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Research

A survey of pharmacy experiential learning in substance dependence

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Abstract

Objective: The role of pharmacists in managing patients with substance use disorders has expanded, since the passage of the Drug Addiction Treatment Act of 2000. However, pharmacy experiential education in substance dependence has never been systematically assessed.
Methods: An online survey was administered to the administrators of experiential education in all American Council of Pharmaceutical Education (ACPE)-accredited schools of pharmacy.
Results: Of 73 schools that responded (79.3% response rate), ten (13.7%) offered a sole-standing substance dependence experiential education opportunity and two (2.7%) included substance dependence experiential learning as part of their curricular requirement. The greatest barriers to substance dependence experiential learning were lack of preceptors and qualified sites.
Conclusion: The extent of pharmacy experiential education in substance dependence is limited and variable. Further research is necessary to determine whether overcoming identified barriers would increase the availability of substance dependence experiential learning offerings.
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Keywords: Substance dependence; Pharmacy education; Experiential; Substance-related disorders

Background

Substance use disorders cast an enormous burden on individuals and society by decreasing quality of life and increasing healthcare costs and criminal activities.[1] The latest National Survey on Drug Use and Health, conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), revealed that the rate of substance abuse was increasing.[2] Juxtaposed to this reality are the long-standing stigmas and false beliefs associated with substance use disorders. These have contributed to a failure to accept substance dependence as a chronic disease and to provide adequate training so as to care for this population.[3]

Further complicating the matter, substance abuse terminology is often confusing, stigmatizing, and inconsistently defined. Even leading psychiatric and substance abuse organizations cannot agree. The American Psychiatric Association categorizes substance-related disorders as a group of psychiatric disorders and provides specific diagnostic criteria in *The Diagnostic and Statistical Manual of Mental Disorders Text Revised 4th edition* (DSMIV-TR).[4] Substance dependence and abuses are examples of substance-related disorders. These disorders are defined as ongoing maladaptive patterns of substance use resulting in significant negative consequences. The 5th edition of *The Diagnostic and Statistical Manual of Mental Disorders* is scheduled to be published in May 2013 and is reported to merge the diagnostic criteria for dependence and abuse into

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a single diagnosis of substance use disorder. The National Institute for Drug Abuse (NIDA) defines illicit drug use as drug abuse.[5] NIDA considers substance dependence and addiction as comparable terms with the latter being defined as a chronic, relapsing illness associated with compulsive substance use regardless of consequences. Because the terminology is not standardized, the authors will use the specific terms referenced in the research studies.

The American Society of Health-System Pharmacists (ASHP) and the American Association of Colleges of Pharmacy (AACP) Special Committee on Substance Abuse and Pharmacy Education recognize that pharmacists possess unique knowledge, skills, and responsibilities for assuming an important role in substance abuse prevention, education, and assistance in various clinical settings.[6,7] Pharmacists are experts in the regulations surrounding dispensing of controlled substances, and as a result are helpful in preventing drug diversion. They are also trained to obtain patient's medication history as well as provide medication education for substance abuse and co-morbid conditions.[8]

Pharmacotherapy has become an important treatment component for opioid dependence.[9,10] With the approval of the Drug Addiction Treatment Act (DATA) 2000, pharmacologic management of opioid dependence has shifted from licensed substance abuse treatment facilities or inpatient hospitals to outpatient primary care settings.[11] Yet, there is a paucity of literature on the role of pharmacists in managing patients with substance dependence, other than nicotine dependence, in the United States. To date, there are publications that describe community opioid dependence dispensing services in European countries, where methadone has long been dispensed by community pharmacists.[12–14] Results from several surveys conducted in the United Kingdom showed that a majority of community pharmacists were involved in dispensing controlled drugs for the treatment of addiction.[15,16] In 2005, community pharmacists in England began increased opioid-substitution therapy services, and this change resulted in more positive attitudes toward such services.[17]

Despite the growing recognition of the role of pharmacists in managing patients with substance dependence, the existing U.S. colleges of pharmacy have fallen short in providing adequate training for students. When pharmacists from a local professional meeting were surveyed, 67.5% (306 participants) reported receiving less than two hours of pharmacy school education in addiction/substance abuse.[18] In 1991, the American Association of Colleges of Pharmacy (AACP) published curricular guidelines for didactic substance abuse content.[19] A three-year follow-up survey showed that one-third of responders were unaware of the existence of the guidelines, and only about 50% of the recommendations were followed by the majority of schools.[19]

The importance of substance abuse didactic education in pharmacy curricula has been highlighted in several papers.[18–21] A recent report by the American Association of Colleges of Pharmacy (AACP) calls attention to the successful integration of substance abuse and chemical-dependency programs in the curricula.[22] Among those highlighted were three schools of pharmacy that integrated curricular material on substance abuse into their program. The Accreditation Council for Pharmacy Education (ACPE) requires that 30% of the pharmacy school curriculum be comprised of experiential education (advanced and introductory practice experiences).[23] To the knowledge of the authors, there has been no study assessing the experiential component of substance use disorders or, specifically, dependence education. The need to evaluate the current status of experiential education in substance dependence in the U.S. schools of pharmacy remains. Not surprisingly, evaluation was the first recommendation made by Dole and Tommasello[8] for curriculum reform.

Objective

The present study was designed to assess substance dependence experiential learning opportunities at all U.S. Accreditation Council for Pharmacy Education (ACPE)-accredited schools of pharmacy. The authors also sought to identify barriers to the implementation thereof, and ways by which schools have overcome these barriers.

Methods

This descriptive study used an online survey-administering application (SurveyMonkey®). The study was submitted to the Institutional Review Board and was granted an exemption. The survey questions were developed by the authors of the study (see Appendix). The names and e-mail addresses of the potential responders were collected from the respective school websites (public domain). A link to the electronic copy of the survey was sent to the pharmacy school experiential learning or Advanced Pharmacy Practice Education administrator of each ACPE-accredited school of pharmacy as of 2010. An explanation of the study was attached. Since this was an anonymous survey, four reminder e-mails were sent out to all the responders over a two-month period (February 2011 to March 2011) with a statement to disregard for those who had completed the survey previously.

The survey was comprised of a total of 14 questions. The questions were organized in the following three sections: (1) school demographics, (2) description of available experiential learning opportunities, and (3) barriers. The respondents were asked to provide the location, source of school funding, and school size. Depending on the answer provided under, "Does your school have a component on substance dependence in the experiential clerkship?," the respondents were directed to one of two different question pathways (see Appendix). Schools that offered a substance dependence experiential learning opportunity were asked to describe the current experience and any barriers that might have occurred in its development. Schools that did not have any substance dependence

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