Growing MAT in Family Medicine Residency Soil:
Tips for New Gardeners

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Training the next generation of primary care doctors to be competent, confident, and comfortable when offering Medication Assisted Treatment for substance use disorders is no easy task. Here are some tips and advice, based on our experience, to help get you started::

1. Don't start from scratch. Design your clinic after a successful model you already have in your specific system and culture. Your OB clinic perhaps? Your integrated pain management clinic? Morning huddles/table rounds? Change is easier when there's a blueprint to follow.

2. Don't let paperwork or other "intake" procedures bog things down. Get the patient in and stabilized (on medication and out of the withdrawal/use cycle) as soon as possible. The BH assessments can happen later, in fact, they are more useful when the patient feels better.

3. **Utilize a relationship-based care model.**
    a. Many patients have histories of painful relationships and it may be difficult to trust. Train residents in trauma-informed care and relational skills (boundary setting, etc.)
    b. Don't make patients have to tell their story over and over every time they come in or call in to clinic. Centralize contact with the clinic through one nurse or case manager.
    c. Patients tend to "imprint" on a provider, so allow for patient/provider continuity as much as possible. This may mean keeping the MAT/addictions curriculum separate from a block rotation. Take a longitudinal / across-residency approach to MAT training.

4. Get the whole clinic on board. Not all have to be champions, but even the first smile a patient is greeted with at the check-in desk is part of the treatment/recovery process.

5. Expect financial struggles at first. Designate someone to be in charge of financially advocating for patients by helping apply for patient assistance programs, etc. You may need to seek additional funding sources to keep things going at first (grants, donations, etc.) until you can grow your own mechanisms of getting reimbursed adequately for your services.

6. Most residencies don't have adequate behavioral health resources (substance abuse counselors, intensive outpatient groups, etc.) so partner with your community. Chances are they provide behavioral health services, but without medication, and may be looking for help from you.

Teach residents to…

7. …get comfortable with nuance, ambivalence, and uncertainty. Addiction, as a disease, never manifests the same way from one patient to the next. Success requires the ability to tailor treatment to specific individuals rather than adhere strictly to specific protocols.

8. **…to recognize that the relationship they build with a patient is itself a treatment tool.**
    a. Develop their counseling/motivational interviewing skills.
    b. Model, if possible, what healthy provider/patient relationships look like through clinical teaching and other modalities.

9. …to understand that recovery is growth. Treatment is not an event, but a process. Patients' readiness to grow varies from patient to patient, and across time.
    a. Learn to "Roll with Resistance"
    b. Appreciate the benefits of a harm reduction model.

10. …to appropriately provide 'home inductions' of Buprenorphine. It is safe when done appropriately. Some patients already know their ideal dose from street use, and just want a legal source of the med they already use. Avoiding lengthy office inductions can decrease stress and lessen financial burdens.

11. …recognize stigma within themselves and in others, and battle it through sensitive language and education. For example, teach them that:
    a. Words like "clean", "dirty", or even "sober" can be pathologizing; use "person with an addiction" instead of "an addict", etc.
    b. Just as with other chronic conditions (e.g. diabetes), if a patient's symptoms intensify, the care we provide should intensify. We don't terminate care with a patient just because their disease shows its symptoms. Poor behavior such as lying, emotionally manipulating, lacking accountability, etc. are symptoms of this disorder (the majority of its diagnostic criteria are behavioral by nature).
    c. Boundary setting skills keep patients and themselves accountable and healthy. Learn to establish and enforce healthy boundaries.

12. Enjoy this work. You are literally saving lives. Take time to pause and reflect on the big picture.

Barriers to Substance Abuse Training in Primary Care

Clinician Barriers

- Stigmatization of users
- Lack of time
- Perception of inadequate training
- Lack of confidence
- Inadequate resources
  Lack of BH resources
- Confusion about definitions
- Skepticism about effectiveness of treatment
- Fear about harming doctor-patient relationship
- Low financial compensation
- No systems-wide implementation
- Concerns about patient dishonesty

Training Barriers

- Lack of curricular time
- Inadequate faculty role models
- Can't offer clinical experience
- Negative exposure to "addicts"
- Medical model of addiction not accepted
- Lack of standards for evaluating learners' skills
- Institutional apathy or hostility
- Differences in learning needs across medical specialties

Seale, J. P., Shellenberger, S., & Clark, D. C. (2010). Providing competency-based family medicine residency training in substance abuse in the new millennium: a model curriculum. *BMC medical education*, *10*(1), 33.