Report commissioned by the Office of the Chief Mental Health Nurse – Department of Health and Human Services

Strengthening assessment and intervention skills for ED, mental health and triage nurses managing clients with mental health and amphetamine type substances-use issues

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This project could not have been completed without the assistance of many people.

The first group was the consumers and carers who readily and honestly shared their experiences of presenting to Emergency Departments (EDs) and their admissions to Mental Health (MH) Inpatient Units (IPUs). Their stories were sometimes traumatic, generally sad and always authentic.

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Finally, Anna Love and her team in the Department of Health and Human Services understood the need for targeted nurse education regarding ATS use-related hospital presentations; they designed and guided this scoping project.

Bella Anderson
Project Coordinator

About Nexus

It is common for people with MH issues to experience AOD challenges and vice versa.

This co- occurrence **(**often referred to as *dual diagnosis*) adds complex challenges to engaging, assessing, treating and supporting people to recover.

Assisting services to deliver effective responses to clients with dual diagnosis and other complex needs is the core business of Nexus.

Nexus has been working in the area of Dual Diagnosis – interaction between MH & AOD – for over ten years and understands the challenges and implications for staff, consumers and carers in the context of the broader service system. We also have a proven track record in developing training packages.

As St. Vincent's Hospital in Melbourne is Nexus's auspicing organisation, Nexus embraces the values of St. Vincent's, so, in all our activities we strive to demonstrate:

- **Compassion:** Accepting people as they are.
- **Justice:** Treating all people with fairness and equity so as to transform society.
- **Integrity:** Acting with honesty and truth while ensuring that who we are enables others to flourish.
- **Excellence:** Excelling in all aspects of our healing ministry.

These values combined with our underpinning philosophy of working from a strengths-based, recovery-orientated and evidence-based approach enable us to assist organisations to achieve best-practice when working with people with a dual diagnosis.

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Glossary of terms

AOD	Alcohol and other drugs
ATS	Amphetamine-type-substances (stimulants)
Department	Department of Health and Human Services
Dual Diagnosis	Co-occurring mental health and alcohol and other drug challenges
ED	Emergency Department
HDU	High Dependency Unit (Mental Health Inpatient Unit)
IPU	Mental health inpatient unit
Mental Health Act	The Victorian Mental Health Act (2014)
MH	Mental health
NEAT targets	National emergency access targets
NCETA	National centre of education and training on addiction
VDDI	Victorian Dual Diagnosis Initiative

Introduction:

The Strengthening assessment and intervention skills for ED, mental health and triage nurses managing clients with mental health and amphetamine type substances-use issues—(ATS) Project

THIS PROJECT AIMS TO provide recommendations to the Department of Health and Human Services (the department) regarding current capability/skills issues faced by Mental Health nurses (inpatient and community settings), and Emergency Department mental health and triage nurses in relation to their response to patients with mental health and ATS-use issues /presentations.

BACKGROUND

Methamphetamines and related amphetamine substances aren't new. Whilst the numbers of people using these substances has remained relatively stable at around 2% of the population, the harms are increasing due to a change from powdered to the crystallised form (ice), an increase in the purity of the substance and a reduction in the costs leading to increased use. (Law Reform, Drugs and Crime Prevention Committee, Parliament of Victoria 2014)

Between 2011-12 and 2012-13, the number of methamphetamine-related ambulance attendances increased by 88 % in metropolitan Melbourne and nearly 200 % in regional Victoria (Lloyd, B., Matthews, S., & Gao, C.X. 2014) and methamphetamine-related emergency department presentations rose 20 %. Acute drug-toxicity deaths involving methamphetamine have increased from one in 25 in 2010, to one in 11 in 2012.

In the context of this challenging issue, Nexus was approached to do a scoping project to explore the issues and training needs of the frontline nursing staff with a view to making recommendations regarding the development of an education program targeting the ED, mental health and triage nursing workforce.

Departmental Response

The Victorian Parliament's 2014 *Inquiry into the Supply and Use of Methamphetamines, particularly 'ice', in Victoria* identified the rise in ice use by young people between 20 and 29, and its disproportionate effects in regional Victoria.

In March 2015 the Victorian Government released the Ice Action Plan which offers

- $18 million so that up to 500 more Victorians each year can access drug rehabilitation services (priority is being given to regional and rural services)
- $4.7 million to expand family supports and training for those affected by a loved one's ice use

- A 1800 Ice Advice phone line for families and health professionals
- *$1 million for additional training for our front-line workers and expanded clinical supervision training for AOD and MH workers*
- $1.8 million to enhance the capacity of Needle and Syringe Programs to reduce harm from injecting ice.

Other related commitments include $15 million for 'drug' and 'booze' buses and $500,000 for community action groups.

The plan also reiterates the Government's commitment to a $20 million fund to improve facilities in public hospitals, including mental health services, making them safer for staff, patients and visitors

Preventing occupational violence

Prevention and management of occupational violence for our frontline workforce is a priority for the Victorian Government that has committed $20 million to the Health Service Violence Prevention Fund to make workplaces safer and more secure.

Health and mental health services will be required to report and develop a consistent response to violent incidents.

Standard ice training for all frontline workers

Current training for workers who come into contact with people affected by ice varies significantly across the state. Some good lessons are being learned but aren't routinely shared.

The Ice Action Plan will deliver $400,000 to develop and deliver a standard best-practice training curriculum, which can be tailored to each workplace to better equip workers to respond to the diverse needs of different groups in our communities.

The Victorian Government will also support alcohol and other drug treatment and mental health workers by investing $600,000 to strengthen and extend clinical supervision.

Project Objectives

1. To provide a report to the Department of Health and Human Services (the department) with advice regarding current capability/skills issues faced by mental health nurses (inpatient and community settings), and ED mental health and triage nurses in relation to the management of clients with mental health and use amphetamine type substances issues /Presentations.

2. To provide advice/recommendations to the department on

   a) effective/best practice for mental health nurses and ED staff in management of clients accessing ED who may have a mental health issue and/or use ATS, and

   b) appropriate support structures (using national and international data) and training to maximise skill and capabilities to effectively the mental health nurse workforce providing services to this clients in Victorian emergency departments, mental health inpatient and community service settings.

3. To develop a framework for an education program that will increase the assessment and intervention skills of Emergency Department (ED), mental health and triage nurses in working with clients who may have a mental health issue and/or use amphetamine-type substances (ATS- including ICE).

4. As part of the scoping, we will engage with other frontline workers – ambulance; Police / Pacer teams; ED Triage Nurses & Medical staff. Although the primary focus of the scoping will be directed at MH Nurses / Nurses, this cannot and should not be done in isolation from the other frontline service providers as an integrated response to this issue is required.

5. Scope out integrated practice response frameworks when working with clients who present with concurrent MH and ATS issues.

6. Link the outcomes and information obtained from the scoping process to support the implementation of Victoria's Ice Action Plan initiatives related to training for our front-line workers and the expanded clinical supervision training for drug treatment and mental health workers.

Executive Summary

The following report was commissioned by the Office of the Chief Mental Health Nurse.

The aim of the project was to scope the training and support needs of mental health nurses and other nurses working in Victorian emergency departments and mental health nurses working in mental health inpatient units regarding working effectively with clients who present with challenges related to their use of amphetamine type substances (ATS) including methamphetamine- commonly known as ice.

This scoping was completed using two on-line surveys and a series of nurse focus groups across a range of workplaces; these first-hand reports were enhanced by input from a carer focus group and a consumer focus group and reviewed by an expert advisory group.

The report is supported by a literature search (local and international) which sought to identify existing ATS / methamphetamine training packages for frontline nurses in EDs and MH IPUs. The search identified no specifically designed or targeted training programs related to this issue for this nursing group. However, a number of useful clinical guidelines were sourced which could be used to inform the development of such a program. They are attached in appendix G. The use of these guidelines to develop a training program for this nurse-group was beyond the scope of this project.

The information obtained from this scoping project has been extensive and outlines what the ATS-related training and support needs of this particular nursing group are. However, our discussions identified some somewhat unexpected matters including discharge-related duty of care concerns, interruptions to the sharing of patient-related collateral information between nurses and carers, questions regarding system-wide responsiveness to carer distress and the lack of accessible data regarding ATS presentations to MH and AOD services state-wide. The discussions also highlighted the benefits of a formal *pathway of care* that identifies essential medical and nursing interventions with role delegation, and the usefulness of an audit process to assess a service's capacity to respond to a person presenting with ATS use-related challenges.

Overall, in the absence of relevant literature, this scoping project represents a new body of evidence associated with training and support needs of mental health (MH) nurses and other nurses for Victoria. The material and recommendations in this report may inform other workforce activities and projects that will come out of the ICE Action Plan.

It does not matter whether they are employed in MH, ED or triage roles, nurses throughout this process identified that they want to meet the needs of patients presenting with ATS use-challenges.

1. Training regarding triage ATS-responsiveness, ATS-use screening and addressing stigma

Recommendations

1.1 That triage nurses receive training in the application of an appropriate ATS screener, including the use of advanced communication skills when screening agitated and distressed people

1.2 That relevant nursing staff receive training regarding substance-dependence and recovery

1.3 That reflective practice sessions be provided to nurses to assist them to respond effectively to patients likely to have a history of discrimination

1.4 That peer-educators be engaged to assist relevant nursing and medical staff to explore and understand the lived experience of substance use and recovery

1.5 That workplaces address stigma and notions of deservingness, especially regarding substance dependency

2. Training regarding effective responses to behavioural challenges

Recommendations

2.1 That nurses and all relevant staff receive training in responding to patients exhibiting challenging behaviours as a result of their ATS use, and that this training incorporate material describing ATS use-related brain changes so learners can link altered cognition and capacity with their patients' behaviour and likely stressors

2.2 That all relevant staff receive communication-skills training regarding responding to people experiencing delusions and other psychotic phenomena

2.3 That consumers, carers and peer-consultants be engaged in any review, development and evaluation of appropriate behavioural-response training packages

2.4 That the Department considers the variety of treatment environments when reviewing credentialing processes for behavioural- response training packages to ensure the training can be adjusted for individual workplaces

2.5 That all relevant staff receive training in identifying a patient's needs for a specialist treatment environment, the safe transfer of patients to these settings and applying specialling guidelines (integrated code-grey responses)

2.6 That consumers and carers with ATS use-related lived experience participate in the development of any plans to build specialised patient treatment environments

3. Training in comprehensive ATS-related assessment and gathering collateral assessment information

Recommendations

3.1 That current assessment tools be audited to determine whether they contain elements relevant to ATS-use assessment, and that these elements be inserted into the current assessment tools if necessary

3.2 That relevant nurses receive training in the use and application of ATS use-sensitive assessment-elements including assessment of the patient's health needs

3.3 That nurse educators, who may have little experience with working with patients' ATS challenges, be up-skilled to deliver education in the use and application of these assessment elements

3.4 That nurses receive training and ongoing mentoring regarding the collection of collateral information related to a patient's presentation, whether the person has been admitted under the MH Act or not

3.5 That carers participate in the review of local collateral information-gathering processes

4. Training in standard medical protocols regarding the management of ATS use-related intoxication and ATS withdrawal symptoms

Recommendations

4.1 That *all* front-line nurses and medical staff receive training in applying standard protocols regarding responding to ATS-intoxication and treating ATS withdrawals

4.2 That mentoring be provided to staff as they learn to apply these protocols

4.3 That nurse educators, who may have little experience with working with patients' ATS challenges, be up-skilled to deliver training in the use and application of these protocols

4.4 That standard protocols be adopted to respond to ATS-related intoxication (see Appendix G)

4.5 That standard protocols be adopted to treat ATS withdrawal (see Appendix G)

5. Training in relevant legal frameworks

Recommendations

5.1 That non-MH nurses receive training in the application of the Mental Health Act (2014)

5.2 That relevant nurses receive training in the application of the Severe Substance Dependence Treatment Act (2010)

5.3 That the Department re-issue guidelines regarding legal matters relating to patient searches, weapon confiscation and visitor management outside gazetted MH services.

5.4 That nurses receive training, ongoing mentoring and reflective practice sessions facilitated by suitably experienced staff to explore their *Duty of Care* responsibilities to patients with complex needs

6. Training in integrated treatment processes

Recommendations

6.1 That a comprehensive ATS-related *Clinical Pathway of Care* be developed and trialled to assist staff to respond effectively to patients at every phase of their treatment journey

6.2 That consumers and carers participate in the development and evaluation of any prototype *Clinical Pathway of Care*

6.3 That inter-sectorial partners be involved in the development of any such *Clinical Pathway of Care* to ensure that the pathway responds to, and follows, patients transferring between treatment settings and service-types

7. Training in effective discharge and transfer of patients with ATS use-related challenges

Recommendations

7.1 That relevant nurses receive training in AOD Brief Interventions and harm reduction education for consumers

7.2 That relevant nurses receive training in harm reduction education for carers, and making referrals for carer-support

7.3 That relevant nurses receive training in AOD / dual diagnosis discharge planning

7.4 That nurses receive information regarding the AOD sector and AOD referral processes

7.5 That relevant nurses receive training in AOD and dual diagnosis group-facilitation for inpatient MH settings

7.6 That mentoring and reflective practice sessions be provided to assist relevant nurses to develop robust AOD and dual diagnosis group-facilitation and treatment planning skills

7.7 That effective links be forged between MH, ED and local AOD services for the development of integrated discharge pathways, sharing of information and maintenance of collaborative recovery-planning capacity

7.8 That non-MH nurses receive training in assisting patients to manage their MH symptoms

8. General training matters

These recommendations arose from the distillation of information obtained through the surveys and the nurse focus groups.

Recommendations

8.1 That preceding all training for front-line nurses regarding ATS-related skills, workplaces adopt evidence-based ATS-related polices and practice guidelines

8.2 That training for ED, MH and triage nurses regarding responding to patients presenting with ATS use-related challenges

- be delivered in flexible formats, allowing work places and nurses to determine their needs, prioritise their topics and access the material, and that training regarding the more medical and skills-based learning be delivered in face-to-face sessions
- be followed by reflective practice and mentoring sessions
- be embedded through regular and routine practice

8.3 That nurses receive regular updates regarding ATS use-related matters, and that policy and practice guidelines be amended to accommodate relevant changes in ATS use patterns, contamination issues and consumption practices

8.4 That consideration be given to linking training regarding ATS use with continuing professional development credits

8.5 That consumers and carers be engaged in the development and evaluation of all nurse training material

9. Developing ATS System-responsiveness

Recommendations

9.1 That the Department develops and trials an ATS-responsiveness audit tool for health services to assess and plan for their readiness and capacity to support patients presenting with ATS use-related issues

9.2 That consumers and carers have input into any review of the system's preparedness to respond to ATS use

Please label it Figure 1 so it sits with all the other tables on an uneven page number

I have listed it in the index as Page 19 – if you change this you will need to adjust other things

Figure 1

ATS Training Framework

Strengthening assessment and intervention skills for emergency department, mental health and triage nurses managing clients with mental health and amphetamine type substances (ATS)use

Domain	Clinical interaction	Staff development	Provision of Care	Policy
Key Elements	• All Consumers will be treated with dignity and respect at time of triage • Apply an ATS screen at ED triage entry • Comprehensive brief assessment of ATS use and risk • Decrease stigma associated with ATS use • All care provided will be personalised, responsive and recovery focused	• That all clinical staff are provided with education and training to assist with recognising, responding to and treating consumers who use ATS • Clinical staff with receive training to improve knowledge of relevant legislation	• That organisations support clinical staff to attend training • That organisations support staff to receive mentoring and supervision from experts • That organisations implement policy and procedure for ATS treatment/ withdrawal and discharge planning	• The DHHS collaborates with consumers, carers and clinical staff to develop an ATS responsive system • The DHHS supports organisations to deliver training and education to Clinical staff, carers and consumers

Project Report

Methodology

Data gathering for this project included a literature search, two on-line surveys, seven nurse focus groups, a consumer focus group, a carer focus group and written submissions

Literature Search

We completed a literature search regarding training packages and programs for triage and MH nurses working in Emergency and Acute MH services responding to patients presenting with ATS use-related issues.

Finding nothing specifically related to our target group, we gathered a number of articles related to working with people experiencing ATS use-related challenges, and evidence-based guidelines and protocols regarding effective ATS-responsiveness and have added these as Appendix G. This material could form the basis of nurse-specific training sessions and be incorporated into ATS-related integrated treatment processes.

On-line surveys

We developed and promoted two on-line surveys (the first 24/2/15 - 8/3/15 and the second 9/6/15 – 1/8/2015) to gather relevant data for this project

Survey 1 (Questions attached as Appendix A)

This first survey asked respondents for information including their qualifications, history of relevant training and training priorities.

They were also invited to comment on system-responsiveness to patients presenting with ATS use-related challenges.

This survey included a number of open-ended questions which were then coded and analysed—the results were used as the basis of the survey 2 design where identified issues were explored at greater depth.

There were 73 respondents to survey 1— 69 completed every question.

Workplace location	Number of respondents
Metro	50
Regional	16
Rural	7

Figure 2- Respondents' workplace location – survey 1

Survey 1 respondents worked in a variety of roles within MH and ED workplaces.

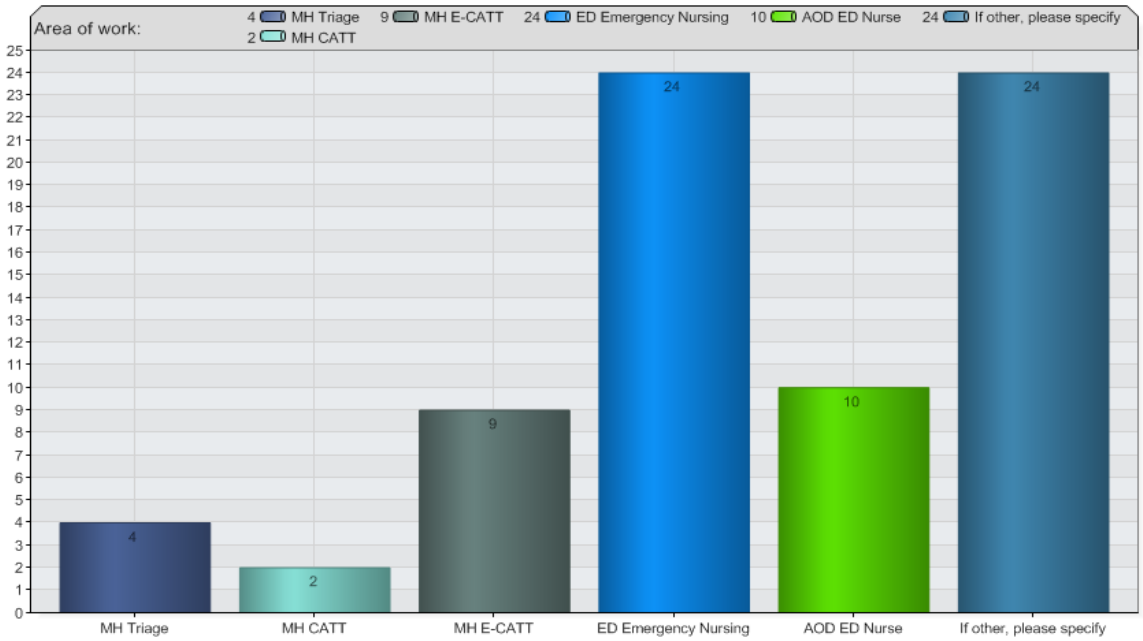

Figure 3 – Respondents' roles – survey 1

Many survey 1 respondents had completed post-graduate training including AOD courses (5), MH (7) and emergency nursing (2).

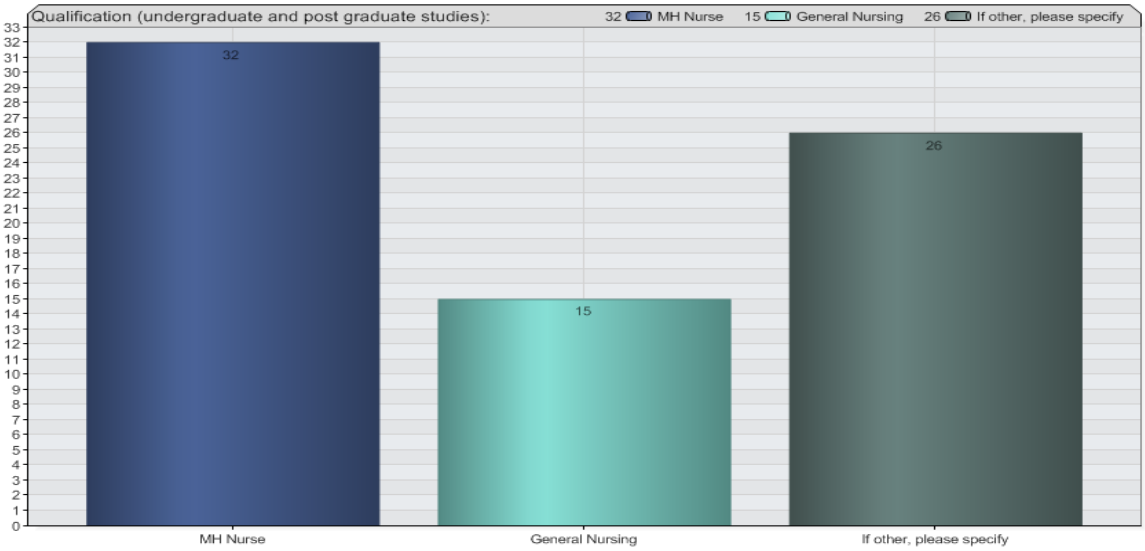

Figure 4 – Respondents' qualifications – survey 1

Survey 1 respondents had worked in their current role an average of 6.8 years (median 5).

Survey 2 (questions attached as Appendix B)

The second survey was built on the initial findings from survey 1, and explored staff training priorities, key themes, system challenges and opportunities. We also asked about previous training, practice-confidence and preferred training methods.

There were 419 respondents to survey 2—193 completed every question.

Workplace location

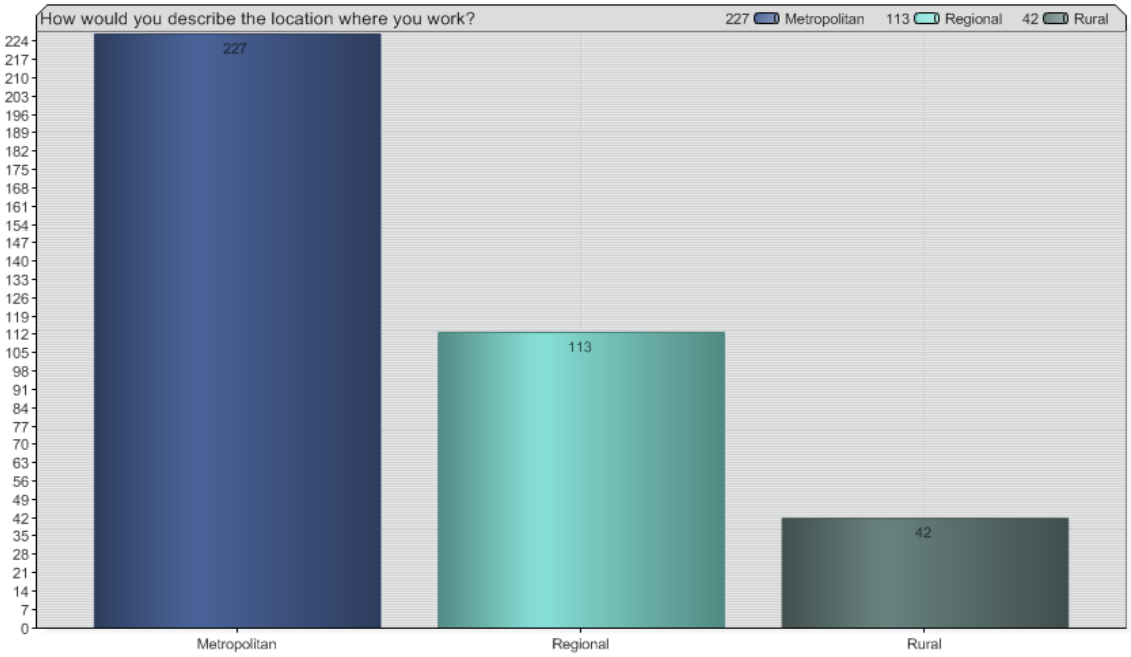

Figure 5 – Respondents' workplace location – survey 2

47 % of survey 2 respondents worked in Emergency Departments, while 53% worked in acute MH services. The average time working in their ED role was 5.94 years (median 5 years) and in acute MH the average time in their role was 12.13 years (median 9 years)

Nurse focus groups (Questions attached as Appendix C)

This scoping project sought to collect information relating to nurses working in a variety of settings and using a range of skill-sets and competencies. It must be noted that nurses working in EDs have a different focus than those working in MH units.

To explore questions related to systems, and confirm the survey 1 descriptions of nurse skill-sets and training needs, we facilitated 7 focus groups (FGs). The sites were chosen to capture the experience of nurses working in a mixture of metro and non-metro health services, particularly those locations identified as having ATS use-related issues. Vic Gov (2014) *Inquiry into Supply and Use of Methamphetamines, Particularly "Ice"* Parliament of Victoria Law Reform, Drugs and Crime Prevention Committee

The FG participants were honest about their experiences, capacities and day-to-day struggles to provide care within often limited resources.

Having ED and MH nurses in the same groups not only enabled us to gather a range of experiences and opinions, it also encouraged them to appreciate their differences and enabled some groups to plan to close identified service-gaps.

Focus groups sites

Site	Number of attendees	MH	Non-MH
Wangaratta / Wodonga	6	5	1
La Trobe Valley Health	3	2	1
Inner-metro	8	5	3
Outer-metro	12	8	4
Goulburn Valley Health	7	4	3
Barwon Health	11	9	2
MHaP / Pacer metro	7	7	0
	54	40	14

Figure 6 - Focus group sites

Consumer and Carer Focus Groups (Questions attached as Appendix D and E)

We facilitated a carer focus group and a consumer focus group where participants described their journeys from home, through admission to ED or hospital, and discharge. Almost all their concerns reflected the nurses' experiences.

These groups were metro-based; the participants were recruited through AOD services and Carer Consultants.

We attempted to capture the rural experience through facilitating a carer group in Mildura but potential attendees dropped out due to their concern about the lack of anonymity in their regional community (stigma).

	Number of attendees	Gender	Age	Self-described ethnic background
Consumer group	10	8 males 2 females	9 < 40 1 > 40	Australian
Carer group	9	2 males 7 females	9 > 40	3 European 3 Anglo-Indian 3 Australian

Figure 7 - Consumer and carer focus groups

Findings

Nurses want solutions and assistance

Respondents of survey 1 were asked to list their 3 main challenges when responding to the needs of this patient group. They provided a mixture of training and systems issues; the training priorities are identified in bold.

Theme / topic	1st Response	2nd Response	3rd Response	Total
Managing aggressive / challenging behaviour	**43**	**19**	**15**	**77**
Working with people who are pre-contemplative and unlikely to follow through with a care plan	4	7	6	17
Lack of formal protocols to respond to people using ATS (integrated care)	**4**	**7**	**6**	**17**
Difficulties with supporting ongoing care/a lack of effective linkages with AOD services	**3**	**2**	**8**	**13**
Assessing MH and AOD symptoms (Dual Diagnosis) and their impact on each other	**4**	**3**	**3**	**10**
Managing withdrawal syndromes	**2**	**7**	**1**	**10**
Resource limits / staffing levels / access to expert staff	2	5	3	10
Managing ATS intoxication	**4**	**3**	**1**	**8**
Environmental limits / lack of short stay beds / lack of low stimulus room / bed block	3	2	3	8
Poor staff attitudes to clients- stigma	1	2	5	8
Managing psychosis / self-harm	**1**	**5**	**1**	**7**
Effective communication with clients	**2**	**2**	**1**	**5**
Lack of housing / clients' chaotic lives		3	2	5
Managing re-admissions	2		2	4
Treatment plans for involuntary clients (including issues re restraint / legal powers)		**3**	**1**	**4**
Challenging families / friends bringing drugs into hospital			2	2
Managing drug-seeking behaviour		**1**		**1**
Inappropriate referrals to MH services			1	1
Sharps danger			1	1
General staff-confidence			**1**	**1**
Trauma			1	1

Figure 8 – Respondents' challenges – survey 1

When **survey 2 respondents** were asked about their highest 5 priorities for training and assistance, they answered:

Training Topic	
1. Responding to ATS use-related challenging behaviour	**73.17%**
2. Management of ATS intoxication	**58.54%**
3. Management of ATS withdrawal	**55.61%**
4. Assessing the needs of patients with ATS presentations	**47.8%**
5. Assessing the MH needs of patients with ATS presentations	36.59%
6. Delivering Brief Interventions to patients with ATS presentations	32.2%
7. Assessing the physical needs of patients with ATS presentations 8. Integrated ED responses to patient with ATS presentations	31.71% 31.71%
9. Nurse legal frameworks – patients unable to give informed consent	30.73%
10. Developing discharge plans for patients with ATS presentations	27.32%
11. Delivering Harm reduction education to patients and carers re ATS	25.85%
12. Management of MH symptoms	22.44%
13. Making effective referrals to AOD services for patients using ATS	20.98%
14. Making effective referrals to MH for patients using ATS	9.76%

Figure 9 – Respondents' training priorities – survey 2

These results were mirrored by FG participants.

We also asked survey 2 respondents to prioritise their training needs regarding more generic ATS-related topics.

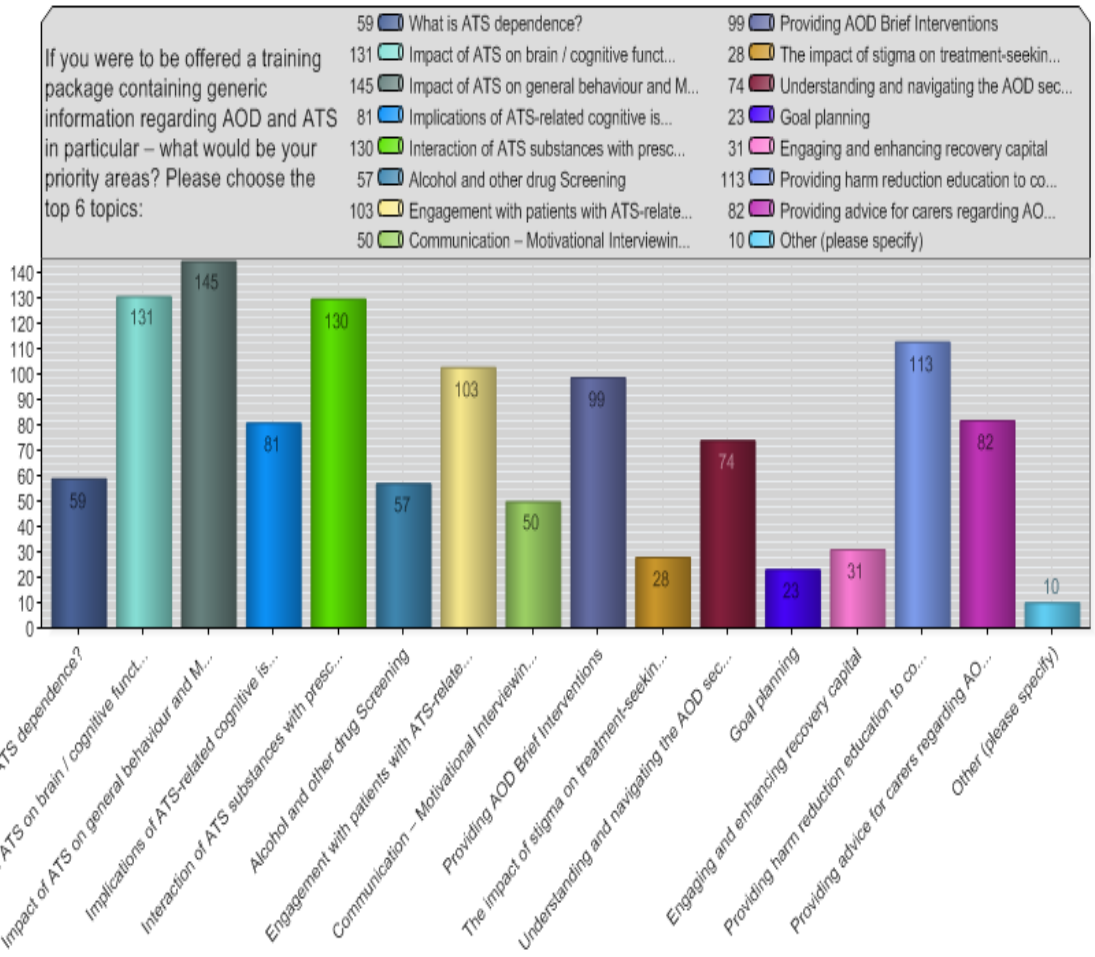

Figure 10 – Respondents' generic ATS-related training priorities – survey 2

Though data was collected from a range of nurse-participants working in a variety of treatment settings, their training priorities and concerns regarding ATS-related system-responsiveness were remarkably congruent across the surveys and the FGs.

Staff safety and responding to challenging behaviour was paramount to participants, they rated managing ATS-related intoxication and withdrawal highly followed by assessment training and developing treatment plans that reflect the patients' AOD / dual diagnosis needs. Legal issues and stigma were also priorities for them.

The data and themes in this report were considered by members of the Expert Review Group (ERG) and confirmed as priority issues for nurses and systems. (ERG Terms of Reference attached as Appendix F)

All percentages in this report have been rounded up or down for ease of reading

Themes and specific recommendations.

Nurse participants made it very clear that their capacity to access training and put new skills into place was dependent on their service's ability to support them, adopt new policies and protocols, and provide treatment settings able to adjust for practice change. Without this support, they believe they are likely to lose new skills and return to old practices.

To best meet the objectives of this project, and reflect the data we gathered, we found it impossible to separate nurse ATS-responsiveness from their workplaces' capacity to respond effectively to patients presenting with ATS use-related challenges.

Our findings are presented as if we were following a patient's journey through a hospital admission, linking recommendations for nurse training to those related to system change.

1. Training in triage ATS-responsiveness, ATS-use screening and addressing stigma

Recommendations

1.1 That triage nurses receive training in the application of an appropriate ATS screener, including the use of advanced communication skills when screening agitated and distressed people

1.2 That relevant nursing staff receive training regarding substance-dependence and recovery

1.3 That reflective practice sessions be provided to nurses to assist them to respond effectively to patients likely to have a history of discrimination

1.4 That peer-educators be engaged to assist relevant nursing and medical staff to explore and understand the lived experience of substance use and recovery

1.5 That workplaces address stigma and notions of deservingness, especially regarding substance dependency

Nurse participants explained that triage nurses are usually the first people to interview the patient and their carers, take the first notes and respond to the presented issues.

Nurse participants believe it is important that triage nurses can identify common ATS use-related challenges, make an immediate assessment of the patient's level of distress and needs, and determine the speed at which the patient needs to move from the desk to an ED cubicle for support and treatment.

Triage-nurse participants reported working within stringent time-limits (sometimes 1 – 3 minutes per patient) and reported being generally untrained in completing AOD triages, and ATS-screening in particular.

Consumer participants reported becoming frustrated by triage processes and being triggered by what they thought were irrelevant questions.

Whilst 85% of the nurse participants reported working with this client group at least once a week, with 24% more than daily, it appears that many triage nurses are yet to receive any training in assessing people with ATS use-related challenges.

It must be noted that there was some discussion between nurse participants about whether triage nurses should be expected to complete an ATS screening or whether they should receive training regarding accurate coding of these patients for swift admission into an ED cubicle for screening by ED staff.

Whether they complete the triage process or code the patients for urgent admission, nurse participants believed that triage nurses need to be skilled in asking ATS-relevant questions at the first point of contact.

A literature search found no validated ATS related screening tools, however a simple screener was developed by Drug and Alcohol Services of South Australia (2008) the *Dips Checklist for psychostimulants* which asks questions such as: have you slept too little, been picking at your skin, felt suspicious or paranoid. Such a tool would require some research before being relied on as an adequate screening tool for ATS use.

It has been reported that some local services may be using a variation of the *The alcohol, smoking and substance involvement screening test (ASSIST*) (Humeniuk, R. et al 2010) to screen for ATS use, by choosing to use those questions they believe are most essential for screening ATS use and amending the wording to focus specifically on this substance.

Lee, N. et al. (2007) in their *Clinical treatment guidelines for alcohol and drug clinicians*. *No 14: Methamphetamine dependence and treatment* make it clear that many patients using ATS may have used other substances prior to presenting to ED, and that any screening process and training should be sensitive to these other substances.

Waiting room management post-triage

Nurse participants reported that in any ED waiting room, at any time, there will be patients with a range of health concerns. Some were described as being able and willing to wait quietly no matter what their condition whilst others were reported as being unable to tolerate the generally sterile space, the patient mix and the stimulation of television sounds, code-calls and ambulance sirens.

Some consumer participants reported sitting in ED waiting rooms having psychotic thoughts and feeling very intimidated, others were desperate for sedation and felt they needed to become aggressive to get their needs met. Carer participants reported fearing for the safety of other people in waiting rooms when their family member harboured homicidal thoughts not identified at triage, and worrying that they may not be able to contain the person until they were assessed or admitted.

Nurse participants reported that some services 'fast-track' patients with substance-use issues to commence treatment while other services don't wish to comply with what they may see as 'manipulative' behaviour.

It is of note that consumer participants, even those brought to ED against their will, reported satisfaction with receiving early assessment and treatment.

Whilst this report will not make a formal recommendations regarding waiting room management, it is important to note that the topic arose in a number of FGs and further exploration and review would appear indicated.

Stigma

A report by the Australian Injecting and Illicit Drug Users League (2011) *Why wouldn't I discriminate against all of them?' A report on stigma and discrimination towards the injecting drug user community*. suggests that patients using drugs experience stigma in health and other settings. These people are often stereotyped as being a burden on the public purse, unemployed, providing nothing to society and as causing unnecessary and costly harm to themselves. And though there is no specific evidence related to health outcomes for drug users, similarly marginalised groups such as those with mental illness and those affected by HIV experience poorer health outcomes and higher numbers of hospitalisations than other members of the community.

National Centre for Education and Training on Addiction produced a training program to combat stigma related to drug use (2006). Their *Health professionals' attitudes towards licit and illicit drug users: a training resource*, explores the nature of deservingness and finds that stigma (non-deservingness) remains a potent barrier to people seeking help, and can be an obstacle to health professionals engagement with patients and investment in their treatment outcomes.

Many participants in the consumer FG and some carer participants described feeling unwanted in the hospital setting. Their descriptions of these experiences were confirmed by the nurse participants of FGs, who explained regretfully that the stress of managing heavy workloads, multiple competing-priorities and feeling overwhelmed by the complexity of ATS-use challenges may sometimes express itself in judgemental or dismissive body-language.

Nurse participants and the consumer participant on the ERG explained that patients with substance-use issues often have histories of marginalisation, discrimination and poor socio-economic backgrounds, especially those with a co-occurring MH challenge, and are often highly sensitive to the response of others.

While every FG session described the impact that stigma has on staff satisfaction, the consumer and carer participants discussed the impact that stigma has on consumer trust and, potentially on, staff safety.

Consumer and carer participants explained that whether they've experienced discrimination in the past or not, the way they are welcomed to a service will affect their level of trust, comfort and willingness to cooperate with standard procedures—that feeling dismissed may trigger anxiety and anger.

Nurse participants confirmed that all patients, no matter what their health issues are, deserve the best treatment available and should never be victims of discrimination. In general, they suspected that any violence and chaos associated with ATS-related presentations may have had an impact on some nurses' sense of patient-deservingness and that this unwanted judgementalism would reduce if protocols were in place to increase staff safely.

13% of the respondents of survey 2 rated training regarding 'The impact of stigma on treatment-seeking and hope' highly (figure 10); this interest was supported by FG participants.

Nurse participants explained that they rarely see the results of effective treatment of substance dependency and expressed interest in knowing more about the condition and recovery rates, and being exposed to people in recovery.

It is of note that Best, D. & Lubman,D. (2012) in their article *The recovery paradigm, a model of hope and change for alcohol and drug addiction* explain that 58% of people with a history of substance dependence will recover and go on to lead satisfying and meaningful lives. It would seem useful to have such information available to ED and IPU staff.

The Andrews Government has committed $400,000 to develop and deliver a standard best-practice training curriculum, which can be tailored to each workplace to better equip workers to respond to the diverse needs of different groups in our communities.

2. Training regarding effective responses to behavioural challenges

Recommendations

2.1 That nurses and all relevant staff receive training in responding to patients exhibiting challenging behaviours as a result of their ATS use, and that this training incorporate material describing ATS use-related brain changes so learners can link altered cognition and capacity with their patients' behaviour and likely stressors

2.2 That all relevant staff receive communication-skills training regarding responding to people experiencing delusions and other psychotic phenomena

2.3 That consumers, carers and peer-consultants be engaged in any review, development and evaluation of appropriate behavioural-response training packages

2.4 That the Department considers the variety of treatment environments when reviewing credentialing processes for behavioural- response training packages to ensure the training can be adjusted for individual workplaces

2.5 That all relevant staff receive training in identifying a patient's needs for a specialist treatment environment, the safe transfer of patients to these settings and applying specialling guidelines (integrated code-grey responses)

2.6 That consumers and carers with ATS use-related lived experience participate in the development of any plans to build specialised patient treatment environments

There is no doubt that safety at work is of absolute importance; this has been raised from team leadership through to Government. However, violence against nurses remains at a worrying level, whether ATS use-related or not.

Nurse participants recognised that there are many training packages available, generally adapted for the local environment, eg training packages in the MH field will reference the Mental Health Act and contain cooperative training between nurses and security teams related to seclusion processes. An example of this is the *Therapeutic response to aggression management* used at St Vincents Hospital in Melbourne (St Vincents Hospital Melbourne. 2014). Other workplace training packages may have other focuses,

However, does such training reduce the risk of violence against staff? Survey participants who had received training believed they needed more and that such training is useful.

Anderson, L., FitzGerald, M. & Luck L. (2010) in their comprehensive literature review: *An integrative literature review of interventions to reduce violence against emergency department nurses,* linked good reporting practices to better risk assessment, system evaluation, and risk mitigation, however their other finding were not immediately relevant to the local (Victorian) situation as they focused on the use of weapons such as guns and knives and metal detectors.
Jenner, L., & Lee, N. (2009) in *Responding to challenging situations related to the use of psychostimulants: A practical guide for frontline workers,* were unwilling to make any guarantees about

the outcomes of following their program and suggest only that their suggestions could assist workplaces to review their current protocols.

And even the highly respected review performed by the National Collaborating Centre for Nursing and Supportive Care (2005) reviewing mental-health related challenging behaviours, in *Violence: the Short term Management of Disturbed/Violent Behaviour in Psychiatric In-patient Settings and Emergency Departments*, admits that there is no conclusive link between training and reduction in violence. Rather than rely on evidence-based data, they developed their training guidelines through consultation with health professionals.

It appears that every violent incident is unique and that the variety of workplaces, staffing and patient profiles, and external matters eg drug use patterns, make research in this area problematic. However, nurse participants reported feeling more confident (less vulnerable) after training in responding to challenging behaviour.

87% of survey 2 respondents reported being required to manage ATS use-related challenging behaviour at least weekly, including 66% frequently (a few times a week) and *26 % daily.*

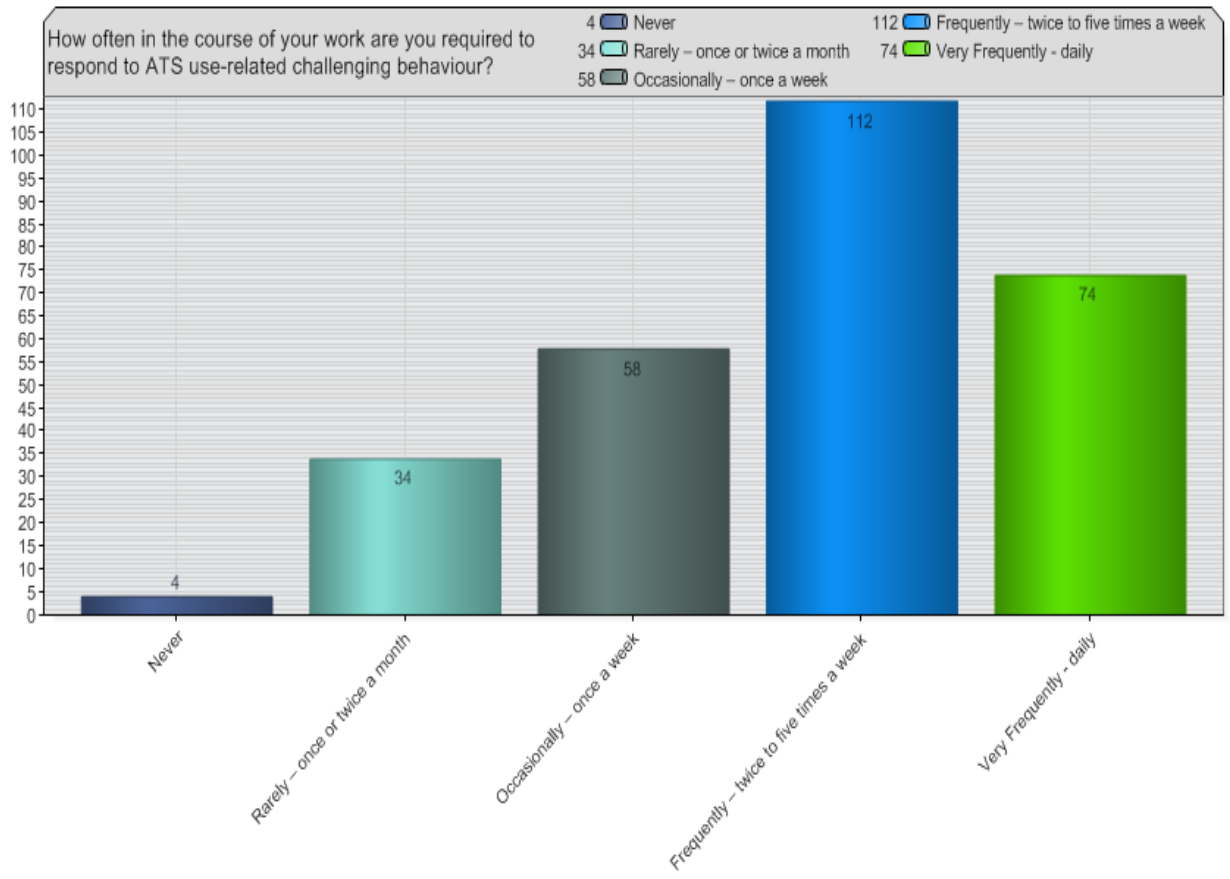

Figure11- Frequency of respondents' requirement to respond to ATS use-related challenging behaviour – survey 2

Respondents of both surveys prioritised the management of challenging behaviour very highly (as seen in Figures 8 & 9) and this was mirrored by the FG discussions.

FG nurse participants identified the impact that poorly managed intoxication and substance-withdrawal can have on a person's mental health, impulsivity and behaviour, and they believed that a lack of a coordinated response to ATS use-related behaviour may leave nurses, other staff and patients at risk. They suggested that the adoption of medical protocols must accompany any adoption of effective behavioural-response practices.

It is of real interest that whilst 59% of survey 2 respondents had *already received* training in responding to challenging behaviour (18 % in the last 2 years) as had a significant majority of FG participants—overwhelmingly, respondents of survey 1 rated challenging behaviour as their most significant concern, 73% of participants of survey 2 gave it a similar priority and the majority of FG nurse participants wanted more behavioural- response training.

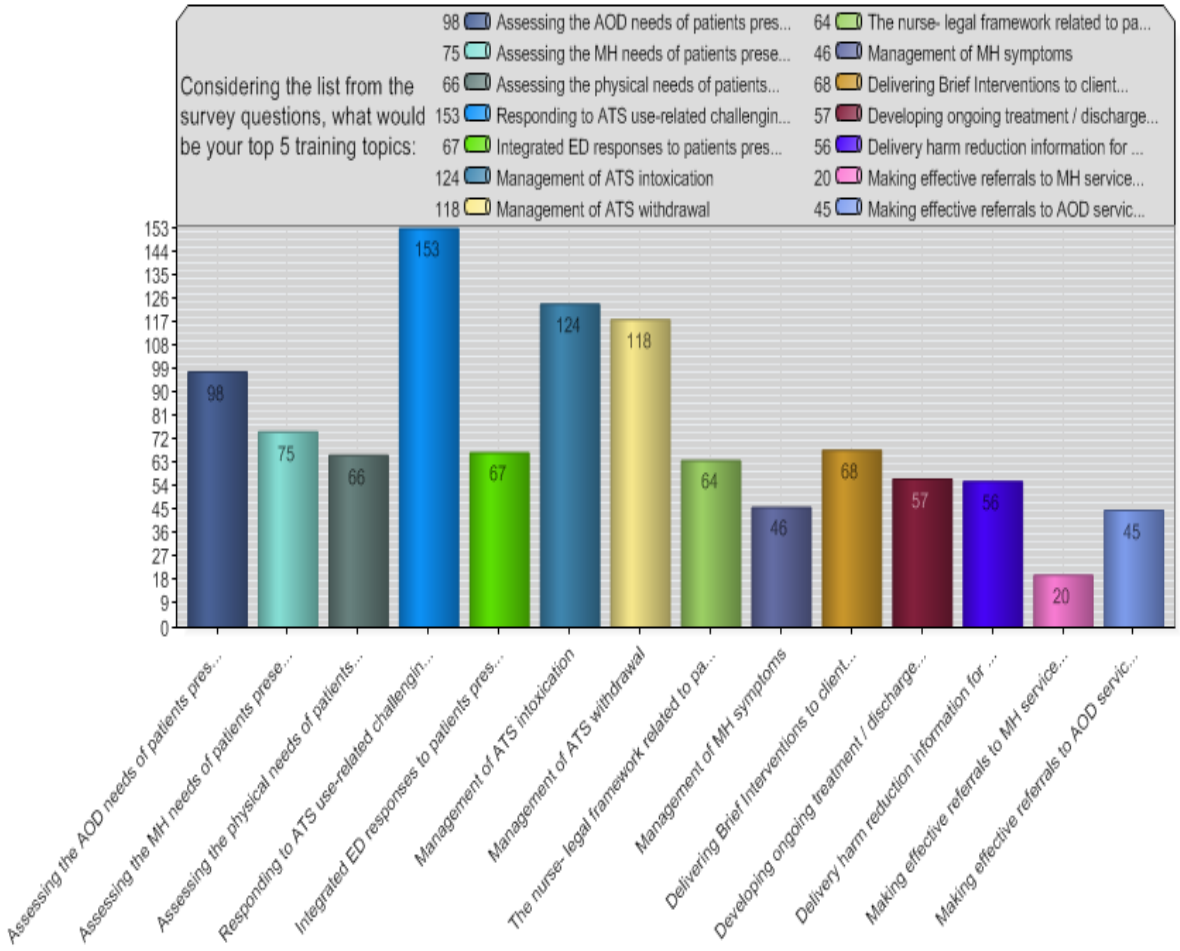

Figure 12 – Respondents' training priories – survey 2

Further exploration of the desire for more training amongst those who had already attended such sessions suggested that some nurse respondents believe that the standard training they received may have been insufficient for responding to this particular patient group; some, that the interventions may not have fitted their particular work setting— ie practices that may be effective in a MH IPU may not be so useful in a busy ED; some that their whole team is yet to be trained; and some that they have not had sufficient experience applying the interventions to become competent, especially in some rural or regional services where these codes are called relatively infrequently.

FG nurse participants were also very clear that for behaviour-response training to be effective, it must be consistently applied across their workplaces and be regularly practiced to maintain its integrity through frequent application or trial-runs.

Survey 2 respondents suggested that access to, and ongoing mentoring, by expert staff and clinical supervision would increase their confidence in responding to challenging behaviours, and FG nurse participants spoke of the pressing need for ED re-design to improve staff safety and the effectiveness of code-greys.

When describing challenging events, FG nurse participants demonstrated signs of high arousal, suggesting these incidents might have had such an impact on them (existing trauma) that they may loom large in their memories and have an ongoing impact on their sense of safety at work.

Whilst out of scope of this project, the notion of nurse self-care was a silent presence through most of the FG discussions of workplace safety.

It is of note that the Victorian Government has committed $20 million to the Health Service Violence Prevention Fund to make workplaces safer and more secure.

Provision of appropriate treatment environments for people experiencing ATS use-related challenges eg Psychiatric Assessment and Planning Units (PAPUs), Behaviour Assessment Rooms (*BAR* rooms)

Nurse participants explained that many services struggle to provide an appropriate treatment environment for someone requiring low stimulation, safety and privacy, and one-to-one specialist treatment, and that this is particularly true for non-metro and smaller services.

Nurse participants of FGs and the survey respondents suggested that a lack of appropriate treatment environments is likely to increase the risk of violence, patient-frustration and the general stress levels in open-plan EDs where staff are providing a range of supports and treatments to other, sometimes high-need, patients.

Nurse participants working in EDs with PAPU and BAR room spaces reported more confidence in their code-grey processes and believed the availability of these treatment environments improved their capacity to provide effective integrated care for this patient group.

Consumer participants had a variety of responses to being nursed in these settings: some preferred the low stimulation and one-to-one nursing, whilst others felt closed in. Most explained that their response to the treatment environment was affected by the quality of the communication they received from staff.

It is of note that the Andrews Government has committed $20 million to improve facilities in public hospitals, including mental health services, making them safer for staff, patients and visitors

Family support and follow-up

This project was designed with nurses' needs in mind; however, by facilitating carer and consumer focus groups, we collected many accounts of violence to families and friends.

Carer participants described chilling events where the patient was, or was not, transferred from home to an ED for assessment. Their request to have their family member taken somewhere for treatment often followed a violent episode or a period of threats and bullying.

It seemed that only when the patient was admitted to a MH unit, were carers referred for support and education.

Even though it would seem that most families of people using substances have been significantly affected by this use, those transporting a family member for help after violence or other distressing events reported a lack of referrals to carer support services or expressions of concern from staff.

Whilst the needs of the families and other carers is outside the scope of this project, the current Government's focus on Domestic Violence *encourages us to suggest that consideration be given to offer routine follow-up to families calling police, ambulance services and the CAT team regarding ATS use, and those bringing in their family member to an ED.*

It is of note that the Andrews Government has committed $4.7 million to expand family supports and training for those affected by a loved one's ice use.

3. Training in comprehensive ATS-related assessment and gathering collateral assessment information

Recommendations

3.1 That current assessment tools be audited to determine whether they contain elements relevant to ATS-use assessment, and that these elements be inserted into the current assessment tools if necessary

3.2 That relevant nurses receive training in the use and application of ATS use-sensitive assessment-elements including assessment of the patient's health needs

3.3 That nurse educators, who may have little experience with working with patients' ATS challenges, be up-skilled to deliver education in the use and application of these assessment elements

3.4 That nurses receive training and ongoing mentoring regarding the collection of collateral information related to a patient's presentation, whether the person has been admitted under the MH Act or not

3.5 That carers participate in the review of local collateral information-gathering processes

Lee, N. et al (2003 p.20) suggest that people using amphetamines require assessment of all aspects of the their drug use, indicators of severity of dependence, withdrawal symptoms and significant periods of abstinence, evidence of dependence on or withdrawing from other drugs, risk behaviour associated with mixing drugs, including overdose of toxicity, psychosocial factors and treatment goals.

Nurse participants believed that assessing this patient group requires the addition of drug-testing to determine what substances have been used. They also discussed the need to collect accurate, information / collateral information regarding the amount the patient has been using, the mode of administration, recent sleep patterns, and whether there is a history of aggression or agitation when in health facilities.

Nurse participants requested that all relevant nursing staff be trained to assess patients presenting with ATS use-related challenges because, whilst some of their services have specialist staff to complete elements of a comprehensive assessment eg ED AOD nurses, these staff may not be available after-hours and assessments must be completed whenever a patient presents.

Survey 2 indicated that 85 % nurses are required to assess people for ATS use-related concerns regularly, of these, 68 % assess these patients more than once a week and 24% participants assess this patient group daily.

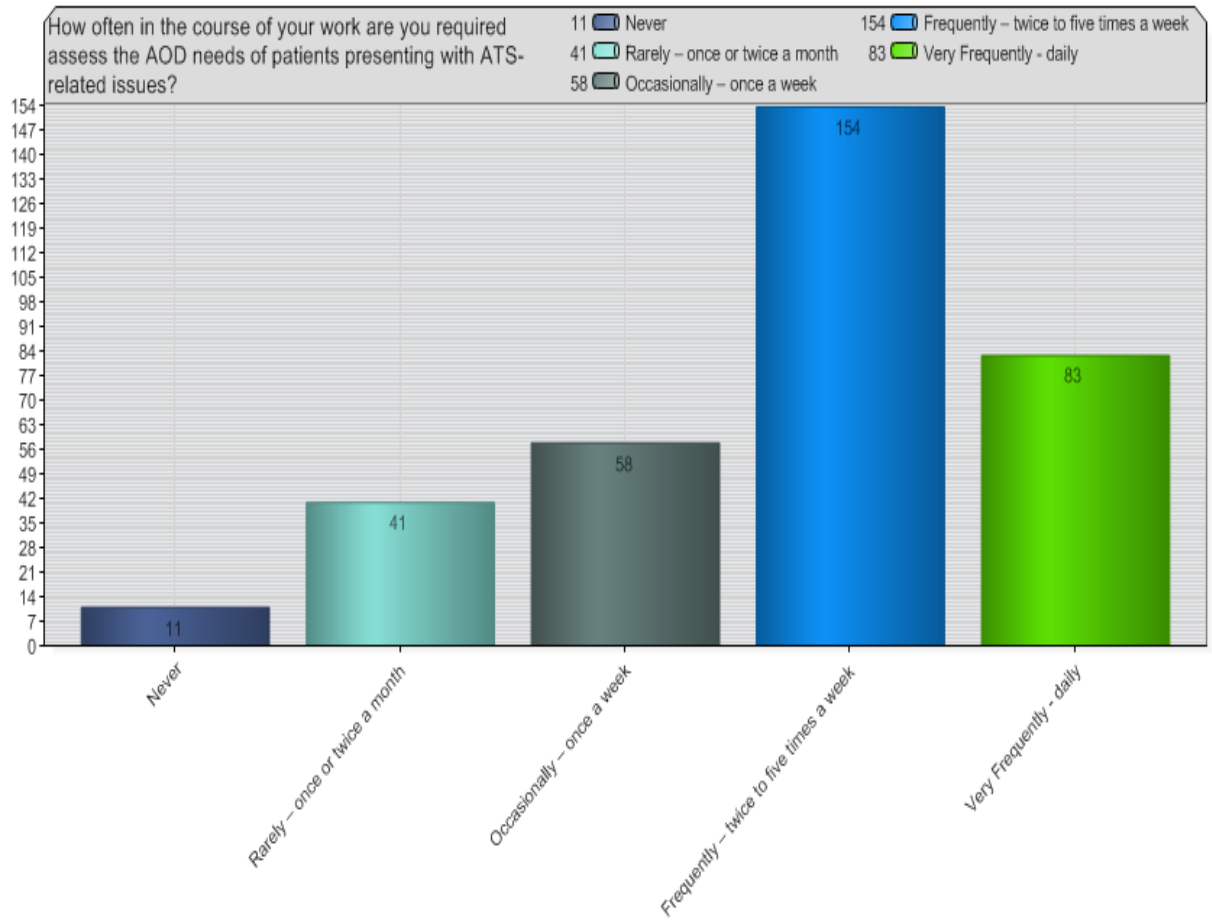

Figure 13 Frequency with which respondents complete ATS assessments – survey 2

52% of the respondents were reasonably confident they were completing assessments well, yet assessment training was still rated very highly by all nurse groups.

Of note, many consumer and carer participants were not confident in the assessments they had experienced and felt that people were often assessed as being well enough to go home when they were still psychotic, agitated and fearful.

Although at least 69 % of survey 2 respondents reported having already received MH assessment training and 62 % AOD assessment training, they and the FG nurse participants requested further assessment training.

Many of the non-MH nurse participants in the FGs were at pains to reinforce the need to complete comprehensive physical health assessments for this patient group; they explained that health issues can easily be overlooked in a crisis of mental health symptoms and behavioural challenges. They insisted that no matter how much pressure is exerted to transfer a patient to a MH Unit for containment, that a comprehensive medical check must be completed, all relevant pathology investigations be ordered and parenteral hydration provided where necessary.

46% of survey 2 respondents said they had never received specific training regarding assessing the health needs of patients using ATS, yet 82% are required to complete these assessments more than weekly, with 27% completing them at least once a day.

When offered a range of training methods to increase their confidence in their assessment skills, most survey respondents requested more sessions of standard face-to-face training, followed by requests for guidelines and mentoring. FG participants rated clinical supervision and mentoring highly.

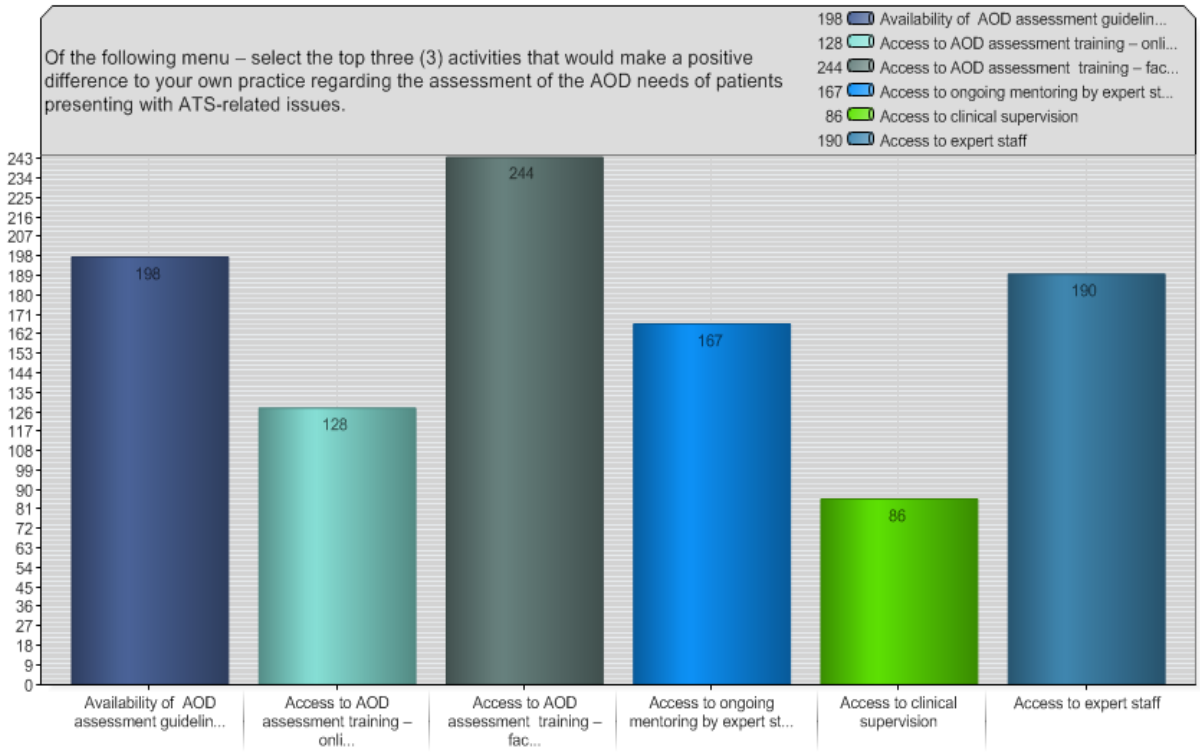

Figure 14 – Activities to increase confidence in respondents assessing the AOD needs of patients with ATS use-related issues – survey 2

Nurse participants reported that some EDs use 'dip-stick' urine drug testing equipment which they said takes some of the *guesswork* out of determining which substances the patient may have used recently. Those using this equipment described its usefulness.

Consumer and carer participants reported high satisfaction with staff who asked relevant questions; these interactions inspired trust in the team and the treatment setting.

When reviewing the data gathered regarding assessment, the ERG suggested that it is important to note that many patients are poly-drug users, and assessment tools need to ask questions or trigger tests regarding other drugs including alcohol, and drug interactions including prescribed and non-prescribed medication. They noted that many substances contain contaminants and 'fillers', and advised that all relevant staff be updated regularly regarding common substance-inclusions and local substance-use trends.

Gathering collateral assessment-information

The identification of any psychotic phenomena is an essential element of a comprehensive assessment (Mueser,K. et al (2003) yet consumer participants described withholding information about their paranoid ideas, strange thoughts or aggressive behaviour from staff, especially when hoping for an early discharge from treatment.

Carer participants explained that as they are often the people transporting the patient to hospital or contacting the police or MH services for help, they are highly likely to be acutely aware of the person's thoughts and behaviours, yet are often excluded from the information-gathering process, especially when the patient is being admitted under the Mental Health Act. They were concerned that it appeared many nurses felt they couldn't interview them or collect collaborative assessment-information from them against a patient's stated wishes.

Many times this information related to violent incidents, treatment episodes or other drug use and was pertinent to understanding the patient's current presentation and the development of an accurate Risk Assessment.

Tensions between *seclusion and restraint reduction targets* and responding to aggression

In 2005, all Australian Governments agreed to act to reduce and, where possible, to eliminate the use of seclusion and restraint of people with mental health issues.Whilst supporting this aim, nurse participants described the tension between working within these targets whilst admitting increased numbers of ATS-affected people who may be intoxicated, paranoid or aggressive.

Whilst it is not within the scope of this project to comment on, or make any recommendations about, this situation, this tension was mentioned many times in the FGs.

4. Training in standard medical protocols regarding the management of ATS use-related intoxication and ATS withdrawal symptoms

Recommendations

4.1 That *all* front-line nurses and medical staff receive training in applying standard protocols regarding responding to ATS-intoxication and treating ATS withdrawals

4.2 That mentoring be provided to staff as they learn to apply these protocols

4.3 That nurse educators, who may have little experience with working with patients' ATS challenges, be up-skilled to deliver training in the use and application of these protocols

4.4 That standard protocols be adopted to respond to ATS-related intoxication (see Appendix G)

4.5 That standard protocols be adopted to treat ATS withdrawal (see Appendix G)

Although standard protocols for the management of ATS use-related intoxication and withdrawal have been readily available for some time eg Baker, A., Lee, N. & Jenner, L. (2003) and Jenner, L. et al (2006) and Lee, N. et al (2007) , 41% of our survey respondents reported having no access to such guidelines even though 80% of them work with people experiencing ATS intoxication at least weekly (with 29% of them daily) and 76 % treat people in ATS-withdrawal at least weekly (with 13 % of the respondents daily).

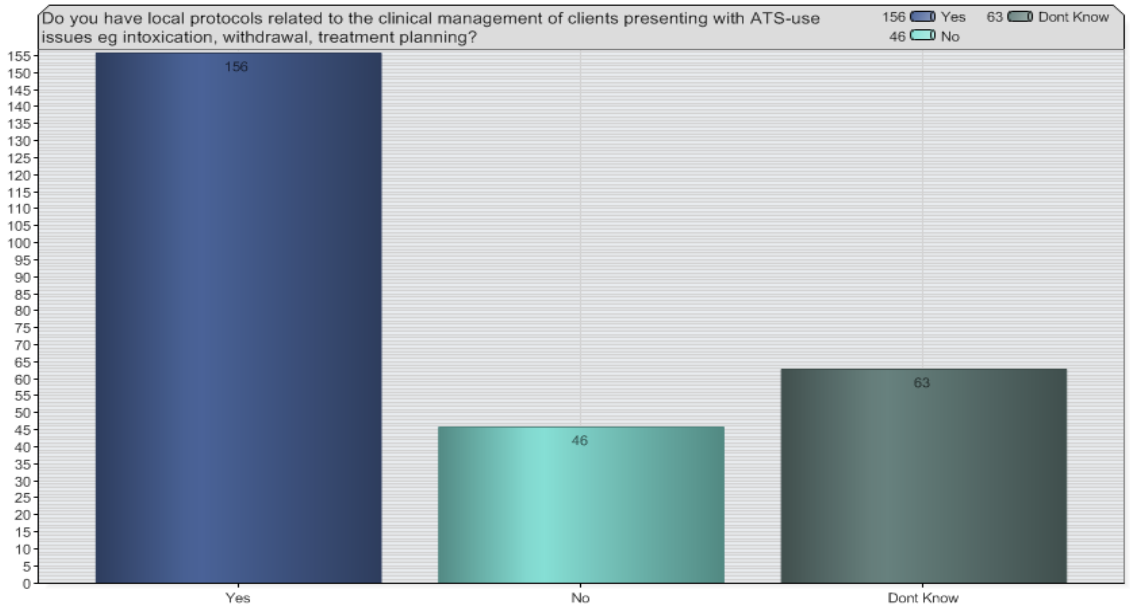

Figure 15 – Availability of ATS- related medical protocols to respondents – survey 2

Exploring this further, it appears that nurse participants working in non-metro services have less access to ATS-related medical protocols than those working in metro settings.

Responding to ATS intoxication

Survey respondents and most nurse participants rated training in responding to ATS intoxication as their second highest training priority, their first being *Responding to ATS-related challenging behaviour*. Many nurse participants believe that if they can respond better to intoxication— the incidence of challenging behaviour may reduce.

46% of the survey respondents had already received training regarding responding to ATS-related intoxication and 56% of the same group believed they were able to support and treat people experiencing ATS intoxication reasonably well. However, almost 60% wanted training and rated face-to-face training and mentoring more highly that having access to guidelines and self-directed learning.

Nurse participants asked for clear medical protocols that articulated with other elements of holistic clinical pathways for this patient group; they suggested that providing training without protocols may prevent effective skill-development and confidence-development.

Some services have developed useful ATS treatment frameworks such as *Guidelines for the management of acute behavioural disturbance due to amphetamine-type stimulant intoxication* (Loke, K. 2014) at St Vincents Hospital, which offers guidelines related to responding to ATS intoxication, toxicity, withdrawals and medical complications,

Supporting and treating people experiencing ATS-withdrawals

Nurse participants explained that amongst the group of people presenting to EDs requiring support and treatment for ATS intoxication, some present in withdrawals and this condition becomes more likely the longer the patient remains in hospital.

It must be noted that, whilst this project has focussed on ED and MH IPUs, it is clear from nurse participant and ERG discussions that patients with ATS-use challenges can be found throughout the hospital setting

It is of interest that nurse participants reported that some services use alcohol withdrawal scales and alcohol withdrawal medication-regimes to treat a range of substance use issues. This treatment is not appropriate for ATS withdrawal.

77% of survey 2 respondents reported being required to support and treat people with ATS-withdrawals at least weekly, with 49% of respondents performing this activity at least twice a week and 13 % at least daily.

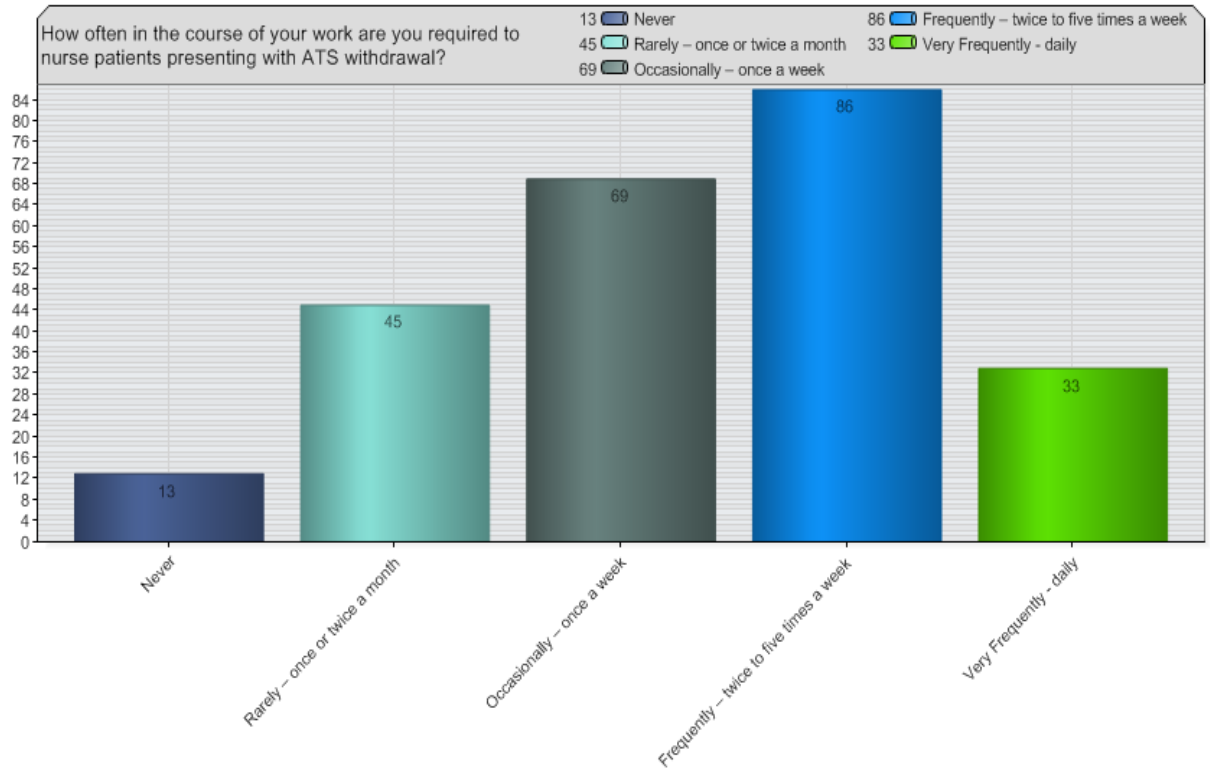

Figure 16 - Frequency with which respondents nurse people experiencing ATS-withdrawals – survey 2

56% of survey 2 participants and more than 50% of nurse participants had received some training in ATS-withdrawals yet still rated managing ATS withdrawals as their 3rd highest training priority, preferably taught face-to-face training with follow-up and mentoring.

As with ATS-intoxication, many nurse participants believed that inadequately treated withdrawal symptoms are linked with episodes of challenging behaviour.

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5. Training in relevant legal frameworks

Recommendations

5.1 That non-MH nurses receive training in the application of the Mental Health Act (2014)

5.2 That relevant nurses receive training in the application of the Severe Substance Dependence Treatment Act (2010)

5.3 That the Department re-issue guidelines regarding legal matters relating to patient searches, weapon confiscation and visitor management outside gazetted MH services.

5.4 That nurses receive training, ongoing mentoring and reflective practice sessions facilitated by suitably experienced staff to explore their *Duty of Care* responsibilities to patients with complex needs.

Nurse participants explained that they work within legal frameworks when delivering support and treatment to patients. Some of these frameworks are very clear to them eg the Mental Health Act, while others such as *Duty of Care* are more opaque.

These matters were raised by survey 1respondents in answer to an open-ended question and the results explored further in survey 2 and the FGs.

Firstly, nurse participants suggested that non-MH nurses require more training and support to apply the new MH Act (2014). Secondly, the ERG raised the notion that many nurses, and other health professionals, have little awareness of, or understanding of how to apply, the Severe Substance Dependence Treatment Act (2010).

Other legal matters raised by nurse participants included: searching patients' property, confiscating and disposing of illicit material and restricting a person's visitors if nurses suspect the visitor may be bringing substances into hospital.

It is of note that in 2014, the Office of Chief Psychiatrist (Victoria) developed *Criteria for searches to maintain safety in an inpatient (MH) unit—for patients staff and visitors*.

Duty of Care

Nurse participants from both MH and ED treatment settings spoke of their concerns regarding the long-term outcomes for people with ATS use-related challenges.

They discussed the effect that staffing limits and ED-environmental design have on their capacity to work with their patients, and believed if they were able to engage with patients long enough, and were skilful enough, they may be able to assist them to make positive changes in their lives.

Many nurse participants felt they were not meeting the needs of this patient group, and expressed significant discomfort when:

- discharging a patient back to the community when they felt the patient had received little intervention by their service;
- discharging a patient without education or referral for follow-up;
- watching a patient discharge themselves to a potentially dangerous environment;

- suspecting that the patient may use substances and drive a vehicle; and
- suspecting that a patient may wish to retaliate against those people who transported them, or arranged to have them transported, to hospital.

They asked about their legal responsibilities in these situations, were worried about the patient and the community, and concerned they might be breaching nursing ethics.

They explained that these concerns create personal and system stress, reduce their job satisfaction and can potentially impact on theirs and other nurses' general health.

6. Training in integrated treatment processes

Recommendations

6.1 That a comprehensive ATS-related *Clinical Pathway of Care* be developed and trialled to assist staff to respond effectively to patients at every phase of their treatment journey

6.2 That consumers and carers participate in the development and evaluation of any prototype *Clinical Pathway of Care*

6.3 That inter-sectorial partners be involved in the development of any such *Clinical Pathway of Care* to ensure that the pathway responds to, and follows, patients transferring between treatment settings and service-types.

Mueser, K et al (2003 p. xvi) in their seminal book *Integrated treatment for dual diagnosis – a guide to effective practice*, describe integrated treatment as

" … the seamless integration of psychiatric and substance use interventions in order to form a cohesive, unitary system of care."

They provide compelling evidence that, for good treatment outcomes, people need interventions that treat both (all) aspects of a person's condition, and that overlooking a person's MH or AOD challenges and responding to one only, is highly likely to result in poorer prognosis, higher rates of relapse, significant use of emergency services, increased risk of suicide and early mortality, and poorer global functioning.

Whilst Mueser et al (2003) discussed treatment for substance use and psychiatric conditions, FG nurse participants made it clear that they understood that people presenting with ATS use-related issues also have significant general health issues that need to be addressed.

Due to the 24 hour care available in hospitals, the FG participants identified the need to provide integrated care using a team approach, and 32 % of the survey recipients indicated a significant interest in the notion of training in integrated (team-based) treatment processes.

FG nurse participants discussed working in nursing and medical teams, and confirmed that teamwork is essential when supporting patients with complex needs who tend to require more time and resources to recover. They explained that this patient group may re-present to one service multiple times or engage a number of services who may be providing different interventions. Even within one hospital, one patient may be accessing a range of staff members who may have little contact with each other.

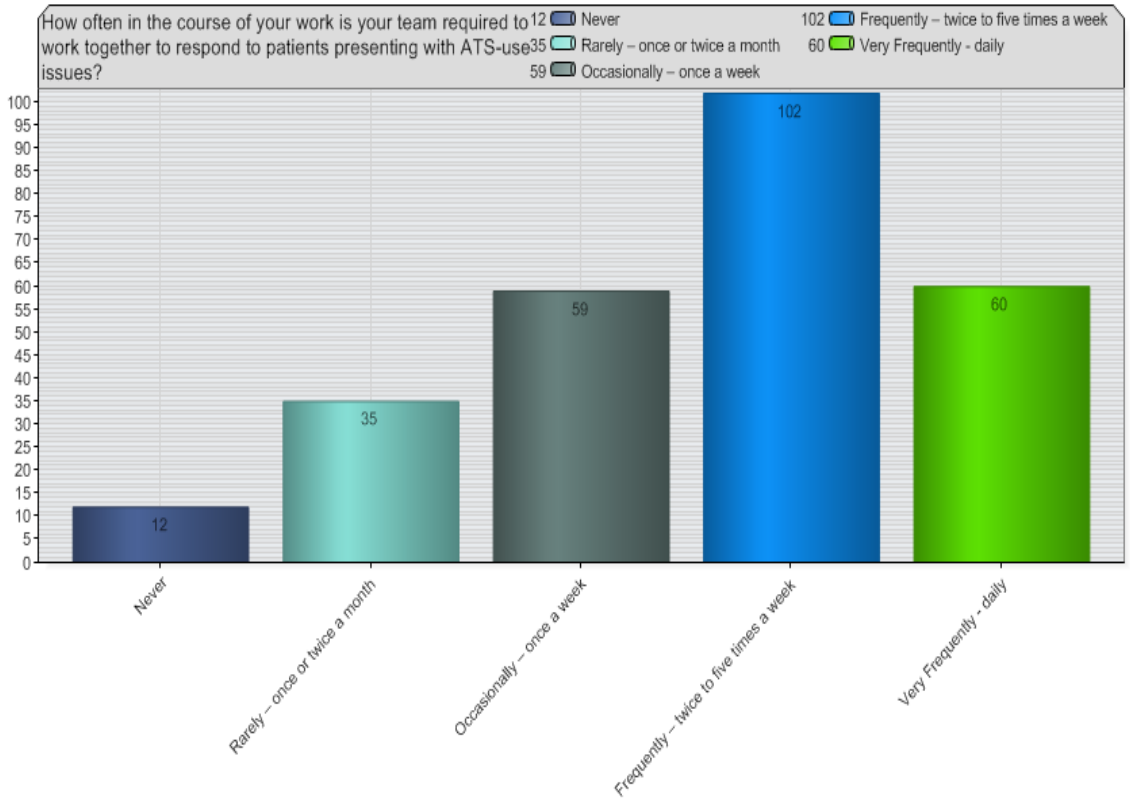

Figure 17 - Frequency with which respondents reported providing team-based responses to patients with ATS use-related challenges – survey 2

The nurse participants understood that patients presenting with ATS use-related challenges require a number of phase-based treatments and support and asked "who does what intervention and when?" They explained that if the patient doesn't have an inpatient case manager, they may not receive what they need for each phase of their treatment journey.

It is of interest that Petrakis,M., et al, (2011) in their paper *Fidelity to clinical guidelines using a care pathway in the treatment of first episode psychosis,* describe the benefits of using a formal care pathway to prompt clinician activities eg comprehensive assessment and family engagement, ensure fidelity to clinical guidelines and support effective documentation of a person's treatment. By using this pathway, St Vincents Mental Health Service was also able to identify areas for clinical improvement and plan service development initiatives.

Elements of the St Vincents care pathway include comprehensive biopsychosocial assessment, provisional risk assessment, contact with family, family education and investigations.

Without knowing such pathways existed, nurse participants expressed a strong interest in the development of such a tool for patients with ATS use-related challenges.

As the notion of integrated care was explored in depth by the FG nurse participants, it became clear that training in integrated care was a much higher priority for them than indicated in the survey table, as many thought that *integrated support* was a mixture of all the key training elements.

22% of survey 2 respondents said their team worked with this patient group at least daily, however only 43% of this group had confidence in their team-based response while 14% reported having no confidence in it at all.

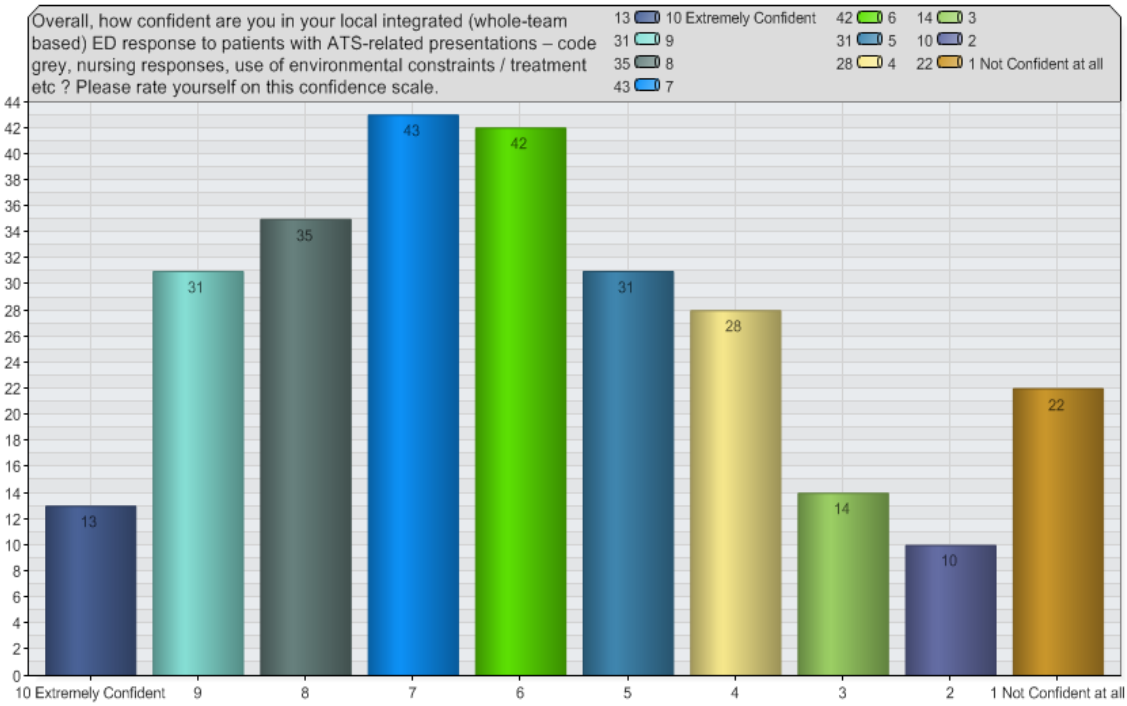

Figure 18 – Respondents' confidence in their team based / integrated Responses to people with ATS use-relayed challenges – survey 2

Of note, 38% of survey respondents reported receiving some training regarding an integrated or team-based approach to this patient group and 39% had access to integrated protocols.

Consumer and carer participant feedback supported the nurses' assessment of hospitals' lack of effective integrated (team-based) responses to people with ATS use-related challenges.

What is included in a clinical pathway of care?

Nurse participants in the FGs devoted considerable time to the description of an effective integrated *clinical pathway of care*.

They agreed that any pathway should be based on standard evidence-based protocols and be relevant to any treatment setting.

They believed that such a pathway should offer prescribed interventions including:

- step-wise triage;
- screening and assessment processes that would trigger standard responses;
- admission processes which may include early access to a bed / ED cubicle;
- specific low stimulus treatment environments and extra staff-support including specialling;
- guidance for use of restraint and seclusion;
- processes for safe transfers between treatment settings without interruption to care
- standard medication regimes and pathology testing;
- guidance regarding AOD focussed brief interventions, education and counselling;
- assertive AOD / dual diagnosis referral whilst the patient remains an inpatient; and
- helpful responses to carers' needs.

They explained that all actions should be linked with specific staff roles to reduce confusion.

They believed that this was not necessarily an exhaustive list as the development of any pathway would need to arise from local workplace settings, and such a pathway would need to be flexible enough to respond to the changing opportunities and limits of local conditions.

FG nurse participants saw the activity of developing of such a tool as offering hospitals, community primary care providers and AOD agencies the opportunity to work together and mend, or reinforce, inter-sectorial relationships.

Whilst supporting the development of, and training in, integrated / team based approaches to this patient group, nurse participants acknowledged that the development and adoption of such a pathway would require significant endorsement and support from senior and other medical staff.

7. Training in effective discharges and transfers of patients with ATS use-related challenges

Recommendations

7.1 That relevant nurses receive training in AOD Brief Interventions and harm reduction education for consumers

7.2 That relevant nurses receive training in harm reduction education for carers, and making referrals for carer-support.

7.3 That relevant nurses receive training in AOD / dual diagnosis discharge planning

7.4 That nurses receive information regarding the AOD sector and AOD referral processes

7.5 That relevant nurses receive training in AOD and dual diagnosis group-facilitation for inpatient MH settings

7.6 That mentoring and reflective practice sessions be provided to assist relevant nurses to develop robust AOD and dual diagnosis group-facilitation and treatment planning skills

7.7 That effective links be forged between MH, ED and local AOD services for the development of integrated discharge pathways, sharing of information and maintenance of collaborative recovery-planning capacity

7.8 That non-MH nurses receive training in assisting patients to manage their MH symptoms

Many of the interventions listed in the above recommendations are commonly offered to clients of AOD services and there are many manuals describing the skills required and the usefulness of the interventions.

Brief interventions, harm reduction education, family work and recovery goal planning activities are described by Lee, N. et al (2007) and group work for people with a dual diagnosis is explored in Mueser, K et al (2003) and Frameworks for Health (2008).

As mentioned in the discussion regarding Duty of Care (see recommendation 5.4), many nurse participants were concerned about how to best support patients when they are the subject of early discharge to the community.

They recognised that some of these discharges are determined by the service, whilst others are the result of patients discharging against medical advice or absconding.

In each case, nurse participants expressed concern regarding:

- the patient's ongoing safety and the safety of others;
- their general health and mental stability; and
- their likelihood to use substances and re-present in increased distress.

They described their frustration with the lack of clear pathways to AOD and community MH follow-up, and their concern about their legal and ethical responsibility in these cases.

Nurse participants described discharging people they believed had not been helped by contact with their service. They explained that most patient admissions to ED are short, and many admissions to MH IPUs of patients with ATS use-related issues are merely until the person is more settled, whereupon they discharge themselves.

However, when patients are admitted to short stay units / beds for monitoring, kept for a few days in an IPU, or expressed an interest in receiving dual diagnosis interventions and discharge planning, nurse participants were very interested in having the skills to provide this support or knowing how to refer the patient to a clinician or service that does.

ED and MH IPU nurse participants alike described their unfamiliarity with, and interest in, providing useful AOD interventions to patients, and support and referrals for carers.

Whilst out of the scope of this project, every nurse-FG expressed concerns about the 4 hour NEAT targets. Nurse participants believe this time limit restricts their capacity to provide adequate responses to this patient group and to others with complex psycho-social and health needs.

Providing Brief Interventions (BIs)

There has been significant research regarding the effectiveness of the provision of BI's in time-poor environments (Ballesteros, J. 2006) and most nurse participants were aware of these interventions; in fact, although only 48% of the survey respondents had received any formal training in their use, 81% regularly provide them in the course of their work.

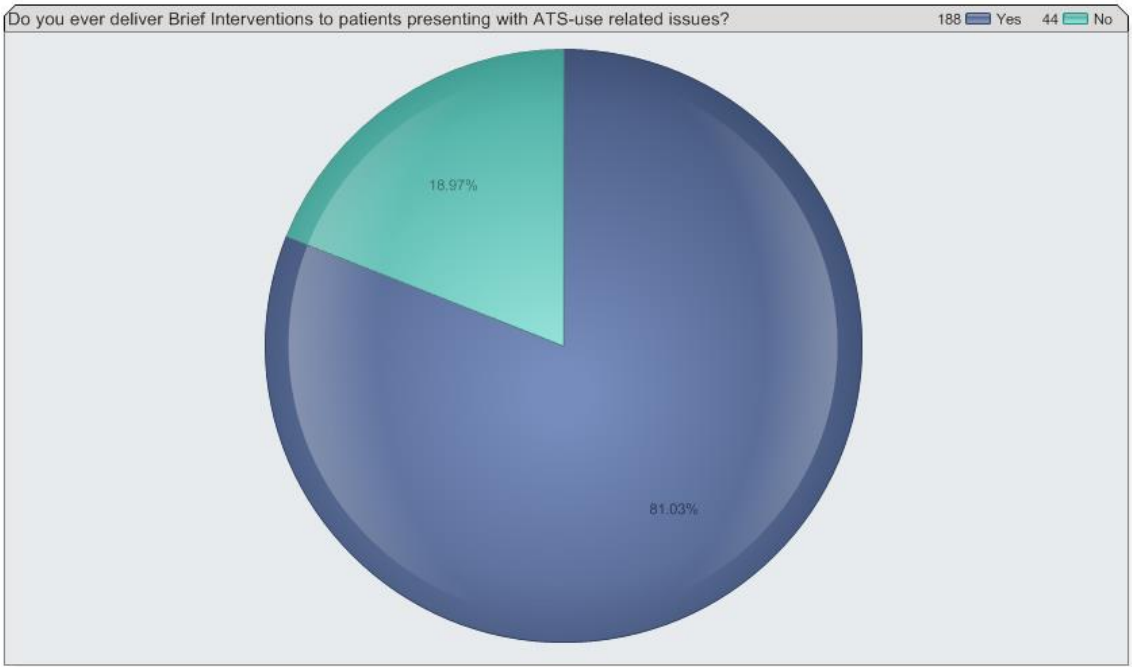

Figure 19 – Frequency with which respondents deliver BIs to Patients with ATS Use-related Challenges – survey 2

32 % of survey 2 respondents prioritised training regarding offering Brief Interventions highly. This is a significant result when rated against more medical interventions.

FG nurse participants explained that training in BIs, harm reduction education and carer support are more likely to be prioritised by nurses working in environments where medical and code-grey protocols are understood and well utilised.

Providing harm reduction education for patients and carers

Harm reduction education can be offered in a range of places at any time; it is considered to be an essential component of any AOD-related treatment or discharge process. (Lee, N. et al 2007)

80 % of survey respondents reported being required to provide harm reduction education to consumers (and carers), however, only 61% of the respondents had received training, and half of this group received their training more than 2 years ago when ATS-focused presentations were un-likely to have been emphasised.

27% of the survey respondents prioritised harm reduction education training within the list of nurse-related training options and 52% within the generic options.

Consumer and carer participants report that many inpatient staff may not be equipped to provide this type of education to individuals or in groups.

Consumer participants described extended admissions in MH IPUs for ATS use-related challenges when they received no AOD education, counselling or referrals to the AOD sector on discharge, even when it was clear they had extensive substance-use histories.

Consumer and nurse participants alike spoke highly of any contact with staff familiar with AOD issues, whether it was an AOD nurse in ED or a dual diagnosis expert on the inpatient unit.

Consumer participants welcomed clear information regarding how long they should expect to feel mentally unwell after discharge, and making the link between their psychotic symptoms and substance use.

Carer participants were interested in talking to MH professionals about how they should respond to psychotic thinking and asked to have these behaviours role-modelled to them. They believed that having these skills would help them avoid communication traps and reduce the risk of domestic violence.

Discharge Planning

In order to create effective plans, nurse participants described needing information about referral options within community and private AOD sectors, being able to speak with some authority about these services, developing simple discharge goals and providing harm reduction education.

Referring carers for support

Participants in the Carer FG expressed huge gratitude at being seen by AOD-competent staff in ED, having their experiences validated and being referred to carer support groups or carer consultants.

Those attending carer support groups described the relief they felt when realising they were not alone; they also received practical advice regarding supporting their family member, taking care of themselves and accessing the AOD sector.

Recent changes to the community MH service system and the recommissioning of the AOD sector have broken many of the pre-existing links between services and clinicians. Nurse participants believe it is essential that new links be forged and partnerships re-established to provide effective support to patients with ATS use-related challenges and others with complex needs.

Discussions with consumer and carer participants uncovered a wealth of experience and opinions regarding MH IPU, AOD and dual diagnosis guidelines and management. It would make sense to invite consumers and carers to review the current AOD-related practices in hospital settings as they relate to ATS use-related presentations to ensure they reflect patients' and carers' needs.

Assisting patients to manage their MH symptoms

Whilst it may appear that a discussion regarding training to help patients manage their MH symptoms may not be an obvious component of the broader topic of discharge planning, to participants, these interventions are as important to discharge planning as they are to providing support to patients whilst in EDs or MH IPUs.

Nurse participants reported being required to provide interventions for acute MH symptoms, coach patients in their own management of these symptoms and advise carers of what they can do to support a person's ongoing mental health.

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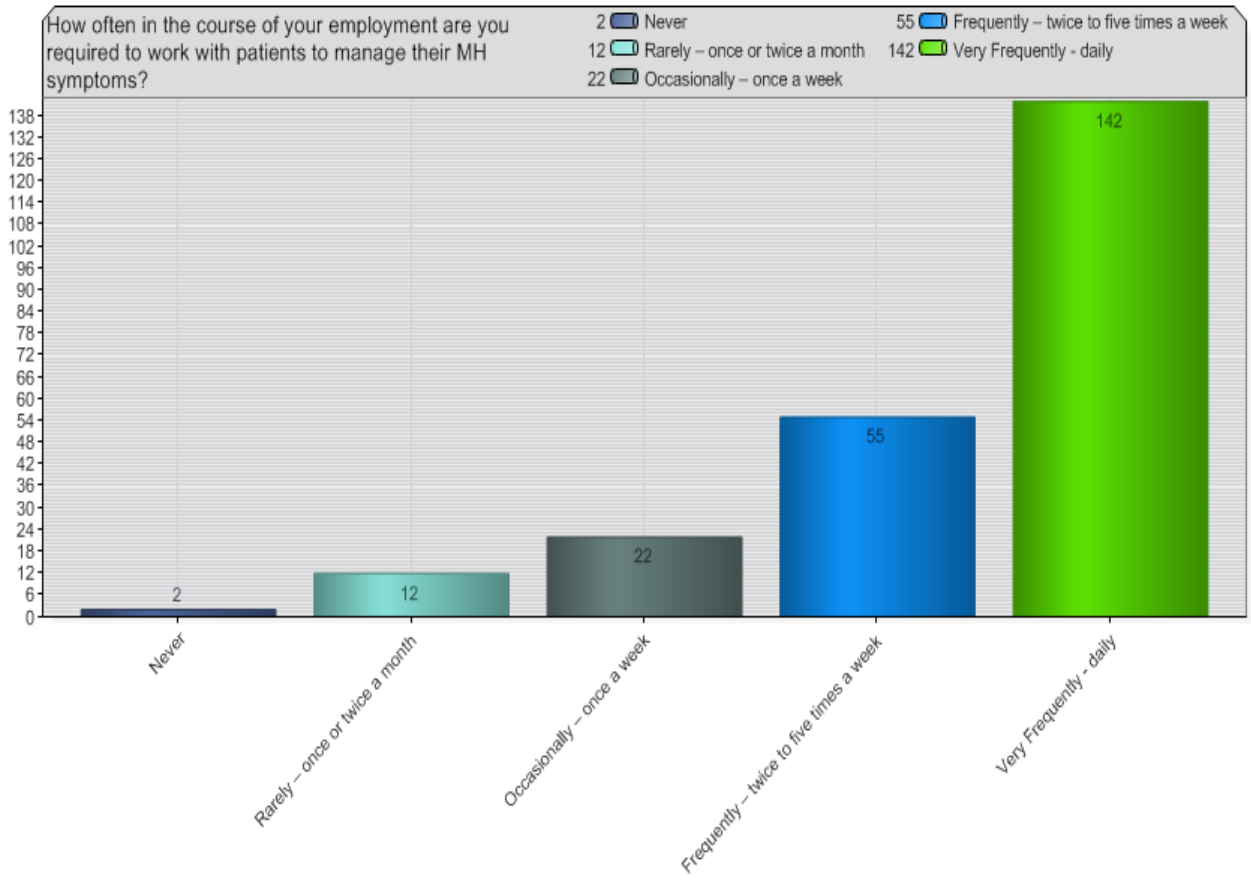

Figure 20 – Frequency with which respondents are required to assist patients to manage their MH Symptoms – survey 2

Nurse participants explained that MH nurses are more likely to be called to support a patient experiencing MH symptoms; however non-MH nurses are required to support this patient group when specialised staff are unavailable eg. after hours.

94% of survey respondents reported being required to manage people's MH symptoms at least weekly with 61% at least once per day—the skills required in these circumstances include identification of the symptoms and effective communication skills.

Almost 100% of non-MH survey respondents rated training regarding assisting patient to manage their MH symptoms highly. Common MH symptoms include psychosis, suicidal ideation, anxiety and MH-related agitation.

8. General training matters

These recommendations arose from the distillation of information obtained through the surveys and the nurse focus groups.

8.1 That preceding all training for front-line nurses regarding ATS-related skills, workplaces adopt evidence-based ATS-related polices and practice guidelines

8.2 That training for ED, MH and triage nurses regarding responding to patients presenting with ATS use-related challenges

- be delivered in flexible formats, allowing work places and nurses to determine their needs, prioritise their topics and access the material, and that training regarding the more medical and skills-based learning be delivered in face-to-face sessions
- be followed by reflective practice and mentoring sessions
- be embedded through regular and routine practice

8.3 That relevant nurses receive regular updates regarding ATS use-related matters, and that policy and practice guidelines be amended to accommodate relevant changes in ATS use patterns, contamination issues and consumption practices

8.4 That consideration be given to linking training regarding ATS use with continuing professional development credits

8.5 That consumers and carers be engaged in the development and evaluation of all nurse training material

Roche, A., & Pidd, K (2010) in *Alcohol & Other Drugs Workforce Development Issues and Imperatives: Setting the Scene. National Centre for Education and Training on Addiction*, suggest that education and training are only part of the factors affecting workers' performance. And that, while education and training can build the skills and knowledge of individual workers, increasing the transfer of skills and knowledge into sustainable work practice change and quality service-delivery depends on a range of organisational, structural, and systemic factors largely beyond the control of individual workers.

Although this project scoped the training needs of a range of nurse participants with differing skill sets working in a variety of treatment settings, rural and metro, it appears that many of the barriers to, and opportunities for, training and new skill-uptake are similar eg staffing limits, attitudes, treatment environment design.

Throughout the FGs, nurse participants were very clear that for practice change to occur, it must be supported by all levels of nurse management and medical staff, and that adopting formal medical protocols must precede the training. They also discussed workplace flexibility and culture, linking change to a willingness to embrace mentorship, release staff for training sessions and provide opportunities to practice new interventions.

Nurse participants were highly supportive of training and grateful to be given the opportunity to discuss priorities. They believed that training provides useful skills and increases nurse-confidence.

Survey respondents also linked recent training with increased staff confidence. For example, ED survey respondents receiving training in MH assessment in the last 2 years related their confidence in that practice higher than those receiving training earlier, and, of course, both of these survey sub-groups rated their confidence higher than those receiving no training at all.

And, not unexpectedly, survey respondents' confidence in delivering an intervention was linked with the frequency with which they are required to practice this intervention, So it would appear that nurse confidence in delivering interventions is increased by access to relevant training followed by the opportunity to practice their new skills.

Nurse participants believed that linking staff training with workplace safety and professional development credits would encourage training up-take and assist team leaders to prioritise such training in busy workplaces.

Barriers to training

While survey respondents and FG nurse participants expressed a general optimism that training improves their confidence, the data suggested that, in some areas, training had made little change to work practices or staff confidence eg responding to challenging behaviour.

FG nurse participants suggested that barriers to skill-uptake and practice-change include: NEAT targets, treatment-environment design, staff-turnover, rotation of medical staff, increases in the staff-casualisation of acute health services, and nurses having little time to attend training sessions.

They also commented on the lack of AOD or Dual Diagnosis training in undergraduate nursing courses which means that trainers cannot presume all nurses have existing basic-competency in these areas. Some FG participants believed this lack of core training may support the false impression held by some staff that AOD skills are not necessarily part of nurses' jobs.

Of note, when considering why nurses might request training they have already completed eg. behavioural response training, nurse participants suspected that these requests may have more to do with nurses seeking security and a sense of increased control over their workplaces rather than a need to refresh their existing skills.

Nurse participants warned against mandated or assessed training. They believed that mandating ATS use-related / dual diagnosis training and insisting that such training include formal assessment processes may make such training less attractive.

Existing training resources

Whilst appreciating the barriers to training, nurse participants identified resources and opportunities for training and ongoing mentoring within the existing service system eg AOD nurses in ED, Addiction Medicine Departments. They believed these key staff members could assist local services to develop training calendars, provide training sessions and offer mentoring and clinical supervision.

They explained that nurse preceptor systems could be adapted to provide reflective practice sessions, and some nurse participants mentioned the benefits available from secondary consultation with services such as the Victorian Dual Diagnosis Initiative (VDDI), dual diagnosis training, and access to existing manuals and guidelines.

Training methods

Survey 2 explored nurses' preferences regarding training methods.

Whilst survey respondents supported online training and access to information and clinical guidelines, most preferred face-to-face sessions with ongoing mentoring and access to expert staff, reporting a distinct preference for face-to-face training methods for training in medical hands-on interventions eg assessments, responding to ATS intoxication.

Nurse participants supported this split and suggested that any new skills need to be embedded by early and frequent application. They explained that where workplaces offer fewer opportunities to practice these new skills, nurses and mentors should be encouraged to create practice or 'dummy-runs'.

Post-training support

There is a body of work that has focused not only on the importance of training but also on training transfer. This body of work is based on the premise that for training to result in changes in work practices, knowledge and skills gained in the training environment need to transfer to the workplace. There are numerous factors, both internal and external to the training environment that can assist and prevent training transfer. (Pidd, K.et at 2004)

Survey respondents supported post-training mentoring and clinical supervision to assist them to become more confident in applying their new skills.

Nurse participants expressed satisfaction with contact with, and receiving advice from, AOD and MH experts, however, they recognised that many of these colleagues are not available afterhours when people present with substance-use issues, and that all relevant staff need the capacity to meet the needs of this patient group.

FG nurse participants discussed the benefits of making ATS and other substance-use related skills part of the mandatory training calendar. Whilst some participants were enthusiastic about this, others reported that training may become less attractive if it is mandatory and that such sessions may become a 'tick-box' activity and lose their currency.

Many nurse participants said they were already obliged to complete a long list of mandatory training units and advised against adding more topics that may not relate to everyone's area of specialisation.

It appears that training is more likely to be taken up if linked with increased staff safety and recognised as Continuing Professional Development credits.

Peer educators

The usefulness of peer educators was raised in a number of FGs. Nurse participants and the ERG believe that the use of peer educators in the development and provision of nurse training can ensure that it is respectful, practical and responsive to the common issues experienced by people with ATS use-related challenges.

Of note, NCETA has been contracted to provide a range of training for front-line staff regarding ATS use-related issues. It is essential that this training be adaptable for use in the specific treatment settings offered by hospitals, eg. offering a Brief Intervention within a busy ED may be different to offering something similar as part of an AOD intake episode.

9. **Developing ATS System-responsiveness**

Recommendations

9.1 That the Department develops and trials an ATS-responsiveness audit tool for health services to assess and plan for their readiness and capacity to support patients presenting with ATS use-related issues

9.2 That consumers and carers have input into any review of the system's preparedness to respond to ATS use

As mentioned at the beginning of this report, and confirmed by the linking of nurse-specific recommendations to those related to treatment settings under the theme headings, it is clear that the effectiveness of ATS-related nurse training is linked with the ATS-responsiveness of their workplace systems and physical environment.

We have called this a) nurse ATS-responsiveness and b) system ATS-responsiveness.

Nurse participants explained that system ATS-responsiveness is required at all levels—from staff attitudes, staff training, adoption and adherence to protocols, staffing systems, treatment environments, patient-transfer activities to discharge planning and linkages with local AOD services etc.

Whilst it is not outside a single health-service's capacity to develop and complete an ATS-responsiveness audit, it makes sense that a standard auditing process be used across the sector that not only evaluates what a service has in place but suggests other elements they may wish to embrace.

Auditing tools also provide health services with opportunities to bench-mark themselves against similar services, measure and report their own progress.

There is nothing new or complex about creating auditing tools, they exist for similar work eg the Dual Diagnosis Capability in Addiction Treatment (SAMHSA. 2011), tool which measures a service's investment and capacity to respond to patients with a dual diagnosis.

Developing and applying such an auditing tool would not only assist a service to assess how well they meet patients' needs, but would help health services develop an environment where nurse ATS-related training would be most effective as nurses' new skills could be applied consistently and as taught.

Appendices

APPENDIX A Survey 1—Questions

The following survey is designed to gather information from senior MH nursing staff who are dealing with Acute ATS & MH presentations at the front end of service delivery i.e. MH triage; CATT; E-CATT; ED AOD Liaison / Care coordinator and Addiction Medicine positions and elements within crisis and emergency services. The information provided will be used to inform the development of a relevant training and support package for these workers.

1 Area of work

MH Triage
MH CATT
MH ECATT
ED Emergency nursing
AOD ED Nurse
Other

2. Qualification – undergrad / post grad

MH Nurse
General Nursing
Other

3. Work Location

Metro
Regional
Rural
Other

4. Work Setting

Hospital
Community
Other

5. Client Age Range

Youth
Adult
Older adult
Aged

6. Specialist populations you work with

Aboriginal
CALD
Forensic
ABI
LGBT
Other

7. **Number of years postgraduate**
8. **Years in current role**
9. **List any other significant roles, knowledge and past experience related to AOD and mental health**
10. **Based on your work role and contact with clients presenting with ATS and MH (including ice) related issues. What are your 2 biggest challenges when working with these clients?**

11. If a training and support package was developed, what are 3 to 5 essential elements that you like to see included that would assist you in working more effectively with this client group.

12. From your perspective (based on your current role), what limitations or gaps in service delivery can you identify that would help effectively responding to clients who present with ATS and MH issues?

13. In the past 2 years have you received any specific training around working more effectively with clients who present with ATS intoxication and MH issues?

14. Please list the name of the training(s) you have participated in?

15. Please state the duration of training hours received:

16. In respect to this client group, has this training improved your skills?

Screening
Assessing
Recognition
None of the above

17. When working with this client group, has this training changed your work practice in:

Treatment
Interventions
None of the above

18. Has this training improved your knowledge around working with both ATS and MH withdrawal and intoxication?

Yes
No

19 Do you have any current resources / programs available to you in your role to specifically support you around ATS and MH presentations?

Yes
No

20. Please list these resources / programs.

21. How important is it to you to receive training in working with clients who present with ATS and MH related issues?

1 not important	2	3	4	5 important

22. Currently, how confident are you when working with this client group

1 not confident	2	3	4	5 very confident

23. Do you have any additional comments or suggestions you would like us to consider when developing a training and support system around this issue?

APPENDIX B **Survey 2 —questions**

An opportunity to assist our health services to respond effectively to patients presenting to Emergency Departments and Acute Mental health Services with ATS (Amphetamine-type-substance) use issues.

Demographics:

i) **How do you identify yourself?** Male/Female / Transgender / Intersex

ii) **How long have you been working as a nurse?** Yrs--- Mths---

iii) **Where do you currently work** –A) Emergency Department or B) Acute MH Services?

A) **How long have you been working in ED?** Yrs---Mths---

What is your role in the Emergency Department?

Registered Nurse
ECATT / MH liaison nurse
AOD liaison nurse
Triage nurse
Short Stay Unit nurse
Other

How long have you been working in your current role? Yrs---Mths---

B) **How long have you been working in Acute MH Services?** Yrs---Mths---

What is your role in Acute MH Services?

MH Triage nurse
MH inpatient services nurse
CATT
Community Case Manager - nurse
Other

How long have you been working in this role in Acute MH Services? Yrs---Mths---

What is your employment status?

Full-time
Part-time
Casual

How would you describe the location where you work?

Metropolitan
Regional
Rural

Have you undertaken post-graduate studies in mental health or AOD?

MH
AOD
Both

How much does your role involve responding to patients presenting with alcohol and other drug issues?

None
Very little
Some
A lot
All

Section A - Assessment and early response:

1. Assessment of the AOD needs of patients presenting with ATS-related issues

A) How confident are you in assessing the AOD needs of patients presenting with ATS-related issues? Please rate yourself on this confidence scale – 1 not confident at all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B) Have you received any training regarding assessing the AOD needs of patients presenting with ATS-related issues?

No
Yes within the last 2 years
Yes longer than 2 years ago

C)How often in the course of your work are you required assess the AOD needs of patients presenting with ATS-related issues?
Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently – daily

D)**How well do you think you complete these assessments?**
Not at all well
Fairly well
Quite well
Very well

E)**Of the following menu – select the top three activities that would make a positive difference to your own practice regarding the <u>assessment of the AOD needs of patients</u> presenting with ATS-related issues.**

Menu options –

- Availability of AOD assessment guidelines / principles
- Access to AOD assessment training – online self-directed
- Access to AOD assessment training – face to face workshops
- Access to ongoing mentoring by expert staff
- Access to clinical supervision
- Access to expert staff

2. <u>Assessment of the MH needs of patients presenting with ATS-related issues</u>

A) How confident are you in assessing the MH needs of patients presenting with ATS-related issues? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B) Have you received any training regarding <u>assessing the MH needs</u> of patients presenting with ATS issues?

No
Yes within the last 2 years
Yes longer than 2 years ago

C) How often in the course of your work are you required to assess the MH needs of patients presenting with ATS-related issues?

Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently – daily

D) How well do you think you complete these assessments?

Not at all well
Fairly well
Quite well
Very well

E) Of the following menu – select the top three activities that would make a positive difference to your own practice regarding assessment <u>of the MH health</u> needs of patients presenting with ATS-related issues.

Menu options –

- Availability of MH/ dual diagnosis assessment guidelines
- Access to MH/ dual diagnosis assessment training – online self-directed
- Access to MH/dual diagnosis assessment training – face to face
- Access to ongoing MH/dual diagnosis mentoring by expert staff
- Access to dual diagnosis clinical supervision
- Access to expert dual diagnosis staff

3. <u>Assessment of the physical health needs of patients exhibiting ATS-related issues</u>

A) How confident are you in <u>assessing the physical health needs</u> of patients exhibiting ATS-related issues? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B) Have you received any training regarding <u>assessing the physical health needs</u> of patients exhibiting ATS-related issues?

No
Yes within the last 2 years
Yes longer than 2 years ago

C) How often in the course of your work are you required to <u>assess the physical health needs</u> of patients presenting with ATS-related issues?

Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently - daily

D) How well do you think you complete these assessments?

Not at all well
Fairly well
Quite well
Very well

E) Of the following menu – select the top three activities that would make a positive difference to your own practice regarding assessment of the physical health needs of patients presenting with ATS-related issues.

Menu options –

- Availability of information and assessment guidelines
- Access to training – online self-directed
- Access to training – face to face
- Access to ongoing mentoring by expert staff
- Access to clinical supervision
- Access to expert staff

4. <u>Responding to ATS use-related challenging behaviour</u>

A) How confident are you in responding to ATS use-related challenging behaviour? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B) Have you received any training regarding responding to ATS use-related behaviour?

No
Yes within the last 2 years
Yes longer than 2 years ago

C) How often in the course of your work are you required to respond to <u>ATS use-related challenging behaviour</u>?

Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently - daily

D) How well do you think you respond to ATS use-related challenging behaviour?

Not at all well
Fairly well
Quite well
Very well

E) Of the following menu – select the top three activities that would make a positive difference to your own practice regarding responding to ATS use-related challenging behaviour.

Menu options –

- Availability of guidelines regarding the containment and management of challenging behaviour
- Access to training – online – self-directed
- Access to training – face to face workshop
- Access to ongoing mentoring by expert staff
- Access to clinical supervision
- Access to expert staff

5. Local protocols regarding an integrated ED response to patients presenting with ATS use-issues

A) Do you have local protocols regarding an integrated (whole-team based) ED response to patients presenting with ATS-use issues?

Yes
No
Don't know

B) Overall, how confident are you in your local integrated (whole-team based) ED response to patients with ATS-related presentations – code grey, nursing responses, use of environmental constraints / treatment etc ? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

C) Have you received any training regarding an integrated (whole-team based) ED response to patients with ATS-related presentations?

No
Yes within the last 2 years
Yes longer than 2 years ago

D) How often in the course of your work is your team required to work together to respond to patients presenting with ATS-use issues?

Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently – daily

E) How well do you think your team works together to respond to patients presenting with ATS-use issues?

Not at all well
Fairly well
Quite well
Very well

F) Of the following menu – select the top three activities that would make a positive difference in embedding effective ED integrated (whole-team based) responses to patients with ATS-related presentations in your workplace.

Menu options –

- Availability of local integrated response protocols
- Access to integrated response training – online self-directed
- Access to integrated response team training / workshops – face to face with treating team
- Access to ongoing mentoring by expert staff
- Access to clinical supervision
- Access to expert staff

Section B Working with clinical guidelines and local practice protocols

6. Do you have local protocols related to the clinical management of clients presenting with ATS-use issues eg intoxication, withdrawal, treatment planning?

Yes
No
Don't know

7. Managing ATS intoxication

A) How confident are you in recognising the signs of ATS intoxication in patients presenting for assistance? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B) How confident are you nursing patients presenting with ATS intoxication? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

C) Have you received any training regarding the nursing of patients presenting with ATS intoxication?

No
Yes within the last 2 years
Yes longer than 2 years ago

D) **How often in the course of your work are you required to nurse patients presenting with ATS intoxication?**

Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently – daily

E) **How well do you think you nurse <u>patients presenting with ATS intoxication?</u>**
Not at all well
Fairly well
Quite well
Very well

F) Of the following menu – select the top three activities that would make a positive difference to your own nursing practice regarding <u>management of ATS intoxication</u>.

Menu options –

- Availability of relevant local clinical management guidelines
- Access to intoxication-management training – online self-directed
- Access to intoxication management training – face to face
- Access to ongoing mentoring by expert staff
- Access to clinical supervision
- Access to expert staff

8. <u>Managing ATS withdrawals</u>

A) How confident are you in recognising the signs of ATS withdrawal in patients presenting for treatment? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B) How confident are you in nursing patients <u>presenting with ATS withdrawal</u>? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

C) <u>Have you received any training regarding nursing patients presenting with ATS withdrawal</u>?

No
Yes within the last 2 years
Yes longer than 2 years ago

D) How often in the course of your work are you required to nurse <u>patients presenting with ATS withdrawal?</u>
Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently - daily

E) How well do you think you nurse <u>patients presenting with ATS withdrawal?</u>

Not at all well
Fairly well
Quite well
Very well

F) Of the following menu – select the top three activities that would make a positive difference to your own nursing practice regarding the management of ATS withdrawal.

Menu options –

- Availability of relevant local clinical management guidelines
- Access to withdrawal-management training – online self-directed
- Access to withdrawal management training – face to face
- Access to ongoing mentoring by expert staff
- Access to clinical supervision
- Access to expert staff

9. <u>Working within legal frameworks</u>

A) How confident are you with working within <u>the legal framework</u> related to patients who may <u>not</u> be able to provide you with informed consent including involuntary patients, patient- restraint and containment? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B) Have you received any training regarding <u>legal frameworks</u> of care for <u>patients unable to provide informed consent</u> ?

No
Yes within the last 2 years
Yes longer than 2 years ago

C) How often in the course of your work are you required to nurse <u>patients who are unable to provide informed consent</u>?

Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently - daily

D) **Of the following menu – select the top three activities that would make a positive difference to your own practice related to involuntary patients, patient- restraint and containment**.

Menu options –

- Availability of relevant information regarding nurse legal issues
- Access to training regarding nurse legal issues and these patient- online self-directed
- Access to training regarding nurse legal issues and these patients – face to face
- Access to ongoing mentoring by expert staff
- Access to clinical supervision
- Access to expert staff

Section C: Ongoing Treatment and intervention:

10. Managing MH symptoms

A) How confident are you in working with patients to manage their MH symptoms – psychosis, self-harming etc? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B) Have you received any training regarding working with patients to manage their MH symptoms?

No
Yes within the last 2 years
Yes longer than 2 years ago

C) How often in the course of your employment are you required to work with patients to manage their MH symptoms?

Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently - daily

D) How well do you think you work with patients to manage their MH symptoms?

Not at all well
Fairly well
Quite well
Very well

E) Of the following menu – select the top three activities that would make a positive difference to your own practice regarding working with patients to <u>manage their MH symptoms</u> – psychosis self-harming etc.

Menu options –
• Availability of MH guidelines regarding symptom management • Access to MH training regarding symptom management – online self-directed • Access to MH training regarding symptom management – face to face workshops • Access to ongoing mentoring by expert staff • Access to clinical supervision • Access to expert staff

11. <u>The delivery of Brief Interventions to patients presenting with ATS Issues.</u>

(Definition of Brief Intervention – a time limited intervention to raise awareness, share knowledge and get a patient thinking about making changes to improve their health and behaviours. The intervention can be brief and 'opportunistic', lasting as little as 30 seconds, or extending over a few sessions lasting 5-60 minutes. Brief interventions often consist of informal counselling and information on certain types of harms and risks associated with drug use and/or risky behaviours)

A) In your role, is there an expectation that you <u>deliver Brief Interventions</u> to patients presenting with ATS issues?

Yes
No
Not sure

B) Do you ever <u>deliver Brief Interventions</u> to patients presenting with ATS-use related issues?

Yes
No – go to question 12 B

12. A) How confident are you in <u>delivering Brief Interventions</u> to patients presenting with ATS-related challenges? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B)Have you received any training regarding delivering Brief Interventions to patients presenting with AOD challenges?

No – go to question 12 E
Yes within the last 2 years
Yes longer than 2 years ago

C) How often in the course of your work are you required to <u>deliver Brief Interventions to patients</u> presenting with AOD challenges?

Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently - daily

D) How well do you think you <u>deliver Brief Interventions to patients</u> presenting with AOD challenges?

Not at all well
Fairly well
Quite well
Very well

E) Of the following menu – select the top three activities that would make a positive difference to your own practice regarding <u>the delivery of Brief Interventions to patients</u> presenting with AOD challenges.

Menu options –

- Availability of information about the delivery of BIs to patients with AOD-related issues
- Access to training about the delivery of BIs to patients with AOD-related issues – online self-directed
- Access to training about the delivery of BIs to patients with AOD-related issues – face to face
- Access to ongoing mentoring by expert staff
- Access to clinical supervision
- Access to expert staff

13. <u>Treatment / discharge plans for patients with ATS-related issues</u>

A) How confident are you in <u>developing ongoing treatment / discharge plans</u> with patients with ATS-related issues? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B) Have you received any training regarding the <u>development of ongoing treatment / discharge plans</u> with patients with ATS-related issues?

No
Yes within the last 2 years
Yes longer than 2 years ago

C) How often in the course of your work are you required to <u>develop ongoing treatment / discharge plans</u> with patients with ATS-related issues?

Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently - daily

D) How well do you think you <u>develop ongoing treatment / discharge plans</u> with patients with ATS-related issues?

Not at all well
Fairly well
Quite well
Very well

E) Of the following menu – select the top three activities that would make a positive difference to your own practice regarding the <u>development of ongoing treatment / discharge plans</u> with patients with ATS-related issues.

Menu options –

- Availability of AOD / Dual Diagnosis treatment / discharge planning guidelines
- Access to AOD / Dual Diagnosis treatment / discharge planning training – online self-directed
- Access to AOD / Dual Diagnosis treatment / discharge planning training – face to face
- Access to ongoing mentoring by expert staff
- Access to clinical supervision
- Access to expert staff

14. <u>Harm Reduction information delivery</u>

AOD Harm reduction education is the provision of useful information and advice regarding minimising the potential risks to the patient if they continue to use substances, specifically ATS. This education would include material regarding the mode of substance-administration, blood borne viruses, MH issues, dose-related risks, dependence, withdrawal and ATS acquisition.

A) In your role, is there an expectation that you <u>deliver AOD Harm Reduction education</u> to patients / carers presenting with ATS issues?

Yes
No
Not sure

B) Do you ever <u>deliver AOD Harm reduction Education</u> to patients / carers presenting with ATS use-related issues?

Yes
No – go to Question 15B

15. A) How confident are you in <u>delivering harm reduction information</u> to patients / carers regarding ongoing use of ATS and other substances? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B)Have you received any training regarding <u>delivering harm reduction information to patients / carers</u> regarding ongoing use of ATS and other substances?

No – go to question 15 E
Yes within the last 2 years
Yes longer than 2 years ago

C) How often in the course of your work are you required to <u>deliver ATS-related harm reduction information to patients / carers?</u>

Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently - daily

D) How well do you think you deliver ATS-related <u>harm reduction information</u> to patients / carers?

Not at all well
Fairly well
Quite well
Very well

E) Of the following menu – select the top three activities that would make a positive difference to your own practice regarding the delivery of <u>ATS-related harm reduction information</u> to patients / carers.

Menu options –

- Availability of ATS-related harm reduction information
- Access to ATS-related harm reduction training – online
- Access to ATS-related harm reduction training – face to face
- Access to ongoing mentoring by expert staff
- Access to clinical supervision
- Access to expert staff

16. <u>Making referrals to MH services.</u>

A)How confident are you in referring patients to MH services on discharge from ED? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B)Have you received any training regarding referring patients to MH services?

No **Yes within the last 2 years** **Yes longer than 2 years ago**

C) How often in the course of your work are you required to <u>refer patients to MH services</u> on discharge from ED?

Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently - daily

D) How well do you think <u>you refer patients to MH services</u> on discharge from ED?

Not at all well
Fairly well
Quite well
Very well

E) Of the following menu – select the top three activities that would make a positive difference to your own practice regarding the <u>referral of patients to MH services</u> on discharge from ED.

Menu options –

- Availability of MH agency information and referral processes / criteria
- Access to training / MH agency information and referral processes / criteria – face to face
- Access to ongoing mentoring by expert staff
- Access to clinical supervision
- Access to expert staff

17. <u>Making referrals to AOD services.</u>

A) How confident are you in <u>referring patients to AOD</u> services on discharge from ED? Please rate yourself on this confidence scale – 1 means not confident all – 10 extremely confident.

1 not confident at all	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 extremely confident**

B) Have you received any training regarding <u>referring patients to AOD services</u>?

No **Yes within the last 2 years** **Yes longer than 2 years ago**

C) How often in the course of your work are you required to refer patients to AOD services on discharge from ED?

Never
Rarely – once or twice a month
Occasionally – once a week
Frequently – twice to five times a week
Very Frequently - daily

D) How well do you think you refer patients to AOD services on discharge from ED?

Not at all well
Fairly well
Quite well
Very well

E) Of the following menu – select the top three activities that would make a positive difference to your own practice regarding the referral of patients to AOD services on discharge from ED.

Menu options –

- Availability of AOD agency information and referral processes / criteria
- Access to training / AOD agency information and referral processes / criteria – face to face
- Access to ongoing mentoring by expert staff
- Access to clinical supervision
- Access to expert staff

18. Considering the list from the survey questions, what would be your top 5 training topics:

- Assessing the AOD needs of patients presenting with ATS-related issues
- Assessing the MH needs of patients presenting for ATS-related issues
- Assessing the physical needs of patients presenting for ATS-related issues
- Responding to ATS use-related challenging behaviour
- Integrated ED responses to patients presenting with ATS use-issues
- Management of ATS intoxication
- Management of ATS withdrawal
- The nurse- legal framework related to patients who may not be able to provide you with informed consent
- Management of MH symptoms
- Delivering Brief Interventions to clients presenting with ATS-related issues
- Developing ongoing treatment / discharge plans for patients presenting to ED with ATS related issues
- Delivery harm reduction information for patients / carers of patients presenting to ED with ATS-related issues
- Making effective referrals to MH services for patients presenting to ED with ATS-related issues
- Making effective referrals to AOD services for patients presenting to ED with ATS-related issues

19. If you were to be offered a training package containing generic information regarding AOD and ATS in particular – what would be your priority areas? Please choose the top 6 topics:

- What is ATS dependence?
- Impact of ATS on brain / cognitive functioning
- Impact of ATS on general behaviour and MH
- Implications of ATS-related cognitive issues on communication / goal planning and follow-through
- Interaction of ATS substances with prescription medications, alcohol and other substances
- Alcohol and other drug Screening
- Engagement with patients with ATS-related issues
- Communication – Motivational Interviewing
- Providing AOD Brief Interventions
- The impact of stigma on treatment-seeking and hope
- Understanding and navigating the AOD sector
- Goal planning
- Engaging and enhancing recovery capital
- Providing harm reduction education to consumers and carers
- Providing advice for carers regarding AOD issues, referrals and support
- Other (please specify)

APPENDIX C Nurse Focus Group Questions

1. Considering the following list taken from the survey, **please select the 2 training topics** you think are the most important to your workplace and explain why you made this choice.
   - Assessing the AOD needs of patients presenting with ATS-related issues
   - Assessing the MH needs of patients presenting for ATS-related issues
   - Assessing the physical needs of patients presenting for ATS-related issues
   - Responding to ATS use-related challenging behaviour
   - Integrated ED responses to patients presenting with ATS use-issues
   - Management of ATS intoxication
   - Management of ATS withdrawal
   - The nurse- legal framework related to patients who may not be able to provide you with informed consent
   - Management of MH symptoms
   - Delivering Brief Interventions to clients presenting with ATS-related issues
   - Developing ongoing treatment / discharge plans for patients presenting to ED with ATS related issues
   - Delivery harm reduction information for patients / carers of patients presenting to ED with ATS-related issues
   - Making effective referrals to MH services for patients presenting to ED with ATS-related issues
   - Making effective referrals to AOD services for patients presenting to ED with ATS-related issues

2. **An integrated ED response to patients presenting with ATS use-issues. What does this mean to you?**
   Eg. Which staff do what, who takes ultimate responsibility for the patient's progress through ED / MH, screening processes, triage responses, what treatments are offered, managing challenging behaviours – processes / protocols, which staff are best prepared / most skilled? Etc.

3. If you were given training and / or guidelines relating to effective responses to patients presenting with ATS-related challenges, **what, if any challenges, do you see for putting this new knowledge and these skills into place in your organisation**? Eg. Staff turnover, ED targets, lack of appropriate treatment environment, lack of senior staff support etc.

4. If you were given training and / or guidelines relating to effective responses to patients presenting with ATS-related challenges, **what opportunities and helpful existing resources exist in your organisation for putting this new knowledge and these skills into place?** Eg. Access to expert staff, high staff interest, good staff education system, senior staff support and professional development processes etc.

APPENDIX D Consumer Focus Group Questions

1. Considering **your own experiences** going to Emergency Departments:
    - **How many times** have you been to emergency departments for help with something to do with your ice-use?
    - **Why did you go?** What symptoms were you experiencing?
    - **Who took you?**
    - What were you **hoping to receive** by going there?

2. **What did you find challenging about your time** in the emergency departments? What if any **recommendations** would you make to address these challenges? Eg staffing, staff skills, medication, other treatment, physical environment, waiting times etc

3. **What did you find helpful about your time** in the emergency departments? Eg skilled staff, physical environment, medication, other treatment, advice and support etc

4. **What were the outcomes** of your going to the emergency departments for help? Eg treatment for the symptoms, referral to mental health or alcohol and other drug services, advice, suggestions for follow-up support etc.

APPENDIX E Carer Focus Group Questions

1. Considering **your own experiences** going to Emergency Departments:
    - **How many times** have you taken your family member or friend to emergency departments for help *with something to do with their ice-use?*
    - **Why did you take them there?** What symptoms were they experiencing?
    - **Did you engage a service** to take them there? Eg CATT or police etc
    - What were you **hoping they would receive** by attending the emergency departments?

2. **What did you find challenging about your time** in the emergency departments with your family member / friend *with an ice-use problem*? What if any **recommendations** would you make to address these challenges? Eg staffing, staff skills, medication, other treatment, physical environment, waiting times etc

3. **What did you find helpful about your time** in the emergency departments with your family member / friend *with an ice-use problem*? Eg skilled staff, physical environment, medication, other treatment, advice and support etc

4. **What were the outcomes** of your taking your family member / friend to the emergency departments for help? Eg treatment for their symptoms, referral to mental health or alcohol and other drug services, advice, suggestions for follow-up support etc.

APPENDIX F Terms of Reference for Expert Review Group (ERG)

'*Strengthening assessment and intervention skills for ED, mental health and triage nurses managing clients with mental health and amphetamine-type substances-use issues'* project.

Recent nurse concerns and media attention have focussed on the plight of patients with methamphetamine-use issues and the challenges for front-line staff working with them.

To respond to these important matters, the Chief Mental Health Nurse team is leading the '*Strengthening assessment and intervention skills for ED, mental health and triage nurses managing clients with mental health and amphetamine-type substances-use issues'* project.

Nexus Dual Diagnosis Team (St Vincent's Hospital) has been engaged to conduct a scoping project to understand the current issues and needs of mental health and emergency department nurses in relation to management of clients with mental health and amphetamine-type-substance-use issues.

This project will collect and analyse information from nurses, managers, consumers and carers regarding staff training and support needs, and the system-changes required to better provide safe, effective interventions for these patients.

Role of the ERG

- The ERG will review the collected data to ensure that the preliminary analysis accurately reflects the experience, intentions and suggestions from the survey and focus groups

- The ERG will review the first draft of the final report to ensure it adequately captures the data and analysis, and clearly expresses the recommendations.

The term of the ERG

This is a very time-driven project and will require the ERG to meet twice only.

- The ERG responsibilities will commence prior to the first meeting when participants will be provided with copies of the early analysis of the data.

- The ERG responsibilities will cease with their reading and providing feedback regarding the minutes / notes from the second meeting.

ERG Membership

The ERG membership consists of:

- Departmental Representative
- Dual Diagnosis Psychiatrist
- Addiction Medicine Consultant
- Carer representative (MH)
- Consumer representative (AOD)

- ED / AOD Liaison – Rural
- ECATT – Metro
- ED NUM - metro
- MH Inpatient manager – Outer Metro
- Ambulance / Paramedic representative

Responsibility

The ERG is responsible for

- bringing their expertise to the ERG
- remaining focussed on a state-wide and future view
- completing their designated tasks – reviewing the early data and the first draft of the final report

The members of the ERG will commit to

- reading all the relevant material
- attending both meetings
- providing clear and timely input so as not to hold up the project
- notifying the convenor as soon as practicable if any matter arises which may be deemed to be a conflict of interest or could be expected to affect the progress of the reviews.

Members of the ERG will expect that they will

- be provided with all relevant and accurate material regarding the project
- be given adequate time to read and consider any material under review
- be provided with a meeting environment that encourages open and honest discussion

Meetings

- All meetings will be chaired by Chris Hynan, Manager of NEXUS, or delegate
- As this is a time limited project, there will be no quorum
- All decisions will be made by consensus
- Meeting agendas, minutes and papers will be provided by Nexus
- Meetings will be held in the conference room / sunroom L2 Bolte Wing St Vincents Hospital

APPENDIX G Literature search

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APPENDIX H

Survey Respondents' Demographics:

Survey 1

Total Responses	73	Completes	69

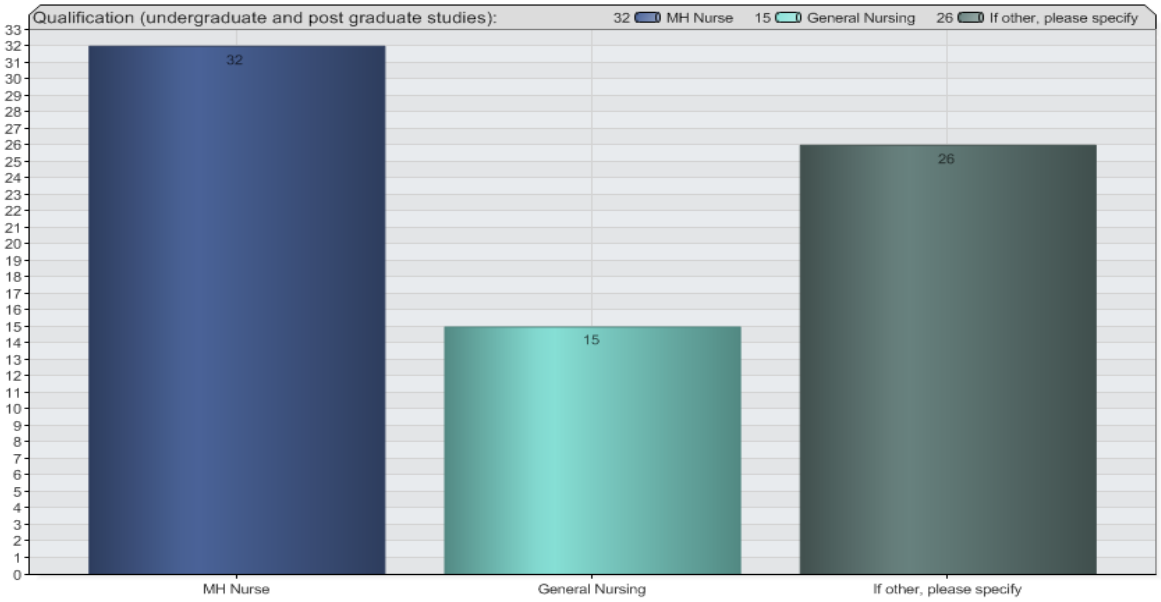
Workplace location

	Responses	Percent
Metro:	50	68.49%
Regional:	16	21.92%
Rural:	7	9.59%
If other, please specify:	0	0%

Work setting

	Responses	Percent
Hospital:	59	80.82%
Community:	10	13.7%
If other, please specify:	4	5.48%

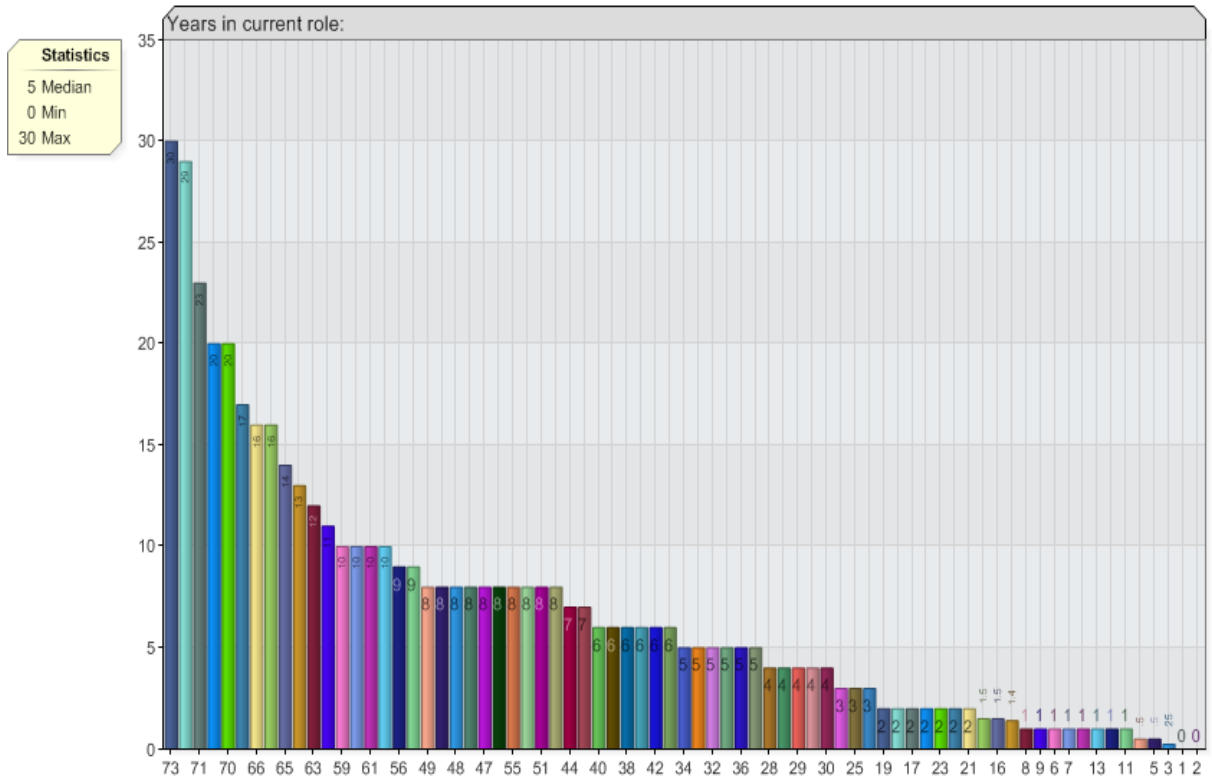
Professional qualification



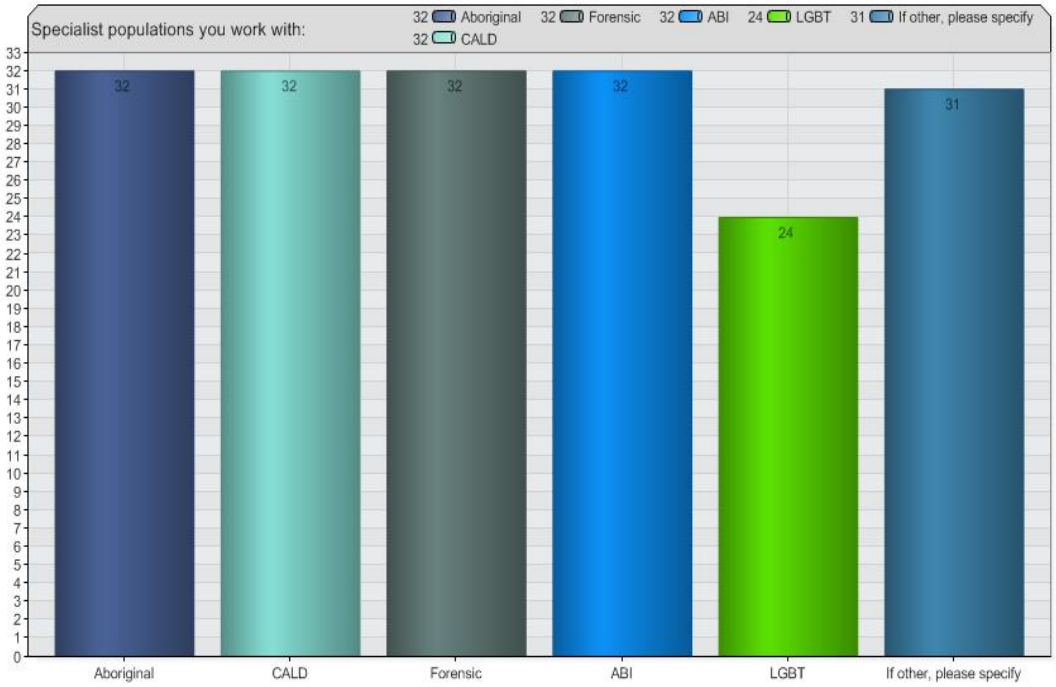
Area of work:

	Responses	Percent
MH Triage:	4	5.48%
MH CATT:	2	2.74%
MH E-CATT:	9	12.33%
ED Emergency Nursing:	24	32.88%
AOD ED Nurse:	10	13.7%
If other, please specify:	24	32.88%

Years of which survey respondents have worked in their current role



Survey participants work with a range of population groups



Survey 2

Total Responses:	441
Completes:	199

How do you identify yourself?

	Responses	Percent
Male:	92	21.15%
Female:	343	78.85%
Transgender:	0	0%
Intersex:	0	0%

How would you describe the location where you work?

	Responses	Percent
Metropolitan:	227	59.42%
Regional:	113	29.58%
Rural:	42	10.99%

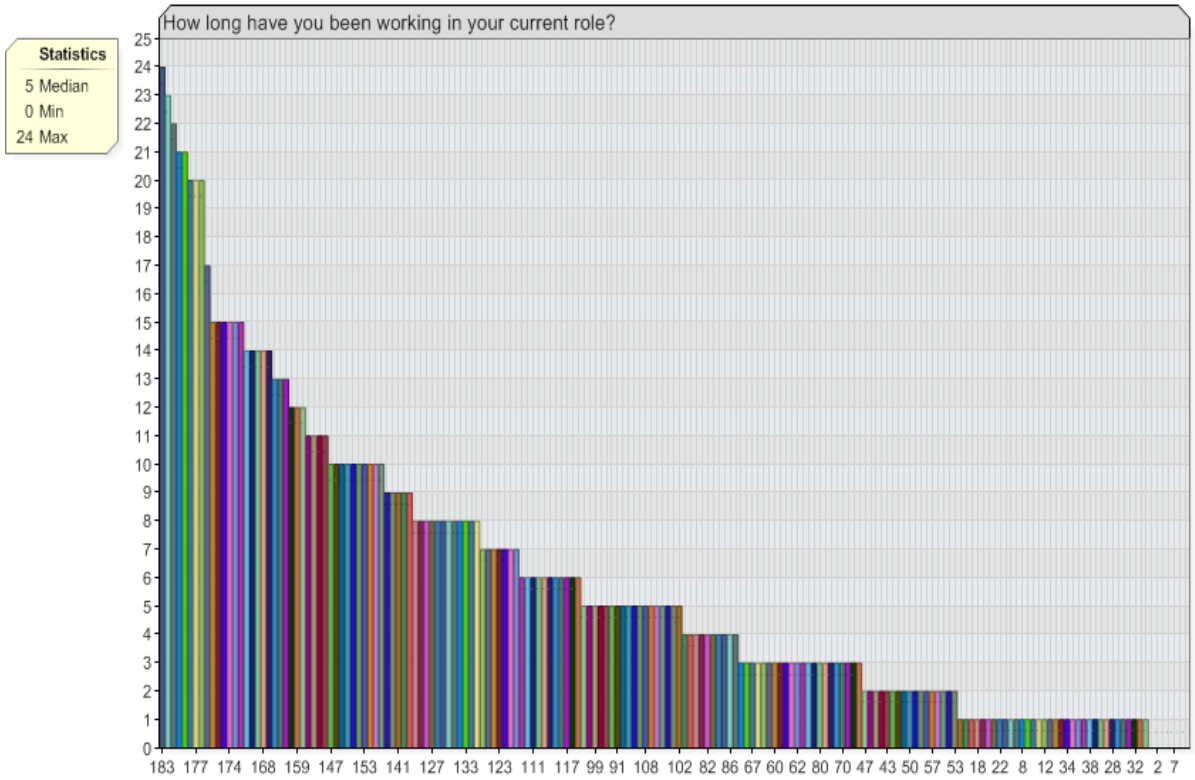
What is your role in the Emergency Department?

	Responses	Percent
Registered Nurse:	91	45.5%
ECATT / MH liaison nurse:	31	15.5%
AOD liaison nurse:	4	2%
Triage nurse:	19	9.5%
Short Stay Unit nurse:	2	1%
Other:	2	1%
If other, please specify:	51	25.5%

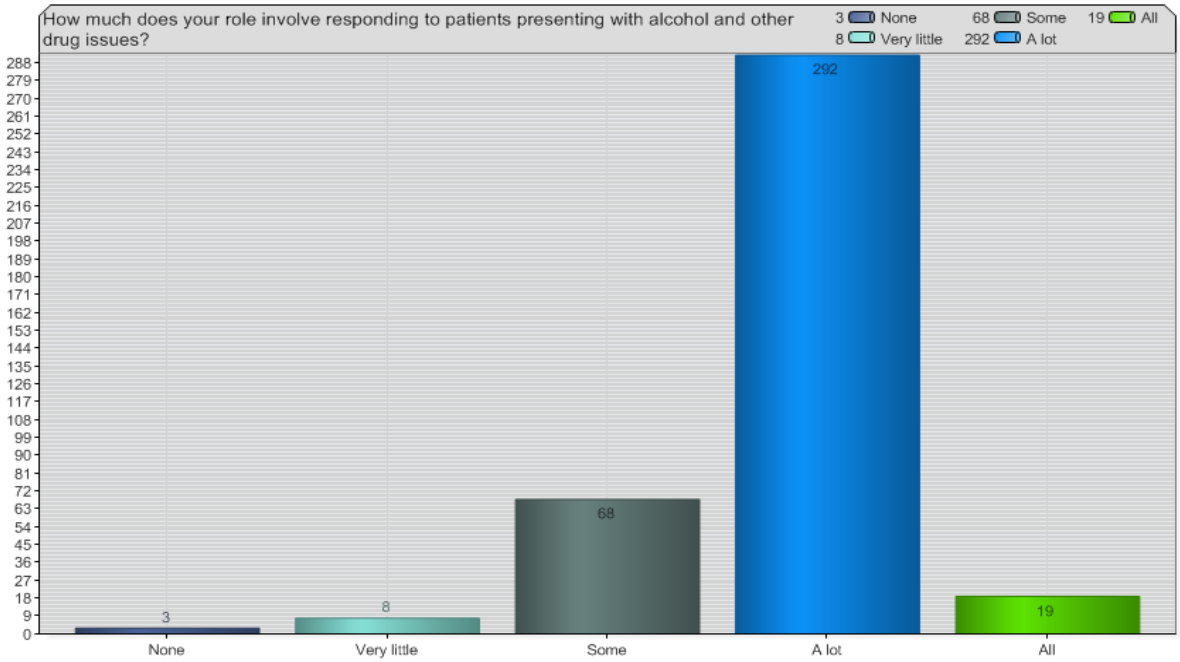
What is your role in Acute MH Services?

	Responses	Percent
MH Triage nurse:	13	6.25%
MH inpatient services nurse:	113	54.33%
CATT:	18	8.65%
Community Case Manager - nurse:	21	10.1%
Other:	2	0.96%
If other, please specify:	41	19.71%

Years of which survey respondents have worked in their current role



Proportion of survey respondents' role dedicated to working with people presenting with AOD issues

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