Screening and Brief Intervention for Drug Use in the Emergency Department:

Perspectives of Nurses and Consumers

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Background

- The emergency department (ED) represents **a frontline point of access** for people with acute behavioral disturbances and concurrent illicit drug use [1]

- **Differentiating the cause of acute behavioural disturbance in the ED is both complex and challenging**, especially when behaviour threatens staff safety [2,]

1. Rikki, J., Cindy, W. & Kim, U. 2018. Rates and features of methamphetamine-related presentations to emergency departments: An integrative literature review. Journal of Clinical Nursing, 27, 2569-2582.
2. Sibanda, N. C., Kornhaber, R., Hunt, G. E., Morley, K. & Cleary, M. (2019). Prevalence and Risk Factors of Emergency Department Presentations with Methamphetamine Intoxication or Dependence: A Systematic Review and Meta-analysis. *Issues in Mental Health Nursing*, 1-12.

Evidence

Research

- The ED visit provides **a potential window of opportunity for screening, brief intervention and referral to treatment** (SBIRT) [3, 4]
- **Opportunity for a "*teachable moment*"** [4]

Policy

- *Emergency departments should take every opportunity and be resourced to promote public health and the prevention of illness and injury….(including).. screening for drug and alcohol misuse, and undertaking brief interventions where appropriate*." [5]

3. Butler, K., Reeve, R., Arora, S., et al. (2016). The hidden costs of drug and alcohol use in hospital emergency departments. *Drug and Alcohol Review,* 35**,** 359-366.

4. Woodruff, S. I., Eisenberg, K., McCabe, C. T., Clapp, J. D. & Hohman, M. (2013). Evaluation of California's Alcohol and Drug Screening and Brief Intervention Project for Emergency Department Patients. *Western Journal of Emergency Medicine,* 14**,** 263-270.

5. Australasian College for Emergency Medicine (2015). Policy on Public Health,. Document No P56
ed.: Australasian College for Emergency Medicine.

The Gap

- **How can problematic drug use can routinely be identified and treated among patients who present to the ED?**

- What is the evidence regarding **uptake and patterns of referral** for those most at risk of harmful drug use?

Aims

1. To determine the prevalence of illicit substance use for all individuals admitted to the ED Behavioural Assessment Unit (BAU) [6].

2. To explore perspectives of staff and consumers regarding routine drug screening and brief interventions for drug use.

6. Gerdtz MF, Yap C., Daniel C., Knott J., Kelly P., Braitberg G (2019). Prevalence of Illicit Substance Use Among Patients Presenting to the Emergency Department with Acute Behavioural Disturbance: Rapid Point-of-Care Saliva Screening. (Unpublished - submitted manuscript under review).

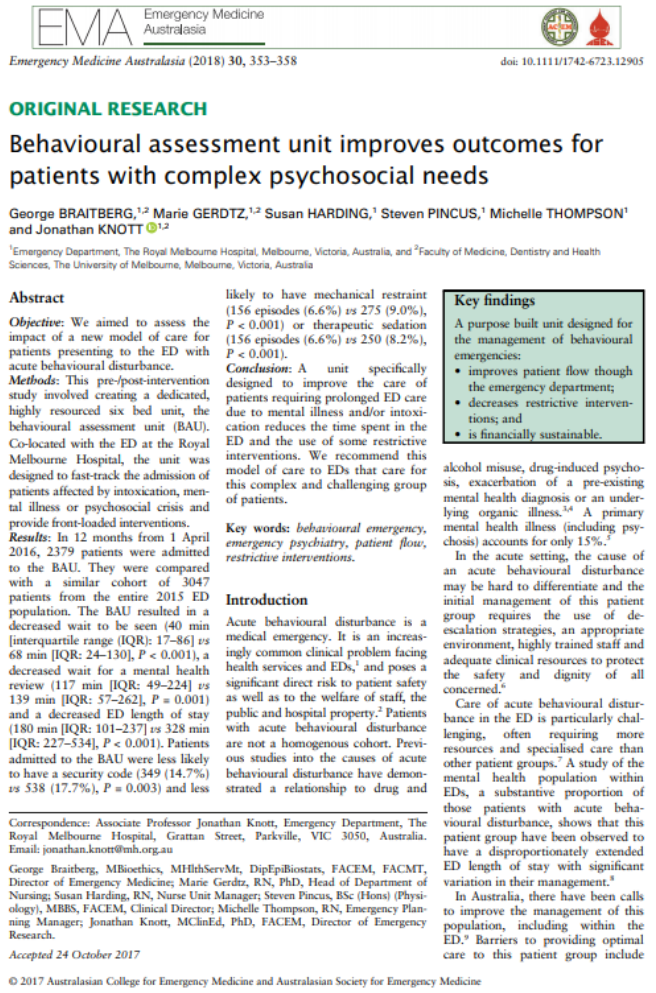
Approach and Setting

Design

- Observational study of prevalence
- Focus group interviews with nurses regarding barriers and enablers to drug screening
- Consumer survey regarding public acceptability

Setting

- Metropolitan tertiary referral hospital ED
- 6 bed Behavioral Assessment Unit (BAU) co-located within the ED [7]



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ORIGINAL RESEARCH

Behavioural assessment unit improves outcomes for patients with complex psychosocial needs

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Abstract

Objective: We aimed to assess the impact of a new model of care for patients presenting to the ED with acute behavioural disturbance.

Methods: This pre-/post-intervention study involved creating a dedicated, highly resourced six bed unit, the behavioural assessment unit (BAU). Co-located with the ED at the Royal Melbourne Hospital, the unit was designed to fast-track the admission of patients affected by intoxication, mental illness or psychosocial crisis and provide front-loaded interventions.

Results: In 12 months from 1 April 2016, 2379 patients were admitted to the BAU. They were compared with a similar cohort of 3047 patients from the entire 2015 ED population. The BAU resulted in a decreased wait to be seen (40 min [interquartile range (IQR): 17–86] *vs* 68 min [IQR: 24–130], $P < 0.001$), a decreased wait for a mental health review (117 min [IQR: 49–224] *vs* 139 min [IQR: 57–262], $P = 0.001$) and a decreased ED length of stay (180 min [IQR: 101–237] *vs* 328 min [IQR: 227–534], $P < 0.001$). Patients admitted to the BAU were less likely to have a security code (349 (14.7%) *vs* 538 (17.7%), $P = 0.003$) and less likely to have mechanical restraint (156 episodes (6.6%) *vs* 275 (9.0%), $P < 0.001$) or therapeutic sedation (156 episodes (6.6%) *vs* 250 (8.2%), $P < 0.001$).

Conclusion: A unit specifically designed to improve the care of patients requiring prolonged ED care due to mental illness and/or intoxication reduces the time spent in the ED and the use of some restrictive interventions. We recommend this model of care to EDs that care for this complex and challenging group of patients.

Key words: *behavioural emergency, emergency psychiatry, patient flow, restrictive interventions.*

Introduction

Acute behavioural disturbance is a medical emergency. It is an increasingly common clinical problem facing health services and EDs,[1] and poses a significant direct risk to patient safety as well as to the welfare of staff, the public and hospital property.[2] Patients with acute behavioural disturbance are not a homogenous cohort. Previous studies into the causes of acute behavioural disturbance have demonstrated a relationship to drug and alcohol misuse, drug-induced psychosis, exacerbation of a pre-existing mental health diagnosis or an underlying organic illness.[3,4] A primary mental health illness (including psychosis) accounts for only 15%.[5]

In the acute setting, the cause of an acute behavioural disturbance may be hard to differentiate and the initial management of this patient group requires the use of de-escalation strategies, an appropriate environment, highly trained staff and adequate clinical resources to protect the safety and dignity of all concerned.[6]

Care of acute behavioural disturbance in the ED is particularly challenging, often requiring more resources and specialised care than other patient groups.[7] A study of the mental health population within EDs, a substantive proportion of those patients with acute behavioural disturbance, shows that this patient group have been observed to have a disproportionately extended ED length of stay with significant variation in their management.[8]

In Australia, there have been calls to improve the management of this population, including within the ED.[9] Barriers to providing optimal care to this patient group include

Key findings

A purpose built unit designed for the management of behavioural emergencies:

- improves patient flow though the emergency department;
- decreases restrictive interventions; and
- is financially sustainable.

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7. Braitberg, G., Gerdtz, M., Harding, S., Pincus, S., Thompson, M. & Knott, J. (2018). Behavioral assessment unit improves outcomes for patients with complex psychosocial needs. *Emergency Medicine Australasia,* 30**,** 353-358.

Observational study (July-December 2017)

Aim

Determine the prevalence of meth/amphetamine and cannabis use among individuals admitted to BAU

Outcomes

1. the prevalence of amphetamine-type stimulants and cannabis use among patients using POC saliva testing and self-reported drug use.

2. Secondary outcomes were rate of acceptance and referral outcomes for patients who tested positive for, or who self-reported amphetamine-type and/or cannabis use.

Observational study (July-December 2017)

Approach

Prospective observational study

Participants

- All patients admitted to BAU over a 6 month period

Screening Brief Intervention Referral to Treatment [8, 9, 10]

8

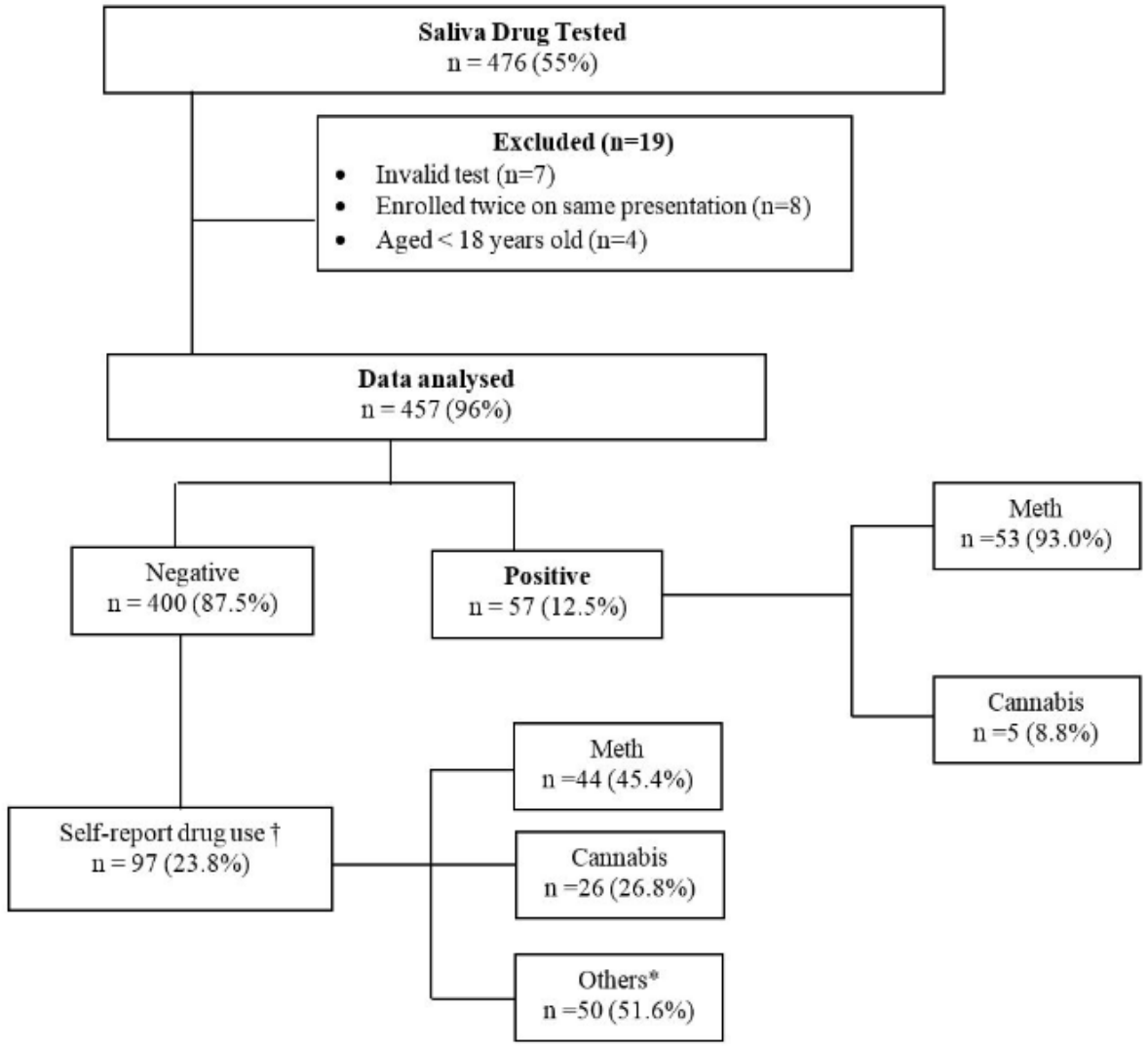
9.

8. Securetec Drug Wipe® Twin
9. Melbourne Health & Substance Use and Mental Illness Treatment Team (SUMITT) (2015). Reducing Harm from Methamphetamines.
10. Gerdtz MF., Yap, C., Daniel C., Knott J., Kelly P., Innes., Braitberg G (2019). Amphetamine-type Stimulant Use among Patients Admitted to the Emergency Department Behavioural Assessment Unit: Screening and Referral Outcomes . (Unpublished - submitted manuscript under review).

Results

Combined prevalence of meth/amphetamine and other drug use was **21.2%**

85.6% accepted referral to the alcohol and other drug clinician



†Patient may report more than one illicit drug use

**Others drug use included diazepam, heroin, LSD, GHB, synthetic cannabis, nitrous oxide, cocaine*

Focus Groups (August-October 2018)

Aim

- To explore perspectives of ED clinicians regarding drug SBIRT.

Approach

- Qualitative - thematic analysis

Setting

- Metropolitan tertiary referral hospital ED

Participants

- Nurses (30)

How is the current model of care implemented?

What are the barriers and enablers of SBIRT?

Results – 5 focus groups n=30

Barriers and enablers to SBIRT in the BAU exist at three levels:

- **Patient** (receptiveness to screening)
- **Staff** (knowledge and perceptions of role)
- **Systems** (time pressures, lack of established pathways to referral, communication between ED-AOD services)

Results – barriers to SBIRT (Patient)

Patient receptiveness

- *"… sometimes I don't probe because you can see they're getting agitated with you by asking the questions,* ***you're increasing their behaviours and potentially become more dangerous and escalated*** *…"*

- *"…I think it's a bit touchy with some people because people get quite defensive about it, not because they've taken it, but because they can't believe that you're going to ask them that question, so* ***you kind of don't want to get off on the wrong foot with your patient****…"*

Results – barriers to SBIRT (Staff)

Knowledge

- *"… we **don't have a skill set** for that, and so you think that **it's not your role**, you think that is actually an important conversation and **I don't want to go in there and give the wrong information**, so I'm just going to step back from that…"*

Role delineation

- *"I don't know if that changes the patient care…which again makes me **wonder if ED is the right point at which to do** how much of the work…"*

Results – barriers to SBIRT (Systems)

Time pressure

- *"… so often **we don't ask, because you get so pushed just to do the work** and get them out, the 4 hour rule screws everything…"*

Pathways to referral

- *"when you come to behavioural drug affected patients, **there's no pathway, there's no guideline**, there's no nothing. So **no one really knows what to do**…"*

Collaborative approach to ED-AOD services

- *"…on the Friday, they're on a bender…and they will say , ok, just refer to drug and alcohol, but, there's no drug and alcohol so we'll put in an after hours referral and it's like **I don't know what's going to be and is that collected? Is that being followed up?"***

Results –Enablers to SBIRT (Staff and systems)

Knowledge

- *"…if you were to empower the nurse with sort of information on harm minimisation strategies and effects of illicit substances, nurses would go oh wow I'm allowed to say things like that. Because it's very formal, it's extremely factual, it would be amazing…"*

Collaboration

- *"…it'd be good for us to clarify if we make a referral will AOD clinician follow up these high risk out of hours, just I think communicating that to all the nurses will increase your compliance for referrals…"*

Resources

- *"If we just have a brochure we have some simple information we can give them…we can give them something that they can hold onto and take with them…"*

Consumer survey (March-April 2019)

Aim

- To explore perspectives of ED consumers regarding drug SBIRT.

Participants

- English speaking adults with no symptom distress or cognitive impairment and able to provide written consent

Setting Sample

- Metropolitan tertiary referral hospital ED
- Random stratified sample (by location) of 20 participants per day

Survey

Patient Beliefs and Attitudes Survey

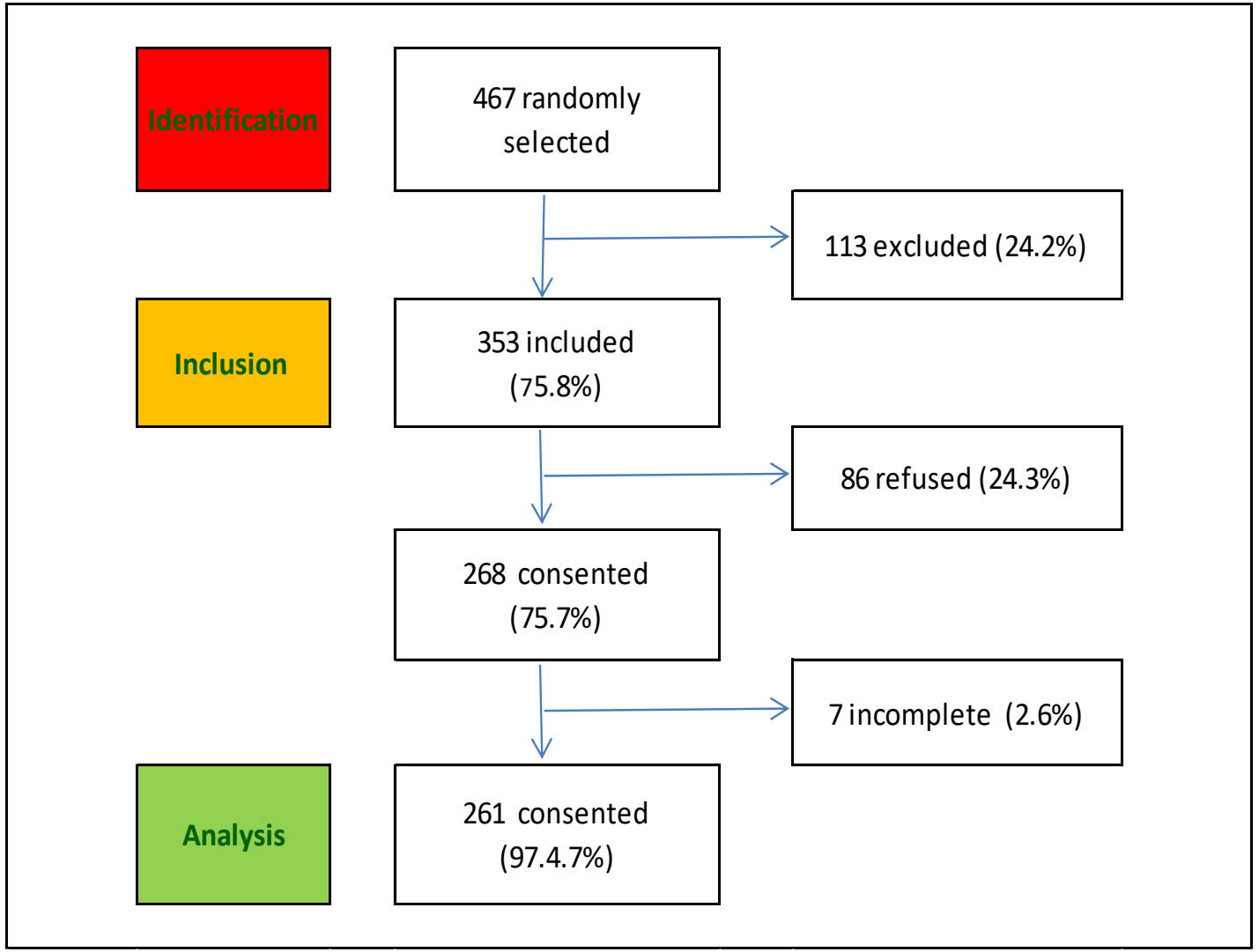
- 11 items measured on 5-point Likert Scale indicating level of agreement
  - Appropriateness
  - Thoughts
  - Level of comfort
  - Relevance/importance to visit
  - Preferences

These questions ask about attitudes towards Alcohol and Drugs screening in the Emergency Department.

Mark your level of agreement with the following statements.

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
It is appropriate to be questioned about my alcohol consumption during my emergency department visits.	○	○	○	○	○
It is appropriate to be questioned about my substance (e.g. cannabis, ICE) consuption during my emergency visits.	○	○	○	○	○
I feel I am being judged by the emergency department staff if they ask me about my alcohol consumption.	○	○	○	○	○
I feel I am being judged by emergency staff if they ask me about my substance use.	○	○	○	○	○
I feel comfortable answering questions related to my alcohol consumption during my emergency visits.	○	○	○	○	○
I feel comfortable answering questions related to my substance use during my emergency visits.	○	○	○	○	○
It is important for emergency staff to know about my alcohol consumption.	○	○	○	○	○
It is important for emergency staff to know about my use of substances.	○	○	○	○	○
It is a good idea to screen everyone for alcohol and substance use during their emergency department visits.	○	○	○	○	○
I'd prefer to self-complete the alcohol and substance use questionnaire instead of being asked by the emergency department staff.	○	○	○	○	○
I'd prefer to have these questions being asked by the attending nurses instead of the attending doctors.	○	○	○	○	○

Results


Identification
467 randomly selected
113 excluded (24.2%)
Inclusion
353 included (75.8%)
86 refused (24.3%)
268 consented (75.7%)
7 incomplete (2.6%)
Analysis
261 consented (97.4.7%)

Results (N=261)

- 85% it is appropriate it is to be questioned about substances
- 88% comfortable answering questions about substance use
- 89% agree it is important for staff to know about substances use
- 80% believe it's a good idea to screen everyone

Key points

- The **prevalence of illicit substance** use among individuals admitted to BAU unit **is high**.
- **Most patients** who screened positive for illicit drug use were **willing to be referred to AOD clinician**.
- The ED visit represents a window of **opportunity in which nurses cans screen for drug use, implement education regarding harm minimisation, and make referral to AOD services**.
- Key challenges for clinicians in initiating SBIRT are related to **time pressures, role legitimacy and lack of training**.
- The vast majority of the consumers who were interviewed **felt it was appropriate to be questioned about drug use and were comfortable answering questions** related to this during their ED visit.