SHARED CARE

Specialist alcohol and drug services
and GPs working together

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Preface

Structure of the guidelines

The guidelines are presented in three parts:

Part A provides an introduction to the concept of shared care, and takes the reader step by step through the development of a shared care program between alcohol and drug specialists, and GPs.

Part B contains work sheets designed to assist with the planning and implementation of a shared care program.

Part C (Appendixes) provides:

- Case studies – brief histories of four shared care programs developed between alcohol and drug specialists, and GPs
- Some useful tools for the assessment of GP alcohol and drug training needs
- Samples of some key documentation used in a shared care program

A note on terminology

Alcohol and drug services treat 'clients', GPs treat 'patients'. This difference in terminology is just one example of the ways in which the specialist alcohol and other drugs (AOD) services, and GP cultures differ. These guidelines aim to encourage awareness of the 'other' culture and enhance understanding and cooperation between the two.

As the key audience for this publication is alcohol and drug services, the term 'client' has mostly been used. Where the context is exclusively one of general practice, the term 'patient' has been used.

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Introduction

Background and rationale

A NEW APPROACH TO HEALTH SERVICE DELIVERY IN VICTORIA

Governments are looking increasingly for new ways of delivering services. Those involved in planning and delivering health services will be aware of new imperatives, characterised by concepts such as:

- the integration of primary, secondary and tertiary sectors
- ‘seamless’ service delivery, or continuity of care, to clients
- ‘bundles’ of care which include both specialist and primary care services
- more effective care (better value for expenditure)
- outcomes-driven care

These general health service concepts have increasingly come to underpin alcohol and other drugs (AOD) treatment and service provision in Victoria, and have led naturally to a re-examination of the dominance of centralised specialist services and the possibility of extending treatment into alternative settings.

This drive to ‘broaden the base’ of AOD treatment was fully endorsed by the Victorian Government’s Department of Human Services in its policy document *New directions in alcohol and drug services* (1994). It continues to form the basis for policy direction as set out in the more recent document *Victoria’s alcohol and drug treatment services: The framework for service delivery* (1997).

This redevelopment of AOD services highlights the primary position of general health and welfare professionals in the assessment and management of drug and alcohol problems. It clearly indicates that the elements of a quality specialist AOD service will be that it is accessible, targeted to clients, and embedded in community linkages and networks.

For AOD services this has meant a broadening of service delivery beyond their own specialist secondary and tertiary sector. General practitioners (GPs) are now seen to have an important role to play in reducing the health risks of alcohol and drug misuse.

However, the management of drug users in general practice can present difficulties and concerns, not least in terms of workload.

The last five years or so have seen a major restructuring of both AOD service provision and the organisation and structures of general practice. In a sense these changes have complemented each other, with AOD services seeking to involve GPs more, and general practice seeking to increase its involvement in broad community health issues through its Divisions of General Practice.

There has also been a large body of research undertaken in the area of brief and early interventions, and community-based treatments within the alcohol and drug area. In particular, this work has investigated the perceptions GPs bring to AOD work, and potential barriers to GPs doing more work in the AOD field.

For GPs to participate effectively in the management and treatment of those with drug and alcohol related problems, it is fundamental that they develop the necessary knowledge, skills and confidence. The provision of appropriate education, training and support services to GPs is increasingly recognised as essential for this to occur.

THE EVOLUTION OF SHARED CARE

As a result of these moves towards integrated specialist and primary health care, and in response to GP training needs, the shared care method of service delivery was developed.

Shared care has been defined as:

> The joint participation of GPs and specialists in the planned delivery of care for patients with a chronic condition, informed by an enhanced information exchange, over and above routine discharge and referral letters (Hickman, 1995).

THE ELEMENTS OF SHARED CARE

Certain components are usually deemed to be important in the development of a workable shared care program, namely:

- clarification of the roles of both the GP and the specialist service (including professional and legal responsibilities), with an emphasis on the GP as coordinator or case manager. This may include clarity about available services as well as the use of clinical protocols.
- commitment to high quality communication in both directions, with a particular emphasis on timely advice and access to assessment
- a system for detecting 'non-attenders'
- periodic but regular face-to-face contact between GP and specialist, often with an educational or case review focus
- flexibility of arrangements
- ongoing GP education, based on adult learning principles
- evaluation and review of the system

These components will be discussed in more detail in Step 2.

Work sheet 1 may be useful for you to record your initial thoughts on this definition of shared care and what it may mean for your organisation.

A number of shared care models of clinical service delivery have recently been developed and trialed in areas of medical practice such as obstetrics and diabetes. Although they have been successful within those fields, they are not easily replicated in the AOD field.

There have also been a number of GP/mental health shared care programs in Victoria which have been successful despite GP reluctance and the chronic and complex nature of the clients' problems – issues common to AOD shared care.

SHARED CARE IN THE ALCOHOL AND OTHER DRUG SECTOR

The models adapted for use in the alcohol and other drug sector have focused on integrating two main elements:

- joint provision of clinical services by GPs and specialist AOD agencies to individuals with alcohol and drug problems
- education and training for GPs

There are only a small number of AOD-specific shared care models in existence, and most of these are found in countries with health funding structures different from Australia's. Their utility as a model for the local setting has been limited because they have been developed for other cultural settings and often narrowly focus on one drug such as alcohol or methadone.

Many important lessons have been learnt in the projects that have been undertaken. This is a pioneering and fledgling area of work, and those working on these shared care projects have accumulated broad skills and knowledge. This experience and practice wisdom needs to be documented in a way that will enable future organisations and individuals who want to work with GPs to establish effective AOD shared care services.

All of these developments underpin these shared care guidelines. It is important for the staff of any service to understand the changes in the health, and alcohol and drug field fully in order to develop their own rationale for developing shared care with GPs.

ALCOHOL AND OTHER DRUG SERVICES: THE MOVE TOWARDS COLLABORATION

In addition to general health service policy changes, since 1994 major restructuring of drug and alcohol service delivery in Victoria has occurred. The new model of service represents a shift towards the embedding of drug and alcohol services within the generalist health and welfare sectors.

There is evidence that treatments managed within the community by GP and other primary care workers are as effective as those provided by specialist services.

Funding agreements in this model mean that many specialist AOD services will increasingly need to work with GPs in collaborative programs. This change has been felt most

strongly in withdrawal services and methadone provision services. The current alcohol and other drugs service system emphasises the need to build collaborative links with GPs. To facilitate such links and support GPs in managing AOD problems, some regional offices of DHS have funded GP liaison and support positions.

Specialist AOD service providers are thus, through necessity, investing more time and resources in establishing effective links with GPs. This reliance on GPs, the shift in vision and culture, and the development of new skills and ways of working has not been an easy transition, partly due to the scarcity of guidelines and examples in best practice.

Under the Primary Care Partnerships strategy (previously known as PHACS, or Primary Health and Community Support), GPs and Divisions of General Practice are considered key links, and the close working relationship between GPs and state-funded service providers will be essential for effective planning and coordinated delivery of primary care services. General practice is now well placed to introduce shared care models to facilitate this collaborative delivery of services.

UNDERSTANDING THE SERVICE SYSTEM

The Victorian alcohol and other drugs service system can be understood in terms of the types of services available. In practical terms, these services may exist alone or be provided with other services at the one location. The development of successful shared care models requires an understanding of these service types and the service system as a whole.

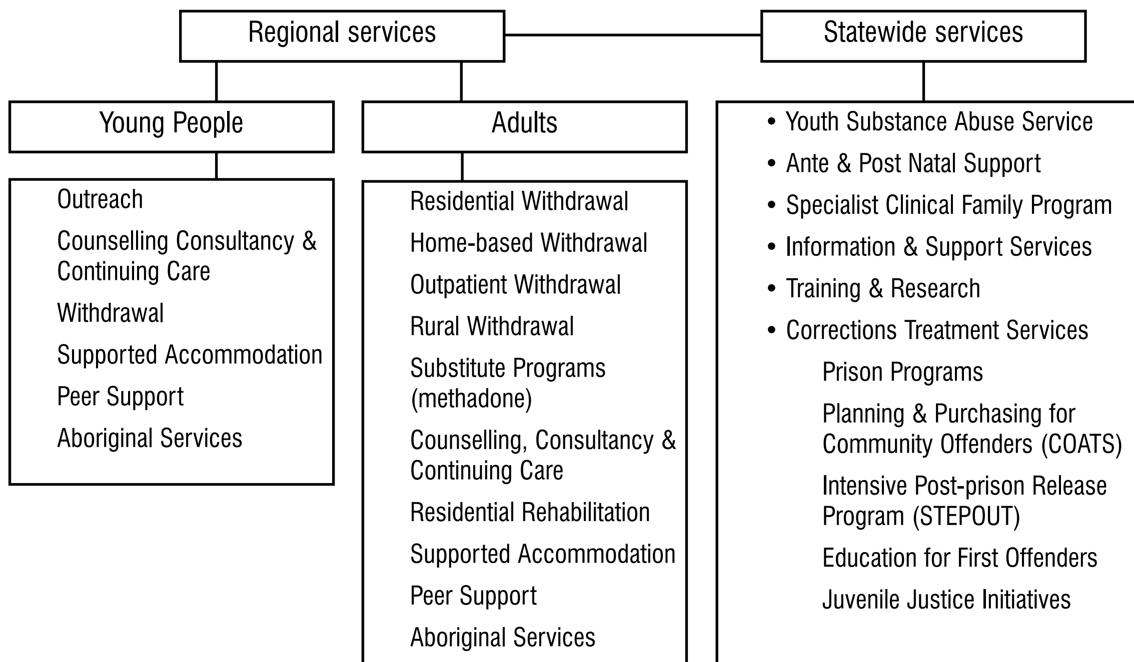


Figure 1: Drug Treatment Services: The Framework for Service Delivery, March 1997

Residential Withdrawal

Residential withdrawal services provide alcohol and drug withdrawal to adults and young people through a community residential drug withdrawal service or through hospital-based treatment.

Home-based Withdrawal Rural and Metropolitan

Home-based withdrawal services are provided in cases where the withdrawal syndrome is of mild to moderate severity and the client is able to be supported by a family member or friend at home, overseen by an experienced nurse in conjunction with a medical practitioner, preferably the client's GP.

Outpatient Withdrawal

Outpatient withdrawal services are provided to clients who have a withdrawal syndrome that can be appropriately managed without admission to a residential service.

Rural Withdrawal Support

Rural withdrawal services combine a short hospital stay (where required) with a period of home-based withdrawal.

Substitution Pharmacotherapy: Specialist Methadone Services

While the methadone program is usually administered through GPs, the need for specialist methadone services occurs where there are associated complex medical, psychiatric or psychological problems. Specialist methadone services often operate in association with a general hospital.

Counselling, Consultancy and Continuing Care

To provide a range of services and support appropriate to the needs of clients who have alcohol and drug use problems, services provided may include assessment, treatment and consultancy, outreach, referral and ongoing case management.

Residential Rehabilitation

Residential rehabilitation services provide a 24-hour staffed residential treatment program of an average three months duration. They provide a range of interventions that aim to achieve lasting change and assist reintegration into community living.

Supported Accommodation

Supported accommodation provides a supportive environment to help clients achieve lasting change and assist their reintegration into community living.

Peer Support

Peer support is the provision of mutual support and information by individuals with personal experience of alcohol and drug use for individuals who may be having, or have had in the past, difficulties associated with alcohol and drug use.

Aboriginal Services

Aboriginal alcohol and drug services provide culturally appropriate prevention, education, information and support programs for Koorie people, and aim to reduce the incidence of alcohol and drug problems in Koorie communities.

GENERAL PRACTICE: A NEW EMPHASIS ON EDUCATION AND COLLABORATION

Since 1992 there have been significant changes in the organisation of general practice in Australia. The main impetus for these changes came from a consultative committee comprising representatives from the Royal Australian College of General Practitioners (RACGP), Australian Medical Association (AMA) and Commonwealth Department of Health. This committee in conjunction with the National Centre of Epidemiology and Population Health held a conference and workshop with stakeholders to address issues of workforce distribution, financing and other issues. The aims were to explore strategies for harnessing the potential of general practice as a central plank of a primary health care system, and to examine ways of addressing the low morale among GPs.

The resulting General Practice Strategy was introduced in 1992. It consisted of a number of elements including:

- an undergraduate rural program
- a rural incentives scheme
- strengthening of the quality assurance and practice accreditation initiatives
- the Divisions and Project Grants Program (now the General Practice Divisions Program)

The General Practice Divisions Program has seen the establishment of over 100 geographically-based Divisions of General Practice across Australia. All areas of Australia are covered and all GPs will have a local Division of General Practice (in which they may or may not participate actively). The aims of the Divisions Program are to allow GPs to organise and collaborate with each other and with other health service providers, policy makers, community groups and consumers in addressing health issues in their community. It has allowed GPs to move out of the consulting room and work on health promotion programs and public health issues.

Most Divisions have a board consisting of GPs (sometimes with community group representatives), and are run by an executive. Most employ non-GPs as project workers under a range of titles from Program Coordinator to Community Liaison Officer.

Divisions have run projects ranging from hospital liaison through to integrated diabetes programs. Most projects have included an educational component, many of which have been accredited under the RACGP Continuing Medical Education (CME) program. At the beginning of 1998 the organisation of Divisions moved from one-off project funding to block grant funding of broader program streams.

All Divisions have conducted a needs analysis in their area, some in conjunction with a local Community Health Centre, Public Health Unit or local council. Some have identified alcohol and other drugs issues as a need in their community, and have responded by developing AOD projects, alone or collaboratively. In Victoria, for example, in 1997 and

1998 Divisions developed 14 CME activities ranging from 2–23 hours in duration, and two practice assessment activities. All of these projects aimed to improve GPs' skills in dealing with AOD issues and clients.

ALCOHOL AND DRUG WORK FROM A GP PERSPECTIVE

Over the last 30 years GPs have increasingly felt excluded from the field of AOD work. This is partly because specialist and centralised services have for many reasons, structural, philosophical or political, claimed the domain as their own. In some instances a culture of distrust has even developed, based in part on a concern about confidentiality and sharing of information among health professionals.

The end result has been that many GPs have not seen AOD work as a legitimate or 'core' part of their work, and many specialist AOD workers have not seen GPs as an essential part of the alcohol and drug system.

In addition, many GPs were trained at a time when AOD education was largely focused on 'end stage' patients who had long-term and irreversible, mainly alcohol-related, damage. This led to a sense of pessimism about AOD work, and about the chances of achieving successful outcomes for patients. While treatment options have changed and improved, many GPs still maintain their pessimism and are reluctant to take on AOD patients.

Another factor limiting GP involvement in AOD care is the current structure of general practice that to some extent places GPs in competition with each other. This has meant that many have become reluctant to address what they see as difficult and sensitive issues – for many GPs, AOD use falls into this category – from fear of losing patients.

Many GPs also believe that patients with AOD problems are demanding and will increase their workload, and so are reluctant to take them on. This is particularly so if they also feel AOD work lacks legitimacy and is doomed to a poor outcome.

As well, many GPs are confused about how to access services, and this compounds their reluctance to either raise the issue of AOD problems with their patients or to try to get specialist help if they are faced with a patient with complex AOD problems.

The evidence supporting the effectiveness in general practice of early and brief intervention and the philosophy of harm minimisation are thus new to general practice and only slowly becoming part of mainstream practice.

Who should use these guidelines?

This set of guidelines is intended as a program guide specifically for AOD agencies attempting to increase the involvement of GPs in the care of their clients.

It is not intended as a guide for managing clients within a shared care model, nor is it intended as a guide for individual GPs seeking to increase their involvement in AOD work (although it may be usefully read by such GPs).

This is a practical publication that will offer something of use to you and/or your agency – whether you are starting out fresh to the field, have some experience working with GPs, or are trying as a Division of General Practice to help your local AOD services develop more GP-friendly policies. This means that not all sections will be relevant to all users of the guidelines. Nevertheless there should be something here that will assist agencies and staff to improve GP involvement in their AOD services.

Much of the material is directed at ways in which GPs can be supported in AOD work by other agencies. These guidelines look at ways to support GPs, to engage them in taking up work that they have traditionally, over the last 30 years, not been involved in, and to sustain their involvement in a way that is mutually satisfying for both the GPs involved and the AOD agency.

Users of the guidelines may include:

Specialist alcohol and drug service providers

These readers, whose core business is AOD work, will be looking primarily at ways to involve GPs in their agency's client care in order to improve the effectiveness of their specialist service.

Government departments preparing tender briefs or examining submissions by service providers

These readers will be seeking to ensure that tender briefs and submissions are written in a way that ensures optimal involvement of GPs, according to principles of best practice.

Divisions of General Practice or other GP organisations

These readers will have prioritised management of AOD problems in their community and will be seeking to facilitate the linking of AOD specialist services with their GP members in a way that effectively meets the community's needs.

Other groups

Other groups may also find these guidelines useful, for example, other health and welfare workers in a primary care setting; local government; AOD researchers and individual GPs.

How to use these guidelines

This publication will assist you or your agency to work through the issues related to shared care work and help you plan and implement a shared care program that works for both local GPs and your agency. Some sections have a check list or work sheet that can be used to guide planning and action. At appropriate points within the text of Part A readers are directed to the relevant work sheets, which are located in Part B.

The guidelines may be read by a staff member of a specialist service who has decided to work more closely with GPs and GP organisations. This person will browse most sections of the guide, and may find the work sheets useful.

Alternatively, the guidelines may be used as the basis for a planning exercise for a service as a whole, either as a stand-alone exercise or as part of a broader strategic planning process. In this case all the staff participating in the planning might read the sections on background information. An 'idealised' process has been outlined below for an organisation using the guidelines in this manner.

Developing shared care involves much in-house work prior to actually designing and implementing a program. Early sections of the guidelines can be read and worked through without involving GPs, although some of the issues raised in the work sheets may be usefully revisited when work with GPs begins.

The guidelines consist of eight main components, located in Part A:

Introduction

This includes the background and rationale, providing important information about recent changes to, and current arrangements for AOD and GP services. It is essential reading for those undertaking shared care.

Select literature review

This contains an overview of some of the key writings on shared care.

Step 1. Confronting the culture

Discussing attitudes around AOD clients and issues, and how they affect the care we provide, the treatment philosophies we use, and the work relationships we develop are all vital parts of working collaboratively. This step examines the reasons for working with GPs, possible areas in which to work with GPs, and any barriers to working with GPs.

Step 2. Exploring the components of shared care

This step includes clarification of the role of the alcohol and drug specialist service and that of GPs in developing a shared care program, as well as an overview of the components of shared care programs.

Step 3. Planning and getting started with your shared care program

It is important to consider the capacity of your service to work collaboratively. This step looks at assessing skills, individuals, resources and commitment, and examining the opportunities for collaboration.

Step 4. Action

In Step 4 the 'nuts and bolts' of a shared care program are presented, along with check lists for developing a program.

Step 5. Maintaining your program

This step focuses on the importance of ongoing support of all staff involved, as it ensures the long-term viability of shared care.

Step 6. Evaluation and monitoring

The activities presented in Step 6 are important not only for funding bodies, but to enable your program to be refined.

Select literature review

This literature review briefly considers treatment of AOD problems in general practice before examining shared care between AOD specialist services and GPs.

Treatment of AOD-related problems in general practice

There is ample evidence that significant numbers of patients routinely presenting to GPs are misusing drugs, licit or illicit. For example, estimates have been made that 10 to 15 per cent of GP patients are drinking at hazardous or harmful levels, and that less than half of these are known to GPs (Wallace et al, 1988). GPs see 80 to 90 per cent of the general population in any year (Bridges-Webb, 1992) and drug-misusing patients are known to consult GPs more frequently (Wallace et al, 1988).

There is also clear evidence that brief interventions with drug-misusing patients in GP settings are of comparable effectiveness to more intensive interventions that are offered by specialist services (Wallace et al, 1988; Bien et al, 1993).

There has been a drift towards drug misusers being cared for in specialist centres over the last 30 years, and there is evidence to suggest that people cared for in such a way suffer from lack of provision of comprehensive primary care services (Glanz, 1994; Banks & Waller, 1988). On the other hand, there is some evidence to suggest that access to specialist care is difficult for significant numbers of people with AOD-related problems and that GPs are managing complex AOD problems without the benefit of specialist care.

Much work has been done in examining what barriers exist to GPs doing more AOD work (Durand, 1994). These barriers include a low sense of:

- role legitimacy (that this is a legitimate area of concern for a GP to focus on with their patient)
- self-efficacy (that effective interventions are available and able to be used by GPs)
- confidence and knowledge (for example about safe drug use and withdrawal)

In addition, the issue of negative GP attitudes to drug users has been identified as a major barrier to increasing their involvement in this work (Deehan et al, 1997; Davies & Huxley,

1997). A survey of drug user attitudes to GPs has shown that drug users tend to select GPs with positive attitudes (Hindler et al, 1996).

In summary:

For large numbers of people with AOD-related problems, general practice is a point of contact with health services.

While GPs often do not identify AOD problems, when they do, they can be effective at intervening with the majority of these patients.

GPs are managing some patients who have complex problems, with poor access to specialist services.

The traditional emphasis on specialist care has potentially created a bottleneck, limiting access to specialist assessment for some patients.

The result is less than ideal care for large numbers of these patients.

There are well-known barriers to further GP involvement in AOD work within their practices.

Shared care

A generic review of shared care literature was undertaken by Hampson et al (1996). They found that measures such as improved patient familiarity; a decrease in travelling and waiting times; greater convenience; and a more integrated balance between preventive and treatment activities could be used as a proxy for measurement of effectiveness in shared care. Factors that facilitated effective shared care included patient co-op or shared care cards, ongoing GP education, written management protocols (guidelines), an efficient recall system, protected GP time, effective communication, and a shared care liaison officer.

Management guidelines in particular were considered to be useful largely to the extent that they functioned as an educational tool, and ensured that shared care was not used as a mechanism for 'dumping' patients from one provider to another.

Pritchard and Hughes (1995) extensively reviewed currently-operating shared care systems in the UK. They identified seven key factors in the development of effective shared care:

- well-functioning teamwork within both specialist and primary care (GP) settings
- shared understanding of goals
- shared understanding of roles
- shared knowledge base and agreed guidelines
- effective communication (including with clients)
- knowledge-based decision support (critical management stratification)
- evaluation and audit

Harris et al (1995) have reviewed the literature on intersectoral collaboration and outlined the preconditions of effective intersectoral collaboration as follows:

Necessity: each party can see clearly that their core business to some extent involves a move to collaborative work. This is especially important in considering the extent to which GPs and specialist AOD agencies see the involvement of each other as necessary.

Opportunity: Is the environment opportune?

Capacity: Are the skills and resources in place?

Relationships: Are they existent or do they need to be created? Are they mutually respectful?

Planning: Are there good principles of project management and an action plan in place?

While planning and management are often the sole focus of attention, all preconditions are essential to any effective inter-agency collaboration.

Shared care programs can operate in a variety of ways. Hickman et al (1994) conducted a survey of shared care programs in the UK across a variety of clinical disciplines, and classified them according to the mode of communication. They listed five varieties of program:

Basic model: communication by standard letter

Community clinic: face-to-face communication during the visit

Liaison model: communication around case-based meetings. A 'contract' may be agreed upon.

Shared care record card: communication via a patient-held card

Computer-assisted and email-based shared care: communication by computer of an agreed data set

They point out that levels of technological sophistication do not necessarily equate with effectiveness.

Many writers identify good communication as crucial to the conduct of shared care. Hampson et al (1996) note the current poor communication between hospital and GP, observing that if this relatively simple line of communication cannot be improved it bodes poorly for the prospects of doing so among complex multidisciplinary teams. They conclude that information technology offers the best avenue for facilitated communication.

Pritchard and Hughes (1995) note the importance of managing change within organisations in attempting to introduce shared care schemes.

Hickman et al (1994) note the importance for standard of care of identifying non-attenders and responders within any shared care model. They argue that unless measures are specifically built into programs this is unlikely to occur. This is especially so for programs using the 'basic model' and shared record programs.

In a *British Medical Journal* editorial, Farrel and Gerada (1997) argue that shared care is an ideal model, but that it needs the support of well-developed specialist services, and that communication is the key to it working well. There were a number of letters written in

response, all of which emphasised the need for further training, but with a number of qualifications.

These included the argument that training must be based on the identified learning needs of the GPs, should not try to turn GPs into 'experts', may lead to the development of relevant local guidelines, and may need to challenge deeply held attitudes. Other necessary features included the need for access to specialist assessments within an agreed time scale (Van Teijlingen & Porter 1997; Bury & Sherval 1997; Preston & Campion-Smith 1997; Lester & Bradley 1997; Mason 1997).

AOD shared care

One of the few AOD shared care programs reported in the literature is from Glasgow where Gruer et al (1997) report on the functioning of a GP-centred treatment scheme for opiate dependent drug users. This scheme is largely concerned with the development of a community-based methadone prescribing service. It involves a number of key factors:

An informal needs assessment noted the poor access to specialist support and the extra time, resources and commitment GPs' AOD work involved.

Opportunistically, there was a supportive environment within the local health authority to a number of suggested changes.

Extra resources and ongoing training/education were important.

AOD specialists, counsellors and pharmacists were recruited at an early stage and involved in the development of the program.

Clear referral pathways and clinical guidelines were established by all parties.

The program resulted in a significant recruitment of GPs into a difficult clinical area, widespread increase in methadone prescribing and a large increase in the amount of supervision of methadone dispensing.

The Inner City Project (Patterson, 1997) was a demonstration project that aimed to enhance the skills and the capacity of GPs to deal with patients with alcohol and drug problems. It did this through the development and implementation of training programs and a shared care model of service delivery in conjunction with specialist alcohol and drug services tailored to the needs of the participating GPs. The project had two components:

a service delivery component whereby delivery of clinical services to clients with alcohol and drug problems was coordinated by GPs and a community alcohol and drug nurse. Participating GPs also had access to consultant alcohol and drug specialists: medical practitioners, psychiatrists, physicians, psychologists, social workers. Features of the shared care model were refined through consultation with participating GPs.

a program of ongoing training specifically tailored to the needs of participating GPs, with considerable emphasis on linking training to the shared care service delivery

The Central Coast GP Project has worked with GPs on the NSW Central Coast. The project established a telephone consultancy service that set as a benchmark immediate access to AOD doctor advice for GPs, as well as a training and education component. The project has achieved a 60 per cent coverage of GPs.

The next phase of the project has been establishing direct links to GPs by redirecting clients who ring for assessment to their GP, or linking them with a GP if they did not already have one. This linking is combined with support to the GP in assessment by faxing assessment instruments at the time of linking (Wood 1998/1999).

Greenwood (1992) in Edinburgh found that involving GPs in shared methadone prescribing involved:

- being clear about what the GP could expect from the specialist service
- involving the GP in the development of a management plan before it is signed off
- organising ongoing informal case conferences, meetings, newsletters and support of prescribing GPs

Monheit (1995) has reported on the implementation of a controlled drinking project in general practice in Melbourne. This had some shared care features in that it attempted to clarify referral paths and roles of a specialist counselling service to enable GPs to address their patients' drinking problems. The main problem with the project was a tendency of the participating GPs to use the service as a 'dumping' process and not to take on client care themselves. Importantly, change among reception staff and a 'product champion' (that is, someone who would promote the project) were seen as essential to any success the project had.

Strang et al (1992) report on the functioning of Community Drug Teams (CDTs) in the UK. They note how CDTs were supposed to undertake a liaison and consultancy function to both GP/primary care and specialist AOD services. They explain the difficulties that arose through CDTs taking on a caseload, the blocks that developed in the system, and how despite intentions, CDTs ended up functioning as yet another specialist service.

GPs who had been initially keen to be involved became more reluctant when faced with specialist services that once again could not 'deliver' the service the GPs felt they needed (that is, the level of 'shared care' to support them in the work). The authors also note the development of a small number of GP specialists as opposed to the involvement of the broad population of GPs. This has had advantages and disadvantages.

The St Vincent's Hospital AOD Shared Care Scheme (now called the Affiliate Program) trained 34 GPs through clinical placements in local AOD specialist services and education in brief interventions, with the production of a resource kit for GPs. It also spent some time clarifying and publicising referral pathways for GPs. The program has identified the appropriateness of both establishing face to face contact between GPs and specialist services as a form of 'familiarisation training', and effecting structural and attitudinal change within care systems as the two essential elements of shared care.

Part A

The Steps to Shared Care

Step 1: Thinking about working with GPs

Introduction

It is often easy to become swept up in the enthusiasm of developing a program, setting out goals and objectives, and deciding on strategies to achieve them, without addressing the prior issues of:

- identifying your core services: defining exactly what you do, what your core business or service is
- clarifying why you wish to involve GPs: as an organisation, asking what GPs can offer your service (what are the benefits?), and deciding what you can offer them in return (being clear about your services)
- examining your cultural context: analysing potential barriers that may stand in the way of working together. These frequently relate to issues such as attitudes, skills and organisational capacity (commitment, resources and so on) and assessing where your service is at and its readiness to change.

The experience of shared care programs is that unless these issues are addressed early, subsequent program development will falter. It is time well spent. As an exercise, it may also promote teamwork within your own agency.

Identifying your core services

It is necessary to:

- clarify your core services
- discuss the degree to which your agency sees involving GPs as necessary to that service provision

Although these issues are likely to be addressed during the same discussion, they are nevertheless distinct.

This process may involve a focus group of staff or a series of staff interviews, in which they consider potential areas for involving GPs, discuss anticipated problems and suggest solutions. (Alternatively, it could form part of a broader strategic planning exercise for the service.)

Work sheet 2 can be used to identify your core services and establish which of these are relevant to working with GPs in a shared care capacity.

It will be important to list:

- the core goals and strategies of your service
- all the areas of your work where you think GPs are or could be involved
- all the benefits you think could flow from more collaborative work with GPs

Clarifying the need for GP involvement

There are compelling reasons for actively involving GPs in the care of clients of alcohol and other drugs (AOD) services and AOD work generally. One reason is that GPs are an accessible and universal entry point into care for many AOD clients. GPs see over 80 per cent of the population in any year, and alcohol and drug misusers are known to consult more frequently than average. Thus, involving GPs may be an essential part of ensuring that specialist services are widely accessible.

Services may feel overwhelmed with their client load, and find that they are constantly helping clients access primary care services through a general practice. Linking a client to a general practice may be a way of ensuring they receive access to general health care not provided by specialist services.

There is strong anecdotal evidence that care of clients with AOD problems is best managed within a shared care model. While this has not been formally evaluated within the AOD field (as it is a relatively recent phenomenon), this evaluation has been done in areas such as diabetes and obstetrics, where good outcomes have been demonstrated.

There is common acceptance in many countries that shared care for AOD clients should be promoted as widely as possible. The Task Force reviewing services for drug users in the UK, for example, made this one of its central recommendations (BMA 1997).

A good example of this is in the management of outpatient or home-based withdrawal. Your specialist service may be in a good position to provide assessment, counselling and monitoring of clients, but you will clearly achieve better outcomes for your community and clients if:

- you are widely accessible to the whole community, many of whom present to GPs with drug-related problems
- you can ensure that your client is able to access medical care for problems such as hepatitis, peptic ulcer, infected injecting sites or contraception needs

This liaison with GPs should take place over and above any liaison about prescribing issues.

In summary, there are good reasons for your AOD service to involve GPs in the care of its clients. These include:

- increased accessibility of your service
- access to primary care for your clients
- effectiveness of overall care

Examining your cultural context

The next step involves looking at the cultural context of your organisation. It is important that this process also includes trying to gain some insight into the culture of general practice, and how that impinges on the way GPs approach AOD work.

It involves analysing potential barriers and assessing where your service is currently at in terms of working with GPs and your readiness to change.

Initially this may involve staff within your service. Ideally, however, this should occur as a joint exercise, involving staff at your own organisation and local GPs.

ANALYSIS OF POTENTIAL BARRIERS

Analysis of potential barriers to shared care is an important issue to discuss in the first instance:

- any risks that staff may perceive in working more closely with GPs
- any areas of possible conflict

Perceived risks

There are many reasons why GPs may be reluctant to take on what they see as more AOD work. A commonly reported concern is that they might be overwhelmed with AOD patients in the practice, leading to other patients going elsewhere, and the GP being left with 'difficult and demanding' AOD patients.

Your service may also sense risks to greater involvement with GPs. Staff may fear that referrals from GPs could result in the service being swamped with client numbers that it is unable to handle. On the other hand, staff may have concerns that they will lose control of their clients' treatment to GPs with whom they feel they do not share common treatment philosophies.

It is important to allow people to discuss these concerns and create an atmosphere where they can be acknowledged.

Possible conflict

Differing AOD treatment philosophies and approaches to health care can be potential sources of conflict. Clarifying the attitudes of staff members is an important step in beginning to involve GPs further.

This will affect how you decide to proceed, what educational or familiarisation sessions you may run for GPs, and what level of involvement you may initially expect from staff.

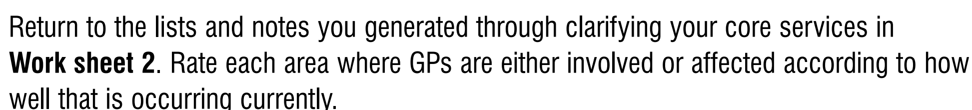
ASSESSING WHERE YOUR SERVICE IS AT

After analysis of these potential barriers, discussion may then progress to understanding where your service is at:

- the current situation:
  how well your service feels it is currently working with GPs
- readiness to change:
  how important the staff feel it is to change, if things could be improved

  how confident the staff are that things can change

The current situation



Return to the lists and notes you generated through clarifying your core services in **Work sheet 2**. Rate each area where GPs are either involved or affected according to how well that is occurring currently.

It may be useful to lead a discussion on why that might be and to discuss any barriers staff see to improving the situation.

Work sheet 3 can be used to evaluate how well you are currently working with GPs and identify barriers to improvement.

Readiness to change

Bringing about change in the way people work involves understanding their beliefs and attitudes, just as bringing about change in a client's drug use behaviour involves them examining their attitudes.

Ensuring someone is ready to change is similar to ensuring an organisation is ready to change. Without building a sense of importance – that the change is needed – and confidence – that change is possible – very little will be achieved, no matter how appealing the program is.

It is important that expectations remain realistic. Changes in practice will occur slowly and gains may seem small. It is important to see the development of new collaborative relationships with GPs as a long-term undertaking which will require commitment over a long period of time.

Health professionals change practice through trying a new behaviour and experiencing a successful interaction. A number of such successes can breed a new attitude over time,

based on a relationship between GPs and specialist service staff. Identifiable staff with responsibility for maintaining these relationships will be important.

The culture of separation that has developed between GPs and specialist services has tended to make the development of shared care programs difficult. GPs have been reluctant to be more involved, and specialist workers have been reluctant to seek assistance from GPs whom, with a few exceptions, they have seen as having a different philosophical approach to AOD work.

Developing a shared care program involves directly confronting this culture, and attempting to bring about a cultural change in the way both groups think and work. This can be an ambitious task.

Ways of building an awareness of these issues in your service may involve promoting the benefits of involving GPs through disseminating literature which supports the involvement of general practice in the AOD field or examples of good practice from the shared care literature.

This could occur through

- focus groups of staff
- planning meetings, either alone or with GPs
- clarifying GPs' ideas of what they see as their core business as part of a training needs analysis

Use **Work sheets 1** and **2** for running focus groups

The end result is a nurturing of the sense of necessity in working collaboratively. Only when both GPs and specialist AOD services see that it is necessary to collaborate will new ways of working be sustainable.

Whatever method is chosen, it is important to:

- develop a clear sense about what benefits collaboration with GPs will offer your service and your clients
- list the potential barriers to achieving this
- use these findings to lead a discussion on how ready to change the organisation staff feel

Step 2: Exploring the components of shared care

Introduction

Existing shared care projects vary enormously in what they offer. Some project models offer a purely consultancy service whilst others have become actively involved in the delivery of specialist care on a shared basis. This section looks at the different elements that make up a shared care program:

- clarification of roles
- continuum of GP–specialist involvement
- clinical protocols and guidelines
- communication strategies and referral pathways
- educational opportunities
- evaluation and review

Clarification of roles

Clarifying the role of your service in relation to both GP involvement and client care is an essential aspect of any shared care program.

FOR YOUR SERVICE

During the writing of this guide, one GP commented that from his perspective the biggest hurdle for shared care was to get AOD specialist services to agree that GPs had a role in the ongoing care of clients.

The process of overcoming such hurdles needs to start with your service. Thinking about the roles of GPs and specialist services is, in one sense, a natural extension of the sort of thinking outlined in the exercise clarifying your core business, or services. While your organisation will naturally play many roles in client care, clarifying roles in relation to GPs is important. For example:

> Do you actively encourage referrals from GPs?
>
> How do you arrange care for your clients after the treatment is completed?

The aim of clarifying the roles of the specialist service and GP is to ensure that each party starts with the same expectations of what will be achieved by collaborating. One shared care program in the UK found that initially there was great willingness on the part of GPs to be involved. This enthusiasm rapidly waned when it became clear that the specialist service could not deliver the promised level of access for clients and support for GPs.

You also need to clarify the extent to which you offer outreach services and harm reduction interventions. Be clear about your core business, or services, and what you can offer GPs.

This does not mean that specialist services should not be willing to take on a new role based on an assessment of GP needs and how the agency wants to improve.

What is important is to be open and proactive in making sure your local GP community understands your agency's role or what is being proposed. When working with a smaller group of more interested and committed GPs, who are already involved with your service, there may be the chance to engage in negotiating what each party's role will be.

FOR INDIVIDUAL CLIENTS

There is another level at which it is important to clarify roles, namely in relation to individual clients. This might be called the negotiation of an individual client management plan.

Flexibility is important, especially when this process of negotiating roles for the service becomes one of negotiating roles in relation to an individual client. This means acknowledging the varying skills and confidence levels among GPs (see below and Step 4). The specialist's role for a given type of client will vary depending on the GP.

Clearly the role of a GP with little training and some ambivalence to AOD work will be a minimal one. In this case the agency will need to do most of the AOD work, while retaining access for clients to that GP and encouraging the client and GP to stay involved for general primary health care.

On the other hand, a GP with extensive AOD knowledge and experience may retain a major role in the assessment and management of even quite complex clients. In this case the specialist service may need to be involved as a consultancy service, and perhaps involved in the provision of welfare, counselling or other services.

One way to negotiate this is through the completion of a standard pro-forma management plan in which each party agrees upon what they will do for a client. These plans are a proxy for a client-held record (as in diabetes or obstetrics care).

In practice, they have generally been found to work poorly with the general GP community, although they may be of value in a smaller local network, especially if their format is a result of a consultation process with GPs. Many GPs report that they prefer the 'roles' of specialist and GP to be negotiated on a one-to-one basis, usually by phone initially and perhaps confirmed in a letter at a later date.

An example of a pro-forma management plan can be found in Appendix 3.

Levels of GP–specialist involvement

Initially you may wish to let GPs know about the specialist drug and alcohol services that they can access. Many GPs are unfamiliar with the current AOD service system or may not be aware of changes in service provision in your agency. Given that some GPs will only be interested in referring clients to specialist agencies, it is useful to inform them of current services you offer. Others will be more active in management of alcohol and drug problems, and then there are a few GPs with a 'specialist' interest in the area.

Figure 2 illustrates the range of GP expertise and the corresponding level of involvement in management of AOD problems that they prefer.

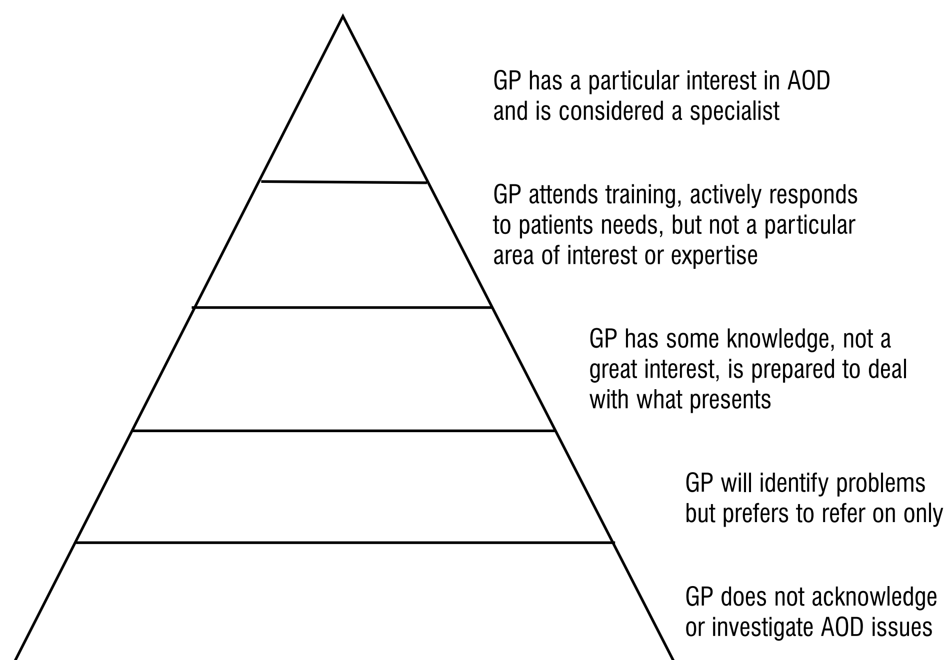


Figure 2: Levels of GP–specialist involvement

Work sheet 4 can be used to clarify your role, the information that you provide about what you do, and your knowledge of GP roles.

Clinical protocols and guidelines

Clinical protocols and guidelines refer to written and agreed upon plans for managing common clinical conditions according to standard guides. They may be based on evidence of the effectiveness of a particular treatment, or they may be based on consensus among experienced professionals.

Much has been written on the value or otherwise of clinical protocols. They have been researched in a wide range of clinical fields. In the AOD field they have mostly been researched in the area of prescribing practices among GPs.

In general, protocols or guidelines are more likely to be taken up by GPs if they:

- are developed as part of an ongoing consultation with a group of GPs in a local area.
- are detailed to the GPs by someone responsible for GP liaison from the agency attempting to promote them. In particular, they are more likely to be taken up if the 'detailer' is an experienced nurse or a GP themselves.

One of the main values of clinical guidelines is that they can form the subject of an educational activity. The educational activity can focus on an area identified as problematic to both GPs and specialist service, with a view to developing a set of agreed guidelines that both GP and specialist service will use.

Communication strategies and referral pathways

COMMUNICATION

Communication is one of the most fundamental issues to address when planning a shared care program. The experience of most shared care programs and GP needs analyses has been that GPs rate communication as the highest priority when describing a successful or valued shared care program. Looking at and improving communication pathways will be absolutely vital to the success of any program.

A useful way to think about communication systems with GPs is to assess whether you are working with a dialogue (ideal), or a serial monologue (less ideal). In other words, with an individual client:

- Is the flow of information essentially one way? Either party may feel the information they send is going into a 'black hole'.
- Is there genuine opportunity for discussion? This may occur mainly through case discussions, informal meetings and so on.

There are a number of useful ways to begin to analyse a communication issue, for example through GP interviews, case reviews of particular problems or a focus group. What is

important is trying to understand the systems and structures of the flow of the information in and out of your agency. For example:

When a referral is taken, how is it dealt with?

Who responds initially, a clinical worker or administrative worker?

How is it recorded?

Where is the information then sent?

How long does it take to respond?

How are urgent requests for advice on clients handled?

Is there a system for advising GPs if a client they have referred does not attend?

The individual client management plan in Appendix 3 is an example of an aid to communication, although its usefulness will depend very much on how individual staff approach it and whether they negotiate the plan with the GP. This plan could include an automatic notification from either party to alert the other regarding clients' missed or rescheduled appointments.

One approach that has been tried in managing Emergency Department patients in hospitals is a 'fax back' system, where the GP completes a referral form and faxes it to the hospital prior to the patient arriving. There is space for the GP to record the patient's file record number.

The hospital faxes back information on the management of the patient, using the record number to ensure anonymity and confidentiality. This could potentially be adapted for use in AOD shared care.

REFERRAL PATHWAYS

Clarifying how clients enter and leave your service, and negotiating possible changes to this with the local GP community is a useful exercise to undertake. Reviewing these pathways can form the focus of part of a planning session with GPs.

It is important to include reception and administrative staff in this exercise if they are involved in taking calls from clients and GPs, arranging appointments and so on.

Educational opportunities

This is considered in detail in Step 4. At this stage it is important to consider ways in which your current services offer opportunities for GPs and specialist services to meet in an educational setting, whether it be based on case reviews or other forms of education.

Evaluation and review

This will be considered in detail in Step 6. At this stage it is important to ask to what extent your service currently has opportunities for reviewing the services you offer, the quality of care, and relationships with the GP community.

Step 3: Planning your shared care program

Introduction

Before setting up a shared care program it is worthwhile taking time to reflect on the broad issues that will ultimately affect the outcome of your work. You have already spent time:

- clarifying your organisation's core services, or business, and how that interfaces with general practice
- developing a clear idea of the benefits that could come from working more closely with GPs
- allowing full discussion about fears and concerns staff may have about closer working relationships with GPs
- deciding how important it is for your service to work differently with GPs

The next step is to study and understand your own agency and its willingness and ability to achieve effective shared care arrangements.

This means looking at your service and its capacity to work collaboratively with GPs. This step is an opportunity to identify gaps and build your organisation's resources in readiness for embarking on a shared care program.

You can do this by working through:

- an organisational audit
- a staff skills and attitudes audit
- a review of your individual staff resources
- a review of your practical resources

Organisational audit

The success of shared care work depends on a commitment to a new way of working that has the potential to fundamentally shift the organisation at every level. Creating an environment where this can succeed requires looking at the capacity of the organisation to work in this way, and if this capacity does not currently exist, developing strategies for building it.

Work sheet 5 may serve as a useful check list for assessing your organisation's capacity to work to a shared care model. It summarises some of the material covered earlier.

Skills and attitudes audit

Specialist AOD services aim to reach all those in the community who may need the services that they provide. To achieve this they need to ensure that they are relevant to their community. Through working more collaboratively with GPs, AOD services can increase the range of clients using their service.

Competence and ability to achieve effective shared care processes will be a part of ensuring continued funding. It is important that workers from all areas of a service understand this and share in the responsibility of ensuring that shared care goals are achieved.

It is crucial that all staff members contribute to shared care in their different areas of work. This means staff need to be willing to change and expand their work practice. They may need to become more flexible and outward-looking. Although this change can present challenges it can also ultimately lead to increased worker satisfaction.

Drug and alcohol shared care work requires staff to have multi-faceted skills. Attracting skilled staff with sound knowledge and skills in AOD work is an important factor to consider when implementing shared care work. GPs will only perceive highly skilled workers as being credible service providers.

Drug and alcohol workers need to be able to provide training to GPs through collaborative case management work and to communicate to GPs in terms that are well understood and accepted. This will require an understanding of current medical approaches to patient care and the general practice environment. Workers also need to be genuinely committed to shared care work and enjoy working equally in both specialist and general practice settings.

Work sheet 6 can be used to plan staff training and development. It is useful for assessing the existing skills within the agency and identifying which areas need improving.

Individuals

Individuals can be vital to the success of any organisational change. The capacity of any specialist service to develop new relationships with local GPs will depend on the commitment that exists at management levels within the service, as well as those working in direct care.

The CEO, the Board or Management Committee, the administrative staff and direct care workers all need to be committed to shared care. Also important is an enthusiastic 'product champion' within the organisation to keep the issue of shared care on the agenda. This internal promotion is necessary because individuals not committed to the change can obstruct the development of shared care.

In summary, the following staff skills and experience will assist in running a successful shared care program:

- understanding of the AOD and GP service systems
- sound direct care experience in a wide range of service types
- highly developed drug and alcohol clinical skills especially in the areas of assessment, treatment matching, withdrawal management, harm reduction strategies, brief interventions, and motivational interviewing skills
- experience in working with a range of external agencies and forming ongoing and effective links
- good education skills and experience with both clients and GPs
- good communication skills, both verbal and written
- enthusiasm and a commitment to working with GPs

Resources

Drug and alcohol services need to be able to respond quickly to GPs. This requires establishing an infrastructure that can facilitate as immediate a response as possible.

The person who answers the telephone in a specialist service should be able to respond immediately to a GP's request. Effective programs will ideally have a duty worker available to answer calls in and out of business hours, who is able to respond to the requests of the GP in the shortest possible time.

Requests can range from secondary consultations to immediate withdrawal services, so organisations must have the flexibility to meet these needs. This is why it is desirable to clarify with GPs at the beginning of a shared care development exactly what your service's role is and what you can provide.

Some programs are designed so that the duty worker can perform a phone assessment and then make an appointment with the client for appropriate treatment/intervention or refer

the client to a more appropriate service. If you are unable to provide the immediate response requested by the GP you should be able to assist in some way at the time, and arrange a follow-up.

An identifiable 'GP Liaison Officer' may be an important way not only to demonstrate a commitment, but also to ensure that adequate resources are being devoted to the program and that GPs have a clear knowledge of how to access your service.

A disadvantage of this is that responsibility for 'GP issues' may be left to one person. The slow process of changing the 'culture' of working with GPs won't begin if 'GP issues' are sidelined in this way instead of being mainstreamed.

Responsiveness will be enhanced if workers have access to mobile phones, pagers, fax machines and resources such as the Trace Directory (produced by Turning Point Alcohol and Drug Centre).

FUNDING ISSUES

Developing new collaborative relationships will require the allocation of resources. One option may be to join with local Divisions of General Practice to seek specific funding for a shared care initiative.

Increasingly, however, organisations will need to see that working collaboratively with GPs is not an extra 'add-on' activity but is rather an effective and beneficial way to work that should be seen as part of a service's core business. It may mean reallocating staff time and support strategies. In this sense, special funding may not be needed, simply a reallocation of priorities within existing funding and programs.

Step 4: Action

Introduction

You have now reviewed your service's capacity to develop shared care arrangements with GPs through your organisational audit, skills and attitudes audit, and an examination of the staff and infrastructure resources available. This implementation step describes the 'nuts and bolts' of setting up your shared care program. The key components are:

- clarifying your working relationships with GPs
- developing clear goals and objectives
- working with Divisions of General Practice
- identifying local GPs
- conducting a training needs analysis (TNA)
- recruiting GPs
- educating and training GPs

Clarifying your working relationships with GPs

It is likely that you will have some relationships with the GPs with whom you have worked. At some stage it will be necessary to meet formally with GPs and negotiate to reach a shared understanding of the main issues that need to be addressed by shared care. This will involve clarifying what GPs think are their core responsibilities in the AOD area, and comparing them to those of your own organisation.

Initially this may involve one-to-one interviews with GPs, examining in some detail the work involved with AOD clients, as well as a list of problems and possible solutions. This may be undertaken as part of a training needs assessment (see below).

Alternatively a joint 'concept modelling' or 'concept mapping' exercise (Pritchard, 1995) may be a useful way to proceed at this point. It is a powerful way of ensuring that all stakeholders have a say about the main problems and possible solutions. It can also be used in a service mapping exercise, helping your organisation clarify what you regard as your core business in relation to other organisations.

Whatever method is used it is important now to compare what you see as the potential areas to work together on with those areas that GPs see as important. Similarly you must allow AOD staff as well as GPs the chance to outline what they see as the main problems and possible solutions.

A valuable approach might be to set up a formal arrangement either within your service or within the Divisions where AOD issues and shared care arrangements can be addressed. This could take the form of a reference group or steering committee that includes AOD workers and GPs and which might meet regularly in these early stages. Consult the 'Working with Divisions of General Practice' section below for more details.

Work sheet 7 can be used to summarise issues that need addressing in working with GPs and suggestions for working more collaboratively.

Developing clear goals and objectives

You should now be able to generate the aims and objectives of your shared care program from activities carried out so far. You can do this by using the lists you developed in the preceding sections and working with all those who will be involved in your shared care program to set out objectives that relate to the perceived problems.

Through discussion, try to prioritise them. Begin to develop strategies for addressing them. It is important to ensure that the objectives are both achievable and measurable. Allocate a responsible person for following through the implementation of each strategy and set a time for reviewing progress.

As discussed above, many problems can be encountered in shared care programs if you are not completely clear about what your agency's role is and why you are working with GPs. If you are not clear at the beginning about what work you do and how you can work collaboratively with GPs, your service may run the risk of being reduced to:

- receiving referrals for specialist care management only
- receiving inappropriate referrals from GPs
- losing the interest and willingness of GPs to work with you
- not being able to ensure your clients receive access to general practice care

Work sheet 8 is designed for developing and setting out the goals, objectives, persons responsible and time frame for a shared care plan. Included is an example with these

details filled in, showing suggested goals to deal with possible problems, strategies to achieve the goal, who would need to work on it and how long implementation might take.

Working with Divisions of General Practice

Divisions vary widely in their areas of interest and the structures they have developed locally to run their programs. It is important not to make assumptions about their knowledge or involvement in AOD issues. It will be helpful to do some background reading (for example, annual reports and published needs analyses) prior to seeking collaboration.

Importantly, many Divisions of General Practice have a community liaison strategy and officer who may be able to help you with your initial inquiries.

In general, Divisions are interested in working collaboratively to achieve improved population health outcomes in their community. In addition, Divisions are increasingly being asked to identify how they are addressing the needs of disadvantaged or marginalised groups in their community, which may be important in encouraging them to look at AOD issues.

It is very likely that there will be more than one Division of General Practice in the catchment area for your agency, so it may be necessary to develop shared care with more than one Division. It will be important to see if a Division has any individual staff or GP members with a particular enthusiasm for working on AOD issues.

There are many ways you can work with Divisions to promote your program. Divisions have regular contact with GPs through newsletters and mail-outs. They provide ongoing educational activities and support for GPs through a variety of programs.

Work sheet 9 contains two check lists. The first is a check list of your knowledge of local Divisions of General Practice and a record of progress on developing relationships with local Divisions of General Practice. The second can be used to identify key staff, GPs and programs.

Identifying local GPs

Your local neighbourhood is the best place to start looking for GPs to work with. The best and most efficient way is to get a list from your local Division of General Practice. Some Divisions will not part with a member list but will undertake a mailing on your behalf.

More importantly, Divisions will be more likely to give you this information once you have their support in what you are trying to achieve, and have consulted them in the planning stages of the program.

Many of the Divisions have previously conducted audits and needs assessments that have enabled them to identify GPs who have expressed an interest in AOD issues. Looking for GPs who have expressed interest in homelessness and youth issues is another approach.

It is also valuable to look at recent referrals from GPs to your agency to find GPs who are already accessing your service and who may be willing to become involved in shared care work.

If there is a GP liaison or support person in your region, they will be working with GPs who are interested in AOD issues.

Conducting a training needs analysis (TNA)

One aim of any shared care program should be to enhance the practice skills of GPs in drug and alcohol work. To achieve this you will need to undertake a training needs analysis. This will allow you to identify the areas in which GPs need training as well as encourage involvement of GPs in AOD work. There are several methods to choose from to conduct a TNA and these are discussed below in the section 'Education and Training'.

Recruiting GPs

One of the most difficult stages in establishing a shared care program is in recruiting GPs. GPs vary enormously in the amount of interest and commitment they have to AOD work. This will mean that when recruiting you will need to use a range of approaches to attract initial interest from them. The experience of shared care programs to date is that recruitment is a challenging process that requires continuous effort.

A variety of approaches can be used to recruit GPs, each of varying effectiveness. You may decide to use one approach or a combination of strategies. The following is a list of approaches that can be useful.

NEWSLETTER ARTICLES

There are several GP newsletters in circulation but perhaps the most accessible is the newsletter produced by most Divisions of General Practice. Articles can be written in a variety of formats but should describe the shared care program in detail and what it can offer GPs. A person and contact number should be provided for GPs who want more information about the program.

NEWSLETTER ADVERTISEMENTS

You may wish to buy advertising space to promote your shared care service. Again, you will need to be concise and interesting and clearly state the benefits for GPs and their patients if they become involved in your shared care work.

DIRECT LETTERS TO INDIVIDUAL GPS

GPs receive an enormous amount of written material each week and are often selective about what they will read. Some GPs will read most of their mail while others read very little. Keep this in mind if you are considering a general mail-out. If the letter could be incorporated into a general mail-out by a General Practice Division then it is more likely to be read.

FLYERS

Flyers can also be developed and incorporated into a newsletter or general mail-out. Flyers can be designed with a tick box section for GPs to fill out if they are interested in the program or want more information. Flyers should be designed for easy reply by faxing back or posting.

TELEPHONE CONTACT WITH A TARGET GROUP OF GPS

You are most likely to have phone contact with GPs regarding recruitment if they are responding to written information they have received about the program. At this point you must be very clear about the service you are offering and how it should work. You must be able to confidently answer all enquiries from the GP.

GPs may not have much time to hear about your shared care program over the phone. The receptionist will often screen calls if the doctor is with a patient. One strategy is to establish the best time to ring the GP rather than expect a return call. This may be early in the morning or even mid-evening, depending on the hours worked. Some GPs may even wish to take this type of call at home during the evening. As GPs are committed to seeing patients much of the day, you will have to work hard to engage them by phone.

EDUCATION SESSIONS

A good way to meet GPs and discuss drug and alcohol work is to provide education sessions. These sessions need to be specifically designed to meet the needs of GPs and should reflect an understanding of general practice.

PRACTICE VISITS

There are several advantages to visiting a GP at the site of their practice. It is often the most convenient arrangement for the GP. It allows you to get a feel for their practice and the environment. It is also an opportunity to meet the receptionists and practice managers and explain to them your role in AOD shared care. You may also be able to identify practice partners who are interested in the program or would like more information.

Be prepared to wait, as there will be patients who will be given first preference in seeing the GP. You may be able to avoid this by arranging to meet at the beginning or end of the day. You will have limited time with the GP so you will need to be clear about the aim of the visit. It is important that you advise the GP how much time the interview will take and what will be involved.

You may choose to spend this time orientating the GP to your program and explaining what your role is and what you can offer. If you are conducting a training needs assessment then more time may be needed to complete questionnaires or semi-structured interviews. (For more about this refer to 'Education and Training', in particular the section on TNAs).

If this is a first visit you will need to promote yourself as a capable and reliable specialist AOD worker. This can be followed by a brief but detailed account of your agency and its role. Finally, explain to the GP the ways in which you can collaborate and support each other in drug and alcohol work. You can also use this visit to get to know the individual GP and their special interests. The following is a list of areas that you may wish to include in discussion at a practice visit:

Your background experience in the AOD field and your relevant qualifications

An overview of your organisation and the services it provides

How services are provided

Other staff involved in different services and their general experience and qualifications

What service area you are currently working in

Why you are interested in working with GPs

Your understanding of the difficulties GPs have in working with patients with AOD-related problems (check this out with the GP)

How you wish to work with GPs (check this out with the GP)

What the GP sees as the best way to work with you and your service (negotiate around this if you need to)

What the special interests of the GP are in the AOD area

Any specific AOD needs of the practice

How you might assist the GP in these identified areas ('where to from here' assistance)

Some shared care programs have undertaken to pay GPs for their time if an extended interview is conducted in practice hours.

Bearing in mind the following points will increase your success:

- sell yourself
- be prepared to follow up
- be patient
- get to know individual GPs and their special interests
- get to know current practice and level of skills

Appendix 2 contains a TNA questionnaire that can be used to guide a practice visit interview.

Education and training

As previously mentioned, one aim of a shared care program should be to improve the current practice of GPs in relation to prevention, detection, early intervention and management of patients with AOD-related problems. To achieve this you will need to incorporate training and education into your shared care work.

Most GPs have received some training in relation to AOD work in their undergraduate curriculum. The amount of time and the focus of training will vary as many changes have occurred over the years to undergraduate curricula.

In recent years more AOD training has been made available to GPs in recognition of their increasing role in drug and alcohol work. Training has shifted its focus towards increasing clinical competence and practice behaviour in a wider range of drug and alcohol interventions.

The following is a brief overview of the key elements involved in conducting a training program for GPs.

TRAINING NEEDS ASSESSMENT

One of the difficulties in determining the training needs of GPs is the enormous variation in their interest and commitment to AOD work. GPs will be very different in their attitudes towards drug and alcohol use, their knowledge and skill levels and the way that they work in the clinical setting. They will also feel differently about the legitimacy of their role and their effectiveness in AOD work.

You will need to gain an understanding of the GPs you are working with in relation to these factors in order to plan effective training. To gain such a profile a training needs assessment will need to be conducted.

Reasons for conducting a training needs assessment include:

- to identify gaps in knowledge
- to identify skills competency
- to plan a training program (to decide on the training format and training methodology)
- to identify current clinical practice in AOD intervention/management
- to identify barriers to GPs' willingness to be involved in AOD training
- to identify individual interests that can be built upon in training
- to identify local issues or practice issues that can be addressed
- to determine the level of support GPs require
- to encourage GP involvement in AOD work

There are several methods to choose from in implementing a training needs assessment. The most frequently used include focus groups, individual interviews, questionnaires or a combination of any of the three.

Individual interviews

GPs will need to be given notice that the purpose of the interview is to conduct a needs assessment, an explanation of what it is and how long the process will take. Generally this interview will require an hour. The interview can consist of open questions or follow a semi-structured format. A design for a semi-structured format is included in Appendix 2.

Advantages of individual interviews include the opportunity:

- to observe the GP's workplace
- to meet other staff including receptionist/practice manager
- for more time with individual GPs
- for better understanding of individual needs and interests
- for more time to discuss local issues
- to get to know the GP better and build rapport

Disadvantages include the possibility of:

- being more time consuming than focus groups
- resulting in little or no interaction/sharing of ideas among GPs
- requiring more resources, for example a car, documentation, staff

Focus groups

Focus groups have increasingly been employed to gather data that will assist in the development and implementation of effective AOD training strategies for GPs. You can obtain data from a diverse range of opinions and explore issues in greater depth.

Some effort is required to organise focus groups and recruit GPs. GPs will need to be given plenty of notice. It is also useful to give them a reminder call a week prior to the event. The best time to schedule focus groups for GPs is usually a weekday evening. Be very clear about the purpose of the focus group and the issues that will be explored so that GPs can give it some thought beforehand. A focus group design and format is included in Appendix 2.

Advantages of focus groups are that they:

- obtain a wider range of opinions. Data will be more representative of the wider cross-section of GPs.
- are less time consuming than individual interviews
- produce more interaction and dialogue between GPs
- allow GPs an opportunity to familiarise themselves with a service (and vice versa) if the group is held at an AOD specialist organisation

Disadvantages of focus groups are that:

- less time is spent with individual GPs
- less opportunity is available for GPs to discuss their individual interests and issues
- verbose participants may dominate or take up more time

Questionnaires

There are very few standardised and validated training needs analysis questionnaires specifically designed for GPs. You may wish to design your own questionnaire or use pre-existing ones. The advantages of using existing ones is that they generally have been validated.

It is worth thinking about how appropriate a questionnaire is for use with GPs as some are designed for non-medical health and welfare workers. It is best to be present when administering the questionnaire, to answer any questions. This also ensures that it is completed and returned in as little time as possible.

One questionnaire that has been used successfully with GPs in existing shared care projects is the ‘General Practitioner Needs Analysis Questionnaire’ (Edwards et al, 1995). This GP needs assessment questionnaire was developed and piloted by the NSW Central Coast Area Health Service in 1995.

The questionnaire comprises questions adapted from previous questionnaires as well as specifically constructed questions. It is attached in Appendix 2.

One other standardised questionnaire that can be used is the ‘Shortened Alcohol and Alcohol Problems Perception Questionnaire’ (SAAPPQ) (Anderson, 1987). It is also attached in Appendix 2.

PLANNING AND IMPLEMENTATION

Once you have identified the training needs of the GPs you are working with you will need to determine the most effective way of providing training. There are several methods you can use including:

- lectures/didactic presentations
- small and large group work
- experiential methods, including role plays and skills rehearsal
- case presentations and discussion
- videos
- self-learning computer programs
- audio tapes
- reading material

Successful training programs and events usually use a combination of methods. The learning objectives of a training program will influence the selection of training methods. The training needs assessment will have asked GPs what their preferred learning method is and this should be taken into account in the design of the training. Other factors that will influence your choice will be the amount of time and resources you have available.

TRAINING FORMAT

The choice of training format will depend on whether you are training groups or individual GPs. Training individual GPs can often be undertaken in the process of shared care work. It offers specialist workers the opportunity to be effective role models for GPs. Through joint management of clients, specialist workers can model behaviour that can be observed by the GP or provide information that will increase AOD knowledge. Training GPs in groups has the advantage of peer interaction and education.

Learning objectives should be clearly written and understood. They should include statements of precise performance standards or targets within a defined time frame such as specific knowledge or skills acquisition. It is important for training to be relevant to general practice and mindful of the context in which GPs work.

GP training should also adhere to adult learning principles which recognise that effective teaching builds on existing knowledge, skills, behaviours and life experiences, and aims to restructure them into new behaviour patterns.

TRAINERS

It is a myth that GPs will only want to be trained by medical experts. Experienced practitioners in the AOD field and GPs with interest and experience in AOD work have successfully provided training in Victoria in recent years.

TIMING

The preferred time to attend training will vary among GPs and it is best to consult with them. Generally weekday evenings are best although some GPs will be willing to set aside a whole or half day on the weekend. Weekday business hours (except perhaps a long lunchtime meeting) are impractical and not worth considering. If training is provided on a weekday evening most GPs will attend directly from their practice and will be tired. It is a good idea to provide light refreshments or supper as most GPs will not have had time to eat.

EVALUATING TRAINING ACTIVITIES

The resources available often determine the methodology selected to evaluate training activities. At the very least it is important to know which training activities can be improved and which work well. It is important to plan your evaluation strategies in the early stages of training development. Clear aims and objectives for training activities provide a guide for what to evaluate. This can include looking at ways to improve on the delivery of the training.

Detailed discussion of evaluation of training activities is beyond the scope of these guidelines; however, some approaches are briefly presented as a starting point.

You may choose to use a participant satisfaction questionnaire that basically asks for feedback from participants on their satisfaction with the way the training was implemented, including delivery, quality of training resources, venue, catering and so on. This approach will usually seek information on what was most and least useful in terms of the training and what should be included or omitted in future. The information will assist in making changes to improve your training.

A pre- and post-training knowledge test is another questionnaire you can use. Questions must be related to training content. This gives good baseline data on current levels of knowledge. You should expect an improvement if the test is reapplied directly after training. You may wish to reapply the test at a later time to determine how much is remembered a week or month after training. Examples of questions designed to establish baseline knowledge and changes are included in Appendix 2.

It is far more difficult to measure changes in clinical practice. Given that it will not be possible to directly observe the GP in their clinical practice you will need to rely on self-reported changes. One approach may be to give the GP a case vignette and ask how they would manage this patient. You could repeat this with the same vignette post training and note any changes.

Another method may be for GPs to do a pre- and post-training self audit on their clinical practice that would look at areas such as history taking (whether they ask patients specific questions about their drug and alcohol use), interventions and management, and referrals.

Focus groups or group interviews can be useful ways to receive feedback from GPs about your training program. Again you need to plan these well and be very clear about the information that you wish to gather.

THE RACGP QUALITY ASSURANCE AND CONTINUING EDUCATION PROGRAM

As a part of improving and maintaining standards in general practice, the Royal Australian College of General Practitioners (RACGP) oversees an ongoing program of continuing education for GPs. Involvement in this program is a formal requirement for ongoing vocational registration of GPs. (Vocationally registered GPs attract higher rebates from Medicare.)

Your educational program will have a much higher chance of success if it is accredited for points towards this Quality Assurance & Continuing Education (QA&CE) program.

The program has three objectives:

1. To promote GP participation in effective and efficient quality assurance and continuing medical education by:

- encouraging and identifying high quality activities which are accessible to GPs
- giving credit for participation in high quality educational activities

2. To demonstrate the accountability of GPs to the community by:

- documenting participation in effective quality assurance and continuing medical education which responds to community needs
- discussing quality general practice with community groups
- identifying constraints on the delivery of quality general practice care

3. To enhance the professional responsibility of individual GPs and Australian general practice by ensuring that the QA&CE Program meets acknowledged world standards for quality improvement systems.

There are two main components to the program, Continuing Medical Education and Clinical Audit.

Continuing Medical Education (CME) points

This covers educational sessions on topics identified as important to GPs. Activities are designed to help GPs enhance the knowledge, skills, attitudes and judgment necessary to improve the health care of their patients and community.

Considerable research has identified ways to improve the effectiveness of Continuing Medical Education. The QA&CE Program incorporates these findings into the adjudication criteria for CME. Continuing Medical Education embraces many formats, including university courses, CD ROM, courses delivered via the Internet, seminars and workshops.

Point allocation for educational activities is assessed according to strict, predetermined criteria (these are available from the state offices. Points are allocated at two different levels to reflect the relative educational value of different CME activities: either two or three points per hour. The RACGP maintains a confidential record of each GP's QA&CE activities.

Clinical Audit (CA) points

This involves GPs examining an aspect of their practice (such as management of patients with AOD-related problems) by auditing what they do (for example, managing 50 patients with alcohol abuse) against a standard of best practice. Clinical audit activities are based on a clinical audit cycle consisting of five steps. Five points are allocated per step of the quality assurance cycle completed, with completion of a minimum of four steps required.

What is important is to involve the RACGP and GPs themselves in identifying both the need for the education sessions, and the development of the educational sessions and/or clinical audit activity.

Contact the RACGP to obtain more information. Use **Work sheet 10** to assist you.

Step 5: Maintaining your program

Introduction

Maintenance is an important component of a shared care program. A key part of this is support for GPs, and also specialist staff. This can be achieved through:

- newsletters
- meetings/education and training
- specialist drug and alcohol support agencies

Support for GPs

One of the problems for shared care programs has been the development of a small number of ‘specialist’ GPs who have taken on large workloads of patients with AOD-related problems. While this has some benefits in allowing those GPs to develop expertise, the potential for burnout is a real problem. In addition, it doesn’t address the fact that the majority of the population is seeing GPs other than these ‘specialists’. Unless we strive to involve the majority of GPs in AOD work we will achieve nothing in terms of:

- confronting the ‘culture’ around AOD work
- increasing access to specialist services through GPs picking up their patients’ AOD-related problems early
- achieving the wide use of brief intervention techniques so important to their success

This highlights the need for supporting GPs in AOD work. In this role you are working as a community support worker, where the GPs are the community. You too will naturally need to be supported within your own organisation.

There are a number of ways you can help support GPs:

NEWSLETTERS

These can be occasional or regular, integrated with the Division newsletter or produced separately. They should include:

- examples of practice and case studies
- changes to services, new issues and feedback on the shared care program
- information regarding upcoming events or meetings
- interesting or relevant literature
- resources

MEETINGS/EDUCATION AND TRAINING

Clearly any ongoing educational program will also form a part of a support structure for those GPs involved (see Step 4).

DRUG AND ALCOHOL CLINICAL ADVISORY SERVICE (DACAS)

This is a 24-hour telephone clinical advisory service for health professionals, including GPs, specifically designed to address problems of clinical management. Telephone:

Metropolitan area 03 9416 3611

Country areas (toll free) 1800 81 2804

DIRECT Line

This is a 24-hour telephone advice line for the general public. It can also provide advice on a range of AOD services for health professionals. Telephone:

Metropolitan area 03 9416 1818

Country areas (toll free) 1800 13 6385

These two 24-hour telephone advice lines should be clearly identified to GPs as sources of advice and support. Both numbers are included in the *Trace Directory*.

Step 6: Evaluation and monitoring

Introduction

Making evaluative decisions is something clinicians do all the time: they interact and observe, make judgements, modify their approaches and re-evaluate the impact. Undertaking an evaluation is simply a more formal and systematic means of doing some aspects of what you already do.

Program evaluation involves drawing on a broader range of information, potentially from a greater range of sources than you would in your day to day clinical decision making. This should enable staff to develop a deeper understanding of the program and to inform strategies for positive change.

Evaluation can be carried out on a number of different levels. One distinction is between evaluative review and evaluative research. Evaluative research typically focuses on outcomes and is less common, more expensive and more complex than evaluative review. For the present purposes, this step concentrates on evaluative review.

At some point you will want to find out the views of people outside your staff group, and you will want to review data that is being gathered as part of your program. You will probably also want to review not just whether your new activities are operating according to plan, but whether they are leading to achievement of the goals you set for the program. You may also decide that you want or need to be able to tell GPs, other service providers, or funding bodies about your program, how you have gone about it, and what it has achieved. This all falls under the systematic process of evaluation.

Purpose of evaluation

Establishing the purpose of your evaluation is the important place to start. In planning your evaluation, be sure you achieve a clear and common understanding of why it is being done.

Your evaluation will probably reflect a combination of purposes, namely, to:

Improve your program: while it is still in its early stages, or in order to decide whether it is worth continuing an established program in its present form or time to consider other strategies for achieving your goals

Ascertain the merit of your program: in order to be able to make an informed assessment of the program (useful if you wish to tell others of your program or apply for funding)

Be accountable: to your funding body if there is one and to those who are involved or who have some other interest in the program

Approaches to evaluation

There is no one way to evaluate. Like any review, evaluation is an expression of different world views and different priorities. What an accountant will be looking for in an evaluation will probably be quite different from a disgruntled service user or staff member. Many evaluation models in the human services field emphasise the importance of service user participation at all stages of the process.

Once you have a clear understanding of the specific purpose of the evaluation you can match it to the type of evaluation.

FORMATIVE EVALUATION

Formative evaluation is concerned with ongoing program development and improvement. This approach aims to maximise the success of a program by providing information early in the life of a program. For a formative evaluation, it may be appropriate to consider program processes, outputs, or even outcomes. Undertaking a formative evaluation may be 'built in' to the goals and activities of the program when it is being developed.

PROCESS EVALUATION

This focuses on understanding how the program was implemented, and may also consider the unintended consequences which can occur. It enables a clear description of program intent, design and the extent of the implementation. (This means that any impact evaluation that may subsequently be carried out will be based on a realistic appreciation of what is occurring.) Process evaluation can also seek to examine differing understandings of the objectives of a program that are held by the different stakeholders.

IMPACT EVALUATION

Impact evaluation considers the impact of a program which has been implemented. This is most commonly used when a program is sufficiently 'settled' to be able to attribute the impact to the program. It can focus on the impact in terms of the program objectives or goals, or it may be expanded to include a wider range of program effects such as the

needs of those who are to benefit from a program. Impact evaluation commonly looks at the short-term impact of a program.

OUTCOME EVALUATION

Outcome evaluation seeks to examine the longer-term effects of the program, again usually in relation to the program objectives or goals. Assessing outcome is usually complex and costly, as it can be extremely difficult to attribute a particular outcome to a particular program while taking into account the range of factors beyond the scope of the program that may also influence the outcome.

MONITORING

Monitoring is a less systematic form of evaluation that draws on the experience of those involved in implementing and maintaining the shared care program.

Once your program starts, it will be useful to review progress periodically, at least every few months. This can occur as part of a regular meeting such as a staff meeting. If you have a reference group or advisory committee for the program it will be part of their role to review and monitor progress.

Progress can be reviewed by revisiting **Work sheet 8** and any other documentation you have drawn up about the details of the shared care program and its implementation (for example, minutes of meetings or correspondence between your organisation and local Divisions of General Practice).

Each activity that forms part of the shared care program can be reviewed according to how well it is operating, and whether it is proceeding according to the set time frames. If there are any 'glitches' in implementing your program, which is not uncommon, different approaches and solutions can be discussed and you might modify the 'strategies/activities' section of Work sheet 8 accordingly.

You may also decide that time frames need to be adjusted, or that the person responsible for getting an activity going needs more practical support. It is also a good opportunity to acknowledge those aspects of the program that are proceeding smoothly and the efforts that have been required to achieve this.

Timing your evaluation

It is immensely valuable to plan and build in evaluation from the beginning of a shared care program, although you can carry out an evaluation at any stage. As discussed above, regular monitoring while the program is being implemented gives you the opportunity to improve it as you go.

If evaluation is 'built in' at the beginning, you have the opportunity to gain a picture of the important aspects of implementing the program that have an impact on how well it runs.

Planning a formal and systematic evaluation from the beginning also means that you can set up systems for data collection 'as you go'.

If planning the evaluation is left until just before it is carried out, you may find that you have missed the opportunity to make use of some data because it needed to be collected from the start. (If you set up a data collection system at the beginning of the program, you can include review of the operation of the system as part of regular program monitoring.)

One way to ensure that evaluation is planned and built in from the start is to include evaluation of the program as a program goal (see **Work sheet 8**).

Planning your evaluation

Keep it realistic and manageable. It will be most practical to select a few particular aspects of your program for evaluation. It is unwise to proceed with an evaluation that is bigger than that which you can realistically accommodate.

If it seems worthwhile to broaden the scope of an evaluation, you need to be confident that resources are allocated to enable staff to conduct and coordinate the evaluation or to employ an external consultant.

Make your evaluation useful. This will be achieved through thinking carefully about the purpose of your evaluation, the questions that those involved would like answered, and communicating results in an appropriate form. For example, GPs will be more likely to take notice of the evaluation if it tells them things they would find useful or interesting, and if results are communicated in a manner that is short and to the point.

If you need it, get some advice. If you have not had much experience in carrying out an evaluation, you may find it useful to seek some assistance, particularly at the beginning when you are planning the evaluation.

If your shared care program is operating in conjunction with Divisions of General Practice, it may be valuable to plan your evaluation with them as well. They will in any case need to undertake an evaluation from their perspective and Divisions have extensive experience organising data collection and in planning and carrying out evaluations.

Evaluation methods

DATA COLLECTION FOR PROGRAM DEVELOPMENT AND IMPLEMENTATION

It is most likely that a combination of data collection methods will be appropriate in any evaluation you conduct; which to use will depend on which aspect/s of the program you wish to evaluate, which questions you wish to answer, and what will be realistic to undertake. A sensible approach is to use data that already exists, if possible.

Describing the development of your program, the needs assessment and collaborative meetings that have taken place, and the consultation that has occurred, are all important and will contribute to your process of evaluation.

If appropriate for the type of evaluation you are doing, in addition you can include a system for documenting people's reflections and experiences as they go, rather than asking them later on. For example, this could take the form of journals, regular short interviews, or records of program review discussions (see 'Monitoring' above).

Keeping accurate records on a database of the number of GPs visited or involved in training will be useful, to which additional data can be added about educational activities in which GPs have participated. Evaluation of training activities (see Step 4) can also be included here as part of the overall shared care program evaluation.

It is useful to set up systems that allow you to identify shared care 'episodes' that occur within the program.

These systems could include shared care occurring at a number of levels, for example:

- through a GP known to your organisation who makes a referral within your shared care program structures
- through a GP not known to your organisation who makes a referral and is offered shared care by your service
- through a client who self refers to your service and is linked with a GP active within the shared care program
- through a self-referred client who is linked with a previously unknown GP who subsequently accepts an offer of shared care

This relies on being clear at the outset about your program goals: what types of links your program is trying to make and what counts as shared care for your service.

It is important to remember that change is likely to be slow. Describe the processes that are moving slowly in the right direction, even if there is not yet clear evidence of dramatic changes in practice.

FOLLOW-UP QUESTIONNAIRES

You may wish to undertake a follow-up questionnaire with a subset of the GPs your service has had contact with. This might assess not only changes in attitudes and knowledge but it might also include some questions relating to the shared care service provisions, and the satisfaction that GPs and staff have with these.

KEY INFORMANT INTERVIEWS

Interviewing 'key informants' has become a commonly used approach in evaluation. Key informants are individuals who have specific knowledge and insight into the issues which are being explored.

In evaluation, it is valuable to find out the views of key informants who may hold different perspectives on evaluation questions, to enable a greater depth of understanding.

An appropriate format and method of analysis for key informant interviews needs to be considered to ensure that the interviews can provide useful and meaningful information.

CLIENT CASE STUDIES

Using an evaluation method which provides insight into the experience of clients within the shared care program can be a valuable option. With careful consideration of appropriate ethical issues this could be achieved through client interviews and selected information from agency records.

CLINICAL AUDIT ACTIVITY

Undertaking an RACGP Clinical Audit (CA) activity may provide GPs with data on their practice in an area of AOD work. Redoing the activity 12 months later may show evidence of change in practice that may be attributed to working within a shared care scheme with the attendant educational program. CA activities are discussed in Step 4.

Work sheet 11 can be used for planning the design (purpose and focus) and methods (identification of data sources and practical issues) for your evaluation.

Part B

Work Sheets

Preliminary identification of your involvement in shared care

This work sheet can be worked through by one staff member prior to a staff meeting.

Element of shared care	Our organisation already does this well	Our organisation could improve how it does this	Staff members who are mainly involved or affected
Clear about the roles of GP and specialist service eg through negotiation			
Use of clinical protocols eg referral forms, management guidelines			
Communication with GPs eg Does this happen at all? Does it happen well?			
Detecting ‘non-attenders’ eg notiying GPs of patients who miss appointments			
Educational interactions with GPs eg case review			
Flexibility in arrangements with GPs			

Clarifying your core services

Allow free discussion at all stages of this exercise.

List the goals and objectives for your service or program. List the service activities (strategies) you employ to work towards each goal. Rate each strategy with the degree to which it either affects GPs or depends in some way on GPs and their practice (on a scale of 1 to 5).

List your reasons for involving GPs in your work. Finish by brainstorming and making a list of all the benefits that could flow from working with GPs.

Goal	Service activities (strategies) we employ to achieve this goal	Affects or depends on GPs (1=low, 5=high)

Reasons to include GPs in our work:

____

____

Benefits that can flow from working with GPs:

____

____

How well are you working with GPs currently?

In column 1, list those services activities (strategies) that you identified in Work sheet 2 as affecting GPs or depending in some way on GPs and their practice. (Those rated as low in Work sheet 2 need not be considered.) Put the rating in column 2 and complete the work sheet.

Service activity (strategy)	Degree to which it affects /depends on GPs (1 = low, 5= high)	How well collaboration or communication is currently occurring	Barriers to improvement

Clarifying roles for your service

Work through this alone or in a staff group.

Statement	Does not apply to our agency	Our agency has not addressed this	Our agency could do this better	Our agency does this well	Action we could take
The services we provide to clients are clear in our strategic plan and in information available to the community.					
The way clients access our service is clear in information available to the community.					
The services we specifically provide to GPs are clear in information available to our GP community.					
The way GPs access our service is clear in information available to our GP community.					
Our service is clear about our relationship with the GP community and our expectations of them.					
Our service is clear about the range of services provided by the GP community.					

An organisational audit

Work through this sheet alone or in a staff group.

Statement	Does not apply to our agency	Our agency has not addressed this	Our agency could do this better	Our agency does this well	Action we could take
We have a statement in our strategic plan about working with GPs.					
Our organisation's policy and practice reflect a commitment to collabor-ative work with GPs.					
Our organisation implem-ents programs that increase the likelihood of GP involvement.					
Our organisation has the flexibility within its range of services to meet the needs of GPs.					
Our organisation has a specific program devoted to promoting shared care work with GPs.					
Our organisation has a process for dealing with conflict.					
Our organisation is willing to change to achieve better shared care work with GPs.					

Skills and attitudes audit

Work through this sheet alone or in a staff group.

Statement	Does not apply to our agency	Our agency has not addressed this	Our agency could do this better	Our agency does this well	Action we could take
Staff have had the opportunity to discuss concerns about working with GPs.					
Staff demonstrate an awareness of general practice issues.					
Staff demonstrate the interpersonal and communication skills necessary to work with GPs.					
Staff demonstrate an understanding of general practice issues.					
Staff demonstrate a willingness to work with GPs.					
Staff express confidence in working with GPs.					

What new skills do staff need to learn?

____

____

Working with GPs: Summary of issues

Respond to these questions in a focus group with GPs or by summarising data gathered from GP visits or interviews.

List the areas you have highlighted as potential areas for working with GPs:
List the main problems or issues for GPs in relation to your service that have emerged from your consultation with the Division and GPs:
List the main suggestions in point form that have been made by staff for working more collaboratively with GPs:
List the main suggestions in point form that have been made by GPs for working more collaboratively with your service:

Developing goals, objectives and strategies

This work sheet can be completed in a GP focus group or meeting.

Problem identified	Goal	Service activities (strategies)	Time frame	Responsible
eg GPs unable to refer patients easily for assessment No clear, identifiable way for patients to be accepted into the service	Develop a clear and simple entry system for patients into our system.	Establish a daily duty worker available 8am—6pm. Upskill duty workers in phone assessment. Purchase a mobile phone for duty worker. Avoid rostering duty worker to other activities.	4 weeks 3 months 1 week 4 weeks	Program or clinic manager
eg AOD workers unable to easily locate a GP for patients who self-refer	Ensure duty workers are able to locate a GP for a self-referred patient within one week.	Develop a list of GPs with interest and training in AOD work, who are willing to accept patients. Negotiate with Division/s to obtain relevant GP database subset/s. Ensure training needs assessment or practice visit program questionnaire includes an opportunity to update GP skills, availability, contact details.	3 months altogether	GP liaison officer or subset of steering committee
eg Don't know what will make a difference	Evaluate the shared care programs.	Document the process of setting up & running program. Gather, collate and analyse data on GP involvement: numbers, satisfaction etc. Gather, collate and analyse data on types of GP contact with agency.	4 months 12 months 12 months	Designated person/ subset of steering committee

Developing goals, objectives and strategies

This work sheet can be completed in a GP focus group or meeting.

Problem identified	Goal	Service activities (strategies)	Time frame	Responsible

Working with Divisions: Check list A

Tick 'yes' or 'no' for each statement.

Statement	Yes	No
I am familiar with the Divisions of General Practice in my health region.		
I have met with staff of the local Divisions of General Practice.		
My service is on the mailing lists of local Divisions of General Practice.		
I am familiar with the findings of the Divisional needs analyses.		
I am aware of the strategies the Divisions use to liaise with and collaborate with other organisations (eg the community liaison officer, the community advisory group, the consumer reference group).		
I have considered the potential of working with other projects and programs in the Divisions of General Practice.		
I am familiar with the recruitment and promotional strategies the local Divisions use, and have considered how we can collaborate on this.		
I have met with key workers from the Divisions.		
The Divisions are clear about the proposed operation of our shared care program.		
The Divisions are clear about what our service does and how it operates.		
I actively seek advice from the Division about possible strategies to recruit GPs.		
We are clear about how we will work together.		

Working with Divisions: Check list B

It may be useful to photocopy this work sheet and fill in a separate one for each Division of General Practice that you are interested in working with, if there is more than one.

………………... Division of General Practice

Key people	Name of person/ Meeting arranged	Involvement in drug and alcohol work	Potential areas for working together
Executive Officer			
Community Liaison Officer			
Program Coordinator			
Administration Staff			
GPs who are interested in AOD issues			

Current programs	Contact	Potential for participation

Royal Australian College of General Practitioners (RACGP) check list

Work through this sheet alone or in a staff working group.

RACGP

Contact phone and address — 1186 Toorak Rd, Hartwell, VIC 3125
PO Box 2000, Burwood, VIC 3125
Ph: 03 9809 0566 Fax: 03 9809 0622

What is the role of the RACGP?

____
____
____

What is the potential for working with the RACGP?

____
____
____

Who are the contacts in the QA&CE Department?

____
____
____

How do you apply for CME/CA points?

____
____
____

What is the potential for designing a Clinical Audit activity for GPs that may assist in our shared care program?

____
____
____

Other

____
____
____

Planning your evaluation

Discuss these questions with those responsible for carrying out the evaluation. Seek input from others for whom the evaluation is relevant.

DESIGN

What is the purpose of the evaluation?	What will be evaluated?	What questions will the evaluation answer?
		Evaluation type will be: formative process impact outcome

METHOD

Data sources:		
Allocation of resources: staff time, other resources (including external)		
Time lines:		
Reporting:	To whom?	In what form?

Part C

Appendixes

Appendix 1

Case studies

The Inner City Project

This was a collaborative project between the Melbourne Division of General Practice and Turning Point Alcohol & Drug Centre. The project involved an extensive needs analysis and 20 hours of formal drug and alcohol training for a group of 25 GPs. The second component of the project was the development of a shared care model of clinical service delivery. This model involved a community drug nurse who met regularly with GPs to discuss the management of shared care clients and one-to-one training. The nurse provided consultation and direct care services including assessment, counselling, referral, and withdrawal.

Referral pathways were developed as well as communication protocols and shared care documentation. Training and shared care mechanisms were tailored for individual GPs.

Contact: Sharon Patterson, Turning Point Alcohol & Drug Centre Inc, 54–62 Gertrude Street, Fitzroy, VIC 3065. Telephone 03 9235 9808.

St Vincent's Hospital Department of Alcohol & Drug Studies: GP Affiliate Program

This program involved placing GPs in a range of half-day clinical sessions with local specialist AOD services. The aim was to increase the familiarity of GPs with the service and to introduce them to an assessment instrument used by that service. They had a chance to meet staff from the organisation, and to see an assessment or review performed (with the client's consent).

A short educational workshop was provided in brief intervention and motivational interviewing, and a resource manual was provided to the GPs.

Efforts were made to clarify the referral pathways into the service, and to educate reception staff to identify affiliated GPs and assist their enquiries. A total of 34 GPs undertook clinical placements and attended workshops over a period of 18 months.

Contact: Dr John Furler, North Richmond Community Health Centre, 23 Lennox Street Richmond, VIC 3121. Telephone 03 9429 5477.

Alcohol Problems in General Practice Project

This project employed a full-time nurse educator/counsellor who was available to GPs in the Inner Eastern Melbourne Division of General Practice. GPs could contact the nurse to provide direct care services (assessment, referral, counselling) for clients that the GP identified had alcohol-related problems. The nurse also undertook training needs analysis of GPs in relation to alcohol knowledge and current clinical practice. A full weekend training workshop was provided for 25 GPs where a range of AOD specialist physicians and

advanced practitioners presented. Topics included early detection and brief intervention, motivational interviewing and controlled drinking strategies.

Contact: Sandra Roeg, Turning Point Alcohol & Drug Centre Inc, 54–62 Gertrude Street, Fitzroy, VIC 3065. Telephone 03 9254 8061.

Central Coast GP Project

This project has been run by the NSW Central Coast Alcohol and Other Drug Service in an area with about 270 GPs.

The first phase involved an extensive needs analysis of the GP community, undertaken by a full-time worker during which the heterogeneity of GPs became apparent. Recommendations of the needs analysis included:

- a local consultancy service
- education and training for GPs

The implementation phase involved establishing a local telephone consultancy service which operates in business hours taking 20–30 calls a week. The education and training program includes a regular newsletter.

Overall about 60 per cent of the local GPs have either attended training or used the consultancy service.

The next phase involves establishing structures whereby if a client rings for an AOD issue they will be detailed and linked back to their GP who will be automatically provided with the assessment pro forma by fax. Other structural and systematic changes are being made.

Contact: Helen Astolfi, Telephone 02 4320 2637.

Appendix 2

GP questionnaires and focus group format

The Short Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ)

(Anderson, P., & Clement, S., 1987)

Below is a series of statements about working with clients with alcohol-related problems. For each statement please indicate the extent of your agreement or disagreement with it by ticking the box on the scale that best corresponds to your answer.

1. I feel I know enough about the causes of drinking problems to carry out my role when working with drinkers.

Strongly agree			Neither agree nor disagree			Strongly disagree

2. I feel I can appropriately advise my patients about drinking and its effects.

Strongly agree			Neither agree nor disagree			Strongly disagree

3. I feel I do not have too much to be proud of when working with drinkers.

Strongly agree			Neither agree nor disagree			Strongly disagree

4. All in all I am inclined to feel I am a failure with drinkers.

Strongly agree			Neither agree nor disagree			Strongly disagree

5. I want to work with drinkers.

Strongly agree			Neither agree nor disagree			Strongly disagree

6. Pessimism is the most realistic attitude to take towards drinkers.

Strongly agree			Neither agree nor disagree			Strongly disagree

7. I feel I have the right to ask patients about their drinking.

Strongly agree | Neither agree nor disagree | Strongly disagree

8. I feel that my patients believe I have the right to ask them questions about their drinking when necessary.

Strongly agree | Neither agree nor disagree | Strongly disagree

9. In general, it is rewarding to work with drinkers.

Strongly agree | Neither agree nor disagree | Strongly disagree

10. In general, I like drinkers.

Strongly agree | Neither agree nor disagree | Strongly disagree

Practice visit questionnaire

(Developed by Sharon Patterson for the Inner City Project)

SECTION ONE: GENERAL INFORMATION

1. Name:______________________________

2. Address of general practice ______________________________
____

3. Practice hours ____________________

4. Where else do you work and when? ______________________________

5. What type of practice do you mostly work in? (solo, group, other) __________

6. Do you have a computer? YES NO
Is it: Macintosh PC
Email Address ______________________________

7. Do you have a fax machine? YES NO
If yes, what is the number? ______________________________

8. What are the names of your receptionist/s? ______________________________

9. Would you be prepared to do home detoxification? YES NO MAYBE
If you have concerns, what are they? ______________________________
____

10. Are you or have you ever been a methadone prescriber? YES NO USED TO
If you have concerns, what are they? ______________________________
____
____

SECTION TWO: YOUR PRACTICE AND HEALTH DELIVERY

11. What particular drug use do you see as the most prevalent in the patients that attend your practice? (eg alcohol, heroin, smoking, benzodiazepines)

    Please rate:

    1. ____________________
    2. ____________________
    3. ____________________
    4. ____________________
    5. ____________________
    6. ____________________

12. What particular drug use related problems are most prevalent in the patients that attend your practice? (eg benzodiazepine/opiate seeking, dependency, associated high risk behaviour)

    List ____________________

13. What alcohol and drug services do you think should be provided in the local area that aren't already available?

SECTION THREE: TRAINING

14. What alcohol and drug training have you attended in the past?

15. What training do you need to enhance your clinical skills in the management of drug and alcohol problems? Please rate in order of need, with 1 representing lowest priority and 5 representing a high need.

☐ *Management of withdrawal*
outpatient/inpatient

☐ *Assessment*
alcohol
benzodiazepines
heroin
amphetamines
nicotine
cannabis

☐ *Brief interventions*
motivational interviewing (assisting patients to change)
counselling
education

☐ *Pain management*
assessment
strategies
behavioural problems

☐ *Dual diagnosis*
assessment
harm reduction
management of
referral/liaison

☐ *Methadone prescribing issues*

☐ *Controlled drinking*
assessment
strategies
follow up/monitoring

☐ *Blood borne viruses*
HIV/HBV/HCV
management of
harm reduction/education

☐ *Amphetamine and other psychostimulant use*
harm reduction
behavioural problems
withdrawal

- [ ] *Family issues*
- [ ] *Information about services*

  withdrawal services

  support services
- [ ] *Counselling skills*
- [ ] *Relapse prevention*

  follow up

  monitoring

  strategies (including cognitive behavioural therapies)
- [ ] *Managing potentially violent patients*

  prevention of aggression

  practice strategies to minimise incidents

  practice strategies to intervene when patient is threatening or violent
- [ ] *Drug interaction/overdose*
- [ ] *Other (Please specify)*

  ____

  ____

  ____

General Practitioner Needs Analysis Questionnaire

(Edwards, C., Roche, A., Gill, A., Polkinghorne, H., Evershed, K., & Mant, A., 1995)

SECTION 1

1. How many years have you been practising as a general practitioner? _______ years

2. How many general practitioners are there in your practice, including yourself? _______

3. What is your gender? Male Female

4. What is your age? ______ years

5. How many general practice patients would you see in an average week? (Please tick one box)

   0–50 ☐

   51–100 ☐

   101–150 ☐

   More than 150 ☐

SECTION 2

6. How effective do you feel you are in helping patients achieve change in each of the following areas?

	Very effective			Very ineffective
a. Not smoking	☐	☐	☐	☐
b. Reducing alcohol consumption	☐	☐	☐	☐
c. Reducing benzodiazepine use	☐	☐	☐	☐
d. Reducing illicit drug use	☐	☐	☐	☐

7. How confident do you feel in working with the following aspects of drug and alcohol problems?

   1 = very confident

   2 = relatively confident

   3 = not very confident

   4 = not confident at all

(Please place a number from 1 to 4 in the boxes provided)

	Alcohol	Benzodiazepenes	Nicotine	Illicit drugs
a. Assessment	☐	☐	☐	☐
b. Detox	☐	☐	☐	☐
c. Counselling	☐	☐	☐	☐
d. Referral	☐	☐	☐	☐
e. Brief intervention	☐	☐	☐	☐

SECTION 3

8. Please indicate whether the following are signs and symptoms of withdrawal from the drugs listed below, after daily use for several months.

   (Please write 'Yes', 'No' or 'Don't' in the boxes provided)

	Rhinorrhea	Prolonged sleep	Depression	Agitation	Delirium	Tremul-ousness	Seizures
Benzodi-azepines	☐	☐	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐	☐	☐
Nicotine	☐	☐	☐	☐	☐	☐	☐
Opiates	☐	☐	☐	☐	☐	☐	☐
Ampheta-mines	☐	☐	☐	☐	☐	☐	☐

9 The mother of a 21-year-old man with recurrent psychosis reports that he was using amphetamines prior to his admission. Would you: (Tick one box only)

a. Add a benzodiazepine to his treatment for approximately one week ☐

b. Refer to detox unit ☐

c. Increase the dose of haloperidol ☐

d. Aim ultimately to withdraw him from all treatment ☐

e. Explain that amphetamines can precipitate psychotic relapse ☐

10. A 28-year-old woman asks your advice on alcohol consumption during pregnancy. Your advice is that: (Tick one box only)

a. She should refrain from all alcohol consumption ☐

b. She may have the equivalent of 14 drinks spread over a week ☐

c. She may have up to 3–4 drinks a day ☐

d. She maintains her usual drinking pattern ☐

11 How many grams of alcohol in a standard drink? ______ gm

12 According to NHMRC guidelines, maximum recommended alcohol consumption levels should not exceed:

_____ standard drinks per day for men

_____ standard drinks per day for women

All people should have least _____ alcohol-free days per week

(Please circle your answer for the following questions)

13. Heavy alcohol use is known to be associated with hypertension. True False Don't Know

14. Results of the following tests are likely to show elevated levels in patients with heavy drinking patterns:

a. Gamma-glutamyl transferase	True	False	Don't Know
b. HDL cholesterol	True	False	Don't Know
c. Urea	True	False	Don't Know
d. Magnesium	True	False	Don't Know

15. Alcohol withdrawal seizures:

a. Most commonly occur within 48 hours after last drink	True	False	Don't Know
b. Are focal in type	True	False	Don't Know
c. Rarely lead to status epilepticus	True	False	Don't Know

16. A person who has developed a tolerance to alcohol is likely to be tolerant to a variety of other depressant drugs, such as hypnotics and minor tranquillisers (eg diazepam, oxazepam). True False Don't Know

17. Confusion and post-op delirium can be symptoms of alcohol withdrawal. True False Don't Know

18. Excessive alcohol use can cause:

a. Panic attacks	True	False	Don't Know
b. Auditory hallucinations	True	False	Don't Know
c. Depression	True	False	Don't Know
d. Mania (bi-polar affective disorder)	True	False	Don't Know

19. A doctor's advice to stop smoking:

a. Is twice as effective when combined with a follow-up visit	True	False	Don't Know
b. Results in a one-year quit rate of about 40%	True	False	Don't Know
c. Is more effective in patients that have a smoking-related illness	True	False	Don't Know
d. Is provided to more than 75% of smokers in a primary care practice	True	False	Don't Know

20. Nicotine patches:

a. Are usually contraindicated in patients with heart disease	True	False	Don't Know
b. Are most effective for patients who demonstrate evidence for high nicotine dependency	True	False	Don't Know
c. Are used to help patients cut down the number of cigarettes they smoke	True	False	Don't Know
d. May cause reduction in blood pressure	True	False	Don't Know

21. A 55-year-old female patient has been taking diazepam 5mg q.i.d., plus a hypnotic at night, for 5 years:

a. Adding an additional sedative drug (eg ozaxepam 30mg t.d.s) is likely to lead to coma	True	False	Don't Know
b. Stopping her present medication is likely to produce withdrawal symptoms	True	False	Don't Know
c. There is no danger in her having 3–4 standard drinks after work	True	False	Don't Know
d. Substitution of a long-acting barbiturate should be contemplated	True	False	Don't Know

22. Withdrawal from benzodiazepines (120mg Serepax per day) can be performed on an outpatient basis over a period of 1 to 2 weeks. True False Don't Know

23. The following are indications for long-term benzodiazepine prescription:

a. Sleep disturbance	True	False	Don't Know
b. Alcohol dependence	True	False	Don't Know
c. Depression	True	False	Don't Know
d. Anxiety	True	False	Don't Know

24. The concept of dependence on alcohol or other drugs is defined by physiological criteria alone. True False Don't Know

25. Below is a list of forms of treatment for patients with drug and alcohol problems. How effective do you believe each of these interventions are?

	Very effective			Very ineffective
a. Residential rehabilitation program	☐	☐	☐	☐
b. Alcohol sensitising drugs (eg Antabuse)	☐	☐	☐	☐
c. Long-term counselling	☐	☐	☐	☐
d. Alcoholics Anonymous	☐	☐	☐	☐
e. Brief advice by medical practitioner at early stage of problem	☐	☐	☐	☐
f. Training in controlled drinking	☐	☐	☐	☐
g. Detox program	☐	☐	☐	☐
h. Methadone program	☐	☐	☐	☐

SECTION 4

26. Please indicate the frequency with which you obtain information on your patients in each of the following areas:

	Almost always	Regularly	Occasionally	Rarely/Never
a. Smoking	☐	☐	☐	☐
b. Alcohol consumption	☐	☐	☐	☐
c. Benzodiazepine use	☐	☐	☐	☐
d. Illicit drug use	☐	☐	☐	☐

27. Approximately how often do you usually refer a patient to a service outside your practice for drug or alcohol advice? (circle)

Never	once a day	1–2 times a week	1–2 times a month	3–4 times a year	once a year or less

28. The following are types of resources we may be able to provide to help you work with patients with drug and alcohol problems. Please choose three resources that you feel would be most helpful to you and number their adjacent boxes from 1 to 3 in order of preference.

Videotapes for use with patients ☐

Local Drug and Alcohol Consultancy Service ☐

Training workshops ☐

Literature for distribution to patients ☐

Information on where to refer patients ☐

Self-learning computer program ☐

Informative drug and alcohol literature ☐

29. If we were to run a workshop that you were interested in attending, what would be the most convenient time for you to attend? (Please tick one box only)

Weekday morning	☐	Weekend morning	☐
Weekday afternoon	☐	Weekend afternoon	☐
Weekday evening	☐	Weekend evening	☐

GP focus group format

INTRODUCTION

Pre-reading material should be sent to the participants outlining:

- who is organising the focus group
- the purpose of the focus group, for example, to gain material not available through reading and interview or to assist in the planning of a shared care program
- some background literature, for example, about your service

At the start of a focus group, GPs should be introduced by the facilitator and given an explanation of the purpose of the group. This should be followed by an explanation of the procedure for the group.

Focus groups work the best when all group members have the opportunity to contribute and where there is no expectation of 'right' or 'wrong' answers. GPs should feel free to say what they think and not what they think other people want them to say. The facilitator should reinforce that they are interested in a range of ideas and opinions.

GPs should be informed that a tape recorder will be used and that confidentiality is assured. Throughout the focus groups any questions should be answered and encouraged.

QUESTIONS

The questions for the focus group could be formulated from preliminary talks with a number of key staff or GPs known to your service, the material generated by working through the work sheets, reading of literature in the area and findings of a GP drug and alcohol training needs analysis questionnaire.

INTERVIEW GUIDE

The focus group protocol should commence with a broad introductory question that all GPs are able to answer without feeling uncomfortable.

Focus group 1: GP Training

Question 1

Ask all GPs to introduce themselves and give a brief explanation of what they hope to gain from participating in training.

Question 2

'What are the difficulties you have experienced when working with patients who have drug and/or alcohol problems?'

Prompt

Scenario One

Tracey is a 22-year-old single woman presenting at your practice on a Monday morning. Tracey states: 'I've been feeling really sick since Sunday morning. I was up all night vomiting and I didn't feel I could keep breakfast down. I've also got diarrhoea and a headache so I didn't go to work today. I think I just need to rest and take a Panadol or something but I need a doctor's certificate.' Upon examination you detect nothing abnormal. You note from Tracey's records that this is the third time in the past three months that Julie has presented with similar complaints on a Monday.

You ask Tracey if she is prepared to explore some lifestyle issues that could be related to her ill health. Things such as exercise, tea, coffee, alcohol or other drug use. Tracey discloses that she smokes cannabis (5 grams) weekly and consumes up to twelve stubbies (24 standard drinks) over the weekend. Tracey explains that she rarely drinks alcohol during the week and does not smoke cigarettes.

Scenario Two

Nic is a young 24-year-old male who presents at your practice in a chaotic state, home less, friendless and moneyless. He has been living on the streets for a week or two, using whatever drugs he can get. His drugs of choice are heroin and benzodiazepines, but he drinks alcohol and takes any other drugs that may be available. He does not appear physically dependent, but has a very long history of use on a daily basis. Nic says that he is really motivated to cease drug use and wants to clean up his act and get a 'normal life'.

Nic states that in the past he has successfully ceased drug use through the use of Serapax and requests a maximum script of 30mgs. He continues to add that he has tried every other possible alternative approach to address his drug use issues but everything else fails dismally so there is no point in exploring these further.

Question 3

'What types of patients with drug and alcohol problems do you feel uncomfortable with?'

Question 4

'What do you want or need to do better in your work with these patients?'

Question 5

'What training do you require to achieve this?'

Question 6

'Has past drug and alcohol training been relevant to general practice?'

'If it has, how so?'

'If it hasn't, why not?'

Question 7

'What are some of the barriers to training that you have experienced?'

Prompt: Time constraints, not pitched at right level, practice issues

Question 8

'What methods of drug and alcohol training would you find most useful?'

Question 9

'How can training be made more accessible to you in terms of location?'

Question 10

'How do you see the role of the specialist drug and alcohol worker in the provision of training?'

Focus group 2: Shared care

Commence with an explanation/introduction to AOD specialist workers and their organisations, and a general service overview. Provide a briefing on the hours that services are available, how to contact drug and alcohol workers through pager, mobile phone or fax. Distribute business cards.

Question 1

'What do you know about shared care practice?'

Question 2

'What are the difficulties you have experienced when working with patients who have drug and alcohol problems?'

Question 3

'What factors affect your management of drug and alcohol problems?'

Prompt: Time constraints, aggressive or manipulative behaviour, multiple problems, they don't get better

Question 4

'How can these be addressed through the shared care arrangements?'

Question 5

'How do you need to work with specialist drug and alcohol worker/s to enhance your clinical skills?'

Question 6

'What are some issues that you have thought about with regards to accessing specialist drug and alcohol worker/s?'

Question 7

'What are some of the potential problems that you think may occur?'

Question 8

'What can be done about solving them?'

Question 9

'How would you ideally want to work with specialist drug and alcohol worker/s?'

Appendix 3

Aids to communication

Example of a shared care management plan

Shared Care Management Plan

Date	GP Tasks	Alcohol and drug nurse tasks

PLAN

Example of telephone consultation form

Telephone Referral Form

Name of GP: ____________________

Contact Details of GP: (How does the GP want to communicate?)

Address: ____________________

____

Telephone: ____________________ Fax: ____________________

Email: ____________________

Date of referral: ______ / ______ / ______

Name of Patient: ____________________

Date of Birth: ______ / ______ / ______

Presenting Problem/s:

____

____

____

____

Patient Wants:

____

____

____

____

Complications:

____

____

____

____

Arrangements made:

____

____

____

____

Home-based Withdrawal Service Referral Form

Patient name: ____

Date of birth: ______ / ______ / ______

Patient's address:

____

____

Telephone: ______________________

GP Name: ____

Telephone: ______________________ Fax: ______________________

SUITABILITY FOR HOME-BASED WITHDRAWAL

Department of Human Services guidelines suggest the following criteria for home-based withdrawal.

PLEASE TICK IF IN PLACE FOR A REFERRED PATIENT

- ☐ no withdrawal complication predictors: head injury/loss of consciousness/fits
- ☐ no serious medical or psychiatric condition
- ☐ not pregnant
- ☐ non-drug-using support person
- ☐ access to telephone
- ☐ stable drug-free habitat
- ☐ single substance dependence
- ☐ not geographically isolated

After consideration of the above criteria, I believe the referred patient to be suitable for home-based withdrawal.

GP signature: ______________________

Home-based Withdrawal Service Referral Form cont

REASONS FOR REFERRAL

____

____

____

____

CURRENT PRESCRIBED MEDICATIONS

Medication	Dose	Frequency	Reason for Prescription

PRESCRIBED MEDICATIONS FOR HOME-BASED WITHDRAWAL EPISODE

Date	Medication	Dose	Frequency	Route	Cease

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