

Supporting Aboriginal Community Controlled Health Services in screening and alcohol care: where to from here?

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Introduction: Primary care offers potential early detection and treatment for unhealthy alcohol use. But there are many competing health issues – even more so for Aboriginal and Torres Strait Islander ('Indigenous') Australians.

Method: This cluster randomised trial tested a model of service-wide support for screening and care for unhealthy alcohol use among 22 Aboriginal community controlled health services (ACCHSs). Half of the services received support early; the other 11 were wait-list controls. Support included training, sharing of knowledge and experience between services, and second monthly feedback of routinely collected data. We tested whether the odds of clients being screened with AUDIT-C, and of having treatment recorded within 2-monthly periods improved at services following implementation of support (using multilevel logistic regressions).

Results: AUDIT-C was rarely used at baseline. There was substantial variation in screening and treatment rate at services over time. Over two years of support, the increase in odds of clients being screened with AUDIT-C was 7.95 [95% CI 4.01, 15.63] times larger at services receiving support relative to waitlist control services. Similarly, odds of staff recording talking treatments (brief advice/counselling; using practice software items) or prescribing relapse prevention medicines increased more at supported services (OR=1.89, 95% CI=1.19-2.98, p=0.01). Recorded screening and treatment rates remained low in both arms, even after support.

Discussion and Conclusion: Talking therapies are likely to be under-recorded in the practice software variables.

This collaborative, multi-component support helped services to significantly increase alcohol screening and recorded care. Further work is needed to enable clinically significant gains.

Implications for Practice and Policy: Nationally, fragmented and insecure funding for ACCHSs, lack of practice software prompts and variable clinical guidelines remain barriers. Support programs need to be adaptable to differing service strengths and challenges, and robust to staff turnover. Alcohol care should be included within continuing quality improvement programs.

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