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2016 NCSBN Discipline Case Management Conference - The Opioid Epidemic: Swinging the Pendulum

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Event
2016 NCSBN Discipline Case Management Conference

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Presenter
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[[00:00:10]]
- [Colleen] Thank you. Good afternoon. It's an honor to be here before the National Board today, and I hope that... This is very different probably than what you guys are talking about, but we'll try to keep it lively. So I am very vested in working with nurses in addiction, both at work caring for patients with addiction and obviously for nurses that may be struggling with addiction as well. So we're all in the midst of a horrific opioid crisis, an addiction crisis, as we're so calling it. And so I just wanted to talk about kind of like where we were, where we are, where we're headed. And this doesn't show too well. I apologize. But back in 1999, we had an overdose epidemic. And as you can look from this slide, there's not the red dark areas are the areas where there was really high prevalence of opioid overdoses. And that was in 1999. So we take that same slide and we bring it to 2014. That map doesn't look very pretty. It may look pretty, but it's not very healthy. So we have a horrific, horrific epidemic. And this is something that's affecting all of us. You guys work in discipline all the time, so you're directly impacted by it, but it's not something that anyone is untouched by at this point. And so, when you look at the crisis that's happening, this is actually a really empowering study to me that shows us what's happening. We're getting healthier as a society as far as prevention and education and learning how to take care of disease and learning about how to care for cancer patients and how to keep people alive longer and improve quality of life and how to change our lifestyles. So our deaths and our mortality has improved greatly, except when you look at our opioid poisoning deaths, and that's what it's actually affecting. And right now, it's affecting a population which many of us [[00:02:01]] might say, "Why that group?" We look at white middle-aged men, and that population is actually increasing in mortality by 2% a year, and that's what that data is showing you. So you can see other countries on there and how their mortality is decreasing and ours is actually increasing by 2% a year in white middle-aged men. So you think about why, and then you think about... Look at the traits. Look at what men do. They do a lot of labor-intensive work injuries, accidents, and that sort, which may be some of the reason there, we're also seeing a large group of young adolescents and young adults that are actually becoming impacted by it now, too. That data just has not shown, but that is actually happening. So then this just came out from the Obama administration, which I'm like on the ground with this big time with what's happening every single day because there's a lot happening, and this is really staggering. More people in this country are dying. And you're probably all hearing this now, but

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we've been talking about this since 2005, and I often say, "Did everyone just get a memo that we have a problem? Like, where has everyone been?" I mean, we have been screaming about this for a long time, and it's unfortunate that it takes, you know, a crisis, and we all know this. People start paying attention when there's a crisis, but we don't stop and prevent and think about it before then. But more people are dying in this country from overdoses than motor vehicle accidents. And in 2005, in the state I live in, in Massachusetts, that was a statistic, as it was in the entire Northeast corridor. So we were impacted by this much earlier on, but now it is a national epidemic. But do we hear about it every day? In some of our states, we do. Some of our states are talking about it. Some of our states are putting it in the obituaries, and their families are speaking out about it, and you're seeing it in the news media. But others still lay silent. So we still have a lot of work to do, but we have a really large, large problem. That problem meets the number of 129 people a day. [[00:04:00]] So can you believe if we were standing in this room and we were losing 129 people a day to the Zika virus? What would be happening? So we are losing 129 people a day to the opioid epidemic and we are responding, but clearly not to the magnitude that we'd be responding to other diseases. And so, what's flaring this epidemic? Why are we here? How did we get here? We all know prescriptions. We've all been vilifying this for a while. The doctors have been getting beaten up pretty badly. I'm just happen they don't mention the nurse practitioners when they talk about the doctors every day. But this epidemic has lots of pieces to it. So there's that piece and there's other pieces to it. But they're clamping down on the prescribing, so that's been happening gradually over a period of time, granted right now it's happening much more aggressively than it was back in 2009. And so the incarcerations, the jails, the criminal events that occur from that, the hospitalizations, the accidents, the injuries, the diseases, the comorbidities that we're seeing in the hospitalizations, the anoxic brain injuries, the endocarditis, the valve issues. This thing is hitting everywhere. And so, how did we get here? How did we end up here? Again, a long, long period. But back in the 1800s, there were actually morphine clinics where people could get treated for their addiction. And then there became a period of time, we all know about the Harrison Narcotics Act. But before that happened, you could actually purchase heroin over the counter at your local pharmacy. Bayer was manufacturing heroin back in the 1800s. So I mean, things have changed. We had Mrs. Winslow's Soothing Syrup which had morphine in it, and they were giving it to kids for teething. I mean, imagine what we would do with that today. But think about... Who remembers paregoric? Putting that on kids' gums. So this has been something that's been fueling a long time. Then the Harrison Narcotics Act came into place and you could not treat someone's addiction [[00:06:00]] with pain meds. It became against the law. But with that, so what happens to all these people that got caught in this period where they had this addiction, and now they have nowhere to go? Overdoses, crime, violence. New York City was horribly impacted by this epidemic, with lots of overdoses, crime and violence, and the overcrowding of the prisons. And then we all know about what's happened in the pharmaceutical industry. Some of it is science. People have been doing research and learned about greater medications to treat pain and give people better relief. But those pain meds were used in some places where they shouldn't have been and for longer periods of time than they should have been. And then who remembers the fifth vital sign? So we're nurses. We're taking care of people. You're being told by the Joint Commission that you now need to ask this question. We all know the smiley faces that are out there. So you ask a question about a subjective point of care for somebody. They give you an answer. What do you do? You treat it. So we ended up with this prescribing that actually directly correlates to the Joint Commission's accreditation issues. So did that really fuel this? I'm sure it had something to do with it. The higher doses and the strengths of these medications I'm sure had something to do with it as well. And then from there, we ended up with this crisis. So we're prescribing more opiates than anybody in the world, we have the smallest

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population, and we ended up with this overdoses crisis, and we all are now responding. And it's late. We're late in the game, but we need to do the best we can to try to get a handle on this. So why are we seeing so many overdoses? Heroin has been around for years. Opiates have been around for years. Why does this look so different? And so again, we talk about the strength and the purity of the opioids that people abuse and use and are prescribed, and then we look at the strength and the purity of the heroin, which has increased dramatically the purity of that, as well as the mixing of it with other agents, including fentanyl. And we just came out and spoke about Prince the other day, [[00:08:00]] and they basically finally confirmed that he did die from an opioid overdose and that the opioid he died from was fentanyl. And for those that are not aware of what's going on out there, the heroin is mainly fentanyl in a lot of locations or it's laced with fentanyl. And it is not pharmaceutical grade fentanyl, contrary to what Dr. Oz had to say, and that is not what's killing people on the street. This is not pharmaceutical fentanyl. This is fentanyl that's being manufactured, and it is deadly. So people are mixing things. We see this craziness. It's like we can't even figure out when someone comes in to try to and assess and evaluate what's going on. They're opiate screened. Their urine screen is negative for everything, but they're clearly impaired because they're using other things that aren't even picking up. So the polysubstance use is definitely a factor here. And when there's an overdose, it's not just heroin or fentanyl or an opioid on board. It's multiple agents that people are finding. So things are changing. Chronic diseases. People are becoming sicker. People that are abstinent for a period of time, their tolerance goes down within three days. We know when someone leaves the House of Correction, they're 129 times more likely to have an overdose within two weeks than someone else in the general public because their tolerance is down and they have a disease, but we don't treat them unfortunately. So what is that face of addiction? What is that we're looking at? Do we look at this young child that's growing up in the suburbs who has everything and think this person is going to end up with a substance use disorder? No, we don't. Do we think of people that are actors and people that are rich and famous and have everything in life and think they're going to be using Propofol and die from it? Or other actors and Prince and Heath Ledger and people from our own families and our communities? What does addiction look like? What is that face? It's much like HIV. It does not discriminate. And you folks know this firsthand because you're dealing with nurses who struggle with substance use disorder. And our teens, our kids are attending each other's funerals. [[00:09:59]] I mean, this is outrageous. We need to do something to change this. We need to do more prevention and education. We're going to need to hit this earlier, which is a big part of what's being talked about now. So addiction, this substance use disorder hits us in so many places. The medical community is very much impacted. Our health system, the cost of the disease, the crime, violence communities, places that never knew what heroin was, let alone finding needles on playgrounds and kids overdosing in bathrooms. So things are really shifting into a really bad place. The accidents, the injuries, the violence, the crimes that are connected with this as well. So we've done a lot of work. We're still talking, and you can probably hear the way we talk about this disease is so important. The way we acknowledge that it is a disease is really important. We've spent a long time really shifting it to the side, sending people to their counselor, looking at that person differently, but we have to stop that. If we're ever going to get a handle on this and if we are going to talk about this that it is a disease, we have to speak about it as if it's a disease and we have to acknowledge that person struggling with a disease. So ending the stigma is really, really important, not just to our communities and to people that we know, but to the patients, to the people that we're caring for, to acknowledge that we know that they have a disease. It has all different components to it, but it has genetic, biological, and environmental factors, and those all contribute to whether someone potentially may or may not end up with a substance use disorder. But it's not a moral failing. It's somebody made a bad choice. And we don't always make bad choices that change our

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brain or that hijack our mid-brain that make it then almost impossible to step back from that. So the stigma around this is really... And we're struggling with this so much. And I think it depends on where you live and what part of the country. I'm in the Northeast, and we're definitely a lot ahead of a lot of places, [[00:12:00]] but we're still struggling. We still have... Law enforcement wants to give people, everyone Vivitrol because why? Because it feels more punitive. You can just block them, and they won't get any pleasure. But is that really going to work for everybody? Is everyone going to take it? How many people out of jail are actually taking that? So it's about treating the patient and not looking at them differently and not looking at that disease different than we would other chronic, relapsing diseases. The stigma of addiction is the reason why there's social and legal discrimination against people that have a disease. This is something that came from David Rosenbloom, who writes for Join Together. And I think it's just really impactful to speak that transforming the shame and hiding from its effects is really, really important. Looking at this, we say it's a disease. I went to nursing school. I graduated in 1984. We didn't talk about addiction, but we know that it's a disease. We know it has the same characteristics as other chronic, relapsing diseases. We know that the AMA declared it a disease back in 1956. But again, we don't address it that same way. But we also know that when we don't treat it that it progresses, it becomes terminal, and people die. And the death rate from addiction is horrific, yet it's something that we continue to think about. "Should we do this? Should we do that? Should we raise the cap? Should we provide treatment? Should people be abstinent?" But yet, we keep knowing and the science keeps telling us what's working and what does work, but we don't go there. So what happens in the brain of the person with addiction is their brain literally becomes hijacked and that making of those right decisions, those things that we process and think through every single day, and hopefully "Should I buy that dress? Should I not buy that dress? Should I have that chocolate cake? Should I not?" When you think through that, that's not the way a brain of someone who has an addiction works. They have a compulsive need to have that drug to feel normal. And without that, they don't feel normal. They're flat. They have no amp. They have no pleasure. They're depressed. They're anxious. They can't sleep [[00:14:00]] because their brain literally has been reset to a higher-than-normal level in order to feel normal. So it's not just that easy when mom comes back and says, "I don't understand. Why did he use? I just got him back from rehab. I just spent $30,000 and I remortgaged my house. Why did he do that to me?" Well he didn't do that to her. His brain is screaming at him, and unfortunately, he doesn't know how to control that. So this is where the difference lies. We talk about addiction and we talk about it as a disease, but are we really thinking about it that way? And sometimes, I feel like we're not. And so think about it as other diseases that have behaviors associated with it. The difference between addiction and other diseases is the difference of the behavior. The diabetic continues to eat the hot fudge sundae, and they're not taking their medication, they're not checking their insulin, they're not dieting, they're gaining weight, their toes have been amputated, their kidneys are shutting down. We continue to treat that person. We never think differently about it. Or the hypertensive patient continues to drink two 12-packs, drank when he watched the game yesterday, had another heart attack, needs another stint, comes in with chest pain, and we treat him. And the asthmatic continues to smoke and can't breathe, and the inhaler is not working, and now they need to be intubated. We treat them. But the person with addiction walks in, and they came back to the residential and they used, we kick them out. We give them their green trash bag and send them on the road. That person has just as likely of a chance, if not greater, than the person with those other chronic, relapsing diseases to die. What we don't like is their behavior. They broke the rules. They didn't follow what they were supposed to do. Well, neither did the others. We all know how hard it is to change behavior. Think about what happens on January 1st. How many people make a New Year's resolution, and how many people are still doing that by January 10th? Behavior is hard to change. And

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when one's brain has been hijacked, it makes that even harder. So we just need to keep that in mind. It's not the person we dislike. It's the behavior. [[00:16:01]] The behavior is awful. There's no disputing it. And the behavior is awful because the person can't go to CVS and buy some heroin. So they're engaging in illegal behaviors to manage their disease because their brain is screaming at them to use that drug. So we look at what happens, like how well does that person do when we treat them, and we know when that person doesn't get treatment. They relapse, and the same as the person on hypertensive meds. And we hear this all the time. How long are you going to need to be on that medication? Well, how long are you going to be taking your antihypertensive meds? When people come off, people relapse. And I know this is a bone of contention, especially in different professions as far as patients being on medications, but we know the relapse rates are great when people have an opioid use disorder and they're not taking medication. It doesn't mean everyone needs medication, but there's just a higher prevalence of people that actually do need to be on medication. So what is this costing us? What is this doing? What's happening? This is something that's impacting everybody. First of all, there's no one, I don't believe, that doesn't know somebody that's been impacted. But the cost to the economy and to society and to the productivity and to the world where we all live and take care of people and work every day is great. It's greater than $120 billion in lost productivity. That's huge. That's horrific. People amongst us that are struggling with this disease, people who can't get to work, people who are not performing at the top of their game. The healthcare cost. You would think this would get everyone's attention because we're all worried about cost in healthcare. Capitated care, ACOs, what's going to happen? Don't worry Admissions. Medicare is not going to pay for it. So if we don't start treating this, those things are all going to go by the wayside because there's so many people struggling with addiction. And the criminal component of this, the crime, the violence, the readmissions. We're getting better about talking about this as a disease and treating it and not incarcerating everybody, but it's still a large problem in the criminal justice system. So we also know that those that have a substance use disorder, [[00:17:59]] 67% of them work full-time. So if you have a substance use disorder and you're working full-time and you're not getting treatment, you're not going to be productive. You're not going to be contributing what you should be to your workplace. 48% of them working full-time, 19% part time, and 13% are unemployed. We know our turnover and our absentee rates are greater in folks that have a substance use disorder. They can't stay with a job. They're moving around. They're late. You guys know all of this. So there's definitely signs and things that are going on that we see in someone struggling with this disease. So on a federal level, Obama is working really hard, and with Michael Botticelli, who is our White House Office of Drug Policy and Control, used to be called the drug czar, but he doesn't like that name. And so he's been moving mountains as to changing the face of this disease. I don't know if anyone saw "60 Minutes" this week, Sunday night. Anyone see it? Or before, when he was on it and they just plain talked about his struggles and his recovery? Can you imagine the person who's the drug czar is in recovery? I mean, it's impressive. He was actually the Bureau Director in Massachusetts. If you have a minute to pull up "60 Minutes" and look at that, it's just really astounding to look at this. But he's changed the disease. He's changed how we speak about it, how we're looking at it. And he's working to get criminal justice on board, and he's working to get everybody on the same page and address this as the disease that it is. So they're putting more funding into medication treatment. They're putting funding into evaluating what works and what doesn't because we need to know what we need to do and how we need to do things better to treat this. More on prevention education. Huge needs. We've got to get to the kids early. We've got to get to everybody early. People need to understand it's not just your parent telling you what to do. Our kids all think that. "My parents are just telling me what to do." But we know that if kids use drugs or alcohol between the age of 12 and 17, they are 67% [[00:20:01]] more likely to develop an addiction.

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Sixty-seven percent. If they use drugs between the ages of 18 and 25, they're 26% more likely to develop an addiction. People say, "What are you talking about? When you're 18, your brain is matured." We know now in science that your brain isn't fully matured until the age of 23 or 24, so we shouldn't be kicking those kids out. We shouldn't be sending them to vote and to go to war. They can't even process and make decisions because their frontal lobe is still developing. So we really need to work on our younger adolescents and our young adults and to not drink and not use drugs so that we can impact the rest of their future, because when their brain does fully develop, it's going to be higher functioning, for sure. So a lot is being spent here. A lot is being inputted into communities, to schools, and to education, to try to impact this. And this is part of the CARA bill, which is the president's budget that's going on right now. So the environment, that's what we're looking at. What we're seeing with the nurses and the folks that we're caring for. Environmental factors are huge. And so, we know when people have access to things. If you live in a household and everyone drinks alcohol or everyone is shooting heroin, you're potentially going to use drugs or drink alcohol. If you're living in a neighborhood and all your friends are using, you're potentially going to go there. So the peer pressure, the environmental factors are a huge component. So if you have a nurse that's in an environment and they're exposed to those drugs, we know that again. That's a place that fuels this epidemic, unfortunately. But the good news here... I mean, that's where we are. We have a horrible problem happening. There's no disputing it. And we probably only know a very small part of it, those that actually have been caught and have been brought to the attention of the boards. But what about those that are still out there? So now we have an opportunity. I see this as a really positive opportunity in the workforce in that now we can look at... We're looking at this differently. We're talking about it as a disease. [[00:22:00]] We're taking away the stigma. We're accepting it as a disease, and we're integrating treatment. We're talking about treatment and medicine together. We're talking about medical providers treating this disease. Before, it was "Go see your counselor. Go to detox," because they didn't have much to offer. We're educating providers. We're helping them to learn how to talk to patients, how to have therapeutic conversations, how to not keep somebody on opiates for the rest of their lives, how to use other alternatives. And so, now is the time where these advances are happening, where science is continuing to learn more about cocaine and alcohol and opioid dependence that we can change the landscape and we can work on how we can treat this differently and how we can change what's happening. And we're changing our language. We're changing how we're talking about this. We're talking to the patient because they have a disease. They have a horrible disease. There's no disputing that. And acknowledging and validating that is so powerful to the person who has been knocked down 100 times, who's been treated like a junkie that they say they are, who tells you that they relapsed, that they're clean, that they're dirty. Those are not ways we should be talking about people's diseases. So I feel like not just in nursing, but we're here to talk about nursing that this is a place where we can educate our community, where we can do better. Why aren't we addressing this in the workforce? Why isn't every place where nurses work having this as part of orientation? Why aren't we acknowledging we have a disease and we're impacted by that, and potentially we could have a substance use disorder or one of our colleagues could have a substance use disorder? Why aren't we making that a part of orientation? We've got to do cultural diversity. We've got to do HIPAA, confidentiality, infectious control every year. We do all of those, but we never talk about substance use, and when we know the cost of substance use, not just to our employees but to our patients and to our community and to the headlines that you may get in that newspaper. So why don't we leverage this, and instead of the negative spin, [[00:24:00]] talk about it upfront, about it as a disease, about what we potentially could do, what our resources are, not burying the EAP in that human resources manual that no one could find and no one knows what it means? So here is the time

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where we actually had a recovery month last year and we talked about addiction around our hospital for the entire month, and we did educational things, and we had boards up and we had people writing on them, and people came out of the woodwork. Some self-disclosed, some talked about their family, and some called me anonymously on the phone and we just talked. Some have this underground community where they talk to each other. We need to bring that up. We need to help people to understand this is a disease and how to recognize it, how to help their colleagues. It's not about just getting everybody in trouble. We've got to stop waiting for the pixus [sp] alarm to sound. It's too late in what's happened. I mean, Mass General hit the front of the paper a few months ago with somebody who got like 5000 oxycodone that was diverted. I mean, that's not okay. And how many patients have been impacted by that? So it's time to give a hand up and not to wait for that crisis to happen. And I feel like this is... It was really discouraging to me, though, because Michael Botticelli, who is the director, I'm very close to him and I talk to him a lot, and so I sent him an email when I was getting ready to do this, and I said, "So Michael, all of these great things we're doing, but what are we doing for the workforce? What are we doing to talk to employees?" The construction industry. We know it's a huge problem. They're out there on steel shooting heroin. That's not okay. And so somebody is going to get hurt. Somebody does get hurt. But he said to me, "Colleen, we have so many things going on, but this isn't one of them." This isn't one of them? I mean, we need to be having these conversations in the workplace. We know nursing and CDC are getting on board. We know that our partners are getting on board and talking about pain management. We're doing a lot more education. [[00:26:00]] We're bringing it out there. Some states have gotten to the point where they put that you have to do one hour or one CEE on substance use disorder or on impaired practice or on how to address substance use or what it is. So just putting it out there and letting people know that it's okay to talk about it or how to get resources is really important. Also, the AACN President of Nursing went to the White House a few months back and, you know, met and spoke about what the nursing schools are doing. This is great. We're starting to address it in nursing schools, and we know that's another big problem. But once they're out of nursing school and people are in practice, no one is doing anything. Most facilities don't even screen for substance use disorder. They do urines when you go to the Home Depot, but we don't do a urine when you get a job in a healthcare facility where you're taking care of people's lives. So really looking at those things differently, I think, is really important. So we need to hit this. We need to hit it hard. We need to keep our target on what it is we're trying to accomplish. We're trying to help people. We're trying to manage their disease. We're trying to keep the public safe, and we're trying to keep people safe. And you guys hear it over and over, I'm sure, when the nurse that gets caught, they're so relieved that they got caught because it stopped that cycle. As hard as it was and as awful as that all was to go through, it was the best thing that happened. We need to help people earlier, and we need to prevent the crises that happen later. So where do we go from here? What do we do? We need to be guided by science. There's a lot of research that's happening. It's still not great. We've got a toolbox that's pretty empty, with few resources as far as medications in it. How do we manage this? How do we get people the help they need? And what's allowed? We know that Vivitrol works very effectively in the healthcare community as far as physicians go. Physicians being on it, there was greater than 80% were abstinent at six months when they have a high motivation. We know that in nursing. People are motivated because it's their license [[00:28:00]] and their livelihood, so it's a little different than other entities. We need to replace that stigma. We need to talk about this as a disease. We need to accept and acknowledge and tell them, "I'm really sorry you have this horrible disease." And when we're treating that patient who has that disease that's been in recovery for 20 years and now they have to have hip surgery, that's real horror and that's hard stuff for folks. Again, so treating the disease as a disease that it is. So our lives begin and end when we become silent about the things that

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matter. We can't be silent about this. This is killing our families, our communities. It's affecting our healthcare costs and our healthcare settings, and we're not providing safe care by not talking about it. So I want to end there and leave it open for questions, which I thought was more important than me just talking at you. Thank you.
[[00:28:52]]
applause
[[00:29:00]]
Does anyone have any questions?
- [Patricia] Colleen, that was an excellent presentation. I'm Patricia from the National Patient Safety Foundation. I spoke this morning and I talked about root causes. One of the things that we recently did was a survey of our constituents about what they knew and understood about opioids. And you talked about education in nursing schools, and we're seeing a lot of educational mandates for CE or maintaining licensure that's coming in prescribing, but what we heard loud and clear is people forget how to assess pain. They don't know how to do it anymore. A lot of the fundamentals are missing, and their practice in terms of developing care plans for patients who are needing pain treatment is also really, really fractured. So I would encourage you to think about not only thinking about the prescribing end, [[00:30:01]] but really going back to the basics because that's a major gap area for people. The other thing I wanted to say was my husband is actually a funeral director, and in the span of two and a half weeks, we buried five adolescents and young adults in a very, very small community that we live in. We literally, to your point, had the high school students and young college students running from one funeral home to the other in different towns that were really just a couple of miles away. But it was a bad batch that hit the State of Massachusetts and really, really was very, very destructive. Thank you.
- Thank you. And to comment on your well-taken points around the opioids, it's so true. And the other thing that's happening is the pendulum is not just swinging for the opioids. It's swinging for people with pain, and it's swinging in the wrong direction for them. And people are being vilified. People are going to pharmacies, and people are being treated poorly, and the pharmacist is looking at them with that suspicious look, and the doctor is not filling it until the absolute minute it's refilled, and doctors are cutting people off, and this prescription monitoring program. They couldn't give a urine, or they missed it because somebody died. And then there's the doc who calls us up and they're like, "I have this lady. She's 70 something and she's been on oxycodone 5 milligrams twice a day for the last 40 years. What should I do?" Nothing. And so then you have the little old lady who's calling you and she's screaming, "I have to get off these drugs. I'm addicted!" And they're not addicted. They're dependent. They're physically dependent. And that's very different. And that's a message we really have to spread out there and to educate folks on. They have a physical dependence. Yes, if you stop it, you're going to have withdrawal. Absolutely. But if you stopped your antidepressant rapidly, you'd have withdrawal as well. You can't stop it that way. But if somebody is on it and has a chronic pain for an appropriate reason, or if they're on a really low dose and they've been on it for a million years, you've got to figure out [[00:32:00]] pros and cons of what to do and what not to do. And I think we're getting so quick into just throwing people out. And then they're throwing them out and they're not offering them anything else, and they're not hooking them up with an addiction service. They're not giving them any referrals. They don't know what to do, and then they're going to the street and they're using heroin, and then they're overdosing. And the other thing on the overdose that you spoke about is the other thing that's happening because people are using fentanyl. It's looking like the "Pulp Fiction" movie out there. Who saw "Pulp Fiction?" They got the needle in the arm, and he goes, "That's not what an overdose looks like," because usually with an overdose, it happens two or three hours later after it's peaked, but with

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fentanyl, it's happening immediately, because think about what happens when you give someone fentanyl and they go into surgery. They go out, right? So patients are going out literally in bathrooms, in mother's houses. Parents are finding their kids left and right. People are using, shooting for the first time and injecting and dying. So we're also talking to people about harm reduction. If you do know someone who's struggling, don't use alone. Don't use in a bathroom. Don't use in a bathroom where a door goes in. Parents can't get to their kid. I mean, the horror stories are outrageous. Now people are using in bathrooms next to emergency rooms. They're using in our hallways because they know there's people there if they find them. They're wrapping the pull cords around their arms so if they go out, the light goes off. So desperation out there is really great right now, and this is just a really horrible, horrible time, and people have an awful disease, and we need to help them get a treatment because they can't just stop, and that's the reality. And that 129 a day is now a campaign that's going on. And if you Google searched "129 a day," every single day, it's coming up a story, typically of somebody young, and it's telling a story of what's going on because that's what's happening in America. We're losing an entire population right now, and it is more white middle-class kids that we're seeing in families. [[00:33:59]] There's definitely a difference in the population that we're seeing as well. People think we're only paying attention to it because now it's a white disease. I don't care why we're paying attention to it because we have a problem, but yes, it is a white disease at the moment. Questions?
- [Woman 1] I just have a quick comment about prevention. NCSBN created some resources a couple of years ago, and we could use all your help in getting them out there. And what they are is they're part of the prevention piece. We have two continuing education courses on substance use disorder. One is just for the nurse, and it's not for someone that's using. It's for those nurses that don't know about it yet, or know a little bit about it yet. And the other course is for supervisors. And then we also created two posters to be used in hospitals and facilities to kind of talk about, to just break the ice over substance use disorder and nurses. So if you're going out there to do a presentation or someone else that your board of nursing is going out to a facility, take our free-of-charge posters. They talk about our courses. But if you want to think about making a CE required about substance use disorder here, NCSBN has the course already provided for you. All you have to do is mandate that they take it.
- That's actually a great point. I actually looked at your resources, and they are absolutely wonderful. And it would be so great if in orientation, we actually used those resources and gave them to people and did some more prevention education upfront. And the CE is another piece of that. And then so how do we get healthcare providers to become more educated and to understand this? And so that piece with the nursing schools is coming into play, and now the medical schools in Massachusetts and in other places are mandating and putting it into the schools, and some of the graduate programs are putting it into the nursing schools as well. But it would just be so great. If this was on an exam, [[00:36:01]] you know what happens. So we start talking more about it. I mean, this is a huge disease, and there's nobody who doesn't work on a floor and doesn't have a case load of five to seven patients that one to three of them don't have alcohol, tobacco, or opiate, or cocaine disorder. I mean, look at the disease mortalities that our patients came in the hospital for. People are impacted in this in great rates. And we're not even talking about alcohol. And actually, alcohol is a bigger problem than opiates right now, but no one is talking about alcohol. But I don't think anyone is ever going to talk about alcohol. But alcohol is a huge issue. And actually, Vivitrol is actually becoming a little bit more effective than doing nothing and giving people a long-acting injection. It takes away the craving and it doesn't do anything, and so it's an effective tool. So we need to be looking at everything we have and trying to do a better job taking care of the whole person. Yes?
- [Woman 2] Question back here. One second.
- [Man] Hi. I saw briefly in one of your slides that part of the current epidemic among all the other

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factors may be the focus that boards have put on pain management rules, pain contracts, and making sure that prescribers are, I guess, for lack of a better term, holding patients accountable, and that when people are cut off abruptly, they immediately do what they can, which includes the heroin, which is of unknown strength and quality. And I was wondering because in my experience, if a provider is really making patients tow the line with the pain contract and cuts them off when they violate it, that seems to be okay, and yet if they continue to enable by giving more, that's not okay. [[00:37:59]] So it seems to be the safe thing for providers to do to just abruptly cut people off and fire them, kick them out of their practice. What do you think boards should be doing for the public to really ensure safety?
- It's an important question. I think the important thing is for us, we're not supposed to abandon patients. And so if we do cut them off, we need to be referring them to another level of care or to another treatment resource or to something else. And unfortunately, what I think happens a lot is the doc just fires them. And some of that is out of anger. They're just pissed off that that patient was screwing around with their meds and their treatment, and they had no idea that's what's going on. And we got to take the personal piece out of it and remember the person has a disease, but trying to get them to treatment because we don't want them to die. And they may not be able to hear that provider when they're walking out that office because they're just pissed, like "You just shut off my medication." Or it could be somebody who's diverting it. But giving them that number at least, somewhere to call, and something that they can then do when they hopefully calm down later or when they're desperate later and they now need to do something versus ending up on a street and overdosing. And the suicide rate is another factor which we didn't talk about. The suicide rate is increasing dramatically. And I don't know what the numbers are, but I'm sure that some of it is fueled by this epidemic because if you can imagine... I can't imagine having a brain hijacked, needing a drug, and without it, feeling the worst flu of your life, multiply it by 10, and then the mental component of that, not being able to feel pleasure and can't sleep and can't sit still and "I'm anxious," and "My back hurts," and everything is horrible, and not being able to do anything about it. And so I think that's a piece of this as well. There was a question back there, I think. There you are.
- [Woman 3] How do you feel, or what is your opinion about nurses working while on Suboxone?
- So there's been a lot of research [[00:39:59]] to show that Suboxone does not cause someone to be impaired. So they're not sedated. It's restoring their brain changes. People are not nodding out. It doesn't peak and cause that kind of an effect. If it does, then the person potentially is on something else... And see, that's the problem. People like to take other things to bump effect. So you're not getting an opiate effect anymore because now "My opiate problem is under control, so I'll take some Neurontin, or I'll take some..." The list goes on. I won't go there. But Suboxone itself is very, very effective. And we treat hundreds and hundreds of people. I have 700 people just in our clinic on Suboxone. And we have lawyers and we have nurses, but they're not under the board's direction, so nobody knows about them. We have politicians and CEOs, construction workers, lawyers. I mean, people that are in the trades, and they're not impacted. They're not impaired. They're invisible. And so that's the piece. It's these people that are in treatment that are doing well are invisible, and what the public sees is those that are not doing well. And there's a lot of people that are not doing well. There's a lot of people that are not going to do well for a long time or maybe forever, and that's what I think impacts people making those decisions that you can't do this, you can't do that. But it's a hard one. I know. It comes up all the time.
- We're out of time now, but I want everyone to help me in thanking Colleen.
- Thank you.

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