Addiction Teaching and Training in the General Psychiatry Setting

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Over 20.1 million Americans have a substance use disorder (SUD) of whom only 6.9% receive treatment [1]. One in seven people in the USA develops a SUD over the course of their lifetime [2]. According to the 2018 National Survey on Drug and Health, 3.2 million people had both a SUD and serious mental illness (SMI) within the past year [3].

While almost 20% of patients with psychiatric disorders suffer from a co-occurring SUD, psychiatric training guidelines require only 2% of psychiatric residency (i.e., 1 month out of 4 years) be spent learning how to treat addictions [3, 4]. This is the largest disparity between illness prevalence and training commitment in psychiatry residency, a disparity which may be influenced by the historical stigmatization of this patient population. Training barriers include lack of faculty with addiction expertise, limited access to different levels of care for rotation sites, and the time and effort required to change pre-existing rotation schedules [5–7]. In the face of a national crisis in opioid misuse and other addiction treatment, access to care remains compromised by insufficient physicians willing and able to treat addictions [4]. While subspecialists have a critical role to play, there are too few addiction-trained psychiatrists to handle this crisis alone. Education in addictions should be a core domain of psychiatric residency

training to ensure that residents have necessary competence to fulfill clinical and workforce needs.

In 2017, the American Association of Directors of Psychiatric Residency Training (AADPRT) Taskforce on Addictions was created to try to improve addiction training in psychiatry [6]. The Taskforce's needs assessment survey of general psychiatry training directors found that, while most programs indicated they have addiction-trained faculty, programs still feel under-resourced. Faculty pressures such as productivity demands contribute to difficulties in addiction-trained faculty meeting the educational needs of an understaffed institution. A majority of respondents sought educational resources [6].

In this manuscript, we provide a model of how to recognize addiction learning opportunities already present in the general training environment and develop successful educational experiences to maximize such opportunities. The ultimate goal of addiction training in general psychiatry settings is to develop an appropriate knowledge base to treat patients with SUD confidently and compassionately, foster a positive attitude toward patients with SUDs and the benefits of treatment, and establish a sense of responsibility toward substance use as a clinical problem within every psychiatrist's domain [8]. By identifying and drawing upon learning opportunities within the general training environment, programs can augment their existing addiction education and meet these goals successfully.

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Core Interviewing Skills

Core skills in addictions for general psychiatry residents are summarized in Table 1 [9, 10]. Core interviewing skills can be taught in various settings, including general outpatient, inpatient, emergency department, and consultation-liaison (CL) services. Identification and screening for SUDs is a key first step in teaching residents to conduct a comprehensive substance use history. While all patients should be routinely

Table 1 Core skills in addictions for general psychiatry residents

Core skills	What to teach	Resources
Diagnostic interview	Diagnostic criteria Alliance building Non-stigmatizing language Core components of substance history: substances used, route of administration, frequency, problems experienced, withdrawal symptoms, treatment history	<i>Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition</i> (DSM-5) [9] American Psychiatric Association (APA) Practice guideline for the treatment of patients with substance use disorders, 2nd ed. [10] Substance Abuse and Mental Health Services Administration (SAMHSA) guidance on language and stigma: https://www.samhsa.gov/sites/default/files/programs_campaigns/02_webcast_1_resources-508.pdf National Institute on Drug Abuse (NIDA) guidance on language and stigma: https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction
SUD screening: broad screening for SUDs	Screening to Brief Intervention (S2BI, adolescents) NIDA Drug Use Screening Tool: Quick Screen (NMASSIST) Tobacco, Alcohol, Prescription Medicine and Other Substance Use (TAPS) Brief Screener for Alcohol, Tobacco and Other Drugs (BSTAD)	Screening and Assessment Tools Chart (NIDA): https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools APA adapted NIDA Modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) tools: https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/american-psychiatric-association-adapted-nida-modified-assist-tools (for clinician- and self-administration) Tools to assist in integrating tobacco treatment into clinical care: https://www.cdc.gov/tobacco/basic_information/for-health-care-providers/clinical-tools/index.html
SUD screening: focused screening for specific substances	Alcohol Use Disorders Identification Test (AUDIT-C) Cannabis Use Disorder Identification Test – Revised (CUDIT-R) Tobacco use protocol	AUDIT-C screening tool: https://cde.drugabuse.gov/instrument/f229c68a-67ce-9a58-e040-bb89ad432be4 CUDIT-R screening tool: http://mycannabisiq.ca/portfolio/cudit-r-revised-2010/ Protocol for Identifying and Treating Patients Who Use Tobacco: https://millionhearts.hhs.gov/files/Tobacco-Cessation-Protocol.pdf
Appropriate use of an interpretation of laboratory testing	Measures of intoxication (blood alcohol level, breathalyzer) Urine drug screen	ASAM Consensus Statement: Appropriate Use of Drug Testing in Clinical Addiction Medicine: https://www.asam.org/docs/default-source/quality-science/appropriate_use_of_drug_testing_in_clinical-1-(7).pdf?sfvrsn=2 ASAM Drug Testing Pocket Guide: http://eguideline.guidelinecentral.com/i/840070-drug-testing-pocket-guide/31 Clinical Interpretation of Urine Drug Tests: https://www.mayoclinicproceedings.org/article/S0025-6196(1630825-4/fulltext
Identifying and managing other co-occurring psychiatric disorders	Recognizing co-occurring mood, psychotic, attentional, and other disorders	SAMHSA Tip 42: Substance Use Treatment for Persons with Co-Occurring Disorders: https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004
Identifying and managing co-occurring medical disorders	Narcotic bowel syndrome Negative effects of tobacco Pain Bacterial and viral infections in people who use substances	NIDA Notes: Substance Use Disorders Associated with Major Medical Illnesses and Mortality risk: https://www.drugabuse.gov/news-events/nida-notes/2017/10/substance-use-disorders-are-associated-major-medical-illnesses-mortality-risk-in-large-integrated#:~:text=PatientsWithSubstanceUseDisorders,oranySUDthanin Providers Clinical Support System (PCSS) module on Medical Considerations for Patients with Opioid Use Disorder: https://learning.pcssnow.org/p/MedicalConsiderations
Management of intoxication, overdose, and withdrawal	Alcohol Opioids Other substances	ASAM Alcohol Withdrawal Management Guideline: https://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management PCSS module on Management of Opioid Overdose and Withdrawal: https://pcssnow.org/education-training/training-courses/management-opioid-withdrawal-overdose/
Brief motivational interventions and stages of change	Engaging the patient Focusing Evoking Planning using OARS : O pen questions, A ffirming, R eflection (a listening response), S ummarizing Relapse prevention	Motivational Interviewing Network of Trainers (MINT): https://motivationalinterviewing.org/ Rosengren DB. <i>Building Motivational Interviewing Skills: A Practitioner Workbook</i> . 2nd ed. New York: The Guilford Press; 2018 [12]

Table 1 (continued)

Core skills	What to teach	Resources
Harm reduction strategies	Opioid overdose prevention Diversion prevention Needle exchange programs Educational/vocational training Suicide prevention Resources related to interpersonal violence Resources related to housing insecurity and other social determinants of health	SAMHSA Opioid Overdose Prevention Toolkit: https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742 Canadian resource on safe consumption: https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites.html Centers for Disease Control and Prevention (CDC) resource on syringe service programs: https://www.cdc.gov/ssp/syringe-services-programs-faq.html National Domestic Violence Hotline: https://www.thehotline.org
Behavioral interventions	Motivational enhancement therapy Cognitive behavioral therapy Contingency management/reinforcement approach	Combining Medications and Behavioral Interventions (COMBINE) I Combined Behavioral Intervention - Therapist Manual v 4.0: https://web3rdmil.com/assets/guides/research/Miller-CombinedBehavioralInterventionTherapistManual.pdf
Mutual and self-help organizations	12-Step: Alcoholics Anonymous, Narcotics Anonymous, Help Guide: Overcoming Alcohol Addiction, American Addiction Centers Non-12-Step: SMART Recovery, Women for Sobriety, Lifering, Recovery Dharma, Intherooms	12-Step resources: www.aa.org/pages/en_US/find-aa-resources www.na.org/meetingsearch https://www.helpguide.org/articles/addictions/drug-abuse-and-addiction.htm Non-12-Step resources: https://www.smartrecovery.org/ https://womenforsobriety.org/ https://www.lifering.org/ https://recoverydharma.online/ https://www.intherooms.com/home/
Medications for addiction treatment (MAT)	Buprenorphine waiver training Medications for opioid use disorder (MOUD) and alcohol use disorder (MAUD)	PCSS Waiver Training for Physicians: https://pcssnow.org/medication-assisted-treatment/waiver-training-for-physicians/ PCSS module on Medications for Addiction Treatment: https://pcssnow.org/education-training/training-courses/supporting-recovery-with-medications-for-addiction-treatment-mat/ PCSS module on Pharmacotherapy for Alcohol Use Disorder: https://learning.pcssnow.org/p/PharmacotherapyForAUD PCSS module on Medications for Opioid Use Disorder: https://learning.pcssnow.org/p/MedicationforOUD
Determining appropriate level of care	Appropriate level of care for patient needs and existing resources	American Society of Addiction Medicine (ASAM) Criteria: https://www.beaconhealthoptions.com/pdf/members/Introduction-to-The-ASM-Criteria-for-Patients-and-Families.pdf https://www.asamcontinuum.org/knowledgebase/what-are-the-six-dimensions-of-the-asam-criteria/ https://www.asam.org/asam-criteria/about https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/
Engaging families and patient's organic support system	Identifying and engaging support system Identifying appropriate roles while respecting confidentiality Working with peer support specialists if available	Parents of Addicted Loved Ones: https://palgroup.org/ National Association for Children of Addictions: https://nacoa.org/ International Association of Peer Supporters: https://www.inaops.org/

screened for alcohol and drug use, potential barriers such as limited time and negative clinician countertransference can impede this assessment [11]. Fortunately, residents can learn strategies to enhance the therapeutic alliance and improve the accuracy of patients' self-report regarding substance use.

Residents should begin by assessing the use of less stigmatized substances such as nicotine and caffeine, followed by alcohol, to establish an initial level of comfort before moving on to illicit substance use. A comprehensive substance use

history should include substances used, route of administration, frequency of use, problems experienced, withdrawal symptoms, and history of SUD treatments, including both medication and psychosocial treatments. Patients should also be asked about non-medical use of medications or use of over-the-counter or prescription drugs in any way other than prescribed. Questions about substance use should be asked non-judgmentally, for example asking about "recreational" or "social" use of substances rather than "illicit" use of drugs.

Cannabis carries less social stigma than other drugs, and patients are often more willing to openly discuss their cannabis use. In fact, providers may need to ask about cannabis use specifically, since many individuals may not consider cannabis a drug when asked about drug use.

Including language that normalizes substance use can help. Rather than asking, “Do you drink alcohol?” the resident might ask, “How many drinks per day do you drink?” or “In the past year, how many times have you used x?” If a patient endorses use of a substance, open-ended follow-up questions might include, “How do you feel about your X use?,” “What is it that you like about X?,” or “What do you not like about X?” If patients appear guarded, normalizing substance use and communicating universal screening as part of clinic policy may help alleviate stigma concerns and fears of resulting sub-optimal medical care. Patients may also need to be educated that substance use is an important aspect of their psychiatric history and that effective interventions are available from their psychiatrist to help treat or reduce harm from substance use. Even patients successfully in recovery on buprenorphine or methadone may sometimes not disclose this information in the emergency department for fear they will be denied needed analgesia for acute pain syndromes.

Motivational interviewing (MI) is a critical skill to learn and to practice in working with patients with SUD and is a logical next step as the trainee masters the fundamentals of acquiring a comprehensive substance use history. MI may be taught by addiction-certified physician faculty; residents also can gain important exposure to a variety of MI strategies through observation of interdisciplinary colleagues, such as social workers and psychologists. Core MI topics to include in resident education include the overarching “RULE” principles (**R**esist the righting reflex, **U**nderstand the patient’s motivation, **L**isten with empathy, and **E**mpower the patient) as well as demonstration of specific language and alliance [12]. MI education can also occur outside of the addiction rotation, for example as part of general psychiatric interviewing or psychotherapy didactics series. Highlighting the applicability of this core skill to work with patients of all backgrounds, even those without SUD, can help promote resident engagement.

“Harm reduction” is an approach to care that is central to meeting patients wherever they may be at on their recovery journey. Historical addiction treatment has focused primarily on promoting complete abstinence from substance use. Harm reduction recognizes that cessation of substance use is only one of many worthy goals of treatment and reducing substance-related harm to individuals, their families, and communities is an important target. In contrast to typically prescriptive and proscriptive medical care, harm reduction posits a non-judgmental attitude to drug and alcohol use. Examples of large-scale harm reduction strategies include syringe exchange programs and opioid treatment programs, colloquially known as methadone clinics [13].

Residents will need to learn that clinical features, social factors, and professional biases can contribute to under-recognition of SUD in specific populations. For example, adolescents, perinatal women, and geriatric patients may be less likely to be screened for substance use due to assumptions that these groups are less likely to use substances. In the geriatric population, SUDs may be challenging to identify because symptoms of alcohol and drug use can resemble illnesses common in later life, and this population many have difficulty identifying their risky substance-related behaviors [11, 14].

Screening instruments can be helpful tools when used as an adjunct resource to support obtaining a comprehensive substance use history. No specific screening instruments for SUD have consensus support in psychiatry as most were developed for primary care populations and lack data on sensitivity/specificity in psychiatric populations. Standardized assessment tools can help provide psychiatric residents with a useful structure and introductory vocabulary for assessing substance use (see Table 1).

Stigma

Unlike schizophrenia or major depressive disorder, SUD has historically been viewed as a moral failing and social problem rather than a chronic mental illness. Although the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) devotes an entire chapter to “Substance-related and addictive disorders,” treatment of SUDs often remains siloed from mainstream mental healthcare [9]. Negative attitudes toward patients with SUDs begin in medical school [15] and increase through residency and professional practice [16, 17]. This decline has been explained in part by residents having most exposure to SUDs in acute care settings such as inpatient units or emergency services when patients are usually at their functional nadir [18].

Language related to SUD shapes attitudes among healthcare professionals. Commonly used terms like “substance abuse” and “drug abuser” explicitly and implicitly convey that patients are at fault for their disease [19]. Stigmatizing terminology such as “alcoholism” and “addict” has been shown to negatively impact physician attitudes and compromise patient care [20, 21]. Negative attitudes among healthcare professionals regarding patients with SUD are linked with reduced empathy and engagement with patients, reduced delivery of evidence-based treatment services, and poorer patient outcomes [21].

To reduce the stigma associated with SUD, the US Surgeon General’s lexicon of nonjudgmental and clinically accurate preferred terms such as “substance use,” “misuse,” and “substance use disorder” are advised [2]. Avoidance of terms like “addict” or “drug user” and instead encouraging person-first language such

as “person with a SUD” is recommended. In addition, terms such as “clean” or “dirty” to describe drug testing results or a person using substances should be avoided; describing the drug test as “positive” or “negative” for a substance or the person as “using” or “not using” the substance is preferable.

Most required addiction rotations are short term (typically 1 month) and take place in high-acuity settings including the emergency room, consult services, or inpatient units [18, 22] where patients may only be pre-contemplative about treatment. Residents may become discouraged and develop an impression that patients with SUDs are resistant to help. Such negative attitudes should be addressed directly. Trainees may need anti-stigma and implicit bias awareness education to work through their countertransference. Sequential reflective narrative exercise is an example of a potential activity.

Field trips in the community to develop familiarity with local addiction resources can also combat stigma. In-person contact with patients in recovery such as attending Alcoholics Anonymous (AA) meetings challenges learners’ negative perceptions, broadens their understanding of SUDs, and also improves attitudes [23].

Teaching About Addictions in General Settings

The prevalence of SUDs in all clinical settings gives trainees opportunity to learn about addictions across the spectrum of care. Table 2 outlines the challenges and opportunities for teaching about SUDs in the most common training settings, including outpatient rotations that offer unique educational benefits relative to acute care settings. Working longitudinally with patients with SUD over the trajectory of their chronic illness allows trainees to see treatment work, increasing the likelihood they may consider SUD treatment as part of their future practice [5, 18].

Within these settings, residents should gain experience and familiarity with medications for addiction treatment (MAT) for tobacco, alcohol, and opioid use disorder (OUD). Of note, the acronym MAT previously stood for medication-assisted treatment, but now refers to medications for addiction treatment. This new acronym reflects a shift in understanding within addiction psychiatry in recent years toward acknowledging the more central role and efficacy medications can have for some SUD patients.

Buprenorphine is an approved MAT agent that been transformative for outpatient OUD treatment. An integral part of this process is completing the required 8-h training to obtain a “buprenorphine waiver” (sometimes called “X-waiver”) to prescribe buprenorphine to patients with OUD. This requirement has been cited as a

barrier to access to care for patients who were unable to find a waived buprenorphine prescriber. Nevertheless, it has been shown that psychiatrists who completed buprenorphine training during residency hold more favorable views toward and are more likely to prescribe buprenorphine after training as compared to those who did not complete training.

The mere ability to prescribe buprenorphine, however, is insufficient for competency in the treatment of OUD; residents need practice prescribing to patients in a variety of settings while still in training and under supervision. By role modeling buprenorphine care, faculty can serve as positive examples to trainees of how buprenorphine treatment can be integrated into their future careers. In the absence of buprenorphine-prescribing faculty within one’s academic department, psychiatry training programs can forge connections with community or private practice psychiatrists who provide buprenorphine care and provide opportunities for residents to receive ad hoc supervision in this treatment.

Educational Strategies for Teaching Addiction Psychiatry in Community Settings

Other available options for community-based learning can include community clinics; supported living environments, such as sober housing; mutual-aid/self-help groups; and mandated treatment settings such as court-mandated diversion programs or physicians’ health services for healthcare providers with SUD; methadone clinics; syringe exchanges and safe injection sites; and day programs. Local supportive living environments such as sober housing or therapeutic communities may welcome visits from trainees and offer an opportunity to hear directly from clients about their lived experiences with SUD and recovery. Similarly, inviting people in recovery to speak at resident didactics, case conferences, or grand rounds can help residents see SUDs through the eyes of the patient and not just the eyes of the clinician. Peer support providers as colleagues may also offer residents the opportunity to learn from the lived experience of these individuals.

Self-help or mutual aid groups can also be a valuable learning venue available either in person or online. Participation in such groups can help residents gain an appreciation for the patients’ experience of these groups, and the exposure to patients in recovery can counterbalance the erroneous impression residents may have from inpatient settings that patients with SUD never improve. Finally, visits to other treatment settings, such as forensic services, drug courts, healthcare providers’ health services, or pain management clinics, can help round out the residents’ understanding of the scope of available treatment options for individuals with SUD.

Table 2 Challenges and opportunities for teaching addictions in residency training

Setting	Challenges	Opportunities (see also Table 1)	Sample teaching strategies
Outpatient clinic	<ul style="list-style-type: none"> - Time constraints on comprehensive evaluation, developing therapeutic alliance - Competing clinical priorities (e.g., identifying comorbid psychiatric diagnoses vs addressing acute psychosocial needs) - Limited availability of addiction-expert faculty supervisors - Reluctance of patients to disclose full history; pre-contemplative patients 	<ul style="list-style-type: none"> - Developing relationships over time - Seeing full spectrum of recovery - Learning and practicing evidence-based screening, brief intervention, referral to treatment - Learning community-based referral options - Practicing motivational interviewing to facilitate behavior change - Learning psychotherapeutic interventions to enhance coping skills and promote relapse prevention - Providing harm-reduction education (e.g., safe needle use) - Gaining experience with medication for addiction treatment (MAT) for tobacco, alcohol, and opioid use disorders - Using telepsychiatry for patients with SUDs in areas without treatment 	<ul style="list-style-type: none"> - Learning appropriate levels of care and community disposition options - Online buprenorphine waiver training - Training on Screening, Brief Intervention, and Referral to Treatment (SBIRT) alongside primary care colleagues or peer educators
Consultation-liaison service	<ul style="list-style-type: none"> -Competing acute medical/surgical needs -Conflation of SUDs with psychosocial needs and deferred to social work -Limited availability of addiction-expert faculty supervisors -Lack of collaboration with primary teams to address SUD treatment 	<ul style="list-style-type: none"> - Consulting to patients with SUDs, often in advance stages of disease with medical or surgical complications, psychosocial challenges - Learning potential legal consequences of substance use - Practicing motivational interviewing - Learning brief interventions - Diagnosing and treating acute intoxication, substance withdrawal, substance-induced delirium, physical complications of substance use including infectious disease and organ failure - Psychoeducation regarding recommended limits for safe alcohol use and harm reduction education (e.g., safe needle use) - Developing skills in buprenorphine - Collaborating across disciplines between primary and consulting teams - Integrating with transplant, oncology, and pain management clinics 	<ul style="list-style-type: none"> - Bedside teaching from collaborating and/or integrated teams (pain medicine, transplant, etc.)
Inpatient units (adult and child)	<ul style="list-style-type: none"> - Engaging patients in treatment - Limited availability of addiction-trained supervising faculty - Fast-paced environment and brief treatment relationship 	<ul style="list-style-type: none"> - Recognizing and treating withdrawal syndromes (e.g., alcohol, nicotine, benzodiazepines, cannabis, stimulants) - Learning systems of care for SUD in the community (e.g., sober housing, support groups, intensive outpatient programs, population-specific resources such as supported housing for pregnant patients with SUD) - Learning difference between substance-induced vs primary psychiatric presentations (e.g., major depressive episode versus cocaine withdrawal) 	<ul style="list-style-type: none"> - Observed interviews (faculty and resident), two-way mirror - Brief lectures, in-services, journal clubs - Faculty demonstrations of MI, alliance building - Reflection exercises to consider countertransference, treatment pessimism, etc.
Emergency department	<ul style="list-style-type: none"> - Fast-paced environment - Brief, short-term patient encounters - Patients may be pre-contemplative - Negative countertransference and provider hopelessness regarding patients' recovery 	<ul style="list-style-type: none"> - Education on symptoms and treatment of agitation secondary to substance use, medical complications of substance use, and overdose - Learning levels of care and opportunities community-based - Peer teaching to medical or nursing colleagues regarding SUD - Initiating buprenorphine and other MAT 	<ul style="list-style-type: none"> - Case-based teaching on symptoms of intoxication for various substances - Resident presentations key topics (stages of change, stigma, or common countertransference concerns) - Case conferences

Table 2 (continued)

Setting	Challenges	Opportunities (see also Table 1)	Sample teaching strategies
Additional opportunities	- Lack of addiction resources in-house	Community-based resources: - Correctional and forensic facilities - Residential schools - Intermediate and long-term residential facilities - State hospitals - Group homes - Nursing homes - Sober houses - Homeless shelters - Community-based practitioner offices - Support meetings	

Use of educational venues outside of a program's home clinic or inpatient unit may be as simple as a half-day or daylong visit, or may be developed into full rotations. With any offsite rotation, it is imperative to ensure proper resident supervision is available and provided. Planning on-site supervision with site leadership before implementing a clinical experience is essential.

For programs with limited local resources for SUD education, online training can enhance programs' in-house and community resources. Online education in SUD is offered through a number of organizations, including Providers Clinical Support System (PCSS). PCSS also offers mentorship through a national network of clinicians with expertise in treating substance use disorders, co-occurring mental disorders, and pain management including discussion forums as well as one-on-one mentoring. Other high-quality online educational material is available through the American Academy of Addiction Psychiatry (AAAP) and American Society of Addiction Medicine (ASAM).

Discussion

Meeting both the Accreditation Council for Graduate Medical Education training requirements and the overwhelming clinical need for psychiatric expertise in SUDs may seem daunting for any training director. However, many opportunities exist for teaching and training in addictions within structures and services already available to general psychiatry residencies. Training directors may be able to make substantial improvements in addiction programming by trying one or two of the options presented here that are most achievable within their training program.

Instead of focusing on program deficiencies, program directors can empower faculty to recognize SUD teaching moments

wherever they occur in clinical and didactic experiences. Teaching opportunities present themselves when seeing a patient with delirium tremens on the CL service, stimulant-induced psychosis on an inpatient psychiatry service, a near opioid overdose in the emergency department, a patient in longer-term recovery in the general psychiatry clinic, or a patient reporting relapse on alcohol via a telehealth visit.

Educators should approach addiction teaching from a dimensional and not a categorical perspective and with a "progress not perfection" mindset. Even if programs lack subspecialized addiction services or trained faculty, making small steps in enriching the educational experience of learners can have a long-term cumulative effect on improving clinical care. In addition to utilizing local resources and teaching opportunities nested within general training settings, help and community can be found by connecting to colleagues and by reaching out to professional organizations such as AAAP and ASAM, as well as tapping into the rich online resources for addiction psychiatry teaching on the AADPRT website. These organizations also provide opportunities for psychiatry residents to present posters/workshops and apply for awards (i.e., travel) that could help motivate them to consider pursuing fellowship training in addictions.

Declarations

Adherence with Ethical Standards This paper does not qualify as research and does not involve human subjects, so we did not seek IRB approval.

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