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CAN A "TREATMENT SPECIALIST" ALSO BE SEEN AS A "PREVENTION SPECIALIST" AND VICE VERSA?

A Contribution by Jeff Lee from the ISSUP INEP Plus Facilitators Training Course.

Many individuals working in treatment automatically consider themselves to possess particular skills for engaging in prevention work. I have some concerns about this notion. Obviously, the spectrum of how we address individuals with substance use disorders includes a component related to prevention. This suggests that the contribution of prevention likely focuses on the "Indicated" aspect and that the approach is carried out from the perspective of the "problem." The focus is not from the "Universal" or necessarily "Selective" viewpoint. In other words, treatment specialists enter the arena of prevention from a particular, and often limited, perspective on how to address the issue more broadly, as well as the principles of prevention. This reflects the need for treatment specialists to undergo further training to specialise in the preventive field. This is necessary for them to present themselves as "experts" or specialists in prevention.

It is less common to find prevention specialists positioning themselves as treatment specialists due to their work experience, despite the overlap between treatment and prevention. This would indicate recognition that a treatment specialist requires specific knowledge and skills, including training to assume their role as a treatment specialist.

What is considered "treatment" is also communicated and understood more easily than in the case of prevention. There is often greater clarity about what "should" and "should not" be done when providing treatment services and working with those with substance use disorders. Prevention is broader because it deals with entire populations. Prevention is a multidisciplinary activity and involves a wide range of stakeholders. It takes place in a variety of settings. This sets it apart from treatment and makes the science of prevention more extensive compared to treatment, which has a more focused approach and a target group of providers and clients. "Preventionists" need to have knowledge in their repertoire about human development, human behaviour, laws, communication, social behaviour, group dynamics, physiology, pharmacology, research, epidemiology, among others.

The target group for prevention also varies depending on the required approach, whether it is universal, selective, or indicated. It is only now that the science of prevention has identified and recognised this, and has begun to provide relevant training for prevention specialists, particularly evidence-based. One outcome of extending prevention practice may be the emergence of "general preventionists" and, for example, prevention specialists in schools, who will be a different group from those specialising in environmental prevention. What has become clear is that prevention is a complex area that requires appropriate training and understanding before anyone claims to be a specialist or "expert."

Using my soccer analogy, it is possible that we all play on the same team, but there is a big difference between those who are good defenders (treatment) and those who can play midfield (prevention/education).

So, to answer my question about whether a "treatment specialist" can also be seen as a "prevention specialist" based on their knowledge and experience in the treatment area, I would recommend extreme caution and skepticism. Having expertise in one does not mean having it in the other.

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Can treatment specialists become trainers and/or facilitators of a preventive program?

I would add that a similar question should be asked about whether prevention specialists can necessarily become trainers and/or facilitators of a preventive program.

I believe that we first need to ask ourselves what constitutes a specialist or "expert" in treatment or prevention. For me, the answer is someone who has the appropriate knowledge, skills, and competencies; who has received adequate training, and, where possible, is accredited in their specialty and has relevant experience applying it in real-world scenarios. These ingredients should allow someone to be on the path to becoming a specialist or expert, while recognising that there will always be new knowledge and experiences, as well as training, to enhance their competencies.

An "expert" in treatment applies their expertise to their work within a treatment-centered context and carries out their work using what is understood as evidence-based practice principles.

The same applies to the prevention expert who may have an overview of the breadth and complexity of prevention but may only have the opportunity to apply it in certain scenarios and contexts. In this sense, "preventionists" may be specialists in certain aspects of prevention, from the perspective of experience, within a generic understanding and perhaps limited experience of working in different dimensions of prevention.

Again, using the soccer analogy, the treatment specialist is an expert "defender," while the midfield of prevention requires someone who understands the role of this position and who may have the experience to perform according to the different demands presented.

So, what about the role of the trainer/facilitator? **Being a specialist in something does not automatically make one a good trainer or facilitator of that specialty**. Doctors, for example, are extremely qualified, informed, and experienced, but their ability to communicate it to others, including their patients, is often questionable. "Communication" is the keyword, along with "what and how to communicate." So, what makes a specialist trainer/facilitator? This is an important question but different from what makes a treatment or prevention specialist. However, the most important thing when making decisions is who can be considered an appropriate trainer/facilitator. For me, a specialised trainer or facilitator must demonstrate that, within their experience, they include the following skills, abilities, and competencies. There are other points to add to the list, but these are my initial ideas.

So, a competent or specialised trainer or facilitator must demonstrate the following in their practice:

Communication skills: understanding and ability to:
- Listen
- Show learning and contributions
- Communicate orally
- Understand and identify nonverbal communication
- Be aware of individual needs and concerns

Clarity
- Objectives
- Expected learning outcomes

Sensitivity
- Gender
- Cultural
- Language
- Standards

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Group dynamics
- Understanding of how groups function and the roles assumed by their members
- Ability to manage a group and its learning
- Ability to provide group activities and exchanges
- Appreciation of the learning process

Knowledge

- Understanding of the topic or access to where relevant information can be found
- Understanding of relevant and unnecessary information
- Helping individuals find answers to questions, rather than always providing them

Promoting learning instead of lecturing or giving presentations

- Seeing training as a process of sharing and learning to empower the learner, rather than just transferring knowledge from the leader to the group

Appropriate methodologies
- Understanding of the methodologies required to involve the group in collaborative work to ask questions, share, and promote learning and understanding
- Humility
- Sense of humor

At this point, my analogy with soccer is that every team needs a coach who helps players perform their best. That coach does not have to be a soccer specialist or have the skills and abilities of those they are coaching. However, they require coaching competencies to preserve and improve the skills of their "specialists." There are coaches who were previously players, which helps inform their role as a coach, as a trainer/facilitator.

So, what does this mean for answering my question about whether a treatment or prevention specialist can become a trainer and/or facilitator of a preventive program?

The logic of my argument would indicate that unless someone meets the criteria to be a prevention specialist and a specialist trainer/facilitator, it would not be appropriate to accept them as a trainer/facilitator in prevention matters. Likewise, regarding training in treatment, someone should not be considered a trainer/facilitator in treatment unless they have the training criteria and are a treatment specialist. My only outstanding question is to what extent it is necessary to have achieved, experienced, and applied their specialisation in prevention, even if they have the experience of being a trainer/facilitator? If I am a trained, qualified educator/communicator/facilitator, to what extent do I need to know about prevention? If I can access and understand the information, knowledge, and "content" of prevention principles, can't I use my experience as an educator/facilitator to communicate this to others, particularly if the level required in my participants does not match what I have accessed and understood?

In other words, regarding INEP Plus, I can access and learn the "content" and principles of prevention at the necessary level, which my specialisation or competencies as a trainer/facilitator will subsequently utilise when implementing the program with others. However, many participants in the INEP Plus Course are developing their training/facilitation skills and competencies at the same time they are acquiring the content and principles of prevention. I suggest that those receiving initial training to be facilitators demonstrate that they understand not only the content but also that they understand and are capable of applying facilitation skills when implementing the program

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with others. Experience in treatment is irrelevant to this process and may even negatively impact the new learning objectives.

It is impossible to “know everything” in the learning area being “facilitated.” What is needed is the ability to offer ways in which knowledge can be built and answers to questions can be found. We need “preventionists” - those who are qualified and have knowledge of prevention science and its breadth - but the prevention facilitator does not have to be an expert preventionist. We need someone who knows how to facilitate and who helps the facilitated group to be able to access appropriate knowledge, learning, and interest in achieving the goals at hand.

In summary, I propose the prerequisites for becoming a trainer/facilitator in prevention, and specifically with reference to INEP Plus, that the key competencies are those of a trainer/facilitator. In addition to this, there should be an understanding of the content and principles of prevention offered through the INEP Course that will enable the trainer/facilitator to communicate learning and content using their facilitation skills. Those specialised in treatment who take on the role of INEP Plus facilitators will need to set aside that expertise and would be better off considering the prevention content of INEP from the perspective of someone new to the field and as someone who wants to become a competent facilitator who demonstrates the necessary skills and abilities.

What do you think?

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International Project on the Psychoactive Prescription Medication Use – Data Sources and Cooperation Between the Czech Republic and Norway

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The use of psychoactive prescription medications with abuse potential is of increasing concern in the Czech Republic and other European countries. Monitoring to establish the extent and consequences of prescription medication misuse is essential in implementing targeted public health efforts to reduce the associated risks and promote overall well-being.

The Department of Addictology of the First Faculty of Medicine, Charles University in collaboration with the Norwegian Institute of Public Health and the University of Oslo (Norwegian Centre for Addiction Research), was involved in a project aimed at identifying data sources for research and monitoring the use of psychoactive prescription medications and exchanging research experiences between the Czech Republic and Norway.

The Initiative "*Studying psychoactive prescription medication misuse in the Czech population: Exchanging expertise in pharmacoepidemiological registry-based research and strengthening collaboration with Norway*" [EHP-BFNU-OVNKM-4-145-2024] has been financed by the Fund for Bilateral Relations within the framework of the EEA and Norway Grants 2014-2021 ("Bilateral Fund") and was conducted between March and July 2024.

Rationale for the Initiative

In the Czech Republic, the high prevalence of psychoactive prescription medication use is reflected in the increased number of patients seeking addiction treatment. From an epidemiological perspective, this issue has received limited attention, and the health consequences related to the use of psychoactive prescription medications are not systematically monitored. In contrast, in Norway, the high prevalence of prescription opioid use and overdose deaths related to the use of prescription opioids has led to the adoption of various measures, including the implementation of robust research (e.g., the POINT project – Preventing an opioid epidemic in Norway: Focusing on treatment of chronic pain), monitoring, and intervention processes aimed at preventing further escalation.

Secondary data sources, such as national health registers and prescription databases, are excellent sources of epidemiological data, enabling the tracking of the prescribing and dispensing of controlled medications and the health consequences of their use. However, in the Czech Republic, the availability and quality of these data, as well as their potential for research, remain uncertain.

Initiative objectives

One of the initiative's main goals was to investigate the availability of data curated by Czech state institutions and determine their openness and usability for research and monitoring the use of

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psychoactive prescription medications. We aimed to answer two key questions: Do we have data to monitor the use of psychoactive prescription medications and their health consequences in the population? And how high-quality and open are these data?

Furthermore, the initiative aimed to strengthen Czech-Norwegian research collaboration, gain theoretical, methodological, and analytical know-how from Norwegian experiences with (pharmaco) epidemiological registry-based research, and assess the potential for research into the use of prescription medications in the Czech Republic and Norway.

Project outputs are available at https://osf.io/nzy7x/.

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