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Ministry of Health and Population

General Secretariat of Mental Health and Addiction Treatment

وزارة الصحة والسكان

الأمانة العامة للصحة النفسية وعلاج الإدمان

Nursing Training Manual for Substance use Treatment

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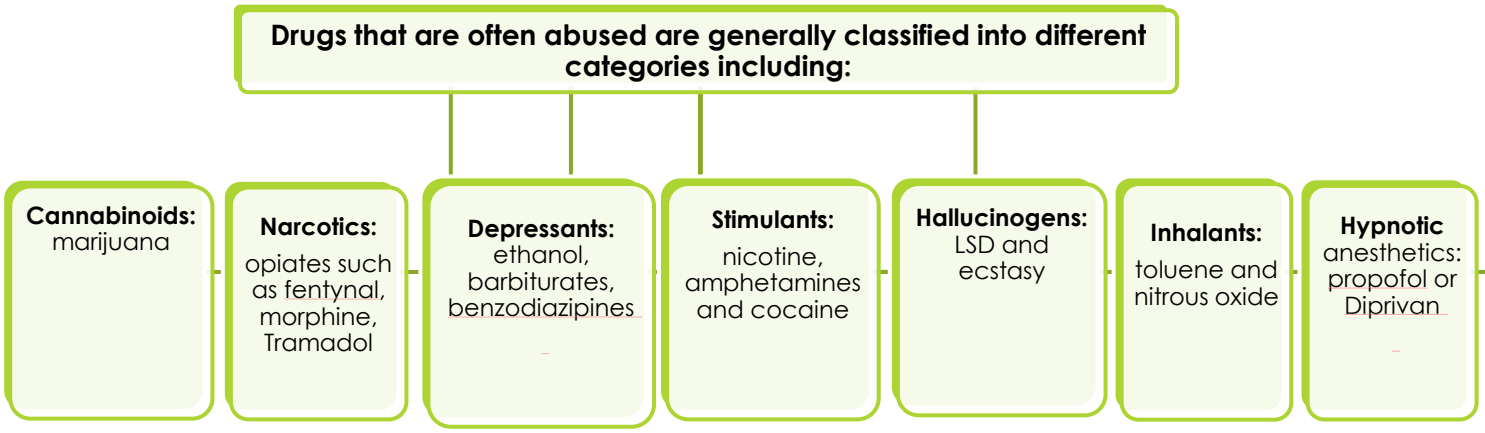
INTRODUCTION

- **What is Addiction?**

"Drug addiction is a brain disease that can be treated. It is an altered physiologic state due to repeated administration of a drug, the cessation of which results in a specific syndrome."



- These substances, along with alcohol, can produce a feeling of pleasure, relaxation or relieve negative feelings.

- As the dependence or addiction progresses, the benefits of using substances decreases and more drugs or alcohol are needed to feel the same level of pleasure.

- **What are the risk factors, especially those that tend to make all individuals more susceptible to developing a substance use disorder?**

1. **Biological factors:**
   - There is a genetic component that is influenced by environmental and social factors.
   - It is estimated that genetic factors account for 40 to 60 percent of a person's vulnerability to addiction.

2. **Psychological factors:**
   - Depression
   - Anxiety
   - Low self-esteem
   - Low tolerance for stress
   - Other mental disorders (e.g. learning disabilities)
   - Feelings of hopelessness
   - Loss of control over one's life
   - Feelings of resentment

3. **Social factors:**
   - Expectations about the positive effects of the drugs and alcohol
   - Access to or an availability of drugs
   - Peers using alcohol and drugs
   - Poor interpersonal relationships

4. **Demographic factors:**
   - Male gender
   - Low socio-economic status
   - Unemployment

5. **Behavioral factors:**
   - Use of other substances (e.g. nicotine)
   - Aggressive behavior in childhood
   - Conduct disorder
   - Impulsivity and risk-taking behavior
   - School-based academic or behavioral problems (including dropping out, involvement with the criminal justice system or the first illegal use at an early age)

The role of nurses in the stages of treatment of addiction

Stages of the treatment plan:

Stages of recovery:

1. Withdrawal symptoms 1-2 weeks
2. Early Recovery (Honeymoon) 4 weeks
3. Extended recovery phase (the wall) 12-16 weeks
4. Adaptation phase more than 16 weeks

1) <u>Stage of withdrawal symptoms:</u>

- Lasts from one to two weeks
- Characterized by the occurrence: mood disorder, loss of energy, sleep problems, problems with concentration, many irritations (direct and indirect).

Causes of relapse:

- For many cheers
- Hard mood
- Sleep problems
- Lack of time
- The presence of nearby stimuli (people, things, places)
- Fear of withdrawal symptoms

Nursing homes and how to overcome them:

- Make a daily schedule
- Helps avoid stimuli
- Helps to implement the principle of the day only
- Helps reduce anxiety and improve mood
- Reverses addictive lifestyle and ensures continuity

Mistakes:

- Unreasonable, unbalanced table
- Develop a daily schedule by others
- Lack of support from those around

2) <u>Early Recovery (Honeymoon)</u>

- 4 weeks
- Features: Increased activity, enthusiasm and optimism
- Individuals may feel at this time that healing has been.

Causes of relapse

- Overload, overwork and compensation
- Lack of concentration and stress.
- Memory problems
- Feelings are excessive and volatile
- Fear of being overweight

- People and places (stimuli)
- Inability to prioritize
- Full recovery, treatment ceased

Nursing homes and how to overcome them:

- Stop thinking ___ Attention to thoughts and agitation
- Behavioral cognitive distraction
- Help the patient to relax
- Help him participate

3) <u>Extended Recovery Stage (Wall):</u>

- Stretching from 12-16 weeks
- The harder the stages of recovery, the more prone to relapse
- Dysuria, excess nervousness
- Problems with concentration and stress
- Loss of confidence
- Despite the continuing change and recovery features

Causes of relapse

- Problems in personal relationships
- Loss of the recovery system
- Loss of motivation and constant stress
- Loss of feeling of comfort and happiness
- Justification of relapse and old behaviors
- Substitution

Justification for relapse:

- They pushed me to relapse (my wife, my brother, my friends, my manager)
- You need drugs for this reason (passport, divorce, weight gain, happiness)
- I was testing myself (I see work better, I see my friends, ...)
- It's not my fault.
- It was an accident and got and salvation (I went Farah ....)
- I felt that I am not valuable (depressed ....)

The role of nursing in how to overcome:

- Continued follow-ups and meetings
- Continuous participation
- Continued recovery system

4) <u>Adaptation phase:</u>

- More than 16 weeks
- The individual returns within the family in a normal lifestyle
- Start thinking about compensation, relationships, marriage and work
- A sense of achievement and continued change

Causes of relapse:

- Substitution
- A sense of healing and increased confidence
- Loss of recovery system
- Non-acceptance of addiction and its stages and recovery and stages as a chronic treatment

Nursing homes and how to overcome:

- Instruct the patient to balance between:
    - the work
    - joy
    - relations
    - Recover
    - Spirituality
    - Health and sleep

The role of nursing in evaluation:

- Personal history of the patient.
- The history of abuse in detail.
- History of treatment and previous relapses.
- Analysis of current relapse.
- The role of nursing in psychological education:
- Explain to the patient the following:
    - Disease, its nature,
    - Treatment and its stages
    - Relapse keys
    - Identify relapse keys for each patient and develop a plan to deal with them

The role of nursing in dealing with eagerness:

- Encourage the patient to join activities completely away from the substance
- Encourage the patient to talk about passion
- Deal with the idea of encouraging the patient to
- Stop thinking about helping the patient to
- Talk to a friend or fellow of the recovering
- Talk to a psychotherapist encouraging the patient to
- Praying encourage the patient to

The role of nursing in psychological rehabilitation:

- Help the patient to:

Replace the pleasure of drugs with healthy fun.....

Treatment of the patient socially..... This process aims to reintegrate the addict into the family and society, and treatment here depends on improving the relationship between the parties addicted on the one hand and the family and society on the one hand and

help the addict to restore the confidence of his family and his community and give him a new opportunity to prove his seriousness and his keenness to heal and life Natural.

- Family therapy.

The role of parents in dealing with relapse and help prevent it:

- Explain the nature of the disease and relapse to parents.
- Talk to them about past setbacks.
- Find out their observations about the keys to the patient's relapse.
- Work with them to prevent subsequent setbacks.

Three Foundational Concepts

These are three core nursing foundational concepts that act as a frame-work that guides therapeutic interaction between nursing staff and the substance use disorder patients.

1. Therapeutic Relationship
2. Recovery Perspective
3. Harm Reduction

1. Therapeutic Relationship

"Therapeutic Relationship" describes:

A relationship that occurs between a client and the nurse that is goal-directed and works towards advancing the best interest for the client.

"Therapeutic Relationship" focuses on:

- The definition and theories which influence the nurse-client therapeutic relationship.
- Recognize and understand different phases of the therapeutic and non-therapeutic relationship.
- Recognize professional boundaries, counter transference, transference, and power dynamics of the nurse-client therapeutic relationship.
- Understand and implement effective therapeutic communication skills (i.e., listening, respect, empathy) in assessment and care planning.
- Promote cultural competency and safety in therapeutic relationships.

Examples:
Key qualities of a therapeutic relationship include active listening, trust, respect, genuineness, empathy, and responding to client concerns.

"Therapeutic Relationship "questions nurses should be able to answer during their interaction with clients:

- How would you know that you have established a therapeutic relationship?
- What do therapeutic boundaries look like in different settings/situations?
- Which boundaries never change?
- When is it okay to touch? When is it okay to use humor?
- How do you terminate the therapeutic relationship?
- How would you determine if the client's needs are being met?
- How do you address observed boundary violations between other clinicians and clients?
- How long can you sit without saying anything? (the importance of silence).

"Therapeutic Relationship" recommendations:

1. Establishment of a therapeutic relationship requires reflective practice. This concept includes: self-awareness, empathy, awareness of boundaries.
2. Understand the process of a therapeutic relationship and be able to recognize the current phase of his/her relationship with the client.
3. The nurses' workload is maintained at levels suitable to develop therapeutic relationships.
4. Staffing decisions must consider client acuity, complexity level, and the availability of resources.

2. Recovery Perspective

"Recovery Perspective" describes:

- A process in which people living with mental health issues are actively engaged in their own journey of well-being and live a satisfying, hopeful, and contributing life, even when mental health problems cause ongoing limitations.
- Recovery journeys build on individual, family, cultural, and community strengths and can be supported by many types of services, and treatments.

"Recovery Perspective" focuses on:

- Definitions and principles of recovery.
- Understand concepts related to dignity, hope, empowerment and resilience.

- Identify differences between medical model versus recovery models.
- Identify barriers and facilitators to recovery.
- Acknowledge the importance of experiential knowledge (i.e. lived client experience).
- Identify strategies to promote recovery.

"Recovery Perspective" questions nurses should be able to answer during their interaction with clients:

- Who defines recovery?
- Does recovery mean that you no longer have an illness?
- What is the difference between medical care versus recovery care?
- What are the benefits of peer support?
- How would you promote informed choice to clients in care planning?
- How do you balance autonomy with beneficence?
- How do we promote recovery to a client who is hospitalized against their will (e.g. by court order)?
- How would a nurse engage in a conversation about what brings meaning to someone's life?

"Recovery Perspective" recommendations:

- Understanding that each individual has a right to design their own path towards wellness.
- Honoring diversity and being culturally responsive and safe.
- Building positive environments that address clients' true needs and fostering a language of hope.
- Expectations for recovery should be adjusted according to the severity of a person's illness
- Acknowledging that recovery is:

a. A long-term process of internal change and that are processed through various stages.
b. Personal and unique to each individual.
c. An ongoing process of refining oneself and learning to accept one's vulnerabilities, overcoming stigma, regaining hope and control in one's life.
d. Involves becoming engaged in meaningful social activities and community.

3. Harm Reduction

"Harm Reduction" describes:

An approach to practices, programs, and policies that aim to reduce the adverse health, social, and economic consequences of substance use without requiring individuals to abstain from substance use.

"Harm Reduction" focuses on:

- Key principles of harm reduction.
- Identify harm reduction approaches in practice.
- Harm reduction does not exclude abstinence as an option
- Harm reduction supports individual's physical and mental health (e.g., engaging in unprotected sex, or driving after drinking).

Examples:
The aim of a harm reduction approach is to reduce the negative consequences of risky behaviors, including the harmful effects of substance use.

"Harm Reduction" questions nurses should be able to answer during their interaction with clients:

- What are the benefits and barriers of a harm reduction approach?
- What is the difference, similarity, and relationship between harm reduction and abstinence?
- What is an example of harm reduction safe sexual practices?
- Does handing out condoms promote sexual activity?
- Do needle exchange programs promote drug use?

"Harm Reduction" recommendations:

- Accept that at any given time some people are not ready to choose abstinence.
- Accept that substance use occurs in society and work to minimize its harmful effects.
- Integrate principles of harm reduction when working with clients who use substances and when treating those at risk.
- Before integrating the principles of harm reduction, nurses must be aware of and address their own attitudes and biases.

Three Mental Health Skills

Three Mental Health Skills that should be applied during the first encounter with substance use client.

1. Mental Health Screening(MHS)
2. Suicide Risk Assessment and Self-Harm
3. Crisis Intervention

1. Mental Health Screening (MHS)

Mental Health Screening (MHS) describes:

A structured assessment of client's current cognitive, affective and behavioral functioning.

Mental Health Screening (MHS) focuses on:

- Understand the purpose of the MHSin relation to assessment and care planning.
- Identify the different components of the MHS.
- Be able to perform and document an MHS.
- What are the benefits and challenges of conducting an MHS?
- When should the MHS be conducted?
- Discuss how the MHS contributes to the health assessment.
- What elements of the MHSrelate to risk?

Mental Health Screening (MHS) questions:

APPENDIX: Mini-mental state examination (MMSE)

"Mental Health Screening (MHS)" questions nurses should be able to answer during their interaction with clients:

- What causes mental illnesses (e.g., depression)? (e.g. hormonal, medication side effects).
- What medical illness(es) are you at higher risk of because of addiction?
- What mental illness(es) are you at higher risk of because of addiction?
- What is a concurrent disorder?
- What is the nurse's role in the acute phase of illness? What is the nurse's role in rehabilitation?
- What assessments are completed to determine changes in the mental status?

Mental Health Screening (MHS) intervention:

- Learn about co-morbidities, and levels of disability related to mental disorders.
- Identify potential cognitive deterioration (e.g. delirium) especially during intoxication, detoxification or as side effects to certain psychotropics.
- Identify the potential for mild cognitive deficits associated with the use of drugs.
- Screening to determine whether particular problems may be present, which may indicate the possible degree of addiction severity.
- It is important to introduce a screening tool in a non-threatening way, which will help reduce anxiety.
- After using the screening tool, it is important to give individualized feedback about the results.
- Notification to treating physician for intervention, in case of presence of concurrent psychiatric symptoms or cognitive deterioration.
- If it is determined that the client has a coexisting substance disorder and mental illness, he or she may be assigned to a special program that targets both problems.

2. Suicide Risk and Self-Harm Assessment

"Suicide Risk and Self-Harm Assessment" describes:

- Self-harm is the expression of inner pain, hopelessness and helplessness experienced by people.
- Self-harm can be due to suicidal thoughts, a coping mechanism, or to simply feel better and get relief from pain

"Suicide Risk and Self-Harm Assessment" focuses on:

- Understand the prevalence, risk factors, and language of suicide and self-harm.
- Understand the purpose of and differences between suicidality and self-harm behaviors.
- Identify the components of the suicide risk/self-harm assessment.
- Perform and document a suicide risk assessment/self-harm assessment.
- Develop a safety plan in collaboration with the client (Appendix).

Examples:
Skills to integrate suicide risk, self-harm assessment and developing a safety plan in addiction.

"Suicide Risk and Self-Harm Assessment" questions nurses should be able to answer during their interaction with clients:

- How would you explore the client's spiritual and beliefs about death?
- Does age, gender, or additional health concerns make a difference in terms of attitude regarding suicide?
- How might our beliefs about suicide play out in our interactions with clients?
- Can talking about suicide cause suicide?
- What's the difference between suicide and self-harm?
- What might it mean if a person is engaging in "cutting behaviors" to deal with stress?

"Suicide Risk and Self-Harm Assessment" intervention:

- A comprehensive assessment of risk involves interviewing the client, reviewing the medical records and/or gathering information from family.
- A clinical interview and valid and reliable assessment tools may beused to gather information specific to:
    a. Presence of risk factors.
    b. Lack or presence of protective factors (e.g., spirituality, hope).
    c. Suicidal intent.
    d. Plan and its lethality.
    e. Access to means.
    f. Time frame.
    g. Hope.
    h. Previous suicide attempts.

- Nurses need to develop safety plans in collaboration with clients.
  (A safety plan indicates how clients should respond to their suicidal urge by outlining coping and problem-solving skills).

- APPENDIX: A template of a safety plan

3. Crisis Intervention

"Crisis Intervention" describes:

- A crisis: "An emotional upset, arising from situational, biological, psychological, socio-cultural, and/or spiritual factors".
- This state of emotional distress results in a temporary inability to cope by means of one's usual resources and coping mechanisms.
- Unless the crisis is alleviated, major disorganization may result.

"Crisis Intervention" focuses on:

- The definition of a psychiatric/addiction crisis and relevant frameworks regarding crisis intervention.
- Identify mental distress.
- Have a basic understanding of mental health first aid.
- Have the ability to intervene to support a client experiencing a crisis.
- Identify individualized triggers, strengths and resilience.
- Understand care planning strategies to prevent and support people through crises.

"Crisis Intervention" questions nurses should be able to answer during their interaction with clients:

- What makes a crisis? Who defines it?
- At what point does a crisis become an emergency?
- How would you engage in a conversation about crisis prevention and management?
- What happens to your attention and cognitive functions when you are in crisis?

"Crisis Intervention":

- Implicate crisis intervention strategies in routine client care
- Offer the client community resources that can be used in crisis
- Perform risk assessment to a client in crisis
- Find opportunities that might unfold as a result of a crisis
- Completed safety and comfort plan—Appendix

Eleven Functional Health Patterns Assessment

These are eleven functional health assessments that are supposed to be applied each follow up session, for accurate management of clients.

1. Health Perception - Health Management Pattern
2. Nutritional - metabolic pattern
3. Elimination pattern
4. Activity and exercise pattern
5. Sleep Rest Pattern
6. Cognitive -Perceptual Pattern
7. Self-Perception -Self- Concept Pattern
8. Role- relationship pattern
9. Sexuality- productivity pattern
10. Coping -Stress Tolerance Pattern
11. Value- Belief Pattern

1. Health Perception Health Management Pattern

Health perception Health Management Pattern describes:

- Client`s perceived pattern of health and wellbeing and how health is managed.

Health perception - health management Pattern focuses on:

- The person's perceived level of health and well-being, and on practices for maintaining health. Also evaluates habits including smoking and alcohol or drug use.
- Contamination and risk for contamination
- Effective therapeutic regimen management
- Readiness for enhanced therapeutic regimen management
- Health -seeking behaviors (specify)
- Noncompliance.
- Risk for infection.
- Risk for injury.
- Risk for preoperative positioning injury.
- Risk for poisoning.
- Risk for suffocation.
- Risk for trauma.

Examples:

- Compliance with medication regimen, use of health promotion activities such as regular exercise, annual checkups.

Health Perception Health Management Pattern questions:

How the person describes his current situation?

- What do you do to stay healthy?
- Do you drink alcohol or use tobacco products?
- Do you have regular checkups with your physician? Do you listen to and follow any suggestions made by your health care provider?
- Have there been any problems illness or injuries in this person`s life?
- Can the person report the names of current medications he is taking and their purpose?
- If this person has allergies, what does he do to prevent problems?
- What does the person know about links between lifestyle choices and health?
- What does the person do to improve or maintain his health?
- How big is the problem to finance health care for this person?
- In general, how is the family`s health?
- What does this person know about medical problems in family?

Health Perception Health Management Pattern intervention:

- The number of leukocytes was followed for three days.
- Hands were washed after touching patients.
- Gloves wore when needed.
- Patient was advised about their diet and liquid intake.
- Health education about IV injection risks.

2. Nutritional - metabolic pattern

Nutritional - metabolic Pattern describes:

- Pattern of food and fluid consumption relative to metabolic need and pattern.

Nutritional - metabolic Pattern focuses on:

- The pattern of food and fluid consumption relative to metabolic need.
- Nausea.
- Appetite.
- Impaired dental integrity.
- Impaired oral mucous membrane.
- Impaired skin integrity.
- Deficient fluid volume.
- Excess fluid volume.
- Readiness for enhanced fluid balance.
- Risk for deficient fluid volume.
- Hyperthermia.
- Hypothermia.
- Imbalanced nutrition: more than body requirements.
- Imbalanced nutrition: less than body requirements.
- Readiness for enhanced nutrition.
- Impaired swallowing.
- Risk for aspiration.
- Risk for impaired liver function.
- Risk for unstable blood glucose.

Example

- Condition of skin, teeth, hair, nails, mucous membranes, height and weight.

Nutritional metabolic pattern questions:

- Describe the daily food intake for you and your family? Do you consider yourself and your family healthy eaters?
- Describe the daily fluid intake for you and your family? Do you drink alcohol?
- Do you consider yourself over or under weight? Is there any unexplained weight gain or loss?
- Do you suffer from any digestive problems (e.g. nausea)?
- Do you have any discomfort or diet restrictions?
- Do you have any problems with liver and kidney functions?
- Do you suffer from any dental problems?
- Do you have any trouble swallowing?
- Do you have any problems with your blood glucose level?
- Are you allergic to any type of food?
- Do you receive any drugs that may affect gastrointestinal function for example cause drying of saliva or delayed gastric emptying?
- Do you have any past history of parenteral feeding (specify)? Why?

Nutritional metabolic pattern intervention:

- Monitor the patient's nutritional intake.
- Assess height, weight, activity and rest level.
- Note the condition of the oral cavity.
- Note the total daily calorie intake; maintain a diary of intake, as well as times and patterns of eating.
- Evaluate energy expenditure and establish an individualized exercise program.
- Provide opportunity to choose foods and snacks meeting dietary plan.
- Monitor weight weekly.
- Consult with dietitian.
- Review laboratory studies as indicated (e.g. glucose, serum albumin and electrolytes).
- Refer for dental consultation (if necessary).

4. Elimination pattern

Elimination pattern describes:

- Excretory function (bowel, bladder, and skin).

Elimination pattern focuses on:

- Diarrhea.
- Constipation.
- Urinary incontinence.
- Urinary retention (acute / chronic).
- Diaphoresis

Example

- Frequency of bowel movement, voiding pattern, pain on urination, appearance of urine and stool and excessive sweating.

Elimination pattern questions:

- Describe regular bowel elimination for you? Frequency? Character? Discomfort (pain)? Difficulty (constipation / diarrhea)?
- Describe regular urinary elimination pattern for you? Frequency? Discomfort (pain)? Problems with control (incontinence / retention)?
- Do you suffer from excessive perspiration?

Elimination pattern intervention:

- Record the elimination times, frequency and characteristics of stool.
- Restrict certain types of food (if indicated), e.g. caffeine, too much oil, fiber, milk, salt and carbohydrates.
- Start intravenous replacement (if indicated).
- Ask doctor to administer anti-diarrheal agents/ antibiotics (if indicated).
- Educate for what to do in case of diarrhea or with family members to prevent dehydration.

5. Activity and exercise pattern

Activity and exercise pattern describe:

- Exercise, activity, leisure, and recreation.

Activity and exercise pattern focus on:

- The activities of daily living, including self-care activities, exercise, and leisure activities.
- Fatigue.
- Decreased cardiac output.
- Delayed surgical recovery.
- Ineffective airway clearance.
- Ineffective breathing pattern.
- Ineffective tissue perfusion.
- Impaired spontaneous ventilation.
- Impaired physical mobility.
- Impaired bed mobility.
- Impaired transfer ability.
- Impaired walking.
- Self-care deficit.
- Readiness for enhanced self-care.
- Risk for activities intolerance.

Example:

- Exercise and hobbies may include cardiovascular and respiratory status, mobility, and activities of daily living.

Activity and exercise pattern questions:

- Do you exercise? What type? How often? If not, why?
- What do you like to do in your spare time?
- Do you suffer from any problems with the motor system?
- Do you suffer from any respiratory problems?
- Do you suffer from any defect in healing wounds?
- Do you suffer from any problems with growth and development?
- Are you receiving or having past history of muscle-bulking agents as anabolic steroids? What is the dose and pattern of use?
- Do you use drugs that may affect coordination of movement and muscle activity or have sedative side effects? Which type? What is the dose and pattern of use?

Activity and exercise pattern intervention:

- Encourage the patient to maintain a 24-hour fatigue or activity log for at least 1 week.
- Help the patient with developing a schedule for daily activity and rest.
- Emphasize the importance of frequent rest periods.
- Assist the patient with setting priorities for preferred activities and role responsibilities.
- Promote sufficient nutritional intake.
- Encourage an exercise conditioning program (if needed).
- Encourage the verbalization of feelings about the impact of fatigue.
- Help the patient to develop habits promoting effective rest/sleep patterns.

6. Sleep Rest Pattern

Sleep Rest Pattern describes:

- Patterns of sleep, rest, and relaxation.

Sleep – Rest Patternfocuses on:

- The person's sleep, rest, and relaxation practices.
- Careful assessment of environmental factors and of the patient's bedtime routine is necessary before recommending drug therapy.
- To identify dysfunctional sleep patterns, fatigue.
- Insomnia.
- Sleep deprivation.
- Readiness for enhanced sleep.

Examples:

- Clients' perception about sleep quality, quantity and energy, sleep aids and routines clients use.

Sleep - Rest Patterns Questions:

- Do you feel that you are generally well rested and able to perform your daily activities?
- How well do you fall asleep? Stay asleep? Do you use any aids to help you sleep?
- Do you awaken feeling rested and refreshed?
- Describe to the patient the sleep-wake cycle.
- Does this person appear physically rested and relaxed?
- Do you take medications with CNS stimulating effects which interfering with sleep (e.g. Theophylline, Ritalin)?

Sleep - Rest Patterns intervention:

- Care interventions were made before patient sleeps.
- Practicing relaxation techniques before sleep.
- Light and noise were minimized in the room.
- Advice patient to Apply sleep hygiene steps
- Daylight sleep was minimized.

7. Cognitive -Perceptual Pattern

Cognitive perceptual Pattern Describes:

- Sensory perceptual and cognitive patterns.

Cognitive perceptual Pattern focuses on:

- The ability to comprehend and use information by the sensory functions.
- Sensory experiences such as pain and altered sensory input.
- Disturbed sensory perception.
- Confusion.
- Acute pain.
- Chronic pain.
- Decisional conflict.
- Readiness for enhanced decision making.
- Deficient knowledge.
- Disturbed thought processes.
- Impaired memory.
- Readiness for enhanced comfort.
- The ability of the individual to understand and follow directions

Examples:

- Vision, hearing, taste, touch, smell, pain perception and cognitive functions such as language, memory and decision making.

Cognitive -Perceptual Pattern questions:

- How educated is this person?
- Do you have any hearing difficulty?
- Do you have any visual difficulty? Do you have routine eye exam?
- How do you learn best? Preference for visual or audio aids? Do you have difficulty learning?
- Can this person express himself clearly and logically?
- Does the person have any disease that effect mental or sensory functions?
- If this person has pain, describe it and its causes?
- Are you having any change in memory? Concentration?
- Are you having any difficulty in taking important decisions?

Cognitive -Perceptual Pattern intervention:

- Diagnosis and treatment which the patient received to the abnormalities found.
- Providing Information to the patient with the treating physician.

8. Self-Perception -Self- Concept Pattern

Self-Perception -Self- Concept Pattern Describes:

- Client`s self-concept pattern and perceptions of oneself.

Self-Perception -Self- Concept focuses on:

- The person's attitudes towards self, including identity, body image, and sense of self-worth.
- Anxiety.
- Death anxiety.
- Risk for loneliness.
- Chronic low self-esteem.
- Disturbed personal identity.
- Readiness for enhanced self-concept.
- Disturbed Body image.
- Fear.
- Risk for [actual] self-directed violence.
- Risk for [actual] others- directed violence.
- Hopelessness.
- Readiness for enhanced hope.
- Powerlessness.
- Risk for compromised human dignity.

Examples:

- Body comfort, body image, feeling state, attitudes about self, perception of abilities, objective data such as body posture, eye contact, voice tone.

Self-Perception -Self- Concept Pattern questions:

- Define who are you, apart from your illness/condition?
- Are you ready to accept your illness/condition or need for treatment?
- Do you feel good about yourself, most of the time?
- Have you ever felt that you have lost hope?
- Describe this person`s feeling state?
- Is there anything unusual about this person`s appearance?
- Does this person seem comfortable with his appearance?

Self-Perception -Self- Concept Pattern intervention:

- Accepting the client.
- Help the client to focus on strengths and accomplishments.
- Encourage participation in group activities to have support from peers.
- Provide instructions in assertiveness techniques.
- To recognize the difference between assertiveness, aggression and passivity.
- Teach effective communication skills to avoid judgmental statements.

9. **Role- relationship pattern**

Role- relationship Pattern Describes:

- Client's pattern of role engagement and relationships.

Role- relationship pattern focuses on:

- The person's roles in the community and relationships with others.
- Evaluating Satisfaction with roles, role strain, or dysfunctional relationships.
- Caregiver role strain.
- Complicated grieving.
- Dysfunctional family processes: alcoholism and substance abuse.
- Impaired social interaction.
- Social isolation.
- Impaired verbal communication.
- Ineffective role performance.
- Interrupted family processes.
- Readiness for enhanced communication.
- Readiness for enhanced family processes.
- Readiness for enhanced parenting.

Examples:

- Perception of current major roles and responsibilities (e.g. father, husband), satisfaction with family, work, or social relationship.

Role- relationship pattern Questions:

- How do you describe your various roles in life?
- Do you have now any positive role models?
- Which relationships are most important for you at the present? (e.g. marriage-friendships)
- Are you currently going through any big changes in role or in relationship? What are they?
- Who do you live with (e.g. Alone, family)? What was the family structure in which you grew up?

Role- relationship pattern intervention:

1. Develop trusting relationship with patient. Be honest; keep all promises.
2. Offer to remain with patient during initial interactions with others.
3. Provide group situations for patient.

10.Sexuality- reproduction pattern

Sexuality- reproduction pattern describes:

- Pattern of satisfaction and dissatisfaction with sexuality and reproductive patterns.

Sexuality- reproduction pattern focuses on:

- The person's satisfaction or dissatisfaction with sexuality patterns and reproductive functions.
- Ineffective sexual patterns.
- Sexual dysfunction.
- Planning for contraception

Examples:

- Difficulties with sexual functioning and satisfaction with sexual relationship.

Sexuality- reproduction pattern Questions:

- Are you satisfied regarding sexuality?
- Are you having currently sexual relationships? Is it suitable for this person's age and situation?
- Are you planning for reproduction or not? Use of contraceptives or not?
- **Female** – when did your menstruation begin? Last menstrual period? Any menstrual problems?
- Do you have children? Is this your first pregnancy?
- Are you receiving any drugs to enhance your sexual function?

Sexuality- reproduction pattern intervention:

- Take sexual history and note client’s expression of areas of dissatisfaction with sexual pattern.
- Assess areas of stress in client’s life and examine relationship with sexual partner.
- Assist therapist in planning behavior modification to help clients who desire to decrease variant sexual behaviors.

11. **Coping -Stress Tolerance Pattern**

Coping -Stress Tolerance Pattern describes:

- General coping pattern and its effectiveness in terms of stress tolerance.

Coping -Stress Tolerance Pattern focuses on:

- The person's perception of stress and coping strategies
- Support systems
- Evaluated symptoms of stress
- Effectiveness of person's coping strategies.
- Disabled family coping.
- Impaired adjustment.
- Post-traumatic syndrome
- Readiness for enhanced coping.
- Readiness for enhanced family coping.
- Risk for self-mutilation.
- Risk for suicide.
- Stress overload.

Examples:

- Client's usual manner of handling stress, available support systems, perceived ability to control or manage situations.

Coping -Stress Tolerance Pattern questions:

- Are you feeling tense or relaxed most of the time? When?
- How does this person usually cope with problems?
- Do these actions help or make things worse?
- Did this person have any treatment for emotional distress?
- Are there any big life changes in the last year or two?
- Who is the most helpful for you to handle things? (e.g. Listening, support).
- Are they frequently available to you?
- Do you use any medications, drugs, or alcohol?

Coping -Stress Tolerance Pattern intervention:

- Encourage client to verbalize feelings, fears, and anxieties.
- Encourage client for independence.
- Educate client variant types of relaxation techniques

12. Value- Belief Pattern

Value- Belief Pattern describes:

- Patterns of values, beliefs (including spiritual) and goals that guide client's choices or decisions.

Value- Belief focuses on:

- The person's values and beliefs.
- Moral distress.
- Impaired religiosity.
- Readiness for enhanced religiosity.
- Risk for spiritual distress.
- Readiness for enhanced spiritual well-being.

Examples:

- Religious affiliation, what client perceives as important in life, value-belief conflicts related to health, special religious practices.

Value- Belief Pattern questions:

- What values did this person learn as a child that is still important to her/him (honesty-helping others- success-….)?
- What is your treatment and rehabilitation goals?
- What are the hobbies and leisure activities that may be important for recovery?
- Do you share in any charity, social, political or any other activities?
- What support system does this person currently have (e.g. familial- materialistic-…)?
- Is religion important in your life and your family's life? Does this help when you are faced with difficult situations?
- Describe your plans for the future. Do you generally get what you want from life (e.g. good relationships- successful work-...)?

Value- Belief Pattern intervention:

- Meditation.
- Mindfulness.
- Encourage practicing religious beliefs.

Nursing management of special populations in substance use treatment services

1. Older people with alcohol and drug problems

Older service users tend to have more complex co-morbidities and social care related problems, and therefore nurses can potentially add value to their service, including:

1.Intervention:

No more than one or two relatives should be involved with the health care provider; having too many people present may be confusing for the older person.

2. Detoxification:

Most older patients should be withdrawn from alcohol or drugs in a hospital setting:

- To ensure medical safety, due to high potential for developing dangerous abstinence symptoms such as a seizure or delirium.
- The presence of another major psychopathology
- Unstable co morbid medical conditions
- A lack of social supports in the living situation or living alone

3. Treatment Settings:

- Patients who are acutely suicidal or medically unstable need one-on-one monitoring.
- The initial dose of a drug for management of withdrawal symptoms should be one-third to one-half the usual adult dose, sustained for 24 to 48 hours to observe reactions, and then gradually tapered with close attention to clinical responses.
- Providing advice on falls prevention.
- Testing for and providing advice on diabetes, ischemic heart disease, hypertension, Parkinson's disease and dementia.

4. Treatment Approaches

- A focus on coping with loneliness, and loss (e.g. death of a spouse)
- A focus on rebuilding the client's social support network.
- A pace and content of treatment appropriate for the older person that can overcome sensory and cognitive impairment.

- Treat older people in age-specific settings where feasible
- Create a culture of respect for older clients.
- Keep the treatment program flexible.
- Include help in tobacco smoking cessation.
- Staffing Considerations: Whenever possible, employ staffs who have completed training in gerontology.

2. Females with alcohol and drug problems

Fundamental components of working with women who are using substances

1. Respectful

- Respect is a vital tool in the elimination of stigma.
- All nurses, regardless of their beliefs, must provide nonjudgmental compassionate care.

2. Relational

- The process of recovery moves forward through interactions with others in long-term, supportive, trust-based relationships.
- Therefore, paying attention to the relational dynamics of interpersonal connections in day-to-day life

3. Self-Determining

- Women have the right to determine their own paths of change.
- Support women's autonomy and decision making.

4. Women-Centered

Women-centered care recognizes that, in addition to being linked to fetal and child health, family health, and community health, women's health is important in and of itself.

5. Harm Reduction Oriented

- Harm-reduction strategies help to minimize known harms associated with substance use.

e.g. advising service users on methods of contraception and access to reproductive health services.

6. Violence and Trauma-Informed

- Trauma is defined as an experience that overwhelms an individual's capacity to cope, e.g. child abuse.
- Multiple and complex links exist between experiences of trauma and addictions.
- At times, interventions with service providers can in themselves be re-traumatizing for women.
- *Trauma-Informed Care intervention:*

- Realizes the widespread impact of trauma
- Recognizes the signs and symptoms of trauma in clients.
- When is a good time to discuss trauma? How do you engage in this topic?

- When might you delay the discussion?
- Seeks to actively resist re-traumatization.
- What is the impact of different restraints in relation to trauma?

- *Six Key Principles:*

1. Safety

2. Trustworthiness and transparency

3. Peer support

4. Collaboration and mutuality

5. Empowerment and choice

6. Recognition of cultural, historical, and gender issues

7. Health Promoting

- Promoting women's health involves attending to how the social determinants of health (e.g. poverty, experience of violence, stigma and social context) affect overall health.

8. Culturally Safe

- Women who seek help from service agencies need to feel safe, and accepted for who they are, with regard to both their cultural identity.

e.g. Recognition of the influence of migration on a woman's identity

9. Supportive of Mothering

- Supporting women's choices and roles as mothers
- Recognize the possible short- and long-term influences that a loss of custody may have on a woman.

3. Pregnant Women with alcohol and drug problems

Top barriers to Seeking Help and Support

- Shame and guilt
- Fear of having a child removed from their care
- Feelings of depression and low self-esteem
- Belief or hope that they can change without help
- Unsupportive or controlling partner
- Not having enough information about available services
- Waiting lists at addictions treatment Agencies

Components of Nursing Care for Pregnant Women with Drug Addiction example:

Visit	Procedures	Components of Care Plan
Intake prenatal care visit	Routine labs: CBC, rubella, hepatitis B, C, HIV, blood type and RH factor, urine analysis, urine drug screen, tuberculosis screen	Address substance abuse treatment program,social services, housing,Legal and domestic issues.
Routine follow-up visits	– Routine prenatal care visit – Urine drug screen – Conduct history on drug use – Dosage of maintenance therapy(if indicated)	Assess for compliance with substance abuseprogram, pregnancy complications, socialservice issues, legal and housing issues,employment issues, domestic issues, smokingCessation and prenatal education.
15 to 20 weeks gestation	Perform ultrasound to check for abnormalities	Same as previous visit.
24 to 28 weeks gestation	Perform ultrasound to measure fetal growth – Identify a pediatric care provider – Provide referral for an anesthesia consult	Same as previous visit, plus arrange a hospital consultation for the neonatal abstinence syndrome and intensive care nursery.

4. Breast feeding with alcohol and drug problems

• Develop for each unit a seamless standardized protocol for substance abuse screening: ante partum, intrapartum, postpartum (maternal history, urine drug screen and newborn drug screen).
• Develop and adhere to a standardized protocol for the evaluation and treatment of a neonate demonstrating possible signs of Neonatal Abstinent Syndrome (NAS).
• Provide breastfeeding support with lactation consultants
• Encourage the feeding of the NAS newborn with breast milk in addition to high caloric formula if the mother is willing.

Proposed guidelines for breastfeeding in the setting of substance use treatment(Adapted from Boston Medical Center – Guideline for Breastfeeding in the Setting of Prenatal Substance Use)

Treatment program criteria:
Mothers with a history of substance use disorder must be enrolled in an Addiction Recovery Program during the pregnancy to be considered eligible to breastfeed which includes compliance with prenatal care and addiction recovery treatment, as follows:

a. Prenatal care compliance criteria:
1. Mothers must have received adequate prenatal care defined as attendance of 50% or more of prenatal visits in order to be considered eligible to breastfeed. At least 2 of these visits should be within the last 2 months prior to delivery.
2. Consult with the Breastfeeding Team if the mother delivers preterm.

b. Addiction recovery treatment compliance criteria:

- Admission urine toxicology screening:
  1. A urine toxicology screen will be obtained for all mothers with substance use disorder on admission to Labor &Delivery.
  2. Testing for marijuana (THC) is not routine or recommended. THC use is determined by maternal verbal report; routine testing is unreliable as it does not reflect true usage.

- For those with a negative urine toxicology screen for 4 or more weeks prior to delivery: Those mothers are eligible to provide breast milk to the infant.

- For those with a positive urine toxicology screen less than 4 weeks prior to delivery:
  1. Mothers are ineligible to provide breast milk to the infant at the time of delivery.
  2. Mothers may be re-considered for eligibility weekly.

3. When the mother meets criteria (3 consecutive negative urine toxicology screens at least 1 week apart), she can begin providing milk to the infant. The infant's medical team will then be notified.
4. Mothers who do not meet the criteria listed above will be encouraged to formula feed.
5. Instructions on how to safely formula feed her infant will be provided to the mother.
6. If mother insists on breastfeeding, mother will be informed that this is not recommended according to guidelines. This discussion will be documented in the medical record.

- If at any time there is concern for the safety of infant, mother and infant may be separated by an Attending Physician Order. The decision to separate mother and infant should be an interdisciplinary decision supported by 2 supervisory level individuals: the baby's Attending Physician AND another Attending Provider, nurse manager or social worker.

APPENDIX

Functional Health Patterns Model (Case Sheet)

Personal Data

Name: …….Age Y: M: **Sex:** ☐**M** ☐**F**
ID Number…….....
Address: …….
Contact Person: ……..… Phone Number: ……..
ID Number…….....
Religion: ☐Moslem ☐ Christian ☐ Others
Nationality: ☐ Egyptian ☐ Others
Occupation: ……
Marital Status:☐ Single ☐ Married ☐ Widowed ☐Separated ☐ Divorced
Education:

☐ Illiterate	☐ Reads and Writes	☐Primary School
☐ Preparatory School	☐ Secondary School	☐ University
☐ Postgraduate	☐ Technical School	☐ Others Occupation

Source of referral……
Complaint of the patient……
Complaint of the informant

Health Perception – Health Management Pattern

Patient history:

Family History:

Diagnosis:
Treatment:

Vital Signs:

Body Temperature:
Pulse:
Blood Pressure:
Respiration:

Nutritional – Metabolic Pattern

Length:
Weight:
Nutritional Status:
Daily meals no:
Daily liquid taken:
Special diet:
Anorexia:
Nausea:
Weight loss:
Teeth Status:
Others:

Elimination Pattern

Constipation
Diarrhea
Distention:
Hemorrhoids:
Bladder incontinence:
Dysuria:
Urinary catheterization:
Diaphoresis:
Others:

Activity – Exercise Pattern

Exercise:
If not, why?
Problems with movement:
Dyspnea:
Others:

Sleep – Rest Pattern

Average sleeping hours:
Daytime sleeping:
Habits that help you fall asleep:
Waking up tired:
Factors that affect sleeping in hospital room:

Cognitive – Perceptual Pattern

Vision problems: Hearing Problems: MMSE:
Self-Perception -Self- Concept Pattern
Define yourself: Do you accept your condition: Do you need treatment: What do you feel about yourself, most of the time:

Sexuality- productivity pattern
Any change in sexual patterns: Sexual dysfunction: Plan for reproduction: Contraception:
Role – Relationship Pattern
Job: Role in family: Any barriers for communication: Accept the treatment and participation:
Coping -Stress Tolerance Pattern
Any big life changes in the last year: Coping mechanism with problems: Key person to handle problems:

Value- Belief Pattern
Treatment goals: Hobbies and leisure activities: Meditation: Religious practices:

Drug History and Assessment

Drug History and Assessment

1. When you were growing up, did anyone in your family drink alcohol or take other kinds of drugs?
2. If so, how did the substance use affect the family situation?
3. When did you have your first drink/drugs?
4. How long have you been drinking/taking drugs on a regular basis?
5. What is your pattern of substance use?

a. When do you use substances?
b. What do you use?
c. How much do you use?
d. Where are you and with whom when you use substances?

6. When did you have your last drink/drug? What was it and how much did you consume?
7. Does using the substance(s) cause problems for you? Describe. Include family, friends, job, school, other.
8. Have you ever experienced injury as a result of substance use?
9. Have you ever been arrested or incarcerated for drinking/ using drugs?
10. Have you ever tried to stop drinking/using drugs? If so, what was the result? Did you experience any physical symptoms, such as tremors, headache, insomnia, sweating, or seizures?
11. Have you ever experienced loss of memory for times when you have been drinking/using drugs?
12. Describe a typical day in your life.
13. Are there any changes you would like to make in your life? If so, what?
14. What plans, or ideas do you have for seeing that these changes occur?

CAGE* Substance Abuse Screening Tool

Directions: Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

CAGE Questions

1. Have you ever felt you should cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Scoring:

Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

*CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener

Safety and comfort plan

Safety and Comfort Plan

Reprinted from "Safety and comfort plan" by the Professional Practice Office, 2016 Centre for Addiction and Mental Health (CAMH).

Student name: **Student number:** **Date:**

1. Who participated in developing this safety plan

Client	Family	Significant Other
Clinical Staff	Friend	Other

2. What makes me feel safe?

_____
_____
_____
_____

3.Some things that make me angry, afraid, very upset, or cause me to go into crisis:

_____
_____
_____
_____

4. How do I know when I am becoming, or in, distress/crisis?

My warning signals.

_____
_____
_____
_____
_

5. What does it look like when I am in distress or losing control?

What would others see?

_____
_____
_____
_____

6. When I'm in distress/crisis, I need:

_____
_____
_____
_____

7. What activities or coping strategies can I try to calm and comfort myself?

Activities that have helped me feel better when I'm having a hard time:

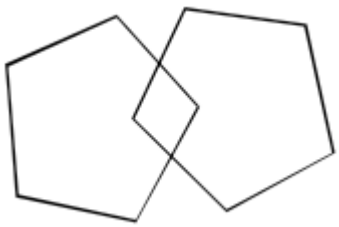
_____
_____
_____
_____

8. What can others do to help?
Identify who can help and how they can help. Are there other resources that can help?
_____
_____
_____
_____

9. What gets in the way of me using my strategy?
Barriers, obstacles, or situations that impact my ability to apply this safety plan:
_____
_____
_____
_____
_

10. What would others notice about me when I'm coping effectively?
Things others may notice about me when I am no longer in distress/crisis:
_____
_____
_____
_____

The Mini-Mental State Examination (MMSE)

Maximum	Score	
		ORIENTATION
5	( )	What is the (year) (season) (date) (month)?
5	( )	Where are we (state) (country) (town or city) (hospital) (floor)?
		REGISTRATION
3	( )	Name 3 common objects (e.g. "apple", "table", "penny"). Take 1 second to say each. Then ask the patient to repeat all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until they lean all 3. Count trials and record. Trials:
		ATTENTION AND CALCULATION
5	( )	Ask patient to count back by sevens, starting at 100. Alternately, spell "world" backwards. The score is the number of numbers or words in the correct order. (93___86___79___72___65___) (D____L___R____O___W____)
		RECALL
3	( )	Ask for the 3 objects repeated above. Give 1 point for each correct answer. (Note: Recall cannot be tested if all 3 objects were not remembered during registration.
		LANGUAGE
2	( )	Name a "pencil" and "watch"
1	( )	Repeat the following: "No ifs, ands, or buts."
3	( )	Follow a 3-stage command: "Take a paper in your right hand, Fold it in half, and Put it on the floor."
1	( )	Read and obey the following Close our eyes.
1	( )	Write a sentence.
1	( )	 Copy the following design.
Total Score	_____	compare this score against norms for education and age.

Scoring:

- The maximum score for the MMSE is 30.
- A score of 25 or higher is classed as normal.
- If the score is below 25, the result is usually considered to be abnormal (indicating possible cognitive impairment).
- Impairment may be classified as follows:

Mild – MMSE score of between 21 and 24.

Moderate – MMSE score of between 10 and 20.

Severe – MMSE score of less than 10.

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date and Time ____/____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

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