APA Resource Document

Resource Document on Education and Training for Substance Use Disorders

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Prepared by Jill Williams, MD, Shelly Greenfield, MD, Andrew Saxon, MD, Marshall Forstein, MD, Bradley Stein, MD, Erick Hung, MD, Jonathan Avery, MD, Tristan Gorrindo, MD

Purpose of the Workgroup

To develop recommendations to improve the training and education for medical students, resident physicians in training, and practicing physicians in substance use disorders.

Summary of the Issue

Current training of physicians in the recognition and treatment of substance use disorders (SUD) is inadequate to meet the needs of such a diverse and growing population of patients. Medical schools, physician training (residency) programs, and continuing education programs for physicians in practice, provide limited training in the treatment of SUDs. The scope of training on SUDs is disproportionate to the population health need to address these problems, and many with SUDs go undiagnosed and untreated. In the past decade there have been marked advancements in the science of addiction, which includes an expanding range of evidence-based pharmacologic and behavioral treatments. Despite these advances and a growing knowledge base, the educational requirements in psychiatry and other medical residencies have not shifted, leaving many physicians ill-prepared to manage SUDs in practice (1). Deficits in knowledge and clinical skills among physicians-in-training and those in practice are compounded by negative attitudes and stigma toward individuals with SUDs. The lack of adequate curriculum, disproportionate exposure to end-stage addiction, and lack of faculty expertise all may contribute to negative attitudes (2). In addition, the lack of availability of competently trained faculty to provide clinical supervision is cited as a major barrier by residency program directors working with physicians-in-training (3). Through the DATA 2000 Act, office-based prescribing of buprenorphine could occur after completion of an 8-hour training equivalent and federal registration process. This waiver training as it currently exists has been cited as a regulatory barrier that prevents some prescribers from providing office-based medications for addiction treatment (MAT) although at the same time, it may be the only education certain physicians receive. The barrier may not be merely the education hours, but also other components of the process such as the federal registration process, limits on patient numbers and concern for regulatory inspections. There is ample evidence that physicians and medical trainees need more training in SUD. The mandated 8-hour waiver training can only be removed if broader, more systematic efforts at educating physicians are put into place. This can be implemented at every level from medical school, through residency training and continuing education for those in practice. Access

to virtual (online) training and mentoring programs for supervision from an addiction physician specialist make this accessible, even in locations with few local resources. ***At a minimum, all physicians need to be able to 1. Screen for SUD and provide referral, follow up, and/or appropriate evidence-based treatment 2. Recognize the complex medical and psychiatric comorbidities associated with SUD, and 3. Practice appropriate prescribing of drugs with abuse potential. At the Federal level, an interagency coordinating meeting or workgroup could develop recommendations to address SUD education across the healthcare spectrum.***

Background Information

Medical Student Education

Although a recent survey of US medical schools indicates that most cover "substance abuse," there is a lack of standardization, and many cover the topic in elective coursework, rather than required coursework (4). Common barriers include a lack of addiction- trained physicians, provider stigma and lack of knowledge, and insufficient curriculum time. Educational interventions relating to SUDs are effective in improving medical students' knowledge, skills and attitudes and several schools have developed innovative education methods in response to the recent opioid crisis (5).

Non-Psychiatry (Medical/ Surgical) Residency

Many studies have demonstrated a need for improvement in resident practice habits, finding that non-psychiatric residents often fail to appropriately screen for, or diagnose alcohol and other substance use disorders in their clinic and hospitalized patients (6). Residents can develop more negative attitudes about patients with SUD as their residency progresses, with studies finding worse attitudes in senior compared to junior residents. Addressing attitudes in addition to core didactic curricula and providing relevant training experiences are essential, and greater mentorship from senior clinicians, as well as more longitudinal training experiences may enhance the overall training experience (7). Curriculum should go beyond just medical consequences of substance use and incorporate DSM criteria and behavioral aspects of SUD.

Psychiatry Residency

The ACGME requirement for SUD-related education and training in psychiatry residency has not changed substantially for many years and is only a 1-month equivalent of addiction treatment experience. In many residency programs, this training takes place in inpatient settings that do not provide specialty care for SUDs or provide access to addiction psychiatrist supervisors. Recent surveys of psychiatry residency programs confirm ongoing gaps in basic areas of SUD training with only 40% mandating buprenorphine waiver training. Only 1% of graduating psychiatry residents enter fellowship specialty training for addictions.

Psychiatrists and Other Practicing Physicians

In addition to targeting physicians in training, more efforts are needed to enhance education about SUD for practicing physicians. This is both to meet the immediate need for services to combat the current opioid crisis and to support the mentoring of the next generation of physicians. Effective methods for screening, brief counseling and medications for SUD are not reliably provided in primary care settings. One study of PCPs showed that many failed to make a correct diagnosis of alcohol abuse

(94%) or drug disorder (40%; 8). Failure to diagnose a SUD may allow exacerbation of the condition, while contributing to higher health care costs. General psychiatrists in practice do not routinely incorporate addiction treatment into their practice, and a national survey of psychiatrists indicates that more than 80% were uncomfortable with providing office-based treatment for opioid use disorder (9). Despite recommendations for integrated co-occurring care, many psychiatrists lack the expertise to manage complex needs in patients with comorbid substance use disorders. Online and live continuing education programs can target these learners who are already in practice as these methods are able to impact practice change, especially when they are enhanced by technical support, learning collaboratives and/or follow up consultation (10,11).

Need for Other Supporting and Broader Systems Efforts

Efforts to educate the physician workforce are needed but will not be able to address all barriers to SUD treatment, as many other enhancements are needed. A key effort is the need to include increased rates of reimbursement for physician services and expansion of patient support services to build a truly comprehensive system of collaborative care. Enhanced payment for individuals who receive specialty training in addictions currently does not exist, and is a barrier to physicians pursuing fellowship training and working in the SUD field. Other systems change efforts would be synergistic to these efforts but are beyond the scope of this document, such as incentives or performance metrics for large systems of care supported by the Centers for Medicare & Medicaid Services.

Recommendations

There are opportunities at every level of the physician education continuum. Below are specific recommendations. A more comprehensive review of recommendations, discussed at a national conference of Federal Agencies in 2006, can be found in Wyatt and Dekker (12). At the Federal level, an up-to-date interagency coordinating meeting or workgroup could develop recommendations to address SUD education across the healthcare spectrum, and would be useful to coordinate a larger effort.

Medical Schools

- Medical students would benefit from a standardized, interdisciplinary core curriculum on SUDs that provides a base for future learning, helps reduce stigma towards individuals with SUD, introduces basic screening and treatment approaches, and addresses the complexities and comorbidities of SUD. This education should include topics of pain management and appropriate prescribing of controlled substances. The role of structural racism in the recognition and treatment of SUD among different populations should also be included.
- Medical students should have early exposure to addiction physician specialists who can serve as important role models.

Non-Psychiatry (Medical/ Surgical) Residencies

- The Accreditation Council of Graduate Medical Education should strengthen existing SUD requirements to ensure that residents in all (non-psychiatric) residencies receive standardized training experience on SUDs that is based on performance of clinical skills and readiness for practice, including screening and referral for treatment. This should include core general

knowledge, as well as additional knowledge of particular relevance to specialty and subspecialty practice within a specific field of training.
- All physicians-in-training should possess the knowledge and skills to provide medications for addiction, including for opioid, alcohol and tobacco use disorder with the expectation that graduating residents will be prepared for treatment of SUDs in a community or office-based practice.
- All physicians should be trained in the stigma and negative regard that impact physician attitudes and practices towards patients with SUDs.
- Other groups have similarly called for Core Competencies in SUD for all residents (11) that include training in Screening, Assessment, Use of Medications and Referral for Specialty Care when indicated.

Psychiatric Residency

- Psychiatrists are uniquely positioned to diagnose and treat substance use disorders, co-occurring psychiatric disorders, and recognize suicide risk and prevention in these high-risk populations. Emphasis in addressing addiction and co-occurring should be incorporated into all aspects of psychiatry residency training since patients with SUD are seen at all levels of care. Supervision and discussion of individuals with SUD can be provided throughout inpatient and outpatient levels of care, and should include access to an Addiction Psychiatrist.
- Ensure that psychiatry training programs have access to resources to help them incorporate enhanced training in SUD with the goal of bolstering resident competencies in assessing and treating these conditions. This can be incorporated through a variety of additional extensive didactic or experiential methods.
- All psychiatry residents should complete the buprenorphine waiver training (or equivalent).
- Training for psychiatry residents should include more extensive training in screening, evaluation and treatment of all relevant SUDs (including but not limited) alcohol use disorder, stimulant use disorder, opioid use disorder, sedative/hypnotic use disorder, cannabis use disorder, tobacco use disorder and other substances).
- Training experience should include various levels of patient acuity and corresponding care (outpatient to residential).
- Training on SUD treatments should include FDA-approved medications for opioid, alcohol, and tobacco use disorder, (and others that may be FDA approved when developed in the future).
- Training on SUD treatments should include knowledge of the range of evidence-based behavioral therapies and competency to practice at least one. This might include, but is not limited to, ability to integrate motivational interviewing concepts and techniques into patient assessments and sessions.

Continuing Medical Education for Physicians in Practice

- Faculty development for teaching faculty should include opportunities for all supervisors to receive updated knowledge and clinical guidelines to better guide the residents' care of patients, and address stigma and barriers to care for individuals with SUDs.
- The 8-hour curriculum that satisfies the Data Waiver application is a fairly succinct overview of the use of medication for addiction treatment for opioid use disorder that includes basic training on approach to SUDs. Although this training has been cited by some as a barrier to MAT prescribing, it currently does not exist in any other form of physician education. Efforts to

eventually remove the Waiver training could only succeed when other more comprehensive educational measures have been instituted.

- Continued access to education with continuing medical education credits is essential to encourage practicing physicians to enhance their knowledge of SUDs. This includes ongoing access to resources such as the Providers' Clinical Support System (PCSS), which provides free education in a range of topics on SUDs including the 8-hour Data Waiver training.
- Education efforts should include not only didactic curricula, but also mentoring and opportunities for supervision and technical assistance with complex cases from addiction specialists.

Strategies for Achieving Change

Below are strategies to promote change and improve efforts to increase the awareness of SUDs in all aspects of medical training in proportion to their scope and impact on the population. It is expected that trainings might be delivered in a variety of live, in-person as well as virtual (online) methods. Online training that is done asynchronously (pre-recorded) should remain an option and there should be increased opportunities for remote, online supervision to areas without local expertise. For more comprehensive review, see also Wyatt and Decker (12).

- Grant programs
    - Medical school loan repayment programs for residents who pursue addiction subspecialty training.
    - Expansion of general psychiatry postgraduate training slots to increase physician addictions workforce, with additional pay for faculty who have specialty training in addictions.
    - Support medical and other health profession schools to expand or develop education and training programs for substance use prevention and treatment.
- Real-world training that comes from clinical supervision is essential to addressing issues of attitude and stigma as well as mastering competencies in identifying and managing psychiatric co-morbidities including pain as well as consulting to other healthcare providers. Investments are needed at all levels of medical education to provide the greatest impact and lasting change in medical schools.
    - Promote curriculum requirements based on hours or competencies through Liaison Committee on Medical Education (LCME) medical school accreditation standards.
- Residency programs
    - Promote common core requirement for clinical learning about SUDs with supervision based on hours or competencies for all physicians-in-training through the ACGME.
    - Ensure access to psychiatry residency experiences and supervision to enhance access to specialty care and co-occurring conditions.
- Testing Organizations (USMLE)
    - Promote increased emphasis on SUDs in national examinations for physician licensure.

References

1. Addiction Medicine: Closing the Gap between Science and Practice. Report of the National Center on Addiction and Substance Abuse at Columbia. 201. https://www.centeronaddiction.org/addiction-research/reports/addiction-medicine-closing-gap-between-science-and-practice
2. Geller G, Levine DM, Mamon JA, et al. Knowledge, attitudes, and reported practices of medical students and house staff regarding the diagnosis and treatment of alcoholism. JAMA. 1989;261:3115–3120.
3. Schwartz AC, Frank A, Welsh JW, Blankenship K, DeJong SM.Addictions Training in General Psychiatry Training Programs: Current Gaps and Barriers.Acad Psychiatry. 2018 Oct;42(5):642-647.
4. Academic Medicine's Response to the Opioid Crisis. Report of the Association of American Medical Colleges. Feb 2019.
5. Muzyk A, Smothers ZPW, Akrobetu D, Ruiz Veve J, MacEachern M, Tetrault JM, Gruppen L. Substance Use Disorder Education in Medical Schools: A Scoping Review. Acad Med. 2019 Nov;94(11):1825-1834.
6. Polydorou S, Gunderson EW, Levin FR. Training physicians to treat substance use disorders. *Curr Psychiatry Rep*. 2008;10(5):399–404.
7. Avery JD, Taylor KE, Kast KA, Kattan J, Gordon-Elliot J, Mauer E, Avery JJ, Penzner JB. Attitudes Toward Individuals With Mental Illness and Substance Use Disorders Among Resident Physicians. Prim Care Companion CNS Disord. 2019 Jan 3;21(1):18m02382.
8. The National Center on Addiction and Substance Abuse at Columbia University. Missed opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse. Accessed at www.casacolumbia.org/templates/publications_reports.aspx?keywords=2000
9. West JC, Kosten TR, Wilk J, et al. Challenges in increasing access to buprenorphine treatment for opiate addiction. Am J Addict. 2004;13(suppl 1): S8-S16.
10. Carrol Zhou , Allison Crawford, Eva Serhal, Paul Kurdyak, Sanjeev Sockalingam. The Impact of Project ECHO on Participant and Patient Outcomes: A Systematic Review. Acad Med 2016 Oct;91(10):1439-1461.
11. Ockene JK, Zapka JG. Provider education to promote implementation of clinical practice guidelines. Chest. 2000 Aug;118(2 Suppl):33S-39S.
12. Wyatt SA and Dekker MA. Improving Physician and Medical Student Education in Substance Use Disorders. JAOA 2007; 107(9), Supplement 5, ES27-ES36.