



Public Health
England

The role of addiction specialist doctors in recovery orientated treatment systems

A resource for commissioners,
providers and clinicians



Royal College of
General Practitioners



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The Substance Misuse and Associated Health Unit (SMAH) formally Substance Misuse Unit (SMU) was established in 2001 to promote the wellbeing and recovery of individuals through providing RCGP accredited face-to-face and e-learning training that is evidence based, quality assured and outcome focused. The clinical leadership also plays a major role in shaping national policy, working on behalf of RCGP with parliamentary groups, round tables, etc.

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Executive summary

Addiction specialist doctors can be a vital resource to local alcohol and drug recovery systems, and have a crucial role in championing recovery, ensuring this is visible throughout the system, and supporting commissioners and providers in delivering recovery-orientated systems. This document, agreed by Public Health England, the Royal College of Psychiatrists and the Royal College of General Practitioners, builds on the standards described in **Delivering quality care for drug and alcohol users: the roles and competencies of doctors**¹ and identifies a number of essential functions which can usually only be carried out by addiction specialist doctors. They are required for a properly balanced, flexible, continually-improving and progressive local alcohol and drug recovery system, which is capable of meeting a full range of need. They include to:

- diagnose, assess, plan and deliver support, care and medical treatments to individuals with the most severe and complex diagnoses and needs. This includes the assessment and management of their risks, and the effective and safe provision for any complex prescribing needs, including use of injectable opioids, novel medications, high-dose prescribing and polypharmacy. Alongside this they have a role in the safe and effective choice of highly specialised psychosocial interventions or suitable interventions for those with severe and complex needs
- lead and manage safely the introduction, and appropriate evaluation of innovative pharmacological approaches; and wider treatment innovations
- provide expert clinical advice and support to a wide range of multidisciplinary substance misuse practitioners, both within and outside their teams
- provide suitable expert advice on substance misuse disorders and related issues, to non-clinical services, such as the courts and professional regulatory bodies, wider social services teams, professionals involved in adult and child 'safeguarding' cases and accountable and responsible officers involved in the oversight of prescribing and supplying controlled drugs by healthcare practitioners
- liaise with a wide range of clinical non-substance-misuse services, to support their assessment and care for their patients with substance misuse disorders and physical and mental health problems, particularly those with complex needs, those

¹Royal College of Psychiatrists and Royal College of General Practitioners, CR173 (2012)
www.rcpsych.ac.uk/publications/collegereports/cr/cr173.aspx

at high risk of harm and those who utilise high levels of community and healthcare resources

- provide essential supervision for doctors in training (particularly for those training as addiction specialists), and by on-going peer support for the continuing professional development of existing specialist colleagues and intermediate and generalist doctors locally who are involved in the treatment of substance use disorders
- provide an expert leadership role to substance misuse services on all aspects of clinical governance, safety, quality and clinical effectiveness, to promote appropriate recovery-oriented care
- provide expert medical support for commissioners, including contributing to local strategic needs assessment, analysis and planning. This can be provided by external addiction specialist doctors, for example during the active phase of a re-tendering process when a potential conflict of interest can exist
- provide expert advice to assist local managers develop their services and to assist policy makers in their development of policy and of clinical guidance for the field.

The alcohol and drug misuse sector has seen significant change since 1 April 2013, with changes in commissioning from primary care trusts (PCTs) to local authority-based public health, and a more mixed economy of providers. This calls into question the current reliance on the NHS to develop and support addiction specialist doctors. It is however essential to continue to provide safe and effective services, and have a workforce with the necessary skills to meet the needs of service users.

Background and context

This resource comes against a backdrop of substantial and significant change for the alcohol and drug misuse sector. Changes in commissioning, primarily the move from PCTs to local authority-based public health and an increasingly mixed economy of providers, mean a proportion of medical treatment for alcohol and drug misuse is now delivered by the non-statutory and private sectors. While this has the potential to support effective and enhanced services it will require the sector to move away from reliance on the NHS to develop and support the expertise of addiction specialist doctors. Increasingly, the capacity of non-NHS providers to support and train the next generation of specialists will need to be developed if the skills of addiction specialist doctors are to be retained within the alcohol and drug treatment sector.

Safe and effective alcohol and drug services need staff with the necessary skills, or access to appropriate expertise, to meet all the needs of the population, including those with very complex needs. The Francis Report² underlines this, emphasising the responsibilities of commissioners and providers in relation to service user safety and quality of clinical care. Effective and safe clinical care begins with frontline professionals working in services, as described in **Quality in the new health system – maintaining and improving quality from April 2013**³.

Professionals working within services, whether frontline workers, clinical leads or service managers are responsible for their own professional conduct and competence, and for the quality of care that they provide. At the same time, the shift to local authority-based public health commissioning has meant a shift in clinical governance responsibilities. Local authority-based directors of public health have new responsibilities to ensure that any clinical services they commission using the public health grant (including alcohol and drug services) “have appropriate clinical governance arrangements in place that are equivalent to NHS standards”⁴. Local authority-based commissioners will want to be assured by the boards/senior leadership of their commissioned providers that effective safeguards are in place to protect the interests of service users, and that:

²Final Report of the Mid Staffordshire NHS Foundation Trust Inquiry (2013) www.midstaffspublicinquiry.com/report
³National Quality Board (2013) www.gov.uk/government/uploads/system/uploads/attachment_data/file/127420/Final-NQB-report-v4-160113.pdf.pdf

⁴Department of Health Factsheet – The new public health role of local authorities www.gov.uk/government/uploads/system/uploads/attachment_data/file/127045/Public-health-role-of-local-authorities-factsheet.pdf.pdf

- there is clarity on the distinct roles and responsibilities within locally commissioned service provision
- all frontline professionals are working within the limits of their competence
- there is a clear and agreed approach to taking swift and coordinated system wide action in the event of a serious quality failure being identified, in order to rapidly protect service users

At the same time, local partnerships are continuing to work towards developing local recovery orientated treatment systems commissioned on the basis of recovery outcomes. **Medications in recovery: re-orientating drug dependence treatment**⁵ supports this work, and the development of effective and safe recovery-focused systems that make the most appropriate use of the skills and competences of addiction specialist doctors.^{6 7}

Scope of this document

The focus of this document is on addiction specialist doctors. Other relevant professional bodies have also developed, or are planning to develop, documents which outline their contribution to the alcohol and drug treatment sector. Some of the roles of addiction specialist doctors this document describes could also be met by other professions. For example, clinical psychologists can provide ‘expert oversight of the provision of psychosocial interventions’. However, some of the roles described can only be delivered by addiction specialist doctors.

The document is for doctors who work in adult services (community and prison based), with alcohol and drug users, including illegal drugs, over the counter and prescribed medication, legal highs, and solvents.

⁵Recovery Orientated Drug Treatment Expert Group (2012) <http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf>

⁶The British Psychological Society (2012)
<http://www.nta.nhs.uk/uploads/contributionofpsychologiststorecoveryorientateddrugandalcoholtreatment2012-022013.pdf>

⁷Royal College of Psychiatrists (2012) <http://www.rcpsych.ac.uk/files/pdfversion/OP85.pdf>

Delivering quality care for drug and alcohol users: the roles and competencies of doctors (CR173)⁸

This resource helps commissioners and providers ensure that all doctors working with people who use alcohol and drugs have the right level of competency for the roles and responsibilities they undertake.

The document defines three levels of competency that should be represented in all recovery-orientated systems: general, intermediate and specialist – with addiction specialist doctors having the competences required to diagnose and to treat the most severe and complex service users, and also adopt key roles in clinical leadership – comprising clinical governance and innovation, supervision, appraisal and training, and leading service development.

Addiction specialist doctors will either be consultant psychiatrists with formal recognition of specialist competence by the General Medical Council (GMC), or will be GPs who have achieved a wide recognition of their addiction specialist equivalence by undertaking additional training and developing suitably specialised experience.

Delivering quality care for drug and alcohol users: the roles and competencies of doctors contains detailed information about the distinct training and levels of competence required of addiction specialist psychiatrists and GPs (reproduced in annex 2 of this document). It provides further information on the training, qualifications and supervision arrangements currently available for doctors in this field and sets out recommendations for the training, qualifications and supervision requirements that should be expected of doctors at each level of competency (Chapter 4). The document also sets out principles for commissioning (Chapter 5) that show how high-quality and cost-effective services will need to employ doctors at all levels of competency.

This resource supplements *Delivering quality care for drug and alcohol users: the roles and competencies of doctors*, by providing further information in relation to addiction specialist doctors.

⁸RCPsych and RCGP. *Delivering quality care for drug and alcohol users: the roles and competencies of doctors - a guide for commissioners, providers and clinicians*. London: Royal College of Psychiatrists and Royal College of General Practitioners; September 2012.

The contribution of addiction specialist doctors to alcohol and drug treatment systems

As described in *Delivering quality care for drug and alcohol users: the roles and competencies of doctors*, addiction specialist doctors have a particular contribution to make to recovery outcomes for alcohol and drug users. The possible roles of addiction specialist doctors are outlined here to support commissioners and services to understand the potential of the role and then plan for, commission and support them within this context. They are also outlined to support addiction specialist doctors, where appropriately commissioned, to realise the full potential of the role.

Key roles for addiction specialist doctors

Championing recovery

It is vital that recovery is visible throughout the system. Addiction specialist doctors should promote this in the roles they undertake, from championing recovery at a strategic and systems leadership level, to fostering a culture of hope and belief in recovery in clinical work with service users and supervision and guiding the workforce. Doctors are well placed to champion recovery and play a leadership role, in their services and when working collaboratively across a range of services.

Clinical governance and innovation

The clinical leadership of specialist alcohol and drug services is a key role for addiction specialist doctors. They can take responsibility for leading on all aspects of clinical governance and quality assurance, including clinical effectiveness and service user safety across services in their areas. They can act as advisors on commissioning and implementing policy through their input into local structures. They will normally be suitably expert to champion implementation of evidence-based care. They often lead on innovations locally, and can contribute to expanding the research evidence base. They should be in a position to lead development of new clinical guidance and of local and national service protocols.

Working with complexity/severity

Addiction specialist doctors work with people with the most severe and complex needs. Working with them and with other doctors and professionals, they will be able to lead on planning and delivering support and medical treatment that promotes their recovery. Examples of particular roles include:

- working with people with the most severe or complex needs to devise and initiate a recovery care plan, drawing on the full range of treatment models and settings, in collaboration with other professionals as appropriate
- providing expert advice to other doctors, non-medical prescribers and other clinicians on diagnosis, assessment and recovery care planning, for example, on complex drug interactions, comorbid drug-related physical and mental health issues, alcohol relapse prevention prescribing, and integration of psychosocial and medical treatment
- assessment and management of risk – including risk of suicide and harm to others, assessment of psychiatric and physical comorbidity, and need for further medical treatment and/or onward referral
- expert oversight of provision of psychosocial support, based on comprehensive knowledge of research evidence
- leading introduction of innovative interventions to improve outcomes and quality of provision
- complex prescribing, for example injectable opioid substitution treatments (which also requires a licence for some treatments)

Liaison with other services

Individuals with the most severe problems and complex needs will usually require close liaison with a range of other services. This liaison will at times require expert analysis and authoritative liaison by an addiction specialist. Expert liaison work relating to delivering care for alcohol and drug users is likely to include:

- liaising with relevant professionals to support delivery of recovery outcomes (including social care, criminal justice, housing, medical, psychiatric, employment, children and families professionals)
- working at the interface between alcohol and drug services and mainstream mental health
- working at the interface between alcohol and drug services and the acute physical health sector, for example, treatment of blood-borne viruses and acute liver disease, cancer care, diabetes, managing the health complications of ageing and palliative care
- providing liaison alcohol and drug services in acute medical and psychiatric settings

- providing expert advice to courts
- working with children's services for the protection of children and also vulnerable adults
- providing expert advice to accountable officers and responsible officers

Supervision, appraisal, training and revalidation

Ensuring that adequate supervision and appraisal arrangements are in place and that professionals are working within the limits of their competency is an important aspect of clinical governance. Addiction specialist doctors are competent to supervise and appraise doctors at all levels of competency, and may also have a responsibility to supervise and appraise professionals from other disciplines, such as nurses or drugs workers in prescribing services. Generalist doctors can take on more complex cases only if they have access to supervision from more specialist colleagues. Addiction specialist doctors also have the required competency to undertake the following:

- supervision, support, training and advice to keyworkers on delivery of psychosocial interventions
- supervision of doctors wishing to train as addiction specialists
- provide support, advice, supervision, mentoring and appraisal to intermediate and generalist doctors in treating alcohol and drug use disorders and supporting people using alcohol and drugs
- advise responsible officers on competency issues arising for doctors working with people using alcohol and drugs in the context of revalidation
- advise accountable officers on appropriate uses of relevant controlled drugs
- carry out specialist assessment of fitness to practise for the GMC and other professional organisations, and expert assessment of people using alcohol and drugs in childcare or criminal proceedings
- supervise specialist prescribing regimens, for example injectable opioid substitution treatment

For more information about supervision and training, please see annexes 3 and 4, and **Delivering quality care for drug and alcohol users: the roles and competencies of doctors.**

A key requirement of addiction specialist doctors is to ensure they revalidate themselves and other doctors within their organisations. From 2013 a five-year rolling programme begins to revalidate all doctors. The responsibility for revalidation lies with the responsible officer. It requires a range of assurances, including yearly appraisal and evidence of audit and reflective practice. Supervision from an experienced doctor as well as peer supervision needs to take place to allow these activities to be monitored adequately.

Expert contribution to local needs assessment, commissioning and service development

Addiction specialist doctors are uniquely placed at the interface between service delivery and strategy/planning to make expert contributions to local needs assessments. Their research expertise can help to ensure that commissioning decisions reflect the latest evidence and clinical guidance, for example, in relation to new and emerging drugs. As commissioning moves to local authority-based public health, commissioners will increasingly be required to make decisions based on population-health outcomes, and addiction specialist doctors who oversee treatment systems with significant numbers of service users can make a vital contribution to local analysis. Addiction specialist doctors also have a crucial role to play in providing support, advice and ideas to service managers, commissioners and policy makers, within their own service and more widely. They have a responsibility to contribute to the full range of key management decisions on service design and development. This contribution is likely to include:

- understanding and supporting the broad medical treatment needs of the population
- understanding and (working with other services) responding to the likely demand for treatment for blood-borne viruses and/or alcohol-related conditions
- using expertise to contribute to the development of appropriate local primary and secondary prevention interventions and appropriate clinical service provision in line with research and national guidance
- using knowledge of local alcohol and drug related needs to endorse and champion the delivery of brief interventions to address alcohol and drug misuse in its early stages
- appropriate local responses to new and emerging drugs
- appropriate responses to addiction to over the counter and prescription-only medications

- providing expert clinical and scientific advice and advocacy on alcohol and drug matters to policy makers nationally
- supporting the development of the alcohol and drugs workforce locally and nationally, as well as the wider social care system.

Research and audit

Addiction specialist doctors are often uniquely placed to contribute to research and audit and to establish links with local academic institutions. They can champion and lead research and innovation to develop new clinical guidance and service protocols, locally and nationally. Research expertise is also vital to ensure that interventions and guidance keep pace with new and emerging drugs (such as 'legal highs'), and recent medical discoveries on the complex ways in which alcohol and drugs affect the body and mind, as well as developments in related disciplines such as psychology.

Current issues for commissioners, providers and clinicians

Changing composition of the provider landscape

The composition of the alcohol and drug treatment system has been changing in recent years, with a shift from mainly NHS provision to a more mixed economy of service providers. Feedback from commissioners and providers has indicated that the number of specialists (many are addiction psychiatrists) in local treatment systems is reducing, due either to recommissioning of services or cutting of posts within existing services. Aspects of these changes have the potential to bring significant improvement. However, there are potential risks that some new systems will not have the capacity to retain or support addiction specialist doctors. This in turn may lead to a reduction of capacity for clinical leadership, complex case-management and ability to contribute specialist expertise to training, research and policy development.

Possible solutions

- addiction specialist doctors develop their local clinical leadership roles and demonstrate their effectiveness. If the added value of the addiction specialist doctor is apparent, then commissioners may be more motivated to retain them as a resource. For smaller systems, this might involve sharing specialist resource across a number of areas
- early involvement of addiction specialist doctors and other senior clinicians in performance management discussions and commissioning decisions can help to ensure that services are delivering the best possible care to service users
- where recommissioning is required, input from addiction specialist doctors and other senior clinicians can ensure that new services have appropriate clinical standards in place as well as appropriately matching staff competency to service user complexity and severity. However, to avoid potential conflicts of interest during retendering processes, independent addiction specialist input should be sought
- commissioners and providers may wish to review existing care pathways and service configurations, to make sure that best use is being made of any local addiction specialist doctor resource. Effective use of multidisciplinary teams can free up addiction specialist doctor resource to focus on roles that require specialist medical competences
- where contracts pass from statutory to non-statutory service providers, commissioners and providers should consider working together to ensure the

system can attract and retain addiction specialist doctors via Transfer of Undertakings (Protection of Employment) (TUPE), secondment arrangements or recruitment. Commissioners may wish to address these issues explicitly in developing service specifications and reflect them in scoring as part of the tendering process

- where posts are lost as a result of system reconfiguration, commissioners, providers and local clinical leads should consider working together to agree service models and care pathways that maintain clinical standards, appropriately match service user complexity to professional competency, and ensure that all frontline professionals are working within the limits of their competency
- consider including in service specifications from service providers provision for addiction specialist doctors to contribute to training, research and policy development. This may help to encourage more addiction specialist and other doctors to transfer to a new provider under TUPE rules when contracts change from one provider to another
- the proposed ‘specialist in substance misuse’ qualification for GPs may attract more GPs currently working with alcohol and drug misusers to undertake the further training and development required for them to achieve specialist equivalence. Providers employing specialty doctors registered with RCGP may wish to encourage this
- consider developing multidisciplinary systems – for example strengthening links to mainstream physical and mental health services, to ensure that the full range of physical and mental health comorbidities of service users can be addressed

Reduced availability of specialist training placements

Clinicians often express concern that the lack of any certainty about the availability, shape and duration of addiction specialist posts in the future deters trainees from entering the sector. Also, falling numbers of addiction specialist doctors within the sector will lead to reduced capacity of some treatment systems to train and supervise the next generation of addiction specialist doctors. The development of training placements in the non-statutory sector may go some way to alleviate this position.

Non-statutory providers and the NHS providers may consider collaboration as the best way forward and find ways to rotate postgraduate students. Commissioners and providers can help to promote the development of training placements by ensuring that provision is made for training in tender specifications and bids.

Possible solutions

- commissioners and providers work collaboratively to ensure ongoing of specialist training posts in alcohol and drug misuse services are available. This will involve engaging with the appropriate deanery (responsible for managing and delivering postgraduate medical education and supporting the continuing professional development of all doctors), which in most cases would be the role of the provider. The Royal Colleges of Psychiatrists and GPs may be able to help with this
- commissioners and providers may want to be aware of the increased risk to existing posts when contracts pass from one provider to another, and consider making provision to mitigate these risks in tendering processes
- commissioners and providers may want to make provision for trainee posts when developing service specifications (acknowledging the resource implications as well as the resource benefits of such posts)
- commissioners and providers to consider working across localities to maximise opportunities for establishing training posts across deanery areas
- providers to work collaboratively with the royal colleges to promote specialising in addiction as an attractive career option for trainee doctors

Self-audit checklist

These checklists support commissioners and providers in implementing the standards described in this resource, and the source publication, 'Delivering quality care for drug and alcohol users: the roles and competencies of doctors'

Commissioners	Providers	Essential/ desirable	Yes	No
Have you sought assurances from all commissioned providers that the doctors they employ are working within the limits of their competency? Do local clinical governance arrangements ensure all doctors working with alcohol and drug users are working within their competence for the roles they carry out?	Are doctors employed by you working within the limits of their competency?	Essential	Continue to review regularly	Review urgently as part of clinical governance processes and take immediate action to address
Have you sought assurances from all commissioned providers that systems are in place	Are systems in place to support doctors employed by you, including regular supervision	Essential	Continue to review regularly	Review as part of HR and clinical governance processes and

<p>to support doctors employed in local services, including regular supervision and appraisal, Continuing Professional Development (CPD) and training?</p>	<p>and appraisal, CPD and training?</p>			<p>take action to address</p>
<p>Are sufficient numbers of specialist and intermediate doctors employed to allow effective training and research activity to train the next generation of specialists and equip the treatment system with the skills and innovative approaches for the future?</p>	<p>Do you have capacity/resources to take on trainee posts and contribute to training the next generation of specialists? Do you have capacity/resources to undertake research activity to equip the local system with innovative approaches and interventions for the future?</p>	<p>Desirable</p>	<p>Continue to review regularly</p>	<p>Service providers to work with commissioners to make a case for the benefits of training posts and research and development activity while identifying the resource implications. Further support is available from RCPsych/RCGP</p>

<p>Do care pathways and protocols ensure that people with more severe or complex needs, or at higher risk, have their case referred for assessment and supervision by specialist and intermediate doctors? Do service users have access to specialist and intermediate doctors, including through a personal consultation, should they need it?</p>	<p>Are addiction specialist doctors available to provide clinical leadership, specialist input and oversight in relation to the most complex and severe service users?</p>	<p>Essential</p>	<p>Continue to review regularly</p>	<p>Review urgently as part of clinical governance processes and take immediate action to address. This could include recruitment or setting up referral pathways to appropriate alternative services</p>
<p>Does the local alcohol and drug system have adequate numbers of specialist, intermediate and generalist doctors in the right proportions to ensure a comprehensive and cost-effective service, covered by suitable</p>	<p>Do your services have adequate numbers of specialist, intermediate and generalist doctors in the right proportions to ensure a comprehensive and cost-effective</p>	<p>Essential</p>	<p>Continue to review regularly</p>	<p>Commissioners and service providers to work together as part of local needs assessment to review medical capacity and ensure it is sufficient to</p>

supervision and clinical governance arrangements?	service, covered by suitable supervision and clinical governance arrangements?			meet local needs
Do addiction specialist doctors make expert contribution to local needs assessment and commissioning? Are they involved in commissioning decisions, particularly those relating to service redesign and service specification development? Does needs assessment include a review of workforce competency aimed at ensuring an appropriate match of competency to service user complexity?	Are your addiction specialist doctors actively involved in commissioning, including needs assessment and service redesign?	Desirable	Continue to review regularly	Commissioners and service providers to work together to ensure addiction specialist involvement in decisions relating to service redesign and service specification development. <i>NB: to avoid potential conflicts of interest during retendering processes, independent addiction specialist input should be</i>

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				<i>sought.</i>
Do local retendering processes reflect local priorities in relation to retention of addiction specialist doctors/other addiction specialist roles?	Do tender bids include provision for the training of addiction specialists, provide opportunities for engagement in research, or otherwise seek to attract addiction specialists to TUPE across to the new provider?	Desirable	Continue to review impact of tendering on retention of addiction specialist roles.	Consider revising service specifications and tender scoring processes to ensure appropriate weight is given to retention of addiction specialist expertise

Further information and support

Public Health England (PHE)

Through our national and centre-based alcohol and drugs teams, PHE engages with local partners, supporting them by provision of evidence and guidance to:

- invest effectively in prevention and health promotion
- protect the public by providing a comprehensive range of health protection services
- commission and deliver safe and effective healthcare services and public health programmes
- ensure interventions and services are designed and implemented in ways that meet the needs of different groups in society advancing equality of opportunity between protected groups and others, and reducing inequalities

Please contact your centre-based alcohol and drugs team in the first instance.

Clinicians may also find it helpful to contact the Royal College of Psychiatrists or the Royal College of General Practitioners for advice.

The following resources are also available:

Alcohol dependence and harmful alcohol use (CG115) (National Institute for Health and Clinical Excellence, 2011)

Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications (CG100) (National Institute for Health and Clinical Excellence, 2010)

Alcohol-use disorders: preventing the development of hazardous harmful drinking (PH24) (National Institute for Health and Clinical Excellence, 2010)

Delivering quality care for drug and alcohol users: the roles and competencies of doctors (Royal College of Psychiatrists and Royal College of General Practitioners, 2012)

Drug misuse and dependence: UK guidelines on clinical management (Department of Health and devolved administrations, 2007)

Guidance for commissioners of drug and alcohol services (Joint Commissioning Panel for Mental Health, 2013)

JSNA support pack for commissioners of recovery in communities (National Treatment Agency, 2013)

Medications in recovery: re-orientating drug dependence treatment (Recovery Orientated Drug Treatment Expert Group, 2012)

Recovery diagnostic tool (requires NDTMS login details for access - National Treatment Agency, 2012)

Review of the effectiveness of treatment for alcohol problems (National Treatment Agency, 2006)

Signs for improvement: commissioning interventions to reduce alcohol-related harm (Department of Health, 2009)

Annex 1

Working group members

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Matthew Hibbert – Joint Commissioning Manager, Somerset Drug and Alcohol Partnership

David Jackson – Manager, Safer Middlesbrough Partnership, Public Health and Wellbeing Dept., Middlesbrough Council

Dr Gordon Morse – Medical Director, Turning Point Substance Misuse Sector

Steve O'Neill – Joint Commissioning Manager Drugs and Alcohol, Gloucestershire County Council

Professor Fabrizio Schifano – Chair in Clinical Pharmacology and Therapeutics, University of Hertfordshire; Consultant Psychiatrist (Addictions), CRI

Public Health England observers and secretariat

Rosanna O'Connor, Peter Burkinshaw and Dr Mike Kelleher (observers)

Emma Christie and Daniel Burn (secretariat)

Annex 2

Levels of competency for doctors working with alcohol and drug users⁹

Table 1 The three levels of competency for doctors working with people using drugs and alcohol. 1 Generalist, 2 Intermediate, 3 Specialist

	1	2	3
Supporting people to recover			
<i>Advice and information</i>			
Provide information and advice on harms and risks to people using drugs and alcohol, their families and carers	✓	✓	✓
Work to reduce stigma faced by people who use drugs or alcohol	✓	✓	✓
Provide advice on medical interventions and treatment to people using drugs and alcohol in support of their recovery needs and goals, and to reduce harm as appropriate	✓	✓	
Develop educational materials on drug and alcohol use to support prevention and recovery	✓	✓	
<i>Identification and diagnosis</i>			
Correctly identify people using drugs and alcohol and diagnose substance use disorders	✓	✓	✓
Provide support and advice to generalist doctors on identification of substance use disorders and appropriate referral pathways	✓	✓	
Provide support and advice to intermediate and generalist doctors on appropriate identification and diagnostic tools and strategies	✓		
<i>Assessment and recovery care planning</i>			
Carry out basic assessment of drug and alcohol use, associated strengths, harms, risks, urgency, and need for referral to more specialist services	✓	✓	✓
Carry out risk assessment of suicide and harm to others, and assessment of psychiatric comorbidity, and need for further medical treatment and/or onward referral	✓	✓	✓
Carry out comprehensive assessment of drug and alcohol use, associated strengths, harms, risks, urgency, and need for referral to more specialist services	✓	✓	
Work with people with less severe or complex needs to devise and initiate recovery care plan in collaboration with other professionals as appropriate	✓	✓	
Carry out comprehensive assessment of people with more severe or complex needs using drugs or alcohol, including strengths, risks, comorbidities, and need for interventions	✓		
Advise intermediate and generalist doctors on assessment and recovery care planning	✓		
Work with people with the most severe or complex needs to devise and initiate a recovery care plan, drawing on the full range of treatment models and settings, in collaboration with other professionals as appropriate	✓		
<i>Providing support, care and medical treatment</i>			
Support people using or recovering from drugs or alcohol use in caring for their general mental and physical health and wellbeing	✓	✓	✓
Liaise with relevant professionals (including social care, criminal justice, housing, medical, psychiatric, employment professionals)	✓	✓	✓

⁹RCPsych and RCGP. Delivering quality care for drug and alcohol users: the roles and competencies of doctors - a guide for commissioners, providers and clinicians. London: Royal College of Psychiatrists and Royal College of General Practitioners; September 2012.

cont.

Table 1 The three levels of competency for doctors working with people using drugs and alcohol. 1 Generalist, 2 Intermediate, 3 Specialist

	1	2	3
Provide appropriate management of assisted withdrawal where facilities allow	✓	✓	✓
Implement relevant mental health legislation for drug and alcohol users and lead on supporting people with more complex psychiatric comorbidity (psychiatrists only)	✓	✓	✓
Provide appropriate support and interventions for families and carers of people using or recovering from drugs or alcohol use	✓	✓	✓
Prescribe appropriately for people using or recovering from drugs or alcohol, including opioid substitute prescribing and provision of medications to prevent relapse	✓	✓	✓
Address health needs and comorbidities of drug or alcohol users with more severe or complex needs, in collaboration with other professionals	✓	✓	
Arrange or provide appropriate psychosocial interventions for people using or recovering from drugs or alcohol	✓	✓	
Carry out, with the person receiving support, regular review of recovery care plans	✓	✓	
Lead on provision of support and medical treatment for people with the most severe and complex needs		✓	
Appropriately prescribe injectable opioid substitution treatments (if licensed) and other complex prescribing (e.g. innovative or off-label uses of medicines)		✓	
Provide liaison drug and alcohol services in acute medical and psychiatric settings		✓	
Provide expert, specialised support for vulnerable groups of drug and alcohol users, such as young people, homeless people and pregnant women	✓	✓	
Provide specialist interventions for new emerging drugs of misuse		✓	

Clinical leadership

Clinical governance and innovation

Be aware of research and clinical guidelines on drugs and alcohol relevant to clinical role	✓	✓	✓
Participate in research and clinical governance activities, including clinical audit	✓	✓	✓
Lead on aspects of clinical governance, including clinical audit	✓	✓	
Provide leadership on all aspects of clinical governance, and take responsibility for ensuring they comply with various national standards		✓	
Lead on development of local clinical guidelines and protocols and contribute to national initiatives		✓	
Lead research and innovation in treating substance use disorders and supporting drug and alcohol users, to improve services and care		✓	

Supervision, appraisal and training

Provide general training in treating substance use disorders and supporting people using drug and alcohol to generalist doctors and other staff	✓	✓
Provide training for medical undergraduates and postgraduates in treating substance use disorders and supporting people using drug and alcohol	✓	✓
Provide training and supervision for medical trainees and staff in other disciplines ^a in treating substance use disorders and supporting people using drugs and alcohol	✓	✓

cont.

Table 1 The three levels of competency for doctors working with people using drugs and alcohol. 1 Generalist, 2 Intermediate, 3 Specialist

	1	2	3
Supervision, support, training and advice to keyworkers on delivery of psychosocial interventions			✓
Provide support, advice, supervision, mentoring and appraisal to intermediate and generalist doctors in treating substance use disorders and supporting people using drugs and alcohol			✓
Provide supervision for non-medical prescribers	✓	✓	
Advise responsible officers on competency issues arising for doctors working with people using drugs and alcohol in the context of revalidation		✓	
Advise accountable officers on appropriate uses of relevant controlled drugs		✓	
Carry out specialist assessment of fitness to practise for the General Medical Council and other professional organisations, and expert assessment of people using drugs and alcohol in childcare or criminal proceedings		✓	
<i>Service development</i>			
Support service provision and development locally	✓	✓	✓
Contribute to service management locally	✓	✓	
Champion service user involvement and provide advocacy for service users	✓	✓	
Manage specialist in-service user services for people using drugs or alcohol		✓	
Provide expert clinical advice on drug and alcohol use to commissioners and providers regarding appropriate service provision and development in line with research and national guidance		✓	
Provide expert clinical advice and advocacy on drug and alcohol matters to policy makers nationally		✓	
Support medical workforce development locally and nationally		✓	

a. Postgraduate medical training is subject to specific requirements relating to trainers, for example psychiatry trainees must be supervised by an appropriately qualified trainer in psychiatry.

Table 2 Recommended training, qualifications and supervision for the three competency levels

Competency level	Recommended training, qualifications and supervision	Examples of doctors who work at this level
Specialist	<p>Either:</p> <ul style="list-style-type: none"> - Listed on the GMC's Specialist Register as a psychiatrist with an endorsement in substance misuse <p>Or:</p> <ul style="list-style-type: none"> - Other training, experience and supervision equivalent to this, as certified by the GMC through an appropriate Certificate of Eligibility for Specialist Registration (CESR) <p>Or:</p> <ul style="list-style-type: none"> - Completion of RCGP training and evidence of experience (see pp. 26–29) 	<p>Consultant addictions psychiatrists</p> <p>Specialist GPs (proposed: approved doctor in substance misuse)</p> <p>Specialists with equivalent overseas qualifications (e.g. Australian addictions medicine specialists), UK-qualified doctors from other medical backgrounds (e.g. public health) who have developed specialist expertise</p>
Intermediate	<p>Either:</p> <ul style="list-style-type: none"> - GP on the GMC's GP Register and have completed the RCGP Certificates in the Management of Drug Use, both Parts 1 and 2, and the RCGP Certificate in the Management of Alcohol Problems in Primary Care, and - undertake a specialist peer-led appraisal at least every 2 years to supplement their annual appraisal as a GP, and - undertake relevant annual CPD <p>Or:</p> <ul style="list-style-type: none"> - Listed on the GMC's Specialist Register as a psychiatrist (but not necessarily with an endorsement in substance misuse), and - extensive experience of working with people using substances under the supervision of a consultant addictions psychiatrist 	<p>GPs with a special interest (GPSIs) in substance misuse</p> <p>Psychiatrists whose original training was not in addictions psychiatry, but who have developed a clinical interest in working with people using substances</p>
Generalist	All doctors will have had some basic training in working with people using drugs and alcohol, but an agreed set of core competencies for training in all medical disciplines needs to be developed	<p>Consultants in other areas of psychiatry, including general psychiatrists</p> <p>GPs, who may or may not work with substance misusers under enhanced service arrangements^a</p> <p>Doctors in emergency departments, acute medical, surgical and psychiatric wards, and general physicians</p>

CPD, continuing professional development; GMC, General Medical Council; GP, general practitioner; RCGP, Royal College of General Practitioners.

a. General practitioners are contracted to provide core (essential and additional) services to their service users. The extra services they can provide on top of these are called enhanced services.

Note: trainee doctors, specialty doctors (previously staff grades and associate specialist doctors) should be considered to have satisfied these recommended criteria at each competency level, as long as they are working towards substantive completion of the criteria under the strict supervision of a fully qualified doctor of at least that level, who regulates both their clinical work and their training.

Annex 3

Supervision for doctors working in addiction services

Introduction

Supervision in clinical practice is well established for trainee doctors and there are clear guidelines for how both educational and clinical supervision should take place for trainees produced by the deaneries (for example, Professional Development Framework for Supervisors in the London Deanery 2012)

A review of the empirical evidence (Kilminster et al. 2007) clearly demonstrates a link between supervision of doctors and:

- service user safety
- enhanced quality of care
- more rapid acquisition of trainee knowledge, skills and professional attitudes.

There is an assumption that supervision occurs for non-trainees, including staff and associate addiction specialist doctors and consultant medical staff but there is little formal guidance on how this should happen.

CR173 outlines the competences needed for doctors to work in addiction and the professional background they are likely to come from.

Why do doctors need supervision?

Regulatory requirements from the CQC and the GMC are set out in the roles and competencies document (CR173) and these requirements apply to all doctors.

From 2013 a five-year rolling programme begins to revalidate all doctors and give them a licence to practice. The responsibility for revalidation lies with the responsible officer. It requires a range of assurances, including yearly appraisal and evidence of audit and reflective practice. Supervision from a more experienced doctor as well as peer supervision needs to take place to allow these activities to be monitored adequately.

If doctors are well supervised it can improve service user safety and quality of care as well as improving the doctor's skills. It will enable them to work flexibly in treatment services and improve recovery outcomes for their service users. It can provide a basis for performance review when that is necessary.

What should it consist of?

Supervision can be broadly divided into two types. First, clinical supervision that provides an opportunity for staff to reflect on their clinical practice with an experienced colleague. Second, managerial supervision that provides the opportunity for line managers to ensure staff are working to a satisfactory standard within the employing organisation's agreed policies and guidelines. They can take place together or separately.

Clinical supervision

The principles underpinning the process of clinical supervision should be, as a minimum, the following;

- doctors should have appropriate training to participate fully as a supervisor or supervisee
- arrangements for supervision within the identified supervisory process should be agreed during the annual appraisal
- a record of the supervisory process should include the outcomes and monitoring of agreed actions. This should be retained by the supervisee and discussed in the annual appraisal
- if service user identifiable information is discussed, both parties are responsible for ensuring this information is kept confidential
- if the supervision process results in advice regarding service user management, the supervisee is responsible for ensuring that this is recorded in the service user notes

Examples of workplace based assessment activities which could be incorporated into clinical supervision:

- case-based discussions
- direct observation of practice
- critical appraisal of clinical evidence.

The content of the supervision will be led by the supervisee.

Managerial supervision

The details of the managerial supervision process will be defined by employing organisations. Doctors will be supported in delivering high-quality service user care by a process that:

- is provided within the line management structure
- includes case-load review, data and resource allocation
- includes review of agreed objectives and performance
- ensures outcomes of managerial supervision are recorded and discussed as appropriate within the appraisal process and job plan review
- the content of the supervision will be led by the supervisor

CPD and peer groups

In addition to supervision the doctor is required by the Royal Colleges CPD guidance to be a member of a peer group which monitors their CPD activity. This is required for revalidation.

Frequency of supervision

Frequency of supervision should always be proportionate to the seniority and experience of the doctor and the complexity of the client caseload. A less experienced doctor will require weekly supervision and this should be the norm but less frequently may be sufficient for someone with more experience. It should take place every month as an absolute minimum for anyone below specialist level.

If the doctor is in a service where contact with the supervisor is daily then formal supervision can be less frequent but if the contact is infrequent then formal supervision needs to be robust. Doctors working towards their CESR (certificate of equivalence with the specialist register) may need more supervision. Others where performance is an issue will again need more supervision.

Supervision of doctors working on a sessional basis

To avoid doubt, employers of doctors, including those working on a sessional basis who may be employed for the majority of the time by another organisation, are responsible for supervising any work carried out within their organisation.

Supervision for the addiction specialist

It is good practice for addiction specialist doctors, like all doctors, to have some sort of supervision. This is in addition to the process of appraisal and job-planning and can contribute to its objectives. For consultant psychiatrists supervision is often done as part of a peer group, which also approves consultants' CPD according to the Royal College of Psychiatrists' CPD policy. In some trusts or provider organisations supervision is also offered from a more senior doctor such as a clinical or medical director and this would be considered good practice.

Primary care addiction specialists need to have adequate and appropriate clinical supervision and are encouraged to keep a portfolio of evidence including the following by way of minimum standards to be reviewed and updated on an annual basis:

- evidence of participating in quarterly supervision with an experienced clinical lead in alcohol and drug misuse
- completing at least one specialist clinical audit in alcohol and drug misuse treatment and care
- participating in delivering education and training in the field of addictive behaviour
- involvement in facilitated case file review and root cause analysis of a significant incident
- specialist CPD in excess of 15 hours a year
- involvement in research and development and/or service evaluation
- involvement in local medicines management procedures
- understanding and contributing to an alcohol and drug misuse performance and outcome framework relating to individual clinical practice

Trainee doctors will have supervision as defined by their training provider.

Supervision for staff and associate doctors (SAS) in addiction

This group of medical staff have a range of grades and titles. Their titles have changed over the last few years but most are now called 'speciality doctors' although some staff with the title 'associate specialist' or 'staff grade' still remain. The title medical officer is also used. The grade contains within it different sorts of doctors who have a range of experience in alcohol and drug misuse services. Most come from a psychiatric

background and may already have gained their MRCPsych (Membership of the Royal College of Psychiatrists) or may be working towards it even though they are not in a training post. Others may not be intending to take it although they do have psychiatric experience and would consider themselves psychiatrists. Other doctors come from different backgrounds and may have experience in primary care or other medical specialities. Many of these have trained abroad and may have limited experience in the UK in any speciality.

Most speciality doctors are not on the specialist register and are not eligible to become consultant psychiatrists (or indeed a consultant in any other speciality). However, if they do have psychiatric experience they can go back into a higher training post to complete their training or can gain admission to the register by proving equivalence with a higher training.

In practice much of the day-to-day medical work in alcohol and drug misuse services, especially those where there are no trainees, is done by speciality doctors. As the providers of those services become more diverse many speciality doctors are employed by voluntary sector services or by partnerships of NHS and voluntary sector providers. They are also employed in many different types of service configurations and may be geographically distant from their line managers. As resources become more scarce they may be working as the only doctor in a service. The doctors themselves often come from a range of career backgrounds with a variety of different experiences and may not have had a conventional training in work with alcohol and drug misusers.

The supervisor for an SAS or speciality doctor should be a senior colleague, usually a consultant addiction psychiatrist or other specialist in addiction, such as a primary care specialist. The definition of a specialist is defined in CR173.

Implications for providers

Providers need to have access to specialists (as defined in CR173) who can supervise SAS doctors and senior addiction specialist doctors who can supervise specialists. They need to be adequately trained (including with CPD) to do this.

Services need to be organised in such a way that doctors and supervisors have the resources for regular supervision including sufficient time in their job plans.

Supervision needs to be monitored by provider organisations with yearly audits of supervision being carried out. These must include audits of supervision notes.

References/sources

Cope D. Supervision for career-grade psychiatrists in managed settings: position statement PS2/2010 (on behalf of the Special Committee for Professional Governance and Ethics). London: Royal College of Psychiatrists; July 2010.

Kilminster S, et al. AMEE guide no. 27: effective educational and clinical supervision. Medical Teacher 2007; 29(1): 2-19.

London Deanery. Professional Development Framework for Supervisors in the London Deanery. London: London Deanery; 2012.

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Annex 4

Training requirements for addiction specialist doctors

Psychiatry

Doctors wishing to train as addiction psychiatrists first have to complete a basic training in psychiatry, which usually involves a six-month full-time placement in an addiction service. After passing all three parts of the RCPsych membership exam (the syllabus contains the theoretical basis of, and practical skills in, addiction) they can go onto higher training. In three years of higher training they have to do at least another year of full-time work in an addiction service as well as that in general adult psychiatry. After this training they gain admittance to the GMC specialist register, which entitles them to apply for consultants posts. If they do not train via this conventional route some can gain entry to the specialist register by demonstrating their equivalence to the training.

Primary care

GPs wishing to train as addiction specialist doctors need to have the RCGP certificates 1 and 2 then gain significant experience during which they have high-quality supervision from another addiction specialist, allowing them to work through the informal training process as described in ‘Delivering quality care for drug and alcohol users: the roles and competencies of doctors’. At the time of publication of this resource the move to develop a system of accreditation for GP specialists falls within the remit of the GMC and its role in establishing a system of credentialing.¹⁰ In advance of a system for credentialing, RCGP recommends that individuals who seek recognition as specialists in addiction (primary care) are able to show evidence that they have achieved RCGP level 2 competence in drugs and alcohol, completed more than 15 hours a year of specialist CPD, and participated in the annual appraisal and revalidation system. They must also produce of a portfolio of evidence that demonstrates the core competences and has been externally and independent assessed by a suitably qualified clinical lead in addictions. The RCGP has developed courses that enable GPs to demonstrate the ability to work at this level as a minimum standard. GPs must provide evidence of formal training by completing complimentary specialist courses approved by the RCGP, RCPsych or other organisations to achieve the appropriate level of competence required.

¹⁰Credentialing is ‘the establishment of a process which provides formal accreditation of attainment of competencies (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practice in that area in the context of effective clinical governance and supervision as appropriate to the credentialed level of practice.