THE ALCOHOL EDUCATION AND REHABILITATION FOUNDATION LTD

EVALUATION OF INTERVENTIONS PROMOTING PHARMACOTHERAPIES FOR ALCOHOL MISUSE

FINAL REPORT
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J HALES & L SCORSONELLI

HEALTH OUTCOMES INTERNATIONAL

Health Outcomes International (HOI) Pty Ltd
Suites 1&4, 51 Stephen Terrace, St Peters SA 5069
(PO Box 1038, Kent Town SA 5071)
Ph 08 8363 3699 Fax 08 8363 9011
Email: info@hoi.com.au
ABN 80 081 950 692
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EXECUTIVE SUMMARY

In 2004, the Alcohol Education and Rehabilitation Foundation Ltd (AERF) funded six projects that addressed the use of pharmacotherapies for alcohol dependence. Pharmacotherapy involves the use of medication in the treatment of problematic drug dependence. There has been considerable research, nationally and internationally, into the use and effectiveness of this type of treatment. This form of drug therapy is very useful in addictions to such substances as heroin, alcohol and other drugs that affect the body in a predominately biological manner.

Of the original six projects, two subsequently merged and one did not proceed to implementation. The four projects that proceeded to completion were:

- Pharmacotherapy Alcohol Treatment (PAT) Project (Bendigo, Victoria)
- Shared Care Alcohol Projects (SCAP) (Victoria)
- Breaking Down the Barriers (Tasmania)
- Call-Back Telephone Counselling Service for GP Patients on Pharmacotherapies for Alcohol Dependence (Western Australia)

While all of the projects had as their primary focus the engagement of GPs in the provision of pharmacotherapies to patients with alcohol dependence, they differed markedly in their duration, mechanisms for engagement and their geographic coverage.

Health Outcomes International (HOI) was commissioned to undertake a meta-evaluation of the projects. The meta-evaluation provides an opportunity to contribute to the evidence-base regarding treatment outcomes for pharmacotherapies and the circumstances that influence treatment uptake. This report presents a synthesis of the findings from the funded projects. Further details of the findings from the individual projects are contained in their separate evaluation reports.

The various projects funded under the AERF pharmacotherapies initiative adopted very different approaches to the application of this treatment modality for alcohol dependence. All have been successful, albeit to different degrees, in meeting their specified goals, and have contributed to the knowledge base about the application of this form of treatment.

Perhaps most importantly, the projects illustrate that there is no "single best way" to the engagement of GPs in pharmacotherapy. There are significant barriers to GP engagement that are both attitudinal and knowledge-based in their nature. Broad-based "passive" mechanisms that seek to engage GPs in this form of treatment have been shown to have limited effect and low levels of uptake, at least in the short term. More "proactive" and personalised approaches have been more effective, but are also much more resource intensive, and are likely to be more costly and difficult to apply on a larger scale. Consequently, a long-term strategy that seeks to address both the attitudinal and knowledge barriers to pharmacotherapy use by GPs is required.

The experience of GPs once they engaged in the use of pharmacotherapies, and where a shared care approach has been adopted (involving the support of drug and alcohol clinicians providing counselling services) have been reported as being very positive. The large majority of GPs participating in these projects reported having increased their knowledge of, and willingness to use, pharmacotherapies for patients with alcohol dependence. However, the shared care model was found to be most effective when there were clearly defined roles and regular communication pathways between the various clinicians involved in patient care.

Finally, whilst the funded projects were not designed as, nor intended to be, trials to test the efficacy of pharmacotherapy for alcohol dependence, those projects involving patient treatment found that, at least for some patients, pharmacotherapy can assist in reducing their alcohol intake. The active support and involvement of their GP was an important factor in achieving this outcome.

Each of the projects developed a range of resources that have the potential for broader application in similar initiatives, details of which are outlined in this report and in the separate project evaluation reports. These warrant further consideration in any future projects or programs of this nature which seek to engage GPs in drug and alcohol treatment and the analysis of their effectiveness.

2

INTRODUCTION

2.1 BACKGROUND

The Alcohol Education and Rehabilitation Foundation Ltd (AERF) was established by the Australian Government in 2001. It was awarded a grant of $115 million to address prevention, treatment, research and rehabilitation for the misuse of alcohol and "sniffing" (particularly petrol, paint and glue).

In the course of the 2004 Treatment and Rehabilitation Funding Round, the AERF allocated a sum of $2 million for projects that addressed the use of pharmacotherapies for alcohol dependence and embraced AERF's core objectives. In particular, applicants were requested to focus on initiatives that encouraged the use of pharmacotherapies particularly by General Practitioners (GPs) to address alcohol misuse in non-residential treatment settings.

Six (6) intervention projects were initially funded, two of which subsequently merged and one did not proceed to implementation. These projects each had the following objectives:

- The prevention of alcohol and other licit substance misuse, including petrol sniffing, particularly among vulnerable population groups such as Indigenous Australians and young people;
- Supporting evidence-based alcohol and other licit substance misuse treatment, rehabilitation, research and prevention programs;
- The promotion of community education, encouraging responsible consumption of alcohol and highlighting the dangers of licit substance misuse; and
- The promotion of public awareness of the work of the AERF and raise funds from the private sector for the ongoing work of the AERF.

Health Outcomes International (HOI) was commissioned to undertake a meta-evaluation of the projects. The meta-evaluation provides an important opportunity to contribute to the evidence-base regarding treatment outcomes for pharmacotherapies and the circumstances that influence treatment uptake.

2.2 ROLE OF PHARMACOTHERAPIES IN TREATING ALCOHOL MISUSE

Alcohol is the most commonly used licit drug in Australia. The National Drug Strategy Household Survey (2007) identified that nine out of ten Australians aged 14 years or older had tried alcohol at some time of their lives, and 83% had consumed alcohol in the 12 months preceding the 2007 survey. Further, approximately one in ten adults consumed alcohol in a way considered "risky or a high risk" to their health, in the long term.[1] In 2003 "alcohol dependence and harmful use was ranked 17th in the 20 leading cases of burden of disease and injury in Australia."[2,3] High consumption of alcohol can increase the risk of "heart, stroke and vascular disease, liver cirrhosis

1 Australian Institute of Health and Welfare (2008). *2007 National Drug Strategy Household Survey: First Results*. Drug Statistics Series Number 20. Cat. No. PHE 98. Canberra: AIHW.

2 Australian Institute of Health and Welfare. (2006a). *Australia's Health 2006*. AIHW Cat. No. AUS 73, AIHW: Canberra.

3 Australian Bureau of Statistics, (2006) *Alcohol consumption in Australia: A Snapshot 2004-05*, URL: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4832.0.55.001/

and some cancers", and can also contribute to "disability through accidents, violence, suicide and homicide."[4]

Pharmacotherapy involves the use of medication in the treatment of problematic drug dependence. There has been considerable research, nationally and internationally, into the use and effectiveness of this type of treatment. This form of drug therapy is very useful in addictions to such substances as heroin, alcohol and other drugs that affect the body in a predominately biological manner. Pharmacotherapy tends to focus more on the chemical aspects of the body, and the optimal way to repair or counteract drug differences or imbalances in the body. [5]

Pharmacotherapy medication can be used to alleviate withdrawal discomfort, as maintenance substitution therapy and to assist in achieving abstinence. Alcohol dependence is a prevalent disorder characterised most often by chronic relapses and deterioration in the face of numerous attempts at treatment.[6] Two key pharmacotherapies, acamprosate and naltrexone, have been identified as showing promise in the treatment of alcohol dependence.

Acamprosate is a synthetic GABA analogue that is thought to restore the N-methyl-D-aspartate (NMDA) receptor tone following increased neuronal hyperexcitability during alcohol withdrawal. The efficacy of acamprosate in the treatment of alcohol dependence has been studied in several double-blind randomised placebo-controlled trials. The majority of studies have shown beneficial effects of acamprosate relative to placebo in increasing the days of cumulative abstinence and rate of abstinence. However, three studies have failed to reveal any improvements in outcome measures of alcohol dependence, and few have reported data on heavy drinking measures.[7]

Naltrexone is a long-acting, opioid receptor antagonist that is thought to block alcohol-stimulated increases in endogenous opioid activity, and subsequently reduce the reinforcing effects of alcohol. The efficacy of naltrexone in delaying relapse in alcohol dependent individuals has been reported in numerous randomised, placebo-controlled, double-blind studies, and most consistently with concomitant psychosocial treatment. However, several studies have reported only marginal benefits with significant side effects, and have failed to demonstrate any beneficial effect of naltrexone relative to placebo on drinking outcomes.[8]

In a comparison of the two pharmacotherapies, meta-analyses suggest that acamprosate may be useful for achieving *abstinence*, whereas naltrexone appears to be beneficial for the *reduction* in heavy drinking.[9]

2.3 THIS DOCUMENT

HOI's meta-evaluation of the AERF-funded projects is aimed at learning from the interventions separately and collectively, including identifying the processes, barriers and enablers to engaging GPs and consumers in pharmacotherapy interventions for alcohol misuse.

This document presents HOI's findings from the meta-evaluation, and has been informed by documentation and reports provided by the projects and their evaluators, and discussions with the project officers and internal evaluators.

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4 Australian Bureau of Statistics, (2006) op. cit. and World Health Organisation. (2004), *Global Status Report on Alcohol 2004.* WHO: Geneva.

5 Treatment – the role and practical application of pharmacotherapies. www.nt.gov.au/health/healthdev/aodp/illicit_drugs/Illicit_Drugs_Report_C.pdf, 117-231.

6 Anton, R., Et al. (2006). Combined Pharmacotherapies and Behavioral Interventions for Alcohol Dependence The combine Study: A Randomized Controlled Trial, *Journal of the American Medical Association, 295 (17),* 2003-2017.

7 Morley, K., Teesson, M., Reid, S., Sannibale, C., Thomson, C., Phung, N., Weltman, M., Bell, J., Richardson, K., & Haber, S. (2006). Naltrexone versus acamprosate in the treatment of alcohol dependence: a multi-centre, randomized, double-blind, placebo-controlled trial, *Addiction, 101,* 1451-1462.

8 Huang, M., Chen, C., Yu, J., & Chen, C. (2005). Double-blind, placebocontrolled study of naltrexone in the treatment of alcohol dependence in Taiwan. *Journal of Addiction*; 10: 289–92.

9 Morley, K., Teesson, M., Reid, S., Sannibale, C., Thomson, C., Phung, N., Weltman, M., Bell, J., Richardson, K., & Haber, S. (2006). Naltrexone versus acamprosate in the treatment of alcohol dependence: a multi-centre, randomized, double-blind, placebo-controlled trial, *Addiction, 101,* 1451-1462.

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PROJECTS OVERVIEW

This chapter provides a summary of each AERF-funded pharmacotherapy project. As each project has submitted detailed project reports to AERF as part of their individual reporting requirements, this report should be read in conjunction with the project reports for a more complete understanding of the activities undertaken.

3.1 PHARMACOTHERAPY ALCOHOL TREATMENT (PAT) PROJECT (BENDIGO, VICTORIA)

Location: Bendigo Division of General Practice

Project Focus: GP Training and Patient Support

The *Pharmacy Alcohol Treatment (PAT)* Project was conducted by the Bendigo and District Division of General Practice (now known as the Central Victoria General Practice Network)) and ran over three years (2005-2007). Its goal was to provide a more comprehensive General Practitioner (GP) continuum of care to patients and their families by reinforcing the benefits of pharmacotherapy treatment of alcohol misuse and aiming towards greater patient compliance with, and retention in that model.

Specific objectives of the PAT project were:

- To develop and implement a model that would raise the level of awareness of GPs to the advantages of prescribing pharmacotherapies in the treatment of alcohol misuse.
- To increase the level of education and training within the GP population on the use of pharmacotherapy and its essential elements including identification, assessment, brief interventions and motivational interviewing, leading to a better continuum of care.
- To provide clinical support and interventions to GPs, the patients and their families in the psychosocial aspects of their overall treatment and secure better outcomes as part of the continuum of care, including greater patient compliance and retention.
- To develop and implement an internal evaluation methodology, including how to disseminate and promote the concepts of the model in the broader GP community, AOD service sector and with policy makers.

The Project Officer commenced duties in November 2005, in an environment where there was a perceived "saturation of mental health/drug and alcohol training."[10] Consequently there was a concern that GPs in the area would not be receptive to yet another alcohol initiative. This required the Project Officer to invest time collaborating with other Divisional personnel and influential GPs to develop an effective range of acceptable mechanisms by which GPs would engage with the project. From the information provided in the Final Report on the project, this adaptability and responsiveness to GPs was an essential element characterising the project, and a significant contributor to the overall success of the project.

The focus of PAT was on increasing the confidence of GPs' knowledge, skills, attitude and behaviour in the area of pharmacotherapy medicine. It was envisaged, that this in turn, would increase the uptake of pharmacotherapy interventions by GPs. The model on which the PAT training program was based was a previous training program titled "Training On Wheels", which

10 Cheryl Martin Consulting (March 2008). "Pharmacotherapy Alcohol Treatment (PET) Program – Final Report."

was administered by the Bendigo and District Division of General Practice, and was considered to be quite successful. In addition, the Project Officer also had a clinical role that saw him interacting with and supporting patients of the project. This aspect of the project also took on increasing importance in engaging and supporting GP participation in the project.

The PAT project team comprised a Project Officer (with the multiple roles of Project Officer, Clinician and GP Educator), the Division's CEO, and a Project Reference Group. Clinical supervision was provided by a Clinical Psychologist who was part of the Division's Better Access to Mental Health Program.

The internal evaluation of PAT commenced in November 2005 and adopted a Program Logic approach for its methodology. The internal evaluator and Project Officer met on a regular basis to review and discuss the project's evaluation questions and assumptions, indicators, measurements and data sources. The Final Report of the evaluation was completed in March 2008, and was the major information source for the meta-evaluation.

3.2 SHARED CARE ALCOHOL PROJECTS (SCAP) (VICTORIA)

Location: Southern Health & St Vincent's Hospital, Victoria

Project Focus: GP Training and Engagement of Consumers

The *Shared Care Alcohol Project (SCAP)* comprised two projects operating across two locations: St Vincent's Health and Southern Health. The projects aimed to support patients with alcohol dependence in the post-withdrawal period, provide education and clinical advice to their GPs, and encourage patients and GPs to consider using anti-craving medications where appropriate. More generally, the project aimed to increase GP interest and involvement in managing alcohol dependence.

Patients participating in the project were mainly from withdrawal units and hospitals wards or outpatient departments. Patients were provided with case management and encouraged to consider anti-craving medications if appropriate. Doctors were provided with written management plans and information on anti-craving medications, and invited to contact addiction medicine staff for more advice and support if required. Both sites provided education to GPs, including lectures and small group learning. More interactive forms of education such as mentoring and clinical attachments had minimal uptake partly because of limited doctor interest and also due to limited capacity at both sites to promote or provide this form of GP education.

The evaluation of SCAP had the following aims:

- Assess if the clinical intervention increased the prescription rate of anti-craving medications to suitable patients, and explore factors associated with uptake of anti-craving treatment;
- Evaluate outcomes including ongoing treatment with anti-craving treatment at three months and improvements in health and alcohol consumption and dependence; and
- Assess if the intervention had been successful in encouraging general practitioners to be more active in managing alcohol dependence, including prescribing anti-craving medications.

The evaluation used multiple methods including: a de-identified clinical audit of all participating patients across both sites (covering presenting illness, and comorbidity, use of anti-craving medications, and involvement of their GP in managing his/her alcohol problem); a formal patient participant survey at baseline and at three months; a formal GP survey; and qualitative interviews with patients, GPs and professional stakeholders.

The Final Report of the evaluation was completed in July 2007, and was the major information source for the meta-evaluation.

GP SUPERVISED AMBULATORY ALCOHOL DETOXIFICATION WITH RAPID INDUCTION ONTO ABSTINENCE MAINTENANCE PHARMACOTHERAPIES (GPAAD) (NSW)

Location: Sydney West Area Health Service

Project Focus: GP Training

This project sought to provide training to GPs in various alcohol detoxification and alcohol abstinence maintenance approaches. It was intended that two local Divisions of General Practice would participate in the project and assist in supporting the local GPs when participants were recruited.

Due to changes in personnel and organisational restructuring of the NSW Area Health Services, this project did not proceed and is not reported on.

3.3 BREAKING DOWN THE BARRIERS (TAS)

Location: Tasmania

Project Focus: GP Training and Education

The *Breaking Down the Barriers (BDB)* Project was conducted by the Drug Education Network inc (DEN) with the aim of raising the awareness of Tasmanian GPs of the advantages of combining pharmacotherapy and psychosocial counselling as a treatment option for alcohol dependant individuals who have a treatment goal of modifying their alcohol use or total cessation.

The specific objectives of the BDB Project were:

- To increase GP awareness and level of knowledge of pharmacotherapy as a treatment option for individuals who are alcohol dependent including an in-depth understanding of the barriers to the use of pharmacotherapies;
- To develop and disseminate a range of educational training products designed to encourage GPs to consider using pharmacotherapy treatment for individuals who are experiencing difficulty with alcohol use;
- To promote an increase in the number of GPs considering pharmacotherapy as a treatment option through the use of educational training products; and
- To develop and implement an internal evaluation methodology that will include the collection of statistical evidence to support the outcomes of each phase of the project such as an insight into some of the barriers which may inhibit GPs from utilising pharmacotherapy treatment.

The Project Implementation Plan identified five key phases over three years from 2005 to 2008. These comprised:

1. Survey of Tasmanian GP attitudes towards, and knowledge of, pharmacotherapy treatment for alcohol dependence;
2. Analysing the data collected during Phase 1;
3. Developing resources tailored to the needs identified from GP data analysis results and feedback;
4. Distributing and disseminating the resources developed to Tasmanian GPs; and
5. Evaluating the impact of the project on Tasmanian GP attitudes and behaviour.

The Project experienced a number of difficulties, particularly in the early stages of its operation, especially in regard to the processes for contacting GPs across Tasmania and their engagement. Despite these difficulties, a number of outputs were produced by the Project, including:

- A baseline measure of GP knowledge and awareness of pharmacotherapy treatment;

- Identification of significant gaps in the literature available to GPs, service providers and the general community in the field of pharmacotherapy and counselling as a treatment option for alcohol dependence;
- A Resource Kit to assist GPs in understanding and implementing pharmacotherapy was distributed to every Tasmanian GP;
- Education sessions for GPs accredited by the Royal Australian College of General Practitioners (RACGP) for four Category 2 Continuing Professional Development (CPD) points; and
- Promotional posters for use in GP's rooms and a brochure with an alcohol use self-assessment screening tool for use by patients.

The Project was evaluated by a Research Officer employed by DEN but who was independent of the operational aspects of the Project. The Final Report from the Project was presented in December 2008, and forms the major information source for the meta-evaluation.

3.4 CALL-BACK TELEPHONE COUNSELLING SERVICE FOR GP PATIENTS ON PHARMACOTHERAPIES FOR ALCOHOL DEPENDENCE (WA)

Location: Western Australia

Project Focus: Engagement of GPs and Consumers

This project was undertaken by the WA Drug and Alcohol Office, began in April 2005 and was completed in July 2006. The objectives of the project were to:

- Develop and trial an effective and accessible counselling service for patients considering prescription of, or prescribed, alcohol pharmacotherapies by their GP. This included the development of appropriate protocols.
- Develop a therapeutic relationship with patients through the use of telephone counselling and support sessions that promoted abstinence, compliance with medication, support and relapse prevention.
- Provide patients with information that help them to develop skills to avoid and deal with high risk drinking situations.
- Develop and implement an internal evaluation methodology that included the collection of statistical evidence such as the number of ADIS counsellors trained, GP referrals received and call-back sessions provided to patients.

The model comprised the GP as the prescriber, while the Alcohol and Drug Information Service (ADIS) provided the requisite expertise to offer assessment, support, counselling and monitoring of patients prescribed alcohol pharmacotherapies, and if necessary, referral to an alcohol and drug agency. ADIS provided counselling through a series of call-back telephone counselling sessions negotiated with patients, which included the development of an individualised treatment plan and counselling support plan. The partnership between the GP, the ADIS counsellor and the patient ensured informed decision making regarding treatment and better outcomes.

A core resource of the project was the General Practitioner Pack comprising a referral pad that included:

- A one page referral form;
- An algorithm for referral;
- A frequently asked questions (FAQ) page; and
- Information regarding ADIS services.

The GP referred the patient to ADIS following consultation. An ADIS counsellor then contacted the patient via telephone within 24 hours, introduced themselves and explained that they were calling following a referral from their GP. ADIS then provided counselling through a series of call-back telephone sessions negotiated with the patients. Referral to the call-back service supported the Medicare requirements of GPs.

4

EVALUATION FINDINGS

This chapter provides an overview of the findings from HOI's review of the individual projects' findings and evaluations. A brief summary of each projects' major findings is presented, followed by a synthesis of common themes and messages across the projects.

4.1 EVALUATION FINDINGS FROM INDIVIDUAL PROJECTS

4.1.1 PHARMACOTHERAPY ALCOHOL TREATMENT (PAT) PROJECT (BENDIGO)

The initial evaluation framework for the PAT Project was developed using a Program Logic approach. Subsequent to its initial write-up, the implementation and review of the strategies meant that the evolving process embodied in the Program Logic approach continued. The evaluation had a predominantly qualitative focus, with some inclusion of quantitative measures as descriptive statistics. Thematic analysis and triangulation from all data sources formed the basis of the evaluation report.

DATA COLLECTION

Data collection strategy for the evaluation included:

- Satisfaction surveys to all primary and shared care referring GPs;
- Semi-structured interview follow-up with two GPs;
- Feedback surveys to all Reference Group members
- Interviews with the PAT Project Officer/Clinician;
- Analysis of the PAT Project Officer/Clinician journal;
- Analysis of patient demographic data;
- Analysis of patient satisfaction data;
- Analysis of Medicare pharmacotherapy prescribing data; and
- Semi-structured interviews with four patients/family members.

RESULTS

The PAT project's initial intentions were to engage 20 GPs and to deliver comprehensive GP continuum of care to at least 320 patients and their families during the life of the project.

At the conclusion of the project in December 2007, 47 GPs were involved, more than double the original target. Of these, 31 were primary referrers and 27 were engaged in shared care of PAT patients, with some GPs involved in both groups. Of the "shared care" group, 12 were solely involved in shared care; 11 were both primary referrers and involved in shred care; and 4 had left the area.

A total of 109 patients participated in the PAT Project – 66% through primary referrers and 34% from shared care GPs. Of these, 39 were female and 70 were male, and they ranged from 17 to 76 years of age.

The evaluation report notes that referrals in the second year of operation of the Project were 137% higher than in the first year, with the increase attributed to the growing confidence among referring GPs in the Project. The largest increase was in the 21-40 year age group, suggesting that GPs were screening for alcohol problems at a younger age than previously.

GP feedback on the PAT Project (obtained by a written survey and semi-structured interviews of two participating GPs) was extremely positive. The feedback indicated that the Project had successfully achieved its three key objectives (see Section 2.1). In particular, the report notes that:

> "*the level of awareness and efficacy of pharmacotherapy as a treatment modality is now well accepted by the cohort of GPs referring to PAT*"[11]

Data on prescribing patterns for acamprosate and naltrexone both demonstrated an increase over the life of the PAT Project, although no tests for significance were applied. When compared to two other Divisions of General Practice of similar size, the increase in prescribing patterns (both in terms of the number of prescribers and the number of prescriptions) for these two drugs was further magnified.

Participating patients completed two standardised instruments at their initial assessment – the AUDIT (Alcohol Use Disorders Identification Test) and the SADD (Short Alcohol Dependence Data). The analysis of the results of these screening tools suggested that GPs became more "sensitised" to potential alcohol misuse, with those patients recruited in the second year of the project generally being at the lower end of the "risk" scale, compared to those patients recruited in the first year of the Project.

The analysis of the type of treatment goals established by patients indicates that a higher proportion of patients recruited in the second year of the Project sought to control their drinking rather than aim for abstinence. The analysis of the extent to which treatment goals were achieved recognises the complexity of this concept, having regard to the nature of the goals themselves and the timeframes over which results may be measured. The analysis, whilst perhaps incomplete at the time the evaluation report was prepared, certainly indicates that a significant proportion of patients were achieving the goals they had set.

Patient perceptions of the PAT Project were obtained via a survey at the completion of their treatment cycle. The survey covered the following domains:

- Patient satisfaction;
- Sense of control related to drinking;
- Confidence in future well-being;
- Recommending the Project to a friend;
- How logical the therapy seemed;
- Understanding about pharmacotherapy drugs;
- Overall score for therapy; and
- Intention to be compliant.

In all of these domains, high levels of satisfaction and confidence were reported, with over 90% of patients rating each domain in the top three rating scales. These responses were also replicated in four case study interviews.

ENABLERS

The evaluation report for the PAT Project identified a number of factors that facilitated the development and implementation of the Project. These included:

- A flexible and responsive referral process which participating GPs found easy to engage with;
- The time effectiveness of the PAT model, which expedited access by patients and managed their care efficiently;
- A team approach to implementation;
- The personal and professionally respected relationship between the PAT Clinician and referring GPs; and

[11] Cheryl Martin Consulting (March 2008). "Pharmacotherapy Alcohol Treatment (PET) Program – Final Report." pp15.

- The auspicing role of the local Division of General Practice which facilitated GP participation.

BARRIERS

A number of barriers were also identified in the evaluation report, including:

- An environment in which there were a number of other GP training and education programs, potentially leading to a "saturation of mental health/drug and alcohol training";
- Initial apathy among many GPs;
- A general lack of knowledge and awareness of the role of pharmacotherapy in alcohol treatment among GPs;
- The time taken to build positive and professionally credible relationships with GPs;
- The time required to develop appropriate educational resources; and
- The significant demands on the Project Officer/Clinician in fulfilling both roles.

COMMENTARY

The PAT Project is regarded as having been highly successful both in terms of the number of GPs engaging with the Project, and the level of GP and patient satisfaction with the services provided. The final report from the study states:

> *"..the PAT project exemplified an innovative and enthusiastically approached project that understood and skilfully worked within its local context, resulting in a range of very positive outcomes for the project. These included more than doubling the number of GPs aimed to engage in the project as well as developing a range of innovative treatment tool descriptors and outcome measures that were used and now warrant further research. The model was not only enthusiastically embraced by GPs as accessible, flexible and effective for them to use, it also proved to be efficacious and highly valued by patients and families."*[12]

The report also notes, however, that the future sustainability of the project represents a considerable challenge. This is due to the need ongoing for funding, and the fact that a large part of its success may be attributed to the personality and drive of the PAT Project Officer/Clinician.

4.1.2 SHARED CARE ALCOHOL PROJECTS (SCAP) (VICTORIA)

The *Shared Care Alcohol Projects (SCAP)* were conducted at Southern Health and St Vincent's Health. At St Vincent's the project was implemented by a SCAP nurse who worked in conjunction with an addiction medicine physician. At Southern Health, the responsibility for implementing the project was spread across the Addiction Medicine Unit in order that any changes in clinical practice would occur for all staff, rather than be limited to a small number of project workers. This was also expected to enable such changes and communication with GPs to continue after the project was completed.

DATA COLLECTION

Data collection supporting the evaluation of SCAP comprised a clinical audit, a formal patient survey at baseline and three months, and a formal GP survey, together with qualitative interviews with patients, GPs and other professional stakeholders.

The clinical audit used de-identified information recorded for each patient with alcohol dependence seen as part of the project.

Patient surveys were conducted at baseline and three months after enrolment in the project. The survey included the Audit, Leeds dependence scale and the SF12. It also included a questionnaire specifically designed for the project covering patient experiences and their opinion of the

12 Cheryl Martin Consulting (March 2008). "Pharmacotherapy Alcohol Treatment (PET) Program – Final Report." pp15.

treatment, with an emphasis on anti-craving medications and the relationship with their GP. The questionnaire included the validated General Practice Assessment Questionnaire (GPAQ) which assesses the GP's interpersonal skills and the patient's confidence in their GP's clinical skill-set.[13] A sample of patients was asked to participate in a qualitative evaluation, which explored issues about anti-craving medications and treatment for alcohol dependence.

A survey of GPs was conducted six weeks after their patient had contact with the clinical team. This survey focused on GP attitudes towards people with alcohol dependence, their experiences with drug and alcohol treatment services and anti-craving medications. Medicare data was also collected on the frequency with which they were prescribed anti-craving medication prior to and post their enrolment in the study.

RESULTS

Clinical Audit

Combined data from the clinical audit across the two sites showed that of the 326 patients audited, 76% involved in SCAP were assessed as being suitable for anti-craving medications, of whom 7% were already taking anti-craving medications. Of those invited to take these medications for the first time, half agreed to do so. The common factors associated with patients agreeing to take anti-craving medications were them wanting ongoing assistance for their alcohol dependence, and having a GP who was actively involved in managing alcohol dependence.

Patient Survey and Qualitative Interviews

Of the 68 patients participating in the formal evaluation, two-thirds were recruited from withdrawal units and one-third from inpatient wards. Of these, around half (n=40) were taking anti-craving medications at baseline, and half of them were doing so for the first time.

At three months, two-thirds of those who had commenced taking anti-craving medications were still taking them. Patient opinions about the usefulness of anti-craving medications were more positive at the three-month survey than at baseline, with the majority agreeing that they had been quite or very useful. One-third of the sample was abstinent, and there were marked improvements in general health, alcohol consumption and alcohol dependence for most patients.

The most common form of treatment patients were receiving for alcohol dependence at three months was GP treatment either alone or in conjunction with another treatment modality. One-third were receiving no treatment.

Most of the patient sample had a regular GP and most talked to their GP about alcohol. Patients were generally satisfied with the GP and found it useful to talk to them about their drinking. There was no change in the level of their satisfaction with their GP at three months compared to baseline. Qualitative interviews with patients revealed that patients valued GP personal qualities and attitudes towards their drinking as much or more than their clinical competence in dealing with alcohol problems.

GP Survey and Qualitative Interviews

Forty-three GPs with a patient involved in SCAP participated in a postal survey, with twelve participating in qualitative interviews. Most of them agreed that GPs need more training in managing alcohol problems, and felt that their patients would benefit from better access to counselling, withdrawal facilities and addiction specialists.

GP attitudes towards working with drinkers were more likely to be positive if they had ten or more hours of training in alcohol problems and if they said they had an interest in alcohol problems. Whilst SCAP aimed to provide support to GPs in working with drinkers, only one-third agreed that they could find someone to help them formulate a plan with a drinker.

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13 Ramsay J, Campbell J, Schroter S, Green J, Roland M. (2000). "The General Practice Assessment Survey (GPAS): tests of data quality and measurement properties". *Family Practice;* 17: 372-379 and Bower P, Mead N, Roland M. (2002). "What dimensions underlie patient responses to the General Practice Assessment Survey? A factor analytic study." *Family Practice, 1(5)*: 489-95.

Around half of the sampled GPs rated themselves confident to prescribe either naltrexone or acamprosate. However, only one-third of the surveyed GPs considered that SCAP had increased their confidence and interest in managing patients with alcohol problems. Mixed views were expressed about SCAP, with those that were satisfied being pleased about the communication about their patients' treatment provided through SCAP. The majority of GPs either had limited awareness of SCAP or thought it did not provide what they expected from a shared care program. Suggestions for program improvements from GPs included a more structured shared care program, greater communication about complex patients, and a more assertive approach to patient follow-up.

Drug and alcohol clinicians were critical of GPs' knowledge and attitudes towards people with alcohol dependence, including their knowledge of anti-craving medications. SCAP was regarded by them as being useful in supporting GP to prescribing anti-craving medications and in providing mechanisms for communicating with GPs. However, most felt that the project had not been successful in engaging GPs in educational activities, and in working more closely with the Addiction Medicine Departments.

ENABLERS

Although not specified in the evaluation report for the SCAP, a number of factors that facilitated the Project may be inferred from its contents. These included:

- The drug and alcohol project nurse visited GP surgeries to provide tailored education and support to GPs depending on their learning needs;
- The majority of participating GPs expressed the view that provision of drug and alcohol care was an integral part of their clinical role (although this may have been reflective of a biased sample of GPs); and
- The majority of patients were satisfied with their GP and valued their assistance with their alcohol dependence.

BARRIERS

A number of barriers were identified in the evaluation report, including:

- Apathy, and in some instances antagonism, among some GPs to dealing with patients with alcohol dependence;
- Limited training of GPs in managing alcohol problems;
- A lack of knowledge and awareness of the role of pharmacotherapy in alcohol treatment among GPs;
- Limited provision of intensive educational methods such as academic detailing;
- A focus on throughput, in both the Addiction Medicine Units and in GP surgeries, which was inconsistent with the time requirements to treat this patient group; and
- Limited impact of the shared care model used in SCAP on GPs, together with difficulties in engagement between GPs and drug and alcohol clinic.

COMMENTARY

The SCAP is regarded as having demonstrated that anti-craving medications can be provided by alcohol and drug clinicians in conjunction with GPs, and that patients will comply with treatment after three months. GP treatment, either alone or in combination with another treatment modality, is the most common form of treatment at three months, reinforcing the importance of the role of the GP in treatment.

However, SCAP was regarded as not having been effective in engaging with GPs, a finding that was seen as being reflective of a failure by GPs and drug and alcohol clinicians to engage effectively. The final report from the study states:

> *"A more useful model might be to enrol complex patients into a more structured shared care project with at least one specialist review visit and clearer protocols*

for GPs about care in between specialist visits. Education could be better targeted to the interests and needs of the smaller group of GPs."[14]

4.1.3 BREAKING DOWN THE BARRIERS (TAS)

The primary aim of the BDB Project was to raise the awareness of GPs in Tasmania of combining pharmacotherapy and psychosocial counselling as a treatment option for alcohol dependant individuals. The project was undertaken by the Drug Education Network Inc., Tasmania (DEN).

EVALUATION METHODOLOGY

The evaluation of the BDB was undertaken over the final five months of the project, and involved:

- A review of project planning and reporting documentation;
- An interview with the Project Officer responsible for implementing the project;
- The design, distribution and analysis of a post-intervention survey into the attitudes, behaviour and use of pharmacotherapy treatment options by GPs;
- The design, distribution and analysis of a telehealth conferencing education session for pharmacotherapy treatment options by service providers; and
- The design of a service provider resource kit feedback form.

The final report from the evaluation noted a number of limitations to the study, particularly in regard to the small sample size of the GP surveys and the limited period after the distribution of the resource kits and its implications in regard to the capacity to measure their effectiveness.

RESULTS

The baseline survey of GP knowledge and awareness identified the type of information that GPs required, in what format, and the most effective methods of dissemination to assist GPs to increase their knowledge about, and confidence in using, pharmacotherapy for treating alcohol dependence.

The project identified a significant gap in the relevant literature available to GPs in the area of pharmacotherapy and counselling as a treatment option. Consequently, the resource Kit developed by the project's staff sought to address this gap, and included:

- A booklet about using pharmacotherapy and counselling for the treatment of alcohol dependence;
- A contact list of Tasmanian drug and alcohol services specifically relating to alcohol related issues;
- A screening tool – the AUDIT – to be used by or with the patient to assess whether they may require assistance with reducing or ceasing their alcohol intake;
- A "pharmacotherapy quick chart" with easy-to-understand information about the relevant pharmaceuticals to be given to the patient; and
- The literature review developed in Phase 1 of the project.

A copy of the Resource Kit was sent to every GP (n=538) in Tasmania in August 2008.

To support the Resource Kit, an education session on "Pharmacotherapy for Alcohol Dependence" was developed, with accreditation by the Royal Australian College of General Practitioners (RACGP with four Category 2 Continuing Professional Development (CDP) points. These sessions were advertised across a number of media, and offered to GPs, service providers, health workers and other interested organisations and individuals in an effort to increase community awareness of pharmacotherapy. Promotional posters and a brochure were also produced to promote the service in waiting rooms and consultation spaces.

Presentations were made to a number of public forums and conferences, and the attendance at these sessions and the feedback received appear to have been positive. In addition, GP

[14] Moore E, Clark N et al (July 2007). "Evaluation of the Shared Care Alcohol Project" pp17.

education sessions were planned and widely promoted across the three GP Divisions in Tasmania. However, response to these sessions was disappointing, and consequently did not proceed. However, an education session held through the University of Tasmania Department of Rural Health Telehealth conference series was attended by 60 participants, suggesting a greater reach than face-to-face meetings.

Although the feedback received to date on the value of the Resource Kit has been limited in both coverage (48 survey respondents) and duration (conducted 10 weeks after the dissemination of the Kit), the responses received to date have been very positive, and suggest that it has potential as an education and information resource in the longer term.

ENABLERS

- A dedicated and enthusiastic Project Officer;
- The collection of empirical data on GP knowledge and preferences for information dissemination;
- A comprehensive literature review that sought to address these deficiencies; and
- The development and widespread dissemination of a Resource Kit for use by GPs and other service providers.

BARRIERS

- Resistance among GP Divisions to distributing the baseline surveys to GPs and the provision of mailing lists and a reticence to promote the survey;
- A low response rate to the initial survey of GPs (21 out of 558);
- Limited time commitment and availability of some Steering Committee members;
- Delays in survey data analysis and reporting;
- Limited knowledge and awareness among GPs of treatment options for alcohol dependence and the role of pharmacotherapy; and
- Lack of attendance at the GP education sessions, causing them to be cancelled.

COMMENTARY

The Breaking Down the Barriers project is regarded as having achieved most of its expected outcomes, despite challenges experienced in engaging with GPs and their representative organisations. It has produced some significant outputs, particularly the literature review, the Resource Kit and the education session materials that have the potential for wider application and sustainability in the longer term. However the utility of these materials and the extent of their uptake and use remain uncertain, and will require further monitoring an evaluation over a longer period to determine whether GPs refer to them and apply them on a more consistent basis.

The final report from the project notes:

> *"... as a result of this project all Tasmanian GPs now have the opportunity to increase their knowledge and awareness of pharmacotherapy as a treatment option for alcohol dependence through the Resource Kits and the RACGP accredited education sessions. These sessions will now be part of DEN's core activities, thus allowing for some sustainability of project outputs beyond the life of the project."* [15]

4.1.4 CALL BACK TELEPHONE COUNSELLING SERVICE FOR GP PATIENTS ON PHARMACOTHERAPIES FOR ALCOHOL DEPENDENCE (WA)

The development of the call-back service provided by ADIS was informed by a literature review, a small exploratory study of consumers and clinicians, and collaboration with healthcare professionals and other agencies. GP packs were disseminated to every GP in the State,

[15] Drug Education Network Inc. (December 2008) "Breaking Down the Barriers Final Report" pp 9.

supported by all 12 Divisions of General Practice, the State-based organisation and the GP Network in October/November 2005. The project was promoted through a range of Division education events, newsletters and existing projects.

DATA COLLECTION

Surveys were disseminated to GPs and ADIS counsellors. As part of the negotiated treatment plan, patients were contacted via telephone to seek their feedback on various elements such as treatment goals and the service received. Patients who were referred at first or subsequent contact were also invited to participate in a survey.

RESULTS

Forty-six GPs out of 1,987 primary care medical practitioners (as estimated by AIHW, 2004) referred a total of 68 patients. Forty-one of the GPs were from metropolitan Perth, with the remaining five located in regional areas.

Among the 68 patients:

- 28 were referred at first contact to other agencies due to refusal to use pharmacotherapies. Referral agencies include inpatient detoxification, home-based withdrawal, community drug service teams and residential rehabilitation services;
- 14 were unable to be contacted on the number provided;
- 24 engaged in treatment by commencing a negotiated treatment plan, including prescribed alcohol pharmacotherapies;
- 10 patients completed their counselling sessions;
- 8 patients were lost to contact whilst still engaged with the service; and
- 5 patients decided that they no longer wanted to use alcohol pharmacotherapies or be involved with the project, and were referred to an appropriate agency.

General Practitioner Survey

A survey of participating GPs received 21 responses (a response rate of 46%). The main results from this survey were:

- Seventy-one percent of responding GPs reported that their patients had "somewhat" or "definitely" been helped by the call-back service and that the service was considered to "save time";
- More than half of the GPs surveyed reported that they were more likely to prescribe pharmacotherapies with aid of the program;
- Eighty-one percent of responding GPs felt that the feedback they received was "definitely" or "somewhat" useful;
- Most of the GPs stated that they would use a similar service for other drugs; and
- Half of the respondents stated that the service assisted them in meeting Medicare requirements for prescribing.

Patient Survey

Patients participating in the service were followed up in a telephone survey for their perspectives on the service. The following findings summarise the responses received:

PATIENTS COMPLETING THEIR TREATMENT PLAN (N=10)

- 90% reported being "very satisfied" with the call back service; that they has "definitely" received the service they wanted; and that they would recommend the service to others;
- 70% had a stated goal at the beginning of treatment of becoming abstinent; 20% wanted to reduce their drinking; and 10% wanted to become a social drinker. Of these, all indicated that they had "partially" or "fully" reached their goal, with no participants identifying that they would return to "old drinking patterns".

PATIENTS REFERRED AT FIRST OR SUBSEQUENT CONTACT (N=15)

- 93% reported being "very satisfied" with the call back service; that they had "definitely" received the service they wanted; and that they would recommend the service to others.

ENABLERS

- Support from Divisions of General Practice in promoting the service among GPs across the State;
- Clearly defined protocols and processes for referrals to the service and to other agencies;
- The GP Pack and its associated Referral Form and algorithm for referral were regarded as being particularly useful;
- Well designed and received training of drug and alcohol counsellors providing the ADIS call-back service;
- Feedback mechanisms from counsellors to GPs regarding patient treatment progress and outcomes;
- Comments from participating GPs were very positive, reporting that the service was successful in encouraging them to prescribe pharmacotherapy treatment; and
- Participating patients, both those completing their treatment plan and those referred elsewhere, were supportive of the service.

BARRIERS

- The response by GPs to the invitation to use the service (46 out of approximately 2,000) was considered to be low. This may reflect either apathy towards or an unwillingness to engage with patients with drug and alcohol dependence, or a lack of awareness of pharmacotherapy treatment for alcohol dependence;
- Take-up of the service by GPs in regional areas was particularly low, despite recognition of the high incidence of alcohol dependence in some regions; and
- A number of patients were lost to treatment due to an inability to contact them by phone, despite repeated efforts.

COMMENTARY

The Alcohol Pharmacotherapy Call Back Counselling Service utilised the existing infrastructure of the ADIS telephone service to provide counselling and referral services to patients who were willing to participate in pharmacotherapy services for their alcohol dependence under the protocols developed for the project. This approach has the potential to provide a cost-effective approach to accessing pharmacotherapy services as it extends the capacity of existing resources into a new area. However, despite a State-wide promotion to encourage the engagement of GPs in the project, the level of participation by GPs was low, as was the number of patients participating in the project.

Despite this low participation rate, the response by participating GPs and their patients was extremely positive, indicating high levels of satisfaction with the service among those using it. The service has been integrated into the core business of ADIS as from 1 August 2006, and continues to provide both GPs and patients with accessible treatment.

4.2 SYNTHESIS OF FINDINGS

A number of common themes and lessons emerge from the analysis and comparisons between the individual pharmacotherapy projects funded under the AERF initiative, as discussed below.

4.2.1 ATTRACTING GPS

All projects funded under the AERF initiative reported difficulties in attracting GPs to providing pharmacotherapy services for alcohol dependence, at least initially. This was particularly evident

in the WA Call Back and the Tasmanian BDB projects, both of which were State-wide projects but achieved low participation rates among GPs. In comparison, the PAT and SCAP projects in Victoria both exceeded their original targets for GP participation (although the level of GP satisfaction in SCAP was noticeably lower than that reported in the PAT project).

The reports from the various projects identify several factors that influence GP participation:

- Apathy, and in some instances resistance, among many GPs towards engaging with patients with drug and alcohol dependence;
- Limited training of GPs in managing alcohol problems;
- A lack of knowledge among GPs of the application and effectiveness of pharmacotherapies for the treatment of alcohol dependence; and
- The absence of, or limited access to, specialist drug and alcohol clinicians to support GPs in providing pharmacotherapies and associated counselling services.

This combination of attitude and knowledge limitations among GPs clearly is not easily or quickly addressed. The Bendigo PAT and Victorian SCAP projects proved to be more successful in engaging GPs, although they adopted different approaches. In the case of the Bendigo PAT project, its success in attracting GPs to the project may be attributed largely to the considerable time and energy expended by the Project Officer/Clinician in talking to local GPs and developing a close working/professional relationship. In the Victorian SCAP project, the recruitment of patients, and thereafter the engagement of their GP in the project, provided an alternative route of GP engagement. It is noted, however, that both of these projects operated in defined geographic areas, and it is questionable if the same approaches could be could be applied to wider areas without incurring significant costs.

In order to engage more GPs in the use of pharmacotherapies for alcohol dependence, a wider information and educational campaign is likely to be required. In this regard, the importance of the role of Divisions of General Practice in promoting and supporting these services has been identified in several of the project reports. For example, the fact that the Bendigo PAT project was auspiced by the local Division of General Practice was identified as a particularly important factor in the acceptability and legitimacy of the project to GPs.

The second element, namely GP knowledge, education, requires a more concerted effort to increase GP knowledge of, and hence engagement in, the use of pharmacotherapies for the treatment of alcohol dependence. This may call for the availability, delivery and participation in effective education programs for GPs as part of their professional development activities. In this regard, we refer to the education session developed by DEN in Tasmania on "Pharmacotherapy for Alcohol Dependence", with accreditation by the Royal Australian College of General Practitioners (RACGP) with four Category 2 Continuing Professional Development (CDP) points. Although the uptake of this session thus far has been low, (bearing in mind the limited period of its availability to date), such a program warrants further consideration for wider application, as it seems to fit well with the current mechanisms and approach to GP education and professional development.

A further element identified in engaging GPs in pharmacotherapy treatment for alcohol dependence is the mechanism by which they are engaged. In the WA Call Back project, the Bendigo PAT project and the Tasmanian BDB project, the first point of contact was the GP (albeit using very different methods of contact) who (with the exception of the Tasmanian BDB project) then referred patients to the project. In the Victorian SCAP project, the first point of contact was the patient attending a drug and alcohol service or inpatient ward, with subsequent contact made with their GP. The results from the various projects do not indicate that one method is necessarily superior to the other in terms of attracting GPs to the program. However, the more personal approach adopted in the Bendigo PAT and Victorian SCAP projects certainly indicates a higher take-up rate by GPs approached in these projects compared to the approaches used in the WA Call Back and Tasmanian BDB projects, reinforcing the importance of establishing relationships between practitioners in services of this type. Again, however, the capacity to implement such a process on a wide scale is likely to be problematic.

4.2.2 ATTRACTING PATIENTS

The mechanisms by which patients were attracted to pharmacotherapy services also varied between the various projects. In the WA Call Back and Bendigo PAT projects, GPs identified potentially suitable patients for the project and referred them to the project. In the SCAP project, drug and alcohol clinicians at inpatient and withdrawal units undertook this activity, then subsequently engaged their GP. Both approaches appear to have met with similar success in terms of their capacity to attract patients to the pharmacotherapy service.

In both instances, the reports from the projects identified the importance of the relationship between the patient and their GP in underpinning their willingness to engage in the service. This relationship seems to rely as much on the personal attributes of their GP (i.e. demonstrating a genuine interest in their patients' well-being and willingness to discuss their drug and alcohol concerns) as on their clinical expertise in treating drug and alcohol dependence or knowledge of pharmacotherapies.

4.2.3 REFERRAL PROCESSES

The importance of having simple and straightforward referral processes from the GP to the pharmacotherapy service was identified in both the WA Call Back and Bendigo PAT projects. This was particularly evident in the WA Call Back project where there was no established relationship between the different health professionals. In the Bendigo PAT project, the relationship established between the GPs and the Project Officer/Clinician required a less formal referral mechanism.

It is noteworthy that the feedback provided by GPs in the WA Call Back project evaluation highlighted the utility of the GP Pack, and especially the Referral Form included therein was particularly positive, and worthy of further consideration in other like programs in the future.

4.2.4 SHARED CARE APPROACH

The WA Call Back, Bendigo PAT and Victorian SCAP projects all adopted a shared care approach to the pharmacotherapy service, an approach that is regarded as appropriate given the need for specialist drug and alcohol counselling as part of the service, and the current limited capacity/willingness of GPs to undertake this component. However, the share care models adopted appear to have been more clearly articulated in the WA Call Back and Bendigo PAT projects than in the Victorian SCAP project (note that the Tasmanian project focussed on GP education and awareness and did not include a service delivery component).

In the former two projects, the GP was the prescriber of pharmacotherapies, while drug and alcohol clinicians provided counselling and support services to the patient. There were clearly articulated role definitions, including the development of treatment plans, and defined regular feedback mechanisms between the different practitioners. By comparison, the Victorian SCAP project seems to have suffered somewhat in this regard, as evidenced by the comments provided by both drug and alcohol clinicians and GPs. The report from that project identifies that a more structured approach with defined protocols and roles would have been of benefit, and should be considered in any such future programs. This is consistent with the findings from the WA Call Back and Bendigo PAT projects.

4.2.5 TREATMENT PLANNING

Having an agreed individualised treatment plan negotiated between the drug and alcohol clinician, the GP and the patient was identified as being an essential element of the WA Call Back, Bendigo PAT and Victorian SCAP projects. Such an approach caters for the expectations and intentions of patients in entering treatment, and sets realistic targets for them to aspire to. The reports from the projects indicated that these might range from becoming a "social drinker", reducing their alcohol intake/frequency, or complete abstinence. Monitoring of progress towards these goals during treatment, with feedback to both the patient and their GP is an essential component of the service model. Further discussion of gaol achievement is provided below.

4.2.6 PATIENT OUTCOMES

The identification and measurement of patient outcomes is recognised as being particularly complex in the drug and alcohol field. This is reflected to some degree in the different measures used by the various projects participating in the AERF initiative. For example, the WA Call Back project reported against the number of patients completing their treatment program, and those that were lost to follow-up. The Victorian SCAP project used a number of clinical measures, with an emphasis on retention in treatment.

The Bendigo PAT project adopted a more complex (and perhaps ambitious) approach that sought to cater for this complex environment. The approach sought to recognise:

- The different goals that patients set (e.g. abstinence versus control);
- The fact that there are intermediate goals that may be achieved on the way to the ultimate goal;
- Patients may require different time periods to achieve their goals; and
- As in many chronic conditions, patients may have periods of relapse between periods of compliance.

By way of example, the following classification of goals set and progress achieved was developed in the Bendigo PAT project:

AAch = Abstinence the goal, Achieved

ACAch = Abstinence the goal, Control Achieved

CAch = Control the goal, Achieved

CAAch = Control the goal, Abstinence Achieved

APer = Abstinence the goal, still Persisting

CPer = Control the goal, still Persisting

ARel = Abstinence the goal, but full Relapse occurred

CRel = Control the goal, but full Relapse occurred

ANI = Alcohol Not the Issue

AO = Assessment Only

LC = Lost Contact

By including a numerical code that denoted the elapsed time at which these goals and outcomes were recorded, the PAT project was able to monitor individual patient progress over time, which highlighted where the patient was on their journey. However, the regular recording and subsequent analysis of the data collected using this approach was beyond the resources of the project nearing its completion, and consequently the utility of this outcomes measurement system is yet to be fully tested. Nevertheless, it provides a useful example that may warrant further investigation and trialling in different settings (and for different treatment modalities) in the drug and alcohol field.

Although the projects funded under the AERF Initiative did not have as their primary objective testing whether or not pharmacotherapies were effective in the treatment of alcohol dependence, all those with patients participating in treatment demonstrated that, at least for some patients, pharmacotherapy in association with drug and alcohol counselling, assisted them in reducing their alcohol intake.

4.2.7 CONCLUSION

The various projects funded under the AERF pharmacotherapies initiative adopted very different approaches to the application of this treatment modality for alcohol dependence. All have been successful, albeit to different degrees, in meeting their specified goals, and have contributed to the knowledge base about the application of this form of treatment.

Perhaps most importantly, the projects illustrate that there is no "single best way" to the engagement of GPs in pharmacotherapy. There are significant barriers to GP engagement that are both attitudinal and knowledge-based in their nature. Broad-based "passive" mechanisms that seek to engage GPs in this form of treatment have been shown to have limited effect and low levels of uptake, at least in the short term. More "proactive" and personalised approaches have been more effective, but are also much more resource intensive, and are likely to be more costly and difficult to apply on a larger scale. Consequently, a long-term strategy that seeks to address both the attitudinal and knowledge barriers to pharmacotherapy use by GPs is required.

The experience of GPs once they engaged in the use of pharmacotherapies, and where a shared care approach has been adopted (involving the support of drug and alcohol clinicians providing counselling services) have been reported as being very positive. The large majority of GPs participating in these projects reported having increased their knowledge of, and willingness to use, pharmacotherapies for patients with alcohol dependence. However, the shared care model was found to be most effective when there were clearly defined roles and regular communication pathways between the various clinicians involved in patient care.

Finally, whilst the funded projects were not designed as, nor intended to be, trials to test the efficacy of pharmacotherapy for alcohol dependence, those projects involving patient treatment found that, at least for some patients, pharmacotherapy can assist in reducing their alcohol intake. The active support and involvement of their GP was an important factor in achieving this outcome.