Building workforce capacity to address substance use in primary health care: preliminary results from a mixed-methods pilot program

Matthew W. R. Stevens, Rowena Ivers, Joanne Telenta, and Robert L. Ali

ABSTRACT

Background. Primary health care is critical to the prevention of alcohol, tobacco and other drug-related harms. Scaling-up screening, brief intervention and referral to treatment (SBIRT) within primary health care can reduce the burden of substance-related diseases, and improve downstream healthcare services. Building knowledge, skills and confidence among general practitioners (GPs), particularly in rural, regional and remote areas, to deliver SBIRT is an essential step. Therefore, this study aimed to pilot test a skills-based training program for GPs designed to build capacity for SBIRT delivery. Methods. This pilot study investigated the acceptability of a structured, educational skills-based training program among GPs, as well as its preliminary effectiveness in inducing changes in confidence to deliver SBIRT, and in increasing knowledge about low-risk alcohol guidance. The training package was designed by experts in addiction medicine and public health, and involved a series of online webinars and in-person workshops at four locations across the South Eastern NSW Primary Healthcare Network catchment. Results. A total of 18 GPs registered for the training, with six completing the final webinar. The GPs who completed all sessions demonstrated increases in confidence to deliver SBIRT and alcohol guidance knowledge from baseline. Qualitative feedback found the program acceptable, and GPs were able to successfully implement learnings into practice, and promote to colleagues. Conclusions. The results indicated the potential of this program at a national level, but highlighted the need for a range of additional incentives to encourage uptake and ongoing implementation.

Keywords: alcohol, ASSIST, dependence, general practice, primary healthcare, rural medicine, SBIRT, secondary prevention, substance use.

Background

Primary health care plays a vital role in preventing and treating acute and chronic diseases, including addressing harms related to the use of alcohol, tobacco and other drugs (ATODs). In Australia, alcohol and illicit drugs account for 7% of the national burden of disease (AIHW 2020). Tobacco, alcohol and illicit drug use ranked first, sixth and ninth, respectively, among the top 10 avoidable risk factors associated with morbidity for 2019 (Murray et al. 2020). ATODs are associated with various adverse physical and mental health outcomes, including an increased risk of several chronic diseases and cancers (AIHW 2020). Addressing the severity of substance use disorders through sustainable, cost-effective, evidence-based approaches can reduce the impact of these problems. Screening, brief intervention and referral to treatment (SBIRT) offers a time- and cost-effective evidence-based public health approach designed to match symptom severity with treatment intensity (Babor et al. 2007).

In Australia, national evidence-based guidelines recommend that all general practitioners (GPs) conduct screening for alcohol, tobacco and illicit substance use (RACGP 2018). The guidelines also provide guidance on delivering a brief intervention. However, despite this guidance, ATOD use remains a significant public health issue in Australia. Nationally representative data show that a majority of Australians report regular alcohol...
consumption, and significant proportions also continue to smoke tobacco and/or use illicit drugs (AIHW 2020). Some individuals are consuming ATODs at hazardous or harmful levels, with recent data indicating that one-in-four report monthly binge drinking, one-in-nine smoke daily, and one-in-25 misuse prescription medication (AIHW 2020). Despite these patterns of use increasing the risk of harm to the individual, many of these people are unlikely to be dependent and, therefore, may not require specialist care to reduce their use. As 90% of Australians visit a primary health care clinic at least once per year (AIHW 2022), GPs offer an opportunity to identify at-risk individuals through targeted screening, while a brief psychosocial intervention can help to reduce hazardous and harmful use (Dutra et al. 2008; DiClemente et al. 2017). Screening may also identify individuals at risk of dependence, who may also require additional management, including pharmacotherapies, more intensive counselling or referral for addiction specialist care and treatment.

SBIRT delivered within primary health care settings has the potential to reduce the preventable burden of ATOD-related disease and facilitate treatment for those in need of further assistance (Babor et al. 2007; Agerwala and McCance-Katz 2012; Kaner et al. 2018). Furthermore, raising awareness among GPs regarding the current guidelines around low-risk alcohol consumption, recommended by the National Health and Medical Research Council (NHMRC; 2020), can increase rates of SBIRT delivery for alcohol use in primary health (Sturgiss et al. 2021). Given GPs are the first point of contact for many entering the healthcare system, prioritising awareness of current guidelines is necessary.

In addition to reducing preventable disease burden, SBIRT delivered within primary health care may positively impact downstream healthcare services. Previous studies have found that individuals with undiagnosed substance use disorders frequently attend primary healthcare services before seeking care from acute services or specialist mental health services (Goldbeck et al. 2012; Sara et al. 2017). Detection and intervention during the primary health care consultation may prevent the progression of many of these cases. A recent study at an Australian hospital emergency department found almost 40% of individuals attending the emergency department were screened as being at moderate risk for a single substance; pointing to a potential missed opportunity for SBIRT at prior settings (Stevens et al. 2022). Although this may be due to a variety of reasons, it highlights the importance of building capacity of the primary health care workforce to confidently and capably deliver a brief intervention for substance use disorders in terms of prevention of future harm.

Unfortunately, there are a number of barriers that impact the uptake and utilisation of SBIRT in primary health care settings. On one hand, knowledge and skills gaps limit the confidence of health care workers to the delivery of SBIRT for substance use disorders, including primary health care (Miller et al. 2001; O’Connor et al. 2011). These gaps may lead to avoidance of investigation during consultation, or may increase the likelihood of referral to specialist treatment service regardless of the severity of their substance use (Babor et al. 2007). Improving role clarity, and addressing perceptions of modifiability of substance use behaviours have the potential to increase the effectiveness of SBIRT implementation (Anderson et al. 2003; Ketterer et al. 2014).

On the other hand, however, knowledge-based interventions will often fail during implementation, because they do not adequately account for the structural barriers (e.g. time and resource pressures, lack of sufficient reimbursement, stigma and discrimination; Grol 1997; Grol and Grimshaw 2003; Fischer et al. 2016). Often it is the structural barriers that are the crucial determining factor to the success of an innovation. Therefore, it is imperative that knowledge-based interventions take this into account. However, this remains an ongoing challenge (RACGP 2023).

This study

The present study pilot tested an educational, skills-based training program for scaling up screening and brief interventions for ATODs in a general practice setting. The study employed a mixed methods approach to evaluate the program’s acceptability among GPs, and its preliminary effectiveness, with three specific aims. First, we aimed to assess whether training in SBIRT increased GPs’ confidence to apply this technique. Second, given alcohol is the most commonly used substance in the region (and, therefore, many patients will attend for issues potentially related to alcohol misuse), we also aimed to assess whether the delivery of information around NHMRC recommended low-risk alcohol guidelines raised awareness and confidence in communicating current advice. Finally, we aimed to assess qualitatively whether GPs had gained knowledge and insights around SBIRT delivery due to the training, and to understand the program’s acceptability to the target audience. Although not explicitly assessed, we also aimed to contribute to ongoing efforts in reducing the stigma and discrimination towards people who use alcohol and other drugs, as well as assessing the scalability of this program at a national level.

Methods

Participants and study design

This study employed a mixed-methods design, focused on identifying changes in knowledge and perceived confidence at the completion of an educational training program. The ‘training program’ described in a later section, was delivered as a series of professional development activities for GPs working within the Primary Healthcare Network (PHN) catchment area. The inclusion criteria for this study encompassed GPs currently practicing within the COORDINARE – South Eastern NSW PHN catchment area. Other non-GP health professionals, or GPs not working within the catchment
area, had the option to attend the training, but were not included in the analyses. This was done to ensure a consistent basis for comparison. Only one non-GP participant, a practice nurse who took part in the training, was excluded from the analysis. GPs who completed the entire program were compensated through the maximum allowable number (i.e. 40) of accredited professional development points by the Royal Australasian College of General Practitioners (RACGP). Recruitment occurred through direct advertising on the PHN’s website and newsletters. GPs were able to participate in the training without being enrolled in the data collection aspect of the study. Nevertheless, all participants who signed up to the training agreed to be enrolled in the study. This project was approved by the University of Adelaide Human Research Ethics Committee (Approval number 22/67) in July 2022.

**Expert advisory group**

Prior to development of the program, an expert advisory group consisting of GPs working within the PHN catchment was established. This process involved engaging PHN staff, including those coordinating alcohol and other drug projects, and a number of regional health coordination consultants, and five local GPs with knowledge and experience in ATOD prevention/management. Subsequent contact was made with all GPs, and four agreed to form an expert advisory group. Their clinical practices were spread throughout the South Eastern NSW PHN catchment. The group helped prioritise training delivery by identifying key locations for the training. They also advised on logistics related to delivery and resource development, and one of the GPs facilitated the accreditation process with the RACGP to receive the maximum allocation of accredited professional development points.

**Training program**

The training program was developed by an experienced clinician and specialist in addiction medicine (RA), and involved a hybrid of online webinars and in-person skills workshops. The total training time was 6 hours, staggered across three sessions; including an introductory webinar (90 min), a face-to-face skills-based workshop (180 min) and a follow-up webinar (90 min).

**Introductory webinar**

The introductory webinar aimed to encourage sign-up for the full in-person training program by providing information around substance use disorders and their management in primary health care settings. The webinar was partitioned into two sections, with the first section providing an overview of the current level of substance use within South Eastern NSW PHN, and outlining the risks and harms associated with various patterns of use. The remaining section focused on a discussion of the evidence for the effectiveness of SBIRT as a prevention and early intervention strategy. Discussion also involved identifying current knowledge and awareness of the current NHMRC low-risk alcohol guidelines. Two instances of the introductory webinar were held live, on separate mid-week evenings, 6 days apart. This was designed to mitigate the risk of low turnout due to scheduling conflicts. Both sessions were also recorded, with a link to view the recording provided to all participants for the purposes of review a later date.

**In-person workshops**

The in-person workshop was the core component of the training program. The face-to-face session was built around a case-based learning approach to SBIRT. The model featured application of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST; Humeniuk et al. 2008) to screen for substance use disorders, and how to follow up with a brief intervention (for moderate risk) or referral to specialist services (for higher-risk use). The 3-h workshop included a 30-min Q&A session, providing participants with the opportunity to ask about specific cases and discuss possible solutions with peers. Clinicians were provided with resources, including the ASSIST clinical forms, information sheets related to specific drugs and drug classes, and decision-tree charts for conducting the ASSIST. The resources were designed and adapted to encourage the GP, when appropriate, to screen for substance use.

**The ASSIST**. The basis of the in-person skills-based workshops is to deliver screening and brief intervention using the ASSIST. The ASSIST is an eight-item questionnaire that assesses the risk of harm for all drugs, legal and illegal, as well as for misuse of prescription medication (Humeniuk et al. 2008). ASSIST is a World Health Organization-endorsed instrument, designed specifically for use in primary health care settings. ASSIST screens for the risk of harm, and stratifies risk into low, moderate and high risk of harm, and connects each level of harm to a follow-up brief intervention. In the case of high-risk use, the brief intervention is designed to facilitate referral to specialist treatment services for further assessment. ASSIST has been validated in a number of settings and is available in a number of languages (Humeniuk et al. 2008).

**Follow-up webinar**

The final webinar aimed at reconnecting with the cohort to identify and solve challenges experienced with introducing and scaling up SBIRT in their clinical setting. The final webinar was divided into two sections, with the first section focused on identifying potential barriers and enablers to implementation, both at the individual level (e.g. knowledge, attitudes) and at the structural level (e.g. organisational constraints, lack of resources, time). The remaining section was dedicated to group discussion among the GPs, who shared their experiences with the barriers and enablers of uptake and utilisation in their own practices. Feedback was
gathered from the group related to improvement of program content and design.

Program delivery
Throughout 2022, the Australian primary health care workforce was overburdened with competing priorities related to COVID-19. Locally, the South Eastern NSW PHN workforce were also dealing with the consequences of flooding that engulfed parts of the state. As such, flexibility in the timing of training delivery was essential, and although the project was initially scheduled to launch in early 2022, the expert advisory group recommended delaying the launch until after June 2022 to prevent GP burnout.

Once agreement had been reached by all stakeholders for the delivery schedule, the local PHN placed an advertisement for the training on its website’s events page, and communicated it directly through newsletters and email. The first series of introductory webinars occurred in July and August 2022. In August and September, the in-person workshops were conducted across four locations in South Eastern NSW: Wollongong, Goulburn, Bateman’s Bay and Queanbeyan. Following the in-person sessions, all attending GPs were invited to participate in the final webinar, which was held in November 2022.

Measures
All GPs who registered for the initial webinar were asked to complete a baseline survey with basic demographic questions (e.g. age, sex, clinical experience); as well as questions related to delivery of SBIRT and knowledge of the NHMRC low-risk alcohol consumption guidelines. A final survey was provided to GPs who attended the follow-up webinar to assess changes over time.

Confidence in SBIRT delivery
All participants were asked to separately rate their confidence in their ability to conduct screening, and confidence to conduct a brief intervention for substance use disorders for someone who scored at moderate risk of harm. Participants were also asked to give confidence ratings (out of 100) upon completion of training. Changes in confidence were assessed by comparing results at baseline and follow up.

Awareness of NHMRC recommendations
Participants were also asked a series of questions related to the specific NHMRC guidelines, including what the current guidelines recommended for: the general population, for adolescents, for women who were pregnant or breastfeeding and in what year the latest recommendations were published. Participants were asked the same questions upon completion of training. Changes in knowledge and awareness were assessed by comparing the proportion of correct results at baseline and follow up.

Knowledge of SBIRT processes
To understand whether GPs had gained any changes in knowledge as a result of the training, participants were asked the following questions at follow up: ‘If a patient were to disclose to you the consumption of drugs or alcohol at levels that you would consider to place them at moderate risk (based on their ASSIST score) from their consumption, what steps would you include in a brief intervention?’ and ‘Since training, have you delivered a brief intervention for risky substance use? If so, how successful was it, and do you think you could, or should, have done anything differently?’ The questions were open-ended, which allowed participants to reflect on their own experiences. We also did not define success, so participants had the freedom to discuss what they thought success meant in their own case.

Ethics approval
This project was approved by the University of Adelaide Human Research Ethics Committee (Approval number 22/67). This research was undertaken with appropriate informed consent of participants.

Results
Participant characteristics
In total, 18 practitioners attended one of the introductory webinars and participated in one of the in-person sessions. Six out of the 18 (33.3%) attended the final webinar and completed the full-training program. All attendees were GPs, with the exception of one practice nurse. GPs were predominantly male, and ranged in age from 40 to 77 years, with between 7 and 50 years of clinical experience. Table 1 presents a summary of demographic characteristics at baseline and follow up.

Confidence in SBIRT delivery
The mean confidence for screening (out of 100) increased by approximately 8% (s.d. = 17.6; t(5) = 1.46, P = 0.132) from

<table>
<thead>
<tr>
<th>Table 1. Characteristics of sample at baseline and follow up.</th>
<th>Baseline (n = 18)</th>
<th>Follow up (n= 6)</th>
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<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>55.2 (12.0)</td>
<td>57.2 (14.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male sex, n (%)</td>
<td>10 (55.6%)</td>
<td>4 (66.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical experience</td>
<td>29.3 (14.1)</td>
<td>28.0 (17.3)</td>
<td></td>
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<tr>
<td>Screening confidence</td>
<td>59.7 (17.0)</td>
<td>67.5 (11.5)</td>
<td>1.46</td>
<td>0.132</td>
</tr>
<tr>
<td>BI confidence</td>
<td>56.7 (22.1)</td>
<td>71.0 (9.1)</td>
<td>1.26</td>
<td>0.103</td>
</tr>
</tbody>
</table>

BI, brief intervention.
baseline (see Table 1). Although, the mean confidence for brief intervention delivery increased by approximately 13.5% (s.d. = 22.7; t(5) = 1.26, P = 0.103). Increases were not statistically significant in both cases. Due to the limited number of participants completing both assessments (n = 6), kernel density estimation was used to visualise changes in the distribution of confidence ratings. Fig. 1 displays kernel density estimations of confidence ratings for both domains, with baseline ratings depicted in blue and follow-up ratings in orange. The peak of each distribution represents the estimated mean confidence rating for each domain. Confidence ratings were higher at follow up (i.e. peaks further to the right), and were more concentrated (i.e. narrower distribution) than the baseline ratings, suggesting that the program is likely to have been effective in boosting confidence.

Knowledge of SBIRT processes

Responses by GPs reflected largely positive experiences, mainly related to SBIRT, particularly for reducing alcohol consumption. For example, one individual noted:

Yes, for alcohol use. I’ve had review with a patient where they reported significant improvement in their sleep pattern, particularly upon limiting to 2 units of alcohol daily. I feel this was a successful intervention.

Another provided more general positive experiences with their patients:

Yes I have. I think the two episodes were successful, judging by the patients’ cooperation and willingness to give input.

Another reported more content knowledge about substance use disorders and how to provide care:

I can now explain to patients about their level of addiction, and plan for further management and referral.

Knowledge of NHRMC guidelines

Knowledge and awareness of the NHMRC low-risk alcohol guidelines were also assessed at both timepoints. Table 2 outlines the number and proportion of correct responses to each guideline at baseline and follow up, and the sum total number of correct responses at each timepoint. At baseline, only 50% of GPs were able to correctly report guideline 1, whereas 83% and 89% were able to correctly identify guidelines 2 and 3. At follow up, all GPs correctly identified all three guidelines.

On aggregate, seven GPs (39%) identified all four correct answers at baseline, with a total of nine GPs having identified either two (28%) or three (22%) correct answers, respectively. At follow up, two-thirds of GPs reported all four correct answers, whereas the remaining third correctly identified three answers. One-way repeated measures ANOVA found small, but not statistically significant, differences from baseline to follow up (F(1.5) = 4.31, P = 0.093; Fig. 2).

Program acceptability

We also canvassed opinions of the GPs attending the program to assess whether the program was acceptable to the target audience. Qualitative feedback suggests that the program was acceptable, and the participating GPs were satisfied with the outcomes:

I’ve seen the results when applied to my patients, where mainly alcohol is the issue. Within six weeks of the training, my patients have literally taken the advice, changed their lifestyle, and, without direction, told me all of the benefits that they have noticed. One patient said: ‘I can’t believe it, I’m sleeping better than I’ve slept for years,
Table 2. Total number (and proportion) of correctly identified NHMRC guidelines, by item and aggregate total, among GPs from baseline to follow up.

<table>
<thead>
<tr>
<th>Item</th>
<th>Baseline</th>
<th>Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline 1</td>
<td>10 (56%)</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>Guideline 2</td>
<td>15 (83%)</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>Guideline 3</td>
<td>16 (89%)</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>Year published</td>
<td>9 (50%)</td>
<td>4 (67%)</td>
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</table>

No. of correct responses

<table>
<thead>
<tr>
<th></th>
<th>Baseline (%)</th>
<th>Follow up (%)</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td>1 (6%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>1</td>
<td>1 (6%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>2</td>
<td>5 (28%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>3</td>
<td>4 (22%)</td>
<td>2 (33%)</td>
</tr>
<tr>
<td>4</td>
<td>7 (39%)</td>
<td>4 (67%)</td>
</tr>
</tbody>
</table>

Note: Baseline n = 18; Follow up n = 6.
Guideline 1, 2020 NHMRC guideline for health adults; Guideline 2, 2020 NHMRC guideline for children and adolescents aged under 18 years; Guideline 3, 2020 NHMRC guideline for women who are pregnant, planning to get pregnant or are breastfeeding.

Discussion

This project investigated the acceptability and preliminary effectiveness of a program designed to increase confidence and capacity among GPs to deliver SBIRT for the prevention of substance-related harms. The results indicated an increase in confidence to deliver SBIRT as a result of training. The project also aimed to raise GP awareness of the latest NHMRC low-risk alcohol guidelines. The results demonstrated a higher level of recognition of the guidelines. The third aim of this study was to assess the acceptability of the program from a qualitative perspective. Feedback suggests that GPs found the program to be acceptable, and were able to successfully implement what they had learned into their practice, and to educate their colleagues. A positive downstream effect of this program may be in the formation of a network of champions who can encourage their colleagues and peers to undertake the program to improve their own standards of care.

Although the results are preliminary and the sample too small to detect any changes to population-level substance use, this study supports the need for training primary health clinicians to conduct targeted SBIRT. More work is needed to ensure a consistent approach to implementation, including buy-in from organisation leadership (Rahm et al. 2015). However, the findings are consistent with the findings from the RACGP’s Alcohol and Other Drugs Program, which found increased GP confidence to treat patients through skills-based training in SBIRT (RACGP 2023).

In our study, attendance was limited due to competing priorities during the COVID-19 pandemic and regional floods in 2022. Other studies suggest that many GPs experienced burnout and decreased work performance during this time (Prentice et al. 2023). This had a significant impact on recruiting GPs into the study and maintaining their commitment for completion. Greater incentivisation, or compartmentalising the program into two- or three separate, yet accredited activities,
may encourage a wider scope for attendance, while also reducing the risk of attrition. A second limitation is the lack of control group of GPs who did not receive the training. The small number of registrants at the outset made the inclusion of such a group unfeasible. Although control groups are often unnecessary for pilot studies, the inclusion of a comparator may have provided deeper insights into the nature of changes in knowledge and confidence beyond that captured here.

GPs may be reluctant or unwilling to enquire about substance use due to a lack of knowledge and training, and/or a lack of confidence in their ability to respond (Roche et al. 2002; Kowalski and Barrett 2020). One of the primary benefits of this program is providing GPs with a framework for understanding the interaction between substance use and the other medical conditions they treat. Crucially, the training highlights how the same skills and lifestyle interventions can apply to both conditions. Furthermore, the intervention has demonstrated efficacy in reducing the severity of the impact of the other chronic health conditions (Madras et al. 2009). To save time during consultations, the screening component could be completed by a practice nurse. Alternatively, in a situation where there is no practice nurse, the ASSIST has been validated for self-completion (Humeniuk et al. 2008), allowing the GP more time with the patient.

A final consideration is the role that programs such as these play in contributing to breaking down stigma and discriminatory attitudes towards people with substance use disorders. Attitudes towards the use of alcohol and other drugs, particularly illegal drugs, are a major barrier to enquiry about substance use (Ketterer et al. 2014). Ideally, these programs offer clinicians an opportunity to challenge stereotypes and facilitate self-reflection on their own implicit biases. However, such programs primarily attract the health care workforce who already recognise that substance use disorders commonly occur, and are modifiable through routine medical approaches, and/or those with a personal interest in managing alcohol and other drug issues (Wilson et al. 2022). This means these programs may be subject to selection bias, where participating GPs are already less prone to discriminatory attitudes towards substance use. Future programs could focus on ways to identify and increase engagement among GPs who may not feel as comfortable with delivering care to those with ATOD use. For example, this might be achieved through targeted or cohort-level approaches that highlight the role of substance use disorders as modifiable risk factors for other chronic and mental health conditions.

**Conclusions and future directions**

The current program was developed to increase knowledge and skills in early identification and intervention for substance use disorders among patients who attend primary health care settings in regional New South Wales. The program aimed to develop knowledge and skills on identifying substance use disorders through targeted screening, managing those conditions with brief interventions and referring patients to specialist services where necessary. It also aimed to raise awareness of the latest NHMRC low-risk alcohol guidelines, so they could discuss them with their patients. Although the program faced challenges due to competing priorities related to COVID-19, it did result in small, measurable increases in self-reported GP confidence in delivering SBIRT to their patients and correctly identifying the NHMRC guidelines.

The program’s preliminary results are promising, but more can be done to ensure its success in the future. Promoting examples of good practice after successful implementation following the training can be highlighted. The PHN can engage GPs who successfully completed the program to act as SBIRT champions, creating a network to drive uptake at the local level. This may also create interest and enthusiasm, and challenge stigma and discrimination around people who use alcohol and other drugs.

Incentivised payments may also help improve the successful uptake of programs such as this. Evidence from trials of pay-for-performance schemes in the USA has demonstrated improvements in patient outcomes related to substance use disorders (Garner et al. 2012). The Commonwealth Government Practice Incentives Payment scheme is a quality improvement initiative that could have application, with general practices currently incentivised for screening for tobacco, and screening for alcohol using AUDIT-C. A Medicare Benefits Schedule item to deliver SBIRT for all substances is another option, similar to the item for smoking cessation (item 93680). These actions are likely to increase GPs’ interest and enthusiasm for delivery of SBIRT in the future.

**References**


National Health and Medical Research Council (NHMRC) (2020) Australian guidelines to reduce health risks from drinking alcohol. Commonwealth of Australia, Canberra.


**Data availability.** The data that support this study cannot be publicly shared due to ethical or privacy reasons and may be shared upon reasonable request to the corresponding author if appropriate.

**Conflicts of interest.** The authors declare that they have no conflicts of interest.

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**Author affiliations**

1Department of Pharmacology, School of Biomedicine, The University of Adelaide, Adelaide, SA 5000, Australia.

2Graduate School of Medicine, University of Wollongong, Wollongong, NSW 2522, Australia.

3COORDINARE – South-eastern NSW PHN, Wollongong, NSW 2500, Australia.