Dying to Feel Better

Some Nursing and Psychiatric Perspectives About Caring for People with Substance Use Disorders and Their Babies[1,2]

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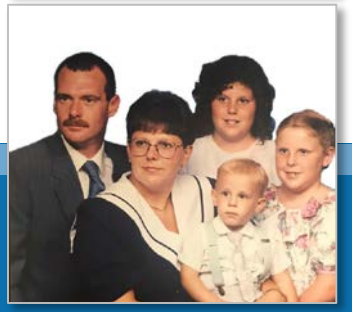
A Presentation for the Indiana Neonatal Abstinence Syndrome Summit
September 28, 2017

East Liverpool, Ohio
Police Department

[1] This presentation will take an unusual perspective of this clinical challenge; thank you for your willingness to change what you believe about substance users and how you interact with them—in spite of how you feel about them.
[2] This presentation is also a difficult and deeply personal story.

Stephanie Lynn Burchett, March 16, 1983 – December 22, 2016

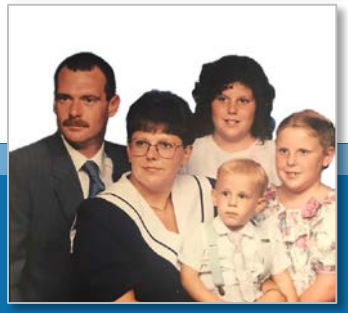
Why does this matter?



- Full of energy, she walked at seven months.
- Everyone she knew loved her; she lit up every room she entered.
- She excelled in sports, particularly tennis.
- Loving, caring and bighearted, she loved spending time with her friends and family.
- She took some colleges classes and wanted to help others.
- She underwent back surgery in high school and was treated with opioids.
- She was treated with medication-assisted treatment (MAT), inpatient rehabilitation and counseling.
- She suffered numerous relapses before her death from an overdose.

Sarah Lynn Burchett, March 11, 1985 – October 12, 2014

Why does this matter?



- Always independent, she had a close network of friends and enjoyed learning new things.
- She excelled in sports, particularly tennis, and she traveled to play tennis in Australia and Fuji.
- She graduated as her high school valedictorian, graduated from Flagler College with majors in psychology and sociology in St. Augustine, FL, and she intended to study law.
- She was eager to succeed.
- Kind and thoughtful, she wanted to make us proud.
- She underwent a lumbar spinal fusion and fixation at age 22 and was treated with opioids.
- She was treated with MAT, inpatient rehabilitation and counseling and suffered numerous relapses before her death from an overdose.

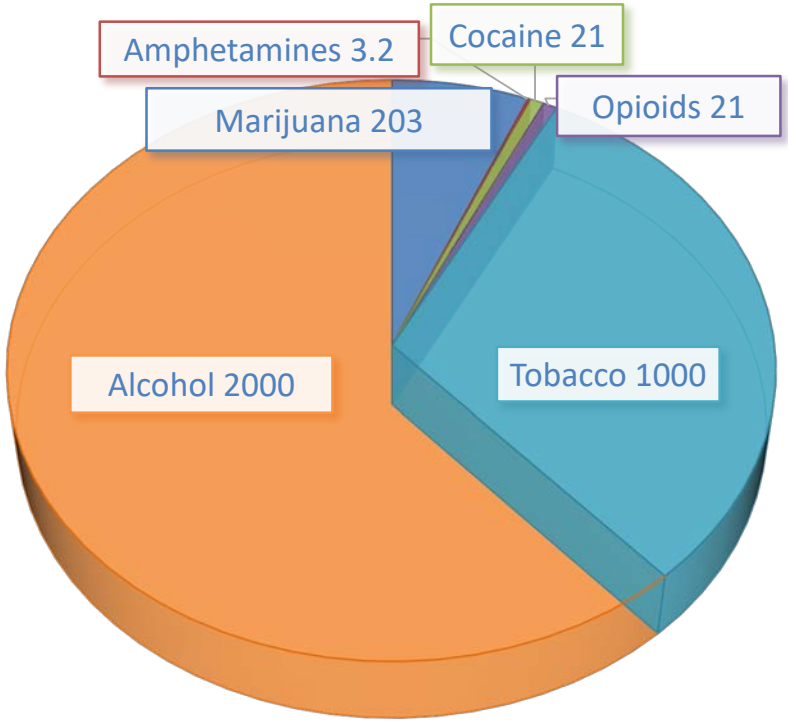
What are the objectives of this presentation?

- Every day, billions of our brains—and the humans they manage—crave and use substances.
- When that use creates intolerable complications, substance users often look to us for help.
- And we can actually help these sufferers—though not as much and as many of them as we would like.
- We have all embraced certain beliefs about substance use, and these beliefs impact how we feel and treat these patients.[1]

- After this presentation, you will be able to answer the following questions:
  - What painful realities about substance abuse must we face before we can be helpful?
  - What are our perspectives (beliefs) about substance users?
  - What are we doing for pregnant women who are using substances?
  - How are we treating newborns with Neonatal Abstinence Syndrome (NAS)?
  - What are some of our results?
  - What else can we all do to help?
- We will be more effective if we focus on **us** instead of **them**.

[1] **Tell stories here about the painful stigma to which you and your daughters were subjected.**

What are some of the painful realities we must face?[1,2,3]



Millions of Users

- Drugs are not the problem; the human brain is the problem.
- Brain-driven **choices** are the keys to the problem—and the solution.
- Prevention is the place to start.
- While opioid use is getting enormous attention right now, alcohol and tobacco are killing hundreds of thousands of us every year.
- No matter what treatment options are available, people will still use substances and die trying to feel better.
- Not everyone will recover—but some will.
- While many of us make poor choices, our negative attitudes about these people and their poor choices are the major barriers to progress.

[1]The Lancet, January 6, 2012
[2]WHO
[3]GreenFacts.org

What are some of our perspectives[1,2] about people who use substances to feel better?

- Substance abuse is a common clinical problem, and these people need our help—and they will often reject it.
- According to the Substance Abuse and Mental Health Administration (SAMHSA), 22 million people needed treatment for illicit drug use in 2014; only 4.2 million received treatment.
- We aspire to provide evidence-based recommendations and treatment with an attitude of genuine respect and caring.
- While their difficult behaviors will often incline our brains to create unpleasant feelings and provoke unhelpful behaviors, our brains—not their behavior—are the larger problems during our interactions.
- There is no good reason for us to resent these noncompliant patients any more than our other noncompliant patients.
- Some of these patients do improve or recover completely with treatment; their situation is dire but not hopeless.
- **If any of us wishes to make a significant change in our lives, we must change what we believe and what we do—in spite of how we feel.**
- This means that counseling is **always** indicated even though it is often rejected or not taken seriously, neither by our patients, nor us.
- "Positive addictions" are often helpful.

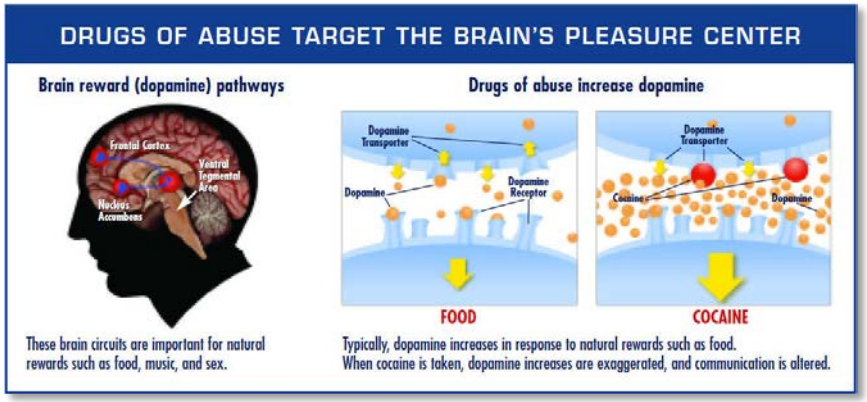
[1] We understand that some of you may not share our perspectives and that you may choose to continue to feel resentful, angry and miserable when these patients seek you out; beliefs not supported by science are especially resistant to change.
[2] When we recently proposed that we transform SOMC into an Anger-Free Workplace (AFW), a number of people insisted that, "I am not giving up my anger!"

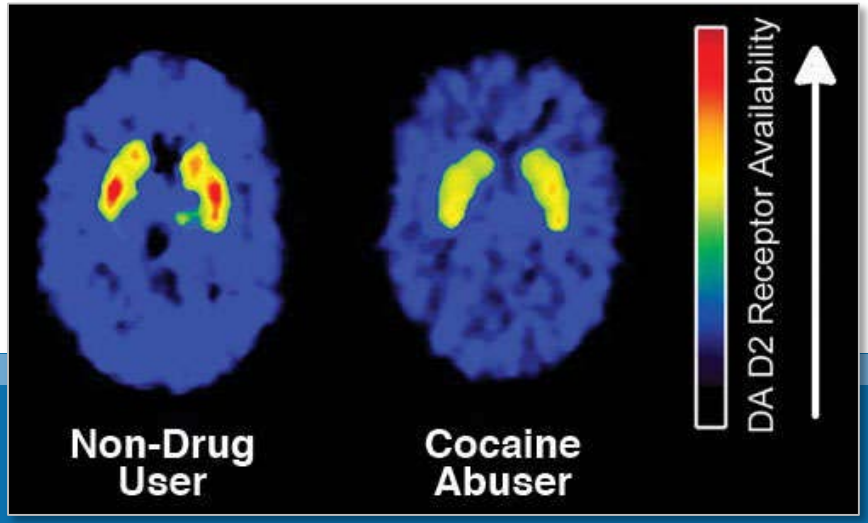
What are some of our perspectives about people who use substances to feel better?

- We health professionals should all abandon this absurd “pain scale” and judge the intensity of pain on functional impairment and nonverbal cues instead.
- We should stop relying on drug salespeople to educate us about the drugs they are pushing.
- We should refer all substance abusers to providers who adhere to the National Institute of Health’s (NIH) Principles of Effective Treatment.
- The evidence is clear; those substance abusers who fully comply with appropriate Medication-Assisted Treatment (MAT) and counseling clearly do better than those that do not.[1,2]
- Methadone (Dolophine®, Methadose®), buprenorphine (Suboxone®, Subutex®, Probuphine®), and naltrexone (Vivitrol®) are used to treat opioid addiction, and they are effective when used wisely.
- Naloxone (e.g., Narcan®) is an opioid receptor antagonist medication that can eliminate all signs of opioid intoxication to reverse an opioid overdose.
- While substance abuse and its treatment evoke strong feelings, mistaken beliefs, conflicting attitudes and behaviors, almost **everyone agrees that we should provide babies born to addicted mothers with the best-possible care to give them their best chance for living successful lives**.

[1] We providers hold all varieties of irrational beliefs about MAT.
[2] And these patients always have comorbid conditions such as depression, anxiety and hepatitis.

What must we understand about the neuroscience of substance use?[1]

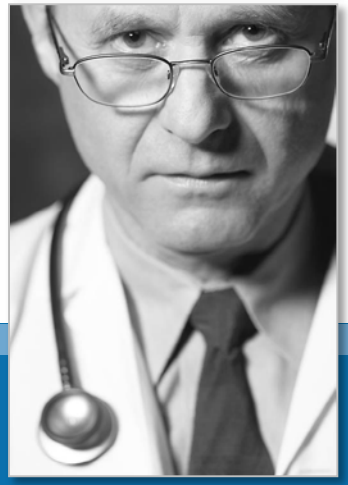




- We all have a hard time resisting the ingestion of substances that cause our brains to generate feelings of pleasure.
- Substances with abuse potential trigger the release of dramatically increased levels of dopamine, the neurotransmitter that creates feelings of pleasure and the urges to use that substance again.
- Susceptible brains quickly become addicted.
- Substance users still have a choice, but it is a much tougher choice than we must make about whether to eat that donut.
- And many of us are failing to make good choices about those donuts!

[1] NIH National Institute of Drug Abuse

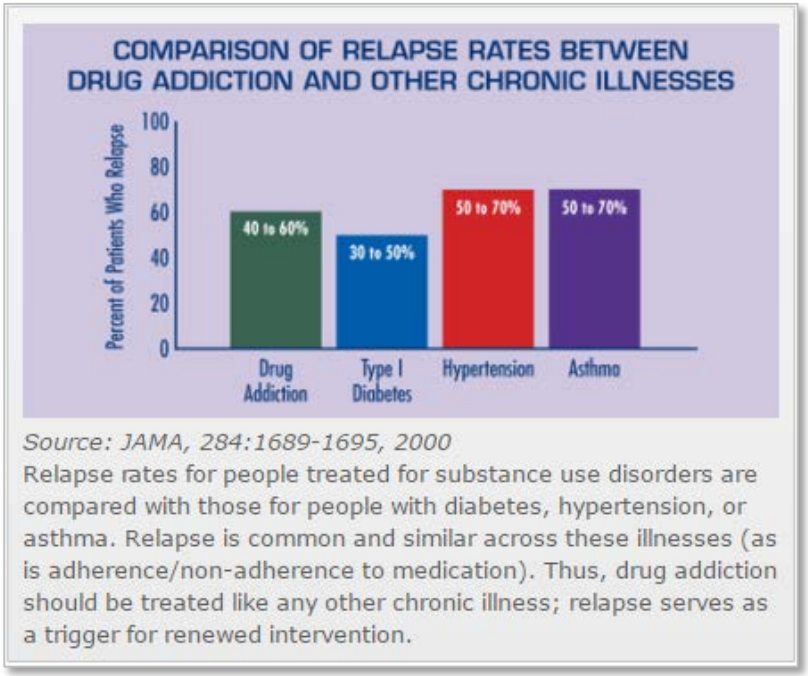
How do substance abusers “make” us feel?[1]



- Angry
- Resentful
- Overwhelmed
- Hopeless
- Impatient
- Tired
- Fearful
- Burnt out
- Unappreciated
- Disrespected
- And so on

[1] **Changing this one mistaken belief will change your life: No one can make us feel anything; only our brains can do that.**

How do our feelings about substance abusers "make" us behave?



Source: JAMA, 284:1689-1695, 2000

Relapse rates for people treated for substance use disorders are compared with those for people with diabetes, hypertension, or asthma. Relapse is common and similar across these illnesses (as is adherence/non-adherence to medication). Thus, drug addiction should be treated like any other chronic illness; relapse serves as a trigger for renewed intervention.

- We ignore the evidence that does not support what we believe about these people and their choices.
- We suppress our feelings and ruminate.
- We distract ourselves by caring more and trying harder.
- We vent our frustrations.
- We avoid them.
- We confront these patients when we are angry.
- We give into their demands because it is easier.
- We punish these patients with extended waits, failure to return calls, etc.
- We keep doing things to "help" that actually make matters worse.[1,2]

[1] Tell a story here about your frustrations with your daughters' behaviors and treatments.
[2] People and health care professionals with high Emotional Intelligence (EQ) do not permit their feelings and urges to hijack their brains—and behavior.

What questions should we ask ourselves when we encounter a substance user?[1,2]

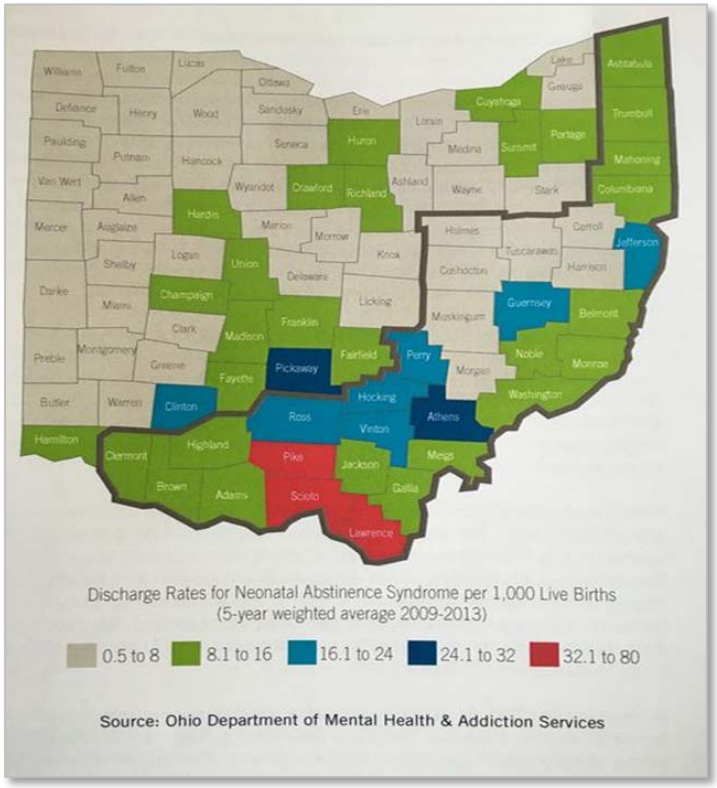
What **FEELINGS** is my brain creating now?

What **BELIEFS** is my brain using to create my feelings now?

What **BEHAVIORS** is my brain urging now?

[1] Asking and answering these questions were how Teresa Ruby and her colleagues began to grapple with our NAS challenge.
[2] Theresa will now discuss what her team has done in response to our challenges with Neonatal Abstinence Syndrome (NAS), and the results they have achieved and sustained.

What is the extent of our problem with Neonatal Abstinence Syndrome (NAS)?



- We are privileged to work and serve in one of the unhealthiest regions in America.[1]
- Substance use of all kinds is rampant.
- Obesity and sedentary lifestyles are the norm.
- On average, there were 8.8 discharges for NAS per 1,000 live births statewide between 2009 and 2013.
- Counties with the highest rates of NAS discharges were **Scioto (76.0),** Lawrence (66.7) and Pike (57.7).
- This is more than **8 times higher** than our state average.

[1] **In spite of these challenges, SOMC has been on the Fortune 100 Best Places to work for 10 consecutive years. We are a Magnet organization. Our employee and physician satisfaction scores are among the highest in the nation. We have generated a positive operating margin for 25 consecutive years, the only hospital in our neighborhood to do so.**

What have we done for addicted mothers and their babies?

- We deliver care to 1200 mothers and newborns each year; we are a Level I nursery.
- We have developed, implemented and standardized a process for identifying, evaluating, treating, and discharging newborns who are experiencing signs and symptoms of NAS.

[1]Our interrater reliability is now consistently > 90% and when the score is > 8, two experienced nurses assess the child independently.

What have we done for addicted mothers and their babies?

- In 2003, we began to see the first babies with Neonatal Abstinence Syndrome (NAS) and one of our pediatricians began developing our morphine withdrawal protocol for the treatment of NAS.
- As the plague spread, our experts were invited to speak to their colleagues across the region.
- We were asked to become partners in the Ohio Perinatal Quality Collaborative (OPQC)
- We worked hard to improve our interrater reliability scores on the Modified Finnegan Neonatal Abstinence Scoring System.[1]

[1]Our interrater reliability is now consistently > 90% and when the score is > 8, two experienced nurses assess the child independently.

What have we done for addicted mothers and their babies?

- In 2010, we began umbilical cord testing for all at-risk mothers and babies.[1,2]
- In 2011, one of our OBGYN physicians finally persuaded his colleagues to drug test 100% of their patients on admission for delivery.
- In 2012, we invited a local chemical dependency counselor to educate 100% of our maternity staff on, "Addiction Is A Disease."
- In 2012, one of our physician champions started a controversial Subutex (buprenorphine) weaning protocol for pregnant mothers at a local residential facility for addicted pregnant women; their babies did much better, but this approach is not yet evidence-based, and this physician has now discontinued this practice.[3]

[1]About 25% of our mothers are judged to be at risk.
[2]About 13% of our cords are positive for polysubstance use, and the United States Drug Testing Lab (USDL) has informed us that we have more polysubstance positive cords than any other hospital in America.
[3]The withdrawal from Subutex appears to be easier than from methadone or Suboxone (buprenorphine + Narcan (Naloxone))

What have we done for addicted mothers and their babies?[1]

- Our nurses consult SOMC Social Services on every at-risk mother.
- Our nurses consult occupational therapy (OT) for every newborn being treated for NAS.
- Our nurses and Safety department have worked to improve safety concerns
- Our nurses and social workers advocate for the mother and baby with Children's Services.
- Our nurses have employed skin-to-skin techniques, lighting, positional aids, music, swings, low-lactose formula changes and other evidence-based strategies.

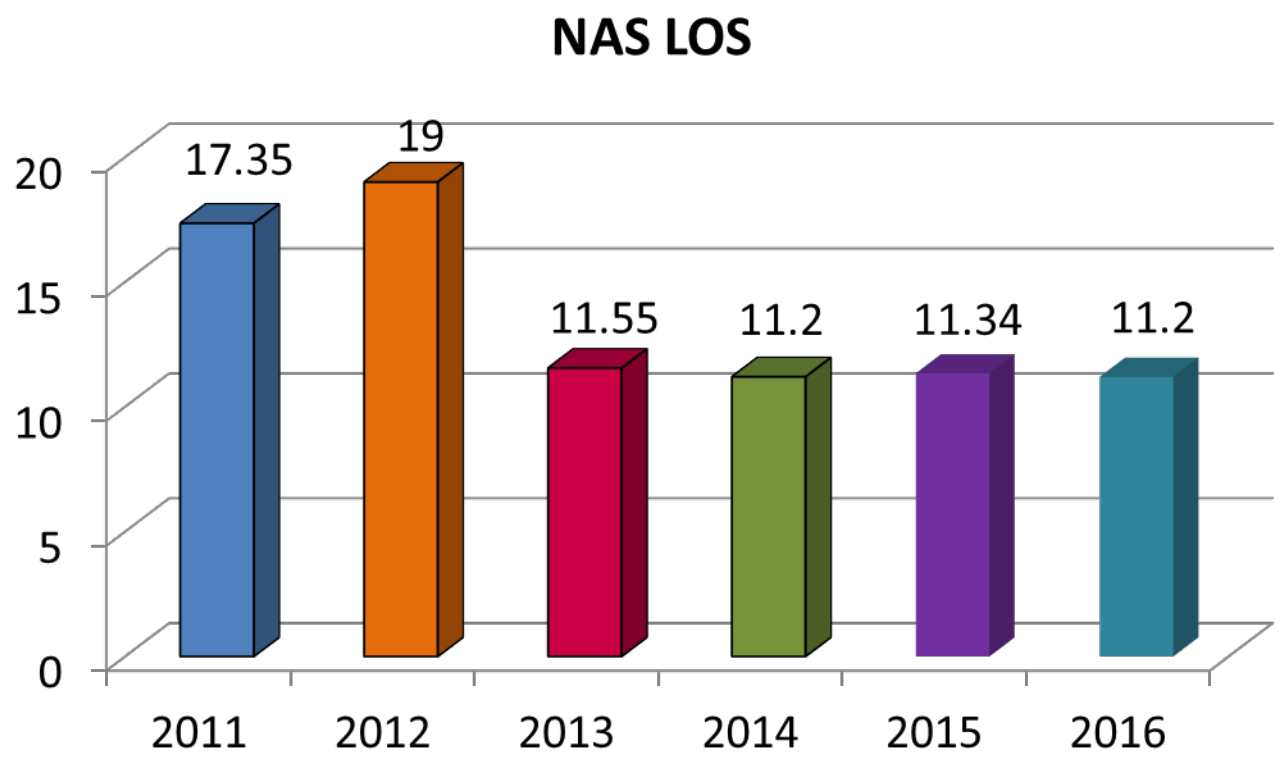
[1]This is just a partial list of the way our caregivers are making a difference.

What have we done for addicted mothers and their babies?[1]

- Our nurses have “adopted” the residents of our local residence facility and provided gifts, orientation sessions and hospital tours.
- Our nurses and physicians have created a SOMC task force and participate fully in related state and regional advocacy and scientific organizations.
- Our nurses provide education to the community on NAS.

[1]This is just a partial list of the way our caregivers are making a difference.

What are some of our results?



What are some of the things we are doing at SOMC to make a difference?

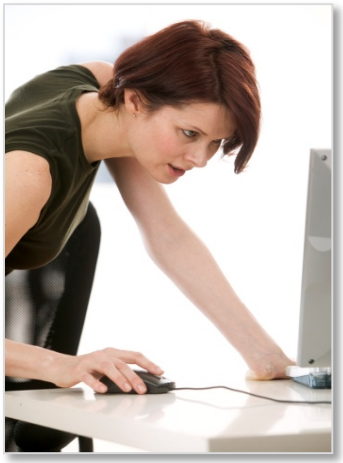
- We are recruiting and supporting SOMC chemical dependency champions.
- We are taking care of pregnant mothers and their babies.
- We are supporting all community efforts by providing needed resources and focusing on our common ground instead of our differences.
- We are urging our physicians and advanced practitioners to follow CDC guidelines for prescribing opioids for pain.
- We are managing the medical and surgical complications of drug abuse.
- We are offering medical withdrawal services to assist dependent persons in their transition to the stable management of their chronic disease.
- We are changing our beliefs, our behaviors and, as a result, our feelings.

What have we learned?

- We will encounter a lot of challenging substance users.
- How challenging they turn out to be is mostly up to us.
- Their feelings trigger their difficult behaviors; our disruptive feelings trigger our disruptive responses.
- We have no control over substance users; we can exert more control over ourselves.
- Now we know what is wrong, and what needs to be done.
- Doing the right thing demands that we change what we believe and how we behave—in spite of how we feel.
- We cannot save all of them, but we can help some of them save themselves.
- Will you join me in the lifelong struggle to help these sufferers make a difference in their lives?[1,2,3]

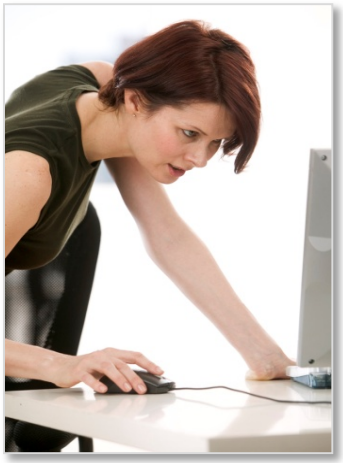
[1] In spite of my best efforts, I was not able to persuade my wonderful daughters to make the right choices in their lives.
[2] I have decided to honor their memories and their suffering by continuing my efforts to help other substance users make better choices.
[3] Please join me in this noble quest.

Where can you learn more about the substance use and NAS?



- Read Neonatal Abstinence Syndrome by Prabhaker Kocherlakota
- Read Dreamland: The True Tale of America's Opiate Epidemic, by Sam Quinones.
- Download and read Opioid Epidemic in the United States.
- Download and read Prescription Opioid Misuse, Abuse, and Treatment in the United States: An Update.
- Read Today's Heroin Epidemic.
- Read the UpToDate Summary and Recommendations for the treatment of opiate addiction.
- Encourage all of your providers to visit the Turn the Tide website, read the letter from the Surgeon General, Take the Pledge and download the Treatment Options.
- Explore the Ohio Department of Health's Drug Overdose Data and Publications.
- Read Managing Drug-Seeking Behaviors & Super Users in the Emergency Department.
- Read A Systematic Approach to Identifying Drug-Seeking Patients.
- Read The Drug-Seeking Patient in the Emergency Room.

Where can you learn more about the substance use and NAS?



- Dr. Karen D'Apolita-Complete program. DVD&Manual for assessing signs and symptoms of IVAs using the Finnegan Scoring Tool
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- Patrick SW, Davis MM, Lehman CU, Cooper WO. Increasing evidence and geographic distribution of neonatal abstinence syndrome: United States 2009 to 2012. J Perinatal. 2015:35(8):650-655.
- Hall, E., et al. Implementation of a Neonatal Abstinence Syndrome Weaning Protocol: A Multicenter Cohort Study. Pediatrics, 2015:136(4):e803-e810.

Where can you learn more about the SOMC leadership culture?

- Join the discussion about practical approaches to more effective leadership on the SOMC Leadership Blog.
- Download, read and reflect on The SOMC Leadership Culture: An Informed Consent and Commitment Document For Aspiring SOMC Leaders.
- Read Expectations for SOMC Leaders carefully.
- Learn more about Southern Ohio Medical Center here.
- Learn how we are transforming SOMC into an anger-free workplace here.
- Learn more about how to cope with the routine challenges of leadership more effectively by reading A Portable Mentor for Organizational Leaders.

How can you contact us?

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Are there other questions?