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INSIGHTS INTERVIEW

Addiction Medicine Clinician Shortages Require Innovative Treatment Approaches

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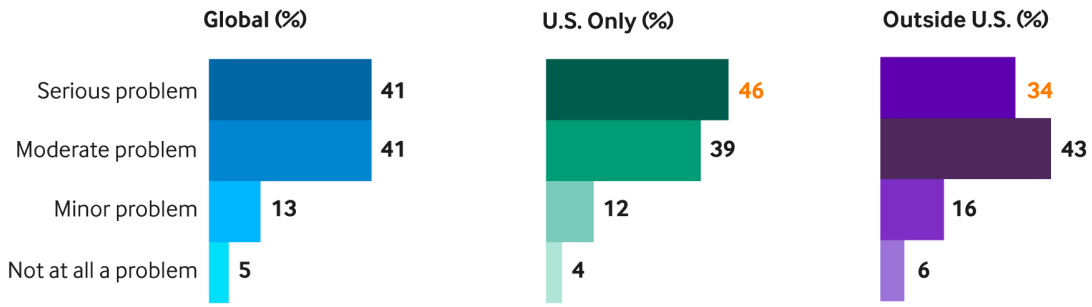
Interviews from NEJM Catalyst Insights Council members on the challenges to addiction medicine and substance use disorder treatment.

Substance use disorder (SUD) is a serious problem throughout the world, say members of the NEJM Catalyst Insights Council. In an April 2023 survey of the Insights Council — composed of clinicians, clinical leaders, and executives at organizations around the world that are directly involved in care delivery — 82% of respondents report that addiction medicine specialist shortages are a moderate or serious problem within their organization (Figure 1), and nearly three-quarters (74%) say addiction medicine services within their community are not very sufficient or not at all sufficient to meet the needs of the patient population (Figure 2).

FIGURE 1

Addiction Medicine Specialist Shortages Are Problematic

How much of a problem are addiction medicine specialist shortages within your organization?



Statistically significant differences are noted in orange

Base: Global – 804; U.S. only – 464; Outside U.S. – 340 (may not total 100 due to rounding)

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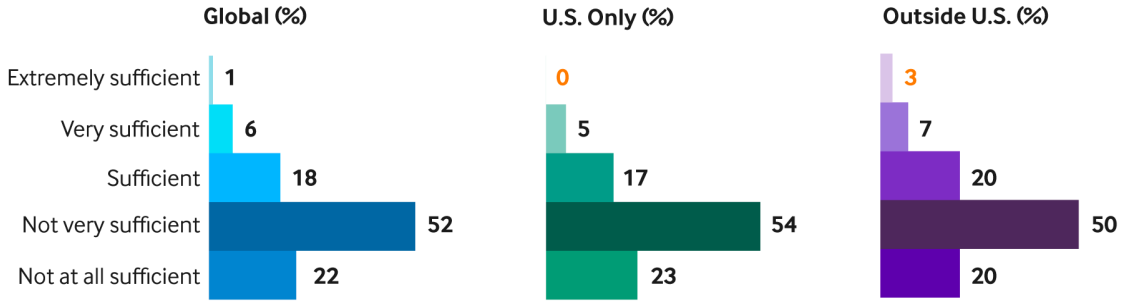
FIGURE 2

Addiction Medicine Services Largely Fall Short of Patient Needs

How sufficient are addiction medicine services (including addiction psychiatry) within your community to meet the needs of the patient population?



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Nalan Ward, MD, is board-certified in Adult and Addiction Psychiatry and is Chief Medical Officer of Beth Israel Lahey Health Behavioral Services in Massachusetts. She says that current shortages in addiction medicine specialists mean that health care providers of all types will have to play a bigger role in providing addiction care.

"Responsibility to care for patients with SUD typically falls on primary care and psychiatry," she says. "However, we're experiencing a workforce shortage crisis in health care right now and the overdose death rates are at their highest level. I think this responsibility needs to belong to all physicians. It is more important than ever that physicians screen patients for substance abuse and initiate treatment or refer them to other resources in the community."

As an example of access challenges, Ward mentions opioid use disorder (OUD) treatment using methadone. "Methadone by itself is a very effective medication and has its advantages, but access can be very challenging in practice. Methadone treatment is provided under strict federal regulations, and historically its use has been very stigmatized. In many states, patients have to jump through hoops to get into a methadone clinic because there simply aren't enough of them. Patients also have to dose every day by physically going to the clinic, making it very inconvenient in a lot of ways. Relaxing some of the regulations would go a long way toward improving access."

Despite the current challenges to addiction medicine, Ward sees some signs of improvement. "There are a number of different initiatives in Massachusetts right now to increase the number of providers with training, including increases in residency slots and adding more addiction medicine programs for primary care providers. Over the past 10 years, medical school curricula have placed a greater emphasis on addiction training, and recent graduates are far better trained than previously."

Umberto Nizzoli, PhD, MPH, MCA, FAED, is a clinical psychologist, President of European Chapter of the Academy for Eating Disorders, and Professor at the University of Rome. He is also past President of the Italian Society for the Study of Eating Disorders (SISDCA), and former Director of the Mental Health and Addiction Program at the Local Health Authority of Reggio Emilia and former head of its Drug Abuse Unit. He says addiction medicine services are mostly sufficient in Italy.

"Italy's National Health Service (Servizio Sanitario Nazionale) is actually fairly decentralized and health care is delivered through 20 independent regions," he says. "While addiction services are generally good across the country there can be big differences between the regions, and the level of services can also vary depending on the substance being abused. For example, services for patients using psychostimulants can be very different between regions."

Nizzoli says opioid addiction is a serious problem in Italy, although regulations for methadone treatment are less strict than in the United States and patient access is better. "It can be prescribed freely through substance abuse rehabilitation organizations such as SerD (Servizio per le Dipendenze), which has over 560 facilities across the country. Because of this approach, patients are less stigmatized when using methadone and have a better chance of recovery."

Methadone is a controversial topic in Italy, he says. "There are competing views on methadone as a treatment. When drug treatment programs were first created here over 40 years ago, they were mainly driven by the Catholic Church, which was against its use. Today, there are many people who support methadone use, including many health care professionals, and every region supports its use to varying degrees."

Italy lacks an addiction medicine specialist certification, Nizzoli says. "Addiction medicine is not a formal specialization in Italy, and it's not a requirement in order to work at a substance use disorder unit. Typically, you need to have a degree in medicine or psychology and some training on addiction. But the challenge has been deciding who owns the practice. Is it internal medicine,

psychiatry, pharmacology, or toxicology? Because we've had difficulty reconciling these different disciplines, we haven't been able to create a specific specialization."

A.J. Reid Finlayson, MD, FASAM, is Professor of Clinical Psychiatry and Behavioral Sciences at Vanderbilt University Medical Center in Nashville, Tennessee, and Director of the Vanderbilt Comprehensive Assessment Program. He says that medical students are increasingly receiving addiction medicine training, but much more is needed.

"Students get some exposure to addiction medicine, but certainly not commensurate with the extent of the problem," says Finlayson. "This is especially true when you consider the substantial range of health impacts, including morbidity caused by tobacco, alcohol, opioids, and methamphetamine. At Vanderbilt, medical students are exposed to inpatient as well as outpatient addiction treatment, but we need to do more."

Along with specialist shortages, Finlayson says patients face problems with continuity of care. In fact, 69% of respondents in the NEJM Catalyst survey report that care transitions are not very sufficient or not at all sufficient for patients with addiction at their organization.

"A continuum of addiction management — like cancer management — systematically organized from diagnosis to satisfactory stabilization and recovery monitoring would help. Addiction care is fragmented in emergency rooms, psychiatric and detox units, and residential treatment facilities."

Finlayson says harm reduction initiatives suffer from similar drawbacks. "Harm reduction programs are insufficient without also providing an integrated system of care. Offering people syringes and safe injection sites and then standing by with naloxone appears to legitimize dangerously unsafe drug use. While it helps keep them alive, it needs to be paired with treatment."

Finlayson suggests that Recovery Courtsand Physician Health Programs use coercion effectively and produce recovery outcomes far superior to treatment as usual. "Often drug victims have been resuscitated repeatedly prior to their fatal overdose. This indicates that involuntary commitment, which is legal but underutilized in many states, might be employed to initiate treatment."

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Disclosures: Jonathan Bees has nothing to disclose.