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Closing the gap between needs and supply of training in addiction medicine

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ABSTRACT

Substance use disorders represent a significant social and economic burden globally. While effective interventions exist, the overall treatment coverage remains limited, with lack of an adequately trained workforce as one of the prominent reasons. World over, recent initiatives have been taken to improve the training in addiction medicine, however further efforts are required in building curriculums which are internationally applicable. We, as a Network of Early Career Professionals in Addiction Medicine (NECPAM) from different parts of the world, believe that perceived training needs of professionals in the area have not been explored in details as yet. We propose that a peer led model of assessing the training needs using a standardised structured tool can be used to overcome this void. The findings from this can be used to propose (a) core set of competencies that is based on views of those working in the field that is (b) flexible enough in its implementation to address a variety of specific needs of the addiction medicine professionals.

Contribution:
SA, MD, BR, DP, AS, VC, DK contributed substantially to the conception and design of the paper. SA and DK worked on the initial draft which was subsequently analysed by VC, MD, BR, DP, JK. All authors read and approved the final manuscript.

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Substance use and substance use disorders (SUDs) are major contributing factors to global morbidity and mortality. According to recent reports, 43% (2.3 billion) of global adult population had consumed alcohol during past 12 months with more than 5% (283 million) having alcohol use disorders (1); whereas about 6% (275 million) used drugs at least once in 2016, with about 0.6% (31 million) suffering from drug use disorders (2). About 3 million deaths were attributable to alcohol use and 450,000 deaths attributable to drug use. .The systematic analysis of global burden of disease study concluded that 4.2 % and 1.3% of Disability adjusted life years (DALYs) were attributable to alcohol and drug use respectively (3). . Such trends has been of increasing concern to public health and strengthening workforce in addiction medicine would contribute towards facing these challenges.

Research has shown that effective pharmacological and psychosocial strategies exist for treatment of SUDs. While, improving the actual access to treatment requires multi-faceted approaches at all levels of the system, increasing adequately trained workforce can potentially improve treatment outcomes. Despite SUDs being a common public health issue, there seems to be a reluctance among general practitioners, physicians and psychiatrists to treat and manage these conditions(4). . In addition to several cultural, political and legal factors, stigma and incompetence in handling SUDs have been cited as important factors contributing to having a lower regard towards persons with substance use disorders and towards working with them. A review of effectiveness and organisation of addiction medicine training across the globe highlighted a lack of standardised addiction medicine training programmes at graduate and post graduate level of medical education with exception of few psychiatry and family medicine courses. The review identified several barriers in developing addiction medicine training in medical education including limited availability of curricular time, poor inter-departmental coordination, insufficient faculty members qualified in teaching about addiction medicine and lack of addiction treatment facilities that can be used as education sites for clinical experiences(5) The WHO ATLAS-SU survey on Resources for the Prevention and Treatment of Substance Use Disorders, conducted in 162 countries, highlighted the deficiencies in SUD training programmes globally. Almost one-third of the countries reported an absence of training programmes for any of the workforce for the management of SUD's, while 60% of low-income countries lacked such training programmes. Worldwide, the highest availability of postgraduate training exists for psychiatrists (52% of countries) and other doctors (49%), and the lowest for counsellors (23%) and community health workers (19%)(6).

WHO, in laying out global strategy on human resources for health, has strongly emphasised building the capacity and capability of workforce in order to achieve the sustainable development goals(7). Over past decade, efforts have been made to create a specialist training pathway in the field of addiction medicine, with numerous training programmes initiated in developed countries(8). For example, certain countries like Canada, Netherlands, United States, Australia have initiated fellowships in Addiction medicine, and some (Canada, North America) have extended these schemes to non-physicians. However most countries do not have such fellowships and access to quality education at the undergraduate/ medical school level remains an issue everywhere. While it is beyond doubt that specialisation will improve the overall quality of care for SUDs, the replicability of such programmes in low resource settings, which have a higher burden of SUDs and poorer access to treatment, remains unclear. Traditionally, the training in SUDs in the majority of low and middle income countries have followed an *ad libitum* approach where instead of having a well laid out plan for training, the provision of care and hence training has been mostly on ad hoc basis, and often inadequate. These programmes are short-term, focus on a set of narrow aims and are often planned with limited consideration for future training needs. Therefore an approach is required which is not as resource intensive as specialised training, but

target the needs of these professionals by taking into account their views with clear goals and flexibility in implementation.

Although there is substantial literature highlighting the deficiencies in training on SUDs in undergraduate and postgraduate training, the actual needs of professionals have not been fully characterised. Specifically, there is a lack of information from low income countries, especially on training needs of medical and other professionals in the field. As a result, it is difficult to make recommendations. For example, a review could only find nine studies in the last fifteen years which focussed on training needs in addiction medicine(5). Five of these studies from United States evaluated the faculty perceptions about the existing services available for residents in addiction training and one German study assessed the services available for undergraduates. There was only a single study which aimed at developing a curricula in addiction medicine for health care professionals and explored the training needs from their perspective. This study proposed a number of core competencies including screening, assessment and diagnosis, management and treatment, and management and referral of medical comorbidities (9). In the absence of scientific evidence, recommendations have been given by international scholars that highlight certain core set of competencies to be covered at undergraduate and post graduate levels, as well in continued medical education(10). Although relevant, these recommendations cannot be assumed to be representative of the daily practice situation. Therefore, we call for assessment of training needs of the professionals working in addiction medicine, at various educational levels and in various countries. This proposed training needs assessment will be different from previous assessment in terms that it will be a) peer-led, b) using structured, validated instrument, and c) focus on early career professionals working in addiction medicine across many countries simultaneously.

It must be kept in mind that professionals who manage SUDs are from a variety of professions (e.g. psychiatrists, specialist physicians, general practitioners, nurses, psychologists, social workers and counsellors), and have significant differences in training needs. Secondly there are different service requirements which these health professionals are expected to provide. There exist significant socio-demographic cultural and political variations which impact the management of SUDs in different regions of the world, as well there is a vast difference in the training provided in different parts of the world, with specialist courses in one part and lack of basic health workers in all medical fields in other parts. Assessment of training needs in professionals working in addiction medicine would help highlight the basic skill deficit and knowledge requirements. One of the ways to assess these needs is by using a peer-led learning model, a structured and validated instrument that exhibits excellent psychometric qualities and that yields itself to being adapted for use as a web-survey distributed globally.

Apart from focusing on training needs among varied professions, emphasis must also be on those professionals who are at an early career stage. These are the individuals who are likely to be the leaders and stakeholders in field of addiction medicine in future. Therefore, addressing the issues most pertinent to them will empower and enhance their capabilities(11). Investing in early career professionals will serve as a timely replacement for already ageing workforce in addiction medicine(12).

Conclusion

Addiction medicine training programs differ significantly in their content covered and duration (from few weeks to three year) across the globe. Because of such heterogeneity, the clinical skills vary among professionals and usually not sufficient. We, as early career professionals from different countries feel

that better training is required to handle SUD management and prevention. There should be enhanced focus on the identification of the specific training needs of the early career health professionals engaged in providing SUD services. We advocate for: (a) core outcome set of competencies developed upon and with attention to views of those in the field and (b) flexible enough in its implementation to be sensitive to a variety of specific needs. i.e. Structured set of aims with flexibility of implementation. To achieve that we suggest actions which ask professionals what they really need and develop set of training aims (core outcome set of competencies) for training based on these views with flexibility in implementation which is sensitive to specific cultural and organisational circumstances. As a starting point we propose to assess the training need among addiction professionals worldwide. We believe that combining these evidence-based findings with the training of healthcare workers would make the existing programmes more relevant, effective and acceptable to treatment providers and patient alike.

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