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Obstacles to alcohol and drug care

Are Medicare Locals the answer?

Background
Harms related to alcohol and drug use have an enormous cost on the community, yet most patients with substance use disorders do not receive care from primary healthcare providers. The establishment of a system of large primary healthcare organisations (Medicare Locals) across Australia provides an opportunity to address this service gap.

Objective
This article considers barriers to delivering alcohol and drug interventions from primary healthcare settings, strategies for their resolution, and the ensuing benefits for patients.

Discussion
Help seeking for alcohol and drug problems is low. Stigmatisation can be countered by policy development, training and support to increase staff awareness and skills, and building relationships with specialist services. Co-location, outreach clinics, and collaborative models simplify access, tailor intensity of interventions, and improve patient satisfaction and health outcomes. Screening and brief intervention at intake, with appropriate training and support for nursing staff, can advance the delivery of timely and effective care.

Keywords
substance related disorder; health services; community health services

Harms related to alcohol and illicit drug use are a significant issue for Australia, and are exacerbated by growing concerns regarding prescription drug misuse.[1,2] Primary healthcare services are well placed to deliver timely interventions that help address these issues, thereby reducing the degree of harm experienced by individuals and local communities, as well as the cost of healthcare provision.[3] This principle is reflected in the current approach to healthcare reform in Australia, which emphasises a comprehensive model of care based on community need. Healthcare reform includes the establishment of 61 Medicare Locals (MLs) that will 'coordinate primary healthcare delivery and tackle local healthcare needs and service gaps. They will drive improvements in primary healthcare and ensure that services are better tailored to meet the needs of local communities'.[4]

The coordinating role of MLs suggests it is important to configure these organisations so that a wide range of health needs, including alcohol and drug problems, are detected and addressed within their local community. While about 1 in 20 Australians meet criteria for a substance use disorder (5.1%), this figure more than doubles for those aged 16–24 years (12.7%). Help seeking is low among this group, particularly within primary care.[5] According to the 2007 National Survey of Mental Health and Wellbeing, fewer than 30% of Australians with a 12 month substance use disorder consulted a general practitioner, and the proportion was particularly low (7%) for young men.[5] Primary care patients do not readily acknowledge substance use concerns to their medical practitioner, and GPs are often unaware of such problems, particularly when patients do not have a history of substance abuse or mental health treatment.[6] This is concerning given the morbidity and mortality associated with these disorders, the fact that untreated illness worsens comorbid conditions,[7,8] and the strong evidence on treatment effectiveness.[9–11]

Despite a strong evidence base on effective service design to support help seeking, provide timely interventions, and facilitate access to specialist care, implementation of these design strategies is often limited within many primary care services. This article explores obstacles to alcohol and drug care, strategies that primary healthcare services can use to address these challenges, and the associated benefits (*Table 1*).

Increase staff responsiveness to help seeking, through organisational commitment, awareness raising and skills development

Stigmatisation of those with alcohol and drug problems is common.[12] Negative attitudes are held by members of the general community, health workers,[13] and even those with alcohol and drug problems.[14] These views pertain to who is responsible for the problem and its solution, whether the 'drunk' or the 'junkie' should be left to their own devices, and if anything can be achieved through intervention.[15] For these reasons, hiding one's problem becomes a viable option – despite the negative impacts on physical and mental health, as well as one's family, and difficulties in areas such as employment, relationships and housing. Many people approach a service only after a crisis,[14] years after problematic substance use and associated concerns have commenced;[16] or they do not seek help at all.[17]

Services need capacity to identify and respond to substance use problems in their patients. This involves strategies to build and reward staff skills, knowledge and motivation;[18] countering stigmatisation;[13] addressing staff confidence;[19] and ensuring all patients are screened for alcohol and drug disorders. Strategies are drawn from the management literature and involve building an organisational culture that incorporates responsiveness to alcohol and drug concerns as part of core business and organisational identity.[20–22] These strategies operate within services and across the service network. They include (see also *Table 1*):

- formalising the organisation's commitment to addressing substance use concerns through specific policies and value statements
- identifying staff with relevant skills and highlighting their role as enablers of service responsiveness (eg. as a source of advice for other staff, as an example of alcohol and drug service delivery)
- including awareness raising about alcohol and drug use problems as health concerns, as well as the effectiveness of treatment, in workforce development structures such as induction for new employees and training
- implementing policies targeting prescribing practices, peer supervision and regular reviews where drugs of dependence are involved
- facilitating access to training posts in addiction medicine for general practice trainees
- disseminating information through MLs on achievements made in the provision of screens, brief interventions and referral to specialist care
- formalising links between primary health and local alcohol and drug services (eg. memoranda of understanding, collaborative models, shared planning)
- using state and national initiatives to fund specialist support through collaborative models such as outreach clinics and referral pathways to addiction medicine physicians, psychologists and psychiatrists (eg. under the Better Outcomes initiative).

Overcome the discontinuity of care between primary and specialist services

There is long standing debate regarding the best place for services targeting problematic substance use. Specialist alcohol and drug services have poor visibility,[23] and patients rely on word of mouth, including peer networks,[24] to identify services. In reality, even when patients are engaged with specialist alcohol and drug services they will need access to primary healthcare for other medical concerns and ongoing care.

Integrated and coordinated models that operate across primary health and specialist alcohol and drug services are important. These models reduce practical barriers by simplifying referral pathways between services and improving organisational efficiencies and patient outcomes.[25–27] As with other areas of health, staff familiarity with patients receiving alcohol and drug care reduces feelings of stigmatisation, fear and avoidance.[28]

Some groups benefit particularly from the provision of specialist services within primary care settings. Providing substance abuse or mental health clinics in the same location as primary healthcare for patients aged 65 years or more brings maximum benefit in terms of patient engagement and retention. The distance between facilities is a key factor: as the distance between the primary care centre and specialist clinic increases (eg. same building, same health campus, separate facility but within a few kilometres), engagement decreases.[26]

There is also evidence supporting the provision of opiate pharmacotherapy within primary healthcare. Patients have increased access to other health services, including preventive care, and there is scope to develop appropriate management regimens for patients with chronic pain. In addition, receiving opiate pharmacotherapy treatment from a primary healthcare service may assist in reducing the isolation patients feel when attending specialist programs.[29]

Another approach to integrated care involves specialist outreach clinics. These clinics can operate in different ways: they may occur at the primary care facility, involve a consultation and liaison model, or include a specialist as the practitioner first encountered by the patient. Gruen et al[27] examined research on outreach clinics providing simple consultations or input as part of a multifaceted intervention, compared with usual care. The clinics performed better than usual care in relation to service delivery and patient outcomes. Patient access and satisfaction improved and service costs were reduced. The quality of treatment was better, as were health outcomes.[27]

When patients have co-occurring conditions or advanced substance use problems, collaborative care may be best. This approach draws from the chronic disease management model and involves a team of health professionals with specific areas of expertise.[30] Teams may operate from the primary healthcare clinic and extend to specialist facilities, particularly for interventions such as withdrawal, counselling or pharmacotherapy review. The shared expertise and information available to the team means a comprehensive, tailored response is possible.

Collaborative care also works well for patients with substantial mental health concerns, with benefits in the areas of patient comfort, quality of care, adherence and treatment outcomes.[25] Research involving people with substance use problems is limited, however an investigation of treatment models for patients with mental health concerns and elevated levels of alcohol abuse has shown that patients want their providers to communicate with one another.[31]

While case management is a common feature of collaborative care, it is critical when patients have multiple needs and would benefit from facilitated referrals to social services, such

Table 1. Evidence based strategies for addressing alcohol and drug concerns within primary healthcare settings

Barrier	Strategy	Benefit
• Stigmatisation of alcohol and drug problems • Reluctance to seek help • Organisational culture that does not promote responsiveness to alcohol and drug problems	• Formalise the organisation's commitment to addressing substance use concerns through value statements and policies, workforce development programs and inter-agency linkage development	• De-stigmatisation of substance use problems • Increased staff awareness, confidence and skills • Inter-agency partnerships developed • Established patient pathways between primary health and specialist care
• Limited visibility of specialist alcohol and drug services • Lack of integration of alcohol and drug care in primary healthcare	• Adopt integrated models that include specialist alcohol and drug services and linkage to mutual aid support. This may involve: – specialist alcohol and drug services in primary healthcare (same building where possible) – specialist alcohol and drug clinics 'outposted' to primary healthcare – multidisciplinary care teams – case management • Offering space for mutual aid groups to meet within practice or providing assertive linkage	• Simplified referral pathways between services • Access to a comprehensive model of care • Increased service efficiencies • Improved quality of care • Improved patient satisfaction • Better patient outcomes • Tailoring interventions to patient need and stage in treatment
• Lack of detection of risky and problematic substance use • Failure to 'seize the moment' and provide interventions in an opportunistic way • Interventions not tailored to level of need	• Screening and brief intervention for all patients, delivered by nurses and incorporated into daily practice	• Raising awareness among patients • Increasing staff awareness, skills and confidence in the area of substance use • Embedding an effective approach to risky substance use across the patient population • Formalising staff contribution to a holistic model of healthcare

as housing or employment support. Research on case management for drug abusers has identified benefits in terms of service linkages and reductions in drug use (the latter for heroin users only).[32] Primary care services should assign case managers as needed, or incorporate case managers within their multi-agency collaborative care teams. In addition, evidence suggests that a manualised approach to case management may increase linkages.[32]

Having an integrated approach is also important for maintaining an appropriate continuum of care, as patients progress through different stages of treatment and recovery.[33] A stepped care approach to treatment, involving individualised care that varies according to patient stability and risk for relapse, means that patients can be diverted to lower level interventions where appropriate, thereby supporting service efficiency while maintaining service quality.[34] Effective linkages with mutual aid groups (eg. Narcotics Anonymous, Alcoholics Anonymous, SMART recovery) provide access to peer support during and following formal treatment, thereby reducing reliance on clinical services,[35] and enabling access to individuals who successfully model recovery.[33]

Provide timely intervention to reduce risky alcohol and drug use

The strategies outlined above often focus on those with advanced alcohol and drug problems and associated concerns. However, primary healthcare also has a substantial role to play in the detection of risky substance use – particularly alcohol and cannabis. Screening and brief intervention (SBI) for risky alcohol use in primary care is well supported by the evidence[36] and should include young people who are likely to be experimenting with alcohol and drugs.[37]

Many attempts have been made to increase GP engagement in alcohol and drug service provision, while substantial barriers exist.[38] Primary healthcare practitioners are sometimes reluctant to question patients about their substance use, or offer treatment that is unfamiliar or unsupported.[39] Medical practitioners may lack confidence in their skills and knowledge in this area[19] and worry about obtaining access to specialist services if they are required.[3] Targeting other practitioners in the primary healthcare setting, particularly practice nurses, would increase the breadth of options for alcohol and drug service delivery and should include screening, awareness raising and brief intervention. A comparison of SBI implementation across GP clinics in the United States showed substantial rates of delivery when mid-level professionals (usually nurses) rather than medical providers were involved.[40]

Positive staff attitudes toward SBI, and management strategies that account for competing demands on nurses' time and their concerns about patient complexity are important.[36] Having dedicated resources for staff awareness and support, such as online training modules, and

leaders with advanced skills and knowledge about risky substance use and dependence, such as alcohol and drug nurse practitioners, would further enable SBI delivery.[41,42]

Conclusion

Healthcare reform provides an opportunity to implement service models that will address a long-standing disconnect between primary health and alcohol and drug care. Evidence based strategies that support help seeking and responsiveness, overcome discontinuity of care across different healthcare providers, and provide timely intervention for at risk and problematic substance use, can guide the configuration of primary healthcare services, as coordinated by MLs. This will enable a high level of responsiveness to alcohol and drug use problems across our community.

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