Building treatment capacity for alcohol use disorders in primary care

A case study
What we know about alcohol use disorders

- 1:4 adults drink to a degree where they put their own health and wellbeing or that of others at risk.

- 1.6m (5.9%) of adults are estimated to be alcohol dependant, the majority of which are likely to be moderately alcohol dependant.

- The incidence of alcohol use disorders is known to be higher in certain groups including adults with severe and enduring mental illness, offenders, problematic drug users and homeless adults.
The relationship between alcohol use and health

Alcohol can be:
- A primary cause of injury, chronic disease and mortality
- A contributory factor in injury, chronic disease and mortality
- An inhibiting or exacerbating factor in the management of chronic disease

Increasing and higher risk alcohol can co-occur with other health risks including:
- Poor diet and obesity
- Smoking
- Substance misuse
What we know about General practice engagement with alcohol harm reduction agenda

- Evidence suggest that primary care is the optimum setting for identifying and ‘treating’ the majority of alcohol use disorders. The exception being more severe and complex patterns of dependency.

- A number studies have indicated variable, but predominantly low levels of primary care identification and treatment of alcohol use disorders.

- GP’s often treat more complex alcohol use disorders due to perceived barriers in accessing specialist treatment, most significantly waiting times for specialist services, and patient reluctance to accept referral to specialist services.
Enhancing and building treatment capacity in primary care

- Our starting point:
  - Approximately 5% of our (estimated) in need dependent drinkers accessing treatment.
  - Average wait for assessment by specialist treatment of 14 weeks with 40% of referrals estimated to be moderately dependent.
  - The volume, quality and effectiveness of treatment in primary care unknown.
Our assumptions:

- Majority of AUD’s can be effectively treated in primary care.
- There is some resistance by both GP’s and patients to treatment in this setting.
- Patient and practitioner choice are important to an effective response.
- Limited ‘specialist’ capacity should be focused on:
  (a) Treating more severe and complex alcohol dependency
  (b) Enabling effective treatment in other non specialist settings (primary, secondary and mental healthcare) through advice, training etc.
Learning from the practitioner/patient experience

Our objectives:

- To measure current patient experience of the general practitioner response to alcohol dependent patients.

- To review the effectiveness of existing primary care based treatment for alcohol dependence.

- To understand the kind of model that general practitioners want in terms of treating alcohol dependence, what role they wanted to play in treatment.
Patient experience:
Based on structured interviews with 55 (alcohol dependant) clients who had engaged with local alcohol treatment services

<table>
<thead>
<tr>
<th></th>
<th>No (%)</th>
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</thead>
<tbody>
<tr>
<td>Registered with a GP</td>
<td>54 (98%)</td>
</tr>
<tr>
<td>Had discussed their alcohol with their GP</td>
<td>52 (95%)</td>
</tr>
<tr>
<td>Had received a positive response from their GP</td>
<td>35 (67%)</td>
</tr>
<tr>
<td>Identified their GP as the first point of contact when seeking help</td>
<td>37 (67%)</td>
</tr>
<tr>
<td>Had ever been treated for their alcohol dependence by their GP</td>
<td>15 (27%)</td>
</tr>
<tr>
<td>Number seen more than once by their GP through out prescribed (7-10day) managed withdrawal</td>
<td>5 (38%)</td>
</tr>
<tr>
<td>Number treated by their GP for alcohol dependence three times or more</td>
<td>6 (40%)</td>
</tr>
<tr>
<td>Number actively referred by GP to Community Alcohol Team*</td>
<td>28 (51%)</td>
</tr>
<tr>
<td>Number told to refer themselves to the Community Alcohol Team</td>
<td>12 (22%)</td>
</tr>
<tr>
<td>Number prescribed medication to reduce relapse</td>
<td>5 (9%)</td>
</tr>
</tbody>
</table>

*
Anecdotally patients told us:

- That when told to self refer they were not always given information on how to refer themselves.

- That often there was no structured interventions e.g. counselling, day care offered to them after GP prescribed treatment or follow up post treatment, with many relapsing because of this.

- Many who were referred waited a long time for assessment by the CAT to be told that they weren't a priority.
Measuring the general practitioner experience

A brief online survey of general practitioners and face to face meetings told us that:

- There was a significant level of treatment for AUD’s in primary care.

- Treatment was often limited to prescribing to manage withdrawal with limited comprehensive treatment planning.

- Some GP’s want to treat AUD’s but needed appropriate support, training and access to specialist advice.
The commissioning response

- Establish a pilot GP/nurse prescriber led clinic for moderately dependent drinkers.

- Increase the capacity and broaden the remit of the primarily care liaison service.

- Aim to identify a GP champion in every practice supported by a comprehensive training program.
Fresh Start: A GP led response to alcohol use disorders.
Fresh Start Clinic

Dr Johannes Coetzee
Background

- “One size fits all model”
  - No differentiation between mild/moderate dependent drinkers
  - Latter not seen as priority
  - CAT overwhelmed with referrals
  - Waiting time to treatment 18 weeks
  - 40% could be safely seen in primary care
Model initially developed to treat only patients requiring assisted withdrawal

Model evolved to treat a spectrum of AUD’s

Wrap around service: Extended brief advice; In-house counselling; Binge drinking groups; 1:1 family work; Family Groups; Recovery worker
Fresh Start Clinic

- Remove stigma, increase uptake/retention
- Referrals from across the borough (GP’s, A/E, IAPT etc.) and Self referrals
- Operating principles based on specialist alcohol services
- Non dependent patients; ext. BA, counselling
- Alcohol dependent syndrome; Planned alcohol detoxification and After Care
- Severe dependency; Preparatory work + IP detox
- Links with Third Sector, Counselling services in extended hours, Structured Day Care, Support Groups/ Family work
- Audit trail
- General Practice offers anonymity

Specialist nurse practitioner

Central to the success of the Clinic
Patient Demographics

- Age Distribution

- 56% Male, 44% Female

- 42% Employed

  - Sick days taken 18.92
  - (n=218)
Process

- Measures to critically appraise the effectiveness of treatment offered
- Serious incidents are audited
- Standardised tools used for assessment and to measure outcomes
- Service is responsive to the needs of patients, (employed, counselling in extended hours)
- Targeting DNA’s; Telephone and letter
Productivity

- Referrals received – 915
- DNA – (20-30%) (265)
- Assisted withdrawal not required – (404)
- Alcohol detoxification completed – 245
- Very low drop-out rates whilst undergoing detoxification
- No waiting list in operation and waiting time to treatment is 7 days or less
## Outcomes
**Diagnosis Alcohol Dependent Syndrome**

<table>
<thead>
<tr>
<th>Year</th>
<th>Detox</th>
<th>Abstinence</th>
<th>Relapse</th>
<th>Relapse re-engage</th>
<th>Secondary Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>59</td>
<td>44 (74%)</td>
<td>15</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>68</td>
<td>52 (76%)</td>
<td>11</td>
<td>4</td>
<td>2 Abstinent 6/12</td>
</tr>
<tr>
<td>2011</td>
<td>56</td>
<td>47 (83%)</td>
<td>18</td>
<td>7</td>
<td>All controlled drinking</td>
</tr>
<tr>
<td>2012</td>
<td>33</td>
<td>18 (54%)</td>
<td>10</td>
<td>7</td>
<td>Controlled</td>
</tr>
<tr>
<td>2013</td>
<td>32</td>
<td>26 (81%)</td>
<td>6</td>
<td>6</td>
<td>Controlled</td>
</tr>
</tbody>
</table>
Outcomes - GP’s

- Improve treatment completion rates
- Majority of patients who relapse, re-engage
- Reduced Re-treatment rates
- Improvement in MH and LFT’s
- Improve social functioning of patients
- Increased Choice; Patients and GP’s
- Prevention of developing severe relapsing form of alcohol dependency
Outcomes - Commissioners

- Secondary
  - Unlocked hidden capacity within CAT
  - Reduced waiting times from 18 weeks to 18 days
  - CAT; focus on treating patients with complex needs
  - Improve GP confidence
  - Rapid response to referral
  - Reduction in hospital admissions
THANK YOU FOR LISTENING

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