Podcast Transcript

Nurse Suicide and Substance Use Disorder: The Shocking Truth

Episode 1 – Sober Evidence of SUD-Suicide Link

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Guest

Judy E. Davidson, DNP, RN, MCCM, FAAN

- **Nurse scientist at University of California San Diego**
- **Research focus includes workplace wellness, mental health issues, and suicide and suicide prevention among healthcare professionals**
- **Led the development of the first suicide prevention program for nurses, which was awarded Edge Runner status, or a model for replication, by the American Academy of Nursing**

Marie Manthey, PhD (hon), MNA, FAAN, FRCN

- **Multi-award-winning author**
- **Credited with the development of the primary nursing care model**
- **Recognized in 2015 as an American Academy of Nursing Living Legend**
- **Participated in the development of the Minnesota Nursing Peer Support Network**

Host

Theresa Gaffney, PhD, MPA, RN

- **Assistant Professor, Marymount University Malek School of Nursing Professions**
- **Former Vice President, Product Development at the American Nurses Association**
- **Former Executive Director at the American Academy of Nursing**
- **Former President of the Virginia Board of Nursing**

Reviewer

Lisa Simani, APRN, MS, ACNP

- **Editor, Nurse Regulatory/Compliance Planner for Elite Learning**
- **20 years of publishing experience**

Lead author of peer-reviewed articles for print- and web-based nursing continuing education provider companies.

Transcript

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DR. JUDY DAVIDSON, GUEST: And what we found was startling and shocking to us. It wasn't what we were looking for. We had no idea we were going to come across this. But 94% of the nurses who died by suicide with checkmark yes for known job-related problems had one of three main issues. They either had chronic pain that was uncontrolled, and they needed to leave the profession; or they had mental health illnesses that were uncontrolled and needed to leave; or they were being worked up in their job for substance use disorder, a disease. And the process of working them up and out of their jobs led to psychological damage that led to suicide.

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DR. THERESA GAFFNEY, HOST: Welcome. I'm Terri Gaffney for Elite Learning. As COVID-19 rages on, another outbreak threatens the well-being of healthcare professionals. According to reports, the strain of patient care during the COVID pandemic has exacerbated burnout, substance abuse disorders, post-traumatic stress disorder, and, gravely, suicide ideation or suicide among healthcare providers. The highly publicized story of Dr. Lorna Breen is a case in point.

Dr. Breen, an emergency medicine physician in New York City during the height of the pandemic's first wave, and by all accounts a dedicated, happy professional with a wide circle of supportive friends and family, died by suicide in April 2020. Dr. Breen had reportedly worried she would lose her license after having sought mental health assistance and was treating patients with COVID-19 while she contracted the disease herself.

Alva Daniels, a respiratory therapist in Virginia, also buckled under the strain of treating waves of patients with COVID-19. As reported in the Washington Post, Daniels lamented his inability to save patients from the onslaught of the disease. He took his own life as the Delta variant began to hit hospitals hard last summer.

While not highly covered in the media, let's not forget we've also lost nurses to suicide. That's why it's important for healthcare professionals to recognize the critical need to support the health and well-being of their colleagues. In this podcast, I'm joined by Dr. Judy Davidson and Dr. Marie Manthey.

Dr. Davidson is a nurse and thought leader whose research has centered on suicide of healthcare professionals, suicide prevention, workplace wellness, and second-victim syndrome. You may recognize Dr. Manthey's name. She was a founder of primary nursing care delivery who was named a Living Legend of the American Academy of Nursing in 2015. Dr. Manthey, who is currently president emeritus of Creative Health Care Management, will talk with us about mental health and substance use disorder.

Before we begin, it's vital that we all make note of a resource that will help you or a colleague struggling with mental health during the pandemic and beyond. The National Suicide Prevention Lifeline can be reached by phone at 800-273-8255 or on its website at suicidepreventionlifeline.org.

Now, let's get started. Judy, let me begin with you. Much of your work has focused on assessing the prevalence of nurse suicide. Recent reports indicate that nurse suicides exceed those of people in the general population. However, your research elaborates on these claims and offers a deeper glimpse into the data. Can you unpack the prevalence of nurse suicide for us?

DAVIDSON: Oh, thank you so much for asking. Yes, we looked at data from the Centers for Disease Control, [and] the NVDRS, National Violent Death Reporting System. This is the only database in the country that codes the deaths by occupation. So, we could pull all the nurses out of it and study it over time.

We took all of the years that the CDC has been collecting this data, from 2003 to 2017, and looked at each year to see, compared to others – female nurses compared to female others, males compared to male nurses – where do we lie. And surprisingly and shockingly to us, this is not a new problem. It's not a problem because of the pandemic. It's been a problem for all of the years that the CDC has been collecting this data.

So we've been at a higher risk than the general population since at least 2003. And that's just the earliest year of the data. That data is always a couple of years behind. So, we won't know about what happened during the pandemic until two years from now, right? The most current year of data that's available is 2019.

GAFFNEY: My goodness. Wow, so this has been an ongoing problem. And we're really not talking about it enough. So how did gender and race affect the prevalence of nurse suicide?

DAVIDSON: Well, what we found in our data is surprisingly, unlike other social justice issues, this issue of suicide is disproportionately, in nurses, a white female problem. Males are at higher risk than the general population of men. But the females, it's a stronger signal. And we've seen that also – my research team has looked at physician suicide as well. And physicians, in general, are not higher than the general population. But female physicians are at higher risk.

So there is an issue of being female in the healthcare workforce that is increasing risk. We need to look at issues in all of our IDE – inclusion, diversity, equity – initiatives. We need to look at oppression within the workplace and address gender oppression, any issues related to that, to help prevent suicide.

GAFFNEY: Gender oppression?

DAVIDSON: Yeah.

GAFFNEY: So, when we think about what you've just said, that it's a white female problem and we need to address gender oppression, let's talk a little bit about the risk factors. What are some of the risk factors that are leading us in this direction?

DAVIDSON: Well, we did a special sub study looking primarily at nurses that were coded in the record to have job-related problems prior to their death by suicide. And in those nurses, we were trying to look to see, is there anything in the narratives that the law enforcement agent or the coroner writing those death notes that could lead us to actionable items? What is it about our jobs that is known at the time of death that we might be able to take action on to improve this situation?

And what we found was startling and shocking to us. It wasn't what we were looking for. We had no idea we were going to come across this. But 94% of the nurses who died by suicide with checkmark yes for known job-related problems had one of three main issues. They either had chronic pain that was uncontrolled, and they needed to leave the profession; or they had mental health illnesses that were uncontrolled and needed to leave; or they were being worked up in their job for substance use disorder, a disease. And the process of working them up and out of their jobs led to psychological damage that led to suicide.

So, I didn't finish the previous sentence. Ninety-four percent of these nurses were either unemployed or losing their jobs at the time of their death. And that shocked us. And when you look at those three big buckets of problems – chronic pain, mental health issues out of control, or substance use disorder – they're all treatable. In my mind, these were preventable deaths.

GAFFNEY: That is very interesting with those three job-related risk factors. One of the questions that comes to my mind that I'm curious about is digging into that chronic pain risk factor. We know that nurses have a lot of musculoskeletal injuries. Did you by any chance uncover anything there related or connected to chronic pain?

DAVIDSON: Yes. We don't know the reason for chronic pain in all of those cases. But for those where it was mentioned, some of it was the musculoskeletal pain and injury from work-related injuries. So some of it was related to work-related job injuries. Others were related to fibromyalgia or chronic disease.

But in all cases of chronic pain, you might say to yourself, could we have done better? And then this leads us to a very important point. At the time of transitioning out of a job, if a nurse is leaving the profession early, premature retirement, that is a very vulnerable period of time that needs to be managed well. And I'm not sure, as a habit, we provide psychological resources to people leaving the profession early.

GAFFNEY: So, job loss, whether it's voluntary or involuntary, is a critical point in time to look into this is what I hear you saying.

DAVIDSON: Definitely. Job loss is an extremely important period of time. There's something about the way nurses connect to their identity as a nurse that really is damaging if it's not managed well during the transition and can lead to death by suicide.

GAFFNEY: That's a very important point that you're making, how nurses connect to their identity. Are there any home stressors? You've talked about some job stressors. Are there any home stressors we need to consider?

DAVIDSON: Well, what we found was a fair amount of home stressors that were secondary to work. You're having problems on the job and that leads to problems with sleep or that leads to problems with your marriage. You're losing your job. And that causes financial strain, which has downstream effect on the family. The primary issues with family seem to be less important than the primary issues with the job. So I think we need to take ownership on some of this because there is opportunity for action within the profession.

GAFFNEY: Absolutely. So substance use has long been correlated with suicide. And the literature indicates that alcohol intoxication is associated with a six-fold increased risk of suicidal acts. Your research has demonstrated that there's an interdependent relationship between substance use and suicide. So let's talk a little bit more about your insight into the relationship between these two factors.

DAVIDSON: Well, we have looked at the overlap between mental health issues, substance use disorder, which is a mental health issue – that's a subset. Substance use disorder is a disease that is classified under mental health. So, it is one of the mental health disorders. And yes, there is overlap.

And part of the problem with substance use disorder in nursing is that we don't make it easy for these nurses to be able to get the treatment they need when they're risking substance use behaviors get out of control. So there's an inequity amongst nurses that does not exist in most of the general population, whereas, in many states, if you know a nurse that has problems with substance use, you're supposed to

report that nurse to the Board of Nursing, who will then take action and could take their license, livelihood, ability to work, ability to bring in an income. And then how can you pay for your treatment without that income?

Whereas in other professions, you might take a leave of absence, go for treatment, and then come back able to work while continuing treatment after the acute treatment. And in nursing, it's just not that way. We're not treated the same as other humans.

GAFFNEY: So, this seems like a good time to bring in Dr. Marie Manthey. And we've talked about substance use disorder. It can affect anyone regardless of age, ethnicity, gender, economic circumstances, or occupation. And Marie, you founded a nonprofit peer support group for nurses who are struggling with substance use disorders. So, would you mind sharing a little bit about your insight and your story with us?

MANTHEY: No, I'd be happy to. Thank you. Yes, we founded about seven years ago an organization called the Minnesota Nursing Peer Support Network. And it is designed specifically to deal with one of the major problems leading to suicide. And that is the symptom – I'm going to call it a symptom of stigma and shame, which we experience in extremely painful ways.

And I'm linking it – in my own mind, it's linked this way also as well – with the issue of the moral failure in the nursing profession. We have a belief –I'm going to call it a belief – that substance use disorders are caused by moral failures and that people who succumb to the addiction are morally damaged people. And we treat them as such, as long as they're continuing to be connected in many ways with the Board or with the recovery process.

My personal experience – and it's a long and harsh experience – has been that the conspiracy of silence is one of the biggest problems we're dealing with in nursing. Where there should be transparency around what is clearly a disease, we keep the cone of silence over it so tight that my own story shocks me when I say it.

First of all, I've been around for a long time in nursing, like 60 years. Forty of those years, I've been in recovery from the disease of alcoholism. And during that period of time, I spent a lot of my energy in both fields – in recovery and in nursing – and accomplished a great deal of things in addition that I'm being recognized for, the Living Legend being one of them, during that time of recovery from alcoholism, according to the conspiracy of silence, after I was a morally damaged person. I wasn't.

Anyway, I went through those next 40 years working in my profession with full intelligence, and commitment, and energy, and passion. And at the same time, I was in the process of recovery. I was in the process of helping other people recover as well with full intelligence, and passion, and commitment that I had within me. And so I'm a fairly intelligent person. And I spent 40 years in these two fields without ever really seeing what we do when the Board gets involved with a nurse's license, without ever seeing what we do when we begin the investigation, when we begin the accusation or the action to be taken about a person's problem.

We are shocked out of our minds when we find nurses who have become addicted using patient medications and shooting themselves up in bizarre places of their body at bizarre times on duty. We are shocked because we haven't really ever accepted the fact that this is a disease. It's a progressive disease. It never goes away. It will continue to be present. And you can recover from it fully. But the conspiracy of silence problem leads to nothing but secrecy, shame, and stigma.

So, in my own story – my own story, yes – my addiction followed a very predictable pattern of use, abuse, addiction. So, I began using at a time in my life when I was at quite a peak of accomplishment. I was in the process of developing primary nursing. And it was a very exciting process. There was all kinds of incredibly positive creative energy within that project.

And at the same time, I just had my second child. Mark was an infant. And I had a 5-year-old daughter. And my husband was going to school at that time. But there was an awful lot going on in my life. This was the time when there was a lot of uproar in society as well. And I was active socially in some of the movement processes.

So there's a lot going on. And I began to move into a realm where a drink before dinner was normal with a lot of the people I was associating with. And I found that drink before dinner really helped me over a very bad rough spot – the rough spot being coming off of the high of work, that high of creative energy, and having two little kids who needed a mother. And I was empty. I didn't have much energy left inside of me. And I felt terrible.

And not only that, I was also the cook, and the laundry and cleaning, and doing all the "housewifey" stuff. We couldn't afford any outside help. And I wasn't doing that very well, either. So I was forgetting to get the meat out of the freezer to cook dinner. I wasn't getting around to doing the things that I should be doing to have a smooth-running house. And that was really bothering me.

When I had that drink before dinner night, after night, after night, after night – and it's a really important part of the movement into addiction. The daily drinking is a smooth path into addiction. And my use-abuse addiction pattern certainly showed up over the next 10 years.

I left that position at the university, where we had created primary nursing. And I became chief nurse, for the first time, of two hospitals that were merging in St. Paul. And at that time, my marriage also failed. And so I had even more of a reason to have – and I went from one drink before dinner to two drinks before dinner. And I thought that was just fine. What I didn't understand is that, in this process of use-abuse addiction, you cross over invisible lines. And once you cross over a line, you don't go back.

And so once I got up to two drinks before dinner, I never went back to one drink before dinner. Once I started having one drink after dinner, I never went back to not drinking after dinner. It was just that slow progression. Everything was fine in my life. I was getting kudos. I was being successful. I was doing decentralization and empowerment work in my own hospital and getting a lot of recognition within the profession, within my own state, and drinking every night, and drinking every night, and drinking before dinner. And that progression continued.

Within a couple of years, I was recruited to go to Yale-New Haven. And I was recruited heavily. I think there were three trips out there, one involving the kids. And it was a very attractive place. I felt it was one of the top 10 hospitals for where I was in my professional career.

And the CEO who was hiring me said, I think in the second visit, said something like, we're having a cocktail party tonight at my house for you. Everybody wants to meet you. And she was naming all the bigwigs who would be there. And then he said, I hope you like martinis as much as I do. And I said, I love martinis.

And it was like the green light was on. I had been trying to slow down and trying to stop. But now the green light was on, it was just full speed ahead. And for the next 3years, I really drank to blackout or

pass out nearly every night. Blackout and pass out are two different brain actions. But with a blackout, you don't lose your judgment. With a pass out, you become unconscious.

So oftentimes, I was the administrative person on call in a blackout. And the terror that I felt the next morning is – I don't even know how to begin to tell you what that was like. The shame that I felt when I realized what I was doing and I couldn't stop – now I'm at the point where I'd give anything to just quit. I can't stand myself.

And every morning, I'd go to work. And, I'd say, I don't have to drink tonight. I don't have to drink tonight. Every night going home, driving home, I'd say to myself, anyone with a job like mine – everybody with a job like mine – has to have at least a drink. I mean, that's just absolutely normal. And then I would drink to blackout or pass out every night.

The sense that I knew what I was doing, that I could not not do it was probably the most pain I've ever experienced, self-inflicted in a way, yet not. So anyway, there was an intervention done by my bosses. The chief medical officer at Yale-New Haven and the chief executive officer took me out to dinner. And they said, we know you have a problem. And I said, I know. Yes.

So this was the big step one. I admitted that I had a problem. And they told me I had to go to treatment. And I said outpatient because then I could handle my job. And they said inpatient. I said outpatient. They said inpatient or you're going to lose your job. So I went to inpatient.

And while I was there, they fired me. So that was probably the worst thing that happened to me because – so you know that I became a nurse when I was 5 years old practically. There was an incident where I was cared for. And the passion I had for nursing was never part of my internal being. It was always part of it.

So for me to have become an alcoholic and have lost one of the top jobs in the country while being a single parent of two kids in New Haven, Connecticut, where I had only lived for a couple of years and didn't have any deep friendships, was really, really a tough time. Fortunately, I was guided into understanding that this was a disease. And thank God I knew enough about healthcare to know the definition of a disease. And I could see it is a disease.

So I was able to push back a little bit personally from moral failure, although my shame knew no boundaries at that time. My shame of losing my profession, my shame at losing nursing, wasn't really so much about the alcoholism as it was about the loss of my wonderful profession.

I had some wonderful guides through the early recovery period. And I want to make a distinction here now between treatment and recovery. Treatment is a specific series of activities that take the person away from their life and give them a lot of information, a lot of guidance, a lot of strategies to use for the rest of their life.

Recovery as a much longer process. It is a lifetime process that results in a transformation. And that transformation is incredibly important in nursing. Some of the studies that have been done of nurses in recovery who are employed again as nurses reflect a really important transition in that transformation. And that is that while they are nurses; they are persons first. So instead of being only a nurse, totally only a nurse, one is a total person in recovery and a nurse. So that's a very important aspect of that transformation.

At any rate, the peer support network grew. Finally, there was an incident that brought me together with the alcoholism and my profession in a very specific event in Texas where I was a keynote speaker.

And I came back from that experience understanding finally, finally I saw clearly what we do in nursing with the action of the Board and the alternative processes for recovery.

And I came back and learned that, in Minnesota, every health professional except nursing had peer support organizations – physicians, dentists, lawyers, pharmacists, everybody, but not nurses. Nurses were just left alone and totally isolated. So the development of the Peer Support Network was a great experience in that we became a nonprofit. We are an independent organization with about eight meetings going on a month, where nurses come together and talk to each other about what's going on in their own recovery.

Nurses just talking to nurses to provide healing. I can't emphasize strongly enough how important it is for nurses to have an opportunity to talk to nurses because, again, the shame and stigma is so great by yourself and the isolationism of being in nursing and in recovery is still so strong that the healing begins when they are able to share that. And so there's just been a wonderful experience of starting this.

And we operate with independence with the Board of Nursing. And we operate with independence from the Alternative Program that provides the monitoring. And we are a strong entity within the healthcare system in Minneapolis. I think that the Peer Support Network is providing a lot of healing and an opportunity for people to be able to lift the cover off the secrecy issue because we have a speaker's bureau. And we'll go out and speak to groups of people about our experience. And we are able to tell stories that otherwise would never be told.

So, lifting the lid off the can of worms, we need to take a look at what's going on in nursing and expose it and find the ways to provide healing. I know Judy has been talking about the HEAR Program. And I think that's one of the best solutions to some of these terrible problems that's been developed yet.

GAFFNEY: So here you are at the top of your career professionally. And Judy mentioned our connection in nursing with the profession to our personal identity. And you're struggling to do it all – the family, the marriage, the work. And we mentioned earlier that this is a disease process. And the notion that you're bringing forward, Marie, this conspiracy of silence, how can we address that?

MANTHEY: Oh, we need to have people like me out there talking about the reality of it and people who have accomplishments and who have status. I mean, after I accepted my award for the Living Legend, I said there when I accepted it that much of the work they were recognizing had been done during the 37 years, at that time, that I had been in recovery from the disease or alcoholism.

People came up to me at that meeting afterwards and said, I'm so glad you said that. I've been going to AA for 18 years and nobody knows. And this was the dean of the school of nursing. And people came up there, and they told me their positions. And they told me how refreshing it was to have somebody tell the truth.

I can't tell you how often at the academy I'm still approached, people being so grateful. We need more of this. We need more discussion about it. We need more education about it. We need more people who can take the risk. I'm in a position where I can take the risk of never being employed again, which is the risk because I was able to build my own company. But there shouldn't be that risk. There is absolutely no reason I wouldn't be a useful employee whatever I did in these last four years.

(SOUNDBITE OF MUSIC)