



GPs still see themselves at the heart of family medicine – but are drug and alcohol users always kept in view?

DDN reports on challenges highlighted at this year's SMMGP conference in Liverpool

AGENTS OF CHANGE

From cradle to grave?

GPs are uniquely placed to help clients at every step of their journey, as well as provide a clear pathway through the maze of services, SMMGP delegates heard

A 46-YEAR-OLD MAN was taken to A&E with a seizure. After being stabilised and put on a short stay observation ward, he was seen by an alcohol specialist nurse (ASN) who did a survey of alcohol dependency questionnaire and discharged him the next day on a reducing regime. On the third day he was back at 4.30am with a headache and vomiting and referred to ophthalmology. On day five he had a CT scan and was found to have a subarachnoid haemorrhage.

The following day when the ASN went back to see him, the patient said: 'I suppose it's my fault. They're very busy and I deserve what's happened.' As Dr Lyn Owens, nurse consultant and clinical lead for alcohol services at Liverpool PCT, who shared this story said: 'Someone should have picked up the alcohol problem.' But the other major point she was making was about dignity in patient care – how medical staff and patients relate to each other, which can become 'an issue of capacity with patients with drug or alcohol problems'.

'What patients want from nurses hasn't changed,' she said. 'They need to feel cared for and respected. They need to feel listened to and that the listening is unconditional and they're not making a judgement – that they will get good care no matter why they're there.'

'Our patients have the perception that health professionals value them less than other patients,' she added. 'But we need to realise that anyone can run into difficulties. The more positive the experiences of our patients, the more we'll be able to dispel these perceptions.'

'Old style patriarchal doctoring used to be from cradle to grave, and social cohesion went with those ideas,' commented Paula Byrne, lecturer in social health at Liverpool University. 'But unfortunately some things went very wrong... there is the idea of an underclass that are disaffected and disengaged. There are good reasons why people abuse alcohol and drugs – the gaps between rich and poor have got worse.'

However GPs were now becoming more political and making policy demands. 'This is the juncture where things have to change,' she said, drawing parallels with feminism in the early 70s, where shouting loud challenged the status quo.

'This conference is one of the last vestiges of radicalism – GPs have a unique situation as agents of change,' she said. 'The professional position is shifting – you need to be a patient advocate and a policy guru.'

Mark Gabbay, head of the division of primary care at Liverpool University warned against complacency. While there was plenty of evidence for methadone and buprenorphine maintenance, the means were 'not an end in itself'. 'Let's think about the root of the problem... the link between problem drug use and deprivation – poverty of opportunity,' he said.

'We need to be advocates of prevention, not on the treatment roll – "get 'em in, get 'em assessed and included in statistics and on a script with infrequent reviews, pile 'em high". We need to be active partners with our clients.'

'Some of it is common sense, giving them resources for stability,' he added.

'We need to be putting pressure on people like me to make sure there are real options,' said Paul Hayes, head of the National Treatment Agency. 'Our clients are entitled to access mainstream services, but we shouldn't shy away from the fact that it is often difficult... our challenge is to make the aspirations the actual experience of service users.'

Dr Chris Ford wanted to level the field of patient care at the outset: 'We need to stop talking about cannabis users, cocaine users, opiate uses... we need to start talking about people with a range of needs.' ■

Constantly fighting discrimination

Dr Deborah Noland, a GPwSI (GP with a special interest) in Liverpool, shares some of the day to day frustrations in trying to bring better care to her drug and alcohol patients

'MY JOB AS A GPwSI IS CONTINUING TO BE DIFFICULT. Our practice provides care for the homeless within Liverpool and we provide support, counselling and scripts when necessary for chaotic patients. We would love to be able to offer drugs counsellors, but we are unable to as these clients are seen as being too chaotic for shared care. This client group is being discriminated against. All other patients have choice – these patients are only allowed to go to the drug dependency unit if they want drug worker support.

The drug dependency service still has a poor reputation within the drug using community – although this is improving with the appointment of a new approachable consultant – so many of these vulnerable clients refuse to go. We have had to make the decision therefore to casework this difficult client group ourselves and transfer them to our drugs workers when they are deemed stable enough for shared care. This is far from ideal and these difficult clients should be a higher priority to see drugs workers.

My other problem is that the drugs and alcohol services work independently – I feel they should work together, as so many of our clients have both problems. The alcohol service is currently being reviewed, but at the moment there is no provision for home detoxes and very little support for primary care. I got funding approved for an alcohol worker to work with the homeless and students to prevent readmissions to hospitals, with funding for research, but the appointment has been blocked by the DAAT. Yet again I am waiting for a decision while people with alcohol problems have to wait. I have been assured that it is because they want to provide more, but I feel it would be good to start somewhere rather than continually waiting.

On a positive note, working closely with David Young – who is medical director of the Lighthouse Project providing shared care support in Liverpool – has been very positive and we feel supported as a practice. I am also looking forward to liaising with the new consultant Dr Mohammed at the drug dependency unit – closer working to support chaotic groups can only benefit our clients.' ■

Cradle to grave... or pillar to post?

Asking for help from several GPs has left **Doug** feeling disaffected and disengaged

WHEN I FIRST WENT TO SEEK HELP FOR MY DRUG USE I was working as a housing worker, so it was difficult to actually ask for help. I went to my GP because I felt unable to approach local drug services as I knew a lot of workers from previous jobs and from the organisation I worked for.

The GP was unhelpful from the start, stating that I really should have gone through local drug services. However she wouldn't refer me out of county either, but wouldn't give a reason why.

Eventually I managed to get started on a Subutex script but was then forced into going off sick from work. I had managed until that point to continue working and had kept my problems from work – I never scored locally and kept my use very discreet. But because the GP noticed my name on some minutes from a local forum and realised I worked with some of the patients from her practice, she threatened to inform my employer if I didn't, as she felt I was a risk to my clients

– her colleagues were scripting some of them. So now I was off sick, getting a full-time wage still and with lots more time on my hands. As a consequence of this my crack use rocketed and my heroin use went up with it.

I informed the doctor of what was happening and she stated that this was all too much for her to deal with. She referred me to another doctor who was a psychiatrist and head of forensic medicine and had experience of dealing with fellow professionals. I didn't get on with this chap at all and eventually ended up lying about my use just to get away from him and to try and return to work. However none of this worked and eventually I left the city I was living in.

For the next two years I managed to keep going on meds (methadone) I was buying on the black market. So now my illicit drug use was under control but I was left with a methadone habit.

Again I decided to move towns and went to see local drug services where I had a very difficult time trying to explain to the doctor there that I didn't have a problem with any illicit drugs but was struggling to get off the methadone. They eventually did script me but every time I talked about reducing the methadone, I was discouraged and told that I was trying to do too much. So I reduced my methadone right down to a very low level on my own and went back to see the doctor to ask for a 'rattle pack', ie some meds to alleviate the symptoms of coming off the methadone, but I was told that they didn't do anything like this and never would.

I have just registered with a new GP and had to visit her to get my other meds sorted out (I am hypothyroid and suffer from migraines and high blood pressure). She unwillingly sorted these out, berating me for visiting a new surgery before my records had been transferred over and saying that she really didn't like giving me any medication without having seen my previous notes. So now I am dreading having to return to see her when she does have my notes, because I need to come clean about my previous drug problems and have no idea what sort of reaction I will get. ■

