the AOD GP Education Program Reference Group, Royal Australasian College of Physicians Chapter of Addiction Medicine, PHNs and AOD organisations who shaped the AOD Program's structure and promoted the program regionally.

The RACGP acknowledges the involvement of the diverse group of GPs and AOD professionals across the country who contributed to the delivery and continuous improvement of the AOD Program. Thank you for your role in the delivery of online workshops, small group discussion sessions, webinars and online modules as well as your mentor support to program participants.

The RACGP acknowledges the following staff members who contributed to the AOD Program's development and delivery:

- Alanna Burgess
- Dr Judith Culliver
- Dr Deborah Hawthorne
- Anna Irwin-Schutze
- Emily Jackman
- Louise Kerr
- Dr Ronald McCoy
- Lauren Peterson
- Stephen Razos
- Dr Mark Rowe
- Julie-Ann Undrill
- Dr Genevieve Yates

Thank you to Dr Craig Fry and Dr Fiona Clay for their advice and guidance of the AOD Program evaluation.

A special thank you to our AOD Program GP participants who took the opportunity to expand their AOD knowledge and skills, enabling them to better support their patients and improve health outcomes for patients in their local community.

Acronyms, initialisms and other shortened forms

5As	ask, assess, advise, assist and arrange
ACRRM	Australian College of Rural and Remote Medicine
ACT	Australian Capital Territory
AHPRA	Australian Health Practitioner Regulation Agency
AOD	alcohol and other drugs
AOD Program	Alcohol and Other Drugs GP Education Program
CPD	continuing professional development
DoH	Australian Government Department of Health and Aged Care
FAChAM	Fellowship of the Australasian Chapter of Addiction Medicine
FPS	Focussed Psychological Strategies
FTE	full-time equivalent
GP	general practitioner
IMG	international medical graduate
KPI	key performance indicator
LGBTQIA+	lesbian, gay, bisexual, transgender, queer, intersex, asexual and others
library	AOD GP Education Resource Library
NT	Northern Territory
NSW	New South Wales
MATOD	Medication-Assisted Treatment of Opioid Dependence
MMM/MM	Modified Monash Model/Monash Model
OECD	Organisation for Economic Co-Operation and Development
PHN	Primary Health Network
PLP	personalised learning plan
program	the AOD Program
Project ECHO	Project ECHO (Extension for Community Healthcare Outcomes)
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
SA	South Australia
SD	standard deviation
SUD	substance use disorder
WA	Western Australia
WONCA	World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians

Executive summary

The Department of Health and Aged Care (DoH) commissioned The Royal Australian College of General Practitioners (RACGP) Alcohol and Other Drugs GP Education Program (the program/ AOD Program) between 2019 and 2023. Despite being delivered through the global pandemic, the program reached 3042 general practitioners (GPs), representing approximately 10% of the national full-time equivalent (FTE) GP workforce. Of the GPs who participated, a higher proportion were female and from rural and remote regions.

A flexible grant contract enabled the RACGP to design and deliver a high-quality and positive education experience for GPs. The AOD Program enhanced GP participants' confidence, skills and knowledge across a range of substances and consultation components.

The success of this program would not be possible without the commitment from GP participants; contributions from highly skilled stakeholders across the country in the program design; and the large group of multidisciplinary AOD experts, led by GPs, who were highly engaged throughout the program.

Program design and delivery

The program approach was innovative, peer designed and delivered 'by GPs for GPs' within the paradigm of a strengths-based approach to GP education and AOD care. The comprehensive program offered choice and flexibility, by modes (online, live, asynchronous), learning approach (online modules, mentorship, case-based discussions) and progression through tiers of scaffolded education levels (foundational through to advanced AOD skills). Participants were empowered to curate their own educational experience in accordance with their needs and preferences. Approximately half of the total grant funding was returned to the GP community through remuneration for completion of two of the five main program options. Remuneration was an essential component of successful GP engagement, in the context of the global pandemic, GP overwork and financial insecurity.

Program evaluation

A rigorous mixed methods program evaluation was conducted. Primary outcome data were collected in questionnaires embedded into the program and completed before and after Treatment Skills training. Multiple data sources were used, including GP participants, facilitators, mentors and AOD expert trainers, and program staff. Data were collected through application forms and other artefacts, such as activity logbooks, personalised learning plans, participant reflections and membership data. Qualitative evaluation involved post-program focus group interviews with GP participants, mentors and AOD expert trainers. Findings were synthesised to address primary evaluation questions and an evaluation framework that informed program relevance, coherence, effectiveness, efficiency, impact and sustainability.

Key findings

GP participants were highly satisfied with the program. Nearly all participants reported that the program met their needs and that the included content and materials were highly relevant to their clinical practice – a testament to the 'by GPs for GPs' approach. Significant increases in GP confidence were found post-training across each component of the 5As framework for behavioural change – to 'ask', 'assess', 'advise', 'assist' and 'arrange' – with the most significant increase occurring in confidence to 'assist' patients. Significant increases were also observed in GP participants' confidence to treat various substances, including alcohol, cannabis, benzodiazepines, stimulants, heroin and illicit/diverted prescribed opioids, legally prescribed opioids and other drugs. The most significant increases in confidence were seen with the treatment of patients using stimulants, heroin and/or illicit/diverted prescribed opioids. The program evaluation also found increased GP knowledge, skills and self-efficacy, and reduced patient stigmatisation, demonstrating that the program reduced common barriers to GP-led AOD care.

The RACGP used its relationships within general practice and the wider medical profession to design and deliver an effective and efficient continuing professional development (CPD) program. The AOD Program demonstrates the RACGP's commitment to its members and ability to understand the diverse needs of GPs. The design of the AOD Program is a practical model to implement for future AOD GP education and CPD, and GP education more broadly.

Recommendations

The delivery and evaluation of this program identified several critical recommendations for DoH's intervention.

1. Engage GPs more frequently on DoH's established priority issues, using GPs' understanding of community healthcare needs as generalists at the 'coal face', as well as their strengths in whole-person care, chronic disease management, and management of comorbid physical, psychological and social (biopsychosocial) factors.
2. Expand grant funding opportunities that support GP education, enabling influential GP peer engagement, flexibility of design, responsiveness to individual and environmental needs, increased relevance and efficiency.
3. Increase funding for projects aimed to improve integration between GPs and other healthcare specialists to increase knowledge transfer, clinical networking and support patient outcomes in areas of complex need. The AOD Connect: Project Extension for Community Healthcare Outcomes (ECHO) model should be considered.
4. Support both research and policy development targeting the pivotal role of general practice, enabling optimal AOD care and healthcare for those with complex medical needs in general practice, increasingly recognised as an escalating national and international priority having been exacerbated by the COVID-19 pandemic.
5. Advocate for the essential role of GPs in the AOD workforce, promoting the continuing RACGP AOD CPD education opportunities and the available resources as useful tools for not just AOD-related medicine but a range of complex medical issues in higher-risk patient populations.

Program sustainability

The AOD GP Education Resource library (the library) is the feature legacy item of the AOD Program. All the tools and resources developed over the life of the program have been made available in the library as a means of providing ongoing support for GPs treating AOD and ensuring that skills learned are put into clinical practice. The library is key to sustainability of the AOD education delivered by the program and is freely available on the RACGP website. This site will be regularly maintained and updated after the program has concluded as part of the Education Strategy and Development (ESD) team's ongoing responsibilities. Features of the site include:

- AOD resource list – a searchable list of over 180 links to relevant AOD tools and resources. Resources are also grouped into 27 AOD-specific topics, so that GPs can quickly access resources on key themes such as 'harm minimisation' or 'trauma-informed care'
- access to AOD training – quick links to AOD courses and webinars developed over the life of the program, including links to state-based training and national AOD training courses
- whole-of-practice resources – resources designed for all practice staff in the primary care setting, outlining ways to facilitate best practice outcomes for patients who use AOD. This includes reception staff, practice managers, nursing/clinical staff, and GP leaders/supervisors and team-based learning.

The library stores an expansive collection of AOD education resources that were developed during the program (for example, case study videos), and directs GPs to AOD guidelines and further education.

Overall, the site is a comprehensive database for GPs and general practice teams to support the care for patients who use AOD.

- It is as a resource depository for experienced AOD professionals and AOD program participants. It provides easy access to up-to-date clinical resources that GPs will find useful in a consult, in between consults, or as part of their ongoing professional development. While the landing page provides content that can be accessed by anyone, RACGP members will have access to a wider range of educational content, including best-practice videos developed by the RACGP during the AOD program. This is in response to program participants requesting easy web-based access to the program content so that they can revisit best-practice footage and strategies prior to implementing with their patients.
- The library also provides information for less experienced GPs who find it challenging to support patients who use AOD. It addresses common 'pain points' experienced by GPs and outlines recommended approaches, available resources and possible educational modules for their professional development. It has educational content that GPs can undertake on their own, with a mentor/supervisor, or in a small group learning environment.

Notable program outputs

The program produced the following publications.

- Peer-reviewed academic manuscripts
  - Macaulay S, Grinzi P, Slota-Kan S. Engaging patients who use alcohol and other drugs – A practical approach. Aust J Gen Pract (accepted June 2022).
  - Macaulay S, Grinzi P, Slota-Kan S. GP-led alcohol and other drugs withdrawal: Supporting patient choice, safety and success. Aust J Gen Pract (under review, submitted September 2022).
  - Brickley B, Fox Miller L, Grinzi P, Williams L, Lindsay E, Macaulay S, Slota-Kan S. Qualitative evaluation: Impact of Australian general practice alcohol and other drugs education. Br J Gen Pract 2023. DOI: 10.3399/BJGPO.2022.0181.
- International peer-reviewed conference
  - Grinzi P, Macaulay S, Slota-Kan S. By GPs for GPs: Designing a successful Australian alcohol and other drugs continuing professional development program. WONCA World Conference 2023, Sydney, New South Wales (submitted December 2022).
- National peer-reviewed conference
  - Home-based low-risk alcohol withdrawal: A practical workshop for GPs. A practical skills-based workshop, GP22, November 2022, Melbourne, Victoria.
  - The Alcohol and Other Drugs GP Education Program. An evaluation findings poster presentation, GP22, November 2022, Melbourne, Victoria.
- Advocacy
  - RACGP submission on the National Alcohol and Other Drug Workforce Development Strategy
  - The program informed the development of RACGP education framework in 2021.

Navigating this report

This report is a final program report that includes evaluation.

- It commences with a description of the AOD Program background, context and management (including design, delivery and risk management).
- The evaluation methodology and method section describes the evaluation framework, key evaluation questions, design, method and ethical considerations.
- The results section outlines the progress towards the DoH's key performance indicators (KPIs) and findings of the program's primary outcomes: confidence to treat, treatment barriers and the exploration of participant sub-groups.
- All other findings and data are in the report appendices.
  - Appendices A to H contain evaluation findings of the key program pathways, including raw data and six- to 12-month follow-up data.
  - Appendix I contains data from the staff evaluation.

Data from the appendices, the results section, and information relating to the program design and delivery have been synthesised to address the evaluation framework, and inform the discussion, recommendations and conclusion.

The RACGP Alcohol and Other Drugs GP Education Program

The $7.9 million Education Package and Training Grants for GPs in Drug and Alcohol Addiction was funded by the Australian Government Department of Health and Aged Care (DoH). The primary aim of this DoH grant was to improve support and increase available resources to GPs to treat alcohol and drug addiction.

The RACGP developed and delivered nationally the Alcohol and Other Drugs GP Education Program (AOD Program) between 2019 and 2023. The design and delivery of the program sought to address the DoH funding objectives and the needs of the college's GP members. The RACGP strives for all communities in Australia to have access to well-trained, competent GPs who deliver high-quality evidence-based care.[1] We support our members with CPD opportunities, tools and resources that GPs need to thrive and deliver high-quality care.[1] In support of this, the RACGP employed best practice program design and delivery principles, as well as robust data collection and analysis methods, to monitor and evaluate program performance. This report informs an evidence base for development of future GP education and training programs. Key recommendations on GP education, policy and practice have been identified through the program evaluation and are included.

Background

GPs are specialists in generalism; they provide care throughout a patient's life, including acute care, chronic disease management and preventive care. GPs are positioned at the front line of the Australian healthcare system and are one of the most highly accessed healthcare professionals.[2] Most GPs regularly see patients who use AOD. Substance use is highly prevalent in Australia and is a key risk factor for preventable disease and death.[2,3] The risks and harms of substance use include dependence, injury (to self and others), health problems and social harms such as violence, crime, financial difficulties and homelessness.[4] Support for GPs to optimise care for patients who are impacted by AOD use and may have complex needs is a national priority.

Many Australians have low health literacy and are not aware of the impact of their substance use on their health.[5] Multiple physical or mental comorbidities often need to be managed alongside substance use and are exacerbated at higher levels of substance use.[6] Alcohol is a legal and socially acceptable substance in Australia, yet it is the psychoactive substance that causes the most disability and death.[7] The current Australian guidelines suggest that for most adults, drinking no more than 10 standard drinks in a week will reduce the risk of dying or disability from an alcohol-related illness to 1% – a risk that may be considered quite high in other areas of medical decision making. Alcohol has a causal relationship with poor mental health, the most common patient presentation in general practice.[8] Targeted health interventions delivered by GPs can increase health literacy and reduce AOD use and its associated harms.[9]

GPs are well positioned to deliver essential behavioural interventions that support patients to minimise substance-related harms, reduce their AOD use and live healthier lifestyles. However, initiating a sensitive and impactful conversation with a patient about their substance use within a consultation can be challenging.[10] Many GPs lack the confidence to deliver AOD-related interventions and facilitate behavioural change in patients within the time constraints of the general practice setting.[11–13] Limited access for patients to AOD specialist care and support services, a lack of GP knowledge and attitudes such as perceptions of the GP's role to treat AOD and community stigmatisation of patients using AOD, all further impact the care delivered by GPs.[14,15]

Prior to the AOD Program, there was a lack of available AOD education and professional development programs for GPs. Typically, AOD

education had focused on clinical interventions for individual substances, with resources and clinical guidance better suited to those working within specialist AOD services. These resources have limited applicability and relevance to the Australian general practice setting.[6,16,17] Furthermore, there are few practical strategies for GPs to incorporate AOD patient clinical care in general practice. There was an identified need for GP AOD training to promote a 'whole-person care' approach, which acknowledges the complex environmental, social and individual determinants of AOD use. This approach recognises that treatment plans are tailored to a patient's individual needs and circumstances and are delivered over time to enable sustained behavioural change by patients.

The program was designed with the understanding that GP-led AOD care is complex, individual and influenced by the clinical setting of general practice. AOD care can be more effectively managed in general practice by increasing GP confidence, skills, knowledge and improved connection to those with AOD expertise.[18] Improved GP confidence equips GPs to open discussions about AOD use with their patients, implement best practice approaches, minimise harm and implement safer prescribing practices. An increased national capacity of GP-led AOD care will improve patient and community outcomes, improve GP satisfaction in caring for patients with AOD-related issues and ensure the workforce addressing AOD is more evenly distributed, less reliant on AOD specialist services and more cost effective.

Organisational context

The AOD Program was managed by the Education Governance and Development team, within RACGP Education Services. The team comprises GP medical educators, education advisers, learning designers, content developers, and a range of project and program staff. A dedicated group of additional staff was recruited to manage the design, delivery and evaluation of the program.

Embedding the AOD Program within an effective team experienced in educational strategy, educational design and project delivery minimised risks to the program, given program staff were GP education experts. The organisational context optimised the design and delivery of the program, with existing management and governance structures, operational frameworks, procedures and networks. Program contributors within the RACGP included Legal Services, Procurement Services, Finance Services, Media and Marketing, Communications, IT project office, Member Services, Advocacy Unit, National Events, state faculties, Specific Interests faculty, Rural faculty, Aboriginal and Torres Strait Islander Health faculty, and National Evaluation and Quality.

Program governance

The RACGP Chief Education Officer, Head of Education Governance and Development, and Program Lead provided oversight of the program. An AOD Reference Group was established in May 2019 to provide user and AOD expert advice into the Program. The AOD Reference Group included GPs with a specific interest in AOD, who represented a diverse range of GP needs and included representatives from:

- RACGP Education Services
- RACGP Specific Interests, including Addiction Medicine, Custodial Health, and Pain Management networks
- RACGP Rural
- RACGP Aboriginal and Torres Strait Islander Health.

The AOD Reference Group provided advice and recommendations throughout the life of the program. On eight occasions, the reference group engaged in structured meetings with the RACGP Education Governance and Development team between May 2019 and July 2022, and provided advice on program aims, product specifications and planning processes.

Grant contract and stakeholder involvement

To assist with the RACGP's grant negotiation process with the DoH, the RACGP engaged GP representatives, GP medical educators and AOD subject matter experts to provide advice on the potential scope of works to be completed through the funding. The consultation of stakeholders led

to a finalised grant contract with a clear purpose, intended outcomes and scope. Importantly, the contract's specified deliverables were sufficiently flexible to enable the RACGP to act on the advice provided by GPs and subject matter experts. This meant that the program was able to pivot during the global pandemic, transitioning all educational modalities to online options. This flexibility contributed to the success of the program because it permitted the refinement of the content, increased the accessibility of the education, and enabled the program to respond to the emerging needs of GP participants.

Draft program guidelines and an education schema were developed in 2019 that outlined a range of learning experiences and educational options the RACGP was considering for the program. A national consultation process was conducted between July and September 2019 to obtain feedback from potential users (GPs) and associated organisations about GP learning needs and preferences. Specifically, the Royal Australasian College of Physicians (RACP) Chapter of Addiction Medicine was consulted, as required by the DoH contract. The consultation enabled identification of training presenters and facilitators from each state and territory, and provided other AOD education providers (PHNs, regional training organisations and AOD specialist services) an opportunity to share their experiences and learnings from providing AOD education.

Over 60 organisations were invited to provide feedback, with responses received from a diverse range of individuals and organisations. The consultation engaged multiple stakeholders within organisations and snowballed through contacts. A total of 76 responses were received via an online consultation form. This feedback informed the program's overall structure, product specification and educational design for each program pathway, approach to delivery, participant recruitment and AOD expert trainer engagement.

Program aims and design

The RACGP set five key objectives to address the deliverables outlined in the DoH contract:

1. Raise awareness of AOD use and the resources available to GPs
2. Deliver a high-quality educational experience for RACGP members
3. Foster AOD communities of practice and connections between GPs
4. Improve GPs' ability to support patients at higher risk for problematic AOD use
5. Improve GPs' confidence to deliver whole-person care for patients who use AOD

The program design was informed by:

- DoH key performance indicators, objectives and activities
- review of available clinical guidelines and practical AOD resources
- review of available AOD education to avoid duplication of education (a DoH specification)
- RACGP strategic objectives
- RACGP educational framework
- extensive stakeholder consultation, including the Addiction Medicine Chapter of RACP.

The program focused on providing a comprehensive approach to clinical assessment and treatment, applicable to a broad range of scenarios and complexity, moving away from substance-specific education. The program design and individual product specifications:

- were developed and delivered 'by GPs for GPs'
- were based on a whole-person care approach, using GPs' strengths in chronic disease management, and management of comorbid physical, psychological and social (biopsychosocial) factors

- promoted the use of the 5As (ask, assess, advise, assist, arrange) framework[19] to structure patient consultations (a DoH specification). The 5As framework is key in the provision of preventive care and is a structured approach for behaviour change consultations[20]
- were flexible and tailored to meet the needs of GPs in a range of settings, communities, career stages, patient engagement and diverse learning preferences
- were comprehensive, covering all requirements outlined in the DoH grant to improve GP confidence to engage patients in preventive healthcare, assess patients' readiness for change, screen for AOD use, deliver brief interventions, employ harm-minimisation strategies, conduct home-based withdrawals, treat mild to moderate substance use and know when to refer to AOD specialist services
- were reflective, using a quality management process to collect and monitor performance to sustain participant engagement and optimise the educational outcomes for GPs
- remunerated GPs on completion of Treatment and Advanced Skills training.

Members accessed the program via five central pathways to cater for different learning needs, preferences and existing AOD knowledge and skills and experience (Figure 1).

- Essential Skills, Treatment Skills and Advanced Skills (Pathways 1, 2 and 3 respectively) offered education that catered for:
  - different levels of knowledge or skill, with Essential Skills providing an introduction into AOD care within Australian general practice, through to Advanced Skills, which assumed a stronger level of specialist AOD knowledge and experience upon entry to training
  - diverse learning needs (using a variety of teaching and learning methodologies)
  - a variety of learning preferences (offering choice in learning experiences), for example Treatment Skills Training was offered as two products: a self-directed online course and as a live online workshop format.
- AOD Connect: Project ECHO (Pathway 4) provided an AOD case-based discussion forum for GPs to connect weekly with their colleagues and AOD experts in a community of practice format.
- High-Risk Groups (Pathway 5) commenced development in 2021 and was launched in 2022, following extension of the program delivery from June 2021 to December 2022. The RACGP identified an opportunity to develop whole-person care education for patients at higher risk of harm associated with substance use, which was a DoH contract specification. Four online AOD learning modules were developed on:
  - supporting behaviour change for patients at higher risk
  - supporting people who have experienced trauma
  - supporting Aboriginal and Torres Strait Islander peoples
  - supporting people in contact with the criminal justice system.

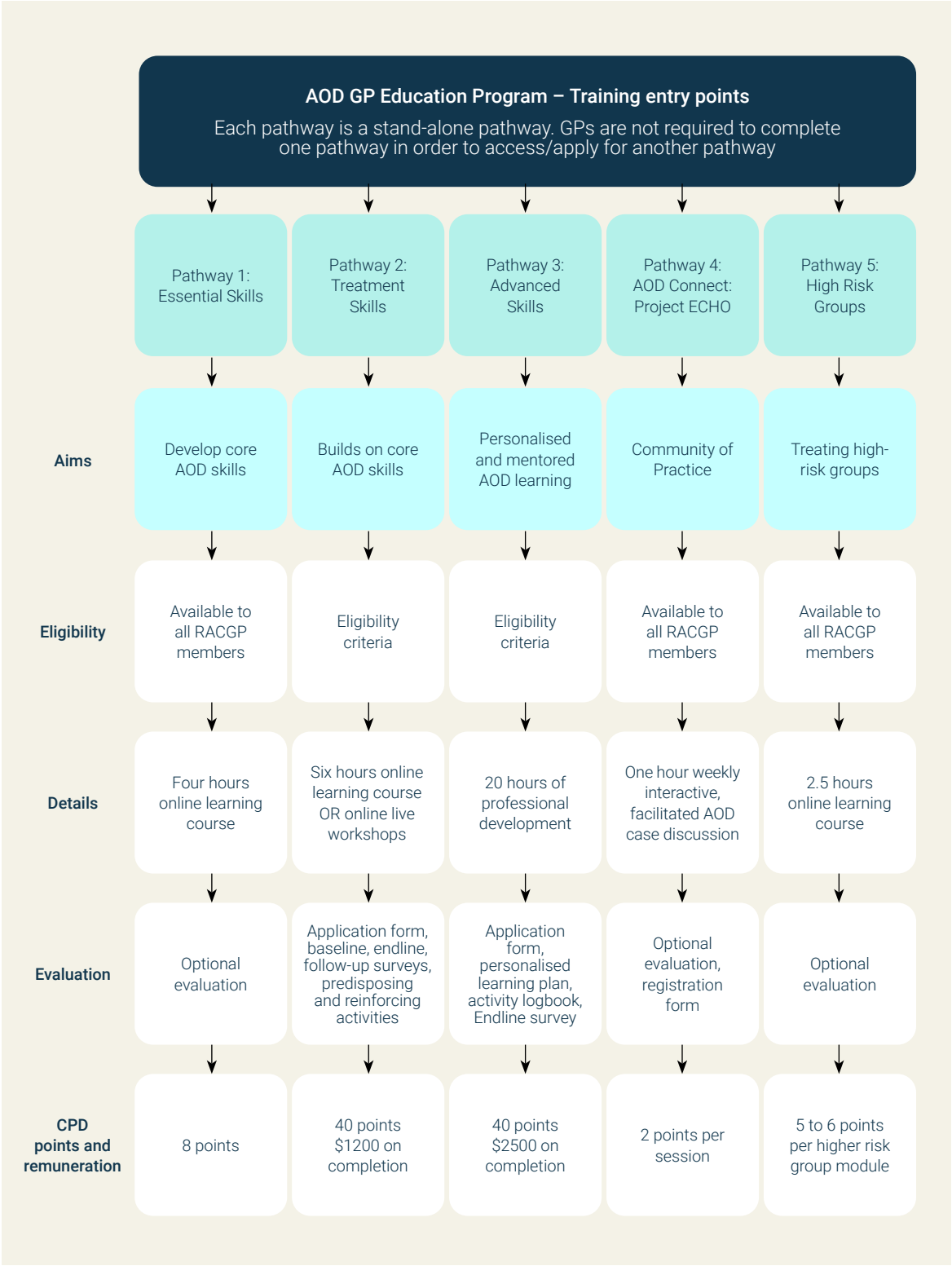

Figure 1. Alcohol and Other Drugs GP Education Program schema

Product specification

All the program's educational products were developed using the RACGP's CPD framework for the 2020–22 triennium. The application of the framework involved a needs analysis, development of learning outcomes and product description. The product description outlined the educational design, implementation schedule, participant assessment and evaluation framework for that product. Participants who completed an educational product received a certificate of completion and allocation of CPD points associated with that product.

Essential Skills (Pathway 1), Treatment Skills (Pathway 2) and High-Risk Groups (Pathway 5) used the RACGP's learning management system (LMS), *gplearning*, for delivery of educational resources and coursework.

Designing for participant remuneration

A grant payment was provided to GP participants who completed Treatment Skills (Pathway 2) and Advanced Skills (Pathway 3) training. To access one of the remunerated training pathways, members were required to apply to the program. Application assessment criteria, terms and conditions, an online application platform and tracking system were developed for these two pathways. A grant payment portal was implemented to track GP payments. These measures ensured participant recruitment aligned with DoH specifications, which included that:

- priority access was provided to GPs in rural and remote areas (Monash Model [MM] 3–7) and those treating high-risk populations for AOD use
- members could only complete a product in an incentivised pathway once
- GP participants could only access one AOD Program (either the RACGP or ACRRM) with registration information shared monthly with the ACRRM.

AOD online database

An AOD online database, a DoH specification, was launched in 2019 and made accessible via the RACGP's AOD GP Education Program website. This database linked to other AOD GP education nationally, including state-based opioid pharmacotherapy courses, and was continually updated throughout the program. It was transformed in July 2022 into the AOD GP Education Resource Library (the library), as the one of the legacy products for the program. The library is freely accessed by any person with an interest in supporting treatment of AOD use in primary care, and features content specifically designed for whole-of-practice use.

Program content development

The AOD Program was developed to align with the DoH contract objectives and activities. A multi-phased approach was used to further determine the needs and priorities of RACGP members while ensuring the DoH's funding priorities were addressed. An audit of the available AOD education and a review of relevant literature was conducted. A draft program schema and guidelines were developed in consultation with the AOD Program reference group and circulated to stakeholders in a comprehensive stakeholder engagement process, as outlined above. The content and education approach included in each program option is summarised in Table 1 and Table 2.

Table 1. Program options and included content

Program option	Content outline
Essential Skills	• AOD use in Australia • Ask – how to screen patients • Assess – AOD use, dependence, stage of change, comprehensive motivational interviewing techniques • Advise – brief interventions, harm minimisation, motivational interviewing • How and when to Arrange – AOD service information, triage and referral • List of foundational AOD resources and links (for example, 5As framework webinar)
Treatment Skills	• Build on essential core skills • Ask – about AOD use • Assess – AOD use and patient assessment, readiness for change and how to employ the processes of motivational interviewing • Advise – on harm minimisation • Assist with – creating treatment plans for patients – GP-managed withdrawal and relapse prevention – GP-led home alcohol withdrawal and relapse prevention – pharmacotherapy for opioid use disorders – GP self-care and safety • Arrange – referral pathways – GP-review with ongoing longitudinal care
Advanced Skills	• Individualised and GP participant-led mentor-assisted training • Participants designed and implemented their own personalised learning plan and set their own learning outcomes • Participants were supported by an AOD mentor. • A series of six 90-minute on-demand 'Advanced Skills webinars' were delivered. Topics included: – the inherited pain patient – how to help patients who have turned to alcohol at a time of crisis – GP burnout prevention, containment and boundaries – substance use lapse and relapse – the changing role of pharmacotherapy, the bigger picture and depot buprenorphine – recreational drug use • AOD use in pregnancy
AOD Connect: Project ECHO	• GP participant-led weekly case-based discussion • Virtual AOD community of practice • Sessions were facilitated by a panel of AOD educators from general practice and other medical specialties
High-Risk Groups	• Facilitating behaviour change: – theories and models – putting motivational interviewing into practice

Table continued on the next page.

Program option	Content outline
High-Risk Groups	• Trauma and AOD use – principles of trauma-informed care – working with specific groups – trauma and general practice
	• Supporting Aboriginal and Torres Strait Islander peoples who use AOD – exploring cultural bias and cultural competence and how this affects motivational interviewing and brief intervention – using lived experience and a strengths-based approach
	• Supporting people in contact with the criminal justice system who use AOD – role of primary care and main factors effecting health, motivational interviewing, stage of change and AOD use on prison release – checklist of key factors for the health and care planning of individuals at prison release
AOD library	• Synthesis of content from all program options • Resources for whole-of-practice team

Table 2. Educational approaches and program options aligning with the DoH grant requirements and RACGP curriculum

	Essential Skills	Treatment Skills	Advanced Skills	AOD Connect: Project ECHO	High-Risk Groups	AOD library
Face-to-face/live online format		✓		✓		
Online webinars			✓			✓
Case studies incorporated appropriate responses to high-risk group populations	✓	✓	✓	✓	✓	✓
Contextualised to locality of GPs			✓	✓		
Emphasis on best practice in the care of individual population levels			✓	✓	✓	✓
Canvass a range of issues particular to members' local contexts (for example, rural and remote, and socially disadvantaged communities)			✓	✓	✓	✓
Identify the precursors of drug and alcohol addiction	✓	✓	✓	✓	✓	✓
Include content on the 5As framework for brief interventions from the RACGP SNAP guide	✓	✓	✓	✓	✓	✓
Address universal approaches to AOD assessment and management, applicable across all AOD substance classes	✓	✓	✓	✓	✓	✓
Provide detail on opioid substitution therapy, including relevant state and territory legislation		✓	✓	✓	✓	✓
Outline key psychological and cultural issues	✓	✓	✓	✓	✓	✓
Address contemporary issues in treatment	✓	✓	✓	✓	✓	✓

Table continued on the next page.

	Essential Skills	Treatment Skills	Advanced Skills	AOD Connect: Project ECHO	High-Risk Groups	AOD library
Describe the effects of drug and alcohol addiction across the life cycle, including to family and community	✓	✓	✓	✓	✓	✓
Encourage collaboration with other services involved in care	✓	✓	✓	✓	✓	✓
Outline the ongoing role for GPs in supporting treatment, recovery, release prevention	✓	✓	✓	✓	✓	✓
Encourage the development of a checklist of appropriate contacts and resources in the GP's locality, including local referral options	✓	✓	✓	✓	✓	✓

Program delivery

Delivery timeline and phases

The program delivery project management phases are shown in Figure 2.

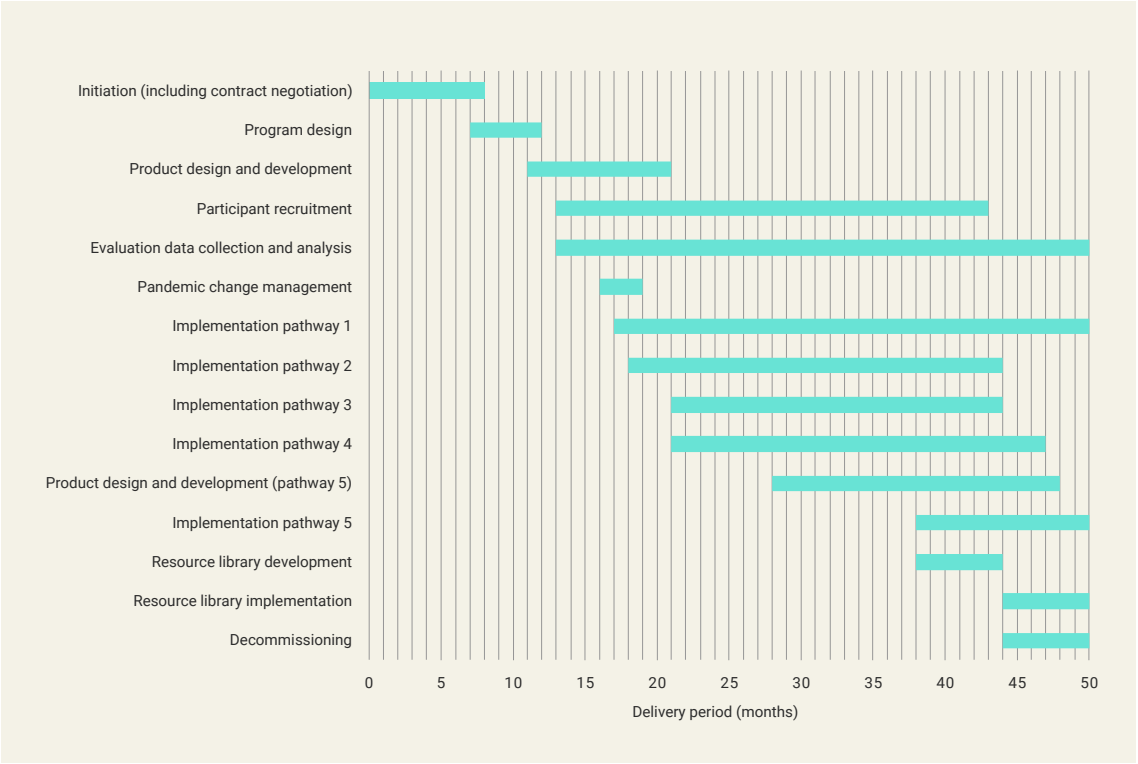

Figure 2. AOD GP Education Program project management phases, November 2018 to December 2022

The program's key delivery milestones are shown in Figure 3.

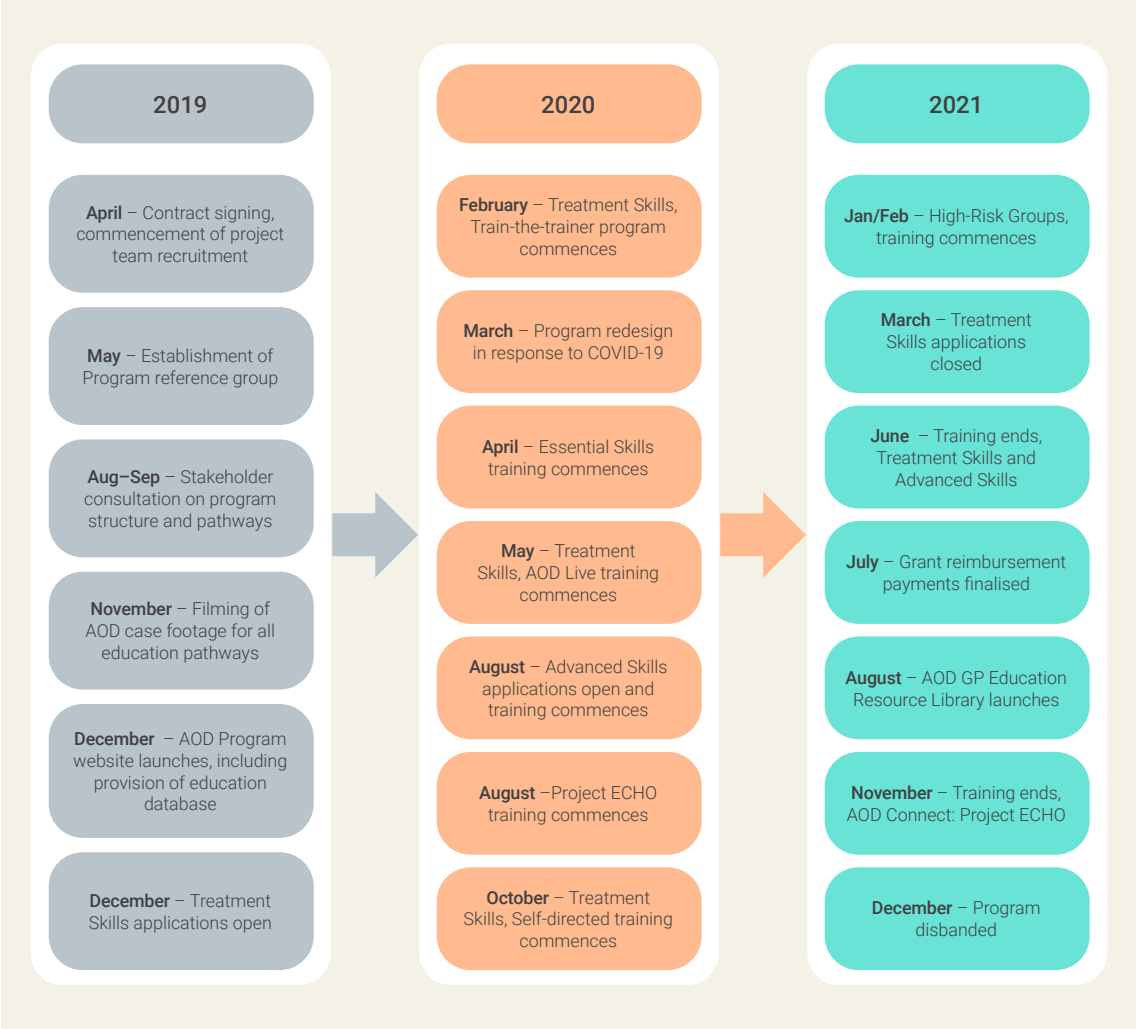

Figure 3. Program key delivery milestones

AOD expert trainer engagement and onboarding

The RACGP's stakeholder engagement activity identified a pool of potential GP and multidisciplinary educators and AOD subject matter experts across the country. As educational pathways were rolled out, the size and scope of the pool of AOD experts were enhanced through the maintenance of an expression of interest form on the AOD Program website. These AOD experts were trained by the RACGP and contributed to the program as a presenter, facilitator, mentor or subject matter expert. The largest pathway to use external AOD expert trainers was Advanced Skills (Pathway 3) with 210 individuals providing personalised mentor support to program participants. In total, 258 multidisciplinary experts contributed to the development and delivery of the program's educational products, of which 148 were actively practising GPs. These AOD expert trainers were able to record their contributions as part of their CPD for the 2020–22 triennium.

The available AOD expertise was drawn upon to film clinical case-related footage, develop educational content and deliver educational products. Over 40 experts received training by the RACGP as part of the onboarding process to deliver face-to-face or online workshops (Pathway 2) or facilitate the RACGP's online case discussion series (Pathway 4). Over 25 of this team contributed to the delivery of more than one program pathway. This core group of trained experts were significant contributors in ensuring the program was peer delivered 'by GPs for GPs', optimising relevance to the general practice setting, and they were key informants for quality assurance activities.

The RACGP's onboarding training processes for AOD expert trainers was influenced by the pandemic. It affected the capacity of AOD experts to assist in the delivery of the program, which led to a combination of risks and opportunities for the program. The RACGP onboarding program was revised and conducted online, which allowed AOD experts to be recruited and trained across the country rather than by state and/or territory. The online onboarding process occurred in a similar way to the learning experiences of participants completing the main education offerings in the program. The national approach to recruiting experts supported the program delivery but resulted in challenges for AOD expert trainers to assist program participants to address state-based specific guidelines and referral processes.

Participant recruitment

The RACGP set internal completion targets (for internal use only), well above DoH measures, to ensure many GPs were able to access training and to inform AOD Program planning and budgeting. To address these targets, the RACGP used a comprehensive marketing and media approach for participant recruitment, drawing upon the range of mechanisms available within the RACGP to reach and engage members. Targeted and segmented marketing was undertaken to ensure program targets were addressed and access was provided in accordance with the program's eligibility criteria. Marketing campaigns across different platforms were delivered to align with launch dates for program pathways. Recruitment strategies included:

- social media (Facebook, Instagram, LinkedIn, Twitter)

- In Practice (curated news magazine for RACGP members) and *Australian Journal of General Practice* (*AJGP*) advertisements
- *newsGP* articles highlighting AOD use, particularly in light of the pandemic
  - Why we should care about substance use amid a pandemic
  - Has COVID-19 changed Australia's alcohol consumption?
  - New alcohol and other drugs resource for GPs
- RACGP website web tiles, website banners, Outlook signature banners, messages on hold
- RACGP Faculty newsletters, electronic mail
- media releases.

The RACGP collaborated with PHNs to promote the program to GPs in local community settings, as outlined in the DoH contract. The RACGP provided PHNs with regular reports and updates, an onboarding webinar, media kits and quarterly registration information in their state/territory.

Word-of-mouth, through stakeholder engagement, ongoing presenter and participant feedback significantly expanded the program reach. Applications increased as more GPs completed training and recommended it to colleagues.

Change management: The impact of COVID-19

The flexibility of the program contract allowed the RACGP to rapidly adapt and thrive in response to the challenges that presented with the COVID-19 pandemic. With face-to-face education impossible, training was adapted to live online workshops (using Zoom videoconferencing). The focus of training shifted to developing online communities of practice. The following changes were made to the program design during the pandemic:

- Treatment Skills (Pathway 2) full-day workshops were converted into (online) Zoom workshops, delivered at three 90-minute sessions over three consecutive weeks
- AOD Connect: Project ECHO (Pathway 3), originally intended as a reimbursed pathway for rural members, was no longer reimbursed, and was made freely available to all RACGP members as a means of developing peer-supportive communities of practice during the pandemic
- rural travel grants were no longer required to support rural GP workshop participation.

Face-to-face workshops were cancelled nationally, reducing the need for presenter and participant travel, and removing the risk of COVID spread within the GP workforce. Delivery costs were also reduced due to the absence of venue and travel expenditure. Changes necessitated by the pandemic came with both benefits and opportunities.

- Reach – efficiencies gained from the absence of face-to-face learning enabled the RACGP to offer more funded training places. Approximately 2500 GPs completed Treatment Skills training, well exceeding the RACGP's original allocation of 1800 training places.
- Access – all eligible members had access to several training pathways and learning experiences, regardless of their place of residence, which was particularly beneficial for those in rural and remote practice.
- Quality – the program used a strong, cohesive and multidisciplinary network of presenters and facilitators from across Australia who were onboarded by the RACGP and delivered training. The development and use of a network of AOD experts facilitated a consistent, high-quality educational experience for all attendees. Online learning promoted confidence within the presenter team, as they became increasingly familiar with the learning content, delivery format and their specific role.
- Time – an additional 18 months for program delivery with the extension of the program to December 2022 enabled the program to build a track record. Program participants were able to recommend the training to their colleagues, and those who completed Essential Skills or Treatment Skills benefited from additional time to also access Advanced Skills training or AOD Connect: Project ECHO, developing a strong community of practice. Additional time meant further education could be developed

and delivered, such as the High-Risk Group pathway (Pathway 5).

- Support – for participants whose IT skills and knowledge limited their ability to participate in online workshops, operations staff were available to support GP participation. Detailed user guides on Zoom etiquette and online training requirements were developed and provided to all Treatment Skills – AOD Live participants. Facilitators and participants were briefed on appropriate use of behaviour and use of Zoom according to Project ECHO's objectives.

Project management: Performance, quality and risks

Performance management and quality assurance

To assess the achievement of the DoH AOD Program objectives and key performance indicators, the RACGP collected a wide range of operational and evaluation data on program performance and quality of the remunerated pathways. A range of lead and lag performance measures were regularly monitored. The key data sources, performance targets and quality assurance indicators defined by the RACGP as part of the program evaluation activities included:

- 1800 completions of Treatment Skills training
- 300 completions of Advanced Skills training
- at least 20% of participants from rural and remote areas (MM 3–7)
- at least 50% of participants treating two or more identified higher-risk patient population groups (for example, Aboriginal and Torres Strait Islander patients, those who were veterans or had experienced trauma)
- a range of different types of RACGP members applying to the program (GPs in training, New Fellows) with a variety of characteristics (for example, international medical graduates)
- equitable distribution of applications from all Australian states and territories
- monitoring of 'no-show' rates for online education workshops and activities
- monitoring of participant withdrawal rate and reasons for their withdrawal
- monitoring of participant evaluation surveys on a range of factors regarding the educational content and their online learning experience
- applications to the program assessed within 10 business days
- AOD inbox enquiries responded to within three business days.

The program team also implemented a range of activities to manage product quality and program performance.

Education pathway rollout was implemented using plan-do-study-act cycle of continuous improvement.[21] Lesson logs were created to capture feedback from presenters, coordinators and participants after delivery of an education session. Reflection and discussion between the program team and expert trainers occurred about levels and quality of participant engagement, questions raised by participants and session materials. These quality management processes helped identify program strengths, weaknesses and opportunities for improvement, which were implemented during the program period. Examples of program quality improvements made include:

- Treatment Skills – AOD Live (Pathway 2) – to increase the quality of participant engagement, role-play scenarios were changed to GP-led case discussion
- Advanced Skills (Pathway 3) – to address a high withdrawal rate the application process was improved to help members identify if they had capacity for the time-investment required, and to offer more personalised support to members through the application process. In later intakes, applicants were required to submit their personalised learning plan (PLP) and secure a mentor prior to be accepted onto this pathway, compared to initial intakes where GPs were accepted onto the pathway before submitting their PLP and mentor

- High-Risk Groups (Pathway 5) – with capacity created due to contract extensions, new educational content was developed to increase the available education for supporting population groups at a higher risk of harms from AOD use. Four additional online learning modules were developed to address this RACGP-identified gap.

Risk management

Risks were continually identified, monitored and addressed over the life of the program. Risk management protocols were implemented using a rating scale of likelihood and impact. Weekly team meetings and monthly reporting provided opportunities to identify and discuss risks, develop mitigation strategies and escalate risks when necessary. Risks were tracked in a register and reported to the DoH in six-monthly progress reports.

Evaluation methodology and method

Purpose

The purpose of the RACGP-designed program evaluation was to gather data required to monitor program implementation outcomes and continuous improvements needs, and assess the program's success in achieving the DoH AOD Program objectives and key performance indicators (KPIs). The evaluation findings presented in this report can be used to inform future GP education strategies, AOD advocacy and general practice research. They may also indicate whether RACGP-led education and training in other priority clinical areas may benefit from a similar investment in a comprehensive education program.

Evaluation framework

The program evaluation was conducted in the pragmatic paradigm.[22] This view lends itself to the use of a variety of data collection methods and sources to address questions in complex social settings.[22] A monitoring and evaluation plan was developed that was informed by the RACGP monitoring and evaluation framework and RACGP logic model template. Findings synthesised to address the six key evaluation criteria published by the Organisation for Economic Co-Operation and Development (OECD) DAC Network on Development Evaluation.[23] The evaluation criteria provide a framework that was used to determine the merit or worth of the program and inform evaluative judgements.[23] Data sources were triangulated to enhanced validity and trustworthiness and address the six key evaluation criteria, as shown in Table 3.

Table 3. Adapted OECD evaluation criteria

Evaluation criterion	Definition
Relevance	The extent to which the intervention objectives and design respond to beneficiaries, global, country and partner/institution needs, policies and priorities, and continue to do so if circumstances change
Coherence	The compatibility of the intervention with other interventions in a country, sector or institution
Effectiveness	The extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups
Efficiency	The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way
Impact	The extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects
Sustainability	The extent to which the net benefits of the intervention continue or are likely to continue

Monitoring and evaluation plan

Key questions

Based on the program logic model developed in late 2020, an AOD Program monitoring and evaluation plan was developed in April 2021 (available on request from Program Lead) to define the evaluation questions, required data, resourcing issues, design and methods, stakeholders and schedule. The plan outlined the evaluation approach and primary evaluation questions (Table 4), quality improvement strategies, method, risks, plan for dissemination, and a schedule for evaluation activities. Primary evaluation questions were developed with secondary questions, to align with the evaluation criteria chosen to guide the program evaluation. The monitoring and evaluation plan and program logic model were vital to the evaluation and were reviewed and modified over the life cycle of the program.

Table 4. Primary evaluation questions mapped to evaluation criteria

Evaluation criterion	Primary evaluation question
Relevance	Is the intervention and its design consistent with the needs and priorities of GPs and the policies of the DoH?
Coherence	To what extent are there synergies between the AOD Program and other RACGP educational-focused interventions?
Effectiveness	Did the AOD Program deliver what was intended? If not, why not?
	What unintended consequences or outcomes (positive or negative) were produced?
Efficiency	To what extent were the program's activities produced with the best use of resources (financial, staff, organisational)?
Impact	How has the AOD program influenced appropriate stakeholder community and what capacities has it built?
Sustainability	What evidence suggests that the AOD program effects will be maintained six or more months after the AOD program is completed?

Source: Adapted from Organisation for Economic Co-operation and Development. Evaluation Criteria 2022.[23]

Evaluation design

The evaluation design involved mixed methods. Quantitative and qualitative evaluation approaches were used within a single, complementary mixed design.[24] Figure 4 illustrates the evaluation timeline. KPIs were assessed in the quantitative paradigm and monitored for each pathway. They included the number of pathway completions and withdrawals, participant ratings of education relevance to current practice needs, and ratings of the extent to which the program pathway met overall learning needs.

Primary outcome data were collected before and after Treatment Skills training using questionnaires. Qualitative data were collected before and after the program through open text responses on surveys, and within 12 months of program completion through focus group interviews. Data were collected through application forms and other artefacts, such as in Advanced Skills training, where activity logbooks and GP reflections were used as data sources. Qualitative and quantitative data were synthesised to address the primary evaluation questions in this report.

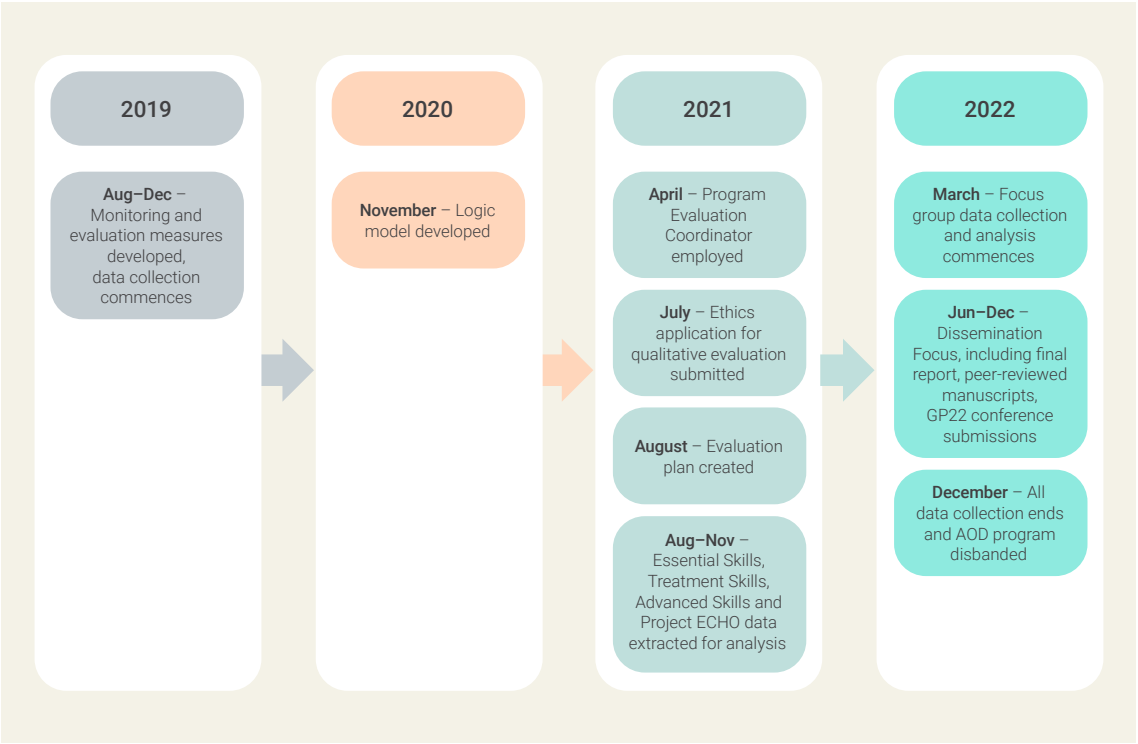

Figure 4. Program evaluation timeline

Data collection

Primary outcome measures

Primary outcomes were related to the knowledge, skills and attitudes of GP participants, and were measured in surveys through a single-group, within-subjects quantitative design. There were two cohorts of Treatment Skills completers, those who completed the 'AOD Live' (on Zoom) and those who completed the training 'self-directed' (online, asynchronous). Primary outcome measures were:

- self-reported confidence to treat different substance categories (alcohol, cannabis, illicit and legal opioids, benzodiazepines, stimulants and other drugs) by each criterion within the 5As framework for behavioural change
- self-reported behaviour to actively screen for different substance categories (alcohol, cannabis, illicit and legal opioids, benzodiazepines, stimulants and other drugs)
- self-reported perceived role to treat different substance categories (alcohol, cannabis, illicit and legal opioids, benzodiazepines, stimulants and other drugs).

Secondary outcome measures

Secondary outcome data related to the GP barriers to AOD care. They were collected in the same fashion as primary outcome data, and explored perceived barriers to treatment across 16 different items, which include perceived lack of knowledge, lack of support, lack of time, patient stigmatisation, perceived self-efficacy and lack of ability to facilitate behavioural change.

Demographic data

Demographic data were collected through the application processes and baseline surveys, and extracted from the RACGP membership database. Demographic data collected included age, gender, RACGP membership type, Aboriginal and/or Torres Strait Islander status, location of university qualification, state/territory and postcode.

Other measures

Each training pathway contained specific measures, such as measures of experience and satisfaction, reason for participating and participant reflections. As an example, in Project ECHO, data relating to the content of each session were collected via observation and reflection by program staff. For Treatment Skills and Advanced Skills training, baseline surveys included measures of the number of AOD patients seen per week and whether participants cared for patients from populations at higher risk of AOD harms: low socioeconomic status, people who have experienced trauma, Aboriginal and/or Torres Strait Islander people, LGBTQIA+ people, people experiencing homelessness, veterans and people in contact with the custodial system. Participants also described whether they were qualified Medication-Assisted Treatment of Opioid Dependence (MATOD) providers, and whether they actively prescribed suboxone and/or naltrexone. There was a staff evaluation session, in which data were collected through a workshop with operational staff, content developers and medical educators.

Qualitative evaluation: Focus group interviews

Focus group interviews[25] were conducted with program participants and AOD expert trainers. Data from these interviews were analysed thematically.[26] The qualitative evaluation has been published by the *British Journal of General Practice* in a paper by Brickley et al.[27]

Data analysis

Descriptive data analysis for the main quantitative outcomes included calculating means, standard deviation (SD), minimum and maximum. Likert scale data were treated as corresponding number values: 1 strongly disagree, 2 disagree, 3 neither agree nor disagree, 4 agree, and 5 strongly agree. To describe the clinical profile of GP participants, an Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) score[28] and Modified Monash Model (MMM) classification[29] were determined based on participants' postcodes. Qualitative data, such as that collected in open text surveys, were analysed for categories using the constant comparison method.[30] Quantitative and qualitative data were synthesised to address evaluation questions. Quantitative analyses were guided by an additional list of evaluation questions and aims developed by the program team.

Change outcomes were used to inform the impact and effectiveness of the training. Change outcomes were calculated as the change from baseline (post minus pre). These were also averaged over a range of sub-categories, such as drug types or across the 5As measures. General linear models were constructed for each mean change outcome to understand the relationship between the key demographic characteristics and the impact of the training. This approach was also used to compare the delivery modality for Treatment Skills (live versus self-directed training). Single predictor models were used, as well as a multi-predictor model for the total change to understand the relative impact of the various predictors. In this multi-predictor model, interaction relationships were explored for the four main model predictors but, in the presence of the other factors, only the main effect of age was statistically significant. The significant observed effect of international medical graduates (IMGs) in the single predictor models appears to be a consequence of the difference in the age distribution for IMGs. The results have been provided as means and standard errors, along with F-tests of significance. Box plots and line charts have also been used to display the distribution of the change scores across various levels of the predictors. All analyses were performed in an online evaluation program used for statistical analysis, SPSS (Version 29) and the threshold for statistical significance was $p<0.05$.

Ethical considerations

The planning, conduct and reporting of this evaluation was informed by the National Statement on Ethical Research published by the National Health and Medical Research Council[31] and the Guidelines for Ethical Conduct of Evaluations published by the Australian Evaluation Society.[32] Qualitative evaluation activities (focus group interview component) received ethics approval from the RACGP National Research and Evaluation Ethics Committee (Number: 21-084). While quantitative evaluation activities did not undergo formal ethics committee review, all such activity was undertaken in accordance with accepted ethical principles and practices, the RACGP monitoring and evaluation framework, and RACGP Privacy policy.

Results

Key performance indicators (KPIs)

The DoH KPIs for the number of program participants and satisfaction were exceeded across the remunerated pathways of the AOD Program.

Number of program participants

Overall, **3042 GPs** completed the program across pathways with and without remuneration.
Table 5 shows the number of program participants who completed the remunerated pathways and attracted a grant payment.

Table 5. Numbers of participants of remunerated options

	DoH KPI	Number of GPs who completed training
Treatment Skills – AOD Live	**1100**	598
Treatment Skills – Self-directed		1878
Advanced Skills		239
The number of individual GPs who completed training		2521*

**The number of individual GPs who completed an incentivised pathway of the program and received a training grant. It is not the sum of GPs who completed different pathways. Many GPs did both Treatment Skills and Advanced Skills.*

Training satisfaction

Overall, GPs were highly satisfied with the program. Table 6 shows the level of satisfaction among participants who completed remunerated program pathways.

Table 6. Total training satisfaction outcomes

	DoH KPI satisfaction	Learning needs: Training met my overall learning needs	Relevance: Training was relevant to my current practice needs	Training elements: Training elements were satisfactory/unsatisfactory
Treatment Skills – AOD Live	80%	95.9% agreed (n = 594)	99.8% agreed (n = 594)	89.3% highly satisfied[a] (n = 102)
Treatment Skills – Self-directed	80%	98.5% agreed (n = 1870)	99.3% agreed (n = 1870)	86.8% highly satisfied[a] (n = 639)
Advanced Skills	80%	99.1% agreed (n = 238)	99.1% agreed (n = 238)	94.7% agreed (n = 192)[b]

DoH, Department of Health and Aged Care; KPI, key performance indicator

[a]An average rating from 10–20 different measures that assessed satisfaction through various elements of the training, such as the application process, course navigation, presenter knowledge and experience, and CPD accreditation. All elements rated over 80%.

[b]Agreement in responses from 23 different statements exploring suitability, ease of use and positive views of various elements of the training, such as webinars, personalised learning plans, logbooks and interaction with the AOD team.

Non-remunerated training

Non-remunerated training included online learning activities and a weekly AOD case-based discussion group, AOD Connect: Project ECHO, which were freely available to all members. Completions and optional survey completions for non-renumerated training are included in Tables 7 and 8.

Table 7. Online learning modules: Completions and satisfaction ratings

	Course completions (30 August 2022)	**Optional survey completions** (30 August 2022)	**Optional survey** Rate how well your own learning needs were met by this course	**Optional survey** Rate the relevance of this course to your individual general practice
Essential Skills	746	321	76% entirely met	89% entirely relevant
High-Risk Groups – Supporting behaviour change for patients at higher risk	31	12	83% entirely met	92% entirely relevant
High-Risk Groups – Supporting people who have experienced trauma	22	7	71% entirely met	100% entirely relevant
High-Risk Groups – Supporting people in contact with the criminal justice system		Launched October/November 2022		
High-Risk Groups – Supporting Aboriginal and Torres Strait Islander peoples		Launched October/November 2022		

Table 8. Community of practice: Completions and satisfaction ratings

	Individual GP attendances	**Optional survey completions*** (30 August 2022)	**Optional survey** To what degree was the following learning outcome met: Identify skills and approaches that enhance the quality of care provided to patients who use AOD	**Optional survey** To what degree was the following learning outcome met: Develop strategies to enhance the quality of care provided to patients who use AOD
AOD Connect: Project ECHO (Pathway 4)	299 (Series 1–4)	729	80% entirely met	80% entirely met

**Indicates number of survey completions, not the number of ECHO participants. Participants accrued CPD points for their attendance and were required to complete this survey to accrue points for their attendance.*

Applications

Applications to the remunerated pathways of the program are included in Table 9. This includes the outcomes of each application and the completion rate for each remunerated pathway.

Table 9. Applications to program (remunerated pathways – Treatment Skills and Advanced Skills)

	Applied	Rejected	Withdrawn/ declined	Completed	Completion rate
Treatment Skills	3190	119	595	2476	77%
Advanced Skills – Intake 1 and 2	278	N/A	103	175	63%
Advanced Skills – Intake 3	75	N/A	11	64	85%
Total	3543	119	709		

Most Treatment Skills withdrawals were due to duplicate applications and those unable to complete self-directed training within the three-month deadline. Most rejections were due to failure to meet eligibility criteria. In Advanced Skills, notable withdrawals in Intake 1 and 2 were due to COVID-19 pandemic, inability of participants to progress the training within the time frame, participants unable to find suitable mentor, participants preparing for Fellowship exams.

Applications by state/territory

A breakdown of Treatment Skills applications is included in Figure 5a and Figure 5b. These demonstrate the proportion of total applications that came from each state/territory, and the percentage of eligible members who applied in each state/territory.

Figure 5a. Breakdown of Treatment Skills applications by state/territory

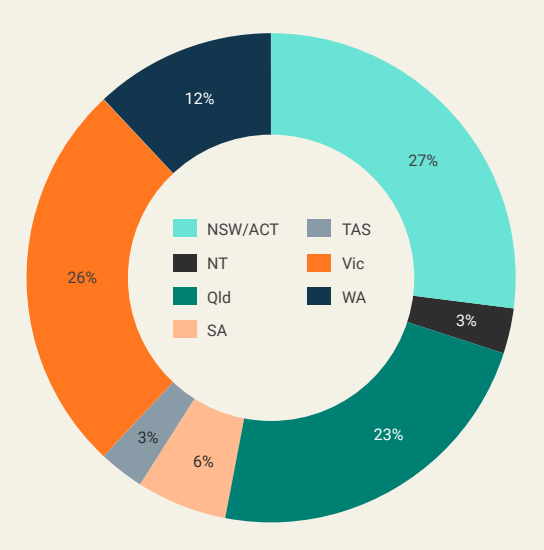

Figure 5b. Percentage of eligible members in each state/territory who applied for Treatment Skills training

NSW/ACT	8%
Victoria	10%
Queensland	10%
WA	15%
SA	8%
Tasmania	11%
NT	23%

Participants' demographic characteristics (completers only)

Table 10 provides an overview of the demographic characteristics of GPs who completed each program pathway.

Table 10. Participants' demographic characteristics by program pathway

Program pathway	Gender	Average age	Career stage[a]	Location	IMG	Top five countries for IMGs	Number of high-risk groups[b] treating
Essential Skills (n = 744)	56% F 44% M	43	1% Student 27% Pre-Fellow 31% New Fellow 38% Mid-career 2% Late career	75% Metro 22% Rural/remote 3% Unknown	49% IMG 43% Australian 8% Unknown	Iran India UK Myanmar Bangladesh	
Treatment Skills – AOD Live (n = 598)	59% F 41% M	44	10% Pre-Fellow 43% New Fellow 44% Mid-career 3% Late career	75% Metro 24% Rural/remote 1% Unknown	49% IMG 45% Australian 6% Unknown	UK India Sri Lanka Bangladesh Iran	24%: 0–1 40%: 2–3 29%: 4–5 2%: 6–7 5%: Unknown
Treatment Skills – Self-directed (n = 1878)	57% F 43% M	41	18% Pre-Fellow 45% New Fellow 36% Mid-career 1% Late career	76% Metro 23% Rural/remote 1% Unknown	46% IMG 46% Australian 8% Unknown	Myanmar UK India Iran Egypt	24%: 0–1 42%: 2–3 30%: 4–5 3%: 6–7 1%: Unknown
Advanced Skills (n = 239)	50% F 50% M	42	20% Pre-Fellow 37% New Fellow 42% Mid-career 2% Late career	75% Metro 24% Rural/remote 1% Unknown	45% IMG 50% Australian 6% Unknown	Egypt UK India Iran Nigeria	3%: 0–1 21%: 2–3 42%: 4–5 27%: 6–7 7%: 8–9

Table continued on the next page.

Program pathway	Gender	Average age	Career stage[a]	Location	IMG	Top five countries for IMGs	Number of high-risk groups[b] treating
AOD Connect: Project ECHO Series 1–4 (n = 262)	55% F 45% M	48	27% Pre-Fellow 29% New Fellow 40% Mid-career 4% Late career	79% Metro 18% Rural/remote 3% Unknown	74% IMG 22% Australian 4% Unknown	India Sri Lanka Iran Egypt Bangladesh	
High Risk Groups – Supporting behaviour change (n = 29)	69% F 31% M	45	38% Pre-Fellow 21% New Fellow 38% Mid-career 3% Late career	69% Metro 24% Rural/remote 7% Unknown	62% IMG 24% Australian 14% Unknown		
High risk groups – Supporting people who have experienced trauma (n = 22)	68% F 32% M	43	41% Pre-Fellow 32% New Fellow 23% Mid-career 5% Late career	73% Metro 27% Rural/remote	59% IMG 36% Australian 5% Unknown		

Abbreviations: F, female; IMG, international medical graduate; M, male

[a]*Career stage: Pre-Fellowship, any member who has not yet reached Fellowship; New Fellow, any member with Fellowship within the last five years; Mid-career, any Fellow for greater than five but less than 35 years; Late career; any Fellow for longer than 35+ years*

[b]*Treatment Skills and Advanced Skills (intake 1 and 2) – Seven high-risk groups identified on application form: Aboriginal and Torres Strait Islander peoples, people in contact with the criminal justice system, people experiencing homelessness, LGBTQIA+ people, people with low socioeconomic status, veterans, those who have experienced trauma. For Advanced Skills intake 3 (***n** **=** *64 GPs), nine high-risk groups explicit on application form: Aboriginal and Torres Strait Islander peoples, people in contact with the criminal justice system, people experiencing homelessness, LGBTQIA+ people, people with low socioeconomic status, veterans, those who have experienced trauma, young people, pregnant women.*

Multi-completers

There were 3042 individual participants who interacted with the program and completed various combinations of program pathways, both remunerated and non-remunerated. Table 11 highlights the number of participant interactions with program pathways, with most participants completing only a single program pathway.

Table 11. Participant interactions with program pathways

	Number of GP participants
Completed 1 Program pathway	2461
Completed 2 Program pathways	479
Completed 3 Program pathways	79
Completed 4 Program pathways	19
Completed 5 Program pathways	4
Total individual participants	3042

Progression through the program

One hundred and ninety-four of Advanced Skills participants completed Treatment Skills; 66 Treatment Skills – AOD Live participants went on to complete Advanced Skills; 128 Treatment Skills – Self-directed participants went on to complete Advanced Skills. However, participants also progressed through the program in other ways, with a variety of entry points.

The most popular pathway combinations are shown in Table 12.

Table 12. Most popular pathway combinations

Pathway combinations	Number of GP participants
Treatment Skills only	1933
Essential Skills only	360
Essential Skills and Treatment Skills	280
ECHO only	137
Treatment Skills and Advanced Skills	115
Treatment Skills and ECHO	50
Advanced Skills only	31

Table continued on next page.

Pathway combinations	Number of GP participants
Treatment Skills + Advanced Skills + ECHO	24
Essential Skills + Treatment Skills + ECHO	15
Essential Skills and ECHO	14
Essential Skills + Treatment skills + Advanced Skills + ECHO	13

Note: Essential Skills, Treatment Skills, Advanced Skills and ECHO pathways only. Does not include the High-Risk Group pathway.

Evaluation criteria

Summary

Table 13 provides a high-level overview of the program's primary evaluation questions, the evaluation findings that addressed these questions and where in this report the evidence can be found.

Table 13. Summary of evaluation findings mapped to evaluation criteria and primary evaluation questions

Evaluation criteria	Primary evaluation questions	Summary	Activities/evidence in this report
Relevance	Is the intervention and its design consistent with the needs and priorities of GPs and the policies of DoH?	The AOD Program was developed to align with the DoH contract objectives and activities. An AOD education audit and review of relevant literature (including DoH publications and polices) were completed. This was supported by the contract negotiation and inclusive stakeholder engagement processes, which were vital to understand and respond to the needs and preferences of GPs.	• Background • Discussion • Appendices A–F, I
Coherence	To what extent are there synergies between the AOD Program and other RACGP educational-focused interventions?	The program was informed by best practice GP education approaches (for example, RACGP education framework and RACGP curriculum). The design prioritised whole-person care, a strengths-based approach, behaviour change theory, remuneration upon completion, flexibility and progression.	• Background • Discussion • Appendices A–F, I
Effectiveness	Did the AOD Program deliver what was intended? If not, why not? What unintended consequences or outcomes (positive or negative) were produced?	The program enhanced GP participants' confidence to treat AOD across a range of commonly used substances. The program reduced treatment barriers by increasing GP self-efficacy, skills and knowledge, and reducing patient stigmatisation.	• Appendices A–I • Results, effectiveness • Discussion • Focus group interviews • (published separately)
Efficiency	To what extent were the program's activities produced with the best use of resources (financial, staff, organisational)?	The RACGP expertise and experience with GP education, existing resources and active primary care relationships enhanced the efficiency of the design and delivery of the program. Over half of the grant funding was directed back into the general practice community, enabling engagement with the GP Program. The online delivery modes were low cost and highly accessible to potential participants.	• Discussion • Appendix I • Focus group interviews • (published separately)
Impact	How has the AOD Program influenced appropriate stakeholder community and what capacities has it built?	Engaging a high number of GPs early in their career, who are caring for patients with high needs, suggests that impacts of the program will be wide ranging and long lasting. The program facilitating mentoring, created a community of practice, which fostered connections by GPs across primary care. After the program, some GPs have undertaken further training, shared their learnings with others, become accredited MATOD prescribers and managed complex AOD presentations.	• Discussion • Appendices A–I • Focus group interviews • (published separately)
Sustainability	What evidence suggests that the AOD program effects will be maintained six or more months after the AOD program is completed?	Program materials have been synthesised onto a freely accessible online AOD library, which also links to several ongoing AOD education offerings. GPs are reporting using resources provided during the program to assist with patient management more than six months after the program.	• Background • Results, sustainability • Appendices A–I • Focus group interviews • (published separately)

Effectiveness

Confidence to treat across the 5As framework

From pre- to post-program, there was growth in confidence to treat across each component of the 5As framework for behavioural change (refer to Figure 6 and Appendix G).

The largest growth in confidence was in 'Assist' and 'Arrange' care across all substances.

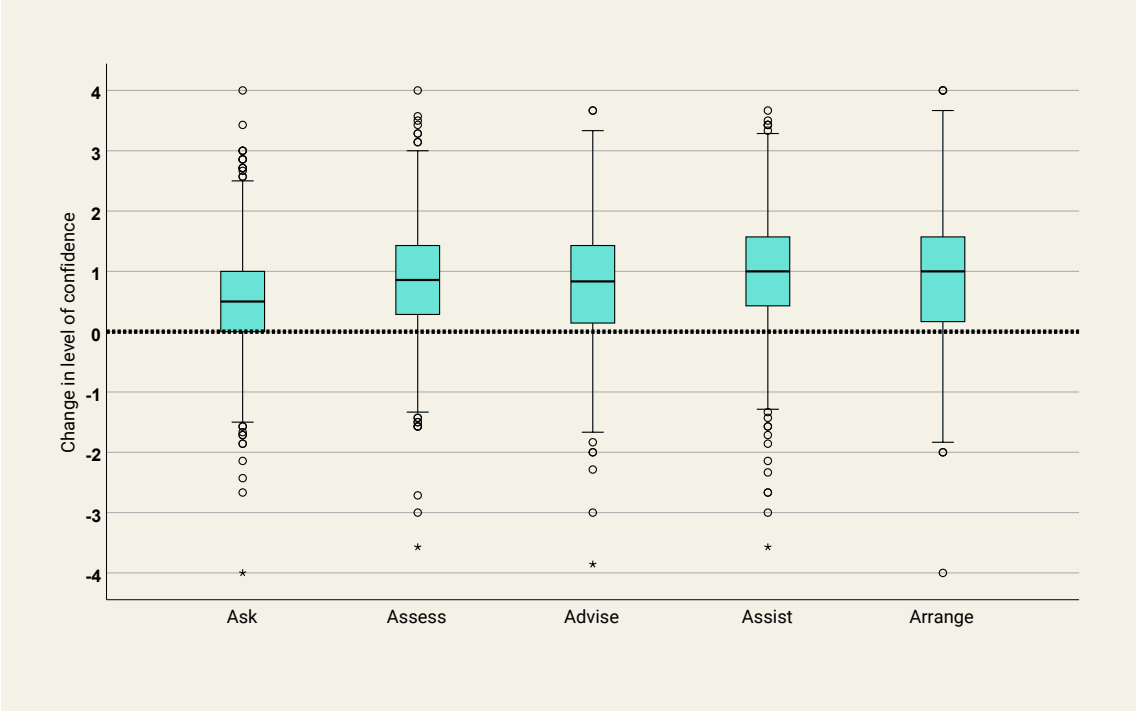

Figure 6. Mean change in confidence to treat across the 5As framework

Confidence to treat across the 5As framework by substance

From pre- to post-program, there was increased confidence to treat across all substances (refer to Appendix G). The largest growth occurred in confidence to address use of stimulants and illicit opioids (refer to Table 14), followed by other drugs.

- At baseline, on average, GP participants neither disagreed nor agreed that they felt confident to treat stimulants and other drugs.
- At endline, on average, GP participants were confident to care for all substances, including stimulants and other drugs.
- Alcohol had the lowest median increase in confidence throughout the training, however confidence to address alcohol was high before training.
- At endline, on average, alcohol was the only substance that participants were highly confident to address.

Table 14. Mean change in confidence to treat opioid use

Drug	Mean change ± SD	Median change
Legal and illegal opioids (AOD Live, n = 593)	0.70 ± 0.83	0.60
Legal opioids (Self-directed, n = 1417)	0.76 ± 0.78	0.80
Illicit opioids (Self-Directed, n = 1417)	0.96 ± 0.93	1

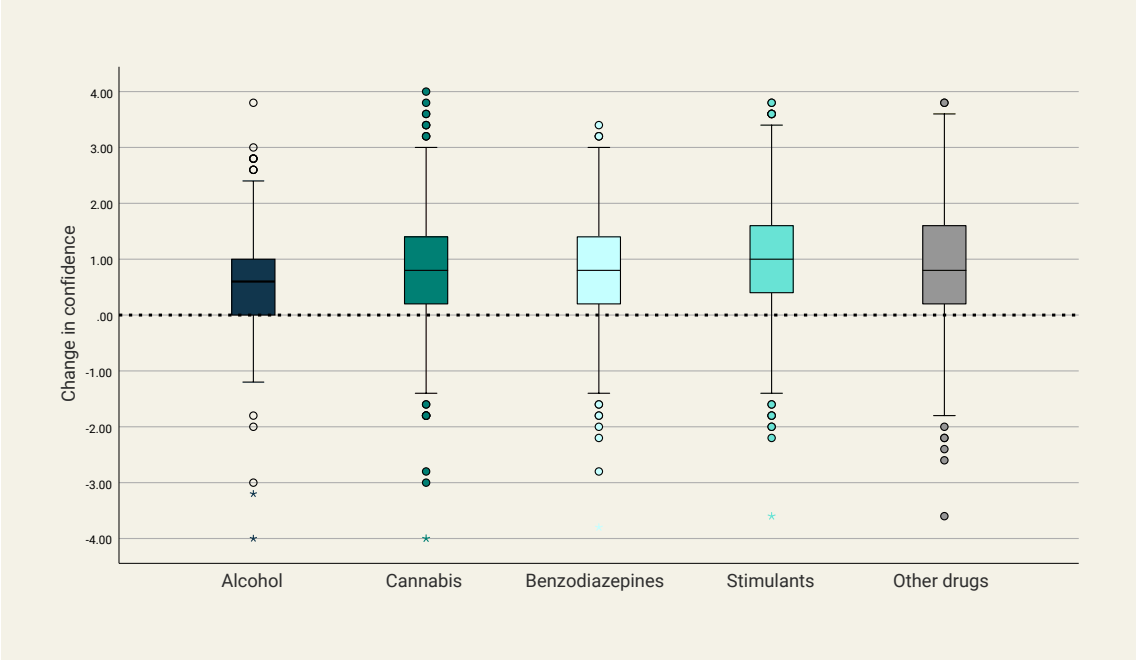

Figure 7. Mean change in confidence to treat by drug (n = 2010)

Perceived role to treat and self-reported screening

From pre- to post-program, there was growth in self-reported screening behaviour across all substances. From pre- to post-program, on average, there were improvements in GPs' role recognition to treat AOD (refer to Figure 8).

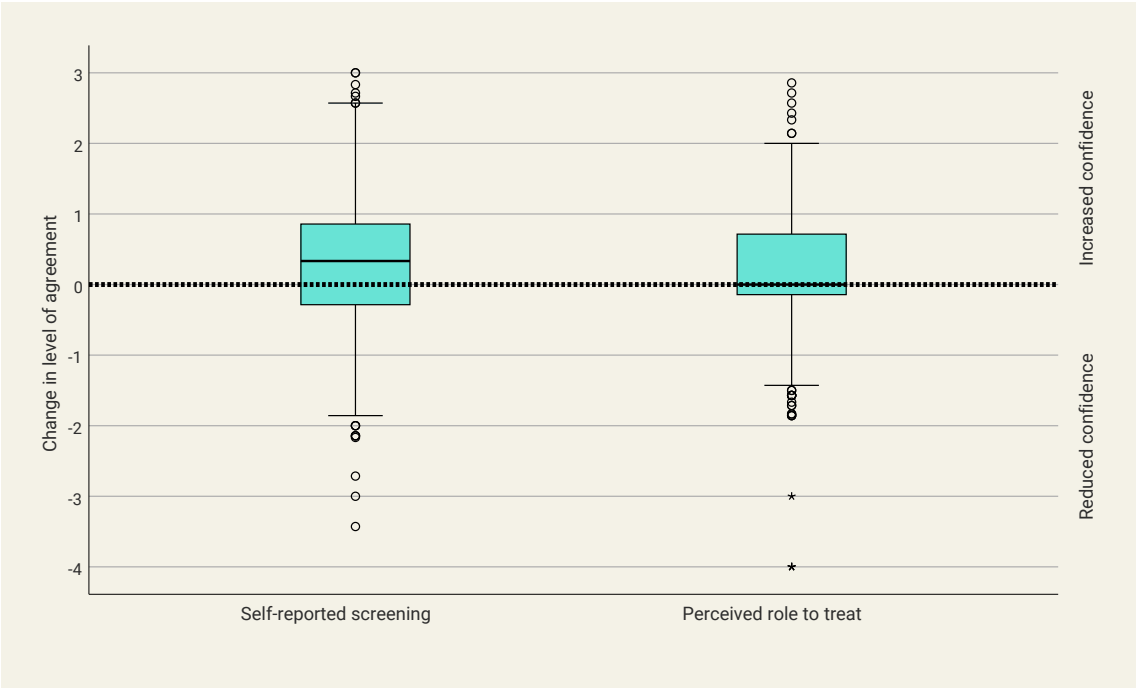

Figure 8. Mean change in role recognition and self-reported screening

Self-reported treatment barriers

Overall, GP participants reported fewer barriers to AOD treatment after the program (refer to Table 15 and Appendix G). A median change of −1 (moving from neither agree nor disagree to disagree) was found in nine out of the 16 assessed treatment barriers.

The strongest decreases were related to barriers regarding GP knowledge, skills and self-efficacy, and patient stigmatisation.

Table 15. Change in perceived treatment barriers

Category and measure	Outcome
GP self-efficacy, knowledge and skills My ability to provide care for my patients who are experiencing problematic use of AOD is limited because (n = 2009): • 'I don't have the necessary clinical support' • 'I don't have the necessary knowledge' • 'I don't have the necessary clinical skills' • 'I don't have the necessary time' • 'Of the lack of effective treatments'	On average, moved from 'agree' to 'disagree' (median change=−1) On average, moved from 'neither disagree nor agree' to 'disagree' (median change=−1)
Patient stigmatisation My ability to provide care for my patients who are experiencing problematic use of AOD is limited because (n = 2009): • 'Patients are resistant to change' • 'Patients are chaotic' • 'Patients are unreliable' • 'Most patients are not interested in changing their use'	On average, moved from 'neither disagree nor agree' to 'disagree' (median change=−1) On average, moved from 'agree' to 'disagree' (median change=−1) On average, moved from 'disagree' to 'strongly disagree' (median change=−1)

Training mode (AOD Live versus self-directed)

The two training modes resulted in comparable improvements in participants' self-reported screening behaviour, role recognition and confidence across the 5As framework (refer to Appendix G).

- Growth in self-reported screening from pre- to post-program was higher among AOD Live participants (self-directed 0.28 ± 0.02 versus AOD Live 0.36 ± 0.03 $p<0.05$).
- Increases in confidence to provide 'advice' from pre- to post-program was higher among those who did self-directed training (self-directed 0.93 ± 0.02 versus AOD Live 0.51 ± 0.04, $p<0.01$)

Participant sub-groups

Males and females

There were comparable improvements in participants' self-reported screening behaviour, role recognition and confidence across the 5As framework by gender (male n = 873, female n = 1140) (refer to Appendix G7).

Increases in confidence to 'arrange' from pre- to post-program was higher among females compared to males (females 1.00 ± 0.03 versus males 0.88 ± 0.03, $p<0.01$)

International and Australian medical graduates

Increases in reported screening behaviour, and confidence to 'assess', 'assist', 'advise' and 'arrange' were statistically higher in IMGs (n = 928) compared to Australian trained doctors (n = 943) (refer to Appendix G). However, both international and Australian medical graduates benefited from the program.

There are differences in the age distribution between the international and Australian medical graduates sampled (with IMGs being older on average), which may explain some of the observed differences in confidence.

Rural and remote GPs

Rural and remote GPs (MM 3–7) (n = 465) and GPs in major cities or metropolitan areas (MM 1–2) (n = 1531) had comparable improvements in self-reported screening behaviour, role recognition and confidence across the 5As framework (refer to Appendix G).

Career stage

There were comparable improvements between New Fellow (n = 922) and mid-career GPs (n = 782) for self-reported screening behaviour, role recognition and confidence across the 5As framework (refer to Appendix G).

Age

All age groups reported improvements on all measures, except for role recognition among GPs aged 65 and older (refer to Appendix G).

On average, GP participants aged 34–44 years and 45–54 years had a higher level of improvement across the 5As compared to other age groups.

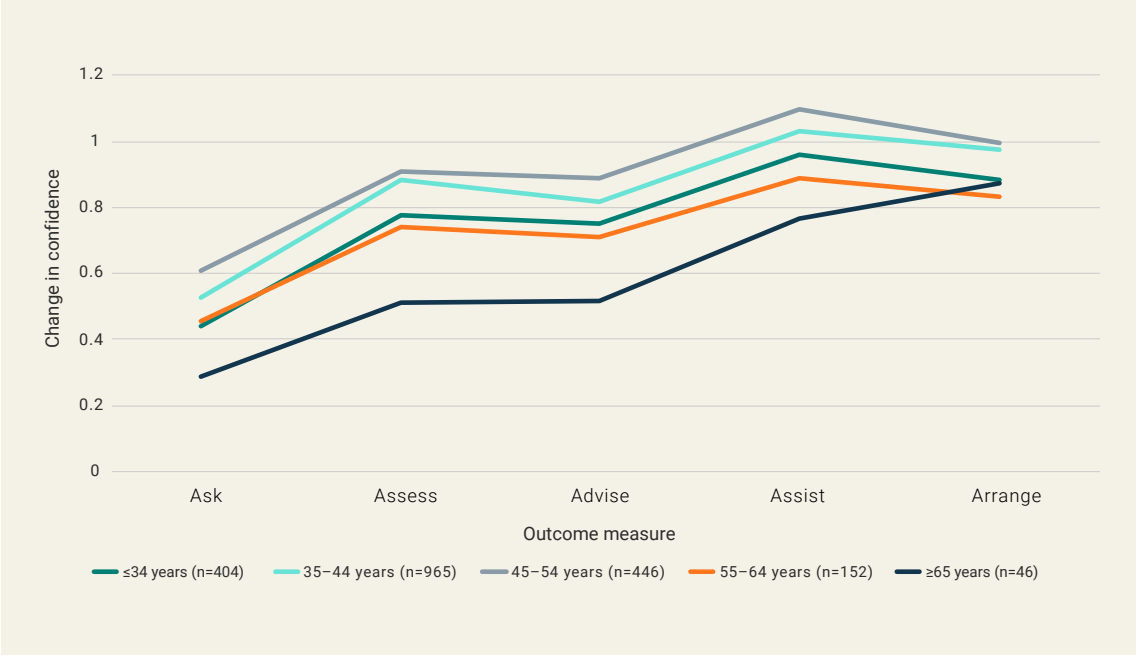

Figure 9. Mean change in confidence across the 5As framework by age group

Discussion

This report describes the design, delivery and evaluation of the highly successful RACGP AOD GP education program. GPs across Australia significantly engaged with the program across a variety of remunerated and nonremunerated education options. The program improved GPs knowledge, confidence, and attitudes to deliver whole person AOD care. The evaluation findings highlight opportunities to support future GP-led AOD care and demonstrate the overall success of the program through its achievements, benefits, and sustainable impacts.

Key findings

Program design and completions

- There were 3042 GP participants, representing 10% of the FTE GPs in Australia, demonstrating that the RACGP successfully tripled the DoH target number of GP program completions.
- Funding was vital to address barriers to GP engagement in CPD.
- A peer delivered 'by GPs for GPs' design and an inclusive stakeholder engagement process established program relevance and coherence.
- The RACGP's expertise in GP engagement and education, and established infrastructure, resources and relationships increased the efficiency of the program design and delivery.

Profile of program participants

- **Gender:** Fifty-six per cent of participants were female. This demonstrates the program engaged a higher proportion of female GPs, with 2020–21 statistics indicating that only 41% of the GP FTE workforce are female.[8,33]
- **IMG:** Forty-nine per cent of participants were IMGs (8% unknown). This demonstrates the program engaged GPs reflective of the GP workforce, with 2020–21 statistics indicating that GPs who received their initial medical qualification from overseas make up 52% of the GP workforce.[8,33]
- **Rurality:** Thirty-one per cent of GP participants were from MM 3–7. This demonstrates the program engaged a higher proportion of rural and remote GPs, with 2020–21 statistics indicating that GPs in rural and remote areas make up 17% of the GP workforce.[33]
- **Average age:** The average age of participants was 43.8 years. This demonstrates the program engaged a younger cohort of GPs, with 2020–21 statistics indicating that the GP workforce is ageing, with over 40% of the GP FTE workforce aged 55 years or older.[8,33]
- **State:** Between 8% and 23% of eligible members from each Australian state/territory applied for Treatment Skills training. A higher proportion of eligible GPs applied from the Northern Territory (NT) (23%). The NT has the lowest number of GPs per 100,000 people compared to all other Australian states/territories.[8,33]
- **Caring for higher-risk patient population groups:** Advanced Skills GPs reported treating a higher number of higher-risk groups: Treatment Skills treated 4+ higher-risk groups (34% of participants) versus Advanced Skills 4+ higher-risk groups (76% of participants).

Program effectiveness and impact

The AOD Program:

- improved awareness and understanding of whole-person, GP-led, AOD care
- increased awareness and access to resources to assist in GP-led AOD care
- enabled participants to foster connections with AOD mentors, GP peers and clinicians from various disciplines to collaborate in GP-led AOD care
- significantly increased GP confidence to treat a variety of commonly used substances – the largest shifts in confidence were observed among substances with lower confidence levels

at baseline: heroin or illicit/diverted prescribed opioids; and stimulants

- significantly increased confidence using the 5As framework to facilitate behavioural change by patients – largest shifts in confidence were observed among 5As components with lower confidence levels at baseline: to 'assist', to 'arrange' and to 'advise'
- reduced treatment barriers, by increasing GP knowledge, skills and self-efficacy and reducing patient stigmatisation.

Program sustainability

There were ongoing, sustainable program impacts through the development of a freely accessible online resource library containing all program materials and ongoing education opportunities.

Effectively engaging general practice

The ability for the RACGP to engage GPs in the delivery of the program was critical for its success and impact. The program received over 3500 applications for Treatment Skills and Advanced Skills training, representing approximately 12% of the GP workforce providing primary care services in Australia.[33] A further ~1000 GPs completed Essential Skills, Project ECHO or Higher-Risk Groups training. This rate of engagement is comparable to a national general practice CPD program commissioned by Dementia Australia between 2015 and 2017.[34] The evaluation of the Timely Diagnosis in Dementia program attributed the program's high GP engagement to delivering face-to-face and online education options.[34] The AOD Program drew upon the RACGP's active relationships and strengths to achieve a high level of GP engagement, despite being delivered during the pandemic when face-to-face education was not possible and GPs' clinical workloads were high.

GPs who practise in rural and remote areas represented 31% of all completions, which is significant considering GPs in rural and remote areas make up only 17% of the GP workforce.[33] People who live in rural or remote areas have higher rates of treatment seeking for AOD compared with those who live in major cities.[35] In addition, the burden of AOD use increases with remoteness, and those in rural and remote areas were more likely than those in major cities to drink alcohol in risky quantities.[35] The high representation of rural and remote GPs indicates the program's success in engaging GPs with high need. Key actions that supported this were offering suitable, flexible education options that can support access; targeted marketing strategies by the RACGP, sustaining effective relationships with stakeholders who assisted with recruitment (for example, PHNs) and prioritising access to remunerated training options for rural and remote GPs.

There were several reasons for the successful engagement of GPs across the diverse workforce. Offering remunerated education options with eligibility criteria protected education places for GPs in high need, increasing their access. Treatment Skills and Advanced Skills GPs reported to frequently manage AOD issues within high risk patient populations. Furthermore, the program design demonstrated the RACGP's understanding of the diverse needs of GPs. GPs who are IMGs have diverse backgrounds, skills, and experiences compared to Australian-trained doctors and this leads to distinct training and professional development needs.[36] A priority need among the GP IMG population is professional support and networking.[36] Project ECHO was established as a community of practice platform, for connection, case-based discussion, professional support and networking. GP IMGs strongly engaged with this option: approximately three-quarters of all Project ECHO participants were IMGs, a rate considerably higher in comparison to other education options (Project ECHO IMGs: 79% vs other pathways: 45–59%).

The evaluation findings show that this education program was needed by GPs. The program delivered a high-quality educational experience, and program participants recommended the program to their colleagues. The most influential driver for participation in the program was whether GPs self-identified treating AOD as a learning priority. The core program participants were New Fellow and mid-career GPs, with more than half of all completers under age 44, suggesting program impacts will be sustained into the future as participants' careers progress. Engagement of GPs in CPD during the earlier stages of their

career is important because practitioner age and experience level influence attitudes, awareness, level of confidence and practice intention regarding the screening and treatment of AOD.[37] The program has strongly evidenced the RACGP's capacity to understand GPs' needs and engage them in CPD.

Demonstrating value for money

Remunerated education options attracted the most GP participants, with over 80% of total program participants completions in remunerated pathways. GPs invested over 19,636 hours across the Treatment Skills and Advanced Skills pathways. If completed during consulting hours, it would be at the expense of 59,088 patient consultations lasting 20 minutes ('level B'), although participants tended to use time outside of their clinic hours for CPD. Patient care is the priority of all GPs; this investment into the program highlights GPs' commitment to enhancing AOD knowledge and skills to provide higher-quality AOD care. This is demonstrated by GPs who tended to complete above the minimum 20 hours of Advanced Skills learning activities, were regular attendees at the weekly Project ECHO community of practice, and completed multiple program options (one-fifth of all GPs).

Approximately $3.92 million, or 50% of the grant funding, was provided to GPs and Advanced Skills mentors as reimbursement for program participation. For program participants, financial remuneration and time constraints were a barrier to GPs actively treating AOD-related issues. In focus group interviews, program participants described that being reimbursed made them feel valued, and because of this, GPs valued and interacted with the program a lot more. One GP stated reimbursement for participation influenced the way they approached the course, which in turn made them feel more interested in AOD. Participants said the payment motivated GPs to show commitment and dedicate time to engage with the program and its resources. In addition, participants reported the payment to increase their self-esteem, suggesting that the payment could be linked to the observed increase in GP self-efficacy. It is apparent that reimbursement was a driver of GP engagement, program effectiveness and impacts.

The program demonstrated the RACGP's commitment to GPs by reinvesting funding directly into the general practice community, and this enabled GPs to engage in CPD on a priority health issue. In wider research, a survey of 8118 GPs found that, on average, GPs complete five hours of non-billable work per week (excluding research and education activities).[38] The significant amount of non-billable work GPs complete is contributing to the concerns of financial viability and job satisfaction expressed by GPs in the recently published General Practice *Health of the Nation* report.[8] The education component of GPs' non-billable workload appears set to increase in 2023, as GPs will be required to complete 50 hours per year of CPD activities. This increase in work can exacerbate the unsustainable workload and burnout among the profession, leading to increased rates of job dissatisfaction and early retirement. Future GP CPD programs must ensure financial support/reimbursement of GPs for their participation, to sustain and strengthen the GP workforce in DoH and national priority health issues, providing equity and opportunity for GPs similar to their non-GP specialist colleagues.

Designing an innovative and purposeful program

Strengths-based education and clinical practice

A peer-delivered 'by GPs for GPs' design was crucial to the success of the program. The GP-led influence on the program design resulted in the inclusion of strengths-based education values and principles.[39] A strengths-based approach focuses on the strengths, capacities and aspirations of individuals and uses these as a catalyst for positive change and growth.[39] Rejecting the traditional deficit model of learning, a strengths-based approach aims to use individual strengths to overcome adversity, identifying and enhancing what has worked well.[39] Concepts of desirable difficulty formed part of this process, for example where content, access to education, time commitment or financial sacrifice were deemed too difficult and offset the desirable nature of the tasks, engagement was lost. Where the pathway was made easier yet still a challenge, the tasks became more desirable, the level of

difficulty was tolerated and engagement restored. This strategy was identified by the RACGP as particularly important for delivering general practice education during the pandemic. GP medical educators embedded in the RACGP program team, in addition to GPs representing special interest areas (for example, Aboriginal and Torres Strait Islander health) in the program's reference group led the design of the program. As program designers, GP medical educators had a broad understanding of the range of needs and preferences of potential program participants, and shared their values, strengths and weaknesses.

The strengths-based design appreciated that each GP participant is an expert; they best know their circumstances and their needs for AOD knowledge and skill development.[39] The GP strengths of resilience, optimism, commitment to their patients, whole-person care, chronic disease management, longitudinal and relationship-based care were engaged in the design and delivery of the program. A strengths-based paradigm of GP education influenced the program content. In Treatment Skills training, video-recorded case examples included a structured approach to facilitate behavioural change for AOD use that modelled language in line with the 5As framework. Video vignettes of patient care demonstrated GPs providing strengths-based care, such as using principles of active listening, evoking patient values and identifying protective factors conferring resilience. Feedback from participants confirmed that these case scenarios were valued, epitomising whole-person patient care, patient empowerment and self-determination. Strengths-based approaches run through the models of care integral to AOD treatment, trauma-informed care, cultural competence and motivational interviewing. The success of the program has shown the importance of a strengths-based design for GP education.

Previous health interventions have found engaging GPs in new initiatives challenging. In 2019, a diabetes care project was pilot tested and learnings about the engagement of general practice in Australia were published.[40] The pilot program found that to increase GP engagement, any new intervention needs to draw upon active partnerships in general practice, be co-developed with GPs to meet their needs, have considerable lead-in time to develop rapport with GPs and raise awareness, and have dedicated support staff within practices to reduce the demand on already overburdened practice staff.[40] To successfully engage and meet the needs of GPs, future GP education programs should be peer delivered 'by GPs for GPs' and adhere to strengths-based values and principles.

Empowering GPs and offering choice, flexibility and progression

The commitment to empower GP participants in their education and program experience stemmed from the values of strengths-based education design. The empowerment of GPs during the program influenced consistently high ratings of:

- meeting overall learning needs
- relevance to current practice
- GP satisfaction with training.

The comprehensive program offered choice and flexibility, with educational level scaffolding (foundational to advanced skills), flexible mode of delivery (online, asynchronous) and a varied learning approach (online modules, mentor-assisted learning, case-based discussions). Participants entered the program at any level, in accordance with their individual needs and preferences, with the most common entry points being Treatment Skills and Essential Skills. Qualitative findings from staff and program participants found that the tiered and flexible educational design empowered GPs to address a variety of gaps in knowledge, skills and confidence to treat AOD. Offering progression was important because GPs recognised that their learning needs evolved over time. Approximately one-fifth of all program participants completed more than one program pathway, illustrating that some GPs progressed through the program as their needs evolved. The most common combination was Essential Skills and Treatment Skills, while some only attended ECHO sessions, and other GPs progressed through all program options. One participant who progressed through several program options reflected in a post-program focus group interview: '[The program] encouraged me to go on and learn more, I ended up spending time in a drug and alcohol unit'. This highlights diverse

GP needs in different settings and communities, at different stages of their career and learning.

Treatment Skills (self-directed) was the most completed program option. Participants' improvements in role recognition, reported screening behaviours and confidence to treat AOD were similar across the live and self-directed modalities of Treatment Skills training. While many participants enrolled because treating AOD was a self-identified learning priority, participants of Treatment Skills (self-directed) rated the ability to complete the training at their own pace as the largest motivator for enrolment. In wider research, GP feelings about the CPD topic is typically the strongest motivator for participation, for example, GPs report participating in a specific CPD opportunity due to experiencing challenges with patient care or feeling insufficiently confident about a presenting issue or topic.[41] A different study identified course relevance to clinical practice as the largest motivator for participation.[42] The multifaceted program design empowered GPs to engage in education opportunities best suited to their own learning needs and preferences, permitting GPs to engage in group-based learning or individual learning as preferred.[42] The program design addressed common barriers to participation among GPs such as a lack of time to complete the CPD opportunity, and lack of potential educational relevance to clinical practice.

Empowering GPs by offering choice, flexibility and progression is essential to meet GPs' needs. Despite the program taking only six hours to complete, 54% of GPs who completed Treatment Skills (self-directed) completed the program within 30 to 90 days. Qualitative findings suggest that this may be because participants spent more time with the materials, especially on topics participants wanted more time with – withdrawal management, opioids, dependence and pharmacotherapy treatment. GPs were more likely to complete modules in addition to clinic hours. Participants also described completing the self-directed course alongside other colleagues, and completing the training to assist with specific patients, which meant remaining in the course to access course materials as their patients presented (just-on-time learning). These findings are consistent with findings of pedagogy research exploring self-regulation in self-paced, open and distance university learning.[43] Student evaluation of a flexible, empowering learning model found that the design enabled them to 'go deeper' on a topic that interested them.[43] The asynchronous, flexible design allowed them to study in a more intensive way, rather than being restricted to learn about a topic during an activity.[43] The AOD Program has shown that online, asynchronous education is an essential offering to address the diverse needs of GPs, while leading to improved confidence, skills and knowledge. Online education should be included in all future GP education offerings as a strategy to increase access by GPs to CPD at a lower cost.

Benefiting from multiple program options

Essential Skills training

Essential Skills was the second most accessed program option, in spite of the absence of remuneration upon completion. The online, self-directed delivery mode, with no application process or eligibility criteria, made the course highly accessible. Of the main program options, Essential Skills had the highest proportion of GPs in training (27%). University students and affiliate/associate RACGP members who may not have been currently practising in general practice also engaged with the course. Given the program ran over three years, Essential Skills was an important 'hook' to the program for those on a pathway to Fellowship. Essential Skills provided foundational knowledge, built confidence and created a desire among GPs to further develop their AOD skills and knowledge. Essential Skills was often a gateway to other education options in the program – although, some participants entered the program elsewhere then completed Essential Skills, to refresh foundational AOD knowledge.

Participants who completed Essential Skills described key takeaways:

- develop capacity to identify those at higher risk of AOD issues
- screen and assess
- use a structured management approach
- incorporate the transtheoretical model of behaviour change into treatment

- implement new practice-wide systems
- coordinate team-based care.

These benefits are promising for the future of GP-led AOD care, given the high proportion of GPs in training and those on a pathway to Fellowship, having completed this pathway. To sustain these benefits, the central teachings in Essential Skills training should be included in the syllabus as core learning for all GPs in Australia.

Treatment Skills training

The delivery of Treatment Skills training enhanced GP participants' clinical confidence for behavioural change consultations. This change was demonstrated in the quantitative survey and qualitative focus group interviews. Compared to before the program, GP participants demonstrated higher levels of confidence after the program, to deliver AOD care across key consultation aspects that influence behaviour change: to 'ask', 'assess', 'advise', 'assist' and 'arrange'. The largest mean increases were seen in confidence to 'assist' and 'arrange' care. These findings reflect the intention for Treatment Skills to extend GP's existing skillset. GPs have been observed to deliver the 5As framework only partially in consultations and can be less likely to 'assist' and 'arrange' care.[44] A US study analysed 461 audio-recorded primary care consultations to explore GP-led weight loss counselling and found that GPs routinely 'ask' and 'advise' on weight loss but rarely 'assist' and 'arrange'.[44] In a different study, early-career GPs in Australia reported lower confidence to 'assist' and 'arrange' care across multiple substances.[37] Baseline AOD program data is in support of this, with 'assist' recording the lowest confidence across the 5As framework. Previous research has shown that patients who receive care that includes the 'assist' and 'arrange' components of the 5As framework are more likely to change their behaviour.[45] The high level of confidence across each component within the 5As framework suggests that GP participants are more likely to provide care that encompasses the whole 5As framework, and this can be applied across a range of presenting patient behaviours and conditions.

The delivery of Treatment Skills training enhanced GP participants' confidence to deliver AOD care across a range of commonly used substances. The largest growth from pre- to post-training occurred in GP participants' confidence to deliver the 5As framework in care for patients using stimulants, other drugs, and heroin or illicit/diverted prescribed opioids, in comparison to other assessed substances. The substances that GP participants gained the most confidence to treat are commonly implicated in unintentional drug-induced deaths in the community. Drug overdose is the leading cause of death for Australians of all ages, and it kills one Australian every four hours.[46] In 2020, opioids, benzodiazepines and stimulants contributed to 52%, 36% and 32% of all unintentional drug-induced deaths respectively.[46] However, more than half of all unintentional drug-induced deaths involved three or more drug types, with less than one-third involving one drug type only.[46] In addition to drug-induced death, alcohol, stimulants and benzodiazepines contribute to approximately 70% of drug-related hospitalisations.[47] Growth in GP confidence across multiple substances may strengthen GP-led treatment of polysubstance use and reduce the burden of drug-induced deaths and hospitalisations. After the course, GP participants were very confident to treat patients using alcohol and legally prescribed opioids; and confident to treat patients using cannabis, benzodiazepines, stimulants, heroin or illicit/diverted prescribed opioids, and other drugs. In responses to the six- to 12-month post-program survey, GPs reported managing a planned withdrawal from multiple substances, including alcohol, legally prescribed opioids, benzodiazepines, cannabis, heroin/illicit opioids, stimulants and other drugs (with individual GPs nominating several different substances). Educational impacts on GP care for multiple substances reported with this program may be explained by the emphasis on teaching concepts that can be applied to a variety of substances, such as readiness for change, motivational interviewing, harm minimisation and relapse prevention. The findings demonstrate the value of delivering GP education that does not focus on a single substance and is built upon a core AOD treatment approach that is grounded in behaviour change theory.

GP recognition of their role to treat AOD is a necessary prerequisite for GP-led AOD care. In our program participants, role recognition across all substances was high before training and very high after training. After training, there was very little difference between role recognition to treat alcohol

compared to all other substances. This shows that GPs who completed Treatment Skills training firmly believe it is their role to treat patients impacted by a wide range of substances. Our findings align with survey research published in 2020, in which over 90% of GPs in training study participants agreed that it was their role to ask patients about use of several substances: alcohol, benzodiazepines, cannabis, stimulants, opioids and other drugs.[37] On average, after the course, GP participants agreed that they actively screened patients for all assessed substances. However, GP participants more commonly agreed to actively screen for alcohol use compared to other substances, with screening behaviour tending to decrease for simulants, benzodiazepines, illicit opioids and other drugs. Despite recognising it is their role to care for patients impacted by these substances, some GPs do not report screening all their patients for these substances. This finding suggests that there may be barriers for GPs to actively screen all patients for AOD use. A qualitative study exploring alcohol screening suggested that GP screening frequency is reduced by (1) social and cultural attitudes about drug use, impacting GP willingness to ask questions about drug use, and (2) the dynamics of doctor–patient interactions; for example, screening for drug use may threaten the doctor–patient relationship.[48] Future work should explore the barriers and facilitators to GP AOD screening across a range of substances. To assist GP-led AOD care, future work could explore innovative strategies for general practice team-based care to support GPs to screen for substance use.

Treatment Skills training reduced GP participants' perceptions of barriers to AOD treatment, particularly among barriers related to GP-self efficacy, knowledge and skills. Self-efficacy has been described as 'a unifying theory of behavioural change'.[49] Change in behaviours occur through a patient's belief that they can perform the required new behaviour, and GPs provide interventions that enhance patient's self-efficacy for change.[49] Therefore, the enhanced AOD-care self-efficacy among GP participants is likely to optimise GP-led behaviour change consultations and AOD care. The program design may have contributed to greater GP self-efficacy. The strongest influence on self-efficacy is 'performance mastery', in which the experience of having a successful outcome from a personal action provides confidence in one's ability.[49] Data from qualitative focus group interviews illustrated that GP participants practised skills during small group education (AOD Live) for case-based discussion and role-plays, and simultaneously with real patients (self-directed). Enhanced self-efficacy can support GPs during the current high-demand general practice environment through greater coping behaviours and capacity to sustain these behaviours in the face of obstacles.[49]

GP patient stigmatisation views, on average, were reduced throughout the training. After the program, GPs more frequently disagreed with the views that patients are resistant to change, chaotic, unreliable, and are not interested in changing their AOD use. Survey research in a US primary care setting has highlighted the importance of GPs' beliefs and attitudes towards patients using substances.[50] Survey respondents were 185 active drug users, of whom, 40% reported to have avoided healthcare due to anticipated mistreatment.[50] Aspects of social mistreatment by the primary care provider included disapproval, embarrassment and shaming.[50] A priority for this education program was to support GPs to engage people safely and appropriately in AOD care through non-stigmatising language. Expert AOD trainers modelled language for GP participants to use in consultations in line with each component of the 5As framework. The use of non-stigmatising language has been shown to enable clinicians to better address the complex issues surrounding AOD use, resulting in better engagement in treatment, improved treatment outcomes and decreased harms.[51] In wider literature, education that improves GP confidence to assess and manage alcohol issues has been linked with decreased potential stigma with raising alcohol issues with patients.[52] However, the ability for education to decrease patient stigmatisation by GPs in AOD care is not yet fully understood. This is one of the first GP education programs to generate outcomes of reduced patient stigmatisation among GPs, akin to the program's focus on developing GP participants' AOD consultation skills, including interpersonal skills (empathy, respectful language, boundary setting, conflict management), and connections.

Advanced Skills training

The intradisciplinary and multidisciplinary relationships formed during Advanced Skills

training between mentors and GP mentees led to benefits for both parties. Advanced Skills GP participants were early-career GPs (average age 42, 57% pre-Fellow or New Fellow) dealing with complex patient caseloads (76% seeing four to nine high-risk patient groups, over half reported having AOD patients referred to them). This was unexpected as the course was initially designed for GPs at the 'Advanced' career stage, although we found that these GPs engaged in the course as a mentor. The mutual benefits for GPs' and mentors' support of outcomes 7 to 10 of the National AOD Workforce Strategy 2015–18, relate to enhancing the capacity of the GP AOD workforce and, specifically, increasing capacity to support patients from high-risk population groups impacted by AOD.[53] Advanced Skills mentors supported mentees to critically engage their beliefs, biases and habits of mind, while immersed in the setting of general practice and patient care. Mentors helped GPs identify their AOD strengths and weaknesses and supported them to build a PLP to address their learning needs. GP participants expressed that the program helped them increase self-actualisation and self-awareness of their AOD skills, and these led to greater confidence to deliver AOD interventions. In wider literature, this type of clinical support and teaching has been shown to encourage problem-solving, critical thinking and reflection.[54] In this way, mentoring has been shown to influence professional identity development by heightening awareness and enhancing humanistic values, key components of delivering quality and safe care to patients and families.[54] Mentors expressed concern for continuing AOD support for GPs, despite some mentors offering to continue to support the mentee after the training ceased. Future work should seek to ensure continuing AOD support can be provided to GPs managing complex AOD issues.

The individualised and participant-led training provided flexibility and enabled GPs to tailor training towards their own learning needs. The most frequently documented learning priorities for Advanced Skills GP participants were:

- deliver a GP-led planned withdrawal from alcohol use disorder
- prescribe medication-assisted treatment for opioid use disorder
- use motivational interviewing techniques.

To achieve this, with support of their mentor, GPs tended to complete online modules and courses, review clinical guidelines and read and participate in case reflection, including discussion with their mentor and/or other colleagues. The evaluation findings evidence that participants filled GP education gaps; improved their awareness of pathways between GP and specialist AOD services; and, through new relationships, increased their access to AOD specialist advice and access to collaborative care for patients with complex AOD presentations. These factors were explicitly requested by GPs in a qualitative study that explored strategies to assist GPs to manage patients impacted by AOD use, published in 2022.[18] The use of PLPs helped GPs develop knowledge, skills and confidence, suggesting it is an effective method for CPD, in agreement with previous research on PLPs.[55] However, some GPs found this challenging to develop, and relied on support from their mentor and/or the RACGP AOD team. The support provided by the RACGP AOD team addressed this issue of desirable difficulty throughout the training and had a positive impact on the program option's completion rate. The success of Advanced Skills contrasts with many previous mentoring programs in general practice.

AOD Connect: Project ECHO

Project ECHO was successful in fostering a national AOD community of practice over Zoom. Development of communities of practice within educational curricula is seen as an important element of medical educational design.[56]

A community of practice offers a range of benefits, including:

- the utility to develop participants' professional identify through engagement and participation ('becoming an insider rather than outsider')
- experiential learning
- reflection, supported by role models
- transfer in explicit and tactic knowledge from role models and mentors to learners
- continuity of engagement in learning opportunities.[56]

A confidential, psychologically safe environment was developed for GPs to discuss complex AOD patient cases among a panel of AOD GP experts and addiction medicine specialists. Establishing a safe and productive culture took time, although once this was achieved, GP attendees were observed to support each other and expressed feeling inspired by their colleagues. Several factors influenced the success of the online community of practice. A core group of GPs who attended sessions regularly welcomed new participants and were instrumental in developing an inclusive, engaged and safe culture. Next, facilitation skills and panel composition were important factors. The panellists' mentoring and communication skills ensured sessions were respectful, GP participant-led, case-based, and adhered to an 'all teach, all learn' philosophy. One regular participant organically became a role model and mentor in the group, and subsequently accepted an invitation to be a panellist. Administrative support to manage GP case submissions prior to the session, provide technical assistance and manage reminder invitations were crucial to the success of the community of practice.

Approximately three-quarters of the GPs who attended Project ECHO were IMGs. IMG GPs make up 52% of the Australian general practice workforce,[33] and make an essential and valuable contribution. They have diverse backgrounds, skills and experiences, and distinct training and professional development needs compared to Australian-trained doctors.[36,57] Of the IMG GPs who completed ECHO, three of the five most cited countries where they had received their university medical qualification were Iran, Egypt and Bangladesh. In these countries, alcohol consumption is limited and/or forbidden by law or religion. Conversely, in Australia, alcohol use is prevalent nationwide, with substance use such as cannabis and stimulants more prevalent in specific regions or communities. Contextual differences between an IMG GP's university training leads to challenges in adapting to their Australian practice context. Challenges include a lack of orientation to the Australian healthcare system, and lack of awareness and understanding of local AOD treatment guidelines, resources, governance, regulations and prescribing options.

Project ECHO session content helped address IMG GP priority needs, which include the development of communication and language skills, professional support and networking. Many IMG GPs feel inadequately prepared for care of Aboriginal and Torres Strait Islander patients.[36,57] Some IMG GPs are stigmatised by non-recognition or non-acceptance of their medical skills and qualifications, which can lead to lack of confidence to raise AOD with patients and arrange team-based care.[58]

Project ECHO sessions covered:

- patient-centred communication and interpersonal skills, such as building rapport and developing therapeutic relationships with patients
- motivational interviewing techniques and strategies
- establishing and adhering to boundaries with patients (saying 'no')
- addressing complex cases.

In addition to supporting IMGs, these topics, the community culture and collegiality can serve to potentially prevent GP burnout and support the GP AOD workforce. Burnout has been cited by GPs who engaged in AOD treatment.[59] Burnout has significant consequences for the GP's own health and that of their patients.[60] Transdisciplinary learning, supervision and support for GPs through GP education and training have been shown to prevent burnout.[61] Future work should seek to fund, maintain and expand upon this established, well-functioning community of practice. An AOD community of practice should be available to all GPs who want to foster connections with their colleagues, seek out mentors, develop skills and improve confidence in supporting patients who use

AOD. It has shown utility for addressing the priority needs of IMG GPs and potential to reduce GP burnout, enhancing longevity of GP AOD practice.

Evaluation strengths and limitations

This program evaluation investigated the effectiveness of an innovative, national, multi-year GP AOD education program designed to enhance GP confidence, knowledge and skills, and reduce barriers to treatment. A key strength of the evaluation was the rigorous design employed, which included a mixed methods approach with synthesis and triangulation of data and data sources. This was further enhanced by the large, heterogenous sample of GPs who engaged with the AOD Program, including a significant proportion of GPs who practise in rural and remote areas. The collection of primary outcomes data was built into the program activities via the delivery of structured online participant surveys and focus groups, for which high response rates were obtained.

One limitation of this program evaluation is the absence of patient measures, which means it is not known whether the program directly reduced AOD use. The identification of patients of GP program participants, and inclusion of patient measures, such as interviews, surveys and/or a review of medical records was not feasible within the timeline of the grant. Future GP education programs that are funded for longer periods should identify a cohort of patients to include in the evaluation to assess sustainable impacts and patient health outcomes. Longitudinal program outcomes are challenging to determine. The absence of incentives and remuneration provided to participants to complete the six- to 12-month follow-up led to a low response rate (12%). This low response rate hindered analysis of longitudinal outcomes due to a limitation of the number of GPs who submitted surveys at all three time points (pre-program, post-program, and six to 12 months after completion).

The program evaluation primary outcome measures used a 5-point Likert scale, which has limitations and assumptions upon interpretation. Likert scale measures introduce a risk of response bias and this is common in surveys that are administered to health professionals. Self-serving or social-desirability bias are types of response bias that may be present, where participants may provide inaccurate survey responses, for example incorrectly indicating that they are confident to treat AOD due to wanting to maintain a perception of self-esteem and professional competence.[62] The use of Likert scale measures, time taken to compete surveys, and placement within program activities could have introduced an acquiescence effect.[63] The acquiescence effect describes the tendency for a person to provide affirmative answers to items of a questionnaire, regardless of the content of these items.[63] There is also a risk of self-selection bias, given participants autonomously applied and engaged with the program. Self-selection bias has minimal impact given the analyses does not aim to be generalised to a population outside of program participants. It is possible that completing surveys prior to engaging in the education could have raised participants' awareness of specific topics and therefore altered how they approached the education and influenced their responses to the post-program survey.

Recommendations

Key recommendations resulting from the development, delivery and evaluation of the AOD GP Education Program include:

1. Engage GPs more frequently on high-priority issues, using GPs' strengths in whole-person care, chronic disease management and management of comorbid physical, psychological and social (biopsychosocial) factors. To ensure GPs remain engaged in activities that they find beneficial to their clinical practice, we recommend to:
   - explore the development or continuation of programs and platforms that facilitate peer engagement
   - use GPs' strengths – whole-person care approach, chronic disease management, and management of comorbid physical, psychological and social (biopsychosocial) factors.
2. Enhance grant funding opportunities that enable GP CPD education and respond to the diverse needs of GPs across Australia. Future funding of GP CPD education should facilitate programs that:
   - prioritise influential GP peer engagement – a design that is 'by GPs for GPs', which takes into consideration the pragmatic and cultural aspects of general practice
   - offer flexibility and progression, empowering GPs to lead their education experience
   - understand and respond to individual and environmental needs to deliver education options that are relevant to GP clinical practice
   - promote education grant stewardship by established education providers and member-based professional organisations that prioritise the diverse needs of their members and have a track record of efficiency, effectiveness and impact
   - provide equitable support for GPs to engage in professional development (in line with the support to engage in CPD that is provided to non-GP medical specialists)
   - include provisions for funding to support GPs to participate in education programs.
3. Provide or maintain funding for projects, especially established successful projects, aimed to improve integration between GPs and other healthcare specialists to increase knowledge transfer, clinical networking and support patient outcomes in areas of complex need – the AOD Connect: Project ECHO model should be considered.
4. Support research and policy development targeting the pivotal role of general practice; enabling optimal AOD care and healthcare for those with complex medical needs in general practice, increasingly recognised as an escalating national and international priority and having been exacerbated by the COVID-19 pandemic.
5. Advocate for the essential role of GPs in the AOD workforce, promoting the continuing RACGP AOD CPD education opportunities and the available resources as useful tools for not just AOD-related medicine but a range of complex medical issues in vulnerable patient populations.
6. Overcome known barriers to AOD treatment by increasing investment in longer GP consultations, mental health consultations and telephone consultations to maximise the opportunities for GPs to effectively care for patients who use AOD.
7. Advocate for increased funding of the primary healthcare sector by the Australian Government, recognising that GPs serve as the healthcare integration point between healthcare teams that enables GPs to continue practising high-quality care that is person-centred, safe and facilitates team-based care in the face of increasing patient complexity, multidisciplinary care needs, an ageing population, poorer social determinants of health, increased AOD use and mental health burden.

8. Leverage existing, evidence-based, successful GP education programs to provide best practice educational experiences in adult learning that are 'fit for purpose' to increase intervention reach, efficacy and relevance via funding maintenance of established programs and ongoing key GP stakeholder engagement.
9. Support and resource GPs currently experiencing record levels of stress and burnout in the face of high clinical workloads, by providing support for the diversity of professional needs to increase resilience and job satisfaction through mentorship, small group community of practice, one-to-one casework support, advocacy and funded professional development.
10. A strengths-based approach to GP education development should be used when designing educational activities, whereby the experience is made as desirable as possible, with a level of difficulty that makes it challenging, yet still appealing.

Conclusion

GPs play a pivotal role in leading the treatment of people impacted by AOD use in the community. This report has shown that the RACGP designed and delivered a high-quality, impactful educational experience. Approximately 10% of the national primary care GP workforce engaged in this program to optimise the care for patients who may be using a variety of commonly used substances in Australia. The education design 'by GPs for GPs', leveraging a strengths-based approach and addressing 'desirable difficulty' was effective.

Overall, after the program, GP participants recognised that it is their role to treat AOD, report actively screening their patients for AOD use, and have confidence to treat AOD for multiple substances and support behavioural change. Program effectiveness was demonstrated by significant growth in confidence to treat AOD, improved AOD skills and knowledge, and reduced barriers to treatment among GP participants from pre- to post-program.

Program impact was demonstrated through the development of a national, online community of practice, in which GP participants taught and mentored their peers, and evidence of program participants fostering multidisciplinary clinical connections. Resources of the program will be sustained through continued online education offerings by the RACGP and the maintenance and promotion of a freely accessible library of AOD resources.

This program is likely to have a long-lasting impact on the country because it has empowered GPs to lead AOD care and raised GP confidence to provide continuing, community and team-based care to support individuals and families impacted by AOD use.

References

1. The Royal Australian College of General Practitioners. Organisation strategy: Operating plan FY 2023–2025. East Melbourne, Vic: RACGP, 2022.
2. Australian Institute of Health and Welfare. Australia's health 2022: In brief. Canberra: AIHW, 2022.
3. Australian Institute of Health and Welfare. National Drug and Strategy Household Survey 2019. Canberra: AIHW, 2020.
4. Alcohol and Drug Foundation. Drug facts. Sydney: ADF, 2021. Available at https://adf.org.au/drug-facts/ [Accessed 16 December 2022].
5. Jayasinghe UW, Harris MF, Parker SM, et al. The impact of health literacy and life style risk factors on health-related quality of life of Australian patients. Health Qual Life Outcomes 2016;14(1):1–13.
6. Marel C MK, Kingston R, Gournay K, et al. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. 2nd edition. Sydney: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales, 2016.
7. World Health Organization. Alcohol – Fact sheet 2022. Available at www.who.int/news-room/fact-sheets/detail/alcohol [Accessed 4 September 2022].
8. The Royal Australian College of General Practitioners. General Practice Health of the Nation 2022. East Melbourne, Vic: RACGP, 2022.
9. Rodgers C. Brief interventions for alcohol and other drug use. Aust Prescr 2018;41(4):117.
10. Meier PS, Barrowclough C, Donmall MC. The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. Addiction 2005;100(3):304–16.
11. McCormick KA, Cochran NE, Back AL, et al. How primary care providers talk to patients about alcohol: A qualitative study. J Gen Intern Med 2006;21(9):966–72.
12. Moriarty HJ, Stubbe MH, Chen L, et al. Challenges to alcohol and other drug discussions in the general practice consultation. Fam Pract 2011;29(2):213–22.
13. Sturgiss E, Lam T, Russell G, et al. Patient and clinician perspectives of factors that influence the delivery of alcohol brief interventions in Australian primary care: A qualitative descriptive study. Fam Pract 2022;39(2):275–81.
14. Anderson P, Kaner E, Wutzke S, et al. Attitudes and management of alcohol problems in general practice: Descriptive analysis based on findings of a World Health Organization international collaborative survey. Alcohol Alcohol 2003;38(6):597–601.
15. Anderson P, Wojnar M, Jakubczyk A, et al. Managing alcohol problems in general practice in Europe: results from the European ODHIN survey of general practitioners. Alcohol Alcohol 2014;49(5):531–9.
16. Manning V, Arunogiri S, Frei M, et al. Alcohol and other drug withdrawal: Practice guidelines. 3rd edition. Richmond, Vic: Turning Point, 2018.
17. Haber P, Riordan B. Guidelines for the treatment of alcohol problems. 4th edition. Sydney: Specialty of Addiction Medicine, Faculty of Medicine and Health, The University of Sydney, 2021.
18. Wilson H, Schulz M, Rodgers C, et al. 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.
19. Sturgiss E, Van Weel C. The 5As framework for obesity management: Do we need a more intricate model? Can Fam Physician 2017;63(7):506–8.
20. The Royal Australian College of General Practitioners. Approach to preventive care in general practice. East Melbourne, Vic: RACGP, 2022. Available at www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgpguidelines/view-all-racgp-guidelines/snap/approach-to-preventive-care-in-general-practice [Accessed 16 December 2022].
21. Johnson CN. The benefits of PDCA. Quality Progress 2002;35(5):120.
22. Morgan DL. Pragmatism as a paradigm for social research. Qualitative Inquiry 2014;20(8):1045–53.
23. Organisation for Economic Co-operation and Development. Evaluation criteria 2022. Paris: OECD. Available at www.oecd.org/dac/evaluation/daccriteriafor evaluatingdevelopmentassistance.htm [Accessed 16 December 2022].
24. Ghiara V. Disambiguating the role of paradigms in mixed methods research. Journal of Mixed Methods Research 2020;14(1):11–25.
25. Parker A, Tritter J. Focus group method and methodology: current practice and recent debate. Int J All Res Educ Sci Methods 2006;29(1):23–37.
26. Braun V, Clarke V. Reflecting on reflexive thematic analysis. Qualitative Research in Sport, Exercise and Health 2019;11(4):589–97.
27. Brickley B, Fox Miller L, Grinzi P, et al. Qualitative evaluation: Impact of Australian general practice alcohol and other drugs education. Br J Gen Pract. DOI: 10.3399/BJGPO.2022.0181.
28. Australian Bureau of Statistics. Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016. Canberra: ABS, 2018.
29. Australian Government Department of Health and Aged Care. Modified Monash Model – Fact sheet. Canberra, 2020. Available at www.health.gov.au/resources/publications/modified-monash-model-factsheet [Accessed 16 December 2022].
30. Dye JF, Schatz IM, Rosenberg BA, Coleman ST. Constant comparison method: A kaleidoscope of data. The Qualitative Report 2000;4(1/2):1–9.
31. National Health and Medical Research Council. National statement on ethical conduct in human research 2007 (updated 2018). Canberra: NHMRC, 2018.
32. Australian Evaluation Society. Evaluation resources: Ethical guidelines 2022. Available at www.aes.asn.au/ethical-guidelines [Accessed 16 December 2022].

33. Australian Government Department of Health and Aged Care. General practice workforce providing primary care services in Australia. Canberra: DoH, 2022. Available at https://hwd.health.gov.au/resources/data/gpprimarycare.html [Accessed 16 December 2022].

34. Casey A-N, Islam MM, Schütze H, et al. GP awareness, practice, knowledge and confidence: Evaluation of the first nation-wide dementia-focused continuing medical education program in Australia. BMC Fam Pract 2020;21(1):1–16.

35. Australian Institute of Health and Welfare. Alcohol and other drug use in regional and remote Australia: Consumption, harms and access to treatment 2016–17. Canberra: AIHW, 2019.

36. Brown J, Kirby C, Wearne S, Snadden D. Remodelling general practice training: 'Tension and innovation'. Aust J Gen Pract 2019;48(11):773–8.

37. Wilson H, Norris R, Tapley A, Magin P, Klein L. Role legitimacy, comfort and confidence providing tobacco, alcohol and other drug care: A cross-sectional study of Australian early-career general practitioners. Educ Prim Care 2021;32(1):19–26.

38. Brown A, Enticott J, Russell G. How do Australian general practitioners spend their time? A cross-sectional analysis of Medicine in Australia: Balancing Employment and Life (MABEL) data examining 'non-billable workload'. Aust J Gen Pract 2021;50(9):661–6.

39. Waterhouse P, Virgona C, Wilson L. Working from strengths: Venturing towards strength-based adult education: Adelaide: NCVER, 2008.

40. Ogrin R, Aylen T, Rice T, Audehm R, Appannah A. Engagement of primary care practice in Australia: Learnings from a diabetes care project. Aust J Prim Health 2019;25(1):82–9.

41. Kjaer N, Steenstrup A, Pedersen L, Halling A. Continuous professional development for GPs: Experience from Denmark. Postgrad Med J 2014;90(1065):383–7.

42. Yee M, Simpson-Young V, Paton R, Zuo Y. How do GPs want to learn in the digital era? Aust Fam Physician 2014;43(6):399–402.

43. Kocdar S, Karadeniz A, Bozkurt A, Buyuk K. Measuring self-regulation in self-paced open and distance learning environments. International Review of Research in Open and Distributed Learning 2018;19(1).

44. Alexander SC, Cox ME, Turer CLB, et al. Do the five A's work when physicians counsel about weight loss? Fam Med 2011;43(3):179.

45. Rueda-Clausen C, Benterud E, Bond T, Olszowka R, Vallis M, Sharma A. Effect of implementing the 5 As of obesity management framework on provider–patient interactions in primary care. Clin Obes 2014;4(1):39–44.

46. Penington Institute. Australia's annual overdose report 2022. Melbourne, Vic: Penington Institute, 2022.

47. Australian Institute of Health and Welfare. Alcohol, tobacco and other drug use in Australia, 2022: Impacts. Table S1.8b. Canberra: AIHW, 2022. Available at www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugsaustralia/contents/impacts/health-impacts [Accessed 16 December 2022].

48. Tam CWM, Zwar N, Markham R. Australian general practitioner perceptions of the detection and screening of at-risk drinking, and the role of the AUDIT-C: A qualitative study. BMC Fam Pract 2013;14(1):18.

49. Bandura A. Self-efficacy: toward a unifying theory of behavioral change. Psychol Rev 1977;84(2):191.

50. Meyerson BE, Russell DM, Kichler M, Atkin T, Fox G, Coles HB. I don't even want to go to the doctor when I get sick now: Healthcare experiences and discrimination reported by people who use drugs, Arizona 2019. Int J Drug Policy 2021;93:103112.

51. Wilson H. How stigmatising language affects people in Australia who use tobacco, alcohol and other drugs. Aust J Gen Pract 2020;49(3):155–8.

52. Miller ER, Ramsey IJ, Tran LT, Tsourtos G, Baratiny G, Manocha R, et al. How Australian general practitioners engage in discussions about alcohol with their patients: A cross-sectional study. BMJ Open. 2016;6(12):e013921.

53. Australian Government Department of Health and Aged Care. National Alcohol and Other Drug Workforce Development Strategy 2015–2018 Canberra: DoH, 2014. Available at www.health.gov.au/resources/publications/national-alcohol-and-other-drug-workforce-developmentstrategy-2015-2018 [Accessed 16 December 2022].

54. Kaufman DM. Teaching and learning in medical education: How theory can inform practice. Understanding Medical Education: Evidence, Theory, and Practice 2018:37–69.

55. Evans A, Ali S, Singleton C, Nolan P, Bahrami J. The effectiveness of personal education plans in continuing professional development: An evaluation. Medical Teacher 2002;24(1):79–84.

56. Cruess RL, Cruess SR, Steinert Y. Medicine as a community of practice: Implications for medical education. Acad Med 2018;93(2):185–91.

57. McGrath P, Henderson D, Holewa H. Language issues: An important professional practice dimension for Australian international medical graduates. Commun Med 2013;10(3):191.

58. Iredale R. Luring overseas trained doctors to Australia: Issues of training, regulating and trading. International Migration 2009;47(4):31–65.

59. Jones D, Davies P. Burnout in general practice. InnovAiT 2016;9(6):364–9.

60. Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. Ann Intern Med 2002;136(5):358–67.

61. Cooke GP, Doust JA, Steele MC. A survey of resilience, burnout, and tolerance of uncertainty in Australian general practice registrars. BMC Med Educ 2013;13(1):1–6.

62. Elston DM. Participation bias, self-selection bias, and response bias. J Am Acad Dermatol 2021:S0190-9622(21)01129-4 .

63. Hinz A, Michalski D, Schwarz R, Herzberg PY. The acquiescence effect in responding to a questionnaire. Psychosoc Med 2007:4.

Appendix A. Essential Skills training

Introduction

Essential Skills training was offered as a free, on-demand online learning course for all RACGP members on the RACGP LMS, *gplearning*. This training sought to provide GPs with core skills and strategies to improve their approach to conversations about AOD use, identify higher-risk groups, and safely and effectively manage patient behaviours that GPs can find challenging in consultations. It supported GPs to screen for substance use, assess patients' readiness for change and determine appropriateness of referring to AOD treatment services.

The training was designed for students, GPs in training, IMGs and RACGP members who wanted to refresh their basic or fundamental AOD general practice knowledge and skills in the current Australian context.

Training grant	Not applicable
Timeline	Continuous (April 2020 – December 2022)
Delivery	Available on-demand on *gplearning*
Duration	Four hours
CPD points	Completion of Essential Skills training was accredited for 8 points in the RACGP CPD Program for the 2020–22 triennium.
Learning outcomes	1. Outline key features of AOD use in Australia and identify higher-risk groups. 2. Describe how to screen patients for AOD use. 3. Explain a safe and effective approach to engage with a person experiencing risky AOD use. 4. Assess readiness to change in a patient experiencing alcohol and/or substance use disorders. 5. Determine appropriate patient management including when to refer to AOD treatment services.

Analyses

Participant demographics

Table A1 describes the demographics of the first 744 participants who completed Essential Skills training.

Table A1. Essential Skills training participant demographics

Characteristic	Participant demographics
Gender	56% female, 44% male
Age	Average age 43
Career stage	1% student, 27% pre-Fellow, 31% New Fellow, 38% mid-career, 2% late career
Rural/remote status	75% metropolitan, 22% rural or remote, 3% unknown
Country of medical qualification	49% IMG, 43% Australian, 8% unknown
Top five countries of medical qualification for IMGs	Iran, India, UK, Myanmar, Bangladesh

IMGs, international medical graduates

A mixed methods evaluation was conducted on data collected between 30 April 2020 and 15 August 2021. The total number of training completions of Essential Skills training in this period was 552.

Optional post-training survey: Key findings

- The response rate for the optional post-training survey was 41.3%, with 229 completers out of a possible 554.
- When asked to rate how well their own learning needs were met by the training, **99%** (n = 229) of participants expressed their learning needs were met or partially met.
- When asked to rate the relevance of the training to their individual general practice setting, **99%** (n = 229) of participants expressed the training to be entirely or partially relevant.

Optional post-training survey: Analyses of free-text responses

Four themes emerged from the analyses. All themes relate to the influence of the training on participants and their clinical practice. An explanation of each theme and narrative quotes are described in Table A2. The themes were:

1. equipping GPs with the confidence, skills and tools to screen all patients for AOD use
2. developing profession-wide, structured approaches to manage AOD use
3. prioritising patient-centred care to support AOD management
4. establishing general practice systems and delivering team-based care.

Table A2. Essential Skills: Post-training survey

Qualitative data collected in the optional Essential Skills post-training survey was grouped into key themes. Table A2 provides a description and illustrative quotations for each theme.

Theme	Description and illustrative quotations
Equipping GPs with the confidence, skills and tools to screen all patients for AOD use	Many GPs perceived that the Essential Skills training had a marked impact on their confidence and ability to manage AOD use in practice. Participants considered the training was 'well organised and structured' and they valued the information, resources and tools provided. One participant reported developing a greater understanding of the benefits of screening for AOD and increased confidence to address AOD: *'Highlight benefits of screening and improve confidence in raising the question of possible AOD in routine consultations.'* The training equipped GPs with the confidence to raise the topic of AOD within patient consultations. One GP felt confident to do this with all patients, and said the training helped '*form part of regular screening to all patients*'. The training included many tools to support AOD screening, assessment, intervention and sustained behaviour change. These tools were viewed by GPs as applicable and relevant to their practice. One participant said the tools helped: *'improve my AOD assessments with more straightforward and systematic approach'.* Along with screening and assessment, identifying patients impacted by AOD issues is important as it can inform earlier intervention and contribute to greater management of AOD across primary care. One participant expressed that the training developed their skills to recognise patients who may be at risk of AOD-related issues: *'It will help identify patients who are at risk of AOD related… problems, to be assessed and managed earlier.'* The Essential Skills training equipped GPs to evaluate AOD use within their current patient base. For one GP, the training highlighted how to approach this systematically by '*help[ing] produce a clinical audit*', whereas another GP proposed greater screening for AOD, a review of documentation and called for immediate intervention for high level AOD consumers: *'See how many clients had an updated alcohol history and if any action has been taken on those who screen as high consumers.'*
Developing profession-wide, structured approaches to manage AOD use	Participants valued the framework for AOD management and the structured approach provided. Many participants considered that the structured approaches, such as the 5As framework, could be implemented by all GPs as a '*consistent approach amongst different doctors*'. GPs must use specific language, questioning and listening techniques to best deliver AOD care. One GP emphasised the value of learning through video consultations that modelled the delivery of an AOD approach or framework: *'I believe that watching the videos was helpful to see possible language to use and techniques in practice which would make me more comfortable to have these conversations with patients as such ensure appropriate assessment and management of their substance use.'*

Table continued on the next page.

Theme	Description and illustrative quotations
	Adhering to a structured approach to AOD management helped GPs mitigate the common barriers to AOD management, as one GP felt the training developed a: *'Clear framework to help start to help patients with AOD issues and how to deal with common barriers faced in clinical practice.'* The structured approaches in this training provided a clear strategy for some GPs, which they could then use to address AOD issues as they arose in clinical practice. One GP felt this to be particularly valuable for patients with complex AOD issues: *'I have learnt multiple strategies to assess, engage and evaluate alcohol and substance issues with my patients. I have adequate tools to help manage the difficult and complex patients with the help of structured tools.'* Approaches to AOD were also tailored to address patients who had different motivations to change their behaviours. One GP considered the approaches in this training helped to address AOD in patients who had not considered a change: *'I now have a more systematic approach for addressing drug and alcohol concerns, particularly as it relates to pre-contemplative drug seeking patients'.* Using the transtheoretical model (of behaviour change) to identify a patient's stage of change was a key learning for GPs to overcome the initial barrier of raising the topic of AOD use and motivating the patient to change. One GP reported that the training provided new skills and strategies to address the key issue and motivate patients to change their behaviours. *'It is always difficult to engage patients regarding their SUD [substance use disorder] and motivate them to stop or reduce substance use, especially when they are dependent on it for a long time. Challenging them and raising doubts about their consumption is a good starting point and I will try to follow this process. Once patients get motivated to come for a change in their use, it becomes easier for a health professional to proceed further regarding management. First step is always a difficult one.'* While tailored to AOD care, the structured approaches in this training could be transferred to other issues or illnesses. One GP made this explicit and reported that the training enhanced their day-to-day clinical skills: *'I found this actively really helpful in positively reinforcing my day-to-day approach with AOD patient assessment.'*
Prioritising patient-centred care to support AOD management	Participants recognised that effective AOD management involved delivering individualised, relationship-focused, patient-centred care. Humanistic care, speaking openly and honestly with patients, involving patients in treatment planning, and prioritising patient safety were key elements of patient-centred care that fostered AOD management. Patient-centred care also involves completing a thorough assessment and becoming aware about the patient's whole situation prior to delivering AOD interventions. One GP made explicit that the training developed skills for patient-centred care: *'Better understand patients with AOD use in my practice. I can identify them better and speak openly to discuss their problem and together come up with a management plan to help curb their problematic use.'*

Table continued on the next page.

Theme	Description and illustrative quotations
	Prioritising patient-centred care enhanced GPs' confidence and willingness to address AOD issues in practice. Simply, one GP stated: *'It will help me relate to the patients and feel more confident in managing them'.* A different GP said it would: *'improve my own willingness and comfort to assess AOD in practice'.* Addressing AOD issues through a patient-centred lens helps maintain patient safety, and one GP felt the lessons in the training helped them enhance patient safety. *'It helps me to think [about] all aspects of my AOD… patients at my practice, including better assessment, proper referral, more safety for them.'*
Establishing general practice systems and delivering team-based care	New learnings influenced clinicians to consider establishing new systems in practice, such as for screening, referral and follow-up. One participant said: *'We might set up systems to triage such patients for safety and get them back later for follow-up.'* Along with new systems, participants considered establishing practice-wide policy, for example to manage drug-seeking patients. One GP said: *'I've got a strategy for managing some patients that ask for prescription meds. A practice policy needs to be made.'* The training supported GPs to review and re-hone their skills and ability to manage AOD issues. It also developed participants' awareness of their own clinical practice, and this helped GPs recognise when to seek support and coordinate care. One GP said: *'Better safety-netting and discernment between what I can manage safely in general practice, and what I need to refer on to a D&A* [Drugs and Alcohol] service' The training reinforced that GPs are not the only health professional to assist with AOD intervention and management. One GP expressed that the training helped them recognise patients with AOD issues and coordinate a team-based care arrangement. The training highlighted available referral services and made GPs feel more confident to lead team-based care arrangements. *'Early recognition and referral to AODS with shared care arrangement between myself, specialist and multidisciplinary team.'*

Optional post-training survey: Additional comments

Additional comments were provided under three broad categories: positive perceptions of the training, constructive feedback and challenges to apply learnings in practice. An explanation of each category and examples of narrative quotes are described in Table A3.

Table A3. Essential skills: Additional comments

Category	Definition	Evidence (illustrative quotations)
Positive perceptions of the training	Participants commented on the aspects of the training they valued, such as the learning format, content and resources.	*'This was an excellent course!!! Good amount of high quality, evidenced based information delivered in a format that was perfect for learning the essential skills of evaluating and management drug and alcohol concerns in general practice.'* *'Excellent course! Very helpful, particularly enjoyed the range of videos showing very useful and practical examples of how to engage with patients.'* *'The videos showing examples of clinicians handling difficult conversations was very helpful! Overall, a fantastic module.'* *'I think it was really valuable, particularly as these issues seem to come up in consults regularly.'* *'Very well designed, great videos, excellent resources. Would recommend.'*
Constructive feedback	Participants provided constructive feedback to enhance the training for future GP education programs.	*'Would be useful to learn a bit more about withdrawal symptoms of AOD use and how to manage.'* *'I would've liked additional resources to further motivational interviewing education and training.'* *'The information was very dry. Ways of making it more interactive to apply the principles and less focussed on copious amounts of stats and acronyms without ability to practice applying them to help with retention and application of information might be worth exploring. In general, the principles are excellent but it was highly content dense and hard to remain focussed or retain such a large volume of information despite interest in the topic.'* *'Very long and many acronyms to remember. May need to simplify so that it is clear which system to use e.g. FLAAGS etc. Good to have a summary of the different systems at the end.'*
Challenges to apply learnings in practice	Participants reported there to be barriers in practice to successfully deliver AOD interventions. One participant reported a mismatch between the course content and their current practice.	*'Getting my patients back for subsequent longer appointments is often not achievable as my patients are incredibly chaotic, and only attend when they have a specific needs/agenda (need a form signing… or needing their drugs [prescription]).'* *'I believe an unavoidable shortcoming lies in the reality that so many of those with serious AOD and mental health co-morbidity have burned all their supports and lack trusted persons and the skills maintain supports.'* *'Overall good and helpful. I found some of the doctor patient interactions more in depth than I would expect to go e.g., with the patient coming in for an STI check. I'd touch on the issues and explore more down the track I feel.'*

Appendix B. Treatment Skills training

Introduction

This appendix focuses on participant engagement with the training, participant demographics, experience and satisfaction.

Treatment Skills training was developed for GPs to build and expand on their core AOD consultation skills covered in Essential Skills training (refer to Appendix A). Essential Skills training was not a prerequisite for Treatment Skills training.

Treatment Skills were designed to advance a GP's AOD knowledge and skills in the context of whole-person-centred care. Participants were trained in how to assess the reasons why a patient is using AOD, determine approaches to managing any physical or mental health comorbidities and, where appropriate, identify if the patient had a mild, moderate or severe substance use disorder. Participants were enabled to create a repertoire of strategies to support people who use AOD, including harm minimisation, withdrawal, weaning and opioid replacement therapy.

Participants could complete Treatment Skills training via one of the following two course modalities:

1. Treatment Skills training: 'AOD Live' workshop: Face-to-face training delivered in an online workshop format for participants who preferred an interactive, face-to-face learning experience. Each 'AOD Live' series was delivered as three 90-minute Zoom workshops over three consecutive weeks. Participants were required to attend all three workshops in a series and complete all evaluation activities to successfully complete training. GP AOD medical educators delivered the training with each workshop consisting of a didactic presentation followed by case-based discussion and self-reflection in small groups.
2. Treatment Skills training: Online Self-directed (*gplearning*): Self-directed training was designed for GPs who preferred access to a wide range of AOD educational content and best practice toolkits delivered via an online learning module that they could complete at their own pace. The structured, self-directed learning involved a mixture of core modules, optional modules, case studies and self-reflection exercises.

Training grant	$1200
Timeline	AOD Live (continuous: May 2020 to September 2021) Self-directed (continuous: October 2020 to June 2022)
Delivery	AOD Live (Zoom videoconference) Self-directed (on-demand, via *gplearning)*
Duration	Minimum of six hours
CPD points	Accredited for 40 points in the RACGP CPD Program for the 2020–22 triennium
Learning outcomes	1. Assess why a patient is using AOD, the severity of the risk and their readiness for change. 2. Discuss approaches to treating problematic AOD use, including enhancing patients' motivation to change. 3. Design a tailored treatment plan for patients using a whole-person care approach. 4. Create a plan to assist patients to withdraw from AOD or minimise use and harm, in accordance with the patient's goals and needs. 5. Develop AOD treatment skills that are respectful of patient needs, while protecting the GP's health and boundaries.

Analyses

Participant demographics

The total number of participants who completed Treatment Skills training between May 2020 and June 2022 was 2476 (Pathway 1 AOD Live n = 598; Pathway 2 Self-directed n = 1878).

Table B1 describes the demographics of the 2476 participants who completed Treatment Skills training.

Table B1. Treatment Skills training participant demographics

Characteristic	AOD Live – participant demographics	Self-directed – participant demographics
Gender	59% female, 41% male	57% female, 43% male
Career stage	10% pre-Fellow, 43% New Fellow, 44% mid-career, 3% late career	18% pre-Fellow, 45% New Fellow, 36% mid-career, 1% late career
Rural/remote status	75% metro, 24% rural/remote, 1% unknown	76% metro, 23% rural/remote, 1% unknown
Country of medical qualification	49% IMG, 45% Aust, 6% unknown	46% IMG, 46% Aust, 8% unknown
Top five countries of medical qualification for IMGs	United Kingdom, India, Sri Lanka, Bangladesh, Iran	Myanmar, United Kingdom, India, Iran, Egypt

The mixed methods evaluation was informed by data collected from participants who completed the course between June 2020 and December 2021.

Engagement and participant demographics

Table B2 provides an overview of the Treatment Skills training completions, withdrawals/rejections and training completion rate.

Table B2. Treatment Skills completions and withdrawals/rejections

Variable	Number
Training completions	2266
Self-directed completions	1668
AOD Live completions	598
Withdrawn/attrition	426
Training completion rate	81.2%
Common reasons for dropout	Did not complete training on time (n = 316) Training allocation reached (n = 38)
Rejections	117
Common reasons for rejection	Insufficient justification for application (n = 40) Not active in general practice (n = 63)

Table B3 describes the number of Treatment Skills completions from each state/territory and the proportion of the sample each state/territory represents. The number of RACGP members who were eligible to apply for the program from each state/territory is also included

Table B3. Treatment Skills training completions and number of members eligible to apply for training

Variable State/territory	Number of participants (% of total sample)	Eligible RACGP members
NSW	573 (25%)	10,132
Queensland	471 (21%)	7,277
Victoria	616 (27%)	8,565
SA	140 (6%)	2,492
WA	289 (13%)	3,581
Tasmania	82 (4%)	854
NT	45 (2%)	365
ACT	44 (2%)	705

Table B4 describes participants who identified as Aboriginal and/or Torres Strait Islander.

Table B4. Treatment skills training participants who identified as Aboriginal and/or Torres Strait Islander

Identify as Aboriginal and/or Torres Strait Islander	Number (%)
Yes	11 (<1%)
No	2079 (92%)
Prefer not to say	91 (4%)
Not reported	(85 (4%)

Participants' clinical profile

The following data on the clinical profile of participants were collected during the application process:

- 21% were MATOD prescribers, 79% were not MATOD prescribers
- 58% were active prescribers of naltrexone, 42% were not active prescribers of naltrexone
- 19% were active prescribers of suboxone, 81% were not active prescribers of suboxone

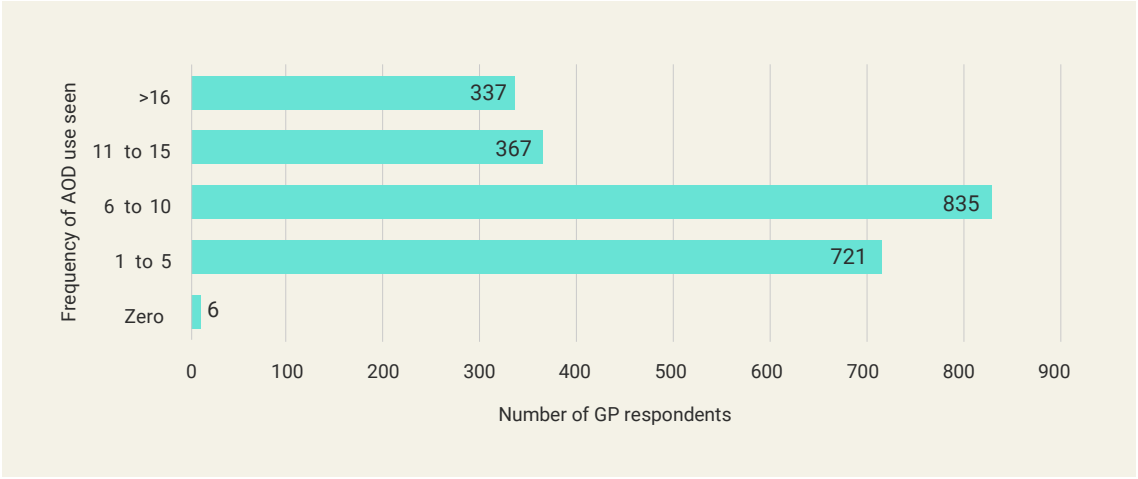

Figure B1. Frequency of AOD use seen each week

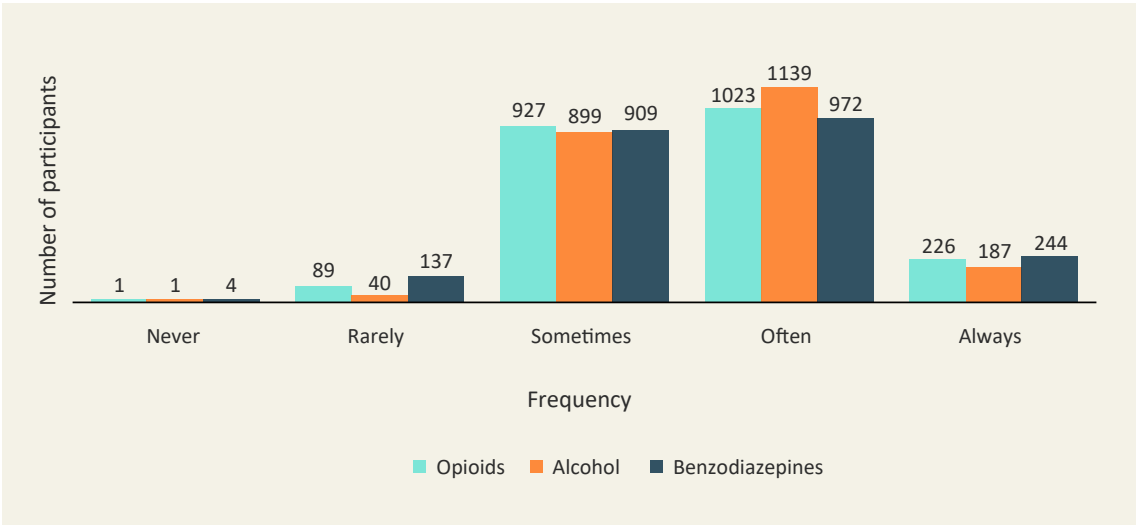

Figure B2. How often GP participants struggled to assist people impacted by alcohol, opioids and benzodiazepines (n = 2266)

Table B5 describes participants' Index of Relative Socio-economic Advantage and Disadvantage (IRSAD).

Table B5. Treatment Skills participants' IRSAD

IRSAD score	Number of GPs (% of sample)
1	323 (14%)
2	636 (28%)
3	569 (25%)
4	393 (17%)
5	253 (11%)
N/A	92 (4%)

Participants self-reported the groups they were treating that were at a higher risk of harms from AOD use. On average, GP participants delivered general practice services to approximately three high-risk patient populations per week (mean: 2.7; SD: 1.5; min: 1; max: 7) (refer to Table B6).

Table B6. High-risk groups treated by Treatment Skills participants

High-risk group	Number of GPs (% of sample)
Low socioeconomic status	1676 (74%)
Trauma	1304 (58%) (n = 246 not reported)
Aboriginal and/or Torres Strait Islander	423 (19%)
LGBTIQA+	1055 (47%)
Homeless	1058 (47%)
Veterans	384 (17%)
Those in contact with the criminal justice system	138 (6%)

Motivations to undertake training

For GP participants of the AOD Live pathway, the largest motivators to undertake the training are described in Table B7.

Table B7. Factors influencing a GP's motivation to enrol in Treatment Skills training

	Top five factors that did influence a GP's motivation to enrol	Top five factors that did not influence a GP's motivation to enrol
AOD Live	1. Treating AOD use is one of my identified learning priorities. 2. The completion pathway suited my needs. 3. The program was free to complete. 4. The program was an accredited CPD activity for the 2020–22 triennium. 5. I would receive a payment upon the program's successful completion.	1. I am seeing more AOD use in my practice as a result of COVID-19. 2. To connect with other GPs who experience similar challenges in their practice. 3. The opportunity to discuss cases in small groups. 4. The program was developed by the RACGP. 5. The program was an accredited CPD activity for the 2020–22 triennium.
Self-directed	1. I could complete Treatment Skills training at my own pace. 2. Treating AOD use is one of my identified learning priorities. 3. The program was free to complete. 4. The completion pathway suited my needs. 5. I would receive a payment upon the program's successful completion	1. I am seeing more AOD use in my practice as a result of COVID-19. 2. The program was developed by the RACGP. 3. The program was an accredited CPD activity for the 2020–22 triennium. 4. To learn from expert GPs who experience similar challenges in their practice. 5. I would receive a payment upon the program's successful completion.

Course duration

Treatment Skills training (Self-directed) participants (n = 1419) completed the course on average after 42 days (SD: 30 days).

- Approximately 42.9% completed the course within 30 days.
- 29.9% completed the self-directed course within 30 to 60 days.
- 24% completed the self-directed course within 60 to 90 days.
- 3.2% completed the course after 90 days.

Pre/post-training survey: Key findings

Relevance

Fourteen hundred and twenty post-training surveys were analysed (self-directed pathway).

- 99% of participants agreed the program was relevant to their current practice needs (29% agreed, 70% strongly agreed).
- 99% of participants felt they were able to find and use appropriate assessment tools and clinical guidelines to safely treat AOD use (38% agreed, 61% strongly agreed).
- 99% of participants rated e-learning to complete skills-based AOD education (*gplearning*) as effective (93% effective, 6% partially effective).

Participants were asked to rate to what extent the training addressed five key learning outcomes (refer to Table B8).

Table B8. Ratings of Treatment Skills key learning outcomes

Key learning outcome	Met or exceeded expectations	Partially met or did not meet expectations
Assess why a patient is using AOD, the severity of the risk and their readiness for change	99%	1%
Discuss approaches to treating problematic AOD use, including enhancing patients' motivation to change	99%	1%
Design a tailored treatment plan for patients using a whole-person care approach	96%	4%
Develop AOD treatment skills that are respectful of patient needs, while protecting the GP's health and boundaries	97%	3%
Create a plan to assist patients to withdraw from AOD or minimise use and harm, in accordance with the patient's goals and needs	95%	5%

Participant satisfaction

Participants of the self-directed pathway rated their satisfaction across 10 items, which related to various training elements, including the application process, training platform (*gplearning*), course length, course content and resources provided.

- A rating of 1 represented low satisfaction and a rating of 5 represented outstanding satisfaction.
- A total of 623 GPs responded to 6210 items related to satisfaction.
- An average rating of 4.35 was recorded across all items, indicating outstanding satisfaction.

Participants of the AOD live pathway rated their satisfaction across 20 items, which related to various training elements, including the application process, communication with RACGP staff, workshop schedule, survey demands, duration, resources provided, the RACGP website, and the knowledge and skills of the workshop presenters.

- A total of 91 GPs responded to 1820 items related to satisfaction.
- An average rating of 4.45 was recorded across all items, indicating outstanding satisfaction.

Treatment Skills training topics

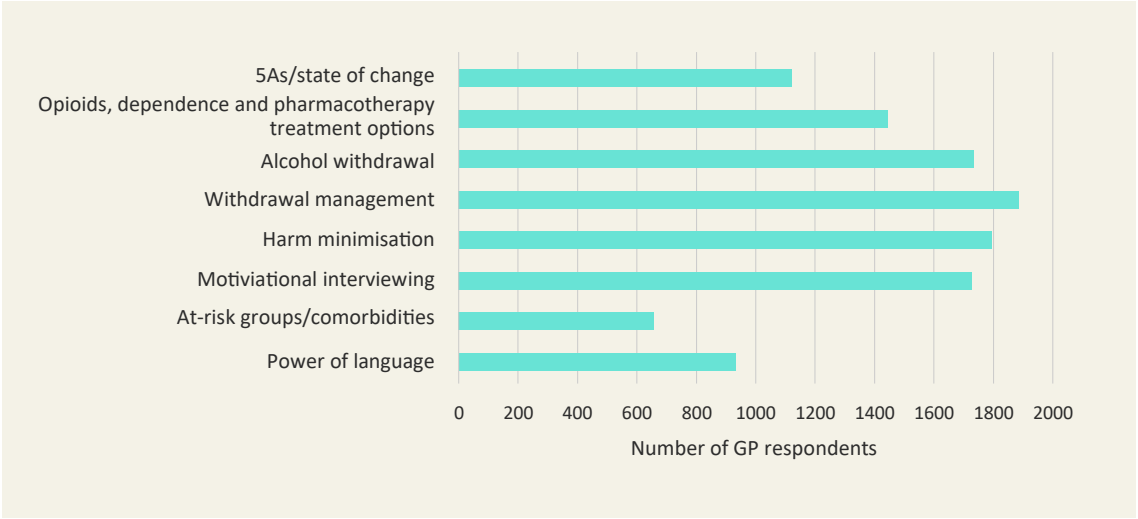

Figure B3. Responses to the question, 'What topics did you find most useful?'

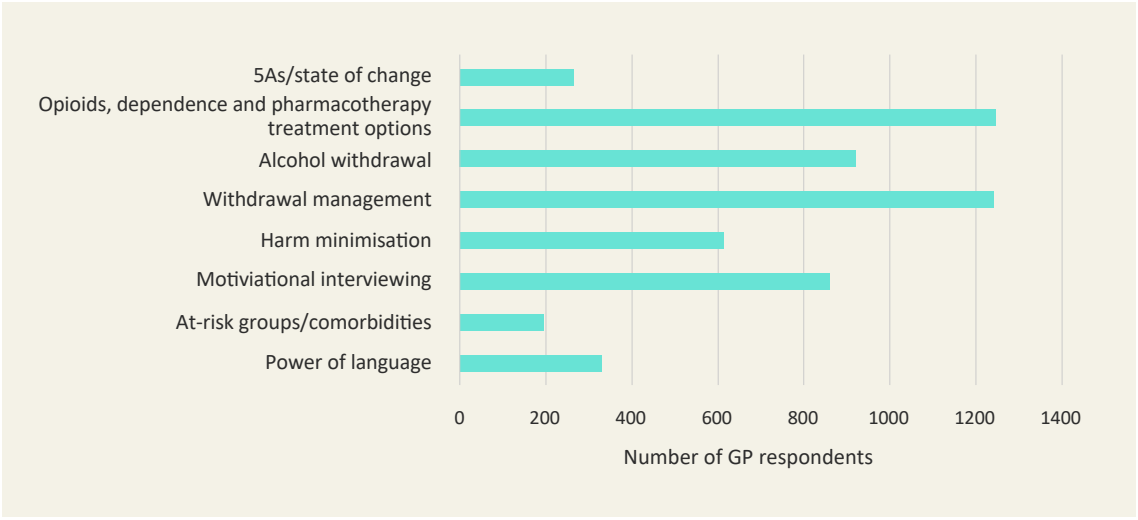

Figure B4. Responses to the question, 'What topics would you like to spend more time on?'

Appendix C. Advanced Skills training: Part 1 – GP participants

Introduction

This appendix focuses on Advanced Skills training GP participant ('mentee') participation. Advanced Skills training was offered to RACGP members seeking in-depth training to address substance use issues relevant to their local community.

To be eligible for this pathway, RACGP members were required to provide evidence that they were currently treating patients with substance use issues or had prior training in AOD. Participants applied through an online application form that was assessed by the RACGP.

Training was self-directed, individualised and GP-centred. Participants designed and implemented their own personalised learning plan (PLP) to address their individual learning needs and to support the needs of patients within their community or general practice setting. GP participants set their own learning outcomes (a minimum of two, maximum of four) by identifying up to four key learning objectives in their PLP.

Participants were required to complete at least 20 hours of AOD-related CPD activities to address the learning needs and priorities identified in their PLP. Plan activity was required to include a mix of education modalities, such as webinar attendance, online learning modules, patient data analysis, mentor case-base discussion and professional reading, and activities were recorded in an activity logbook. Participants were required to complete an evaluation survey on completion of training and were encouraged to share their knowledge and skills with others.

Participants were supported by an AOD mentor who provided them with minimum of six hours of individual guidance and feedback throughout their training. Mentors were Australian Health Practitioner Regulation Agency (AHPRA) registered individuals with suitable AOD experience and qualifications. Participants identified their own mentor; however, participants in regional/remote areas received support to connect them with a suitable mentor.

To offer a mix of educational content to support Advanced Skills participants, a series of six 90-minute Advanced Skills webinars were delivered by RACGP AOD Program medical educators. Participants could include these webinars in their activity logbook, and they were available on-demand. Topics included:

- The inherited pain patient
- How to help patients who have turned to alcohol at a time of crisis
- GP burnout prevention, containment and boundaries
- Substance use lapse and relapse
- The changing role of pharmacotherapy, the bigger picture and depot buprenorphine
- Recreational drug use
- AOD in pregnancy

Training grant	$2500
Timeline	Intake 1 (August 2020 to March 2021) Intake 2 (May 2021 to November 2021) Intake 3 (December 2021 to June 2022)
Delivery	Participant-led
Duration	At least 20 hours
CPD points	Accredited for 40 points in the RACGP CPD Program for the 2020–22 triennium
Learning outcomes:	1. Determine the patients at high risk for AOD use in your local community, the substances they use and the common problems they experience. 2. Design and implement a 20-hour AOD PLP. 3. Generate a short list of guidelines that can be used in your general practice setting to support your patients. 4. Develop strategies such as harm minimisation with your mentor to improve patient outcomes in your general practice setting. 5. Determine local AOD referral pathways and services that you can use in the coordination and care of your patients.

Analyses

The total number of participants who completed Advanced Skills training was 239. Three intakes were delivered successfully between August 2020 and June 2022.

Participant demographics

Table C1 describes the demographics of the first 238 participants who completed Advanced Skills training.

Table C1. Advanced Skills training participant demographics

Characteristic	Advanced skills participant demographics
Gender	50% female, 50% male
Age	Average age 42
Career stage	20% pre-Fellow, 37% New Fellow, 42% mid-career, 2% late career
Rural/remote status	75% metro, 24% rural/remote, 1% unknown
Country of medical qualification	45% IMG, 50% Aust, 6% unknown
Top five countries of medical qualification for IMGs	Egypt, UK, India, Iran, Nigeria

IMGs, international medical graduates

A mixed-methods evaluation of Advanced Skills was informed by data from intakes 1 and 2 that was collected between August 2020 and March 2022 (Table C2).

Table C2. Advanced Skills applications, completions and attrition rate

Variable	Number of participants
Number of applications	270
Number of completions	170
Attrition	100 (37%)
Common reasons for dropout	Competing priorities such as increased workload due to the COVID-19 pandemic (n = 47) Inability of participants to progress the training successfully within appropriate time frame led the RACGP AOD team purposefully withdrawing participants from program (n = 24) Participants unable to find mentor (n = 16) Sitting/preparing for fellowship exams (n = 10)

Table C3 describes the number of Advanced Skills completions from each state/territory and the proportion of the sample each state/territory represents.

Table C3. Advanced Skills training completions

Variable State/territory	Number of participants (% of total sample)
NSW	35 (21%)
Queensland	38 (22%)
Victoria	49 (29%)
WA	19 (11%)
Tasmania	8 (5%)
NT	5 (3%)
ACT	8 (5%)

Table C4 describes participants who identified as Aboriginal and/or Torres Strait Islander.

Table C4. Advanced Skills training participants who identified as Aboriginal and/or Torres Strait Islander

Identify as Aboriginal and/or Torres Strait Islander	Number (%)
Yes	2 (1%)
No	155 (91%)
Prefer not to say	6 (4%)
Not reported	6 (4%)

Participants partnered with mentors from a variety of health professions (Figure C1).

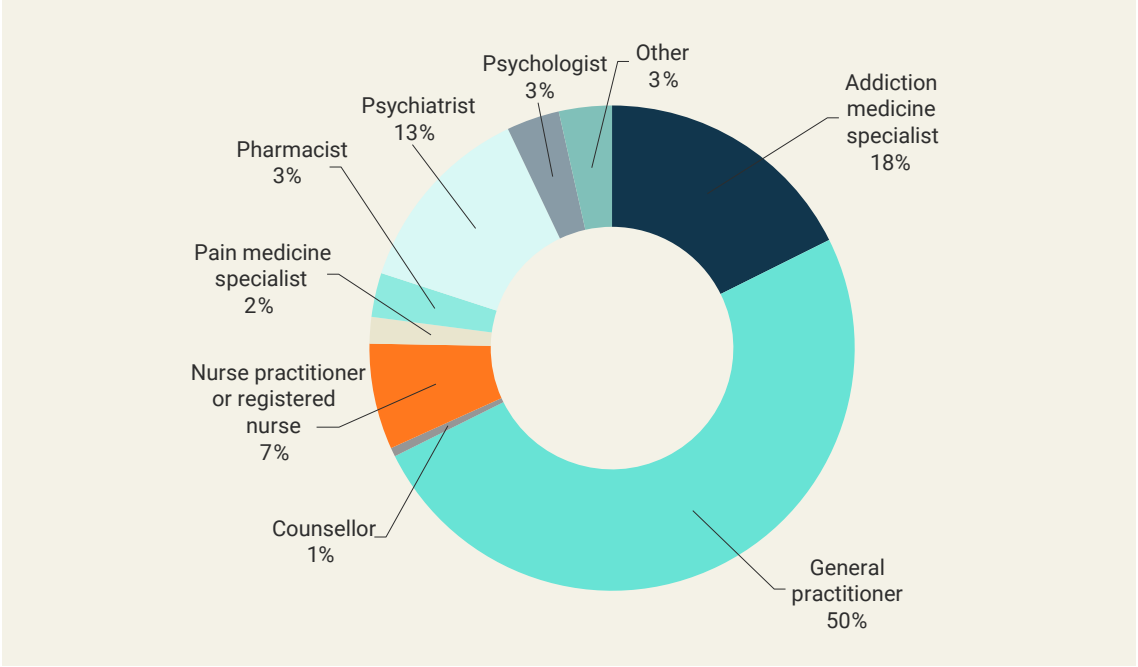

Figure C1. Profession of Advanced Skills participants' mentors

Participants' clinical profile

The following data was collected from participants prior to commencing Advanced Skills training:

- 61% had completed accredited opioid dependence training, while 39% had not
- 37% were GP supervisors, 63% were not
- 52% had AOD patients referred to them by colleagues/services/other patients, while 48% did not.

Figure C2 depicts the number of AOD patients seen by Advanced Skills GP participants each week.

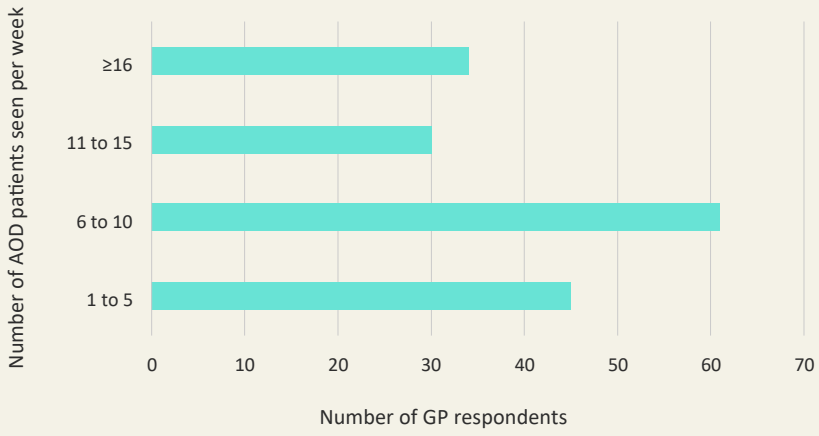

Figure C2. Advanced Skills participants' frequency of AOD interactions

Participants self-reported the groups they were treating that were at a higher risk of AOD use (Table C5).

Table C5. High-risk groups treated by Advanced Skills participants

High-risk group	Number of GPs (% of sample)
Low socioeconomic status	157 (92%)
Trauma	135 (79%)
Aboriginal and/or Torres Strait Islander	132 (78%)
LGBTIQA+	114 (67%)
Homeless	94 (55%)
Veterans	68 (40%)
Those in contact with the custodial system	51 (30%)

Factors that motivated participants to enrol in the training

The strongest motivators for GPs to enrol in the training were:

- seeing more AOD use in practice
- treating AOD use was one of their identified learning priorities
- ability to personalise plan according to their experience and needs
- ability to be supported by a mentor of their choice
- free to complete and attracted reimbursement upon completion.

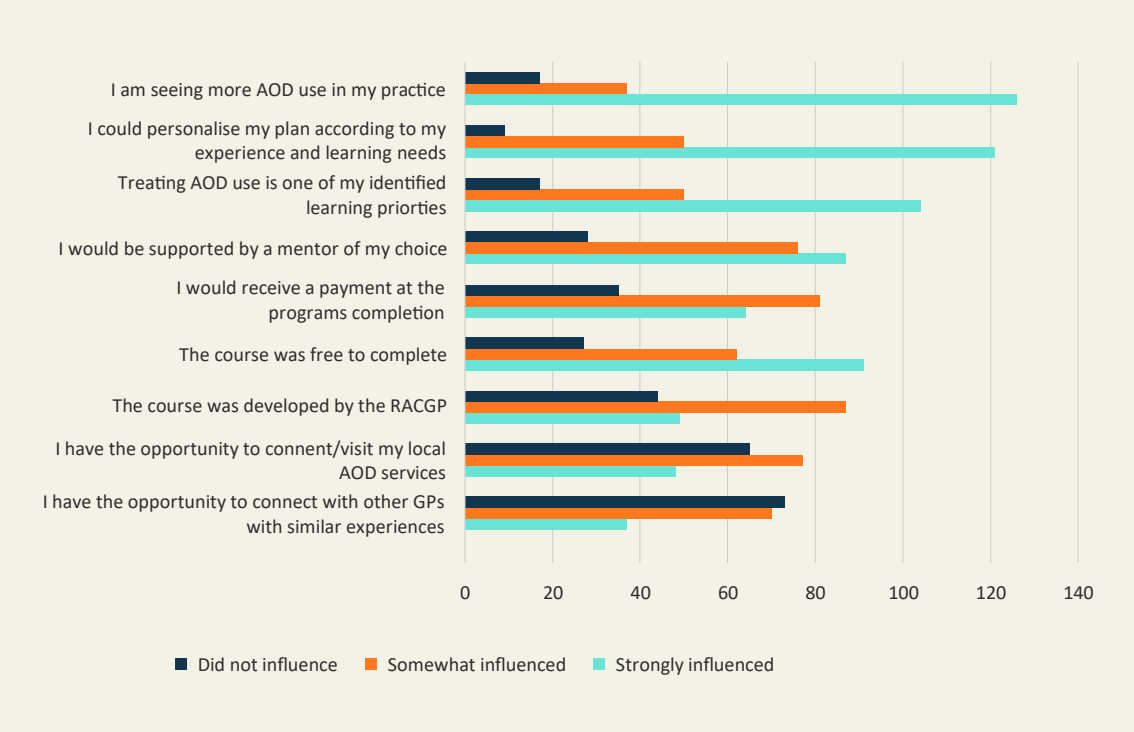

Figure C3. Factors that influenced Advanced Skills participants' motivation to enrol

Personalised learning plans (PLPs)

In their PLP, participants established up to four learning priorities of their own choosing. Most GPs set four priorities (n = 108, 64%), although 52 GPs (31%) set three priorities and 10 GPs (6%) set two learning priorities.

The three most frequently documented learning priorities were:

1. deliver a GP-led planned withdrawal from alcohol use disorder
2. prescribe medication assisted treatment for opioid use disorder
3. use motivational interviewing techniques.

The priority learning areas or goals reported in participants' PLPs are shown in Figure C4.

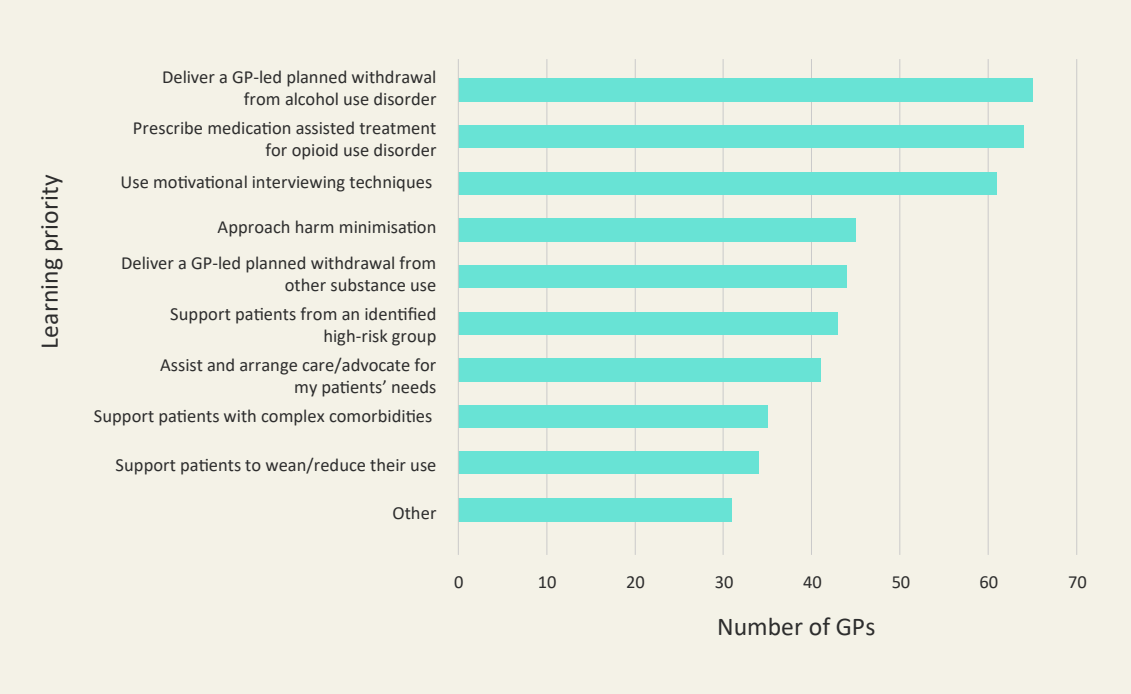

Figure C4. Learning priorities identified by GPs and documented in PLPs

Logbook activities

Tables C6 and C7 describe aspects of logbook activities.

Table C6. Total duration of learning activities documented

	Mean (SD)	Median	Mode	Min	Max	Interquartile range (IQR)
Total logbook duration (hours)	32.7 (25)	25.0	21	20.0	252.0	10.0

Table C7. Types of learning activities documented

	Duration (hours)			
Activity type	**Mean (SD)**	**Median**	**Max**	**Interquartile range (IQR)**
Online modules/courses	8.4 (8.4)	6.0	51.5	11.3
Webinars/podcasts	2.6 (3.5)	1.5	22	4
Reviewing clinical guidelines or additional reading	8.3 (7.6)	6.8	50	8.9
Developing resources	0.71 (1.8)	0	10	0
Case reflection (including discussions with mentor and/or colleagues)	5.9 (5.9)	4.3	35	6.0
Clinical placement	4.7 (18.0)	0	166	3.4
Other	2.0 (9.2)	0	96	0

Post-training survey

The following responses are from complete data (note that participant numbers vary – not all questions were mandatory and in some cases participants did not respond to a question):

- 99% agreed the program was relevant to their current practice needs (82% strongly agreed, 17% agreed, 1% strongly disagreed) (n = 170)
- 99% agreed the program addressed their overall learning needs (70% strongly agreed, 29% agreed, 1% strongly disagreed) (n = 170)
- 98% expected to implement skills learned from the program in their practice (78% strongly agreed, 20% agreed, 2% strongly disagreed) (n = 170)
- 92% of participants were easily able to find a suitable mentor (51% strongly agreed, 41% agreed, 7% disagreed, 2% strongly disagreed) (n = 170)
- 78% knew their mentor prior to completing the course (44% strongly agreed, 34% agreed, 14% disagreed, 8% strongly disagreed) (n = 170)
- 99% would recommend their mentor for a similar program in the future (69% strongly agreed, 30% agreed, 1% disagreed) (n = 170)
- 69% felt developing their PLP took longer than anticipated (19% strongly agreed, 50% agreed, 28% disagreed, 3% strongly disagreed) (n = 170)
- 91% felt developing their PLP was fairly straightforward (28% strongly agreed, 63% agreed, 9% disagreed) (n = 170)
- 99% felt they got the guidance needed after approaching the AOD inbox (99% agreed, 1% disagreed) (n = 130)
- 99% felt communication from RACGP AOD team was clear and supportive (99% agreed, 1% disagreed) (n = 129)
- 100% felt overall, the activities they undertook were a good investment of their time (100% agreed) (n = 131)
- 97% felt Advanced Skills training allowed them to participate in activities that they would not otherwise had time to complete (97% agreed, 3% disagreed) (n = 170)
- 93% felt that 20 hours was a suitable requirement for the length of the program (93% agreed, 7% disagreed) (n = 170).

Participants' post-training reflections on learning goals

Upon completion of the training, participants wrote a reflection on their learning goals. Table C8 provides examples of reflections as related to the three most common learning priorities.

Table C8. Participant reflections in relation to learning priorities

Learning priority	Participant reflections (illustrative quotations)
Deliver a GP-led planned withdrawal from alcohol use disorder	*'I was very happy to be able to guide a patient through how to safely participate in a well planned and prepared home alcohol withdrawal program. This is a patient I know well with a complex medical background including organ transplantation, polypharmacy and mental health concerns - it was actually very rewarding for our relationship to successfully manage her home alcohol withdrawal. She had many years of specialists (and me!) telling her to cut down the alcohol, but I now have more practical tips gained from the AOD webinars and resources to create the plan. She has now been 2 months without alcohol and her partner is considering cutting back now himself.'* *'I have taken away valuable evidence-based practice guidelines on what to prescribe for the short term and long term management of alcohol and cannabis withdrawal. This was an area that I previously didn't feel confident in due to lack of knowledge. From researching a wide range of resources and incorporating them into my notes, I now feel able to manage both alcohol and cannabis withdrawal, have a general approach and know how to approach longer term management when needed. I will change my practice through being more confident in prescribing short term diazepam for alcohol withdrawal and being more readily able to recognise the signs and symptoms of withdrawal. When longer term management is needed, I feel more confident to explore these avenues and also where to look for further information, guidelines and support. With respect to cannabis withdrawal, I shall encourage more symptomatic management and gradual reduction as I had previously thought that diazepam was the only option but through achieving this learning outcome I have now more knowledge and this will change my practice. I shall share this knowledge I have gained with my colleagues in both medical practices that I work with. I shall also share this document with medical students and the registrars that come to our practice. I shall share my knowledge with others at clinical meetings.'* *'This activity reinforced my knowledge and skills in assessing and conducting a home alcohol detox strategy. Screening of patients with the following tools, Alcohol Use Disorders Identification Test (AUDIT), Severity of Alcohol Dependence Questionnaire (SADQ), and Kessler Psychological Distress Scale (K10), initially to assist in understanding a patient's level of use and risk. I also learnt limitations and what would go wrong during a home detox treatment and the importance of arranging possible interventions in advance. Post-detox follow-up reviews and support are essential to prevent a relapse.'*
Prescribe medication assisted treatment for opioid use disorder	*'I have developed an opioid treatment flowchart which reminds the doctor to screen for co-morbidities (such as other substance/medication use, psychiatric conditions like depression/ anxiety, sleep apnoea) prior to commencing opioid treatments, as well as to consider other non-pharmacological treatments such as psychologist/dietitian/physio/other medical specialities. It guides the doctor to create clear goals and establish rules with the patient for use of opioids, and to monitor for effectiveness of treatment as well as looking out for aberrant behaviour which may indicate dependence or addiction. I have also read and implemented the NPSWise opioid tapering algorithm into everyday practice - and have encouraged many people to gradually wean off opioid use if the condition is not indicated. Insight from my mentor is very helpful in this area as being an addiction medicine specialist, he explains treatments such as MATOD [Medication Assisted Treatment of Opioid Dependence], and how to manage withdrawal symptoms such as insomnia. He also guides me on referral pathways such as DACAS hotline number, ways to refer to Drugs and Alcohol Services SA, indications for inpatient treatment etc. In the future I hope to share this flowchart and referral pathways/local services knowledge with doctors outside of my practice.'*

Table continued on the next page.

Learning priority	Participant reflections (illustrative quotations)
	'I found it valuable to get strategies to promote safe prescribing at a proximal level. It was also helpful to get specific pharmacological guidance on approaches to initiating opioid replacement therapy, which had felt like something that is beyond my scope of practice previously, but now feels like a more realistic tool to use. It was also valuable to gain awareness of resources and supports available to a GP in managing patients whose substance use issues require more specialised support.'
	'I learnt about how to identify prescription shoppers, how to develop an opioid management plan, identifying red and orange flags and how to help my patients understand their pain and biopsychosocial factors that can impact it. Also understanding when to refer and where to refer for help. I will be sharing what I have learnt at the upcoming doctor's meeting at our clinic. I have an interest to further extend my skills and have registered to do the next part of Medication-Assisted Treatment for Opioid Dependence [MATOD] – Module 2 – for Victorian GPs.'
Use motivational interviewing techniques	*'I have definitely learned a lot more about motivational interviewing techniques than I was previously aware of. I have used these skills with patients I have seen in the last few weeks, with hopefully some benefit and plan to continue to use these skills wherever the opportunity arises to practice them and maintain them. Even outside of AOD, I have been able to use some of these motivational interviewing skills. This is a skill that I feel will be useful to share with medical students and colleagues alike. I will also refer them to particular resources discussed the motivational interviewing frameworks I have learnt about, particularly FRAMES approach.'*
	'My main take away message were the techniques in motivational interviewing, and helping patients set achievable goals. This has already affected my practice; in that I have found myself spending more time exploring with patients bite sized approaches to make healthier lifestyle choices. I shall be discussing with colleagues, as well as documenting in patient notes, as we have a team approach, my assessment of patients as well as the approach I am taking with them, which should hopefully allow for me to share my new learned techniques with others. I also plan to have brief, casual conversations with my colleagues when I work with them to discuss motivational interviewing techniques to further my knowledge base and share what I have learnt.'
	'The most important part that I need to change is my ' righting reflex' which seems have affected my ability to do effective motivational interviewing. The videos and the Insight modules have made realise the need to change the way I communicate with my patients through effective communications taking into account the 'change talk' and 'sustain talk'. I have lost rapport with few patients due to some resistance created by my old communication techniques which made them quite resistant for change. Rolling with resistance is something new to me and I am now incorporating it with my chats with AOD patients.'

Post-training survey: Additional comments

Additional comments were provided under six categories. Categories relate to the impact of the training on participants, perceptions of the training model and participants' perceptions of the AOD team. An explanation of each category with examples of narrative quotations are described in Table C9.

Table C9. Post-training survey: Additional comments

Category	Definition	Evidence (illustrative quotations)
Perceived impact of the training on GP participants' skills, knowledge, and clinical practice	Participants felt the training strengthened their clinical knowledge and skills; and developed their confidence to address AOD issues in practice.	*'I felt like I didn't know what to do before. This made me realise you don't have to do much, but just be there for your patients and guide them in their journey. I feel more confident in my approach and my patients are much more engaged!'* *'I found this program really valuable to increase my knowledge and confidence to address AOD issues in practice.'* *'Overall, a very good program to motivate and help GPs improve their skills and knowledge in AOD.'* *'I thought the training was excellent and the AOD project team were great! Thank you for such a great experience. I really do feel it will be very impactful on my practice and allow me to improve my care for those people experiencing troubles with substance use. Thank you!'* *'Thanks for the opportunity to strengthen ties with the AOD service in my community and strengthen my own skills.'* *'Overall, a really great program. I got a lot out of it, made some connections with my local team, was able to teach some info to my registrars, and hopeful this relationship will grow.'*
Perceptions of grant payments on engagement	Grant payments increased meaningful participation among some GPs.	*'It was a great program for a topic that I think a lot of GPs are under-skilled in. It is a topic that has huge implications on the health of the nation, and I feel grateful that I have had the opportunity to upskill in it. The financial incentive played a huge part in my decision to do the program which I feel is very smart. It is difficult to decide what programs to dedicate your spare time to, so it is nice (and logical) to offer busy GPs what is essentially paid study leave, which other specialities receive. I will be recommending this training to other GPs, and I hope we can make a big difference to substance use in future.'* *'I have really appreciated the opportunity for renumerated learning in an area of need and having access to a supportive mentor is invaluable.'* *'The payment allowed me to take time off to attend an outpatient clinic for a morning, have meetings with Sublocade and Buvidal reps and also help prepare the webinar (available on Sydney North Health Network website, well attended and great feedback afterwards). These activities would not have been viable otherwise.'*
Advanced Skills training provided an opportunity to participate in specialised learning	The training offering provided GPs with a formal opportunity to address learning needs in a specialised area of general practice.	*'This was a great opportunity to do something I had wanted to do for a long time. I think it is an extremely valuable opportunity and important to making changes in AOD treatment.'* *'I believe it was a good opportunity to focus on an area that an average GP is usually not very familiar with and it was an eye opener how prevalent alcohol and other drugs are in our society.'* *'The training just gave me the push to carve out the time to do [professional development] on topics that had been learning needs for a long time.'*

Table continued on the next page.

Category	Definition	Evidence (illustrative quotations)
Advantages and challenges of mentors	Participants showed an appreciation of having an AOD mentor throughout the training. Some participants were challenged to find and partner effectively with an appropriate mentor.	*'The requirement of mentorship was a very valuable learning experience and one that should ideally be replicated in other areas of GP skills. It allowed individuals to tailor learning to their previous knowledge/level of expertise that a generic course would not have allowed.'* *'I really enjoyed the mentorship component and was able to connect with an addiction medicine specialist mentor I would otherwise not get the opportunity to meet. So, thank you!'* *'Really enjoyed working with my mentor getting practical and locally relevant advice.'* *'It has been a good learning venture. However, I think this is just the beginning of the learning process. I'll need assistance in practice when I start treating substance abuse disorders. I also think, the RACGP AOD team should be more vigilant in finding a suitable mentor for this program. I had difficulty in finding my mentor. My mentor was very co-operative. But he was very far from my practice. If I could manage a mentor around my practice, I would be able to explore more local help for practical option.'*
Perceptions of the self-directed training model	Generally, the self-directed approach to training was viewed to enhance flexibility and enable GP participants to identify their own learning needs and tailor education strategies to address any identified learning needs.	*'The self-directed nature of this Advanced Skills training was excellent by enabling me to learn about exactly what I wanted to and what was relevant to my patient cohort. It filled a lot of gaps in my knowledge which I had been wanting to fill!'* *'This type of self-directed learning is a great way for GPs to identify areas they require more knowledge/training/experience in as it forces you to take a look at your knowledge base and the gaps therein. The suggestions put forward by the college were on the whole very helpful.'* *'This is a challenging area to upskill practitioners in. Initially I was actually unsure about the fact that the program had no didactic teaching built into it. It was only on reflecting and considering my learning needs that I realised that the flexibility of the program was quite helpful.'* *'Excellent program, good to have been able to complete it at my own pace and got appropriate information and help as I needed extension of the deadline.'* *'I like the self-paced program but would prefer to have a mix of supported and self-paced learning.'* *'Fantastic program, great flexibility especially given the current pandemic'*
The RACGP AOD team and the delivery of Advanced Skills training	The RACGP AOD team was accessible, understanding and responsive to the needs of participants. The AOD team provided ongoing support to all participants, and this contributed to the success of the program.	*'Project team has supported me very well throughout the program. The application process was simple. I felt so well supported especially when I was in much need for extension due to change in family situation.'* *'They [RACGP AOD team] are very prompt to answer my queries and very supportive when I had questions especially when I required a little extra time to complete a task. They were very understanding.'* *'The support I have received has not been overbearing but certainly responsive and supportive when I have needed it. I am very grateful for the opportunity and the support.'*

Appendix D. Advanced Skills training: Part 2 - Mentors

Introduction

This appendix focuses on Advanced Skills training mentor participation. Mentors provided Advanced Skills GP participants with individual guidance and feedback throughout their training. Mentors were AHPRA-registered individuals with suitable AOD experience and qualifications. Mentor medical specialities included general practice (over half of all the mentors), addiction medicine, nursing, pain medicine, psychiatry, psychology, pharmacy and counselling (refer to Figure C1 in Appendix C). Participants identified their own mentor; however, support was provided to participants in regional/remote areas to connect them with a suitable mentor.

Mentors provided a minimum of six hours support to their GP participant ('mentee') as they developed and implemented their PLP. They also verified to the RACGP that their mentee had completed the activities outlined in their logbook. Mentors were required to submit a post-training evaluation of the program, which explored their Advanced Skills mentoring experience. Mentors were reimbursed $1500 (including superannuation and subject to relevant taxation) for a minimum six hours of support they provided to an individual participant. Mentors could mentor a maximum of three GP participants/mentees on the Advanced Skills training pathway.

Consultation payment	$1500 (excluding GST and subject to relevant taxation
Timeline	Intake 1 (August 2020 to March 2021) Intake 2 (May 2021 to November 2021) Intake 3 (December 2021 to June 2022)
Delivery	Participant-led
Duration	At least six hours mentor support
CPD points	Accredited for 40 points in the RACGP CPD Program for the 2020–22 triennium

Analyses

One hundred and ninety-seven Advanced Skills training mentors mentored a total of 239 GP participants. Some mentors mentored more than one GP.

Participant demographics

The mixed methods evaluation was informed by data collected from 87 mentors between **October 2021 and March 2022**: n = 21 mentors had more than one mentee; n = 16 had two mentees, while n = 5 had three.

Table D1 describes the demographics of these 87 mentors.

Table D1. Mentor demographics

Characteristic	Percentage
RACGP membership type	84% Fellow, 7% member, 6% associate, 3% GP in training
Rural/remote status	82% metro, 18% rural/remote
Country of medical qualification	61% Aust, 32% IMG, 7% unknown

IMG, international medical graduate

Table D2 describes the number of Advanced Skills mentors from each state/territory and the proportion of the sample each state/territory represents.

Table D2. Advanced Skills mentors by location

State/territory	
NSW	21 (24%)
Queensland	8 (9%)
Victoria	31 (36%)
WA	10 (11%)
Tasmania	5 (6%)
NT	2 (2%)
ACT	2 (2%)
SA	8 (9%)

Table D3 describes participants who identified as Aboriginal and/or Torres Strait Islander.

Table D3. Mentor participants who identified as Aboriginal and/or Torres Strait Islander

Identify as Aboriginal and/or Torres Strait Islander	Number (%)
Yes	0
No	63 (72%)
Prefer not to say	10 (11%)
Not reported	14 (16%)

Post-training survey quantitative findings

The post-training mentor survey resulted in the following findings:

- 91% of mentors found the Advanced Skills mentor role satisfying, 9% a little satisfying (n = 87)
- 90% of mentors agreed that the material provided by the RACGP adequately prepared them for being an Advanced Skills mentor, 10% did not agree (n = 87)
- 81% of mentors considered that being an Advanced Skills mentor fully met their expectations, 18% considered that it partially met their expectations, 1% considered that it did not meet their expectations (n = 87).

Post-session survey qualitative findings

Five main themes developed around mentors' perceived benefits of their relationship with their mentee:

1. Developing participants' AOD knowledge, skills and confidence by supporting self-actualisation and self-awareness
2. Sharing experiences and specific AOD treatment advice
3. Helping mentees identify and access relevant AOD support
4. Building relationships with participants that provided mutual benefit and development
5. Sustaining relationships and continuing AOD support

Refer to Table D4 for more on these themes.

Table D4. Mentors' reflections on the benefits of the relationship with their mentee

Theme	Description and illustrative quotations
Developing participants' AOD knowledge, skills, and confidence by supporting self-actualisation and self-awareness	Mentors perceived that their main role within the program was to develop the knowledge, skills and confidence of their mentees to manage substance use. Mentors considered that development and learning was driven by the mentee and guided by the mentor. One mentor reflected: *'perhaps steering self-directed learning might be the most impactful outcome of my support'.* Steering participants to self-directed learning involved directing mentees to resources, clarifying and validating knowledge, and broadening understanding of AOD use. A different mentor reflected: *'I think doctor [name redacted] is a skilled and open-minded clinician, and quite honestly I am not sure if my involvement was anything more than being a catalyst in learning. I think I was able to direct her to some resources, and also assist her in formulating her thinking and treatment plan re the cases we discussed.'* Mentors built relationships with mentees through establishing common ground, such as the common purpose of AOD management, and having open, honest discussions. Mentor–mentee discussions were important, and enabled mentors to assess knowledge, skill and confidence levels of mentees. Mentors were then able to assist mentees to identify their strengths and weaknesses and develop a personalised plan to address their learning needs: *'It [my mentorship] enabled my colleague to realise his strength and weaknesses, enabled him to improve his knowledge base and enhance his skill set. My colleague feels more confident in his ability to use resources appropriately, prioritise tasks, collaborate and advocate for his patients.'* *'We were able to discuss the content of her learning, apply it to practice and/or case studies and reflect on where improvements could be made. Having me there allowed my mentee to explore her strengths and identify areas she wished to continue working on.'* The established relationship between mentors and mentees led to information exchange, such as discussion of experiences, learnings and clinical cases. Mentors encouraged mentees to reflect on their practice and any strengths and weaknesses. One mentor felt they supported their mentee by *'encouraging reflection on interests, blind spots, and [providing] specific ways to increase knowledge and skills'.* Mentee reflection directed by mentors supported mentee's self-actualisation, where participants identified their own capacity to manage AOD use. Higher levels of self-actualisation resulted in mentees undertaking learning initiatives to address weaknesses, which led to greater confidence to address substance use within patient consultations.

Table continued on the next page.

Theme	Description and illustrative quotations
Sharing experiences and specific AOD treatment advice	Mentors perceived that sharing experiences and helping mentees identify and access AOD support were important components that contributed to the development of their mentee. Mentors were experienced AOD providers who related to their mentee through empathy or their background and experience. One mentor said: *'I'd like to think I helped [my mentee] hone her focus given the limited of time to a clinical area that was most useful. Part of my suggestions came from a personal reflection of the things I wish I knew more about when I was a rural / regional GP. I organised [my mentee's] clinical attachment such that she could sit in on a number of new patient assessments with different clinicians, in the hope she could learn from the different styles and approaches.'* Many mentees identified specific learning needs to develop as part of their PLP; and mentors drew upon their skills, knowledge and experiences to provide specific support for complex AOD issues. As part of the Advanced Skills training, one mentor based in New South Wales supervised their mentee's Opioid Treatment Accreditation Course (OTAC). The mentor said: *'I also supervised her for the OTAC, which subsequently helped to enhance her knowledge and confidence in prescribing OAT [Opioid Agonist Therapy].'* A different mentor felt they had a meaningful impact on their mentee's knowledge of risk management for community-based alcohol use detox: *'[I] assisted in shaping the direction of learning and clarified tricky issues such as community detox, especially around the management of risk.'* Sharing experiences and case-based discussions enhanced the range of approaches used by GPs to manage AOD use. One mentor said they advised their mentee '*to look broadly and to avoid simply prescribing for symptom alleviation*.' A different mentor explored harm minimisation approaches with their mentee and strategies to respond to cues in consultations; they reflected on the training: *'I think it [my guidance] enabled her to calibrate her responses to patients, where to continue to pursue matters with the patients, where to back off. I think she better understood the harm minimisation approach, the need to accept where the patient was in terms of wanting to change…'* Mentors considered that the act of providing support in the form of de-briefing discussions and reflection on AOD treatment approaches assisted GP participants to '*consider alternative different strategies to overcome barriers and Improve patient care*'. Case discussions were seen as a valuable strategy to address 'real world' issues and bridge theory to practice. One mentor viewed their role as to provide *'motivational support and stimulate creative problem-solving'*. Being readily available for their mentee was important and supported the impact of the training on participants. The following illustrative quotations highlight reflections by two mentors who drew upon their experience to support mentees develop treatment approaches to address AOD use: *'Balancing action (diagnosis – treatment) with client readiness ('soft skills' – selling the treatment, readying the client to accept the treatment). I am available for her to talk with after – to help build confidence in using her knowledge and skills.'* *'I think visitors/trainees/mentees are often surprised by the positive atmosphere during consultations – patients looking to make big in their lives and ways we may facilitate/ support these changes. While approaches vary for particular substances it is the overarching approach which I try to convey.'*

Table continued on the next page.

Theme	Description and illustrative quotations
Helping mentees identify and access relevant AOD support	Mentors helped GPs identify relevant resources and AOD support services through their established network and advanced understanding of stakeholders in the AOD sector. This was an important component of training and was seen to aid development of AOD skills and management after the program was completed. Several mentors described their impact on expanding their mentee's AOD network: *'[Name redacted] was already a very knowledgeable GP registrar when she started this AOD program; and works at a clinic with good AOD support (i.e. very experienced GP AOD practitioners). However, having me as her supervisor allowed her access to AOD support in both the community general practice setting and hospital setting.'* *'I provided [name redacted] with opportunities to observe specialist clinical practice and be involved in MDT [multidisciplinary] discussions including specialist treatment planning from MDT perspective.'* *'I was able to introduce [name redacted] to a wide-ranging network of AOD specialists for potential observed practice and ongoing peer supervision if required.'* Mentors helped GP participants feel confident to reach out for support when needed, including engaging specialist support and/or team-based case. One GP reflected: *'I am hoping it [my mentorship] has helped Dr [name redacted] put theory into practice. I also hope it may help her feel confident to reach out for support when she is seeing challenging presentations, and not feel that she has to face everything alone. I think she may find it easier to judge what can be handled as a GP as opposed to what may need specialist support and/or team care. We did quite a bit of role play work around motivational interviewing and stages of change, as Dr [name redacted] found the communication issues around AOD work to be the most challenging.'* In addition to linking in mentees with important AOD stakeholders, mentors provided direct support to mentees and discussed clinical tools. One mentor viewed their role to provide direct support to GP who had limited support due to being in an isolated area: *'We could regularly catch up and for me to provide him support was very valuable and worthwhile'.* A different mentor provided support to their mentee by discussing legal issues and clinical tools that are highly relevant the mentee's patient base and learnings needs. *'I was able to inform her of the pending introduction of Qscript and the new Queensland Poisons and Drugs and how it will impact her practice. I was able to discuss the positives and negatives of tracking scripts of drugs of dependence from pregabalin to oxycodone and how to talk to patients about this when creating an opioid treatment plan.'*

Table continued on the next page.

Theme	Description and illustrative quotations
Building relationships that provided mutual benefit and development	The mentor–mentee relationship was an opportunity for shared learning, which led to benefits for both the mentor and mentee. One mentor viewed the training as '*a supportive role with side-by-side learning*'. When the mentor was a GP, the mentor realised benefits such as improved AOD approaches, increased self-reflection and professional development regardless of career stage. One mentor said: *'It [mentoring] gave me a chance to reflect on my own management style and impart some skills to my mentee'.* The act of teaching and two-way information exchange reinforced the AOD knowledge of mentors, particularly with complex cases and patient populations: *'To be honest, I probably learnt more from [name redacted] than she did from me, but the process of explaining approaches to managing certain patient groups gave me an opportunity to hone my own knowledge.'* Many mentors participated in the program because of their passion for teaching others and passion for AOD management; one GP reflected: *'I love talking about challenging aspects of AOD consults, and the issues themselves, so it was a lovely opportunity to engage with keen caring GPs on one of my favourite areas. I enjoy mentoring younger doctors for lots of reasons: I love the challenges they come up with, it makes my brain consider things deeply, I love seeing them increase in confidence and skill sets. It's also an additional way to contribute to helping people with AOD issues: helping other GPs grow their passion for this area and destigmatising treatment in this area. I find it immensely satisfying to see attitudinal changes in GPs – as they become more patient centric and less judgemental in their approaches to people with AOD problems.'* Sharing information across disciplines was viewed as extremely valuable in advancing AOD management, and mutual benefits were also reported when the mentor was not a GP. *'I was able to offer her a perspective outside of general practice and she was able to offer me a GP's perspective – it was mutual knowledge sharing'*
Sustaining relationships and continuing AOD support	Mentors from a range of disciplines valued the opportunity to form supportive relationships with GP participants. One mentor said: *'It is a great program and allows for an individualised professional development and allows specialists to provide better support to their GP colleagues.'* There was some concern about the program ending. One mentor called for it to be continued to promote local clinical networks and support the confidence and knowledge of GPs. One mentor said: *'I strongly support the ongoing provision of this program. AOD is an important area of medicine, and this model works well for improving confidence, knowledge and local networking.'* Some mentors anticipated that the relationships that developed as part of Advanced Skills training would continue after the conclusion of the program. Some mentors expressed interest in maintaining these relationships, one mentor said: *'We have established a collegiate dialogue which I am very happy to be an ongoing arrangement. This will enable us to engage in a "peer support" model moving forwards.'* Sustaining these relationships and continuing AOD support could lead to further benefits for patients, clinicians and systems: *'This is a good starting point for many GPs, but I feel they would benefit from ongoing support so that they can apply the skills in clinical practice more confidently.'*

Mentor satisfaction

Overall, mentors were highly satisfied with the program. All mentors were asked about the most satisfying components of the training and five main components emerged (Table D5).

Table D5. Mentors' reflections on the most satisfying aspects of the training

Category	Definition	Evidence (illustrative quotations)
Teaching and exchanging information	Two-way exchange of information between mentors and mentees satisfied mentors. Satisfaction was increased when mentors realised the development of mentees because of their teaching.	*'Motivated GPs at our clinic to commence regular peer-supervision meetings as a forum to discuss complex clinical cases. Satisfying to see colleagues upskill in a high needs clinical area.'* *'It's good to enable another clinician to gain confidence in managing these patients. So often clinicians don't understand how addiction affects different people and don't know how to interpret their associated behaviours … and write them off as being 'too hard'. It's been satisfying seeing [name redacted] gaining a deeper understanding of addiction, and how and when to help.'* *'A lot of GPs have been "burnt" by patients with addiction who have lied to them, and this turns them off from treating other patients with addiction. GPs don't get taught how to have good boundaries that protect both them and their patients especially when it comes to addiction. Being able to help [name redacted] put in some safeguards and helping her develop her knowledge and skills has been a pleasure.'* *'It brings me personal enjoyment and job satisfaction knowing I can use my knowledge and experience to help GPs in my local area, and benefit the AOD treatment/outcomes of local patients.'* *'I enjoyed being able to foster a deeper understanding of how best to treat patients presenting with alcohol or drug dependence in the community. To clarify any misconceptions and be able to provide an insight from someone working with AOD clients every day I believe is highly valuable to GP's or those wishing to learn more about how to treat patients thoroughly, safely and compassionately.'*

Table continued on the next page.

Category	Definition	Evidence (illustrative quotations)
Practical applications and case discussions	Discussions of practical applications, including real case discussions, managing AOD in priority patient populations, and advocating for AOD management and prevention satisfied mentors.	*'We talked about how to break "big picture" goals down into achievable parts, and if feeling overwhelmed calling forth the basic principles of care: be patient centric, non-judgemental approach, evidence based, and safety focused.'* *'And helping my mentee reflect on the importance of advocacy for patients who live in a world where there is a vast amount of stigma directed against them. And learning how important our role is in challenging the assumptions that might be judgmental and coming from our fellow health professionals.'* *'It helped to excite interest in AOD issues pertinent to consumers in the Watchhouse and the forensic consumers. The participant was able to gain a more in depth understanding of opioid dependence, medication assisted treatment, new pharmacotherapy, problems with complicated alcohol withdrawal. She has also completed the online module for the OTP [opioid treatment program] prescribing course. She is considering the benefits and potential for improved health outcomes from providing opioid pharmacotherapy to forensic consumers in the Watchhouse.'* *'I think going forward this will develop into an "AOD clinic", where clients can be supported in the GP practice on site.'* *'Practical application of systems approach that I have learned in Aboriginal Community Controlled Health Service. Shared learning to strengthen my motivational counselling and consultation skills. Refreshed knowledge of evidence and resources.'* *'I love talking about challenging aspects of AOD consults, and the issues themselves, so it was a lovely opportunity to engage with keen caring GPs on one of my favourite areas. I enjoy mentoring younger doctors for lots of reasons: I love the challenges they come up with, it makes my brain consider things deeply, I love seeing them increase in confidence and skill sets. It's also an additional way to contribute to helping people with AOD issues: helping other GPs grow their passion for this area and destigmatising treatment in this area. I find it immensely satisfying to see attitudinal changes in GPs – as they become more patient centric and less judgemental in their approaches to people with AOD problems.'*
Better outcomes for patients	Mentors felt their involvement in Advanced Skills training increased their mentees' and their own AOD knowledge and skills. Mentors were satisfied as they felt Advanced Skills training contributed to better outcomes for patients using AOD.	*'It [Advanced Skills training] gives me the opportunity to work using shared care principles, collaborate closely with my GP colleagues and improve outcomes for our patients.'* *'This opportunity to act as RACGP AOD Advanced Skills Mentor helped me to reinforce my own knowledge and skills around drug and alcohol. As a result, I will serve my patients better.'* *'We discussed cases of difficult, ethically challenging patients which brought clarity to [name redacted] management of them.'* *'The treatment of substance misuse is a passion for me. I feel this is a very neglected area of medicine and general practice. I was able to convey the enthusiasm I have for this to [name redacted] and show her how rewarding it is to treat this very marginalised group of clients/ patients. We discussed several patients, and I was able to help [name redacted] with her decision-making process in this difficult field.'*

Table continued on the next page.

Category	Definition	Evidence (illustrative quotations)
Building mentors' capacity and supporting AOD advocacy	Mentors were satisfied because they felt Advanced Skills training provided an opportunity to build capacity among GPs for AOD support and advocacy.	*'Having a chance to update/refresh the knowledge and skills to manage AOD problems and to work collaboratively with my colleague building a common practice when dealing with drug/alcohol problems in the clinic and developing a safe prescribing (for drugs of addiction) policy.'* *'It [Advanced Skills training] gave me a chance to reflect on my own management style and I believe impart some skills to my mentee.'* *'The opportunity to destigmatise, increase confidence in and normalise the management of AOD problems in general practice.'* *'Helping my mentee reflect on the importance of advocacy for patients who live in a world where there is a vast amount of stigma directed against them. And learning how important our role is in challenging the assumptions that might be judgmental and coming from our fellow health professionals.'*
Developing relationships and sharing information across disciplines	The development of new relationships across disciplines satisfied mentors. Within these relationships, mentors-mentees shared AOD approaches and discussed coordinating care, which may support comprehensive AOD management by GPs.	*'Although this may sound self-serving, I would expect this to lead to some of the (already intense) clinical burden being taken off the addiction service which would free up currently scarce clinical resources.'* *'Being a mentor, having [name redacted] present discussing case management, made me reflect on my practice. He is very knowledgeable about mental health, so our discussions were very interesting. Also, because he is a local GP, he is now more aware of what we offer in Next Step and knows he can contact us if he needs any assistance or to refer someone into our service.'* *'As a specialist it allowed me to understand further on some of the challenges faced by GPs.'* *'With my background in psychiatry, I was able to introduce the concept of predisposing, precipitating and perpetuating factors when managing AOD and the importance of the holistic approach.'*

Mentor challenges

Mentors also faced some challenges in supporting GP participants on the Advanced Skills pathway. Refer to Table D6 for more information.

Table D6. Mentors' reflections on the challenges of the Advanced Skills pathway

Category	Definition	Evidence (illustrative quotations)
Limited time and competing priorities	Mentors were challenged by time constraints; like the mentee, they were working AOD professionals. To best support their mentee, mentors wanted to be available to mentees and spend time with them.	*'Finding the time when we could both meet.'* *'I think we both live busy lives – both professionally and personally. We worked hard to schedule times that were both agreeable. We used telephone on times we could not meet face to face (I live 40 km away from Dr [name redacted]). Whenever we did meet however, I felt valued and that our time was well spent. She was always prepared with her questions and any extra cases to discuss.'* *'Finding time to meet for our discussions around case studies, with both of us leading busy professional lives.'* *'I had not undertaken mentoring previously, and now have more ideas about how I could do this if the opportunity arose again.'* *'Time commitment greatly exceeded my expectations. Hard to co-ordinate time with a busy GP whilst busy also myself.'* *'I was initially worried about several factors initially – about my time availability, establishing clear communication channels/availability, agreeing to review at regular intervals about the progress and my skill levels in taking on the challenge to help a GP.'*
Navigating complex challenges of AOD management	Mentors were challenged to support mentees to address and overcome barriers to treatment, such as AOD stigma, medico-legal concerns, differing views and approaches to treatment, and limited local support and/or resources.	*'There is still an underlying fear of prosecution from AHPRA, and she is quick to want to terminate the therapeutic relationship based on said guidelines.'* *'To overcome the treatment barrier and stigma that some patients with addiction problems may have.'* *'Having differences in approaching cases and then reviewing them through the best practice guidelines.'* *'My experience that there are times that I could not assist the patients to improve which gives me a sense of inadequacy to mentor others.'* *'Guiding the participant with practical application of undertaking AOD in remote Australia with limited resources, and access to services.'*
Teaching components	Throughout the course, mentors were challenged by components of teaching, such as articulating their own knowledge to mentees, assessing mentees' knowledge and ensuring their teaching was relevant to their mentee's practice.	*'The most challenging aspect was putting into words the "internalised" knowledge I have built up in my role and finding ways to link them to existing theories/therapies.'* *'Maintaining the participant's momentum.'* *'Having to have the answers – feels a bit like pressure at times.'* *'Trying to make the content of any discussion relevant and focused for the participant.'* *'Ensuring I was providing guidance rather than [a] didactic answer.'* *'The most challenging part is assessing the mentee degree of knowledge and experience while dealing with his patients. Also trying to support him as much as I can by sharing my knowledge and past experience.'*

Appendix E. AOD Connect: Project ECHO

Introduction

AOD Connect: Project ECHO ('Project ECHO') was an AOD case-based discussion group, freely available to all RACGP members every Thursday evening. The objective of Project ECHO was to offer a community of practice to all members who were interested in developing their AOD skills. Sessions were facilitated by a panel of AOD educators from general practice and other medical specialties. The format allowed for discussion of treatment and management of AOD patients with the aim of improving clinical practice.

Project ECHO had an 'all teach, all learn' philosophy and allowed GP participants to discuss cases (of varying complexity) and learn from each other's experiences, while also providing access to clinical expertise of other AOD medical specialists.

It was particularly relevant for GPs working in rural or remote areas, who have limited access to allied health or AOD specialist services. Project ECHO also provided the opportunity to offer support on self-care, boundary setting and burnout prevention in the management of complex AOD cases.

RACGP members registered to attend Project ECHO sessions. Cases and questions for discussion would be submitted prior to attendance or raised during the sessions. Content for discussion was prioritised by participants in attendance to address their collective and specific individual learning needs when treating patients in a general practice setting.

Participant numbers were capped at 25 participants per session to ensure a robust and inclusive discussion. The cap on group size was increased to 35 during the COVID-19 pandemic to allow more GPs to benefit from regular support as they navigated increased substance use within the community.

Training grant	Not applicable
Timeline	Weekly one-hour drop-in session (July 2020 to November 2022)
Delivery	Videoconference (Zoom)
Duration	One hour
CPD points	Accredited for 2 points on completion of an optional post-session evaluation survey in the RACGP CPD Program for the 2020–22 triennium
Learning outcomes	1. Engage in a virtual community of practice with skills and interest in AOD. 2. Identify skills and approaches that enhance the quality of care provided to patients who use AOD. 3. Develop strategies to enhance the quality of care provided to patients who use AOD.

Analyses

Participant demographics

Table E1 describes the demographics of the first 262 participants who completed the optional post-session evaluation survey.

Table E1. AOD Connect: Project ECHO participant demographics

Characteristic	Participant demographics
Gender	55% female, 45% male
Career stage	27% pre-Fellow, 29% New Fellow, 40% mid-career, 4% late career
Rural/remote status	79% metro, 18% rural/remote, 3% unknown
Country of medical qualification	74% IMG, 22% Aust, 4% unknown
Top five countries of medical qualification for IMGs	India, Sri Lanka, Iran, Egypt, Bangladesh

IMGs, international medical graduates

Five series were delivered successfully between July 2020 and November 2022. The mixed methods evaluation of the project was informed by data from series 1 to 3 that was collected between November 2020 and December 2021. The total number of participants who attended Project ECHO (series 1 to 3) was 266.

Table E2 describes the number of participants from each state/territory who attended and completed an AOD Connect: Project ECHO optional post-training survey, and the proportion of the sample each state/territory represents.

Table E2. AOD Connect: Project ECHO post-training survey completions

Variable State/territory	Number of participants (%)
NSW	86 (36%)
Queensland	52 (20%)
Victoria	77 (29%)
WA	17 (6%)
Tasmania	8 (3%)
NT	3 (1%)
ACT	5 (2%)
Overseas	7 (3%)

Table E3 describes participants who identified as Aboriginal and/or Torres Strait Islander.

Table E3. AOD Connect: Project ECHO participants who identified as Aboriginal and/or Torres Strait Islander

Identify as Aboriginal and/or Torres Strait Islander	Number (%)
Yes	0
No	239 (90%)
Prefer not to say	15 (6%)
Not reported	12 (4%)

Attendances and session delivery

One hundred and twenty-eight participants attended more than one session. One hundred and thirty-eight participants completed one session only.

The group size (excluding panellists) ranged from 7–36 in series 1, 11–23 in series 2 and 12–24 in series 3.

Of those who attended more than one session, over 25% attended 10 or more sessions, forming the community of practice.

Table E4 shows the number of participants who attended each series and the number of sessions delivered in each series.

Table E4. Number of AOD Connect: Project ECHO participants and sessions delivered, series 1, 2 and 3

Variable	Series 1 (number)	Series 2 (number)	Series 3 (number)
Participants	185	104	76
Sessions delivered	21	19	20
Mean participants per session (SD)	20.6 (8.4)	17.3 (3.2)	17.3 (3.0)

Table E5 demonstrates the number of sessions attended per person, and the number of sessions attended per person for those who attended more frequently than one session.

Table E5. AOD Connect: Project ECHO attendance

Variable	Mean (SD)	Median	Minimum	Maximum	Interquartile range (IQR)
Sessions attended per person (all participants)	4.2 (6.5)	2	1	47	2
Sessions attended per person (among those who attended more than one session)	7.1 (7.9)	3	2	47	6

Project ECHO development and session content

Over the first month, there were lower levels of engagement and interaction among participants. This was a predictable outcome in the context of creating 'psychological safety' and a 'safe container' for sharing. While participants may have attended eager to learn, intervention from the panel was needed to encourage active participation in the group. Series 1 contained a 20-minute didactic component at the start of the session. An unintended consequence of this was creation of a learning culture that placed importance on the panellist experiences, resulting in participants being more passive in their participation and hesitant to share their experiences. The RACGP AOD team recognised this in Series 1 and changed the format of Project ECHO to a completely case-based format. After the didactic component was removed, participant interactivity and the number of returning participants increased. The attending RACGP project officer session administrator noted participants began to display greater comfort (experience of psychological safety) and willingness to share their experiences and offer encouragement to others who provided a viewpoint. Participants were encouraged to contribute via the chat function, or through verbal discussion. This led to participants sharing in an open and vulnerable fashion, describing instances in practice where things went wrong for them, and gave participants and panellists the ability to offer alternative strategies to improve health and safety outcomes for the patient and the GP. A regular core group of GP participants helped create an inclusive, engaged and safe culture to new participants, which encouraged more complex cases and questions to be raised at subsequent sessions. AOD Connect: Project ECHO was successful in creating a 'safe container' for GPs, creating a community of practice that facilitated learning and debriefing.

The AOD team refined the panel composition to further encourage participant engagement and interaction and uphold the 'all-teach, all-learn' philosophy. The more effective panel members had substantial mentoring and education experience, in addition to AOD clinical knowledge and experience. The RACGP also invited a regular GP participant to sit as a panellist to strengthen the GP voice. The panel remained consistent from June 2021 to November 2022 and along with regular attendees have together created a successful online peer support group for all RACGP members.

An RACGP Project Officer attended all Project ECHO sessions, observed interactivity and documented the topics raised by participants for discussion. Topics commonly discussed in Project ECHO were:

- patient-centred communication and interpersonal skills, such as building rapport and developing therapeutic relationships with patients
- 'assessing' patients' stage of change using behaviour change models
- motivational interviewing techniques and strategies
- coordinating psychosocial interventions, such as peer support, Alcoholics Anonymous and SMART Recovery
- harm-minimisation approaches
- patient safety in the context of detox and relapse prevention therapies
- strategies to treat and manage AOD patients with mental health comorbidities and complex psychosocial issues
- establishing and adhering to boundaries with patients (saying 'no')
- understanding the signs of opioid misuse and substance use disorder
- using screening and assessment tools, including when to coordinate further investigations (for example, imaging)
- considerations when prescribing opioids among people with chronic non-cancer pain
- substance use disorder – criteria and case study.

Optional post-session survey quantitative findings

The total number of GP participants who completed the survey was 240. Nine out of 10 GP attendees completed at least one post-session evaluation survey (response rate 90.2%).

Participants were invited to complete an evaluation survey after each session. A total of 894 surveys were completed by participants. One hundred and twenty survey completers attended only one session. One hundred and twenty survey completers attended more than one session.

Learning outcomes

When asked to rate if the program met the learning outcome of helping GPs to identify skills and approaches to enhance the quality of care provided to AOD patients, 99% of participants expressed that this learning outcome was met (82%) or partially met (17%). Only three responses out of a total 467 survey completions indicated that this was not met.

Participant experience

As part of quality improvement, a set of 'participant experience' questions were added to the survey during Series 2. Participants rated their satisfaction across 20 items, which related to various training elements, including the training mode (videoconference), cost, preparation and assessment, engagement and facilitators. A rating of 1 represented low satisfaction and a rating of 5 represented outstanding satisfaction.

A total of 58 GPs responded to 5300 items related to satisfaction. An average rating of 4.77 was recorded across all items, indicating outstanding satisfaction.

Optional post-session survey: Qualitative findings

Four themes developed from the analyses. All themes relate to the influence of the training on participants and their clinical practice. An explanation of each theme and their narrative quotes are described in Table E6. The themes were:

- fostering an AOD community of practice
- managing complex patient cases
- improving the management of AOD use in patients in the context of whole-person care
- teaching pharmacotherapy and safer prescribing strategies.

Table E6. Main themes arising from the analyses: Survey respondents' reflections

Theme	Description and illustrative quotations
Fostering an AOD community of practice	Project ECHO participants and panellists shared a common purpose of improving outcomes for patients who use AOD. Participants appreciated that the sessions brought GPs from across Australia together to discuss AOD cases with a panel of experts that included addiction medicine specialists and expert AOD GPs. One GP participant said the most valuable aspect of the training was: *'The variety of opinions and strategies offered by the panel of experts and other participants'.* Participants expressed that the case discussion format empowered GPs to share information (such as best practice approaches to individual cases), build relationships, and support and encourage their GP colleagues. The GP-led case-oriented sessions allowed participants to advance their understanding and support in day-to-day challenges. Open GP-led case discussions provided opportunities for problem-solving, reflection and critical inquiry. The blending of ideas created new knowledge to advance AOD professional practice. One GP acknowledged: *'I brought up a case and the advice I got was very good'.* Collectively, these aspects of Project ECHO fostered an AOD community of practice. GP participants expressed the most helpful aspects of Project ECHO were: *'Exchange of ideas from all participants, including the more experienced members of the session.'* *'Hearing others share about their patients with AOD issues and hearing advice from other more experienced doctors.'* *'The ability to interact with colleagues about real cases.'* Participants were located across the country, with some located in areas with minimal AOD support services. Some GPs felt supported by hearing other GPs' AOD management experiences, as the session provided an opportunity '*[to recognise] that my colleagues at all levels have the same frustrations but also successes*', and '*the ability for us all to hear about what our hero GPs' are doing at the coal face*'. When asked to comment if sessions had impacted their clinical practice, one GP said: *'I apply something new every time. I learned that many of my GP colleagues face the same dilemmas as I do. So proud of the two GP's spending so much time with these patients.'*
Managing complex patient cases	Participants expressed that they greatly valued the freedom to discuss management of complex AOD cases with their GP colleagues and a panel of experts. Participants often presented complex, real cases they were challenged by in practice, and cases they were currently managing. One GP said: *'[The] general discussion [was] excellent to broaden [my] approach with complex challenges'.* The types of complex cases presented by GPs were highly diverse. Participants discussed the management of AOD issues in the context of comorbid conditions, such as: '*insomnia and [AOD] management*', '*pregnant women who are dealing with substance abuse*', '*pain management in elderly populations*', '*pelvic pain management*', '*physical and emotional pain and trauma*'. Complex clinical considerations arose from the case-based discussions, which participants found helpful. Complex clinical issues included: '*dealing with difficult patients*', '*complexity with drug diversion*', '*complexity of getting to psychiatric diagnoses*', '*the approach to complex SUD [substance use disorder]/mental health/GBV [gender-based violence]*', '*differentiating between substance abuse from ADHD [attention deficit hyperactivity disorder]*', '*ADHD and stimulant use disorder are underdiscussed topics, this was so helpful*' and '*discussion about suicidal risk assessment*'. Flexible case discussions allowed participants to shift the specific focus from AOD towards other relevant clinical issues such as, '*discussion about approaches to [manage] chronic pain*', '*chronic pain management in patients with PTSD [post-traumatic stress disorder]*', '*distinction between food addiction and eating disorders*' and '*indication for medical cannabis*'.

Table continued on the next page.

Theme	Description and illustrative quotations
Improving the management of AOD use in patients in the context of whole-person care	The mix of possible strategies to approach management of an individual AOD case in sessions highlighted the complexity of AOD to participants and conveyed that there is no universal approach by GPs to manage AOD use. Participants considered that a forum to discuss various management approaches was important to develop '*strategies to enhance the quality of care among patients who use AOD*'. The knowledge of GP participants of how to approach and manage AOD use in patients improved because of their participation. One participant reflected '*relationship support is key to improving patient outcomes – a very useful strategy*', while another participant expressed that the most useful aspect of the session that they attended was discussion on '*talking therapy and effectiveness of incentives for abstinence of drugs*'. A clear advantage of the training was the opportunity to build on discussion/ideas among participants and panellists: *'Discussion of strategies to address the patient's presentation and reluctance to consider other treatment alternatives'* Participants identified specific tools and approaches they learned through their participation that improved their knowledge and skills. For pain assessment and opioid use management, one GP indicated they would implement the '*OPQRST [onset, provocation, quality, radiation, severity, time] mnemonic*'. Whole-person care was at the core of many AOD management approaches. One participant valued the '***hand method***', which is a strategy to remember and address five different components of whole-person care. A different GP emphasised the '*importance of psychosocial history in managing [AOD] patients*', because of what they had learned through their participation. Case explorations led to discussion of the '*steps in motivational interviewing*', and identification of guidelines and resources, such as the '*DSM V criteria for opioid use disorder*'. Participants improved their approach to AOD management by improving core consultation knowledge in the context of whole person care. One GP learned new communication strategies for opioid-seeking patients: *'I borrowed some comments to address the patients seeing me for opioids for the first time.'*
Teaching pharmacotherapy and safer prescribing strategies	By describing AOD cases and justifying their approach to the case, GP participants taught while concomitantly learning from their colleagues. Pharmacotherapy and safer prescribing practices were one of the most common topics where information was exchanged. Participants discussed strategies to support patients with challenging behaviours, and strategies to support the safer prescribing of drugs of dependence. This discussion helped participants to recognise their own limitations: *'[The session led me to identify that I] need to improve my knowledge about opioids. Don't just turn away someone with a drug issue.'* MATOD and prescribing to manage withdrawal were commonly discussed. Two GPs reported the discussion of naloxone in high-risk patients, and acamprosate versus naltrexone versus baclofen to be the most helpful aspects of the session to their practice. Participants learned strategies to set boundaries in their room when dealing with drugs seeking patients, and developed: *'Awareness of various regulations and issues that need to be considered when patients present with their benzodiazepine and opiate dependency'.* Pain management and difficult patients were common points of discussion in complex cases. As a result of participation, one GP developed knowledge of an '*empathetic way of responding to requests for benzodiazepines'*. The discussion of complex pain management cases identified a variety of pharmacotherapy-related tools and practical approaches for GP participants. Participants reflected on these tools and approaches and how they will impact their practice: '*safe prescription strategy for a [patient with] drug addiction [or a] drug seeker*'; '*offering staged dispensing*'; *'[I will] utilise an opioid calculator more often*'; '*the tapering techniques were particularly interesting (reducing long acting Vs short acting)*'; '*benzodiazepine safe weaning dosage for dependency*'; '*I learnt simple way of converting Targin to Norspan*'.

Post-session survey: Additional comments

Additional comments were provided under three broad categories:

- perceptions of interactivity between participants and panel
- positive experiences with the training
- positive perceptions of the training approach.

An explanation of each category and examples of narrative quotes are described in Table E7.

Table E7. Additional comments from the post-session survey

Category	Definition	Evidence (illustrative quotations)
Perceptions of interactivity between participants and panel	Participants valued being able to connect with GP colleagues and the panel of experts.	*'The advantage of a zoom driven meeting is that people from other states get to share experiences with one another.'* *'Great ideas and wonderful expertise.'* *'Very pleased at the level of expertise of the panel and supportive approach to various ways of managing doctors and their queries. This makes for a collegiate and non-threatening approach that can only assist with better patient care.'* *'I really appreciate the respectful way the addiction specialists acknowledge the participants' contributions to the forum. They are very supportive.'* *'I love the inclusiveness of the forum. A space where all are made to feel welcome, and any comments are encouraged.'*
Positive experiences with the training	Participants' felt the training sessions were useful and relevant to their practice.	*'This is a great support for us GPs across Australia. Thank you so much!'* *'Excellent session and very helpful not just for the case patient but for lots of similar presentations.'* *'Really enjoy the panel and discussion of cases, great feedback provided to the presenter also find the way the panel asks questions really supportive and interesting.'* *'Very pleased with the opportunity to learn more about cases presented.'* *'The reassurance that it is alright to direct patients to another avenues for help. The importance of self-care and not taking too much on was very good advice. Thank you for the extremely beneficial session.'*
Positive perceptions of the training approach	Participants felt that sessions were well run and organised and valued the flexibility of the training.	*'Weekly meetings are amazing so for any weekly challenge we know that there's some helpful ones very ready to help me in.'* *'The video and sound quality were good. The Zoom links sent to my email account allow me to access these sessions each week.'* *'Structure of teaching very good.'* *'Good facilitation of the discussion with one person keeping an eye on the chat and another looking out for people wanting to speak on video or audio.'*

Appendix F. Higher-Risk Groups

Introduction

Pathway 5**,** Higher-Risk Groups, was launched in 2022, following extension of the program delivery from June 2021 to December 2022. The RACGP identified an opportunity to develop whole-person care education for patients at higher risk of harm associated with substance use, which was a DoH contract specification and program objective. Four online AOD learning modules were developed:

- Supporting behaviour change for patients at higher risk
- Supporting people who have experienced trauma
- Supporting Aboriginal and Torres Strait Islander peoples (not yet released)
- Supporting people in contact with the criminal justice system (not yet released).

Training grant	Not applicable
Timeline	Continuous (January 2022 – ongoing)
Delivery	Available on-demand on *gplearning*
Duration	2.5 to 3 hours per higher risk group module
CPD points	Accredited for 5 to 6 points on completion for the RACGP CPD Program for the 2020–22 triennium, depending on which higher risk group module is completed.

Each module had an optional post-course evaluation survey which explored whether the training met GPs' learning needs, and relevance to clinical practice.

Analyses

Participant demographics

Table F1 outlines key demographics of participants who completed the 'Supporting behaviour change' and 'Supporting people who have experienced trauma' High-Risk Groups online learning activities.

Table F1. High-Risk Groups participant demographics

Module (completions)	Gender	Average age	Career stage	Rurality	Location of university medical qualification
High-Risk Groups – Supporting behaviour change (n = 29)	69% female 31% male	45	38% pre-Fellow 21% New Fellow 38% mid-career 3% late career	69% metro 24% rural/remote 7% unknown	62% IMG 24% Aust 14% unknown
High-Risk Groups – Supporting people who have experienced trauma (n = 22)	68% female 32% male	43	41% pre-Fellow 32% New Fellow 23% mid-career 5% late career	73% metro 27% rural/remote	59% IMG 36% Aust 5% unknown

IMG, international medical graduate

Supporting behaviour change for patients at higher risk

Thirteen participants responded to this question. They were asked to rate:

- the degree to which the following learning outcomes were met
  - discuss theories and models of behaviour change – 12 entirely met, one partially met
  - determine appropriate motivational interviewing strategies based on a patient's stage of change –12 entirely met, one partially met
  - create a plan to improve a patient's success in making behaviour changes – 13 entirely met
- how well their own learning needs were met by this course – 11 entirely met, one partially met and one not met
- the relevance of this course to their individual general practice – 12 entirely relevant and one partially relevant.

Supporting people who have experienced trauma

Eight participants responded to this section. They were asked to rate:

- the degree to which the following learning outcomes were met
  - interpret the signs, symptoms and behaviours of those who have experienced potentially traumatic events – five entirely met, two partially met, one not met
  - discuss the factors that predispose some groups to experiencing potentially traumatic events – eight entirely met
  - discuss the impacts of vicarious trauma on the GP – eight entirely met
- how well their own learning needs were met by this course – six entirely met, two partially met
- the relevance of this course to their individual general practice – eight entirely relevant.

Appendix G. Quantitative analysis: Treatment Skills training

Analyses

Role recognition, actively screen, confidence across the 5As and treatment barriers were assessed using Likert scales.

A key is applicable in the tables that follow where descriptive data is described (means, median, standard deviation, change):

- 1 strongly disagree
- 2 disagree
- 3 neither agree nor disagree
- 4 agree
- 5 strongly agree.

Self-directed pathway

Table G1. Raw data: Treatment Skills training self-directed pathway (n = 1418)

		Alcohol use		Cannabis use		Legal opioid use		Illicit opioid use		Benzodiazepine use		Stimulant use		Other drug use	
		Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
As a GP I consider it my ***role to assist*** my patients with:	Strongly disagree	1	2	1	2	0	2	1	2	1	2	3	2	5	4
	Disagree	0	1	7	1	3	1	29	11	5	3	27	11	18	13
	Neutral	11	0	90	35	32	9	116	68	33	10	116	66	144	101
	Agree	416	269	578	407	468	342	559	475	515	364	582	482	584	483
	Strongly agree	990	1148	742	975	915	1066	713	864	864	1041	690	859	667	819
I actively **screen** for:	Strongly disagree	0	3	5	2	9	3	29	10	11	2	21	4	32	15
	Disagree	9	2	143	62	116	46	258	127	135	56	216	99	209	121
	Neutral	24	5	259	137	249	170	370	334	305	192	357	275	399	344
	Agree	609	458	735	797	705	716	577	673	714	741	610	736	595	670
	Strongly agree	776	952	276	422	339	485	184	276	253	429	214	306	183	270
I feel confident **asking** about:	Strongly disagree	1	2	2	2	4	2	19	5	3	2	13	3	15	5
	Disagree	7	2	60	3	56	5	210	24	74	6	198	21	197	34
	Neutral	49	2	195	44	169	25	367	145	232	26	337	130	365	193
	Agree	565	305	703	552	713	516	548	644	689	544	591	673	578	644
	Strongly agree	796	1109	458	819	476	872	274	602	420	842	279	593	263	544

Table continued on the next page.

		Alcohol use		Cannabis use		Legal opioid use		Illicit opioid use		Benzodiazepine use		Stimulant use		Other drug use	
		Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
I feel confident to **assess**:	Strongly disagree	1	3	8	2	4	2	27	2	6	1	30	1	39	2
	Disagree	29	1	166	11	95	1	299	22	115	5	321	21	305	36
	Neutral	134	1	435	54	310	24	546	158	354	22	514	160	574	242
	Agree	803	365	637	668	757	559	444	729	736	604	455	756	419	736
	Strongly agree	451	1050	172	685	252	834	102	509	207	788	98	482	81	404
I feel confident to provide **advice** about:	Strongly disagree	2	2	8	2	8	2	37	1	8	2	51	4	57	5
	Disagree	41	2	215	14	115	4	362	27	156	9	398	25	388	33
	Neutral	134	2	500	89	301	33	556	141	351	35	570	200	621	316
	Agree	852	360	561	656	770	543	378	755	725	609	345	781	301	730
	Strongly agree	389	1054	134	659	224	838	85	496	178	765	54	410	51	336
I feel confident to **assist** with:	Strongly disagree	8	3	27	2	12	3	68	3	18	3	81	6	85	9
	Disagree	106	2	346	22	200	11	479	71	259	17	506	77	483	75
	Neutral	308	5	582	149	451	67	580	259	511	95	592	336	629	419
	Agree	782	458	392	742	631	696	244	754	543	705	213	721	195	682
	Strongly agree	214	952	71	505	124	643	47	333	87	600	26	280	26	235
I feel confident to **arrange** support for:	Strongly disagree	4	3	17	4	12	3	32	3	15	3	35	3	41	4
	Disagree	60	2	180	12	142	5	221	10	161	10	264	15	250	20
	Neutral	167	7	386	47	304	22	425	58	368	28	433	79	494	141
	Agree	843	360	635	510	735	490	565	545	683	511	539	569	494	547
	Strongly agree	344	1048	200	847	225	900	175	804	191	868	147	754	139	708

Table G2. Treatment Skills Self-directed training: Role recognition, screening behaviour and confidence to treat pre- and post-program findings

				Direction of shift in confidence/agreement from baseline		
Measure with number of respondents		**Baseline (m ± SD)**	**Endline (mean ± SD)**	**Negative (n)**	**Neutral (n)**	**Positive (n)**
I consider it my role to assist patients with… (n = 1418)	Alcohol	4.7 ± 0.49	4.8 ± 0.42	183	894	341
	Cannabis	4.4 ± 0.64	4.7 ± 0.54	237	694	487
	Legal opioids	4.6 ± 0.54	4.7 ± 0.48	231	801	386
	Illicit opioids	4.4 ± 0.73	4.5 ± 0.64	294	652	472
	Benzodiazepines	4.6 ± 0.57	4.7 ± 0.50	225	784	409
	Stimulants	4.4 ± 0.73	4.5 ± 0.64	289	647	482
	Other drugs	4.3 ± 0.74	4.5 ± 0.69	316	626	476
I actively screen for… (n = 1418)	Alcohol	4.5 ± 0.57	4.7 ± 0.52	247	748	432
	Cannabis	3.8 ± 0.88	4.1 ± 0.76	239	556	569
	Legal opioids	3.9 ± 0.89	4.1 ± 0.77	335	511	572
	Illicit opioids	3.4 ± 1.00	3.8 ± 0.89	359	450	609
	Benzodiazepines	3.4 ± 1.00	3.8 ± 0.89	314	494	610
	Stimulants	3.6 ± 0.97	3.9 ± 0.84	341	466	611
	Other drugs	3.5 ± 0.97	3.7 ± 0.90	381	438	599

Table continued on the next page.

				Direction of shift in confidence/agreement from baseline		
Measure with number of respondents		**Baseline (m ± SD)**	**Endline (mean ± SD)**	**Negative (n)**	**Neutral (n)**	**Positive (n)**
I feel confident to ask about… (n = 1418)	Alcohol	4.5 ± 0.60	4.8 ± 0.45	176	749	493
	Cannabis	4.1 ± 0.80	4.5 ± 0.58	209	551	658
	Legal opioids	4.1 ± 0.79	4.6 ± 0.56	200	565	653
	Illicit opioids	3.6 ± 1.00	4.3 ± 0.74	227	419	772
	Benzodiazepines	4.0 ± 0.83	4.6 ± 0.57	193	515	710
	Stimulants	3.7 ± 0.98	4.3 ± 0.71	218	463	737
	Other drugs	3.6 ± 0.97	4.2 ± 0.78	258	454	706
I feel confident to assess… (n = 1418)	Alcohol	4.2 ± 0.68	4.7 ± 0.48	118	543	757
	Cannabis	3.6 ± 0.87	4.4 ± 0.62	116	414	888
	Legal opioids	3.8 ± 0.81	4.6 ± 0.55	110	472	836
	Illicit opioids	3.2 ± 0.92	4.2 ± 0.71	120	337	961
	Benzodiazepines	3.7 ± 0.83	4.5 ± 0.56	106	435	877
	Stimulants	3.2 ± 0.93	4.2 ± 0.69	129	333	956
	Other drugs	3.1 ± 0.91	4.1 ± 0.75	151	359	908
I feel confident to provide advice on the use of… (n = 1418)	Alcohol	4.1 ± 0.70	4.7 ± 0.47	85	545	788
	Cannabis	3.4 ± 0.88	4.4 ± 0.66	103	383	932
	Legal opioids	3.8 ± 0.83	4.6 ± 0.57	105	467	846
	Illicit opioids	3.1 ± 0.93	4.2 ± 0.70	93	307	1018
	Benzodiazepines	3.6 ± 0.86	4.5 ± 0.60	91	455	872
	Stimulants	3.0 ± 0.91	4.1 ± 0.72	93	301	1024
	Other drugs	2.9 ± 0.89	4.0 ± 0.76	122	336	960

Table continued on the next page.

				Direction of shift in confidence/agreement from baseline		
Measure with number of respondents		**Baseline (m ± SD)**	**Endline (mean ± SD)**	**Negative (n)**	**Neutral (n)**	**Positive (n)**
I feel confident to assist patients with… (n = 1418)	Alcohol	3.8 ± 0.81	4.7 ± 0.52	66	420	932
	Cannabis	3.1 ± 0.89	4.2 ± 0.70	87	321	1010
	Legal opioids	3.5 ± 0.87	4.4 ± 0.63	110	386	922
	Illicit opioids	2.8 ± 0.89	3.9 ± 0.80	115	262	1041
	Benzodiazepines	3.3 ± 0.88	4.3 ± 0.67	84	367	967
	Stimulants	2.7 ± 0.85	3.8 ± 0.81	118	268	1032
	Other drugs	2.7 ± 0.84	3.7 ± 0.82	118	310	990
Confidence to arrange support for patients with… (n = 1418)	Alcohol	4.0 ± 0.74	4.7 ± 0.49	97	487	834
	Cannabis	3.6 ± 0.92	4.5 ± 0.63	107	384	927
	Legal opioids	3.7 ± 0.88	4.6 (0.56)	92	423	903
	Illicit opioids	3.4 ± 0.97	4.5 (0.63)	94	363	961
	Benzodiazepines	3.6 ± 0.89	4.6 ± 0.59	102	378	938
	Stimulants	3.4 ± 0.98	4.4 ± 0.67	100	348	970
	Other drugs	3.3 ± 0.97	4.4 ± 0.74	129	324	965

AOD Live pathway

Table G3. Raw data: Treatment Skills AOD Live training (n = 594)

		Alcohol use		Cannabis use		Legal and illicit opioid use		Benzodiazepine use		Stimulants use		Other drug use	
		Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
As a GP I consider it my role to assist my patients with:	Strongly disagree	0	1	0	1	0	1	0	1	1	1	1	1
	Disagree	0	0	3	2	1	0	0	0	6	4	5	4
	Neutral	3	1	45	19	18	10	14	7	44	30	63	33
	Agree	192	125	251	176	214	162	221	154	253	190	254	207
	Strongly Agree	399	467	295	396	361	421	359	432	290	369	271	349
I actively screen for:	Strongly disagree	0	1	11	3	5	2	2	2	16	3	22	6
	Disagree	4	0	61	24	58	16	40	10	93	36	106	53
	Neutral	16	3	128	68	130	69	120	71	176	120	194	150
	Agree	272	193	276	299	293	317	300	293	228	300	207	278
	Strongly Agree	302	397	118	200	108	190	132	218	81	135	65	107
I feel confident asking about:	Strongly disagree	0	1	3	1	0	0	0	1	7	1	9	2
	Disagree	6	0	30	0	23	1	28	1	71	5	90	10
	Neutral	14	0	88	19	99	14	84	19	169	52	168	73
	Agree	252	130	292	231	315	241	325	225	242	291	229	283
	Strongly Agree	322	462	181	342	157	337	157	347	105	244	98	225

Table continued on the next page.

		Alcohol use		Cannabis use		Legal and illicit opioid use		Benzodiazepine use		Stimulants use		Other drug use	
		Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
I feel confident to assess:	Strongly disagree	0	1	7	2	0	1	0	1	9	1	8	3
	Disagree	23	0	71	3	28	1	12	2	90	9	77	13
	Neutral	99	1	169	25	84	17	57	17	168	59	180	100
	Agree	315	169	242	281	325	259	353	259	229	327	260	305
	Strongly Agree	157	422	105	282	157	315	172	314	98	197	69	172
I feel confident to provide advice about:	Strongly disagree	2	1	15	1	4	1	69	1	15	2	174	4
	Disagree	58	0	126	5	57	1	30	3	147	14	99	22
	Neutral	169	0	241	40	155	22	0	19	243	78	1	105
	Agree	285	184	180	288	304	270	208	279	161	339	88	335
	Strongly Agree	80	408	32	259	74	299	287	291	27	160	232	127
I feel confident to assist with:	Strongly disagree	2	1	19	1	14	2	11	2	37	4	40	5
	Disagree	55	0	137	11	110	9	105	3	215	27	215	40
	Neutral	100	4	244	72	187	61	192	54	240	143	243	171
	Agree	346	236	169	312	241	321	255	312	92	320	81	298
	Strongly Agree	91	352	25	197	42	200	31	222	10	99	15	79
I feel confident to arrange support for:	Strongly disagree	3	1	10	1	5	1	8	1	19	0	20	1
	Disagree	30	0	72	2	65	0	78	3	101	7	128	9
	Neutral	72	5	159	27	137	13	149	13	176	36	182	52
	Agree	349	180	285	243	302	232	292	255	241	250	210	252
	Strongly Agree	140	407	68	320	85	347	67	321	57	300	54	279

Table G4. Treatment Skills AOD Live training: Role recognition, screening behaviour and confidence to treat pre- and post-program findings

				Direction of shift in confidence/agreement from baseline		
Measure with number of respondents		**Baseline (m ± SD)**	**Endline (m ± SD)**	**Negative (n)**	**Neutral (n)**	**Positive (n)**
I consider it my role to assist patients with… (n = 594)	Alcohol	4.7 ± 0.48	4.8 ± 0.44	96	334	164
	Cannabis	4.4 ± 0.65	4.6 ± 0.58	114	261	219
	Legal and illicit opioids	4.6 ± 0.56	4.7 ± 0.52	118	295	181
	Benzodiazepines	4.6 ± 0.54	4.7 ± 0.50	106	308	180
	Stimulants	4.4 ± 0.68	4.6 ± 0.64	126	263	205
	Other drugs	4.3 ± 0.71	4.5 ± 0.65	122	265	207
I actively screen for… (n = 594)	Alcohol	4.5 ± 0.59	4.7 ± 0.51	107	281	206
	Cannabis	3.7 ± 0.96	4.1 ± 0.80	139	174	281
	Legal and illicit opioids	3.7 ± 0.90	4.1 ± 0.75	129	197	268
	Benzodiazepines	3.9 ± 0.84	4.2 ± 0.74	136	205	253
	Stimulants	3.4 ± 1.0	3.9 ± 0.84	136	168	290
	Other drugs	3.3 ± 1.01	3.7 ± 0.90	146	159	289
I feel confident to ask about… (n = 593)	Alcohol	4.5 ± 0.60	4.8 ± 0.44	72	309	212
	Cannabis	4.0 ± 0.84	4.5 ± 0.58	78	233	282
	Legal and illicit opioids	4.0 ± 0.77	4.5 ± 0.55	72	225	296
	Benzodiazepines	4.0 ± 0.77	4.5 ± 0.59	69	225	299
	Stimulants	3.6 ± 0.95	4.3 ± 0.68	81	186	326
	Other drugs	3.5 ± 0.99	4.2 ± 0.75	95	175	323

Table continued on the next page.

				Direction of shift in confidence/agreement from baseline		
Measure with number of respondents		**Baseline (m ± SD)**	**Endline (m ± SD)**	**Negative (n)**	**Neutral (n)**	**Positive (n)**
I feel confident to assess… (n = 593)	Alcohol	4.2 ± 0.67	4.7 ± 0.48	51	223	319
	Cannabis	3.5 ± 0.91	4.4 ± 0.63	49	170	374
	Legal and illicit opioids	3.6 ± 0.85	4.5 ± 0.58	45	182	366
	Benzodiazepines	3.7 ± 0.84	4.5 ± 0.59	42	188	363
	Stimulants	3.1 ± 0.90	4.2 ± 0.69	54	124	415
	Other drugs	3.1 ± 0.90	4.1 ± 0.77	63	127	403
I feel confident to provide advice on the use of… (n = 593)	Alcohol	4.4 ± 0.71	4.7 ± 0.49	91	269	233
	Cannabis	3.9 ± 1.42	4.3 ± 0.66	159	232	202
	Legal and illicit opioids	4.1 ± 1.24	4.5 ± 0.59	140	259	194
	Benzodiazepines	4.0 ± 1.31	4.4 ± 0.60	152	243	198
	Stimulants	3.3 ± 1.71	4.1 ± 0.72	200	129	264
	Other drugs	3.2 ± 1.74	3.9 ± 0.77	203	104	286
I feel confident to assist patients with… (n = 593)	Alcohol	3.8 ± 0.82	4.6 ± 0.53	37	193	363
	Cannabis	3.1 ± 0.90	4.2 ± 0.72	48	124	421
	Legal and illicit opioids	3.3 ± 0.93	4.2 ± 0.70	53	180	360
	Benzodiazepines	3.3 ± 0.89	4.3 ± 0.67	50	158	385
	Stimulants	2.7 ± 0.86	3.8 ± 0.79	56	102	435
	Other drugs	2.7 ± 0.88	3.7 ± 0.82	72	106	415
Confidence to arrange support for patients with… (n = 593)	Alcohol	4.0 ± 0.78	4.7 ± 0.51	42	210	341
	Cannabis	3.6 ± 0.90	4.5 ± 0.62	42	175	376
	Legal and illicit opioids	3.7 ± 0.88	4.6 ± 0.56	38	189	366
	Benzodiazepines	3.6 ± 0.90	4.5 ± 0.59	35	178	380
	Stimulants	3.4 ± 0.98	4.4 ± 0.66	47	151	395
	Other drugs	3.3 ± 1.00	4.3 ± 0.72	52	143	398

Confidence using the 5As framework

Table G5. Overall change from pre- to post-training across the 5As framework

5As framework component	Pre mean ± SD	Post mean ± SD	Mean change ± SD	Median change
Ask (n = 2010)	3.95 ± 0.68	4.47 ± 0.52	0.52 ± 0.83	0.50
Assess (n = 2010)	3.54 ± 0.67	4.39 ± 0.51	0.85 ± 0.84	0.86
Advise (n = 2010)	3.53 ± 0.77	4.34 ± 0.51	0.81 ± 0.93	0.83
Assist (n = 2010)	3.13 ± 0.69	4.15 ± 0.56	1.02 ± 0.89	1.00
Arrange (n = 2010)	3.58 ± 0.78	4.52 ± 0.55	0.95 ± 0.95	1.00

Confidence using the 5As framework by substance

Table G6. Overall change from pre- to post-training in confidence to treat by substance

Drug	Pre mean ± SD	Post mean ± SD	Mean change ± SD	Median change
Alcohol (n = 2010)	4.13 ± 0.54	4.71 ± 0.41	0.58 ± 0.68	0.60
Cannabis (n = 2010)	3.57 ± 0.69	4.41 ± 0.52	0.84 ± 0.86	0.80
Benzodiazepine (n = 2010)	3.68 ± 0.67	4.48 ± 0.49	0.80 ± 0.94	0.80
Stimulants (n = 2010)	3.19 ± 0.76	4.17 ± 0.57	0.98 ± 0.98	1
Other drugs (n = 2010)	3.14 ± 0.76	4.06 ± 0.62	0.91 ± 0.98	0.80
Legal and illegal opioids (AOD live, n = 593)	3.74 ± 0.67	4.45 ± 0.48	0.70 ± 0.83	0.60
Legal opioids (Self-directed, n = 1417)	3.78 ± 0.64	4.54 ± 0.47	0.76 ± 0.78	0.80
Illicit opioids (Self-directed, n = 1417)	3.23 ± 0.74	4.18 ± 0.62	0.96 ± 0.93	1

Self-reported screening behaviour and role recognition

Table G7. Overall change in screening behaviour and role recognition from pre- to post-training

Measure	Pre mean ± SD	Post mean ± SD	Mean change ± SD	Median change
Screen (n = 2013)	3.77 ± 0.65	4.07 ± 0.61	0.30 ± 0.85	0.33
Role (n = 2011)	4.49 ± 0.54	4.64 ± 0.49	0.15 ± 0.72	0

Screening behaviour, role recognition and the 5As framework by training mode

Table G8. Mean change in primary outcomes by training mode (AOD Live versus Self-directed)

Measure (mean change from baseline)	Estimated marginal means (mean ± standard error)		Tests of between-subjects effects	
	Self-directed (n = 1419)	AOD Live (n = 594)	*F*	*p*
Screen	0.28 ± 0.02	0.36 ± 0.03	4.05	0.044*
Role	0.15 ± 0.01	0.15 ± 0.03	0.00	1.000
Ask	0.51 ± 0.02	0.53 ± 0.03	0.19	0.660
Assess	0.84 ± 0.02	0.86 ± 0.04	0.27	0.604
Advise	0.93 ± 0.02	0.51 ± 0.04	90.4	<0.001*
Assist	1.04 ± 0.02	0.97 ± 0.04	2.44	0.118
Arrange	0.96 ± 0.03	0.93 ± 0.04	0.33	0.568

**Significance accepted at p<0.05*

Participant sub-groups

Males and females

Table G9. Mean change in primary outcomes by gender (males versus females)

Measure (mean change from baseline)	Estimated marginal means (mean ± standard error)		Tests of between-subjects effects	
	Females (n = 1140)	Males (n = 873)	*F*	*p*
Screen	0.31 ± 0.03	0.29 ± 0.03	0.41	0.51
Role	0.18 ± 0.02	0.12 ± 0.02	2.81	0.09
Ask	0.53 ± 0.03	0.50 ± 0.03	0.45	0.50
Assess	0.88 ± 0.03	0.81 ± 0.03	2.99	0.08
Advise	0.80 ± 0.03	0.81 ± 0.03	0.03	0.87
Assist	1.00 ± 0.03	1.03 ± 0.03	0.43	0.51
Arrange	1.00 ± 0.03	0.88 ± 0.03	8.89	0.003*

**Significance accepted at p<0.05*

International and Australian medical graduates

Table G10. Mean change in primary outcomes by location of university medical qualification (Australia versus overseas)

Measure (mean change from baseline)	Estimated marginal means (mean ± standard error)		Tests of between-subjects effects	
	International medical graduates (n = 928)	Australian-trained doctors (n = 943)	*F*	*p*
Screen	0.39 ± 0.03	0.22 ± 0.03	20.12	<0.001*
Role	0.13 ± 0.02	0.17 ± 0.02	1.12	0.29
Ask	0.52 ± 0.03	0.51 ± 0.03	0.09	0.76
Assess	0.89 ± 0.03	0.80 ± 0.03	6.32	0.012*
Advise	0.85 ± 0.03	0.76 ± 0.03	4.17	0.041*
Assist	1.08 ± 0.03	0.94 ± 0.03	11.86	<0.001*
Arrange	0.94 ± 0.03	0.96 ± 0.03	0.33	0.57

**Significance accepted at p<0.05*

GPs in major cities and metropolitan areas, and GPs in rural and remote areas

Table G11. Mean change in primary outcomes by rurality (major city and metropolitan versus rural and remote)

Measure (mean change from baseline)	Estimated marginal means (mean ± standard error)		Tests of between-subjects effects	
	Major city or metro (Monash Model [MM] 1–2) (n = 1531)	Rural or remote (MM 3–7) (n = 465)	*F*	*p*
Screen	0.30 ± 0.02	0.32 ± 0.04	1.33	0.72
Role	0.16 ± 0.02	0.15 ± 0.03	0.04	0.84
Ask	0.50 ± 0.02	0.56 ± 0.04	2.09	0.15
Assess	0.83 ± 0.02	0.88 ± 0.04	1.14	0.29
Advise	0.80 ± 0.02	0.83 ± 0.04	0.48	0.49
Assist	1.00 ± 0.02	1.07 ± 0.04	2.07	0.15
Arrange	0.94 ± 0.02	0.98 ± 0.04	0.95	0.33

**Significance accepted at p<0.05*

Age

Table G12. Mean change in primary outcomes by age

Measure (mean change from baseline)	Estimated marginal means (mean ± std. error)					Tests of between-subjects effects	
	≤34 years (n = 404)	35–44 years (n = 965)	45–54 years (n = 446)	55–64 years (n = 152)	≥65 years (n = 46)	*F*	*p*
Screen	0.23 ± 0.42	0.32 ± 0.03	0.34 ± 0.04	0.31 ± 0.07	0.13 ± 0.13	1.60	0.17
Role	0.11 ± 0.04	0.17 ± 0.02	0.20 ± 0.03	0.10 ± 0.06	-0.14 ± 0.11	2.94	0.02*
Ask	0.44 ± 0.04	0.53 ± 0.03	0.61 ± 0.04	0.46 ± 0.07	0.29 ± 0.12	3.31	0.01*
Assess	0.78 ± 0.04	0.88 ± 0.03	0.91 ± 0.04	0.74 ± 0.07	0.51 ± 0.12	4.27	0.002*
Advise	0.75 ± 0.05	0.82 ± 0.03	0.89 ± 0.04	0.71 ± 0.08	0.52 ± 0.14	2.79	0.25
Assist	0.96 ± 0.04	1.03 ± 0.03	1.10 ± 0.04	0.89 ± 0.07	0.77 ± 0.13	3.18	0.013*
Arrange	0.88 ± 0.05	0.98 ± 0.03	1.00 ± 0.05	0.83 ± 0.08	0.87 ± 0.14	1.63	0.16

**Significance accepted at p<0.05*

Career stage

Table G13. Mean change in primary outcomes by career stage (pre-Fellowship, New Fellow, mid-career, late career)

Measure (mean change from baseline)	Estimated marginal means (mean ± std. error)				Tests of between-subjects effects	
	Pre-fellowship (n = 280)	New Fellow (n = 922)	Mid-career (n = 782)	Late career (n = 29)	*F*	Significance (*p*)
Screen	0.41 ± 0.05	0.28 ± 0.03	0.30 ± 0.03	0.20 ± 0.16	1.74	0.15
Role	0.11 ± 0.04	0.16 ± 0.02	0.18 ± 0.03	-0.22 ± 0.13	3.14	0.024*
Ask	0.48 ± 0.05	0.51 ± 0.03	0.54 ± 0.03	0.29 ± 0.16	1.08	0.36
Assess	0.82 ± 0.05	0.87 ± 0.03	0.85 ± 0.03	0.60 ± 0.16	1.12	0.34
Advise	0.79 ± 0.06	0.83 ± 0.03	0.79 ± 0.03	0.45 ± 0.17	1.79	0.15
Assist	1.03 ± 0.05	1.03 ± 0.03	1.00 ± 0.03	0.82 ± 0.17	0.65	0.58
Arrange	0.86 ± 0.06	0.98 ± 0.03	0.95 ± 0.03	0.86 ± 0.18	1.22	0.30

**Significance accepted at p<0.05*

Career stage: pre-Fellowship, any member who has not yet reached Fellowship; New Fellow, any member with Fellowship within the last five years; mid-career, any Fellow for greater than five but less than 35 years; late career; any Fellow for longer than 35+ years

Treatment barriers (AOD Live and Self-directed)

Table G14. Overall change in perceptions of treatment barriers (n = 2007)

	My ability to provide care for my patients who are experiencing problematic use of alcohol and other drugs is limited because…	Pre-mean ± SD	Post-mean ± SD	Mean change ± SD	Median change
GP self-efficacy, knowledge and skills	I don't have the necessary knowledge	3.38 ± 0.96	2.13 ± 0.85	−1.24 ± 1.26	−1
	I don't have the necessary clinical skills	3.30 ± 0.94	2.2 ± 0.089	−1.10 ± 1.30	−1
	I don't have the necessary clinical support	3.58 ± 0.88	2.47 ± 1.02	−1.11 ± 1.34	−1
	I don't have the necessary time[1]	3.36 ± 0.96	2.82 ± 1.09	−0.53 ± 1.46	−1
	Of the lack of effective treatments[2]	3.11 ± 0.88	2.25 ± 0.83	−0.86 ± 1.18	−1
Patient stigmatisation	Patients are resistant to change[3]	3.65 ± 0.86	2.90 ± 1.01	−0.76 ± 1.32	−1
	Patients are chaotic[4]	3.44 ± 0.90	2.80 ± 0.98	−0.64 ± 1.30	−1
	Patients are unreliable	3.30 ± 0.90	2.69 ± 0.94	−0.62 ± 1.28	−1
	Patients are likely to be violent and intimidating	2.82 ± 0.93	2.38 ± 0.90	−0.44 ± 1.31	0
	Patients bring these issues on themselves[5]	2.02 ± 0.90	1.78 ± 0.86	−0.24 ± 1.22	0
	I do not think that patients will take my advice	2.53 ± 0.85	2.03 ± 0.75	−0.50 ± 1.12	0
	Most patients are not interested in changing their use	2.71 ± 0.91	2.27 ± 0.87	−0.43 ± 1.24	−1
	I think patients will resent me asking them about their use	2.31 ± 0.84	1.91 ± 0.77	−0.40 ± 1.11	0
	I don't like patients who use alcohol and other drugs	1.80 ± 0.81	1.59 ± 0.73	−0.21 ± 1.07	0
Other	I don't see patients with alcohol and other drug problems	1.65 ± 0.70	1.56 ± 0.67	−0.09 ± 0.95	0
	Alcohol and other drugs problems are not an important issue in my general practice	1.75 ± 0.77	1.61 ± 0.76	−0.14 ± 1.08	0

[1] *Mean change (females: −0.71 ± 0.1 versus males: −0.41 ± 0.1, p<0.05)*

[2] *Mean change (IMGs in MM 1–2: −1.1 ± 0.8 versus IMGs in MM 3–7: −0.6 ± 0.1, p<0.05)*

[3] *Highest mean change among participants aged 45–54: −0.94 ± 0.1 versus lowest mean change among participants aged <34 years: −0.51 ± 0.1 (p<0.05)*

[4] *Highest mean change among participants aged >65: −0.96 ± 0.3 versus lowest mean change among participants aged <34 years: −0.43 ± 0.1 (p<0.05)*

[5] *Mean change (IMGs: −0.08 ± 0.8 versus Australian-trained doctors: −0.37 ± 0.9, p<0.05)*

Appendix H. Treatment Skills training: Six- to 12-month follow-up survey

Introduction

The purpose of the follow-up survey was to explore impacts of the AOD Program six to 12 months after the training. Key interest areas were whether modifications to clinical practice had been sustained, whether GPs had sought further AOD training, and whether skills, confidence and knowledge gains from the AOD Program had translated to benefits for patients.

A follow-up survey was distributed via email in seven different rounds to participants who had completed Treatment Skills training within six to 12 months of the invitation. Each email invitation was followed up with at least one reminder within two to four weeks. The voluntary Treatment Skills follow-up survey closed in June 2022.

The total number of participants who were sent the follow-up survey between August 2021 and June 2022 was 1902. This did not capture all Treatment Skills training participants as some had opted out of all email communication after completing the course, and some were ineligible as they had completed the training within six months.

Analyses

Participant demographics

The total number of respondents was 305 (response rate: 16%). The total number of completions was 275 (30 incomplete responses).

The analysis in Table H1 is informed by those who completed 93% or more of the survey (n = 280 after one duplicate was removed). A total of 2476 GPs completed treatment skills; 11% of these participants responded to the follow-up survey.

Of the 280 respondents, 65% (n = 181) completed multiple pathways, and 35% (n = 99) only completed treatment skills training.

Table H1. Pathway completions in addition to Treatment Skills training by participants

Treatment skills Pathway completions	Number (total 181)
Essential Skills training	114
Advanced Skills training	29
AOD Connect: Project Echo	1
Essential Skills training and Advanced Skills training	27
Essential Skills training, Advanced Skills training and AOD Connect: Project ECHO	3
Essential Skills training and AOD Connect: Project ECHO	7

We asked whether GPs had undertaken further training in the six to 12 months after completing Treatment Skills training on the following topics:

- chronic pain
- dual diagnosis
- trauma-informed care
- Focussed Psychological Strategies (FPS) skills training
- Medication-Assisted Treatment of Opioid Dependence (MATOD)
- Fellowship of the Australasian Chapter of Addiction Medicine (FAChAM).

Their responses are given in Figure H1.

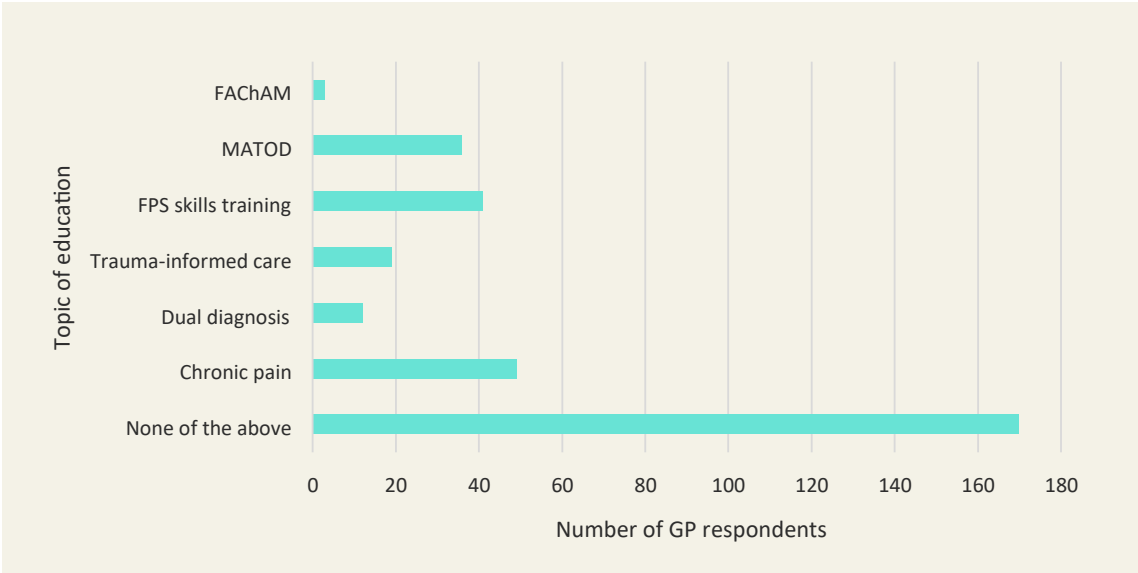

Figure H1. Further education following Treatment Skills training (n = 280)

Participants who undertook further training within the six to 12 months of completing Treatment Skills training (n = 113) were asked whether they did this as a result of the AOD Program. Responses were: yes 44%, no 31%, 17% unsure, 8% unknown.

Participants were asked about whether they agreed with the following statements about whether/how the training helped them (Figures H2 and H3).

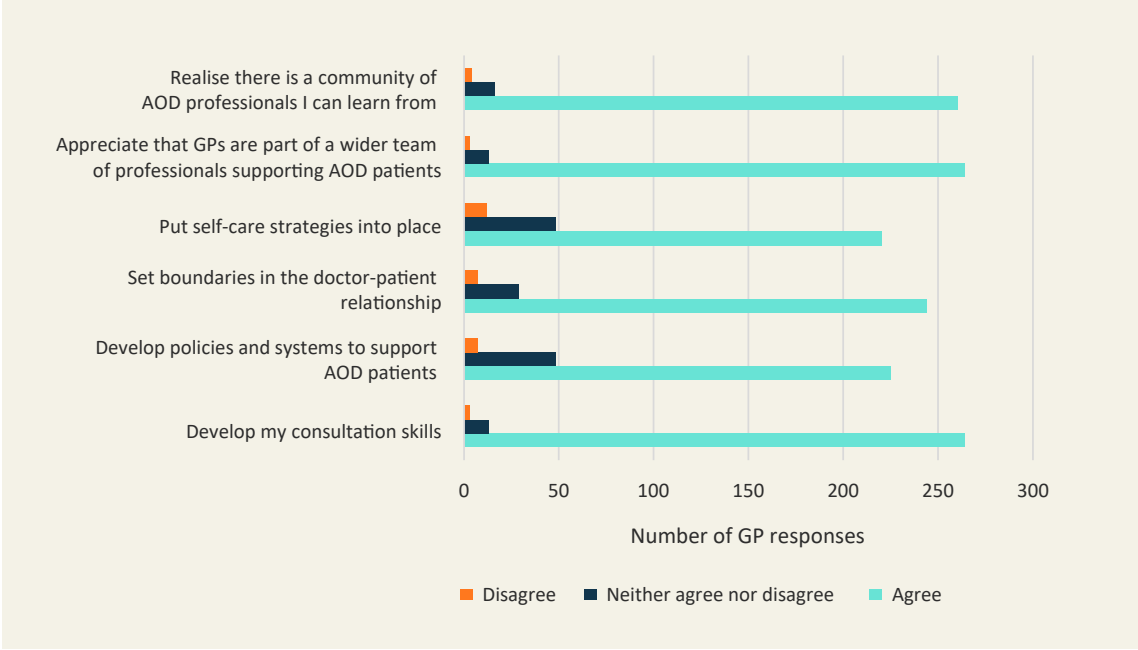

Figure H2. Responses to statement, 'Treatment Skills training helped me ...' (n = 280)

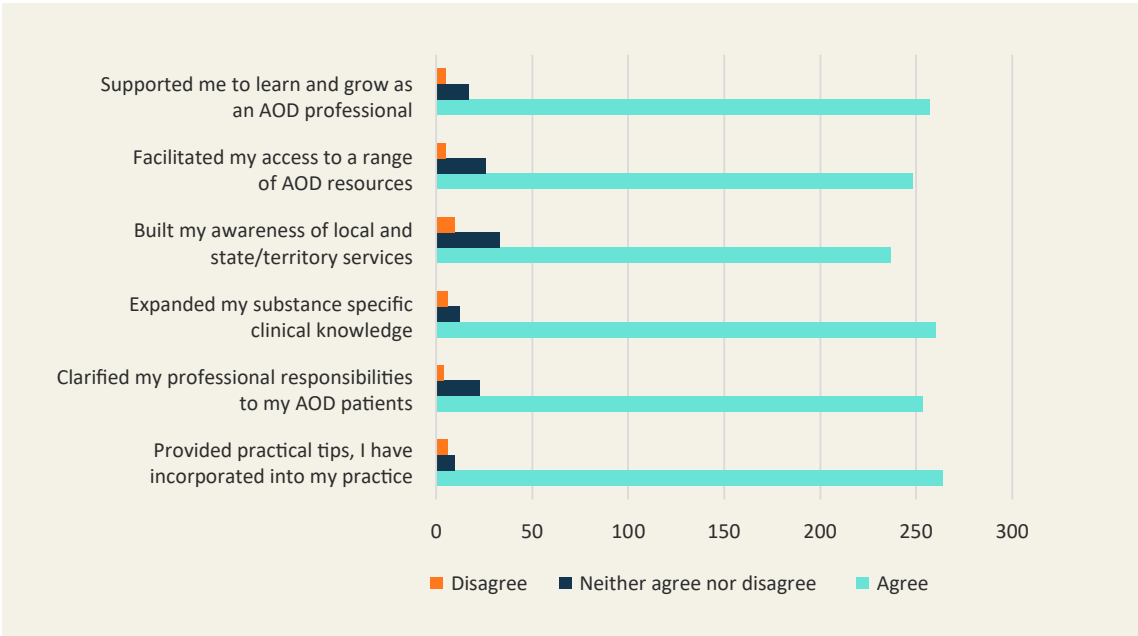

Figure H3. Responses to statement, 'Treatment Skills training ...' (n = 280)

For each statement described in Figures H2 and H3, less than 5% of respondents disagreed or strongly disagreed. Participants were more likely to strongly agree to:

- appreciate that GPs are part of a wider team of professionals supporting AOD patients
- realise there is a community of AOD professionals they can learn from
- provided practical tips they have incorporated into their practice.

Participants were more likely to neither agree or disagree, or disagree to:

- develop policies and systems to support AOD patients
- put self-care strategies into place
- build awareness of local and state/territory services.

Figure H4 demonstrates the degree to which GPs consider patients who use various substances challenging to treat.

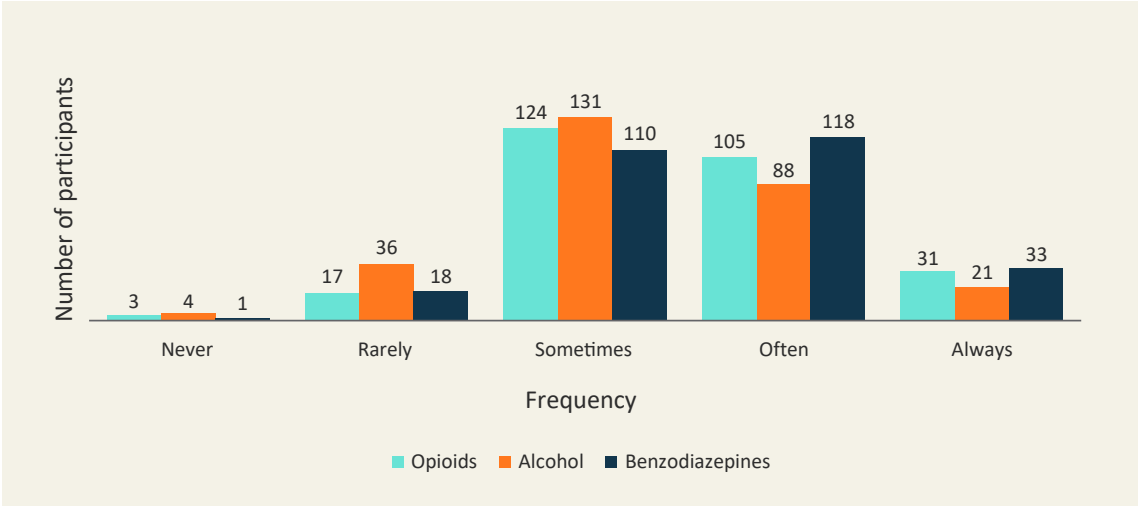

Figure H4. How often do GPs consider patients who use alcohol, benzodiazepines and opioids challenging to treat? (n = 280)

Perceived role to treat AOD

- Sixty-six per cent (n = 183) of respondents perceived it was their role to support patients who used any of the following: alcohol, cannabis, legal and illicit opioids, benzodiazepines, stimulants and other drugs.
- Only one GP reported not to consider it their role to support patients who use alcohol.
- More GPs felt their role was to support patients with alcohol (n = 279), legal opioids (n = 270) and benzodiazepines (n = 267) as compared to stimulants (n = 231) and other drugs (n = 196).

Barriers to care

The statement, 'My ability to provide care of my patients who are experiencing problematic use of AOD is limited because …', received the following responses.

- My ability to provide care for my patients is not limited (n = 93).
- Of those who reported limitations to their ability to treat care for patients experiencing problematic use of AOD, the five most common problems were:
  - remuneration for treating AOD is insufficient (n = 106)
  - I don't have the necessary time (n = 96)
  - I don't have the necessary clinical support (n = 80)
  - patients are unreliable (n = 72)
  - patients are likely to be violent and intimidating (n = 44).

Treatment skills confidence

At the six- to 12-month follow-up, GPs' confidence to care for people using AOD in accordance with the 5As framework was high across all seven categories of drugs assessed. Confidence to care for patients using illicit opioids, stimulants and other drugs were lower compared to confidence to care for patients using alcohol. Refer to Tables H2 to H5.

Table H2. Participants' confidence in screening (asking) patients about their use of AOD

	Alcohol	Cannabis	Legal opioids	Illicit opioids	Benzodiazepines	Stimulants	Other drugs
Mean	4.6	4.4	4.4	4.1	4.3	4.2	4.1
SD	0.53	0.63	0.59	0.78	0.60	0.73	0.76

Key: 1, strongly disagree; 5, strongly agree

Table H3. Participants' confidence in assessing (take a comprehensive history/examine) patients with problematic use of AOD

	Alcohol	Cannabis	Legal opioids	Illicit opioids	Benzodiazepines	Stimulants	Other drugs
Mean	4.5	4.2	4.3	3.9	4.3	3.9	3.9
SD	0.55	0.65	0.57	0.77	0.59	0.76	0.80

Key: 1, strongly disagree; 5, strongly agree

Table H4. Participants' confidence in providing advice to patients regarding their AOD use

	Alcohol	Cannabis	Legal opioids	Illicit opioids	Benzodiazepines	Stimulants	Other drugs
Mean	4.4	4.1	4.2	3.8	4.2	3.8	3.7
SD	0.55	0.69	0.59	0.78	0.62	0.78	0.79

Key: 1, strongly disagree; 5, strongly agree

Table H5. Participants' confidence in assisting and arranging support for patients with problematic use of AOD

	Alcohol	Cannabis	Legal opioids	Illicit opioids	Benzodiazepines	Stimulants	Other drugs
Mean	4.3	4.0	4.2	3.9	4.1	3.8	3.8
SD	0.59	0.71	0.63	0.79	0.65	0.77	0.78

Key: 1, strongly disagree; 5, strongly agree

Confidence to treat by stage of change

We asked participants to rate their level of agreement with: 'I am confident that I can adapt my advice to a patient's readiness to change'. There was a high level of agreement with the statement, indicating at six to 12 months after training, GPs felt confident to adapt their advice in line with their patient's readiness to change (Table H6).

Table H6. Participants' confidence in adapting their advice according to patient readiness to change

Stage of change	Median score	Mean	SD
Pre-contemplative	Agree	4.22	0.60
Contemplative	Agree	4.28	0.55
Preparation	Agree	4.30	0.55
Action	Agree	4.30	0.58
Maintenance	Agree	4.19	0.58
Relapse	Agree	4.07	0.70

Key: 1, strongly disagree; 5, strongly agree

Impact on practice: Treatment skills and patient care

Since completing the AOD Program:

- 89% could effectively manage a patient's presenting AOD problem and their comorbidities (n = 280) (9% unsure, 1% no, 1% have not had relevant patient presentations)
- 85% had used resources provided during the training to assist with managing a patient (n = 280) (9% use other resources, 6% report not needing resources).

Further impacts are described in Table H7 and Figure H5.

Table H7. Impact on practice since completing the AOD Program

Questions and responses	Number	Percentage of respondents
To what extent are you using screening tools? (n = 280)		
I use screening tools (Audit-c, Assist, SAD-Q)	157	56%
I've tried screening tools (Audit-c, Assist, SAD-Q) but I prefer to ask the questions informally throughout a consult	73	26%
I intend to use screening tools (Audit-c, Assist, SAD-Q) but haven't yet	40	14%
I don't use screening tools (Audit-c, Assist, SAD-Q)	8	3%
I would like to use screening tools but don't know how	2	1%
Have you supported a patient who has presented in immediate crisis from their AOD use? (n = 279)		
No, I have not yet had a patient present in a point of crisis	103	37%
Yes, I used a brief intervention (such as FRAMES, FLAGS) to support the patient	90	32%
Yes, I managed the consult informally without referring to a brief intervention (such as FRAMES, FLAGS)	86	31%
What proportion of your patients did you provide advice to regarding their use of alcohol and other drugs in the last month? (n = 280)		
All of my AOD patients	43	15%
Most of my AOD patients	89	32%
More than half	42	15%
Less than half	80	29%
I have not seen any AOD patients in the last two weeks	22	8%
My AOD patients are not at this stage	3	1%
None	1	<1%
What proportion of your AOD patients have you helped to modify their AOD use in the last month? (n = 280)		
All of my AOD patients	6	2%
Most of my AOD patients	46	16%
More than half	57	20%
Less than half	140	50%
My AOD patients are not at this stage	21	8%
None	10	4%
Since completing the AOD GP Education Program, have you managed a planned withdrawal from AOD use? (n = 280)		
Yes	156	56%
No	73	26%
Not applicable (no relevant patient presentations)	51	18%

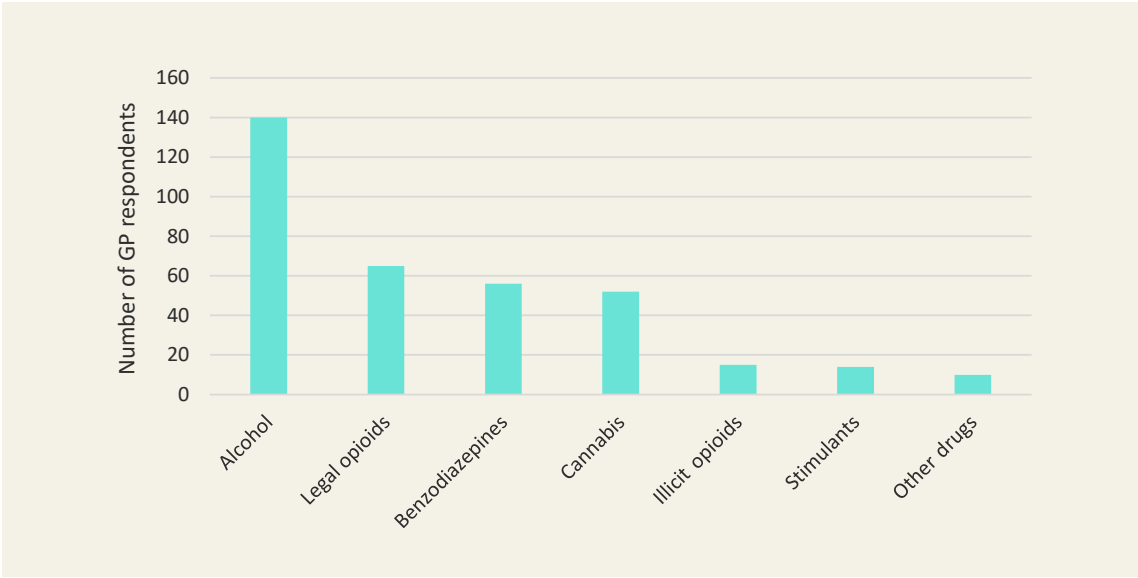

Figure H5. Responses to the question, 'What substance(s) have you managed a planned withdrawal from AOD use?' (n = 156)

Impact on clinical practice: Prescribing and further training

Table H8 describes clinical practice impacts since completion of the AOD Program.

Table H8. Impact on prescribing and further training since completing the AOD Program

Questions and responses	Number	Percentage of respondents
Since completing the AOD GP Education Program, have you become a Medication-Assisted Treatment of Opioid Dependence prescriber? (n = 280)		
I am a new prescriber	18	6%
I have done the training but am not yet prescribing these meds	35	13%
I am an experienced prescriber	24	9%
I have not yet done the training	147	53%
I am not planning on doing the training	56	20%
Since completing the AOD GP Education Program, have your prescribed naloxone (nasal spray or injection) for overdose prevention? (n = 280)		
Yes	49	18%
No	231	83%
Since completing the AOD GP Education Program, have you prescribed naltrexone or acamprosate (tablets for alcohol abstinence)? (n = 280)		
Yes	172	61%
No	108	39%

Impact on clinical practice: Interaction and connection with others

Fifty-one per cent of respondents reported sharing their new AOD knowledge or skills with other colleagues (35% no, 14% unsure) (n = 280). We asked those who said they share AOD program knowledge and skills to describe the support they provided. Responses were categorised into five main topics. Evidence for each category is seen in Table H9.

Table H9. Sharing AOD Program knowledge with others

Type of support	Illustrative quotations
Discussing cases and providing practice-wide support	*'I presented a case at a recent GP group meeting.'* *'Discussion of cases, sharing of assessment, opinions and management strategies with other GPs.'* *'Provide consultations for colleagues in the same GP practice.'* *'I have developed a MATOD policy and that has been put to the clinical director. I have been able to support GPs with their questions and recommended the course.'*
Teaching, advising and sharing resources	*'Teaching for registrar and medical students about motivational interviewing and cannabis withdrawal management.'* *'Educating fellow GPs and GP Registrars and medical students at my practice about DACAS and other AOD services.'* *'Mentorship.'* *'Imparted treatment options and guided colleagues where to look for resources and support.'*
Supporting others from a range of health care disciplines	*'I have given phone advice to a few GP and specialist colleagues.'* *'I supported my co-worker at the clinic and Nursing staff from Residential Detoxification Unit.'* *'I work in youth mental health with a colleague who is a registered nurse and is currently studying mental health nursing. We have regular case discussions and planning sessions about clients with AOD issues, often with co-existing PTSD/anxiety/depression and occasionally with co-existing eating disorders.'*
Supporting others to reduce AOD stigma and develop approaches to manage complex conditions	*'Encourage my colleagues to screen for AOD and normalise doing so for all patients.'* *'I have spoken to a few other GPs about EtOH home detox and the resources I use!'* *'I have discussed use of naltrexone and community alcohol withdrawal and detox management with colleagues.'* *'Managing alcohol withdrawal plan created by AOD service. Maintaining abstinence in patients after completing their withdrawal. Weaning of benzodiazepines used over years (failed sometimes). Supporting cannabis withdrawal.'*
Supporting others to navigate the local health system and coordinate AOD care	*'Information as to local programs available for training in Methadone/Suboxone prescribing.'* *'Shared information about NSW regulatory requirements and support networks.'* *'Discussion about their use and how to reduce or quit; referral to local AOD unit; referral to pain specialist, psychiatrist, and psychologist.'* *'Shared questionnaires from the AOD Program. List of the psychologists specialized in the treatment /counselling of people with AOD.'* *'I have been able to get patients linked up to the local pain clinic, I have also helped patients get access to counselling for alcohol dependence.'*

Views of the AOD Program

At follow-up, participants rated their level of agreement with the following statements.

- RACGP staff were instrumental to my completion (24% strongly agreed, 44% agreed, 24% neither disagreed nor agreed, 6% disagreed, 2% strongly disagreed) (n = 273).
- I could identify with the case presentations (62% strongly agreed, 30% agreed, 6% neither disagreed nor agreed, 2% disagreed) (n = 274).
- The program was well organised and structured (33% strongly agreed, 63% agreed, 3% neither disagreed nor agreed, 1% disagreed) (n = 272).
- Clinical interaction optimised my learning opportunities (30% strongly agreed, 52% agreed, 15% neither disagree nor agreed, 3% disagreed) (n = 253).
- The level of training was appropriate (33% strongly agreed, 61% agreed, 5% neither disagreed nor agreed, 1% disagreed) (n = 273).
- The content was relevant and applicable to my needs (38% strongly agreed, 59% agreed, 2% neither disagreed nor agreed, 1% disagreed) (n = 274).
- I have recommended/will recommend the program to others (39% strongly agreed, 55% agreed, 6% neither disagreed nor agreed) (n = 274).

Appendix I. Staff evaluation

Introduction

Understanding the views and perspectives of staff who were involved in the design and delivery of the AOD Program was an important aspect of this evaluation. A Zoom workshop brought together all team members with a focus on continuous improvement of programs. The sessions sought to evaluate the program, exploring the following areas of importance:

- program structure
- program stakeholders
- operation of program
- quality of educational content
- team structure, roles and responsibilities
- program strengths, weaknesses and opportunities.

Method

An online workshop with AOD program staff (n = 18) was facilitated by skilled evaluators (n = 2). The workshop consisted of a background information briefing following by splitting up into two different breakout rooms, one with operational staff (n = 7) and the other with medical educators and content developers (n = 11). In each breakout room, a skilled evaluator posed semi-structured interview questions to the group and facilitated discussion.

Discussion was documented and curated by a nominated scribe. All participants had an opportunity to review notes, make modifications and add more information after the workshop. For analysis, the data was organised into a table, which the AOD team reflected upon and discussed.

Analyses

Data from the staff evaluation workshop was organised into Table I1.

Table I1. Staff evaluation findings

Operational staff	Medical educators and content developers
Strengths	
Organisational • Strong leadership, a great team culture because of leadership. All staff were willing to collaborate and support each other. Strong ownership of individual roles in the AOD team. • Strong, highly skilled project team, everyone was very supportive of one another/the program and this foundation impacted the success of the program. • Significant and diverse member base. **Program design and objectives** • We needed to think about how we deliver best practice GP education and reach as many members as possible. We wanted to train as many GPs as we could, in many ways, aiming for more positive outcomes for participants. • Providing an individual/tailored experience to each individual member engaged with the program. • Running an AOD email inbox, to see that everyone is being kept track of members are communicated with/to individually with specific communication based on their needs. • The way information was presented: practical skills-based education, easier for GPs to adopt within their practice and improve outcomes/build outcomes. • Engaged evaluation early in the foundation of the program: ensured that required data capture points were set up from the beginning and understood how we can best evaluate and what needs to be in place to support this. • Participants grateful for the opportunity to be remunerated for their participation rather than having to pay to participate in the program. • ECHO: GPs can network and have access to support from clinicians (other GPs, addiction medicine specialists) around Australia. National representation on panel. Cost effective – didn't need a physical location to run ECHO, or to purchase expensive IT equipment or pay for/book rooms. This meant that we could pay more participants to attend the training. Panellists didn't need to travel to attend meeting. Participants could join from anywhere (at their clinic, on the way home from work, when overseas – some members do ad-hoc work overseas). No disruptions/cancellations – GPs who were mildly unwell or had to self-isolate could still join sessions.	**Organisational** • The team worked extremely well together given the diversity of people and skills involved. The team was very positive, effective and rewarding. The team was highly motivated, accessible, approachable and great to work with. • Collegiate atmosphere. • Instructional designers' perspective, combined with RACGP medical educators who are familiar with educational design plus subject expert was a real strength. **Program design and objectives** • Variety of content provided with education delivered in different formats. • Different ways GPs could get involved (various options of learning described as 'one of the best things of the program'). • Flexibility to pivot from one education delivery format to another with pandemic restrictions. • 'By GPs for GPs', a laser like focus of what would help GPs in a practical situation. Understanding what works and what doesn't for GP education. Quite often GPs get talked at rather than engaged. Sometimes education can focus on academics, 'hit and miss'. • Innovation – ECHO, pivoted from being 'talked at' to being catered for GPs; reduced didactic content and moved towards more GP-led case discussion, over time culture became more established where mostly always a case, sometimes two. • Most successful education delivery method: Treatment Skills Self-directed pathway – substantial enough time on each subject which are complex based around the sheer volume of people using this pathway over a couple of years. • At-risk series: dive into subtopics, scaffolding in treatment skills allowed this deeper diver and targeting. Because core content so well we could springboard. • I think the blended approach (combing online preparatory work with webinars etc.) was the most effective approach. Paying GPs to attend the training was a great incentive, not because of the amount of the payment, but the fact that GPs felt that their time was literally valued.

Table continued on the next page.

Operational staff	Medical educators and content developers
Strengths (continued)	
Funding • Sufficient funding meant we were able to provide learning outcomes that met a wide group of needs leading to great outcomes for patients/community. **Stakeholder engagement and collaboration** • Identified cohort of experts at the foundation stage. Advice obtained from leaders in the area to get a good understanding of what the key issues/areas were within the AOD sphere. **Outcomes** • Provided gold standard education to the maximum number of GPs possible. We made it a priority to ensure we provided education that met the needs of multiple audiences and delivered in ways that we could reach a wider audience. Contract requirement of 1100 completions was not significant enough for us given the size of our member base and hence, we wanted to maximise accessibility. • 2400 completions within Treatment Skills – well above contract target and exclusive of other education options. • While the majority of our GPs completed the course without having any issues, we needed to provide support for those who could not find the course, misread emails and didn't complete activities in full.	**Program design and objectives (continued)** • The program structure adapted well to the pandemic and GP educational needs. GPs were not restricted to attending because of geographical location. The comprehensive GP based approach was effective – education 'by GPs for GPs'. • Different tiers – basic, intermediate, advanced (not done before in RACGP). Richness in having so many GPs involved. Resulted in nuanced and effective educational involvement. Different GPs have different styles. Innovative. Clinically where there was a lot of grey zone, pitched appropriately, to and froing meant eventually the final product gave different options, not just black and white but appropriate grey zone. Wide review of what was existing and filled the gaps for primary care. How to draw complexity, best way to simplify this into something actionable (for example, 5As). • The focus on general practice is unique in AOD programs. The 'by GPs for GPs' approach reinforced the role of peer influence in change clinical behaviours. This ethos was embedded throughout the entire program and was a strength supporting the program's success. • Not so much an improvement, but just to reinforce the importance of GPs teaching GPs rather than specialists. This is far more effective in training GPs to delivering realistic GP-based care in emerging areas. Peer education is by far the strongest tool for change, and the AOD Program used this to maximum effect. • The adaption during the pandemic was extremely effective. As a side issue, doctors in rural and remote areas could easily attend the training, as geographical location did not impact upon participation. • National roadshow approach of delivering face-to-face workshop was high risk trying to standardise that across Australia. Not one clinician had the time or willingness to deliver a program over the entire country. Individual's competency. Pandemic – some positives is the timing, being able to pivot resources to create online training, innovation, bringing that energy to design, overcome barriers for rural remote and address capacity. **Funding** • AOD team needed to advocate for GPs, setting expectations for funders as to what the priorities were. **Stakeholder engagement and collaboration** • What worked well was having a reference group of solely GPs who could make sense of feedback and distil – rural, Aboriginal and Torres Strait Islander health faculty and specific interests. Recommend diversity of voices for example, more experienced, New Fellows, gender, ethnicity – on staff, very helpful and enriching. • The funder – DoH – only two performance indicators, retaining intellectual property rights of content development (now the legacy of the program). Scope of program – generic and broad, difficult as overwhelming but meant the focus could pivot to meet GPs' needs initially and as they arose over time. Money helps people engage, 'unlock headspace' to meaningful participation – stakeholders above more likely to engage if salaried and in their remit of usual work, more difficult to engage individuals and contractors not salaried to participate as stakeholders. **Outcomes** • Increasing the number of GPs with AOD skills

Table continued on the next page.

Operational staff	Medical educators and content developers
Weaknesses	
Zoom • AOD live – issues presenting because of people needing to use Zoom and being inexperienced in using Zoom. • Running online workshops meant smaller audiences (reduction of 80 places to max 45 – ideally 30 to 35). Needed to run a significant number of workshops to try and make up for the lack of spaces available. • AOD Live groups contained participants from all over Australia, meaning that participants and presenters were not necessarily located in the same state/territory. Therefore, it was difficult for participants to forge relationships/find support systems in their own community. **AOD Live** • Initially started with role-plays during session, noted that this was not optimal in zoom format as compared to face-to-face. Changed to group discussion-based approach. • There were numerous changes to the presentations and participant handbooks in 2020, to try and make the information as user friendly as possible. • Initially allocated cases for discussion; however, noting that people often turned up unprepared, moved to model where facilitators discussed the case. • A lot of work required in moving participants to alternate series due to absence/late arrivals – moved to 'one change rule' which was effective in managing this and should have been implemented earlier. **COVID-19 provisions** • Lack of immediate COVID support to our members during the pandemic, knowing that with lockdown there was a significant increase in AOD use and given contract constraints we were unable to provide specific tailored support around this.	**Preparation and development of content** • More time at the beginning of the grant to film the cases better. • Inclusion of smoking cessation would have been useful. • More support for instructional designers – clearer story board to then be able to develop the videos. • Useful to have an academic expert to input into the development of the academic framework, at the very beginning, literature review of what works and what doesn't. This was progressed in stakeholder engagement but could have been strengthened. **Team disruptions** • Staff working from home as a result of the pandemic influenced collaboration. As one example of how this led to a weakness, reference group meetings were less effective in the online format.

Table continued on the next page.

Operational staff	Medical educators and content developers
Member contact	
Significant support provided to members by operational team • One operational staff person said: *'I have regular contact with members. I usually receive around 20 phone calls during a week, and I make around 10 phone calls a week. Most of the time between 5 to 15 minutes if it's related to the course and their access. If it's related to TechOne it takes a minimum 45 minutes, in addition to another 20 minutes of inviting the member to a Zoom meeting and ask them to share their screen. I can then troubleshoot their problems. I receive seven to 10 emails a day, not including the LITMOS emails. At the moment, I process 30 GP payments for a week. Many members don't like the TechOne process, they don't find it user friendly. They view it as unnecessary step. Some of them are uncomfortable to send or attach their bank statement, resulting in another phone call for me to explain to them personally. I assure the GP that their bank statement will be discarded after getting checked with finance. It takes time to explain that this a college-wide process and not something the AOD team has implemented. In many cases this doesn't come via email and the GP requires a personal phone call to ease their concerns.'*	• Established systems and processes to manage administration, which enabled GPs to focus their queries to be more content related and the team were able to provide more tailored responses. • Session reminders and pre/post activity reminders were essential.
Other/closing comments	
• Members could benefit from mentoring programs (both GP and experts). • Members indicate that *'General practice can be isolating and that it's helpful to have a network/experienced colleague to reach out to'*. Members also rely on the regular weekly support that ECHO provides. • We received lots of positive and encouraging feedback through phone conversations and emails. • The reimbursement was a strong motivator for some GPs to complete the program, but some also just had a genuine interest in completing AOD training irrespective of the grant.	• Recommendation – create a pool of experts who have gone through a trial who you know how they work or operate in education before the program has started – as much as you can as early as you can. RACGP could foster content experts and delivery experts of GP medical educators. • *'The AOD Program focused on GP skill development – very practical. Being a reviewer of all gplearning activities, I personally felt that the modules were of very high quality, and I was pressed by the depth and breadth of the training, especially around the practical skill developments. Terrific culture and leadership displayed throughout the team and Education Strategy and Development (ESD) team, providing support on organisation, deliverables but also important social and emotional wellbeing support throughout pandemic.'* • *'The payment to GPs made the GPs feel valued – this was a great motivating factor for change. It was not a huge program cost, and in terms of the program outcomes, incredibly cost-effective.'* • *'I really enjoyed the breadth of the educational content – it really was diverse and reflected the reality of Australian general practice – this was another program strength.'*

RACGP
Royal Australian College
of General Practitioners

Healthy Profession.
Healthy Australia.