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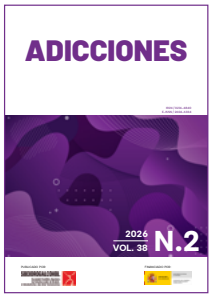

EDITORIAL

Equity in healthcare: Why addiction consultation-liaison services should be present in all hospitals

Equidad asistencial: Por qué la interconsulta en adicciones debe estar presente en todos los centros hospitalarios

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The prevalence of substance use disorders (SUD) among hospitalized patients constitutes a public health problem of the utmost magnitude. Between 20% and 45% of patients hospitalized for a medical or surgical reason have a SUD. In the United States and Canada, up to 44% of hospitalized patients have a SUD. In the United Kingdom, one in five hospitalized patients has an alcohol use disorder (Department of Health and Social Care, 2025; Donroe et al., 2025). In our Mediterranean European context, 800 patients admitted for medical conditions were assessed, identifying high or moderate risk alcohol consumption in 8% and tobacco use in 35%. Those consuming alcohol at a moderate or high risk pattern (according to the ASSIST scale) showed worse functioning and longer hospital stays (Pons-Cabrera et al., 2025).

Hospitalization constitutes a privileged clinical opportunity to intervene in SUD. In our retrospective cohort of 96 patients assessed during their hospital admission by the addiction consultation-liaison service in 2023, we observed that 71.9% were admitted for reasons directly related to substance use, 62.5% had psychiatric comorbidity, and 42.7% met criteria for severe SUD. Despite this complexity, acceptance of referral to the specialized service was very high (89.6%) and 73.3% attended the first psychiatric appointment. Although retention decreased at six (44.2%) and twelve months (32.6%), abstinence rates (per-protocol analysis) remained high: 82.5% at the first visit, 81.6% between 0–6 months, and 64.3% between 6–12 months. These data suggest that hospital admission constitutes a period of maximum receptivity to change, where early intervention could modify the patient's clinical trajectory and allows reaching patients who would not seek treatment on their own.

These conclusions align with the recommendations of an expert group (Delphi methodology including professionals and service users) for addressing substance use in hospitals, which proposes 84 strategies to standardize screening, management, and follow-up of these patients (Donroe et al., 2025). These recommendations highlight the need to include an addiction specialist in the management of hospitalized

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patients with SUD, the creation of a multidisciplinary group to treat patients with this health problem, and the active participation of psychiatrists in the care process.

The presence of psychiatric comorbidity (depression, anxiety, personality disorder) and severe addictive disorders that impact patients' quality of life and functioning makes a structured and integrated approach necessary (Lozano et al., 2017).

Tulloch et al. showed that medical factors (such as the presence of psychosis or physical comorbidity), demographic factors (such as gender), and organizational factors (including self-discharge or hospital size) consistently influence the length of stay (Tulloch et al., 2011). This suggests that organizational and clinical factors—including the integration of specialized liaison teams in addiction psychiatry—can optimize stays and improve care outcomes.

The most robust evidence on the impact of addiction specialist intervention during hospitalization comes from the START trial, which showed that patients who received specialized consultation during hospitalization doubled their likelihood of initiating medication for opioid use disorder and significantly increased their linkage to outpatient follow-up after discharge (Ober et al., 2025). The *American Hospital Association* highlights that care transitions are one of the most critical points for ensuring treatment continuity and reducing SUD-associated mortality (American Hospital Association, 2025). Initiating medication for alcohol use disorder (MAUD) at the time of discharge was associated with a 42% reduction in the combined risk of readmission or 30-day mortality, but only 2% of patients received this treatment at discharge, evidencing a significant treatment gap (Bernstein et al., 2024). Furthermore, receiving a visit from an addiction-specialized psychiatrist during hospitalization for an episode of alcoholic hepatitis was associated with lower mortality (Durkin et al., 2025).

Novel hospital-based interventions for patients with alcohol-related liver disease are showing promising results. The MyWayUp randomized clinical trial demonstrated that a gamified digital intervention, complemented by motivational interviewing, tripled the probability of keeping patients in addiction treatment at six months, improved adherence by 50%, significantly reduced alcohol consumption in the first month in those with active use, and improved prognostic liver parameters such as MELD-Na (Oliveras et al., 2026). These results suggest that digital interventions can overcome traditional barriers such as stigma and logistical difficulties.

The review of care transition strategies (Krawczyk et al., 2023) shows that interventions combining screening in emergency departments or during hospitalization, peer navigation (expert patients who support newly diagnosed individuals), and early follow-up are associated with higher rates of therapeutic linkage, which is consistent with the cohort of 96 patients described above.

The British clinical guideline on alcohol treatment recommends specific care strategies for patients with alcohol use during acute hospitalizations and the use of so-called "alcohol care teams (ACTs)". ACTs are multidisciplinary teams specialized in the management of alcohol use disorder in the hospital setting (Department of Health and Social Care, 2025). Furthermore, during the COVID-19 pandemic it became evident that addiction consultation-liaison teams constitute a central element for the proper care of patients with SUD in a context of health and social crisis (López-Pelayo et al., 2020).

The integration of all this evidence demands a structural change. Hospitalization should not be considered merely an acute care episode, but a therapeutic window of opportunity for patients admitted with medical conditions and psychiatric comorbidity, especially for patients with severe medical illnesses or high relapse risk. In order to optimize this opportunity, we propose:

- Universal screening for SUD and psychiatric comorbidity in hospitalized patients, for example using standardized instruments administered by nursing staff (AUDIT-C, ASSIST).
- Addiction consultations integrated into medical and liaison psychiatry services, along with the creation of multidisciplinary teams, and ensuring these services are considered in budget allocation by administrations.
- Brief, protocolized interventions during admission, based on scientific evidence such as motivational interviewing.
- Systematic assessment for initiating medications for alcohol, opioid, and nicotine use disorder when indicated from hospitalization.
- Structured transition models with intensive follow-up after discharge.
- Integration of digital tools, such as MyWayUp, to improve adherence and ensure continuity of care.
- Integrating a gender perspective with the aim of improving detection of certain conditions in women and reducing barriers to treatment access.
- Ensuring rights-based care (WHO Quality Rights) and respecting bioethical principles including autonomy, privacy and confidentiality, beneficence and non-maleficence, and equitable justice.

Our model of hospital-based addiction care in the consultation-liaison context is summarized in Table 1 and incorporates all the available evidence described above. This model demonstrates that nine out of ten patients consider continuing follow-up after the intervention of a specialized psychiatry and addiction team, and that three out of four attend the first appointment.

Overall, the available evidence consistently suggests that hospitalization represents an optimal window to intervene in SUD, improve clinical outcomes, and reduce associated morbimortality. Inaction in the face of this window means

Table 1
Our addiction intervention model

Methodological principles	Addiction medicine. Motivational interviewing and brief intervention. Complex case management and ensuring care continuity. Addressing complexity: medical, psychiatric, cognitive, and social comorbidity. Multidisciplinarity and training of medical/nursing teams. Ensuring human rights and patient-centered care (Quality Rights WHO model). Continuous updating of evidence to improve care processes.
Intervention objectives	First-order: patient safety by reducing withdrawal risks, preventing self-discharge, elopement, or premature discharge, and ensuring patient comfort. Second-order: achieving linkage to outpatient services, motivating for abstinence, initiating relapse prevention, and use of risk-reducing medications.
Phase 1: stabilization and building patient engagement through motivational interviewing*	Identifying withdrawal risk and preventing it (including risk of seizures or hallucinosis). Preventing and treating Wernicke's syndrome. Guiding the treating medical team on the most common complications (e.g., intracranial hemorrhages, hepatic or infectious diseases). Coordination with nursing and integration in addressing withdrawal symptoms and related behavioral problems: advanced practice nurses identify priorities and coordinate with the patient's responsible nurse.
Phase 2: diagnosis and addressing the patient's main concerns (focus on motivational interviewing)	Diagnosis of substance use disorder based on diagnostic classifications using information from the patient, their relatives (with explicit consent), and the medical history. Diagnosis of mental health comorbidities, especially the most frequent (depression, anxiety, post-traumatic stress disorder). Diagnosis of severe cognitive impairment or dementia. Diagnosis of social, relational, housing, or economic problems affecting prognosis and discharge plan.
Phase 3: motivation and evocative work in motivational interviewing*	Motivational interviewing sessions to address ambivalence, explore reasons and motivations for change beyond the acute illness. Exploring the patient's own resources, their support network, and the system's tools that can help achieve their goals. Exploring the patient's short- and medium-term objectives.
Phase 4: ensuring care continuity and planning work in motivational interviewing*	In a shared decision-making model, deciding the best place to address care after hospitalization: full or partial hospitalization (day hospital) in psychiatry/detoxification unit, home hospitalization, addiction follow-up center or mental health center, primary care. Considering social support, disorder severity, medical and psychiatric comorbidities, detoxification status, relapse risk, patient preference, and logistical and organizational barriers (place of residence, mobility and transport difficulties, etc.). Exploring community resources that may contribute to their well-being.
Cross-cutting	Working with the treating medical team and nursing staff on basic addiction concepts and contingencies arising during admission. Reducing stigma, facilitating the work of professionals, and creating a multidisciplinary team to support the patient's hospital and post-discharge process. Shifting from the view of "difficult patient" to "patient with a treatable problem". Working with the family in the same direction whenever possible (with prior patient authorization). Considering the gender perspective in all phases of the intervention.

losing an effective opportunity to modify the trajectory of substance use disorder.

Conflict of interests

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Author contributions

Conceptualization: L. B.-S., H. L.-P., M. T. P.; Writing – original draft: L. B.-S., H. L.-P.; Writing – review and editing: L. B.-S., N. A., M. B., M. C., L. M., L. P., M. T. P., L. O., Ò. J., H. L.-P.; Supervision: H. L.-P., M. B., L. M.

Use of artificial intelligence

Artificial intelligence tools were used solely for writing support. The scientific content was entirely developed and validated by the authors.

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