

Letter to the Editor

Adolescent Substance Use Disorders and Psychiatrists: Competent Assessment and Treatment?

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Although there are some data regarding the quality and quantity of addiction training in child and adolescent psychiatry residency programs,^{1–3} there is a notable lack of data regarding the extent of formal training and continuing education in the area of substance use disorders (SUDs) among practicing adolescent psychiatrists (who may or may not have completed fellowship training). The American Society for Adolescent Psychiatry (ASAP) Task Force on Adolescent Substance Abuse and Addiction developed and mailed an anonymous, 16-item, multiple-choice survey to its 482 members in order to:

- determine the perceived prevalence and importance of adolescent SUDs in members' practices;
- find out which substances of abuse are routinely screened for by members;
- assess members' level of training in SUD, both during and after residency/fellowship (ie, amount of CME devoted to this topic); and
- ascertain members' comfort level in diagnosing and treating adolescent SUDs.

Unfortunately, only 32% of the surveys were returned completed.

Of the respondents, 57% completed formal training in child and adolescent or adolescent psychiatry and 4% completed formal training in addiction psychiatry. Forty-eight percent reported that more than 30% of the patients in their practices

were adolescents. Fifty-seven percent noted that more than 30% of their adolescent patients suffered from SUDs comorbid with another psychiatric disorder. In contrast, 74% reported that fewer than 10% of their adolescent patients suffered from SUDs alone (ie, without a comorbid psychiatric diagnosis). Seventy-nine percent felt that SUDs were "very important" or "extremely important" in their practices.

Eighty-two percent of respondents reported that they always ask patients about use of substances. Ninety-five percent ask about alcohol, 86% ask about nicotine, 85% ask about cocaine, 76% ask about amphetamine, 64% ask about MDMA, and 68% ask about benzodiazepines. Fewer inquire about opioids (55%) and inhalants (55%), and still fewer routinely ask about GHB or ketamine (22% and 24%, respectively).

Although practicing psychiatrists who treat adolescents appeared to acknowledge the prevalence and importance of substance use disorders in their practices, the majority of survey respondents (56%) reported receiving one month or less of formal SUDs training. Despite this sub-optimal level of training, 57% had devoted fewer than nine hours of CME credit to SUDs in the preceding three years. Perhaps somewhat surprisingly, 61% were unfamiliar with the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Guidelines for the Treatment of Adolescent SUDs.⁴

Despite this paucity of formal training in SUDs, when questioned about their level of comfort in the treatment of adolescent substance use disorders, a large percentage (66%) reported feeling "quite comfortable" or "totally comfortable." This suggests that many adolescent psychiatrists may overestimate their own knowledge and skill in assessing and treating SUDs in their practices. Many respondents (72%) did report plans to complete more than eight hours of CME credit in SUDs in the next three years. Though laudable, this goal may be overly optimistic, especially considering these respondents'

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subjective comfort level in diagnosing SUDs and their CME histories.

There are several limitations of this study. First, the survey response rate was 32%, which increases the probability that the results were affected by a selection/response bias. Therefore, the current results may not accurately reflect the practices and needs of most ASAP members or non-ASAP psychiatrists who treat adolescent patients.

Second, a large majority of respondents (78%) reported practicing for more than twenty years. This is likely not a representative sample of all currently practicing psychiatrists who treat adolescents and probably skews the “SUDs training experience” results (the formal ACGME requirement for SUD training in psychiatry residency training programs was instituted in January 2001).

Finally, this study did not evaluate respondents’ actual competence in diagnosing and treating adolescent SUDs. Future studies might assess practicing adolescent psychiatrists’ skills in these areas, perhaps even quantifying their diagnostic accuracy against a “gold standard” such as the Adolescent Diagnostic Interview (ADI). Similar studies have

been conducted with pediatricians.⁵ Such studies could also determine if the amount of training and subjective level of comfort in diagnosing and treating SUDs were correlated with clinicians’ diagnostic accuracy and overall clinical competence.

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