A Survey of Addiction Training Programming in Psychiatry Residencies

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The authors surveyed 50 psychiatry residency training programs to examine the current status of addiction training and the impact of the new Residency Review Committee addiction training criteria for general psychiatry residencies. Only 5 programs did not already meet the new 1-month full-time equivalent addiction training requirement, and those programs anticipated only modest changes. The modal full-time equivalent addiction experience was actually 2 months, with great diversity in timing and settings. Respondents, however, often felt that their programs relied on one key addiction supervisor and that affiliated PGY-5 addiction residents usually had only limited roles in teaching and supervising the general psychiatry residents. (Academic Psychiatry 2002; 26:105–109)

Concerns about the quality and effectiveness of addiction psychiatry training experiences in general psychiatry residencies resulted in new general psychiatry residency program requirements, which took effect in January 2001. The new addiction psychiatry requirement of the Residency Review Committee (RRC) specifies "one-month full-time equivalent supervised evaluation and management of patients with alcoholism and drug abuse in inpatient and/or outpatient settings, including familiarity with rehabilitation and self-help groups" (1). The previous RRC requirement had no specified minimum duration, and there was concern that even a one-month requirement might be onerous for some programs.

Qualified supervisors and appropriate settings for addiction psychiatry training experiences are not readily available to every program. Interest in evaluating the difficulties that training programs might have in trying to meet this new requirement, and in determining the ways programs currently structure such training experiences, led the American Psychiatric Association Committee on Training and Education in Addiction Psychiatry and the American Academy of Addiction Psychiatry Education Committee on PGY-1–PGY-4 Training to jointly sponsor this survey of general psychiatry programs.

METHODS

A survey instrument was developed by the authors and finalized by consensus. Survey items included the following: whether the general psychiatry residency program currently had a required addiction psychiatry clinical experience, and if so, in which year(s); the duration; and whether it was full-time or part-time. Concerning the principal clinical addiction

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training experience, details were requested regarding the types of training settings and services, and what the residents' clinical roles and responsibilities were. Open-ended questions were used to explore the type of supervision, supervisors' qualifications, strengths and weaknesses of the addiction training, and any changes necessary to meet the new one-month addiction training requirement. We also asked whether there was an affiliated addiction psychiatry residency training program, and if so, what role the addiction residents had in the training of the general psychiatry residents.

We sampled general psychiatry residency training programs approved by the Accreditation Council for Graduate Medical Education (ACGME), using the 2000-2001 *Graduate Medical Education Directory* (2). Most general residency programs do not have affiliated addiction residency training programs; we moderately oversampled general residency programs with such affiliated programs because we were interested in their impact. We did not formally randomize our survey process, but we attempted to achieve geographic balance by sampling a proportionate number of programs within each of the seven American Psychiatric Association (APA) geographic areas. Programs were contacted until 50 supplied the survey information.

The authors telephoned programs, arranging to interview the appropriate, available individual who could answer the survey questions; this was usually the general residency training director, and when not, his or her designee (often the addiction residency training director or chief resident; sometimes an addiction resident). When circumstances permitted, in-person interviews were conducted. We rejected the easier methodology of mailings or e-mailings, seeking clearer and more complete answers and more effective responses by using open-ended questions.

We anticipated that a moderate number of programs would be experiencing difficulty finding a suitable addiction training experience. We expected that most core clinical addiction experiences would be approximately four to six weeks, and that there would be two or three varieties of "typical" clinical experiences based on single clinical services. We predicted that programs having an affiliated addiction residency training program would provide more extensive and stronger clinical addiction training experiences for the general psychiatry residents, with addiction residents significantly involved in this training.

Statistical analyses employed chi-square, z-tests, and t-tests. All z-tests and t-tests were two-tailed, and t-tests used independent measures.

RESULTS

We surveyed 50 general psychiatry residency programs in the year 2000, before the new requirements took effect. The 185 current ACGME-accredited general psychiatry residency training programs in the 50 U.S. States, Washington, DC, and Puerto Rico are not evenly distributed geographically. For example, 31 (almost 17%) are in New York State alone, and 4 states have no programs. Our sampling process resulted in a distribution of surveyed programs not significantly different from the numbers of accredited programs per APA area ($\chi^2 = 0.97$, df = 6, not significant; Table 1). The 50 surveyed programs had an average complement of 30.8 residents (range 5 to 61 residents; SD = 14.34), slightly but significantly larger than the average of 26.6 residents (SD = 14.09) for all 185 accredited programs ($z = 2.14$, $P = 0.03$).

At the time of our survey, there were 38 ACGME-accredited addiction psychiatry residency programs, so that 21% of all general psychiatry programs had such an affiliated PGY-5 training program. Of our 50 surveyed programs, 19 (38%) were affiliated with one of these addiction psychiatry residency programs, a significantly higher percentage ($\chi^2 = 9.34$, $P = 0.02$).

TABLE 1. Program distribution by American Psychiatric Association geographic area

Status	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7
Surveyed	6	8	6	10	12	5	3
Not surveyed	9	23	19	30	35	11	8
Total programs	15	31	25	40	47	16	11

Note: Chi-square goodness-of-fit distribution, critical value (0.05, df = 6) = 12.59; $\chi^2 = 0.975$.

The 19 surveyed programs with such an affiliation had a larger resident complement (38.9 residents), probably explaining our surveyed programs' larger average size compared with the average for all accredited programs.

As shown in Table 2, almost all surveyed programs already had a required addiction clinical experience (47 of 50; 94%), and two of the remaining three had an elective addiction clinical experience, which could be made mandatory. The other program did not anticipate significant problems in implementing the requirement. Only two programs with a required addiction clinical experience did not meet the one-month full-time equivalent (FTE) requirement, one having two-thirds and the other three-quarters months FTE.

The modal period (FTE) for the core clinical addiction training experience in our surveyed programs was 2 months, and the mean was 1.71 months. Programs with an affiliated addiction residency program had a trend toward having longer FTE addiction training experiences (1.99 months vs. 1.54 months; $t = 1.77$, $df = 48$, $P = 0.08$). Of the 47 programs with a required clinical experience, 31 (62%) provided a full-time experience. Another 2 (4%) reported a divided clinical experience: a full-time module, and a distinct part-time module on a different addiction service. There was no consensus on when to schedule the core clinical addiction experience (PGY-2 was most common, but all years were represented), and for 16 programs (32%) the core experience could be in one of several different years. The responses indicated that this great variability represents more logistical convenience than educational rationale.

Our open-ended questions resulted in more variability in responses than anticipated, not allowing for meaningfully quantified analysis but providing some interesting reports. For example, surprisingly, most programs that had PGY-5 addiction psychiatry residents did not use them for supervision of the general residents in the core clinical experience.

TABLE 2. Core addiction psychiatry training experiences in the programs surveyed

Core Addiction Rotation (full-time equivalent months)	Programs Requiring This Experience, *n* (%)
None	3 (6)
>0, <1	2 (4)
1	12 (24)
>1, <2	8 (16)
2	15 (30)
>2	10 (20)
Total	50 (100)

The training models were very diverse, and not only in terms of the type of facility and service the core experience was based in. Most programs actually combined several different services in the core rotation, sometimes as many as three or four. Laudable creativity was directed toward having residents exposed to different types of patients in different levels of care. One program's core experience consisted of an outpatient module of two to three hours per week for two years, allowing exceptionally long follow-up of addiction patients.

The resident's clinical role, however, was rather routine. Usually the resident was based in a dual-diagnosis, rehabilitation, detoxification, or intensive outpatient service, and would perform initial assessments, carry a case load, participate in family meetings, and psychoeducational groups, and attend other groups as an observer or co-leader. Occasionally the resident was more involved in consultation or had opportunities for longer-term follow-up of patients in an ambulatory setting.

Several program directors expressed concern that residents rarely had opportunities to follow patients from an addiction service for an extended period of time (i.e., as outpatients over a span of months). When programs could arrange extended follow-up, the respondents deemed this to be a strength. Other identified strengths included the availability of patients from different socioeconomic classes (interestingly, seeing patients from "different cultures" was mentioned by only two programs, one of which had a well-developed clinical program serving patients of Southeast Asian origin), as well as training on a detoxification service; having multiple types of clinical settings; and the quality of supervision, which a training director would often specifically extol.

Perceived weaknesses included the limitations of a single setting (when that was the case), sometimes with a fairly homogeneous population, and inability to follow patients over an extended period. Several programs mentioned the lack of a detoxification service. No one mentioned lack of opportunities for research unless explicitly asked; lacking such opportunities did not seem to be perceived as a significant weakness. Another concern, particularly for off-site

services, was the possibility that residents might be only passively involved in treatment groups. Lack of encouragement to have residents prescribe disulfiram or naltrexone was cited as a weakness by several training directors. Several programs indicated their addiction experience would be better if they had a second dedicated addiction supervisor.

DISCUSSION

Adequate addiction training is a critical need; it is relevant for a large percentage of patients, and it needs to be comprehensively addressed throughout a physician's training (3,4). Except for model programs such as that detailed by Halikas (5), however, there has been little study of how addiction psychiatry is actually being taught to psychiatry residents in the field. Little has been known of the clinical settings, durations of core clinical experiences, diversity of clinical populations and levels of care, and quality of supervision for general psychiatry residents. We found considerable diversity among program characteristics in these areas; although this was not easily analyzed, it testified to the perceived importance of addiction psychiatry and to training directors' resourcefulness in providing clinical experiences.

Underscoring the perceived importance of addiction training, the modal time on a core clinical experience is already twice the new requirement in surveyed programs. The few programs that needed to make changes to meet the new RRC requirement did not anticipate significant difficulties. Training directors attempted, when possible, to expose residents to addiction training in different types of settings with different patients and different levels of care. Infrequently reported, however, was the ability to follow patients with substance use disorders with qualified addiction supervisors over an extended period of time. When patients with substance use disorders could be followed further, it was usually in a clinic with no specific addiction supervision. It appeared that many programs lack good ambulatory detoxification and ambulatory rehabilitation addiction experiences, which have been identified as critical educational needs (6,7).

Very often the practical matter of resident placement involved the availability of an appropriate training service and of good addiction supervisors. In the current climate of increased administrative and staff changes, where addiction services may become disaffiliated from the training program or good addiction supervisors lost, several program directors indicated that providing a good addiction training experience was an ongoing concern. This was particularly so when the service was off site. Often, unfortunately, there seemed to be just one key supervisor, and the training director voiced frank concern about the integrity and quality of the addiction psychiatry training experience if this supervisor were to leave. Although not all of our respondents knew whether their addiction teachers/supervisors had addiction board certification, another recent survey reported that 25% of psychiatry residency addiction teachers had addiction board certification from the American Board of Psychiatry and Neurology and another 15% from the American Society of Addiction Medicine— possibly reflecting growing interest in securing certified teachers (8).

Our hypothesis that programs with affiliated addiction residencies might be stronger was difficult to test, although programs with affiliated addiction residencies did display a trend toward more extensive addiction psychiatry training experiences. We were surprised to find that many general psychiatry residency programs did not make any appreciable use of the addiction residents for supervision of the general residents. Perhaps as addiction psychiatry residencies become more established, addiction residents will be appreciated as a more valued resource.

By design, our surveyed programs more often had affiliated addiction residency programs; they were therefore slightly larger than the average accredited psychiatry residency program, which may have affected some study questions. Our findings must also be tempered by our not having formally randomized our survey process.

Consistent with the training recommendations of the Group for the Advancement of Psychiatry Report on Addiction Treatment (9), we feel particularly strongly that learning appropriate therapeutic attitudes must begin early and be continually emphasized in training, an issue that frequently came up in our interviews. The early inculcation of appropriate therapeutic attitudes is as important as knowledge of neurobiology of addiction, detoxification, 12-step groups, motivational enhancement, cognitive-behavioral therapy, relapse prevention, and harm reduction (6,10,11). Often a resident enters training with a sense of ther-

apeutic nihilism, which may be exacerbated by selectively seeing those patients who return by way of emergency department visits or repeat detoxifications or admissions, rather than encountering those who are succeeding in recovery. Such attitudes may also be reinforced by exposure to the negative attitudes of other clinicians on those services, and by the resident's own fear of failure with such patients, the feeling that he or she cannot connect with the patients or offer much to them. Residents from some other cultures where drug use (and sometimes alcohol use) are even more stigmatized may also have specific religious backgrounds (e.g., the Islamic prohibition against alcohol) that cause them to distance themselves from patients with substance use disorders. Residents may feel confused by the street lingo and drug argot of these patients; conversely, substance use disorder patients may easily become impatient with a resident's failure to understand.

We feel that regardless of when a core addiction training experience takes place, adequate early training in communicating and developing hopeful and helpful attitudes is critical. From our interviews, this did not seem to be routinely occurring. We recommend that this early training include 1) a primer on slang terms for drugs; 2) some specific knowledge about 12-step recovery programs (at least the first few steps, sponsorship, and the 90 meetings in 90 days concept) so that residents can converse meaningfully with patients; 3) some information on harm reduction; and 4) an understanding of the "stages of change" and motivational interviewing.

Regarding the latter, several of us have been successfully using the first few chapters of *Motivational Interviewing* by Miller and Rollnick (12). This brief introduction not only promotes understanding and feeling empowered to work with patients with substance use disorders, but is also relevant to working with patients with personality disorders. Offering such instruction (preferably including several role-playing exercises) has the added value of teaching some fundamental psychotherapeutic skills. For the investment of several hours of teaching, one can experience the rewards of seeing constraining attitudes change and seeing trainees becoming more hopeful and skillful in responsibly engaging challenging patients.

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