

## Priority Topics and Key Features for the Assessment of Competence in Addiction Medicine

This collection of priority topics and key features for assessment was developed by the College of Family Physicians of Canada (CFPC) Working Group on the Assessment of Competence in Addiction Medicine, from 2016 to 2018. It outlines what to assess to determine competence at the enhanced skills level, following the CFPC's traditional approach of developing priority topics, procedures, and their key features.

The goal of these priority topics and key features is to guide the assessment of competencies required for awarding Certificates of Added Competence (CAC), both for residents in enhanced skills programs and for practice-eligible candidates, and to inform the curriculum and training development.

When using this document, it is critical to remember that the priority topics and key features listed are not meant to be an exhaustive scope of practice in addiction medicine, nor do they represent a checklist for the determination of competence. They represent a guide to focus the sampling of performance. When trainees consistently demonstrate most of the key features across a good sample of the priority topics, it can be inferred that they have acquired competence in addiction medicine.

It is also important to bear in mind that, because there is a great overlap between crucial competencies that are required for different priority topics, the tendency was to avoid repetition and list key features selectively.

Successful candidates for a Certificate of Added Competence in Addiction Medicine are expected to have demonstrated core competence in family medicine, including the [Six Essential Skills](#) and [Procedures](#).

The order of the appearance of the priority topics listed reflects a logical sequence in which they would be dealt with in a clinical environment.

The term "addiction" in this document refers to both substance use disorders and behavioural or process addictions.

Finally, this is a living document that will be regularly revisited and updated to ensure its relevance.

### How the priority topics and key features were developed

The Working Group on the Assessment of Competence in Addiction Medicine (seven members) acted as the nominal group, generating an initial list of priority topics through an individual survey, which was followed by group discussion and consensus. A survey to a larger group of family practitioners (227 recipients; 34 per cent response rate), representative of physicians from across the country, generated another independent list. The lists of priority topics generated by the nominal group and the larger reference group were very similar, both in the topics named and the priorities assigned, with a strong positive correlation of 0.68.

Key features were developed and finalized for all topics using the nominal group technique, which included four iterations of individual comments, multiple discussions, and consensus building. Through this iterative process a final list of 13 priority topics was identified. Deliberate attention was made not to duplicate priority topics already included in the Evaluation Objectives for Family Medicine unless a specific focus to addiction medicine was identified.

## How to use the priority topics and key features

It is important to note that materials in this booklet are intentionally selective and not comprehensive. It is most desirable and useful to assess what will best discriminate between competent and less competent individuals. Priority topics do not represent an extensive list of topics that should be covered in training, but rather a selective list of areas for assessment that can help teachers/assessors to infer overall competence in addiction medicine. Key features represent the critical or essential steps in the resolution of a clinical situation or problem, so the achievement of underlying competencies can be inferred. All key features refer to observable actions, not knowledge. They do not cover all necessary steps (e.g., history, physical examination, diagnosis, management), but only those that are critical and most likely to be missed.

As such, the priority topics and their key features are not meant to be used in a checklist approach when assessing competence. They are best used for guiding assessment efforts (e.g., sampling, observation, reflection) over time to build a case for overall competence or the lack thereof. They may also be useful in the following situations:

For trainees:

- Use as a guide for self-reflection on competence and development of a learning plan, particularly prior to and during clinical experiences
- Use as a guide for soliciting feedback from preceptors/assessors

For preceptors/assessors:

- Compare and contrast materials in this document with your assessment strategies and adjust as necessary
- Use as a guide for assessing your trainees, including soliciting feedback, developing questions to ask trainees, and completing field notes
- Use as a guide to help develop learning plans for your trainees
- Use as a self reflection guide to assess your teaching

For programs:

- Use as assessment standards when making decisions about residents' successful completion of training
- Use as a guide to develop assessment strategies
- Use as a guide to plan curriculum that can adequately expose trainees to the priority topics and procedures

## **ADDICTION MEDICINE**

Priority Topics for the Assessment of Competence: Addiction Medicine Key Features

April 2018

### **Working Group on the Assessment of Competence in Addiction Medicine**

Peter Butt, CCFP (EM), FCFP

John Fraser, CCFP, FCFP

Lisa Lefebvre, CCFP, FCFP

Ron Lim, CCFP

Stéphanie Marsan, CCFP

Launette Rieb, CCFP, FCFP

Mat Rose, CCFP

### **College of Family of Physicians of Canada Staff**

Sid Feldman, CCFP (COE), FCFP - Clinician educator

Roy Wyman, CCFP, FCFP - Director, Certificates of Added Competence

Tatjana Lozanovska - Manager, Assessment Design, Development and Production

Nadia Mangal, MPA - Project Coordinator, Certification and Assessment

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Priority Topics for the Assessment of Competence: Addiction Medicine Key Features

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## Priority Topics

1. Clinical boundaries
2. Addiction medicine screening, assessment, and triage
3. Treatment planning and continuing care
4. Management of intoxication and withdrawal
5. Harm reduction within the continuum of care
6. Pharmacotherapy
7. Psychotherapeutic techniques
8. Concurrent mental health disorders
9. Medical comorbidities
10. Pain and addiction
11. Special populations
12. Advocacy
13. Provider health and resilience

## Priority Topic 1: Clinical boundaries

1. When caring for patients with addiction, organize your practice to facilitate best care and optimize safety (e.g., flexibility in scheduling, office policies, office layout, adequate time, team approach).
2. When caring for a patient with addiction, who is demonstrating poor boundaries with you or one of the team members:
  - a) Explain acceptable and unacceptable behaviour(s) and potential consequences
  - b) Consistently maintain your own professional and personal boundaries, as intense interactions are common
  - c) Document incidents, and discuss and develop a plan with team members
3. When a patient with addiction is requesting medications that have misuse potential, corroborate the patient's history with objective information (e.g., physical findings, urine drug screening, medication registry)
4. When there is a discrepancy between the patient's expectations and best practices:
  - a) Set expectations based on logical reasoning (not emotional response), clinical practice guidelines, and patient-specific factors
  - b) Set clear boundaries, but stay flexible in order to negotiate a common ground
  - c) Communicate in a transparent, honest, and non-judgmental way, and document clearly the discussion and plan
5. When emotionally triggered by a challenging interaction (e.g., after being manipulated by a patient):
  - a) Use self-reflection to identify and explore personal responses
  - b) Manage personal responses appropriately, including asking for help
  - c) Develop strategies to prevent emotional responses from interfering with clinical care
6. When confronted by an aggressive patient:
  - a) Evaluate the nature and level of threat and match the response accordingly
  - b) Defuse aggression (e.g., use non-violent intervention)
  - c) Ensure safety of the patient, yourself, coworkers, and others
  - d) Debrief and review clinic protocols
7. When a patient initiates a sexualized interaction:
  - a) Recognize early signs and respond in a therapeutic way (e.g., maintain professional boundaries, clearly address the behaviour with the patient)
  - b) Reflect on your role, feelings, and personal risk factors involved
  - c) Manage your role accordingly, including asking for help when needed

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8. When the physician-patient relationship is compromised:
  - a) Negotiate and document the terms of re-engagement
  - b) Recognize when it is irretrievable (e.g., physical/sexual assault, significant threat to you, staff, or your family, litigation)
  - c) Take the necessary steps to end the physician-patient relationship when irretrievable (e.g., discuss with team members, notify the patient in writing, facilitate transfer of care, notify appropriate organizations or authorities)

## Priority Topic 2: Addiction medicine screening, assessment, and triage

1. When assessing a patient with a potential addiction issue in a non-urgent situation:
  - a) Create emotional safety (e.g., verbal and non-verbal communication, non-judgmental and non-threatening interviewing style, safe environment, trauma-informed approach)
  - b) Remain objective, avoiding assumptions and stereotyping
  - c) Establish a therapeutic relationship, maintain healthy skepticism about the information shared, and seek corroborative information
  
2. When collecting clinical information:
  - a) Consider the patient's readiness to respond to specific questions
  - b) Obtain a comprehensive, bio-psycho-social-spiritual history, which must include:
    - Detailed substance use history (e.g., route of administration, quantity, frequency, withdrawal features)
    - Detailed process addiction history, (e.g., gambling, sexually compulsive behaviour, obsessive video gaming)
    - Capability to perform activities of daily living (e.g., personal and family care, finances, medication management)
    - Trauma history and how it can mimic concurrent mental health disorders
    - Recovery capital (i.e., internal and external resources that facilitate recovery)
    - Social determinants of health (e.g., housing, vocation, education, income, access to food, access to harm reduction supplies, communication/language/literacy)
    - Self-identity (e.g., culture, gender, ethnicity) and potential conflicts
    - Spiritual assessment (e.g., explore personal beliefs, sources of meaning and purpose)
  - c) Ensure that the physical exam includes checking for indications and sequelae of drug use
  - d) Use validated screening and assessment tools (e.g., Alcohol Use Disorders Identification Test, Drug Abuse Screening Test, Addiction Severity Index) in context
  - e) Ensure appropriate investigations (e.g., pregnancy test, blood-borne pathogens, urine drug screen) and follow-up
  
3. For a patient with a diagnosed addiction:
  - a) Clearly communicate that addiction is a treatable medical condition
  - b) Identify prevention and harm reduction strategies that might be necessary
  - c) Develop a bio-psycho-social-spiritual treatment plan, with appropriate matching to treatment setting, considering patient goals and the stage of and readiness for change
  - d) Address the patient's need for primary care
  
4. When a patient with addiction presents with a new complaint, keep a broad differential diagnosis (i.e., do not assume that the complaint is due to the addiction)



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5. When assessing a medically or psychiatrically unstable patient with addiction substance use disorder (e.g., intoxication, withdrawal, acute psychosis, suicidal):
  - a) Determine the level of risk of acute and evolving complications
  - b) Triage according to the toxidrome, level of risk, acuity, and available resources
  
6. In a patient presenting with symptoms suggestive of intoxication or withdrawal, identify medical or psychiatric comorbidities/conditions that could:
  - Mimic the symptoms of intoxication or withdrawal (e.g., head trauma, metabolic disorders, and septicemia)
  - Complicate or intensify intoxication/withdrawal syndromes or impact on placement decisions (e.g., pregnancy, suicidal ideation, liver cirrhosis, head injury)
  
7. In a high-risk patient who does not meet criteria for a substance use disorder or process addiction, promote primary and secondary prevention strategies.

## Priority Topic 3: Treatment planning and continuing care

1. When planning treatment for patients with addiction:
  - a) Assess for withdrawal risk and plan treatment accordingly
  - b) Consider all bio-psycho-social-spiritual elements (e.g., patient's needs, values, strengths) and encourage complete wellness. Pharmacotherapy alone is less likely to be effective in the long term.
  - c) Consider confounding factors for treatment (e.g., concurrent disorders; financial, legal, or social barriers)
  - d) Assess the stage of and readiness for change and match it to the treatment plan, (e.g., for the pre-contemplative patient use motivational strategies)
  - e) Use standardized patient placement tools (e.g., American Society of Addiction Medicine criteria)
  - f) Develop a structured but flexible, step-wise treatment plan with the patient
  
2. While providing ongoing care for a patient with addiction:
  - a) Reassess bio-psycho-social-spiritual components as they change over time and modify the treatment plan accordingly
  - b) Reassess the stage of and readiness for change, adjust the treatment accordingly, and encourage the patient to assume responsibility
  - c) Remain vigilant and recognize early signs of impending relapse with stable patients
  - d) Reassess risk of harm to self and others regularly (e.g., impaired driving, suicide, overdose)
  - e) Consider the patient's view of their own disability and coach for optimal function.
  
3. While integrating aspects of the patient's culture, ethnicity, and spirituality into treatment:
  - a) Discuss the potential for including traditional treatments
  - b) Encourage exploring spiritual identity and its role in healing
  - c) Remain sensitive to prior and/or ongoing cultural trauma, critical historical incidents that have impacted the community/ethnic group, and adapt approach accordingly
  - d) Support the patient to recognize and address any related conflicts (e.g., due to stigma)
  
4. When advising a patient with addiction regarding their family and social network:
  - a) Consider both positive and negative impacts of the family and social network on the patient's addiction and on treatment (e.g., recognize healthy and unhealthy relationships, and coach with regards to appropriate boundaries)
  - b) Consider the impact of the patient's addiction on the family and social network (e.g., loss of trust, resource strain, assault, child care) and refer for family/relationship therapy when needed
  
5. When a patient's immediate social sphere (e.g., drug culture, partner, family, friends) poses a risk, or enables the addiction while in treatment or recovery:
  - a) Explore the influence of drug use culture and its influence on the patient
  - b) Encourage the patient to recognize triggers
  - c) Establish management or exit strategies with the patient

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- d) Acknowledge and address their sense of loss from the deliberate disconnect
  - e) Counsel the patient to draw strength and resilience from establishing new spheres of belonging that promote treatment and recovery
6. When using biological testing:
- a) Choose and interpret appropriately, based on the indications and limitations of each test (e.g., awareness of limitations of immunoassay, local laboratory protocols)
  - b) Use strategies to reduce and detect tampering
  - c) Respond to the results in a non-punitive therapeutic manner and adjust the treatment plan accordingly
7. When working with other providers in caring for a patient with addiction:
- a) Share information within limits of confidentiality and ensure a unified approach to care (e.g., address provider splitting)
  - b) Take steps to address any expressed prejudice to reduce stigma

## Priority Topic 4: Management of intoxication and withdrawal

1. For a patient presenting with intoxication or withdrawal:
  - a) Identify the effects of all substances used (e.g., illicit drugs, over-the-counter, complementary and prescription medications), and tailor treatment accordingly
  - b) Identify emergencies (e.g., toxidromes, hepatic encephalopathy, Wernicke's encephalopathy, delirium tremens, drug induced psychosis) and treat appropriately
  - c) Adjust pharmacotherapy and protocols to evolving medical conditions
  - d) Initiate the development of a comprehensive long-term treatment plan
2. For a patient with reduced opioid tolerance (e.g., following detoxification, incarceration, or missed doses):
  - a) Counsel the patient on the risk of potential lethal overdose
  - b) Offer opioid agonist or antagonist therapy, provide harm-reduction advice and resources as appropriate (e.g., a take-home naloxone kit)
3. In a community with a high rate of serious overdose and intoxication, participate in the development of a comprehensive prevention and response system.
4. For a patient withdrawing from gambling or another process addiction, manage the dysphoria and craving using behavioural and pharmacological approaches.

## Priority Topic 5: Harm reduction within the continuum of care

1. For all patients with addiction:
  - a) Incorporate relevant harm-reduction strategies at every point along the continuum of care (e.g., take-home naloxone kit for all opioid users, use of condoms or latex barriers)
  - b) Advocate for appropriate community harm reduction resources (e.g., needle exchange programs, supervised consumption sites, safe-ride programs)
  
2. When using harm reduction strategies for a patient with addiction:
  - a) Regularly assess the impact and efficacy of the harm-reduction strategies implemented and adjust accordingly
  - b) Validate patient successes and encourage life enrichment even if the patient chooses not to engage in treatment
  - c) Regularly revisit treatment goals, stage of and readiness for change, and potential for further recovery (i.e., movement towards optimal health), emphasizing that addiction is a treatable disorder

## Priority Topic 6: Pharmacotherapy

1. Before prescribing any medications for the treatment of addiction, review with the patient the options, risks (e.g., physiological dependency, overdose, metabolic influences), benefits, and limitations of pharmacotherapy (e.g., regulatory restrictions, need for lifestyle adjustment)
2. When starting pharmacotherapy for patients with addiction:
  - a) Integrate non-pharmacological approaches
  - b) Consider drug interactions (including over-the-counter medications and herbal remedies), cost, and access
  - c) Ensure prescriber availability and continuity of care
  - d) Adjust prescribing in the presence of high risk situations (e.g., loss of tolerance, such as release from a correctional facility, hospital, or detox facility)
  - e) Develop a plan for the cessation of pharmacotherapy as indicated
3. When prescribing medications with potential for abuse, monitor regularly including:
  - Ongoing medication and substance use
  - Toxicological testing
  - High-risk situation (e.g., change in physiological status such as postpartum period, medical comorbidities, change in psychosocial stability)
  - Changes in tolerance and risk of overdose
  - Medication adherence, hoarding, and diversion
  - Communication with dispensing pharmacies
4. For a patient receiving take-home doses of medications of potential misuse, recognize and address the risk to the patient (e.g., overdose, coercion, and violence), family, and the community (e.g., diversion).
5. Before initiating a medication taper:
  - a) Assess patient's clinical stability and readiness
  - b) Assess and communicate risk for relapse and overdose
  - c) Negotiate a flexible taper strategy, including a contingency plan
  - d) Integrate adjunctive pharmacological and non-pharmacological approaches

## Priority Topic 7: Psychotherapeutic techniques

1. When considering psychotherapeutic counselling for patients with addiction:
  - a) Establish sufficient rapport, taking into consideration challenges specific to this population (e.g., trust, trauma, personality disorder, concurrent disorders)
  - b) Use a trauma-informed evaluation to determine suitability of the counselling approach
  - c) Match the intervention to the patient's stage of and readiness for change
  
2. When providing psychotherapeutic counselling for patients with addiction:
  - a) Employ a structured yet flexible evidence-based approach (e.g., motivational interviewing, cognitive behavioural therapy, dialectical behavioural therapy)
  - b) Reflect on your limits and the potential harm you can cause by exceeding them, and refer when needed
  - c) Teach patients self-management techniques (e.g., grounding skills)
  - d) Include the concept of life enrichment (e.g., exercise, pro-social interactions, volunteering, hobbies) even for patients who may not be ready for a change regarding their addiction
  - e) Employ strategies to mitigate the risk of escalation, intimidation, or capitulation with aggressive patients
  - f) Explore relapse dynamics—normalize but do not enable

## Priority Topic 8: Concurrent mental health disorders

1. In all patients with addiction:
  - a) Evaluate the bidirectional relationship between addiction and mental health disorders (e.g., cocaine-induced psychosis, anxiety triggering alcohol use)
  - b) Avoid both overdiagnosis and underdiagnosis of concurrent mental health disorders
  - c) Evaluate suicide risk regularly
  
2. When managing patients with mental health disorders and addiction:
  - a) Develop a concurrent treatment plan
  - b) Integrate the use of non-pharmacologic approaches (e.g., psychotherapy, lifestyle management)
  - c) Prescribe psychotropic medications, considering the potential interaction with substances of abuse and of their addictive/abuse potential (e.g., bupropion, quetiapine, gabapentin, z-drugs)



## Priority Topic 9: Medical comorbidities

1. When caring for patients with addiction:
  - a) Adopt practices to reduce fragmentation of care
  - b) Maintain a high level of suspicion for common comorbidities depending on substance (e.g., liver dysfunction with alcohol) and route of administration (e.g., septal perforation with intranasal use, endocarditis with intravenous drug use, blood borne infections with intranasal or intravenous use)
  - c) Assess for medical comorbidities that may impact capacity (e.g., fetal alcohol spectrum disorder, head injury, Korsakoff syndrome) and take appropriate steps
  - d) Educate patients repeatedly about possible risks and comorbidities even when patients are pre-contemplative, as it can reduce harms; do not assume that patients are aware of the impact addiction has on their health
  
2. When developing a treatment plan for a patient with addiction and medical comorbidities:
  - a) Adjust the addiction treatment based on medical comorbidities (e.g., alcohol withdrawal management in a patient with previous myocardial infarction)
  - b) Collaboratively and concurrently address medical comorbidities (e.g., HIV, Hep C, liver disease)

## Priority Topic 10: Pain and addiction

1. When performing an addiction medicine assessment of a patient presenting with pain:
  - a) Determine whether the patient has a substance use disorder, a pain condition, or both
  - b) Determine the relative contribution of all bio-psycho-social-spiritual components
  - c) Determine the appropriateness of their current pharmacotherapy and be specifically mindful of the potential adverse health effects (e.g., multiple sedating medications, drug interaction, escalating doses, diversion)
  
2. In a patient with a substance use disorder presenting with pain:
  - a) Do not assume that this is drug-seeking behaviour (e.g., obtain detailed pain history, perform a thorough physical examination so that significant pathology is not missed)
  - b) Look for medication side effects (e.g., opioid induced hyperalgesia, allodynia, withdrawal-associated injury site pain)
  - c) Look for contributing psychiatric comorbidities (e.g., somatoform disorder, depression)
  
3. When developing a treatment plan for patients with substance use disorder and pain:
  - a) Ensure a concurrent treatment plan exists that addresses the relative contribution of both
  - b) Educate the patient about realistic treatment outcomes
  - c) Support the patient to develop a skill set to address overreliance on medication (e.g., encourage active self-management and non-pharmacological therapies)
  - d) Optimize the use of non-opioid pain medications
  
4. When considering opioid therapy for a patient with pain and substance use disorder:
  - a) Consider a therapeutic trial of a medication that is more appropriate for both chronic pain and addiction (e.g., buprenorphine or methadone for opioid use disorder, non-opioid medications for other substance use disorders); avoid use of multiple opioids
  - b) Ensure appropriate dispensing intervals and amounts that are proportional to the risk identified
  - c) Do not assume that opioid agonist therapy for maintenance will be sufficient for superimposed acute pain
  - d) Ensure acute pain treatment is time limited (i.e., avoid prescribing opioids for longer than the anticipated recovery)
  - e) Use tapering and relapse mitigation strategies when discontinuing a therapeutic trial of opioids

## Priority Topic 11: Special populations

1. When treating a pregnant patient or a new mother with a substance use disorder (SUD):
  - a) Offer pharmacotherapy treatment options that are safe for pregnancy and breastfeeding, including modification of titration and tapering procedures
  - b) Make every effort to support the maternal-baby bond, including keeping mother and child together whenever possible
  - c) Explain to the mother your legal obligations to report to child protection services if the situation requires, and encourage a proactive collaborative approach
  - d) Discuss physical safety, food security, and harm reduction strategies, especially before hospital discharge
  
2. For a newborn of a mother with substance use (e.g., benzodiazepines, opioids):
  - a) Assess repeatedly for neonatal abstinence syndrome
  - b) Interpret validated scale scores (e.g., Finnegan Neonatal Abstinence Scoring System), considering all other comorbidities in the baby that would influence the score
  - c) Use standardized treatment protocols
  
3. When caring for patients with addiction who live with children:
  - a) Familiarize yourself with patient rights and your legal obligations (e.g., reporting, apprehension, urine drug-screening)
  - b) Educate patients on the safe storage of medications, illicit drugs, and drug use paraphernalia
  - c) Educate patients on the risk of poisoning for themselves and their children, and provide mitigation strategies where possible (e.g., naloxone kits)
  
4. When caring for youth:
  - a) Use validated screening tools for youth (e.g., CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) and HEADSSS (Home, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression, and Safety from injury and violence)
  - b) Recognize youth-specific signs and symptoms of addiction (e.g., school absences, declining academic performance)
  - c) Ensure adequate mental health assessment (including learning disorders)
  - d) Screen for adverse childhood events, including child abuse (e.g., sexual, physical, emotional, neglect, economic)
  - e) Facilitate input from supports while considering confidentiality
  - f) Address youth-specific barriers to treatment (e.g., fear of residential treatment programs)
  - g) Provide preventive education and harm-reduction counselling that is youth-sensitive
  - h) Advocate for youth-specific resources for education, prevention, and treatment

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5. When working with incarcerated populations with addiction within their institutional setting or after release:
  - a) Familiarize yourself with inmate culture, including high-risk use behaviours
  - b) Address the risk of relapse, changes in tolerance, and the high risk of overdose at the time of release
  - c) Address the unique circumstances for providing health care in correctional institutions, and transitions to and from the community (e.g., addressing stigma, institutional policies)
  
6. In older adults with addiction:
  - a) Be aware of atypical presentations (e.g., confusion, delirium, falls)
  - b) Review all psychoactive medications and consider de-prescribing when appropriate
  - c) Screen for concurrent disorders and cognitive impairment (e.g., dementia, depression, anxiety, chronic pain)
  - d) Recognize the effects of physiological changes of aging and consider adjusting the type and/or dose of medications (e.g., use lorazepam instead of diazepam in alcohol withdrawal)
  - e) Address older adult-specific barriers to treatment (e.g., patient fears of loss of independence, treatment centres that do not take patients with cognitive impairment)
  - f) Don't make assumptions regarding older adults and addiction (e.g., older adults do not use street drugs or have sexual addiction), and avoid therapeutic nihilism
  
7. When caring for workers with addiction in safety-sensitive occupations:
  - a) Recognize unique occupational needs and risks connected to safety-sensitive positions, including reporting requirements
  - b) Use and interpret biological tests in the context of the specific workplace (e.g., health care workers' access, chain of custody protocol)
  - c) Choose pharmacotherapy based on the occupational context and regulations (e.g., physicians, pilots, mariners, truck drivers)
  - d) Recognize the unique requirements of formal monitoring programs (e.g., occupational health and safety, physician health programs, regulatory authority) and adjust treatment accordingly

## Priority Topic 12: Advocacy

1. When advocating for patients with addiction:
  - a) Address timely access to comprehensive primary care (e.g., medical home) and a full range of services
  - b) Be receptive to advocacy from others
  - c) Remain professional and collegial to reduce stigma
  
2. When advocating for a patient with addiction:
  - a) Collaborate with the patient when planning any advocacy (patient-physician partnership)
  - b) Empower the patient to be their own advocate
  - c) Ensure that patient vulnerability and confidentiality is protected from exploitation
  
3. When advocating on a systems level for a patient population with addictions:
  - a) Address stigma through an evidence-based approach
  - b) Include public health interventions, educational approaches, and preventive components (e.g., within families, schools, health care facilities, communities)
  - c) Provide leadership in developing collaborative, interprofessional programs

## Priority Topic 13: Provider health and resilience

1. When caring for patients with addiction:
  - a) Monitor your own personal and professional limitations and vulnerabilities, and seek help when needed (e.g., physician health program)
  - b) Proactively develop an action plan to prevent burnout and mitigate the effects of vicarious trauma (e.g., self-care activities like mindfulness and exercise, workload management, peer support, crisis planning)
  - c) Embed ongoing self-reflective practice, and identify ways to build resilience individually and in the team
  
2. When collaborating with other practitioners in providing health care to challenging patients with addiction:
  - a) Recognize the value of a positive personal peer support network
  - b) Seek and accept constructive feedback and support
  - c) Recognize burnout, illness, and/or impairment in colleagues, and provide appropriate feedback and support
  
3. In a compromised patient-physician relationship:
  - a) Clearly identify the causes, including your role (e.g., disrupted boundaries/attachment, transference and counter-transference)
  - b) Objectively manage the compromised relationship with self-awareness and negotiation (e.g., ask for assistance or advice, professionally address the issues with the patient)