Expanding the treatment landscape

Detoxification of the dual diagnosed patient in primary care with the specialist nurse

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Recent research has shown that young men and women of all ages are drinking more now than ever before (Alcohol Needs Assessment Research Project, 2005). The potential impact in terms of health and social well-being as well as law and order is massive, which is recognized by the Government in a series of recent report (NTA, 2007, Cabinet Office, 2004.)
The medical consequences include cardiovascular problems, hypertension, and liver damage through hepatitis. So what can health professionals do in primary care? Presented here is a typical case study that illustrates that the specialist nurse is a valuable resource for improving patient care and providing support for GP's (primary care) in the area of alcohol treatment. It shows this through primary care, and particularly community detoxification regimes of alcohol.

It shows in addition the importance for nurses of developing 'shared care' in the field of alcohol treatment. Detoxification from alcohol in a shared care setting is effective (and cost effective) when part of a treatment package including psychosocial interventions (National Audit office, 2008). Importantly, this paper highlights the crucial and beneficial role a nurse specialist can play in treating patients in the clinical specialty of alcohol misuse.

Alcohol is seen as a specialist area crossing over into mental health; however, many patients can be managed in primary care with the support of an experienced and knowledgeable specialist nurse. Most of the patients seen in primary care often appears with the diagnosis of depression and are already on anti-depressants mainly SSRI's. Often this dual problem is seen as an area for specialist services. This paper argues that this cohort of patients can be managed and successfully treated in primary care, especially in the area of alcohol detoxification. This paper illustrates this through basic audit and research and a typical case study.

Alcohol Specialist Nurse Post (Islington)

Typically, there are two types of referral from General Practice that are seen in this role of the specialist nurse for alcohol. The first can be categorized as patients with complex physical needs where alcohol is a major contributing factor such as Ascities or Jaundice. The others can be categorized as dependent drinkers (normally having to drink everyday and suffering withdrawal symptoms if prevented from drinking alcohol)

Part of the role looked initially at increasing the level of assessment for all GP's in Islington and to provide expertise and advice. However, the role has changed and patients who are dependent on alcohol and drink every day are the most typical clients seen in this role. They often request a desire to give up alcohol altogether.

The role of detoxification and making patients alcohol-free has played an increasing role in Islington with the appointment of a specialist nurse in 2005. This role has increased with the advent of nurses taking on the role of non-medical prescribing. . This has enabled the nurse to take on supplementary prescribing of regimes for patients.

The approach used protocols developed from Government guidelines (MOCAM and Effectiveness Review refs). The important point to remember is that unlike the specialist alcohol services, the detoxification regime in primary care will be less intensive. This is largely because of reduced risks shown by the patient (such as risk of non-compliance or risk of seizures). In addition, the patient needs to be able to shows some psychological concepts such as a good degree of 'insight' into their alcohol pattern, to be considered for a detoxification from alcohol in primary care.

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Background:

There is no consensus on the "best" setting for detoxification from alcohol although there is some evidence supporting community over residential approaches (original DH research from the 1980's and the SCAN 2007 guidelines outlining best practice to conducting detoxification in primary care as the first option on grounds of cost effectiveness unless there are contraindications.

Recent studies analysed by the National Treatment Agency (Department of health, 2007) showed that detoxification regimes are more effectively achieved when psychological services are used together with clinical input, such as medication. Therefore using psycho-social therapies and pharmological approaches to provide holistic care (Review of the effectiveness of treatment, 2006)

Detoxification for a patient in NHS Islington entails the nurse providing the psychosocial interventions with the prescribing the detoxification regime. The medication used is Librium and the dose starts from 25 mgs QDS and decreases 5 mgs a day. A standard detoxification regime for a patient wanting a detox would look as follows on a prescription (www.cks.nhs.uk/PCAS primary care guidelines, 2008):

Day1: 25 Mgs QDS (Librium)
Day2: 20 Mgs QDS
Day3: 15 Mgs QDS
Day4: 10 Mgs QDS
Day5: 5 Mgs QDS

Finish.

Importantly, to ensure safety the patient has to be in a position where drinking on top of the medication is unlikely. Some GP's do not feel skilled enough in treating this cohort of patients and some might not have the time to manage detoxification of the patient safely either (Smith, 1996).

Many of the patients also stated that they were very depressed when drinking and it is still debatable whether to start on anti-depressants or not when someone is drinking in a dependent pattern. However many were on anti-depressant and all stated that their mood improved when they successfully complete an alcohol detoxification regime and stayed dry for more than one month.

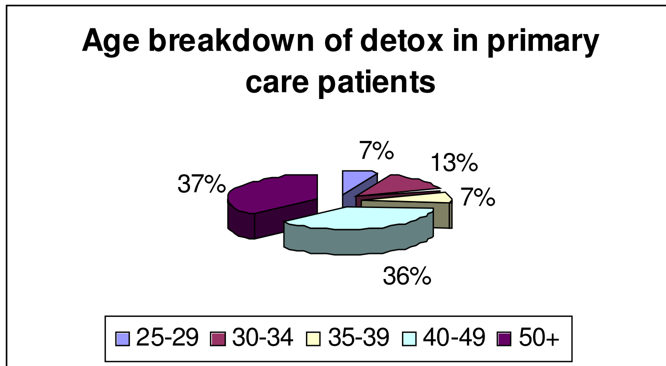
In this case the role of the specialist nurse is advocated to address this gap... This is illustrated from the case study shown in this paper.

Methodology

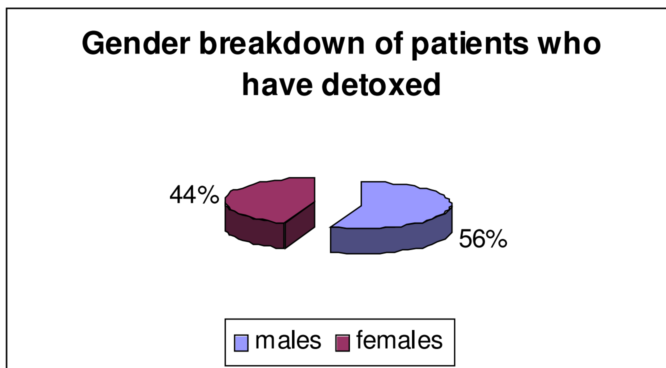
The paper describes patients who underwent a detoxification with the specialist nurse in Islington in 2006/2007. In total there were 45 completed detoxification regimes off alcohol. Also, with the specialist nurse at least two sessions were allocated to preparation of the patient to detoxify and prepare for relapse prevention. . In some cases, this was more than two sessions where there was a need to develop motivation as well as working on coping skills. The nurse is a registered independent prescriber but as yet under PCT guidelines cannot prescribe independently; only supplementary under a Clinical Management Plan. Therefore, the detoxes are a shared care arrangement with the prescribing completed by the GP and nurse under a supplementary prescribing plan and all the management by the nurse specialist.
The research took the form of two stages. First was an evaluation and audit of the patients who undertook a detoxification package in primary care in Islington. At the audit stage, All 45 patients' details were entered on a database and analysed for gender, and age. Ethnicity was not completed as the majority was White British and, despite the high proportion of BME residents in Islington, no Asian or Caribbean clients were present in this sample... Also, data was examined on the number of sessions attended for preparation, and the length of dry time achieved.
The second stage used structured qualitative questionnaires and all 45 patients were interviewed through a series of semi-structured interviews conducted in primary care. The interviews were then coded and analysed into themes which were repeated and had commonality with other interviews. There was much difference in the responses but also many common themes, which emerged. Also, many interesting and rich information which can emerge from good qualitative data, and is shown in one of the interviews which was representative of the other interviews conducted. The audit and subsequent research was approved through Camden and Islington ethical board.

Results:

Shown in this section are the demographics of the people who completed a community detoxification regime in 2007.

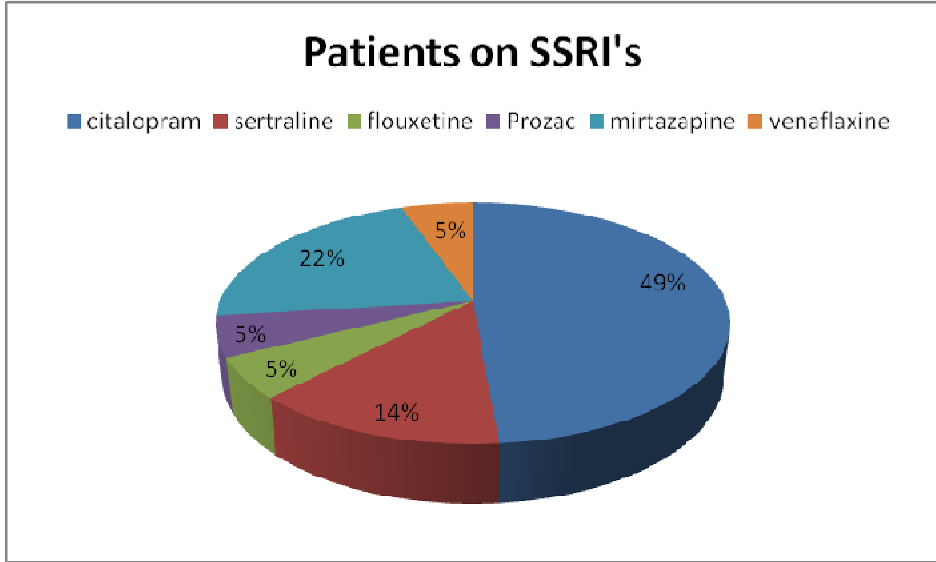


This graphs shows that there is a significant older population who presented to the specialist nurse for starting an alcohol detoxification regime. This population had longer alcohol histories and had also had more experience of alcohol services. Often they would have undergone an alcohol detoxification before from the GP with no support. However, they were seen after the detoxification period for up to and including six months to a year.

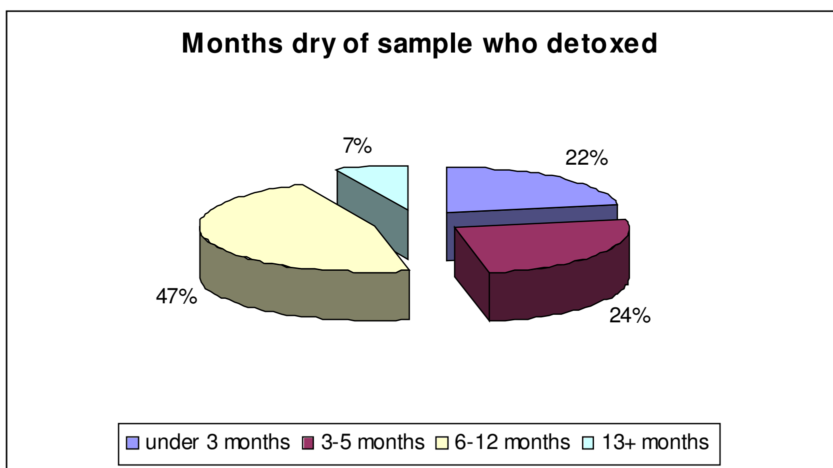


The gender graph shows a higher proportion of females detoxified off alcohol through the specialist nurse in primary care. This is a figure that is larger than the average seen in substance misuse in general which is a more male dominated population in the ratio of 3:1 (Fernandez, J, 2007).
The demographics show an over-representation of British white, female patients...
However, when the qualitative work was completed the data was very common regardless of gender and below is a typical case study illustrating the findings of the research.

The next graph shows the number of patients who are on SSRI's and where treated fro depression before the detoxification was managed and prescribed through the specialist nurse.



There was 85% (38) of patients on anti-depressants and all were on SSRI's as this appears to be the preferred options for GP's rather than prescribing tricyclics such as amiltripyline.
Citalopram and sertraline are suggested by the nurse as better anti-depressants to use as they are less affected by the use of alcohol (www.cks.nhs.uk, 2009). Mirtazapine was used to help patients who suffer with insomnia and depression; often in this case alcohol was often used to aid sleep. Venaflaxine was used for severe and moderate depression (BNF, 2008).
Therefore there was a significant cohort of patients on anti-depressants who came looking for treatment for their alcohol and wanted a detoxifcation off it. As stated when this cohort went through a period 'dry' they all stated that their depression was not a problem and the medication was more effective. However, no-one stooped taking their medication in the time this research was conducted over the year of 2008.

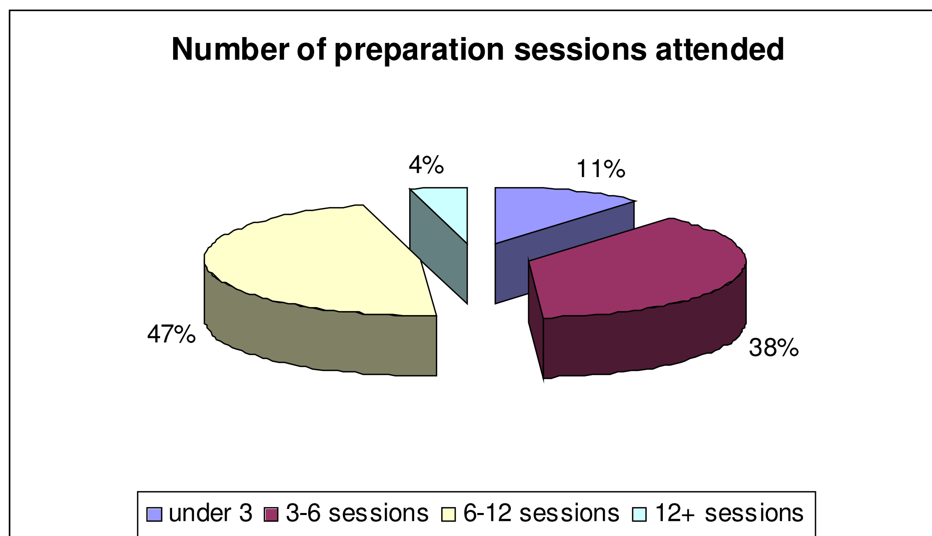


It is interesting when compared with the above chart that despite the number of units consumed all the people who entered a detoxification off it. The regime did seem to

obtain the completion of the detoxification regime and also were able to achieve some dry time. Over 50% (54) were able to stay dry for 6 months and longer which is good for the treatment outcome but also important for the patient to achieve if trying to change their behaviour pattern with alcohol. This is with the cohort in the majority having a dependent pattern. The outcome is a favorable one and the 7% who achieved abstinence of over 12 months is an interesting cohort which will be examined in more detail later.

Preparation or good assessment?

It would appear logical that the more engaged and willing a patient was the better the outcome would be. Hence the number of sessions was examined to see if there was any real relationship between this and achieving dry time. The cohort who attended less than 3 sessions will be examined in more detail later with a typical case study. Therefore the 11% are in this paper analysed in more detail with arguably atypical results.



The 11% was examined to see if there is any correlation between the number of sessions and the ability to stay dry for longer. Logically it would appear that the less sessions attended, there would be less preparation work achieved and therefore the outcome would be poorer... All in this group were drinking everyday and at times heavily. The 80% were drinking at a level of 150-200 a week and if they did not drink, they experienced mild withdrawals. In terms of logic a few sessions and heavy drinking pattern would not look a good candidate for detoxing. However the figures for the success of this group were surprising. In hindsight and further investigation they had had previous experience of detoxification regimes and had already achieved 'dry' time in the past. Therefore, in many ways they were a good cohort to try and detoxification in the community. Below is an in-depth case study of one of the 11%. This case study has a high degree of typicality.

Gareth: 55 Male

Gareth has been at his general practice since he was a young boy and the surgery knows him well. Alcohol was a prominent part of his life since adulthood nd so was depression. However, he did not know that at the time and that alcohol made this more of a problem. He started to drink heavily in his twenties. Most of his peers, family and social contacts were also heavy drinkers. . He did not go to his GP for help until his wife asked him to. In the short-term the options for alcohol when he was in his thirties was to start a detoxification regime (i.e. a medically assisted withdrawal from alcohol) in hospital, or be referred to a specialist mental health unit that had experience in alcohol. At that time, most detoxification regimes were performed in a gastro-enterology ward.

"My first detox was easy…but with the medication it was easy but as soon as the tablets ended it was then that I found it difficult. I did not understand that at first (that stopping is not the major problem; it's staying stopped beyond the medication that is often the hardest part). Starting the tablets and coping with the medication was easy and gave you a false sense of security. I mean if I was given more tablets it could have helped."

This maybe sounds a medical model approach of some patients which still exists today. For many perceived illnesses it is often the case in addictions that the psychological aspects of surviving without alcohol are always under estimated in the first detoxification or intervention. But there was very little expertise in this field at the time of Gareth's first detoxification and medication and an applicable medical model was the way the NHS operated in the 1980's. This is a very typical finding from the interviews conducted. But was anything learnt from this clinical experience?

"Every detox taught me more and more. Particularly, at the 'habit' of it all. At times you…or I wondered what was habitual and what was psychological. But you learnt more about your pattern.I also noticed my mood and depression would lift when Ii was off alcohol. I did start to think i could do without anti-depressants."

So from the case study and the interviews overall, all said this and it seems obvious. But it is this basic concept that enabled all the small cohort of 7% to go dry for a substantial period of time. And despite the number of detoxification regimes (and Gareth had five in all over twenty years), he learnt from each detoxification regime. This made each detoxification regime stand a greater chance of success and each time he managed to stay drier for longer. Not all in the interviews could state that and indeed success varied, but in the long-run things seemed to click. Also, each detox seem to enable to stay 'dry' for longer and therefore he was starting to notice 'dry' periods with a lift in his mood.

"I suppose each time you learn whether you want to do this or not. The first time it was my wife and and others I was doing it for. I knew I had to do something…It was embarrassing to interact with teachers and other friends at my daughter's school when I'd been drinking. I knew I did not want to be like this. But the other thing was it was enjoyable drinking and everyone seemed to do it. Also when I was young I was fairly shy

and alcohol helped me to get over this. It was only later after detox three that I seemed to understand how it started."

This is also an important concept that emerged from the interviews, in that, unless you are sure you really want to do a detoxification regime, any compromised position will weaken the potential to make it a successful one. Also, each time and remembering the reasons of why you do not want alcohol again are important in sustaining a dry period. This is further verified in the next statement.

"Not 11 months dry and recognise the true worth of not drinking. I am sure now that I do not want to drink again. This was never that strong in the periods as it is now, from the detoxification regimes I have had in the past. That is a main difference. Also I am aware of the health benefits for myself…particularly after 11 moths off alcohol."

The main question to ask all the 7% was could one detoxification work for a person or are others truly necessary in order to finally benefit from some substantial 'dry' time.

"Well…not sure for most one is never enough…as I said you learn something from every detox regime and I certainly was learning about my pattern on each one. After the first I felt so guilty and embarrassed that I did not think I would be given another chance to detoxification. I know that I can now. Plus the support you can have to stay dry is so much better now. This with my better grip on my alcohol pattern has enabled me for sure to stay dry for eleven months.My mood is better and I am still on anti-depressants but at a low dose of citalopram."

All who were interviewed said the same thing and there was a degree of predictability in this question but it does show that for many the more detoxification regimes the better the outcome and one is never enough in most cases. Certainly the 7% studied here showed that the learning curve which enables a success in the long-term started with their first detoxification and incrementally the experiences of each one mattered in the long run.

<u>Conclusion:</u>

The number of detoxes and assessing how they have changed the patient is an important factor to consider, from the data that emerged from the qualitative interviews conducted in this research. Each detoxification regime completed improved an individual's insight in their dependent pattern on drinking. This improved each outcome of any subsequent detoxification undertaken.

The patient in the typical interview has now been 'dry' for nearly one year. From the primary care perspective this is a great achievement. It also verifies the prescribing plan designed by the nurse and the clinical management plan, as 45 patients safely detoxified with no adverse reactions to Librium.

It also made patients depression better. And in some cases one could argue that to encourage a detoxification regime for someone who is drinking and depressed would be the most effective treatment for their depression.

The case study illustrates a person with a dependent pattern would need more than one detoxification regime overtime. In this particular case examined here 3to 4 detoxification regimes. The national treatment outcomes for drugs and alcohol conducted in 1996 and 2006 showed similar number of detoxification undertaken needed for patients to learn to stay off either drugs or alcohol. Therefore, promoting a more patient approach and a willingness to prescribe a detoxification regime more than once should be promoted in primary care settings.

Overall, this paper shows that the role of the alcohol specialist nurse can be a valuable resource for detoxification of the patients safely and successfully in primary care. It also shows that an experienced nurse in the field is able to assess and plan care effectively for a range of patients with different drinking patterns. It also shows the importance of having a process for detoxification of the patients for alcohol in primary care and a safe and effective clinical management plan.

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