Canadian Centre on Substance Use and Addiction
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Family & Community Medicine UNIVERSITY OF TORONTO
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Summit on Family Medicine's Role in Improving Health Outcomes for People Who Use Substances: Meeting Report

Overview

- Family physicians play a critical role in substance use health, but various factors, such as policies, renumeration, training and stigma have limited the uptake of substance use health treatment, including harm reduction, in primary care settings.
- The Canadian Centre on Substance Use and Addiction (CCSA) partnered with the University of Toronto Department of Family and Community Medicine's Division of Mental Health and Addictions (DFCM DMHA) to host a summit on the role of family physicians in improving health outcomes for people who use substances.
- The summit brought together 50 participants from across Canada, representing family physicians, people with lived and living experience, and others.
- Summit panellists presented evidence of the great potential for enhancing the role of family physicians in substance use health if policies that facilitate involvement and adequate educational supports are in place.
- Panellists with lived and living experience shared the importance of reducing stigma through the use of language and the key role physicians can have in reducing the harm stigmatizing language causes people who use substances.
- The summit resulted in 30 calls to action to be implemented across various sectors, including governments, medical schools, the College of Family Physicians of Canada and non-governmental organizations.
- As a followup to the summit, DFCM DMHA identified six calls to actions of priority that the department is working toward achieving. Further, CCSA held consultations with primary care providers to explore remuneration methods, challenges and opportunities to better support substance use health care.
- CCSA will survey summit participants to identify priority areas for collective action on the 30 calls.

Background

Family physicians are often the first point of contact for those seeking care and frequently develop trusted relationships with patients. Research has demonstrated the effectiveness of integrating substance use care into primary healthcare settings (Angus et al., 2014; Cope et al., 2022; Purshouse et al., 2013). Despite this, the provision of substance use health treatment and harm reduction by family physicians can be difficult for numerous reasons, including the complexity of substance use health issues and comorbidities (Khan, 2017; Wu et al., 2018). Effective implementation of new practices in health care requires addressing broader structural factors (e.g., renumeration, educational systems) and physician-specific factors that affect the use of evidence-based practices (Aarons et al., 2011; Guerrero et al. 2020).

On March 28, 2023, the Canadian Centre on Substance Use and Addiction (CCSA) and the University of Toronto Department of Family and Community Medicine's Division of Mental Health and Addictions hosted a full-day summit on the role of family medicine in improving health outcomes for people who use substances.

Meeting Context

The summit brought together 50 participants from across Canada, representing family physicians, people with lived and living experience (PLLE), and other groups. The gathering was the first of several planned events in CCSA's Strategies to End the Substance Use Crises series. There were panel discussions that featured perspectives from family physicians and PLLE on the state of substance use and addiction care in family medicine, as well as research on substance use and addiction in primary care.

Panel: A Look at Both Sides of Life in the Clinic

The day's first panel featured perspectives from family doctors and PLLE on the state of substance use and addiction care in family medicine.

Dr. Braden O'Neill shared his experience treating patients with substance use disorders as a practising family physician in Toronto. He discussed how stigma affects treatment for people with substance use disorders in family care and recommended four actions for family physicians to improve support:

1. Ask patients about substance use,
2. Prescribe naltrexone for alcohol use disorder,
3. Diagnose and treat co-occurring mental illnesses, and
4. Renew opioid agonist treatments started by other doctors.

Sylv Newhook and Fergus Watt of the Substance User Network of the Atlantic Region shared their lived-experience perspectives. Sylv Newhook spoke of the importance of reducing stigma, stressing that even small changes in language can have significant effects. Fergus

Watt called for doctors to advocate for an end on the war on drugs and the harm it causes people who use substances.

Dr. Francois de Wet shared his experience as Nunavut's chief of staff. He outlined the barriers to providing effective substance use and addiction care in the territory, including the complex needs in the population and the transient nature of many healthcare workers.

Panel: Recent Research from the University of Toronto

In the second set of panel discussions, three researchers presented recent findings from the University of Toronto about substance use and addiction in primary care.

Dr. Sheryl Spithoff discussed her team's findings that family doctors are less likely to offer appointments to people with opioid use disorder than to those with diabetes, suggesting family doctors' discretion is a key barrier to care.

Dr. Abhimanyu Sud spoke of his work examining how drug branding affects health care, focusing on a widely promoted Suboxone-branded (buprenorphine and naloxone) training and education program for physicians.

Dr. Kimberly Lazare shared research looking at the experiences of family medicine residents providing mental health care and their perceptions of gaps in training during their residencies.

Defining What Helps and What Hinders

Before developing calls to action, summit participants identified factors that currently or could support family physicians' capacity to treat and support people who use substances (helps) as well as barriers to effective treatment (hindrances) (see Table 1). Participants then developed and shared potential calls to action and their target audiences for improving family physicians' capacity to offer effective, evidence-based substance use and addiction care.

Identifying Opportunities for Action

Using the helps and hindrances table as a guide, participants then worked in small groups to identify specific actions that would enable family physicians to better support people who use substances. Participants also identified the organization or body that would be responsible for implementing each recommended action. This resulted in a list of 30 possible actions for federal, provincial and territorial governments; the College of Family Physicians of Canada, the Canadian Society of Addiction Medicine and CCSA.

Table 1: Helps and hindrances to family physicians' capacity to treat and support people who use substances

Theme	Helps	Hindrances
Education, training and mentorship	Promotion of family physician training opportunities (e.g., model in emergency medicine where eight weeks of training is covered by the provincial ministry of health) Substance use training for emergency department physicians and staff, who are often the first point of access and can screen for referrals Training for Indigenous physicians, nurses and allied health professionals Mentorships for new family physicians by experienced family physicians, offering opportunities to demonstrate passion in this space (e.g., Atlantic Mentorship Network - Pain & Addiction offers monthly online lectures, group-based learning and access to mentors for case-based learning) Early education and competency training in medical schools for substance use and addiction	Nothing identified
Team-based care and family physicians' access to specialists and supports	Team-based environments and the Family Health Team Model On-demand access to addiction medicine expertise and advice about different treatment options for patients Communities of practice for family physicians in addictions	Lack of co-ordination of community-based care

continued

Table 1. Continued

Theme	Helps	Hindrances
Service delivery and system considerations	Consistent, longitudinal care in communities Access to rapid access addiction medicine (RAAM) or a rapid access addiction clinic (RAAC) Co-ordinated intake and resource curation (e.g., Ottawa Public Health's Mental Health and Substance Use Resource List) New substance use programs based on existing models, such as those used for nicotine replacement therapy	Time constraints and capacity issues (e.g., a lack of family physicians, specialized medical professionals, nurses, personal support workers and social workers — shortages that directly affect family medicine and integrated care) Long waitlists that prevent family physicians from meeting people when they want support Lack of support for trauma-informed care and recognition of histories of abuse, which are common among people with substance use disorders Scarcity of primary care providers and mental health services in some areas, especially rural Impacts on rural communities of provincial and territorial requirements for methadone prescribing Lack of medicalization of substance use disorders One-size-fits-all treatment models (e.g., mandating involvement in 12-step programs) Lack of social supports and wraparound services Growing complexity of medical and social issues to be managed in primary care

continued

Table 1. Continued

Theme	Helps	Hindrances
People with lived and living experience (PLLE), stigma and discrimination	Medical students' and residents' exposure to people in recovery, people who use drugs and healthy ways of reducing harm Treatment of PLLE as equal partners in healthcare spaces, including access to the same training and support as others on the team Improvements to cultural interpretation in primary care and emergency departments based on input from PLLE Co-design with family doctors and PLLE Normalization of discussions about substance use and addiction Conversations among healthcare teams about non-stigmatizing language (e.g., related to prescribing opioids, nicotine replacement therapy)	Breakdown of relationships with patients during their treatment journey Lack of understanding among government officials (e.g., politicians) of the evidence and complexity that surrounds substance use Stigma in healthcare systems and the general population Stigma around youth who use drugs (e.g., conversations about youth who use drugs tend to focus on prevention)
Policy and legislation	Study of effective models from around the world (e.g., drug decriminalization in Portugal) Decriminalization of safe supply, helping maintain relationships with patients because they don't feel criminalized when they walk in the door Support of progressive social policies for housing, food security, income security, etc., and funding for cultural safety, anti-stigma and anti-oppression training for family physician learners and practitioners	Government policies that prevent evidence-based practices (e.g., limitations on the opening of safe consumption services or the public funding of specific medications or programs) Ongoing debate about harm reduction versus abstinence Overfocus of some governments on safe supply as a primary solution Criminalization of drugs Regulations around virtual care and cross-jurisdictional licensing

continued

Table 1. Continued

Theme	Helps	Hindrances
Remuneration and funding	Alternative payment models to facilitate team-based care	Inappropriate remuneration models for family medicine, which disincentivizes family physicians to provide care for patients who use drugs Time-limited funding for new programs for substance use and addiction Undervaluing of family care and by extension family medicine, financially and with respect to expertise Insufficient funding for peer support

Calls to Action for the Federal Government

1. Consider effective accountability mechanisms for funding (e.g., percentage of healthcare workforce trained in substance use care, timeliness of access).
2. Fund national mentorships and paid experiential learning opportunities.
3. Create a national think tank to explore innovative solutions to primary care–based delivery of substance use care.

Justice

4. Provide better support for people with substance use challenges in the federal justice system. This should include timely access to evidence-based care while in the system (e.g., opioid agonist therapy and naloxone) and connections to services and supports when transitioning into and out of correctional settings.
5. Decriminalize the possession and use of substances.

Calls to Action for Provincial and Territorial Governments

Ministries of Health

6. Fund multidisciplinary health teams that include peer support, navigators and addiction medicine consultants.
7. Introducing low-barrier rapid access (e.g., rapid access addiction medicine [RRAM]or rapid access addictions clinic [RAAC]) if not already available.
8. Where applicable, eliminate access bonus exclusion for family physicians in team-based payment models to ensure their patients have barrier-free access to addictions care from other doctors.
9. Implement shared care for substance use with access to addiction medicine expertise.

10. Increase funding for family medicine and introduce funding models that better suit this speciality. Build on existing evaluations of these funding models (Childerhose et al., 2019) to determine whether they can be rolled out further.
11. Shift primary care compensation away from the number of people treated. Otherwise, there's pressure to push people through the system when substance use disorders take time to treat.
12. Expand the concept of the Patient's Medical Home to include medical charts, which would help reduce uncertainty and delays for people transitioning between health systems (e.g., those moving into a federal correctional facility).
13. Act on the recommendations contained in existing reports that have been informed by consultations with clinicians, academics, and PLLE.

Summit Impact

In response to learning that physician remuneration was identified as a priority, CCSA led 13 consultations in fall 2023 with primary care providers, including family physicians and nurse practitioners who provide substance use care from across Canada. The consultations explored remuneration methods and challenges, and identified opportunities for improvement. Findings will be summarized to inform policy and decision makers about compensation frameworks in primary care settings.

Ministries of Child and Family Services

14. Ensure sufficient education for support workers to promote evidence-informed substance use care.
15. Provide educational opportunities on substance use for PLLE, their families and friends.

Calls to Actions for the College of Family Physicians of Canada

16. Advocate for the development and use of substance use competencies among interprofessional bodies at the national, provincial and territorial levels.

Calls to Actions for Faculties of Medicine

17. Engage PLLE to inform curriculum development by faculties of medicine and nursing.
18. Encourage, if not mandate, substance use education as a component of nursing and medicine undergraduate programs.
19. Encourage substance use education during postgraduate training, including exposing students to people experiencing substance use challenges and people in recovery
20. Compile and maintain a list of substance use electives and training opportunities.

Summit Impact

Since the summit, DFCM DMHA has been working in the following areas:

- Updating postgraduate family medicine competencies in mental health and addiction at the University of Toronto in collaboration with diverse subject matter experts including PLLE.
- Doing research to understand ideal models of care for clients and for providers from the perspective of family physicians trained in addiction medicine.

Among the calls to action identified, DFCM DMHA has identified the following as priorities:

- Funding national mentorships and paid experiential learning opportunities.
- Funding its multidisciplinary health teams that include peer support, navigators and addiction medicine consultants.
- Promoting the development and use of substance use competencies among interprofessional bodies at the national and provincial levels.
- Engaging will PLLE to inform curriculum development by its faculties of medicine and nursing.
- Encouraging substance use education during postgraduate training, including exposing students to people experiencing substance use challenges and people in recovery.
- Establishing quality standards for substance use care in its family medicine.

Calls to Actions for Public Educators and Non-governmental Organizations (e.g., CCSA, Canadian Mental Health Association, Canadian Society of Addiction Medicine)

21. Use CCSA's Competencies for Canada's Substance Use Workforce as valuable tools and resources to support the implementation of actions focused on enhancing training and education for providers.
22. Take a multipronged approach to destigmatizing substance use and addiction. Initiatives focused on the public and system levels are needed.
23. Recognize the importance of decriminalizing substance use to increasing the participation of PLLE — who are as much if not more so experts than physicians — on these issues.
24. Advocate for funding for training and substance use care outside of formal residency programs.
25. Elevate the knowledge of PLLE at the policy level beyond the four-year political cycle.
26. Advocate for the federal government to provide long-term funding for effective substance use programs at the provincial level.
27. Establish a mechanism for sharing successful models of care and outcomes to avoid duplicating effort.

28. Establish quality standards for substance use care in family medicine.
29. Serve in a co-ordinator or convener capacity across educational programs and jurisdictions.
30. Establish an effective avenue for knowledge mobilization from experts to government decision makers.

Summit Impact

CCSA is working in collaboration with people with lived and living experience (PLLE), including family and friends across Canada to develop structures, tools, training and policies to ensure meaningful engagement. As a result of the summit and ongoing consultation with PLLE, CCSA is committed to expanding and diversifying its network of family members and friends who contribute to CCSA's work.

Conclusion

The summit resulted in 30 concrete calls to action on how family medicine and supporting sectors can improve health outcomes for people who use substances. To successfully implement the calls to action, governments, academic institutions, the College of Family Physicians of Canada and non-governmental organizations, including CCSA, must all take on a role in facilitating change in family medicine. Summit participants identified many opportunities for family physicians to take a greater leadership role in substance use health. As a follow up to the summit, CCSA will survey participants to identify priorities areas of focus for collective action on the 30 calls to action. Despite the complexity of the issue, the summit highlighted many achievable solutions that, if implemented, would enhance the involvement of family physicians in substance use health.

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About CCSA

CCSA was created by Parliament to provide national leadership to address substance use in Canada. A trusted counsel, we provide national guidance to decision makers by harnessing the power of research, curating knowledge and bringing together diverse perspectives.

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