MEDICAL EDUCATION IN ALCOHOL AND ALCOHOL PROBLEMS

A European Perspective

eurocare

PREFACE

LIPHA, an affiliate of MERCK KGaA, Darmstadt, Germany, is a pioneer in alcoholism research and treatment and supports initiatives in all fields related to alcohol.

In October, 1998, LIPHA gathered together in Lisbon experts from all over Europe to discuss "Under- and Post-graduate Medical Education in Alcohol Problems". This arose from an interest in promoting responses to what all Member Countries of the European Union consider to be a major public health issue.

The objectives of the meeting were:

- to achieve an overview of the different educational programmes in Europe concerned with alcohol;
- to identify gaps in provision;
- to exchange points of view;
- to reach a consensus for a European approach and define guidelines for a minimum educational level in alcohol problems within the normal curriculum of under- and postgraduate medical students.

This book aims to reflect what needs to be done to ensure appropriate management of patients with alcohol-related problems.

FOREWORD

In many fields Europeans are strengthening their collaboration towards the construction of a more unified society.

In the alcohol field, the producers have shown the way in exploiting the economic potential of Europe which resulted from the Treaty of Rome. Far behind them, those working in public health are attempting to unite their efforts to ensure that the development of economic activity is not at the expense of people's health. Today they can rely on recent European treaties, in particular the Treaties of Maastricht and Amsterdam which include public health objectives.

The growing similarity in drinking habits among Europeans implies a convergence in the medical and social problems associated with alcohol and, consequently, in ways of tackling these problems. However, where medical practice is concerned, the national divisions arising from cultural differences remain.

Alcohol is now very much on the public health agenda in Europe, and the time was clearly right, therefore, for an inventory of the various national approaches to medical education about alcohol. Thanks to this study, we are made aware of the real European dimension to this subject. Alas, one of the main findings is that there are clear deficiencies in medical education about alcohol across the whole of Europe.

I hope that this report will lead to improved medical education, common standards, and bridges to be built between public health workers in the different countries of Europe.

We are grateful to Lipha, Affiliate of Merck KgaA, for commissioning and supporting this report, and to Andrew McNeill and the staff of the Institute of Alcohol Studies for their work in preparing it for publication.

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Regional Office for Europe

The Nature of Alcohol Problems

Despite declines mainly in wine-producing countries, Europe remains the region of the world with the highest production and consumption of beverage alcohol, with commensurately high levels of alcohol-related harm. Any idea that to experience a significant problem with alcohol is a rare occurrence is dispelled by the available evidence. 1 North American surveys have found that over 23 per cent of men and 4.5 per cent of women experience alcohol abuse or dependence during their lifetime. Nearly 12 per cent of men and over 2 per cent of women experience abuse or dependence in any one year. North America is around the middle of the international league of alcohol consumption.

In all Member States of the European Union the harms associated with alcohol thus constitute a serious public health problem. Levels of alcohol consumption and harm are rising steeply in some of the newly independent states of Eastern Europe seeking entry to the Union.

Alcohol can be both a health and a social problem. Some of the harm associated with alcohol arises from acute intoxication, some from long-term heavy consumption. There is a range of medical, psychological and social problems associated with alcohol dependence. All types of problems exist in varying degrees of severity.

Intoxication
Long term excessive consumption Dependence

Casualties (accidents and violence)
Physiological (acute & chronic)
Psychological problems
Impaired performance of social roles

Health Problems

Overall, alcohol products are responsible for around 9 per cent of the total disease burden in the WHO European Region, and 40 - 60 per cent of all deaths from intentional and unintentional injury are attributable to alcohol. 2

Acute and Chronic Effects of Alcohol Misuse 3.

Acute

Accidents & injury
Acute alcohol poisoning
Aspiration pneumonia
Oesophagitis
Mallory-Weiss syndrome
Gastritis
Pancreatitis
Cardiac arrhythmias
Cerebrovascular accidents
Neurapraxia
Myopathy/rhabdomyolysis
Hypoglycaemia

Chronic

Accidents & injury
Oesophagitis
Gastritis
Malabsorption
Pancreatitis
Liver damage
- *fatty change
- *hepatitis
- *cirrhosis

Hypertension
Cardiomyopathy
Coronary heart disease
Brain damage
- *dementia
- *Wernicke-Korsakoff syndrome
- *Marchiafava-Bignamisyndrome
- *central pontine myelinolysis

Peripheral neuropathy
Myopathy
Osteoporosis
Skin disorders
Malignancies
Infertility
Foetal damage

References
1 G. Edwards et al: Alcohol Policy and the Public Good. Oxford University Press 1994.
2 European Alcohol Action Plan. Phase 2. WHO 1999.
3 Medical Students' Handbook: Alcohol and Health The Medical Council on Alcoholism London 1998.

Austria
Around 400,000 alcohol dependent.
Population 8.1 million

Belgium
250,000 - 500,000 alcohol dependent requiring treatment
Population 10.2 million

Denmark
14 per cent of men and 8 per cent of women exceed recommended consumption limits
Population 5.3 million

Finland
22 per cent of men and 5 per cent of women "risky drinkers"
Population 5.1 million

France
An estimated five million drinkers are at risk of medical, psychological and social problems, and two million people are dependent on alcohol.
Population 58.3 million

Germany
2.5 million alcohol dependents and 6.5 million `excessive drinkers'
Population 82 million

Ireland
8 per cent of men and 2 per cent of women report signs of alcohol dependence.
Population 3.6 million

Italy
One third of adult hospital patients (in Naples) either have current alcohol problems or are excessive drinkers.
Population 57.4 million

Luxembourg
9000 alcohol dependent
Population 418,300

Netherlands
Around 100,000 treated for alcohol dependence each year.
Population 15.5 million

Portugal
300,000-500,000 alcohol dependent
Population 9.2 million

Spain
1.6 million alcohol dependent
Population 39.3 million

Sweden
An estimated 300,000 people 'whose heavy drinking threatens their health and professional status'

Population 8.9 million

UK

7.5 per cent men and 2.1 per cent women report symptoms of alcohol dependence, and around 1.7 million adults drinking at definitely harmful levels (50/35 drinks per week)

Population 59 million

Source: Overview of National Alcohol Policies in 15 Countries of European Union. Société Francaise de Santé Publique, and the European Commission 1998 and other sources.

The Potential Role of the Doctor

Doctors are potentially not just providers of treatment for those with alcohol-related problems, they are also `gatekeepers' into treatment services and usually the leaders of the multidisciplinary teams involved. Additionally, doctors are well placed to act as advocates for alcohol problems prevention and treatment both within health services and more widely.

Alcohol impinges on a wide range of medical specialisms: accident and emergency; general medicine, general surgery, cardiology, neurology, dermatology, obstetrics and gynaecology, paediatrics, geriatrics, chest medicine, biochemistry, toxicology, haematology, public health, pathology and psychiatry. 4

In our report `Alcohol Problems in the Family' 5, we estimated that around 42 million adults in the European Union will experience alcohol abuse or dependence during some period of their lives. If the assumption is made that each problem drinker adversely affects only one other person, then 84 million Europeans will experience serious problems from either their own or another's drinking. In reality, of course, problem drinkers are likely to affect more than one other person.

People with alcohol-related problems appear in large numbers in clinical settings. Problem drinkers consult family doctors around twice as often as matched controls, especially because of psychological problems and acute injuries. 6 The partners and children of problem drinkers are also disproportionately heavy users of health and social services 5.

Internationally, around 10-20 per cent of patients seen in primary care settings have alcohol-related problems. 7 There is also high prevalence of alcohol problems in secondary care institutions. In the UK, more than 25 per cent of male in-patients in general medical wards have a current or previous alcohol problem, and around 40 per cent of attenders in Accident and Emergency Departments have consumed alcohol before their attendance, 32 per cent having a blood alcohol level over the legal limit for driving. 8

Similarly high prevalence rates have been reported for other European countries. In Portugal, 40 per cent of male and 10 per cent of female admissions to general hospitals are alcohol-related, and in Denmark a recent study of adult medical in-patients in Copenhagen found nearly half (48 per cent) of the men and 16 per cent of the women met criteria of alcohol problems. 9

With regard to psychiatric morbidity, international comparisons are made difficult by differing policies in relation to numbers of beds available and admissions procedures and, in some cases, the existence of policies designed to minimise in-patient admissions to hospitals. However, the available information suggests that alcohol-related diagnoses comprise substantial proportions of the total psychiatric case-load in all EU countries. Thus, for example, in the Republic of Ireland alcohol-related diagnoses comprise 25 per cent of all psychiatric admissions - one third of all male admissions. In Denmark, around 16 per cent of psychiatric admissions are alcohol-related, in Finland 32 per cent, in Portugal 40 per cent and in Luxembourg 43 per cent. 10

Doctors are thus well placed to identify patients with alcohol problems. Not only do they have frequent contact with problem drinkers: patients expect doctors to ask them about their alcohol consumption and believe that they have a right to do so. 11, 12

References:

4 I.B. Glass - Crome: Alcohol misuse as a challenge to medical education: a belated remedy. British Medical Bulletin (1994) Vol.50 no.1.
5 Alcohol Problems in the Family: A report to the European Union.
Eurocare 1998.
6 B.R. Rush. (1989) The Use of Family Medical Practices by patients with drink problems. Canadian Medical Association Journal 140. 35-39.
7 Saunders et al: Alcohol Consumption and Related Problems among primary health care patients: WHO collaborative project on early detection of persons with harmful alcohol consumption etc.
8 'Tackling Alcohol Together' Society for the Study of Addiction. Free Association Books. 1999.

9 S.D. Nielsen et al: Prevalence of alcohol problems among adult somatic in-patients in a Copenhagen hospital. Alcohol and Alcoholism Vol 29 No.5. Sept 1994.
10 Counterbalancing the Drinks Industry. Eurocare 1995.
11 K. Slama et al: Community views regarding the role of general practitioners in disease prevention. Family Practice 6. 203-209.
12 Prevalence detection and treatment of alcoholism in hospitalised patients. Journal of the American Medical Association. 261. 403-407 1989.

Failure to identify Alcohol Problems

Despite their advantageous situation it has been a common theme for many years that doctors often fail to identify alcohol problems. In one series of studies of six hospitals, the false negative rate ranged from 25-91 per cent. 13 There is a failure to anticipate alcohol problems and to ask about alcohol in routine examinations. Where an alcohol problem is identified it does not necessarily follow that any constructive intervention takes place. There is evidence that some doctors may prescribe Drugs of doubtful appropriateness to problem drinking patients, most obviously anti - depressants.14

Even where identification is made, it is often at a late stage. Doctors are most likely to diagnose alcohol dependence in the severely impaired, and less likely to diagnose it in higher income patients, the elderly, and women. 13

As well as late diagnosis, there is also a tendency to treat the symptoms rather than the causes of alcohol problems with the result that treatment may have only transient effects. Indeed, it is not unusual that, in treating the symptoms rather than the causes patients are made fit enough to continue or resume drinking.

There is also a continuing reluctance on the part of many doctors to raise the issue of alcohol consumption in patients whose medical complaints may be related to drinking. Some have referred sardonically to an unspoken `gentleman's agreement', whereby the patient does not volunteer information about his drinking and the doctor does not ask.

References:

13 N. V. Dawson et al:
The effect of patient gender on the prevalence and recognition of alcoholism on a general medical in-patient service. Summary of General Internal Medicine. 7. 38-45. 1992.
14 A. Deehan et al:
How do general practitioners manage alcohol misusing patients ? 1998. Drug and Alcohol Review Vol 17. No 3.

Obstacles to identification

Doctors' willingness or ability to identify alcohol problems may be impaired by internal or external factors. 15

Individual factors are characteristics of individual doctors such as knowledge levels, skills, attitudes, beliefs and expectations. Theoretically, these are acquired or modified by education and training.

Structural features refer to the external circumstances in which doctors work and include factors such as organisational priorities, financial reimbursement, lack of standardisation and quality control.

Emphasis is sometimes given to the supposed failings of individual doctors in regard to identifying alcohol problems and problem drinkers, and, indeed, there is evidence that doctors often possess ambivalent if not downright unfavourable attitudes to such patients. In the words of a UK commentator, 'some doctors are wary of getting involved because of an image of alcohol misusers as time consuming, difficult to manage, manipulative and, by and large, incurable.' 16

It is, however, as pointless as it is easy to engage in simplistic blaming exercises - blaming the patient for having the problem and the doctor for failing to recognise it.

Alcohol problems, particularly in their early stages, are not always easy to detect. The signs and symptoms of alcohol problems often mimic those of other conditions; patients may be resistant to discussing their drinking and may not understand the connections between their drinking and the problems they are experiencing.

As far as the doctor is concerned, his or her efficiency in identifying and treating alcohol problems cannot be considered in isolation from the resources with which they are provided. This includes the structure of the health service in which they work and its relationships if any to specialist alcohol treatment services. Unfortunately, a common theme to emerge from European countries is the often fragmentary nature of the treatment process and insufficient inter-disciplinary cooperation. 17

References:

15 R. A. Walsh: Medical Education about Alcohol: Review of its rule and effectiveness. Alcohol and Alcoholism Vol 30 No6. 1995.
16 A. Paton. ABC of Alcohol. BMJ Publishing Group 1994.
17 Dr C Ansoms Psychiatrische Kliniek This volume.

Responding to Drinking Problems

In a seminal study of community agents, including doctors, the researchers identified three

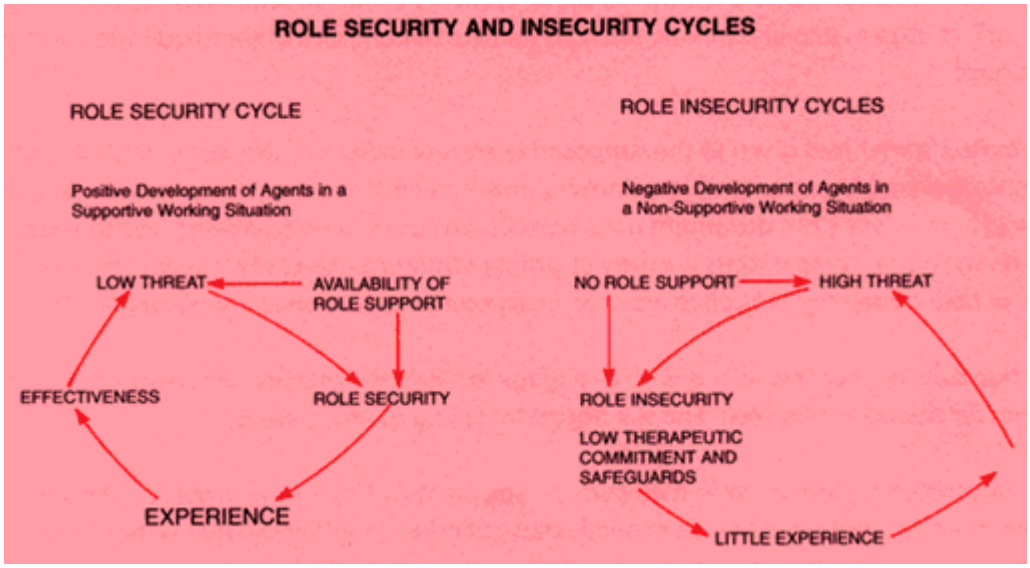
factors influencing their intellectual and emotional preparedness to work with problem drinkers.18 This preparedness was termed Therapeutic Commitment, and its presence or absence was determined by:

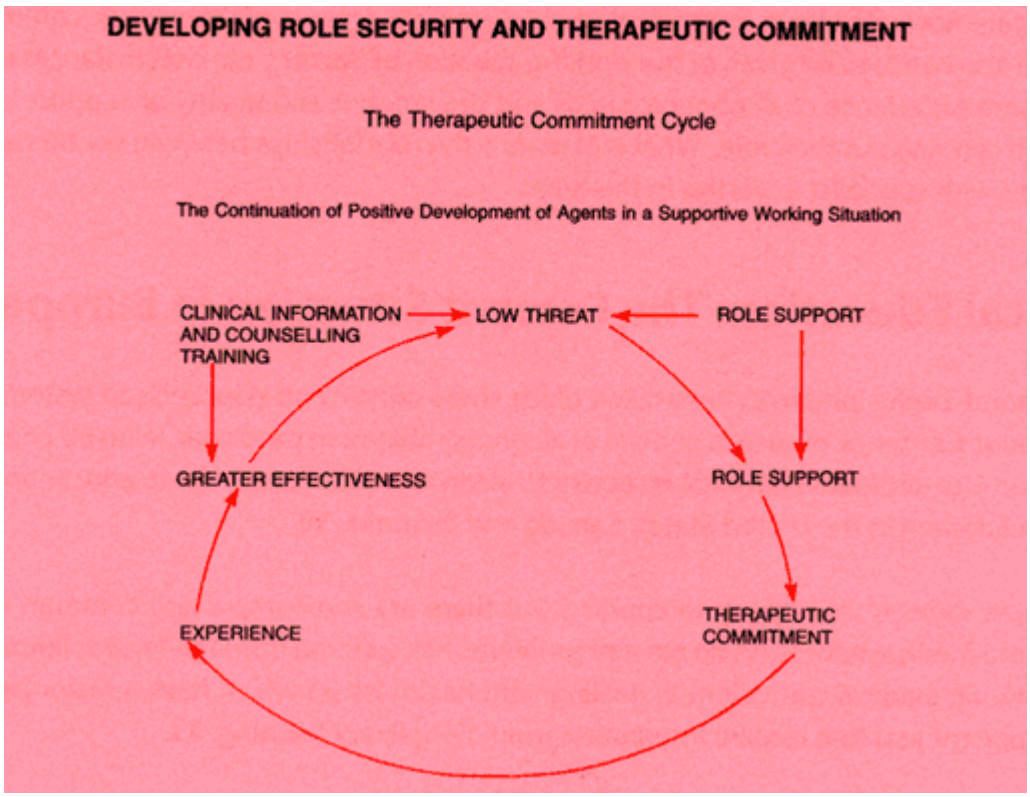
Role Adequacy - the belief that the agents possessed sufficient knowledge to carry out the helping role when working with problem drinkers

Role Legitimacy - the belief that patients accepted their right to ask questions about drinking when necessary

Role Support - confidence that they could obtain expert advice and assistance when needed

Low therapeutic commitment was characterised by a clear pattern of avoidance of problem drinkers. This could take the form of denying their existence in the caseload, or of 'failing' to recognise' patients with alcohol problems, at least until the problems had reached such an advanced stage as to be unmistakable and undeniable. Other avoidance strategies included getting rid of drinkers, for example by referring them to another agency; regarding drinking problems as unalterable, and blaming drinkers for lacking the motivation to change their behaviour. The dominant feature of this negative response was a marked therapeutic pessimism and hopelessness - the belief that there was little point in trying to identify people with alcohol problems because they did not really want, and would not benefit from, the help offered.





In contrast, agents with a high degree of therapeutic commitment did not avoid encounters with problem drinkers or fail to recognise the signs and symptoms of alcohol problems. They did not regard problem drinkers as threatening to their professional competence or self-esteem. They were prepared to ask relevant questions and believed that their intervention was worthwhile, that beneficial change was possible.

Those with a high degree of therapeutic commitment shared a number of characteristics:

- they were experienced in working with drinkers
- they had role support available
- they had received training in counselling- the more hours received, the less anxiety in regard to role adequacy and role legitimacy
- they had clinical knowledge of alcohol and alcohol problems, the key parts of which were: the effects of alcohol on the individual drinker, for example how to recognise acute withdrawal symptoms, patterns of behaviour characteristic of high tolerance, the physical, social and psychological consequences of excessive drinking.

These factors were interrelated. In particular, one of the most important findings of this study was that in those with only limited experience of working with problem drinkers, the possession of even quite substantial knowledge of alcohol and alcohol problems did not reduce anxieties about their role adequacy.

This is consistent with later findings that, even in `rich' programmes in terms of number of curricular hours (36 hours/4 years in the USA), improved knowledge and attitudes in regard to role adequacy acquired during early undergraduate training can reduce significantly during senior years when the student enters his or her clinical rotations and is exposed to alcohol-related clinical situations with poor prognosis as well as pessimistic mentors. 19

The conclusion is unavoidable that education and training programmes on alcohol and alcohol problems are not sufficient in themselves to produce high degrees of therapeutic commitment. Attention also needs to be given to the working situation of doctors, the circumstances in which they acquire experience of alcohol problems and the amount and quality of support available to them in carrying out their role. What is at issue is the relationships between doctors and their colleagues with specialist expertise in this area.

References:

18 S. Shaw et al: Responding to Drinking Problems. Crome Helm 1978
19 Prof. N. el-Guebaly: Medical Education and alcohol-related problems in Canada. Paper presented at the Merck-Lipha Consensus Forum on Medical Education, Lisbon November 1998.

Medical Education: the Present Situation in Europe

Though some useful initiatives have taken place, there remains no standardised system of education about substance misuse in general or alcohol problems in particular. In no EU country has there been a co-ordinated national response to alcohol or substance misuse education such as has been adopted in the United States, Canada and Australia. 20

The picture varies from country to country, but there are some important common features. Everywhere medical education on alcohol problems has suffered from the known limitations of the traditional medical curriculum in dealing with health issues which have a major psychosocial component and that require integrative, multidisciplinary learning. 21

The basic picture to emerge, therefore, is that currently medical education on alcohol appears to be inadequate in both quantity and quality. In some countries, during years of medical training, the time devoted to study of alcohol problems amounts to a few hours.

The amount and type of education provided tends to vary from medical school to medical school, depending on the commitments and interests of individual teachers. Only recently in some countries have steps been taken to integrate education about alcohol problems into the core curriculum. Generally, however, it remains optional and with no real requirement to achieve agreed standards.

Hence, across the European Union, it is still possible for people to qualify and practice as doctors without having obtained, or being required to demonstrate, an acceptable level of competence in regard to substance misuse.

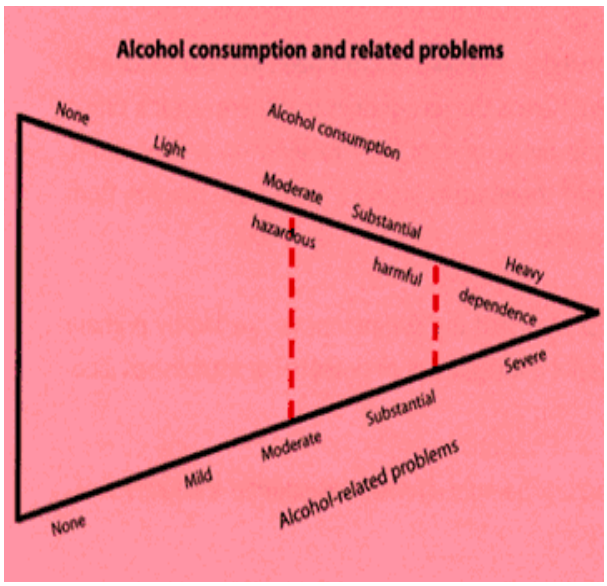
The Way Forward

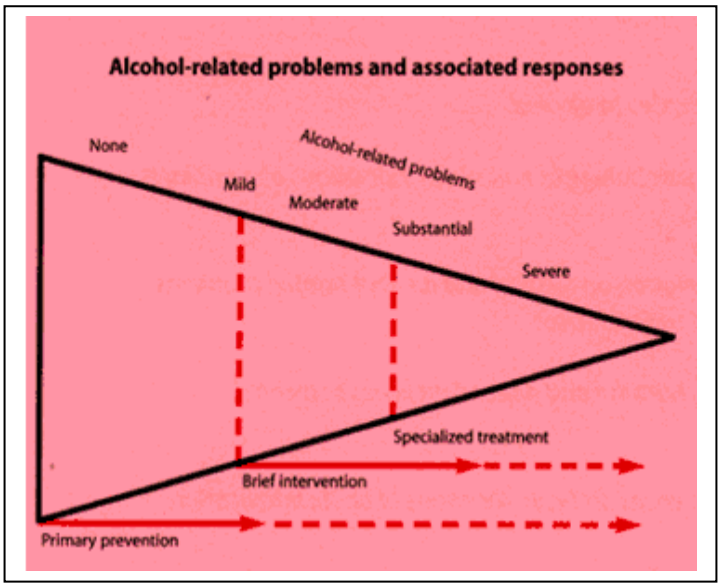
In view of previous neglect, substance abuse and alcohol problems should now be regarded as a priority in medical education and be given a higher profile in the basic curriculum at all levels, under-graduate, post-graduate and continuing medical education.

There is a need to embrace co-ordinated, multi-disciplinary approaches which address lifelong learning. Opportunities to advance this agenda are currently available in many European countries through two interrelated developments: 22

- Health reforms - many countries are strengthening the primary care orientation and input of their health systems. This is commonly associated with an increased emphasis on health promotion, encouraging activities related to the prevention and early detection of alcohol problems. These activities often involve multi-disciplinary team-working.
- Medical education reforms - undergraduate curricula in many countries are becoming more community-oriented and involve greater primary care and general practice input. Postgraduate and continuing medical education are recognising the importance of lifelong learning, practice-based education and multi-disciplinary learning.

<u>The potential of Primary Health Care</u>





There is a clear case for including alcohol in a broader syllabus concerned with substance misuse, especially as alcohol problems are often associated with tobacco, prescribed drugs or illegal drug abuse, especially in younger patients.

Education on alcohol problems is facilitated by the creation of and support for academic departments of Addiction Behaviour, particularly those with a Chair of Addiction. These have been shown to be associated with the most comprehensive alcohol treatment services, the most postgraduate training opportunities and average or above average medical school training. 23

However, while approaches and courses concerned with the addictions and substance abuse in general have much to recommend them, it is suggested that in countries such as Italy it may be unwise to merge alcohol issues completely into a substance abuse framework. This is because of alcohol being seen as an integral part of diet, alcohol consumption thus having a specific cultural meaning very different from that attaching to other forms of substance abuse. 25

There is ample evidence that while it is comparatively easy to devise educational programmes to increase knowledge and instill or change attitudes, it is more difficult to affect actual behaviour. In our view it is therefore essential for evaluation to be an inherent feature of education and training programmes.

In any process of evaluation, it would, of course, be necessary to allow for the fact that doctors' performance is influenced not just by what they know but also, and sometimes crucially, by the amount and quality of role support available to them in their working situation.

Clearly, any initiative to improve medical education on alcohol will to a large extent have to be carried out through and by the various medical specialisms. We believe that the relevant medical authorities should now give serious consideration to establishing or further developing an appropriate system of qualification and accreditation in order to promote uniform standards of competence in this field. In this connexion, international fora such as the International Society of Addiction Medicine could have an important role to play. 26

References:

20 Prof. N. el-Guebaly: Medical educationa and alcohol-related problems in Canada. Paper presented at the Merck-Lipha Consensus Forum on Medical Education, Lisbon November 1998.
21 Kinney et al. Impediments to alcohol education. Journal of Studies on Alcohol. 45 453-459 1984.
22 Pr B. McAvoy Consensus Forum on Medical Education Lisbon 1998. This volume.
23 I.B. Glass - Crome: Alcohol misuse as a challenge to medical education: a belated remedy. British Medical Bulletin (1994) Vol.50 no.1.
24 Broadening the Base of Treatment for Alcohol Problems 1990. Institute of Medicine. Reprinted with permission of National Academy of Sciences. Courtesy of National Academy Press, Washington, DC, USA.

25 F Poldrugo Under- and Postgraduate medical education in alcohol problems. Paper presented at the Merek-Lipha Consensus Forum on Medical Education, Lisbon Novemberv 1998.
26 Prof. N. el-Guebaly: Medical Education and alcohol-related problems in Canada. Paper presented at the Merek-Lipha Consensus Forum on Medcal Education, Lisbon Novemberv 1998.

What Knowledge and Skills are Needed?

There is a growing consensus about the knowledge and skills doctors need in order to identify and treat alcohol problems. The starting point here is the recognition that there is not a single disease entity called `alcoholism' but a wide range of problems existing on a continuum. Medical intervention into these problems itself therefore exists on a continuum ranging from the least to the most intensive. 27 (See Appendix)

A World Health Organization Working Group has listed the competencies needed by primary health care doctors and teams for the successful management of potential or established alcohol-related problems:

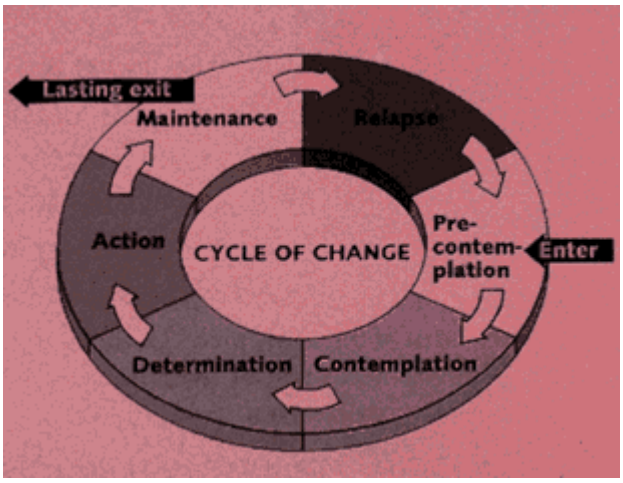
- a knowledge of the prevalence of hazardous and harmful alcohol consumption and related physical, psychological and social problems;a knowledge and appreciation of the effects of patients' alcohol problems on their partners and families;
- an awareness of the patients' personal attitudes to alcohol;
- the ability to identify the various physical, psychological and social indications of a drinking problem;
- the ability to communicate accurate information on alcohol and alcohol-related problems, in an appropriate context, to patients and their relatives;
- the ability to distinguish between low-risk, harmful and dependent levels of alcohol consumption;
- the ability to manage the physical consequences and complications of acute intoxication;
- the ability to take an accurate drinking history;
- the ability to recognise signs of alcohol-related disease;
- the ability to interpret laboratory tests accurately;
- the ability to choose an appropriate management plan (brief intervention or referral to appropriate colleagues or clinics); and the ability to direct and manage the detoxification of patients at home.

"One of the things I don't do is ask too many questions because I don't want to uncover a whole lot of things I can't deal with. So my technique sounds awful but it is to wait until something comes to my attention generally. I am not going hunting out problems I don't know how to treat. I could spend hours and hours every day trying to deal with it. Now if it were obvious how I could deal with it effectively then I might go looking for a few patients." 28

It is suggested below that the competencies needed also include counselling skills.

The WHO proposal also acknowledges but gives insufficient weight to the family aspects of alcohol problems. In primary care settings, it may well be the partner or child of the problem drinker who is the patient. Moreover, partners and children can be harmed severely by the problem drinking, and need help in their own right. The 'Audit' questionnaire has been developed as a cross-national screening instrument for the early identification of harmful drinking, which also detects alcohol dependence with a high degree of accuracy. Audit is consistent with ICD-10 definitions of disorders due to Pychoactive Substance use. (See Appendix)

Another aspect that requires particular attention is the doctor's ability to tailor his or her approach to the patient's readiness to respond. The well-known `cycle of change' model provides a basis for deciding the appropriateness of a particular intervention according to the patient's stage in the recovery process:



People who are not considering change in their problem behaviour are described as **pre-contemplators**. In the **contemplation** stage individuals begin to acknowledge they have a problem and to consider the feasibility and costs of changing their behaviour. As they progress, they move on to the **determination** stage, where the decision is made to take action and change. Once individuals begin to modify the problem behaviour, they enter the action stage, which normally continues for three to six months. After successfully negotiating the action stage, they move to **maintenance** or sustained change. If these efforts fail, a **relapse** occurs and the individual begins another cycle. 29

There is good evidence that many heavy drinkers benefit from simple advice from their doctor about their drinking behaviour. Brief interventions in primary care and hospital settings have been shown to be effective in reducing harmful drinking, especially in men. 30

Some patients, however, particularly those showing some degree of dependence and not yet having arrived at the point where they recognise that their drinking is problematic or that there is any need to change, may be more resistant to advice. These patients are at a `pre-contemplative' stage. At this stage, the first task is to elicit their views and attitudes and to provide information about the risks associated with their current level of consumption.

For these and for all patients, an important task is to stress self-responsibility and to make it clear that the onus lies with them to make the necessary decisions and changes. This motivational interviewing approach may well require special attention in training programmes, as it represents a necessary departure from a traditional concept of the doctor's role. This transition `from curer to counsellor' 31 is however justified by the evidence on the effectiveness of interventions in regard to the addictive behaviours generally.

The essential components of the motivational interviewing approach have been well

summarised with the acronym FRAMES: 32

- Feedback about the risk of personal harm or impairment
- Stress personal Responsibility for making change
- Advice to cut down or stop drinking as appropriate
- Provide a Menu of alternative strategies for changing drinking patterns
- Empathetic interviewing style
- Self efficacy: leaving the patient enhanced in feeling able to cope with the goals that they have agreed.

Dependence

The scientific consensus is that, other things being equal, the greater the dependence, the more likely it is that abstinence will be the desirable goal of treatment.

The main approaches to treatment are normally regarded as:

Twelve Step Facilitation Therapy

Based on the concept that alcoholism is a spiritual and medical disease with stated objectives of fostering acceptance of the disease of alcoholism, developing a commitment to participate in AA as a treatment intervention and beginning to work through the 12 steps. The disease is considered a discrete entity, incurable and treated only by lifelong abstinence.

Motivational Enhancement Therapy

Based on principles of motivational psychology and focuses on producing internally motivated change. The treatment is not designed to guide the client, step by step, through recovery, but instead employs motivational strategies to mobilise the indivdual's own resources.

Cognitive Behavioural Therapy

Based on social learning theory and views drinking behaviour as functionally related to major problems in an individual's life, with emphasis placed on overcoming skills deficits and increasing the ability to cope with situations that commonly precipitate relapse.

Pharmacological Therapy

Encompasses drugs used in detoxification, deterrent drugs, principally disulfiram, and the new generation of anti-craving drugs, such as acamprosate and naltraxone.

For many patients, self-help groups such as Alcoholics Anonymous play a vital role, alone or in addition to the above. All the above approaches may have value in regard to Relapse Prevention. 33

The largest and most sophisticated trial of psychotherapies 34 which examined the effectiveness of 12 Step Facilitation Therapy, Motivational Enhancement Therapy, and Cognitive Behavioural Therapy found that with one exception, and very much contrary to expectations, matching patients to treatments did not substantially alter outcomes. Measured in terms of abstinent days and average number of drinks per drinking days during the year following treatment, all the treatments were effective. The exception was that patients with low psychiatric severity benefited significantly more from 12 Step Facilitation Therapy.
There is now good evidence that both deterrent and anti-craving drugs can help maintain abstinence and prevent relapse alcohol dependent patients when appropriately prescribed as part of a comprehensive treatment programme. 35

References:

27 Broadening the Base of Treatment for Alcohol Problems. Institute of Medicine US National Academy of Sciences 1990.
28 B. Thom and C. Tellez. A difficult business: detecting and managing alcohol problems in general patients. 132A81 405-418 198
29 Prochaska and Diclemente. 1986. Toward a comprehensive model of change, in W. Miller for N. Heather (eds). Treating Addictive Behaviour. Processes of Change. New York. Hermon Press.
30 P. Anderson: Alcohol and Primary Health Care. WHO Regional Publications. European Series No 64.
31 Dr. W. Buisman, this volume.
32 T. Bien et al: Brief interventions for Alcohol Problems: a review. Addiction (1993) 88, 315- 336.
33 N. Heather. Treatment Approaches to Alcohol Problems. WHO Europe 1995
34 Project MATCH research Group. Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH Posttreatment Drinking Outcomes. Journal of Studies on Alcohol. January
35 Relapse Prevention by Acamprosate. H. Sass et al. Archives of General Psychiatry. JAMA. August 1996

The Educational process

The WHO Working Group made the following recommendations on education and training in alcohol and alcohol-related problems, for adoption by medical colleges or faculties of general practice within the Region. 36

1. Education and training should develop in primary health care doctors the knowledge, skills and attitudes needed to deal with alcohol use and alcohol-related problems.

2. Teaching on alcohol and alcohol-related problems should be included in medical education for general practice at all levels: undergraduate education, postgraduate training for general practice and continuing medical education.

3. At the undergraduate level, such teaching should be coordinated by academic departments of general practice and/or public health, where they exist.

4. Education and training programmes should impart:

- an understanding of the behavioural and social determinants of alcohol use and alcohol-related problems;
- a knowledge of the medical, psychological and social consequences of alcohol use, and their diagnosis and management;
- an understanding of the roles of the individual, the family, the community, the medical and related professions, and the government in dealing with alcohol-related problems and;
- knowledge of the principles and methods of health promotion, disease prevention and screening.

5. A multidisciplinary approach should be advocated at all levels of education.

6. Doctors should gain an understanding of the need for intersectoral collaboration in the prevention and management of alcohol-related problems.

7. Education and training programmes should be based on current research findings.

Associated Professions

A key theme of this report is the need to improve the multidisciplinary response to alcohol problems. It follows, therefore, that the education of medical students and doctors should not be seen in isolation from the education of associated disciplines and professions in which the same deficiencies in education in alcohol problems have been identified.

"The training of physicians, because of their influence in the health care system, is crucial and developments that have taken place within this profession can serve as a model for what is needed in for the other disciplines involved (psychology, nursing, social work, counselling). Training efforts can be important tools for bringing about the changes in institutions that are necessary to broaden the base in which screening and brief interventions will need to take place...") 37

Doctors as Patients

It is beyond the scope of this report to explore the issue in depth. Nevertheless, it should be noted that an additional reason for raising the profile of alcohol problems within medical schools and the medical profession is that doctors themselves experience higher than average levels of problems associated with substance misuse including alcohol. Moreover, there is typically a prolonged delay of some years between onset and intervention. During this period, increasing physical, psychological and social damage occurs and the doctors become an ever greater risk to their patients as well as themselves. 38 & 39

This is an aspect that should therefore be included in medical educational programmes and considered in conjunction with improved systems of identification and care of impaired doctors and other health professionals.

References:

36 The role of general practice settings in the prevention and management of the harm done by alcohol use. Report of a WHO meeting. Copenhagen. WHO Regional Office for Europe, 1992.
37 Broadening the Base of Treatment for Alcohol Problems. Institute of Medicine US National Academy of Sciences 1990.
38 D. Brooke et al: Addiction as an occupational hazard: 144 doctors with drug and alcohol problems. British Journal of Addiction 919910 86, 1011-1016
39 D. Birch et al: Alcohol drinking, illicit drug use and stress in junior house officers in north-east England. The Lancet. Vol 352. September 5 1998

Country Profiles

BELGIUM

Belgium is a federal state. In this summary we only focus upon the situation in the Flemish speaking part of the country.

Problems in the treatment of alcoholism.

Several problems and short-comings are frequently encountered:

Late diagnosis

Usually, treatment only starts when the patient suffers from serious medical problems or when he begins to behave in a psychosocially disturbed way. The prognosis is better if diagnosis and treatment occur in the early stages of addiction. Early diagnosis and motivation for treatment are important tasks for both general practitioners and physicians.

Treatment focuses on the symptoms

Because alcoholics only ask for treatment when the symptoms are advanced, the secondary problems tend to be dealt with first. Other components of the complex background are often ignored, for example the psychological and social factors that play a rôle on in the development of alcoholism.

Fragmentary help

Since treatment of alcoholism merely focuses on the symptoms it usually remains temporary and restricted to just one aspect of the problem. Too little attention is paid to all the primary aspects of the problem and insufficient efforts are made to keep patients in continuous treatment.

Insufficient inter-disciplinary co-operation

Strictly medical interventions are often of vital importance in the recovery of the alcoholic, but usually they are insufficient in providing long term stability. Because of the complexity of alcoholism, there is a greater need for more co-operation between the different disciplines, for example, liaison-psychiatry and networking between medical and psychosocial disciplines.

Lack of practical experience

A survey proved that the theoretical medical knowledge of our doctors is very good, but that there is a need for more practical training and experience in the field of early detection, assessment, motivation, orientation and referral, and how to deal with dual diagnosis.

The situation in Belgium:

Medical education is organised at university level. The length of study depends on the speciality. For general practitioners it is 7 years, for specialists (psychiatrists, hepatologists) an additional 5 years. There are four universities where the courses are conducted in Flemish: Antwerp, Brussels, Ghent and, Louvain.

Theoretical and practical instruction mainly focuses on alcohol-related disorders. This material is discussed in all kinds of traditional medical courses (e.g. hepatology, pharmacology, psychiatry). Only in psychiatry, however, is more attention being paid to the development of a wider biopsychosocial vision.

No separate specialised course on the treatment of alcohol dependence exists. More specific issues of addiction are dealt with in several kinds of postgraduate courses. Therefore general practitioners strongly feel the need to follow postgraduate medical education.

Positive perspective.

The above mentioned problems and shortcomings in teaching and practice are clearly recognised by many experts involved with practical medical education. During the last few years more attention has been paid to these aspects in the traditional clinical courses. At present more efforts are being made to offer a better education and training of general practitioners.

On the other hand, no university has yet taken the initiative in organising a specific basic course on this subject, despite its importance. As a result of a wider reorganisation of the teaching at one university, there is an option to approach the sub-aspects of alcoholism in a more integrated system involving different specialists. At another university there used to be a specific post-graduate multi-disciplinary programme for addiction and its treatment. This merely focused on the drug problem and was more orientated to non-medical professionals.

Many local initiatives exist in the context of postgraduate education of general practitioners: lectures, seminars, work-groups where much attention is paid to therapeutical problems. There is also a continuing project, sponsored by the WHO, for a more systematic implementation of the AUDIT in primary care, connected to local awareness training. The feedback seems to be very positive. The VAD, the Flemish umbrella-organisation for the prevention and treatment of substance abuse, is also preparing a specific programme for general practitioners.

Conclusions

Permanent training courses are very important, but at the present only those interested take part and benefit. Before quality in the care of alcoholics and in their environment can be established, basic education at universities must improve.

Dr S. Ansoms

FRANCE

Initial training during medical studies

During medical studies, teaching in alcohol dependence can vary greatly according to the different universities. Since all kinds of dependence, especially alcoholism, are not recognised as a specific field of medicine, there are no specialised teachers. Teaching programmes are left to the judgement of teachers whose specialities vary according to the universities (psychiatrist, internist, hepato-gastro-enterologist, etc.).

The number of hours dedicated to teaching in alcohol dependence may therefore range from none in certain universities to 6 or 8 hours in others.

In Nancy Medical University, teaching in alcohol dependence is divided into two parts:

- for all students there are 4 hours of lectures on alcohol and tobacco dependence during the 6th year. These lectures aim at giving students basic notions on alcoholism: epidemiology, factors of alcoholisation, terminology and classification, and treatment. These lectures are validated by a written examination (essay or multiple choice questions).

- there are 3 hours during the first year of the third cycle of general medicine (7th year) which involve only future General Practitioners. The objective is to help them detect, approach, and treat patients with alcohol problems. This training is more practical and interactive and is applied to small groups (10-15 students), with rôle plays and contributions from recovering alcoholics. The third cycle of medicine is validated by an ECOS examination (evaluation structured by simulated brief rôle plays).

Medical training for professionals

University medical training for professionals includes two types of teaching:

- First the Capacités in Toxicomania, alcohol, and tobacco dependence (Capacités Toxicomanies, Alcoologie et tabacologie). These are national diplomas awarded by the Ministry of Education. Currently there are 17 of them in France. Sometimes several universities co-operate to give the lectures (Nancy and Strasbourg universities, for example).

According to ministerial recommendations, 100 to 120 hours of theoretical lectures must be given over two years. Students must also do 80 half-days of training in registered centres. There is a written examination at the end of the lectures (essay) and an oral examination (e.g. presentation of an essay). These lectures are aimed at medical doctors. The advantage of this training is exhaustive teaching in all addictive behaviours.

On the other hand, the 80 half-days of training represent a major drawback for medical doctors, especially general practitioners, and there has been a low level of registration.

- Along with this type of training, some universities have created a University Diploma on either alcoholism or, more generally, on addictive behaviours.

This type of teaching has two advantages: it is open to either physicians or non-physicians, and is shorter. It usually includes theoretical lectures, and sometimes practical training. The number of teaching hours varies from 40 to 50 according to the universities. It is validated by an essay, and sometimes by a written examination.

Medical training for health professionals outside university

Medical Training for Professionals (FMC for postgraduate continuous education) is now compulsory in France, but sessions of Medical Training for GPs have existed for quite a long time. These consist in either groups of medical doctors (10 to 20) who meet once a month with an expert to talk about one precise subject, or longer and more exhaustive training sessions, e.g. two-day seminars within the framework of the Formation Conventionnelle Indemnisée.

In any case, subjects such as alcohol and any other kind of dependence can be approached whenever medical doctors wish. It must be noted that from this year onwards the National Council of the FMC has defined a certain number of priority subjects. In particular several subjects were identified as priority questions of French public health, such as "prevention and treatment of dependencies" (including alcoholism). These seminars aim at updating professional knowledge and include theoretical presentations, especially in two-day seminars, and practical workshops of rôle plays. Their outcome is assessed by multiple choice questions before and after each session.

The advantage of these seminars is that they address directly GPs interested in this subject, and the programme of these training sessions is prepared by the persons responsible for them.

The drawback lies in that physicians are relatively little interested in these subjects. The number of doctors attending is therefore quite limited. Doctors are reluctant to spend time on alcoholism since they do not consider it as a "real" disease and its treatment requires a lot of time for often disappointing results. Treating alcohol-dependent patients is more a matter of know-how and of behaviour than a matter of theoretical knowledge.

Pr F. Paille

GERMANY

The education of medical students in addiction medicine is extremely variable from one university to another. It depends very much on the personal research and treatment interests of the academic teachers. Addiction medicine topics are dealt with in different specialities of medicine such as biochemistry, physiology, pharmacology and toxicology, internal medicine, neurology and psychiatry. An interview of 91 medical students at the University of Tuebingen revealed that, with the exception of psychiatry, students feel that the quality and quantity of teaching in addiction issues are not satisfactory (1). A similar survey among psychology students produced almost identical results (2).

During residency there is no formalised curriculum for education in addiction of future medicaI doctors in Germany. Most specialities do not deal with these issues at all. Even general practitioners and internists do not have to gain experience with addicted patients. This is true to a lesser extent for psychiatrists also. Again there are differences between universities and other education Institutes. The situation is somewhat better at the universities of Berlin, Essen, Lübeck, Munich, Tuebingen, Mannheim, and Heidelberg.

Since 5 per cent of the adult male German population is alcohol dependent and about 2 per cent of the female population, the diagnosis and treatment of alcoholism plays an important role in daily medical practice. This is in sharp contrast to the shortcomings in addiction education. First attempts are being made to establish a curriculum ("Fachkunde Suchttherapie") for practising doctors. The state of Baden-Württemberg in the southwest of Germany is the first and only to have implemented this curriculum already. It consists of 34 hours of practical training with the focus on drug addiction and substitution treatment. It is now being enlarged to about 52 hours which then will include diagnosis and treatment of alcoholism and nicotine dependence as well. Similar attempts are being made in Bavaria too. A second project aims at establishing an additional qualification in addiction medicine which should take between 2-3 years whilst practising medicine. This "Zusatzitel Suchtmedizin" is still a matter of extensive debate.

The disastrous situation as regards the education of medical students and doctors is fortunately becoming more apparent to the authorities, the professionals, and the general public. The self-governing bodies of doctors (Ärztekammern), following the example of the state of Baden-Württemberg, have initiated programmes for continued medical education in the field of addiction.

There is additional momentum from research since the Federal Ministry of Research and Education earmarked 20-25 million Deutsch-Marks over a period of five years. This will be specifically aimed at improving the delivery of medical and psychological care to those with alcohol or other drug problems, including nicotine, by raising the standards of of the doctors' own training in these fields. Only those grant applications which can show a considerable outreach from university research institutes to family practitioners, community counsellors, and self-help groups will be funded.

It is also noteworthy that the German Government has widened its focus to include all the addictions. Ten years ago only illegal drugs received political attention. Now tobacco and alcohol have been added.

By these measures we hope to make some progress in improving medical education in alcohol and hence alcohol problems in Germany.

Pr K. Mann

References

1 Mann, K., Kapp, B. (1995) Zur Lehre in Suchtmedizin. Eine Befragung von Studenten und Professoren. In: Mann, K., Buchkremer, G. (Hrsg.) Suchtforschung und Suchttherapie in Deutschland. SUCHT, Sonderband, S.38-40.
2 Küfner , H., Haf, C.m., Miehle, K. (1989) Ausbildung von Psychologen im Bereich der Suchterkrankungen. Psychologische Rundschau (Berichte) 40:227-232.

IRELAND

The Health Strategy Documents of 1994 and 1995 contain recommendations concerning the development of a National Alcohol Policy and in 1996 the National Alcohol Policy was published. This policy is directed at encouraging moderation for those who choose to drink, and reducing the prevalence of alcohol related problems. As in previous strategy documents, the importance of a multi-sectoral approach to health promotion initiatives is stressed. It is postulated that an awareness and understanding of the National Alcohol Policy and how it could be implemented in the respective professional areas of responsibility could create an effective support network.

A variety of personnel, mostly non-medical, are engaged in implementing the National Alcohol Policy recommendations. Increasingly, those involved in primary prevention possess or receive training in health promotion, health education and addiction prevention. Health Boards are providing more community based specialised alcohol services (usually co-ordinated by the psychiatric services) and specialised training for professionals (mainly non-medical staff). Voluntary and local initiatives also receive some support from the health boards and other governmental agencies. More employers are training their personnel and supervisory staff in recognising and handling problem drinking.

There is a growing body of research and expertise in Ireland in the range of issues involved in alcohol dependency. Trinity College has recently established an addiction research centre, a collaborative venture between the Department of Social Studies and the School of Pharmacy with the aim of providing a source for competent, independent and critical research into the prevention and management of alcohol and drug problems in Ireland. Postgraduate courses such as the Diploma in Addiction Studies and the Masters in Drug and Alcohol Policy in Trinity College are run from the Department of Social Studies in Trinity and are taken up mainly by non-medics interested in or working in the field of drug and alcohol dependencies. Other third level institutions also offer postgraduate courses in Alcohol and Drug Addiction but in common with postgraduate programmes such as those offered by the Department of Health Promotion in NUI, Galway, they provide expertise and training mainly to non-medical graduates in health promotion, health education and drug dependency. A few general practitioners (GPs), working in the field of drug abuse (but not alcohol abuse) have undertaken their Masters in Drug and Alcohol Policy.

Private enterprises such as some Alcohol Addiction Treatment and Rehabilitation Centres (provided largely by non-medical personnel) provide educational programmes, which contribute, in an informal way, to continuing medical education on a broader understanding of alcohol dependency and its management. Some GPs, who become familiar with such centres, attend their educational programmes. Often these are not systematic, organised programmes but one- off lectures or one-day seminars held several times a year. Occasionally, medical students work in these private institutions or members of staff are invited to give sessions to undergraduate medical students. Formal, rigorous evaluation of the effectiveness of the intervention methods used or of the educational programmes is not common.

The growing body of expertise together with changes in service provision and general education will have an impact on the nature of medical education provided on alcohol dependency and alcohol related problems, even in the absence of formal, integrated medical educational strategies.

With regards medical education the National Alcohol Policy document supports, in particular, the role of primary health care professionals in relation to the early detection of problem drinking. The Irish College of General Practitioners (ICGP) recommended in 1991 that general practitioners should be pro-active in the education, identification, diagnosis and treatment of patients with alcohol related problems.

A multi-faceted approach is essential to combat alcohol dependency and related problems but what is the role of medical education in this? What should it include and what is beyond its remit? What is being taught in medical education in Ireland at the present time?

Medical Education on Alcohol and Alcohol Related Problems

There are five medical schools in Ireland, an extensive network of GP training programmes in each health board region and a well-established postgraduate psychiatry-training programme. Postgraduate programmes are being developed in other specialties but at the present time, the great majority of Irish graduate doctors continue to pursue a period of training abroad in the various medical, surgical and other specialties.

Medical curricula continue to focus primarily on the pathophysiology and the medical and psychiatric treatment of the various alcohol-related clinical problems. Less attention is paid to underlying psycho-behavioural issues, the prevention of alcohol dependency, drinking patterns, identifying problems drinking, the effectiveness of brief interventions, the management of drug dependencies and the long term management of alcoholism.

Undergraduate students in their clinical years, particularly in their medical and psychiatric clerkships, are exposed to a lot of patients with alcohol related problems because of the prevalence of these conditions. Likewise, doctors are frequently exposed to alcohol related disease and the social consequences of problem drinking and alcohol dependency.

Undergraduate Medical Programmes

Pre-clinical programmes

In most of the behavioural science programmes drug or alcohol dependency is not addressed. However, many of these programmes are very much in their infancy in Irish medical schools and this is a potential area where alcohol dependency could be addressed.

In one medical school the first year students have a lecture on alcohol and drug dependency from the Department of Social Studies as part of a series where students are helped to see themselves as potential patients. In another, the third year Behavioural Science Programme has a Field Project Visit Component. An Alcoholics Anonymous (AA) visit is one of six service visits available to students so all students will not participate in the AA visit but all will participate in the discussion of the tutorial group. The students are instructed to attend one meeting and to find out about the ethos of AA, talk to a person attending the meeting on their experience of alcoholism and the role of the counsellor in treating alcohol problems. In the tutorial they discuss the extent of the problem in Irish society and make suggestions for the promotion of healthy drinking habits. A report on the visit is also produced.

Clinical Undergraduate Medical Programmes

The pathophysiology, clinical manifestations, diagnosis and management of alcohol related diseases, such as alcoholic liver disease and its complications, delirium tremens and Korsakoffís Psychosis are studied.

Undergraduate psychiatry programmes

The medical undergraduate psychiatry courses vary in length from six to ten weeks. Alcohol related aspects of Psychiatry have a place in all of the five undergraduate psychiatric teaching programmes in Ireland and are regularly represented in questions on exam papers.

In one of the five Irish medical schools the programme on the topic of alcohol and alcohol related harm includes the following:

One lecture on the diagnosis and management of problem drinking and alcohol dependency (90 minutes): this covers the social and emotional consequences of alcohol related problems, whereas the physical consequences are covered in greater detail in the medical curriculum.

One seminar presented by two of the students on the non-pharmacological management of alcohol related problems: this includes a description of a visit they undertake to an AA meeting.

One joint tutorial run by lectures from the Department of Adult Psychiatry and from the Department of Child and Adolescent Psychiatry looking at how alcohol related problems affect the whole family.

One seminar organised by the alcohol treatment program in one of the teaching hospitals, which looks at issues such as detoxification and the organisation of such outpatient programs.

Issues relating to alcohol often feature in other parts of the undergraduate psychiatry curriculum, especially lectures on history taking, phenomenology, social phobia, co-morbidity and schizophrenia, violence and risk assessment etc.

In addition, students spend half their time on the wards attached to clinical teams, where they would be involved with the presentation and management of patients with alcohol related problems. Each student also presents cases at small group tutorials, and writes up one case in detail: these cases cover all psychiatric problems, but alcohol related problems would be very common.

Another medical school has a twenty lecture series in psychiatry and one lecture is devoted to alcohol and drug dependency. (Previously there was one lecture on alcoholism and one on drug dependency.) Each student must take and present a history from a patient with alcoholism. The department has a ìcomprehensiveî video on alcoholism.

Postgraduate Medical Education on Alcohol and Alcohol Related Problems in Psychiatry

There are several Irish rotational postgraduate training schemes in psychiatry. Trainees gain experience in the different aspects of psychiatry over three to four years and sit the membership of the Royal College of Psychiatrists. During the training period, trainees attend an academic programme that runs during the academic year. In most of these academic programmes two formal lectures are provided to the trainees on alcohol and alcohol related problems. In addition to formal lectures, informal teaching occurs during the weekly ward rounds in the hospitals. There is also a weekly one-to-one supervision of trainees as part of the rotational training scheme. Many patients seen have alcohol problems and therefore discussion of those problems as well as the management of alcohol dependency takes place. (A large proportion of the psychiatric workload contains some alcohol-related aspects. In 1993 the number of admissions for alcohol related disorders to private psychiatric hospitals and public psychiatric hospitals is quite similar, 19.5% and 21.1% of the total respectively (National Alcohol Policy). The Psychiatric Services in each region operate community-based alcohol counselling services and 10% or more of acute emergency admissions to the inpatients psychiatric programmes are alcohol related.)

Trainee psychiatrists are expected to acquire an extensive knowledge on the subject of Alcohol related Psychiatry. Even if patient presentations are, from the clinical perspective, depression, schizophrenia or panic attacks, psychiatry trainees are taught to question the patients about alcoholism, as it is so often part of the picture. In one programme psychiatry trainees spend three months with patients with alcoholism and during this time they attend group therapy with patients suffering from alcoholism.

Continuing Medical Education on Alcohol and Alcohol Related Problems in Psychiatry

Regarding CME, there does not appear to be at present any specific educational programme regarding alcohol and alcohol related problems.

In the public sector in Ireland there is little psychiatry sub-specialisation. The majority of psychiatric consultants are general psychiatrists. (In the private sector there is more sub-specialisation but it is more difficult to monitor the expertise present. Probably specialists in this field of alcohol dependency are largely self ñ trained.)

Postgraduate Medical Education on Alcohol and Alcohol Related Problems in Medicine and Surgery

Liaison psychiatrists note that there is a major deficit in training on alcohol and alcohol related problems for doctors working in postgraduate medical hospitals. There is little or no education in general hospitals either

on, for example, detoxification and the findings in the literature that only 50% of people who present to A&E with deliberate self harm are questioned about their alcohol use. People with deliberate self - harm are clearly at a higher risk of having an alcohol-related problem but there is a dearth of education in these areas.

The Department of Psychiatry at the Mater Hospital is involved in a research project evaluating the prevalence of alcohol dependency and alcohol abuse among medical and surgical patients. They also hope to develop guidelines for the management of alcohol problems within the general hospital.

General Practice Training on Alcohol and Alcohol Related Problems

There are around eight three-year GP training programmes in Ireland. Generally trainees spend the first two years in hospital posts and the third year is spent with a GP in a training practice. Their hospital rotations include psychiatry, A&E and medicine. In these posts they are exposed to the management of patients with alcohol and alcohol - related problems. Each GP Training Programme in Ireland is independent in the design and implementation of its three-year curriculum. GP educators see their role as facilitators of reflective practice and much of general practice training takes a problem-based approach with the GP trainees bringing to their educational sessions' problem-cases for discussion. Because of its prevalence alcoholism often comes up in problem case analysis and this is where trainees get most of their educational expertise on alcoholism. Sometimes in problem case analyses the effect of managing patients with alcoholñrelated problems on the doctors themselves is discussed.

Examples of the content of GP training programmes on alcohol related problems include:

1) Currently, in addition to the SHO and Training practice experience of patients with alcohol problems, there are a number of trainee workshops in first, second and third year. These focus on addiction behaviour in general, on the family system and illness with alcoholism as one focus, on psychological processes and change behaviour, and more specifically on the detection and management of problem drinking. In second year, some trainees opt to visit Tabor Lodge and Arbour House (Alcohol Addiction Treatment Centres) and present their field-week finding to their colleagues. In third year, there is an afternoon seminar with a speaker and patient presentation from Tabor Lodge.

2) A two-hour session on alcohol related problems in small group format covering the following:

- Identifying problem patients
- Local services available
- Current models of management, including home detoxification

3) Six hours of formal education over three years on alcohol issues and a three hour session on brief interventions

Other programmes do not have specific modules which deal with alcohol related problems but may have modules on drug addiction and the GP role in methadone maintenance programmes.

Dr F. Hannon

References

National Alcohol Policy, 1996, Government Publications, Dublin

ITALY

Since alcohol consumption is integrated into the diet, it follows that, in Italy, society is highly tolerant towards alcoholism and alcohol-related problems (1). It is a peculiar feature of Italian life that young people are taught to drink in the family at a very early stage (2) and the family generally plays a major rôle in maintaining control on drinking, as well in the treatment of alcoholism.

Policies to prevent alcohol-related problems are quite recent. The Drug Abuse Act (1990) and a Decree for Suggesting Standards for the Prevention, Screening, Treatment, and Rehabilitation of Alcohol Dependence (1993) include educational interventions. However, education on the effects of alcohol (either positive or negative) is concentrated in primary and secondary school. In some regions (especially in Northern Italy) these educational programmes are well implemented at provincial level under the co-ordination of the Department of Education. Strong societal actions for change meet resistance (3), but, in general, preventative educational programmes targeting young populations are well accepted by all the different interest groups. Recently even the Brewers' Association with the support of the EU Commissions organised an experimental educational campaign involving teenagers (students in school or in search of an occupation) in different Italian areas and its preventive targets had been successfully met (4). Other educational programmes address specific populations. For example, alcoholics treated in rehabilitive programmes, or treated as an alternative to imprisonment. Educational programmes for subjects arrested for drinking and driving do not exist as yet. Other programmes dealing with alcohol and drug education are organised in the Army. Community educational programmes have been offered on a regular basis in the last 20 years by Associations dealing with alcoholics (AA, Clubs) along with the organisation and development of their networking activities.

The medical sector continues to be ambivalent on the issue of education in alcohol-related problems. The reason for this is the moral stigma attached to the consequences of heavy alcohol consumption. This acts as a barrier to medical intervention, and consequently there tends to be very late recognition and treatment of alcohol-related health problems.

There is a sort of vacuum at undergraduate level. Further alcohol education will only continue in postgraduate school after the students received early information in the context of health education in primary and secondary schools. Some information is given in an unstructured way as part of the different courses at the Medical Schools, education on alcohol not being specifically addressed. In places of greater awareness faculty members of universities are organising pilot courses but with uncertain administrative support, lack of structure, and scarce integration with community health programmes. The Nursing Schools, recently reorganised by the Medical School of Italian Universities, could be an important source of alcohol education.

A greater involvement of the universities in this area is envisaged in the future. Since April 1998, legislative norms have granted universities autonomy in the organisation of medical curricula. Thus, local universities will establish priorities on health education in line with the interests of the regional Authorities (which will replace the National Agencies as funding resources). A comprehensive national Act on the Prevention, Treatment, Rehabilitation, and Social Integration of Alcoholics is also pending for discussion in parliament, incorporating teaching activities and the institution of chairs on Alcohol-Related Problems at University Medical Schools.

Finally, at postgraduate medical education levels, where implementation of programmes is a local responsibility, several initiatives have recently been developed. Short courses of continuing medical education (less than 200 hours) are coordinated by Departments of Gastroenterology, Pharmacology, and Psychiatry at different universities. Even doctorates on alcohol studies (requiring 3 years attendance) are offered.

Courses specifically aiming at training General Practitioners are sponsored locally by GP Associations, Regional Health Authorities or Universities with scarce efforts at co-ordination. Specific treatment programmes for Impaired Health Professionals still do not exist in Europe. Recognition of the risk of alcohol abuse among heath professionals (eg medical doctors and nurses), and its major implications for effectiveness in any programme of prevention and treatment of alcohol-related health problems, will probably foster co-operation between different organisations, and greater efforts in training GPs.

Because of the few years experience and the lack of methodology in implementing them, evaluation of effective programmes is very scarce. It is known that medical students, even if exposed to limited information on alcohol-related problems, develop better attitudes in dealing with these health problems in the future (5). However, evenif the students receive adequate information during the teaching of Psychiatry, the space given to the subject is still limited compared with Britain and Canada (6).

Pr F. Poldrugo

References:

1) Poldrugo F and Urizzi R (1992) The Italian Paradox: treating initiatives and falling alcohol consumption. In: Cure, Care or Control: Alcoholism Treatment in Sixteen Countries (Kliongemann H, Takala JP, Hunt G eds), pp 191-204 State University of New York Press, Albany.
2) Poldrugo F and Stratta P (1993) Alcoholism among young people in Italy: an attempt to analyse the phenomenon. Journal on Alcoholism and Related Addictions 29: 73-79.
3) Poldrugo F and Patussi V (1996) Alcoholism and alcohol-related problems in Italy: an overview on recent developments in societal responses and treatment systems. Journal of Addictive Diseases 15: 59-65.
4) The Permanent Observatory on Youth and Alcohol (1997) Young People Between School and Work. Volume 9, Logica, Rome.
5) Poldrugo F, Modonutti GB and Buttolo R (1986) Attitudes towards alcoholism in Italian future teachers and health professionals. Drug and Alcohol Dependence 17: 31-36.
06) Poldrugo F (1992) Esperienza di un programma integrato di ricerca, didattica e terapia dell' alcolismo all' Universita di Trieste. Archivio di Psichiatria Generale 2: 253-256.

NETHERLANDS

For the past fifteen years there has been a consistently high level of alcohol related problems in the Netherlands. This has become evident from the number of admissions to general and psychiatric hospitals and in the provisions made for addiction care. These hospitalisations consist of "admissions due to toxic effect of alcohol", "admissions due to alcohol misuse without addiction", "admissions in relation to Korsakoff's syndrome", "admissions due to alcoholic liver diseases" and "admissions due to alcoholic psychosis". Taking into account the correction for under-reporting, the number of alcohol related hospitalisations will be considerably higher still. In 1997 over 21,000 people with alcohol problems were registered by out-patient addiction care, while there were approximately 2,700 hospitalisations in addiction clinics.

Among young people there is a considerable rise in "binge drinking" (often combined with the use of stimulants such as cocaine), particularly in connection with weekends, holidays, and going out.

In spite of the intensification of alcohol prevention, such as the permanent alcohol instruction campaign in the mass media, which was launched in 1986, there has not been a decrease in alcohol consumption. In the autumn of 1998, the Dutch parliament is to discuss a new bill on alcohol, restaurants and cafés, which is meant prevent the selling and serving of alcohol to youngsters under 18.

Medical education and training in a nutshell

What has happened over the past fifteen years in the field of training education for physicians and specialist doctors in the Netherlands? In 1983 a new education project was launched in the department of medical education of Amsterdam University. On the basis of a study of American experiences, a wide, inter-disciplinary educational programme was developed for second and third-year medical students. Medical specialisms relevant to alcohol dependence, such as pharmacology, psychiatry, medical science for General Practitioners (GPs), neurology and internal medicine, co-operated in this programme. Besides a body of knowledge on substance abuse (supported by manuals, video materials and laboratory sessions), this programme paid a lot of attention to attitude since research had shown that, in the course of their professional education, students of medicine developed an increasingly negative attitude towards the treatment of people

with alcohol problems. It was emphasised, therefore, that early detection and timely intervention would benefit the prognosis considerably.

This Amsterdam initiative was later taken up, in an adapted version, by the Medical Faculty of Utrecht University, resulting in the existence of two undergraduate medical training programmes focusing explicitly on alcohol problems and other addictions.

In 1998 the Medical Faculty of Leiden State University developed a special training programme for GPs on alcohol problems. This programme is particularly aimed at early detection and was extended to all GP education in the Netherlands from early 1990. Currently the impact of these programmes has declined.

ln the early nineties, the Medical Faculty of Amsterdam University conducted research in all medical faculties in the Netherlands into their educational programmes on alcohol addiction. The major findings were:

- alcohol problems receive most attention in psychiatry
- the emphasis lies mainly on the transfer of knowledge
- on average, five to ten hours (modal value: six) are spent on alcohol problems
- there is little co-operation between the medical specialisms
- psychiatry dominates the field, often partly resulting from the fact that professors and teachers also work in the field of addiction care.

The adoption of new standards or protocols by professional associations also affects the development of attitudes to alcohol problems. Too little use has been made of new forms of training and education, such as distance training, the use of specific websites on alcohol addiction, and the like.

In fact, substance abuse has never been a popular theme in the medical training field. There is wide therapeutic pessimism around the treatment of substance abuse.

In addition to these programmes in medical education, two large-scale medical conferences on alcohol addiction have been organised since 1984. These came about largely on the initiative of the so-called Bereave Committee for postgraduate training. On a smaller scale, in different regions of the Netherlands various associations of GPs have organised seminars about alcohol addiction.

Interest in alcohol problems has been highly variable in the past fifteen years. When in the early nineties the Dutch professional association for GPs (NAG) adopted an alcohol standard, the interest of GPs for alcohol problems picked up again.

So far, few results have come from a recent new initiative on the part of some large institutions in the Dutch world of addiction care (1996, Jellinek, Trimbos Institute) to promote the expertise of GPs especially by means of introducing the flowchart of the Plinius Maior Society.

The substance abuse department of the Dutch Association for Psychiatry pays attention to alcohol problems during its annual national conference. People working in the field of addiction care also organise regular training sessions for local GPs, which sometimes grow into longer projects.

Conclusion

Over the last fifteen years a small group of experts has invested heavily in structural innovations in medical professional education. The national reach, however, is too small. There is too much diffuse effort alongside little coherence and co-ordination. The development of new medical curricula (such as in 1983 at the Medical Faculty in Amsterdam) seems to make a positive contribution to a growing interest in substance abuse in medical undergraduate training.

Dr W. Buisman

PORTUGAL

In Portugal, alcohol related problems have never been a priority because they are not a matter of political concern. However, Regional Alcohology Centres have now been created as a result of co-operation between Portugal and the World Health Organization in regard to the European Alcohol Action Plan. These are bringing specialist skills to bear on alcohol-related problems.

The existence of these Centres and also the Portuguese Alcohology Society has created enthusiasm for the subject which has been sustained by the congresses and symposia they have provided for professionals in health and in education. The Centres hold two or three congresses a year.

In addition, and arising from one of the most important concerns in the creation of the Centres, close relations with the Education Regional Directorates were established and annual training for teachers on alcohology organised following the Education for Health Programmes.

The Centres, in partnership with the General Clinic Institutes and the Health Sub-Regions, produced protocols on training in alcohology for health workers.

The Oporto Regional Alcohology Centre has established strong links with industry and provided training in the workplace. It has also advised on the production of workplace alcohol policies.

The Centres also publish bulletins to keep professionals up to date with developments in the field of alcohology.

In 1995 Portugal decided to make the reduction of alcohol related problems a priority and to ensure that the training of teachers at all levels of education reflected this.

Post-graduate courses:

- A number of courses on alcohology have been developed, some by the psychiatry departments of hospitals and some by private educational institutions, for example the Universidade Popular do Porto, sometimes in cooperation with Regional Alcohology Centres.

Much remains to be done. In particular:

- The Regional Centres and the Portuguese Alcohology Society should ensure the practical application of the knowledge of professionals in this area
- Knowledge of alcohol related problems in should be included in the curriculum for training in medicine, nursing, social work, nutrition, psychology, and other relevant disciplines;
- Informative material should be produced for professionals working in the field;

As far as training is concerned, there should be co-operation between the alcohol industry and those working in the prevention of alcohol related problems.

Dr J. Barrias & Dr P. Dias

SCANDINAVIA

There is a long history of discussing alcohol problems in medical training, though the number of hours and the formal structure has varied over time and between countries. The WHO, the European Monitoring Centre for Drugs and Drug Abuse (EMCDDA), as well as the American Association for Medical Education on Alcohol and Drug (AMERSA) have been active in giving support to programmes, teachers, and research.

In some Scandinavian countries, medical teachers with a personal interest gave lectures and distributed material. In Sweden as early as the 18th century Carl von Linné warned against alcohol, and Magnus Huss published an excellent monograph "Alcoholismus chronicus" in 1849 and 1851 which was translated into German and for which he received a French reward. During both clinical and pre-clinical courses, alcohol and other dependence-producing drugs have been mentioned to a varying degree. It was usual for only the later stages of dependence to be mentioned, but very little about early diagnosis, alcohol and drug policy, and prevention.

When the Karolinska Institute produced a new curriculum for medical students in 1983, "beroendelära" or "addiction medicine" was introduced as a mandatory course with 40 hours of of lectures and seminars, 40 hours of clinical training, and a final written examination. Problem Based Learning has later been introduced. Not only is knowledge important, but also the attitudes of students and doctors to alcohol and drug patients and to research.

In Sweden, continuing education was usually not given at universities but was to a large extent organised by the Swedish Society of Medical Sciences and its various Sections. The Section on Addiction Medicine was founded in 1956 and has about 300 members, with representation at the Annual convention of the Society, with workshops and study tours, the latest one during the spring of 1998 to Hungary. The Sections on primary care, general medicine, social medicine, paediatrics etc cover alcohol problems from time to time.

Research training is also important. In Sweden there are 7 professorships in alcohol and drug addiction research, and perhaps 50 theses have been presented. Lectures and seminars regularly occur in the various research departments. Research libraries are available.

Though much that is positive has happened, the situation is never stable. Organisation is fragile and often dependent on particular persons and devoted teachers. Some minimum standard should be guaranteed to ensure both progress and stability over the years.

Swedish education on alcohol and drug problems for medical students - a long term follow up

It has been asserted that doctors may have a negative attitude towards patients with substance abuse problems. A special two-week course in substance dependency was started in the basic training of doctors at the Karolinska Institute (KI) and was greatly appreciated. Five years later it was decided to poll the doctors concerning the basic training and dependency problems.

Method: The medical students who had studied substance dependency at KI in l984-85 and equivalent groups studying medicine at another University in Sweden, where there was a more limited form of instruction in substance abuse issues, answered a questionnaire concerning clinical experience of addicted patients, substance abuse problems, and the basic training.

Results: Responses were obtained from 112 of the 176 individuals. About 40 per cent had worked in a special unit for substance abuse patients, and 90 per cent had had patients with dependency problems and just as many had talked to the patients about their substance abuse. There was a general optimism concerning the possibility of treating substance abusers. However, the respondents were very pessimistic about their own ability to persuade patients to seek treatment and about half of them referred virtually none of their patients with drinking problems to a specialist treatment programme. The KI group was considerably more positive about its basic training in substance abuse matters than the corresponding group; otherwise, there were few significant differences. Almost all respondents stressed the importance of including substance abuse issues in the curriculum.

A Helsinki perspective on medical training about alcohol and drug dependence

The course on alcohol and drugs at the Faculty of Medicine of the University of Helsinki lasts for 1.2 study weeks. It includes two theme days and 32 hours of self-directed learning. The course is held during the last study year of the medical students. The main learning objectives are to give to every student basic abilities in the detection, diagnostics, and treatment of alcohol and drug related problems and diseases including substance dependency. The attitudes and communication skills are particularly emphasised. The course includes the use of a booklet entitled the ABC of Alcohol and Drugs. From the autumn of 1998 this booklet will be supplemented by a new Finnish textbook on addiction medicine. During the course an interactive large group problem-based leaning technique is applied. Furthermore the course includes a two hour visit of an AA-group. Videotapes aimed to improve attitudes towards alcoholics and drug abusers as well as those focusing on communication skills may also be used. An examination based on problem cases is mandatory for every student. During the past two to three years the course has been graded as one of the top three courses of our faculty.

The education unit of Alcohol and drugs of the county of Stockholm

The unit started 1990 and is financed mainly by the special clinics in Stockholm. The aims are to educate doctors, nurses, and paramedical staff in different aspects of the evaluation and treatment of alcohol and drug problems. Current courses are case management for patients with dual diagnoses, relapse prevention, and psychotherapeutic treatment for alcohol and drug patients. In addition there are plans for a new course in cognitive behavioural treatment of dependence disorders.

A two weeks full-time mandatory course in addiction medicine integrated in the internal medicine-surgery curriculum. Experiences from the Malmoe Model

Since 1992 a new clinical curriculum in the medical school at Malmoe General Hospital, University of Lund has been introduced. A two week problem-based course in addiction medicine has been integrated in the teaching of internal medicine-surgery including:

Theoretical learning: A textbook has been written defining the learning goals for medical schools.
Attitudes: the students' own attitudes towards alcohol drinking are discussed in small groups.
Practical skills:

A: The addiction interview.
B: Identification of heavy drinking and subsequent intervention.
C: Assessment of withdrawal symptoms.
D: Ethic analysis.
E: Developing an alcohol-prevention plan on the general practitioner level.
F: Regulations and laws. Case stories on children and spouses of alcoholics are analysed. Children or spouses of alcoholics attend the discussion.
G: Narcotic addiction. Identification of symptomatology indicating heroine, amphetamine and cannabis use.

Examination:
Practical and oral interviews as a part of the total examination of internal medicine and surgery.

SPAIN

Undergraduate education

Until the 1980s, Spanish medical schools paid little attention to alcohol-related problems. Liver diseases, Korsakoff's syndrome, delirium tremens, and their treatments were described, but without looking further into the underlying psychobehavioural problems. Drinking patterns themselves were not analysed or taken into consideration. Drinking was seen as a social, even nutritional, habit, not worth considering other than in cases of consequent disease. In addition, many doctors believed recovery to be virtually impossible for alcohol dependent patients.

In the 1990s there has been only a modest improvement. A report was published in 1995 (1) with data collected from a survey carried out in 1992. The respondents of this survey were professors and students from a sample of Medical Schools and of others in associated professions such as Psychology and Social Work. 90 per cent of teachers reported devoting some hours to drug dependencies, and almost 50 per cent of medical students reported receiving some training. However, only 11.5 per cent considered themselves to be sufficiently trained in this area; 42.6 per cent considered themselves insufficiently trained, and 45 per cent very insufficiently trained.

In the survey, medical students asked for more training, especially concerning treatment skills. Neither the students nor their teachers were very interested in prevention. The University authorities admitted that there was no satisfactory educational programme in relation to drug dependencies, mainly because this subject was not included in the core curriculum and teaching was to some extent a question of the individual teacher's motivation and interests. In the main, teaching on alcohol or other drugs was included as a small part of some other mandatory subject. In the early 90s, optional subjects were seldom available.

However, there has been some progress. Nowadays (1999), almost all Medical Faculties offer "drug dependencies" at least among their optional subjects, although alcohol issues are never offered as a single subject.

In 1998, audiovisual material for under-graduated practitioners (Curso sobre alcoholismo y drogodependencias) was published by the Foundation for Help against Drug Addiction (FAD) and distributed among Medical Faculties.

Post-graduate training

Before the 1980s, it was only in some specialities at Schools of Psychiatry that alcohol and other drugs formed part of the syllabus. Even here, little was taught beyond the undergraduate level. The focus was on alcohol-related psychiatric diseases but neither the core problem of dependencies nor the possible treatment approaches were properly discussed.

There were exceptions. In some schools (for example, Barcelona's School of Psychiatry), special training in alcohol and other addictions was offered to interested students. However, this owed more to the personal dedication of some pioneers in the field than to the syllabus. Most of the professionals entering the field of dependencies had to be self-trained.

This dearth of education led to several courses, seminars and workshops of variable quality offered by a range of public and private institutions. Provision of courses increased during the 1980s, prompted by the growth in drug abuse. Alcohol problems alone had not been able to arouse enough interest on the part of the medical educators.

Around the end of the decade, Spanish Universities became aware of the need for structured training programmes conforming to officially approved standards, so that a good professional level might be guaranteed.

In the Summary Report of the European Symposium on Substance Abuse Education for Health Professionals (2), some recommendations were agreed:

- training on drug dependencies should be an essential part of health professional training both at a under- and a post- graduate level;
- special post-graduate courses should be offered;
- ongoing training should be offered to specialists already working in drug dependencies;
- training the trainers would be the ideal formula and courses should be addressed to multi-professional trainees;
- periodical reviews on the state of the art at national and international level as well as cooperation and training exchange among different countries should be promoted.

Throughout the 1980s, some well structured programmes were offered by Spanish Universities at a post-graduate level. In the 1990's, the master's degrees in drug dependencies (2 years) have been established (3) around the country (Universidad de Santiago de Compostela, Universidad de Barcelona, Universidad Complutense de Madrid, Universidad de Valencia, Universidad de Deusto, Universidad de La Laguna - the last two have been discontinued) with a high qualification level. Four Faculties offer a so-called expert course (1 year): Universidad de Cadiz, Universidad de Albacete, Universidad de Sevilla, and Universidad Complutende de Madrid.

Most of the recommendations quoted above have been implemented, so that education on drug dependencies has reached a high standard, mostly at a post-graduate level. Psychiatrists, general practitioners, nurses, social workers, psychologists, etc. are offered good training opportunities when they choose to specialise in drug dependencies.

These master's degrees have been more oriented to illegal than to legal drugs and this tends to conform to the interests of the participants themselves. Alcohol is our most used and abuse drug, but not our national priority in regard to prevention and treatment.

However, this may be changing. Possibly because of the conspicuous drinking behaviour of our youngsters, particularly week-end binges, both public opinion and those in charge of medical education are becoming more aware of alcohol problems. Consequently, training in alcohol problems is becoming more widely available. Within the master's degrees, an increasing number of hours are devoted to alcohol and several symposia, workshops, and other training facilities are offered to health professionals by Medical Schools and some professional societies (e.g.: Sociedad Espanola de Medicina Familiar y Comurniana - Spanish Society for Family and Community Medicine - and SOCIDROGALCOHOL, the Society for the Scientific Study of Alcohol and Other Drugs). The first organises courses, symposia, and workshops for General Practitioners on intervention in alcohol problems and it includes guidelines for early detection and intervention in its Prevention Activities Programme.

SOCIDROGALCOHOL has organised training for Primary Care professionals in several Spanish communities as well as a number of seminars on motivational interviewing. Its Catalan section regularly offers a course on group therapy for alcoholic patients. In recent years, the annual congress of this society has included workshops, some of them devoted to alcohol education. Since 1994, the County of Cadiz (Andalucia) has organised "Meetings on Drug Dependencies" where several workshops on alcohol and other drugs, lasting for three days, are offered to health professionals. In addition, several local centres working on drug dependencies organise training sessions in alcohol treatment. Several publications (books, manuals, booklets, articles, and even support audio-visual materials) are provided by the national and regional centres.

SOCIDROGALCOHOL, in co-operation with SEMFyC, promotes a distance learning course on Alcoholism (Curso de Formación sobre Prevención y Tratamiento del Alcoholismo). This comprises six units and covers everything from basic concepts to specific treatment strategies, including intervention by GPs. Pupils complete a self-evaluation questionnaire. The course is eligible for training credits.

Spain also has a Spanish version of the European Plinius Maior Society's materials, a series of guidelines and flowcharts useful for training professionals in the management of alcohol problems.

Dr A. Rodriguez-Martos Dauer

References:

1. SOCIDROGALCOHOL, Universidad de Barcelona, Universidad de Valencia, ABS: La situacion sobre drogas en las universidades espanolas. Informe no publicado, Febrero 1995.
2. WHO: Summary Report. European Symposium on Substance Abuse Education for Health Professionals. the Hague, 9-10 October 1989, 3pp.
3. Sanchez-Turet, M: Education about Addiction in Spanish Universities. European Psychiatry, 1998; 13, suppl.4:135

SWITZERLAND

Medical education in alcohol problems: a "patient based teaching" experience in Lausanne, Switzerland

Switzerland is a confederation of 26 cantons. It has 5 medical schools within universities. The medical education is under the authority of the Federatio Medicorum Helveticorum (FMH) which gives certifications for specialists. At the moment there is no provision in medical schools for undergraduate education in alcohol related problems. Postgraduate education is determined by the different specialties, but no mention of alcohol training is included in the disciplines. Usually, addiction training is accredited for one year of postgraduate residency but it is optional. A new law makes continuous education mandatory, creating an opportunity for training in the addiction field, for instance in alcohol related problems for general practitioners.

In 1992 a multi-disciplinary alcohol unit was set up at the General Hospital, Lausanne. The work of this unit includes the referral of alcoholic patients as well as the supervision of medical care and social work co-ordination within the network. Through the opportunities given by hospitalisation and medical investigation, evaluation of in- and outpatients in the presence of the general practitioner and relevant professionals of the network is able to be conducted. Two residents are trained every year in the field of alcohol problems. There is continuous education for all the professionals involved, including the staff of hospital wards and in-town social workers. This experience allows clinical research, for example the prospective study of clinical outcomes of an examined cohort and a pilot study investigating predictive variables of referral or treatment success.

This experience led to the following developments: we created a training module for general practitioners in alcohol related problems as well as a structural concept for implementing and assessing such experiences.

The training module for alcohol problems was based on the analysis of the training needs of general practitioners by focus groups and questionnaires. Analysis of the resources in the alcohol network was conducted as well as definitions of pedagogical objectives. The structure of the modules was evaluated.

New perspectives were afforded by the Lausanne experience, leading to a new Division for substance abuse and a project of inter professional certification in addictions. Guidelines for clinical practice after being edited by the Lausanne alcohol Unit and the Swiss Society of Alcohology.

Dr J. Besson

UK

UK primary care perspective

In the UK there has been no centrally funded approach to improve medical education in alcohol problems, unlike in the United States and Australia. (1) Consequently education and training are fragmented and unco-ordinated at all stages of a doctor's career - undergraduate, postgraduate and continuing medical education (CME). Nationally there is no standardised system for the education and training of general practitioners in relation to prevention, early detection and management of alcohol problems. (2)

Undergraduate

Paton's questionnaire survey of 26 Medical Schools in 1984 revealed that they all arranged some formal teaching in alcohol but only one used a multidisciplinary approach; one had a regular seminar (run by the Medical Council on Alcoholism) and one had three formal sessions. The rest relied on an ad hoc approach by psychiatrists, physicians, pharmacologists, general practitioners and pathologists. Only occasionally were casualty officers, behavioural scientists or psychologists involved.(3)

Crome's questionnaire survey in 1987 involved 13 separate departments in 26 Medical Schools. (4) Of the 70 per cent respondents, 54 per cent provided formal teaching (lectures, seminars, symposia). The average time devoted to substance abuse teaching was 14 hours over 5 years, with an average of 6 hours being spent on alcohol - equivalent to 1 minute per week over the entire period of training. Only 21 per cent of clinical and non-clinical departments ensured that students were examined on the topic. Appeals have been made for a flexible 'core' curriculum or a set of guidelines,increasing the emphasis on the importance of alcohol teaching at every opportune stage in the undergraduate experience (5) and integrating such teaching through the curriculum.(6)

It has also been suggested that each Medical School should make a designated teacher responsible for developing integrated teaching in alcohol (5) and that one department, for example general practice, community and family medicine, psychiatry or public health, should take lead responsibility for organising systematic coverage. (7) (8)

Postgraduate

Once again, training and education are fragmented and limited. The various Royal Colleges have produced reports acknowledging the importance of alcohol abuse but it has been reported that a vice-president of the Royal College of Physicians had stated that 'alcohol is not specifically mentioned in any of the specialty training programmes'.(1) A Diploma in Addiction Behaviour has been developed in London with the aim of 'training the trainers'. Training and education in relation to prevention, early detection and management of alcohol problems in general practice undoubtedly occurs during the 3 year vocational training period but the nature, amount and timing of this are determined by individual course organisers and trainers.

All the Royal Colleges have been urged to recognise the need to integrate relevant information, skills and assessment into postgraduate courses and examinations.

Continuing Medical Education

As is the case with earlier career experiences, training and education for established practitioners is ad hoc and fragmented. Anderson's questionnaire study of GPs in Oxfordshire and Berkshire in 1984 (9) found that 66 per cent of respondents reported less than 4 hours total postgraduate training, or clinical supervision on alcohol. A similar study of GPs in Leicestershire, Derbyshire and Nottinghamshire in 1995 showed that this figure had dropped to 42 per cent - still a significant proportion. (2)

The postgraduate education allowance (PGEA) is the principal component of CME for general practitioners but much of the educational activity is 'didactic, uni-profession and top-down' and shows little evidence of 'any convincing benefits for patient care'. (10) The system allows doctors to play to their strengths rather than identify true educational needs, and is therefore unlikely to facilitate improved training and education on alcohol. The recently published Chief Medical Officer's review of continuing professional development in practice suggests a radical alternative to PGEA - Practice Professional Development Plans (PPDP). These would 'integrate and improve the educational process, developing the concept of the 'whole practice' as a human resource for health care, resembling the health promotion plan in general practice and increasing involvement in the quality development of practices'.

Effective Educational Programmes

There is no shortage of educational materials. The Medical Council on Alcoholism (MCA) is an independent organisation and registered charity which encourages health professionals to identify drinking problems among their patients, and to offer treatment and support. The MCA organises educational events for student and postgraduate participants, publishes Alcohol and Alcoholism: the International Journal of the MCA, Alcoholism, a quarterly newsletter, and alcohol abuse detection leaflets and drinking diaries designed for use by general practitioners. The MCA has produced a list of 8 learning objectives for medical undergraduates, covering the following areas:

- Alcohol

- Alcohol and the individual
- Cost of alcohol misuse
- Clinical problems
- Psychiatric implications
- Identification and recognition
- Management
- Policies

It also distributes Alcohol and Health. A Handbook for Medical Students to all UK undergraduates and Hazardous Drinking. A Handbook for General Practitioners.

Alcohol Concern, the national agency on alcohol misuse, is a registered charity working to reduce the costs of alcohol misuse and to develop the range and quality of services available to problem drinkers and their families. It focuses on education, services, special groups, policy, information, publications and the workplace. It has produced a National Alcohol Training Strategy for all staff who work with people with alcohol problems. In a joint project involving the Standing Conference on Drug Abuse (SCODA) and Alcohol Concern, the Quality in Alcohol and Drugs Services (QUADS) group has produced a draft quality standards manual for alcohol and drug treatment services. The National Alcohol Training Forum, established by Alcohol Concern, has produced Talking it Through - a national vocational training pack for alcohol counsellor training.

In addition there are generic training packs such as Helping People Change (Health Education Authority) and Skills for Change (World Health Organisation).

Finally, the UK Alcohol Forum has recently published Guidelines for the Management of Alcohol Problems in Primary Care and General Psychiatry.

In his review of the rôle and effectiveness of medical education in alcohol, Walsh concluded that 'with a few exceptions, such as the emphasis on feedback training in skill development, most recommendations about alcohol medical education reflect the findings of process evaluations and/or educator opinion. They are not sufficiently informed by theory or based on studies with rigorous methodologies'.Furthermore it is clear that the education of health care providers will require a complex set of responses. Traditional and limited 'educational' responses will not, of themselves, suffice. (A Roche, personal communication).

Conclusion

Although there is no standardised system for the education and training of primary care workers in relation to prevention, early detection and management of alcohol problems, there are well established educational and training models and materials and explicit competencies and training recommendations available. The proposed changes in the NHS and the review of continuing professional development in general practice offer a unique window of opportunity for advancing this agenda in UK primary care.

1998.Pr B.R. McAvoy

References:

1. Walsh RA. Medical education about alcohol: review of its role and effectiveness. Alcohol and Alcoholism 1995; 30: 689-702
2. McAvoy BR. Training general practitioners. Alcohol and Alcoholism 1997; 32: 9-12
3. Paton A. Alcohol Concern 1986; 2 14-16
4. Glass IB. Undergraduate training in substance abuse in the United Kingdom. British Journal of Addiction 1989; 84: 197-202
5. Office of the Chief Scientist. Alcohol related problems in undergraduate medical education. London: DHSS, 1987
6. Ritson EB. Teaching medical students about alcohol. British Medical Journal 1990; 301: 134-135
7. Royal College of General Practitioners. Alcohol - a balanced view. Report from General Practice 24, London: Royal College of General Practitioners, 1986.
8. Glass-Crome IB. Alcohol misuse as challenge to medical education: a belated remedy. British Medical Bulletin 1994; 50: 164-170.
9. Anderson P. Managing alcohol problems in general practice. British Medical Journal 1985; 290: 1873-1875.
10. Department of Health. A review of continuing professional development in general practice: a report by the Chief Medical Officer. London: Department of Health,

The trouble with training: substance misuse education British Medical Schools revisited; What are the issues?

My 1987 survey of substance misuse education in British Medical Schools highlighted inadequacies and inconsistencies in the extent and quality of undergraduate substance misuse training. At that time, the average time allocated to formal training in addiction (lectures/seminars) over five years was 14 hours. At that time respondents were concerned about the lack of specialists in the field. Recommendations were made for a core curriculum where addiction behaviour would serve a model multidisciplinary speciality training. Co-ordination by an individual and/or department was suggested.

The continuing difficulty in engaging general practitioners and generalists in the care of substance misusers, suggested it was time to revisit the issue. Furthermore, the failure to achieve Health of the Nation targets, notably increasing alcohol consumption in women and smoking in teenagers, makes review more pressing.

Methodology

Deans, Heads of Departments of Psychiatry and 13 other specialities in 23 medical schools were surveyed by means of a postal questionnaire during 1996. Departments surveyed were Accident and Emergency, General Medicine, Geriatrics, Medical Education, Neurology, Obstetrics and Gynaecology, Paediatrics, Pathology, Pharmacology, Physiology, Primary Care, Psychiatry, Public Health and Surgery.

Results

The response rate from Deans was 72.7 per cent and Heads of Psychiatry was 68.2 per cent. Psychiatry was perceived to be the major provider of training, and only 10.1 per cent of other departments responded. The overall response rate was 20.5 per cent. Organisation of medical school training: In 18 (81.2 per cent) schools, Psychiatry played the lead role and in 11 (50 per cent) schools one individual was responsible for co-ordination. In 4 (18.2 per cent) centres, there were academic departments of addiction behaviour: of these, 3 have Chairs of Addiction Behaviour.

Training input: Psychiatry provided a mean of 6.7 (range 2-14) hours formal training (lectures and seminars), excluding one model department which provided 30 hours and facilitated and coordinated an additional 30 hours of undergraduate substance misuse education. In 10 (45.5 per cent) of schools training is patchy, limited and requires considerable reorganisation. Although 10 (45.5 per cent) schools provide an average (3) or above average (7) amount, this still remains largely unacceptable.

Informal training was offered in 6(27.3 per cent) specialist addiction units, 11 (50 per cent) general psychiatric units, and 8 (36.4 per cent) general medical units. In only 5 schools elective placements were regularly utilised. Counselling for medical students with substance problems was available in 10 (45.4 per cent) schools.

Post graduate courses: Three centres provide multidisciplinary degree courses in addiction studies at MSc level, while 5 run certificate/diploma level courses. There are three distance learning courses. There is additional post graduate training being offered to medicaI personnel (general practitioners, psychiatrists, dentists, midwives) in 8 centres, law enforcement officers in 5 centres, to social workers and psychologists in 10 centres, counsellors in 6 centres, education authorities in 7 centres, and to clinical scientists in 1 centre. One centre provides a unique opportunity for training primary health care teams.

Limitations to training: Lack of trained personnel and comprehensive service provision to act as placements were seen as an obstacle to training. 40 per cent of respondents considered that extra resources were required to meet Health of the Nation targets. Although 25 per cent Heads of Psychiatry reported that substance misuse was high on the agenda for expansion, a similar number also reported that departments of psychiatry had little say in determining priorities within the medical school and that there were many other competing interests.

Relationship between degree of service provision and training activities: The more comprehensive the service, and the more post graduate training provision, the more likely was medical school training to be above average. Where there were academic departments of Addiction Behaviour (particularly with a Chair of Addiction), were associated with the most comprehensive services, most postgraduate training opportunities and average or above average medical school training.

Discussion

The key finding is that medical students are receiving 6 hours formal training on substance problems during their five year training. These findings may partially explain why most doctors are ill-equipped to deal with substance problems. Psychiatry has doubled input since 1987, but this is offset by diminished input from other departments as compared to 1987. There is little evidence of innovative developments which have substantially influenced the content and context of substance misuse training which most medical students in Britain receive. However, the one department which has demonstrated the scope to effect major change across the breadth of the curriculum, is a model worthy of replication.

The important link appears to be the establishment of academic departments which have the rôle of galvanising experienced clinicians who have protected time from clinical work to engage in training. A securely resource unit with adequate administrative support that can be sustained in the longer term is the way forward. This requires the input of an experienced, motivated leader who can mobilise the diverging interests within a medical school and represent addiction.

Conclusion

Although Psychiatry has an important rôle, integration across specialities, disciplines, institutions and agencies is necessary to provide doctors of tomorrow with an understanding of the varied approaches to substance misuse. The establishment of academic departments of addiction studies in medical schools would influence decision making within university and services, promote scientific credibility and benefit communities.

Pr I. Crome

Reference

Glass IB. Undergraduate training in substance abuse in the United Kingdom.
British Journal of Addiction 1989; 84: 197-202

APPENDIX

International Classification of Diseases 10

Mental and Behavioural Disorders Due to Psychoactive Substance Use

Acute Intoxication

A transient condition following the administration of alcohol or other psychoactive substance, resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psychophysiological functions and responses.

Harmful Use

A pattern of psychoactive substance use that is causing damage to health. The damage may be physical or mental (eg episodes of depressive disorder secondary to heavy consumption of alcohol).

Dependence Syndrome

A cluster of physiological, behavioural and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value.

A definite diagnosis of dependence should usually be made only if three or more of the following have been experienced or exhibited some time during the previous year:

- a) a strong desire or sense of compulsion to take the substance
- b) difficulties in controlling substance-taking behaviour in terms of its onset, termination or levels of use
- c) a physiological withdrawal state when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- d) evidence of tolerance, such that increased doses...are required in order to achieve effects originally produced by lower doses..
- e) progressive neglect of alternative pleasures or interests because of ..substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
- f) persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver..., depressive mood states..., or ...impairment of cognitive functioning..
- Narrowing of the personal repertoire or patterns of ...substance use has also been described as a characteristic feature, for example, a tendency to drink alcoholic drinks in the same way on weekdays and weekends regardless of social constraints that determine appropriate drinking behaviour.

Withdrawal State

A group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a substance after repeated and usually prolonged and/or high dose, use of that substance. Onset and course of the withdrawal state are time limited and are related to the type of substance and the dose being used immediately before abstinence. The withdrawal state may be complicated by convulsions.

Withdrawal State with Delirium

A condition in which the withdrawal state is complicated by delirium.

Alcohol-induced delirium tremens should be coded here. Delirium tremens is a short-lived, but occasionally life threatening toxic-confusional state with accompanying somatic disturbances. It is usually a consequence of absolute or relative withdrawal of alcohol in severely dependent users with a long history of use. Onset usually occurs after withdrawal of alcohol. In some cases the disorder appears during an episode of heavy drinking, in which case it should be coded here.

Psychotic Disorder

A cluster of psychotic phenomena that occur during or immediately after psychoactive substance use and are characterised by vivid hallucinations (typically auditory, but often in more than one sensory modality), misidentifications, delusions and/or ideas of reference (often of a paranoid or persecutory nature), psychomotor disturbances (excitement or stupor) and an abnormal affect which may range from intense fear to ecstasy. The sensorium is usually clear, but some degree of clouding of consciousness, though not severe confusion, may be present. The disorder typically resolves at least partially within 1 month and fully within 6 months.

Amnesic Syndrome

A syndrome associated with chronic prominent impairment of recent memory; remote memory is sometimes impaired, while immediate recall is preserved. Disturbances of time sense and ordering of events are usually evident, as are difficulties in learning new material. Confabulation may be marked but is not invariably present. Other cognitive functions are usually relatively well preserved and amnesic defects are out of proportion to other disturbances.

Residual and Late-Onset Psychotic Disorder

A disorder in which alcohol or psychoactive substance-induced changes of cognition affect personality or behaviour persist beyond the period during which a direct psychoactive substance-related effect mightreasonably be assumed to be operating.

Other Mental and Behavioural Disorders

Code here any other disorder in which the use of a substance can be identified as contributing directly to the condition, but which does not meet the criteria for inclusion in any of the above disorders.

Alcohol use Disorders identification test (Audit)
Circle the number that comes closest to the patient's answer. 1. How often do you have a drink containing alcohol? (0) Never (1) Monthly or less (2) Two or four times a month (3) Two to four times a week (4) Four or more times a week 2. *How many drinks containing alcohol do you have on a typical day when you are drinking? [Code number of standard drinks]

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7 to 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly

(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative or friend or a doctor or other health worker been concerned about your drinking and suggested you cut down?

(0) No
(2) Yes, but not in the last year
(3) yes, during the last year

* In determining the response categories it has been assumed that one 'drink' contains 10g of alcohol. In countries where the alcohol content of a standard drink differs by more than 25% from 10g, the response category should be modified accordingly.

Recorded sum of individual item scores

here_____

The Alcohol Use Disorders Identification Test)(AUDIT): Guidelines for Use in Primary Health Care.

T.F. Baker et al. WHO Geneva 1989.

CONCLUSION

The meeting on medical education on alcohol held in Lisbon reached a consensus in regard to the deficiencies of the present situation and the means of bringing about improvement.

In the first place, it was agreed that across Europe substantial numbers of patients with alcohol-related problems are not identified and treated, at least until those problems have reached an advanced stage. It was also agreed that inadequate medical training is an important cause of this state of affairs. Although recently there have been improvements in some countries, undergraduate education in alcohol problems is generally inadequate in both quantity and quality. What undergraduates learn tends to be determined by their own and their tutors' personal interests as much or more than by the formal curriculum. Opportunities for training at postgraduate level are also limited, and not commensurate with the scale of the burden alcohol problems are known to place on health services. There is a tendency for training at all levels to focus on late stage medical complications and to pay relatively little attention to the psychological and social aspects of the problem.

Even today, therefore, it is still possible for newly qualified doctors to begin practising on the basis of having acquired very limited knowledge and few skills in relation to a problem which is sure to place considerable demands on their professional expertise.

Inadequate medical training is not the only obstacle to improved practice. There is also the question of the range and structure of treatment services and the wider issues of social and cultural attitudes to alcohol. However, improved medical training is a vital component of a better response to this major public health problem. There is now in existence a large body of knowledge on alcohol problems and effective methods of treatment. The Lisbon meeting testifies that there is a consensus regarding the main theoretical concepts and approaches to improved medical training based on the elements of knowledge, attitudes and skills. There is also a consensus that new insights and interventions, both psychosocial and pharmatherapeutic, can contribute to an improved medical response to alcohol problems and to more positive attitudes by doctors.

A determined effort is needed to ensure that in future doctors are better equipped to deal with a major public health problem. This requires the medical authorities, in cooperation with national health departments and with European support and leadership, to prepare and implement an action plan concerned with undergraduate, postgraduate, and continuing medical education in alcohol and alcohol problems.

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