Addiction in Anesthesia
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CA BRN Diversion Evaluation Committee
Introduction

- Addiction is the greatest occupational hazard of the anesthesia profession......

- With death as a very possible result!
Addiction-definition

- DSM (IV-r) Criteria
- Substance use leading to impairment
- Compulsion or craving
- Loss of control, tolerance
- Social, occupational or recreational activities diminish
- Continued use despite adverse consequences
Objectives

- Explain occupational risks
- Identify components of Chemical dependency Rx
- Describe peer assistance effort
- Describe key components of successful recovery and reentry
- Review negative impact of punitive vs. advocacy approach
Trigger Mechanisms for Anesthesia Providers

- Ease of drug availability
- Prior experimentation
- Job-related stress in highly specialized vocation
- Respect not equivalent to responsibility
- Intimate knowledge of pharmacology
- Altered sleep patterns
Prevalence

- General population 4 - 6%
- Nursing 8 – 10%
- CRNAs 10+%  
  - Male 63%
  - 43% currently using other drugs
  - Opioids, Midazolam, propofol
  - Intranasal route on rise
Risk factors for Substance Abuse

- Biogenetic, ethnicity
- Job/life stressors, burnout, depression
- Accessibility along with poor accountability policies/practices
Biogenetic Disease

- Ethnicity- Inuit, Native American
- Addiction is a primary disease
  - Brain disorder (altered neuronal function)
  - Compulsive, drug-seeking behavior
  - Chronic, relapsing
  - Fatal if untreated
- Family Hx – 36% have one ETOH parent
Psychosocial Risk Factors

• Early predictors (5-6 factors = heavy abuse)
  • Emotional Distance in family, psych. Stress
  • Low self-esteem, low spirituality
  • High sensation seeking, high use among peers, early use of substances
  • Misuse of substances in family
Job/Life Stressors

- Family demands
- Shift work – 12/24/48 hrs, mandatory overtime, feel guilty if refuse
- OSHA “ideal”: 15 min breaks x 2, plus 30 min. meal break per 8 hr. shift
- “Real World”: ???
- Temp staff: you train, they get paid more
Occupational Risk Factors

• Caregiver role
• Self-treat, pharmaceutical optimism
  • Access, experience, knowledge
  • Trained to relieve pain
  • Deserve “relief” as much as patient
• Chemical dependency under-emphasized in curriculum
Occupation Risk Factors

- Personal problems, poor coping mechanisms
- Overworked, exhausted, frustrated
- Work alone
- Doctors & patients demanding
- Litigious workplace
- Staffing shortage
- Increasing responsibilities without increasing authority
- Lack of recognition
Occupational Risk Factors

- Healthcare driven by revenue
- Lack of effective Employee Assistance Program, employee support
- Compromised patient safety, no one listens
- If you complain you’re not a team player
- More paperwork than patient care!
Occupational Risk Factors
Students

- High performance expectations
- Decreasing self-esteem
- Financial: loans, debts
- Lack of coping skills
- Moved from expert back to novice
- Decreasing time for self/family
Identification is Difficult

- Inability to reach out, humiliation, guilt, shame
- Fear of consequences
- Enabling by family and coworkers: Conspiracy of silence
How do they Obtain Drugs?

- Falsify record keeping
- Excessive use of narcotics (charted)
- Giving breaks
- Keeping waste
- Switching syringes
- “Breaking” ampules
- Withholding from patients
- Breaking into sealed narcotics
Routes of Administration

- IV
- IM
- PO
- Infranasal
- Rectal
- Sublingual
- Intracardiac
- Penis
Fentanyl

- “incredible erotic and ecstatic high, surpassing any prior similar feelings and fulfilling one’s fantasies”
- High is fleeting, lasting less than 10 minutes followed by a craving to re-experience the UNBELIEVABLE HIGH
Time to Detection

- Sufentanil: 1-6 months
- Fentanyl: 6-12 months
- Alcohol: years
Signs of IVDA Abuse - appearance

- Wears long sleeves
- Pupils pinpoint
- Withdrawal Sx: sweating, vomiting, shaking
- Injection sites/bruises
- Liquid or blood on clothing
- Disappearing from department in agitated mood; returning calm
- Comatose
- Death
Signs of IVDA Abuse

- Extra shifts vs. calling in sick
- Offering breaks
- Locked doors
- No responses to pages/emergencies
- Paraphernalia
Suspected Coworker—what to do

- Observation
- Share concerns with supervisor
- Gather information and DOCUMENT
- Notify Chief CRNA/MDA, well-being committee, EAP or State Peer Assistance
- DO NOT confront a colleague alone
Responsibility: Colleague

- NO Mandatory reporting statute in California
- Legal vs. ethical
- Nurse Practice Act
- AANA code of ethics
- Employer policy
- “You CANNOT do nothing and you CANNOT negotiate with a person using drugs” (recovering addict)
Responsibility: Colleague Practical & Pertinent

• Observation
• DOCUMENTATION
• Reporting indicators & observations to supervisor
• Support confrontation & advocacy
• Support retention/reentry
Responsibility: Supervisor/Facility

• Develop FAIR policies in advance of need
• Once confronted with abuse:
  • Gather documentation
  • Thoroughly assess all info and all options
  • Maintain CONFIDENTIALITY
  • Drug test the suspect but be prepared to test everyone
Planning Intervention

• Verify facility policy
• Know if requirement for mandatory reporting to BRN
• Consult with hospital EAP
• Explore options for treatment:
  • Example: Kaiser EDRP
Confrontation

• A PLANNED EVENT
• NEVER do alone!
• Gather “cast” and rehearse
• Provide valid documentation of observations and records
• Conduct in supportive manner
• Goal is assessment not termination
Treatment

- Treatment does not have to be voluntary to be effective
- Few options
- Detox is not a form of treatment!
- Recovery is lifelong-no cure
- 12 step programs most successful
Resources

- State BRN Diversion Program
- AIR (Anesthetist in Recovery)
- AANA Peer Assistance
- CANA Peer Assistance
- EAP
- AANA Website
- Drug/ETOH Addiction Websites
California BRN Diversion Program

- Voluntary & Confidential Program
- Monitoring and Recovery
- Impaired RNs due to substance abuse and/or mental illness
- May be BRN directed for license retention
California BRN Diversion Program

- Self referral
- Complaint/board referral
- Voluntary
- Confidential
- Usually 3+ years for successful completion
- 1-800-522-9198
Goals of Diversion Program

- Help RNs return to practice safely
- Protect the public
Diversion Program Provides

• Immediate intervention to protect the public from RN whose practice may be impaired

• Effective alternative to longer disciplinary process
Diversion Program Staff

- BRN Manager of Program
  - Oversees:
    - Diversion Program Contractor (Maximus)
    - Diversion Evaluation Committees (DECs)
    - Nurse Support Groups
Contractors Responsibilities (Maximus)

- Maintain toll-free 24/7 telephone contact: 1-800-522-9198
- Comprehensive assessments of applicants
- Monitor applicants and participants
- Assign case manager to each participant
- Case managers are RN’s with Pysch/Addiction competencies
Diversion Evaluation Committee Composition

- 3 RNs
- 1 MD
- 1 Public Member
- Usually each with a background in chemical dependency and/or mental illness treatment
Contractor (Maximus)

- Located in Rancho Cordova
- Contracts with 7 Boards of California
- Social Security Services
- Federal Agencies
DECs

- 16 DECs across the State
- 2 in Sacramento
- Meet quarterly
- Average DEC caseload 30-40
- Meet with 10 -12 participants at each DEC meeting
How DECs make their decisions:

• Intake interview by Maximus case manager
• Reports/ Nurse Support Group Facilitator
• Clin. Assessment “in the field” by LCSW
• Reports from treatment facility, therapist, MD
• Monthly self-reports
• Work-site monitor quarterly report
• Participant interview at DEC
Nurse Support Groups

- About 30 CA Nurse Support Groups
- Group meetings facilitated by RN with mental health/addiction background
- Facilitators approved by BRN Manager
- Design to assist entry into program and support on-going recovery
How to get into the BRN Diversion Program?

- Self-referral
- Board-referral (complaint)
Who Is Eligible?

- RNs with current CA license and CA residence
- RNs mentally ill &/or abusing ETOH/drugs that are affecting nursing practice
- RNs who volunteer to enter and comply with elements of Individualized contracts
Who is NOT Eligible?

- RNs previously disciplined by BRN for substance abuse or mental illness
- RNs previously terminated by DEC for non-compliance
- Caused patient harm (including sexual abuse) or death
Common Entry Contract

- Suspend RN practice (not license)
- Treatment (individualized)
- 90/90
- Weekly RN Support Group
- Random urine test
- Abstinence
- Sponsor with 5+ years sobriety
Common Program Progression

- Meeting requirements slowly decrease to 2-3 per week plus NSG
- Specific types of meetings (AA, NA, Women’s, Men’s, etc.) may be required.
Common Program Progression

- **Practice:**
  - Initially suspended
  - Return to non-patient care
  - Patient-care without access
  - Patient care with full access
  - Very Individualized
  - CRNA moved more slowly to return to Anesthesia practice
In Order to Return to Work

- Job description must be submitted and approved prior to returning to work
- Must obtain work site monitor
- Must authorize communication with work site monitor and DEC
- May require Naltrexone use
Examples of Work Restrictions

• Initially 20 – 30 hours per week
• No more than 40 per week
• No floating
• Not the only RN/CRNA on unit
• No nights, weekends or Holidays
Drug Testing

• Random (must call each AM)
• Test within 8 hours of test day
• Random weekend testing with field monitors
• Test sites arranged for vacations
Cost to RN

- $25 per month
- Treatment program costs
- Body Fluid testing costs
- Nurse Support Group costs
- Heath care costs (psych. Exam)
- Counseling, Therapy, etc.
Reentry Contract

- Random urine/blood screens
- Naltrexone
- No call
- Work-site monitor
- No narcotic keys
- Relapse prevention document
- Consequences for relapse
Successful Completion

- All records are expunged from the RNs file and no evidence can be recovered.
DATA:

• 1100 RNs have successfully completed BRNs Diversion Program
• Average 400 – 500 RNs in program at any one time
• Average 3.5 – 4 years to complete Diversion Program
Relapse- The Dilemma

- 16% of opioid abuser initial relapse symptom was death
- 34% opioid abusers reentry successful
- 70% nonopioid abusers successful
Knowledge and Openness is POWER!
Challenges to the Profession

- Recognize addiction as a:
  - DISEASE requiring Rx
  - Occupational hazard
- Educate – curriculum
- Offer ADVOCACY
  - Available to every CRNA
  - Consistent geographically
Perception: True or False?

- “Nurses circle the wagons.......then shoot inwards!
- “Nursing is an army that shoots it’s wounded”
- “Nursing Eats their young!”
Question?

• If CRNAs can care for strangers (patients) who are afflicted with the disease of addiction, why can they not care for their own colleagues with the same compassion?