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Brief Research Letter

Preliminary Results of Psychiatric Inpatients Referred to an Addiction Medicine Consult Service

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The paper by Priest and McCarty (2018) provides valuable insights into addiction medicine consult services (AMCS) and the care delivered to hospitalized individuals with substance use disorders (SUD). We commend the authors for this and also wish to illuminate further on this topic. As part of a larger quality improvement initiative focused on the acute inpatient psychiatric units, we retrospectively examined the medical records of patients admitted to acute inpatient psychiatric units at St. Paul's Hospital, an inner-city hospital, in Vancouver, British Columbia, who had been referred to the AMCS. It consisted of certified addiction specialist physicians, interdisciplinary trainees and fellows, a clinical nurse educator, and two social workers, one whom provides dedicated support to psychiatric inpatients.

The Analytics and Decision Support Service at St. Paul's Hospital identified there were 391 psychiatric inpatient referrals to the AMCS between April 30, 2016 and May 1, 2017 of which 284 individuals met the criteria. Subsequently, this service randomly selected 45 medical records for evaluation. The research team developed a data collection tool along with a code book to extract data on the patients' characteristics, reasons for referrals, and on the care provided from the patients' medical records. After retrieving the data, R version 3.4.4 was used to generate descriptive statistics. The chart abstraction was approved by the Providence Health Care/University of British Columbia Behavioural Research Ethics Board.

Table 1 shows those in this study were predominantly male (n=29, 64.4%) and the vast majority of individuals (n=40, 91%) had more than one documented SUD. Nicotine use disorder was the most common diagnosis (n=32, 72.7%), followed by stimulant use disorder (n=30, 68.2%), and opioid use disorder (n=23, 52.3%). Most patients were referred due to their opioid use (n=27, 60%), including four (8.9%) for the continuation of opioid agonist therapy (OAT). Sixteen individuals (35.6%) were receiving an OAT at the time of discharge, but only seven (15.6%) had

a documented follow-up plan for this treatment. Take-Home Naloxone (THN) kits were offered to 12 individuals (26.7%) and most (n=10, 22.2%) accepted the offer. The AMCS social worker was involved in the care of over half (n=26, 57.8%) of those referred.

The AMCS provided care to a population with multiple health and social issues (Table 1), most of whom were referred due to opioid use and who were provided OAT. Studies suggest linking patients to outpatient care increases the likelihood of engagement and retention in treatment after hospitalization (Shanahan et al., 2010; Liebschutz et al., 2014; Lee et al., 2017; Wakeman et al., 2017). Arguably, those in our study could have benefited by more robust discharge planning, including a standardized process for arranging and documenting OAT follow-up. Furthermore, the inconsistency in provision of THN kits is concerning, given the wealth of research indicating kit distribution reduces overdose mortality (Dettmer et al., 2001; Banjo, et al., 2014; McDonald & Strang, 2016; Irvine et al., 2018).

The study has several limitations including a small sample, methodological challenges and may lack generalizability to other settings as the study only abstracted psychiatric inpatient charts of those from an inner-city hospital. However, our data provides important insights into the complexity of the psychiatric inpatients referred to the AMCS, corresponds with the current perception that specialized opioid use care is the foremost reason for referring to this service, and identifies the initiation and continuation of OAT by the AMCS as areas for further investigation to improve care delivery.

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Table 1. Reasons for referral, characteristics of and care provided to psychiatric inpatients referred to an inner-city addiction medicine consult service (N=45)

	n (%)
Gender (male)	29 (64.4%)
Age (mean)	41.2
Area of Residence	
No Fixed Address	14 (31.1%)
Downtown Eastside [†]	17 (37.8%)
Other	14 (31.1%)
Income Status	
Employed	4 (8.9%)
Fixed Income [‡]	31(68.9%)
Unknown	10 (22.2%)
Medical co-morbidities[§]	
None	7 (15.6%)
One	17 (37.8%)
Two or more	21 (46.7%)
Documented substance use disorders diagnoses N=44^{††}	
Nicotine Use Disorder	32 (72.7%)
Stimulant Use Disorder	30 (68.2%)
Opioid Use Disorder	23 (52.3%)
Alcohol Use Disorder	15 (34.1%)
Cannabis Use Disorder	10 (22.7%)
Other	3 (6.8%)
Number of substance use disorders diagnoses N=44^{††}	
Two	20 (45.5%)
Three or more	20 (45.5%)
Reasons referred N=45	
Opioid Use	27 (60.0%)
Stimulant Use	25 (55.6%)
Alcohol Use	10 (22.2%)
Cannabis Use	7 (15.6%)
Polysubstance Use	4 (8.9%)
Treatment options ^{**}	4 (8.9%)
Other	7 (15.6%)
Care provided N=45	
Those referred related to opioid use	27 (60%)
- Those referred for continuation of an Opioid Agonist Treatment (OAT)	4 (8.9%)
- diagnosed with an Opioid Use Disorder	23 (51.1%)
- provided Opioid Agonist Treatment (OAT)	16 (35.6%)
- assigned OAT follow-up provider at time of discharge	7 (15.6%)
Offered Take-Home Naloxone kits	12 (26.7%)
Seen by the AMCS social worker	26 (57.8%)

[†]One of the largest open drug scenes in North America;

[‡]This includes those receiving a pension, disability, or income assistance;

‡This includes acute and chronic medical conditions;

****N=44 as one patient did not have a documented substance use disorder by the AMCS;**

“This includes providing information on resources and referring patients for treatment;