The Drug and Alcohol Clinical Advisory Service (DACAS): The Past Five Years

Turning Point
TREATMENT · RESEARCH · EDUCATION

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BACKGROUND

Practitioners who work in general health care settings are often the first point of contact with the health care system, and therefore play a critical role in providing key services and care to individuals with AOD-related issues. Indeed, there is strong evidence that advice and management by primary care providers reduces AOD use and associated morbidity, reduces health care costs, and is well-received by patients. This highlights the value of initiatives that increase the capacity of frontline health practitioners to respond effectively to AOD problems, thereby improving quality of care and outcomes for patients.

The Drug and Alcohol Clinical Advisory Service (DACAS)

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The *Drug and Alcohol Clinical Advisory Service (DACAS)* is provided by Turning Point in Melbourne, Australia. It is a free 24-hour telephone-based specialist AOD consultancy service, established in 1996 to assist practitioners working in general health care settings with the clinical management of AOD issues.

DACAS is funded to provide AOD support to Victorian health practitioners, with service provision more recently extending to Tasmania and Northern Territory. There are currently 12 DACAS specialist consultants, who are addiction medicine physicians and addition psychiatrists.

There are few specialist alcohol and other drug (AOD) services in Australia to support the primary and broader health care sector. Telephone-delivered AOD clinical advisory services provide frontline health practitioners with immediate, accessible, specialist AOD advice that can serve large numbers of patients and clients, irrespective of location. However, no evidence exists on the reach of this type of service, nor performance in responding to service user needs.

AIM

The aim of this study was to perform a retrospective evaluation of routinely collected electronic data from calls made to DACAS during the past five years, to provide information on service use and performance, and to examine the AOD-related issues for which health practitioners are seeking support.

METHOD

This study evaluated routinely collected electronic data from calls made to DACAS between July 2013 and June 2018, and consultant call-backs recorded between July 2016 and June 2018 (prior to this, consultants completed paper or PDF forms), extracting information on call characteristics, caller location and characteristics, enquiry and consultation details.

ANALYSES

Outcome measures were primarily summary statistics, and measures of association using logistic regression. Bonferroni's correction was used to adjust for multiple comparisons.

Remoteness values were imputed using regular expressions to match manually-typed suburbs to a dataset featuring suburb, remoteness-classifier pairs (i.e. "Melbourne", "Major City Australia").

Data were analysed using Stata Statistical Software: Release 15. Remoteness values were imputed in R (3.5.1), and caller geographical locations were plotted according to suburb in R.

RESULTS

CALL DATA

Between July 2013 and June 2018, DACAS received a total of 6,565 calls (1,200+ calls per year).

The highest proportion of calls was received by health practitioners located in major cities (54.4%), followed by inner regional areas (24.5%). Much lower proportions of calls were made to DACAS from practitioners located in outer regional (7.7%), remote (0.5%), and very remote (0.3%) areas.

While most calls to DACAS were from health practitioners located in Victoria, calls were received from all states and territories (*Figure 1*).
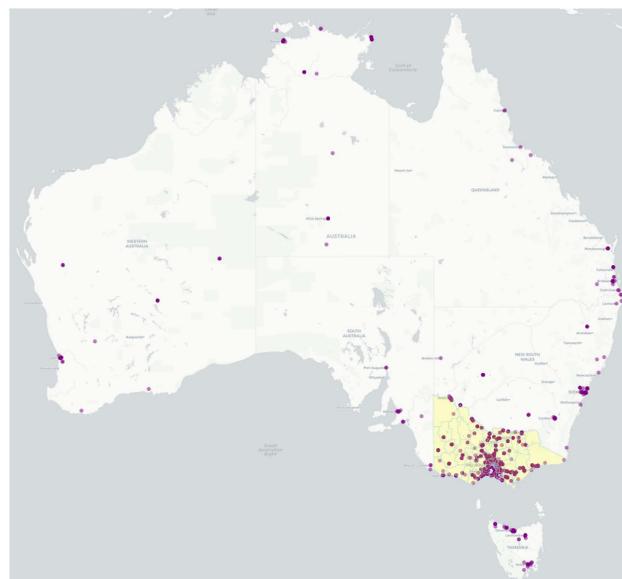

Figure 1. Health practitioner location

The majority of callers were identified to be first-time callers (91%), while 9% were previous callers to the service. Results from logistic regression indicated that, compared to health practitioners living in major cities, practitioners living in very remote areas had significantly higher odds of previously calling the service (OR = 4.1, p = 0.004, 95% CI 1.6 to 10.7).

CONSULTATION DATA

Between July 2016 and June 2018, DACAS consultants recorded information on 1,400 call-back consultations.

Recipients of DACAS Consultation

Call-back consultations were most frequently provided to GPs (36.2%), followed by other medical practitioners (25.6%) and allied health practitioners (14.1%), psychiatrists (11.6%), and pharmacists (9.7%).
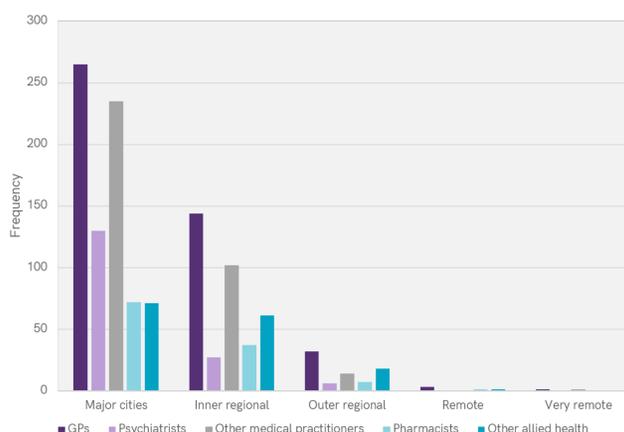

Figure 2. Consultation, by health practitioner and remoteness

Drug of Concern

Practitioners sought consultation for a range of illicit and licit substances, with opioid replacement therapy (ORT) the most common drug of concern class, followed by opioids, alcohol, benzodiazepines (BZD), amphetamine-type stimulants (ATS), and cannabinoids (*Figure 3*).
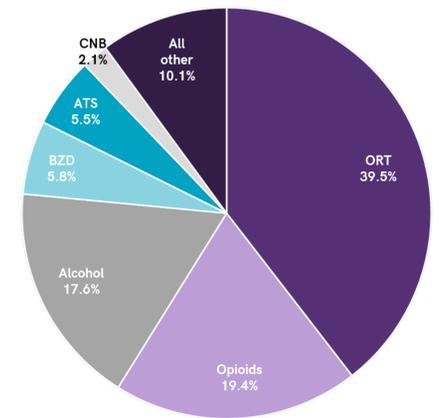

Figure 3. Drug of concern

Results from logistic regression indicated that, compared to GPs, pharmacists (OR = 22.0, p <0.0001, 95% CI 12.4 to 39.0), psychiatrists (OR = 2.8, p <0.0001, 95% CI 1.9 to 4.0), and other medical practitioners (OR = 2.4, p <0.0001, 95% CI 1.8 to 3.2) had significantly higher odds of seeking consultation for ORT.

Compared to GPs, pharmacists had significantly lower odds of seeking consultation for opioids (OR = 0.1, p <0.0001, 95% CI 0.05 to 0.32). Compared to GPs, psychiatrists (OR = 0.3, p <0.0001, 95% CI 0.2 to 0.6), other medical practitioners (OR = 0.5, p <0.0001, 95% CI 0.4 to 0.7), and pharmacists (OR = 0.02, p <0.0001, 95% CI 0.003 to 0.2) had significantly lower odds of seeking consultation for alcohol.

Polysubstance Use

There was indication of a high prevalence of issues around polysubstance within the data. In examining consultants' free-text entries, complex cases of polydrug use and polypharmacy were frequently reported.

DISCUSSION

The results of this study provide information on health practitioners' knowledge gaps (e.g. management of ORT) and level of engagement with AOD issues (e.g. GPs' lower engagement with ORT; GPs' higher engagement with alcohol problems), which can be used to inform workforce development and training initiatives.

Within the data, there was evidence of concerning levels of polydrug use, polypharmacy, and concurrent polydrug use with use of prescription drugs. This indicates the serious nature of some cases in terms of the potential for immediate drug-related health risks, and highlights the complex AOD scenarios that are being encountered by frontline health practitioners.

While telephone-delivered services can play a crucial role in reducing the rural-urban disparities in access to specialist AOD support, it is clear that more needs to be done to increase the reach and uptake of DACAS in non-metropolitan areas.

CONCLUSION

DACAS is a key service, of immense scope. This service provides health practitioners with immediately accessible information and support in their management of complex AOD presentations, to attenuate risk and promote harm reduction. The delivery of this service is also likely achieving capacity building of the broader health sector by increasing AOD knowledge, and promoting more positive and supportive workforce attitudes toward this highly stigmatised health issue.

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