Training experience in drug and alcohol liaison work

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We describe our training experience as members of a drug and alcohol liaison service within a major general teaching hospital. This type of liaison work offers valuable experience in the joint management of patients with well established substance misuse problems and also provides the opportunity for early recognition and preventative interventions.

The importance of a psychiatric liaison service for drug and alcohol problems within the general hospital setting cannot be over emphasised (Ghodse, 1995). Alcohol misuse with its medical and psychiatric complications is frequently encountered in the general hospital and Tomlinson (1992), in his recent report on London hospitals, commented that 30% of acute hospital admissions have alcohol problems. Many of these patients may not have received previous treatment while others may be at an early stage in their drinking careers. The general hospital therefore provides a setting for the acute management of established alcohol related problems and a fertile ground for screening early alcohol problems and for educating patients about hazardous drinking. It also offers the opportunity for initiating brief interventions found to be effective within this setting (Bien *et al*, 1993).

The physical complications of substance misuse are well described (Maxwell, 1990) and substance misusers are regularly encountered in the A&E department (Ghodse *et al*, 1986) and general hospital wards. While the incidence of substance misuse continues to increase, this situation is unlikely to change dramatically. These patients cause particular management problems for general medical and nursing staff and often receive inadequate treatment as a consequence of early self-discharge and failure to attend follow-up appointments (Horn *et al*, 1987). Input from the substance misuse services with advice on management and appropriate prescribing may help resolve these difficulties, improve compliance with medical treatment and facilitate involvement with substance misuse services. Indeed with drug related health problems presenting to various hospital departments, the clinician should always get expert advice and involve the local drug dependency unit and medical social workers in the patient's treatment (Maxwell, 1990). Substance misuse and liaison psychiatry are both important psychiatric sub-specialities and experience in these areas during higher professional training is to be highly valued. This article describes our training experience as members of the Drug and Alcohol Liaison Team at St George's Hospital Medical School.

The study

The Drug and Alcohol Liaison Team (DALT), part of the Division of Addictive Behaviour at St George's Hospital, was an innovative project set up under the directorship of Professor A. Hamid Ghodse in 1989 in order to improve and expand the services available to drug and alcohol misusers. It was felt there was a need for specialist input and closer liaison with medical colleagues in the joint management of patients, to heighten awareness of substance misuse, to encourage screening and early intervention and to educate and train junior medical staff in the assessment and management of drug and alcohol misuse.

The team consists of the senior registrar or clinical lecturer in addictive behaviour (two sessions per week), a research/liaison nurse (two sessions) and a community psychiatric nurse (two sessions) with part-time secretarial support. Overall direction and consultant supervision are provided by Professor Ghodse but day to day clinical coordination and administration of the service is the responsibility of the senior registrar. As many referrals are complicated by pre-existing or concurrent medical and psychiatric conditions the involvement of senior medical and nursing staff was deemed necessary.

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DALT provides a liaison service for St George's Hospital, a major general teaching hospital with approximately 30 000 admissions per year. Patients are seen initially on the general wards, usually within 24 hours of referral although urgent cases can be responded to sooner. Referral requests are telephoned to the team's secretary (thus avoiding delay of the internal post) who records the reason for referral, medical diagnosis and other details on a standardised data collection form before contacting the DALT member. The service also provides a weekly out-patient clinic in the general medical out-patient department. Patients are assessed by the DALT member (senior registrar or nurse) 'on call' that day. For patients with difficult physical or psychiatric complications, or where advice on prescribing is required, medical back-up is provided by the senior registrar. This DALT member continues as the patient's key-worker throughout their hospital stay and out-patient follow-up. All patients referred to the service during the preceding week are discussed at the team's weekly clinical meeting where their management and progress are reviewed and further intervention or referral planned under the supervision of the senior registrar. The meeting also serves as a forum for the exchange of ideas and experience between the different disciplines.

Table 1. Medical conditions of patients referred to DALT, 1993/94.

Condition	*n*	%
Hepatic conditions		
(includes hepatitis and cirrhosis)	56	30
Gastrointestinal conditions		
G.I. haemorrhage	10	5
Acute gastritis	7	4
Pancreatitis	4	2
Other	5	3
Respiratory conditions		
Chronic obstructive airway disease/ chest infections	9	5
Tuberculosis	2	1
Cardiovascular conditions		
Arterial occlusion	4	2
Endocarditis	2	1
Other	2	1
Skin conditions		
(Incl. abscesses, cellulitis, ulcers)	12	6
Neurological conditions		
Convulsions	16	9
Head injury	8	4
Other	2	1
Trauma		
Fractures	8	4
Other	5	3
Overdoses		
(Accidental/non-accidental)	12	6
HIV related conditions	4	2
Miscellaneous conditions	9	5
No diagnosis/missing data	10	5
Total	187	99

Findings

During the year April 1993 to March 1994, we saw 187 new referrals of whom 138 (74%) had primarily alcohol-related problems and 49 (26%) primarily drug-related problems. There were 232 follow-up sessions mainly held in the out-patient clinic. The male to female ratio was 5:2 and patients presented with a wide and varied range of medical conditions; hepatic and gastrointestinal conditions were particularly common (Table 1).

A frequent reason for referral was for advice with regard to detoxification regimes or guidance on appropriate prescribing of controlled drugs to drug dependent individuals. This involved an accurate assessment of the degree on physical dependency followed by careful titration of substitute medication against withdrawal signs and symptoms. In the general hospital setting this process is often complicated by the concurrent need of some patients for opiate analgesia. With regard to alcohol withdrawal our medical colleagues were much more confident in undertaking detoxification. Referrals tended to come later in the patients' hospitalisation and usually included request for counselling or out-patient follow-up. The post presented us with a wide range of clinical situations, for example, how to manage the pregnant opiate user or the addict threatening premature discharge; preventing drug/alcohol abuse on the ward; and the interpretation of urine toxicology. We also had the opportunity of initiating brief counselling interventions along the lines described by Bien *et al* (1993). Advice on harm minimisation was provided for injecting drug users together with education on HIV issues. Arranging for specialist treatment with agencies throughout the district and region formed an important part of our work and made us aware of the number and variety of drug and alcohol services available. Unusual training experiences included the management of analgesic misuse in recurrent or chronic painful conditions (e.g. sickle cell disease) and the assessment of patients being considered for liver transplant.

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We developed close working relationships with the Liver unit, jointly managing patients with alcoholic liver disease or hepatitis resulting from intravenous drug use. Our out-patient clinic was held at the same time and place as the liver clinic which enhanced contact with medical colleagues and facilitated exchange of advice and information. Thus changes in the patients' treatment or progress were easily communicated between treatment teams. Interaction with medical colleagues helped keep us up to date with medical developments (e.g. hepatitis C, interferon therapy) and refreshed old knowledge and clinical skills in general medicine. This arrangement also improved compliance with out-patient appointments; a substance misuse clinic located in medical out-patients might be viewed by patients as less stigmatising than the drug dependency unit.

The post provided opportunities for involvement in management and administrative duties including coordination of the team's clinical activities, supervision of data recording and activity analysis and representing the team at senior management meetings. The team was involved in ongoing audit of the service's response times to referral requests, the application and quality of care plans, and the use of the regional substance use database forms.

We also had the opportunity to train others. In addition to teaching of medical staff during ward consultations we produced printed guidelines on the diagnosis and management of common substance misuse disorders for use by general medical and nursing staff. Informal feedback from junior and senior medical colleagues suggests that this has helped to increase their awareness of, and confidence in dealing with, substance misuse problems and, in the case of one medical team, led to collaboration in a research project. Medical students attached to the Division of Addictive Behaviour spend one afternoon per week with DALT. We aim to teach students to recognise and manage common substance misuse problems which they will encounter as house officers.

Comment

The time spent with DALT during our higher professional training was a rewarding and satisfying experience. It gave us the opportunity of assessing and managing the more complicated (by virtue of concurrent physical illness) and unusual drug and alcohol problems which present to medical and surgical colleagues. It greatly enhanced our understanding of the nature and extent of substance misuse problems within the general hospital and made us aware of the possibilities for brief interventions within this setting. Nevertheless we feel that a detailed evaluation of the team's activities is needed to determine the efficacy and the cost-effectiveness of this type of service for substance misusers and to assess the impact of its educational and training component on medical colleagues. We are encouraged however by Bien *et al* (1993) who commented that brief interventions (for patients with alcohol problems) yield outcomes significantly better than no treatment and often comparable to those of more expensive treatments.

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