Referral Strategies for Patients With Co-Occurring Substance Use and Psychiatric Disorders

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This article provides an overview of research concerning referral strategies for patients with substance use disorder and co-occurring disorders in the emergency department.

The Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health estimates that 42% of 18.9 million adults with a substance use disorder (SUD) in 2011 had a co-occurring disorder. Of these 8 million adults, 56.6% received no care, 32.5% received mental health care, 6.9% received care for both an SUD and mental health, and 4% received care for an SUD alone.\(^1\)

The Drug Abuse Warning Network (DAWN) estimates that 5 million emergency department (ED) visits in the US (1626 per 100,000 population) in 2011 were related to drug and/or alcohol use. Of these visits, 51% were related to illicit drug use, 51% to nonmedical use of pharmaceuticals, and 25% to combined drug and alcohol use. Approximately 40% of ED visits involving illicit drugs resulted in follow-up. Of patients coming to the ED specifically for drug detoxification, 24% were admitted to the hospital, 10% were transferred to a health care facility, and 6% were referred to a detoxification program. For those admitted to the hospital, 2% went to a chemical dependency/detoxification unit and 5.2% went to a psychiatric unit.\(^2\)

These estimates from SAMSHA and DAWN indicate that only a small proportion of patients with SUDs or co-occurring disorders are gaining access to health care with the potential to address all their needs. Deficiencies in resource availability, patient cooperation, adequate triage, or a combination of these issues may be the cause of discrepancy between patient need and patient care. Current research has demonstrated the benefit of screening and intervention practices for SUDs and co-occurring disorders in the ED. How patients can be referred to different services that best optimize treatment outcomes and utilize limited resources is still unclear.

In this article, we review the current literature and guidelines regarding referral strategies for patients with SUDs or co-occurring disorders in an ED setting.

What new information does this article provide?
This article provides an overview of research concerning referral strategies for patients with substance use disorder (SUD) and co-occurring disorders in the emergency department (ED). It summarizes findings from studies, looking at Screening, Brief Intervention, and Referral to Treatment (SBIRT) principles; American Society of Addiction Medicine Patient Placement Criteria; and novel designs, such as the use of technology to streamline provision of care. This article helps us develop an understanding of future directions for research in the area of triage and referral strategies for SUD and co-occurring disorders.

What are the implications for psychiatric practice?
With the limited information available on the topic, this article attempts to highlight strategies that can improve the referral process for patients with SUD and co-occurring disorders in an ED. Health advocates have been shown to improve the rate of enrollment into treatment centers and streamline the process of assessment, intervention, and referral to treatment. They provide personal support and guidance for patients trying to navigate what can be a complex system of care. There is also evidence that technology may improve the efficiency of applying SBIRT strategies in busy health care settings. Overall, greater research in the area of referral strategies is warranted to better optimize patient outcome and resource management.

Screening for substance use and co-occurring disorders
In 2003, SAMHSA launched the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach for individuals at risk for or with an SUD. SBIRT focuses on early intervention and treatment. It involves 3 steps: screening at-risk patients with validated self-administered or clinician-administered scales; brief intervention interview or motivational interview; and referral to
Referral strategies have been adapted to a number of clinical environments, including ED, primary care, and community-based settings. The Academic Emergency Department SBIRT Research Collaborative analyzed implementation of SBIRT in 14 EDs. They found that a brief intervention resulted in reduction of unhealthy drinking at 3-month follow-up; at 12 months, these results were no longer significant. In a meta-analysis, Bray and colleagues found that screening and brief intervention resulted in a small reduction in ED use but had no effect on inpatient or outpatient health care utilization. The SBIRT Research Collaborative investigated the implementation of a curriculum to educate ED staff on SBIRT. They found that training in SBIRT principles increased staff confidence and sense of responsibility to screen patients. Interestingly, staff identified lack of referral sources as one of the barriers to further utilization of SBIRT. Other studies have noted limitations to SBIRT, including altered patient flow through the ED, time required to complete screening and intervention, and low yield of cases compared with number screened.

Another interesting finding from studies on SBIRT is the advantageous use of health advocates. These individuals are trained to recognize and manage patients with SUDs in the ED, thereby diminishing the amount of time required by physicians and other ED staff to intervene. Health advocates can be beneficial not only because of their knowledge about SUDs and referral centers, but also because of their ability to aid the patient in navigating through barriers to accessing treatment. Wright and colleagues provided informal evidence that introducing alcohol health workers into an emergency hospital service in the UK increased the number of patient referrals for specialty counseling.

The benefits of a dedicated addictions staff were also established in a prospective observational trial by Krupski and colleagues. They looked at the effects of brief intervention and/or brief treatment in the ED on admission rates to chemical dependence units. Initial screening, brief intervention, and eventual referral were all provided by chemical dependency professionals. Brief treatment was provided as 4 to 8 sessions with a counselor and focused on assisting the patient to enter a specialized treatment center within a year. They found that patients who received a brief intervention were significantly more likely to enter a chemical dependence unit than were those who did not. The also found that the counselors had a positive effect on attendance to these units.

A study of patients with SUDs aged 12 to 19 years who presented to an ED showed that adolescents were more likely to follow up with a referral for treatment when consistent support was provided. Support included setting up an appointment with a specific counselor, a reminder telephone call before the first appointment, and an offer to transport and/or accompany the adolescent to his or her first appointment. There was a reduction in substance consumption and hazardous behaviors as well as improved GHQ-12 (General Health Questionnaire) scores for those who received the support. The study concluded that attendance to an ED alone for an SUD is not sufficient to change use patterns and that intervention and referral to treatment are beneficial.

**Referral strategies**

The **American Society of Addiction Medicine Patient Placement Criteria** (ASAM-PPC) are decision rules that guide care and assignment of patients to optimal clinical and cost-effective level of care. Both placement matching (resource intensity) and modality matching (theoretical model of care) should be considered in the context of patient need. Level-of-care matching, which involves decisions being made on the basis of cost-effectiveness, can also be considered. The guidelines suggest treatment matching at admission, continued stay, and discharge. To place a patient, they recommend consideration of the diagnosis, assessment of the patient in 6 biopsychosocial dimensions, and determination of severity of illness as well as current level of function. Placement decision is considered the last step in a multidimensional assessment. The criteria are summarized in the **Table**.

The ASAM-PPC did not undergo field testing before their creation and were last updated in 2001. A 2009 study by Chuang and colleagues looked at whether the guidelines are used by outpatient substance abuse treatment units. They analyzed data from the 2005 National Drug Abuse Treatment System Survey that included information from more than 500 centers in the US. They found that 57% of units were regularly using the guidelines to place patients. The most common levels of care provided were I (31%) and II (46%); only 6% offered level IV care. Other studies have examined the impact of using the guidelines for decisions regarding patient care and resource allocation. Findings suggest that use of the guidelines is associated with a reduction in cost of care, improved efficiency in delivery of care, decreased no-show rates to treatment centers, and reduction in use of hospital beds and/or ED visits. Most of these studies were conducted in the late 1990s and early 2000s. More recent studies investigating screening, brief intervention, and
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Since the original publication of these results, DARSSA has been revised and integrated into the connection with a treatment center, and a lack of one-on-one support provided by health advocates. Other barriers may be playing a role, such as difficulty in connecting patients entering treatment. Other barriers may be playing a role, such as difficulty in connecting with the patient after discharge, losing momentum during the gap between discharge and connection with a treatment center, and a lack of one-on-one support provided by health advocates. Since the original publication of these results, DARSSA has been revised and integrated into the treatment center. Treatment was successfully initiated in 4 (8%). Overall, DARSSA showed promise of overcoming the logistical barrier of screening a large number of patients efficiently. The novel design of DARSSA to connect a preexisting database of treatment centers to a patient’s screening assessment is impressive. However, gaps in utility are evident, including the low rate of patients entering treatment. Other barriers may be playing a role, such as difficulty in connecting with the patient after discharge, losing momentum during the gap between discharge and connection with a treatment center, and a lack of one-on-one support provided by health advocates. Since the original publication of these results, DARSSA has been revised and integrated into the treatment center. Treatment was successfully initiated in 4 (8%).

A few studies currently exist that provide guidance on referral strategies. In 2010, D’Onofrio and Degutis published their findings of a 5-year study of Project Alcohol and Substance Abuse Services, Education, and Referral to Treatment (ASSERT) in the Yale-New Haven Hospital Emergency Department. Project ASSERT is an ED-based screening, brief intervention, and referral to treatment program for patients with unhealthy alcohol and other drug use. Their study used health promotion advocates, a detailed but short screening process, and a brief negotiation interview. Applicable patients were referred to a specialized treatment facility. Referral protocols were developed in collaboration with Project ASSERT team members and treatment personnel. Individual facilities were visited by team members to foster partnerships and facilitate referrals. Direct referrals occurred when the patient was transferred directly from the ED to the treatment site. Transportation was arranged by the health advocate and covered by the hospital when necessary. Indirect referrals occurred when there was no space available at the treatment center, the patient was discharged when the center was closed, or the patient was not ready to enter treatment. In these situations, the patient was provided with information on how to contact the treatment facility.

Approximately one-third (31.6%) of screened patients were referred to a treatment program. At 1-month follow-up, 54% of those referred had enrolled in a specialized treatment program. Patients referred directly from the ED to a program were 30 times more likely to enroll in a treatment program. Overall, the Project ASSERT study demonstrated improvement in access to a specialized treatment facility when patients were triaged directly from the ED and supported by health advocates. The study methodology provides examples of how to maximize attendance of patients with SUDs and co-occurring disorders at treatment centers.

Other studies have used technology in an attempt to improve the efficiency of screening and referring patients. Boudreaux and colleagues implemented the Dynamic Assessment and Referral System for Substance Abuse (DARSSA) at both an urban ED unit and a critical care unit to analyze its utility. Patient data were analyzed and the following personalized information was printed for the patient: a report of substance use issues, “quick facts” regarding different substances, a motivational interview worksheet, and a treatment center referral list.

Patients were selectively matched to referral centers on the basis of their insurance status, geographical location, and level of care. A nationwide provider library of accredited SUD treatment facilities as well as independent practitioners was used to generate referrals. With consent, patient contact information was faxed to “best match” treatment providers. Partnerships were made with 7 providers to allow direct referrals. In return, providers agreed to follow up with the patient within 5 days of receiving the referral for telephone screening, discussion of treatment options, and/or scheduling an intake assessment.

The screening tools were provided to the patient using a wireless tablet device. Of the 95 patients enrolled in the study, 85 screened positive for drug and/or alcohol use. Of those who screened positive, 20 received a direct referral to a treatment center and 13 were successfully contacted by the treatment center. Treatment was successfully initiated in 4 (8%). Overall, DARSSA showed promise of overcoming the logistical barrier of screening a large number of patients efficiently. The novel design of DARSSA to connect a preexisting database of treatment centers to a patient’s screening assessment is impressive. However, gaps in utility are evident, including the low rate of patients entering treatment. Other barriers may be playing a role, such as difficulty in connecting with the patient after discharge, losing momentum during the gap between discharge and connection with a treatment center, and a lack of one-on-one support provided by health advocates. Since the original publication of these results, DARSSA has been revised and integrated into the treatment center. Treatment was successfully initiated in 4 (8%).

Looking ahead

In 2009, a breakout session was held at the Academic Emergency Medicine consensus conference “Public Health in the ED: Screening, Surveillance, and Intervention” for alcohol, tobacco, and other drugs. Pertinent recommendations for future research that would best enhance screening and intervention processes for patients with SUDs in the ED were presented. The panel noted that few studies have investigated the referral strategy component of SBIRT and recommended exploration of the following areas: strategies to better link patients who have SUDs and co-occurring disorders with services; analysis of alternatives to community treatment (eg, ED-based pharmacotherapy, outpatient hospital service, inpatient hospital service); determination of the role of stigma on referral and follow-up; and determination of the outcomes of patients referred to different services. A few studies currently exist that provide guidance on referral strategies. In 2010, D’Onofrio and Degutis published their findings of a 5-year study of Project Alcohol and Substance Abuse Services, Education, and Referral to Treatment (ASSERT) in the Yale-New Haven Hospital Emergency Department. Project ASSERT is an ED-based screening, brief intervention, and referral to treatment program for patients with unhealthy alcohol and other drug use. Their study used health promotion advocates, a detailed but short screening process, and a brief negotiation interview. Applicable patients were referred to a specialized treatment facility. Referral protocols were developed in collaboration with Project ASSERT team members and treatment personnel. Individual facilities were visited by team members to foster partnerships and facilitate referrals. Direct referrals occurred when the patient was transferred directly from the ED to the treatment site. Transportation was arranged by the health advocate and covered by the hospital when necessary. Indirect referrals occurred when there was no space available at the treatment center, the patient was discharged when the center was closed, or the patient was not ready to enter treatment. In these situations, the patient was provided with information on how to contact the treatment facility.

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Health Evaluation and Referral Assistant (HERA) program. Improvements to the original DARSSA protocol include an enhanced referral library that contains all treatment centers accredited by SAMHSA as well as an increased dynamic referral partnership with 50 facilities. With 1006 patients enrolled in the HERA study, it promises to provide a more detailed assessment of implementing a computerized program as part of SBIRT. The results of HERA have not yet been published.

Conclusions
Patients with SUDs and co-occurring disorders commonly present to the ED. The Figure illustrates an approach to their management. Multiple studies exist to substantiate the use of screening and brief intervention practices, yet referral strategies to best match patient needs to available resources have not been fully established. A few studies provide suggestions to optimize patient referrals. These include the use of health advocates to support patients through all the steps of assessment, brief intervention, and referral.

The ASAM-PPC provide a basis for referral strategies for patient care. Although they are widely used, few studies have looked at their utility in our current spectrum of treatment centers available to patients. There is evidence that matching patients to specific level of treatment can yield better patient outcomes and reduce health care costs. New advances in technology allow for the use of computerized patient assessment and referral strategies. The benefits of programs such as DARSSA and HERA include efficiency in care, access to a wide treatment center database, and reduced use of ED resources.

Figure. Suggested Approach to Diagnosis and Management of SUDs and Co-Occurring Disorders

TABLE Summary of the American Society of Addiction Medicine Patient Pl...

Disclosures:
Dr Somal is a PGY-5 Resident in Psychiatry at the University of Toronto. Dr George is Professor and Chair in Addiction Psychiatry at the University of Toronto, and Clinical Director of the Schizophrenia Program at the Centre for Addiction and Mental Health in Toronto. Dr Somal reports that he has no conflicts of interest concerning the subject matter of this article. Dr George reports that he is a consultant for and has received grants from Pfizer, Inc; he is a member of the Data Monitoring
Committee for Novartis; he is Deputy Editor of Neuropsychopharmacology; and he is a member of the Risk, Prevention and Interventions for Addictions Study Section for the Center for Scientific Review at the National Institutes of Health.

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