THE DUTCH SYSTEM AND POLICY IN CONTINUING EDUCATION IN SUBSTANCE USE MANAGEMENT*)

Background, developments, new trends and challenges

*Drs.Wim Buisman **)*

1. The system and form of substance use education

In the past 35 years many initiatives were undertaken in The Netherlands to establish a comprehensive system of graduate and post graduate/continuing education in the field of substance dependence (Buisman, 1999).
In the '80's at the Amsterdam polytechnic university, efforts were done to develop a multidisciplinary postgraduate education for psychologists, social workers and nursing professionals.
Moreover, a number of national institutes on substance dependence organized and carried out basic courses on drug treatment and training seminars on actual themes such as substitution treatment, motivational interviewing, HIV prevention etc.
In 1984 a new education project was launched in the department of medical education of the University of Amsterdam. All medical specialities relevant to substance dependence (pharmacology, psychiatry, neurology, internal medicine, medical psychology) cooperated in this program.

**) Paper prepared for the International Symposium on Continuing Education in the Substance Dependence Field, 30 August – 1 September 2005, Berne, Switzerland*

***) Wim Buisman (social and clinical psychologist, MA) is general-secretary of the Council for Competence Building in Addiction of The Netherlands Association for Mental Health and Addiction Care (GGZ Nederland) and international project manager at the Jellinek (Amsterdam)*

Besides presenting a body of knowledge on substance abuse and dependency, this program paid a lot of attention to attitude since research had shown that in the course of their professional education, medical students developed an increasingly negative attitude towards the substance dependence patients.
In 1988 the medical school of the State University of Leiden developed a continuing education program for general practitioners. This program, funded by the Ministry of Public Health, was particularly aimed at early detection and was disseminated to all GP continued education in the Nederland's from early 1990 (but the impact of these programs has declined).

Since the '90's many different activities in continuing education such as conferences, courses, curricula, seminars, workshops, booster sessions addressing addiction problems were carried out in The Netherlands. The vast majority of these educational activities took place "off the job" and often were specifically addressed to one subject (motivational interviewing, double diagnosis and pharmacotherapy). For example:

- Boerhaave seminars for continuing education for medical professionals on alcohol dependence and on drug dependence
- (Annual) continuing training initiated by the section Psychiatry and Addiction of the Dutch Association for Psychiatrists
- Training seminars for multidisciplinary professionals in addiction care mental and general health care of the Trimbos Institute
- In-company continuing training for treatment staff e.g. at the Jellinek Institute (Jellinek School)
- Regional alcohol-related training seminars (acamprosate & motivational Interviewing = Mikado interventions) for family physicians
- Profit oriented and tailor-made training (Libermann foundation, Cure & Care

Due to the fact that new ***chairs in addiction medicine*** were established in Amsterdam (Amsterdam Institute for Addiction Research & Medical Faculty of the University of Amsterdam) and in Rotterdam (Rotterdam Institute for Addiction Research & Erasmus University), in this period much more attention

has been focussed on the problems of substance dependence in the broader fields of policy, (mental) health care, youth care, justice and law enforcement.

Besides these chairs/professors, professional associations have acted as ***interfaces*** between the different sectors as mentioned before. These associations are:

- Section of Addiction Care of the Dutch Mental Health Branch Organisation (GGZ Nederland)
- Dutch Association of Addiction Medicine
- Section Psychiatry and Addiction of the Dutch Association of Psychiatry
- Section on substance use treatment of the Dutch Association for Behavioral and Cognitive Therapy

With regard to the ***coordination*** of continuing education activities in the field of substance dependence, there is no directive system in place. Although the Dutch government sometimes supports specific education projects, no overall educational infrastructure for continuing training on a permanent (funded) basis has been established.
In fact, in the actual circumstances, continuing education is based on a ***free market*** system of training providers, training consumers (professionals working in mental health and the addiction field) and training funders (addiction and mental health services).
Currently, there is no official and general system of certification and ***accreditation*** for continuing education on substance dependence. In case of medical (continuing) training, medical professionals are able to claim training credits through their professional associations that have a license.

As such, the ***status*** of continuing education in the professional substance dependence field can be considered as low because through the current system no direct (financial, career-based) rewards and incentives can be acquired. Nevertheless there are indications that most of the continuing education activities do enhance the level of professionalism.

2. National guidelines and concepts for the content of continuing education

2.1. Background

During many years, the basis for the content of (graduate/postgraduate and) continuing education consisted of international guidelines or recommendations of e.g. the National Council for Public Health (substitution treatment, treatment guidelines for alcohol related problems).
In the late '90's, a unique project was developed by the united addiction services in the Netherlands entitled Scoring Results, with three broad objectives (Osseman, 2003, Schippers et all, 2002):

- To present an analysis of the quality of the Dutch addiction services at that time
- To depict the future of these services
- To outline an action (innovation) plan for the near future

It was the ambition of the field of addiction care services to innovate and improve. It aimed to base all interventions in prevention and treatment on ***scientific evidence*** and/or best practice to organise an effective and comprehensive transfer of knowledge to (future) employees of its services.
The Scoring Results initiative marks the start of a seven years (1998 – 2005) project. Major issues were assigned to so called research & development centres which would address four clusters of interrelated themes: prevention, abstinence-oriented treatment, intake & assessment and social addiction care (including harm reduction).
As a leading principle the project Scoring Results followed this cycle:

- Knowledge development (R & D centres in addiction services)
- Knowledge implementation (publications, protocols, competence building)
- Knowledge circulation (basic training and continuing education)

A major theme in the project was the implementation and circulation (= ***education policy***) of the (new) knowledge collected through the different projects of Scoring Results.

For the conceptual and practical elaboration of the educational policy and the future training and education structure for the addiction care, an innovative training consultancy company (Kessels & Smit) was contracted to create an educational master plan.

2.2. Perspective of continuing education policy

Improvement and innovation (main objective in Scoring Results) depend on how services and individuals (employees) learn, that is: how they acquire knowledge and are able to apply and further develop it.
Kessels & Smit speak of 2 conceptualisations of knowledge (Osseman, 2003):

1) *Stock approach* = knowledge seen as an entity separate from people; a thing that can be put into a database and that can be codified
2) *Flow approach* = experiences, skills and attitude are valued as such, knowledge is seen as a capability or a competence

The Kessels & Smit approach is from a flow perspective, taking as a basic tenet that as soon as knowledge is separated from people, its essence gets lost. An example: *a protocol may describe precisely how an expert would perform a specific task, but ultimately the competence to perform the task must be attained by the professional who will do the job.*
Knowledge may be transferable from one person to another, but competence is not.
New developments in the field will require professionals to develop new competences ***(*see annex)***. In order to do so they have to follow certain routes of training and practice that will require the development of new training schemes. To test if these schemes contribute to the acquisition of the proper competences, the result will have to be evaluated (which is a continuous process).

In a scheme:

Kessels & Smit examined developments in the field of the addiction care. Developments here include a new approach towards substance dependence, shortening of treatment periods and a shift from cure to care. These are driven by science and new treatments and protocols (evidence-based treatment) in the framework of the project Scoring Results and by practical experiences of the professionals themselves.
Major issues include:

- focus on the bio-psycho-social paradigm of treatment
- much more concern with dual diagnosis
- stepped care (effective & cost-effective)
- social addiction care (harm reduction)
- changing position of patients who became clients and care-consumers

To examine the competences required in the addiction sector, a new categorisation was developed on the basis of a report on professions in mental health care: medical cluster (specialist in psychiatry and addiction medicine, nursing cluster, psychology cluster, social work cluster).
Professionals in the addiction services have higher education giving initial competency of a general nature.
Complementary these professionals need continuing education for specific competencies: ***profession specific*** (e.g. medical tasks of a physician) but also ***cross professional*** (e.g. apply for all professionals = attitude and approach towards clients).

Kessels & Smit have concluded that there is a lot of knowledge present in the field of the addiction care itself. This knowledge should be transferred to all concerned within and outside the field.

Transfer of knowledge is seen as a result of the immersion of students in situations that are similar to what they will experience on the job, implying that both knowledge and competence is developed.
Under the present conditions in higher professional (undergraduate/bachelor) education little if any attention is paid to subjects pertaining specifically to the addiction field (Buisman, 2004, Osseman & Buisman, 2003)).
Similarly, for people already working in the addiction field, the opportunities for continuing education and training depend largely on the initiative of addiction services. The training routes chosen by addiction professionals vary considerably from person to person and from profession to profession i.e. medical-non medical.

In order to strengthen the field specific competence of both these who enter the field of addiction care and those already employed in it, a new structure called "**regional training networks**" (RTN) is currently being implemented. On the initiative of the national project "Scoring Results", in 2002 three regional training networks have been established. In principle all institutes and services in the field of substance use treatment & prevention (including a number of mental health agencies) participate in one of these networks; depending on their size, they pay a pro-rate contribution to the maintenance of the RTN.

RTN's are expected to create "in company" training seminars in which all employees of the participating institutions are allowed to receive training.

The main "menu" of the training seminars are the new protocols and guidelines developed within the framework of the project Scoring Results (lifestyle training, intake/assessment guideline, detoxification module etc.). The seminars have a dynamic and interactive nature and fit into the flow approach of Kessels & Smit, meaning that the piloting or the trying-out of new interventions has a direct interface and feedback with the daily experiences of the trainees on the shopfloor. The seminars are facilitated by supervisors or by experts who have been closely involved by the elaboration and the implementation of the (new) protocols or guidelines.
Finally, RTN's are expected to develop ***strategic alliances*** with regional (under) graduate institutes (vocational, academic) to create networks for ongoing training, research & development and evaluation.

With regard to the question "which of the occupational group has implicitly the lead in daily practice of care and in continuing education", the following comments can be given:

1) Currently there is a tendency of more medicalisation in the field of substance dependency; for a number of reasons: more substitution and prescriptions, for drug users more medical and preventive measures (HIV, STD and Hep ABC prevention)
2) Increase of co-morbidity/dual and triple diagnosis cases leading to more intensive psychiatric treatment
3) Consequently more psychiatrists entering the field of substance dependence causing competition in medical authority between them and addiction physicians
4) On the other hand, more influence from psychology and cognitive behavioral professionals in treatment and relapse prevention
5) For continuing education there is only a special training course for addiction physicians (subspecialism in medicine, but still not certified).

6) At present there is a trend to specialize in addiction (differentiate) within the leading professional groups of nursing, social work and psychology.

3. Quality assessment and standards of continuing education

At present there is no comprehensive system that guarantees the quality of continuing education specifically in the field of substance dependence.
Most providers of training programs and courses apply their own quality criteria such as: selection of qualified trainers, theoretical level (evidence-based) of the training, pre-level of knowledge of participants etc.
On the other hand, on the level of mental health training and education, a comprehensive system does exist in the form of the CONO (Central Organisation for Continuing education in Mental Health), the organisation that functions as the main advisory body for the Government (=Ministry of Health).
The CONO consists of so called chambers for psychiatry, psychology, nursing and social work. These chambers in close cooperation and consultation with the specific professional associations (for psychiatry, psychology, nursing etc.) develop criteria for professional competencies in the field of mental health and psychiatry and present them for approval to the general assembly of the CONO.

Currently discussions are going on to prepare (function) differentiations on addiction competence within the mental health field and to create quality criteria to certify these additional competencies on addiction. Besides the professional associations, also the employers/directors in the field of addiction care and mental health and civil servants from the Ministry of Health (and other stakeholders) are involved in this debate.

In spite of the fact that no final decisions have been made, still no comprehensive overall system for quality assessment has been introduced and approved, evaluation of continuing education is (being) applied on different levels:

- All training courses and seminars are evaluated by the participants by self-report questionnaires, however not according to a standard format

- Expectations of learning outcome at the end of training is measured in most cases (monitoring or post-assessment after a certain period is seldomly executed)
- Behavioural effects (transfer to workplace): this is not a structured element of evaluation, however it is sometimes done on team-intermission level
- Team/institution level results: currently not assessed, but planned to introduce this in the future within the regional training networks (under development)

4. Challenges, opportunities and risks

Currently a number of developments can be observed in the fields of (mental) health and addiction that affect the quality and the effectiveness of the services in these sectors. Many are of an international nature and not exclusively Dutch. In the ***first*** place the costs of (mental) health care are increasing (annually by up to 10%), which causes a big burden for the national budget. The risk is that budget-items such as training and (continuing) education and competence building in general might be reduced because they are only perceived as "costs". On the other hand this risk might serve as an opportunity to proof that investments in training & education are necessary to impact efficiency and effectiveness of clinical interventions in the field of addiction and mental health care.

Secondly, health problems are becoming more complicated: people grow older, which leads to a higher demand for treatment and medical interventions.
In the field of addiction, we are faced with dual diagnosis cases (at least in half of all cases) but also with triple morbidity (substance dependency, psychiatric disorders, HIV and/or forensic problems).

Thirdly, as a challenge and an opportunity, many new evidenced based interventions and best practice know-how is available, but still not generally disseminated and implemented within the services.

As a new policy guideline in the Netherlands, this implicates that a high priority (also in funding) is given to new knowledge circulation and implementation (e.g. in so-called "break-through" projects, a method that in a very short time provides stakeholders and
services with new knowledge and interventions to solve urgent problems).

In close connection to the development as mentioned under 3), recently a number of other innovative initiatives have been undertaken:

a) Three Expert Task Forces were established to create evidenced-based ***guidelines for treatment interventions*** for tobacco, alcohol and drug dependence; the Task Force Guideline for Tobacco Dependence (under the auspices of the Dutch Association for Medical Specialists) has launched its Recommendation, in the form of a set of motivational and behavioural interventions, in 2004. In fact this implicates that all medical professionals in primary health care, hospitals, occupational health care etc. are strongly recommended to advice smokers who show up for any consult, to give up smoking and to provide assistance by applying a protocol or a flow-chart for behavioral change.
The guidelines of the Task Forces for alcohol and drug dependence are expected to be launched in 2007.

b) Early 2005 a national ***Council for Competence Building in Addiction*** was set up on the initiative of the Netherlands Association for Mental Health and Addiction, (GGZ Nederland 2004).

In this Council representatives of the (5) main professional associations working in the fields of addiction and mental health, representatives of vocational and academic institutions, ministries and other stakeholders were appointed as members.
According to its mission statement ("ongoing education in substance use management"), the Council's overall objective is:

"To improve and support high quality multidisciplinary training and (under) graduate and continuing education on substance use management in a substantial number of educational settings: vocational, academic, occupational, in-company, regional training networks"

In order to achieve and realize its objective, some of the main activities of the Council are:

- Actively monitor new evidence-based knowledge and practice and communicate and disseminate this to providers of training and education (e.g. the new guidelines of the Task Forces mentioned under a)
- Improve structural implementation of modules on substance use management in medical schools, faculty of psychology, social work, nursing and occupational therapy
- Support and empower the establishment of regional (in company) training networks in which a number of services for addiction care and mental health care participate (based on a joint business training agreement)
- Provide for qualification, certification and accreditation to educational institutions specifically to the domain of substance use management
- Give advice to ministries, stakeholders, professional organisations and institutions with regard to competence building in substance use

Through its members, the Council incorporates many different networks from the educational field, the addiction and mental health sectors, field of research & development, client/patient interest groups, policy and care funders.

c) As a result of the reform of health care and the system for funding health care the Dutch government has decided to establish a new policy and a new system for continuing education in the fields of health and mental health care (including addiction).
In this framework 2 crucial developments can be motioned:

- Establishment of a high level Steering Committee on the restructure of professional disciplines in the field of health care, based on new

requirements and needs in health (higher efficiency, better quality, more prevention, more cost effective)

- Creation of a new ministerial educational fund to finance all recognised continuing education for the medical, psychological, social and nursing professionals;

for the field of addiction care this development asks for a decision to what extent and for which professions a specialisation in addiction is needed to be financially covered by the new fund: addiction physician, addiction psychologist, addiction nurse, addiction social worker? Or is it only a subspeciality or differentiation ***within*** the mental health continuing education?

5) Summary and conclusion

The Netherlands has a long history of training and competence building in substance use management. Unfortunately, due to the lack of an adequate national infra-structure, both the quality and effectiveness of the systems for (under)graduate and of continuing education in substance use management are rather weak.
Since the late '90, under the impact of the national project "Scoring Results", a new ***professional ambition*** in the field of substance use treatment and in the field of continuing education has been created. Essentially, this ambition is aimed at performing and achieving treatment outcomes only through evidence based approaches and interventions.
In order to realize this ambition, high skilled and professional treatment staff is needed for these services to which persons with substance use problems are referred to (substance use and mental health sectors).
Currently new initiatives are under development to create a new national infra - structure for (under)graduate and continuing training of medical and psychological professions and for social work and nursing.

7) References

Buisman, W.R. (1999) ***Medical Education on Alcohol Problems in the Netherlands:*** in Medical Education in Alcohol and Alcohol Problems in Europe, Eurocare, Saint Ives UK

Osseman, D. (2003) ***Assessment of training needs in Dutch addiction services***: In A trainer's tool kit, advancing quality & relevance in addiction training, A-Clinic Foundation, Helsinki

Schippers, G.M., M.Schramade & J.A.Walburg (2002***) Reforming Dutch substance abuse treatment services,*** Addictive Behaviours, 27 995 - 1007

Osseman D. & W.R.Buisman (2003) ***Training in the Health professions with special attention to the addiction services*** in: A trainers tool kit, advancing quality & relevance in addction training, A-Clinic Foundation, Helsinki

Buisman W.R. (2004) ***The Role of the General Physician in Substance Use Management,*** Jellinek, Amsterdam

Raad voor Bekwaamheidsontwikkeling: een gedachtebepaling (2004), GGZ Nederland, Amersfoort (*Council for Competence building in Substance Use Management, mission statement)*

Annex

Competences in the addiction field in the Netherlands

Competences related to specific clusters or professionals within clusters
Related to substances (biopsychic)
- *knowledge of substances — drugs, psychotropic*
- *knowledge of medication*
- *able to notice physical complaints*
- *able to notice mental complaints*
- *able to quickly assess mental, physical condition — diagnose*

Behavioural interventions
- *able to motivate*
- *able to use motivational techniques*
- *able to use behavioural interventions in 4 / 5 session model*

Use new insights, methods
- *working with protocols*
- *working along evidence based lines*

Capabilities that are specific to people in managerial capacities
Able to decide, think in policies
- *able to decide and explain*
- *apply policy from top and able to hand experience from practice higher up*
- *able to cope with tension between policy-level and everyday practice*

Systematic, overview
- *think and work systematically*
- *stick to general principles*

Motivator, coach
- *motivate personnel*
- *assist personnel in coping with unclearness, uncertainty — reorganisation*
- *able to coach*

Co-operative, networker
- *able to collaborate with other organisations, cultivate contacts*
- *good knowledge of social map*

Competences that apply to all workers in the field
Empathy, respect
- *know what it is to be addicted, insight in problems*
- *know what client can and cannot*
- *imagine what the client's situation is like*
- *cope with diversity of culture and ethnic background*
- *cope with different age groups*

Effective communication and collaboration with the client
- *make contact, create rapport*
- *able to collaborate with clients*
- *negotiate with emancipated clients*
- *negotiating skills*
- *guard boundaries, not taking client's responsibilities*

Overview, structure
- *able to work in a structured and systematic fashion*
- *keep track of main issues — stay within bounds of module*
- *know which colleagues work with what modules*

Result orientation
- *able to work result oriented — reach set targets in set time*
- *responsible for result and quality, entrepreneurial attitude*

Multidisciplinary work, collaboration
- *able to work in (multidisciplinary) teams*
- *able to give and take feedback*
- *demand attention for self, ask colleagues for help*

Networking
- *know social map well*
- *keep in touch with other institutions*
- *know when to refer*
- *able to work outreaching*

ICT-competences
- *insight in and proficient with modern communication technology*
- *computer skills*
- *e-mail and internet*

Ability to learn
- *be conversant with latest developments*
- *know where to get knowledge (colleagues, other institutions, education)*
- *open attitude, increase learning capabilities*
- *have clear image of own strengths and weaknesses*

Flexibility, suppleness
- *be flexible in current treatment offer*
- *loosen frameworks, postpone judgement*
- *cope with uncertainty, not knowing what your future in the organisation will be*

Motivation and affection
- *be motivated, motivate yourself*
- *keep affinity with job, despite meagre personnel situation and many changes in organisation*
- *sober attitude, be glad with small steps, no saviour ideals*
- *perseverance, cope with set-backs*