Addressing substance use in primary care

Abstract: ***Problematic use of alcohol, tobacco, and other drugs, including prescription medications, contributes to increased risk for injury, illness, suffering, and premature death across the lifespan. Nurse practitioners can positively impact the health of patients, their families, and communities by addressing substance use and related disorders in primary care settings.***

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Substance use disorders are a leading healthcare concern, both nationally and internationally, yet few primary care providers, including nurse practitioners (NPs), have received sufficient education and training to prepare them to address these growing challenges in their respective practices. The goals of this article are to provide basic information regarding the prevalence and consequences of certain substance use disorders; examine conceptual models of addiction; identify several clinical resources related to substance use; and apply the nursing process to address substance use and related disorders in primary care.

Key words: addiction, nurse practitioner, prevention, primary care, substance use

Prevalence and consequences

Prevalence. Problematic use of alcohol, tobacco, and other drugs, including prescription medications, contributes to the death and poor health of millions of Americans in addition to increasing the high cost of healthcare. According to the national comorbidity survey replication, lifetime prevalence of alcohol use disorders is 18.6%, or nearly 1 in 5 individuals, while other substance use disorders, excluding nicotine, are 10.9%.[1] In 2009, 20.6% of U.S. adults were current cigarette smokers, a percentage virtually unchanged from 2005. The highest rates were found in men (23.5%); those with less than a high school diploma (28.5%); and those below the federal poverty level (31.1%).[2] Recent data show that nearly 14% of U.S. residents—an estimated 34.8 million people ages 12 and older—reported lifetime nonmedical use of prescription pain relievers, such as hydrocodone (9.5%), codeine or propoxyphene (7.8%), and/or oxycodone (6.1%).[3] The majority of individuals obtained these pain medications from a friend or relative for free, and the highest rates of use were among young adults ages 18 to 25.[3,4]

Consequences. Of the more than two million deaths in the United States each year, approximately 1 in 4 is attributable to substance use.[5] Long-term alcohol misuse is associated with liver disease, cancer, cardiovascular disease, and neurologic damage. Tobacco use has been linked to numerous types of cancer, heart disease, and chronic lung conditions, such as emphysema, bronchitis, and chronic obstructive pulmonary disease. Illicit drug use can cause or contribute to many health-related problems depending on the particular substance. For example, a recent meta-analysis linked cannabis use to increased risk for the development of psychotic illness later in life,[6] whereas I.V. drug use has long been associated with painful abscesses, hepatitis B and C, and HIV/AIDS.

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The National Center on Addiction and Substance Abuse reported that the total cost of substance use to federal, state, and local governments in 2005 was at least $467.7 billion.[7] Even these staggering statistics fail to capture the extent of human suffering associated with these disorders or the prevalence and persistence of presenting problems, including accidents, diseases, crimes, child neglect and abuse, unplanned pregnancies, homelessness, unemployment, and other untoward outcomes. In addition, it was reported that 1 in 4 children in the United States (about 18 million or 28.6%) were exposed to alcohol abuse or dependence in their families before the age of 18, and more than half of all adults (98 million or 52.9%) had an alcoholic family member.[8,9]

Conceptual models of addiction

Given these statistics, it is understandable—perhaps even predictable—that many people, including some NPs, might have strong personal feelings about individuals with addictions. In order to provide optimal care, it is important for primary care providers to first examine their own attitudes, beliefs, and potential biases regarding the treatment of patients with possible substance use disorders.

Consider the following conceptual models, keeping in mind that they are not mutually exclusive, that certain aspects of these models may overlap, and that many people may subscribe (to a greater or lesser degree) to aspects of more than one model. While the word "addiction" is generally not used as a formal diagnostic term, it is a core concept surrounding the study and treatment of various substance use disorders and other related phenomena, such as pathologic gambling or other process addictions.

Moral model. A moral or criminal model tends to attribute addiction to personal weakness, a lack of character or willpower, or an outright disregard for social norms. Overtones may be religious, legal, social, political, economic, or racial in nature.[10] The use of substances is often considered to be volitional, solely a matter of personal choice, with responsibility for any related, negative consequences resting with the individual.[11] Social scorn, isolation, or punishment may be harshly imposed, with an eye toward some form of repentance, retribution, or rehabilitation.

Behavioral model. Aligned with social learning theory, behavioral models view addictions as habits that have been overlearned through observation, interactions with the environment, and the development of faulty cognitions, associations, and reinforcement. Just as undesirable behaviors can be learned, they can also be examined, challenged, and changed. Treatment modalities that coincide with behavioral approaches include, but are not limited to, behavioral couples therapy, cognitive behavioral therapy, and relapse prevention.[12-14]

Twelve-step model. While still referring to "alcoholic and drug addiction" as illnesses of mind and body with devastating personal and social consequences, Alcoholics Anonymous (AA) considers alcoholism, perhaps first and foremost, to be a "spiritual malady." This mutual aid society,

which was predicated on the idea of one alcoholic helping another, has sought to induce psychic change in those afflicted with alcoholism through a "spiritual program of action" as set forth in the 12 steps. Spirituality is emphasized and distinguished from religion, and the individual is encouraged to seek his or her own conception of a power greater than self.[15]

Disease model. While not without its detractors, the prevailing medical model for substance use disorders views addiction as a disease. The World Health Organization (WHO) recognized alcoholism as a disease in 1950, followed by the American Medical Association in 1956. In 2004, the Directors of the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) jointly published an article that described addiction as a "disease of the brain," with genetic, developmental, biological, and environmental influences that together "undermine voluntary control."[16] Spirituality is missing from some of these medical models.

Bio-psycho-social-spiritual model. One way to view addictions that reflects the holistic nature of nursing is a bio-psycho-social-spiritual model. This approach has the capacity to combine and synthesize the best elements from several complementary models, including behavioral, disease, and 12-step perspectives. In her text on spirituality in nursing, O'Brien stated that, "Spiritual care cannot be separated from physical, social, and psychological care."[17] In this respect, a bio-psycho-social-spiritual model may be seen as the most inclusive and adaptive approach for nurses to employ in the assessment, diagnosis, and treatment of patients across a broad continuum of substance use, including addiction and recovery.

Definition of addiction

Most recently, the American Society of Addiction Medicine released a public policy statement with the following definition of addiction, one that is clearly and closely aligned with a bio-psycho-social-spiritual perspective:

"Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors...addiction is characterized by the inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunction of emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."[18]

Because our own respective conceptual models of addiction can influence the ways that we perceive and treat those who are afflicted by substance use—either directly or indirectly—it is important that NPs remain willing to assess their beliefs and attitudes regarding these disorders and consider adopting a broader perspective. In addition, so that NPs can be in the best possible position to offer real support and assistance to patients, they may also need to examine their own personal behaviors in relation to alcohol, tobacco, or other substances, and to seek help, if indicated, including specialized treatment.

Substance use and related disorders in primary care

Whether in primary care or other healthcare settings, NPs are ideally suited to help others avoid the misuse of substances and to address substance use disorders among their patients across the lifespan. Historically, alcohol, tobacco, and other substance use disorders were treated almost exclusively from a tertiary care perspective, long after serious consequences had begun to emerge and accrue across multiple domains. Based on more recent research concerning the natural history of these disorders—as well as the efficacy of various treatment modalities—the focus has begun to shift toward prevention and early intervention.

One of the single most important things that NPs can do to help promote healthy lifestyle patterns among their patients is to demonstrate a consistent willingness to raise and discuss issues related to substance use in a clear, supportive, matter-of-fact, and nonjudgmental fashion. This demonstrates to patients that substance use is an important aspect of health in which the NP is interested. In response, it may become easier for patients to answer related questions, voice concerns about their own substance use or that of a family member or friend, accept professional advice, and take constructive action.

Clinical resources for primary care

There is a great deal that NPs can do to increase their own clinical awareness, competency, and efficacy in identifying and responding to potential or actual health risks associated with substance use and related disorders in primary care settings. While a comprehensive, step-by-step process is beyond the scope of an introductory educational offering, there are a number of quality resources that are readily available at no charge through various government agencies. Any and all NPs, particularly those in primary care, are strongly encouraged to access these resources and to benefit from the wealth of information and evidence-based practice guidelines that they offer.

NIAAA

Helping patients who drink too much: A clinician's guide.[19] This guide, which was written for primary care and mental health clinicians, was produced by the NIAAA, one of the National Institutes of Health (NIH). It teaches clinicians how to screen for and respond to heavy drinking among adult patients based on epidemiologic research showing that "men who drink more than 4 standard drinks in a day (or more than 14 per week) and women who drink more than 3 in a day (or more than 7 per week) are at increased risk for alcohol-related problems." A standard drink contains approximately 14 g of ethyl alcohol, as in a 12-oz bottle or can of beer, a 5-oz glass of wine, or a "shot" (1.5 oz) of 80-proof spirits, such as gin, vodka, or whiskey. Correspondingly, a bottle of table wine (750 mL or 25 oz) contains 5 standard drinks, whereas a pint of spirits equals 11 standard drinks, and a "fifth" contains 17 standard drinks.

Recommendations for still lower levels of alcohol consumption are made for those with other potential complicating factors, such as age, coexisting medical or psychiatric disorders, or the use of prescription or over-the-counter medications. Because it is unknown whether any amount of alcohol is safe during pregnancy, it is further recommended that women who are pregnant, or who may become pregnant, abstain from alcohol altogether.

A Clinician's Guide is available for download in a portable document format (PDF) in English or Spanish. Online video training and clinical case presentations are also available, with continuing-education credits offered through Medscape at no cost. Printouts of screening and assessment tools and handouts for patient education are also included as part of this program. Resources also include a PowerPoint slideshow of the *Guide* for instructors to use in teaching and training and an updated version of *Prescribing Medications for Alcohol Dependence* (2008). (See *Clinical resources for primary care providers.*)

Alcohol screening and brief intervention for youth: A practitioner's guide.[20] Available on the same web page as other NIAAA resources listed above, this guide, first published in 2011, seeks to identify children and adolescents, ages 9 through 18, who are at risk for alcohol-related problems. The purpose of this empirically derived early detection tool is to help prevent alcohol-related problems in patients before they start or to address them at an early stage. Among other considerations, drinking during adolescence is associated with increased risk for alcohol dependence later in life.

As stated in the guide, practitioners are encouraged to screen for underage drinking because it is common, risky, associated with other potentially dangerous behaviors, and often goes undetected. Using this approach, all patients in the identified age range are asked two screening questions. At ages 9 to 14 (middle school), risk is increased by having any friends who have used alcohol in the last year. As children grow older, ages 14 to 18 (high school), emphasis shifts to the patient's behavior, and binge drinking by friends also heightens concern. For those who do not drink, healthy behaviors are reinforced, and education is provided. For those who drink, risk is assessed, and advice, assistance, follow-up, and continued support are provided. The Guide (NIH Publication No. 11-7805) and Pocket Guide set are available free by ordering on the website or by calling (301) 443-3860.

Clinical resources for primary care providers

NIAAA
Helping Patients Who Drink Too Much: A Clinician's Guide
Online Training for CEU/CE Credits
Prescribing Medications for Alcohol Dependence
www.niaaa.nih.gov/publications/clinical-guides-and-manuals/helping-patients-who-drink-too-much-clinicians-guide

Alcohol Screening and Brief Interventions for Youth: A Practitioner's Guide (NIH Publication No. 11-7805)
www.niaaa.nih.gov/YouthGuide

NIDA
Screening for Drug Use in General Medical Settings: Resource Guide
NIDA Drug Use Screening Tool
www.drugabuse.gov/medical-health-professionals

SAMHSA
A Guide to Substance Abuse Services for Primary Care Clinicians
store.samhsa.gov/product/TIP-24-Guide-to-Substance-Abuse-Services-for-Primary-Care-Clinicians/SMA08-4075

The National Directory of Drug and Alcohol Treatment Programs
findtreatment.samhsa.gov

Screening, Brief Intervention, and Referral to Treatment (SBIRT)
www.samhsa.gov/prevention/sbirt

NIDA

Screening for drug use in general medical settings: Resource guide.[21] This guide, adopted from the WHO Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), was designed to assist clinicians serving adult patients in screening for drug use. The NIDA-modified ASSIST uses "The Five A's" approach to screening and brief intervention, including ask, advise, assess, assist, and arrange, and is available in hardcopy or PDF versions, along with other resources, on a dedicated portion of the NIDA website.

Substance Abuse and Mental Health Services Administration (SAMHSA)

A guide to substance abuse services for primary care clinicians.[22] Issued as part of the Treatment Improvement Protocol (TIP) series from the SAMHSA and most recently updated in 2008, TIP 24 was designed for use by nurses, physician assistants, and advanced practice nurses to screen, assess, and treat patients with alcohol and other substance use disorders.

In addition to the in-depth guide (Publication ID SMA08-4075), which provides an algorithm to help direct the process, a number of companion resources are also available free of charge, either at the SAMHSA website, or by contacting the National Clearinghouse for Alcohol and Drug Information toll-free at 1-800-729-6686. These additional resources include the *Concise Desk Reference Guide* (SMA09-3740), which is an abbreviated version of the original text, a *Quick Guide for Clinicians* (QGCT24), and the Knowledge Application Program, or *KAP Keys for Clinicians* (KAPT24).

Screening, brief intervention, and referral to treatment (SBIRT). SBIRT is an approach that has gained increased national attention. A government-funded initiative, SBIRT is an evidence-based treatment modality that has been implemented and tested across a variety of clinical settings and professional disciplines, including nursing.

SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and treatment services for people with substance use disorders as well as those who are at risk for developing these disorders. Primary care centers, hospital emergency departments, trauma centers, office-based practices, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.[23]

Efforts are being made to include the screening of hospital inpatients for alcohol and other substance use, with support from entities, such as the Brief Intervention Group (BIG) Hospital Initiative.[24] Effective January 1, 2012, the Joint Commission (TJC) released new, voluntary accreditation standards that coincide with the delivery of SBIRT in hospital settings.[25]

Brief interventions, including those associated with SBIRT, are now reimbursable services through Medicare, Medicaid, and commercial insurers.[26] Eligible providers include physician assistants (PAs), nurse practitioners (NPs), Clinical Nurse Specialists (CNSs), clinical psychologists (CP), and clinical social workers (CSW).[27]

Nurses are playing active roles in these efforts. A recent study by Broyles and colleagues demonstrated high levels of acceptability with nurse-delivered SBIRT among hospital inpatients.[28] Given the sheer number of nurses in the healthcare system and the diverse clinical settings in which they practice, Finnell subsequently issued a clarion call for nurse-led SBIRT across the continuum of care.[29] In a position paper approved by the International Nurses Society on Addictions (IntNSA) and the Emergency Nurses Association (ENA), Strobbe, Perhats, and Broyles encouraged expanded roles and responsibilities for nurses in the delivery of screening, brief intervention, and referral to treatment (SBIRT) for alcohol use, in virtually all healthcare settings and levels of practice, including patient care, research, and education.[30]

Applying nursing process to substance use in primary care

Each of the clinical approaches outlined above share several key elements. In their most abbreviated forms, each involves screening, to quickly assess the extent of alcohol and/or other substance use; brief intervention, a relatively short (5 to 15 minute) semistructured discussion to raise awareness and increase motivation to avoid, reduce, or discontinue any potentially problematic use of alcohol or other substances; and referral to an appropriate level of specialized addictions treatment, if indicated. With certain enhancements, this simple framework can fairly readily be expanded to align closely with the nursing process, a structure that is highly familiar to NPs.

Assessment. This first step in the nursing process may involve a relatively simple verbal screening for the presence or absence of substance use, or it can be extended to include a more thorough assessment. It is recommended that all primary care providers integrate questions about alcohol, tobacco, and other substance use into their clinical conversations on a routine basis—from the very first meeting with the patient and periodically thereafter—in a matter-of-fact, supportive, and nonjudgmental fashion. Risk factors for substance use disorders include, but are not limited to, the following: family history, chronic medical conditions, mental health disorders, a history of sexual abuse or other forms of trauma, and the use of any other substances.

A Clinician's Guide directs the provider to ask about heavy drinking days and, if the screen is positive, to administer the Alcohol Use Disorders Identification Test.[31] Subsequent research has suggested that a number of shorter versions of this tool, including the AUDIT-C, are valid and reliable, with psychometric properties as satisfactory as the 10-item AUDIT.[32] (See *AUDIT-C Questionnaire.*)[33]

Primary care providers can also obtain valuable clinical information through routine lab tests, including urine drug screens (UDS) or blood samples, although additional training and experience may be necessary in order to correctly interpret certain results. Some clinicians may feel uncomfortable, at least initially, seeking this kind of information. It is important for practitioners to be honest with patients about any

tests that are being prescribed and why. It is also important to provide patient education regarding the importance of being informed about these aspects of health in order to help provide safe and effective care, to avoid potential drug-drug interactions, or other complications.

If the patient reports that they do not use substances, they should be asked what factors led to this decision; it may stem from personal or religious values. It could also be in reaction to having been raised in an alcoholic household, or perhaps they are currently in recovery themselves. Either of these examples provide important personal health information and could still point to an increased risk for substance use. In any case, positive verbal reinforcement should be provided along with encouragement for continued healthy behaviors. If it appears that substance use may be a problem, the individual should be commended for his or her honesty if they were able to share this information, and a willingness to help should be expressed.

Diagnosis. It is within the scope of practice for NPs to diagnosis diseases.[34] The publication of the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition, or DSM-5, in 2013 marks a shift in terminology and diagnostic criteria in comparison to the previous edition. In particular, the terms "substance abuse" and "substance dependence" have been abandoned in favor of the potentially less stigmatizing "substance use disorder."

A substance use disorder (alcohol, cannabis, or opioid use disorder) is defined as "a problematic pattern of...use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period."[34] Specific criteria include the following: a loss of control over use; inability to cut down or control use; craving or a strong desire or urge to use; a great deal of time spent obtaining, using, or recovering from the effects of the substance; recurrent failure to fulfill major role obligations; continued use despite related social or interpersonal problems caused or worsened by substance use; important activities that are given up or reduced because of substance use; recurrent use in physically hazardous situations; continued use despite negative consequences; tolerance; or withdrawal.[34]

Severity is rated as mild in the presence of 2 to 3 symptoms, moderate in the presence of 4 to 5 symptoms, and severe in the presence of 6 or more symptoms.[34] A patient is considered to be in early remission if none of the criteria are met for more than 3 months, but less than 12 months, with the possible exception of craving, which does not disqualify an otherwise eligible patient. Similarly, an individual is considered to be in sustained remission in the absence of any of the diagnostic criteria for a period of 12 months or longer, with the same caveat related to the phenomenon of craving.

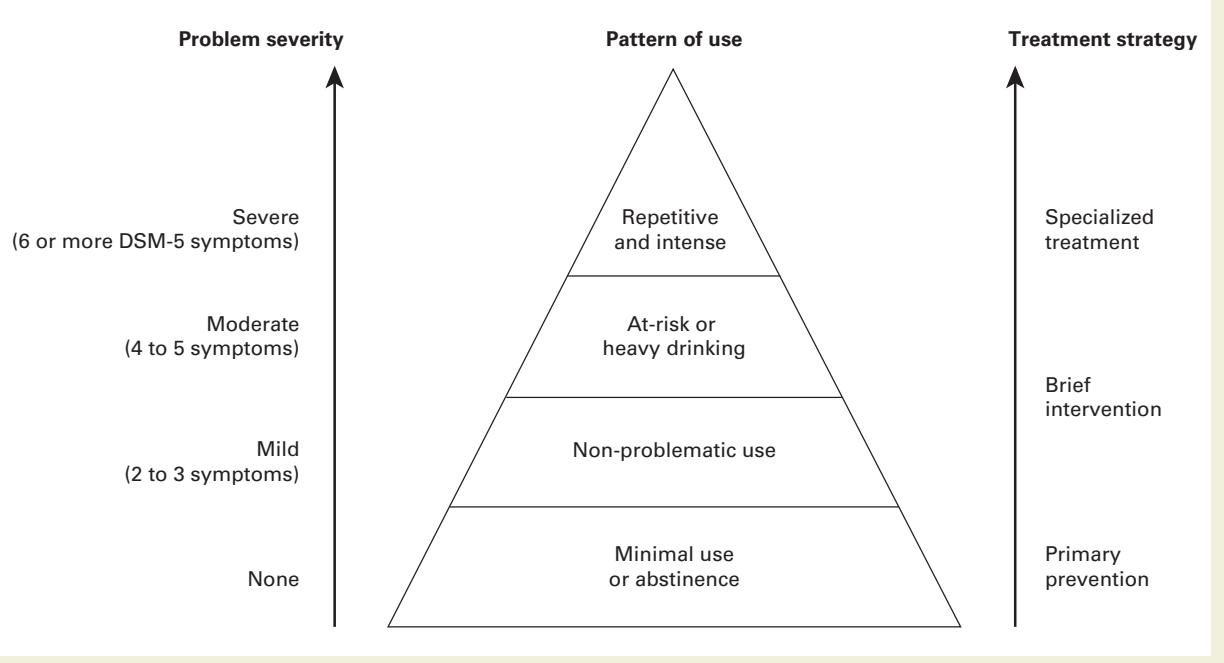
Outcomes/planning. Outcomes/planning is done in cooperation with the patient and should reflect the current level of substance use and appropriate recommendations (see *Patterns of substance use and problem severity direct treatment strategy*).[35] In primary care—unless the NP has special training, experience, and certification in addictions nursing—the indicated "treatment" will most often take the form of a brief intervention. Based on the transtheoretical stages of change model[36] and motivational interviewing techniques,[37] brief interventions are designed to help the patient move toward healthy, adaptive change.

AUDIT-C Questionnaire[33]

	Scoring					
Questions	**0**	**1**	**2**	**3**	**4**	**Score**
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
	If score to 1st question is zero, stop screening here					
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 to 2 drinks	3 to 4 drinks	5 to 6 drinks	7 to 9 drinks	10 or more drinks	
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total Score	

The AUDIT-C is scored on a scale of 0 to12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

Patterns of substance use and problem severity direct treatment strategy



Primary prevention for those who are abstinent or with minimal or non-problematic use. Brief intervention is appropriate for at-risk or heavy drinking. For moderate-to-severe alcohol use disorders, refer the patient to specialized addictions treatment. The use of any illegal substance is inherently problematic.

Adapted from: Brower KJ, Severin JD. Alcohol and other drug-related problems. In: Knesper DJ, Riba MB, Schwenk TL (eds). *Primary Care Psychiatry.* Philadelphia, PA: Saunders; 1997. Used with permission from Elsevier.

For patients who are abstinent from alcohol and other substances or drinking below NIAAA guidelines with no adverse reactions, no intervention is needed beyond positive reinforcement, continued encouragement, and periodic reassessment. For patients with at-risk drinking, the goal is to help motivate them to cut back or quit drinking and to eliminate other risky behaviors. For some, this may involve a referral for further assessment.

For those with moderate-to-severe substance use disorder, the goal is to help motivate the patient to accept a referral to specialized addictions treatment. Once such a diagnosis has been established, recommendations generally include abstinence from the identified substance as well as any other potentially addictive substances. If the disorder includes pronounced physiologic dependence—particularly to alcohol, benzodiazepines, or opioids—or the patient has a history of withdrawal-related seizures or other serious medical conditions or complications, then treatment may need to be initiated on an inpatient basis. The *National Directory of Drug and Alcohol Treatment Programs*[38] is a listing of federal, state, local, governmental, and private facilities that provide substance abuse treatment services. This resource can be obtained for free by calling 1-877-726-4727 or online.

Implementation. Implementation involves moving forward with the plan and making modifications as needed. Progress is seldom linear, and setbacks may occur. If adherence becomes a serious issue, then it is best to not personalize the situation and to remain calm and resolute with the intent to remain helpful. If part of a group practice, then discuss how to handle difficult cases as a team.

Consider establishing an ongoing collaborative or consultative relationship with a Certified Addictions Registered Nurse-Advanced Practice (CARN-AP), another addictions specialist, or one or more local addiction treatment facilities.

Evaluation. Evaluation is a continuous process, and for patients with substance use disorders, this may be a lifelong consideration, as with other chronic diseases. In the short term, ongoing patient assessment may include self-report of any substance use, review of logs or other monitoring tools, repeat UDS or other lab work, and the initiation and maintenance of other health-related behaviors.

Continued use or relapse may require the NP and patient to review and revise the plan and to consider higher levels of care. Even after abstinence and recovery have been successfully established and maintained, risk of relapse remains a possibility, particularly during periods of pronounced stress.

The good news, which is important to share with patients, is that many individuals are able to reduce or eliminate substance use without formal treatment. For those who require specialized treatment, outcomes are positive and on a par with other chronic health conditions.[39] Although difficult to quantify, it has been suggested that millions of individuals have recovered from alcohol and other substance use disorders and are living healthy, satisfying lives.[40]

Other considerations

Mutual help groups. An essential part of treatment and recovery for many individuals with substance use disorders includes regular meeting attendance and affiliation with a mutual help group, such as AA (www.aa.org), Women for Sobriety (www.womenforsobriety.org), Narcotics Anonymous (www.na.org), or SMART Recovery (www.smartrecovery.org). Friends and family members of those with alcohol or other drug problems can seek their own support and recovery in Al-Anon or Alateen (www.al-anon.alateen.org) or Nar-Anon (www.nar-anon.org), respectively. Healthcare professionals are encouraged to familiarize themselves with these organizations and to educate and refer patients to these low- or no-cost support groups.[41]

Medications. When prescribing medications to patients with a history of alcohol or other substance use disorders, try to avoid the use of agents that may place the patient at increased risk for misuse, particularly benzodiazepines and/or opioid medications. For specific procedures that require their administration, associated risks should be reviewed with the patient, and they should be assisted in identifying and implementing additional measures of support and accountability, if indicated. If questions arise regarding the possibility that a patient may be obtaining controlled substances from multiple prescribers, most states have prescription monitoring programs in place, with information available to prescribers, including NPs.[42] Special considerations are also given to complex cases of pain management in patients with substance use disorders, as outlined in a position paper by the American Society for Pain Management Nurses, and endorsed by the International Nurses Society on Addictions (IntNSA).[43]

A number of medications are available to help treat addictions, including acamprosate (Campral), disulfiram (Antabuse), or naltrexone (ReVia [oral] or Vivitrol [injectable]) for alcohol dependence. Buprenorphine (Suboxone) can be used for opioid detoxification or maintenance therapy, although the prescribing of this medication is currently limited to physicians with additional training and a modified Drug Enforcement Administration (DEA) number. Efforts are underway to have these privileges expanded to include advanced practice addictions nurses.[44,45] Opioid replacement therapy is also available using methadone through federally regulated opioid treatment programs. It is generally recommended that pharmacotherapy for addictions be provided only in conjunction with psychosocial treatment.

Addictions nursing. Addictions nursing is recognized as a specialty area of practice. Nurses across a wide variety of practice settings and patient populations may wish to further enhance their skills by pursuing addictions nursing as a specialty or subspecialty. Areas of nursing that are likely to encounter significant numbers of patients with substance use and related disorders may include, but are certainly not limited to, primary care, emergency, trauma, pain management, oncology, gastroenterology, occupational health, pediatric, geriatric, and psychiatric nursing.

IntNSA (www.intnsa.org) is the professional organization most closely identified with the specialty of addictions nursing. Annual educational conferences and membership in the organization provide opportunities to learn from experts while accruing continuing-education credits in nursing; meeting other clinicians, researchers, and educators in the field; presenting individual work in poster, paper, or panel sessions; and to participate in, and contribute to, the growth of this vibrant professional society. The *Journal of Addictions Nursing*, which is published on a quarterly basis, and is listed on MEDLINE and PubMed, is the official journal of IntNSA.

Board certification in addictions nursing is available to qualified candidates who are either RNs or Advanced Practice Registered Nurses (APRN). Following successful completion of the application and examination process, nurses are then designated as a CARN or a CARN-AP through the Addictions Nursing Certification Board.

Implications for practice. Substance use disorders can carry serious consequences for patients, families, and communities. NPs are in an excellent position to help prevent, identify, and treat substance use and related disorders at increasingly earlier stages across the lifespan, thereby decreasing the burden of illness and related complications. Some patients may respond to brief interventions when delivered by NPs in primary care settings, while others may require referrals for further assessment or formal treatment. Specialty certification is available in addictions nursing, and nurses across a wide variety of practice settings are encouraged to develop this area of expertise. People can and do recover from substance use disorders, and NPs can play a vital role in helping their patients consider, approach, initiate, and continue this meaningful and worthwhile journey.

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