



Editorial

Staffing an addiction consult service: Psychiatrists, internists, or both?



1. Background

The national drug overdose crisis has brought renewed attention to the care of patients with substance use disorder (SUD) in the general medical hospital. Steady increases in opioid use disorder have, in particular, fueled a rise in inpatient admissions for infectious sequelae of injection drug use [1]. Hospital admissions for drug use-associated infections doubled between 2002 and 2012 and are now costing our healthcare system hundreds of millions of dollars per year [2]. Some hospital systems, seeing the need to address underlying drivers of these admissions, and acknowledging the limitations of previous approaches to addiction care (e.g. abstinence only, poorly integrated, not evidence-based), have responded in part by re-organizing and expanding inpatient consultation services to meet the addiction care needs of hospitalized patients [3–5,18].

The authors of this article work in two academic medical centers that recently expanded inpatient addiction consultation services, two of us in the American Northeast (M.N. and B.B.) and one in the Southeast (D.M.). We have all worked specifically on addiction consult teams jointly staffed by physicians trained in psychiatry and internal medicine. Two of us have prior clinical experience with a service model where addiction consultations were provided by psychiatrists only. Our longitudinal experiences working on these clinical services have naturally led us to examine the question of optimal staffing arrangements as it pertains to improved patient care and collaboration across practices. While this editorial will focus on the role of two physician specialties, these teams generally benefit from a multidisciplinary approach, including involvement of nurses and nurse practitioners, physician assistants, social workers, pharmacists, and recovery coaches in caring for patients with SUD [6].

2. The case for psychiatry staffing

Addictions are diseases of complex brain circuits implicated in reward salience, stress response and executive function, not dissimilar from other illnesses traditionally considered the domain of psychiatry [7]. While it is undoubtedly the responsibility of all physicians to be aware of these illnesses, psychiatrists play a unique role in their diagnosis and management. Furthermore, the co-occurrence of SUD and other psychiatric conditions is profound; of 20 million Americans with SUD, roughly 8 million are also suffering from a mental illness [8]. Substance use – including acute intoxication – is commonly linked with self-injurious behavior, with upwards of 40% of patients seeking addiction care endorsing prior history of suicide attempts [9]. Accordingly, the disentanglement of these conditions, including the diagnostic assessment of primary versus substance-induced psychiatric illness, the evaluation of acute safety concerns, and the clinical management of co-

occurring psychiatric and substance use disorders, often requires specialized training in psychiatry.

Through training, most psychiatrists are exposed to pharmacologic treatment options as well as behavioral interventions including dynamic, cognitive, behavioral and mindfulness-based therapies. Addiction psychiatry training augments diagnostic and management skills in these areas and deepens understanding of the unique defense mechanisms employed by many patients with addiction. Consultation psychiatry training reinforces a biological approach to addiction, increases the physician's familiarity with the diagnosis and management of addiction in medically-complex patients, and fosters liaison and collaborative skills across multiple services. Certainly, all of these skills are in high demand in the inpatient general medical hospital where severe psychiatric and substance use comorbidities are more prevalent than in primary care populations [10,11].

3. The case for medicine staffing

Internists, and primary care physicians in particular, are trained to care for the whole person; they spend a great deal of time working with patients on behavioral health issues and lifestyle modifications and are knowledgeable in the basic principles of motivational interviewing. They play a unique role in managing the myriad medical complications of drug and alcohol use – including infectious complications and end-organ damage – relative to their counterparts in psychiatry. In addition, the complex relationship between opioid use disorder and chronic pain syndromes [12] necessitates practitioners with deep understanding of both general medical issues and addiction.

Another compelling argument for internist involvement lies in the role of internists as the primary—and often only—physician a patient may see. We know that the vast majority of patients with behavioral health concerns, including SUD, do not seek specialty treatment [13]. In contrast, an impressive 40% of patients with drug use problems in a New York Medicaid population were medically hospitalized in a single year [14]. There is increasing evidence that patients view these hospitalizations as “wake-up calls” or teachable moments that can be profoundly motivating for patients to change their substance use behaviors [15]. The provision of addiction services by internists and primary care physicians allows us to integrate addiction care into general medical care and engage patients as they first enter the health care system. The impact that these interactions have on reducing the stigma associated with substance use disorders cannot be overstated.

Finally, as of 2015, Addiction Medicine is now recognized by the American Board of Medical Specialties (ABMS) as a subspecialty, providing a pathway to addiction training for a significant number of physicians who would not otherwise be eligible for addiction psychiatry training.

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Table 1
Models of addiction consultation service collaboration.

Staffing model	Advantages	Challenges
A) Psychiatry only	Single provider type system, facilitating a standardized consultation approach. In addition to substance use disorder care, providers can offer assistance with questions pertaining to general consultation-liaison psychiatry.	Lack of full integration of psychiatric diagnosis and management into overall medical plan.
B) Medicine only	Single provider type system, facilitating a standardized consultation approach. Providers are more knowledgeable regarding medical complications of substance use.	Co-occurring psychiatric issues may need to be allocated to a different service, potentially causing fragmentation in care delivery and/or cost inefficiency if an additional same-day consultation is required.
C) Combined approach - triage by patient type	Patients pre-screened for presence of acute medical and/or psychiatric complications, then matched with expert in specific field. Collaborative care delivery model.	A priori triage often can be difficult as initial records may be sparse. Increased staffing demands for triage. Most hospitalized patients have some degree of medical complexity.
D) Combined approach - limited scope	Collaborative, integrated approach using providers from both specialties to deliver care regardless of underlying medical/behavioral needs.	Providers may not be using all of their skills with each consultation, and may still require involvement of a separate psychiatry C-L service.
E) Combined approach - curbside consultation	Collaborative approach where internists and psychiatrists can provide domain specific recommendations within the consultation service.	Requires more frequent communication on a busy clinical service.

4. The collaborative model – potential challenges

Psychiatry and internal medicine-trained physicians have distinctive approaches to care in the general hospital setting, and these differences can emerge more clearly when the two specialties are paired on a consultation service.

Though psychiatrists who work on hospital consultation services often possess sufficient knowledge of comorbid medical illnesses to navigate their work with confidence, internists can offer expertise on specific medical aspects of patient's presentation well outside of scope of practice for most psychiatrists. Along similar lines, internists are expected to conduct a full physical examination, as compared with the more focused cognitive and neurological examination that psychiatrists tend to complete. Accordingly, in each of our clinical practices, we have seen internists in the addiction consultation role identify diagnoses related to primary medical complaints that may otherwise have been missed by the team. In fact, by virtue of their repeated exposure to a variety of medically ill patients with addictions, consulting internists may avoid the pitfall of attribution error made by other internal medicine physicians.

Psychiatrists, through their training on consultation-liaison services, develop skills in a variety of relevant areas including the interface with forensic issues like capacity or criminal justice involvement, the differentiation of neuropsychiatric issues like delirium, dementia and catatonia, and the interaction between patients with severe mental illness and the public mental health system. The consulting psychiatrist may also offer a more in-depth assessment of patient's affective state, behavior and cognition. We find that commonly, internists may have varying degrees of experience and comfort with these aspects of consultation psychiatry, despite their high prevalence in addiction consultation work.

As a result of these differences, new services will contend with the marriage of differing cultures, approaches, and styles.

5. The case for collaboration

Both psychiatrists and internists bring unique skill sets and knowledge to the table in the care of patients with addiction and comorbid medical and psychiatric conditions. The opportunities for psychiatrists and internists to learn from one another and sharpen skills that they may have not used since medical school or residency training is tremendous. An internist may teach a psychiatrist on the team about the role of air hunger in a patient with COPD in driving his anxiety and relapse to opioid use, or a psychiatrist might model for internists the

disentanglement of premonitory ADHD and bipolar disorder in a patient with opioid and stimulant use disorder.

For the two specialties to collaborate most effectively, models of care must be piloted and then improved in Plan-Do-Study-Act cycles. Table 1 reviews both single-service and collaborative models, addressing potential advantages and disadvantages of each collaborative framework. One key area of tension between the different collaborative models seems to be the benefit of having each specialty practicing to the fullest extent of their expertise (Model C) versus the simplicity having functionally similar roles for physicians on the service from either specialty (Model D). Model E serves as a proposed synthesis in which a priori triage of consults is not attempted (all physicians can generally perform the initial consultation to address risk assessment, substance withdrawal, and medications for addiction treatment [MAT] initiation), but both specialties review their patients together each day, advise one another on certain aspects of management, and in some cases transition patients after their initial consultation to a physician of a different specialty within the service. As an example, “Mr. Jones” with poorly controlled acute pain and opioid use disorder may be seen by a psychiatrist initially, “Mr. Smith” with poorly controlled schizophrenia and cocaine use disorder may be seen by an internist initially, and a shared card-flipping rounds could result in improved care of each patient either through curbside consultation or consultant transition.

From an economic standpoint, models that leverage indirect consultation and frequent communication through an integrated, medicine-psychiatry addiction consult service may only be feasible in large, high-volume hospitals. For those hospitals that do see a high volume of SUD, recent evidence suggests that effective risk stratification and management by an addiction consult service can reduce length of stay dramatically, with concomitant cost savings in a population enriched with uninsured and underinsured persons [16,17].

6. Conclusion

In the setting of rising morbidity and mortality from substance use disorders, and a national focus on reliable access to high-quality addiction treatment, there is an emerging consensus that addiction must be integrated into routine medical care in order to reach vulnerable patients. Though some hospitals have piloted unique collaborations between internal medicine and psychiatry through addiction consultation services, many are still operating on traditional models of psychiatric consultation in which addiction care is incompletely integrated. This represents an important opportunity to implement and study ideal collaborative frameworks in the hospital setting. We believe shared

consultation services can usher in a new era of collaborative multi-disciplinary addiction treatment.

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