Position Statement on Training Needs in Addiction Psychiatry

Psychiatry has only recently developed training in the area of substance-related disorders. Nevertheless, these illnesses are highly prevalent and are associated with substantial morbidity and mortality. Patients with these disorders often do not encounter or have access to effective treatment. Because of this, the American Psychiatric Association recommends developing improved training to assure that 1) the basic psychiatric residency addresses essential aspects of addiction prevention and treatment, 2) addiction psychiatry fellowships are strengthened to provide needed manpower for consultation, academic teaching, and research, and 3) psychiatrists are trained to provide leadership for the multidisciplinary teams characteristic of this field.

This statement was drafted by the Committee on Training and Education in Addiction Psychiatry.[1] *It was approved by the APA Assembly in November 1995 and by the Board of Trustees in December 1995.*

American psychiatry is faced with an important training challenge in addressing psychoactive-substance-related disorders, which are among the most prevalent and debilitating of psychiatric illnesses. Fewer than one-fourth of the persons in need of alcohol and drug abuse services in the United States actually receive treatment (1), and better training of professionals is needed to engage affected people in treatment and move them toward recovery. In particular, well-trained psychiatrists are essential to the assurance of integrated biopsychosocial treatment and to provision of teaching, clinical supervision, and leadership for multidisciplinary staff. The purpose of this position statement is to promote the psychiatric education necessary to assure effective treatment, prevention, and research for psychoactive-substance-related disorders.

PSYCHIATRISTS PROVIDING CARE

On the whole, alcohol and drug abuse patients constitute about 10% of active psychiatrists' caseloads (2). Federal figures on institutionally based treatment, however, can serve as an indication of the limitation in psychiatry's role in the field. Of 77,000 full-time-equivalent health personnel who were employed by alcohol and drug treatment units in the United States in 1990, only 7% were psychiatrists. This is a small portion of personnel relative to credentialed (33%) and noncredentialed (20%) counselors, nurses (14%), social workers (11%), psychologists (9%), and other physicians (7%). Stated otherwise, there were only 6.3 psychiatrists per 1,000 patients in these programs overall (3, 4).

PSYCHIATRIC TRAINING IN SUBSTANCE ABUSE

Psychiatry departments have improved training in psychoactive-substance-related disorders over the past decade, and in a recent APA survey, most undergraduate and psychiatric residency programs reported offering at least limited teaching in alcoholism and drug abuse and addiction (5). On the postresidency level, as of 1995 there were 46 addiction fellowship programs in the United States, all but two open to psychiatrists, but this reflects a gain of only one program since 1990 (6). The American Board of Psychiatry and Neurology (ABPN) established addiction psychiatry as an added qualification in 1993, and 767 psychiatrists have been certified through the ABPN. After 5 years, however, all candidates for certification will have to complete a fellowship in order to take the examination.

RECOMMENDATIONS

The need for an integrated biopsychosocial approach to the patient is illustrated by recent research on the neurobiology of addiction, new detoxification techniques, behavioral therapies, combined pharmacotherapy and psychosocial treatment, proper dosing in methadone treatment, diagnosis of comorbid psychopathology, and comprehensive care for the HIV-infected patient. In order to achieve this, the American Psychiatric Association recommends that action be taken to strengthen three levels of psychiatric training in substance abuse.

1. *Postgraduate years 1–4 of the general psychiatric residency.* Basic modalities such as detoxification, ambulatory rehabilitation, and treating dually diagnosed patients require a leadership role from the general psychiatric community, emerging from basic residency training. Training of psychiatric residents to provide these services in a competent manner is necessary.

2. *Fellowships in addiction psychiatry.* This new level of training is essential in order to provide academic teachers and consultants for both general psychiatrists and other professionals in the field, as well as expert researchers. It is particularly important for assuring the introduction of new pharmacotherapies for addiction. Availability of resources for this postresidency training is therefore necessary to the continuing development of the addiction psychiatry field and to assuring a stable level of specialty expertise. It is important that these academically based programs be strengthened, even though changes in the health care system may make expansion of advanced postgraduate training difficult.

3. *Training of multidisciplinary teams for addiction treatment.* Multidisciplinary personnel currently play a much larger role in framing the treatment of addiction than they do in general psychiatry. Because of this, addiction programs are often divorced from the strong ties to the biopsychosocial models necessary to ensure quality care. Psychiatrists should therefore be trained to assume leadership roles in proper management, education, and consultation with these diverse disciplines in relation to patients with substance-related disorders.

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