



Research paper

Support of supervised injection facilities by emergency physicians in Canada



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ABSTRACT

Background: Despite evidence supporting the implementation of supervised injection facilities (SIFs) by multiple stakeholders, no evaluation of emergency physicians' attitudes has ever been documented towards such facilities in Canada or internationally. The primary goal of our study was to determine the opinions and perceptions of emergency physicians regarding the implementation of SIFs in Canada.

Methods: We conducted a national electronic survey of staff and resident emergency physicians in Canada using an iteratively designed survey tool in consultation with content experts. Invitations to complete the survey were sent via email by the Canadian Association of Emergency Physicians. Inclusion criteria required respondents to have treated an adult patient in a Canadian emergency department within the preceding 6 months. The primary measure was the proportion of respondents who would support, not support or were unsure of supporting SIFs in their community with the secondary measure being the likelihood of respondents to refer patients to a SIF if available.

Results: We received 280 responses out of 1353 eligible physicians (20.7%), with the analysis conducted on 250 responses that met inclusion criteria (18.5%). The majority of respondents stated they would support the implementation of SIFs in their community (N = 172; 74.5%) while 10.8% (N = 25) would not and 14.7% (N = 34) did not know. The majority of respondents said they would refer their patients to SIFs (N = 198; 84.6%), with 4.3% (N = 10) who would not and 11.1% (N = 26) who were unsure.

Conclusion: The findings from our study demonstrate that the majority of emergency physician respondents in Canada support the implementation of such sites (74.5%) while 84.6% of respondents would refer patients from the emergency department to such sites if they did exist. Given that many Canadian cities are actively pursuing the creation of SIFs or imminently opening such sites, it appears that our sample population of emergency physicians would both support this approach and would utilize such facilities in an effort to improve patient-centered outcomes for this often marginalized population.

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Introduction

Despite aggressive policing and legal strategies directed at reducing drug use in people who inject drugs (PWID), intravenous drug misuse remains an ongoing and increasing cause of morbidity and mortality in Canadian and international populations. High rates of HIV (Government of Canada PHAC, 2014) and hepatitis C (HCV) (Trubnikov, Yan, & Archibald, 2014), as well as other medical and mental health complications secondary to non-prescription intravenous drug use remain a significant issue in this country.

Because of the apparent failure to eliminate intravenous drug use and the complications thereof, many experts advocate for a 'harm reduction' approach; minimize complications in PWID by reducing risk associated with recreational drug use rather than attempting to directly eliminate drug use itself (International Harm Reduction Association, 2010). It is well established that intravenous and inhalation drug use is associated with multiple acute and chronic health complications, including: HIV and HCV, skin infections such as cellulitis, systemic infections such as endocarditis, pneumonia as well as many others (Gordon & Lowy, 2005; Lloyd-Smith et al., 2005; Stein, 1990). Due to complications arising from drug use, people who use and/or inject drugs (PWUD/PWID) frequent emergency departments for treatment and have recurrent hospitalizations for prolonged treatments (Kerr et al., 2005;

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Palepu et al., 2001), all contributing to Emergency Department (ED) crowding and decreased bed access. Programs which provide access for PWID to utilities and utensils, such as crack pipe exchange and needle exchange programs – generally considered to be a primary prevention strategy (i.e. preventing disease such as those seen in the ED before they occur) – have demonstrated significantly reduced disease-related risk practices and disease transmission (Hurley, Jolley, & Kaldor, 1997; Leonard et al., 2008; Strike et al., 2011). Additionally, Insite – North America's first and as of now only (SIF) – has shown to be beneficial in not only providing access to clean utensils for drug use, but in also providing access to social supports, medical personnel and safe environments leading to reduced mortality secondary to overdose (Marshall, Milloy, Wood, Montaner, & Kerr, 2011), decreased transmission rates of HIV (Andresen & Boyd, 2010; Pinkerton, 2011), decreased public injection and discarding of needles (Wood, Tyndall, Montaner, & Kerr, 2006) and an increase in safe injection education directly from nurses (Wood et al., 2008). Additionally, at least weekly attendance at Insite by PWID or contact at any point with addiction counsellors on site were both independently associated with a more rapid entry into a detoxification program (Wood, Tyndall, Zhang et al., 2006). Furthermore, examination of the SIF in Sydney showed no increase in either drug trafficking or drug use in proximity to their site over many years (Freeman et al., 2005; Snowball & Burgess, 2010). The lack of drug use and drug trafficking in proximity to an SIF was similarly found for Insite in Vancouver (Kerr et al., 2006), which also did not demonstrate any increase in the number of PWID (Kerr et al., 2007) nor any decrease in the number of PWID who began methadone therapy (Kerr et al., 2006).

A recent report entitled “Toronto and Ottawa Supervised Consumption Assessment Study (TOSCA)” – the most comprehensive Canadian assessment of potential supervised consumption sites (SCS) to date – recommended that both Ottawa and Toronto would benefit from the implementation of SIFs but not necessarily SCS, which also allow individuals to smoke recreational substances such as crack cocaine (Bayoumi & Strike, 2012). A supervised injection facility is a legally sanctioned public health facility that offers a hygienic environment where people can inject recreational drugs under the supervision of trained staff (Bayoumi & Strike, 2016). The TOSCA report included focus groups and interviews with multiple stakeholders, including local residents and PWID, with the authors ultimately recommending implementation of such sites despite no data on physicians' perspectives regarding SIFs. To our knowledge, no data have ever been published regarding the opinions of physicians in Canada toward such facilities. Furthermore, there is no published data regarding emergency physician opinion toward such facilities anywhere in the world. As emergency physicians see many of the complications associated with drug use in PWID, both in the short-term (e.g. overdose, abscess formation, sepsis) as well as in the long-term (e.g. complications of HIV and HCV such as progressive liver cirrhosis and opportunistic infections), the opinions and views of this healthcare provider population are pertinent in creating policy on this socially and politically divisive issue. The purpose of this study was to determine the opinions of emergency physicians in Canada toward the implementation of SIFs in their communities and the perceived burden of PWID on emergency departments in Canada as no such data currently exists.

Methods

Study design

We conducted an electronic survey of attending staff and resident emergency physicians in Canada, initially sent out

November 2014. A literature search found no existing survey instrument addressing this topic, therefore, we created a questionnaire in order to collect appropriate information. We designed the survey tool iteratively in consultation with content experts in emergency medicine, as well as in epidemiology, public health and preventive medicine. Once consensus was reached, the questionnaire underwent a “think aloud” content and face validity evaluation with three non-eligible medical doctor (MD) members working in an emergency department who were not involved in the creation of the tool. Minor revisions were made to improve question clarity prior to distribution.

The questionnaire (see Appendix) included a mix of 49 closed and open-ended questions and statements with either a yes/no response or 5-point Likert scale from strongly disagree to strongly agree. Two questions had an additional free text answer. The questionnaire elicited respondents' perceptions of ED use and other resource utilization by PWID; knowledge level and feelings toward SIFs; ideal characteristics regarding structure of SIFs; perceived benefit of providing primary prevention at SIFs; and demographics of respondents.

Survey administration

We determined the sample size in order to obtain the largest proportion possible of emergency physicians in Canada. The Canadian Association of Emergency Physicians (CAEP) was chosen as it has the largest collection of emergency medicine physician email addresses in Canada, and allowed the email invitations to be sent by a third-party organization. At best estimate there is approximately 843 FRCPC and 2693 CCFP-EM physicians practicing in Canada as of 2015 (Canadian Association of Emergency Physicians (CAEP), 2016), with the total physician membership in CAEP being 2239 as of December 2015. The CAEP administration sent invitations to complete the electronic survey in English to a subset of the membership who had previously agreed to receive survey invitations from CAEP. The CAEP staff distributed the survey by email to 1353 staff and resident emergency physicians using the CAEP e-mail list. The proportion of staff and resident physicians among the CAEP membership distribution list was not available. We used the online site ‘Fluid Surveys’™ for the creation, delivery and collection of survey responses. We employed a modified Dillman technique (Dillman, Smyth, & Christian, 2014) which included; pilot testing, a pre-notification email followed by an initial survey invitation and three subsequent reminder emails with the link to our survey instrument. No compensation was provided to respondents for completing the survey.

Inclusion & exclusion criteria

We included physician respondents who had treated at least one adult patient in a Canadian ED within the last 6 months. We excluded medical students, registered nurses and all other allied healthcare workers. As well, we excluded emergency physicians who work solely in pediatric centres as the majority of SIFs require participants to be 18 or older to be eligible to use their sites.

Data analysis

We entered the data into Microsoft Excel™ and examined continuous variables for normality. We converted categorical data into numerical data. We treated the Likert scale responses as nominal data, with the number of respondents and percentages reported. Free-form text data were coded into themes by a single reviewer and reported based on these themes.

We defined the primary measure as the proportion of respondents who would support, not support or were unsure of

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