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Health Professional Education on Psychoactive Substance Use Issues

Report based on
WHO Consultation

WORLD HEALTH ORGANIZATION

ABSTRACT

Changes in health professional education on psychoactive substance use disorders have been discussed by experts and leaders in this field for almost 10 years, under the sponsorship of the World Health Organization (WHO), the World Psychiatric Association (WPA) and other international organizations. The present document attempts to compile the major discussions and recommendations made since 1989 and gives examples of initiatives taken by several countries and universities. It presents the current approaches proposed by the Programme on Substance Abuse (PSA) to change education and training in substance use disorders to help meet the increasing demand for services and trained personnel, changes in health systems and the need for quality care for patients presenting such problems. Education and training needs to go beyond the traditional curriculum on pharmacology and toxicology, to provide proper knowledge and skills to assess, treat, care and rehabilitate patients with substance use related problems, starting in the primary health care setting. WHO encourages the use of this document as the basis for discussions and as a lever for proposing and implementing initiatives which can improve the ability of professionals to deal with the problems of psychoactive substance use at the individual, family and community levels.

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1. Background

The magnitude of alcohol, tobacco, solvents, psychotropics and illicit psychoactive substance use problems today is well-documented, and it is estimated that it costs over US$ 125 billion per year in health care and lost work in the United States of America alone. In general medical facilities, an average of 20-40 per cent of patients present with such problems, many of which go undiagnosed. When the sequelae of chronic substance use, such as cirrhosis, trauma, and infection present, only then do they receive proper medical attention, but the patient's primary substance use problem may go untreated. Furthermore, the rate of substance use problems among general psychiatric patients with other disorders has been found to be 25-60 per cent, depending on the region and clinical setting. Despite this, education and training of health professionals has been seriously lacking in this field. For example, training in this area is rarely required in medical, nursing and psychiatric residencies or post-graduate courses in most countries.

There is also good evidence that early and brief interventions for alcohol and tobacco are cost-effective forms of treating and of preventing the development of complications such as dependence. Primary care physicians and other health care professionals are in a key position to recognize and successfully intervene in patients with such problems because a considerable number of such patients present in these settings with a variety of clinical problems. For other substances, while the range of approaches is varied and dependent on the type and pattern of use, considerable improvements in health can be achieved through relatively simple measures.

Health professionals, however, working in primary care settings, are not usually involved with the assessment and management of these problems because of pessimism about their effectiveness, confusion regarding their roles, and the lack of professional education and training in these areas.

In general, medical education has been oriented towards hospital-based clinical practice and training, specialized and basic science research, medical technology, and post-graduate specialty training programmes, and the substance use field is not an exception. As a result, there has been an increased supply of specialists, while generalists are characterized more by the absence of post-graduate specialty training than by having a broad set of skills for community-oriented primary care practice. Treatment for substance use disorders became a matter for the specialist, and this does not serve the needs of a growing number of people in the earlier stages of their substance use related problems, who would still benefit from simple interventions. Hospital-based settings offered a highly skewed set of complex problems which were often not seen in community based primary care practices, giving the impression that substance use problems were incurable and invariably led to chronic and severe dependence. The stigma related to illicit drug use and misconceptions about the etiology of substance use problems as a "moral weakness" led to a decrease in access to treatment for the majority of individuals with such problems. As a result of all of this, the public health impact of substance use problems continues to increase worldwide.

This can change, however, by training primary care providers to respond effectively to substance use problems if they understand the patient's living situation, family and community. They can offer services to meet the patient's individual needs as well as other needs applicable to the entire community, such as health promotion, disease prevention and harm minimization. Well trained health providers will not make premature or unnecessary referrals to specialists but give accessible, acceptable and effective care.

In order to provide professionals with adequate education and training on the assessment and treatment of substance use problems, health professional education and practice must change. In addition, since in many countries health care reforms are also occurring, the health care workforce must be prepared to deal with, adapt and actively contribute to these reforms and new systems. It is hoped that more equitable, accessible, effective and affordable treatment, care and rehabilitation of individuals with substance use disorders can then be provided.

2. World Summit on Medical Education

In 1993, the World Summit on Medical Education proposed a series of recommendations for action to change the medical profession and the role of doctors as one of promoting health, preventing and treating disease, rehabilitating the disabled in a compassionate and ethical way (World Summit on Medical Education, 1993). The doctor "has also to be a better provider of primary care; communicator; critical thinker; motivated life-long learner; information specialist; practitioner of applied economics, sociology, anthropology, epidemiology and behavioural medicine; health team manager, and advocate for communities".

The recommendations from this Summit are given below:

1. There needs to be effective administrative and working relations between universities and the health services, including health care organizations and communities, in order to achieve coherent interactions between education and practice;

2. Ministries of Health and Education, training institutions, and representatives with a public perspective should carefully link their policies and programmes to ensure coherence in the production and utilization of trained staff. In societies where formal national health workforce plans do not exist, it will be necessary to develop agreed approaches in training institutions and user groups in sensitive determination of needs;

3. Medical schools must become more involved in health system development as well as staff training. Research into services and teaching in service settings will expose students to alternative models and possibly create patterns of health care in which they will more readily choose to work;

4. Policies must be formulated policies based on the epidemiological and financial realities of the country with attention to enhancing the status of the primary care doctor;

5. Health sciences institutions should study and teach relevant aspects of health transitions, enabling graduates to anticipate, recognize and respond to significant demographic, epidemiological and behavioural phenomena affecting the populations they serve, and providing relevant care in terms of health promotion, prevention, cure and rehabilitation to the patients they treat and the communities they serve;

6. Broaden and deepen medical education to extend into the area of prevention, public health, ethics, social sciences, health promotion, communication, longitudinal management, infectious disease, human sexuality and human rights. Assure that students actively follow ambulatory patients with AIDS and other chronic diseases through the various stages of their illness, including ambulatory care, for a sufficient length of time;

7. Institutional behaviour of medical schools needs further study, with special attention to the formulation and implementation of their mission. At the same time, medical faculties should create teams from different disciplines to design and implement programmes of general medical education that are more responsive to local needs;

8. Medical school admission procedures should be based on institutional mission and capacity, and national health workforce targets. The principles of selection should be clear, equitable and valid. Medical schools should design admission criteria that address both academic and non-intellectual characteristics, such as social commitment and minority status. Attitudinal assessment techniques should be studied in every medical school for validity in identifying the necessary non-cognitive qualities of would-be entrants;

9. Medical schools should institute programmes to enhance the teaching expertise and communicative ability of their staff. Moreover, medical teachers should be required to improve the educational process. Teachers should be selected, promoted and rewarded, in part, according to teaching ability and contribution to educational development. Monitoring the teacher's performance, including input from students, should be used further to improve teaching;

10. Students should be valued partners at every level of medical education: planning of objectives, medical school governance, curriculum, teaching, and evaluation;

11. The methods of science are essential to defining problems and measuring the impact of intervention in the care of both patients and communities. Therefore, schools must emphasize the scientific approach when imparting learning skills. They must consider departmental reconstruction which promotes horizontal and vertical integration of biomedical science and also the behavioural and social sciences in clinical and community health disciplines. They must emphasize economic, statistical, managerial and informational sciences as relevant to clinical work;

12. Ethics should always receive full attention in the medical school, in all clinical encounters, and in the community. Consultative groups should continually explore ethical principles in relation to the different cultural groups, and devise appropriate curricular models.

13. Educational institutions and associations should encourage active methods of learning which are student-centred and promote the organization of national and regional networks for the production of appropriate and relevant learning materials. Learning strategies should be competency-based and accord with the local needs of health staff. Validation studies of assessment techniques and evaluation of innovations in the curriculum are required;

14. Working Groups at international and regional levels should consider reviewing representative curricula. Examples include those based on systems teaching; or problem based learning; or "core and options", with key modules, such as ethics or primary health care. A carefully sequenced core curriculum supplemented by special study modules holds promise, particularly if it promotes self-directed learning. The core emphasizes foundation, such as critical thinking and communications and interview skills, irrespective of a trainee's future career path. Curricular options provide in-depth learning according to specific interests and needs;

15. There is need for a holistic view in planning for the broad fields of postgraduate education, with policy-making mechanisms that can support production of balanced numbers of generalists and specialists. The postgraduate training programmes need to be carefully related to the local context in which they will be practised, and linked with undergraduate and continuing educational programmes;

16. As CME (Changing Medical Education) depends highly on learner motivation, self-directed learning skills must be mastered in under- and postgraduate education. The content of CME must be responsive to the needs of the practitioners with both professional and public input. CME needs thoughtful education planning including: objectives, strategies, skills and assessment. International CME networks and resource centres are needed for sharing and support. Countries must allocate funds for, and monitor, the overall process and outcome;

17. Multi-professional education, where members of different health professions are trained together, establishes and enhances the ethos of teamwork, and the essential collaboration of medicine with allied health personnel;

18. The many projects and the growing literature on community participation in health and development needs to be embraced by all educational institutions. The community-based process will transform

the community's range of choices. Participation of communities in medical education and in institutional administrative decisions is now essential;

19. Medical schools should identify how to improve communication skills in all future doctors. Methods should include observation of and participation in various communication activities, especially patient interviews and case presentations; and involve written and spoken communication with the public, the different communities, varying cultures, and the media. Teaching staff should be appointed who are competent, to ensure the promotion of such communication skills;

20. Problem-based learning in the community will confront students with real demands for participation on the part of patients and the public. Caring for patients with AIDS or other chronic conditions demands that the student learn how to involve them as partners. Consultative groups reviewing health manpower policy should include adequate community representation;

21. Various environments, both medical and non-medical (workplace, schools, villages, households) will expose students to a more realistic array of health problems, human conditions, and professional role models, to enlarge and enrich their hospital experience;

22. Regardless of an institution's mission, interests, or location, its effectiveness is enhanced by an explicit commitment to the health of a defined population and the supporting health care system;

Given these recommendations, it is clear that isolated changes in health professional education and training on substance use and related problems will not be effective if they occur in the context of traditional views about medical education, and the role of specialists and generalists in primary care in general. It is crucial to realize the difficulties in implementing such a process of change, in order to assure the success of any significant changes in the education and training on substance use disorders.