An Epidemic of Incompetence: Tracing the Roots of the Canadian Opioid Crisis

Anees Bahji[1,2]

1. Department of Public Health Sciences, Queen's University, Kingston, Ontario
2. Department of Psychiatry, Queen's University, Kingston, Ontario

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Corresponding Author:
Anees Bahji, MD
PGY4, Department of Psychiatry, Queen's University
MSc Candidate, Department of Public Health Sciences, Queen's University
Abramsky Hall, Room 328, 21 Arch Street, Kingston, ON, Canada K7L 3N6
Tel: 613 533-6000 Ext. 33355
Fax: 613 533-6388
Email: 0ab104@queensu.ca

Abstract: In Canada and the United States, the rising number of apparent opioid-related deaths have given to the aptly-named opioid epidemic. Despite the criticism physicians have received for their role in opioid overprescribing, physicians may very well be in the position to vanquish the opioid epidemic. While the importance of Addictions training in psychiatry and other disciplines has been recognized in Canada at a national level, training resources are scarce and difficult to implement, even when delivered in online formats. Many have speculated that the delivery of high-quality Addictions training has been hampered by multiple roadblocks endemic to the Canadian medical education system, particularly stigma towards individuals with substance use disorders. In this narrative review, the foundations and approaches to Addictions training and education in a Canadian context are critically examined and potential solutions for existing limitations in the context of the Canadian opioid crisis are presented.

Keywords: Humans; United States; Canada; Education, Medical; Curriculum; Analgesics, Opioid; Behavior, Addictive; Substance-Related Disorders; Psychiatry

Background

In Canada and the United States, the rising number of apparent opioid-related deaths have given to the aptly-named opioid epidemic (Government of Ontario, 2016; Health Canada, 2018). The significant abuse potential of opioids and the ever-increasing prevalence of high potency opioids, such as heroin, fentanyl and its derivatives, have been named as key drivers of the opioid epidemic (Bahji and Bajaj, 2018). However, with growing certainty, research has indicated that inappropriate prescribing of opioids in vulnerable individuals may underlie a large proportion of opioid overdose fatalities (Butler *et al.*, 2016; Health Quality Ontario, 2018). As a result of this finding, physicians have come under fire from multiple sources for their contributions to the current opioid crisis.

Aim

In this narrative review, the foundations and approaches to Addictions training and education in a Canadian context are critically examined and potential solutions for existing limitations in the context of the Canadian opioid crisis are presented.

Addictions Training in Psychiatry

Despite the criticism we have received, physicians may very well be in the position to vanquish the opioid epidemic. Fortunately, the evidence is quite clear that problematic substance use is a health condition that can be managed and treated effectively (U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, 2012). However, as the delivery of evidence-based care in Addictions demands a specific and exquisitely-complex skill set, many have turned to psychiatry for guidance (Shorter and Dermatis, 2012; American Academy of Addiction Psychiatry, 2018). During psychiatric training, we gain an unprecedented amount of exposure to a highly stigmatized patient population, which encourages the development of nonjudgmental attitudes towards individuals from all walks of life. We also gain the ability to screen and diagnose a selection of complex mental disorders and are able to utilize these skills to support a population of patients that are, perhaps, the most challenging in all of medicine. As well, our proficiency with biopsychosocial formulation, our knowledge of complex pharmacotherapy, our expertise with multiple modalities of psychotherapy, and our increasing use of evidence-based strategies equip us with a full armamentarium for individuals with complex, severe, and persistent forms of mental illness, including – but not limited to – substance use disorders. In some ways, the practice of psychiatry embodies the belief that the opposite of Addiction is not abstinence, but connection (Hari, 2015).

Fortunately, the importance of Addictions training in psychiatry has been recognized in Canada at a national level. In 2015, the Canadian Psychiatric Association (CPA) released a two-part position paper (Crockford *et al.*, 2015; Fleury *et al.*, 2015), outlining an overview of the key concepts as well as objectives and detailed recommendations for the content of Addictions curriculum (Tables 1 and 2).

Barriers to Providing Addictions Training

Despite the dissemination of the CPA guidelines, the potential of psychiatry to spearhead the response to the opioid epidemic has not yet been realized. In 2017, the Association of Faculties of Medicine of Canada reviewed the accreditation standards for best practices of teaching in Addictions (as well as opioid prescribing and chronic pain management) across all Canadian medical schools and residency programs. Expectedly, they found significant heterogeneity, identifying diverse methodologies of teaching, curricula, and definitions of competency and divergent pedagogies. In the postgraduate medical education category, none of the seventeen

Canadian psychiatry programs were deemed to be offering best practice standards in Addictions education (The Association of Faculties of Medicine of Canada, 2017). Thus, while psychiatrists play a key role in the treatment of patients with Addictive disorders, and are looked to for expertise by their medical colleagues, the next generation of psychiatrists is clearly not receiving training in Addictions.

Not surprisingly, physician surveys have identified that the majority report a lack of confidence in working in the area of Addictions (O'Gara *et al.*, 2005). Logically, it would follow that Addictions training should be clinically grounded to alleviate these perceived low levels of reported clinical training and the resulting lack of confidence. Unfortunately, while many have suggested that medical students, residents, and allied health practitioners (such as nursing students and practicing nurses) be provided with more resources so that they can acquire the key concepts and skills in Addiction, resources are scarce and difficult to implement, even when delivered in online formats.

Some have speculated that the delivery of high-quality Addictions training in psychiatry has been hampered by multiple roadblocks endemic to the Canadian medical education system (van Boekel *et al.*, 2013). Although illness of any kind need not define an individual, mental and physical illnesses are often regarded differently, and nowhere is that more apparent than in Addictions. A recent systematic review found that negative attitudes of physicians towards patients with substance use disorders were not only highly prevalent, but also a key contributor to suboptimal health care delivery for these patients (van Boekel *et al.*, 2013). Thus, the undue propagation of stigma towards Addictions is a likely culprit.

However, the inherent characteristics of Addictions also contribute to the difficulties in providing high-level training to the next generation of physicians. For example, the inherent multidisciplinary and interprofessional demands of Addictions mean that it is impossible to assign a single discipline or role to accept the full responsibility for its management. Yet, society has encouraged Addictions scapegoating in the wake of the opioid epidemic, with an expectation that at a certain point, someone (or something) will be held accountable for the 'problem'. Furthermore, the complexity of Addictions is often difficult to align with the conventional model of medical education, which has often led to the inappropriate distillation to "substance use disorders" or "screening for red flags".

These issues may be propagated further by the current infrastructure of subspecialty training in Canada and the United States, where there are two competing medical disciplines dedicated to Addictions – Addiction Medicine and Addiction Psychiatry. In the United States, the former receives recognition from the Addiction Medicine Foundation and the American Society of Addiction, while the latter is governed by the Accreditation Council for Graduate Medical Education and the American Academy of Addiction Psychiatry. In Canada, Addiction Psychiatry is not yet a Royal College-recognized discipline in the way that Geriatric, Child, or Forensic Psychiatry are. While it is important to create training pathways in Addictions, this divergence suggests there is a substantive distinction between Addiction Medicine physicians and Addiction Psychiatrists, when in fact, there is not. Leading specialists in both disciplines agree on the definition of Addiction and that its treatment is both an art and a science, which requires a multidisciplinary approach. Despite this extensive accord, practitioners of each draw sharp distinctions between Addiction Medicine and Addiction Psychiatry to serve historical, economic, and professional interests, revealing the importance to both disciplines of recognition from their distinctive colleges, and thus, jurisdiction over the medical treatment of addiction.

Despite this, the findings of some key ethnographic research studies have been particularly staggering. For example, in Philadelphian studies of patients who interviewed about their experience with the health care system by outreach nurses, one man said "I don't want to

live under the bridge, but I can't stop. I don't know how to access treatment…I don't have internet…I don't have phone" (Carlson *et al.*, 2009). These findings suggest that providers may be unfamiliar with the sociodemographic factors that patients inevitably return to upon discharge from hospital, which exponentially increases the odds of recidivism. This, then, informs the so-called vicious cycle of addiction (Mazhnaya *et al.*, 2016).

Unfortunately, internalized stigma towards Addictions exists within psychiatry, too. Historically, the relationship between psychiatry and addictions has been complicated by divergent ideologies and attitudinal beliefs and has resisted the inclusion of Addictions in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). Although there is a gradual move towards integrated care, the remnants of a longstanding tradition that Addiction is not truly a psychiatric illness persist, even today (Gertler and Ferneau, 1974; Avery *et al.*, 2017; Kochański and Cechnicki, 2017). For example, we still refer to Addictive disorders as 'concurrent', which implies that the substance use is a separate – or non-psychiatric – entity (Danda, 2012). While psychiatry is one – if not the only – discipline that aims to formally incorporate Addictions into its training curriculum (Royal College of Physicians and Surgeons of Canada, 2015), few psychiatrics manage patients with Addictive disorders (Kochański and Cechnicki, 2017). Thus, the division between Addictions and psychiatry is ever present.

Conclusions

There is a tremendous need to implode the myths of Addiction. In the words of Elyn Saks (2014), "approaches include medication (usually), therapy (often), a measure of good luck (always) — and, most of all, the inner strength to manage one's demons, if not banish them. That strength can come from any number of places: love, forgiveness, faith in God, a lifelong friendship". Despite these challenges, those who struggle with Addiction can lead full, happy, and productive lives if they have the right resources. With time, we can only hope that the increasing visibility of Addictions will translate to improved training and curricula for the next generation of physicians.

Take Home Messages

- In Canada and the United States, the rising number of apparent opioid-related deaths have given to the aptly-named opioid epidemic; physicians have come under fire from multiple sources for their varying contributions to the current opioid crisis.
- Delivery of optimal addictions education and training for the next generation of physicians is hampered by multiple barriers, including stigmatized views towards patients with substance use disorders, the inherently complex demands of patients who struggle with addiction, current infrastructure of subspecialty training which lacks clearly defined roles for training in addictions, and administrative roadblocks to the provision of evidence-based addictions therapies.
- In navigating the winds of change in the Competency-Based Medical Education (CBME) era, it remains unclear how Addictions will be embraced; to date, there are no defined Addictions competencies in the Canadian CBME infrastructure.
- As the management of Addictions is a multidisciplinary endeavor, provision of care for individuals with Addictive should be a shared responsibility between physicians and health care providers of diverse backgrounds.
- Ideally, we should respond to Addiction in a manner akin to cancer, where recovery is celebrated and even encouraged, and the individual is not blamed for their current state.
- Despite these challenges, those who struggle with addiction can lead full, happy, productive lives if they have the right resources.

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Tables and Figures

Supplementary Table 1: Key Domains of Competence in Addiction Psychiatry, adapted from (Fleury *et al.*, 2015)

Key Domain	**Example**
Attitudinal Skills	Psychiatrists should treat patients with substance use disorders like any other – with compassion, respect, and a nonjudgmental attitude.
Screening and Diagnosis	Psychiatrists should screen for substance-related and addictive disorders routinely with people seeking treatment for mental illness.
Integration with General Psychiatric Practice	Psychiatrist should address addiction as an integral part in the psychiatric care of each patient, regardless of the care setting (e.g., emergency, outpatient-community, consultation-liaison, or specialized addiction center).
Psychosocial Treatments	Psychiatrists should develop proficient-to-advanced competence in motivational interviewing, cognitive behavioural therapy, contingency management, 12-step facilitation, behavioural approaches, and other modalities.
Pharmacotherapy	Psychiatrists should demonstrate advanced competence to assist their patients with pharmacological treatment for their substance-related and addictive disorders as well as for co-occurring disorders
Special Populations	Psychiatrics should be comfortable with providing evidence-based care for addictive disorders across the lifespan (i.e., adolescents, older population) and across special population (e.g., women, Indigenous peoples, and LGBTQ+).

Table 2: Key Domains of Clinical Content in Addiction Psychiatry Curriculum, adapted from (Crockford *et al.*, 2015)

Key Content	**Example**
Substance Effects	Proficient knowledge of the mechanism of action for the primary substances encountered in clinical practice as a foundation for understanding how addiction develops and how different intoxication and withdrawal syndromes occur.
Biopsychosocial-spiritual Formulation	Working knowledge of how the biopsychosocial spiritual risk factors may contribute to the initial and protracted use of addictive substances and behaviours, as well as protective factors.
Addiction Epidemiology	Working knowledge of the prevalence of each of the substance-related and addictive disorders in the population, as well as age, sex, location, and ethnic differences.
Assessment and Diagnosis	Proficient knowledge and skills in the identification of substance-related and addictive disorders.
Stage of Change and Treatment Planning	Proficient knowledge of the different stages of change reflective of the transtheoretical model, how it is assessed, and how it can evolve.
Community Resources	Working knowledge of mutual help resources and how to facilitate involvement in such resources in the community.
Role of Family and/or Community	Working knowledge and skills to recognize the impact of substance-related and addictive disorders on the addicted person's family and community, and how to support them.
Attitudes	Personal awareness of potential biases held towards patients with substance-related and addictive disorders.