CSAM SMCA

SEPTEMBER 2014

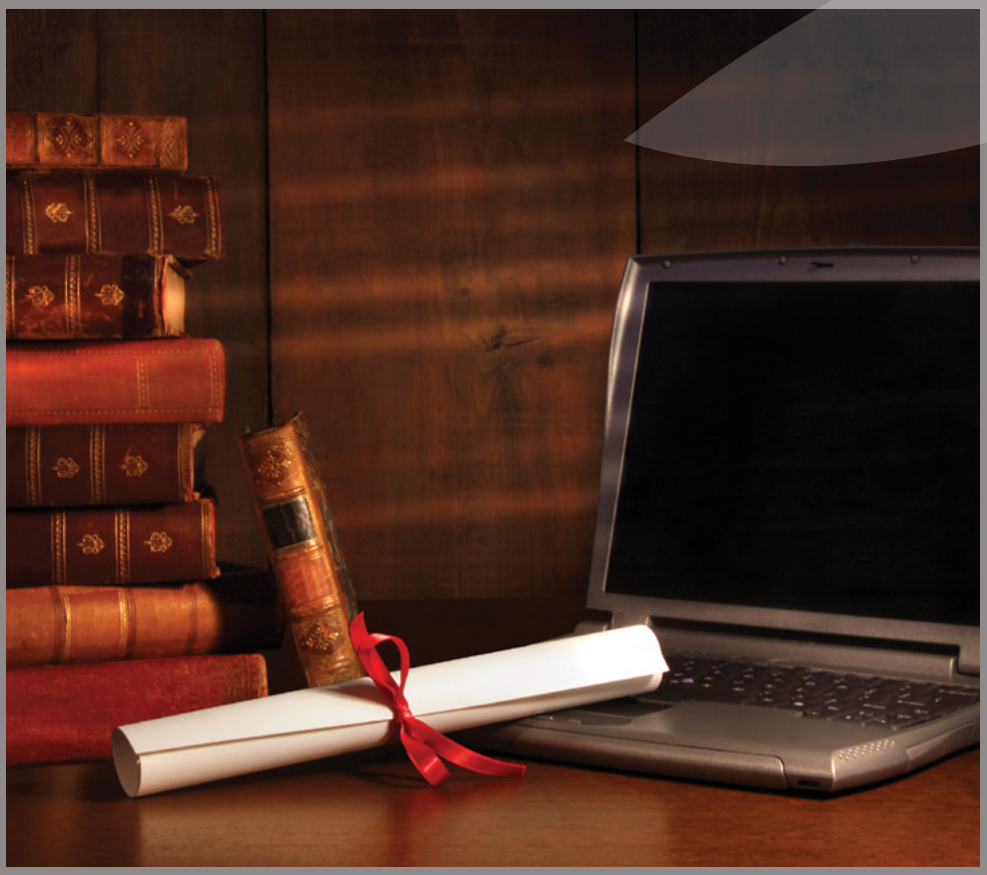
the Canadian Journal of Addiction

Le Journal Canadien d'Addiction

VOLUME 5 NUMBER 3

an official publication of the Canadian Society of Addiction Medicine

Special Edition: EDUCATION AND TRAINING IN ADDICTION MEDICINE



Featured Articles

ISSN 2368-4720 (print) • ISSN 2368-4739 (online)

the Canadian Journal of Addiction
Le Journal Canadien d'Addiction

SCOPE & MISSION OF THE CJA-JCA

The Canadian Journal of Addiction is the official publication of the Canadian Society of Addiction Medicine. It is a new publication whose goal is to provide a unique Canadian forum for presentation of evidence-based, peer–reviewed clinical information and scientific materials, to clinicians working in the field of Addiction Medicine.

SUBMISSIONS TO THE JOURNAL

Instructions to Authors for submission to the journal are located on the **CSAM-SMCA webpages (www.csam-smca.org)**.

DISCLAIMER:

The statements and opinions contained in the articles of the Canadian Journal of Addiction are solely those of the individual authors and contributors and not those of the Canadian Society of Addiction Medicine, its board or staff. The appearance of advertisements in the journal is not a warranty, endorsement, or approval of the products or services advertised or of their effectiveness, quality, or safety. The Canadian Society of Addiction Medicine, its board and staff disclaim responsibility for any injury to persons or property resulting from any idea or product referred to in the articles or advertisements.

ETHICAL POLICY AND REGULATIONS

Respecting the Farmington Consensus, the peer-review process will screen for attempted or actual instances of duplicate publication, plagiarism or scientific fraud. When the above is brought to our attention post-publication, the Editorial Board will review the allegations and publish an appropriate disclaimer. A link to the Farmington Consensus can be found on the CSAM-SMCA webpages.

PERMISSION TO PHOTOCOPY ARTICLES:

Listed in: Canadiana, AMICUS, CCSA Library & Information, Library & Archives of Canada, EBSCO Academic Search Complete, National Library of Medicine, USA, International Society of Addiction Journal Editors, ISAJE, Saskatchewan Health Information Resource Partnership, U of S Health Science Library, Centre for Addiction and Mental Health (CAMH)

ARTICLE REVIEW POLICY:

All articles for publication by this journal are peer-reviewed by two or more reviewers.

CSAM-SMCA WEBSITE:

All contents and materials found in this and every issue of the Canadian Journal of Addiction can also be found on the CSAM-SMCA web site at www.csam-smca.org

MANUSCRIPT SUBMISSION:

All materials for submission and manuscripts must be submitted to the CJA-JCA Editor-In-Chief at admin@csam-smca.org. Online manuscript submission will be available in future issues of the CJA-JCA.

Educational Opportunities and a Call for Synergy

Twenty-five years ago, in 1989, the Canadian Society of Addiction Medicine was tasked with developing educational opportunities for physicians as one of its main objectives. We started with a meeting organized annually to this day and attended by several hundred participants seeking up to date information. The meeting is now complemented by a Fundamentals course for newcomers to the field which is spearheaded by an active Education committee. That committee has also liaised with our College of Family Physicians with some of its members assuming a leadership role in the College's new committee in Addiction Medicine. Unfortunately, there is no such formal liaison with the Royal College of Physicians and Surgeons although psychiatry was the first specialty to develop a set of guidelines for addiction psychiatry as part of its training program.

A dream has been to promote the development of best practices among all physicians who regularly encounter among their patients, individuals with issues arising from their substance use as well as suffering from addiction and its spectrum of disorders from substances and a number of addictive behaviors. Another complementary dream has been to seek validation of the special knowledge, skills and attitudes required in the practice of Addiction Medicine. Canadian physicians have since 1986, sought this validation from the Certification and now the Board Diplomas of the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry. Since 2005, the International Society of Addiction Medicine has also provided certification to 30 Canadian physicians as well as 80 other physicians from 13 countries.

Recently, a number of opportunities in Canada and worldwide have now provided renewed impetus to our educational efforts. Our Journal is pleased to present this special issue describing a number of new training opportunities and educational proposals hoping to stimulate a national dialogue regarding the sustenance of our specialized practices. This issue also coincides with a meeting just held in Nijmegen, Netherlands in August on international educational efforts in our field. My comments derive from the insights arising from the papers in this issue and the submissions and discussions at the meeting in Nijmegen.

Since 2008, a WHO (World Health Organization) directive[1] has spurred a comprehensive effort in the United Kingdom to survey the curricula in substance misuse/undergraduate teaching in the medical schools of England resulting in a set of recommendations and guidelines. We are grateful for the participation of Christine Goodair and Ilana Crome who graciously agreed to summarize their experience. We look forward to a similar effort from our medical schools.

Ramm Hering and colleagues also emphasize the need for collaboration. They provide us with an overview of the evolution of addiction medicine in Canada, fellowship opportunities in Toronto and a summary of a national effort to propose to the Royal College of Physicians and Surgeons an "Area of Focused Competence" (AFC) Diploma in addiction medicine. The University of Toronto has also offered a multidisciplinary Diploma in Addiction for the last few years. In addition, the article reminds us of the input of the Canadian Centre on Substance Abuse (CCSA) and the anticipated Canadian Research Initiative in Substance Misuse (CRISM).

Sharon Cirone, who has led the CSAM Education Committee and now leads the College of Family Physicians' Addiction Medicine Program Committee in the Section of Special Interest and Focused Practice, summarizes the developing aspirations and plans of this Committee. The College has now approved the awarding of Certificates of Added Competence (CAC) to five programs. How far off the mark are we?

Launette Rieb and Evan Wood present a synopsis of recent laudable developments in British Columbia. Of note, is the welcomed role of philanthropy in sponsoring these efforts and empowering this group of specialized academics and practitioners to develop a number of training opportunities and a potential new diploma sponsored by the University of British Columbia.

Ron Lim describes an Enhanced Practice opportunity in Family Medicine at the University of Calgary. The department decided against the use of the term

Fellowship. This may be closer to the intent of the College of Family Physicians. In addition, one or two Fellowships are sponsored by the Department of Psychiatry based on an annual competition among psychiatric subspecialties for these positions.

Addiction Medicine is commonly practiced in multidisciplinary teams and Louise Nadeau's contribution sketches the role of psychologists and other non-medical health providers as part of the team. Of note, one of the seven competencies of the Royal College of Physicians and Surgeons required of graduating specialists is that of "collaborator". This competency is fleshed out in the 2005 guidelines and is being updated as part of the College's new guidelines anticipated for 2015[2].

The above developments are not without their challenges. Hence, the call for synergy! These efforts, all laudable, remain a patchwork of creative initiatives. Required is a consensual strategy on education in Addiction Medicine for Canada. A strategic meeting could be held in conjunction with an annual CSAM meeting. At the meeting in Nijmegen it was apparent that worldwide efforts include a possible handful of Diploma courses averaging two years either multidisciplinary (Toronto) or exclusively for physicians (Radboud University in Nijmegen). The Diplomas are awarded by Universities and may be recognized by the respective Licensing bodies. With political support, Norway has become the first country to recognize Addiction Medicine as an independent specialty and a 5-year training curriculum is being developed. The combined curricula being developed by all concerned will help shape the scope of practice of our profession. This scope of practice will be further shaped by the certification examinations. There is still no world consensus on the scope of Addiction Medicine, with several programs still limiting their scope to substance misuse.

Further to this lack of synergy there has been, to my knowledge, no systematic attempt to determine our workforce requirements[3]. How many addiction medicine specialists would we optimally need in our Society? The article by Hering et al in this issue provides some of the best workforce figures I have seen but we still don't know how far off the mark we are. Psychiatry and several other specialties have had to initiate a number of successive exercises, including workforce surveys, number of unfilled positions, the range of specialist to population ratios, etc. These data eventually determine the need for Fellowships and other required training spots. I do not believe that our current training positions are anywhere near our requirement for sustaining ourselves.

Lastly, I am becoming increasingly aware of the costs to physicians of the ability to practice. In addition to licensing and insurance fees, medical society dues, the costs of training years, examinations and maintenance of competence often in more than one country, all are on a constant upward curve. These costs are a potential deterrent countering our recruitment efforts. Once again, a synergistic strategy will need to examine these costs. Is there a ceiling to these tithes?

We hope that this issue of the Journal will help us become more aware of our options and participate in the anticipated debate about our national education and validation. The issue of course makes no claims to have covered all the angles. We look forward to your feedback in order to do that!

Key Words: Medical education, addiction, medical competencies

Yours truly,

Nady el-Guebaly, *MD*
Editor-in-Chief, CJA-JCA

REFERENCES:

1. World Health Organization. 2008. Policies and Practices for Mental Health in Europe – Meeting the Challenges. (Accessed September 3, 2014, at http://www.euro.who.int/en/what-we-publish/abstracts/policies-and-practices-for-mental-health-in-europe.-meeting-the-challenges)
2. The Draft CanMEDS 2015 Physician Competency Framework. (Accessed September 3, 2014, at http://www.royalcollege.ca/portal/page/portal/rc/common/documents/canmeds/framework/framework_series_1_e.pdf)
3. Fréchett D, Hollenberg D, Shrichand A, Jacob C, & Datta I. 2013. What's really behind Canada's unemployed specialists? Too many, too few doctors? Findings from the Royal College's employment study. Ottawa, Ontario: The Royal College of Physicians and Surgeons of Canada.

Improving the Landscape of Substance Misuse Teaching in Undergraduate Medical Education in English Medical Schools from Concept to Implementation

Christine Goodair *BA (HONS) FRSA*
Professor Ilana Crome *MD FRCPsych*

Address for correspondence:

Christine Goodair
Programmes Manager (Substance Misuse)
International Centre for Drug Policy - Population Health Research Institute
6th Floor, Hunter Wing
St George's, University of London,
Cranmer Terrace London SW17 ORE
Email: cgoodair@sgul.ac.uk
Phone: +44 20 8725 5522

ACKNOWLEDGEMENTS

The project has been funded by grants from the Department of Health, National Treatment Agency and the Society for the Study of Addiction.

ABSTRACT

Briefly describes the work undertaken to develop guidance on the teaching of substance misuse in undergraduate medical curricula and its implementation in English medical schools and to comment upon its applicability in Europe and elsewhere and to other allied health professionals.

Keywords: Medical education, Substance misuse, Addiction

INTRODUCTION

Substance misuse is a major public health challenge both nationally and globally. The use and misuse of alcohol, drugs (licit and illicit), and of tobacco have impacts on individual patients, their families and communities. Doctors within all branches of medicine are very likely to encounter individuals with substance related health problems. The medical profession has a key role in improving not only the health of their patients but also the nation's public health. Research, including surveys into the undergraduate medical UK curricula between the late 1980s and 2004[1], found that substance misuse was generally very poorly represented in the training of our future doctors; and the number of hours allocated to teaching in substance misuse was small[2,3,4]. It was taught mainly within the disciplines of psychiatry and pharmacology, thus reinforcing the false notion that substance misuse is a niche specialty topic[1]. On the other hand, it was also found that there were numerous initiatives in North America, some establishing a core curriculum and others developing teaching and learning innovations, with very little innovation happening in the UK. The lessons were clear: substance misuse has to be integrated into the curriculum of medical students, and it has to be a topic introduced from the very beginning of the course – not least for students' own health and professional behaviour.

Previous initiatives undertaken by St George's, University of London and the World Health Organisation (WHO) on substance misuse education for doctors, pharmacists and nurses resulted in the WHO recommending to governments that substance misuse should be included in the medical curricula. Three international expert groups on medical, pharmacy and nursing education were convened to develop an international guideline for the curriculum development in substance misuse by the Centre for Addiction Studies, latterly the International Centre for Drug Policy (ICDP) on behalf of the WHO[5-7]. Subsequent to these initiatives, the United Nations requested all governments to include substance misuse teaching and learning in the curriculum of the relevant faculties in the universities[8]. Hence, the ICDP made proposals to the Department of Health to facilitate a consensus approach to the enhancement of substance misuse training in medical and nursing schools in the UK. Funding was awarded to the ICDP in 2005 to improve the education of doctors in substance misuse and to develop a consensus approach to substance misuse training in medical schools. A national project was set up that initially developed over two phases. Phase 1 (2005-2007) involved a review of the state of teaching and worked with all UK medical schools to develop consensus guidance, *Substance Misuse in the Undergraduate Medical Curriculum*[10] on the integration of alcohol, drugs and tobacco training in medical

undergraduate curricula. Phase 2 (2008-2011), funded by the Department of Health focused on supporting English medical schools to integrate and implement the guidance through the development of a core Toolkit, provision of teaching and learning resources, and the establishment of a network of those English medical schools willing to pursue change in their curricula. Following the completion of the second phase further funding was awarded for a third phase which involves sustaining the positive changes implemented in the teaching of substance misuse; to update the learning resources developed in phase two and further develop the network into a self-sustaining network involving medical schools across the UK.

A National Steering Group and Expert Panel was established and chaired by the Principal of St George's, University of London, with representatives from the Council of Heads of Medical Schools, the Department of Health, the Home Office, the General Medical Council (GMC), the British Medical Association and its medical student committee, and the World Health Organisation. The Expert Panel had representatives from UK medical schools, professional institutions and UK national agencies. Both phases of the project were overseen by the National Steering Group.

PHASE 1 REVIEW (2005-2007)

During this first phase, the project reviewed the ways in which substance misuse problems was being taught in all 32 UK medical schools. It sought to establish the reasons for its identified ineffectiveness and to make recommendations for its improvement in medical schools throughout the country. The project aimed to understand the reasons why medical education is not preparing doctors properly in this respect; specify initiatives that different medical schools could take to improve matters; and make recommendations for further action.

A survey was undertaken to gather information about the state of substance misuse education in all UK medical schools. The survey found that:

- There was no commonality of approach in what was taught about substance misuse: learning outcomes differed hugely in style, level of detail, and emphasis.
- Many schools covered a lot about alcohol, but relatively few covered teaching about drugs – with this aspect frequently left only to psychiatrists.
- Only two schools planned and coordinated their substance misuse curriculum as a whole. Mostly, the teaching was concentrated in the specialty niches.
- Assessment of substance misuse within curricula was rarely planned. As 'blueprinting' against curriculum outcomes is being increasingly introduced, more formal planning in this area is expected.
- About half the schools had some provision of optional learning about substance misuse through 'Student Selected Components' (SSCs).

The main outcome of Phase 1 of the project was the production of a UK-wide consensus guidance document on substance misuse in the undergraduate medical curriculum agreed by all medical schools, and an associated Toolkit providing guidance on the effective implementation and/or development of high quality substance misuse teaching/training within the undergraduate curriculum.

The curriculum guidance document is a milestone in medical education on substance misuse. It provides three core aims for undergraduate medical education in substance misuse:

1. Students should be able to recognise, assess and understand the management of substance misuse and associated health and social problems and contribute to the prevention of addiction.
2. Students should be aware of the effects of substance misuse on their own behaviour and health and on their professional practice and conduct.
3. Students' education and training should challenge the stigma and discrimination that are often experienced by people with addiction problems.

In addition to these three core aims, six high-level learning outcomes were agreed, each of which was subdivided into component learning outcomes, which could be integrated flexibly across the whole of the curriculum and in varied learning environments. The six key areas being:

1. Bio-psycho-social models of addiction
2. Professionalism, fitness to practice, and students' own health
3. Clinical assessment of patients
4. Treatment interventions
5. Epidemiology, public health and society
6. Specific disease and speciality topics

The corporate guidance was endorsed by General Medical Council and the Department of Health, and cited in Tomorrow's Doctors 2009.

PHASE 2 (2008-2011) IMPLEMENTATION MODEL

Following publication of *Substance misuse in the undergraduate curriculum*, a further proposal for a second phase (Phase 2) was produced and submitted. The intention for

this phase was to provide a time-limited period of intensive support for the development and implementation of the new curriculum guidance into the teaching and learning opportunities of the medical schools at a local level, and into their local curriculum planning processes. Funding was made available for a three year period for implementation support in English medical schools (24) from the Department of Health (England).

The aims of this phase were:

- To complete and validate a Toolkit and teaching and learning resources in order to advance the implementation programme.
- To enhance and equip medical schools to further develop substance misuse learning in their curricula.
- To work with medical schools to pilot and evaluate the implementation of the substance misuse curriculum.

This was done through the appointment of curriculum coordinators in the 18 participating medical schools who worked with local academic champions to identify and map current substance misuse teaching and to recommend and support changes to ensure that substance misuse issues were fully covered in line with national guidance. This mapping was aligned to the national substance misuse key learning outcomes grouped into six key learning areas:

Table 1 shows the number of teaching sessions that occur for each of the overarching learning outcomes (and the average across the 18 medical schools that contributed to this analysis). Teaching sessions are defined as the number of occasions some formal or timetabled teaching/learning occurs that feature issues relating to substance misuse (such as a lecture, a seminar, a problem-based learning case, special study modules and these will vary enormously in the amount of time given to the topic – for example from an hour's lecture to a special study module which may run over several weeks or be a small, but key, part of a problem based learning scenario[11]).

TABLE 1: NUMBER OF TEACHING SESSIONS THAT OCCUR FOR EACH KEY LEARNING OUTCOMES AREA

Learning Outcomes Area	Number of SM Teaching Sessions	Average per School (18)
Bio-psycho-social models of addiction	958	53
Professionalism, fitness to practice and students' own health	418	23
Clinical Assessment of Patients	942	52
Treatment Interventions	921	51
Epidemiology, Public Health & Society	578	32
Specific Disease and Specialty Topics	846	47

** SM: Study Module*

The mapping identified variation in the instances of teaching between schools and within schools, and variation of the extent of provision, as well as areas needing further development. Common areas for all schools requiring further development included iatrogenic addiction; professionalism, self–care and fitness to practice; attitudes and issues relating to stigma; child related issues and social consequences.

Changes implemented by the schools ranged from the re-writing of learning objectives to the development of problem based learning scenarios. Workshops and symposiums were developed that covered ethical issues of substance misuse including the use of external speakers to discuss the misuse of substances by the medical profession. Teaching resources were developed or enhanced through the development of web resources such as virtual patient tutorials and video resources playing out clinical scenarios. Independent learning resources were also developed such as an online addictions study guide, and in one school students set up and hosted an 'Alcohol Awareness Week'[10].

Another key task of this phase was to complete and validate the implementation Toolkit and the accompanying teaching and learning resources (Fast Factsheets), developed to assist the coordinators in their work. The Toolkit was designed as a flexible resource to provide guidance on mapping and implementing substance misuse into the curriculum. The Fast Factsheets, written

by clinicians with in-depth knowledge of substance misuse, provided concise, relevant and up to date information on specific areas of substance misuse teaching. These include Neurology, Infectious Disease, Psychiatry, Gastroenterology, Respiratory Medicine, General Practice, Anaesthesia, Geriatrics, Doctors' Own Health, Communication, Palliative Care, Pharmacology, Public Health, Pregnancy, Alcohol Withdrawal, Young People, Drug Misuse Emergency Medicine, Alcohol Misuse Emergency Medicine, Surgery.

Coordinators found both the Toolkit and Fast Factsheets to be useful resources that could be adapted to meet their local needs. Similarly, teaching staff found the Fast Factsheets to be a very valuable resource – and these were highlighted particularly as being 'educational', 'fit for purpose' and 'readable'. They provided a framework for developing current teaching material as well as being used as stand-alone teaching resources. The mapping exercise highlighted the need for new titles, which were then written and produced.

Medical students were involved in the project in differing ways from undertaking surveys about teaching of substance misuse in their particular schools to providing feedback on the development of materials, revealing a number of important issues:

- Trainee doctors themselves do consider substance misuse as an important aspect of undergraduate medical education in order to equip them for the future, and they have a high level of interest in this.
- Opportunities to prioritise further learning on substance misuse through special study modules, when available, are popular.
- Direct contact with patients and services through placement are considered the most useful way to learn about the management of substance misuse problems.

The students felt a lack of confidence in performing certain key skills with those who misuse substances, including the taking of a history of illicit substance use, discussing the range of options for patients wishing to cut down or stop use, and in being able to recommend appropriate organisations that could help patients in stopping misuse[12].

DISCUSSION

The active work of the first and second phases has enhanced the training and education of student doctors, and established a solid basis for substance misuse teaching. The success of this project clearly involved a combination of active national and local analysis of need followed by the development of local solutions within participating medical schools to enhance and improve teaching of substance misuse across the medical curricula. Time-limited funding for using a model of local coordinators to effect substantial change across their own medical school curriculum was a key element to address the need in the short time-frame of the project. However, coordination and support by a National Coordinator and from the Expert Panel and the National Steering Group had originally initiated and then closely supported these local developments. This was achieved both by the support network of wide clinical and academic expertise, and by development of the support materials. It became clear that the mutual support network for academic champions and coordinators, sustained by the national coordinator, was also a crucial element in providing information and hands-on expertise on how to get things done.

The local approach as used in Phase 2 enabled the changes made by the coordinators to their curricula to be delivered over a rapid timescale, and has led to real and important changes to the teaching and learning opportunities for our future doctors. These changes address key recommendations that were made to improve substance misuse learning. As well as modifying the learning outcomes, the coordinators, supported by the academic champions, introduced a range of initiatives, including new lectures and special study components, and provided additional substance misuse resources for students to use, which support the taught sessions. Initiatives were undertaken to raise awareness of substance misuse issues including workshops, quizzes and working with external organisations. The Toolkit and Fast Factsheets that were developed across the two phases of the project were also important in providing useful materials for use in a wide variety of settings, disciplines and learning opportunities, and for integration across all years of training. The outcomes associated with this project are extensive and the method used delivered enhancement in the training of future doctors regarding substance misuse. This was achieved through establishment and reference to nationally agreed standards, evaluation of local need and a careful approach to implementing change. We now have a much more solid basis for the future training and professional development of medical students concerning substance misuse. They will be able to take the enhanced knowledge and skills with them as they become medical practitioners across the whole field of medicine and public health. And this forms a firmer basis for ongoing professional development.

A key aim of the project was to enhance and equip medical schools to develop and enhance substance misuse

learning in their curricula. This aim has been realised through the work of the curriculum coordinators whose role has been to facilitate the inclusion of substance misuse across the schools' curriculum. This has been achieved in partnership with an academic champion in each school, with support from the national project manager and through meetings and networking with other coordinators, guided by the Director of the Project and steered by the National Steering Group.

The key positive outcomes from the first two phases[12]:

- An agreed high-level curriculum established across all UK medical schools for the first time, and where appropriate some learning objectives have been revised and aligned more closely.
- Substantial improvements in the extent and quality of teaching and training of all doctors taught in those schools, across a wide range of drug and alcohol issues which have already influenced the learning of at least 47,000 future doctors; and benefits will continue to accumulate over time.
- Raised awareness across the medical school curriculum committees of the importance of including drugs and alcohol learning in order to have a broad and integrated curriculum for future doctors.
- Practical and flexible teaching and training materials have been developed and validated by experts with the support of the trainee doctors.

However this left an important question, given the success of the project, is how best to sustain the positive changes implemented in the teaching of substance misuse to our future doctors, so that future graduating medical students continue to be better equipped to deal with substance misuse and to meet the requirements specified by the GMC. From both phases of the project it is estimated that there has already been a real impact on the education of at least 47,000 future doctors and the challenge now is to maintain this in future years.

To ensure the continued benefits of the investment in this project and to maintain the impact of the outcomes in terms of changes and improvements to medical school curricula on substance misuse a key recommendation was to develop a third phase to develop sustainability.

In 2013 funding was awarded to work on sustaining the positive changes implemented.

PHASE 3 SUSTAINABILITY AND MOVING FORWARD

Set up in in 2013 this phase is now in place with the aim of ensuring that the changes implemented in the teaching of substance misuse are maintained so that future graduating medical students continue to be better equipped to deal with substance misuse issues.

The major activities being undertaken include the ongoing development of a network of academics teaching substance misuse to embed changes in curricula and champion substance misuse teaching within their schools, and the updating of the learning resource factsheets and development of new titles and for these to be available through an online open access portal.

CONCLUSIONS

This model comprising national guidance on core curriculum content, a toolkit to aid the implementation process supported with teaching resources has the potential to be adapted and implemented in many different settings.

It can be extended to provide in depth specialist professional training as well as continuing professional development for general practitioners, psychiatrists, and medical specialists such as physicians, obstetricians, and surgeons as well as dentists.

It is eminently suitable for undergraduate, postgraduate and continuing professional training for those professional groups allied to the medical profession including nurses, occupational therapists, social workers, psychologists, and pharmacists.

This model and the curriculum content provides a core learning resource for any organisation that is considering the development and implementation of a programme on substance misuse. While some components are universally applicable, some may need to be developed with the particular programme in mind. However, this gives the opportunity for some initiatives to take account of their own special circumstances and expand the resources in line with their needs.

REFERENCES

1. Falkowski J, Ghodse AH. Undergraduate Medical School Training in Psychoactive drugs and Rational Prescribing in the United Kingdom, British Journal of Addiction 1989; 84:1539-1542.
2. Glass IB. Undergraduate training in substance abuse in the United Kingdom, British Journal of Addiction 1989; 84(2):197-202.
3. Crome IB. The trouble with training: substance misuse education in British Medical Schools revisited. What are the issues? Drugs Education Prevention and Policy 1999; 6:111–123.
4. Crome IB, Sheikh N. Undergraduate medical school education in substance misuse in Britain iii: can medical students drive change? Drugs: Education, Prevention and Policy 2004; 11(6): 483-503.
5. Falkowski J, Ghodse AH. An international survey of the educational activities of schools nursing on psychoactive drugs, Bulletin of the World Health Organization 1990; 68 (4): 479-482.
6. Ghodse, A.H. Report of the WHO meeting on Nursing Midwifery. 'Education in the Rational Use of Psychoactive Drugs' Islamabad 7-11 Aug 1989
7. World Health Organization, United Nations Fund for Drug Abuse Control. Role of schools of pharmacy in the rational use of psychoactive drugs: report from a national seminar in Chengdu, People's Republic of China, in December, 1988
8. International Narcotics Control Board. Annex IV Letter from the President of the International Narcotics control Board to all countries. In: Report of the International Narcotics Control Board on the Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes. New York: United Nations, 2010: 73-74. (Accessed July 10, 2014, at http://www.incb.org/incb/en/publications/annual-reports/annual-report.html)
9. International Narcotics Control Board. Europe National legislation, policy and action paragraph 699. In: Report of the International Narcotics Control Board 2009. New York: United Nations, 2010:109 (Accessed July 10, 2014 at http://www.incb.org/incb/en/publications/annual-reports/annual-report-2009)
10. International Centre for Drug Policy. Substance Misuse in the Undergraduate Curriculum. St George's, University of London: International Centre for Drug Policy 2007. (Accessed July 10, 2014 at http://www.sgul.ac.uk/research/projects/icdp/our-work-programmes/substance-misuse-in-the-undergraduate-medical-curriculum)
11. Carroll J et al. Substance misuse teaching in undergraduate medical education BMC Medical Education.2014, 14:34 DOI: 10.1186/1472-6920-14-34 (Accessed July 10, 2014 at http://www.biomedcentral.com/1472-6920/14/34)
12. International Centre for Drug Policy. Substance Misuse in the Undergraduate Curriculum Project Report. St George's, University of London: International Centre for Drug Policy 2012. (Accessed July 10, 2014 at http://www.sgul.ac.uk/research/projects/icdp/our-work-programmes/substance-misuse-in-the-undergraduate-medical-curriculum)

Increasing Addiction Medicine Capacity in Canada: The Case for Collaboration in Education and Research

Ramm D. Hering *MD CCFP DipPH*[1]
Lisa G. Lefebvre *MD CM, MPH, CCFP, DipABAM*[2]
Pamela A. Stewart *MD CCFP FRCPC*[3]
Peter L. Selby *MB BS FCFP DipABAM*[4]

[1.] *Department of Family and Community Medicine, Faculty of Medicine, University of Toronto,* [2] *Departments of Family and Community Medicine and Psychiatry, Faculty of Medicine, University of Toronto,* [3] *Department of Psychiatry, Faculty of Medicine, University of Toronto,* [4] *Departments of Family and Community Medicine and Psychiatry and the Dalla Lana School of Public Health, University of Toronto*

Correspondence to:

Peter L. Selby *MB BS FCFP DipABAM*
Chief and Clinician Scientist, Addictions Division and Clinician Scientist, CAMH
Professor, Departments of Family and Community Medicine and Psychiatry and the Dalla Lana School of Public Health, University of Toronto
Principal Investigator, Ontario Tobacco Research Unit.
Centre for Addiction and Mental Health (CAMH)
100 Stokes Street, Room 3280D, Toronto, ON M6J 1H4
Telephone Number: 416 535 8501 x 36859
Email: peter.selby@camh.ca

FUNDING:

Dr. Hering is supported by the American Board of Addiction Medicine Foundation's Next Generation Award for Adolescent Substance Use Prevention.

ABSTRACT

Collaboration in addiction medicine education and research is important in Canada. The large unmet need for addiction services will only be met by the relatively small number of addiction clinicians, researchers, educators and policy makers in Canada if they collaborate and grow in a coordinated fashion toward common goals. Leadership from national organizations will facilitate growth in a coordinated fashion, which will allow us to reach the goal of providing adequate treatment for those with addiction and related illnesses as quickly as possible. Recent developments give significant reason to

be optimistic that there will be more rapid progress in the coming years. Important initiatives currently underway include: 1) the expansion of Addiction Medicine training programs across Canada, 2) a new federal government-sponsored initiative to build collaborations in Addictions research, and 3) an application for the first Canadian certification in Addiction Medicine based on a standardized competency based curriculum.

Key Words: Substance Use Disorder, Education, Research, Collaboration

INTRODUCTION

The prevalence of substance abuse in Canada is estimated to be about 11% and the societal costs of addiction have been estimated at a staggering $40 billion per year[1–2]. Despite this tremendous social, medical and economic impact, the majority of patients suffering from addiction do not receive treatment. Those that do, often receive unproven or archaic interventions despite the advances in neuroscience and the development of efficacious treatments in the last two decades.

The large unmet need for addiction medicine care across Canada will be the primary challenge for our field in the coming decades. Increased collaboration within the field of Addiction Medicine will significantly expedite the growth of our field in a rapid and efficient manner. Facilitating such growth in a coordinated fashion would allow us to reach our goal of providing adequate treatment for those with addiction and related illnesses as quickly as possible.

National organizations like the Canadian Society of Addiction Medicine (CSAM-SMCA), and the Canadian Centre on Substance Abuse (CCSA) have been working for years to connect researchers, clinicians, policy makers and educators working in the field of addiction. Moreover, recent developments give significant reason to be optimistic that there will be more rapid progress in the coming years. Important initiatives currently underway include: 1) the expansion of Addiction Medicine training programs across Canada, 2) a new federal government-sponsored initiative to build collaborations in Addictions research, and 3) an application for the first Canadian certification in Addiction Medicine based on a standardized competency based curriculum.

PHYSICIANS PRACTICING ADDICTION MEDICINE IN CANADA

In a recent survey of practicing family physicians in Canada substance abuse was cited as the 3rd most important area of competence for a newly practicing family physician[3]. This was ahead of ischemic heart disease, diabetes and pregnancy. Despite the clear importance of providing care to patients with addiction, a relatively small (but increasing) number of physicians diagnose and treat substance use disorders. Among the approximately 75,000 physicians in Canada, only 1400 have exemptions from Health Canada to prescribe methadone for dependence, and only 250 are members of CSAM-SMCA. Additionally, there are 210 members of the American Society of Addiction Medicine (ASAM) based in Canada, 159 Canadian physicians are certified by the American Board of Addiction Medicine (ABAM), and 8 Canadian physicians are members of the American Academy of Addiction Psychiatrists.

There is an upward trend in Canadian Family physicians/general practitioners (FP/GPs) who provide substance abuse/addictions care. In 2010, 30% of FP/GPs reported offering substance abuse care, increased from 27% in 2007 and 22% in 2004. In 2013, 4.5% of FP/GPs reported having addiction as an area of focus of their practice, an increase from 3.9% in 2010 and 3.2% in 2007[4].

ADDICTION EDUCATION FOR PHYSICIANS IN CANADA

Despite the clear importance of this area of medicine, one reason so few physicians provide care for those suffering from substance use disorders is due to a lack of training in this area. Undergraduate training on Addiction Medicine topics in Canadian medical schools is minimal to non-existent. Recently, psychiatric residency programs have been required to include a 1-month rotation in Addiction Psychiatry, in the first year (PGY1) and a half-day clinic in the fourth year (PGY4) over a six month period, however, there are currently no other Canadian residency programs that require any dedicated exposure to Addiction care. While medical students and residents may do elective rotations in Addiction-related areas in a variety of settings and contexts, the vast majority of new physicians graduate from medical school and finish residency with minimal exposure to addiction training despite caring for patients with addictive

disorders. Therefore, most practicing physicians have minimal competence with respect to the diagnosis and treatment of Addiction. Limited options exist in Canada for residents interested in fellowship training in the prevention, diagnosis and treatment of substance use disorders. The longest-standing fellowship program is at the Centre for Addiction and Mental Health (CAMH) in Toronto. CAMH and its predecessor organizations have been offering 1-2 year clinical and research fellowships in Addictions since the 1980s. The number of positions offered at CAMH grew from 1-2 positions to the current level of 4-6 fellowship positions per year, as funding and number of Faculty increased. Up to three positions are funded by the Ministry of Health and Long-term Care (MOHLTC) of Ontario for family medicine residents as part of the University of Toronto Department of Family and Community Medicine (U of T DFCM) Enhanced Skills Program. There are at least two positions annually for physicians in Addiction Psychiatry and these are funded by CAMH. The program has historically attracted Canadian fellows from many provinces as well as international fellows from countries such as Iran, Ireland, Israel, Nigeria, Saudi Arabia, Tanzania, Ukraine and the UK. Some of these physicians have remained in Canada, while others have returned home to become national experts and leaders in Addiction treatment. These physicians have hailed from a variety of clinical areas including family medicine, psychiatry, anaesthesia, neurology, internal medicine, adolescent medicine, public health, and emergency medicine. In 2013, the CAMH Addiction Medicine fellowship achieved accreditation status from ABAM, one of only 2 such programs in Canada.

There are two other Addiction Medicine fellowships offered in Canada:

- St Joseph's Health Centre (SJHC) in Toronto offers a 6-12 month fellowship for family medicine residents. This program has one position funded annually by the MOHLTC of Ontario as part of the U of T DFCM Enhanced Skills Program.
- New clinical and research fellowships are offered at Saint Paul's Hospital (SPH)/ University of British Columbia (UBC) and are described in detail elsewhere in this special issue.

For psychiatry residents, there are established Addiction Psychiatry fellowship programs at McGill University, Université de Montréal and at the University of Calgary, in addition to the CAMH-U of T program. There are also specialized training opportunities at the University of Ottawa, and at UBC which offers its psychiatry residents the opportunity to do the new SPH fellowship in addictions in their fourth year of residency.

Plans for additional Addiction Medicine training programs across the country are in various stages of development, but continue to grow. McMaster University currently collaborates with Homewood Health Centre in Guelph, Ontario to offer a 6-month third-year enhanced skills program in Family Medicine focussed on addiction and mental health with future plans to expand this to a full one-year fellowship in Addiction Medicine. There is a new third year enhanced skills Addiction Medicine program planned at the University of Calgary for 2015 and programs are being considered at the Royal Ottawa Hospital (University of Ottawa) and St Michael's Hospital (U of T) in Toronto.

COLLABORATION IN ADDICTION EDUCATION: TORONTO

In Toronto, collaboration between the various training programs to provide a rich variety of experiences for fellows has occurred for many years. CAMH and SJHC fellows in both Addiction Medicine and Addiction Psychiatry participate in weekly educational seminars together. Several cross-training experiences exist as well. CAMH fellows complete a mandatory rotation with the SJHC inpatient Addiction Medicine consult service, TCUP (the Toronto Centre for Substance Use in Pregnancy) and the rapid access clinic. Similarly, SJHC fellows often complete a rotation at CAMH in the medical withdrawal unit and in outpatient opioid maintenance treatment. CAMH also offers weekly interprofessional addiction rounds that are webcast internationally and has collaborated with Sick Kids Hospital and the Ontario Medical Association's Physician Health Program. Recently, St. Michael's Hospital has taken the lead on coordinating monthly city-wide rounds in Addiction Medicine that are becoming a popular forum for the local Addiction Medicine community to network and learn together. These various collaborations have enhanced the quality of education for all involved.

COLLABORATION IN ADDICTION RESEARCH IN CANADA

Addiction medicine research in Canada has also been growing recently. The federal government has begun developing a new national consortium in substance misuse research with the Canadian Research Initiative in Substance Misuse (CRISM). This initiative will be unique in that it will focus on translation and implementation. CRISM is modeled after the National Institute of Drug Abuse (NIDA)'s Clinical Trial Network and is jointly funded by the Canadian Institute of Health Research-Institute of Neurosciences, Mental Health

and Addiction (CIHR-INMHA) and the National Anti-Drug Strategy. The need for such a coordinated effort is described in a recent analysis by INMHA for the years 1997-2011 that concluded that "Canadian research centres conducting research in addiction are somewhat isolated from each other and that most collaborations arise from personal relations rather than as elements of larger more integrated entities. Intervention programs that are not based at academic institutions are rarely linked to these research teams; the lack of communication between service providers and academic research teams limits the relevance of intervention research and inhibits the translation and subsequent incorporation of best practices into intervention programs."[5]

CRISM has put a strong emphasis on collaboration, not only between various research groups, but also between researchers, clinicians, administrators and policymakers. All proposals for funding under the CRISM framework are required to have not only a Nominated Principal Applicant who must be an independent university-affiliated researcher but also a primary Service Provider for substance misuse. This Service Provider is intended to be a "knowledge user" who is likely to be able to apply the knowledge generated through the research to inform decisions about health policies, programs and/or practices.

This exciting new funding opportunity has the potential to significantly alter the Addiction Medicine research landscape in Canada, largely due to its emphasis on collaboration. The creation of CRISM has already generated much discussion among numerous research groups regarding how to coordinate their efforts to make the best use of limited resources.

CERTIFICATION OF ADDICTION MEDICINE IN CANADA

One final initiative of importance underway is an application to the Royal College of Physicians and Surgeons of Canada (RCPSC) for an Area of Focused Competence (AFC) Diploma in Addiction Medicine. This AFC diploma application is a perfect example of the kind of collaboration that is achievable in Canada. The application is a joint project of leaders from the CAMH and SPH Addiction Medicine fellowship programs. The training requirements in development are based on the curriculums of both fellowship programs. While both programs were recently accredited by ABAM, the future of this American accreditation for Canadian programs is unclear as ABAM looks to gain official status within the American Board of Medical Specialties. Training certification from a Canadian certifying body based on a uniquely Canadian curriculum is vital to the growth of the field of Addiction Medicine in our country. The proposed one-year AFC diploma in Addiction Medicine from the RCPSC would be open to physicians with primary certification from the RCPSC as well as those whose primary certification is from the College of Family Physicians of Canada. Additionally, established physicians with extensive experience in Addiction Medicine would be eligible to apply for this competency-based diploma without having to do a formal yearlong fellowship.

One of the primary goals of this AFC diploma application is to attract physicians from various backgrounds such as family medicine, psychiatry, internal medicine, pediatrics, public health, emergency medicine and other clinical areas to Addiction Medicine. To this end, efforts are being made to engage physicians from all such clinical areas to collaborate in the design and development of the diploma program. Our hope is that all physicians working in the field of Addiction will ultimately be training and working together in a coordinated and collaborative fashion.

CONCLUSION

Despite the beginning of a significant wave of change in the last few years, the field of Addiction Medicine in Canada continues to consist of a relatively small but dedicated number of clinicians, researchers, educators and policymakers who are often working in relative isolation, with limited national coordination.

Organizations and initiatives like CSAM-SMCA, CCSA, CRISM and the growing number of addiction medicine training programs across the country will benefit from increased cross-sectoral coordination and collaboration in order to advance the field of Addiction Medicine in Canada.

REFERENCES

1. Rehm J, Baliunas D, Brochu S, et. al. The costs of substance abuse in Canada 2002. Canadian Centre on Substance Abuse. 2006. (Accessed September 8, 2014 at http://www.ccsa.ca/Resource%20Library/ccsa-011332-2006.pdf)
2. Veldhuizen S, Urbanoski K, Cairney J. Geographical variation in the prevalence of problematic substance use in Canada. Can J Psychiatry 2007; 52(7):426-33.
3. Allen T, Lawrence K, Crichton T, Carpentier M, Visser S. Defining competency-based evaluation objectives in family medicine. Can Fam Physician 2011; 57: e331-e340.
4. National Physician Survey 2013, 2010, 2007, 2004. (Accessed September 8, 2014 at: http://nationalphysiciansurvey.ca/)
5. Canadian institute of Health Research 2014. (Accessed September 8, 2014, at: https://www.researchnet-recherchenet.ca/rnr16/vwOpprtntyDtls.do?prog=1942&view=browseArchive&browseArc=true&sponsor=CIHR-12&type=EXACT&resultCount=25&next=5

What is New in Addiction Medicine Training at the College of Family Physicians of Canada?

Dr. Sharon Cirone *MD CCFP(EM) ASAM(Cert.)*
Chair, Addiction Medicine Program Committee, Section of Special Interest and Focused Practice, College of Family Physicians of Canada
2333 Dundas Street west, suite 410
Toronto, Ontario M6R 3A6
Tel: 416 537-7000 Fax: 416 537-0132
Email: sharoncirone2@gmail.com

ABSTRACT

Will review the activities of the Addiction Medicine Program Committee of the College of Family Physicians of Canada which is actively involved in the enhancement and development of educational tools pertaining to addiction medicine. The Committee's main focus is to develop an up-to-date, national curriculum in addiction medicine for Family Medicine trainees.

DEVELOPMENT OF AN ADDICTION MEDICINE PROGRAM

In 2008, the Board of the College of Family Physicians of Canada (CFPC) approved a Section of Special Interest and Focused Practice (SIFP)1. While maintaining a strong commitment to comprehensive continuing care, the College also supports Family Physicians whose practices include special clinical interests or areas of focused practice. The Section of SIFP now has over 20 Program Committees representing members across the country who have clinical practices or interests in a variety of areas, including chronic pain, palliative care, child and adolescent medicine, maternal and infant care, and prison health, to name a few.

In 2011, the Board of the CFPC approved the Addiction Medicine Program Committee[2]. This Committee is an active member of the larger Section of SIFP, and thereby contributes to supporting all members with specific areas of clinical interest. The main task of the Addiction Medicine Program Committee, however, is to support members who have an interest in serving their patients with alcohol or substance use disorders or behavioral addictions. The Committee supports members in comprehensive care practices, as well as practices with focused services in addiction medicine. The mission of the Addiction Medicine Committee is:

Substance use disorders are a major cause of morbidity, mortality and health care utilization in Canada. Family physicians play a critical role in reducing the harms caused by substance use, through screening and identification, counseling, pharmacotherapy, and treatment of complications. The mission of the AM section is to promote training and education of family medicine residents and physicians in the management of substance use disorders, by advocating for sound public health policies and by facilitating networking within the profession to achieve these goals.

Despite the burden of illness in Canada, with respect to substance use disorders, many primary care physicians often do not address, or do not feel comfortable addressing addiction issues with their patients. Many physicians currently in practice received minimal to no training in medical school and residency in the area of addictions. The Addiction Medicine Committee is committed to the development of a national curriculum for family practice residents to feel confident to provide care for their patients with alcohol or substance use

issues. Amongst physicians in practice, are teachers and residency program directors. Few academic Family Physicians have expertise in addiction, making them reluctant to address addiction issues in resident seminars or clinical supervision. There is a clear need to train our trainers in this area of medicine so that we may have an adequate number of teachers who feel confident to provide curriculum in alcohol and substance use disorders to our resident trainees and medical students. The enhancement of competence in addiction medicine therefore involves both the development of curriculum for family practice residents as well as CME/CPD for practicing physicians.

ACTIVITIES OF THE ADDICTION MEDICINE PROGRAM COMMITTEE

The Committee, or members of the Committee, have been involved in a variety of activities to enhance education in the area of addiction medicine. Here are some of the activities, thus far:

1. Presentations at the CFPC Family Medicine Forum meeting. This annual conference is attended by over 10,000 Canadian primary care physicians. A variety of topics have been presented, including: office management of alcohol use disorders, urine drug screening, pharmacotherapy for opioid use disorders, cannabis use disorders, and smoking cessation. This year, the Committee is participating in several workshops on medical marijuana. The titles for these workshops are: "Reefer Madness from Cradle to Grave: Information on the new Canadian Legislation for Comprehensive Care Physicians" and "The Yin and Yang of clinical decision making before prescribing medical marijuana".
2. Assistance in the development of Canada's Low-Risk Alcohol Drinking Guidelines and the Screening, Brief Intervention and Referral (SBIR) resource. The guidelines are an updated and excellent office based resource for adults, 25-65 years old who choose to drink alcohol, with information about reducing long-term health risks and injury related harms.

   The SBIR is a web-based guide that offers a three-step alcohol assessment and referral process, supported by related on-line resources. The web site is available at www.sbir-diba.ca, free of charge to health professionals to use with their patients.
3. Canadian Family Physician journal articles. The Addiction Medicine Program Committee has been allotted four submissions per year to CFP with respect to topics on alcohol and substance use disorders. Several articles have already been submitted and we anticipate publication by the fall of 2014. Look for articles on primary care management of alcohol use disorders, clinical guidance in the authorization of medical marijuana and youth substance use issues.
4. Development of curriculum for a national CME/CPD course. The Canadian Society of Addiction Medicine (CSAM-SMCA) hosts a Fundamentals course at their annual meeting. This course is a one-day review of the fundamentals of providing clinical care for alcohol and substance use disorders in primary care. It is a very popular program that is unique in the Canadian landscape of CME/CPD.

   With the multi-year success of this program, the CFPC Addiction Medicine Program Committee is partnering with CSAM to further develop the curriculum of the Fundamentals course with the hope of translating this format to a provincial, and then national College level for dissemination to all practicing physicians, not just those who attend CSAM's annual conference. We look forward, in the next few years, to further developments and a final product of a national CME/CPD product for training practicing physicians in the area of addictions.
5. Contributions to CFPC working groups for core competencies in family practice training. The CFPC is presently reviewing and updating the core competencies in mental health and maternal and infant care. Our Committee has reviewed and given feedback on competencies in these areas that pertain to addiction medicine.

   The Addiction Medicine Program Committee awaits the planned focused review and update of the addiction medicine competencies for family practice training. We consider this the priority activity of this Committee. We are committed to the development and enhancement of skills and competencies for residents going on to comprehensive care family medicine practices and clinical settings.
6. Support for post graduate training in Addiction Medicine. Several Fellowship programs in Addiction Medicine for graduate family practice residents are

offered across the country. At this time, there is no CFPC approved curriculum for these programs and no certification exam.

In 2013, the Board of the CFPC approved the awarding of Certificates of Added Competence (CACs). As of July 2014, residents entering CFPC programs in Emergency Medicine, Care of the Elderly, GP Anaesthesia, Palliative Medicine and Sports and Exercise Medicine will be granted a CAC in their area of special designation, upon successful completion of their program.

The future may hold the development of a curriculum and a certification exam to support the granting of CACs in Addiction Medicine.

7. Development of educational materials for College members. The Addiction Medicine Program Committee worked diligently with the Chronic Pain Program Committee and other SIFP Committees to develop the soon to be distributed guidance documents entitled Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance from the College of Family Physicians of Canada.
8. Maintain a home page for Addiction Medicine on the CFPC website. The page hosts information in the news and medical literature on addiction medicine topics, as well as a list of upcoming events. www.cfpc.ca/Addiction_Medicine_Program_Committee/

SUMMARY

The College of Family Physicians of Canada remains, as always, committed to the training and support of family physicians in comprehensive care. The Addiction Medicine Program Committee is actively involved in many aspects of curriculum development and education promotion to assist training and practicing family physicians to feel competent providing care to their patients with alcohol and substance use disorders as well as behavioral addictions. The Committee also supports colleagues and members with the development of skills and competence for practices with a special interest or focus in addiction medicine.

REFERENCES:

1. The evolution of the CFPC's Section of Family Physicians with Special Interests or Focused Practices (SIFP) including all Board-approved motions. Updated May 2013.
2. CFPC website (Accessed Sept 5, 2014): http://www.cfpc.ca/Addiction_Medicine_Program_Committee/)

CJA — JCA

The Evolution of Addiction Medicine Education in British Columbia

Launette Rieb, *MD, MSc, CCFP, FCFP*[1]
Evan Wood, *MD, PHD, FRCPC*[2]

1 Faculty of Medicine, Department of Family Practice, University of British Columbia, 2 Faculty of Medicine, Department of Internal Medicine, Division of AIDS, University of British Columbia

Correspondence to:

Launette Rieb, *MD, MSc, CCFP, FCFP*
Clinical Associate Professor, Department of Family Practice, UBC
Physician Director, St. Paul's Hospital Goldcorp Addiction Medicine Fellowship, Department of Family and Community Medicine, St. Paul's Hospital
1081 Burrard St. – Hornby St. Site
Vancouver, BC, V6Z 1Y6
Tel: 604-682-2344 x 63240 Fax: 604-263-5552
Email: Launette.Rieb@ubc.ca

ACKNOWLEDGEMENTS

This research was undertaken, in part, thanks to funding from the Canada Research Chairs program through a Tier 1 Canada Research Chair in Inner City Medicine, which supports Dr. Evan Wood.

ABSTRACT

Internationally, improving Addiction Medicine training has been identified as a critical strategy to improve patient care. In British Columbia, a firm foundation has been laid with didactic sessions and clinical exposure in substance use disorders embedded into undergraduate medical education and various residency programs at the University of British Columbia. More recently, with guidance from the American Board of Addiction Medicine and experienced program directors internationally, along with financial support through grants and donations, coupled with community input, an interdisciplinary Addiction Medicine clinical fellowship and a NIDA funded Addiction Medicine research fellowship have been established.

Key Words: Substance-Related Disorders; Education, Medical; Physicians; Medicine/trends; Quality of Health Care

INTRODUCTION

In this article we outline the rationale and growth of Addiction Medicine education involving community input starting at the undergraduate level at the University of British Columbia (UBC), through residency and beyond to the new clinical and research fellowships at UBC and St. Paul's Hospital in Vancouver in the hope that we can assist and inspire others working in the field.

Past research has described the substantial proportion of the global burden of disease attributable to the use of alcohol, tobacco and illicit drugs[1]. At least one in five Canadians will suffer with a substance use disorder in their lifetime and the estimated national cost attributable to that substance use approaches $40 million annually[2]. Families, friends, employers, and neighbours all suffer the burden of the disease. However, despite these substantial health and social costs, there has been a well described discordance between scientific evidence and policy in this area[3], with most of the financial resources going to criminal justice activities that have not been well evaluated[4-6].

Despite this allocation of resources, a growing range of innovative tools have been developed that enable physicians and allied health practitioners to identify, prevent and treat addictive disorders. Unfortunately, while the science of Addiction Medicine continues to progress in leaps and bounds, the medical community has often done a poor job of translating research into improved care of these patients, as has been the case with many other social care organizations. With the majority of resources aimed at addressing the addiction problem going to criminal justice-based strategies and effective medical treatments not available, the medical community must ask itself what role it has played in the past and can it play in the future to affect change. The vast under-training of physicians in Addiction Medicine has not equipped them to adequately help their patients suffering from substance-related disorders and pathological gambling.

For instance, unlike virtually all other medical disciplines, such as cardiology and obstetrics, which graduate an annual wave of well-polished, new specialist

physicians from residency and fellowship programs based within Canada's university-affiliated teaching hospitals, until recently, there has been no fellowship training program in Addiction Medicine in the province of British Columbia (BC). As a result, despite the fact that recent advances in addiction research have helped identify effective new treatments, there are few skilled physicians to prescribe them. Dedicated and caring as they usually are, most Canadian physicians who consider themselves Addiction Medicine specialists assembled their knowledge about addiction treatment on their own after completing their formal medical training through reading and conferences without a standardized curriculum or clinical supervision.

Outside of BC, a recent report from the U.S. National Center on Substance Abuse entitled "Addiction Medicine: Closing the Gap between Science and Practice" highlighted the fact that most people with addiction in the U.S. do not get treatment from a physician at all[7]. Rather, much as in Canada, U.S. addictions care is often provided by "unskilled laypersons." The report's harshest criticism is saved for the medical community. It states, "Most medical professionals who should be providing addiction treatment are not sufficiently trained to diagnose or treat it." Research by this same group has also found that 94% of U.S. physicians "failed to include substance abuse among the diagnoses they offered when presented with symptoms of alcohol abuse." Calling the lack of training of physicians a "monumental lost opportunity," the report describes a "failure of the medical profession at every level—in medical school, residency training, continuing education and in practice—to confront the nation's number one disease."

UNDERGRADUATE MEDICAL SCHOOL CURRICULUM

For over 20 years the University of British Columbia (UBC) has been a leader among other medical schools in the country with 20 hours of Addiction Medicine taught to undergraduate students as part of the Addiction Medicine and Inter-collegial Responsibility (AMIR) training blocks in first and second year. AMIR was founded by Dr. Ray Baker and later directed by other local physician leaders in the field. There are five sessions of three hours in duration in first year and one in second year. These sessions consist of an hour interactive didactic plenary session and two hours of tutorial.

Where Addiction Medicine is taught, rarely do programs get input from patients, their families and the broader community about the issues affecting them. Thus, the opening session for this undergraduate block of teaching is entitled The Human Face of Addiction. The plenary consists of community speakers in recovery telling their compelling stories to an auditorium full of first year medical students in Vancouver and is live streamed to the other medical student training sites throughout the province. Next the students break into small tutorial groups and a community member volunteer joins each group for 2 hours sharing their stories and answering questions. This plenary and tutorial is often not only rated the best of their addiction training block but best of their year. Understanding the disease from a personal perspective helps to overcome myths and judgement and builds compassion. The block contains subsequent sessions on addiction as a brain disease with bio-psycho-social-spiritual manifestations and treatment requirements. Other topics include Physician Health, Medical Marijuana, and Smoking Cessation.

Other undergraduate schools at UBC have also embedded occasional classes in Addiction Medicine including dentistry, nursing, occupational therapy, and pharmacy.

RESIDENCY CURRICULUM

In addition to undergraduate training, for the last 16 years, UBC Family Practice Residents in Vancouver have had 10-15 hours of interactive didactic Addiction Medicine training in their academic curriculum developed and delivered by one of us (LR). Topics from the undergraduate curriculum are expanded on with a focus on assessment, diagnosis and management. Detoxification protocols and medications including agonist therapies are elucidated. The needs of some special populations are represented, for example pregnant women. And specialized topic areas, like pain and addiction, are presented. Motivational Interviewing and other counselling techniques are introduced. At the St. Paul's Hospital site, Family Medicine residents also are required to spend one month training at an inner city clinic that includes a methadone program, youth addiction services, and addiction counselling, among other programs.

Over the last decade various other classes and front line clinical experiences have been provided throughout the province of B.C. by practicing Addiction Medicine clinicians and Addiction Psychiatrists to medical students, medical residents from all disciplines, and to the public.

ST. PAUL'S HOSPITAL GOLDCORP ADDICTION MEDICINE FELLOWSHIP

Given the rapid rate of research and knowledge expansion in the field of Addiction Medicine, and the base of eager learners developed at UBC and St. Paul's Hospital

over the years, more education in the field was being called for. Thus hoping to develop an Addiction Medicine Fellowship in Vancouver, we visited Boston University, the University of Pennsylvania, the Addiction Institute of New York, St. Josephs Hospital in Toronto, and other established training sites for mentorship and advice. With a view to expand addiction medicine teaching at St. Paul's Hospital and UBC beyond residency in this way, an interdisciplinary academic working group was established with clinicians that selected rotations, wrote goals and objectives, and wrote the application for certification by the American Board of Addiction Medicine (ABAM).

In addition to an adherence to the clinical standards established by ABAM, unique to the initial development of this fellowship was community input through a series of focus groups, community visits, and one-on-one meetings that continued through the first set up year and the initial implementation year. Key point and theme extraction was done on the community member narratives (including current users, people in recovery, parents, advocates, and senior Addiction Medicine physicians). For each theme and key point an action plan was developed to integrate the needed learning into the curriculum. These plans and actions were fed back to the community for accountability and accuracy. This development work and part of the curriculum implementation, as well as for the undergraduate teaching in previous years, was financially supported by grants from UBC and the Province of British Columbia (Special Populations Teaching Initiative).

Early in this process a ground-shifting change occurred through a $3,000,000 donation from Goldcorp Inc. to the St. Paul's Hospital Foundation, which enabled the material manifestation of the St. Paul's Hospital Goldcorp Addiction Medicine Fellowship in its totality. Now in its second year and certified for 6 positions by the American Board of Addiction Medicine, the fellowship has fulfilled the communal vision of an interdisciplinary one year clinical training program. The focus is on training physicians from Family Practice, Internal Medicine and Psychiatry, while accepting applications from all other medical disciplines. In addition, currently a six-month position exists for an addiction nurse, training along side the Addiction Medicine fellows. Being intra-professional is another unique feature of the fellowship. Fellows are immersed in exciting clinical experiences in key areas of the field. The foundation of the program is eight weeks on the busy multidisciplinary St. Paul's Hospital Addiction Medicine Consultation Service on which rotation fellows establish assessment and management skills for medically and often psychiatrically co-morbid in-patients. Other core rotations include inpatient and outpatient detoxification, inner city youth addiction and mental health, residential treatment focused on women, chronic pain management, severe concurrent disorders in an in-patient setting, and community based addiction treatment including opioid replacement therapy. In addition, fellows obtain excellent academic training in the science of addiction medicine (substance-related disorders and gambling) through academic half days, stimulating journal clubs attended by staff, textbooks, and conferences. The fellows explore ways to impact public policy, and do advocacy and research projects. All fellows are encouraged to submit first author publications by graduation. Through 2-3 blocks of elective time the individual area of interest of each fellow is supported[8].

In addition, the fellowship offers a weekend field experience with a northern First Nations community where fellows and staff attend to listen and learn from members of a community that have transformed great suffering into wisdom. Fellow narratives of this experience will be presented elsewhere[9].

Recently we have had the good fortune to be part of a groundswell of clinicians, scientists, and policy makers who have submitted an exciting new proposal to unify, standardize, and accredit clinical Addiction Medicine Fellowships across the country through the Royal College of Physician's and Surgeons of Canada's Diploma program.

NIDA RESEARCH FELLOWSHIP AND OTHER ADDICTION MEDICINE LEARNING OPPORTUNITIES

Using the infrastructure provided by this new fellowship, UBC has also expanded Addiction Medicine training opportunities for medical students through the creation of an Addiction Medicine elective as well as elective rotations within the Family Practice, Internal Medicine and Psychiatry residencies. There is also a mechanism for Family Physicians in practice to get an additional 3 to 6 months of training in Addiction Medicine through the UBC Enhanced Skills program. And finally for the first time in Canada, St. Paul's Hospital is able to offer 4 newly

created Addiction Research Fellowship positions sponsored by the US National Institute on Drug Addiction (NIDA). This one-year part-time research fellowship will add academic rigor to training and help advance the science of Addiction Medicine and its integration into clinical practice. Already two of the new research fellows have entered the program after completing the one-year clinical Addiction Medicine fellowship.

CONCLUSION

Ultimately, through the greater incorporation of Addiction Medicine training into medical school and residency programs at UBC, as well as the creation of continuing medical education opportunities and intensive clinical and research fellowship training opportunities at St. Paul's Hospital and UBC, British Columbians will be better served by the greater incorporation of addiction science into evidence-based medical practice. The input from community members whom the fellows will ultimately serve has been vital to this process. These Addiction Medicine physicians will be able to educate many other physicians in training as well as other health professionals.

The development of a broader group of academic and leadership-minded Addiction Medicine physicians also has the potential to help the process of public and policy-maker education required to treat those with substance use disorders with compassion and care, rather than primarily relying on a criminal justice approach that has not served well the interests of public health or the taxpayer[5].

REFERENCES

1. Degenhardt L, Hall W. Extent of illicit drug use and dependence, and their contribution to the global burden of disease. Lancet. Jan 7 2012;379(9810):55-70.
2. Canadian Centre on Substance Abuse. Costs of Substance Abuse in Canada 2002. Available online: http://www.ccsa.ca/2006 CCSA Documents/ccsa-011332-2006.pdf 2006; (accessed January 2013).
3. Reuter P. Why does research have so little impact on American drug policy? Addiction. Mar 2001;96(3):373-376.
4. Wodak A, McLeod L. The role of harm reduction in controlling HIV among injecting drug users. Aids. Aug 2008;22 Suppl 2:S81-92.
5. Werb D, Rowell G, Guyatt G, Kerr T, Montaner J, Wood E. Effect of drug law enforcement on drug market violence: A systematic review. Int J Drug Policy. Mar 2011;22(2):87-94.
6. 2001 Report of the Auditor General of Canada Chapter 11—Illicit Drugs: The Federal Government's Role. Office of the Auditor General of Canada. Available: http://www.oag-bvg.gc.ca/domino/reports.nsf/html/01menu_e.html. Accessed January, 2002.
7. The National Centre on Addiction and Substance Abuse at Columbia University. Addiction Medicine: Closing the Gap between Science and Practice. Available online: http://www.casacolumbia.org/upload/2012/20120626addictionmed.pdf (accessed January 2012).
8. Fellowship details are on our website: www.addictionmedicinefellowship.org
9. Rieb L, Puri N, Thompson M, Wood E. Lighting the ember of hope: Integrating field experience and narrative techniques into Addiction Medicine Fellowship training. AMERSA 2014. Poster presentation. San Francisco, USA. Accepted for presentation.

CJA – JCA

Addiction Medicine and Addiction Psychiatry in Calgary, Alberta

Dr. Ronald Lim *MD CCFP FASAM ABAM(D) CCSAM CISAM*
Clinical Assistant Professor Department of Family Medicine and Psychiatry, Program Director, Resident (R3) Enhanced Skill Residency Program
Department of Family Medicine, University of Calgary
Addiction Centre Foothills Adult Program
6th Fl. North Tower, Foothills Medical Centre
1403 19 Street, NW, Calgary, AB, T2N 2T9
Ph: (403) 944-2025 Fax: (403) 944- 2056
Email: ron.lim@albertahealthservices.ca

ABSTRACT

Addiction is a common chronic brain disease that affects a significant proportion of the North American population. Addiction is not only confined to the use of substances but also extends to behaviors such as gambling. Many addicted individuals suffer concurrent disorders with chronic pain and other psychiatric issues. This has resulted in significant harms and cost to individuals and society. Despite the high prevalence of addiction, physician training in this field of medicine remains fragmented and lacking. This article outlines the post graduate training opportunities to enhance skills in Addiction Medicine and Addiction Psychiatry that currently exist in Calgary.

Key Words: Addiction Medicine, Addiction Psychiatry, Post graduate training, Enhanced Skills

The Enhanced Skills Addiction Medicine Program in Calgary, Alberta (Family Medicine Post Graduate Program Year 3)

INTRODUCTION

Addiction is very common among the North American population. About 20% to 30% of the population smoke and up to 10% abuse alcohol. Illicit drug abuse afflicts about 5% to 7% and prescription drug misuse is increasing rapidly to near epidemic proportions[1]. Increases in opioid prescribing have simultaneously resulted in increases of opioid abuse, serious injuries and overdose deaths[2]. From 1991 to 2004 in Ontario, the mortality rate due to unintentional opioid overdose increased from 13.7/million/year to 27.2/million/year[3]. A prospective study found the illicit users are more likely to use prescription opioid than heroin[4].

Among Canadian youths, 54.9% of students reported drinking alcohol and 22% using marijuana during the past 12 months. 14% reported the use of non-medically sanctioned opioid pain relievers. 8.7% smoked cigarettes[5].

The Alberta Alcohol and Drug Abuse Commission in 2005 reported that 80% of the population reported drinking alcohol in the past year with 20% reporting drinking above safe drinking guidelines as recommended by the Canadian Center for Substance Abuse. 10% of current drinkers estimated to 190,000 individuals have suffered at least one type of harm. 14% of employees reported moderate to heavy drinking and up to 10% admitted to drinking during work hours[6].

Despite the high prevalence, increasing incidence of substance use disorders and their consequences to the individual and society, there is at present no mandatory training requirement in substance use disorders for Canadian Family Medicine residents. Most Family Medicine residents, in either the office or the hospital, complete their training without clinically experiencing evidence-based management of patients with substance use disorders. This has resulted in a current under representation of physicians practicing addiction medicine in primary care. This is reflected in the lack of physician providers in areas like Opioid Agonist Therapy in many provinces including Alberta.

The American Society of Addiction Medicine, whose international memberships comprises of mostly Canadian physicians with an interest in Addiction Medicine, only has a total of 228 International members in 2013. The Canadian Society of Addiction Medicine which is the national organization representing Canadian healthcare providers with an interest in the field of Addiction Medicine only currently has 342 members across Canada with only 14 physician members in Alberta.

OBJECTIVES AND DISCUSSION

The University of Calgary, Department of Family Practice has started an Enhanced Skills training year as a third year

of training. This program was offered in the 2013/2014 academic year with one guaranteed position with the option of expanding to two positions. The positions are open to all graduating residents in Family Medicine across Canada after two years. Physicians who are currently practicing may also apply for re-entry into our program although this is dependent on space and funding availability. We did not have any candidates last year.

The basic goal is to provide the family medicine resident with enough enhanced skills in Addiction Medicine to assess and manage patients with addictive disorders and their consequences effectively within their future comprehensive family practice.

The general objectives of the program will be to develop appropriate skills with competency in:

1) The assessment and diagnosis of substance use disorder and behavioral addiction with and without psychiatric co-morbidity.
2) The assessment and management of the chronic pain and substance use disordered patient.
3) The assessment of stage of change with the appropriate matching to treatment services.
4) The incorporation of psychotherapeutic management involving brief interventions, motivational interviewing, 12-step facilitation, and CBT/relapse prevention.
5) The pharmacology of all substances of abuse including medications to treat substance and behavioral addiction.
6) The management of substance intoxication and withdrawal, opioid agonist therapy and concurrent disorders.

The program will be supervised by preceptors from Family Medicine or Psychiatrists with certification or special interest in Addiction Medicine/Psychiatry. The rotations would include both inpatient and outpatient settings working with interdisciplinary teams. Upon completion of the residency, the candidate will have the option to write the certification examination by either the International Society of Addiction Medicine or the American Board of Addiction Medicine.

We have opted to call our program an Enhanced Skills Year and not a Clinical Fellowship. On completion of our 12 month program, the resident would have gained enough clinical skills and knowledge to practice in a focused area of Addiction Medicine. However our main objective is not to train only physicians intending to practice Addiction Medicine solely but to provide enhanced skills to family medicine residents in Addiction Medicine to complement their comprehensive family practice. Our program is only open to physicians in Family Medicine and not to other specialties. The Department of Family Medicine at the University of Calgary has traditionally also not termed their third year as fellowships and we are keeping with that terminology to be consistent with the other enhanced skills programs. The College of Family Physicians is currently offering Certificates of Added Competence (CACs) in 5 special areas of family medicine but Addiction Medicine is not yet one of them. In the United States, Addiction Medicine is working to be recognised by the American Board of Medical Specialties and in Canada, there is initial work started for Addiction Medicine to be recognised by the Royal College of Physicians and Surgeons of Canada. However these applications are still in the early stages and until there is further clarity, we have opted to call our training program an R3 enhanced skills residency rather than fellowship.

CONCLUSION

In summary, there is a definite lack of physicians trained in Addiction Medicine compared with the increasing numbers of people suffering from the disease of Addiction. The University of Calgary Department of Family Medicine has just started to address this problem by offering an third Enhanced Skills Residency Program starting in 2013. Interest in our program has so far been low but we hope that with ongoing efforts to educate new physicians starting at the medical school level through residency that this will eventually change.

For anyone interested in our program, please visit our website at: **http://wcm.ucalgary.ca/familymedicine/r3/addiction-medicine**

Fellowship Program in Addiction Psychiatry

The new Enhanced Skills year in Family Medicine is building on the faculty and experience of a one year Addiction Psychiatry Program for psychiatric residents and Fellows which has existed for the last 20 years and has graduated specialists from Canada, Brazil and Saudi Arabia. Please contact P. Burgess at **Pauline.Burgess@albertahealthservices.ca**

REFERENCES

1. Principles of Addiction Medicine, 4th Edition. Editors: Ries RK, Fiellin DA, Miller SC, Saitz R. Lippincott Williams & Wilkins, Philadephia, PA, 2009.
2. Kuehn BM. Efforts aim to curb opioid deaths, injuries. JAMA 2009; 301(12):1213-1215.
3. Dhalla IA, Mamdani MM, Sivilotti ML, Kopp A, Qureshi O, Juurlink DN. Prescribing of opioid analgesics and related mortality before and after the introduction of long-acting oxycodone. CMAJ 2009; 181(12):891-6.
4. Fischer B, Rehm J, Patra J, Cruz MF. Changes in illicit opioid use across Canada. CMAJ 2006; 175 (11):1385.
5. Paglia-Boak A, Adlaf EM, Mann RE. Centre for Addiction and Mental Health): Ontario Student Drug Use and Health Survey (OSDUHS) 2011. (Accessed September 4, 2014, at http://www.camh.ca/en/research/news_and_publications/ontario-student-drug-use-and-health-survey/Documents/2011%20OSDUHS%20Docs/2011OSDUHS_Highlights_DrugUseReport.pdf)
6. Alberta Alcohol and Drug Abuse Commission (2006). Canadian Addiction Survey 2004, Alberta report. Edmonton, Alberta, Canada. (Accessed September 4, 2014, at http://www.albertahealthservices.ca/Researchers/if-res-cas-2004-alberta-detail.pdf)

All for One, One for All: Interdisciplinary Collaboration in the Treatment of Addictions

Louise Nadeau, *MA, PhD*
Département de Psychologie
Université de Montréal

ABSTRACT

In the treatment of addictions, the contribution of psychosocial practitioners in an interdisciplinary team is significant. Effective public health interventions have been led by concerted health professionals. Screening for potentially addictive practices is necessary not only in emergency rooms and in the offices of general practitioners but also within mental health and addiction services albeit the resistance of both medical and non-medical practitioners to systematically implement such screening procedures. Temperament and personality assessment can help establish more tailored treatment plans. Given that when treatments are compared with each other the difference in outcomes is typically small and variable it is suggested that successful interdisciplinary teams share facilitative interpersonal skills. A group of concerned and competent practitioners that complement their know-how in an interdisciplinary team may be the optimal solution to provide the help needed by patients throughout the course of recovery.

INTRODUCTION

This paper describes the contribution of non-medical health professionals in the treatment of addictions. Its framework is borrowed from the landmark monograph published by the National Center on Addiction and Substance Abuse at Columbia University entitled Addiction Medicine: Closing the Gap between Science and Practice[1] (CASA). As its title indicates, the document specifies the shared responsibilities of certified physicians in addiction medicine and other certified non-medically trained health professionals. We will thus present the contribution of other health professionals during the key phases of interventions in the field of addictions.

The postulate in addiction medicine is that addiction is a brain disease. This key statement implies that neurobiological processes, including biological vulnerabilities, are involved in addiction disorders. However, this conceptualization does not exclude the fact that the aetiology of addictions may involve multiple psychosocial contributory factors. For instance, the lives of many of our patients show that a history of alcoholism in the family involves more than genetic vulnerabilities. In families in which there was excessive drinking children never learn to drink in moderation. There is a synergy between the biological vulnerabilities that have been transmitted and

social learning processes that take place during development. In these families, nature and nurture are in constant interaction[2]. In other cases, severe childhood neglect and/or abuse can, in and of themselves, prompt a self-medication response such as smoking, gambling, overeating, alcohol and/or drug abuse. If these traumatic childhood experiences go untreated self-medication with potentially addictive practices can precipitate an addiction. To quote Donald Hebb's famous response to a journalist, "genes and environments entwine in the development of addiction as in the area of a rectangle in which both length or width make an important contribution". Corollary interventions with all addictions should involve biological as well as psychosocial components.

PUBLIC HEALTH INTERVENTIONS

Prevalence rates of alcohol dependence, heavy smoking, and obesity vary between countries, between regions in a same country, and between rich and poor neighbourhoods in a same city[3]. Environmental conditions and contextual factors constitute protective or risk factors for addictions. Effective interventions for addictions begin with public health interventions.

In many instances, in Canada, both medical and non-medical health professionals have worked together to elaborate and implement preventative programs. Several Canadian success stories that are the result of concerted efforts are worth mentioning. The development of Canada's Low-Risk Alcohol Drinking Guidelines regrouped administrators, physicians, policemen, representatives of the alcohol and hospitality industries, and scientists[4,5]. For all involved, the common goal was to increase protective factors (the promotion of a culture in which drinking in moderation is the norm) and to reduce risk factors (rendering socially inacceptable practices such as binge drinking and driving while intoxicated). In another field of interest, it was a lobby of mixed health professionals that fought together for the prohibition of smoking in public places. It resulted in a reduction of smoking in Canada. Similarly, the struggle for protected injection sites was led by health professionals with different trainings. The success of these public health interventions is inseparable from the joint efforts of the concerned health professionals working together, one for all, all for one.

SCREENING

In accord with the CASA monograph screening and early intervention services should be provided in regular health care settings. The monograph also insists on the multiple dimensions of addictive practices and their frequent association, giving special attention to smoking. This integrative view of addictions is a major contribution of the addictive medicine model. As is the case in a pharmacological treatment, the effectiveness of any psychosocial intervention can be affected by addictive behaviours, a fortiori if these practices have reached the clinical threshold, and even more so if these practices go undetected.

In Canada, with the exception of emergency rooms and visits to general practitioners, non-medical health professionals deliver front line mental health and addictions services. In public and private practice social workers, clinical psychologists, and nurses should, and need, to inquire about smoking, drinking, drug use, gambling practices, and nutritional habits. When potentially addictive behaviours are sufficiently intense to be considered a risk, concrete help should be offered to the client within the service offered. Therefore, all psychosocial practitioners should be capable of brief interventions or brief treatments for addictive behaviours. If not, they should be aware of the community resources capable of delivering the service to their clients. This position is beyond the addictive medicine model: screening for potentially addictive behaviours should be a universal practice in our country.

The American data presented in the CASA monograph state that adequate screening does not take place in most instances in the US. In the province of Quebec, health authorities have made efforts so that screening for mental health problems takes place in addiction services and that screening for risky addictive practices be systematically performed in mental health services. Nevertheless, the implementation of these screening procedures in public services is far from universal and there are no data available for psychotherapy in private practice. There are reasons to believe that the situation in Quebec parallels that in the rest of Canada and the United States. One can speculate upon the reasons why these evidence-based practices do not take place. The explanations are probably similar in Canada and the USA and similar for medical and non-medical health professionals: lack of adequate training, organizational and structural barriers to providing services, limited motivation in applying evidence-based addiction care practices, financial limits for public services and limited insurance coverage for private practice[6]. Ultimately, to quote Keith Humphreys, psychosocial health professionals "do not like to deal with the [addicted] people and do not feel effective addressing the problem", p. 255[7]. There has been significant progress, but medical as well as non-medical professionals need to improve.

ASSESSMENT

In addition to comprehensive history, validated tests are part of the assessment procedure. In human sciences many undergraduate university curricula include the principles of test construction and assure supervised test administration. As a result, most psychosocial practitioners are enabled to administer, code and interpret tests that are included in addiction assessment packages. It is, in fact, one of the specificities of their professional training. In short, well-trained psychosocial practitioners can and should conduct the psychometric segment of the assessment and most importantly use the results in the elaboration of the treatment plan.

The CASE monograph states that temperament and personality are part of the assessment. The study of personality traits has come a long way in psychology since Allport's seminal book in 1937 and it has remained essentially an expertise of psychologists. Traits are defined as the stable and recurrent modes of a person's behaviour, affects and thoughts. They are conceptualized as "dispositions" or "dispositional constructs"[8] and refer implicitly to the behaviour of individuals in certain social contexts[9]. The most frequently used test is the NEO PI-R[10] and its authors, McCrae and Costa, maintain that these personality factors have a biological basis, not affected by environmental influences, a theoretical position that does not reach consensus among scholars[11]. Similarly to all complex personality inventories the analysis and interpretation of the NEO PI-R requires training, supervision, and experience. If used with competency, the data provided by that inventory can help clinicians better understand the behavioural styles of their patients and offer insights on the patient's subjective experience of wellbeing, on his or her conception of a good life. They also provide insights on dimensions such as compulsive or antisocial traits. This information helps tailor a treatment plan in tune with the patients' personality. It is useful, for instance, in making appropriate choices in assertive training, relapse prevention strategies and motivational interviewing, or any combination of these clinical strategies. In an interdisciplinary treatment team personality assessment contributes to better predict certain problems and anticipate how to respond to these eventualities. It is a key role played by psychologists.

TREATMENT

The following will identify specific strengths of psychosocial practitioners in the treatment process.

A RE-APPRAISAL OF THE SEVERITY OF THE ADDICTION

Assessment provides an initial working plan to begin treatment. In Canada, the primary dispensers of psychotherapeutic treatment are psychosocial practitioners. In the initial assessment interview and in tests relying on self-reports, patients struggling with an addiction may, conscientiously or not, give the good, and not the real, answer concerning their addictive practices[12]. In psychotherapy, while working on personal issues patients may become aware for the first time of the deleterious impact of the addiction in their lives, as if the real destructive nature of the addiction was revealed to them. Connections between problems in their lives and the negative consequences of addictions are made. Likewise a more profound examination of certain behaviours first perceived as conventional and harmless are reconceptualised as damaging and destructive. Patients may also become more aware and empathic about the worry and problems experienced by family, friends and colleagues because of their addiction. In the course of psychotherapeutic work, the patient and the therapist proceed to a reciprocal re-appraisal of the severity of the addiction. An interdisciplinary treatment team could then estimate it necessary to proceed to a re-examination of the treatment plan and its duration, with or without new decisions concerning the pharmacological treatment.

TREATMENT STRATEGIES

Non-medical practitioners play a key role in evidence-based treatment of addictions. As mentioned previously, they are the principal dispensers of treatment in Canada. This paper cannot review the vast literature on evidence-based treatments for alcohol, drug, tobacco, and obesity addictions. The task would be impossible, and comparisons between addictions may not be scientifically feasible. The question under study in this paper needs to be narrowed down.

The data on evidence-based treatments for substance use disorders pose interesting questions in reference to the role of all practitioners in the treatment of patients

addicted to substances. Large multi-site studies have been conducted and the results have been made available to the research and practitioner communities. Several secondary analyses and commentaries of these data banks have been published. Project MATCH compared three behavioural treatments. The UK Alcohol Treatment Trial examined the effectiveness of social behaviour and network therapy with that of motivational enhancement therapy. These studies did not find that one approach was superior to the two others[13,14]. The COMBINE trial examined pharmacological treatment alone, behavioural treatment alone and a combination of both. During treatment the two groups that had received naltrexone or had received a behavioural intervention, with placebo pills and medical management counselling showed the best outcomes. One year after treatment, these between-group effects were similar but no longer significant[15,16]. In addition, there are multiple studies from numerous treatment services, including six conducted in Quebec that show that patients, as a group, improve whatever the psychosocial treatment strategy. In these studies, the main predictor of treatment effectiveness was the patient's status at intake (the severity of dependence and the psychosocial status)[17,18]. A recent paper by Miller and Moyers[19] summarizes the issue: "Even brief treatments are consistently found to be better than no treatment, but when bona fide treatments are compared with each other the difference in outcomes is typically small and variable. The relative advantage of one treatment over another is often so small as to be of little clinical interest." (p.9)

From the current available data on treatment effectiveness, it is impossible to claim that the magic bullet for the treatment of alcohol addiction has been found. To state it differently: there is no evidence that one therapeutic approach, in the long term, is significantly more effective than another. In their paper Miller and Moyers claim that more attention should be given to larger interpersonal factors and the programmatic context in which services are delivered. Their remark probably holds true for other addictions as well. Najavits and Weiss expressed these concerns 20 years ago[20]. Factors such as therapeutic alliance, readiness to change in patients, and contextual variables of the patients' life have now been studied in the mental health and substance use fields[21-26]. The quality of the therapeutic relationship is paramount in motivating patients to enter in a mode of change, and sustain the commitment towards recovery. In a nutshell, to have more successful outcomes, these facilitative interpersonal skills have been defined. Clinicians that are able to establish a therapeutic alliance, to put into words what is going in the session and within the patient, to express emotions, warmth, and empathy, to persuade the patient and give hope, and help solve problems appear to be better at keeping patients in treatment and maintaining good outcomes[27]. This data open an interesting perspective for interdisciplinary teams in addictive medicine. A winning interdisciplinary treatment team, with medical and non-medical clinicians, would be one that shares not only the same theoretical perspective on addictions but also strives at giving patients a maximum opportunity to attain and maintain recovery by emphasizing a fecund therapeutic alliance.

CONCLUSION

This paper has attempted to put forth that effective interventions in the addictions are better accomplished in interdisciplinary work. Team science has been studied during the last 25 years and health research and clinical practice have benefitted from transdisciplinary collaboration[28,29]. The integration of multiple disciplinary perspectives has also facilitated the examination of difficult problems and accelerated problem solving in the field of substance use and abuse[30]. For many of our patients, the struggle with their addictions will be an on-going battle with phases of relative peace and phases in which life would appear so much easier if they smoked, overate, used drugs or drank heavily. If one can trust one or more persons within a collaborative group of competent and committed practitioners with diverse expertise it alleviates the sentiment of being this Atlas who carries alone immense personal burden. Throughout the course of recovery from one or more addictions, the help needed may be of diverse nature – adjustment of medication, problem solving related to housing, work, or/and relationships, introspection concerning one's history to give meaning to it all. Prevention, assessment and treatment of addictions are better done by a group of concerned practitioners that complement each other's know-how in an interdisciplinary team.

REFERENCES

1. National Center on Addiction and Substance Abuse at Columbia University. Addiction Medicine: Closing the Gap between Science and Practice. June 2012. http://www.casacolumbia.org/addiction-research/reports/addiction-medicine. Retrieved June 30, 2014.
2. Hyman S. Susceptibility and "second hits". In R. Coulan (ed.): States of Mind, 1999, p. 27. New York: Wiley.
3. Rapport du directeur de santé publique (Marie-France Le Blanc, Marie-France Raynault, Richard Lessard). Les inégalités sociales de santé à Montréal. Le chemin parcouru.

Rapport synthèse, 2011. Montreal: Agence de la santé et des services sociaux.

4. Butt P, Beirness D, Gliksman LC, Paradis C, Stockwell T. Alcohol and health in Canada: A Summary of Evidence and Guidelines for Low-risk Drinking, 2011, Ottawa (ON), Canadian Centre on Substance Abuse.
5. Rehm, J, Kehoe T, Taylor B, Patra J. Evidence Base for the Development of Canadian Drinking Guidelines: Report prepared for the Low Risk Drinking Guidelines Expert Working Group by the Centre for Addiction and Mental Health, 2009. Ottawa (ON).
6. National Center on Addiction and Substance Abuse at Columbia University, 2012, p. 212
7. Humphreys, K. Stanford Medical School, Personal communication, August 16, 2007. In National Center on Addiction and Substance Abuse at Columbia University. Addiction Medicine: Closing the Gap between Science and Practice. June 2012
8. McCrae RR, Costa, PT Jr. The five-factor theory of personality. In OP Robins & LA Pervin (Ed): Handbook of Personality: Theory and Research 1999; pp.159-181. New York: Guilford Press.
9. De Raad B. Situations that matter to personality. In A Eliaz, SE Hamilton & B De Raad (Ed) Advances in Personality Psychology 2005 (2), 179-204. Philadelphia, PA: Psychology Press.
10. Costa, PT Jr, McCrae RR. Domains and Facets: Hierarchical personality assessment using the Revised NEO Personality Inventory. Journal of Personality Assessment, 1995,64(1), 21-50
11. Cervone D, Pervin PA. Personality: Theory and Research, 12th Edition. 2013. New York: Wiley and Sons, Chapter 8, pp.275-300.
12. Ford EB. Lie detection: historical, neuropsychiatric and legal dimensions. Int J Law Psychiatry. 2006; 29(3), 159-177.
13. Longabaugh R, Wirtz PW. (eds). Project MATCH hypotheses: Results and causal chain analyses. 2001 Bethesda, Maryland: National Institute on Alcohol Abuse and Alcoholism.
14. UKATT Research Team. Cost effectiveness of treatment for alcohol problems: Findings of the randomized UK alcohol treatment trial (UKATT). British Medical Journal. 2005; 331:544-8.
15. Anton RF, O'Malley SS, Ciraulo DA, Cisler RA, Couper D, Donovan DM, et al. COMBINE Study Research Group. Combined pharmacotherapies and behavioral interventions for alcohol dependence: the COMBINE study: a randomized controlled trial. 2006; JAMA;May 3;295(17):2003-17.
16. Moyers TB, Houck J. Combining Motivational Interviewing with cognitivebehavioral treatments for substance abuse: Lessons from the COMBINE Research Project. Cognitive and Behavioral Practice. 2011;18 (1), 38-45.
17. Landry M, Guyon L, Brochu S (eds): Impact du traitement en alcoolisme et toxicomanie. Études québécoises. Québec: Collection Toxicomanies, Presses de l'Université Laval, 2001 (209-219).
18. Nadeau L, Landry M. (eds). Les troubles concomitants de toxicomanie et de santé mentale : résultats de recherche au Québec et réflexions cliniques. 2009, Québec: Collection Toxicomanies, Presses de l'Université Laval.
19. Miller WR, Moyers TB. The forest and the trees: relational and specific factors in addiction treatment. Addiction, 2014; doi: 10.1111/add.12693.
20. Najavits LM, Weiss RD. Variations in therapist effectiveness in the treatment of patients with substance use disorders: an empirical review. Addiction. 1994; 89, 679-688.
21. Baldwin SA, Wampold BE, Imel ZE. Untangling the alliance-outcome correlation: exploring the relative importance of therapist and patient variability in the alliance. J Consult Clin Psychol. 2007; 75(6): 842-52.
22. Beutler LE, Malik M, Alimohamed S, et al. Therapist variables. In Lambert MH, editor, Handbook of psychotherapy and behaviour change. 5th Edition. New York: Wiley, 2003; p. 227-306.
23. Castonguay LG, Beutler LE. Principles of therapeutic change: a task force on participants, relationships, and techniques factors. J Clin Psychol. 2006; 62(6): 631-8.
24. Ilgen MA, McKellar J, Moos R, et al. Therapeutic alliance and the relationship between motivation and treatment outcomes in patients with alcohol use disorder. J Subst Abuse Treat. 2006; 31(2): 157-62.
25. Morgenstern J, McKay JR. Rethinking the paradigms that inform behavioral treatment research for substance use disorders. Addiction. 2007; 102(9): 1377-89.
26. Pilgrim D, Rogers A, Bentall R. The centrality of personal relationships in the creation and amelioration of mental health problems: the current interdisciplinary case. Health Mar. 2009; 13(2):235-54.
27. Anderson T, Ogles BM, Patterson CL, Lambert MJ, Vermeersch DA. Therapist effects: facilitative interpersonal skills as a predictor of therapist success. J Clin Psychol. 2009; Jul;65(7):755-68.
28. Stokols D, Misra, S, Moser, R P, Hall, KL, Taylor, BK. The ecology of Team Science. Understanding contextual influences on transdisciplinary collaboration. Am J Prev Med. 2008;35(2S):S96–S115)
29. Satterfield JM, Spring B, Brownson RC, Mullen EJ, Newhouse RP, Walker, Barbara B, Whitlock EP. Toward a transdisciplinary model of evidence-based practice. The Milbank Quarterly. 2009 ; 87 (2) :368–390
30. Fuqua J, Stokols D, Gress J, Phillips K, Harvey, R. Transdisciplinary collaboration as a basis for enhancing the science and prevention of substance use and "abuse". Substance Use & Misuse. 2004 ;39:10,1457-1514

CSAM SMCA

CSAM BOARD OF DIRECTORS

President
Dr. Ron Lim

Past President
Dr. Brian Fern

President-Elect
Dr. Paul Sobey

Treasurer
Dr. Jeff Daiter

BC Regional Director
Dr. Paul Sobey

AB Regional Director
Dr. Laura Evans

MB Regional Director
Dr. Nichole Riese

Ontario Regional Directors
Dr. Melanie Willows
Dr. Suzanne Turner

Quebec Regional Directors
Dr. Joseph Cox
Dr. Marie-Eve Morin

New Brunswick Regional Director
Dr. Jeff Hans

Nova Scotia Regional Director
Dr. Ramm Hering

Newfoundland & Labrador Regional Director
Dr. Wael Shublaq

Members at Large
Dr. Nady el-Guebaly
Dr. Sharon Cirone

CORPORATE SPONSORS

CSAM would like to acknowledge the support of the following:

Alberta Medical Association – Section of Addiction Medicine
British Columbia – BC Responsible & Problem Gambling Program
Bellwood Health Services
ccgr – canadian consortium for gambling research
Chopra Addiction & Wellness Center
Edgewood – extending the branch of hope
Homewood – Improving Life | Health Centre de Santé
ISAM – International Society of Addiction Medicine
Last Door – Breaking the Chains of Addiction Since 1984
LifeLabs – Medical Laboratory Services
LiquiMedLock Inc. – Compliance packaging solutions.
Mallinckrodt Pharmaceuticals
Mylan – Here for you. Here for your patients.
OATC – Ontario Addiction Treatment Centres
Purdue
Rapid Response – Point-of-Care Diagnostics – BTNX INC.
Reckitt Benckiser Pharmaceuticals Inc.
Shire
Sunshine Coast Health Center
Westminster House – Recovery Centre for Women