Alcohol and other drugs: core medical competencies

Final report of the working group of the medical Royal Colleges

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Contents

Key recommendations

This working group has developed a consensus across 13 medical Colleges and Faculties on the following core competencies, which it recommends should be incorporated into postgraduate curricula for all doctors.

Knowledge

- Effects, common presentations and potential for harm of alcohol and other drugs.
- Addictive potential of alcohol and other drugs, including prescribed and over-the-counter medicines.
- Range of interventions, treatments and prognoses for use of alcohol and other drugs.
- Effects of alcohol and other drugs on the unborn child, children and families.
- Recommended limits on alcohol intake.

Skills

- Be competent to make an assessment of alcohol and other drug use, including taking a history and using validated tools.
- Recognise the wide range of acute and long-term presentations involving use of alcohol and other drugs (e.g. trauma, depression, hypertension)
- Provide brief advice on use of alcohol and other drugs.
- Provide management and/or referral where appropriate.

Behaviour/attitudes

- Work in a supportive, empathic and non-judgemental manner without collusion.
- Be confident and comfortable discussing alcohol and drug use with patients.
- Act appropriately on any concerns about own or colleagues' use of alcohol and/or other drugs.

Foreword

The use of alcohol and other drugs is widely recognised as a major public health challenge with wide-reaching social and economic consequences. In the case of alcohol, the challenge is increasing, with average levels of consumption, and numbers of those drinking hazardously and harmfully, on the rise. The impact on the NHS is extensive, causing over a million hospital admissions per year, and affecting a wide range of services.

Tackling this challenge effectively will require a broad approach, involving all parts of society. It will need to include measures on public education and information; alcohol pricing, labelling, marketing and licensing; law enforcement on illicit drugs; as well as treatment service commissioning and delivery.

Within this broader approach, medical treatment is clearly a key element. Specialist services such as alcohol and drug treatment and hepatology are crucial. But they will always be just part of the picture: only 6% of alcohol-dependent drinkers receive treatment each year. Every day, alcohol and other drug users present across the range of health services and are seen by doctors from every specialty.

There is good evidence that early identification and an appropriate, non-stigmatising response from medical professionals can improve outcomes. For many people, a few minutes of advice can be highly effective, particularly when given by a doctor treating them for medical or surgical complications of their alcohol or other drug use. It can potentially change their behaviour and health risks over the longer term, not only enhancing their own health and well-being but also saving considerable NHS resources.

As medical students, all doctors learn about key aspects of alcohol and other drugs, and the Foundation Programme and several postgraduate curricula cover various competencies pertaining to alcohol and other drugs. But an agreed set of core competencies, incorporated across the postgraduate curriculum for doctors of all specialties, will help to underpin the attitudes and awareness needed to increase rates of identification and treatment. That is what this project sets out to deliver, as a contribution to the wider changes needed to address this major public health challenge.

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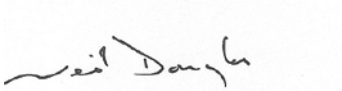

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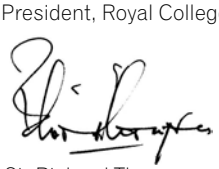

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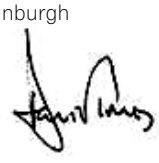

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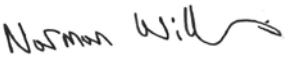

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The need for core medical competencies

The impact of alcohol and other drug use

It is well documented that use of alcohol and other drugs in the UK is a major source of harm to health, as well as of other social, economic and human costs.

While this is true of both alcohol and other, illicit, drugs, it is alcohol that presents the greatest challenge in terms of population levels of harm to health. In England, 25% of the adult population (7.6 million people) drink at hazardous levels, of whom 2.9 million show clear evidence of some alcohol-related ill health (National Audit Office, 2008). By comparison, around 9% of adults report use of illicit drugs once or more in the past year, and there has been an overall decrease in declared illicit drug use, from 11.1% in 1996 to 8.8% in 2010–2011 (Smith & Flatley, 2011).

Typical estimates of the total annual costs attributed to alcohol use in England range from £20 billion (Prime Minister's Strategy Unit, 2004) to £55.1 billion (Lister, 2007). These figures take account of non-medical costs such as alcohol-related crime and lost productivity, but the harm to health alone is significant. It has been estimated that alcohol is directly responsible for some 15 000 deaths annually (Jones *et al*, 2008). It may also be indirectly implicated in as many as 40 000 deaths per year: 10–27% of deaths among men and 6–15% among women aged between 16 and 55 (House of Commons Health Committee, 2009).

And the problem is getting worse: between 1970 and 2000, deaths from liver disease (regarded as a marker for alcohol-related harm to health) in those aged 65 years or under increased fivefold (House of Commons Health Committee, 2009).

For both alcohol and other drugs, harm arises through a complex variety of mechanisms, which can be grouped into three areas:

- effects and risks of acute intoxication (e.g. trauma, sexually transmitted infections, overdose and violence to others)
- chronic direct and indirect toxic effects (e.g. hepatitis, cardiovascular disease, cancers, fetal alcohol syndrome, depression and anxiety disorders)
- addictive propensity of alcohol and other drugs, with the physical, psychological and social harms that ensue.

All of these mechanisms may affect not only the individual, but also those around them (e.g. through violence, drink-driving, abuse, anxiety), particularly children, and so the burden of 'passive harm' is also substantial.

Given the foregoing, it is unsurprising that alcohol and other drug use has a major impact on the NHS, across the entire range of services it provides: from neonatal to elderly care; from community settings, through unscheduled acute care, to highly specialist regional services (e.g. specialist alcohol treatment centres, liver transplant units and regional mood disorder services). Alcohol cost the NHS in England £2.7 billion in 2006–2007 alone (National Audit Office, 2008) and caused over a million hospital admissions in 2009–2010 (NHS Information Centre, 2011).

The need for core competencies

Specialist services focusing on treatment for addiction or for harm directly caused by alcohol and other drugs are a crucial part of medical provision. But the prevalence of use, and the range of harm to health that results, mean that all doctors, across all medical specialties, need to be adept at identifying problematic use of alcohol and other drugs.

This is important for two reasons. First, it allows them to deliver effective treatment for the presenting condition. Second, it allows them to provide patients with brief advice on alcohol or other drug use to help prevent or reduce future harm. For alcohol users in particular, there is strong evidence that brief advice is effective. This is recognised in the recent suite of guidance published on alcohol by the National Institute for Health and Clinical Excellence (NICE): Public Health Guidance PH24 (National Institute for Health and Clinical Excellence, 2010) and Clinical Guidelines CG100 (National Collaborating Centre for Chronic Conditions, 2010) and CG115 (National Collaborating Centre for Mental Health, 2011). A key priority in each of these is that all NHS professionals should be competent to screen for alcohol use as an integral part of practice, and that adults found to be drinking at hazardous or harmful levels should receive brief advice (Box 1).

However, harmful alcohol use and dependence are currently under-identified by health professionals, leading to missed opportunities to provide effective interventions, from opportunistic screening of patients earlier on in their drinking career, through to identifying those with significant alcohol or other drug misuse underlying their presenting complaint. This is one important reason why, of the 1.6 million people who are alcohol dependent in England, only about 6% per year receive treatment (HM Government, 2010).

Box 1 Selected recent policy reports and clinical guidance

'*The available evidence suggests that simple, often early interventions such as identification and brief advice can bring substantial savings by reducing the need for more intensive treatment later […]. However, [this] is only sporadically provided by GPs and health workers, and rarely used in other parts of the heath service such as accident and emergency (A&E) departments*'

– National Audit Office, 2008: p. 7

'*Early detection and intervention [for alcohol] is both effective and cost effective […]. If hazardous and harmful levels of drinking can be detected, there is scope for intervening before patients either acknowledge their own drinking problem or seek help. Detection should be a matter for all parts of the NHS […]. Clinical staff in all parts of the NHS need better training in alcohol interventions*'

– House of Commons Health Committee, 2009: chapter 5

'*Staff working in services provided and funded by the NHS who care for people who potentially misuse alcohol should be competent to identify harmful drinking and alcohol dependence. They should be competent to initially assess the need for an intervention*'

– National Collaborating Centre for Mental Health, 2011: p. 10

In 2010, the British Society of Gastroenterology, the Alcohol Health Alliance UK and the British Association for the Study of the Liver issued a joint position paper on alcohol (Moriarty *et al*, 2010). It made recommendations on alcohol service provision, particularly in secondary care, calling for adequate training across medical specialties in order to support improved provision, underpinned by 'accreditation of competencies at a national level'.

NICE guidance PH24 (National Institute for Health and Clinical Excellence, 2010) recommends that 'NHS professionals should routinely carry out alcohol screening as an integral part of practice', or at least for patients with a condition that may be alcohol related or who are at increased risk of harm from alcohol. It recommends that adults drinking at hazardous or harmful levels receive brief advice, or extended brief interventions, from suitably competent staff. Individuals showing signs of moderate or severe alcohol dependence, or severe alcohol-related impairment or a comorbid condition, should be considered for referral for specialist treatment.

Recent reports from Royal Colleges, the Royal Academy of Medical Sciences, the British Gastroenterology Society, the Alcohol Health Alliance, the Parliamentary Select Committee on Alcohol and the National Treatment Agency, as well as the NICE guidance on alcohol, have presented compelling reasons for a system change in how alcohol and other drug use is recognised and managed across the range of health services to which patients present, with greater emphasis on early identification and intervention.

Delivery of this system change will need to be underpinned by action by commissioners and managers, both within the NHS and in public health and social care. But it will also depend crucially on action by clinical teams and individual doctors, who need to apply the appropriate knowledge, skills and attitudes in caring for patients who use alcohol and other drugs.

The current situation on medical competencies

With this in mind, it is appropriate to review the competencies required of doctors in relation to alcohol and other drugs, and to ensure that medical training gives adequate weight to every doctor's role in this area.

Guidance has already been produced on substance misuse in the undergraduate curriculum (International Centre for Drug Policy, 2007), and the Department of Health of England has now funded an implementation and development phase for the curriculum in 24 English medical schools.

However, competencies gained at medical school need to be reinforced and re-emphasised in postgraduate specialist medical and surgical training – so that it is well understood that managing the complications of alcohol and other drug use is an integral part of every doctor's work, no matter in which area they specialise.

The first task of the working group was to review the current postgraduate curricula for core (basic specialist) training (generally the first 2–3 years after foundation training up to College membership examinations). It found that the curricula of three of the eleven medical Royal Colleges that we examined made no specific mention of alcohol or other drugs, four made brief mention of a few competencies, primarily related to the particular College's specialty, and four contained extensive lists of competencies.

This lack of consistency confirmed the need for a consensus, across the Colleges, on a list of common, core competencies for alcohol and other drugs.

The project: aims, method and implementation

Aims

The key aims of this project, sponsored by the Academy of Medical Royal Colleges and led by the Royal College of Psychiatrists, together with the Royal College of Physicians, were:

- to develop a set of core competencies agreed across medical and surgical specialties; and
- to seek and monitor incorporation of those agreed competencies in the Colleges' postgraduate medical and surgical training curricula.

It is important to emphasise that there is no intention that curricula that already include more specialist competencies should reduce what they expect their trainees to know. Rather, the aim was to provide an agreed formulation of basic competency in this area for all specialties, with which individual Colleges can align their own more specialist competencies as they deem appropriate.

Method

To achieve its aims, the project used a Delphi process (e.g. Alahlafi & Burge, 2005; McClaran & Sinclair, 2006). This is a well-established method for establishing consensus, and it provides an effective structure for group communication about a given topic. It has been effectively used in various healthcare settings, including: defining essential components of care for patients with various diagnoses; medical student curriculum development; responses to major incidents; and examining priorities in different stakeholder groups.

A Delphi process:

- uses a panel of 'informed individuals' (i.e. stakeholders) in the topic under discussion
- is an iterative process which, through a number of rounds, aims to move towards consensus
- uses a system of providing controlled feedback from the group to individuals
- protects participant anonymity, encouraging the free expression of views without the disproportionate impact that influential individuals can have on group processes.

Medical and surgical Colleges and Faculties that are members of the Academy of Medical Royal Colleges, along with lay organisations and patient representatives, were invited to nominate representatives to a working group (see page 6). A group of wider stakeholders (see page 7) were informed of the project and invited to submit comments and ideas for core competencies. The wider stakeholders were supportive of the project, and several submitted possible competencies, which were duly fed into the Delphi process.

The aims of the first meeting of the working group were:

- to discuss and agree whether to deal with alcohol and other drugs separately or together; and
- to generate an over-inclusive list of potential competencies derived from current postgraduate curricula, stakeholder suggestions and working group discussion.

Following debate, it was agreed to develop a single set of core competencies for 'alcohol and other drugs', in recognition of some of the shared underlying mechanisms inherent in their use, while recognising that from a health perspective, alcohol represents the greatest challenge in terms of the range of harms presenting to health, often to patients who are not aware that they are drinking at hazardous levels.

The working group generated a total of 43 potential competencies, which were refined down to 12 over the ensuing iterations. The iterations took place by email, with each working group member ranking each potential competency on a 5-point Likert scale (1 = most essential, 5 = not at all essential) based on the question:

'How ESSENTIAL do you think it is that EVERY doctor should…?',

followed by a list of competencies categorised into knowledge, skills and behaviour/attitudes.

On subsequent iterations, individuals were given, for each item, their own as well as the group median score, and asked to re-score the competencies on the basis of this feedback.

After two iterations, there was little further change in scoring, so those competencies that had received a score of 1 from at least nine members of the working group (a total of 19 competencies) were identified, and working group members were asked to rank these in order of importance in each of the three categories (knowledge, skills and behaviour/attitudes).

The task of the second meeting of the working group was to refine the wording of the competencies, and a final iteration reduced the number of competencies on which there was complete consensus to the twelve listed on page 3 – five relating to knowledge, four to skills and three to behaviour/attitudes.

Implementation

The participating Colleges have made a commitment to incorporating the competencies into their curricula at the first available opportunity. Working group members are in liaison with curriculum leads in their respective Colleges to support this, and the curriculum committees in a number of Colleges have already taken steps towards amending their curricula as necessary. An implementation workshop will be held in June 2012 for working group members, postgraduate curriculum leads and other interested parties from a range of settings (e.g. Colleges, Faculties and Deaneries). This will review implementation, and identify and resolve any emerging problems. A subgroup of the original working group will support and monitor implementation, and report on progress to the Academy of Medical Royal Colleges in spring 2013.

References and further reading

Academy of Medical Sciences (2004) *Calling Time: The Nation's Drinking as a Major Health Issue*. Academy of Medical Sciences (http://www.acmedsci.ac.uk/download.php?file=/images/publication/pcalling.pdf).

Alahlafi, A. & Burge, S. (2005) What should undergraduate medical students know about psoriasis? Involving patients in curriculum development: modified Delphi technique. *BMJ*, **330**, 633–636.

Anderson, P. & Baumberg, B. (2006) *Alcohol in Europe: A Public Health Perspective*. Institute of Alcohol Studies (http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/documents/alcohol_europe_en.pdf).

Babor, T., Caetano, R., Casswell, S., *et al* (2010) *Alcohol: No Ordinary Commodity: Research and Public Policy (2nd edn)*. Oxford University Press.

Department of Health (England) and the devolved administrations (2007) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive (http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf).

General Medical Council (2009) *Tomorrow's Doctors: Outcomes and Standards for Undergraduate Medical Education*. GMC (http://www.gmc-uk.org/education/undergraduate/tomorrows_doctors_2009.asp).

HM Government (2010) *Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery. Supporting People to Live a Drug-Free Life*. Home Office (http://www.homeoffice.gov.uk/drugs/drug-strategy-2010).

House of Commons Health Committee (2009) *Alcohol: First Report of Session 2009–10*. TSO (The Stationery Office) (http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/151/15102.htm).

International Centre for Drug Policy (2007) *Substance Misuse in the Undergraduate Medical Curriculum*. International Centre for Drug Policy (St George's, University of London) (http://www.sgul.ac.uk/research/projects/icdp/our-work-programmes/pdfs/substance-misuse-book.pdf).

Jones, L., Bellis, M. A., Dedman, D., *et al* (2008) *Alcohol-Attributable Fractions for England: Alcohol-Attributable Mortality and Hospital Admissions*. Centre for Public Health & North-West Public Health Observatory.

Lister, G. (2007) Evaluating social marketing for health – the need for consensus. In *Proceedings of the National Social Marketing Centre*, September 2007, Oxford.

McClaran, J. & Sinclair, J. M. A. (2006) Going beyond faculty development evaluation – a Delphi process. In *Proceedings of 12th International Ottawa Conference on Clinical Competence*, New York City, pp. 148–149. Association for Medical Education in Europe.

Morgan, M. & Ritson, B. (2010) *Alcohol and Health: A Handbook for Practitioners (4th edn)*. Medical Council on Alcohol.

Moriarty, K. J., Cassidy, P., Dalton, D., *et al* (2010) *Alcohol-Related Disease: Meeting the Challenge of Improved Quality of Care and Better Use of Resources (Joint Position Paper on behalf of the British Society of Gastroenterology, Alcohol Health Alliance UK and the British Association for the Study of the Liver)*. British Society of Gastroenterology (http://www.bsg.org.uk/clinical/publications/index.html).

National Audit Office (2008) *Reducing Alcohol Harm: Health Services in England for Alcohol Misuse*. NAO (http://www.nao.org.uk/publications/0708/reducing_alcohol_harm.aspx).

NHS Information Centre (2011) *Statistics on Alcohol: England, 2011*. Health and Social Care Information Centre (http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/Alcohol_2011/NHSIC_Statistics_on_Alcohol_England_2011.pdf).

National Collaborating Centre for Chronic Conditions (2010) *Alcohol Use Disorders: Diagnosis and Clinical Management of Alcohol-Related Physical Complications (NICE Clinical Guideline CG100)*. National Institute for Health and Clinical Excellence (http://guidance.nice.org.uk/CG100).

National Collaborating Centre for Mental Health (2007) *Drug Misuse: Psychosocial Interventions (NICE Clinical Guideline CG51)*. National Institute for Health and Clinical Excellence (http://guidance.nice.org.uk/CG51).

National Collaborating Centre for Mental Health (2011) *Alcohol Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence (NICE Clinical Guideline CG115)*. National Institute for Health and Clinical Excellence (http://guidance.nice.org.uk/CG115).

National Institute for Health and Clinical Excellence (2010) *Alcohol-Use Disorders – Preventing the Development of Hazardous and Harmful Drinking (NICE Public Health Guidance PH24)*. NICE (http://guidance.nice.org.uk/PH24).

Prime Minister's Strategy Unit (2004) *Alcohol Harm Reduction Strategy for England*. Cabinet Office, Prime Minister's Strategy Unit (http://webarchive.nationalarchives.gov.uk/+/http://www.cabinetoffice.gov.uk/strategy/work_areas/alcohol_misuse.aspx).

Royal College of Obstetricians and Gynaecologists (2011) Saving mothers' lives: reviewing maternal deaths to make motherhood safer: 2006–2008. *BJOG: An International Journal of Obstetrics & Gynaecology*, **118** (Suppl. 1), 1–203.

Royal College of Physicians (2001) *Alcohol – Can the NHS Afford It? Recommendations for a Coherent Alcohol Strategy for Hospitals*. Royal College of Physicians.

Royal College of Psychiatrists (2008) *Alcohol: Our Favourite Drug*. Royal College of Psychiatrists (http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/alcoholanddrugs/alcoholourfavouritedrug.aspx).

Royal College of Psychiatrists & Royal College of General Practitioners (2012) *Delivering Quality Care for Drug and Alcohol Users: The Roles and Competencies of Doctors: A Guide for Commissioners, Managers and Clinicians* (College Report CR173). Royal College of Psychiatrists, in press.

Royal College of Surgeons of England (2010) *Reducing Alcohol Misuse in Trauma and Other Surgical Patients: Position Statement*. Royal College of Surgeons of England (http://www.rcseng.ac.uk/policy/documents/alcohol-and-trauma-policy-statement.pdf).

Smith, K. & Flatley, J. (eds) (2011) *Drug Misuse Declared: Findings from the 2010/11 British Crime Survey. England and Wales* (Home Office Statistical Bulletin 12/11). Home Office (http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1211).