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### FROM THE EDITOR



Dr Guy  
Ratcliffe

This editorial is of necessity brief because I wish to allow space for two important articles. One is a brief summary of the

recently published National Audit Office review of health services in England for alcohol misuse. The second is a report of the Practitioner Health Programme recently established in London under the auspices of the National Clinical Assessment Service. This project was the subject of much debate at the recent MCA AGM, not least over its potential dissemination throughout the UK. Some members of the MCA contributed to its development, and all involved are to be congratulated for establishing a potentially excellent service for doctors and dentists within a very short time frame.

### National Audit Office report

About a year ago the MCA was approached by the National Audit Office (NAO) to help identify experts within the alcohol treatment field who might collaborate towards the production of an NAO report on alcohol services in England. This work has now been completed and has resulted in a wide-reaching report.<sup>1</sup>

The report is available on the NAO website: [www.nao.org.uk](http://www.nao.org.uk). It is to be emphasised that this audit concerns NHS services provision only with no mention of private providers. Similarly, organisations like Alcoholics Anonymous receive only minimal mention.

#### Methodology

The audit was designed to evaluate those activities of the Department of Health and of the NHS at a local level which were aimed at reducing alcohol harm. Primary Care Trusts (PCTs) and Drug and Alcohol Action Teams (DAATs) received an electronic questionnaire



NAO  
National Audit Office

DEPARTMENT OF HEALTH  
Reducing Alcohol Harm: health services  
in England for alcohol misuse

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL | HC 1049 Session 2007-2008 | 29 October 2008

followed up by emails and telephone calls. Responses were received from 141 (of 152) PCTs and 121 (of 149) DAATs. The questionnaires enquired about commissioning responsibilities, local alcohol strategies, expenditure on services, levels of provision and access to services. Similarly 1,453 GPs completed an online survey to investigate their views on the provision of

Continued overleaf

alcohol and substance abuse services. This group was considered geographically representative of GPs in England. However, other GPs failed to complete the survey and it is possible, therefore, that the sample is representative of GPs with an especial interest in the topic.

The NAO team members interviewed many of the key stakeholders, including specialist providers, GPs, NHS, hospital trusts, DAATs and PCTs, as well as Strategic Health Authorities, the Ministry of Justice, the Department of Health and the Department for Children, Schools and Families.

Interviews with alcohol misusers and their carers were carried out on behalf of the NAO on four focus groups. Similarly, international research was carried out in Australia, Canada, Germany, the Netherlands and the USA to compare the structure and efficacy of interventions in those countries.

The findings that emerged during the various stages of the research were discussed with an expert panel representing a wide variety of organisations and key players involved in the commissioning and provision of specialist alcohol services.

### Main findings

It is not possible to include in a brief article details of all the findings, and the reader is invited to review the report on the NAO website. However, the key findings are summarised as follows:

- 1 PCTs are not consistent in accurately assessing the problems in the area of their responsibility. This has resulted in little correlation between the number of alcohol misusers and the amount spent on specialist alcohol services across PCTs. Sufficiency and cost-effectiveness of services are therefore difficult to assess.
- 2 Many PCTs do not have a strategy for alcohol harm or a clear picture

of their spending on services to address it.

- 3 PCTs often look to their local DAAT to take the lead in commissioning services to tackle alcohol harm. DAATs are not equipped for the role of identifying the larger groups of 'hazardous' or 'harmful' drinkers.
- 4 Local provision of specialist services is not based on a good understanding of communities' needs, and there are wide variations in standards of service provision.
- 5 More expensive specialist treatments have been shown to be cost effective as they reduce the high costs of treating serious alcohol-related disease.
- 6 The new Public Service Agreement (PSA) on alcohol and drugs includes only two (of five) indicators which relate to alcohol: namely, the rate of hospital admissions per 100,000 for alcohol-related harm, and the percentage of the public who perceive drunk and rowdy behaviour in their area. The former will be responsive to specialist services, rather than providing a clear incentive for PCTs to offer more simple, effective activities like brief advice. The second indicator is far more subjective, but will hopefully achieve its aim of reducing harm in the community caused by alcohol.

### Recommendations

- 1 PCTs must tailor planning and commissioning of alcohol services to local needs. The PSA may contribute to this requirement.
- 2 Consistency of detailed data collection across PCTs, via a department framework, is needed.
- 3 Consistency in how the level and cost of alcohol services is recorded locally is needed.
- 4 PCTs need to be provided with

toolkits to allow them to better identify alcohol problems early, thereby potentially reducing the need for expensive treatment later.

- 5 More clarity is needed on the part of PCTs as to their role in commissioning services, rather than expecting DAATs to do this for them. At the same time, funding for alcohol services should be more clearly specified for that purpose.
- 6 PCTs need to better assess the effectiveness and cost-efficiency of services provided.
- 7 Improved cooperation is required between PCTs and other public bodies to identify alcohol misusers.
- 8 The introduction of good evidence-based practice on alcohol harm across PCTs via a professional network of PCTs, DAATs and healthcare professionals is recommended.

### Summary

The NAO report has identified major deficiencies across the various boundaries of healthcare provision, and sets out very clear recommendations to improve recognition of alcohol problems. Once more accurate assessments are made locally then appropriate service provision should follow. What is clear is that alcohol services remain the poor relation when compared to drug services. ■

### References

- 1 National Audit Office. Reducing Alcohol Harm: health services in England for alcohol misuse. London: NAO, 2008.

### Alcoholis publication dates

This bulletin will be published quarterly in March, June, September and December.

*Items for publication should be forwarded to the Editor.*

## The Practitioner Health Programme

Dr Clare Gerada, Medical Director PHP

**As a young accident and emergency doctor I vividly recall a local GP arriving in a blue-light ambulance into the department. The doctor's name was Charles\* and he was in his mid 40s. He came in unconscious following an overdose of insulin. He had tried to kill himself having recently gone through a messy divorce.**

Charles was resuscitated but was left severely brain damaged. What emerged over the next few days was that Charles had had a history of alcohol dependence and had been abstinent for years, but following the divorce had begun to drink to deal with his depression and insomnia. The previous evening he had been found drunk in control of his car by the police. On the night of his admission he had taken a massive overdose of insulin. As a consequence of his overdose, Charles would never return to independent living and was to require nursing home care for the rest of his life. My thoughts at the time were why did the doctor not turn to his GP, or the Samaritans, for help? Why had he suffered in silence?

This paper will discuss the factors that may have made Charles more vulnerable than his non-medical peers to depression and alcohol misuse; why he would have found it difficult to seek help; and will describe a new service that hopefully, and certainly for practitioners in London, should

\* Not his real name.

prevent doctors seeking such tragic solutions to their problems.

### Doctors and mental health

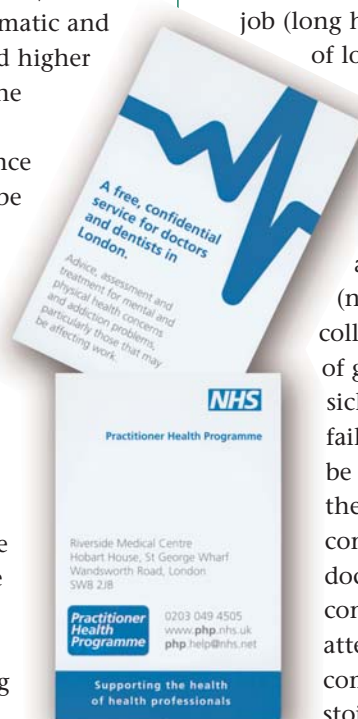
For decades now research has shown that, compared to the general population, doctors have increased rates of mental health problems. Doctors are reported to have high rates of work-related stress, anxiety, depression, somatic and social dysfunction,<sup>1</sup> and higher levels of fatigue than the general population.<sup>2</sup> Depression and substance misuse are thought to be contributory to the increased rates of suicide found in doctors.<sup>3</sup>

Around 7% of doctors have drug or alcohol problems over their lifetime.<sup>4</sup> Doctors are more than three times more likely to die from cirrhosis than the population as a whole, the only higher risk occupation group being publicans and bar staff. Evidence suggests that doctors who misuse drugs also commonly misuse alcohol and prescription medicines, such as benzodiazepines, often interchanging substances according to availability.

Within the profession, certain groups and specialties are even more vulnerable, with female doctors and those working in psychiatry being particularly prone to mental health problems. Boxes 1 and 2 list some of the common health problems found in healthcare practitioners, and some tell-tale indicators.

There are many and complex reasons why doctors appear so vulnerable to mental health problems. These reasons can be thought of as being due to the individual, (perfectionist, recruited for commitment to public service and ability to attend to detail), the job (long hours, frequent change of location/teams/role, isolated working patterns, dealing with high levels of physical and emotional distress) and cultural factors (not wanting to 'let your colleagues down', feelings of guilt and belief that sickness in oneself is a failure, and something to be ashamed of). Some of the qualities that contribute to good doctoring (such as conscientiousness, attention to detail, commitment to caring, stoicism) also, paradoxically, are

contributing factors in predicting vulnerability to mental health problems and act as barriers to seeking help. Feeling ill or dealing with one's own ill health are not subjects that are covered in medical



### Box 1 Examples of problems seen in practitioners

- Acute psychological breakdown, eg: anxiety, situational stress, burnout
- Long-term mental illness/disability, eg: bipolar disorder, brain injury, substance misuse
- Enduring personality problems, eg: psychopathy, paranoia, obsessive-compulsive disorders
- Physical illness, eg: diabetes, thyroid disease, back pain, cognitive disorders

# The Practitioner Health Programme

## Box 2 Indicators of potential mental health issues in practitioners

- Frequent absence from work, especially frequent short-term absence
- Change in personal care
- Constantly late and poor time management, perhaps spending much longer on paper work or consultations
- Inability to prioritise work
- Inappropriate behaviour – perhaps shouting in meetings, being over-familiar with staff
- Frequent complaints and concerns from patients, staff and colleagues
- Withdrawal and isolation from work events, team meetings

school training. Like the rest of the population, practitioners are affected by the stigma often attached to perceptions of mental illness and its treatment.<sup>5</sup> Doctors, especially those working in mental health fields, are particularly reluctant to seek help.

### Doctors as patients

Doctors make bad patients, finding it difficult to approach the very services that they provide and encourage their patients to use. Exemplified by Charles, doctors do not seek help until late, often doing so only after a crisis that has brought them to the attention of

their employers or colleagues; for example, being found drunk at work, being involved in a drink-driving offence or writing fraudulent prescriptions.

Doctors with mental health problems often self-medicate and rarely seek a formal consultation for their problem. It is not uncommon for doctors to self-prescribe antidepressants, anxiolytics and analgesics. This practice of self-medication may be a risk factor for later substance misuse, which is especially common among healthcare practitioners working in anaesthetics, accident and

emergency medicine and psychiatry.<sup>6</sup>

When asked, GPs cite many reasons for not seeking help for their own health. Concerns about confidentiality emerge as one factor, particularly affecting doctors' use of psychiatric services. Younger doctors feel that admitting to psychological problems may impact in a negative way on their career progression.

A sense of embarrassment or guilt is another barrier to consulting other GPs or specialists about illness in themselves or their families.<sup>7</sup> Doctors feel they shouldn't be sick. GPs often feel unable to approach a doctor who may be a local colleague or, worse still, one of their partners. Often the only route to care is self-treatment or 'corridor' consultations with colleagues: *'Can I just have a quick word...'*

### The Practitioner Health Programme

In an effort to address the twin problems of high levels of mental health morbidity and poor healthcare access found amongst doctors, the Department of Health has funded a pilot Practitioner Health Programme (PHP). The PHP is a free, confidential service for doctors and dentists living or working within the London area who have mental health and/or physical health concerns that might be affecting work, or addiction problems of any severity.

The PHP is complementary to existing NHS and non NHS services and is not to replace them. There are indeed many avenues of provision available for sick health professionals, if they choose to use them. Ideally, all sick health professionals should feel able to talk to their general practitioner. General Medical Council (GMC) guidance on doctors' health makes it clear that

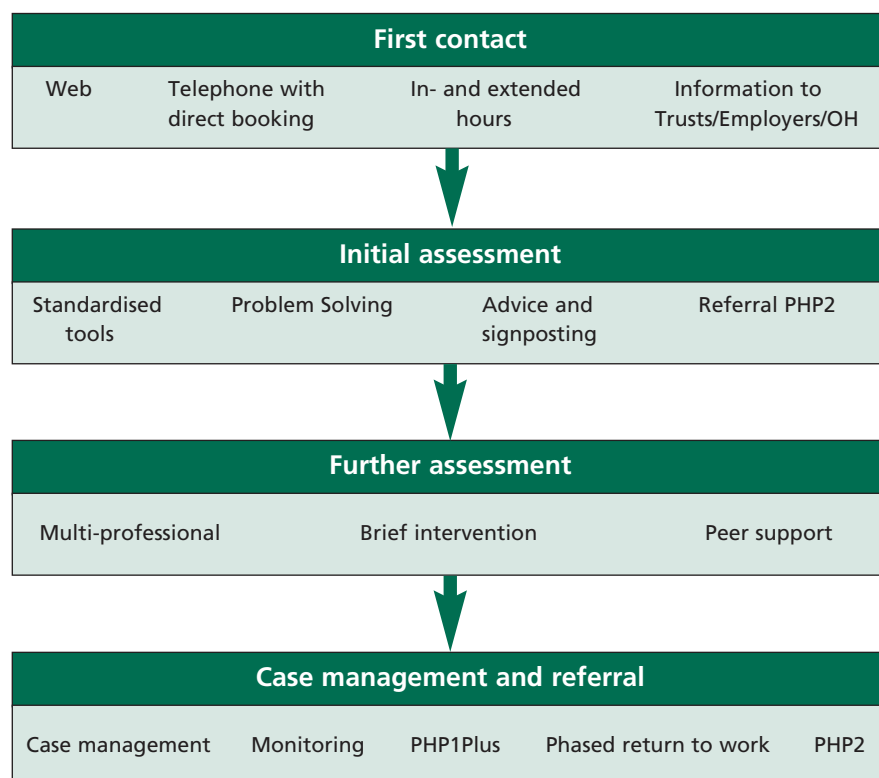


Fig 1. Services provided by the Practitioner Health Programme

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# The Practitioner Health Programme

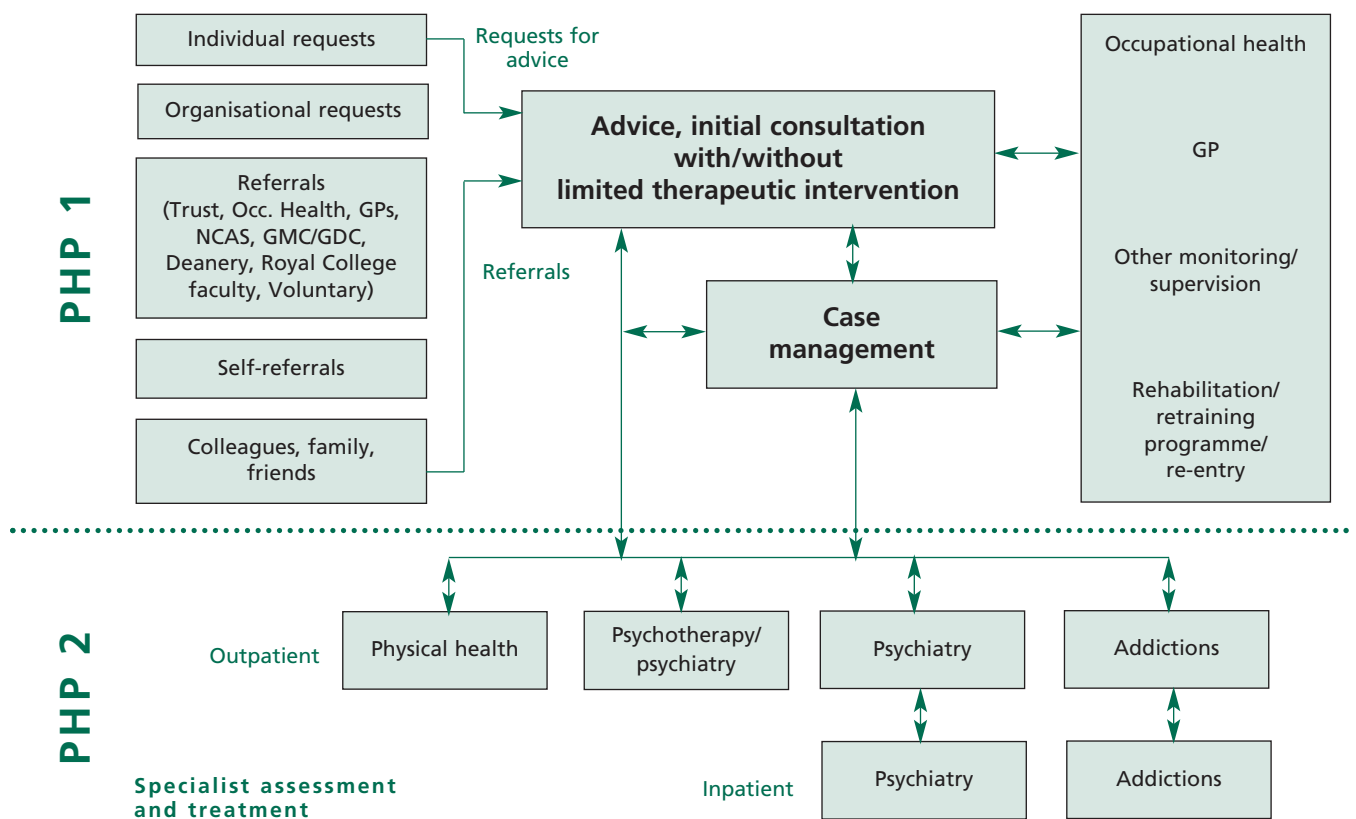


Fig 2. PHP Pathway. Purpose: to provide advice on access to local health services and a route into treatment where local services are unable to meet practitioners' needs.

all doctors are expected to be registered with a GP who is not a family member, but this does not always happen. Practical difficulties, such as frequent changes of address every time a young doctor moves job, mean that registering with a local GP is often placed on the back burner, as more pressing problems take precedence. Where specialist services are required, sick health professionals have to rely on the vagaries of their Primary Care Trust (PCT) to allow them to receive out-of-area treatment.

Occupational health services are available to some doctors but are often poorly used. Their role needs to be clarified and promoted, and rules of confidentiality understood. Occupational physicians need good consultation skills to handle doctors, which some say are their most challenging patient group.

Sick health professionals can of course access the specialist services

that are already in place. These include the BMA helpline, Doctors for Doctors, support schemes set up by some colleges and peer support groups such as the Sick Doctors Trust, British Doctors and Dentists Group, and the Doctors' Support Network. In addition some deaneries fund services, for example MedNet (London), House Concern (Newcastle), Take Time (Leeds) and the Individual Support Programme (Wales).

The PHP service has been established to provide a bridge between sick health professionals and existing services, aiming wherever possible to empower practitioner-patients to engage with existing NHS provision, but mindful of the barriers to this.

The service consists of two parts, PHP1 (primary care-led) and PHP2 (a number of preferred specialist providers).

PHP1 is led by Dr Clare Gerada,

a GP with particular expertise in mental health and substance misuse. The remainder of the team is made up of an addiction nurse, mental health, primary care and occupational health professionals. The service is located in Vauxhall, housed within an existing NHS primary care practice. The service is designed to be easily accessible, aiming to provide practitioner-patients with an appointment within two working days of referral. Practitioner-patients will be offered an assessment by one of the members of the clinical team and from this a treatment plan will be agreed with the doctor and the team.

PHP2 consists of a number of preferred specialist providers. These providers include Catio Nightingale, the Tavistock and Portman NHS Foundation Trust and South London

Continued overleaf

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and Maudsley NHS Foundation Trust. Additional residential provision can be provided by Clouds House in Wiltshire. In exceptional cases, for example if none of the three PHP2 providers are acceptable, doctors can be referred to other providers. PHP2, like PHP1 is provided free to the practitioner-patient and doctors can expect the same level of confidentiality, access and quality as with PHP1.

### Confidentiality and PHP

A major barrier to health professionals seeking help is that of confidentiality, and in particular doctors' concerns about whether, having disclosed mental health or addiction problems, they will be referred to the GMC. The PHP service guarantees the same level of confidentiality as for any other non-healthcare professional patient. An agreement has been drawn up with the GMC to the effect that, unless there are serious risks to patient safety, the practitioner-patient can be treated in an entirely confidential manner. The GMC has also agreed that PHP can have informal, confidential discussions about any doctor where PHP have concerns about patient safety. Only in exceptional circumstances will information be disclosed without explicit consent from the practitioner-patient. Practitioner-

### Contact the Practitioner Health Programme:

Riverside Medical Centre  
Hobart House, St George Wharf,  
Wandsworth Road, Vauxhall,  
London SW8 2JB

Telephone: 0203 049 4505  
Email: [php.help@nhs.net](mailto:php.help@nhs.net)  
Website: [www.php.nhs.uk](http://www.php.nhs.uk)

patients can register with PHP using a pseudonym, though for practical reasons (such as the practitioner forgetting the name they have used) this is not encouraged.

### The future

The PHP service has now been in operation since early October 2008. Even before the service is fully operational referrals have been arriving, confirming the well known maxim 'if you build it they will come'. Doctors (and dentists) have self-referred, and been referred through colleagues, spouses, friends, employers, medical directors, GMC, NCAS, NHS specialists and via self-help support services. The overwhelming response of the practitioner-patients approaching the service is one of relief, that at last there is a space where they can talk, in confidence, about their problem. Relief is often followed by thanks, and then anger that it has taken so long for them to obtain the help they need. The distress and isolation that sick health professionals have to endure underlines the need for such a

service, which hopefully, if proven to be successful, will be expanded to cover the whole country. ■

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**The Medical Council on Alcohol is a small national charity committed to improving the medical understanding of alcohol-related problems**

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