Ethics for Nurses in Opioid Treatment Programs

North Carolina Association for the
Treatment of Opioid Dependence

Jana Burson M.D., Medical Director
Mountain Health Solutions
North Wilkesboro, NC

Nursing ethics

- A set of principles that guide how nurses ought to behave
- Much overlap with medical ethics for other healthcare professionals
- Serve as guidelines for behavior
- Borne out of experience from the professionals that came before you

Nursing ethics

- Code of Ethic for Nurses
  - A guide for how to carry out nursing duties in a manner consistent with quality care and ethical obligations
  - http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.pdf
  - Can order pdf or written copy
- Tend to be similar to other medical professionals
- Nurses in opioid treatment programs may face specific challenges/situations

NAADAC -National Association of Drug Abuse Counselors: some overlap of issues with nurses

- Have ethical guidelines covering:
- Confidentiality
- Relationships with clients
- Relationships with other professionals
- Non-discrimination
- Legal and moral standards
- Competence

Other sources for code of ethics for addiction treatment personnel

- American Association for the Treatment of Opioid Dependency, Inc. (Aatod)
  - For programs and individuals who treat opioid addiction
  - http://www.aatod.org/member-center/canon-of-ethics/
- American Society of Addiction Medicine (ASAM)
  - For physicians
  - http://www.asam.org/docs/publicy-policy-statements/1prin-of-med-ethics-10-92.pdf?sfvrsn=0

Nursing ethics and addiction treatment

The disease of addiction presents ethical concepts not seen in other areas of nursing

Can be disagreement about some underlying ideas

For example:

- How much control does an addicted person have over his choices and behaviors?
- Treatment versus punishment
- Harm reduction versus enabling
- Autonomy versus paternalism

Ethical concepts to be covered

- Beneficence
- Patient autonomy
- Confidentiality
- Professional boundaries
  - With patients
  - Gifts
  - Bartering
- Professional competence
  - Scope of practice issues
- Professional burnout

Ethical decision-making

- Get all of the facts, try to avoid second-hand information if possible. Weigh reliability of the facts given.
- Consider which ethical concepts may apply
- Ask questions:
  - Who will this decision affect?
  - What are the options for action?
  - Are there any facts I don't have?
  - Have all of the affected parties been able to explain their position?
  - Which options will produce the most good/least harm?
  - Which action treats everyone fairly?
  - Which action respects the rights of all parties?

Ethical decision-making

- Get advice/input
  - From your peers
  - From your supervisor
  - From your licensing board
  - From MD or other medical professionals with whom you work
  - If specific to OTP setting, consult SOTA
- Look at code of ethics
- Recognize that at times, one ethical principle may oppose another ethical principle
- Recognize there are shades of gray, each situation is unique

Decision Making Models

Porter and Gallon (2009)	Durham (2006)
Identify the problem Identify the potential issues involved. Review relevant ethical guidelines. Obtain consultation from a colleague or supervisor. Consider possible courses of action. Enumerate the consequences. Decide on best course of action.	Whose interests are involved? Who can be harmed? What universal values apply? Are there values in conflict? What ethical or legal standards apply?

From Stritch, L," Advanced Clinical Supervision: Ethical & Legal Considerations" 2013

Beneficence

- Actions are done for the good, or benefit, of others
- Fundamental ethical principle in medicine
- As applies to people with addiction:
  - All actions in a treatment center should be done for the patient's benefit, not for the benefit of the treatment center or workers at the treatment center
  - No employee of a treatment center should use patients for that employee's own benefit, financially or otherwise
  - Ethical standard is to do no harm to patients

Challenges to beneficence

- Behavior and/or values of addicted patients may be at odds with your own
- Some people, even medical professionals still don't believe addiction is a disease but a moral failing
  - **This is no longer in question**
  - Addiction *is* a brain disease, even if you don't believe it
  - Has the same degree of heritability as other chronic diseases
    - Half of the risk of developing addiction is genetic
  - There are behavioral components, just like other chronic diseases
  - Drugs change the structure and function of the brain

Challenges to beneficence

- Addiction is associated with behavior that can try the patience of medical personnel
  - We deal with a wide range of behavioral dysfunction
  - Some patients are more like ourselves, better able to conform to our expectations
  - We risk treating these patients preferentially

Challenges to beneficence

- Addictive behavior doesn't change quickly even in recovery
- Most behavioral issues of persons with addiction are based in fear
  - Of going into withdrawal
  - Of not getting enough medication
  - Of not getting much desired take home doses
  - Of people judging them harshly
  - Of allowing people to take advantage of them

Challenges to beneficence

- Other behavioral issues seen in patients are survival skills
  - Aggression, bravado, bullying - help people survive in some environments
  - Some patients expect staff to react to them in hostile ways
  - Social norms of people in addiction may be different than in non-addicted society
  - A new patient may not have ways of interacting with others that are deemed “acceptable” by mainstream society
    - May need to remember social skills
    - May need to learn for the first time

Challenges to beneficence

- **Don't blame an addicted patient for behaving like an addicted patient**
- Accept some behaviors as part of the disease
- Drug use is part of the disease
  - Positive drug screens mean a higher "dose" is needed
  - If opioids, may need higher dose of medication
  - If other drugs, higher dose of counseling
  - Positive drug screens mean a re-evaluation of treatment plan is needed

Challenges to Beneficence

- Transference: unconscious redirection of feeling from one person to another
  - Term used for patient or client's re-direction of emotion from a past relationship onto healthcare team
  - Patient may act toward program personnel in a puzzling manner
  - Can be positive or negative

Challenges to beneficence

- Countertransference: same process, occurs in treatment center workers: doctors, nurses, counselor, administrative staff
  - Medical personnel can bring their own issues to work
  - Program personnel may act in a puzzling way toward the patients
  - Personnel may at times feel like addicts need to be punished
  - This is a violation of ethical standards
  - Interferes with good professional boundaries

Transference case study

- One of the new patients reacts to you in an overtly hostile manner, and tells the program manager that you "talk down" to him. He mentions to the program manager that you remind him of an aunt of his who was always very judgmental of him. What should you do?
- 1. Tell him he's being silly, you aren't his aunt, and get over it.
- 2.Refuse to dose him, so he won't have to deal with this issue. Ask your nurse co-workers to take over when he comes for his dose
- 3. Tell yourself it's not your issue, it's his. Treat him with the same care and respect as all other patients.
- 4. Go out of your way to joke with him and try to get him to see how friendly you are.

Beneficence specifically in OTP

- Adhere to best practice standards
  - Read TIP 43 from SAMHSA
- Dosing
  - Patients do better at a blocking dose; physicians should not deny increases just to keep the dose "low"
  - Physicians should not withhold medication or reduce the dose just to punish the patient for bad behavior – this is unethical

Beneficence at the OTP

- Staff at OTPs should never communicate, verbally or otherwise, that medication-assisted treatment is anything other than an evidence-based option for treating opioid addiction
- Advocacy for patients with other members of healthcare community, law enforcement, etc.
- Advocacy even within the treatment team

Beneficence Case Study #2

- Besides working as an LPN at the OTP, you sell vitamins from a home-based office. Because you believe your brand of vitamins can really help the patients at your OTP, you decide you'd like to sell them in the lobby. As an added bonus, you can make a little extra money too. Is this appropriate?
- 1. Yes, because it's something that will help the patients.
- 2. Yes, but only if you get your program manager's approval first
- 3. No. You are attempting to make money off the patients who are there for help with addiction.
- 4. It's not OK if you push patients to buy them, but OK if you set up a stand in the lobby.

Beneficence case #2

- One patients takes almost a month's worth of vitamins before he confronts you, angry because "your" vitamins stripped his methadone. He thinks you are trying to put patients into withdrawal, and threatens to call the state methadone authority. What do you do?
- 1. Refund his money for the vitamins and give him an extra $20 to keep his complaints to himself
- 2. Tell you program manager about his behavior and ask he be transferred to another clinic, since his comments are hurting your sales
- 3. Try hard to explain to him all of the good ingredients in your vitamins
- 4. Do a mental forehead slap. You should have listened to that ethics lecture, and not sold the vitamins

Patient autonomy: “self rule”

- Each patient has the right to self-determination – to decide what will be done for and to them by medical personnel
- Informed consent
- In order to make his own decision, patient must be provided with:
  - Accurate, understandable information about condition, treatment options, etc.
  - Assistance with weighing options if so desired
  - Should be supported during decision-making process without undue influence or duress
  - The patient has the ultimate right to decide to accept treatment, decline treatment, stop treatment

Patient autonomy

Personal autonomy is not globally endorsed by all cultures

Paternalism – authority figure making decisions in the patient's best interest

Do addicts have a diminished capacity to make decisions?

Only if they are profoundly impaired or suicidal

- Autonomy can be outweighed by the rights, health, welfare of other people
  - Public health issues like infectious diseases
  - Autonomy may be in opposition to other ethical concepts
- "One person's rights end where another's begins"

Patient autonomy/beneficence case study

- You work for an opioid treatment program that does not offer buprenorphine. The CEO of the company that owns your treatment program told staff, including you, not to mention buprenorphine as a treatment alternative, because it would lead to a loss of business. Later, a patient entering treatment asks you what you know about buprenorphine, and if it can be a good treatment for opioid addiction. What should you do?

Patient autonomy/beneficence Case Study

- 1. Ignore the CEO's command, since you feel you need to be entirely truthful with patients. Tell the prospective patient all you know about buprenorphine, and suggest the patient talk to your program physician as well.
- 2. Tell the patient that methadone works better than buprenorphine, and discourage the patient from seeking more information about buprenorphine. Your loyalty is to your employer.
- 3. Tell the patient you don't know anything about buprenorphine, and to ask the doctor. You really need this job and aren't going to risk getting fired.
- 4. Discuss the situation with your program manager to decide the best course of action.

Patient autonomy case study #2

- A pregnant patient dosing at 85mg asks you to bring her dose down by 10mg, since she plans to get off methadone completely. What should you do?
- 1. Honor her autonomy and reduce her dose by 10mg.
- 2. You know she could have a bad outcome if her dose is reduced too rapidly. You tell her you brought her dose down by 10mg…but you actually dosed her at her at 85mg.
- 3. Tell her it is ultimately up to her to decide when she wants to decrease, but ask her to talk with your program physician first. Tell her she needs to have all the information before making the best decision about what she wants to do.
- 4.Tell her it's too late to reduce her dose. Since she's pregnant she will have to stay at this dose or go up, but she can't reduce the dose.

Confidentiality

- Most medical professionals must follow HIPPA guidelines
- All staff of addiction treatment programs and mental health programs have to follow stricter guidelines in CFR 42
  - More stigma against people with addiction/mental illness
  - Other medical personnel may not know about this higher standard
- Staff may not tell someone whether or not a particular person is a client, without a signed release
- Of people with untreated addictions, 24% cited the stigma of addiction as a reason they didn't seek treatment.

Exceptions to confidentiality

- Child abuse
- Suicidal or homicidal threats
- Medical emergencies
- Staff communications within a program
- Crimes committed on program premises, or against staff of facility
- Disclosure under special court order
- Appropriately authorized research, audit, evaluation (SOTA, NC DHHS, DEA)

Confidentiality case study #1

- You get a call from a nurse at the local hospital emergency room. A relative of a patient at your opioid treatment program has asked them to call you. Your patient was in an auto accident and is unconscious with major trauma. The emergency department doctor wants to know his usual dose of methadone. Should you:

Confidentiality case study

- 1. Ask the person calling to get the patient's relative to sign a release of information, then fax it quickly.
- 2. Ask for the phone number where the doctor can be reached, then call your doctor so she can make this call
- 3. Get the caller's name and position at the hospital, then tell them the patient's present dose.
- 4. Tell the caller there's no way you can tell if the person who had the accident is a patient or not.

Confidentiality case study #2

- **A police detective arrives at the clinic one morning, explaining that a murder has been committed and one of your clients is wanted for questioning. He wants you to give him all information about the client, and threatens to arrest you for obstruction of justice if you don't do so immediately. You:**

Confidentiality case study #2

- 1-Tell him to contact the state methadone authority.
- 2- Tell him you watch "Law and Order," and know that you don't have to tell him anything, including whether the person he names is a client at the clinic.
- 3-Recognize that since a murder has been commited, you are required to turn over the requested information.
- 4-Tell the officer you appreciate the frustration he must feel, but he'll have to get a warrant, signed by a judge, to get any information, including whether or not the said individual is even a patient.

Confidentiality case study #3

You are the doctor at a methadone clinic and see a patient whom you decide isn't appropriate for treatment. When you tell the patient this, he becomes angry. He says he's going to go home and kill himself, and stalks out of the office. You know he has guns at home, because he hunts bears for a living. You should:

Confidentiality Case Study #3

1-Understand he's just blowing off steam. To call authorities would violate his confidentiality, and would make him not trust addiction treatment professionals

2-Try to enlist the aid of the program manager to talk with him. When that fails, call the police with a description of his car. You don't think he will kill himself, but you don't know for sure.

3-Call the emergency contact number he wrote on intake paperwork for his grandmother, and ask her to have him committed to a psychiatric facility as soon as he gets home.

4-Ask the program manager to wrestle him to the ground and sit on him, while you call the police.

Professional boundaries

- Shape the nature of the relationship with your patient/client
- Different types of boundaries
  - Physical
  - Emotional
  - Financial
- Boundary violations are the most common breach of ethics

"Boundaries protect the welfare of clients who are in a vulnerable position in a therapeutic relationship."

Ethical, Legal, and Professional Issues in Counseling, by Remly & Herlihy, page 179

Boundaries

- The three clinician characteristics most important to the process of change in the client: empathy, genuineness, and non-possessive warmth (Carl Rogers, 1959)
- With these characteristics comes a responsibility to also maintain healthy boundaries
- The client-counselor relationship is unequal – particularly in an opioid treatment center.
- It's easy to take advantage of a client or patient, or even give the appearance of doing so
- Nurses also form relationships with patients and need to have healthy boundaries

Number one thing to remember about boundaries…

- Don't have sex with patients.
- Don't have sex with patients
- **Don't** have sex with patients!!!!!!!!!
- It is never OK to have a romantic and/or sexual relationship with a patient or client OR ex-patient/client

Boundaries

- Nurses, counselors with poor boundaries may:
  - Feel overly responsible for the patient/client
  - Overly identify with the patient
  - Be easily manipulated by patients, agree to unreasonable demands
  - Respond to inappropriate personal questions
  - Fall in love with the patient

Boundaries and dual relationships

Dual relationship means there is a counseling or medical care relationship and another relationship, either concurrently or sequentially

Counselor or nurse/client nonprofessional relationships are nearly always to be avoided, given the potential for harm

We should also avoid nonprofessional relationships with former clients, their romantic partners, or their family members

Can be difficult to recognize – for example, client who slowly becomes a friend

Much more difficult in a small community

Dual relationships

There is a power differential between client and nurse (or counselor)

Different relationships have different roles, expectations, and responsibilities

These may conflict – the greater the incompatibility of responsibilities with both roles, the more potential for harm

The greater the power differential, the greater the potential for harm

Boundaries

- Any time you treat a patient differently than you usually would, check your own motives and check for boundary violation

Boundaries case study #1

- You are a nurse who fills in occasionally at the local methadone clinic. You get paid well and enjoy the work. One day, you recognize a new patient as the guy you buy ginseng from. He tells you he has a fresh batch for sale. You should:

Boundaries Case Study #1

1- Keep buying ginseng from him, since you knew him even before you started work there, but ask him to bring the ginseng to the clinic, so you don't have to go to his house.

2- Tell him sorry, but you won't be able to buy from him, since it's a boundary violation.

3- Go home and smoke dope with him. Ginseng is just a code word for marijuana.

4-Go to his house to buy ginseng as usual, since you already knew him long before you worked for the clinic.

Boundaries case study #2

- You are drawing blood on a patient being admitted to your opioid treatment program. He asks if you know Nurse "X." Nurse X works at your program but happens to be off today. You say yes, you know her, and the patient proudly says, "She's my mom." What should you do?

Boundaries Case Study #2

- 1. Tell him you are glad his mama will be able to keep a close eye on him.
- 2. Say nothing, and complete your work. You must keep this patient's confidentiality
- 3. Stop the admission process and talk to your program manager. This is a boundary violation for the patient and his mother.
- 4.Stop the intake, and telephone his mother right away, to tell her that her son is wanting treatment at her program. She has the right to know that her son is addicted.

Boundaries case study # 3

- You are a counselor, in recovery from addiction, and have six years clean. One day, you see one of your program's patients at a meeting. You should:
- 1. Pretend you don't see him, then never go to that meeting again. It's a boundary violation.
- 2. Greet him warmly and introduce him to all your friends as one of your patients at the methadone clinic.
- 3. Greet him warmly, then offer to find him a sponsor, so he won't have to talk to you, and cause a boundary problem.
- 4. Say hello if your paths cross, but let other recovering addicts be the ones to give him their phone numbers

Boundary challenge: accepting gifts

- Gifts are an ancient way of expressing appreciation and gratitude
- Gifts are more complicated in the healthcare/mental health/addiction treatment setting
- Relationship of counselor/nurse to patient in an OTP is unequal.
  - Counselor/nurse seen as having more power in the relationship
  - A gift can be a way for patient to regain status and power
  - May produce expectations in the gift-giver
  - Gift can be first step on a slippery slope of patient exploitation

Gifts

- Can be an attempt to buy love from the counselor/nurse
- Can be an attempt to manipulate the counselor/nurse into doing something the patient wants.
- Risk management: most substance abuse and mental health agencies establish a “no gift” policy to limit liability
- A professional receiving a gift is unlikely to be viewed in context by a licensing board or in a lawsuit

Gifts

- Many different ways to handle situation
- Each situation is different
- Never OK to accept a gift with high monetary value or sexual overtones
- Gifts such as home grown vegetables from patient's garden, a book, potted plant, cookies: only motive may be appreciation

Possible negative outcomes of refusing a gift

- Refusal of a small or symbolic gift may cause feelings or shame or rejection
- Remember cultural context: refusal of gifts may be offensive in some cultures
- Refusal requires care & tact
- Company policy of “no gifts” removes the refusal from an individual situation to more universal
- Some feel refusal of gifts infantilizes patients

Case study #1: gifts

- A client sees a therapist regarding a difficult personal problem. After six difficult months, the problem is resolved. At their last session, the client gives the therapist an inexpensive paperback copy of a book the therapist had mentioned she'd like to read. The therapist should:
- 1. Ask the client to come to additional sessions to explore the meaning of the gift of the book.
- 2. Smile and say "thank you."

Case Study #1: Gifts

- 3. Smile, say “Thank you,” and then go out for drinks together.
- 4. Tell the client about the organization’s “no gifts” rule, accept the book anyway, and ask the client not to tell anyone.
- 5. Express gratitude and delight that the patient was so thoughtful, then gently inform the client that the gift can’t be accepted.

Case study #1: gifts

Would your answer be different if the client was male, and the therapist sensed an attraction towards her?

How about is the client is also a therapist?

How about if the issue the client needed help with was her endless efforts to buy other people's love with gifts?

What if the book was somewhat pornographic?

What if the book was related to the counseling field?

Case study #2: Gifts

- One patient at your opioid treatment program carves flowers from wood, in an unusual and very artistic way. In the past, you have told her how pretty her flowers are. Today, she brings you a bouquet of them as a gift. What should you do?
- 1. Accept them because you really like them and it would hurt her feelings to refuse them
- 2. Tell her your facility has a “No gifts” policy, and though you would love to accept them, you cannot.
- 3. Tell her your facility has a no gifts policy, but if she agree to put them at your dosing window so everyone who doses there can enjoy them, you can do that.
- 4. Tell her you have to ask your program manager if it is OK to accept the flowers.

Case study #2 : gifts

- Would it made a difference if she usually sells these bouquets for $100 at the craft fair? How about if she usually sells them for $5?
- Would it make a difference if she was really struggling with her recovery, and may soon be asked to go to an inpatient program to treat co-occurring benzodiazepine addiction? How about if she was a level 6 client and had been doing well for years?
- What about if she had recently tried to falsify a urine drug screen, and you felt she was trying to ingratiate herself with you?

Bartering

- Exchange of goods or services without the exchange of money
  - For example, a client paints his therapist's house in exchange for therapy sessions
- Usually not a good idea
- Opportunity for misunderstandings and exploitation to occur

Bartering: case study

- A therapist in private practice has been seeing a client for issues of low self-esteem. During the third month of therapy, the client loses his job. He installs house gutters for a living. Coincidently, the therapist has been looking for a company to install gutters. She mentions this in passing, and the client asks if he can barter for the cost of appointments. He says he can put gutters on her house in exchange for eight one-hour counseling sessions. This would be a great deal for both of them, financially. The therapist should:

Bartering: case study

1. Agree to the arrangement. This will be mutually beneficial, and allow the client to remain in therapy that he needs.
2. Agree to the arrangement, but try to get him to add some extras to the job in exchange for being willing to barter with him

3-Tell the client no, because bartering between a therapist and client is a bad idea, as it can interfere with the work he is doing as a client

4-Tell the client that they can help each other, but money must be exchanged both ways, so proper taxes are paid. Otherwise, it would violate tax laws.

Bartering: a case study

The therapist bartered with the client. After the fourth bartered session, she notices that her gutters are uneven. Overall, he's done a very poor job. What should she do next?

1-Tell him he's done an awful job, and he must re-do the work.

2-Say nothing. His self-esteem is very fragile, and he doesn't take criticism well.

3-Don't say anything, but file a small claims lawsuit. (The therapist has always wanted to be on Judge Judy)

4- Refer him to another therapist, then discuss his workmanship with him

5. Mentally kick herself for getting into a barter with a client. Now she sees why it's not a good idea.

Boundaries: which of the following is OK for a nurse or counselor to do for a patient at an opioid treatment program?

- Give your home phone number to a special client who is in need.
- Be “friends” with patients on Facebook
- Go out for coffee with a patient/client
- Agree to be an NA sponsor for a patient/client
- Agree to be an NA sponsor for a co-worker
- Eat at a restaurant where your patient works
- Eat at a restaurant where your patient/client works, and ask for a discount
- Hire a patient/client to be a baby sitter

Boundaries

- Dual relationships are harder to avoid in small towns and rural areas
- What to do in public places
  - If a patient/client begins to talk to you about a problem, gently ask they wait until a less public moment, at your treatment facility
  - Take the patient/client's cue about whether to acknowledge one another
  - Never tell anyone you know them as a patient at your facility

- Gossip about your clients
  - Of course, never do it
  - If you hear it:
  - Leave the area
  - Do NOT be tempted to contribute, set the record straight, etc.
  - Gossip can cloud your judgment in the future, and may not be true

Case study: when ethical principle collide

- You do an intake on a patient and suddenly remember you know her from the hospital intensive care unit where you both work. She is also an RN, and is entering treatment for opioid addiction. What should you do?
- 1. Refuse to continue the admission process, since she will be too impaired to work while on buprenorphine/methadone
- 2. Continue the admission process, and talk about your concerns about her competence at case staffing later that day, with the doctor and program manager
- 3. Complete her admission process, but later that day call your state's nursing board to report her for being an addict
- 4. Agree to continue the admission process, but tell her she must self-report to your state's board of nursing

Case study

- Ethical principles involved:
  - Confidentiality – CRF 42 says you cannot break the confidentiality of the patient by reporting her to her licensing board
  - Safety of public – nursing board says any nurse with knowledge of an impaired colleague must report this to the nursing board
  - What do you do?

Impaired colleague

- NC medical board says its licensees have a professional obligation “to act” if they have knowledge that another doctor is impaired by addiction
- They acknowledge the conflict between confidentiality (if the addicted professional is getting treatment) and this professional obligation

Scope of practice of RN, LPN in the OTP

- Recently an issue with the NC BON at some OTPs
- NC BON will soon issue a statement, in collaboration with NC SOTA and DHSR, to give more comprehensive guidelines around scope of practice issues at OTPs
- Responsibility for knowing and following scope of practice falls on the nurse, not the employer
- An employer or medical doctor **cannot** expand the nurse's scope of practice, as it is set by NC legislature

Scope of practice for LPNs

- LPNs can participate in patient assessment, planning & evaluation
- LPNs cannot independently perform these functions, only under direct supervision of RN, or MD
- NC BON says “dispensing medication is beyond the scope of practice of both RNs and LPNs”
  - RNs and LPNs may “supply” or “administer” medication, however
- LPNs cannot supervise RNs, nor assign tasks to them

Some concerns

- During induction, dose increases/decreases are determined by the medical doctor
  - RNs and LPNs can use standing orders only if those orders specify the objective and subjective signs & symptoms and the resulting dose change
  - Doctors may order increases based on COWS scores
  - Dose increases cannot be determined by non-medical personnel such as counseling staff
  - RN or LPN can call program physician to report vital signs, physical signs, and take a verbal order for a dose change
  - Dose decreases must be done in similar manner. for example, standing order to decrease dose for sedation

Some concerns: patient impairment

- LPN cannot make an independent assessment of impairment
  - Can collect data and call program physician, who can make decision to withhold dose
  - Can consult with an RN, who can use a standing order from a physician
  - Should NOT consult a non-medical person about impairment
    - Counselors, program managers have no medical training
  - Should not gather data about patient's condition through the dosing window;
    - Should take patient to a private area both to eliminate distraction and time pressure, and to protect patient's confidentiality

LPNs in the OTPs

- OTPs should have policies and procedures in place outlining supervision for LPNs by either an RN or the program physician
- If supervised by the program physician, there should be a significant degree of communication and onsite presence
- LPN must have physician or RN immediately available for unstable patient situations

Physician or RN must be immediately available for unstable patient situations:

- Program physician should always be available by phone or other telecommunication during the hours the program is open
  - Best if physician is always available, even during off hours
- Program may be able to develop an alternate plan for physician/RN **physical** presence requirements in patient emergencies
  - Physician can give an order for the OTP facility to call 911 for transport to hospital for immediate physician evaluation

Some concerns

- NC BON has voiced concerns over some OTP practices which can impede safe and effective care
  - RNs, LPNs asked to do multiple clinical & non-clinical tasks simultaneously
  - Registering patients/taking money/administering doses
  - May be unsanitary as well
- Distracting & likely to cause dosing errors, particularly with time pressure of a line of waiting patients

LPNs in OTPs

- How does NC BON's opinions compare with other states?
  - Wisconsin: http://165.189.64.111/Documents/Board%20Services/Position%20Statements/Nursing/Additional%20Board%20Statements-Nursing.pdf
  - "LPNs who administers methadone in complex patient situation shall be under direct supervision of a physician or RN. …Direct supervision has been generally defined as on-site presence, access or communication within a relatively short time period."
  - Very similar to NC BON's position

More information

- NC BON website: http://www.ncbon.com
- Clarification should soon be made by NC BON
- Here's the position statement regarding LPN and RN duties:
- http://www.ncbon.com/myfiles/downloads/position-statements-decision-trees/lpn-position-statement.pdf

Case study

- You are an LPN working at an OTP and you suspect a patient is impaired. You call him to an empty office and talk further with him. You observe his speech is slurred and he looks sleepy. You call your program physician to report this data, and are given an order not to dose this individual today. When the program manager discovers this, he commands you to dose the patient, because in his opinion, the patient is not impaired. What should you do?

Case study: scope of practice

- 1. Give the patient his usual dose. You do not want to lose your job.
- 2. Ask the two other LPNs working that day to assess the patient, and then tell the program manager that all three of you agree the patient is impaired, and ask him to re-consider his decision.
- 3. Ask the patient's counselor to become involved
- 4. Call the physician again and ask what you should do.
- 5. Refuse to dose this patient. A medical decision has been made by the M.D.

Scope of practice in NC

- **Opioid treatment programs are non-traditional healthcare settings – Nursing Practice Act obviously geared toward more traditional setting**
  - **NC's BON does have the authority to take action against licensees who violate the Act, even though LPNs are doing nothing outside the generally accepted standard of care in other states**

Professional burnout

- Compassion fatigue, worn-out from doing your job
- Burnout often results in:
  - Depression, isolation, anger and irritability
- Burn out can feel like:
  - Loss of physical and emotional energy
  - Loss of idealism, self-esteem,
  - Loss of joy, meaning and purpose regarding your work
  - Loss of sense of fun and friendship at work, loss of a sense of community

Burnout

- We have difficult jobs: require a great deal of maturity and equanimity
  - Not every nurse is cut out for our type of work
- Everyone feels burnout at times
- We are responsible for maintaining our own physical/emotional/spiritual health
- Many of us in the healthcare fields have addiction in our families
- We risk transferring our feelings onto the patients
- Patients already have enough problems; don't make your problem their problem

How to handle burnout

- Healthcare professionals need to learn to recognize our own limits and make changes before having a blow-up or a melt- down
- Talking about the situation can help
  - Trusted colleagues
  - Professional counselor
- Avoid overwork, plan time for your own relaxation
- Manage your expectations of patients' behaviors
- Importance of self-care
  - Less frustration with others when you are healthy emotionally, physically, spiritually
  - Consider 12-step group: AL anon is for friends/family of addicts & alcoholics

Case study: Professional burnout

- You have been working in OTPs for the last eight years, and feel angry when you wake up each day to go to work. You feel like patients at your OTP are all trying to "get over on you" with their lying, sneaky ways. Your program manager has talked with you several weeks ago about your bad attitude, and says patients have complained about your rudeness to them. What should you do?
- 1. Get on a social media site and spill you guts about the way you feel. Venting will help you feel better
- 2. Go out and get drunk. You can release your stress in this way.

Case study: burnout

- 3. Take some time off, and thoughtfully consider if you want to remain in this field
- 4. Assess you own lifestyle. Are you taking care of yourself physically, emotionally, spiritually?
- 5. Re-assess your expectations of patients, as well as your attitudes towards them. Are you behaving in a way that brings out the worst in them by being accusatory, suspicious, less than respectful?

Professional burnout

- What is your method of preventing burnout?
- Is it working?

Professional competence

- Need to stay informed regarding new information in the nursing filed in general, and knowledge specific to the field of addiction nursing
- Attend conferences teaching updated information in our field
- Websites with information about addiction and its treatment
  - http://www.sa4docs.org/
  - http://www.drugabuse.gov/
  - http://www.samhsa.gov/treatment

Professional Competence

- Reading on your own
- International Nurses Society on Addiction
  - Professional specialty organization founded for "Nurses committed to the prevention, intervention, treatment, and management of addictive disorders…"
  - http://www.intnsa.org/about/

Advocacy

- Patients on medication-assisted treatment often face stigma and judgment
- We can be ambassadors of goodwill, sources of information our communities
- Most opposition is based on false information

Professional competence: principles of effective addiction treatment

- **All treatment center personnel should know these principles!**
- No single treatment is right for everyone with addition to drugs including alcohol
- Treatment needs to be readily available
- Effective treatment considers all the needs of the patient
- Treatment plans need to be reassessed and modified continually to meet changing needs of the patient

Principles of effective addiction treatment, continued

- Remaining in treatment for an adequate period of time is essential for treatment success
- Counseling and other behavioral therapies are critical components of addiction treatment
- Medications are an important part of treatment for many patients (methadone, buprenorphine, naltrexone for opioid addiction; naltrexone, acamprosate, disufiram for alcohol addiction)
- Treatment of co-occurring mental disorders should be integrated into addiction treatment.
- Detoxification from drugs is only a first step in the treatment process

Principles of effective treatment, continued

- Even involuntary addiction treatment can be successful
- Treatment providers must monitor for drug use all through addiction treatment
- Treatment programs should assess for infectious diseases (HIV, TB, Hep B & C, syphilis and help patients modify risky behaviors
- Recovery can be a long-term process with the need for repeated treatment episodes

#1 Predictor of patient success

Positive relationship with the personnel at the treatment facility: counselor, nurse, administrative personnel, doctor

I believe we can do more good per hour of work at the opioid treatment program than in any other filed of medicine. We help patients get their lives back, which helps entire families, which helps entire communities. Where else can we do this??

Thank you, nurses, for all that you do!!!

Books to read

Ethics for Addiction Professionals, by LeClair Bissel

Advanced Ethics for Addiction Professionals, by Michael Taleff

The Book of Ethics: Expert Guidance for Professionals Who Treat Addiction, by Laura Weiss Roberts

Ethical, Legal, and Professional Issues in Counseling, by Remley & Herlihy

Case Study

- You are in case staffing when the program physician says of a relatively new patient: “He’s hopeless. I’ve seen his type before. Start a detox at 5mg per week.”
- You feel something is off about this judgment. The patient is relatively new, after all, and you see no pressing need to detox this patient off the program. He isn’t using benzos or alcohol, and isn’t causing any problems for other patients. What do you do?

Countertransference: Case study

- 1. Keep your mouth shut. You are the nurse, she is the doctor.
- 2. Politely offer your opinion that the patient is relatively new, and does not appear to be in danger from overdose at this time. Ask for the doctor's reasons behind her order to detox.
- 3. Interrupt and tell the doctor she's crazy, you don't think the patient should be detoxed, and you will call the medical director if she doesn't agree with you.
- 4.Ask the program manger to intervene

- What are possible reasons this physician has little tolerance with this patient?
  - Counter transference?
  - Lack of knowledge about addiction as a disease?
  - Professional burnout?

Case study

- A counselor has a great relationship with his client. One day, the patient needs an emergency exception for take home doses. The counselor goes out of his way to make sure the exception goes through in a timely fashion; he contacts the program physician for an expedited review, then calls the state opioid treatment authority to do the same.
- The patient returns the next week very grateful for the counselor's efforts. He offers to detail the counselor's car for free in appreciation. (The patient works as a car detailer)

Case study

- Should the counselor accept the patient's offer?
- What ethical issues are raised?
- What complications could arise?
- Does your facility have a policy regarding gifts?

Case study

- One day a counselor notices her client appears off balance and has slurred speech. This patient hasn't dosed yet. What should she do?
- 1. Tell the patient he cannot dose today due to impairment
- 2. Keep quiet. This counselor is not a medical professional, and should not make a decision about impairment, as she has not been trained to do so.
- 3.Tell the patient he's better drink a cup of coffee before presenting to the dosing window.
- 4. Call the nurses' station, report your observations, and ask them to assess the patient.

Case study

- Your medical director, while checking patients randomly on your state's prescription monitoring database, discovers one of your program's patients is receiving a large amount of opioids and benzodiazepines. Your doctor meets with the patient to find out what's going on. The patient says it's none of the program's business, because she doesn't take these medications. She backs this up by pointing to her UDS, which have all been negative for everything except the methadone you dose.

Case study

- She angrily refuses to sign a release of information, saying it will poison her relationship with her other doctor, since he is much opposed to methadone. The patient says she sells this prescribed medication for a hefty profit, and could not afford to be in treatment if she had to give it up.
- What should your medical director do?

Case study

- 1. Call the other doctor anyway, and tell him to stop prescribing because the patient is committing a felony by selling his medication.
- 2. Call the other doctor, but only tell him you are treating this patient with methadone due to addiction, and please don't continue to prescribe controlled substances
- 3. Say nothing. You are afraid this patient will leave treatment and die from an overdose if you push the issue.
- 4. Tell the patient you are unwilling to continue to prescribe methadone in the face of an ongoing prescription. You start a medical taper of methadone. You can't be sure she will never take the medication she is filling, and furthermore can't condone an ongoing felony enterprise which may result in the death of people in the community.

Case study

- What are the ethical issues in this situation?
  - Confidentiality
  - Beneficence
    - To the patient?
    - To the community?
  - Professional competence