PURPOSE:

• To help nurses foster positive relationships with patients that have substance use disorders (SUDs) in order to provide high quality healthcare
OBJECTIVES:

• Identify nurses’ attitudinal barriers and knowledge deficits related to substance use disorders.

• Suggest specific values and skills that nurses can adopt to improve their interactions with patients with substance use disorders.

• Describe preliminary research that informs the University of Maryland's School of Nursing curriculum, and its goals of providing more effective healthcare and reducing health disparities.
ASSUMPTIONS:

• If addiction is seen as a moral failing, it will be condemned.
• If seen as a deficit in knowledge, it will be educated.
• If the addiction is viewed as an acceptable aberration, it will be tolerated.
• If the addiction is considered illegal, it will be prosecuted.
• If viewed as an illness, it will be treated.
• Social policies mirror these different views with strategies ranging from prohibition and criminalization to hospitalization and mandated treatment.

– DiClemente, 2006, p. vii
ASSUMPTIONS:

• All nurses encounter patients with SUDs on a daily basis, in all practice settings
• Patients with SUDs can be challenging to treat
• Nurses require more evidence-based training & skills in the treatment of SUDs
In one year, drug overdoses killed more Americans than the entire Vietnam War did

- 2015 was the worst year for drug overdose deaths in US history. Then 2016 came along.
- 19 percent increase between 2015 and 2016 alone (largest known increase in drug overdose deaths for any single year yet)

*Estimate based on preliminary data
Soaring opioid drug deaths cause U.S. life expectancy to drop for 2nd year

NEW YORK — U.S. deaths from drug overdoses skyrocketed 21 percent last year, and for the second straight year dragged down how long Americans are expected to live.

The government figures released Thursday put drug deaths at 63,600, up from about 52,000 in 2015. For the first time, the powerful painkiller fentanyl and its close opioid cousins played a bigger role in the deaths than any other legal or illegal drug, surpassing prescription pain pills and heroin.
Every day, more than **115** people in the United States die after overdosing on opioids.
Alcohol and Opioids: A Dangerous Combination

Increase in Prescription Opioid Overdose Deaths

Alcohol involved in ~15% of cases

Source: CDC-WONDER, Multiple Cause of Death Data
“Treatment Gap”—Needing but not receiving treatment

It’s much easier in America to get high than it is to get help.

ONLY 1 in 10 people suffering from a substance use disorder receives any type of treatment.

THAT MEANS 90% of people needing help are not getting it.

National Curriculum Committee Addictions Counseling Competencies Model (CSAT, 2017)

- Defines the **knowledge, skills, attitudes** (KSAs) and **competencies needed by all disciplines**, in order to:
  - **Identify** individuals with SUDs;
  - **Assess** their condition;
  - **Intervene** on their behalf; and/or
  - **Refer** them to treatment.

- Discusses roles of other healthcare professionals *(but not so much about nursing)*
National Curriculum Committee Addictions Counseling Competencies Model (CSAT, 2017)
Addictions Nursing: Scope and Standards of Practice (Amer. Nurses Assoc. & the Int’l Nurses Society on Addictions, 2013)

• “The chance that a nurse will meet a person whose substance use puts him or her at risk for adverse health consequences is high.”
  (ANA-IntNSA, 2013, p. 14)
Addictions Nursing: Scope and Standards of Practice (Amer. Nurses Assoc. & the Int’l Nurses Society on Addictions, 2013)

“Focusing nursing education on treatment of substance use and addictive disorders alone results in nurses being unprepared to intervene with patients with risky substance use or those engaging in risky behaviors... such as a single episode of risky alcohol use that could lead to serious health outcomes such as motor vehicle crash, drowning or alcohol poisoning.”

(ANA-IntNSA, 2013, p. 14)
Recommended Addictions Content for All Nurses

- **Stigma**: Non-Judgmental Approaches & Patient-First Language
- **SBIRT**: Screening, Early Intervention & Referral to Treatment
- **Pain**: Safe Opioid Prescribing and Diversion
- **Recovery-Oriented Care**: Effective, Integrated Prevention & Treatment
- **Trauma**: Trauma-Informed Care & Avoidance of Re-Traumatization
- **Gender-Specific Services**: Women, LGBTQ
- **Perinatal Substance Use**: Pregnancy & Neonatal Abstinence Syndrome
- **Medication-Assisted Therapy & Behavioral Interventions**
- **Care Coordination**: Care Continuum; Post-Treatment Recovery Support
- **Psychopharmacology**: Co-Occurring Disorders (psychiatric & somatic)
- **Occupational Health & Safety**: Clinicians with SUDs, Workplace Violence
Safe Opioid Prescribing:
— Avoiding diversion and iatrogenic drug dependence
— Maintaining access to pain medications for those in need
**Addictions Nursing: Standards of Practice (ANA-IntNSA, 2013)**

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>ADVANCED PRACTICE COMPETENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assessment</td>
<td>Initiates and interprets diagnostic tests and procedures; assesses the effect of interactions among individuals, family, community &amp; social systems</td>
</tr>
<tr>
<td>2. Diagnosis</td>
<td>Integrates data; develops differential diagnoses</td>
</tr>
<tr>
<td>3. Outcome Identification</td>
<td>Identifies outcomes based on the evidence and implementation of EBP</td>
</tr>
<tr>
<td>4. Planning</td>
<td>Plans for multi-faceted needs of complex consumers; current evidence</td>
</tr>
<tr>
<td>5. Implementation</td>
<td>Facilitates utilization of systems and resources; Collaboration; Treatment; prescriptive authority</td>
</tr>
<tr>
<td>6. Evaluation</td>
<td>Outcomes</td>
</tr>
<tr>
<td>7. Ethics</td>
<td>Risks, benefit &amp; outcomes; informed consent and refusal</td>
</tr>
<tr>
<td>8. Education</td>
<td>Utilize current research</td>
</tr>
</tbody>
</table>
### Addictions Nursing: Standards of Practice (ANA-IntNSA, 2013)

<table>
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<tr>
<th>STANDARD</th>
<th>ADVANCED PRACTICE COMPETENCIES</th>
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<tbody>
<tr>
<td>9. EBP &amp; Research</td>
<td>Conducting/synthesizing research &amp; other evidence</td>
</tr>
<tr>
<td>10. Quality of Practice</td>
<td>Quality improvements, practice changes, design innovations</td>
</tr>
<tr>
<td>11. Communication</td>
<td>Discussions with patients, families &amp; inter-professional team</td>
</tr>
<tr>
<td>12. Leadership</td>
<td>Improve practice environment; model expert practice</td>
</tr>
<tr>
<td>13. Collaboration</td>
<td>Partner with other disciplines to enhance outcomes</td>
</tr>
<tr>
<td>14. Professional Practice Evaluation</td>
<td>Seeking feedback on professional practice</td>
</tr>
<tr>
<td>15. Resource Utilization</td>
<td>Formulates innovative solutions and evaluation strategies</td>
</tr>
<tr>
<td>16. Environmental Health</td>
<td>Practices in environmentally safe and healthy manner</td>
</tr>
</tbody>
</table>
### Standards of Practice *(ANA, 2015; ANA-IntNSA, 2013)*

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>GENERALIST RN</th>
<th>ADDICTIONS RN</th>
<th>ADVANCED PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>Collects data not limited to demographic, social, physical, functional, psychosocial, emotional, cognitive, sexual, cultural, age-related, etc.</td>
<td>Collects information on the amount frequency, and pattern of alcohol consumption, drug use, tobacco use, and behaviors that may be maladaptive behaviors.</td>
<td>Initiates and interprets diagnostic tests and procedures; assesses the effect of interactions among individuals, family, community &amp; social systems.</td>
</tr>
</tbody>
</table>
Medication Assisted Treatment (MAT): Nicotine Use Disorder*

- Nicotine replacement – (patches/gum)
- Prescription Medications – (Bupropion & Varencicline)

*Combined with behavioral treatment such as CBT

(CDC, Smoking..., n.d.; Fiore et al., 2008; NIDA, 2018, Principles. Of Drug Addiction Treatment...; SAMHSA, Behavioral health treatments and services, 2017; WHO, n.d.)
Medication Assisted Treatment (MAT): Alcohol Use Disorder (AUD)*

- **Naltrexone** – opioid antagonists, also used to treat alcohol use disorder
- **Acamprosate** – to stabilize chemical signaling in the brain (neurotransmitter function)
- **Disulfiram** – Patient experiences unpleasant side effects when he or she consumes alcohol.

*Combined with behavioral treatment such as CBT

(Reus et al., American Psychiatric Association practice guidelines..., 2018)
Medication Assisted Treatment (MAT): Opioid Use Disorder (OUD)*

- **Methadone** - full agonist synthetic opioid
  - Federally regulated clinic
- **Buprenorphine** - partial-agonist synthetic opioid
  - Office-based treatment
  - DATA 2000 – Office-based treatment – Schedule III, IV, and V narcotics by waivered physicians
  - CARA - expanded waiver eligibility to NPs and PAs
- **Naltrexone** – opioid antagonist
  - Outpatient
  - Not a controlled substance
  - PLUS behavioral treatment

*Combined with behavioral treatment such as Contingency Management and/or substance use disorder (SUD) counseling
NIDA Principles of Effective Treatment

1. Addiction is a complex but treatable disease, affects brain function and behavior
2. No single treatment is appropriate for everyone
3. Treatment needs to be readily available
4. Effective treatment attends to multiple needs of the individual, not just drug use
5. Remaining in treatment for an adequate period of time is critical
6. Behavioral therapies – including individual, family, or group counseling – are the most commonly used forms of treatment
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies

(NIDA, 2012)
NIDA Principles of Effective Treatment

8. An individual’s treatment and a services plan must be assessed continually & modified as necessary to ensure that it meets his or her changing needs.

9. Many drug-addicted individuals also have other mental disorders.

10. Medically assisted detoxication is only the first stage of addiction treatment and by itself dose little to change long-term drug abuse.

11. Treatment does not need to be voluntary to be effective.

12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur.

13. Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases as well as provided targeted risk-reduction counseling, linking patients to treatment if necessary.

(NIDA, 2012)
Meta-Analysis: 40 Years of Outcomes Research—COMMON FACTORS

Patient Factors---40%
• STRENGTHS the patient comes through the door with

Relationship Factors---30%
• Patients’ perceptions of EMPATHY, ACCEPTANCE & HOPE

Expectancy & Hope---15%
• Extent to which the patient BELIEVES or EXPECTS that the counselor’s intervention will be beneficial

Model/Technique---15%
• Least Influential Contributors To Change: What we do as helpers; our strategies and techniques


© Fornili, Burda & Selby, 2018
Meta-Analysis: 40 Years of Outcomes Research—
TAKE HOME MESSAGES

Patient Factors
• Focus on STRENGTHS (talents, beliefs, past problem-solving abilities)
• Utilize social supports and resources

Relationship Factors
• Really LISTEN
• Foster good ALLIANCE between patients and staff

Expectancy & Hope
• Convey the “POSSIBILITY OF CHANGE”
• HOPE, OPTIMISM and ENCOURAGEMENT improve outcomes

Model/Technique
• Instead of finding more “effective” models of treatment, we should elicit, amplify and reinforce the PATIENT and FAMILY FACTORS.
• All treatment models can be equally effective (TREATMENT WORKS!)

• Biggest engine of change is the PATIENT and FAMILY, not “us” or our intervention models

• Outcomes improve when we INSTILL HOPE and accommodate our patients

WHAT DOES NOT WORK:

• Outcomes do not improve when we require patients to “fit” or “conform” to our favorite model or technique
MOTIVATIONAL ENHANCEMENT
Problem Recognition, Readiness for Treatment and Motivation

People who show INSIGHT about:

- The RELATIONSHIP between NEGATIVE CONSEQUENCES and
- Their USE of ALCOHOL AND OTHER DRUGS (AODs)

Will probably:

- BE RECEPTIVE to treatment, and
- DO WELL well in treatment.

Problem Recognition, Readiness for Treatment and Motivation

People who:

• Are unable to RECOGNISE their problem,
• FAIL TO DISCLOSE that they have an AOD problem, or
• Exhibit DENIAL and MISTRUST---

Will probably be:

• HARDER TO ENGAGE in treatment; and
• MORE LIKELY to “DROP OUT”
Problem Recognition, Readiness for Treatment and Motivation

These persons need to be **ASSESSED** for:

- TREATMENT READINESS and
- MOTIVATION.

**BRIEF INTERVENTIONS**

focused on pre-treatment

“**MOTIVATIONAL ENHANCEMENT**”

will help improve likelihood of success.

KEY ASSUMPTIONS about MOTIVATION:

• Most people are not completely ready for change!

• If people are not ready to change, we need to:
  • Help PREPARE them for CHANGE;
  • NOT PUSH them into changing when they are not ready.
KEY ASSUMPTIONS about MOTIVATION:

SIGNS OF PATIENT RESISTANCE are:

- Interrupting;
- Denial;
- Ignoring; or
- Arguing

These are clues to check our own behaviors, plans and expectations. Are we rushing ahead to action planning without first checking the patient’s level of readiness?

If so, we may be in a “CONFRONTATION-DENIAL TRAP” — inducing the patient to argue, interrupt, deny the problem, or ignore us.
A New Way of Communicating—Motivational Interviewing and Motivational Enhancement

• Confrontational vs. Motivational Styles—
  – It is not necessary for patients to “hit rock-bottom;”
  – It is not helpful to try to force patients to “accept their diagnosis” (label);
  – It is important for providers to avoid the “Confrontation-Denial Trap.”

• Motivation—
  – Brief Interventions focused on pre-treatment motivational enhancement will improve the likelihood of success.

• Readiness—Nurses can:
  – Help patients gain insight about the relationship between their AOD use and their medical conditions and negative life consequences (Discrepancy);
  – Help patients begin to consider or actually make behavior changes (Stages of change).
WELLNESS & RECOVERY
8 DIMENSIONS of WELLNESS

• Emotional—Coping effectively with life and creating satisfying relationships

• Environmental—Good health by occupying pleasant, stimulating environments that support well-being

• Financial—Satisfaction with current and future financial situations

• Intellectual—Recognizing creative abilities and finding ways to expand knowledge and skills

• Occupational—Personal satisfaction and enrichment from one’s work

• Physical—Recognizing the need for physical activity, healthy foods, and sleep

• Social—Developing a sense of connection, belonging, and a well-developed support system

• Spiritual—Expanding a sense of purpose and meaning in life
RECOVERY from Mental Disorders and/or Substance Use Disorders: Not Just ABSTINENCE

**DEFINITION:**
A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

**4 DIMENSIONS**
- Health
- Home
- Community
- Purpose

https://www.samhsa.gov/recovery
RECOVERY: Not Just Abstinence

- Recovery emerges from hope
- Recovery is person driven
- Recovery occurs via many pathways
- Recovery is holistic
- Recovery is supported by peers and allies
- Recovery is supported through relationships and social network
- Recovery is culturally-based and influenced
- Recovery is supported by addressing trauma
- Recovery involves individual, family and community strengths and responsibility
- Recovery is based on respect – recovering from addiction and psychiatric issues require bravery on the part of the individual. Communities and social systems that acknowledge this lessen the stigma associated with these disorders and offer people a healthier atmosphere in which they can get better and give back
PRELIMINARY RESULTS:
Using Data Regarding Nurses’ Attitudinal Barriers & SUDs Knowledge Deficits to Improve Nursing Curriculum
# Qualitative Themes and Curricular Revisions

(Incomplete Preliminary Data-Not Ready for Prime Time)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommended Curricular Revisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUDs patients are difficult to care for</td>
<td>Difficult behaviors and how they may lead to negative feelings in the nurse</td>
</tr>
<tr>
<td>“Lying” and “manipulation”</td>
<td>Appropriate responses to those behaviors, and how forming safe, trusting relationships help to reduce those behaviors</td>
</tr>
<tr>
<td>Safety and Workplace Violence</td>
<td>Violence prevention in health care facilities</td>
</tr>
<tr>
<td>Nurse-Patient Relationship</td>
<td>How to convey messages that the nurse understands the patient and accepts them</td>
</tr>
<tr>
<td>Stigma &amp; Cultural Competence</td>
<td>Stigma is counterproductive&lt;br&gt;Words and labels matter&lt;br&gt;Culturally competent nursing care</td>
</tr>
<tr>
<td>“Drug-seeking” Behavior and Pain Perception</td>
<td>Safe opioid prescribing&lt;br&gt;Tolerance &amp; Withdrawal&lt;br&gt;Pseudo-addiction</td>
</tr>
<tr>
<td>Mothers and Babies</td>
<td>Perinatal substance use &amp; NAS&lt;br&gt;Parental shame and perceived incompetence&lt;br&gt;Provider behavior can be counterproductive and interfere with recovery process and adequate maternal/child bonding</td>
</tr>
</tbody>
</table>
TAKE HOME MESSAGES FOR TODAY:

• ALL NURSES and ALL HEALTH PROFESSIONALS must have a **basic understanding of SUDs** in order to care for these individuals in their particular practice settings (CSAT, TAP #21)

• ADVANCED PRACTICE NURSES and OTHER MAT PRESCRIBERS need more advanced training ([www.samhsa.gov/medication-assisted-treatment](http://www.samhsa.gov/medication-assisted-treatment))

• Provider attitudes can inhibit one’s ability to provide adequate services to patients with SUDs (Goplerud, Hagle, McPherson, 2017)

• **Any door is the right door.** In integrated care, treatment must have multiple points of entry. There is no wrong door to recovery (SAMHSA, 2006)
What if behavioral health problems and specialty referrals were addressed like other types of health care problems?
For questions, please contact:

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Dept. of Family & Community Health

President-Elect, International Nurses Society on Addictions-IntNSA (2016-2018)
(President, 2018-2020)  www.intnsa.org

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