

Shared care for Alcohol provision in primary care: Is it possible?

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Alcohol in Primary Care:

This is a brief summary of two evaluations of an innovative post provided by Islington PCT, looking at how best to service and support GPs in the specialist area of alcohol. This model shows that it is possible to work in the best interests of the patient while sharing the care between a specialist nurse and the general practitioner. This is shaped from the model of shared-care used in treating patients with substance misuse problems in primary care. However, it has to be noted that the 'binge' drinking population are still hard to find as this model has uncovered a 'new' population of dependent drinkers.

There has been a focus from the Primary Care Trusts, to look at the treatment of alcohol as a specialty with trained nurses and counsellors looking to provide a service for people who wanted to change their pattern of drinking. From a needs assessment on alcohol in general practice (Smith, 1996) a post was created for a nurse to support and provide clinical input into general practice for patients presenting to surgeries with alcohol dependency or problematic drinking. This paper is a summary of some of the evaluative work from the specialist post created which shows that some valuable work can be achieved through creating a specialist nursing post. It has been argued that nurses are able to deliver care by not substituting care from the general practitioner but by complementing them in specific clinical areas such as alcohol (Laurant et al.2004).

In Smith's report (1996) it was stated that GP's on the whole did not feel knowledgeable or expert enough to treat and prescribe for this population. They felt that specialist nurse/clinicians would enable GP's to be supported in this field and therefore encourage more GP's to work with this client group. This initiated the development of the specialist nursing post, which has now been running for two years.

There have been two evaluations running in that time using case studies as the base of examining what a 'typical' client is to the service as well as the demographics of the patients referred and treated. In these papers (www.islingtonpct.co.uk 2006) the set up of shared care was described with the GP complimenting and prescribing for the patient on the recommendation of the specialist nurse. In essence the nurse is the main care co-ordinator of the patient and the GP supporting by prescribing. This is seen as a good way of working with this client group and one in which GP's feel supported and able to work with this vulnerable client group

The case study summary shown below shows what is possible to be achieved for clients in the area with a shared care for alcohol approach in primary care with a 'typical' detoxification client:

Case Study A:

Name: John

Age: 44

Referral: GP referred patient who had shown a willingness to look at his alcohol consumption whilst he was having a health check with his GP. Previously had never engaged with alcohol services.

Client perspective and need: On assessment, the client had shown a clear identification to his social and economic problems being related to his drinking pattern. He had a clear motivation to change his drinking pattern. He had previously been through two self detox's and managed to have a period without drinking of two months, but not more. He had always relapsed through events and changes in his social life, which stressed him, and made him drink, he feels. He wants to see if there is anything he can do to address this. John was drinking every day at levels considered dependent drinking levels. The units he was drinking at were 130 units a week and drinking every day. He described himself as having a dependent pattern but had never been to any alcohol service despite being referred to a specialist service, this was his first experience of treatment for alcohol.

Treatment: On the first session, John had some degree of insight into his drinking pattern. He had acknowledged that this was bad for him, but he had been able to change his drinking habits twice, the problem was maintaining this abstinence. He felt that stress was something he had not coped with well, and had not really addressed. He considered this influential when he was asked to reflect on what he felt were the prominent factors. Also a detoxification regime was to be built towards with a reduction plan before the detox, as John really wanted a life away from alcohol. The detoxification was achieved with the nurse managing the detox and seeing the patient to ensure follow up and measure compliance to the regime, with the GP prescribing. This was indeed sharing the care with the nurse co-coordinating it.

Outcome:

Through building towards abstinence looking at the psychological 'triggers' behind the pattern with the nurse, John's insight into his problematic drinking pattern increased. It became better each time he engaged with a growing ability to problem solve situations which had previously caused him stress. He managed to reduce his alcohol to fifty units a week and then detoxed successfully. He continued to engage after the detox in the sessions for extra support and is still 'dry' which is now six months. He has never previously achieved this before.

Conclusion:

Most GP's would not feel comfortable with treating John in primary care. He was a dependent drinker and therefore would be someone who was referred to the specialist drug/alcohol service. He had never engaged with this type of service but had engaged with one operating out of primary care with a shared care approach and the outcome was beneficial to him. This is a typical case in terms of finding a population of drinkers who have never been able to be treated. Therefore uncovering arguably a 'new' population where positive outcomes can be achieved. The model of shared care for alcohol provision in primary care should be encouraged.

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