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HEALTH CARE PROFESSIONALS REFERRED FOR TREATMENT OF ALCOHOL AND DRUG PROBLEMS

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Abstract — This study reports on 62 health care professionals referred to a specialist drug and alcohol treatment service. Most patients used more than one type of substance. Health problems were common, but were seldom reasons for referral. Self-referral was infrequent. Referral was often subsequent to intoxication at work or persistent absenteeism. Just over half of admissions completed treatment. Multiple drug use was a poor prognostic indicator with fewer multiple drug users engaging with, or completing, treatment.

INTRODUCTION

The work of health care professionals places them at risk of both physical and mental health problems (Higgs, 1995). They are also more likely to develop problems associated with the misuse of drugs and alcohol. It is common for doctors to drink heavily at an early stage of their careers. Birch *et al*. (1998) found that about two-thirds of recently qualified doctors exceeded recommended safe drinking limits, whilst 10% were drinking at hazardous levels. In addition, a quarter of the doctors in this sample were using cannabis, and 10% were using hallucinogens. As many as one doctor in 15 may be affected by drug or alcohol dependence problems at some point during their careers (British Medical Association, 1998). Although more is known about alcohol misuse among doctors, those working in other health care professions are also at risk of developing drug problems. Concern about health care professionals has been expressed in relation to medical students, doctors, dentists, nurses and pharmacists (Edwards, 1975; British Dental Association, 1989; Ghodse and Howse, 1994). Fowlie (1999) has suggested that the misuse of alcohol and drugs by doctors is the major component of concern about the conduct, performance and health of the medical profession.

There are several reasons why doctors and other health care professionals may be at risk of drug and alcohol misuse. The long years of medical training are characterized by intense competition, excessive workload and fear of failure, and few occupations face the intense stresses experienced in the daily practice of medicine. In addition, doctors, nurses and others who work in medical settings have knowledge of, and easy access to, many types of drugs. Misuse of drugs by health care professionals may begin with a 'legitimate' reason such as insomnia, depression or backpain, particularly when health care professionals choose to diagnose and treat themselves, usually inappropriately. This may occur because of a heightened sense of self-sufficiency, and a tendency to minimize the severity of their problems which may delay identification of their problems by themselves or by colleagues. There may be embarrassment at meeting colleagues as patients with the issues of confidentiality that entails, and concerns about the risks to their careers because of substance misuse. These and other factors may create obstacles for health care professionals in obtaining access to conventional health care services.

In the USA, every state has an 'impaired physicians' programme (Hankes and Bissel, 1992). Elsewhere, including the UK, awareness of the problems of health care professionals has been slower to develop. A recent review of the burden of ill-health among National Health Service (NHS) staff in the UK which was submitted to the Department of Health emphasized the importance of developing dedicated services for health care workers with drug and alcohol misuse problems (Williams *et al*., 1998). At present, the NHS provides few specialist services for such professionals (Strang *et al*., 1998). One such specialist treatment service has recently been established at the Maudsley Hospital. This paper describes the personal and social characteristics, occupational background, substance misuse problems, the routes of referral, and the responses to treatment intervention of health care professionals referred to the specialist substance misuse treatment unit during the first year of operation.

SUBJECTS AND METHODS

The sample

The sample comprised all health care workers ($n = 62$) who had been referred between January 1998 and January 1999 for assessment and treatment at a specialist in-patient service for health care professionals with drug and alcohol misuse problems. All patients in this sample received a full and detailed clinical assessment by a consultant psychiatrist with a specialist interest in the addictions. In addition to meeting the criteria for ICD-10 (World Health Organization, 1992) diagnoses of alcohol and/or drug dependence, 26 (43%) of the patients fulfilled ICD-10 criteria for lifetime diagnoses of mental and behavioural disorders. The most common of these was depressive disorder [17 patients (37%)]. Other, less common, problems included anxiety disorder ($n = 4$), eating disorders ($n = 3$), and psychosis ($n = 2$).

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The service

A new service for addicted health care professionals was established by the Bethlem and Maudsley NHS Trust in London in January 1998. The service offers in-patient treatment and aftercare. Core features are rapid response to referral, such that admission can be offered within 3 days of contact, and an emphasis upon confidentiality, enabling the patient to be admitted without necessarily identifying themselves to their employing health authority. Information about the new service was disseminated by targeting public health directors, occupational physicians, and the medical and nursing press.

Treatment is provided on one of two units dedicated to either drug or alcohol misuse. Treatment is largely integrated with the treatment programme for other substance misuse patients, and, as such, includes 'standard' treatment components, such as pharmacological treatment of withdrawal syndromes associated with dependence, psychosocial counselling, and sessions to introduce and develop relapse prevention methods and appropriate coping skills. During treatment, and in addition to the standard treatment package, the patients in this sample received twice weekly counselling sessions with a senior member of the medical staff (either a consultant psychiatrist or a specialist registrar in addiction psychiatry). The planned programme duration for both the drug misuse and alcohol problems treatment was 28 days.

After discharge, all patients were offered follow-up on an out-patient basis for 1 year. The aftercare focused upon relapse prevention, health promotion, and upon issues directly related to occupational rehabilitation and continuing employment. Since patients were referred to this service from a wide geographical area, it was often more appropriate for aftercare to be provided by local services, and efforts were made to establish or support the development of local aftercare arrangements, for example through their local branch of the Doctors and Dentists Support Group, their GPs, or through specialist drug counselling services.

Procedure

Data were collected by semi-structured interviews devised specifically for this study. The research interview covered personal and social demographics, occupational history and occupational stressors, reasons for referral, recent and lifetime use of drugs and alcohol, and physical and psychological health problems. All patients who attended the first interview completed the research questionnaire, which was administered by the clinical nurse specialist or ward doctor. Further information regarding treatment contact subsequent to the research interview was collected by the clinical nurse specialist and one of the two consultant psychiatrists. Basic data were collected by telephone contact, and from referral letters and other communications for those individuals who did not attend the service subsequent to referral.

Analyses of treatment engagement were undertaken by comparisons of those patients who started treatment with the service ($n = 46$) and those who failed to make contact with the service after initial referral ($n = 16$). Further comparisons were made between those who completed in-patient treatment ($n = 24$) and those who failed to complete treatment ($n = 22$). These comparisons were made by multiple logistic regression analysis. The four covariates were age, gender, main type of substance problem and multiple drug use.

RESULTS

Demographics and occupational background

There were no differences between the cases who attended the service for the first interview ($n = 46$) and those who failed to attend ($n = 16$) in terms of age, sex, profession, or main substance problem. The average age for both groups was 44 years; 59% of attenders and 50% of non-attenders were men ($\chi^2 = 0.37$, $P = 0.55$); 46% of attenders and 44% of non-attenders were doctors ($\chi^2 = 0.02$, $P = 0.90$); 59% of attenders had alcohol problems compared to 56% of non-attenders ($\chi^2 = 0.03$, $P = 0.86$).

Among the 46 who attended the first interview, the largest occupational group comprised doctors ($n = 21$, 46%). Eighteen were nurses (39%). The remainder were paramedical staff (including medical laboratory assistants, operating room technicians) ($n = 4$), dentists ($n = 2$) and a pharmacist. Many ($n = 20$, 44%) were of senior grade, with 17 (37%) of middle grade and nine (20%) of junior grade.

Referral

Only 9% of cases were self-referrals. The most frequent reason for referral was poor work performance or absenteeism (41%). In such cases, referral was often made by the employing Trusts or by the occupational health physician. In a number of cases, poor work performance had prompted referral through an increased workload falling upon other colleagues. The second most frequent reason for referral (30% of cases) was disciplinary action or the threat of disciplinary action by the employer or professional governing body. One third (33%) of the referrals were made by a Consultant grade physician. Just under one-third (30%) were made by a Community Drug Team. Other referrals were made by general practitioners (15%) or occupational health services (11%). Doctors were more likely to have been referred by a Consultant or a General Practitioner (GP) ($\chi^2 = 3.07$, $P = 0.08$), and nurses were more likely to have been referred by a Community Drug Team ($\chi^2 = 5.35$, $P < 0.05$). Three patients had been referred for legal reasons (two for drinking and driving offences and one for theft of drugs). Only one person reported that the main reason for them seeking treatment was because of health problems. None of the referrals was prompted directly by the General Medical Council.

In the majority of cases ($n = 27$, 59%), the patient's colleagues were aware of their problem. This was often as a result of an incident in which they had been intoxicated at work ($n = 15$, 33%). Other reasons why colleagues were aware of their problems included persistent absenteeism ($n = 9$, 20%), and detection of drug theft or associated discrepancies ($n = 4$, 9%).

Substance use problems

Alcohol. More than half of the interviewed sample ($n = 27$, 59%) presented with a primary alcohol problem. Among the patients with drink problems, the average quantity of alcohol consumed on a typical drinking day prior to interview was 26 units. The Royal College of Psychiatrists (1986) recommends sensible drinking limits of 21 units per week for men and 14 units for women. One UK unit = 8–10 g of alcohol. The patients presenting with alcohol problems were more likely to be older than those with drug problems ($t = 2.34$, $P < 0.05$) and to be of senior grade ($\chi^2 = 3.88$, $P < 0.05$).

Drugs. For patients ($n = 19$, 41%) presenting with a drug problem, the most common main problem drugs were opiates ($n = 11$, 24%) or anaesthetic agents ($n = 6$, 13%). Opiates included pethidine, fentanyl, pharmaceutical diamorphine, illicit street heroin, methadone, dihydrocodeine, and codeine. Two individuals were referred because of their use of hallucinogens and barbiturates. Eleven patients with drug problems reported that they obtained drugs from medical sources, including theft from a ward or operating theatre supply, using drugs intended for use by patients, using drugs left over from supply to patients, and prescribing drugs to themselves in the name of another patient. Six reported that they mainly obtained drugs from illicit sources.

About half of the patients with drug problems (9/19) reported that their use of drugs was primarily by injection. Drugs used by injection included opiates ($n = 5$) and anaesthetic drugs ($n = 4$). All but one of these patients administered their drugs by intravenous injection. In one case, opiates were administered by intramuscular injection. Other routes of use were oral (eight cases), and smoking illicit heroin (two cases).

Polysubstance use. Most of the patients ($n = 33$, 72%) reported current use of several drugs (other than alcohol). Patients with alcohol or drug problems were equally likely also to be using benzodiazepines ($\chi^2 = 0.49$, $P = 0.80$), with more than one-third of the alcohol patients (37%) and almost half of the drug patients (47%) reporting current use of these drugs. Patients with alcohol problems were less likely than the drug-using patients to be using opiates ($\chi^2 = 22.1$, $P < 0.001$), anaesthetics (Fisher's exact test, $P < 0.01$) or cannabis (Fisher's exact test, $P < 0.001$). Stimulant use was infrequent (cocaine and amphetamines used by six, or 13% each).

Physical and psychological health problems. Many health problems were related to drug and alcohol dependence syndromes. Half of the patients ($n = 23$) had experienced withdrawal symptoms prior to their admission. Other problems included memory blackouts ($n = 9$, 20%), liver disease ($n = 5$, 11%), peripheral neuropathy ($n = 4$, 9%), withdrawal seizures ($n = 3$, 7%), and hepatitis C infection ($n = 2$). Nine (20%) had suffered a non-intentional overdose.

Twenty-six of the patients (43%) had a history of psychiatric treatment prior to referral. Seventeen patients (27%) had previously been treated for depression. Less common problems included anxiety disorders ($n = 4$), eating disorders ($n = 3$) and psychosis ($n = 2$).

About one-third of the patients (35%) reported no specific occupational stressors. The most frequently reported stressors included excessive working hours (26%), followed by interpersonal problems with colleagues (17%) and practice changes or job loss (15%).

Treatment engagement. Twenty-two of the sample (48%) had received previous treatment for substance misuse problems which involved some form of detoxification treatment. There was no difference between patients presenting with primary alcohol problems or primary drug problems with respect to previous treatment contact ($\chi^2 = 0.42$, $P = 0.51$). Patients who completed the current episode of in-patient treatment ($n = 24$) were compared with those who failed to accept or to complete treatment ($n = 22$). The regression model was statistically significant ($\chi^2[4] = 9.79$, $P < 0.05$). Patients with alcohol problems were more likely to engage with and complete treatment than patients with drug problems (Wald = 4.25, $P < 0.05$), and patients using drugs in addition to their main problem substance were less likely to engage with treatment (Wald = 6.18, $P < 0.05$).

A further comparison was made between doctors and other professionals in rates of treatment completion. There was no difference between doctors and other professionals (52% vs 52%; $\chi^2 = 0.00$; $P = 0.98$). When profession was entered into the regression analysis, the regression model was not statistically significant ($\chi^2 = 9.85$; $P = 0.08$).

DISCUSSION

The health care professionals referred for treatment at this new service were drawn from a wide range of professional groups, and, although many were of senior grade, the treatment sample included people at all stages of their careers, from recent qualification to nearing retirement. This is consistent with the findings of Brooke *et al*. (1991). Previous studies at the Maudsley Hospital have focused on addicted doctors (Murray, 1976; Brooke *et al*., 1991, 1993), but many nurses accessed the service and doctors comprised less than half of the total sample. There have been no systematic studies of nurses or other health care professionals in the UK, even though they are the largest workforce in the NHS. The present study suggests that they are also vulnerable to the psychological and physical problems previously described among doctors.

Many of our patients were using more than one drug and concurrent benzodiazepine use was frequent. The use of multiple substances was a poor prognostic indicator with fewer multiple drug users engaging with, or completing, treatment. Many health care professionals also had long-standing problems with severe physical and psychiatric co-morbidity. Psychological and psychiatric problems are often associated with substance misuse problems among physicians (Johnson and Connelly, 1981). Brooke *et al*. (1993) noted that the development of a substance misuse problem cannot be reduced to a single factor. However, several studies have found high rates of psychological and psychiatric problems in such samples. Brooke *et al*. (1993), for example, found high rates of anxiety and depression among their sample of British doctors receiving treatment for substance misuse problems, and their finding that about one-third of their sample had anxiety and depression problems is directly comparable to our own finding that just over one-third of our sample had previously received treatment for depression. In this respect, however, health care professionals probably do not differ from other substance misusers, who frequently present a range of psychological and psychiatric difficulties, and who frequently have contact with psychiatric treatment services (Marsden *et al*., 2000). As with other substance misusers, drug and alcohol misuse may also increase other risks, including suicide, among physicians (British Medical Association, 1993). About one-fifth of our sample had previously taken an overdose.

Physical, psychological and psychiatric problems were rarely a reason for seeking treatment. Self-referrals were also infrequent. In professions which place great store on self-reliance and competence, it is often difficult for the individual to acknowledge problems (Brooke, 1995), particularly those associated with stigma and disapproval, which threaten their livelihood. Referral often followed an incident involving

intoxication at work or persistent absenteeism. Those with responsibility for helping health care professionals, such as occupational health physicians, consultants in public health and local medical committees, need to promote access to treatment to enable health care professionals to obtain help for substance misuse problems at an earlier stage. A recent report from the USA described the chief components of a programme intended for students and junior doctors, which emphasized the importance of early intervention to prevent problems escalating and becoming chronic (Coombes, 1998).

Regulatory bodies in the UK, such as the General Medical Council, now include a procedural track which allows substance misuse problems in doctors to be considered as a health problem, and support treatment and rehabilitation with the aim of returning the doctor to clinical practice, usually under extended supervision. The medical and dental professions have also established several self-support groups, including the Sick Doctors Trust and the British Doctors and Dentists Group. At present, nurses have no such support networks within their profession. The misuse of drugs or alcohol by nurses is regarded as a form of professional misconduct, and can lead to disciplinary procedures of the UKCC (UK Central Council for Nursing, Midwifery and Health Visiting). In 1997, almost three-quarters of the cases considered by the Committee involved drug and alcohol problems. When such problems are identified, there are rarely any therapeutic or rehabilitative structures in place to promote return to work under supervision or to ensure safe clinical practice. This tendency to regard drug and alcohol misuse almost exclusively as a disciplinary matter and the resistance to support the return to clinical practice could be expected to deter nurses from seeking treatment. The recent British Medical Association (1998) report has suggested that procedures should be in place to allow early recognition and management of substance use problems among health care professionals, and that even those who have had very serious problems can be helped to return to productive professional engagement.

It is unclear whether the drug problems among our clients reflected special problems of occupational exposure associated with access to drugs. An alternative view would be that they presented addiction problems which coincidentally occur among health care professionals. The observation that some drug users in our sample were using illicit drugs indicates contact with the wider drug scene. Also, the fact that two of the sample were infected with hepatitis C suggests that their infection stemmed from the shared use of injecting equipment with street users. Further research should investigate aetiological pathways for addictive behaviour in this group.

In-patient treatment has been recommended for health care professionals (Collins, 1991). Treatment in the present study was provided in an in-patient setting, and the clients valued confidentiality at the outset of their treatment, which was helped by geographical separation from their local professional community. However, many spoke of their difficulties in sharing their experiences with a non-professional group of people with substance use problems. The special needs of health care professionals may be better addressed within a dedicated unit, rather than alongside non-professional patients. Some patients withheld from other patients on the ward the fact that they were a health care professionals, whilst in other cases knowledge of their professional status caused special difficulties. One patient reported being asked to prescribe controlled drugs by another patient. The British Medical Association (1998) report has also acknowledged that health care professionals are entitled to the highest standard of confidentiality, and that, where such patients are well-known within their community, reciprocal arrangements between health authorities and provider units may be required. Such arrangements may need to be inter-regional.

Outcomes for physicians are often favourable (Kliner *et al*., 1980; Morse *et al*., 1984; Shore, 1987; Lloyd, 1990, Brooke *et al*., 1991). Overall, in our sample, half the patients completed the in-patient treatment programme. This is not a particularly favourable intermediate outcome, since treatment retention and programme completion have been identified in many studies as related to clinical improvement at subsequent follow-up (Simpson and Sells, 1980; Hubbard *et al*., 1989; Simpson *et al*., 1997; Gossop *et al*., 1999). We do not, at present, have outcome data over the longer-term.

As a group, health care professionals with substance misuse problems deserve investment. It is important that access to treatment be supported by trustworthy and confidential channels of referral and the capacity to respond swiftly to crises when they arise (Strang, 1999). The commitment to early identification of substance use problems among health care professionals, to early intervention and appropriately tailored services and interventions are recommended for the effective treatment of these problems (British Medical Association, 1998). Such measures may also increase the attractiveness of services for users and lead to improved attendance at, and retention within, services.

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