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.