Practice guided learning

KEYWORDS DRUG USE | SUBSTANCE USE | SUBSTANCE USE PROBLEMS | TREATMENT OPTIONS

Substance use 2: nursing assessment, management and types of intervention

Exploring how nurses can assess patients with suspected substance use problems, and how to approach interventions and treatment options with patients

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This second in a two-part unit on substance use examines how nurses can assess patients and look at the treatment options with them. Part 1 examined the extent of the problem, commonly used drugs and why people use them.

INTRODUCTION

Use of substances is part of many people’s lives and will not lead to a health problem. It is important for all nurses to be able to identify those people at risk of developing a problem and understand their role in managing that person’s care.

Nurses can be tempted to think that someone is dependent by focusing on the issue of intoxication. Although this is a part of dependency in itself, the signs or symptoms of intoxication do not provide the whole picture.

Equally important is to find out what happens to the person if they do not have their drug of choice. That is, do they experience withdrawal effects? Are they preoccupied with the substance? Do they seek an alternative?

It is helpful to differentiate between physical and psychological dependence. Rassool (1998) defined psychological dependence as ‘a compulsion or a craving to continue to take a drug because of the need for stimulation, or because it relieves anxiety or depression’.

Physical dependence was defined as ‘…a state of bodily adaptation to the presence of a particular psychoactive drug. This manifests itself in physical disturbances or withdrawal symptoms following cessation of use. The withdrawal symptoms depend on the type or category of drug’ (Rassool, 1998).

Dependency is defined and diagnosed using criteria found in manuals such as the International Statistical Classification of Disease (World Health Organization, 2007) (see Box 1 for a summary).

ASSESSMENT

A range of screening and assessment tools can be used with substance users.

One example is the Leeds Dependence Questionnaire (Raistrick et al, 1994), a 10-item assessment used to measure the severity of dependence on both drugs and alcohol. This is easy for nurses to use or for patients to complete independently. It is quick and can be used both in hospital settings or the community.

Another easy-to-use questionnaire is the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al, 1993). Coulton et al (2006) showed this 10-item questionnaire is valid and reliable in detecting people at risk of developing problems with alcohol. Each item is scored from 0–4; a score of eight or more is associated with harmful or hazardous drinking. A score of 13 or more in women and 15 or more in men is likely to indicate alcohol dependence.

While assessment tools are a valuable aid for nurses, engaging in a conversation about substance use and its impact on the individual is important. They should not just carry out an assessment and move on to the next person or task.

Biological testing methods include urine, blood, saliva and hair analysis. These can be problematic as drugs are metabolised and excreted from the body at different rates. Cocaine can be metabolised in three hours so collecting a sample after this period could give a false negative.

In addition, most biological tests can be adulterated and are expensive to process; a typical urine analysis will cost £30–£40. For many nurses and patients, these tests create mistrust. A clear rationale for using them needs to be made.

PHYSICAL HEALTH

There are many aspects of substance use that have an impact on patients’ physical health. It is vital that this forms part of the assessment process or discussion.

There are well-documented links between intravenous substance use and the risk of bloodborne viruses such as hepatitis and HIV, or alcohol and cirrhosis of the liver.

However, there are many other – sometimes less obvious – factors that have an impact on patients’ physical health.

As psychoactive substances change

BOX 1. SUMMARY OF ICD 10 CLASSIFICATION FOR DEPENDENCY

Three or more of the following:

● A strong desire or sense of compulsion to take the substance;
● Difficulties in controlling substance-taking behaviour in terms of its onset, end or levels of use;
● The substance is often taken in larger amounts over a longer period than was intended;
● Any unsuccessful effort or a persistent desire to cut down or control substance use;
● Increased amounts of time needed to obtain or take the substance or recover from its effects; also progressive neglect of alternative pleasures or interests;
● Persisting with substance use despite evidence of overtly harmful consequences.
Dual diagnosis is the term used to describe someone who is using substances harmfully and has a mental health problem such as anxiety, depression or psychosis. Both conditions are routinely not diagnosed in this patient group.

Over recent years, this area has received increasing attention as policymakers, clinicians, researchers and commissioners try to improve access and treatment options for people with a dual diagnosis.

Many nurses lack confidence or feel they do not have the necessary skills to help such patients, but all the techniques that are discussed in this article can be used by nurses to help people with dual diagnosis.

Perception and thinking, people using them can be more likely to have accidents. So, although a person may come into contact with a nurse because of a cut or fracture, it could be that it is the result of their behaviour while under the influence of the substance.

There are specific risks to patients' physical health from individual drugs or the route by which they are used.

As cannabis is mainly smoked with tobacco, there are the same associated risks to health as with tobacco, such as heart disease, cancer and respiratory problems.

However, when cannabis resin is inhaled with tobacco, the risks increase, particularly to the respiratory system. As the resin has a higher combustion temperature and most people do not use a filter, three times the amount of tar is inhaled. This increases the risk of bronchitis, emphysema and other respiratory problems (Taylor et al, 2000).

The Department of Health’s Talk to Frank website (www.talktofrank.com) is a useful source on the individual physical risks of each substance.

DUAL DIAGNOSIS

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**Figure 1. Cycle of Change**

Source: Prochaska and DiClemente (1983)
the majority of nurses in any setting.

Turning Point (2007) provides useful examples for practitioners in its good practice guide. All the services listed are willing to share resources and welcome contact from those who would like more information.

CYCLE OF CHANGE

Nurses need to understand how people make changes in their lives. Prochaska and DiClemente (1983) first described a model of change called the ‘cycle of change’, which has six stages (Fig 1, p15).

It can be useful to discuss this model with patients to help them understand the process, and ask where they think they are. Then nurses can discuss how they can move from, for example, thinking about changing to making the decision to change.

Practitioners should also find out what support they can offer in this – it could be encouragement or practical help such as advising on or providing the options for any available substitute, such as nicotine patches for smokers.

MOTIVATIONAL INTERVIEWING

Having the motivation to change is an important factor. We can all relate to this by thinking about a change we have made in our lives and what the motivation for that change was.

Motivation fluctuates in us all; none of us can be described as either motivated or demotivated, and therefore neither can patients be described in this polarised way.

Miller and Rollnick (2002) have been influential in our understanding of motivation and defined it as: ‘Motivation can be understood not as something that someone has, but as something that someone does, involving recognising a problem, finding a way to change, and then starting and sticking with that change strategy.’

Miller and Rollnick developed motivational interviewing (MI) as a technique that aims to change behaviour, and which is based on the relationship between the worker (nurse) and the individual.

They believe that it is the patient who has the potential solution and, by working with them, practitioners can encourage them to identify the change that needs to be made and how this can be achieved.

Recognising this and by adopting a non-confrontational or expert stance, nurses can reduce resistance from patients. We all know that no one wins an argument, so simply challenging patients’ substance use is unlikely to change their behaviour.

Miller and Rollnick described a normal state of ambivalence in us all, in that we recognise what it might be good for us to do but are comfortable with our familiar routine. So, we might know that it would be good to lose some weight but we hate exercising.

To maximise the potential in any intervention, including motivational interviewing, nurses and patients need to be at the same ‘point’. This is achieved through genuine respect for and valuing each others’ views. Nurses can foster this by thinking of the relationship as collaborative, and where each person has the ability to find a solution to their problem.

DECISION BALANCE SHEET

It can be difficult to ask patients about their substance use if nurses personally disagree with what they are doing. Although professionally practitioners try to treat everyone equally, people who use substances are adept at knowing how workers view them. One simple and neutral way to begin the conversation around substance use is to use the decision balance sheet (Janis and Mann, 1977).

For example, nurses can ask a person to describe the advantages and disadvantages of using cannabis, in both the short term and the long term. Using this technique allows them to explore the person’s perceived view of the substance and also the relationship they have with it.

There are no right or wrong answers, as it is the individual’s view that nurses are keen to explore. Practitioners may disagree with the person who believes that cannabis helps them think more clearly – but this is an important piece of information that gives some key information about a part of a patient’s life. Nurses should weigh up the risks and benefits of challenging patients’ views, bearing in mind the risk of alienating them.

The decision balance sheet has potential for keeping the conversation open and exploring the person’s views or the importance they attach to aspects of their substance use.

HARM REDUCTION

Harm reduction or harm minimisation aims to reduce the harm that substance users do to themselves or others.

This could include interventions such as needle-exchange schemes, where, for example, intravenous heroin users have the opportunity to exchange their used syringe for a new one. This helps to reduce the potential harm to the individual of infection or abscess. It also has benefits for the community, through the safe disposal of used syringes and paraphernalia and a potentially reduced risk of bloodborne viruses spreading. Such schemes are now widely available through high-street pharmacies and specialist drug teams.

Substitute prescribing is another method of minimising harm. Patients who are dependent on heroin can be offered alternative drugs such as methadone.

There are several potential advantages. The person can stop using heroin without experiencing the discomfort of withdrawal symptoms. The criminal behaviour associated with heroin use is reduced in two important ways – first by the switch to a prescribed drug from an illegal one, and second by potentially reducing criminal activity to raise the money to buy heroin.

In addition to reducing social harms, this method also has the potential to reduce physical and psychological harm, as the quality and dose of methadone is known compared with the variable purity and quality of heroin.

Equally important, patients are put in contact with services that can offer additional
assessment and treatment beyond methadone prescriptions. Although traditionally substitute prescribing has been done by medical colleagues, increasing numbers of nurses are taking on this role with the advent of independent prescribing.

There are other ways of reducing harm that nurses can think about and encourage patients to try. Many substance users will lack confidence about their ability to change – perhaps having tried to do so in the past and not succeeded – so building confidence is key.

Nurses can help by ensuring the proposed change is realistic and incremental. This could be a small step, such as encouraging someone to put their drink down for a minute rather than hold it, or to extend the time between drinks, or changing drinks from 8% alcohol to those with 5% alcohol.

By engaging in this change, the first step has been taken and the person can see it is possible to change, so they are less likely to feel trapped or powerless.

**BRIEF INTERVENTIONS**

Brief interventions include giving advice, being empathic and providing feedback about risk behaviour. It also includes much of what has been outlined so far.

These types of interventions have been shown to be effective, even though they are often opportunistic and quick (Nilsen et al, 2008). They give every nurse the opportunity to play an important role in this area.

**DETOXIFICATION**

For some patients, there is the option of detoxification with the aim of achieving abstinence. Traditionally, this required admission to hospital or a specialist residential treatment centre. Although this may be the only option for some people, because of the potential risks and the need to be monitored more closely, for many patients a community detoxification programme is appropriate.

Nurses can contact their local drug action team to find out which services are available locally and how they can refer someone to them (see http://drugs.homeoffice.gov.uk).

**THE 12 STEPS**

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are the most widely recognised sources of help. These organisations are run on the self-help model and focus on achieving abstinence. Recovery is achieved by working through 12 steps.

Meetings are available where people can share their experiences and gain support through a sponsor system. The sponsor is a person who is drug or alcohol free and can act as a ‘buddy’.

The Alcoholics Anonymous website (www.alcoholics-anonymous.org.uk) gives further useful information about where meetings are and their aims.

For more details on Narcotics Anonymous, see www.ukna.org.

**MODELS OF CARE**

The National Treatment Agency for Substance Misuse is responsible for drug treatment in England, and introduced Models of Care for drug users in 2002, which was updated later (NTA, 2006; 2002).

This guidance stipulated that all clients coming into contact with drug treatment services should have the following:

- An assessment;
- A care plan;
- A care coordinator;
- Regular review.

In 2006, the equivalent guidance for alcohol services was introduced: the Models of Care for Alcohol Misusers (NTA, 2006).

**CONCLUSION**

Given the scale of substance use in our society, all nurses have a role in assessing and managing problems.

Several factors will influence how they carry out that role. These include nurses’ attitudes to people who use substances, their confidence and knowledge in knowing what to do, and whether someone is ready to make a change in their life.

Keeping the belief that everyone has the capacity to change is the key.