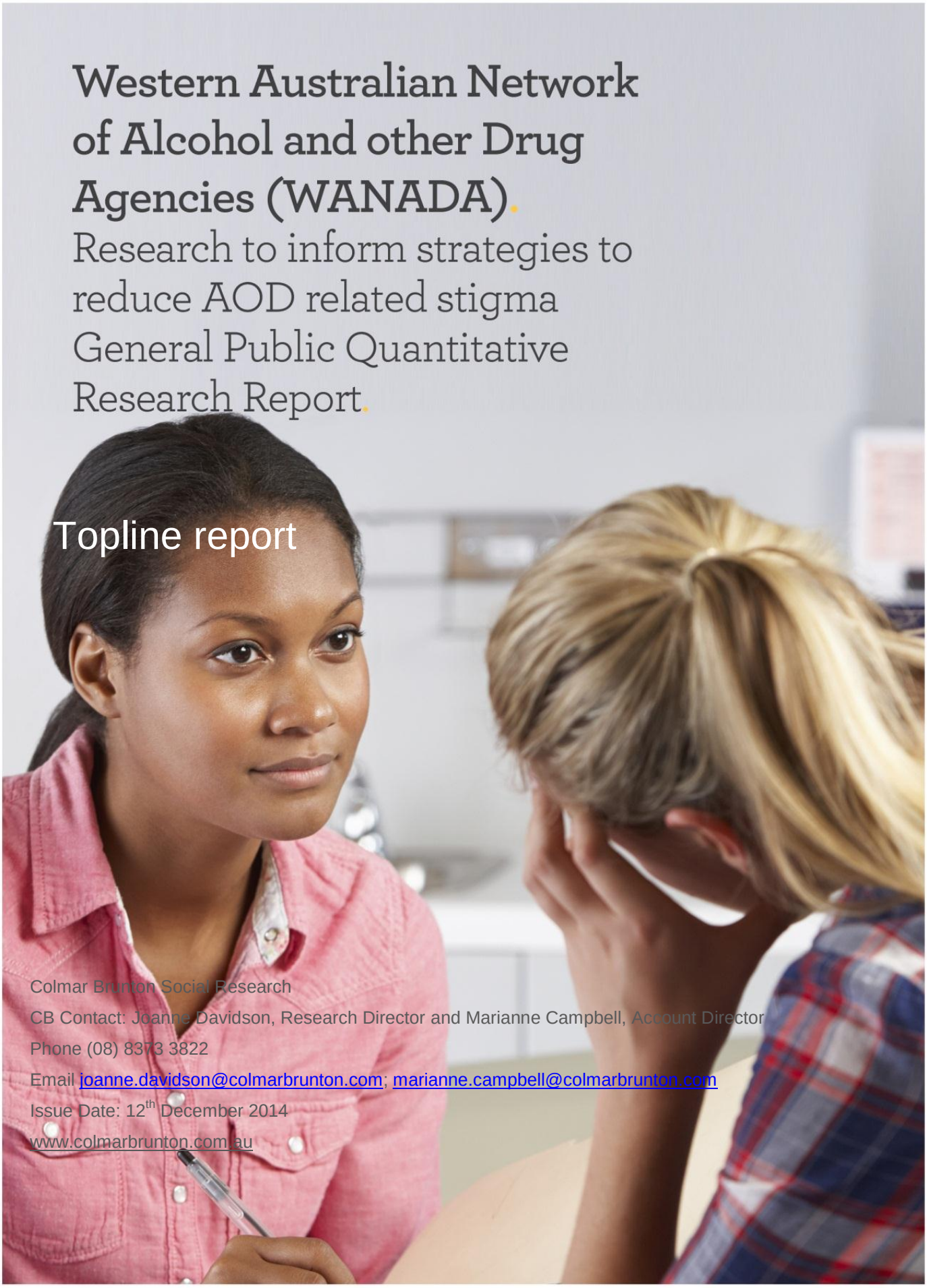
Western Australian Network of Alcohol and other Drug Agencies (WANADA).

Research to inform strategies to reduce AOD related stigma General Public Quantitative Research Report.



Topline report

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1. Introduction and background

Colmar Brunton Social Research was commissioned by Marketing For Change, on behalf of the Western Australian Network of Alcohol and Other Drug Agencies (WANADA) and the Government of Western Australia Drug and Alcohol Office (DAO), to undertake research to inform strategies to reduce alcohol and other drugs (AOD) stigma.

1.1. Background

WANADA

WANADA is the peak body for the alcohol and other drug education, prevention, treatment and support sector in Western Australia. Since its establishment in 1984, WANADA's membership has developed to reflect a 'whole-of-community' approach to alcohol and other drug issues.

WANADA is an association of organisations and individuals working to improve life of people and communities affected by alcohol or other drugs. It is an independent, membership-driven not-for-profit association.

Stigma can have a considerable and wide-ranging effect on an individual's health and quality of life. Stigma can also discourage access to AOD treatment and lead to a reluctance to access health care services due to a fear or, and actual, discrimination. Stigma can also adversely impact a person's access to other support services that deal with issues such as homelessness, mental health, and domestic violence.

AOD stigma

There is anecdotal evidence suggesting that AOD stigma towards consumers of alcohol and/or other drugs occurs across many levels within Western Australian society. Stigma can have a considerable and wide-ranging effect on an individual's health and quality of life. Impacts can include low self-esteem and self-worth, feelings of isolation, disempowerment, exclusion from community life, compromised quality of life, depressive symptoms, unemployment or loss of income, difficulty obtaining housing, problems accessing education, and limited social opportunity.

Stigma can also discourage consumers from accessing AOD treatment, leading to a reluctance to access health care services due to a fear or, and actual discrimination. Stigma can also adversely impact a person's access to other support services that deal with issues such as homelessness, mental health, and domestic violence.

WANADA's position is that stigma and discrimination directed toward people who are affected by AOD use problems, including significant others and those who work in the sector should not be tolerated.

Research is needed to build the evidence base and address existing research gaps to strengthen WANADA's ability to advocate for and develop strategies to address the stigmatisation of AOD users in the WA community.

1.2. Purpose of the research

Quantitative research with the general practitioners and mental health sector workers was required to establish the existence of stigma, its nature, prevalence within these areas of the health sector in WA. This will ascertain what barriers exist for people with alcohol and/or drug dependence to receiving health care in WA.

2. Quantitative research methodology

2.1. Fieldwork

Colmar Brunton conducted two hard-copy surveys of Western Australian general practitioners and people working in the mental health sector in WA.

Questionnaire design

Colmar Brunton developed the questionnaire in collaboration with Marketing For Change and WANADA, with approval from the DAO.

Sampling and fieldwork

The following approach to fieldwork was used:

- A random sample of 2,000 general practitioners in WA were sent a hardcopy survey mid October 2014, with instructions to complete and return by late November 2014.
- A list of 22 mental health organisations were sent several hardcopy surveys in mid October 2014 to distribute within their organisations for completion, and return by late November 2014.

A total of N=154 surveys from general practitioners, and N=29 surveys from mental health sector workers were received. To maximise response rates, participants were offered an incentive of the chance to win one of two $500 gift vouchers.

2.2. Analysis and reporting

A series of crosstabs and frequencies were conducted. Results have been presented separately for general practitioners and mental health sector workers.

Sample sizes

Where sample sizes are low (less than n=30), these are marked by an asterisk (*) in this report. These results should be interpreted with caution.

Interpreting this report

Definitions

The following terms or abbreviations have been utilised throughout this report.

Table 1: Definitions

Term of abbreviation	Definition
ABS	Australian Bureau of Statistics
CBSR	Colmar Brunton Social Research
WANADA	Western Australian Network of Alcohol and Other Drug Agencies (WANADA) and the
DAO	Government of Western Australia Drug and Alcohol Office (DAO)
AOD	Alcohol and other drugs
WA	Western Australia

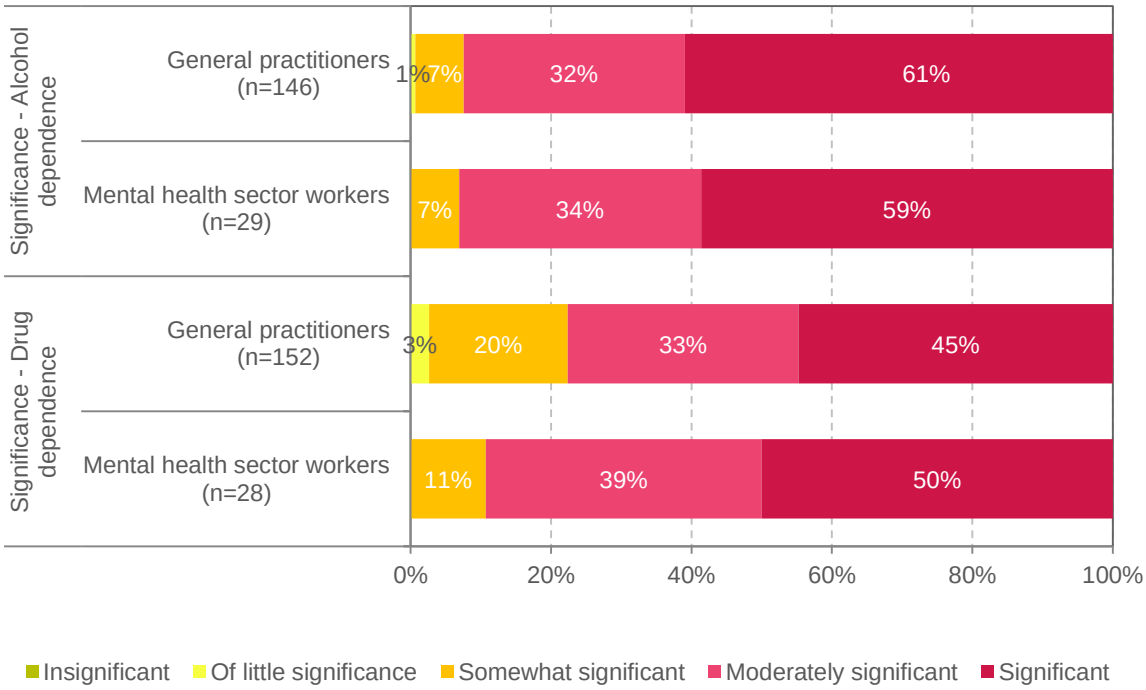
This report presents the topline findings for both surveys.

3. Topline quantitative findings

3.1. Alcohol and other drug dependence

Perceived significance of issue

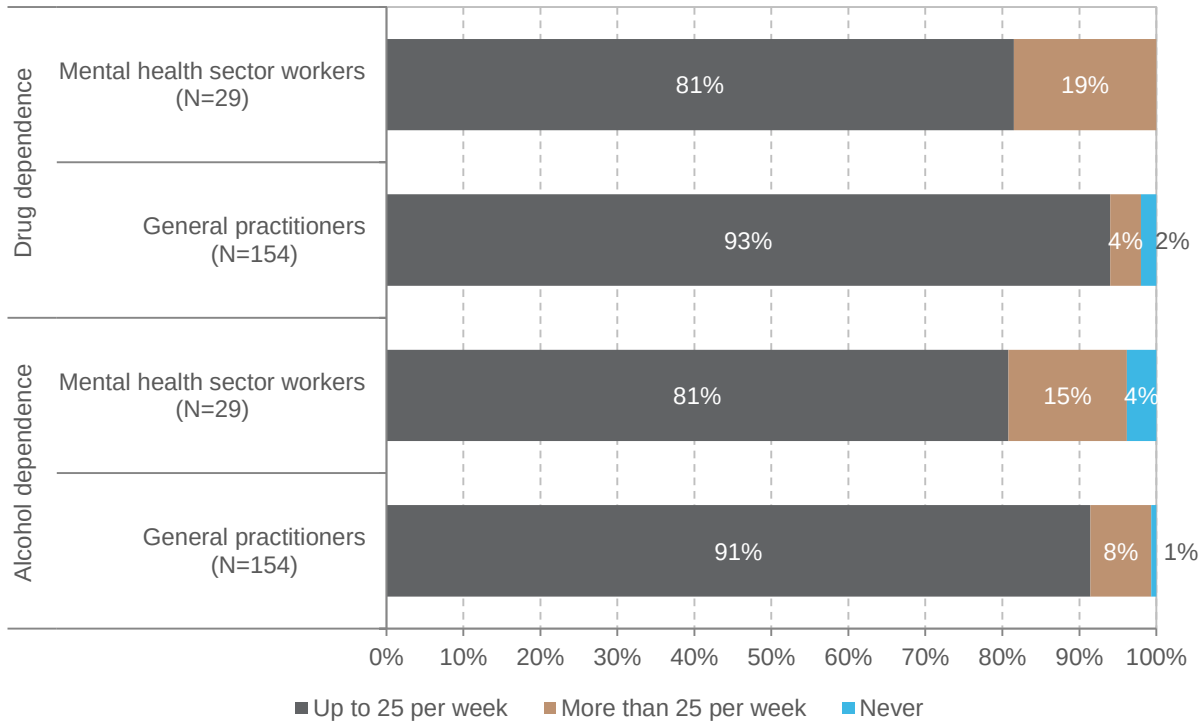
Figure 1: Perceived significance of alcohol and other drug dependence to WA society



Q5. On a scale of 0-10 where 0 is insignificant and 10 is significant, in Western Australia how significant to society is the impact of alcohol dependence / drug dependence?
Base: General practitioners (min n=146); mental health sector workers (min n=28)
Note: Non-responses have been excluded from the chart

Patients and consumer appointments

Figure 2: Frequency of seeing patients / consumers

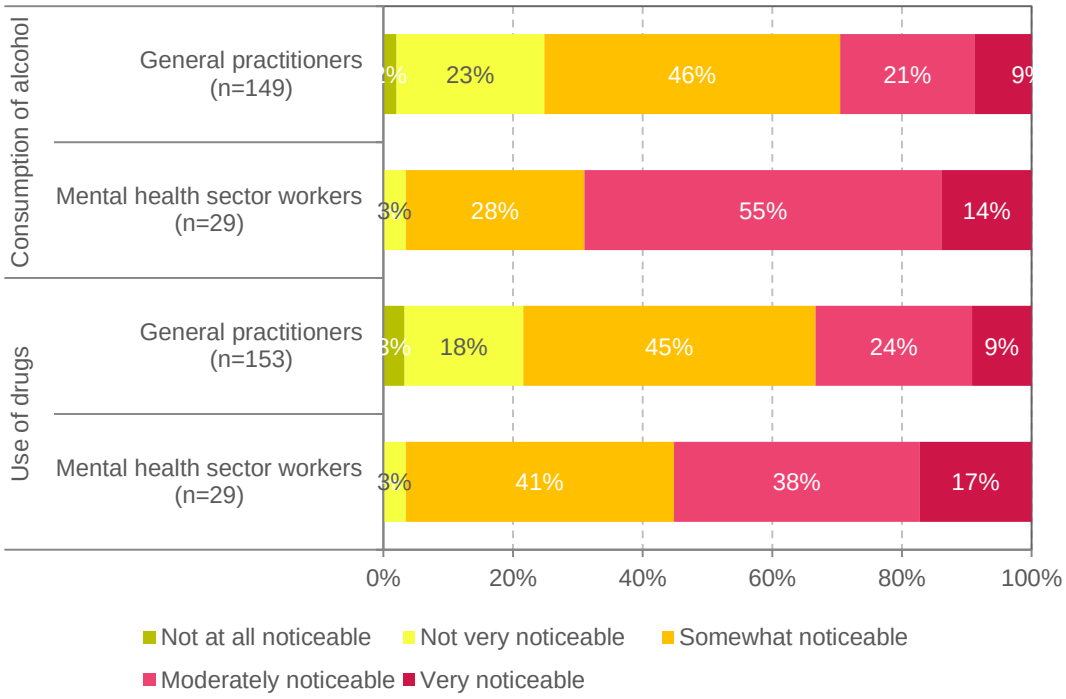


D3: How many patients / consumers on average do you see with problems associated with a) alcohol or b) misuse of drugs each week?
Base: General practitioners (min n=146); mental health sector workers (min n=28)

3.2. Attitudinal stigmatisation

Perceived noticeability

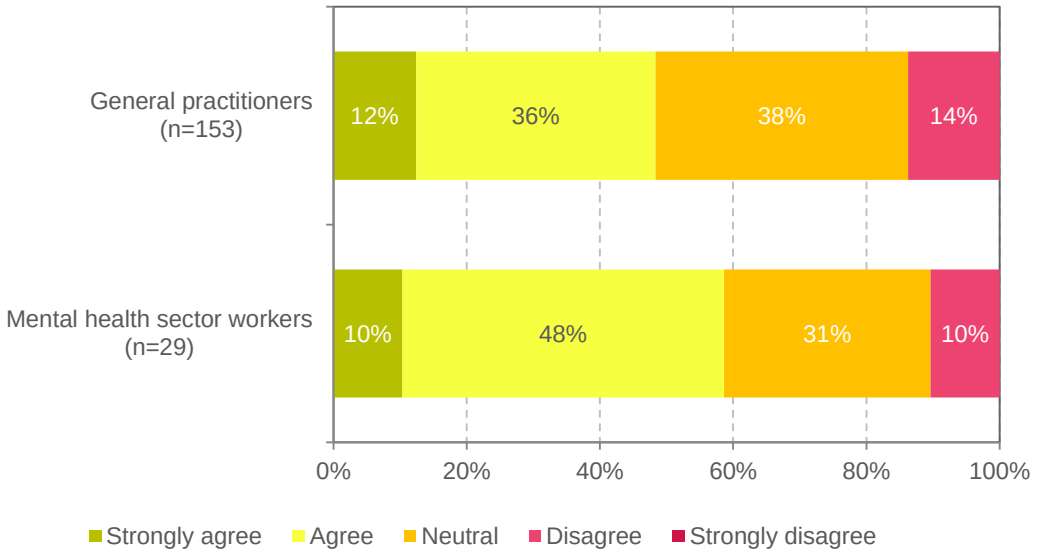
Figure 3: Perceived noticeability of a person with alcohol or drug dependence



Q6. On a scale of 0-10 where 0 is not at all noticeable, and 10 is very noticeable, on appearance alone how noticeable is it to others if someone is experiencing problems associated with:
Base: General practitioners (min n=149); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

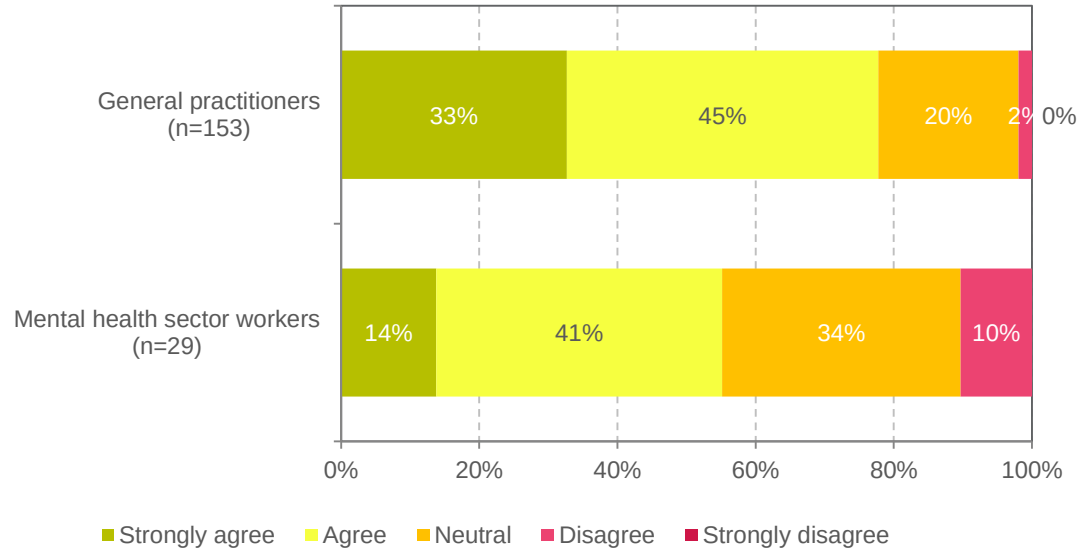
Working with people with alcohol dependence

Figure 4: I feel I know enough about causes of drinking problems to carry out my role when working with alcohol users/consumers who are alcohol users



Q7. Please indicate your level of agreement with the following statements, using a scale of 0-10 where 0 is strongly disagree, and 10 is strongly agree:
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 5: I feel I can appropriately advise alcohol users about drinking and its effects



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Base: General practitioners (n=153); mental health sector workers (N=29)
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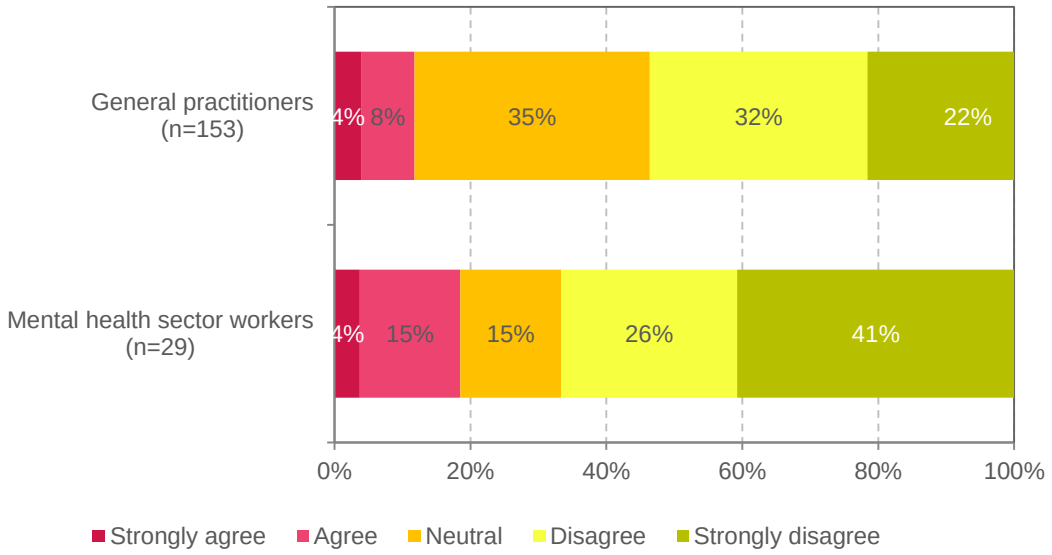
Figure 6: I feel I do not have much to be proud of when working with alcohol users



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Base: General practitioners (n=153); mental health sector workers (N=29)
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Figure 7: Pessimism is the most realistic attitude to take towards alcohol users

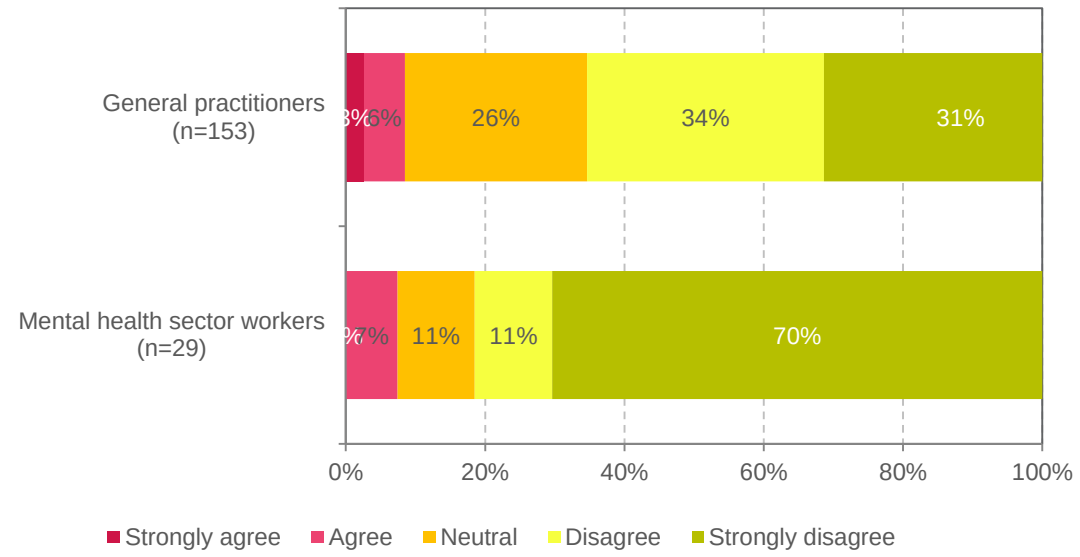

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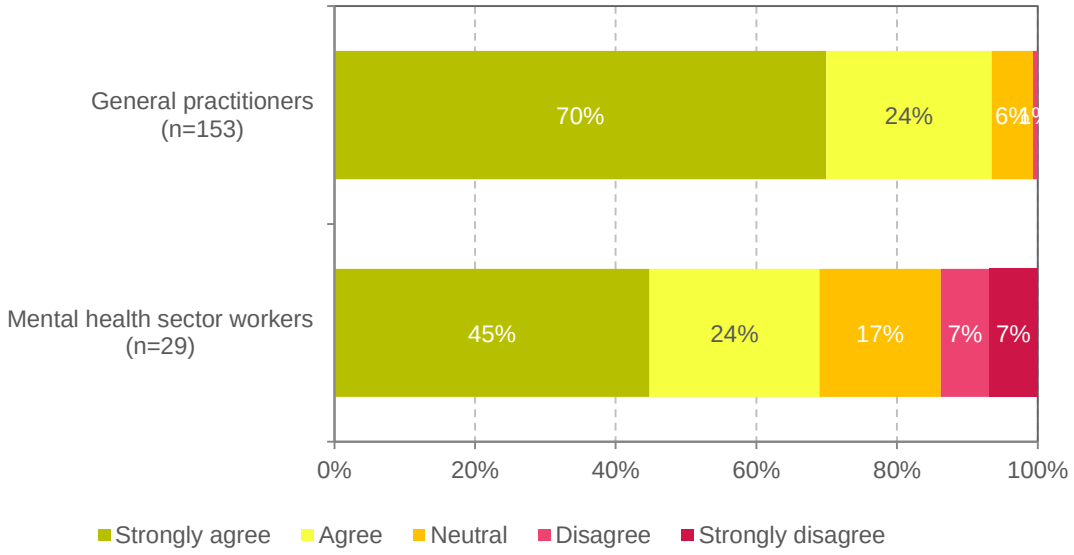
Figure 8: I feel I have the right to ask patients/consumers questions about their drinking when necessary



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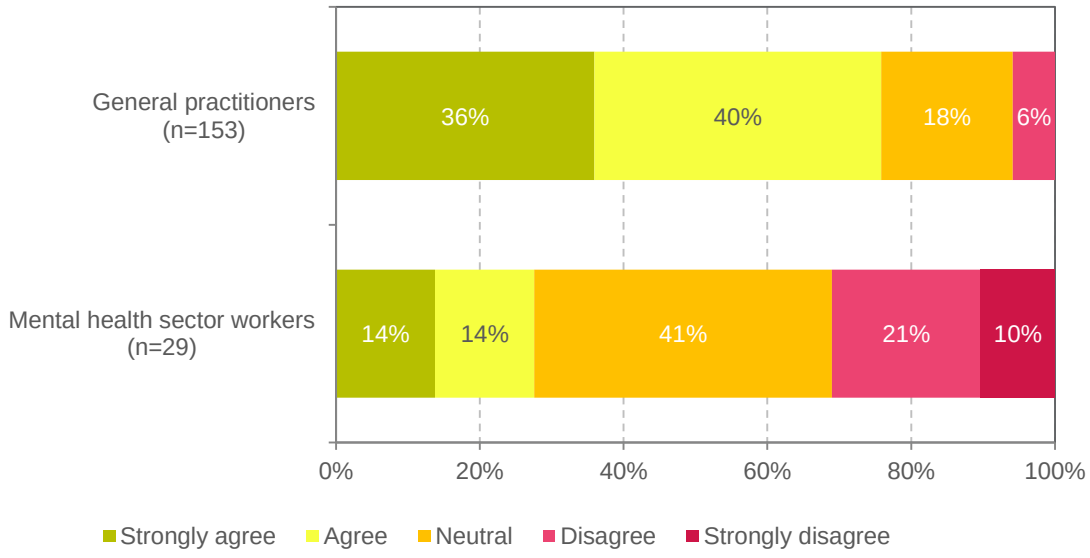
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 9: I feel that patients/consumers believe I have the right to ask them questions about their drinking when necessary



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Base: General practitioners (n=153); mental health sector workers (N=29)
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Figure 10: In general, it is rewarding to work with alcohol users

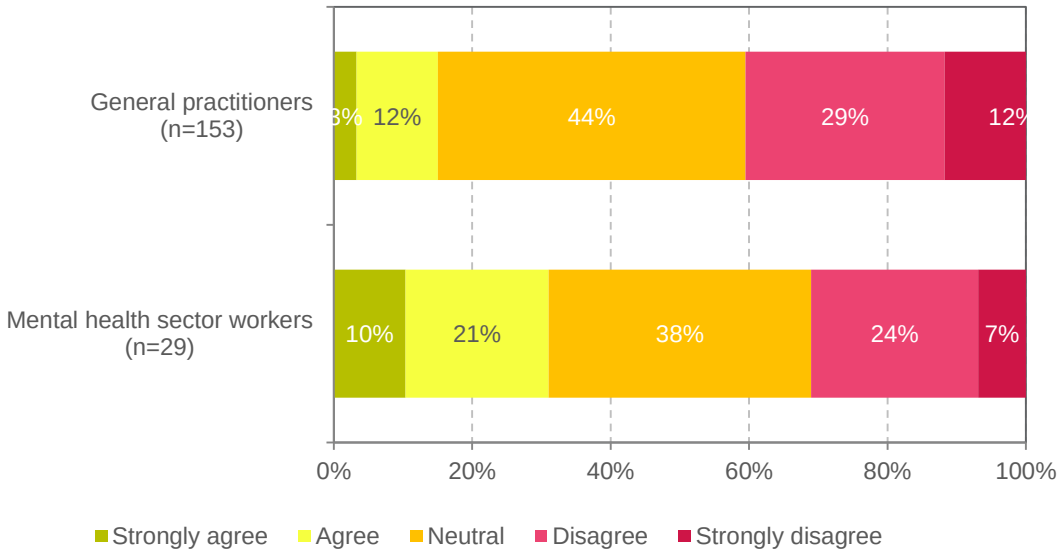

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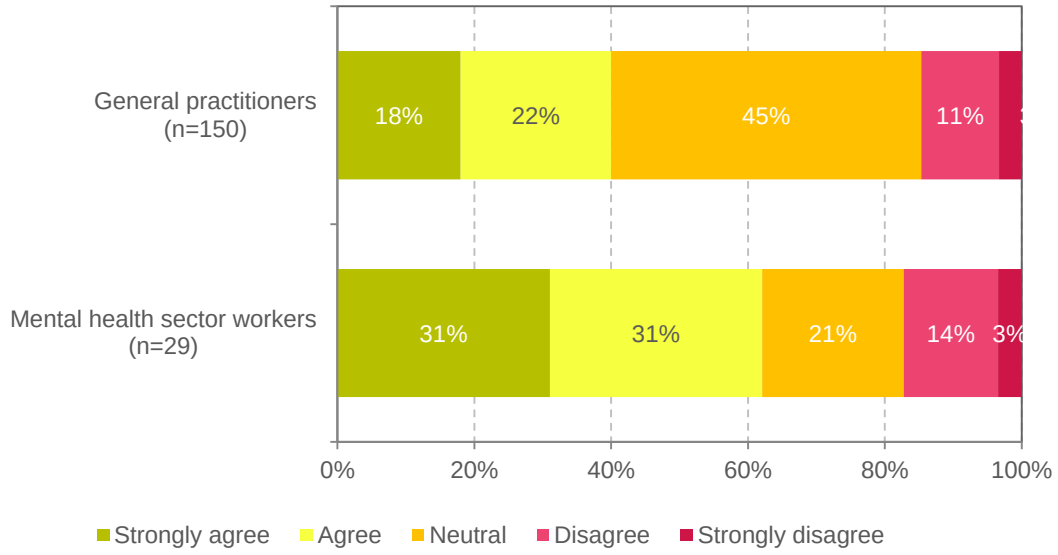
Figure 11: I feel my workplace supports me to do my role when working with alcohol users



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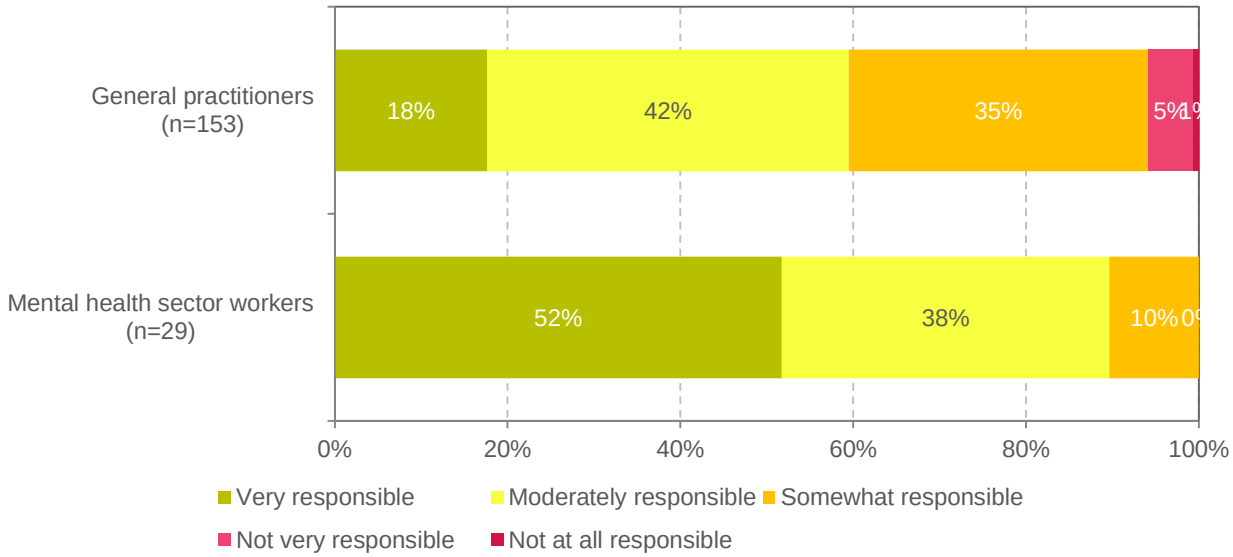
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

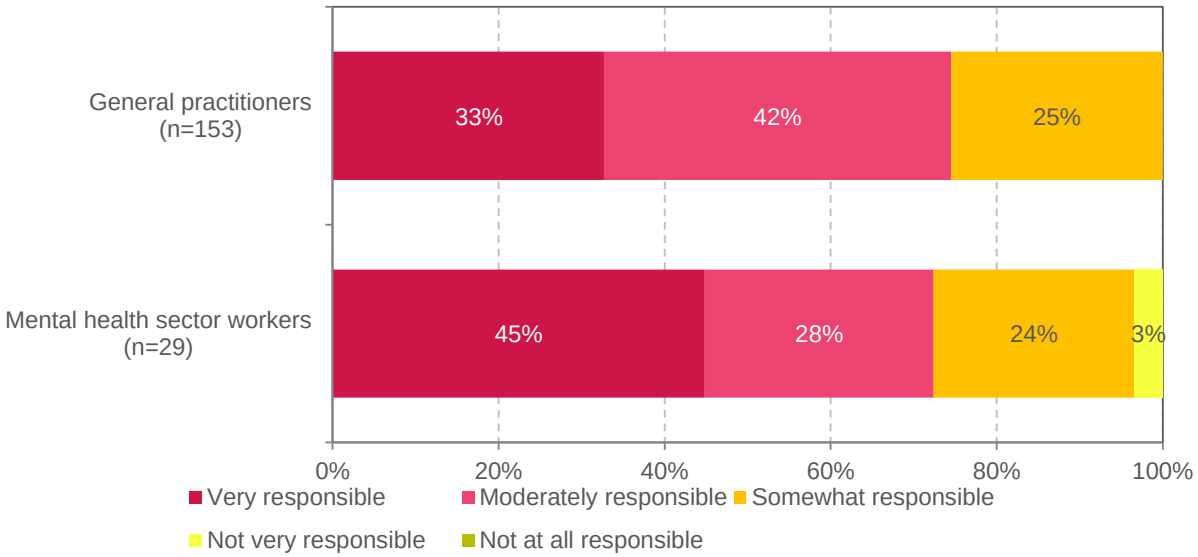
Attitudes towards people with alcohol dependence

Figure 12: To what extent are adverse life circumstances likely to be responsible for a person's problematic alcohol consumption?



Q8. For the following questions, please circle numbers on a scale of 0-10, where 0 is not at all, and 10 is very…
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 13: To what extent is an individual personally responsible for their problematic alcohol consumption?



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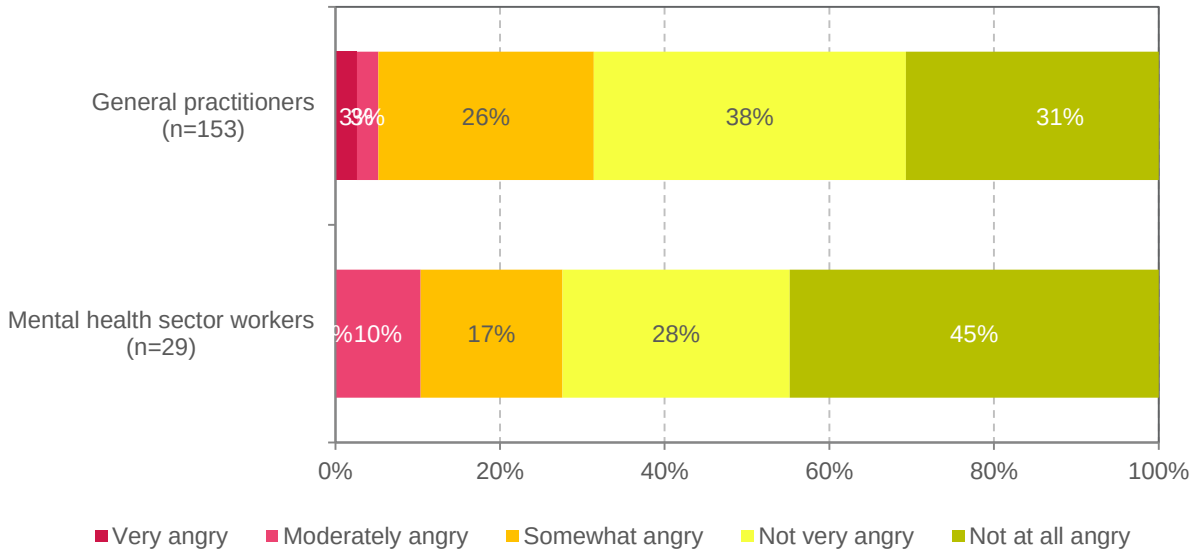
Note: Non-responses have been excluded from the chart

Figure 14: To what extent do you feel angry towards alcohol users?



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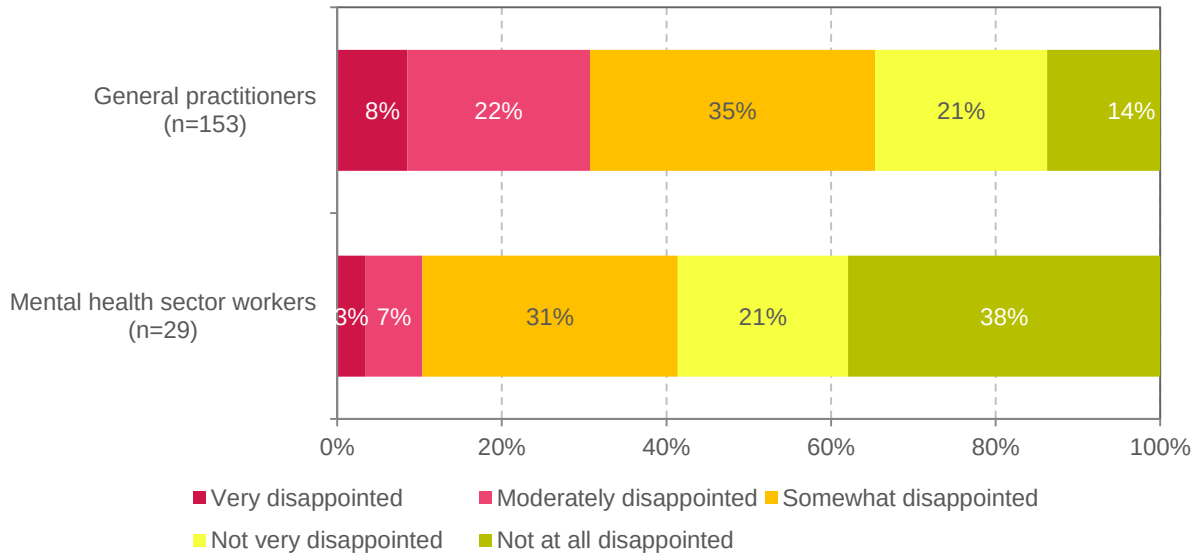
Note: Non-responses have been excluded from the chart

Figure 15: To what extent do you feel disappointed towards alcohol users?



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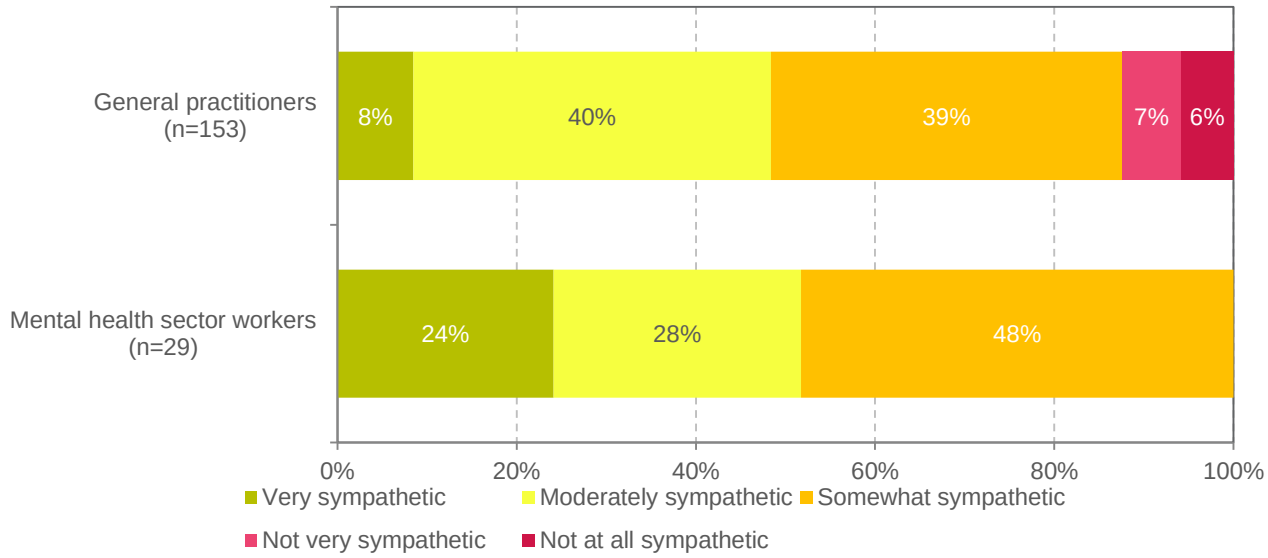
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 16: To what extent do you feel sympathetic towards alcohol users?



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Note: Non-responses have been excluded from the chart

Figure 17: To what extent do you feel concerned towards alcohol users?

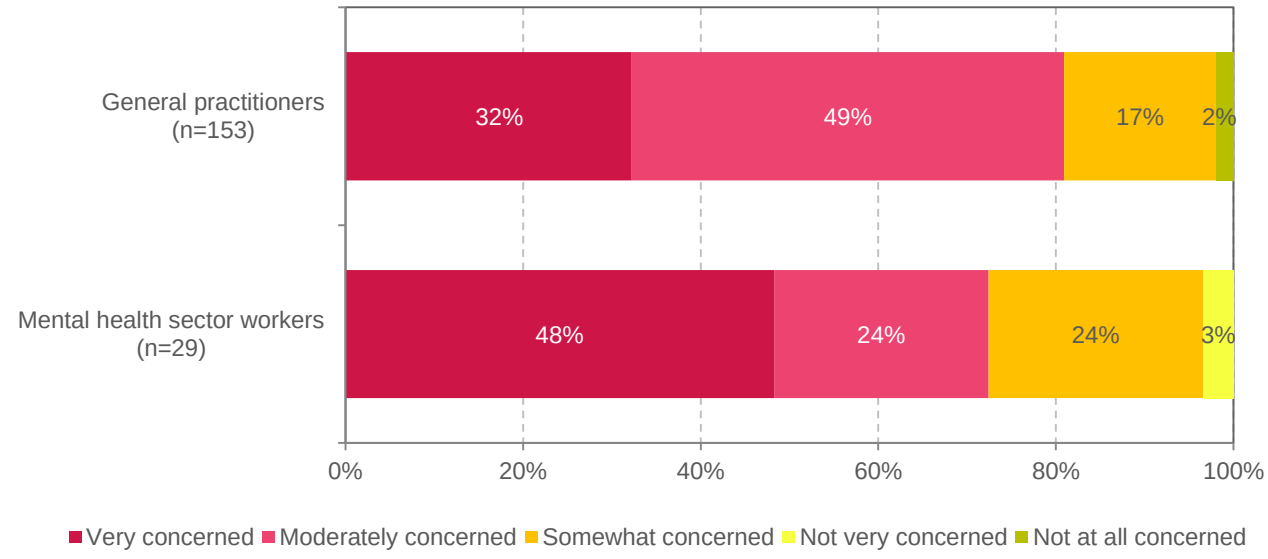

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Figure 18: To what extent do alcohol users deserve the same level of medical care as people who don't consume alcohol problematically?

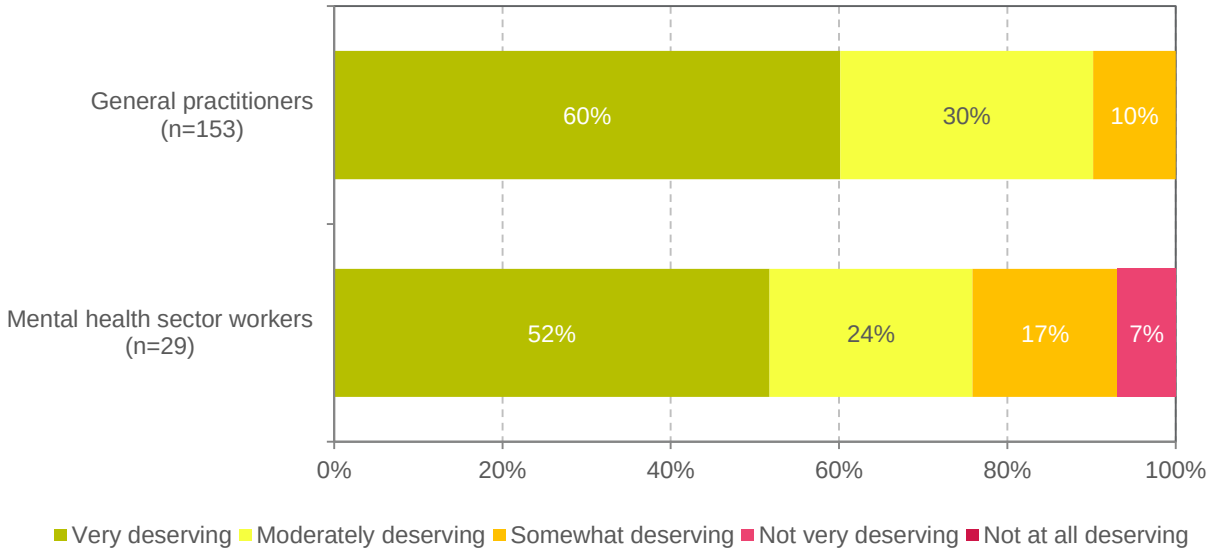

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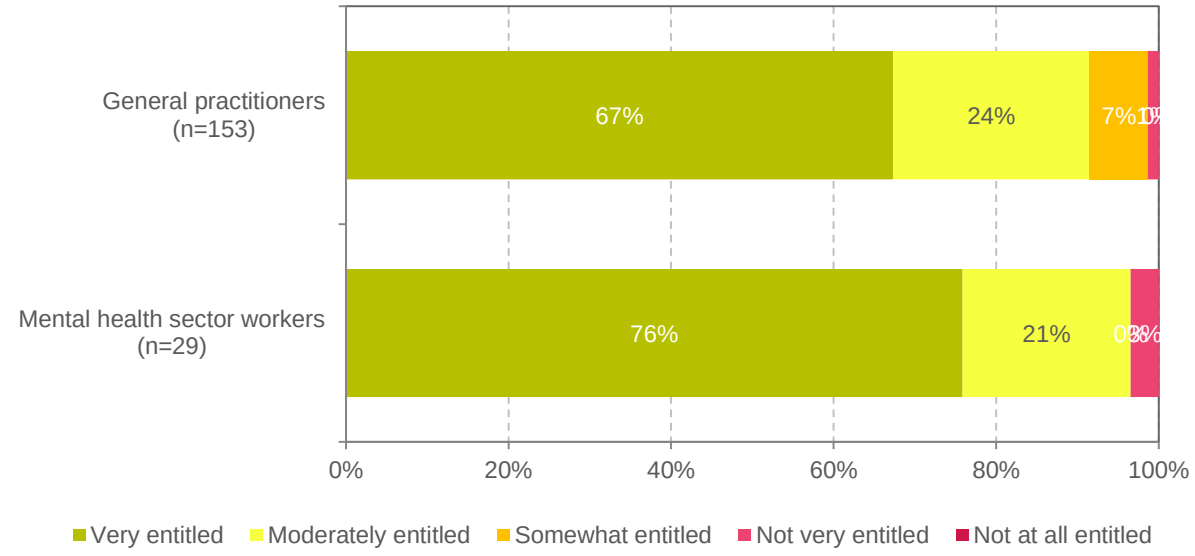
Figure 19: To what extent are alcohol users who have mental health issues entitled to the same level of mental health care as people with mental health issues who don't consume alcohol problematically?



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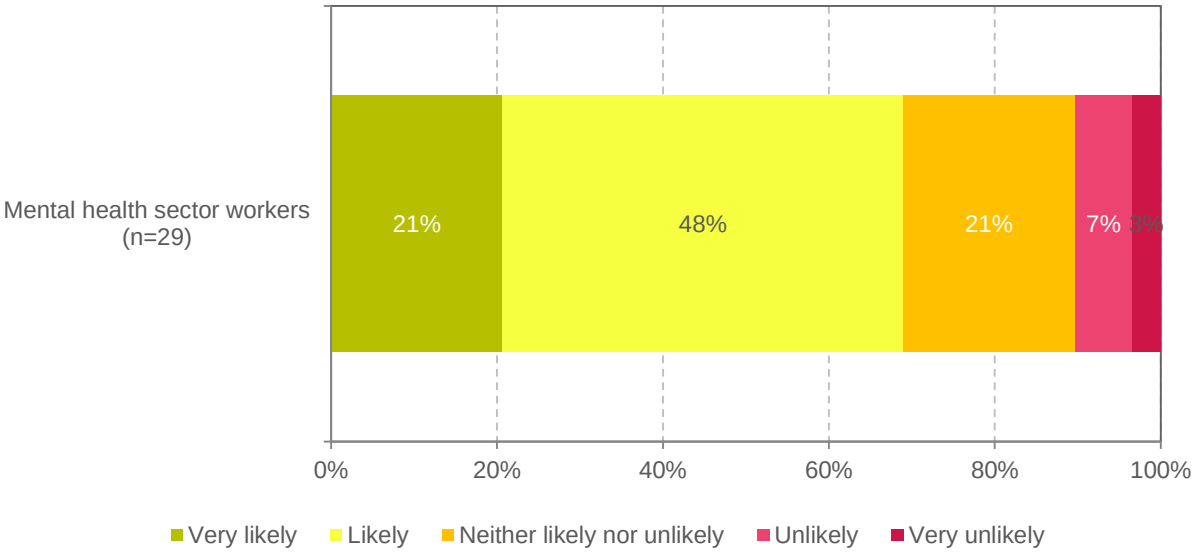
Note: Non-responses have been excluded from the chart

Figure 20: How likely do you think a successful mental health intervention outcome is for alcohol users with mental health problems?



Q8. For the following questions, please circle numbers on a scale of 0-10, where 0 is not at all, and 10 is very…
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Table 2: General practitioners' ranking of difficulties working with patients with alcohol dependency

	Ranked 1st	Ranked 2nd	Ranked 3rd
Patients who are dishonest about their alcohol use	18%	10%	6%
Patients who are referred to other services/professionals but do not follow through	17%	11%	17%
Patients who do not listen or follow advice	12%	19%	11%
Patients who are aggressive	10%	7%	3%
Patients who repeatedly fail to attend appointments	9%	14%	16%
Patients who present while under the influence	9%	13%	7%
Patients who request specific medications without a complete consult	7%	2%	4%
Consultations taking too long	5%	7%	7%
My experience working with patients with an alcohol dependency is limited	4%	3%	5%
Patients who are rude to staff at the clinic	1%	5%	7%
Patients who upset other patients in the waiting room	1%	1%	5%
Patients who are agitated	1%	4%	3%
Other	5%	3%	5%

Q3. What are the top three things that make it difficult to work with patients with alcohol dependency?
Base: General practitioners (n=153)
Note: Non-responses have been excluded from the chart

'Other' verbatim responses given by general practitioners comprised:

- Patients can be impulsive;
- Patients not having the self-worth/strength to make changes;
- When patients deny that their alcohol is a problem;
- Relapsing/Remitting nature of the illness;
- Their past life experiences and personality structure and family background;
- Patients often not wanting to change;
- Difficult long term issues;
- Coexisting mental illness;
- chronic problem, hard to improve;
- Lack of effective support services;
- Failure to respond to treatment;
- High levels of support socially needed for long term success, and medication dispensing is often not there, 2) recidivism, 3) frequent poor insight;
- Poor results for a long time until patients ready to change situation;
- Who do not consider alcohol a problem;
- Accepting their choice.

Table 3: Mental health sector workers' ranking of difficulties working with patients with alcohol dependency

	Ranked 1st	Ranked 2nd	Ranked 3rd
Consumers who present while under the influence	24%	7%	14%
Consumers who are dishonest about their alcohol use	17%	14%	17%
Consumers who are aggressive	17%	17%	7%
Consumers who are referred to other services/professionals but do not follow through	14%	17%	7%
My experience working with people with alcohol dependency is limited	7%	7%	7%
Consumers who are agitated	7%	7%	7%
Consumers who upset other consumers in the waiting room	3%	0%	0%
Consumers who are rude to staff at the clinic	3%	3%	0%
Consumers who repeatedly fail to attend appointments	3%	24%	28%
Consumers who do not listen or follow advice	0%	3%	10%
Other	3%	0%	3%

Q3. What are the top three things that make it difficult to work with patients with alcohol dependency?
Base: General practitioners (n=153)
Note: Non-responses have been excluded from the chart

No 'other' responses were recorded.

Treating people with alcohol dependence

General practitioners and mental health sector workers were both given a case study regarding a person with alcohol dependence. There were subsequently asked a series of questions afterwards regarding each of the possible provider responses below.

General practitioners

Kim has presented to a general practice clinic troubled by ongoing gastritis. Kim does not have an open file at the practice, but states that this has been a regular complaint (more than 4 times in the last 6 months). On close questioning, Kim reveals that he / she has engaged in regular excessive drinking sessions for the past 5 years. Kim is upset, and states he / she drinks heavily every day, and has been drinking heavily prior to this appointment.

Response A: The GP concludes the consultation early, telling Kim there are limited effective treatment options they can pursue, as he / she needs to seek assistance for the alcohol problem, and not drink prior to any subsequent appointments.

Response B: The GP concludes the consultation early, and gives Kim information on safe drinking levels, recommending Kim seek support from an alcohol support service before any subsequent appointments.

Response C: The GP gives Kim information on safe drinking levels and encourages him / her to make another appointment for an extended consultation so they can discuss Kim's history of alcohol use and how to best manage Kim's alcohol consumption.

Mental health sector workers

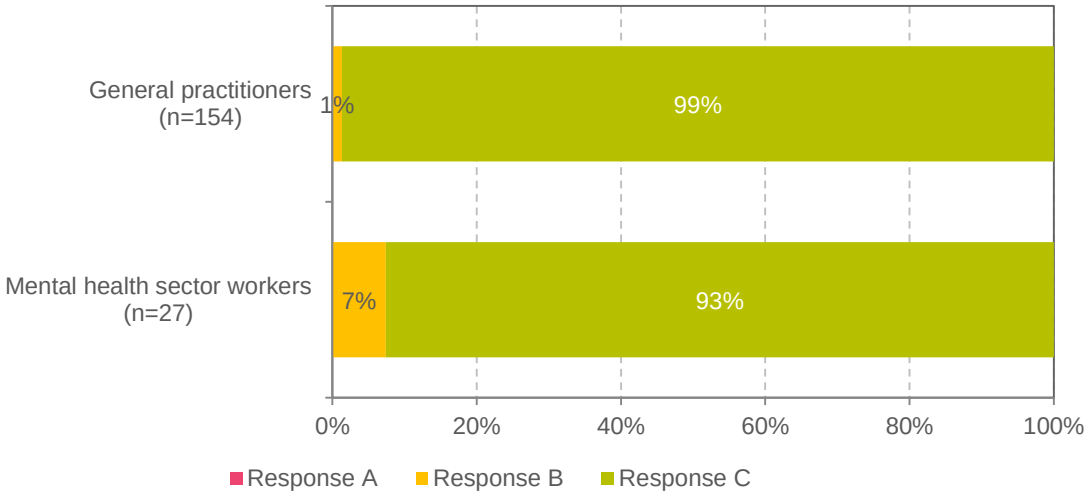
Kim has presented to a mental health service, with a past history of anxiety, depression and suicide. Kim also has a history of excessive alcohol consumption. Kim is upset, and states he / she drinks heavily every day, and has been drinking heavily prior to this appointment.

Response A: The mental health worker concludes the consultation early, telling Kim there are limited effective treatment options they can pursue, as he /she needs to seek assistance for the alcohol problem, and not drink prior to any subsequent appointments.

Response B: The mental health worker concludes the consultation early, and gives Kim information on safe drinking levels, recommending Kim seek support from an alcohol support service before any subsequent appointments.

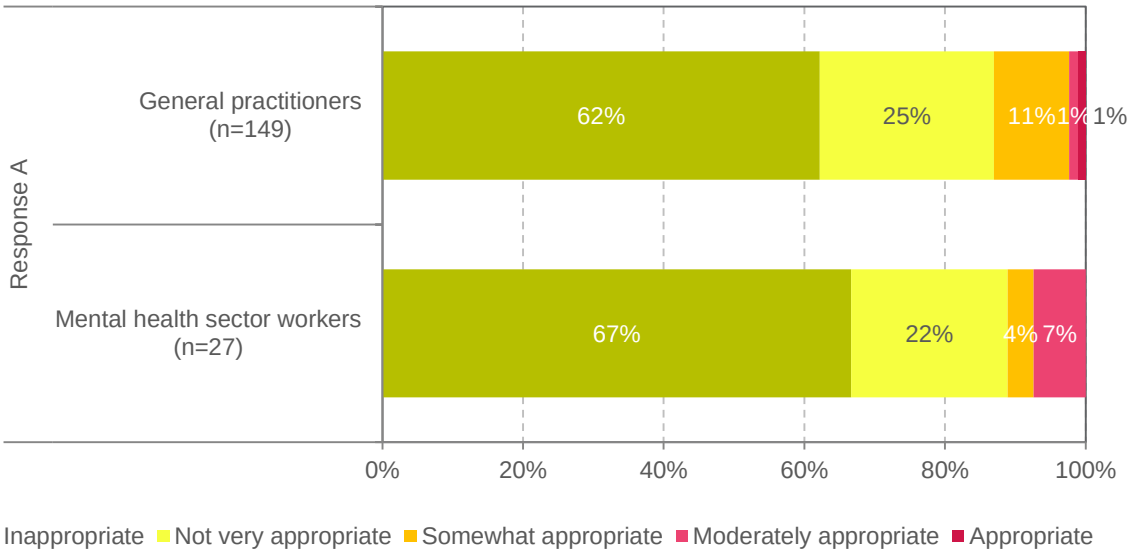
Response C: The mental health worker gives Kim information on safe drinking levels and encourages him / her to make another appointment for an extended consultation so they can discuss Kim's history of alcohol use and how to best manage Kim's alcohol consumption.

Figure 21: Likely response to presentation of patient with alcohol dependence



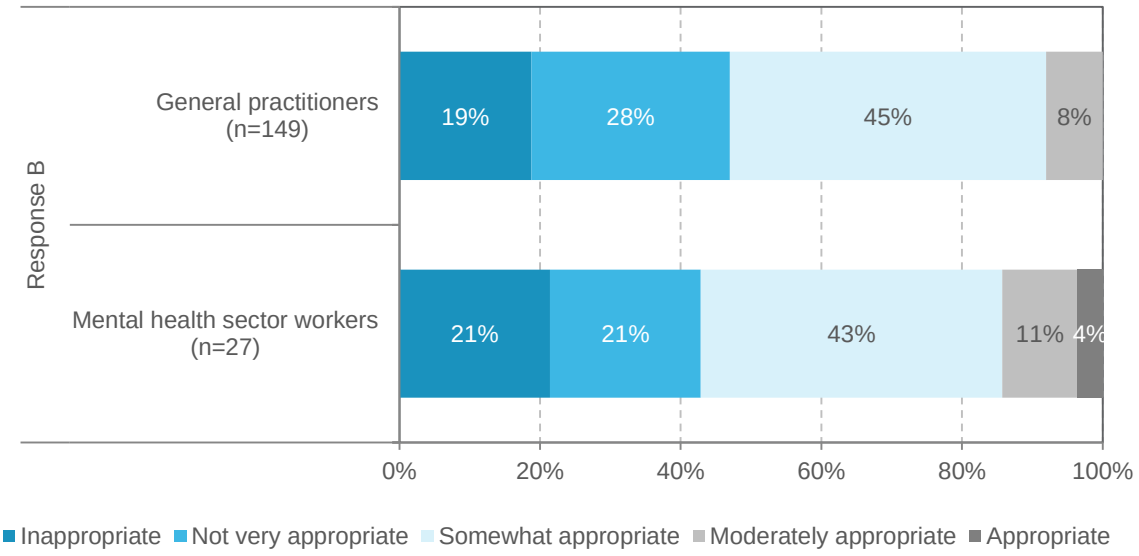
Q1a. Which of the following responses would you be most likely to give?
Base: General practitioners (N=154); mental health sector workers (n=27)
Note: Non-responses have been excluded from the chart

Figure 22: Perceived appropriateness of Response A



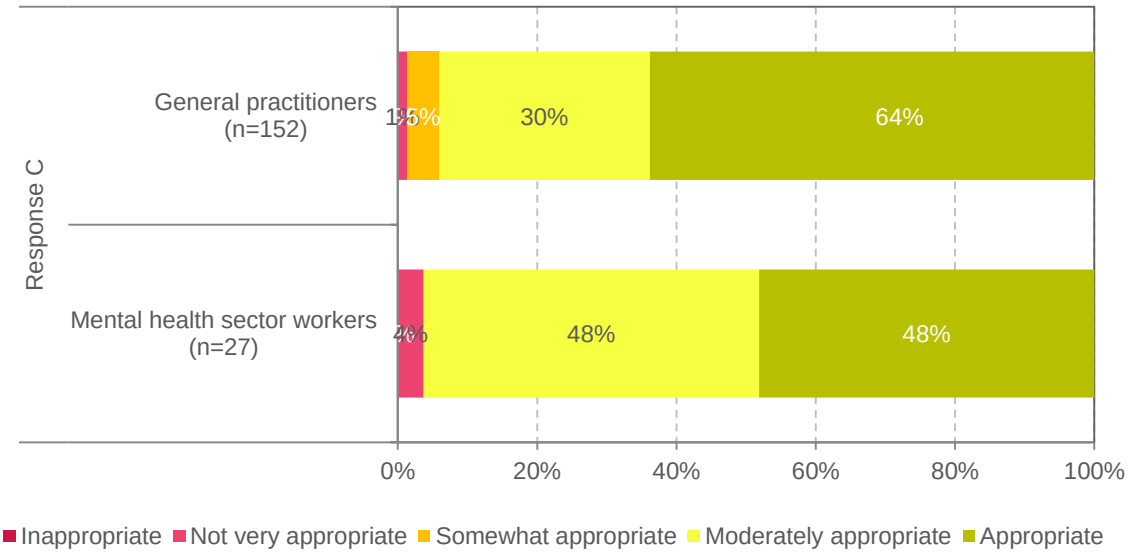
Q1b. On a scale of 0-10 where 0 is inappropriate and 10 is appropriate, how appropriate for Kim is:
Base: General practitioners (n=149); mental health sector workers (n=27)
Note: Non-responses have been excluded from the chart

Figure 23: Perceived appropriateness of Response B



Q1b. On a scale of 0-10 where 0 is inappropriate and 10 is appropriate, how appropriate for Kim is:
Base: General practitioners (n=149); mental health sector workers (n=27)
Note: Non-responses have been excluded from the chart

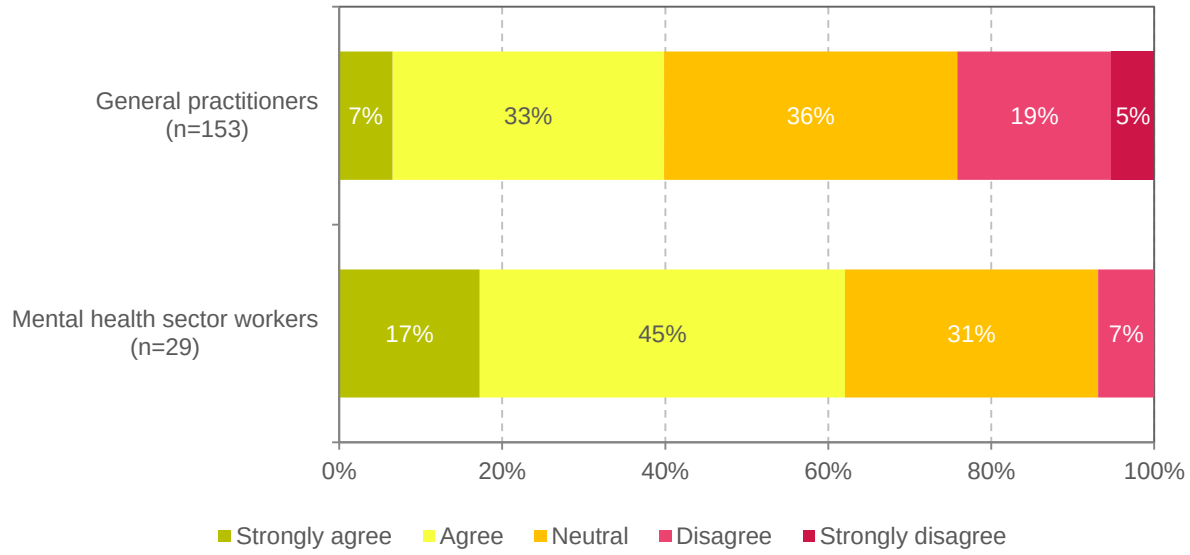
Figure 24: Perceived appropriateness of Response C



Q1b. On a scale of 0-10 where 0 is inappropriate and 10 is appropriate, how appropriate for Kim is:
Base: General practitioners (n=149); mental health sector workers (n=27)
Note: Non-responses have been excluded from the chart

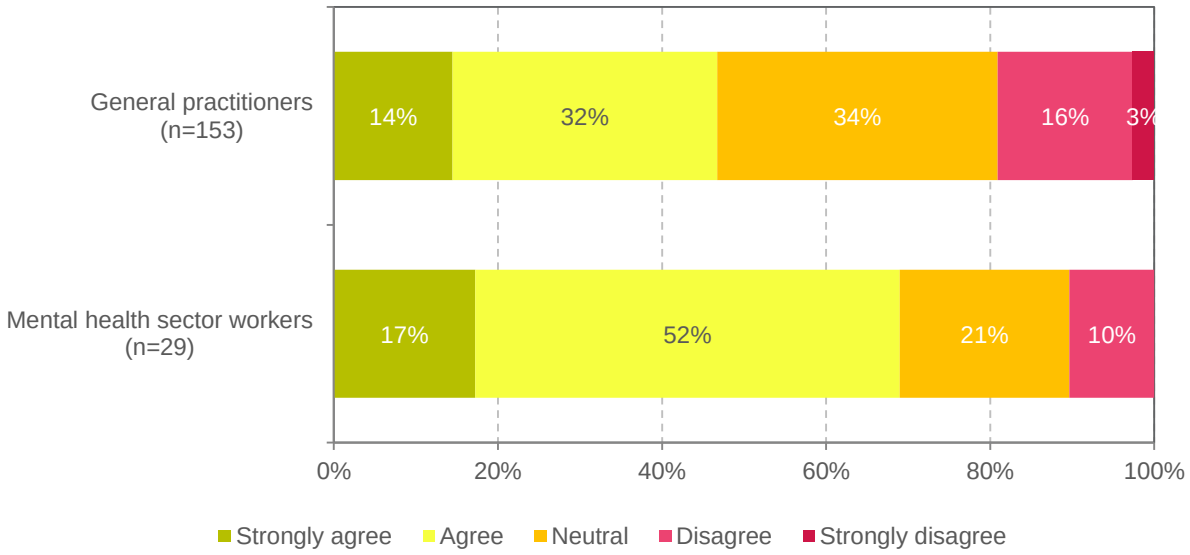
Working with people with drug dependence

Figure 25: I feel I know enough about causes of drug problems to carry out my role when working with drug users



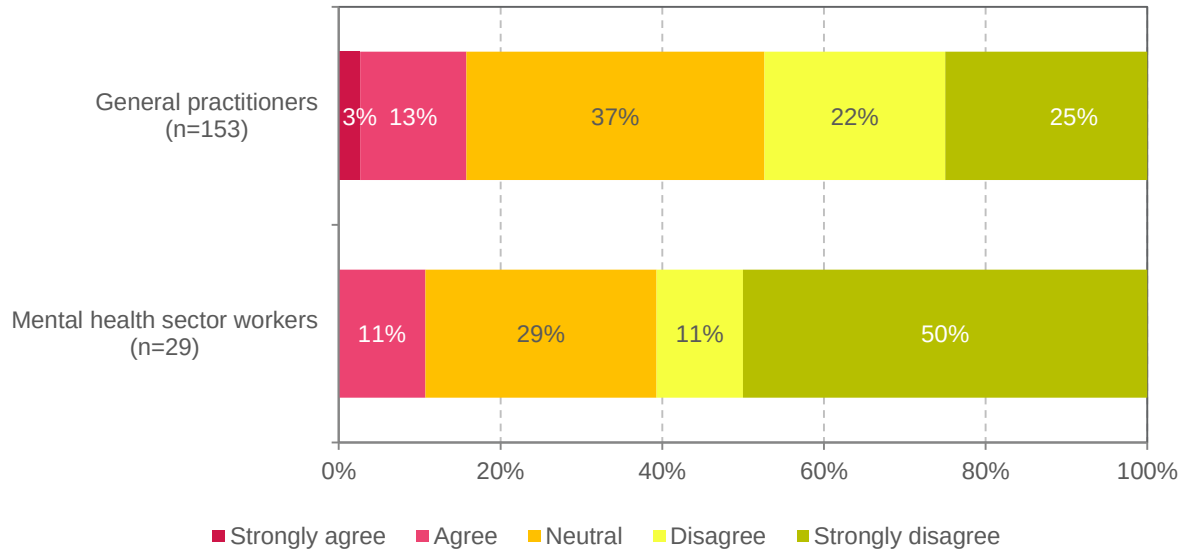
Q9. Please indicate your level of agreement with the following statements, using a scale of 0-10 where 0 is strongly disagree, and 10 is strongly agree:
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 26: I feel I can appropriately advise my patients/consumers about drug use and its effects



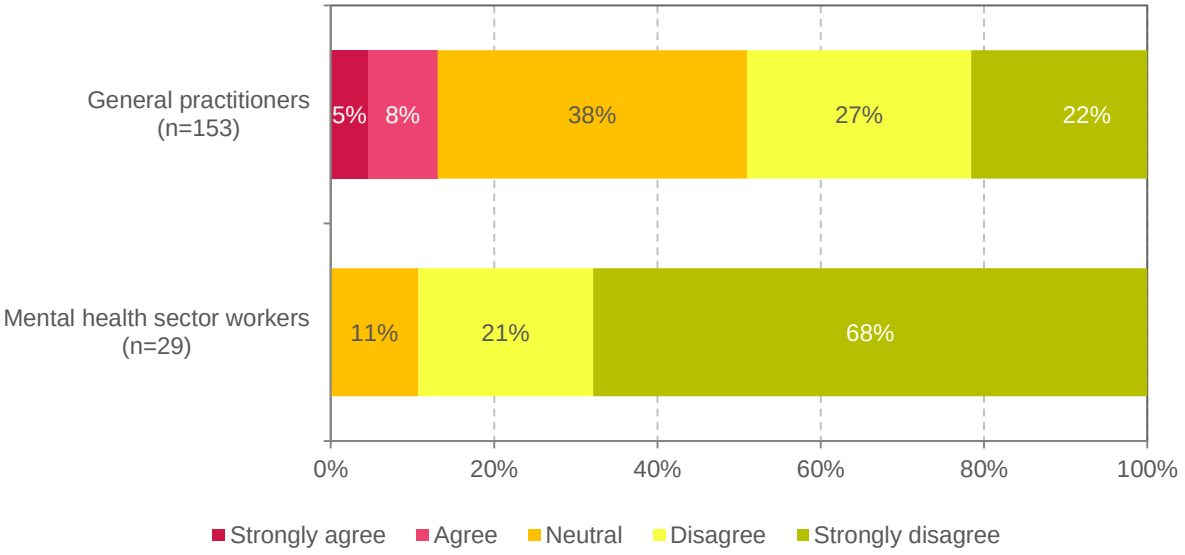
Q9. Please indicate your level of agreement with the following statements, using a scale of 0-10 where 0 is strongly disagree, and 10 is strongly agree:
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 27: I feel I do not have much to be proud of when working with drug users



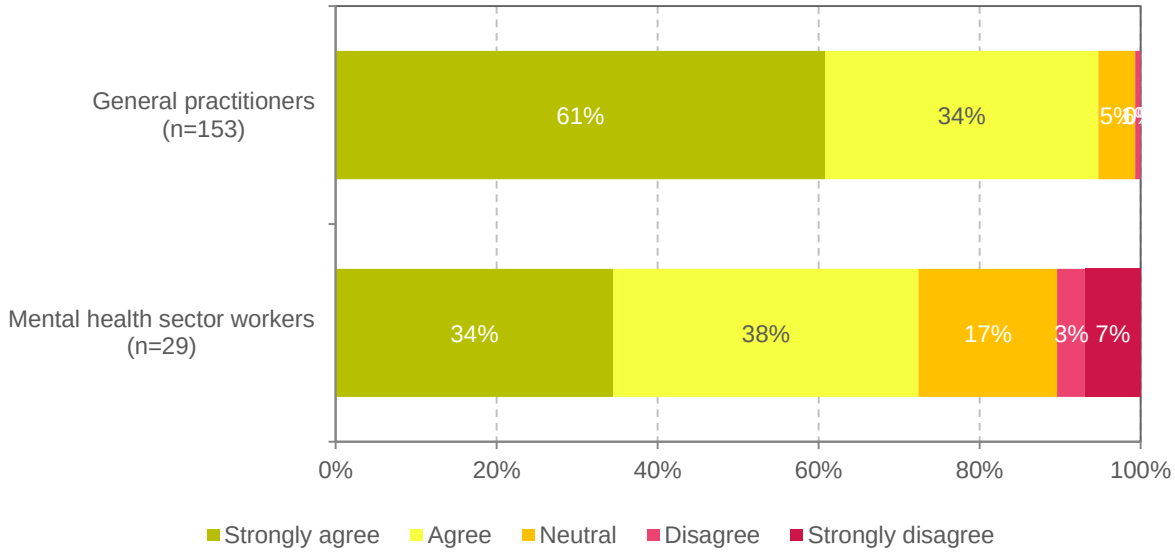
Q9. Please indicate your level of agreement with the following statements, using a scale of 0-10 where 0 is strongly disagree, and 10 is strongly agree:
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 28: Pessimism is the most realistic attitude to take towards drug users



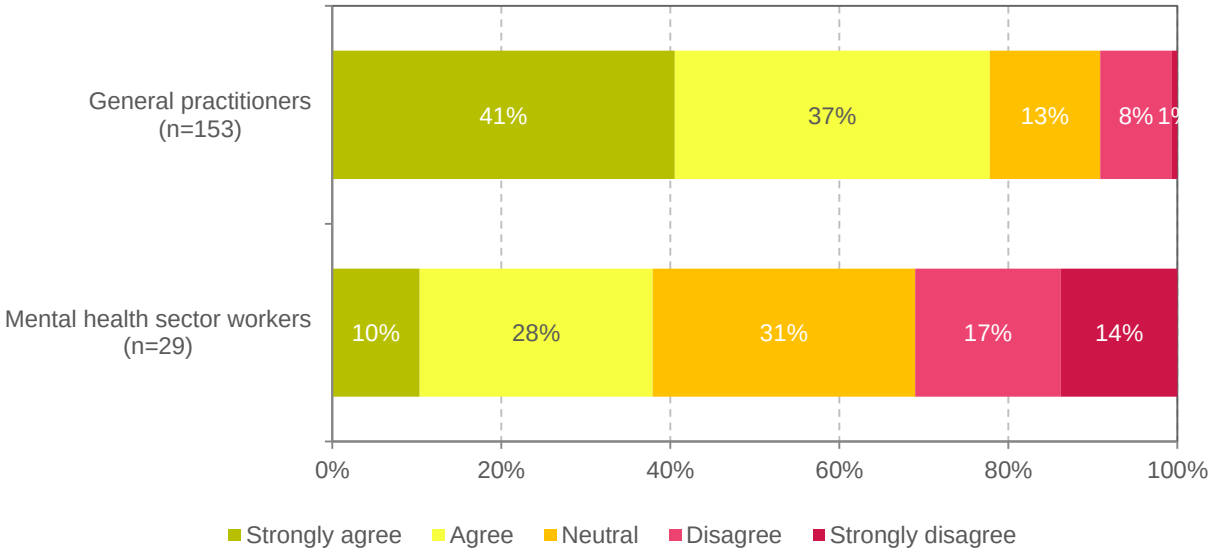
Q9. Please indicate your level of agreement with the following statements, using a scale of 0-10 where 0 is strongly disagree, and 10 is strongly agree:
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 29: I feel I have the right to ask patients/consumers questions about their drug use when necessary



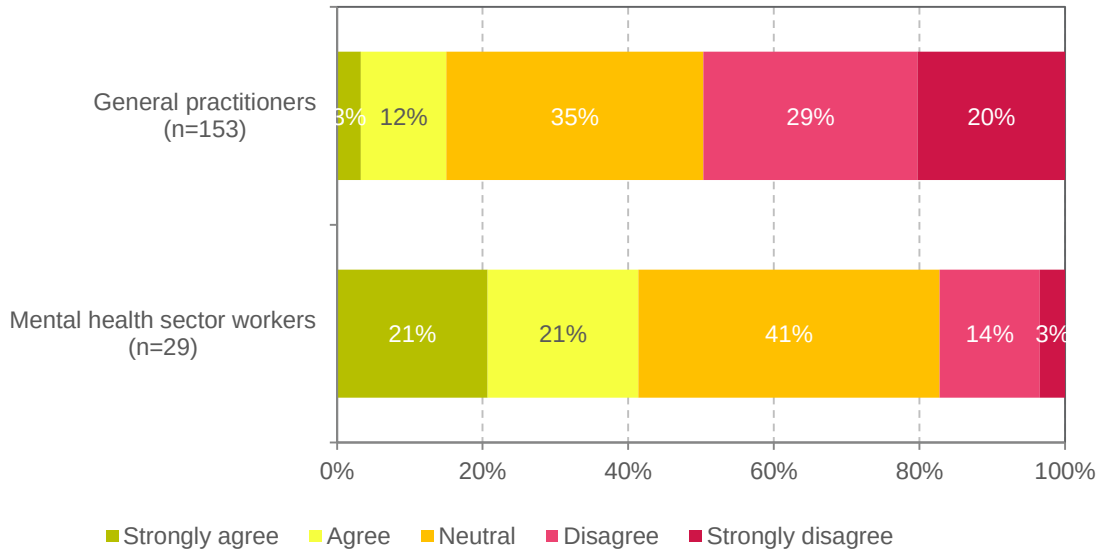
Q9. Please indicate your level of agreement with the following statements, using a scale of 0-10 where 0 is strongly disagree, and 10 is strongly agree:
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 30: I feel that patients/consumers believe I have the right to ask them questions about their drug use when necessary



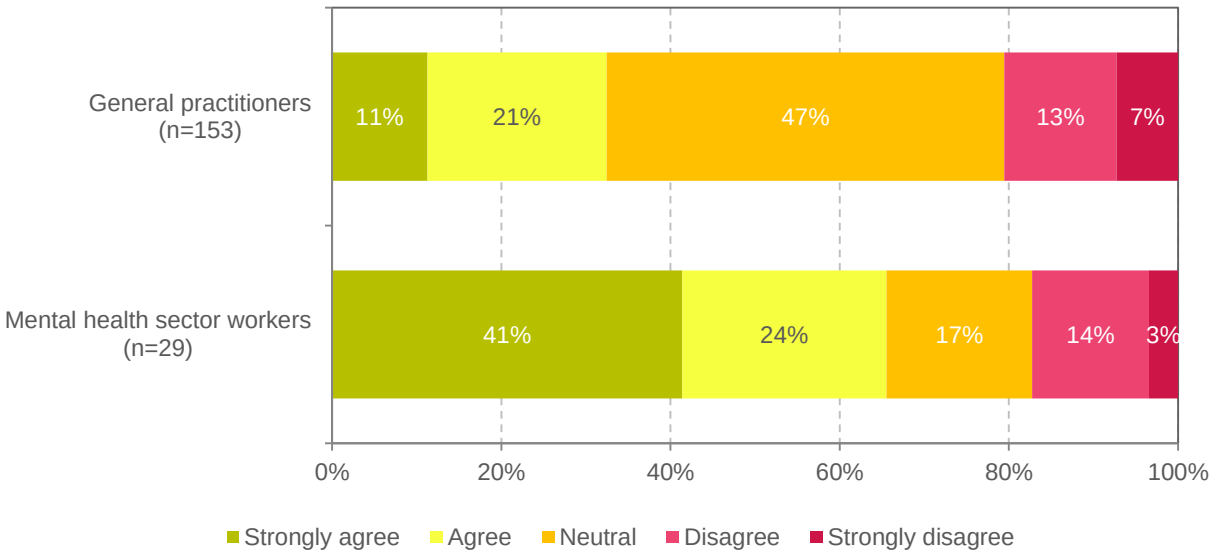
Q9. Please indicate your level of agreement with the following statements, using a scale of 0-10 where 0 is strongly disagree, and 10 is strongly agree:
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 31: In general, it is rewarding to work with drug users



Q9. Please indicate your level of agreement with the following statements, using a scale of 0-10 where 0 is strongly disagree, and 10 is strongly agree:
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 32: I feel my workplace supports me to do my role when working with drug users



Q9. Please indicate your level of agreement with the following statements, using a scale of 0-10 where 0 is strongly disagree, and 10 is strongly agree:
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Table 4: General practitioners' ranking of difficulties working with patients with drug dependency

	Ranked 1st	Ranked 2nd	Ranked 3rd
Patients who are dishonest about their drug use	27%	14%	12%
Patients who request a specific drug/series of drugs without a complete consult	15%	9%	7%
Patients who are aggressive	12%	13%	6%
My experience working with patients with a drug dependency is limited	10%	3%	4%
Patients who repeatedly fail to attend appointments	7%	9%	9%
Patients who do not listen or follow advice	7%	6%	8%
Patients who are referred to other services/professionals but do not follow through	7%	14%	24%
Patients who are rude to staff at the clinic	4%	5%	7%
Patients who present while under the influence	3%	7%	7%
Consultations taking too long	1%	4%	6%
Patients who are agitated	1%	5%	3%
Patients who think they know more about their health than health professionals	1%	8%	1%
Patients who upset other patients in the waiting room	0%	2%	3%
Other	5%	1%	3%

Q4. What are the top three things that make it difficult to work with patients with drug dependency?
Base: General practitioners (n=153)
Note: Non-responses have been excluded from the chart

'Other' responses included:

- Again limited capacity to make changes
- Relapsing/Remitting nature of addiction
- Patients who make excuse of losing/having medications stolen
- Life circumstances, family background, sexual abuse
- Patients not wanting to change behaviour
- Difficult long term issues
- Overuse despite plan
- Patients not sticking to opiate contracts. Lack of real time prescription data
- They try to manipulate you
- Failure to stay off drugs
- Patients bend the rules of the 'contract' then onject when drugs refused
- Using professionals as an alternative drug supply
- Drug users focus on thei habit not their health

Table 5: Mental health sector workers' ranking of difficulties working with patients with drug dependency

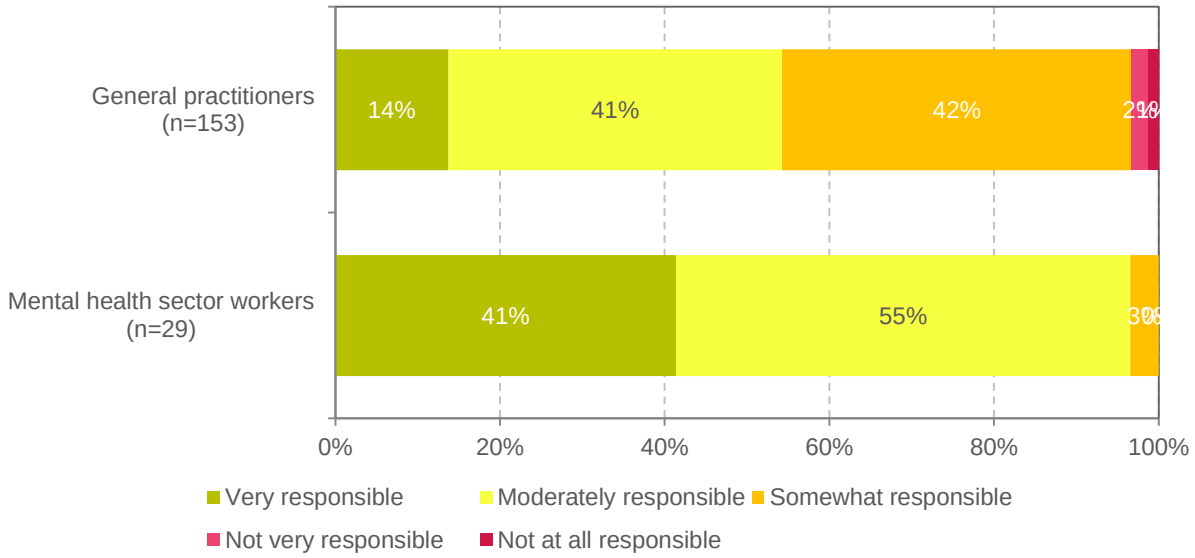
	Ranked 1st	Ranked 2nd	Ranked 3rd
Consumers who present while under the influence	31%	7%	14%
Consumers who are dishonest about their alcohol use	21%	10%	21%
Consumers who are referred to other services/professionals but do not follow through	14%	10%	10%
Consumers who are aggressive	10%	31%	10%
Consumers who repeatedly fail to attend appointments	7%	7%	38%
Consumers who do not listen or follow advice	3%	7%	0%
My experience working with people with drug dependency is limited	3%	7%	3%
Consumers who are agitated	3%	7%	3%
Consumers who upset other consumers in the waiting room	3%	0%	0%
Consumers who are rude to staff at the clinic	0%	10%	0%
Other	3%	3%	0%

Q4. What are the top three things that make it difficult to work with patients with drug dependency?
Base: General practitioners (n=153)
Note: Non-responses have been excluded from the chart

No 'other' responses were recorded.

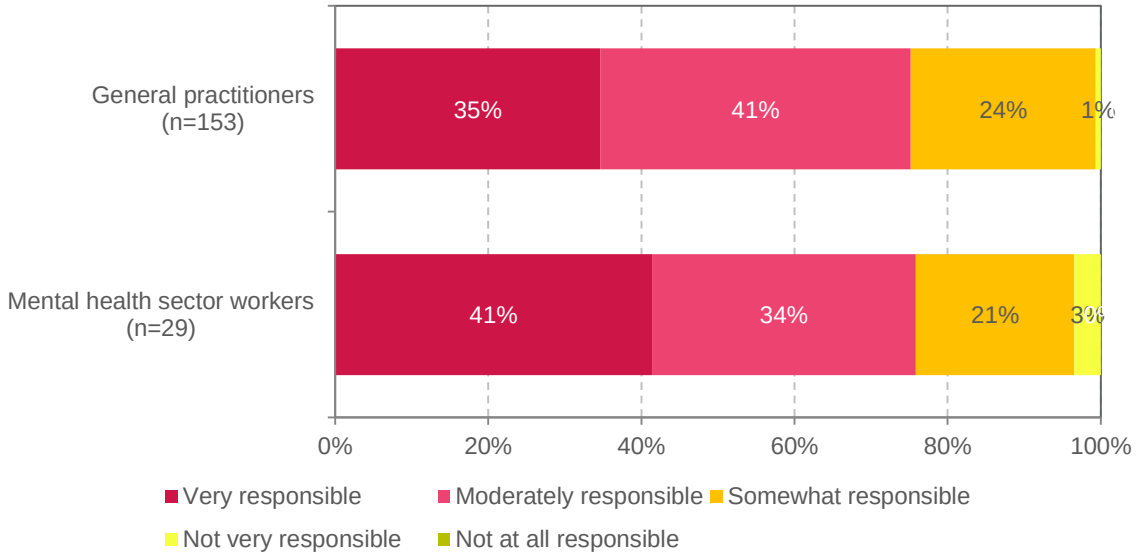
Attitudes towards people with drug dependence

Figure 33: To what extent are adverse life circumstances likely to be responsible for a person's problematic drug use?



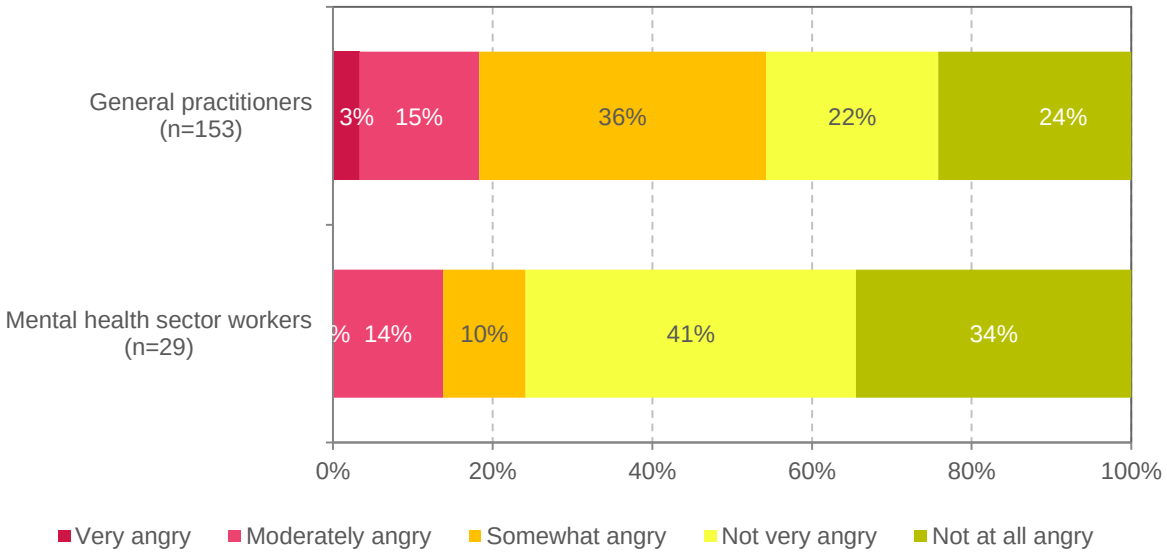
Q10. For the following questions, please circle numbers on a scale of 0-10, where 0 is not at all, and 10 is very…
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 34: To what extent is an individual personally responsible for their problematic drug use?



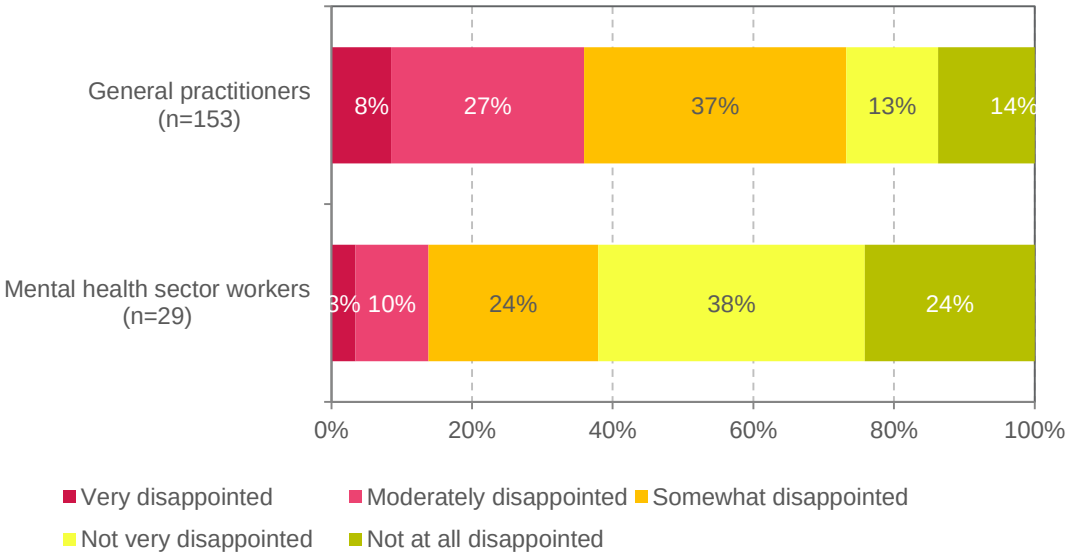
Q10. For the following questions, please circle numbers on a scale of 0-10, where 0 is not at all, and 10 is very…
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 35: To what extent do you feel angry towards drug users?



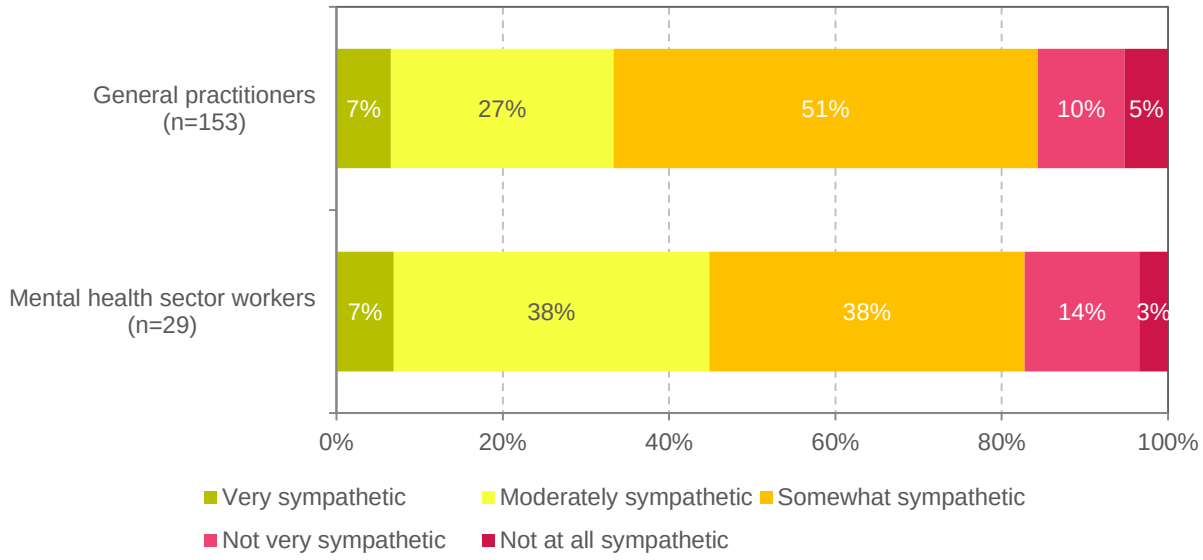
Q10. For the following questions, please circle numbers on a scale of 0-10, where 0 is not at all, and 10 is very…
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 36: To what extent do you feel disappointed towards drug users?



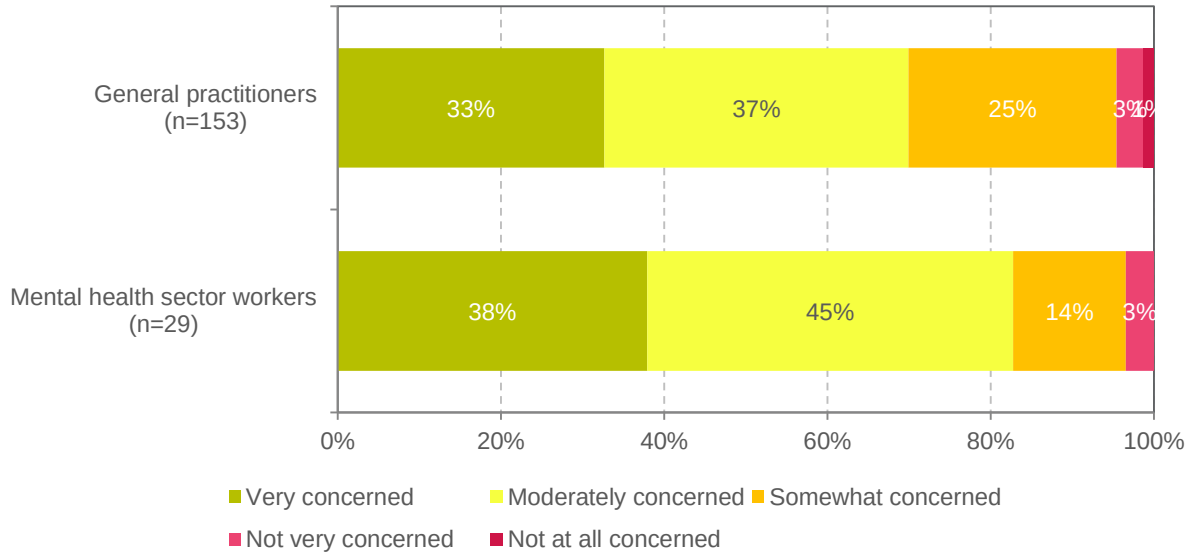
Q10. For the following questions, please circle numbers on a scale of 0-10, where 0 is not at all, and 10 is very…
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 37: To what extent do you feel sympathetic towards drug users?



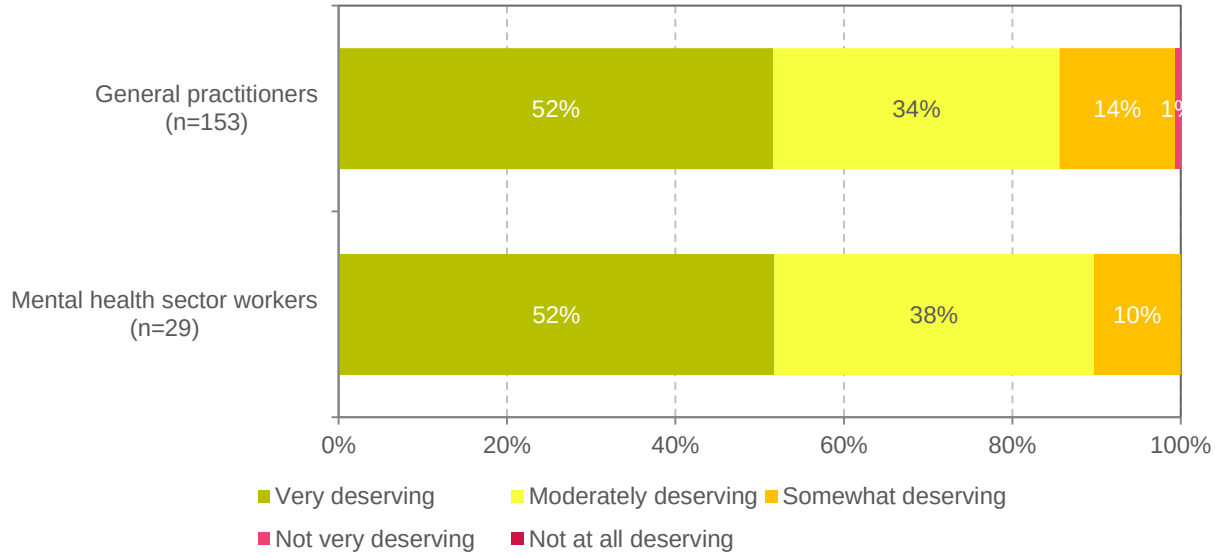
Q10. For the following questions, please circle numbers on a scale of 0-10, where 0 is not at all, and 10 is very…
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 38: To what extent do you feel concerned towards drug users?



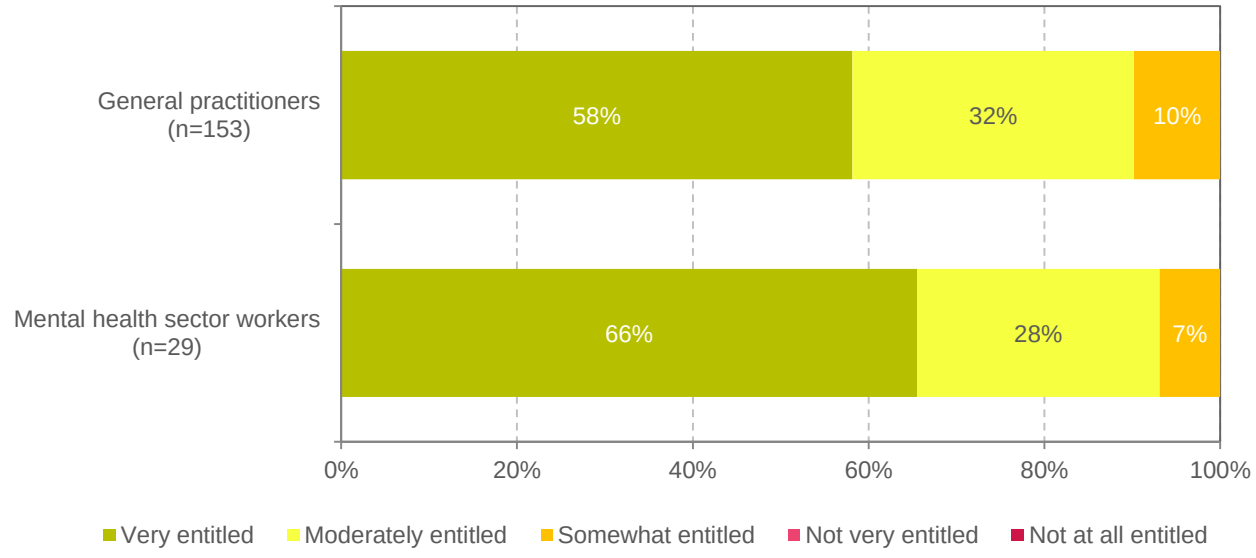
Q10. For the following questions, please circle numbers on a scale of 0-10, where 0 is not at all, and 10 is very…
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 39: To what extent do drug users deserve the same level of medical care as people who don't consume drugs problematically?



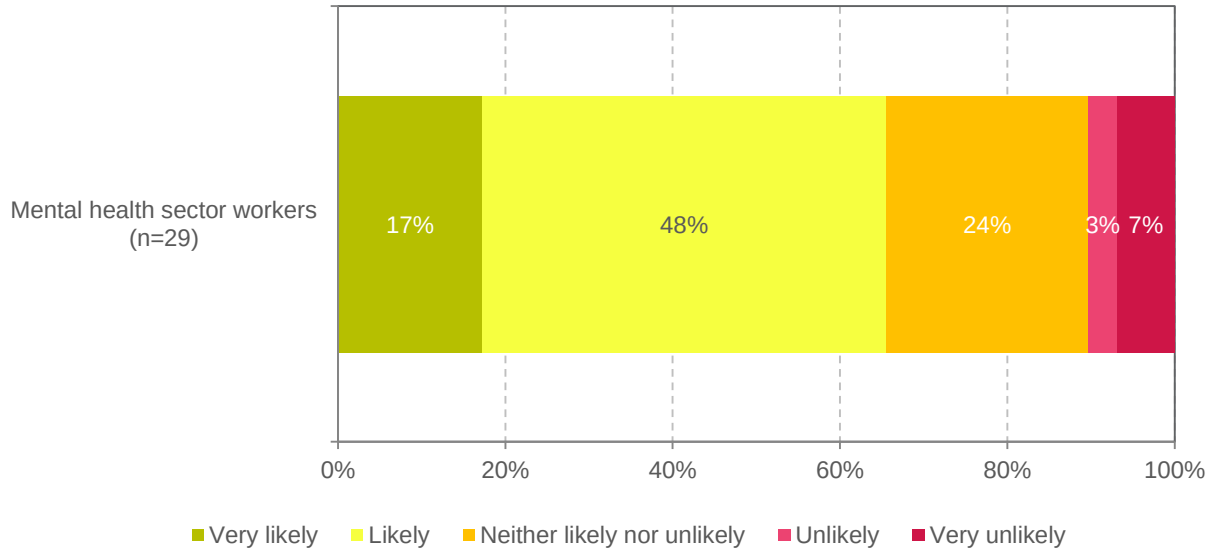
Q10. For the following questions, please circle numbers on a scale of 0-10, where 0 is not at all, and 10 is very…
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 40: To what extent are drug users who have mental health issues entitled to the same level of mental health care as people with mental health issues who don't consume drugs problematically?



Q10. For the following questions, please circle numbers on a scale of 0-10, where 0 is not at all, and 10 is very…
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Figure 41: How likely do you think a successful mental health intervention outcome is for drug users with mental health problems?



Q10. For the following questions, please circle numbers on a scale of 0-10, where 0 is not at all, and 10 is very…
Base: General practitioners (n=153); mental health sector workers (N=29)
Note: Non-responses have been excluded from the chart

Treating people with drug dependence

General practitioners and mental health sector workers were both given a case study regarding a person with drug dependence. There were subsequently asked a series of questions afterwards regarding each of the possible provider responses below.

General practitioners

Alex has presented to a general practice clinic, troubled by ongoing constipation. Alex does not have an open file at the practice, but states that this has been a regular complaint (more than 4 times in the last 6 months). Alex reveals that he / she has been a regular user of heroin over the past 5 years. Alex is upset and states he / she has used drugs prior to this appointment.

Response A: The GP concludes the consultation early, telling Alex there are limited effective treatment options they can pursue, as he / she needs to seek assistance for the drug problem, and not take drugs prior to any subsequent appointments.

Response B: The GP concludes the consultation early, and gives Alex information on safe injecting practices and replacement therapies, recommending Alex seek support from a drug support service before any subsequent appointments.

Response C: The GP gives Alex information on safe injecting practices and replacement therapies and encourages him / her to make another appointment for an extended consultation for the following day so they can discuss Alex's history of drug use and how to best manage Alex's heroin use.

Mental health sector workers

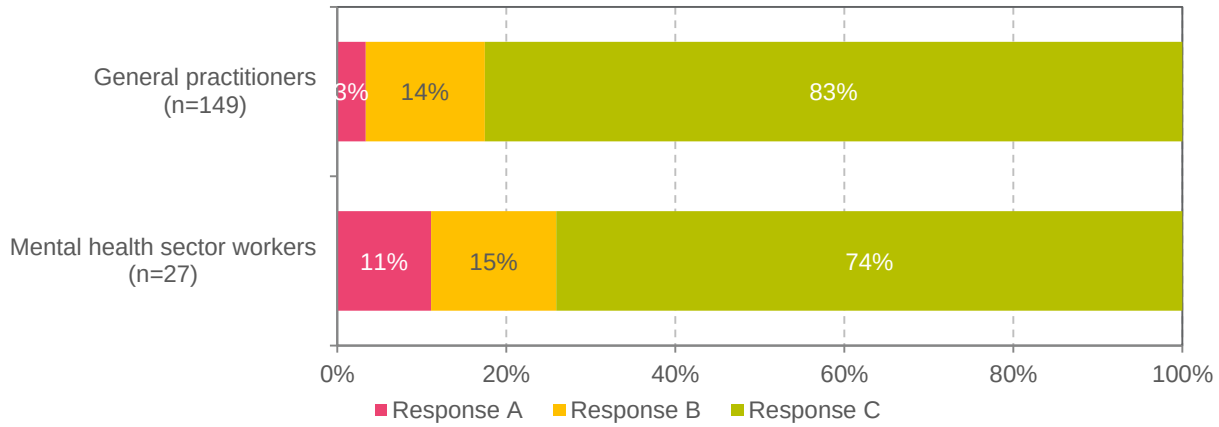
Alex has presented to a mental health service, with a past history of self-harm, hospitalisations for overdose and past use of benzodiazepines and 'ice'. Alex does not have an open file at the service. Alex is tearful, agitated and distracted, and states he / she is very anxious and feels paranoid. Alex is upset and states he / she has used drugs prior to this appointment.

Response A: The mental health worker concludes the consultation early, telling Alex there are limited effective treatment options they can pursue, as he / she needs to seek assistance for the drug problem, and not take drugs prior to any subsequent appointments.

Response B: The mental health worker concludes the consultation early, and gives Alex information on safe injecting practices and replacement therapies, recommending Alex seek support from a drug support service before any subsequent appointments.

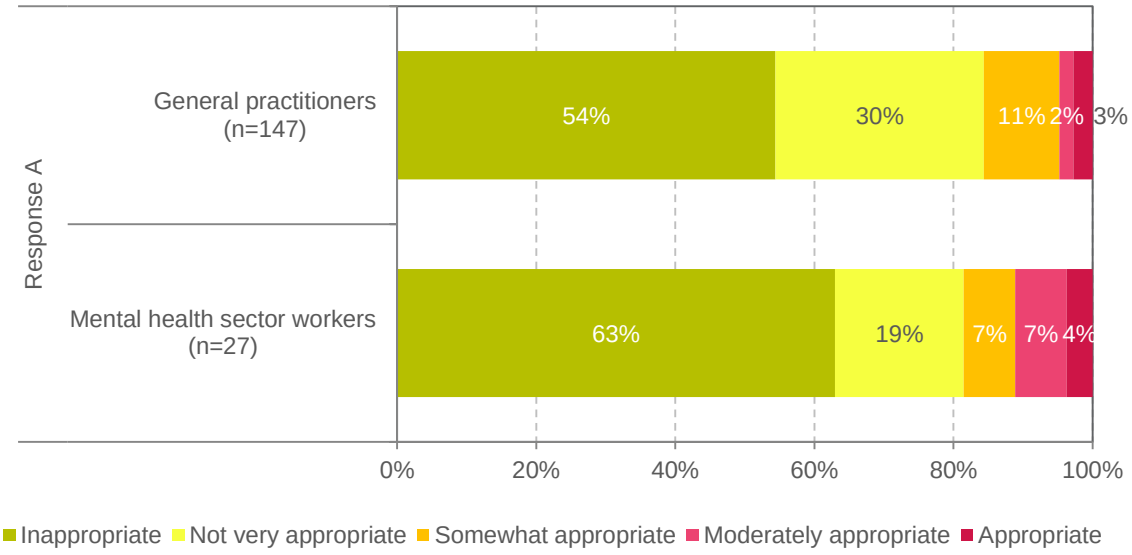
Response C: The mental health worker gives Alex information on safe drug practices and encourages him / her to make another appointment for an extended consultation so they can discuss Alex's drug history and how to best manage Alex's drug use.

Figure 42: Likely response to presentation of patient with drug dependence



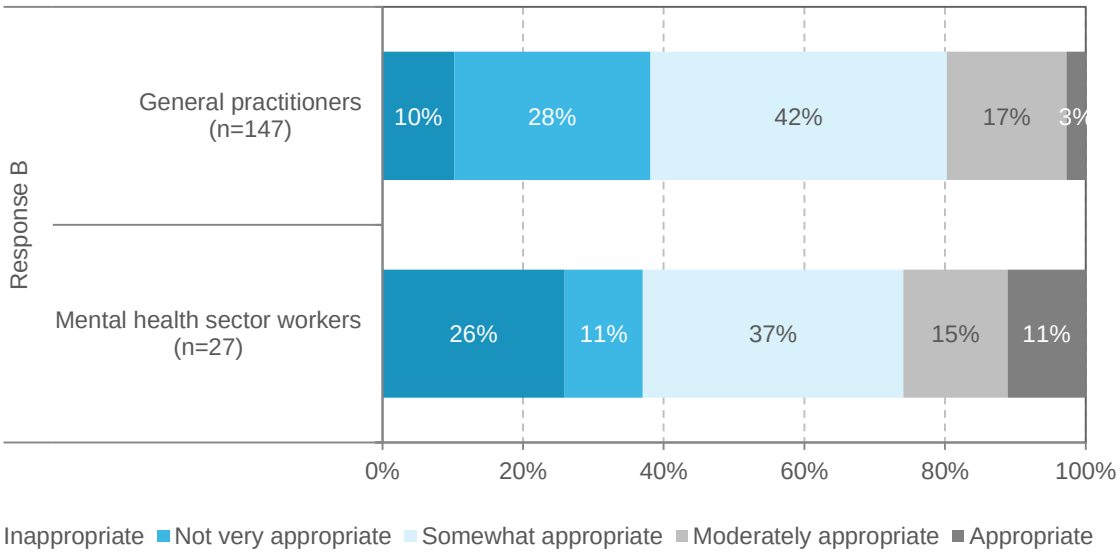
Q2a. Which of the following responses would you be most likely to give?
Base: General practitioners (N=149); mental health sector workers (n=27)
Note: Non-responses have been excluded from the chart

Figure 43: Perceived appropriateness of Response A



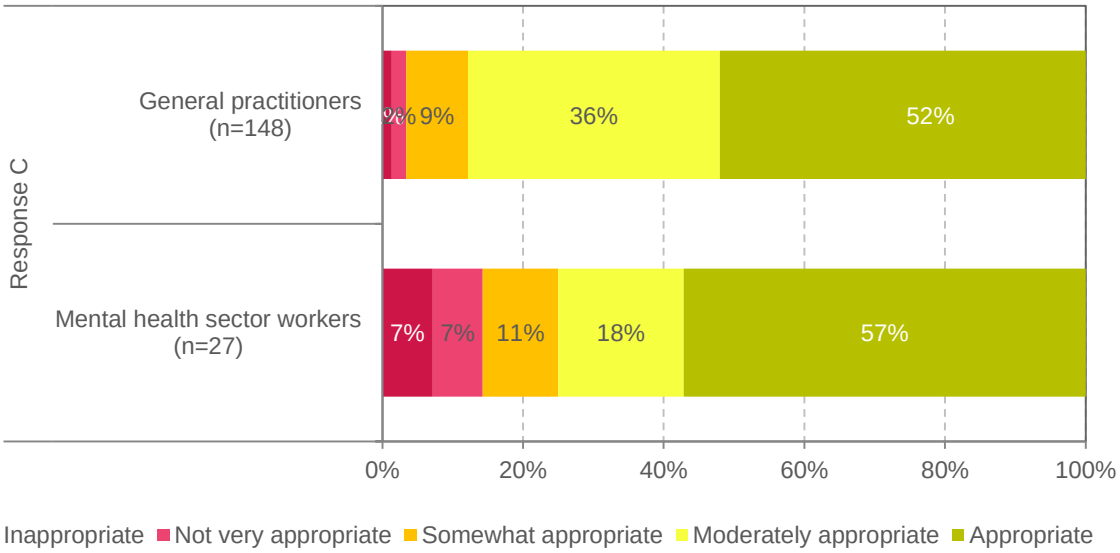
Q2b. On a scale of 0-10 where 0 is inappropriate and 10 is appropriate, how appropriate for Alex is: Base: General practitioners (n=149); mental health sector workers (n=27)
Note: Non-responses have been excluded from the chart

Figure 44: Perceived appropriateness of Response B



Q1b. On a scale of 0-10 where 0 is inappropriate and 10 is appropriate, how appropriate for Kim is:
Base: General practitioners (n=149); mental health sector workers (n=27)
Note: Non-responses have been excluded from the chart

Figure 45: Perceived appropriateness of Response C



Q1b. On a scale of 0-10 where 0 is inappropriate and 10 is appropriate, how appropriate for Kim is:
Base: General practitioners (n=149); mental health sector workers (n=27)
Note: Non-responses have been excluded from the chart

4. Verbatim responses

Rationale to responses for treating people with alcohol dependence

Table 6: GP response for Response B – alcohol

Also give advice how to contact alcohol service and give Rx for the gastritis

Table 7: GP responses for Response C – alcohol

My job is to try to help the patient
A proper approach
In order to make any in-roads, one must have a relationship with the patient and any successes will take time and multiple visits
The reality is that it would be "D" - try to deal with issue then and refer to alcohol service, look for depression as he/she won't come back
Common condition, needs our attention, can easy provide support
Longstanding problem, patient recognises it is a problem but has continued anyway, needs engagement and help to cut down
Kim disclosing his/her intake indicates a readiness for change
Gain initial rapport
Conveys that GP is keen to help address the problem in a more holistic way
Kim has discussed his/her drinking problem and had developed some rapport. He/She may not follow up to get help with unknown agencies without support from a trusted source
Empathy will develop relationship to explore and counsel
Appropriate counselling
To know what makes him to drink alcohol. To indicate the amt. that is safe to drink and the outcome of being an alcoholic
Build trust with patient, more time next consultation to discuss reason for use
This is a chronic ailment. Many co-existing issues
1) Do general physical in first consult, 2) then getting to know and social, physical aspect on his drinking
You as the GP need to provide the help but can only do it when the patient is sober
Am happy to do shared care/detox in consultation with drug and alcohol services, but not if patient does not engage with them first
Appropriate history talking - identifying underlying causes, depression, social issues, relationship, etc.
Kim wants to be helped and is requesting it
[INELIGIBLE]
I think response C is the most likely to be of help
Presence of physical side effect of alcohol abuse may be motivating to change behaviour. Keeping therapuetic relationship open/positive will encourage patient to return
Response A, and partly response B, both acknowledge the problem of drinking but "fob it off" as someone else's responsibility to treat; and don't help that much
Most effective to actually reach patient and built a common ground for further interventions
Need to ascertain reason for increased consumption - manage that and then address all other symptoms
Addiction is similar to many chronic lifestyle illnesses and Kim is entitled to appropriate care
Kim drinks heavily and needs to cut down or cease it. Also needs to explore why she drinks and other physical and mental stress/problems
More supportive, encourage plan of management
Explore more about drinking habit, duration, amount, triggers, before referring
Brief intervention initially, then follow up for further assessment and physical, then referral is appropriate
Need to engage the patient before make referral to a drug and alcohol counsellor. Need to assess risk
Supportive, Kim more likely to engage and return
Most appropriate to develop relationship with patient as intoxicated unable to make a current plan
Because it starts to address the problem she came with

He would need a referral anyway and long wait to be seen by the services and need to deal with this whilst motivation high
His/her drinking behaviour +/- associated mental health problem are clearly the main problem which need further review
There may be underlying issues to probe
Most likely to help patient I believe
Requires comprehensive history and exam. Needs supportive Rx and investigation until appropriate services involved
Kim presented with a physical symptom with a normal appointment. He/She has an underlying drinking problem and anxiety/depression. A blood test should be ordered and a longer appointment made soon
Long term difficult problem
She could be intoxicated and irrational at the consult, needs commitment to change
Actually none of these as we have a drug and alcohol support service on site and I routinely take the patient (walk them!) to these people to manage. However, of options given - C - as if I don't have ability to be able to manage immediately I would need to do a lot more myself (in time-poor GP practice)
Clearly needs and wants more help and requires more in depth time to find out why he is drinking so much and issues behind the obvious addiction
A difficult decision because I run the risk that he/she may not return. Ensuring I have gained his confidence Option C gives me the opportunity to develop strategies
Kim has acknowledged his unsafe alcohol practice and should be helped
Explore reasons behind excessive drinking, explore the health issues
Because of the way you structured my choices!
A) The patient is asking for help - has acknowledged he/she has a problem & has finally presented - a big step! B) the GP is expressing an interest in assisting the patients recovery
It takes time. Do some intervention and then spend more time
Kim has a problem - with xs alcohol causing a physical problem and affecting his/her health
Establish support and get further history and motivational interviewing
So patient feels you care and not just brush them off, also for further history
Best chance of establishing ongoing relationship
I would make at least one serious attempt to engage patient about his issues
Closing off early especially when patient has disclosed sensitive information and intoxicated may perceive being dismissed. Important to "roll with resistance" and acknowledge ambivalence to motivate the patient towards change
She needs additional/ongoing support to improve her health
It is important to make a good rapport with patient for ongoing followup and management
Build on rapport and allow them another chance
Making another appointment tells the patient you have acknowledged their problem and want to help them address it and give it the proper time and consideration with a long appointment
+ alcohol support services information if sober enough to understand
Important to engage with him, show him you are able to help, you care and have optimism about treatment you may be able to provide
Need time to consider properly: drinking, context
A & B are unsympathetic
Kim maybe in the pre-contemplative stage and ready to reduce drinking
To discuss drinking history in detail and organise future management plan
If the patient returns more likely to engage in positive management to change
1) I have never concluded a consultation early. 2) Ensure Kim is aware I will help - no rules - even just support through decision making
Most supportive response and best way to engage Kim in changing alcohol intake
There needs to be a discussion on why alcohol is being abused - i.e. the underlying cause
To maximise chances of good outcome
Because 1) I as a doctor is interested in this field, 2) A & B is used to fob patients off
Early conclusion unhelpful, will be delay in getting support service help
I view alcoholic excess as a symptom and would wish to pursue a proper diagnosis then treatment
Alcohol consumption which consistently results in soratic symptoms needs management. The patient is also acknowledging excessive alcohol which needs extra time to manage
Need a longer consult to start to tackle the underlying problem
Most honestly addresses Kim's problem. Leads to a supportive ongoing relationship
Needs follow up stat, may have a peptic ulcer, needs clinical investigation stat
Need followup, bloods 0 analyze, Ix for abdo pain - gastritis/scope, assess safely and discuss Mx options
I live in the country and alcohol support services are limited
Kim has presented asking for help and I am comfortable to provide care for gastritis, explore other issues in conjunction with alcohol support service

Duty of care, create relationship of trust
Limited information can be retained whilst intoxicated but patient still needs to engage in the process
Alcohol is a common problem
My role as GP is to help my patient (regardless of problem) to become healthier
She has revealed a drinking problem, suggesting she would like help. We need more time to assess and help her, thus the follow-up appointment also lets us know whether she wants to follow-through and seek help or not
Try to engage client, knowing it might not work
Presenting complaint re alcohol Kim appears to be seeking help + willing to engage in therapeutic relationship re alcohol use
It takes a lot of guts for Kim to go to the doctor and admit her problem in drinking abuse. I'll take time to listen too.
Alcohol is major issue here and cause of gastritis. Needs referral and more time
Consultations of this abuse are normally longer than a standard consult and to throw more of patient problems before referral
To engage Kim in management of alcohol dependency
P/G has been open about drinking issues. Pos ready to change. Has symptoms.
It is a more complete approach, the patient will know what is happening
Not appropriate to discuss in great detail treatment options with a drunk patient
Might be the only opportunity to make change for a while
Alcohol support services limited in my town. Would probably over admit to hospital to detox/patient ready
Because I feel I need to gain rapport with Kim and then enable further help.
Engage patient, develop rapport, with an aim to help the patient
Time constraints precents a â€¦ and referral to a detox centre. Need to explore reasons for alcoholism
Good opportunity for intervention
It is the most clinically appropriate
Need to initiate Mx while patient is present (may not come back)
Because this is the most likely response to get a positive result
Response that is most likely to help
She has revealed a problem and needs listening to in depth
He needs export long term Rx
I find the other two options for not lead to further patient contact
Need to develop rapport
Because Kim needs support for decrease alcohol drinking
More effective
To give opportunity to engage; Short term safe drinking advice; Follow up appointment to start long-term treatment and physical assessment
Build rapport
Alcohol use is heavy and now ?. Need to study, cut down and monitor safely. Also, need to further check lipids, DLS
Patient is new to the practice and presented for acute gastritis. It is important to build a relationship with the patient to get a commitment to any intervention which could not be done at consult
Needs follow-up, Attending follow-up shows commitment to getting help
Because the patient has approached you with concerns and a supportive GP can make a difference the patient may never quit drinking but it’s always worth a try
Kim needs assistance for her abuse of alcohol
These type of patients need help and close follow up
Gives patient a chance to engage further with treatment if that is perceived as needed
Counselling education options for management, patient motivation
This is an issue that needs addressing, the patient is upset and admits to heavy drinking so is likely to be willing to consider and accept help to change
If Kim does make the appointment it shows a potential readiness to change drinking behaviour
Appears disturbed, will need multiple appointments
Unless Kim is incoherent, he needs help and follow up
Kim may have a medical complication - oesophageal problem in addition to "gastritis" and needs medical treatment and management of the alcohol consumption
I feel GPs can impart on unhealthy patients lifestyle choices beneficially
Because I take time and action issues as they arise. May be only chance you get to engage patient
To test patients commitment
A positive BAC reduces the patient’s ability to understand or remember the discussion
Chronic long term problem, need ongoing good relationship to make any progress, referral, tests, motivation
I would add that he needs to sober at the next appointment
Would be most useful probably

Chronic problem. Needs immediate harm minimisation, investigate and examination of the root causes and excessive drinking
Clearly she has alcohol control/dependence issue which is effecting her health
Treat the gastro, approach, show a caring approach, and that we are genuinely interested in helping
The drinking may be a symptom rather than the disease which needs treatment
Opens the case for further Drs
Treat gastritis as an effect and alcohol as cause
Keep the door open. Maintain/Establish contact. Duty of care
Ascertain how motivated patient is to make changes
Need to get to 'know' the patient - social, physical, mental histories and investigation
He/she obviously needs help but can't talk effectively when patient affected by alcohol. Will need a lot of work and time to assess and discuss issues of why drinking excessively

Table 8: Mental health sector worker responses for Response B – alcohol

Kim has presented with alcohol being her priority - it would be best to have another appointment for her when she is sober
Presenting issue/immediate is alcohol consumption. To be able to further assist, I feel B was most appropriate

Table 9: Mental health sector worker responses for Response C – alcohol

Past mental health history and risk considerations - has been drinking and upset
Due to past history at mental health together with history of excessive alcohol consumption, Kim needs support, encouragement in extended care and assistance in the best ways to manage her addiction
I am confident in my ability to address both problems (mental health and AOD). The two should not be treated separately. They are one and the same
I have concerns that options not clear about risk management around suicide etc
Mental health worker would need to assess Kim's mood, because of past history, look at ways to connect with other services
Response C doesn't disengage with the person but gives them an opportunity for recovery within the same service
Because we need to use a holistic approach
I would advise Kim to come in for an appointment when she has not consumed alcohol, work out what time of day is better
To allow an opportunity for Kim to present sober and therefore achieve the best support service for Kim
Encourages engagement and help seeking
Takes time to encourage commitment to address issue there is less likelihood of increase in anxiety, depression and suicide
Provides direct support and options
Provides immediate support and makes a follow up appointment to gather information
This was the closest since I would like to assist Kim taking steps to address drinking levels rather than offer no support
As client has past suicidal thoughts, it would be good if further support is rendered. More in depth discussion is needed to identify causes of her behaviours and provide suitable and appropriate interventions. Possible referrals to specialised service could be arranged after the client has been stabilised
Kim probably self-medicates with alcohol. Need to assess what underlying issues require addressing
Good information on safe drinking levels and extended consultation would be beneficial for exploring with Kim how best to support him/her and how responsive Kim is willing to be
Recovery is unlikely without alcohol abuse being addressed and managed
Kim is obviously ignorant about safe drinking. Needs extended consultation when sober
To keep rapport and encourage further support and assistance for Kim
Mental health history and to discuss options to manage
If the client returned while not intoxicated I could help them by referring to appropriate places with good support (About recovery)
Cannot work with persons under the influence. Brief intervention included and subsequent appointment
If Kim has as 'pre-history of suicide' then should would be dead. If she had a history of 'suicidal behaviour', the response is C

Rationale to responses for treating people with alcohol dependence

Table 10: GP responses for Response A – drug dependence

I don't have enough knowledge re: heroin use
I don't know enough about heroin and safe injecting practices and I don't intend to learn
Poor program, poor compliance likely

Table 11: GP responses for Response B – drug dependence

I'd consider C, however I feel ill-equipped to deal with/treat heroin use
I don't feel I have adequate knowledge of illicit drug addiction to be the best person to manage Alex
I would not conclude the consultation early, but am not able to offer substitution therapies so extended consult likely not to be of value as onward referral (e.g. psychiatric) will not be accepted without drug services input
Good harm reducing strategies but prefer follow up with drug service. Note would like to invite patient back re: depression etc.
I have no experience in dealing with heroin addiction and would engage the help of a drug rehab service
Alex may need a team approach and follow up. This may be beyond the GP
Not much point me trying to make a difference. Patient needs specialised services
I have limited/no experience in treating heroin addicts
I don't feel equipped to tackle drug addiction - it needs a team of people with specialised knowledge
I do not regularly Rx heroin users. There is another GP up the road the Rx heroin users and prescribe methadone
I have very limited skill with assisting patients with drug issues
Giving supportive information
Not enough experience to with with drug related patients
He needs specialist drug support service management
Not enough experience to give counselling re managing heroin use
Specialised service required
I have had poor success with patients who have addiction to psychotropic drugs as it is difficult to devote time to addiction problems in our practice
I don't feel I have the resources to deal with heroin use
Specialist required
I'd consider C, however I feel ill-equipped to deal with/treat heroin use
I don't feel I have adequate knowledge of illicit drug addiction to be the best person to manage Alex
Specialist required

Table 12: GP responses for Response C – drugs

Same as above, however I am less competent in helping IV drug users
Proper approach to establish trust and rapport with patient
Again, trying to develop a relationship is the first step in treatment
Probably as above - try to deal with at that consult and run more behind
A) does not help Kim at all, B) gives some help and advice within limited time constraints, C) offers most advice and care
Ditto
No action will follow response A & B other than aggravation
As explained above
Need to get more history from patient, patient unlikely to engage 1st consultation and will need ongoing follow-up and support
This is difficult to treat - a lot of co-morbidities. Needs ongoing monitoring
Knowing treatment options and advising patient safely and appropriately
Alex needs help and is asking for it
Similar to above. Likely to need other health check also
Again, response A & B don't do enough. Patient needs to be walked through the process and educated about the options and his health

Most effective
Need to ensure safe needle to prevent complications which are avoidable
If Alex agreed to accept all advice then better to give him now and have proper long consult next time
cos C is way better than A & B!
To engage Alex and help him with his drug use
If try to change behaviour, need to engage. Need to support patient but not let him use or supply drugs of addiction
It opens the door for engagement with the health service
As above, I would give both these patients a long consultation immediately
Multiple issues to pursue
Patient is upset and there maybe something else going on
Treat his problem. Do blood test if needed. Need for more time to explore dependence and psychosocial issues
To discuss appropriate referral and give support
As above, none of these, but C best of options give. (We have a drug & alcohol support service on site and they normally see the patient same day) Developing rapport/engagement, understanding the patient problems is/are important in facilitating a good outcome, often there has been past abuse or there are psychiatric issues
He is upset and requesting help and unlikely to clean drugs immediately
As stated above, option C gives the opportunity to gain rapport with the patient and then on second appointment a complex treatment can be put in place
Same as Kim
Offer general medical, mental health issues
Because of the way you structured my choices
A) He/she may be asking for help rather than just there for his constipation, B) less judgemental, C) shows an interest in the patient
Again most appropriate but in honesty I don't always discuss safe injecting practices
C ideal but chances are Alex will not front up for another appointment as people with addictions are generally unreliable and do not want to control their problem
Best chance of establishing ongoing relationship
Alex now has presented indicating he wants to get treatment for constipation - a known side effect of opiates. Addressing and treating constipation provides the opportunity to address side effects of opiate use and other known harms
Alex needs additional support to improve health
1) find out more about social circumstances, 2) psychological support, 3) rapport with patient
Response A is rejection, Response B is passing on responsibility and Response C validates their attempt to get help
Same reason as for Q1a. However if the GP feels they are not equipped with the knowledge to deal with heroin addiction they should refer the patient on to someone who can
B->C; would not insist see support service, prefer to seeing me again
Important to establish rapport with Alex, show how urgent his care and treatment of his disease (heroin dependence) is for his overall health and safety
Best of 3 poor choices
Response A is plain wrong, Response B is not enough detail, and Response C is the right way to go about
Supportive response and encourages Alex's ongoing relationship with GP
If looking for best management then needs time for trust and relationship development for can direct appropriately
Response C is most likely to help Alex
Same as in Kim's situation
Don't close consult early, not appropriate, not to see patient before he/she seen by agency
I would like to explore co-morbidities and then get psychiatric assistance
Response A is poor engagement and false information, Response B is poor engagement, needs attention to somatic symptoms, response C is engaged, should begin Rx for gastric symptoms
Most honestly addresses Alex's problem. Rest - as Q1a
Depending on age, the change of bowel habit may need colonoscopy
Need to find out health , testing for HIV etc, options
Need to minimise harm and engage patient in ongoing therapeutic relationship
This is our job!
My goal is to help my patients be healthier, to encourage, to support, to use various strategies to help this patient more towards better health
Engage
As above, Alex is seeking help, willing to engage, presents with drug related symptoms
Same as above. It is hard for patients to seek help and admit their shortcomings and therefore important to give time to patients

To assist Alex to get clear of any drug dependency
Much more active to treat the problem and help the patient
A. doesn't engage patient, B. better than nothing, recognises time constraints, C. Allows exploration of underlying issues
The constipation may or may not be heroin related and still needs appropriate investigation. It's not clear if Alex is ready to consider alteration in drug use, but still needs respect/management regardless
As above - Rapport and safety and consider presenting complaint. Time to research options at return visit
Need to ensure safety of the patient. Need time to get his other health issues and needs in place
Good opportunity for prevention
It is the most clinically appropriate
Need to show interest or patient won't return. Patient came to see GP and not a drug rehab service
Most likely to help
Because it gives Alex more opportunity to involve with quitting drugs
Opportunity to engage; Short-term advice for safe drinking advice; Follow-up appointment for physical assessment and initiate long-term management
Build rapport
As above, need to see clients without substance use
This provides appropriate minimum care that would be expected in primary care
A) no support, no follow up B) no follow up, C) Needs soon appointment
Counselling education , patient motivation, assess risks, options
Patient is upset and requesting help, needs a long consult may not return but options should be offered
Same answer as above
Will need to see dry agencies and not be given narcotics or benzos but also to look at general health
Alex will need ongoing help over many years from experienced professionals
I feel that some information and reappointment is the best outcome
Need time to get background history, need time to see if patient is interested in replacement therapies
A) almost ok except gastritis needs to be addressed medically regardless of whether he is drinking. B) he requires review of gastritis
Would be best
Need to address acute and chronic aspects of the problem
He has a heroin addiction which needs to be addressed
Treat constipation and then discuss heroin problem and more time show care and interest
Duty of care. Establish contact
Discuss options, examine etc. I do methadone/suborone proscribing so and familiar with these tasks

Table 13: Mental health sector worker responses for Response A – drug dependence

Other responses not appropriate but response A also needs more help - seek immediate drug support - A&E?
Due to agitation and risk of escalation the consultation would be ceased but I would call in support or services to ensure Alex is okay

Table 14: Mental health sector worker responses for Response B – drug dependence

My own personal safety with users of ice. Evidence suggests that ice users are treatment resistant
Ongoing support for drugs addiction is an area that I feel is best worked with professional drug counsellor and for my own safety
As the client has no prior diagnosis of mental health, it would be best to encourage him to seek more appropriate services for his drug use. However, possible harm minimisation should be dispensed to ensure safety

Table 15: Mental health sector workers responses for Response C – drugs

Alex's current state
One to past and current mental issues, Alex needs support, encouragement and assistance to best manage his/her mental health issues and addictions
Sending Alex on his/her way without adequate support while he/she is obviously distressed is not appropriate. Also I believe mental health problems & AOD problems should be treated together

Concerns about risk of self-harm
Would use both of responses B & C
Those working in AOD have specialised knowledge to support people, however mental workers need to provide support so those with AOD issues are not pushed from one service to another
Encourage Alex to come the following day to access appropriate treatment. Ensure they have a safe place for the night
Encourages engagement. Other options don't support client to access help
No open file and attending appointment an indicator of wanting to get help for drug use problem
No wrong door and support
Same as answer to Q1a
Same response as in Q1A
Because that's the best possible scenario. Ideally it would be good to keep Alex around for a while and supervise because of past history
Unable to help Alex while drug use continues, however important to discuss and provide options and information
Alex requires awareness raising on safe drug use and side-effects
As with above, I would offer support to this client. What if they have no-one to go with them? What if they have history that is relevant?
The MH worker should still conduct an assessment, assess risk and possible issues and formulate a management plan
C would gain time to gain referral to service and also more history - clinical support would also need to be in place to further support

5. Sample profile

Figure 46: Sample profile

Demographics	General practitioners (N=154)	Mental health sector workers (N=29)
Age group		
25-34 years	7%	17%
35-54 years	51%	59%
55 years and over	42%	24%
Gender		
Male	48%	14%
Female	52%	86%
Time working		
In Australia	18.7 years	7.5 years
Overall	21.8 years	9.5 years
0-5 years	13%	41%
6-10 years	12%	24%
11-20 years	21%	24%
More than 20 years	54%	10%