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A 4-year curriculum on substance use disorders for psychiatry residents

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Abstract

Objective—Substance use disorders (SUDs) are common among patients presenting to general psychiatry treatment settings, and thus it is important that all psychiatry residents be well-trained in the screening, diagnosis, and treatment of outpatients with these problems. Nonetheless, there is a relative shortage of trained addiction psychiatry staff to meet residents' educational needs.

Methods—The authors describe an addiction psychiatry curriculum within a general psychiatry training program to demonstrate practical approaches to educating general psychiatry residents on the treatment of SUDs.

Results—The MGH/McLean adult psychiatry residency training program provides training in addiction psychiatry in multiple treatment settings during the four years of residency. The program uses addiction specialists, non-specialty psychiatrists, and residents and fellows to provide training.

Conclusions—Adult psychiatry residencies can provide comprehensive addiction psychiatry training that spans multiple treatment settings and post-graduate years. This can be accomplished by training general staff psychiatrists, senior residents, and fellows to assist core addiction faculty in providing addiction psychiatry education.

Introduction

In the past, addiction psychiatry was described as a “stepchild” in psychiatric residencies (1). Since then, the need for more comprehensive education regarding the treatment of substance use disorders (SUDs) for general psychiatric residents has been more widely recognized. These advances have largely been driven by increased awareness of the need-to-treatment gap, and the fact that most patients with SUDs will not see an addiction specialist but will seek care from primary care providers, general psychiatrists, or specialists in non-addiction related fields. Patients with substance use problems are common in both adult and pediatric clinical populations (2,3). Furthermore, there is a dearth of formally trained addiction specialists relative to patients with these disorders, underscoring the need for generalists of all fields, particularly psychiatrists, to be well trained in the diagnosis and appropriate treatment of patients with substance use problems (4).

In 1996, the American Psychiatric Association issued two position statements on training needs in addiction psychiatry and substance-related disorders calling for efforts to bolster addiction curricula in general residencies (5,6). In January 2001 the Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (ACGME) mandated a one-month full-time-equivalent supervised evaluation and management of patients with alcoholism and drug abuse in inpatient and/or outpatient settings for general psychiatric training programs (7). A subsequent survey of 50 psychiatric residencies determined that, while most programs were able to meet the minimum ACGME requirements, program directors expressed concerns about certain aspects of addiction training within their programs. These included insufficient opportunities for residents to follow patients over extended periods and in different settings and limited availability of qualified addiction supervisors (8). Others have affirmed that most addiction psychiatry training is not provided by supervisors trained in that subspecialty (9). Given this shortage of supervisors, it appears that addiction fellows are surprisingly underutilized in training residents (8).

Stigma has been cited as an additional impediment to education about the care of patients with SUDs (10). Fostering appropriate attitudes and a sense of professional responsibility for treatment of patients with SUDs by psychiatric residents is essential for training new physicians willing and able to treat these problems. Renner describes these components, along with an adequate knowledge base, as the “clinician’s triad” required for successful clinical care of patients with addictions (11,12). Even brief substance abuse seminars can result in measurable improvements in medical student and resident attitudes towards addicted patients (13,14). Learning appropriate approaches to patients with substance abuse problems is best begun early in training (4,8), where role-modeling and mentoring can facilitate the development of helpful attitudes and a sense of professional responsibility for these patients (10). This should continue through the later stages of training, when senior residents are asked to model this behavior for their more junior colleagues. Despite this, comprehensive training throughout the four-year residency is rare (15).

Recently, there has been increased interest in teaching evidence-based practice in psychiatry residency programs (16). Kay (1991) cites fostering scientific thinking as a primary role for psychiatric residency education (17). Effective substance abuse education will add to residents’ ability to evaluate scientific literature and to integrate thoughtfully this skill into the care of individual patients.

The MGH/McLean addiction education curriculum provides a practical model of a four-year training program in a general psychiatry residency that addresses these issues. This curriculum focuses on the diagnosis and evidence-based treatment of patients with SUDs and co-occurring other psychiatric disorders in a variety of settings. Through the use of specialty and general supervisors as well as residents and fellows, it provides education and modeling of effective work with addicted patients.

Method

The MGH/McLean Adult Psychiatry Residency Training Program initiated a review of its addiction psychiatry training in 2001–2002. The training faculty met at the annual faculty retreat to assess strengths and weaknesses of addiction psychiatry teaching. This retreat was followed by several curriculum planning meetings and recommendations for longitudinal, integrated teaching in addiction psychiatry throughout the four-year program.

Results

A six-part curriculum was initiated in 2002 to be phased in over a three year time period. Major components included: 1) A faculty seminar series in addiction psychiatry to “train the trainers” in fundamentals of diagnosis and treatment of SUDs; 2) The development of two comprehensive training binders in addiction psychiatry for use in PGY-1 and PGY-3 addiction psychiatry rotations; 3) Implementation of a one-month full-time inpatient addiction psychiatry rotation during the internship (PGY-1) year as of July, 2004; 4) The integration of addiction psychiatry teaching on inpatient services during the PGY-2 year; 5) The initiation of a required 10-hour-per-week, two-month substance abuse consultation and outpatient supervision rotation required in PGY-3 year, as of July, 2005; 6) The offering of substance abuse electives in the PGY-4 year including a Chief Residency in Addiction Psychiatry as well as clinical and/or research electives. This curriculum is described in detail below.

PGY-1

All residents participate in a required one-month full-time substance abuse rotation during the PGY-1 year. The main setting for this rotation is a 14-bed alcohol and drug abuse treatment inpatient psychiatry unit where patients receive medical detoxification and initial substance abuse education and treatment. The majority of patients on this unit have other co-occurring psychiatric disorders, including patients with mood and anxiety disorders as well as some acutely suicidal, manic, or psychotic patients. Residents also spend about 10% of their time leading groups in an alcohol and drug abuse partial hospital treatment program with an average daily census of 20 patients, which focuses on substance abuse treatment, relapse prevention, and 12-step facilitation. The partial hospital program receives patients stepping down from the inpatient addiction psychiatry unit as well as direct admissions from the community of patients not requiring inpatient hospitalization.

Primary goals during the PGY-1 rotation include introducing residents to fundamentals of interviewing patients with SUDs; appropriate diagnosis and treatment of patients with co-occurring substance use and other psychiatric disorders; and fostering a sense of enthusiasm for and hopefulness about working with addicted patients. Inpatient work for the PGY-1 resident consists of team rounds assessing new patients, following up with current patients, preparing patients for discharge with appropriate aftercare plans, and leading group therapy sessions. Core competencies expected at the end of this rotation include acquisition of a sound foundation of knowledge and effective skills in diagnostic and therapeutic interviewing, history taking, mental status examination, differential diagnosis, recognition of withdrawal symptoms and implementing detoxification protocols, treatment planning, and appropriate referral of patients with SUDs.

Residents on this rotation receive supervision from multiple faculty members. The attending psychiatrist provides direct supervision during daily unit rounds, where the residents interview patients and direct their care. Additionally, the attending psychiatrist provides weekly individual supervision of residents, during which time complex cases may be discussed in more detail or a patient may be interviewed. Residents also receive supervision from other addiction faculty and residents, including the Clinical Director, the Associate Clinical Director, the chief resident in addiction psychiatry, and the addiction psychiatry fellow. The Clinical Director and the Associate Clinical Director each meet with residents for weekly didactic instruction, covering such topics as interviewing, pharmacotherapy of SUDs, psychotherapy of SUDs, and the “difficult” patient. In addition, the chief resident and the addiction psychiatry fellow each meet with PGY-1 residents for at least one hour weekly. During this time, cases are discussed or patients are interviewed, allowing the senior residents and fellows to model positive, helpful attitudes towards patients with addiction as well as a sense of professional responsibility for these patients.

Also to this end, residents attend with the PGY-3 residents and the chief resident a one-hour interviewing seminar with a different senior staff member each week from the substance abuse treatment service. Interview seminar leaders represent multiple disciplines including psychology, psychiatry, child psychiatry and social work, but most are board certified addiction psychiatrists. This further exposes general psychiatry residents to psychiatrists and other clinicians who are enthusiastic and knowledgeable about the treatment of patients with addictive disorders. Finally, residents have a 3-hour seminar introducing them to group psychodynamics and basic principals of group psychotherapy for addiction.

A culture of evidence-based practice and self-directed learning is introduced by providing residents with an introductory binder containing the rotation description, expectations, core competencies, and recommended readings. Some readings are explicitly discussed during their meetings with faculty and senior residents/fellows, including the introductory chapters of Miller and Rollnick's text on Motivational Interviewing (18), an article on patient evaluation (19), and an article describing the stages of change (20). Other articles review topics including 12-step programs, co-occurring SUDs and other psychiatric disorders, individual and group psychotherapies for SUDs, and the neurobiology of drug reward and addiction. Residents are encouraged to refer to these articles as they encounter different forms of treatment during the rotation. The binder is indexed and topically organized to help residents do so.

PGY-2

During the PGY-2 year, addiction education is integrated into residents' other rotations, reinforcing the expectation that patients with substance problems are found in all health care settings and that most treatment of patients with SUDs takes place outside of substance abuse specialty programs. Core rotations include a 3-month rotation on the Acute Psychiatry Service (APS), a busy emergency room evaluation and management setting at Massachusetts General Hospital (MGH); a 3-month medical psychiatry inpatient rotation at MGH; and a 3-month rotation on the psychotic disorders inpatient unit at McLean Hospital.

Fifty percent of patients that residents treat in the APS have SUDs. Substance abuse education during this rotation is provided through direct patient care (supervised by attending emergency psychiatrists and senior residents) and through formal Substance Abuse Training Seminars. These seminars further residents' knowledge of substance abuse and extend their understanding of treatment to include clinical competence in the emergency room assessment and management of SUDs such as treating acute withdrawal, engaging ambivalent patients, and making referrals to appropriate levels of care.

Substance abuse education continues during the medical psychiatry and psychotic disorders inpatient rotations, where residents manage acute withdrawal and attend seminars and clinical case conferences which teach residents to integrate the psychiatric and substance use disorder histories in planning care, to screen for SUDs in these settings, and to provide detoxification and treatment planning for patients with non-substance-related primary diagnoses. The foundation for these skills was laid during the one-month PGY-1 inpatient rotation and it is expected that the resident will increase his/her competence in these areas by implementing these skills under supervision during the PGY-2 rotations. During the psychotic disorders inpatient rotation, the residents may request substance abuse consultation on their cases from their PGYIII resident colleagues who are rotating on the Substance Abuse Consultation service.

PGY-3

The PGY-3 year generally focuses on outpatient and consultation-liaison psychiatry. Consistent with this focus, during the PGY-3 year, residents participate in a required 2-month, 10-hour-per-week rotation on the Substance Abuse Consultation Service (SACS) (19). During

this rotation, residents provide substance abuse consultations to psychiatric inpatient and partial hospital units that admit patients of all ages with co-occurring psychiatric disorders and SUDs. Residents may spend up to 6 hours performing two to three consultations each week. The emphasis is on integrating treatment recommendations for patients with co-occurring psychiatric and SUDs. In addition, at the beginning of the rotation, residents are asked to identify patients in their own outpatient caseloads who they would like to present to the Director of the SACS during the rotation. Each week, residents meet for two rounds sessions with the Director of the SACS to review their consultations and/or to discuss a patient drawn from the residents' outpatient clinic practices. Residents also meet weekly with the chief resident who presents didactic instruction on eight topics (i.e. diagnosis of SUDs, motivational interviewing, problem drinking and alcohol use disorders, opioid abuse and dependence, marijuana abuse and dependence, methamphetamine and cocaine abuse, tobacco and nicotine dependence, and problem gambling).

The topics are referenced in an "advanced binder" that residents receive during this rotation. This binder includes a rotation description, expectations, instructions on how to do a consult, core competencies, and recommended readings meant to build on residents' ability to provide evidence-based treatment recommendations for their consultation patients as well as to foster residents' ability to provide such care to their own outpatients. Both the binder and the chief resident rounds follow a systematic curriculum organized into introductory topics (such as how to perform a consultation, or a more advanced discussion of brief motivational interventions) followed by topical discussions organized by major substances of abuse as described above. For each substance covered, the binder includes both literature review articles and treatment guidelines. The interviewing skills needed for both consultation and outpatient work are reinforced by the weekly interviewing seminar which PGYIII residents attend with their PGYI resident colleagues who are rotating on the inpatient service.

PGY-4

During the PGY-4 year, residents continue to provide care for patients with SUDs in their longitudinal clinics, and to be provided with supervision on these cases. Residents may choose weekly supervision with addiction psychiatry staff, or receive supervision on a consultative basis in cases where a non-specialist is identified as the primary supervisor. Residents particularly interested in SUDs are provided with support and mentorship for research projects or opportunities for further clinical training in the PGY-4 year; one is selected to be chief resident in addiction psychiatry.

The chief residency is an individualized fourth year program that is designed by the chief resident and the Associate Clinical Director of the ADATP. Core components include work with outpatients and frequent supervision on both clinical work and on providing education on the treatment of SUDs to junior residents, a major role for the chief resident. In addition, the chief resident has the opportunity to co-lead a Suboxone maintenance group in the outpatient Suboxone treatment program, as well as to learn to manage individual outpatients receiving Suboxone. Other opportunities that the chief resident can pursue include further training and clinical practice in relapse prevention treatments, motivational interviewing, and patient education groups.

PGY-4 residents not serving as chief resident are offered opportunities to continue clinical training or involvement in research and teaching projects relevant to patients with SUDs. Many participate in ongoing outpatient work supervised by addiction specialists, pursue research projects, help teach seminars for junior residents, or participate in individualized electives on the different clinical services in the Alcohol and Drug Abuse Treatment Program.

Discussion

The MGH/McLean curriculum offers a model by which addiction specialists, other faculty, clinical fellows and senior residents provide comprehensive training in and modeling of substance abuse treatment in a program that is integrated throughout all four years of residency and across multiple treatment settings. Treatment and training venues include addiction psychiatry rotations, integrated training on other rotations, and consultation to non-addiction inpatient and partial hospital psychiatry units. This allows a focus on patients with other co-occurring disorders and trains residents to work with patients in multiple settings. In addition, it reinforces the idea that general psychiatrists will encounter and need to treat patients with SUDs in their day-to-day practices, helping to foster a sense of professional responsibility for these patients.

The curriculum also addresses the commonly cited problem of a relative lack of qualified addiction supervisors in many residency training programs by training supervisors from non-specialized settings and by allowing core addiction faculty to act as “consulting supervisors” where patient care is being primarily supervised by nonspecialists. This helps both the resident and the non-specialty supervisor to remain engaged in treatment of the addicted patient, rather than referring them elsewhere thereby missing the opportunity to learn about treatment with expert consultation or supervision. Through the “train-the-trainer” sessions, non-specialty faculty also receive training in the MGH/McLean program. Furthermore, the model explicitly engages senior residents, particularly the addiction chief resident and addiction fellow, in teaching residents about the fundamentals of addiction psychiatry and in modeling appropriate attitudes towards addicted patients. In this manner, the resources of specialized clinical faculty are effectively extended by the active inclusion of non-specialists, senior residents and fellows to train junior residents.

In addition to augmenting supervision by addiction supervisors with the inclusion of other faculty and residents who teach addiction psychiatry, this education program addresses the problem of stigma and resulting negative attitudes about addictions. Clinicians from multiple levels, including other trainees, are trained to model appropriate attitudes and approaches to addicted patients. Such clinicians include core addiction faculty and non-specialist faculty, reinforcing the principle that all psychiatrists are responsible for treating these patients. It also provides direct examples of careers in addiction psychiatry through the interviewing seminar and other supervision, including involvement by the senior resident and fellow to model the early stages of such careers which may be most salient to physicians in training. Furthermore, the possibility of serving as addiction chief resident in the future stimulates thought among junior residents of how to become involved in the field during training and beyond.

Finally, the program models evidence-based treatment of addicted patients by providing binders, by systematically reviewing the literature with residents in seminars and supervision, and by training and encouraging residents to use these resources in treatment planning. In this manner, residents are trained to apply principals of evidence-based medicine to collaboratively form an individualized treatment plan with patients and to understand and apply empirically supported models of interviewing, screening, diagnosis, and treatment. The chief residents use the up-to-date resources in the binder as a basic curriculum to provide didactic instruction to junior residents, facilitating ongoing chief resident teaching despite year-to-year transitions as they graduate and are replaced. The chief resident contributes to updating the binder and passes it on to his or her successor.

Conclusions

Clinical competency in treating patients with SUDs is widely recognized as an essential component of general psychiatric residency training. Nonetheless, a relative shortage of addiction-trained supervisors and specialty treatment settings presents a challenge to general psychiatry residencies. The MGH/McLean program provides a practical model by which such training can be integrated into existing treatment and training settings, utilizing non-specialty supervisors, senior residents or addiction fellows to augment teaching by core addiction faculty. This model can be implemented in programs that now rely on a few core faculty members to provide addiction education, extending this resource to provide much needed resident education to meet the needs of patients with substance use disorders.

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