

## VIEWS &amp; REVIEWS



## PERSONAL VIEW

## Training in addiction medicine should be standardised and scaled up

Most health systems lack sufficient doctors trained in addiction medicine to reduce the public health consequences of this increasing societal problem, writes **J Klimas**

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Substance use disorders represent a substantial social and public health burden. An estimated 149 million to 271 million people use illicit drugs worldwide,<sup>1</sup> and the related physical and psychological morbidity places challenging demands on healthcare systems.<sup>2</sup>

Addiction science has identified approaches to treat substance use disorders, particularly through early identification and treatment. Most interventions are underused, however.<sup>3 4</sup> Adequate diagnosis and treatment by healthcare providers fails partly because of lack of knowledge and accredited training in addiction medicine.<sup>5</sup> The public health consequences stemming from high rates of untreated addiction result from a lack of addiction treatment, secondary to a lack of trained physicians. Training doctors better is likely to improve accurate diagnosis and appropriate treatment<sup>6</sup>; it may also help reduce the public health epidemics that can result from improper prescribing, such as the current epidemic of opioid analgesic dependence in the United States.

### Programmes in North America

To this end, new training pathways for diagnosing and treating substance use disorders have begun to emerge internationally.<sup>7</sup> The American Board of Addiction Medicine (ABAM) and the ABAM Foundation have established fellowships in addiction medicine—part of a public health response to a growing burden of substance use disorders, increased incarceration for minor drug crimes in the US, and greater recognition of addiction as a brain disease.<sup>7</sup>

ABAM has accredited 27 of these programmes (including 63 slots for candidates), and one of the largest programmes is based in Vancouver, Canada. In February the American Board of Preventive Medicine announced its intent to bring addiction medicine into the American Board of Medical Specialties (ABMS) as a subspecialty available to diplomats of all ABMS boards. If the discipline gains board recognition, doctors

completing their specialty training in internal or family medicine, paediatrics, and other areas will be able to do more advanced and standardised training on treating and preventing substance use disorders and associated medical problems.

Recently, medical licensing bodies in Canada have acknowledged the increasing interest in addiction medicine among doctors, and they now recognise diplomas highlighting the prospect of addiction medicine training certification by ABAM or the International Society for Addiction Medicine (ISAM).<sup>8</sup>

### The response in Europe and elsewhere

Addiction medicine training in Europe has undergone similar change. The Netherlands has developed one of the most comprehensive systems of addiction medicine training in Europe—a masters degree in addiction medicine,<sup>9</sup> whose success inspired the development of a national training programme on addiction medicine in Indonesia.<sup>9</sup> The Dutch and Indonesian models have both been shaped by the Canadian experience of addiction training.<sup>8</sup> Norway has created a full medical specialty in addiction medicine, in response to its government's mandate from 2010.<sup>9</sup>

In the United Kingdom a project on substance use in undergraduate medical education, led by St George's, University of London, studied the teaching at 19 medical schools and led to the development of national guidelines.<sup>10</sup> The situation in Ireland does not differ greatly from that in the UK before the St George's project; however, O'Brien and Cullen have highlighted the importance of training in addiction medicine to decrease the public health burden from high rates of untreated addiction.<sup>11</sup>

Also, in contrast with the general international underexposure of doctors to education about addiction medicine, Australia has a new scheme offering three years of supervised training, with

continuous assessment and a focus on harm reduction and evidence based treatment.<sup>9</sup>

Finally, the upcoming meeting of ISAM (its 17th world congress, to be held in Dundee, Scotland from 5 October 2015), may be an opportunity to mobilise the membership for an international call to standardise training.<sup>12</sup> Introduced by Cornelis de Jong, speakers at “International Aspects to Medical Education in Substance Misuse/Addictions” will discuss the ISAM’s position, as well as ideas about global standardisation of addiction medicine training and further steps to be taken.

## Training inconsistency hinders progress

Some may argue that time consuming and inflexible specialised training programmes can discourage doctors. Shorter training, such as continuing medical education (CME) meetings or addiction workshops, can vary greatly between countries, similar to the diversity in specialised training.<sup>13</sup> Furthermore, even if public healthcare systems invest in CME-type efforts to improve addiction care, fellowship programmes and other standardised curriculums will be critical to ensure an adequate cohort of teaching faculty that can support CME activities. But, given doctors’ limited time, training in addiction medicine provides tools to enable early intervention, preventing the escalation of addiction that requires more expensive and time consuming treatment.<sup>14</sup>

A barrier to improving public health approaches is the inconsistency in doctors’ training. Despite some progress in standardised curriculums for addiction medicine, evaluations of specific programmes for doctors are lacking. Most countries don’t specifically train doctors in addiction medicine; when they do, this is mostly restricted to a small number of psychiatry programmes that produce a limited number of addiction psychiatrists. As a result, we don’t know which system works best or whether patients benefit. Although these systems have developed differently in a public health response to different needs and contexts, their diversity prevents comparative research and hinders the advancement of education in addiction medicine.

To better tackle the gap between the best evidence and quality of care indicators, the development of training programmes in addiction medicine should be standardised internationally, with parallel efforts by medical schools.

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