RCGP RESPONSE TO ALCOHOL CONSULTATION

PREPARED BY

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1. **INTRODUCTION**

2. This response has been prepared the authors on behalf of the Royal College of General Practitioners.

3. What is general practice?

4. General practitioners provide frontline health care services, and general practice is where most patients have their first and often only contact with the National Health Service. Quintessential of a GP service is open access care, based in a community setting and staffed by professionals able to provide generalist skills across a broad base of physical, social and psychological domains.

5. Other front line services, such as NHS Direct, accident and emergency care and pharmacists are becoming increasingly important.

6. Approximately 98% of the population is registered with a general practitioner and over a three-year period almost all of these patients will make contact with their primary health care services. This places the GP in an ideal position to undertake health promotion and the early detection and management of ill health.

7. Why are general practitioners well placed in relation to alcohol?

8. Because of their regular contact with their patients, general practitioners are ideally placed to undertake the early detection of patients with excessive alcohol consumption. Numerous studies in the

UK and internationally have demonstrated that simple questioning about alcohol, supplemented as appropriate by the use of questionnaires and blood tests leads to high levels of detection. Furthermore, results from a series of randomised controlled trials have demonstrated that brief intervention by the GP or nurse leads to some 20-45% of excessive drinkers reducing their consumption to "sensible" levels. Although there is little good long-term follow-up data, evidence from the United States shows that such effects persist beyond the usual 12 month follow-up period and are associated with reductions in adverse health and social outcomes.

9. WHAT ARE THE IMPORTANT FACTORS INFLUENCING GENERAL PRACTITIONERS INVOLVEMENT?

10. Role legitimacy

11. As stated, general practitioners and primary care nurses have a natural role in the early identification and provision of brief intervention for patients with excessive alcohol consumption. However, many practitioners feel that their role is undermined by mixed and inaccurate messages from other organisations and Governmental sources. For example, whilst the message about tobacco use is now firmly embedded within the national psyche, the messages around alcohol consumption are mixed and confused. As the most effective intervention in general practice is review of consumption and advice to patients to maintain their consumption at "sensible levels", (men no more than 3-4 units per day, and women no more than 2-3 units per day), public health measures to support this are vital. Labelling of all

alcohol drinks with their alcohol content in units together with appropriate health warnings re-enforcing the sensible drinking limits on such beverages would re-inforce the legitimacy of this activity. This already occurs in other countries such as the United States. Effective controls of alcohol advertising to ensure that messages glamorising the misuse of alcohol are not allowed would also provide important support for health professionals undertaking identification and brief intervention.

12. Role adequacy

13. Training in recognition and effective intervention in alcohol is largely ignored in undergraduate and post graduated education, and at best is inconsistent between different medical schools and postgraduate organisations. Alcohol training tends to focus on the complications associated with alcohol dependence and heavy alcohol misuse, such as liver cirrhosis and pancreatitis, rather than on screening and brief intervention before problems develop. This means that most doctors in training encounter patients with alcohol problems at an end stage where prognosis is likely to be poor. General practitioners lack knowledge in the natural history of alcoholism and alcohol related problems, and, unaware of the provision of effective inventions when alcohol intake may not yet be responsible for significant morbidity, develop inappropriately negative attitudes to intervention in patients drinking excessively. Specific areas where GPs lack expertise include:
    a. Identification of excessive alcohol consumption/problem drinkers
    b. Techniques to reduce the risks of excess alcohol intake
    c. Effective screening tools

d. Effective treatment interventions

e. Use of drugs in the management of patients undergoing alcohol withdrawal ("detoxification") and maintenance of abstinence.

f. Understanding of range and roles of treatment agencies

14. Role support

15. The authors undertook a small-scale e-mail survey of views about management of patients with excessive alcohol consumption amongst general practitioners who had undertaken special training in management of patients with drug problems. (Appendix 1) Most general practitioners surveyed felt that they could not undertake any effective intervention without the support of specialist or intermediate services. The most effective service identified was high quality shared care, usually in the form of a community based alcohol nurse specialist – providing close communication with the general practitioner and providing practical support in the provision of assessment, treatment planning, counselling and community (home) detoxification. General practitioners consistently reported positive experiences with the attachment of alcohol outreach workers in practice (analogous to drug outreach workers)

16. Professional self esteem

17. There is a substantial literature on attitudes of general practitioners towards involvement in detection and treatment of patients with alcohol problems. The great majority of the studies have found evidence that, despite convincing evidence from clinical trials demonstrating that GP intervention is effective, GPs and nurses do not feel comfortable with

this work. A recent study explored the reasons for this and identified a number of factors:

a. Inadequate training and lack of certainty about intervention skills
b. Unease about the potential adverse impact of questioning about alcohol on the GP/patient relationship
c. Anxieties about the additional time required to undertake this work
d. Unhappiness about lack of recognition of the work in terms of status and remuneration

18. RECOMMENDATIONS

The Royal College of General Practitioners recommend that: -

<u>19. Public health</u>

20. ***Effective intervention by general practitioners must be underpinned by consistent and nationally (Government) led public health agenda.***
21. ***All alcohol drinks should be labelled with their alcohol content in units.***
22. ***There should be appropriate health warnings (re-enforcing the sensible drinking limits) on such beverages.***

23. ***There should be effective controls of alcohol advertising to ensure that messages glamorising the misuse of alcohol are not allowed.***

24. ***<u>Education and training</u>***

25. ***The General Medical Council as a part of the core curriculum should require training and assessment in the identification and management of patients with excessive alcohol consumption for medical students.***

26. ***Brief awareness training should be provided to all NHS clinical staff, either as part of a rolling training programme or as integral to their professional training. This ideally should be in the form a multidisciplinary meeting lasting say 1 – 2 hours.***

27. ***Appropriate arrangements are established for the accreditation of higher level training (Certificate, Diploma) general practitioners and other primary health care professionals.***

28. ***<u>Revalidation:</u>***

29. ***That all general practitioners are required to demonstrate that they have undertaken work in relation to identification and treatment of patients with excessive alcohol consumption and submitted as evidence for revalidation. Evidence will need to be produced of one or more of the following:***

    i. ***Appropriate training/CPD activity.***

    ii. ***Activity in the practice to raise the levels of identification of patients with excessive alcohol***

consumption –e.g. use of questionnaires, rates of recording of alcohol consumption

iii. ***Activity in the practiced to intervene in patients with excessive alcohol consumption – e.g. information leaflets, drinking record diaries, specially trained nurses/counsellors***

iv. ***Development of close links with other alcohol treatment agencies.***

30. Clinical governance

31. That data on alcohol consumption at PCT and practice level becomes embedded within the clinical governance framework. This will need to include targets for practitioners, practices and PCTs, together with appropriate incentive payments. These could include:

a. ***Targets for recording alcohol consumption on all patients (number of units), for example 30% level of recording in year 1, 60% in year 2 and 80% year three and maintained at this level thereafter.***

b. ***That PCTs as part of their annual report give an indication of the alcohol consumption based on the reports from the practices***

c. ***That PCTs give an indication as to their policy to address the alcohol problems in their areas***

d. ***Financial incentives for general practice for involvement in identification and treatment, measured against agreed performance indicators (see above)***

<u>32. Research into clinical risk markers to aid early identification.</u>

<u>33.</u> That the Department of Health funds research into the development of practical tools to be used as early warning signs to identify problem drinkers. These tools need to be based on common general practice systems, such as prescribing factors or attendance rates.

<u>34. Resources and access to effective services</u>

<u>35.</u> ***Resources should be made available through PCTs including protected and paid time for clinicians to attend training***

<u>36.</u> PCTs should ensure proper provision in relation to identification and intervention for patients with excessive alcohol consumption. There should also be a requirement that effective services, based on a shared care model, should be available in all PCTs, and that these services should be ideally based in primary care.

37. That PCTs be required to make provision for:

a. ***Information leaflets, drinking diaries, computer templates, waiting room displays***

b. ***Ancillary staff – e.g. alcohol outreach workers, additional practice nurse input,***

c. ***Reliable and prompt access to other alcohol agencies, both NHS and non NHS***