Motivational Interviewing on an Addiction Consult Service: Pearls, Perils, and Educational Opportunities

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The national opioid crisis has brought with it a renewed focus on the integration of addiction care into medical settings. Though integration into primary care settings may have represented the first wave of quality improvement in this area—with the emergence of Screening, Brief Intervention, and Referral to Treatment (SBIRT)—the past 5 years have witnessed the expansion of addiction consult services in general medical hospitals [1–6]. Such systemic integration efforts are critical considering the majority of patients with substance use disorders (SUD)—greater than 90%—do not seek specialty addiction treatments but instead seek treatment in hospitals and emergency rooms for the medical complications of substance use [7]. In this article, we describe the unique role of motivational interviewing (MI) in engaging patients on addiction consult services, where unlike other behavioral health specialty care settings, patients usually do not present to hospitals seeking treatment for their SUD. Further, we describe so-called *pearls*, *perils*, and *educational opportunities* based on the experience of the authors, each of whose home institution has initiated a multidisciplinary addiction consult service with varying degrees of integrated formal and informal training in MI.

Though others have lamented the gaps in addiction training in medical school curricula and internal medicine residency training amidst the push toward integration, one area that has witnessed broad dissemination in medical education has been

the transtheoretical model of stages of change [8–10]. The transtheoretical model posits that patients—and indeed people—pass through various stages in their motivation to change unhealthy habits and behaviors, beginning with *contemplation* (before which one is considered *precontemplative*) and progressing through *preparation*, *action*, and finally *maintenance* stages of change. This model provided theoretical support for an approach initially described by the psychologist William Miller, who found that counselor empathy accounted for the largest variance in drinking outcomes in a study of treatment seeking drinkers [11]. Subsequently, he described his clinical method—*motivational interviewing*—that focused on evoking and strengthening the patient's own reasons for change, and ensuring a supportive and non-threatening interpersonal context to facilitate change [12]. Where confrontation was a commonly used approach at the time, he found that arguing with the “resistance” was counterproductive because it evoked additional defense of the status quo [13].

Despite significant evidence supporting the effectiveness of MI, less has been written about effective ways to teach clinicians and trainees to reliably perform high-quality motivational interviewing in the general hospital setting [14–16]. This is problematic not only because studies have demonstrated a link between MI and patient-level changes in behavior but also because these changes are mediated by the quality of the technique itself and the quality of empathy exhibited by the therapist [17]. Therefore, though MI is more difficult to teach and assess compared with other Entrustable Professional Activities (EPAs) in medicine, we nevertheless believe that inculcating fidelity to good technique and accurate empathy is critical to the outcomes for our patients.

Here we outline some *pearls*, *perils*, and *educational opportunities* for providers who rotate on or alongside our addiction consult services. We build off this framework in Table 1 by noting *pearls* and *perils* that are particular to specific provider types (i.e., physicians, social workers, recovery coaches, and nurses).

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Pearl

As providers working in a general hospital, we consider it commonplace that our patients with substance problems will present inconsistent narratives about their recent substance use (e.g., variable durations of abstinence, variable routes of administration), and we learn to expect this reluctance to disclose their substance use honestly given our patients' susceptibility to shame, exacerbated by pervasive stigma [18, 19]. However, we find that the open-ended, non-judgmental questions and reflections of MI tend to elicit more honest reports from our patients about recent substance use. Several of our attendings have observed that patient descriptions of abstinence periods immediately preceding the sentinel admission will gradually shrink, starting with the primary medical team interview ("I haven't use in 6 months"), proceeding on to our consult trainees' interview ("1 month"), and finally to our own interview ("1 day"). We find that MI-consistent techniques like normalization ("many of our patients tell us that..."), accurate reflections ("it sounds like you've completely put the opioids down for the past 6 months"), and subtle empathic prompts ("we don't want to undertreat your pain or withdrawal by missing it") tend to assist our patients in opening up. Since

physicians in particular are stereotypically rushed in the hospital setting, we find that their use of MI techniques can have a proportionally strong effect on patients who may not be used to feeling heard in this way [20].

Peril

Our very positioning amidst the time pressures of the general hospital environment, in which length of stay and discharge metrics are often sacrosanct to hospital leaders, can also lend itself to certain perils in the care of patients with addiction. Physicians, social workers, and recovery coaches alike may be tempted to ask closed-ended questions based on another providers' documentation ("Dr. Smith wrote in the chart that you want to do residential rehab?") or prematurely shift into problem-solving with a patient who has yet to warm to our newfound involvement in very personal decisions. Here we hasten to add that there is a bit of mental health exceptionalism. Patients tend to expect their provider to offer solutions for their other medical complaints. The question "What are your thoughts about your GI pain from your metastatic cancer?" would sound odd to most patients, whereas with mental illness

Table 1 Multidisciplinary addiction consult team roles with their respective MI pearls, perils, and educational opportunities

Role	Pearl	Peril	Educational opportunity
Physician (resident, attending)	Patients with SUD perceive MI-adherent physicians as genuinely, non-judgmentally listening in the hospital, which may facilitate the emergence of the patients' own reasons for change.	Physician acculturation to problem-solving (the "righting reflex") can short-circuit effective MI and result in a "counterfeit yes." Ineffective biopsychosocial treatment plans can follow.	Direct feedback through recordings or in-person observation on "righting reflex"; practice employing accurate reflections when tempted to problem-solve.
Social worker (SW)	SW is ideally less rushed and can practice more extended MI interviews with patients as "cross-check" to ensure counterfeit agreement is not perpetuated.	Culture of problem-solving on medical side and "counterfeit yes" to higher levels of care can result in tail-spinning case management, frustration, and even bum-out.	Ensuring SW educated to perform assessment informed by spirit of MI and independent of plan suggested by other members of team. Direct observation/feedback.
Recovery coach	Peer support through self-identification is not mutually exclusive with MI if handled through spirit of MI (partnering, autonomy, compassion, evocation).	Self-identification and tendency to communicate through "sponsorship" lens (blunt talk, "tough love") may overplay the alliance-hand, can undermine influence and also result in "counterfeit yes."	Didactic education on motivational interviewing paired with direct observation/feedback (education that has not occurred may be incorrectly assumed).
Nurse	Because nurses spend the most time in direct contact with hospitalized patients, opportunities for accurate reflections abound and resulting information can be relayed to all treating teams to inform care. Reflections can also be effective at de-escalating patients who are upset.	Nursing can inadvertently get split from the team when communication breaks down between primary team, consult services, and nursing. Nurses may feel they are "holding the bag" for patient frustration, and without adequate MI training, they may resort to defensive reactions or avoidance.	Didactic education on motivational interviewing paired with direct observation/feedback by nursing peers. Sample curriculum available upon request.

and addiction in particular, poor insight, and related defensiveness are often part of the nature of the brain illness. Yet because we train in acute medical settings first as students and residents, our propensity to problem-solve from early on in clinical training puts us at risk of short-circuiting MI technique. We do so at our own peril. Our attendings have observed countless times what great labor our providers can invest in addiction treatment planning and referral for a single patient, all based on the unfortunate carrying forward of an initial “counterfeit yes” [21]. We can save much time for patients and providers alike by tamping down our problem-solving instinct (also called the “righting reflex”) and adhering to stricter MI technique.

Educational Opportunities

Our *pearl* and *peril* examples highlight that our ability to engage patients with good MI skills as well as our ability to avoid the pitfalls of MI-inconsistent (but overlearned) behaviors rarely develop without repeated didactic and experiential learning opportunities [22]. Put otherwise, the learner needs both a didactic foundation and a series of opportunities for guided reflection on patient encounters in order to hone her skills. At one of our author’s home institutions, the addiction consultation-liaison psychiatrist has lectured extensively at local and national meetings on MI and models this technique for trainees. A multidisciplinary group of clinicians (mostly physicians and social workers) have set up a recurring, bi-monthly “motivational interviewing learning group” session in which participants bring an audio- or video-recording—consented to by the patient—of a recent patient interview in which MI was practiced. The group then collectively listens to the recording, with the goal of assessing the interviewer’s fidelity to MI principles using a form adapted from an evidence-based coding tool, in order to facilitate constructive and affirmative feedback to the clinician-volunteer (a copy of this form can be obtained by emailing the corresponding author) [23]. Addiction psychiatry fellows on the service are required to present at least one audio recording for coding during the rotation. At another of our institutions, in addition to modeling MI on the wards, our faculty provide all trainees with a 20-min chalk-talk on foundations of MI in which trainees learn the context of MI among other evidence-based psychotherapies for addiction, its unique role within the stages of change, and basic techniques to employ during their rotation (e.g., *O-A-R-S* or open-ended questions, affirmations, reflections, and summaries). In similar fashion to the first institution, we ask any trainees who spend more than 2 weeks on service to obtain a patient-consented recording to share with a faculty member as an opportunity for feedback. At the remaining institution in our cohort, all MI-teaching has been done informally based on clinical encounters, both in the form of “chalk talks” and bedside instruction. What is important in the latter case is that on a busy service, instruction of

MI occurs during regular clinical workflow and provides brief, yet high-yield opportunities for trainees.

It is difficult to overstate the importance of effective teaching of MI to trainees at all stages of medical education and across specialties. Though MI is demonstrated as effective for a range of chronic health conditions, here we argue that addiction consult services are unique environments in which to practice and teach MI (both didactically and experientially) in light of the distinct nature of our patients’ disease process and the circumstances under which they have found themselves hospitalized [24, 25]. When surveyed, patients with addiction in these settings have stated their desire for non-judgmental providers who understand addiction and can offer specialized resources [20]. As multidisciplinary services that accept medical students as well as residents from varying medical specialties, addiction consult services can serve not only as a model training milieu for a generation of MI-informed medical providers but as a testing ground for experiential training that truly equips trainees with the tools they need to practice high-quality, effective MI.

Compliance and Ethical Standards All are met in accordance with the guidelines.

Conflict of Interest Dr. Suzuki reports grants from National Institute on Drug Abuse during the conduct of the study, outside of the submitted work. Dr. Marcovitz reports personal fees from Better Life Partners, outside the submitted work. All other authors have no disclosures to declare.

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