Understanding the Addicted Patient in an Emergency Room Setting

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There are no financial disclosures/conflicts of interest

Acknowledgements:
NIDA Clinical Trials Network
Dennis Daley, PhD

Background

- Substance use and abuse implicated in hospital emergency departments (ED) visits
- Illness and injury
- Alcohol & other substances
- More than half of arrested reckless drivers tested negative on alcohol, screened positive for other substances
- Substances beyond alcohol implicated in transportation clashes

Background

- ED study in CA revealed that one third of violence-related injuries involved combined alcohol and other substance use
- Over 2 million ED visits in 2006 (2.3%) were related to either the patient's use of alcohol, another person's use of alcohol, or both (National Hospital Ambulatory Medical Care Survey).

Drug Abuse Warning Network

- 1.7 million ED visits in 2006 related to drug misuse/abuse
- Illicit drugs accounted for 31%
- Nonmedical use of prescription drugs accounted for another 28%
- 7% were related to consumption of alcohol alone by a minor
- 34% were a combination of illicit drugs, alcohol, and/or nonmedical use of prescription drugs

Scope of the Problem

- ED patients are more likely than primary care patients or the general population to report misuse of alcohol, drugs, and tobacco
- Rates of current substance use disorders (SUDs) were 14.7%, and
- They are systematically underreported by patients
- Overall, rates of substance use in the ED range from 4% to 47%, depending on the definitions and methodology used.
- Between ¼ and ½ of patients presenting to EDs are at risk or positive for Alcohol Use Disorders (AUDs)/SUDs
- High prevalence rate of AUD/SUD presentation is a burden on ED systems!

Scope of the Problem: Alcohol

- Many patients seen in EDs have at-risk or problem alcohol use
- Alcohol screening is limited,
- Even fewer patients undergoing routine care receive interventions to cut back or stop drinking
- The "teachable moment," (American College of Surgeons) mandated alcohol screening among admitted trauma patients for Level 1 and 2 trauma centers.
- Screening does occur in routine clinical ED settings, but HOW??? Biomarker such as BAL
- BUT BAL and biomarkers fail to detect the majority of patients with alcohol problems
- Window of opportunity versus "teachable moment"

Scope of the Problem: Drugs

- There is currently little or no routine screening for drug use in the ED setting
- Lack of brief drug-screening tools available and a lack of evidence-based data regarding the efficacy of ED-based drug interventions.
- Rates of actual screening for smoking are low: from 32.5% to 56%

Scope of the Problem

- The ED is an important entry portal into the medical care system, especially for underinsured and uninsured
- Given the epidemiology of substance use among ED patients, the delivery of effective
- Brief interventions (BIs) for alcohol, drug, and tobacco use in the ED has the potential to have a large public health impact.

Screening Instruments

- AUDs:

  1-AUDIT (Alcohol Use Disorders Identification Test): most widely used brief instrument

  2- CAGE (Cutting down, Annoyed by criticism; Guilty feelings, Eye-openers)

  3- DrInC (Drinkers Inventory of Consequences)

Screening Instruments

- SUDs:

  1- DAST-10 (Drug Abuse Screening Test); Most commonly used screening

  2- ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test): suggested by NIDA & WHO; screens for risky use of a variety of substances

Intervention Approaches

- Range between 10 and 20 minutes
- Several forms:
  - Advice, Feedback, or Information
  - General or Specific
- Brief Negotiated Interviewing (D'Onofrio et al., 2005):
  - brief, incorporates feedback and advise along with motivational enhancement strategies
- Brief Motivational Interviewing (Rollnick et al., 1992):
  - brief, directive, and focused towards activating patient intrinsic motivation towards behavior change
  - BMI is supported by research as the most effective BI
  - Most widely used
- Research shows that *any* intervention is superior compared to TAU (no intervention)

How Do People Change?

- People change voluntarily only when:

1- They become concerned about the need for change

2- They become convinced that the change is in their best interests or will benefit them more than cost them

3- They organize a plan of action that they are committed to implementing

4- They take the actions that are necessary to make the change and sustain the change

How can we help patients change their drinking or drug using behavior?

Communication Styles

- Direct
- Guide
- Follow

  - A child runs into the road
  - A child is learning to ride a bike
  - A child is crying and you don't know why

Guiding Style

- May be the most appropriate way to talk to patients about lifestyle changes

What to consider

- Individual choice
- Empathy
- Elicit motivation, rather than impose it
- Readiness to change
  - Importance
  - Confidence

Individual Choice

- Brehm 1966 – Reactance Theory
  - If you take away someone's freedom, they react to it
  - Motivates them to perform the behaviour, even if they don't want to do it that much
  - *"no-one tells me what to do"*

Empathy

- Rogers 1959 – Client-Centered Counseling
  - Show you understand, rather than just say you have
  - Non-directive
  - If someone is expecting to be persuaded, this can be a welcome relief and lowers their resistance

Elicit Motivation

- Bem (1972) – Self Perception Theory
  - If someone sees themselves doing something, they think they like it
  - If they hear themselves saying they will stop doing something, they will think they can and will stop

"People are generally better persuaded by the reasons which they have themselves discovered, than by those which have come into the minds of others"

Blaise Pascal (1623-1662)

Elicit Motivation

- Festinger (1957)– Cognitive Dissonance
  - People feel uncomfortable when they hold two incompatible beliefs
  - This creates an urge to do something to resolve it
  - It is often easier to despise what you 'cannot get' and harder to hold a dissonant thought

Readiness

Prochaska and DiClemente – Stages of Change Model

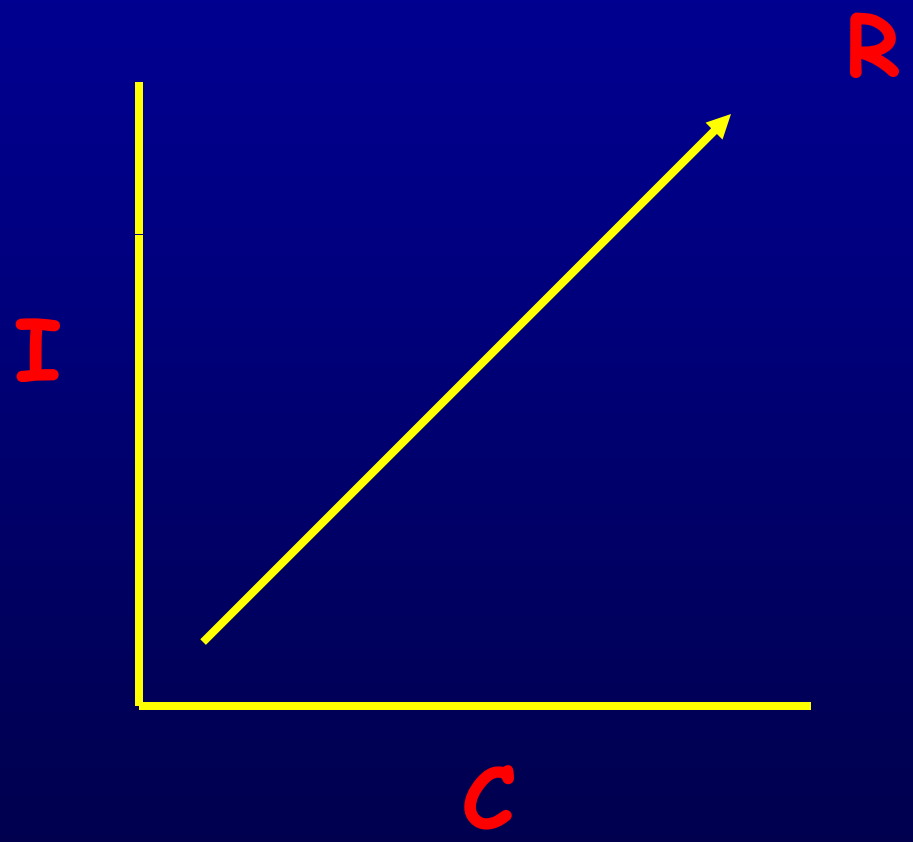
- **Precontemplation**: Not Ready to Change.
- **Contemplation**: Thinking about Change.
- **Preparation**: Planning for Change.
- **Action**: Implementing Behavior Change.
- **Maintenance**: Sustained Change.

Readiness

- Influenced by:
  - Importance
  - Confidence

(Rollnick et. Al 1997, Keller and White 1997)

Readiness



Confidence

- Bandura 1995 – Self-Efficacy
  - If you think you can do it, you will do it
  - If you don't feel you can do it, you may not even try

Brief Interventions (BI)

- Diverse range of theoretically based approaches
- Intervention targets
- & delivery methods to address such issues as education & media-based interventions
- Motivational Interviewing (MI)-based interventions
- & Adherence to health care recommendations

BI

- One form of BI used extensively with health risk behaviors is MI
- MI used primarily with adults and adolescents
- Purposely limited in the number and lengths of contacts
- Provides personalized information designed to increase motivation to improve health-related behaviors

BI

- Six elements associated with BI
- FRAMES
- No single accepted definition of how brief the BI must be

BI

- Feedback regarding personal risk or impairment
- Emphasis on personal Responsibility for change
- Clear Advice to change
- A Menu of alternative change options
- Therapeutic Empathy
- Enhancement of Self-efficacy

BI

- Advantages

1- time to administer
2- cost
3- transportability
4- feasibility
5- adaptability
6- targeting a range of behaviors
7- use as an adjunct to other strategies
8- implemented in stepped-care interventions
9- can manipulate dose and timing
10- prevention or treatment
11- tailored to individual needs
12- less time for training
13- enhances recruitment and retention

- Disadvantages

1- lack power, intensity or duration
2- more expensive than some community-based strategies
3- unable to target some social and environmental factors

Motivational Interviewing

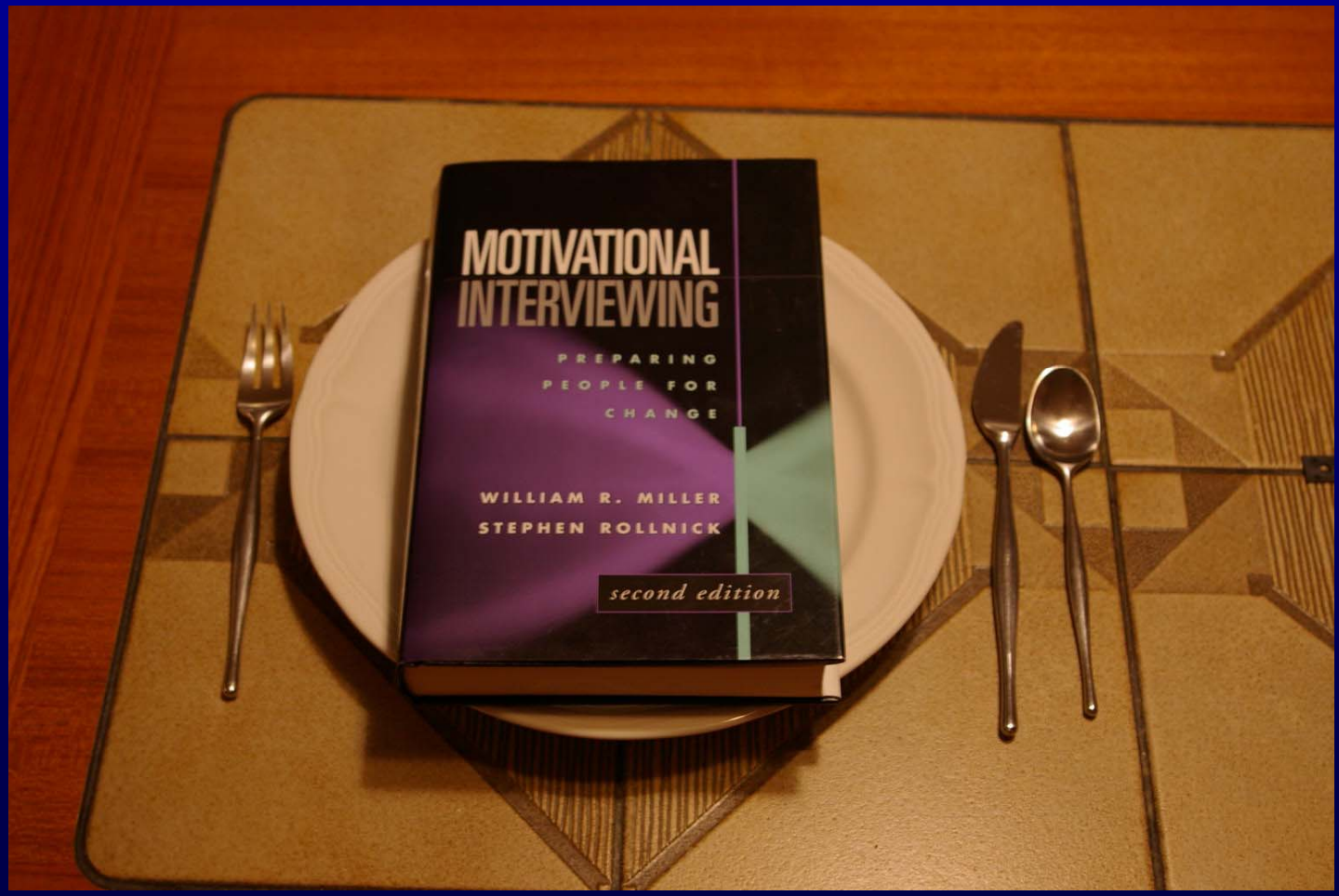
- Developed by psychologists
- The more you confront and persuade, the more the patient will resist
- Counselling style - elicit internal motivation
- Gentle & active listening
- Respect for patient values & autonomy

Definition of MI

- Motivational interviewing is a *collaborative, person-centered form of guiding to elicit and strengthen motivation for change*

Miller & Rollnick 2009

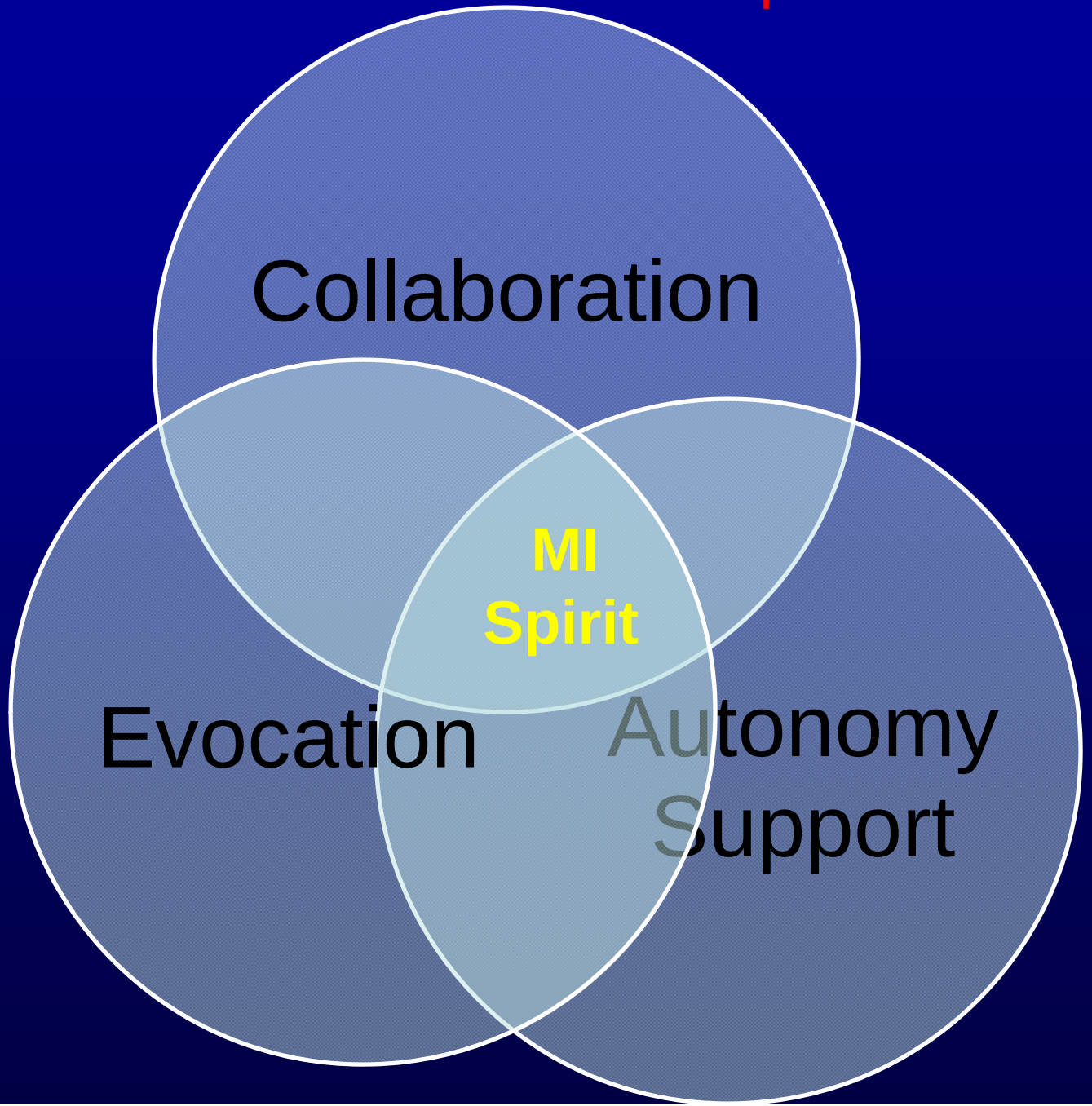
A Taste of MI
More than 1000 Publications in Print



The MI Approach

- Focus on building rapport in the initial stage of counseling relationship
- Central concept: identification, examination & resolution of ambivalence about changing behavior
- MI is a particular kind of conversation about change
- MI is more than the use of a set of technical interventions

Elements of the MI Spirit



'Spirit'

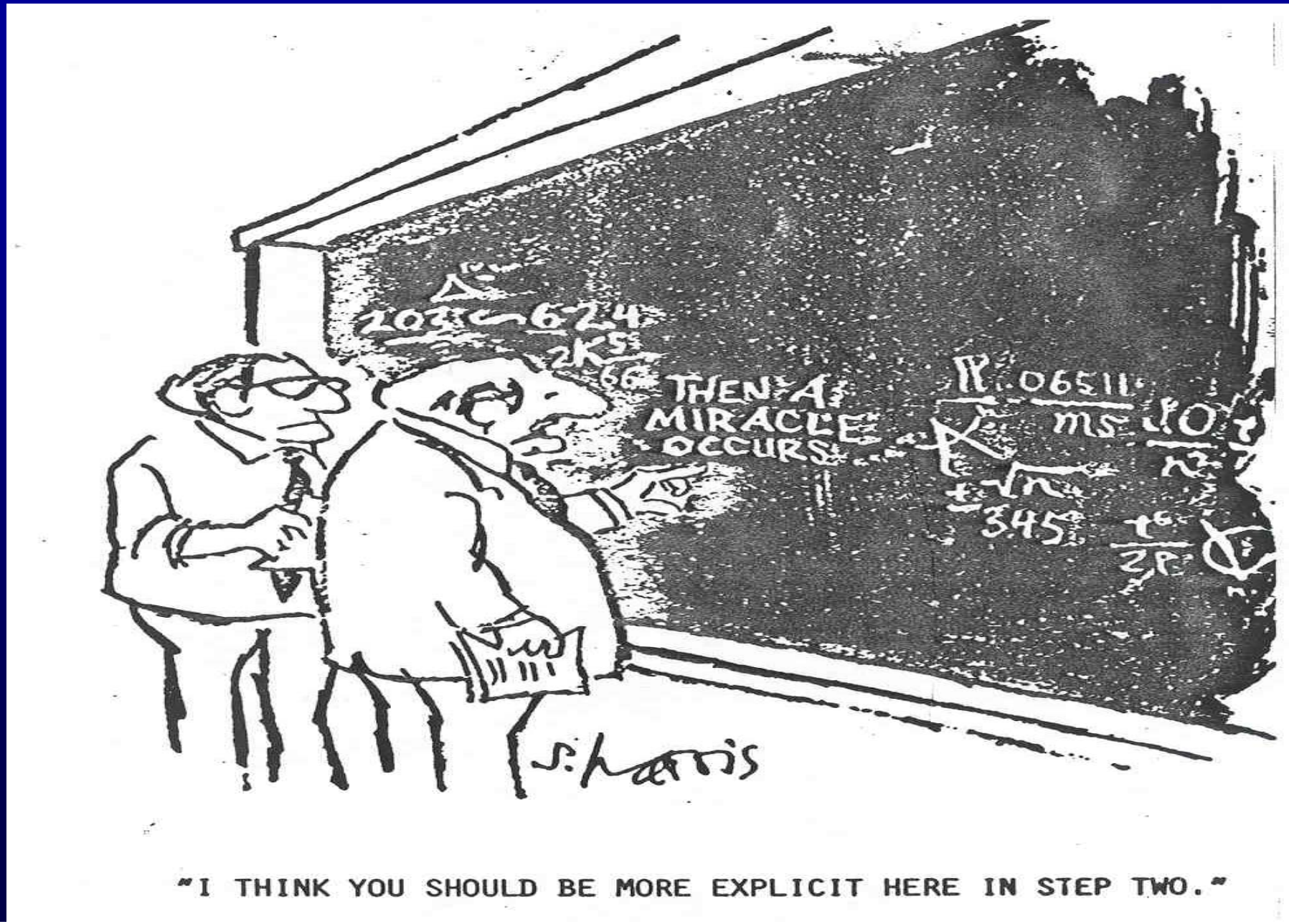
- The way of being with a patient

- The patient resolves ambivalence, not the practitioner
- Elicited from the patient, not imposed
- Quiet, eliciting style
- Listening and understanding the patient

Principles

- Express Empathy
- Develop Discrepancy
- Roll with Resistance
- Support Self-efficacy

Ok, but how do you do it in practice?



"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."

Guiding Style

- 5 Methods "form the fabric" of MI :

OARS: Core skills - learn these first!!!!!

1. (ask) Open-ended questions
2. (make) Affirmations
3. (make) Reflections
4. (provide) Summaries

5. Elicit Change talk

OARS - Closed-Ended vs Open-Ended Questions

- Closed ended questions:
  - Can be answered "yes"/"no"
  - Typically start with "Do" "Did" "Don't" "Can" Can't"
  - Truncate a conversation

Examples:

- *Do you want to stop drinking?*
- *Don't you think your health would improve if you stop using drugs?*
- *Did you ever try to stop drinking?*

Closed-Ended Questions vs Open-Ended

- Open ended questions:
  - Can not typically be answered "yes"/"no"
  - invite more communication
  - Typically start with "How" "What" "In what way" ("help me understand"; how do you see the connection between your injury and your drinking)

Practice: Changing Closed-Ended Questions to Open-Ended

- *Do you want to die from drinking?*
- *Did you ever consider not using crack?*
- *Didn't you think about the benefits of following up with counseling?*
- *Don't you want to be healthier?*
- *Can't you just show up and meet the nurse?*
- *Do you even care about your health?*
- *Did you try to stop using this past week?*

Top 10 Questions (adapted from Rollnick et al. 2010)

- *What changes would you most like to talk about?*
- *What have you noticed about….?*
- *How important is it for you to be healthier?*
- *What are the drawbacks of using alcohol?*
- *What are the benefits of stopping using crack?*
- *In what ways do you see the connection between your drinking and your ED visit?*
- *What are your concerns about meeting with the doctor?*
- *How confident are you about stopping your use of cocaine?*
- *What areas of your life do you want to change ?how does your drinking fit into that?*
- *How are you feeling about your upcoming visit?*

OARS - Affirmations

- Affirmations:
  - Demonstrate support of the patient
  - Build rapport
  - Point to participant's strengths and efforts
  - Can be compliments or statements of patient
- Examples:
- *You're clearly a resourceful person.*
- *That's a good suggestion.*
- *You have a great sense of humor.*
- *You came on time today. Thank you.*
- *I appreciate that you took a big step in coming today.*
- *I am so proud of you! NOT AFFIRMING!*

OARS - Reflections

- Primary skill of MI: takes practice!
- Express empathy
- Can encourage further exploration and shift away from a problematic statement
- Can start with: *So you feel….,Your wondering.., You…*

OARS - SUMMARIES

- Summary Statements:
  - Link together and reinforce material discussed
  - Show that you have been listening carefully
  - Prepare participant to elaborate further
  - Best if succinct (not a monologue)

Eliciting Change Talk

- Change Talk:
  - Strategy to resolve ambivalence
  - "Directive" in that practitioner actively focuses on change talk
  - Is NOT confrontational in nature or style

4 categories of change talk:

1. Recognizing disadvantages of status quo
2. Recognizing advantages of change
3. Expressing optimism about change
4. Expressing intention to change

Importance and Confidence

- How important is it for you to ……..
- How confident are you that you will succeed?
- Scaling Questions (on a scale of 0-10)
  - Why are you at x and not at x
  - What would you need to do to get up to x

Pros and Cons

- How do you feel about……
- What do you like about…..
- What do you dislike about …..
- Tell me about a typical day in your life

Information Exchange

- Information *Giving*
  - A one-way process
  - Combine facts with interpretation & persuasion
  - Decide what to assess & what information to provide
  - Reinforce passivity in patient
  - Ask lots of closed questions

Information Exchange-Personalized Feedback

- Information Exchange
  - Two-way process
  - Encourage patient to be active, to think & discuss
  - Provide information or facts and leave interpretation to patient
  - Elicit-provide-elicit

Alcohol

- The need to identify patients with unhealthy alcohol use
- The need to narrow the gap between patients in need of treatment and those actually receiving services,
- Comprehensive integrated public health approach for the delivery of alcohol Brief Interventions: SBIRT
- This model has been recommended for use in EDs, inpatient trauma units, primary care settings,…
- Supported by NIAAA, CDC, the Committee on Trauma of the American College of Surgeons

Alcohol

- BI consists of a short interactive session, ranging from 5 to 60 minutes, and incorporates personalized feedback, advice, and motivational enhancement
- Reduces substance use to lower risk of future illness and injury.
- Feasible to perform in the ED setting by routine ED clinical staff

Tobacco

- Even low-intensity SBIRT may prompt quit attempts, decreased cigarette use, and quitting, if offered routinely to ED smokers.
- A recent study of 543 smokers in an ED chest pain unit found that a tailored MI with follow-up telephone BI sessions, coupled with initiation of nicotine replacement therapy (NRT) patch, found positive intervention effects on cessation rates at 1 month

SBIRT

- Screening
- BI/BT
- Referral to treatment
- Integration and coordination activities

Referral to Treatment

- A weak point in the SBIRT model
  - Minimal research explores this stage of SBIRT
- Success depends on:
  - Available resources in local community
  - Relationship between ED team and treatment sites.
  - Patient's ability/desire to follow-through with referral
- Using boosters sessions:
  - Research suggests that even minimal follow-up referrals can increase the effectiveness of the BI
  - Booster can be administered in-person or by telephone

Outcome Research - Overview

- 22 studies published AUD/SUD related outcomes for SBIRT in ED
  - 15 studies reported AUD outcomes alone
  - 6 studies reported both AUD and SUD outcomes
  - 1 study reported only SUD related outcomes

- Reported Outcome Criteria:
  - Quantity/Frequency measures
  - Reduction in AUD/SUD related negative consequences
  - Reduction in AUD/SUD assessment scores
  - Increased rates of entry into treatment

AUD Outcomes – SBIRT vs. TAU

- 4 categories of SBIRT vs TAU outcomes:
  - SBIRT showed greater reductions in follow-up quantity/frequency than TAU (n = 6)
  - SBIRT showed greater reductions in AUD related negative consequences, although SBIRT and TAU groups had similar reductions in follow-up quantity/frequency (n = 5)
  - No quantity/frequency data was reported, but SBIRT showed greater reductions in assessment scores than TAU (n = 4)
  - No significant difference between SBIRT and TAU groups on any outcome criteria (n = 2)
    - Both looked at 6-mo or 12-mo F/U
    - Neither study included booster sessions

AUD Outcomes – BI vs. BI

- 5 studies reported AUD related outcomes for different BI models
- Several studies found that information-alone interventions were minimally effective
- Advice or information *with* counseling was superior to information-alone (Blow et al., 2006)
- MI-based interventions were superior to information or feedback based interventions (Monti et al., 1999; Monti et al., 2007; Soderstrom et al., 2007)

Outcomes - SUDs

- 7 studies reported SUD related outcome
- 6 of 7 studies found statistically significant improvements in SUD related outcomes
  - 4 of 5 studies that reported SUD related quantity/frequency data found significant results in favor of SBIRT
  - 2 of 2 studies that reported SUD related levels of treatment engagement found significant results in favor of SBIRT

Outcomes - Population

- Research includes a diverse population base, both in ethnic diversity and age diversity.
  - 4 out of 4 studies find SBIRT to be an effective intervention program across ethnically diverse population groups
  - 4 out of 5 studies find SBIRT to be an effective intervention program with adolescent patients at risk for AUDs/SUDs.

Implementation:

22 publications discuss SBIRT implementation in EDs for AUD/SUD related illness and injury

Good News

- Patients who received SBIRT were more likely to enter Tx (Krupski, et al., 2010)
- ED staff reported SBIRT as an acceptable model for treating AUD/SUD related issues (Graham et al., 2000)
- SBIRT was found to increase the capture rate of AUDs/SUDs by over 50% (Sise et al., 2005)
- SBIRT can be effectively conducted by a variety of middle and upper-level ED clinicians
- SBIRT can effectively be delivered through a variety of modalities

Bad News

- Rates of AUD/SUD screening by ED staff fell by 25% when research staff was not present (Mello et al., 2009)
- Rates of successful SBIRT implementation can be as low as 40% across ED sites (Desy et al., 2008)
- System-level barriers:
  - Long-term funding
  - Support for training and on-going supervision
- Department-level barriers:
  - Need for "buy-in" from ED staff
  - Difficulty of integrating SBIRT within already busy EDs

Costs & Benefits

- Statistical prediction support the likelihood of SBIRT leading to cost savings (Barrett, et al., 2006; Gentilello et al., 2005)
- Costs of SBIRT implementation
  - ranged between $15 and $205 per patient (Barrett et al., 2006; Estee et al., 2007; Fleming et al., 2000; Kunz et al., 2004))
- Benefits of SBIRT implementation
  - ranged between $95 and $366 per patient (Estee et al., 2007; Fleming et al., 2000; Gentilello et al., 2005)
- Projected annual savings of a nation-wide SBIRT program are estimated to be $1.82 billion (Gentilello, et al., 2005)
- Medicare/Medicaid programs are a possible funding source for SBIRT in EDs (Fornili et al., 2007)

Future Direction

- Further research into SBIRT in EDs for SUDs: CTN0047
- Focus on SBIRT targeting at-risk alcohol and substance use, not just dependency
- Develop and support standardized models for training, implementing, and evaluating SBIRT within busy ED settings
- Explore best practices for connecting patients with community resources/treatment options
- Continue to explore cost-saving potential of SBIRT models in ED settings

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