Podcast Transcript

Nurse Suicide and Substance Use Disorder: The Shocking Truth

Episode 2 – Proactive Approaches to Nurse Suicide Prevention

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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**

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Transcript

(SOUNDBITE OF MUSIC)

DR. THERESA GAFFNEY, HOST: So substance use is widely underreported from what I understand. And I think what we're talking about here are many reasons as to why it is not reported. You talked about –

DR. JUDY DAVIDSON, GUEST: The [UNINTELLIBLE] and processes in place drive the reporting underground. That drives the problem. The nurses fear the loss of license and retaliation. And they hesitate to seek treatment on account of that.

(SOUNDBITE OF MUSIC)

GAFFNEY: Welcome back. I'm Dr. Terri Gaffney for Elite Learning. We've been listening to Dr. Judy Davidson and Dr. Marie Manthey as we explore the topic of substance use disorder and nurse suicide. Judy is a thought leader and researcher focused on suicide of healthcare professionals and the impact of substance use disorder. Marie is an icon in nursing who is candid about her own struggles during her long nursing career.

DAVIDSON: I'd like to piggyback off of this, what we can do in the health system environment. One of the things every person with passion can do is to ask for the policy on diversion of medications. When Marie so eloquently talked about her journey with alcoholism, nurses also have issues with drug use. And often, it starts with a disease that they had or an injury, and they were prescribed a narcotic for that disease or injury.

And then they become dependent upon that medication. And then the dependency gets out of control. And then it leads them to diversion. And if they're identified as diverting a medication, they're immediately fired, right? There are very few organizations in the United States that will instead allow that person into treatment, and then if receptive to treatment, retain their position.

And I would like to posit that if we all challenge these diversion policies to be disease-oriented, and treatment first, and do not fire these well-meaning individuals who have a disease that has progressed out of control, as Marie so eloquently stated. In the death narratives, we read it. We read that she was injured on the job. She had back pain. She was prescribed narcotic medication, became dependent on the medications, ended up diverting drugs, was caught diverting drugs, fired from the job, and the next day found dead.

(CROSSTALK)

DAVIDSON: We need to address those structures and processes within our organizations and turn it all around to a disease-oriented approach to care for these nurses who, as you see with Marie being at the top of her game, we're talking about often the best and brightest amongst us that we have no business throwing out.

DR. MARIE MANTHEY, GUEST: Yeah, that's right. In Minnesota, diversion, using the medication of a patient is a felony. And the policy of the Minnesota Hospital Association, up until a couple of years ago, was to advise the administration to call the police. And the police come. And oftentimes, the person has a needle stuck in them someplace at the very end stages. And they'll be taken off the unit even in handcuffs.

This has happened in some of our situations. And a felony conviction requires a jail term. So, they can be sentenced to jail and to then the workhouse after that for a period of time. This is all done under enormous secrecy, enormous secrecy. That person was taken off the unit. Nobody on that unit ever knows what happened to that person. They don't know if they're alive or if they're dead. They never hear from that person again. It's just these conspiracy of silence practices that we have are absolutely deadening.

GAFFNEY: So Marie, that really resonates with me, that story, because, within a couple of years of practicing as a nurse, I remember seeing the state police coming onto my unit and removing a nurse who had been diverting narcotics. And we never knew what happened to that individual. And you've also brought up not only the felony side, but the regulatory issues with the board of nursing.

And so nurses who are reported to the board can have their license suspended or revoked. They're unable to practice, which, Judy, brings it back to that job loss risk factor. So, tell us a little bit more about these alternative programs that are less punitive, but more focused on treatment and recovery.

DAVIDSON: There's a wide range in the way that they're deployed. The National Council of State Board of Registered Nurses has a lovely set of recommendations posted at their site for how they should be operated, and the types of things that we should monitor along the way, and the type of treatment a nurse should receive. But it's up to each individual state to apply those recommendations in the way that they would like to.

So, state to state, we have 50 different ways that they're done. There's only a certain percentage of the United States – not every state in the United States has an alternative to discipline program. And the term alternative to discipline is highly deceptive. What the alternative to discipline phrase means is that you will move toward treatment without reporting the criminal activity. But it doesn't mean that you'll get to retain your job. It doesn't mean that you'll keep your license. It just means you won't end up with a criminal record. That's alternative to discipline.

MANTHEY: Here in Minnesota, the alternative to discipline means that the board won't take action on your license as long as you are in the contract with the alternative program and follow all those rigid steps for the next couple of years like you have to. And a single misstep, a single missed urine, for example, will require by law that you be reported to the board. And then the action on your license will be taken because of the failure to use the alternative correctly.

DAVIDSON: And in California, that's not the case. Your license can be taken within the alternative to discipline program for something as simple as a DUI, which is not driving under the influence or driving –

MANTHEY: – while intoxicated.

DAVIDSON: DWI or DUI depending on which state you live in how they classify it. And I don't want to diminish the fact that a DUI is a bad thing. It definitely is. But in the state of California, you can have a DUI. The DMV reports that to the board of nursing with a delay, maybe a year or two after the event. You can actually have become sober in that time, have no problem, never had a problem in the workplace identified, and still have your license taken. And the state of California has an alternative to discipline program.

MANTHEY: But it's in the board, isn't it?

DAVIDSON: Yes.

MANTHEY: To me, that's crazy that it's controlled by the board, who also has the licensing authority. I mean, I'm so used to it being two separate organizations that are working for different purposes. The board is protecting the public. The alternative to discipline program is helping the person in recovery stay on track and not to relapse in those early years.

DAVIDSON: Yeah, I should add that all of these actions are taken in good faith to protect the public from nurses who should not be practicing under the influence. So that is true. All of these systems were set up in good faith with the public and protection in mind. But there's something about them that is not working 100% according to plan. And we feel, at this point, that the processes could be improved upon.

So I don't want to make these people sound out to be bad people. It is all done for good reason. But we now know there's consequences to the actions of taking a nurse's license when they could possibly be just put on leave to get the acute treatment they need. There's a wide variety of whether the state board of nursing is connected to the alternative to discipline program, whether they're separate entities, and how that whole relationship happens.

I've learned that what they do is normally contract out to monitoring boards so that they have third-party contracts with monitoring boards to monitor these nurses who have issues and that the nurse has to pay for those programs, which is very difficult to do if you're not working, right? So if you cannot pay for the program that the board contracts with to do the treatment, you don't just go out and find your own treatment. You've got to go through a monitoring board that's approved by the board. The whole thing becomes problematic.

MANTHEY: Yeah.

GAFNEY: So, we're talking about the regulatory side, where the board regulates the license to practice nursing. And they have a disciplinary process for nurses who are suffering from this disease.

MANTHEY: Their license is acted upon to protect the public.

GAFFNEY: Right.

And there, is in some states, an alternative to discipline program. But none of this, from what I understand, is touching on the employment situation. So, the nurse could still be fired from the employer.

DAVIDSON: Yes.

GAFNEY: So, it's a catch-22 situation, it sounds like.

DAVIDSON: Yes. So, the employer could take action immediately and fire the nurse. Or if the license is taken, of course, the job goes away, right?

GANEY: Right, right.

DAVIDSON: So alternative to discipline, the definition of that means something different from one state to the next. It's not standardized. There's no standard monitoring of these alternative to discipline programs. They don't report up to something. There's no standard data collected to see which are the good ones versus which are not, right? So, there's no system and process in place to identify best practice and then establish minimal standards that we can tell from the outside.

GAFFNEY: So substance use is widely underreported from what I understand. And I think what we're talking about here are many reasons as to why it is not reported. You talked about –

DAVIDSON: The [UNINTELLIBLE] and processes in place drive the reporting underground. That drives the problem. The nurses fear the loss of license and retaliation. And they hesitate to seek treatment on account of that.

GAFFNEY: So, what are some policies that we can put into place to address not only substance use disorder but nurse suicide?

DAVIDSON: Well, we've developed a program in collaboration with the American Foundation of Suicide Prevention that deploys anonymous encrypted screening for all mental health issues, including substance use disorder, with the end goal of preventing suicide. We call it the Healer Education Assessment and Referral Program, HEAR. And that was developed initially for physicians within UCSD was the first place it was deployed. And then it's been replicated in over 30 medical centers across the country for physicians since.

And then in 2016, we expanded that service for the entire hospital staff, including nurses, after we had some tragic deaths in the workplace. And we've been able to, through that program of anonymous encrypted screening – the anonymous is important because of the fear of the stigma, right? So, no one knows who you are when you do your screening.

And you get encrypted therapy from a therapist through the computer who doesn't know who you are and can even refer you to a counselor, or a therapist, or a psychiatrist, or to a substance use disorder treatment program without anyone knowing. They won't know who you are. You don't know who that therapist is. And it's encrypted and anonymous. And because of the encrypted, anonymous nature, you get around this whole issue of reporting. Do I need to report this person to someone? Well, you can't if you don't know who they are, right? And they can get the treatment they need.

So that program is a model for replication. It's been recognized by the academy as an edge runner. It has been replicated by several other organizations that are now screening nurses routinely. It's proactive, where we push out an invitation for the screening at least once a year. And it's always available.

So the two things proactive and anonymous encrypted – really we think sets it apart from anything else others have done. And it gets past the stigma of shame and gets people into action. We get 40 to 60 nurses every year that we identify with mental health issues that need treatment and refer them successfully into treatment out of a pool of 3,000 nurses. So, 40 to 60 a year, we feel that's a pretty high number for one organization. Just imagine if –

MANTHEY: Is that mandatory?

DAVIDSON: – everyone had that.

DAVIDSON: Judy, is that mandatory?

DAVIDSON: No, it's completely voluntary. And what we find is that the people who have problems know they have problems. And the email that they get from the chief nursing officer asking them to take this screening pushes them into action, that simple email, and knowing that no one will know who they are on the other end. So they're all college-educated professionals, these nurses. They know. So the majority of the people who actually take the screening are people that need the help.

MANTHEY: Yeah, right.

GAFFNEY: So, the proactive and anonymous encrypted nature of this program addresses the things that we were talking about that brings forward that stigma. They're able to access resources. They bypass that regulatory and legal issue so they can stay employed and get the help that they need. This is a very exciting program, the Healer Education Assessment and Referral Program. So, you said it's been replicated at a few institutions. It sounds like we need to replicate this all over.

MANTHEY: I agree.

DAVIDSON: Wouldn't it be nice? And it doesn't cost that much money. You need to be able to have therapists that are available in the workplace that call together a referral panel so that you can refer somebody successfully to someone who will take them. There's a little work involved there.

We have separate therapists doing it. I would challenge the C-suite that they could renegotiate their EAP contracts, employee assistance program contracts, so that they are proactive and use the therapists you're already paying for that just sit there waiting for a call, a reactive system. Turn it on its head, make it proactive.

It would be budget neutral, probably. And then it only cost a couple of thousand dollars a year to negotiate with the American Foundation of Suicide Prevention, who run the encryption behind the scenes and handle your data so that that third-party contract is very inexpensive for what you get from the program. And it works for all healthcare workers, not just nurses, not just doctors. It works for everyone within the system.

MANTHEY: Judy, what would you think of the state nurses association's offering this to its members – the Nursing Association of California, Nursing Association of Texas?

DAVIDSON: That would be wonderful, wouldn't it? If we could systematize it as an offering from the profession. And there is a model for that. The veterinarians do this as a profession, where their professional organization contracts with the AFSP. And then they have lined up third-party vendors, virtual psychological health, so that if you screen moderate to high risk, you'd have to pay for your own treatment. But they refer you to a vendor that's outside of your workplace.

And that even gets to the point where you don't have to go to a doctor that you see walking around in the hallways at work, that you can get referred outside of the system for help and treatment to somebody that's not a friend or neighbor. So there is a model for it that could be replicated. The veterinarians have done it.

MANTHEY: I just think it's so important.

GAFFNEY: Well, you guys have raised some interesting ideas for institutional strategies to address this critical issue of nurse suicide and substance use disorder. You've talked about the diversion policy at hospitals. You've talked about this HEAR Program and how hospitals might renegotiate their EAP contracts or how the state nurses' associations might partner in this endeavor to offer this service to nurses. What about individual efforts? Anything that individuals can do to reduce our personal bias or support those in recovery?

DAVIDSON: Yeah, there's many things we can do. The term peer support is used two different ways professionally – one, the way Marie was explaining and peer support groups that help kind of like Alcoholics Anonymous, peers talking to peers through issues of substance use. But the other form of

peer support, meaning second-victim prevention, using emotional first aiders in the workplace to identify those who might be struggling and lend them an ear, and having those peer supporters. The program for peer support started, I think, at the University of Missouri under Susan Scott and been replicated widely throughout the country.

And those peer supporters are usually trained with triggers to recognize triggers of somebody who might need official mental health treatment– rumination, emotional dysregulation, that sustained suspicion of substance use issues that are out of control. And they learn how to talk to their friend or colleague about using skills in motivational interviewing to turn the conversation into having the person realize they might benefit from seeking help.

So learning how to do motivational interviewing and learning how to talk to a colleague who may be at risk, these are important skills that every nurse in the profession can acquire. The ANA, over the pandemic, called together a task force of about 35 members from all different walks of nursing life to collate resources for nurses on suicide prevention.

And if you Google the term ANA and suicide, you'll get to the web page where this is all gathered together for you. So, it's one-stop-shopping. And there are links to how to do motivational interviewing. And then there's links to the programs developed at the Ohio State University by my colleagues actually teaching you through video simulations how to talk to a colleague at risk. And if you watch that series of six little 4-to-6-minute videos, you'll become quite an expert on how to talk to a friend who might be at high risk and get them to the point where they realize they need to get real treatment for their problems.

MANTHEY: What is that website?

DAVIDSON: AFSP also has an excellent video. It was developed for medical students, but it works for anyone, called "Have the convo." And if you look up "AFSP have the convo" in your browser, you'll come up with it. You listen to that 2-minute video, you'll be able to talk to a colleague about their risks.

So, learning those skills is one thing that's very important to do. I think another is to increase positivity in the workplace, recognize people who are suffering instead of dismantling the buck- up-and-take-it kind of culture that many departments have, so recognizing those that are suffering and recognize them with micro-affirmations, small acts of kindness. And all of those small acts of kindness can build up a more positive, healthy work environment.

MANTHEY: Yeah, Judy, your mental health wisdom and well-being is just wonderful. And I think you've got some excellent, easy-to-use strategies that every nurse can be practicing.

GAFFNEY: Well, you both have shared some exceptional advice for the nursing profession and for nurses who might find themselves in this situation. Now, Judy, much of the research that you've done on suicide, I believe, has been done before the COVID pandemic. And you said that the data kind of lags.

So, with this pandemic and the burden of caring for patients with limited resources and difficult times, it's taking a toll on our workforce. So, can you elaborate on the impact that we might see in the very short term?

DAVIDSON: Well, we do know, from past history, that pandemics increase stress, stress disorders, and suicide. So we know that from SARS and Ebola. It's a fact. So we can anticipate to see a bump in these numbers.

DAVIDSON: If we take action though, there are evidence-based ways to prevent suicide, right? And now, we know some of the risks. So, if we take action on these risks, and deploy these screening programs to find people at risk and get them into treatment, and we make available more therapists to be able to treat these people who need to be referred for treatment, we might be able to blunt or abort that blip that we anticipate we're going to see, right? But it would take everyone taking action to improve the inner workings of the workplace, to decrease unnecessary burdens in the work environment, to identify people at risk and move them into treatment without firing them, to treat these things as diseases and not crimes.

So, we need to take action that way. We need to process, if a nurse needs to leave the profession prematurely, have a process in place to offer psychological support to that person during the transition that we know is pretty dangerous. The other thing with the pandemic is that there's a problem with HIPAA again that when people are isolated and quarantined and home from work, that loneliness and isolation is a very high-risk factor for suicide for somebody that's at risk. And with HIPAA, managers are loathe to tell the employees why that person is home and off duty and keeping it, again, a secret and instead of supporting the person who is home, and ill, and at risk.

So there has to be a way around that. They should be able, the management team, to talk to the person who's home in quarantine and ask their permission to be able to disclose that they're home with this illness so that the team can support them. If we go back to your opening statement about Lorna Breen, she was separated from her work team that she was very connected to. She was home alone in her thoughts in quarantine with COVID when her situation occurred. And we need to think about the hundreds of our nursing colleagues who are at home in quarantine and make sure that they're receiving the support they need to come through that situation.

GAFFNEY: Well said, well said. So, I think that this is a critical time to be having this conversation. And I so appreciate the advice that you have shared with us on how we, as individuals, and how our institutions can help position themselves to really support our nursing workforce, particularly as we continue in this pandemic and life gets more and more challenging for our workforce.

Any final remarks that you'd like to share with us that I haven't asked you about?

DAVIDSON: I know that nurses are sensitive to the focus on resiliency because it sounds, on the surface to those on the front line, that it's their responsibility to do all this prevention work. Resiliency is a part of the puzzle. But we do need to look at the structures and processes in place at the system level to help decrease unnecessary burden on the workforce.

Actions of resiliency, though, are still important. A yoga mat in the break room is not going to solve the problem. But we do need to learn methods of mindfulness to be able to endure the added stress of a chronic pandemic. So, there's two sides to that coin.

Yes, every nurse who learns methods of mindfulness to bolster resiliency will bolster their own inner strength to a point. But we need to make sure that the work environments do not counteract all that hard work on cultivating resiliency. So, there are many systems issues that need to be addressed.

GAFFNEY: Well, thank you. Thank you so much for taking the time to have this conversation with us, to share your wisdom, your life lessons, and your experiences. I hope that our audience has been as inspired as I have been to identify how we can positively impact our own mental health and the mental health of our colleagues during these trying times and into the future.

By identifying the signs of substance use disorder and the factors that contribute to suicide that you all have so eloquently shared with us today, we may help save a life. So, keep your learning going about substance abuse disorder and suicide by exploring the references and resources not only shared by our speakers today, but also in the show notes for this episode. And listen a few minutes longer to learn how you can obtain continuing education credit for this podcast. Thank you for listening.

This is Terri Gaffney for Elite Learning.

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