Rady Faculty of Health Sciences | University of Manitoba

Max Rady College of Medicine
Department of Family Medicine
P228 Pathology Building
770 Bannatyne Avenue
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Objectives: Addiction Medicine and Substance Use

1. In all patients, and especially high-risk groups (e.g. mental illness, chronic disability) opportunistically screen for substance use (tobacco, alcohol, cannabis, prescribed and illicit drugs).
2. In people who use injection drugs:
    a. Screen for blood-borne illnesses (e.g. HIV, hepatitis, syphilis)
    b. Offer relevant vaccinations
    c. Offer harm-reduction advice
    d. Maintain high index of suspicion for injection related illness (skin and soft tissue infections, osteomyelitis, endocarditis)
3. In patients with signs and symptoms of withdrawal or acute intoxication, diagnose and manage it appropriately.
4. Discuss substance use with adolescents and their caregivers. Offer harm reduction advice and brief intervention when high-risk use is identified.
5. Consider substance use as a possible factor in problems not responding to appropriate intervention (e.g. alcohol use in patients with hypertriglyceridemia).
6. In patients for whom substance use is a concern, routinely assess their motivation to stop or decrease their use by employing motivational interviewing techniques.
7. In patients for whom substance use is a concern, take advantage of opportunities to screen for comorbidities (e.g. poverty, crime, sexually transmitted infections, mental illness) and long-term complications (cirrhosis).
8. In patients acutely intoxicated with a risk of violence or aggression:
    a. Rule out underlying medical conditions (e.g. hypoxemia) in a timely fashion (e.g. don't wait for them to sober up).
    b. Ensure the safety of the patient and staff before examining the patient (including appropriate restraints if needed).
    c. Have a plan of action before assessing the patient (be prepared for physical or chemical restraints if needed).
9. Advocate for appropriate community harm reduction resources when possible (e.g. needle exchange programs, supervised consumption sites, safe-ride programs).
10. When using harm reduction strategies for patients with addiction:
    a. Regularly assess the impact and efficacy of the harm-reduction strategies implemented and adjust accordingly
    b. Regularly revisit treatment goals, stage of readiness for change and potential for further recovery, emphasizing that addiction is a treatable disorder.

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11. As it relates to tobacco use and tobacco use disorder:
    a. Understand and educate patients on the physical, psychosocial and financial costs to smoking.
    b. Understand the various forms of smoking and nicotine products (e.g. cigarettes, cigars, e-cigarettes, vaporizers, hookah, chewing tobacco)
    c. Implement a behaviour change strategy for smoking cessation recognizing the stages of change.
    d. Prescribe both pharmacologic and non-pharmacologic therapies to aid patients in treatment
12. As it relates to alcohol use and alcohol use disorder:
    a. Educate patients on risky use of alcohol, referencing Canada's Low Risk Drinking Guidelines.
    b. Recognize and diagnose alcohol use disorder using DSM-V criteria.
    c. Anticipate, recognize and treat alcohol withdrawal in patients cutting back or stopping drinking.
    d. Consider both pharmacologic and non-pharmacologic measures in the treatment of alcohol use disorder.
13. As it relates to opioid use and opioid use disorder:
    a. Routinely monitor patient's use of prescription and non-prescription opioids and recognize and diagnose opioid use disorder using DSM-V criteria.
    b. In patients utilizing prescription opioids, attempt to safely de-prescribe if there is no longer any given indication for its use.
    c. Understand and explain to patients the reasons for avoiding opioid withdrawal management alone (e.g. Increased morbidity and mortality) as treatment for opioid use disorder.
    d. Consider both medication-assisted treatment (e.g. buprenorphine, methadone) and psychosocial treatment options.
    e. Use opioid antagonists promptly in patients with symptoms of an opioid overdose, and ensure patients at high risk of opioid overdose have access to take-home-naloxone
14. As it relates to sedative/hypnotic (benzodiazepine) use and prescribing:
    a. Appreciate the limited evidence-based indications for regular benzodiazepine use and use this knowledge to inform discussion and treatment planning with patients receiving new prescriptions for sedative hypnotics
    b. Explain risks, side-effects and contraindications to benzodiazepine use

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c. Develop an approach to benzodiazepine deprescribing, including building patient motivation, structuring and adjusting a taper and supporting patients experiencing rebound symptoms
d. Understand the abuse potential for benzodiazepines, and the local patterns of use
e. Routinely monitor patient's use of prescription and non-prescription benzodiazepines and recognize and diagnose sedative-hypnotic use disorder using DSM-V criteria

15. As it relates to stimulant use and stimulant use disorder:
    a. Recognize and diagnose stimulant use disorder using DSM-V criteria
    b. Provide harm-reduction education on stimulant use, including discussion related to stimulant induced psychosis and progression to non-resolving psychosis
    c. Identify stimulant intoxication and withdrawal patterns, and appreciate that stimulant withdrawal management is predominantly supportive
    d. Utilize available non-pharmacologic treatment modalities for patients seeking treatment for stimulant use disorder
16. As it relates to cannabis use and prescribing:
    a. Ensure cannabis products are only prescribed medically in clinical situations based on medical evidence.
    b. Educate patients on the potential harms of cannabis use, and engage in harm reduction discussions employing Canada's Lower-Risk Cannabis Use Guidelines.
17. As it relates to gambling and gambling disorder:
    a. Differentiate between pathologic and non-pathologic gambling
    b. Screen patients for pathologic gambling if financial problems, alcoholism and depression are present.
    c. Intervene if the patient is at risk for suicide
    d. Counsel (or seek consultation, if appropriate), to assess and address the patient's reasons for gambling, confrontation of defenses and cessation of pathologic behaviour.
    e. Define treatment goals for patients who are pathologic gamblers recognizing that complete abstinence from gambling may not be necessary for successful treatment.
    f. Refer the patient to community resources such as Gamblers Anonymous.
    g. Enlist the help of the patient's support system in order to help them follow through with treatment recommendations.

** Mapped to the CFPC's 105 priority topics: #95-Substance Use and Addiction