Nurses Need to Play an Active Role in Managing Designer Drug Use

Written by Mary Beth Nierengarten

With the increased use of designer drugs among adolescents, nurses need to take an active role in educating and treating patients as well as in changing health care practice and policy for banning new substances.

Katharine Frances Drobile-Landis, RN, BSN, Community College of Philadelphia, Philadelphia, Pennsylvania, USA, provided a summary of the current evidence on designer drug use among adolescents to help educate psychiatric nurses on the high incidence and dangers of these substances and what signs and symptoms to be aware of for suspected use, as well as the role they should play in changing health care policies.

Based on a systematic review of emerging drugs of abuse (Nelson ME et al. *Emerg Med Clin North Am.* 2014), Ms Drobile-Landis first provided a brief description and accompanying signs and symptoms of 2 commonly used designer drugs among adolescents: synthetic cannabinoids and synthetic cathinoids (bath salts).

First approved in 1985 for the treatment of nausea, synthetic cannabinoids are commonly known as spice, K2, spice gold, or fake weed. Signs and symptoms include anxiety, agitation, confusion, insomnia, hypertension, short-term memory loss, seizure and convulsions, shortness of breath, and psychosis and paranoia.

Existing in a natural form in the leaves of the Khat plant, synthetic cathinones are commonly known as bath salts, vanilla sky, ivory wave, meow meow, and cloud 9. Signs and symptoms include hyperthermia, blurry vision, tachycardia, psychosis, hypertension, agitation, seizure and convulsions, and acute renal failure.

Along with recognizing the signs and symptoms of these substances and providing supportive treatment, Ms Drobile-Landis emphasized the need for nurses to educate adolescents about the dangers of these substances, and the need for abstinence and breaking with maladaptive patterns that lead to their use.

US poison control centers received 2251 calls in 2012 related to bath salts through September 10 [Gershman JA, Fass AD. *P T.* 2012]. Ms Drobile-Landis highlighted efforts over the past several years to ban or regulate these substances in the United Kingdom and the United States. A UK study showed about 1800 queries relating to cathinones over 1 year leading up to the UK ban [James D et al. *Emerg Med J.* 2011], but a survey showed mephedrone was still in demand following the ban [Winstock A et al. *Lancet.* 2010].

Emphasizing the active role that nurses need to take in educating patients about these substances as well as helping to change policy on their use, Ms Drobile-Landis encouraged nurses to report suspected use of these substances to their local poison control center to help identify the extent of the problem and receive guidance on how to manage the problem. She also highlighted that in patients suspected of severe substance use, outside laboratory tests using liquid chromatography and mass spectrometry should be considered.

CIT Reduces Anxiety in Inpatients With Relationship Problems

Written by Rita Buckley

Troubled relationships put psychiatric patients at high risk of relapse, even when they are fully compliant with medication regimens. However, cognitive interpersonal therapy (CIT) can reduce anxiety and possibly improve social skills. Tamra Rasberry, PhD, MSN, RN, Liberty University, Lynchburg, Virginia, USA, presented results of a pilot study to assess the efficacy of intensive cognitive interpersonal therapy (ICIT) in an inpatient setting.

CIT is specifically designed to address relationship conflicts and to help individuals learn how to deal with the negative emotions generated by relationship distress. Key components of CIT include assessing the client's motivation for change and addressing emotion regulation by teaching strategies to develop empathy, assertiveness, and respect. By providing motivated individuals with tools and insights to improve relationships, it reduces interpersonal anxiety and fosters self-regulation of negative emotion—an essential skill to achieve and maintain emotional health. Evidence suggests that ICIT has the potential to accrue similar benefits for inpatients.

The pseudo-experimental, pre- to posttest, nonblinded trial used a short-term ICIT approach with relationship conflict (a largely overlooked area of research) as its sole focus. Targeting known contributors to relapse (ie, criticism, hostility, and emotional overinvolvement), its primary aim was to examine whether a brief ICIT intervention could improve patients' ability to handle close relationships, increase their satisfaction with them, and decrease emotion dysregulation and destructive thought processes. A secondary aim was to provide preliminary evidence for a brief intervention for psychiatric inpatients.

Inclusion criteria included hospitalization with a psychiatric diagnosis, in-hospital availability on Saturday and Sunday, willingness to participate in ICIT or treatment as usual (TAU) groups, and agreement to be contacted after discharge for follow-up. Patients also had to

be aged ≤64 years, with an identified and acknowledged relationship problem. Exclusion criteria were psychosis, organic brain disease, intellectual disability, and acute medical conditions.

Two groups of 20 patients were assigned to either ICIT or TAU. Data were collected through a series of tests (eg, Burns Relationship Satisfaction Scale and the Firestone Assessment of Self-Destructive Thoughts) on relationship satisfaction, emotional regulation, destructive thought processes, and relapse. One-way analysis of variance was used to perform statistical analyses. A *P* value < .05 was considered statistically significant.

CIT therapy sessions consisted of 6 hour-long modules presented over 2 days. A follow-up appointment took place 6 weeks after discharge. Except for one Latino patient, the ICIT group was all white, as were the TAU patients. The average age range of the ICIT group was 40 to 49 years, compared with 30 to 39 years in the TAU group.

The data showed no statistically significant differences in relationship satisfaction or emotion regulation (depression and anger scales) between the groups. The only significant difference was on the Burns Brief Mood Survey, Anxiety Scale ($P = .047$), indicating that the therapy may be particularly helpful for patients experiencing anxiety. Although the majority of patients in both groups had a reduction in symptoms, those in the ICIT group showed greater improvement than their peers in the TAU group.

Community Crisis Respite Centers Provide Cost-Saving Alternatives to the ED for Patients in Crisis

Written by Nicola Parry

Michelle Heyland, MSN, APN, Rush University College of Nursing, Chicago, Illinois, USA, shared fiscal year 2014 results from a community crisis respite program called The Living Room. This program offers a cost-saving alternative to the emergency department (ED) for individuals in crisis.

According to Ms Heyland, approximately 12.5% of all ED visits in the United States involve a mental health or substance abuse diagnosis, and these are more than twice as likely to result in hospitalization than visits without such a diagnosis [Owens PL et al. *Agency for Healthcare Research Quality Statistical Brief #92.* 2010]. These patients tend to receive inappropriate care, for reasons including ED overcrowding, lack of priority triage, and the absence of trained psychiatric professionals to help with crisis de-escalation [Shattell MM, Andes M. *Issues Ment Health Nurs.* 2011; Clarke DE et al. *Int J Ment Health Nurs.* 2007]. Studies have shown that individuals in crisis want to visit a place where they feel safe and respected, and can talk to trained psychiatric professionals who understand their needs [Agar-Jacomb K, Read J. *J Mental Health.* 2009; Clarke DE et al. *Int J Ment Health Nurs.* 2007].

Table 1. Demographics of Guests Visiting The Living Room in Fiscal Year 2014

Demographic	Percentage
Age, y	
18–40	35
41–60	58
≥60	7
Sex	
Men	39
Women	61
Presenting problem	
Suicidal ideation	18
Homicidal ideation	3
Anxiety	28
Depression	25
Other	26

Ms Heyland described a community crisis respite center called The Living Room as one alternative to the ED for providing service to people in crisis. This was named after the familiar home space, and is offered free of charge to clients who are referred to as "guests," in an attempt to emphasize its nonclinical environment. It provides an inviting atmosphere that is warm, welcoming, and without excessive stimuli. The layout allows for guest privacy with a separate area for rest and relaxation.

Staff members are trained psychiatric professionals, and include a therapist and a psychiatric nurse; there are also peer counselors who have a mental illness but have recovered enough to be able to offer help to others in need.

Guests who visit The Living Room are triaged by the therapist to obtain some basic demographics (Table 1), determine the nature of the crisis, and assess the guest's levels of distress, risk, and safety. They then meet with the psychiatric nurse, who establishes the guest's vital signs and also addresses any issues they may have regarding medical conditions or medications, for example.