Addiction and overdose were already at crisis levels before the COVID-19 pandemic; they have only worsened since. Substance use disorders are both highly dangerous and very treatable. This combination demands continued attention. In the face of this pressing public health problem, the June 2022 issue of *Academic Psychiatry* includes papers that offer analysis, innovation, and guidance to educators.

Given the prevalence of substance use disorders and their ubiquity in every conceivable medical setting, we must ensure that all physicians can identify these illnesses and respond with attitudes consistent with their gravity and their treatability. Fuehrlein and colleagues [1] provide a pilot demonstration of one approach. They used a pre-post design to assess whether student scores on the Attitudes and Confidence in the Treatment of Patients with Substance Use Disorders (ACT-SUDS) could be impacted by a single, voluntary 2-hour didactic session. In their didactic, students received an educational module through synchronous Zoom conference, which included video of faculty assessing and intervening with simulated patients, who illustrated alcohol and opioid use disorders, and emphasizing psychosocial interventions. Scores on the ACT-SUDS showed significant improvement in student perception and attitudes, which was also visualizable in an evocative word cloud. Before the intervention, students’ first associations to substance use disorders included “sad,” “struggle,” “dependent,” and “addict”; afterwards, those negative words were replaced by “illness,” “help,” “diseases,” and “treatable.”

One of the challenges in teaching psychiatry is that our work is governed by a distinct set of medico-legal concerns, ethical imperatives, and governmental regulations. These guidelines are even more pronounced in the case of opioid use disorder and the restrictions and waivers involved in prescribing. How can a faculty member efficiently and accurately review and teach the history and law involved? Williams [2] offers a concise primer that will be immediately useful to faculty, residents, and students attempting to navigate this thicket.

The unmet needs in addiction extend beyond caring of the individual patient, to include research and health advocacy. We need physician-scientists who can advance our understanding of disease mechanisms and spark innovations in treatment. Jones and co-authors [3] report on results from 15 years of the Drug Abuse Research Training (DART) program. This program encompasses both an R-25 funded research track during psychiatry residency and a summer fellowship for undergraduate, graduate, and medical students. Jones et al. present data from 122 alumni from both programs, which demonstrate gains in research involvement and scholarly productivity. Equally impressive, through intentional commitment to diversity, the program leadership has improved the participation of women and underrepresented minorities over the years.

In regard to advocacy, Li and colleagues [4] offer a case history and a conceptual model that can guide and inspire the reader. Faced with a particularly severe opioid crisis in their Canadian city, a group of medical students identified the need for more managed opioid treatment programs and greater flexibility in the use of injectable opioid agonists. They worked with local stakeholders and faculty consultants to develop a set of asks and then trained a team of medical student delegates to educate city councilors. Their success led to an invitation to present their recommendations at the local Board of Health and then to collaborating with the board on a proposal to the Ministry of Health. Readers may find particularly valuable their delineation of eight “competency-enabling skills” required for effective advocacy: project management, health literacy, relational engagement, teamwork/collaboration, digital technology/social media use, scientific inquiry/critical thinking, sociocultural sensitivity, and communication. The authors argue persuasively that if advocacy is to be part of a physician’s identity, this complex set of skills is beyond the scope of extracurricular training. Greater commitment to time and space is necessary in the formal curriculum for teaching advocacy.
Juul et al. [5] describe the current state of subspecialty training in addiction treatment. Addiction psychiatry fellowships, which were first approved by the American Board of Medical Specialties (ABMS) in 1991, numbered 53 programs and 92 fellows in academic year 2020–2021. The authors note that these figures represent substantial growth since inception but fall short of what had been hoped for. The creation of a board certification option in addiction medicine by the ABMS in 2015 has provided a welcome addition. These fellowships can be sponsored by anesthesiology, emergency medicine, family medicine, internal medicine, obstetrics and gynecology, pediatrics, preventive medicine, and psychiatry. Growth has been rapid, resulting in 83 programs and 149 fellows in 2020–2021, with approximately 40% sponsored by psychiatry departments. And yet, the authors acknowledge that the need for specialists to treat substance use disorders will continue to far exceed the pipeline for many years to come.

Frank and colleagues’ commentary [6] begins precisely here. If subspecialty boarded experts cannot meet the growing demand, we should ask how we can ensure that general psychiatry graduates are prepared to treat people who have substance use disorders. The authors provide two vignettes of common presentations: uncomplicated alcohol use disorder and withdrawal in a general hospital setting and uncomplicated opioid use disorder and withdrawal in an emergency room. In discussing the cases, Frank et al. do an excellent job of spelling out what the learning needs and teaching opportunities are in the areas of patient care and medical knowledge.

The authors suggest that given the general dearth of subspecialty addiction certified faculty, and their uneven distribution across programs, we would be wise to pursue “teach the teacher” approaches. In this light, the American Academy of Addiction Psychiatry (AAAP) and the American Association of Directors of Psychiatric Residency Training (AADPRT) are to be congratulated on the recent launch of the AAAP-AADPRT Visiting Scholars Award in Addiction Education [7], which provides support for a visiting scholar with expertise in addiction psychiatry to provide education at selected programs. This award is a promising step forward.

Frank and colleagues [6] provide a thoughtful list of subcompetencies in their second table, which outline a reasonable set of expectations. The authors discuss how to embed teaching these subcompetencies in a variety of different settings and through a multitude of modalities. Even so, the authors wonder whether 1 month of dedicated addiction training can achieve these goals. I share this concern. The amount of time currently allocated in the general psychiatry requirements may not be aligned with the prevalence and severity of the clinical need and the body of core psychosocial and pharmacologic skills called for. As a result, the residency program I direct at the University of Texas Southwestern Medical Center now requires both a month of inpatient addiction in the first year and a second month of addiction outpatient or consults in the third or fourth year [8]. Psychiatry has valued the amount of elective space for which the current specific requirements leave room, but it is time to reconsider whether the current allocation of time still achieves the right balance of individual educational flexibility and public health needs. In the meanwhile, DeJong et al. [9] offer practical suggestions for how to optimize the teaching of addictions in general psychiatry settings. The authors demonstrate that there are opportunities to teach motivational interviewing and medication assisted treatment, and reduce the stigma of substance use disorders, in many rotations, including consult services, inpatient units, outpatient clinics, and others.

Finally, lest the magnitude of the task seem overwhelming, it is a gift to be reminded of how much difference addiction treatment can make in the individual patient’s life. Anna Sheen’s beautiful poem “Rewritten” [10] closes with the clinician’s appreciation that together they created “a new language: breathing, lift, light.”

Declarations

Disclosures The author states that there is no conflict of interest.

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