

Stancliff Declaration

Exhibit C



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Addiction Medicine: Closing the Gap between Science and Practice

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Chapter IX

The Education, Training and Accountability Gap

Compounding the profound gap between the need for prevention, intervention, treatment and disease management for addiction and the receipt of such care is the enormous deficit of trained providers; there is a wide gulf between existing knowledge about addiction and its prevention and treatment and the education and training received by those who provide or should provide care. In spite of the evidence that risky use of addictive substances is a public health problem and addiction is a disease:

- Most health professionals* are not sufficiently trained to educate patients about risky use and addiction, conduct screening and interventions for risky use or diagnose and treat addiction;
- Most of those who currently are providing addiction treatment are not medical professionals and are not equipped with the knowledge, skills or credentials necessary to prove the full range of evidence-based services to address addiction effectively;† 1 and

* The term “health professional” as used in this report includes medical professionals (physicians, physician assistants, nurses and nurse practitioners, dentists, pharmacists) and graduate-level clinical mental health professionals (psychologists, social workers, counselors). All health professionals can be trained to educate patients about risky use and addiction and screen for these conditions; brief interventions also can be conducted by appropriately trained health professionals. Diagnosis and treatment requires a trained physician with the exception of psychosocial treatments which can be provided by trained graduate-level clinical mental health professionals working with a managing physician.

† The National Quality Forum (2005) defines evidence-based addiction care to include: screening, brief interventions, treatment planning, psychosocial interventions, pharmaceutical therapy, retention strategies and chronic care management. Effective implementation requires particular skills and training.

- Addiction treatment facilities and programs are not adequately regulated or held accountable for providing treatment consistent with medical standards and proven treatment practices.²

Further complicating the education, training and accountability gap in addiction treatment is the fact that there are no national standards; instead, there is considerable inconsistency among states in the regulation of individual treatment providers and of the programs and facilities that provide addiction treatment services.*

For just about all known diseases other than addiction, treatment is provided within a highly-regulated health care system. In contrast, patients with the disease of addiction are referred to a broad range of providers largely exempt from medical training and standards (for many of whom the main qualification may be that they themselves have a history of addiction) who work within a fragmented system of care with inconsistent regulatory oversight.

The Size and Shape of the Addiction Treatment Workforce

Given the extensive prevalence of addiction in the U.S. and the frequently extensive treatment needs of individuals with addiction, there is a significant shortage of qualified addiction treatment providers.³ According to data collected from 1996 to 1997, there are 134,000 full-time staff and 201,000 total staff (including part-time and contract staff) working in addiction treatment.[†] Only a small proportion of these workers, however, have medical training.⁴

* With the notable exception of the regulation of medication-assisted therapy for addiction involving opioids.

† This estimate includes physicians, registered nurses, other medical personnel, doctoral level counselors, master's level counselors, counselors with other degrees, non-degreeed counselors and other staff. Data on the numbers of professionals who *currently* are providing some type of addiction treatment are not available.

Trained medical professionals and other graduate-level health professionals are less likely than other types of providers to work full-time in addiction treatment; rather, staff members with higher levels of education are more likely to be hired on a contract/part-time basis.⁵ A nationally representative survey of addiction treatment facilities found that one-quarter of the program directors were not full-time employees; only two of the programs surveyed were directed by a physician; 54 percent employed a part-time physician; less than 15 percent employed a nurse; and psychologists and social workers rarely were on staff.⁶ An older study[‡] found that medical professionals and graduate-level counselors each made up only about 17 percent of the full-time staff of addiction treatment facilities and that only 12.8 percent of facilities had a physician on staff full time.^{§7} Another study found that more than a third of clinical supervisors lack any type of graduate degree.⁸

Unlike patient care in the mainstream medical system, which is delivered by highly educated and trained professionals, the staff primarily responsible for patient care in addiction treatment facilities is comprised largely of addiction counselors, many of whom while highly dedicated to addiction care have only a bachelor's degree or, in some cases, no post-high school education.⁹ The Bureau of Labor Statistics reports that there were 76,600 addiction counselors in 2011.^{**10} One study found that 50 percent of facilities have full-time counselors on staff who have no degree; 58.5 percent have a bachelor's level counselor, 61.9 percent have a master's level counselor and 12.0 percent have a doctorate level counselor.¹¹

‡ Data are from 1996/1997.

§ 25.8 percent had a full-time registered nurse and 17.5 percent had other full-time medical staff.

** Addiction counselors are those who "counsel and advise individuals with alcohol, tobacco, drug or other problems such as gambling and eating disorders. May counsel individuals, families or groups or engage in prevention programs." This estimate excludes social workers, psychologists and mental health counselors who provide these services.

Even among physicians, who constitute the group most qualified to treat patients with the medical disease of addiction, required training in addiction is minimal.¹² And there is a severe shortage of physicians with expertise in addiction treatment via the medical specialty fields of addiction medicine and addiction psychiatry.¹³

The American Medical Association (AMA) estimates that of the 985,375 active physicians, there are only 582 addiction physician specialists: 227 addiction medicine physicians and 355 addiction psychiatrists --the two medical sub-specialties specifically trained in addiction science and its treatment--totaling 6/100ths of one percent of all active physicians.¹⁴ However, according to the American Board of Addiction Medicine (ABAM), these estimates are low since they come from a voluntary, self-report survey in which physicians who choose to respond are asked to indicate their specialty and typically mark the field of their primary board certification rather than their subspecialty.¹⁵

Although there are no recent data identifying the actual number of practicing specialists in addiction medicine or addiction psychiatry, ABAM has certified 2,584 addiction medicine specialists and estimates that the number of *full-time practicing* addiction medicine specialists may be about five times the amount of the AMA estimate--approximately 1,200.[†]¹⁶ This estimate still falls far short of the estimated minimum of 6,000 full-time addiction medicine specialists currently needed to meet addiction treatment demands.¹⁷ Even this projection of workforce need in addiction medicine may underestimate the need in several ways: (1) it does not include adolescents; (2) it does not include addiction involving nicotine;[‡] (3) it does not include institutionalized individuals; (4) it assumes that only those who meet clinical criteria for

* Based on data from 2010.

† Data on the number of practicing addiction medicine specialists who are involved directly in patient care are not available.

‡ Unless addressed in the context of addiction involving alcohol or other drugs.

substance dependence as distinguished from *substance abuse* require any form of specialty care; and (5) it is based on data that are six years old.¹⁸ Adjusting ABAM's estimate to address these gaps could increase substantially the number of addiction medicine specialists required to provide needed care.

Likewise, due to the limitations of the AMA survey and the absence of other data, it is impossible to know how many of the 1,137 physicians who are board certified in addiction psychiatry as of 2011¹⁹ currently are practicing in that subspecialty or how much overlap there is with the number of physicians certified in addiction medicine.

Licensing and Credentialing Requirements for Individuals who Provide Addiction Treatment[§]

To help assure adherence to minimum standards in the delivery of medical care, the licensing and credentialing requirements of individuals who may provide such care are clearly delineated and regulated. For physicians, these include extensive graduate-level classroom-based and clinically-supervised training, a focus on

[§] The information provided in this section is based on an extensive review of publicly available documents conducted by CASA Columbia in 2010. This entailed online reviews and updates (using the Internet and the Lexis/Nexis database) of publicly-available federal and state laws and regulations (in all 50 states and the District of Columbia) and of professional association Web sites. CASA Columbia's analysis examined the minimum licensing and certification requirements to practice in each profession in the 50 states and the District of Columbia, and optional certifications. The analysis sought to develop a summary overview of the regulatory landscape. However, because licensing and certification requirements are found in a wide variety of laws and regulations and can change on a state by state basis, and may have changed in certain states since the time of the review, findings from this review cannot be guaranteed to be complete and current. Unless cited to another source, the findings presented regarding licensing and certification requirements are derived from this review. See Appendix A for a description of the methodology.

standards of medical practice²⁰ and the adoption of evidence-based practices for those who wish to become board certified.²¹ In contrast, there are no clearly delineated, consistent and regulated national standards that stipulate who may provide addiction treatment in the United States; instead, standards vary by payer and by state.

In 2010, CASA Columbia examined the addiction-related licensing and certification requirements of individuals who most typically are the providers of addiction treatment and related services in the United States. These include medical professionals such as physicians, physician assistants, nurses and nurse practitioners; mental health professionals such as psychologists, social workers and counselors/therapists; acupuncturists; and addiction counselors. Licensure is a mandatory process required by state law; licensing standards are designed to ensure minimum competency required to practice one's profession and protect public health, safety and welfare. Certification is a voluntary process administered by non-governmental organizations, typically professional associations.²² Certification demonstrates additional expertise within a specific area of one's profession (i.e., a specialty).²³

Of all these groups, addiction counselors provide the majority of addiction treatment in the U.S.²⁴ Indeed the only category of providers specifically required to be licensed to provide addiction treatment in most states is addiction counselors. Yet the requirements in some states for becoming an addiction counselor include only a high school diploma and some practical training--typically involving a focus on the 12-step model.²⁵ Training approximates an apprenticeship model which may fail to promote systematic adoption of evidence-based practices.²⁶ Historically, personal experience with addiction (i.e., being "in recovery") was the primary qualification necessary to become an addiction counselor.²⁷

Unlike providers of medical care who are trained in evidence-based medical practices, few among the broad range of providers who may treat

patients with addiction are trained in or knowledgeable about evidence-based practices in addiction prevention and treatment.²⁸ While medical professionals and some mental health professionals may have the training and skills needed to implement research-based treatments--and regularly come into contact with patients in the target population of risky substance users and those with addiction--most are unprepared to address these conditions. And while addiction counselors, who constitute the largest proportion of the workforce in specialty treatment facilities,²⁹ specifically address addiction, most lack an education grounded in the science of addiction and are not equipped to deliver evidence-based treatments including appropriate medical care and treatment of co-occurring health conditions.³⁰

Compounding this problem is that the diversity in education and training among the different types of individuals providing addiction treatment results in inconsistent treatment approaches and care for patients with addiction.³¹

Medical Professionals

Medical professionals have been regulated at the state level since Colonial times.³² Rooted in their police powers, states have the authority to prohibit the performance of ineffective and dangerous treatments, to license professionals and to define their scope of practice.³³ For specific licensing standards, states largely defer to professional boards and national organizations that accredit education programs. Medical professionals must complete an accredited professional education program and pass a national licensing exam to become licensed by the state in which they practice their profession. State licensing requirements may include minimum education, training or skills demonstrated by earning a specified degree; time spent in clinical training requirements; and passing a licensing exam.

Because risky use of addictive substances is a public health issue and addiction is a medical condition, medical professionals--particularly physicians--should be on the front lines in

treating patients with these conditions, working with a team of other qualified health professionals. However, separate courses in addiction medicine rarely are taught in medical school³⁴ and there are no addiction medicine residencies among the 9,034 accredited U.S. residency programs currently training 116,404 residents.³⁵ Physicians, therefore, lack the basic education and training in addiction medicine that is needed to understand the science of addiction, translate research evidence into practice, screen for risky use, diagnose and provide treatment for addiction and the broad range of co-occurring health problems, or refer patients to other specialists as needed.³⁶

Physicians. To become a physician, an individual must earn a bachelor's degree, complete four years of medical school to earn an M.D. (allopathic physician) or a D.O. (osteopathic physician) and complete an additional three to seven years of post-graduate training in a medical residency training program (also called graduate medical education).³⁷ To become licensed to practice medicine, physicians must pass a three-step licensing exam; allopathic candidates take the United States Medical Licensing Exam (USMLE).³⁸ The USMLE includes addiction as a *possible* subtopic in each step.*³⁹ Those who choose to practice osteopathic medicine must take the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) administered by the National Board of Osteopathic Medical Examiners (NBOME).⁴⁰ Dimension 1 of the COMLEX exam is devoted to "Patient Presentation" where addiction is listed as a subtopic.†⁴¹ These requirements are set by national accreditation organizations (that accredit schools and residency programs) and professional boards (that provide education and licensing standards) to which states defer when they require professional licensing.⁴²

* Within the content areas "Central and Peripheral Nervous Systems: Abnormal Processes" in Step 1 of the exam, "Mental Disorders" in Step 2 and "Behavioral/Emotional Disorders" in Step 3.

† Within the content areas "Population Health Concepts: Disease Detection and Monitoring" and "Cognition, Behavior, Sensory and Central Nervous Systems, Substance Abuse and Pain."

Although physicians in the United States have extensive competency requirements regarding most illnesses, their level of required competency in addiction medicine is minimal given the prevalence of risky substance use and addiction in most patient populations.⁴³ No reliable national data exist on the proportion of medical school curricula devoted to the topic of addiction. A national survey of residency training program directors in seven medical specialties revealed that 56.3 percent of the programs report having required curriculum content in preventing and treating addiction, but that the median number of curricular hours of training ranges from three (emergency medicine and obstetrics/gynecology) to 12 (family medicine).⁴⁴ While most allopathic medical schools do include some addiction content in required coursework,⁴⁵ research suggests that the average school requires few hours of its four-year curriculum to be devoted to the topic.⁴⁶

Physicians may choose to become board certified in a medical specialty, which demonstrates that they have the knowledge, skills and experience to treat patients within that specialty.⁴⁷ The American Board of Medical Specialties (ABMS) has adopted a Maintenance of Certification (MOC) program for all specialties in which physicians must stay abreast of the latest advances in their specialty and demonstrate use of best practices.⁴⁸

CASA Columbia reviewed the board certification exam requirements of the six medical specialties that interact most often and regularly with patients who engage in risky substance use or have addiction to determine their addiction-related content:

- *Internal Medicine*--two percent of the general board exam.⁴⁹ In addition, substance use/addiction is listed as *possible* subtopics in the geriatric medicine^{* 50} and infectious disease⁵¹ subspecialty exams; however, the exact proportions are not specified.
- *Pediatrics*--1.5 percent of the general exam,⁵² five percent of the adolescent medicine exam⁵³ and two percent of the developmental-behavioral pediatrics subspecialty exam.⁵⁴ Substance-related topics also are listed in the pediatric emergency medicine, child abuse pediatrics, and neonatal-perinatal medicine subspecialty exams; however, the exact proportion is not specified.⁵⁵
- *Family Medicine*--no specification in the general board exam,⁵⁶ but the pharmacology of and testing for the use of addictive substances is included as a *possible* subtopic in the optional sports medicine subspecialty certification exam.⁵⁷
- *Psychiatry*--included as subtopics in the general board exam, but the proportion of the total content is not specified.⁵⁸ Also one-half percent of the forensic psychiatry and six percent of the psychosomatic medicine subspecialty exams are devoted to substance use/addiction.⁵⁹ Substance use/addiction also is listed as a subtopic in

the child and adolescent psychiatry, geriatric psychiatry and pain medicine subspecialty exams.⁶⁰

- *Emergency Medicine*--included as a subtopic in the qualifying examination, although the exact proportion and content are unspecified.⁶¹
- *Obstetrics/Gynecology*--included in a subtopic of the general written board certification exam, although the exact proportion is unspecified. Substance use/addiction assessment and counseling are listed as one of 40 patient cases that *may* be covered in the oral exam.⁶² The subspecialty of maternal-fetal medicine explicitly lists substance use/addiction as a competency for the certification exam, but the exact proportion and content are unspecified.⁶³

There are two areas of specialty medical practice in addiction: addiction medicine and addiction psychiatry.

Addiction Medicine. The American Board of Addiction Medicine (ABAM) offers a voluntary certification in addiction medicine to physicians across a range of medical specialties.⁶⁴ The role of the addiction medicine physician, as a member of an interdisciplinary team of health professionals, includes examining patients to establish the presence or absence of a diagnosis of addiction; assessing associated health conditions that are brought on or exacerbated by the use of addictive substances; participating in the development and management of an integrated treatment plan; prescribing and monitoring patients' use of addiction treatment medications and therapies; providing direct treatment and disease management for individuals with severe cases of addiction and providing consultation to other primary and specialty care providers.⁶⁵ To become certified in addiction medicine, applicants must meet specific educational and clinical requirements including:

* Subspecialty certifications in the same area may be offered by more than one medical board. For example, the geriatric medicine subspecialty certification administered by the American Board of Internal Medicine also can be obtained by physicians specializing in family medicine; the adolescent medicine certification administered by the American Board of Pediatrics also can be obtained by physicians specializing in internal medicine and family medicine; the pediatric emergency medicine exam administered by the American Board of Pediatrics also can be obtained by physicians specializing in emergency medicine; and the sports medicine subspecialty certification administered by the American Board of Family Medicine also can be obtained by physicians specializing in internal medicine, pediatrics and emergency medicine.