Nursing care of patients with substance use disorders:

* BG
  + aversion therapy (90% sober for at least a year)
    - Drugs to induce n/v, constrict esophagus
  + CAC III (MH setting)
* Matter of willpower?
  + AMA listed as legitimate disease
* New DSM5: “Substance Use Disorder”
  + Cluster of cognitive/behavioral/ psychological symptoms indicating that the individual continues use despite significant substance related problems
  + Still will hear “abuse” “dependence”; more negative connotations
  + “[substance] use disorder”
    - Marijuana referred to as “cannabis”
  + Criterion: (paraphrased, reference DSM for real wording)
    - Criterion 1-4: Impaired control
      * Substance taken in larger amounts/longer period of time then intended
      * Persistent desire/inability to cut down/control substance use
      * Great time spent in obtaining substance
    - Criterion 5-7: Social impairment
      * Fail to keep social engagements
      * Absence from work
    - Criterion 8-9: Risky use
      * Use in spite of pressing medical advice
      * Situations where dangerous (ETOH and driving)
    - Criterion 10-11: Pharmacological
      * Tolerance: Needs more to get desired effects
      * Withdrawal (or abstinence syndrome): physiological symptoms when taken away
      * Sx of tolerance/withdrawal during appropriate medical tx with prescribed meds should NOT be counted when diagnosing SUD
  + Addiction v dependence
    - Addicted: psychological. Do anything to get substance, interferes with life
    - Dependence: not the intense cravings. If substance taken away, will go through withdrawal.
    - “Drug seeking” pts: typically just trying to avoid withdrawal
      * Prescribed drug use for pain: not going to buy heroin off the streets, but trying to control pain; difficult to treat. Over time, will need greater amount for same relief. LIFETIME STRUGGLE. Pts who accidently OD (not suicide attempt)
  + Healthcare mgmt.
    - Pain clinics
    - Moral quandary: dependence is hard to manage pain
      * Same with benos, sleeping pills.
  + Severity rating:
    - Mild (2-3 symptoms)
      * SBIRT (MI)
    - Moderate (4-5 symptoms)
      * SBIRT (MI)
    - Severe (6+)
  + Specifiers
    - In early remission (3-12 months)
    - In sustained remission (12+ months)
    - In a controlled environment
      * No access to substance, for example jail
    - On Maintenance therapy
* ETOH
  + Slide 2: Fact/figures
    - NIH recommended site
    - ETOH most widely abused; withdraw/ abstinence syndrome life threatening
    - Biggest misnomer: will never quit unless get tx (certain percentage of ppl able to quit)
    - ETOH HUGE attributing factor to ED Admissions; 72 associated medical conditions
      * Thyroid, bp, mh, acute psychosis, renal/hepatic
    - Earlier someone starts drinking, more likely to become addicted
  + Legal limits in Colorado; DRIVING IS A PRIVELEGE NOT A RIGHT
    - Driving Under Influence (DUI): BAC 0.08 (80 mg/dL)
    - Driving While Ability Impaired (DWAI): BAC: 0.05 or higher (50 mg/dL)
      * First time may not lose license or for shorter period of time
    - Underage Drunk Driving (UDD): any alcohol content underage (“Justin Bieber”)
    - Refusal of breathalyzer/BAC: loose license for 1 year. “Implied consent law”
      * When given license, consent to field sobriety test
      * “Reasonable suspicion” but sometimes DUI check points
      * Refusal is admission of guilt
    - DUID: Driving under influence of drugs
  + Pharmacotherapy for ETOH Use Disorder
    - Antabuse (Disulfiram)
      * When first prescribed, given drug and made person drink to experience reaction
        + Flushing, tachycardia, sob, n/v, throbbing HA
      * SE: drowsiness (usually dissipates in weeks), ha, metallic/garlic taste, CAN BE HEPATOTOXIC (monitor liver function tests; usually happens within first 3-6 month)
      * Pt education:
        + Long halflife. Can stay in system up to 2 weeks
        + Caution hidden forms of ETOH: mouthwash, lotions, creams, uncooked foods containing alcohol (i.e. vanilla extract is 35% alcohol)
        + Most effective in liquid form; monitored
      * Negative reinforcement: thought of negative consequence prevents someone from drinking
      * Blocks the enzyme for oxidation of metabolite called acid aldehyde; buildup causes symptoms of ETOH/Antabuse rxn
      * Outcome studies: doesn’t show long term outcomes
        + Preferable if done right/monitored
        + Courts love it
      * Clinic for compliance
    - Naltrexone (like naloxone “Narcan”)
      * Approved 90s
      * Opiate antagonist
      * Mixed reviews
        + Pt can still drink, no SE however will not get “buzz” or high (because receptor blocked)
        + Reasoning: if not getting pleasurable effects, people will not drink as much
        + Still get bad systemic effects of ETOH use
    - Acamprosate (Campral)
      * Sobriety maintenance
      * Cannot start until person has been off ETOH/detoxed 3-5 days
      * Believed to decrease craving for ETOH
      * MOA: agonizing GABA (inhibitory neurotransmitter)
      * Mixed outcome studies
    - Vivitrol (injectable form of Naltrexone)
      * Extended release given q month
    - Topamax
      * Not FDA Approved. Often used “off label” to decrease craving
      * FDA approved: migraines, bipolar disorder, seizures
  + Withdrawal
    - Kindling effect
    - s/sx: termors, nv, diaphoresis (profuse), weakness, tachy/hypertensive; anxious, hallucinations, seizures, delirium tremens (DTs)
      * DTs (“shaking frenzy”) can be fatal: may require IV, ICU admits
        + With treatment: 15% fatal; without tx: 35%
      * Grand mal seizures; Dilantin will not help (especially if HISTORY of szs with withdrawal; again Kindling)
    - Have pt describe their history
    - Tx/Nursing Intervention:
      * Safety (fall prevention)
      * Monitor vital signs
      * Push fluids-juices/Gatorade/water
      * Administer CIWA
      * Pharmacological intervention, ie, short acting benzos
      * Vitamins: Thiamine (B1) to prevent Wernicke Korsakoff Syndrome (encephalopathy) which can be permanent. Referred to as “wet brain”
    - Tx:
      * Pharmacological/comorbidities (utilized only 9% of the time)
      * 12 step programs
      * Inpatient/Outpatient
      * Family therapy
      * Intervention
      * Relapse prevention (focus on confronting denial): cognitive-behavioral, motivational interviewing, solution focused, psycho-educational
  + ETOH and old age
    - Increase in number of alcoholic patients due to sheer increase of number of pts
    - Need to assess/address
    - Also, polypharmacy (Interactions)
    - Assessment
      * Michigan Alcoholism Screening Test, Geriatric Edition (MAST-G)
      * CAGE Questionnaire 2 or more “yes”=problem drinking
        + Cut Down?
        + Annoyed?
        + Guilty?
        + Eye opener?
      * Alcohol screening inventory; EVEN JUST ASKING (SBIRT)
* Opioid:
  + Types:
    - Heorin: smoked/IV/smoked/snorted
      * IV route more dangerous
    - Morphine
    - Oxycodone (prescription pain meds)
      * Addiction/dependency happens quickly
      * Withdrawal severe, but not usually life threatening
        + Can begin within hours of last dose, but cravings last for years
  + Pharmacologic tx: PLAN WITH ALL IS TO TAPER OFF, difficult (success rates?)
    - Methadone (short term or long term): HIGHLY ADDICTIVE
      * HARM REDUCTION
      * Requires high doses to get “high”
    - Buprenorpihne: “weaker” analgesic (SL, transdermal)
    - Suboxone: combo of buprenorphine and naloxone
    - Ideal is to dose for maintenance without getting high
      * UAs to test for (+) methadone; (-) heroine
  + Non pharmacologic tx:
    - Relapse prevention programs
    - NA 12 step programs
    - Contingency mgmt. (vouchers/point systmes)
    - Needle exchange programs
    - Bleach “works”
  + Case study: 34 yo female, baby born 38 wks, born SGA. Labile pain, diaphoretic, withdrawn re: baby
    - Clues: low birth weight/lethargic baby, High BP/HR/Resp, body aches/high pain/ slow labor
    - Narcotic/opioid withdrawal
    - Nursing dx: ineffective denial
      * Outcome: pt will verbalize association of drug use to current situation
      * Interventions:
        + Review definition of drug dependence and categories of symptoms (patterns of use/impairment of use/tolerance)
        + Confront and examine denial and rationalization in peer group; use confrontation with a a caring attitude

Denial major defense mechanism

* + - * + Ascertain reason for beginning abstinence and involvement in therapy
      * Priorities:
        + Pt to provide information about condition/prognosis/tx needs
        + Strengthen individual coping skills
        + Promote family/friend involvement in rehab group
* Stimulants
  + Cocaine
    - Powerfully addictive: euphoric/energetic
    - Smoked (crack), injected, snorted (SL? Google case study)
    - Medical risk:
      * Incr risk of cardiac event; temp/bp/hr
    - Young person w/ s/sx of heart attack: DRUG SCREEN
    - Tx:
      * No FDA approved pharmacologic txs
      * Vaccination showing promise
      * Non pharmacologic: same as other addictions
  + Crystal meth (methamphetamine)
    - Meth started in 1980s Hawaii and moved to west coast; super labs/home labs
    - Snorted/smoked injected
    - Increases release of DA and blocks reuptake
      * Intense euphoria; diminishes with each use; continue using to try and gain feelings again
      * Needed to function
      * Severe structural/functional changes associated with memory and emotion
      * Chronic/relapsing
    - Physiological manifestations:
      * Extreme weight loss, “meth mouth”, anxiety/confusion/insomnia/mood disturbances/ violent behavior
      * Meth induced psychosis (difficult to distinguish from schizophrenia)
        + Meth: usually visual/tactile
        + Schizophrenia: hallucinations usually auditory
    - Tx:
      * Pharmacologic:
        + Antipsychotic meds for pscyhosis (Haldol, risperdol)
        + Modafinil: mild stimulant used but showed no effect
      * Comprehensive Cognitive behavioral tx
      * 12 step programs
      * Contingency mgmt.
* Marijuana
  + Cannabis/Pot/THC
  + ADOLESCENTS: attention/memory/IQ permanent effects even when quit
  + CAN lead to abuse/dependence
    - Amotivational syndrome
  + Legal:
    - 16 states legalized for medicinal use; not legal under federal law
      * Decreases n/v (following chemo), increase appetite, decrease intraocular pressure (glaucoma), analgesic effects
  + SPICE
* Tobacco/Nicotine (covered in previous lectures): MOST PREVENTABLE CAUSE OF DISEASE/DISABILITY IN THE US
  + Tx/medications:
    - Nicotine replacement treatment (gum, patches, lozenges)
    - Bupropion (zyban, wellburin)
    - Verencicline Tartrate (Chantix)
  + SMOKING cessation education/intervention by nurses
* Gambling disorder
* Impaired professionals
  + ETOH use parallels use of public, lower for marijuana, inhalants, hallucinogens, heroin
  + Use of prescription drugs significantly HIGHER
    - Male nurses more likely
  + Abusers by specialties:
    - Oncology
    - Psychiatry
    - Emergency and adult critical care
  + Warning signs:
    - Decrease in overall work quality
    - Errors in judgment
    - Periods of confusion/lack of concentration
    - Missed deadlines
    - Excessive time completing tasks
    - Lack of memory
    - Medication errors
    - Overlooking deteriorating conditions
    - Repeated absenteeism/tardiness
    - Leaving work early
    - Unexplained disappearances
    - Increased use of pain meds recorded
    - Increase in wastage or breakage of drugs
    - Missing drugs/unaccounted doses
  + Health professionals respond well to interventions and have good tx response
    - HELP diverters, not punish
    - Speak to risk mgmt./ managers/etc if suspicion
    - Report to board with evidence

Practice problems:

* + Lippincott Chapter 4, Test 3. Questions 26-100.
  + Saunders, Ch 75, p. 1059. All questions 923-932.