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Commentary: Are Emergency Nurses SBIRT-Ready to Assist Vets and other Chronic Non-Cancer Pain Patients?

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Abstract
Emergency Department (ED) Registered Nurses (RNs) spend significant time treating chronic pain patients. Chronic pain affects up to 100 million Americans (Simon, 2012) and as much as 30% of all opioid pain medications in the United States (US) are prescribed from EDs (Todd, Cowan, Kelly, & Homel, 2010). Abuse of these prescription drugs is America's fastest growing drug problem (Paulozzi, Jones, Mack, & Rudd, 2011). For veterans of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND), chronic non-cancer pain is the most frequent diagnosis (Higgins et al., 2014), and it is closely associated addiction disease.

RNs often use the stigmatizing label "drug-seeking" for certain key patient behaviors and may lack confidence to constructively intervene with these patients (McCaffery, Grimm, Pasero, Ferrell, & Uman, 2005). Screening Brief Intervention and Referral to Treatment (SBIRT) is a successful evidence-based, non-stigmatizing approach for managing patients with substance abuse issues (Agerwala & McCance-Katz, 2012) that can be conducted by nurses (Finnell, 2012).

In this commentary article, we advocate for RN-led SBIRT in both veteran and civilian EDs. Based on results of our SBIRT-readiness survey of ED nurses at one large urban Northern California ED, we found the need for increased RN training on addiction disease with 61% of nurses admitting to using stigmatizing terminology towards these patients, and 53.1% percent stating they given repeat chronic pain patients lower priority.

Keywords
SBIRT, chronic non-cancer pain, prescription opioids, stigma

Cover Page Footnote
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Instituting a nurse-led SBIRT (Screening, Brief Intervention and Referral to Treatment) in every emergency room, both veteran and civilian, would be a major step towards insuring the screening and referral to treatment of a vulnerable population, chronic non-cancer pain patients who may have substance abuse issues. Over the past five years, brief screeners, built into the electronic medical record, have begun to gain wide use, particularly, for alcohol abuse, but also for substance abuse. These screeners offer the possibility for universal screening at a low cost. However, in order to be truly effective, we believe there is first a need to step back and educate emergency nurses on the complexity of the problems of chronic pain management and substance abuse.

Background: The Prescription Pain Medication Epidemic and Veterans

Chronic non-cancer pain has various definitions in research literature but typically refers to pain lasting longer than six months, pain lasting longer than expected time to heal for the underlying injury, or pain that is due to an underlying neuropathic or nociceptive condition (Jovey et al., 2003). Abuse of prescription drugs (opiods) used to treat chronic pain is cited by the Centers for Disease Control (CDC) as America's fastest growing drug problem (Paulozzi et al., 2011). A review by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the CDC of ED visits involving the nonmedical use of prescription drugs from the SAMHSA Drug Abuse Warning Network (DAWN) showed that the estimated number of ED visits for nonmedical use of opioid analgesics increased 111% during 2004-2008 (from 144,600 to 305,900 visits) and increased 29% during 2007-2008.

For veterans, chronic non-cancer pain is the most common reason for disability and is often associated with other chronic health conditions, such as diabetes and cardiovascular issues. Musculoskeletal pain affects female veterans of recent conflicts at a higher rate than males, and in both sexes, chronic pain is highly associated with PTSD, substance abuse and other behavioral issues (Clark, Bair, Buckenmaier III, Gironda, & Walker, 2007; Taylor et al., 2012). Returning combat veterans are presenting at both civilian and Veterans Administration (VA) primary health clinics in large numbers and seeking relief from both physical and psychological pain (Seal et al., 2012). These patients are at risk for addiction and opioid prescriptions may or may not serve them well. With the roll out of the Veterans Choice, Accountability and Access Act of 2014, it is estimated that some 9 millions veterans will be eventually issued Choice Cards, enabling them to seek care outside of the VA (Hicks, 2014), thus making it essential that all ED nurses gain familiarity with treatment of veterans (and all patients) who present to the ED with chronic pain, requesting medication refills, or IV pain medication.

More about SBIRT

The Affordable Care Act and recent White House policy emphasize the use of SBIRT and the adoption of a chronic care, non-stigmatizing approach to management of substance abuse issues. Many states have adopted codes that enable physicians and healthcare organizations to be reimbursed for building SBIRT into their Electronic Health Records and for funding SBIRT training for providers (Kuehn, 2013). Registered nurses, working to the full extent of their education and licensure, are in key roles as members of the interdisciplinary emergency

department team to provide cost-effective SBIRT intervention (Broyles & Gordon, 2010). Use of SBIRT in the ED is in alignment with DNP essential VII, Clinical Prevention and Population Health for Improving the Nation's Health.

SBIRT begins with a Universal Screening of all ED patients for substance abuse using a standardized tool. If a patient screens positive, a Brief Intervention is conducted by a trained staff member. The intervention should be a time-limited non-judgmental counseling session, that seeks to elicit a patient's willingness or interest in behavioral change. A typical Brief Intervention might include:

- Providing information about the screening results.
- Seeking the patient's view and understanding of the results.
- Encouraging the patient to discuss his or her views on how their substance use led to their ED visit, exploring dislikes about substance use, and how they may change behavior.
- Advising patients in clear but respectful terms of the harms of substance abuse.
- Exploring behavior change skills that will reduce substance use and its negative consequences.

The final step of SBIRT is Referral to Treatment or specialty care, if indicated.

Use of SBIRT in the ED, both Veteran and Civilian Populations

Ongoing screening rates for alcohol abuse of greater than 90% have been reported in the Veterans Health Administration primary care system, which in 2003 implemented universal annual alcohol screening with the 3-question Alcohol Use Disorders Identification Test - Consumption (Bradley et al, 2006). Over the last decade, SBIRT use has expanded to included drug misuse screening as well. Washington State Department of Health and Social Services conducted a two-year program testing SBIRT at nine hospitals' emergency departments in Washington (Estee, Wickizer, He, Shah, & Mancuso, 2010) and concluded that SBIRT in the ED is a successful intervention for alcohol and substance abuse from a cost-savings standpoint. Krupski et al. (2010) examined SBIRT in a large, urban safety-net hospital in Seattle, WA where chemical dependency professionals screened patients for both alcohol and drug abuse issues. Krupski et al. (2010) found that people with possible substance abuse disorders who received a brief intervention, regardless of their participation in a brief treatment, were significantly more likely to enter into specialized chemical dependency treatment than similar persons who did not receive a brief intervention. In a three-year study based in a Level 1 trauma hospital, a 96% screening rate (145,394 of 151,597 eligible patients) was obtained by nurses at triage, using a three-question drug and alcohol screener embedded in the electronic medical record (Johnson, Woychek, Vaughan, Seale, 2013).

RN Knowledge of Chronic Non-Cancer Pain Patients in the ED

In contrast to studies that show the effectiveness of SBIRT in the ED at universally screening patients, research that actually examines the attitudes, beliefs and practices of RNs and Advance Practice nurses in either civilian or VA EDs is sparse. And yet, it is known that stigmatization of patients is a barrier to effective care (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013). An exploration of the term "drug-seeking patient," (McCaffery, Grimm, Pasero, Ferrell, & Uman, 2005a) found that ED nurses were most likely to use the term "drug-seeking" in conversation versus general nurses or pain specialty nurses. Traits emergency nurses associated

with “drug-seeking” most often were “abusing pain medicine,” being “addicted to opioids,” and being “manipulative.”

“Drug-seeking” is a stigmatizing label that promotes prejudice towards patients and creates a shame-based context of care (McCaffery et al., 2005a). The nurse’s role in eliminating stigma is to develop rapport with the patient and family, provide education on addiction as a disease, and offer reasonable alternatives when opioids are deemed inappropriate (Oliver et al., 2012). Healthcare providers who stigmatize patients may also feel less willing to intervene positively or lack confidence in their ability to intervene (Aalto, Pekuri, & Seppä, 2001; Skinner, Feather, Freeman, & Roche, 2007). Literature on improving nursing role confidence in substance abuse-related emergency room patients is limited but in a study of student nurses, SBIRT training correlated positively with improved confidence in ability to constructively intervene and assist patients who may have substance abuse disorders (Puskar et al., 2012). Typical training sessions involve role-playing, background information on substance abuse, and training on counseling techniques, such as motivational interviewing.

In order to gauge ED RN readiness for an SBIRT initiative, as well as staff attitudes and practices towards chronic non-cancer pain patients who take opioids, we distributed a convenience survey to staff nurses at a large urban Northern California hospital (non-VA) for a one week period in January, 2014. (IRB exemption for human subjects was obtaining both from the hospital and sponsoring education institution, California State University, Fresno.) There were 49 respondents out of a staff of approximately 200 RNs. Responses showed a need for increased education on addiction disease and on the hazards of stigmatization of patients: 63.3% of RNs surveyed believed that their chronic non-cancer pain patients are addicted to pain medication (Table 1); 70.5% found it difficult to assess patients with “10/10” pain (Table 2); 61.2% sometimes label patients as “drug-seeking (Table 3);” 53% responded that they give low priority to “frequent flyer” chronic pain patients (Table 4); 42.9% said they felt they were often doing more harm than good for these patients (Table 5).

Table 1. RNs Believe Pts Are Addicted to Pain Medicine

	Frequency	Percent
Disagree	8	16.3
Neutral	10	20.4
Agree	22	44.9
Strongly Agree	9	18.4
Total	49	100.0

ARE EMERGENCY NURSES SBIRT-READY

Table 2. Finds it Difficult to Adequately Assess 10/10 Pain

	Frequency	Percent
Disagree	8	16.3
Neutral	5	10.2
Agree	16	32.7
Strongly Agree	19	38.8
Total	48	98.0
Missing System	1	2.0
Total	49	100.0

Table 3. Sometimes Label Patients as "Drug-Seekers"

	Frequency	Percent
Strongly Disagree	3	6.1
Disagree	9	18.4
Neutral	7	14.3
Agree	28	57.1
Strongly Agree	2	4.1
Total	49	100.0

Table 4. Likely to Give Low Priority to "Frequent Flyers"

	Frequency	Percent
Strongly Disagree	2	4.1
Disagree	9	18.4
Neutral	12	24.5
Agree	24	49.0
Strongly Agree	2	4.1
Total	49	100.0

Table 5. RN Feels He or She is Doing More Harm than Good

	Frequency	Percent
Strongly Disagree	6	12.2
Disagree	14	28.6
Neutral	8	16.3
Agree	17	34.7
Strongly Agree	4	8.2
Total	49	100.0

Of the survey respondents, 48.9% said they would be comfortable screening all patients for drug abuse (Table 6); 77.6% believed that prescription drug diversion is a real problem in their community (Table 7), but only one of the nurses surveyed was familiar with the American College of Emergency Physicians (ACEP) clinical guidelines on prescribing opioids in the ED (Cantrill et al., 2012)), which limit the dispensing of opioids from the ED, among many other approaches (Table 8). Demographics for the nurse respondents are shown in Tables 9 and 10. These results indicate to us an interest in SBIRT but a lack of background knowledge to ensure success in effectively counseling patients who might screen positive for substance abuse concerns.

Table 6. Would Feel Comfortable Screening All ED Patients for Drug Abuse

	Frequency	Percent
Strongly Disagree	4	8.2
Disagree	14	28.6
Neutral	7	14.3
Agree	16	32.7
Strongly Agree	8	16.3
Total	49	100.0

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Table 7. RN Believes Diversion is a Real Problem

	Frequency	Percent
Disagree	1	2.0
Neutral	10	20.4
Agree	24	49.0
Strongly Agree	14	28.6
Total	49	100.0

Table 8. Aware of ACEP Guidelines

	Frequency	Percent
Strongly Disagree	20	40.8
Disagree	18	36.7
Neutral	10	20.4
Agree	0	0.0
Strongly Agree	1	2.0
Total	49	100.0

Table 9. Level of Nursing Education for Respondents

	Frequency	Percent
AA/License Only	12	24.4
BSN	32	65.3
MSN	5	10.2
Total	49	100.0

Table 10. Time as ED RN, (in Years) for Respondents

	Frequency	Percent
0 to 3	8	16.3
4 - 10	30	61.2
11 - 20	5	10.2
> 21	3	6.1
Missing System	3	6.1
Total	49	100.0

Recommendations for ED SBIRT Initiatives

Our convenience survey of ED RNs attitudes and practices towards chronic pain patients reinforces findings from the studies extant on this topic: RNs continue to use stigmatizing terminology when referring to chronic pain patients, may or may not take their condition seriously and may be lacking in an understanding of assessment or treatment options. We believe Nurse-led SBIRT is an important step towards improving care for chronic pain patients in the ED, but may require advance staff training in substance abuse and chronic pain assessment in order to be successful.

We believe more RN training is required on addiction disease and chronic non-cancer pain before beginning an SBIRT initiative; RNs showed little knowledge of assessment or treatment guidelines. For RNs who regularly treat veterans with chronic non-cancer pain, increased knowledge of assessment of chronic pain is essential (Douglas, Randleman, DeLane, & Palmer, 2014). Nurse-led SBIRT initiatives in our nation's EDs can identify and assist patients who have substance abuse issues and help to stem the epidemic of prescription opioid overdose. SBIRT offers a chance for more referrals to treatment and better outcomes for all our country's chronic non-cancer pain patients, civilian and veteran alike.

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