Screening, Brief Intervention, and Referral to Treatment Education for Emergency Nurses in 5 Hospitals: Implementation Steps and Hurdles

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Background

The World Health Organization reported that mental and substance use disorders will surpass all physical diseases by 2020.[1] More than 23.5 million individuals (9.4%) aged 12 years or older have been identified as needing treatment for substance use problems, yet only 2.3 million (<10%) received care.[2,3] Furthermore, the total estimated societal costs of substance abuse in the United States amount to approximately $510.8 billion annually.[2,4] Such alarming statistics regarding alcohol and other drug (AOD) problems are compounded by the untold deleterious impact of substance misuse on the lives of individuals, families, communities, and society. Excessive alcohol use accounted for approximately 88,000 deaths per year from 2006 to 2010 and accounted for 1 in 10 deaths among adults aged 20 to 64 years.[5] This impact has garnered the attention of health professionals who are escalating assessment skills and services to individuals regarding harmful AOD use.[6–12]

While emphasis has often been placed on the need for more specialty substance use disorder clinicians to alleviate the treatment gap and increase system capacity,[13] logic dictates increasing the capacity of generalist health care workers to perform more "upstream" public health approaches. Upstream public health approaches address high-risk AOD use before it requires specialty care to reduce the health risks associated with use, thereby decreasing the burden on more costly health care specialties. For example, escalating substance abuse education and skill development opportunities in nursing student education can be one of the many options to decrease the "treatment gap" by increasing the number of skilled professional nurses entering the workforce through preparatory education.[14–16]

Importantly, training emergency registered nurses (RNs) to address substance use in patients presents an ideal approach to addressing health risks associated with substance use because over 600,000 visits to emergency departments involved drugs combined with alcohol in 2011.[17,18] Such daunting statistics contributed to the impetus of the US Prevention Services Task Force[19,20] recommendation for routine screening for alcohol use and the delivery of brief interventions to high-risk drinkers.

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Nurses, who spend the most time with patients[21] and are the most trusted professionals according to public opinion,[22,23] are perfectly positioned to address the health care issues of 24% to 31% of all patients treated and as many as 50% of severely injured trauma patients in the emergency department who tested positive for alcohol use. In fact, the American College of Surgeons Committee on Trauma[24] has required Level I and Level II Trauma Centers to have a mechanism to identify problem drinkers and requires Level I centers to have the capability to provide brief interventions for patients who screen positive. These directives were backed by evidence that early screening by health professionals has been associated with reductions in alcohol use, health care utilization, criminal justice involvement, and societal costs.[6,25–27] Through early screening, emergency nurses along with other health care professionals have the opportunity to prevent patients from becoming AOD dependent and, if a patient is already dependent, to help him or her to access appropriate care.

A substantial health risk reduction impact associated with AOD use can be made by emergency RNs through the evidence-based practice of screening, brief intervention, and referral to treatment (SBIRT) for patients who seek ED care. SBIRT is an integrated public health approach focused on the delivery of early intervention and treatment services for persons at risk of the development of a substance use disorder, as well as for those who already have a substance use disorder.[18,24]

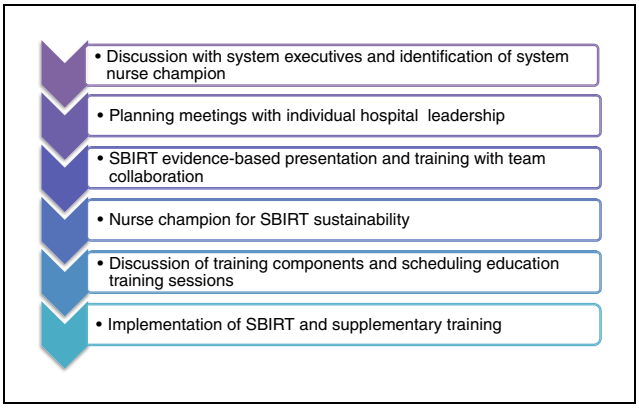
The purpose of this article is to describe the implementation "steps and hurdles" of the grant-funded SBIRT training program for emergency department RNs (EDRN-SBIRT) at 5 regional hospitals where data identified a strong need to screen and intervene with patients who presented to the emergency department. An interdisciplinary collaborative partnership between the hospital leaders, university faculty, and a local organization with expertise in SBIRT training established and championed the goals of the EDRN-SBIRT program to ensure that nursing staff within the hospital emergency departments routinely performed SBIRT to (1) identify and address risky AOD use as it relates to an ED visit and (2) integrate a culturally appropriate,[28] flexible but sustainable and replicable[7] AOD educational and skill-building SBIRT program.

EDRN-SBIRT Program Implementation: Steps

Six steps comprised the EDRN-SBIRT model of implementation (Figure). The initial step required discussion with hospital system executives and subsequent collaboration and approval to access individual hospitals to implement an EDRN-SBIRT training program. At this time, a system SBIRT nurse champion RN was identified who had senior experience in psychiatric nursing, ED psychiatric nursing, and SBIRT. The SBIRT nurse champion joined system discussions to begin to work closely with the training team in all sequential individual meetings and sessions to maintain system communications and avoid potentially cumbersome hurdles for all levels.

Successive planning meetings with each of the 5 hospital administrative leadership groups, including ED administrators, physicians, and select staff to ensure logical development and follow-through of planned policy and procedures for EDRN-SBIRT, followed as the second step. Both steps 1 and 2 involved detailed review and discussion regarding the evidence base for SBIRT and its educational components, trainer qualifications, clearances for grant faculty to be present in the emergency department, and implementation plans to move forward to establish EDRN-SBIRT buy-in, implementation, and sustainability. Although SBIRT offers an extensive potential to affect AOD use risk,[9,10,29,30] several studies produced inconclusive results.[31–33] This made it important to present and clarify information in support of SBIRT as an evidence-based practice to ensure complete understanding of the process, to answer questions, and to encourage EDRN-SBIRT implementation as a policy and procedure throughout the ED training sites.

Our EDRN-SBIRT meeting approach within the emergency department emphasized patient-centered quality improvement and the critical importance of team-based, collegial relationships. Developed and conducted jointly by faculty, nursing administration, and AOD experts, collaborative meetings to implement SBIRT became a learning-community forum created for collaborative inquiry, allowing



FIGURE

Implementation Step Model: Screening, Brief Intervention, and Referral to Treatment (SBIRT).