Alcohol provision in Primary Care

- Outline and case study analysis of the alcohol specialist nurse for alcohol in Islington PCT

- Jeff Fernandez

Outline of role in Islington

- AIM: To provide support and structure for the care of patients with alcohol misuse in primary care.
- Inclusion criteria:
- Anyone with a dependent to binge drinking pattern
- Anyone where intervention would help prevent hospitalisation or referral to specialist service
- Exclusion:
- Any mental health diagnosis and covered by a CMHT
- Any Child protection concerns: referral to specialist service.

Role outline

- Supporting GP's in what is seen as a specialist area of primary care
- All communication of patients through the EMIS system
- Patients booked in through the EMIS system
- No paperwork or referral needed
- Clinic carried out in different setting in primary care.

Clinics and Hosting

- 12 clinics in GP surgeries currently provided with a limited hosting model for patients referred from other surgeries.
- ‘Hosting’ good idea but limited in scope
- Where does this role ‘fit’

Tier model in Islington

- Tier four: detox/rehab
- Tier three: Specialist Service
- AASCI
- Tier two/three: Jeff Fernandez Alcohol Specialist Nurse.
- Tier two: ARP Services: Women Alcohol Service, Rugby House 'New Roots'.
- Tier One: ARP Shopfront; Primary Care.

Development

- Future of Alcohol Specialist Nurse
- AASCI
- A+E prevention role
- Role for Primary care and role RCGP.

Case Study

- Clare
- Presentation: Depression; OCD and alcohol dependent pattern with benzodaizepine habit.
- Age 40
- Ethnicity : White British
- Single mother with child who is now ‘statemented’ at school.
- Drinking one bottle of wine a day.

Previous Plan

- Referral to AASCI
- Child protection concerns
- Did not attend for this service. Therefore poor engagement.
- Referred to me.
- Not someone I would normally work with but poor engagement was the reason for my intervention.
- What should I aim for?

What could I do?

- Aim one: engagement
- Aim two: alcohol awareness
- Aim three: link alcohol use with OCD episodes.
- Use MI to develop pattern awareness.
- What would you aim for?

Motivational Interviewing

- Motivational interviewing a technique used in addictions to move people on the cycle of change.
- Pre-complementation
- Complementation
- Preparation
- Action
- Maintenance
- Relapse

What Did MI discover

- Low self esteem
- Previous history of sexual abuse
- Poor relationship with men in general
- Unable to deal with every day stress.
- What service would benefit this patient?

What was planned

- Increase alcohol awareness of her pattern
- Focus upon control and to increase her thinking of seeing drinking as an option
- To develop informed choice decision-making.
- Plan a reduction in drinking and a detox via the GP surgery

What was Planned

- After completion of the detox
- Start on acamprosate and SSRI.
- Referral to psychology when detox completed for OCD
- To continue to support.

What happened to her now?

- Detoxed and still ‘dry’ after two years
- Still supported and seen by the specialist nurse three monthly
- OCD well managed and sees psychology at Whittingdon annually.
- Off acamprosate and anti-depressants

What is a success

- Debatable in what is a significant period of time ‘dry’. Is two years a success?
- What would you have done: Is there anything different ?
- Could you have managed this patient with help from the specialist Nurse?

Case study 2

- 55 female woman
- Long history of alcohol dependency and depression. Previous fertility problems; in an abuse relationship.
- Socially isolated (arsenal fan)
- Infertility problems led to her drinking initially

Previous treatment

- No referral and no motivation to seek specialist help from other services.
- Started on anti-depressants : Fluoxetine 20 mgs
- Drinking sometimes addressed through health education, patient not receptive to these messages.

Plan

- Patient has a degree of ambivalence which is important to recognise.
- What would you do in this case?
- With no primary care worker is it possible to refer on? If so to what?
- Would you prescribe anti-depressants when someone is drinking in excess of 70-100 units a week ?
- Think of a suitable plan (5 mins)

Plan

- Discuss:
- **Without Specialist Nurse for primary Care**
- **Plan (appropriate):**
- **Refer to psychology at specialist service. In the interim use mental health workers /primary care workers to offer sessions.**
- **Refer to counselling in-house if available.**
- **When seen for appointments look at consumption levels and always give health education messages. Brief intervention research shows that this works.**

What happened

- Drink consumption recorded on sessions to give an accurate (as poss.) idea of where heavy drinking occurred and then the reasons why were explored with MI.
- Looking at ‘triggers’ for this both habitual/psychological
- After six session bereavement from the death of her grandmother (Many years ago) a prominent part of her reason for drinking. MI offered with a further referral to bereavement counselling.
- Flouxetine dose raised with good effect.

Where is the patient now

- Was drinking 70 units a week and now at thirty.
- Still engaged in seeing the alcohol specialist nurse
- Still seeing bereavement counsellor and has benefited from this.
- Working towards a further gradual reduction and aware of the reasons. Her drinking less 'triggered' by emotional/psychological factors.

Key points

- Be aware of local alcohol services that are easily accessible : such as drop-in centres run by ARP.
- Be aware of counselling/psychological services for people who drink are limited but can be accessed at CASA and AASCI.
- If training is required the PART1 and Part 2 in alcohol is available soon from the RCGP.
- This post to be duplicated more and therefore referral to a specialist nurse should be more widely available

The main keys points to remember

- Accurate assessment of drinking levels important and can be done with the fast tool.
- Always try and give health education advice when possible
- If drinking over 100 units seek specialist advice either from Primary Care Nurse or AASCI. Even a phone call for advice is useful.
- If patient has a dual diagnosis or physical complications refer to the specialist nurse in the first instance. If not available refer to AASCI (Specialist Service for Camden and Islington)

Detoxing in Primary care

- Open session

- Questions: Who is suitable for detoxing in the community?
- When would you refer to specialist services?
- When would you refer to in-patient services?
- What would you prescribe and how?

Detoxing in primary care

- Protocol for prescribing detoxes outlined by specialist service (Dr Groves.)
- Nurse able to prescribe detoxes via a CMP
- Is best achieved if the patient can reduce his/her consumption: Increases insight and able to see what their ‘triggers’ are and plan appropriately.

Regime

- Exclusion/inclusion criteria

Use librium/chlordiazepoxide: Not Clomethiazole.

Reducing dose

Difference between females/males

Male starting dose 100m mgs: 25 MGS QDS; 20 MGS QDS; 15 MGS QDS; 10 MGS QDS; 5 MGS QDS.

Female start dose 20 MGS.

Aftercare drugs acamprosate; disulfiram

Shared Care

- Differences to ‘shared care ‘ as we know it
- What is better
- What is happening to the role
- Has it a future?