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The

opioid crisis:

Staff empowerment strategies

By Brooke Schaefer, MSN, RN, FNP-C

Editor's note: Many of the opinions in this article are based on the direct experiences of the author.

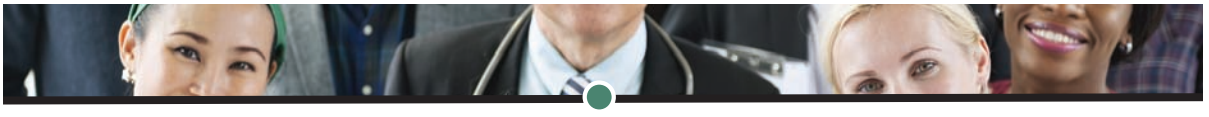
Every corner of healthcare in the US is touched in some way by the surging opioid epidemic. Traditionally, mental health facilities and EDs have provided most of the care for patients who are addicted to opioids. With the scope of this crisis becoming larger every day, nurse managers need to be adept at executing versatile approaches to meet the complex needs of these patients and their families. Exploring underlying preconceived notions, targeting strategies to overcome the stigma of opioid abuse, and implementing appropriate supportive methods are essential. This article reviews the concepts of forgiveness, flexibility, and fortification that can be put into play quickly to improve the care of this patient population.

Where do we start?

Drug addict is a souring, disheartening term often used synonymously with *weakness*, *selfishness*, *immorality*, *prostitution*, and *parental neglect*. Such preconceived biases appear even in the most unintentional, benign conversations when the topic

of opioid abuse is approached. Healthcare professionals may become disillusioned when handling the ongoing and frequently exhausting complexities of patients who are abusing opioids, and caring for these patients when they're reaching rock bottom can cause staff members to experience compassion fatigue.

Healthcare professionals aren't blind to the problem of opioid addiction, but we may feel restricted in our ability to help. Consider these three themes that serve as a guide for staff during the recovery process:



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As the opioid crisis escalates, the collective healthcare community must acknowledge biases to work through them. Illicit opioid use rates in the US continue to rise.[1] In 2017, there were approximately 49,000 opioid-related deaths, exceeding motor vehicle accidents as the leading cause of accidental death in the US for the first time since the introduction of the automobile.[2] And the CDC predicts that the epidemic isn't resolving; overdose deaths will continue to rise over the next year.[2] The data are easy to understand, but the real problem comes with trying to find solutions. It can be challenging for healthcare staff members to understand that patients will seek help only when they're ready. We in the healthcare field need to be ready to take advantage of the patient's motivation whenever it presents itself.

Forgiveness

The idea of utilizing "tough love" became popular with TV shows such as *Intervention*, in which individuals with opioid addiction were given firm boundaries and severe consequences (such as cutting off all ties when rules were broken). Yet, tough love and the use of ultimatums aren't always the most effective strategy, especially in the healthcare setting. Many people struggling with addiction are already cut off from family members for various reasons. Cutting them off from the healthcare community shouldn't be done as a reaction to anger or frustration. My philosophy is that we're our patients' "soft place to land," offering understanding, acceptance, and solutions with a variety of treatment options. I want patients to feel that they can openly share a relapse in a nonjudgmental, trusting environment. With a patient-centered focus, we can work together to come up with a strategy that helps the patient become better connected to resources instead of experiencing repeated isolation.

We strive to be kind, keeping in mind that when caring for patients in any situation, we may not receive entirely truthful information from them. In my state, the INSPECT prescription monitoring database tracks controlled substance refills, who wrote the prescription, and how many pills the patient was issued.[3] To encourage accountability and develop a trusting relationship, I communicate to patients from the beginning that I check the database often. We have a rule in our program that hard truths are spoken out loud. If a drug screen is positive for illegal substances or a patient is acting erratic, it's said out loud with a calm voice directly to the patient. Something that can be very difficult for staff

Action steps

- Role model empathy and kindness.
- Be ready to help patients when they're ready for help.
- Forgive patients and don't hold grudges; give second chances and beyond.
- Be flexible, but don't enable.
- Fortify patients with layers of resilience.

members to understand at first is that they aren't telling the patient something he or she doesn't already know.

When you tell a patient that his or her drug screen is positive for illegal substances, there may be denial but, ultimately, the testing confirmation is concrete, evidential truth. Give power to these truths by saying them out loud in a nonaccusatory manner. I've found this can open the door to a therapeutic dialogue that usually improves the patient's outcomes in the long run.

Many patients who abuse opioids have been in situations over time where lying is a basic survival mechanism. I call these unfavorable coping skills "survival lying." I have a personal philosophy about patients lying to me: I don't have to win the war of who's telling the truth, nor must I prove that the patient is lying. We have safeguards in place to protect the integrity of our program without falling down the rabbit hole of investigating truths or lies. The patient knows up front that if he or she loses medication, I don't refill or replace it. The alternative is the patient visiting us daily to get a single dose of medication, with the caveat that he or she will be screened before receiving each individual dose. We've found that this is an effective strategy to help prevent relapse, particularly in cases where medications are truly lost or stolen. An additional measure of accountability includes therapy attendance tracking.

These are just a few examples of our safeguards, which will vary widely based on your unit or program. As rapport is built over time, lying seems to become less of an issue. I've personally noticed that this occurs after about 1 month of treatment. If a patient has made it that long, he or she is starting to focus more on recovery and a little less on survival.

Forgiveness from the healthcare community is an essential part of providing holistic care. As nurse leaders, we set the tone by not encouraging or feeding into the judgments that "survival lying" can elicit. We must forgive the fact that patients aren't always going to be able to follow the exact guidelines, especially in the beginning. They may show up late, but we must work them into our busy schedules if possible. Our opportunities are limited—perhaps in one moment, the patient was running late, but he or she is now ready to make the necessary changes. We can help inspire our staff members to give patients first chances, second chances, and beyond if needed. Providing understanding and reasonable accommodations can support the sustainability of a patient's road to recovery.

Flexibility

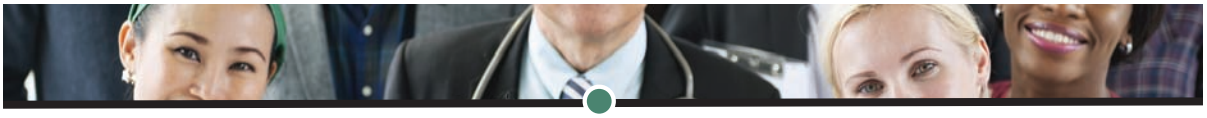
Flexibility and forgiveness often overlap. When we forgive patients for being late to appointments or causing extra stress, we offer flexibility. It's important to remember that individuals have unique needs. I encourage staff members to think about a patient's care as if they're caring for their best friend's daughter or their own family member. Most people would be willing to put in the extra effort for a loved one; we need to encourage staff members to provide above-and-beyond care for these highly vulnerable patients. This is different than enabling a patient's substance abuse. Being flexible is a way to help patients be successful in their recovery.

Relapse can be heartbreaking for patients, their families, and staff. It's important to remain flexible in our approach to this issue and have realistic expectations of our patients and their chronic disease of addiction. Many chronic diseases have treatment relapse rates. For example, 30% to 50% of patients with type 1 diabetes will relapse (defined as needed additional care outside of care established after hospitalization) in their treatment adherence annually.[4] Patients with hypertension or asthma have similar yearly relapse rates of 50% to 70%.[4] One year after discharge for detoxification, 40% to 60% of patients struggling with addiction will relapse.[4] Most patients who relapse do so because they aren't following medical advice related to medication therapy or they've stopped participating in therapy. (See *Medication therapy.*)

Medication therapy[5]

The American Society of Addiction Medicine indicates that opioid addiction medications are an acceptable part of the treatment plan for opioid use disorder (OUD). Withdrawal therapy alone isn't considered to be a complete treatment. When medications, such as methadone and buprenorphine, are used to treat OUD, they reduce overall overdose-related mortality by 75%. Medication therapy also improves treatment program retention and lowers incarceration rates, thereby reducing the financial burden that incarceration causes.

The healthcare model in the US has made significant improvement in the flexibility of care related to diabetes, hypertension, and asthma; we need to provide the same degree of flexibility to patients battling addiction. If a patient relapses and reaches out to us for help, we need to understand that this may be an opportunity for us to provide life-changing care. If a patient relapses, don't cut him or her off; rather, reach out with even greater vigor.



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Flexibility regarding patient appointments can be difficult to accommodate in a busy office. No one desires to stay late after a shift ends or make an adherent patient wait because another patient can't make an appointment on time. However, I urge you to be flexible, within reason, when caring for patients with opioid addiction. Some may argue that patients should value treatment as a priority in their life, but consider that it can be difficult enough to overcome the barriers in the way of getting to appointments, let alone how running out of treatment medications before a long weekend holiday may be the final straw that triggers a potentially life-threatening relapse.

Fortification

To fortify is to strengthen or empower someone physically, mentally, or spiritually. Fortification of patients' lives can make a significant impact on recovery. Patients need fortified layers of resilience to be successful. Healthcare providers in treatment programs can listen, educate, and nurture patients for months, but if a patient goes home to a house filled with others who are abusing opioids, his or her chances for success decrease. Helping these patients find the right resources can be time-consuming and some staff members may feel like this is the role of social work, but social workers may not be readily accessible in all parts of the healthcare model.

Not all managers and staff members are going to feel drawn to devoting their careers to issues surrounding addiction, yet I challenge my peers to take 10 minutes each week to research available resources within their communities. Having an idea of where to send a patient who requests detox may be the single factor that saves his or her life. Make phone calls, reach out, and get names. I try to go in person to our area resources to meet the people who run them and understand how they can help my patients in the future. These steps are all part of the fortification process. Many communities have well-established resources, but communication among them may be lacking. I've found that learning about one area resource often leads to three more undiscovered connections.

Sometimes the fortification that these patients need is to feel accepted and cared for by the healthcare community. Set the example of compassionate care to your staff members and coworkers. Long-standing unit cultures of intolerance can be overcome. I've seen many leaders take their passion for patient care and turn it into a highly motivated team. Kindness can be taught and leading by example is an effective way to do so.

Face-to-face interactions to emotionally fortify our patients are essential. I make it a point of saying hard truths out loud, but I also give praise freely. If we're at the beginning of treatment, I compliment patients for seeking help, honoring small steps toward recovery. At their first drug screen that shows no illegal substances, I celebrate with them. I tell patients how much commitment it takes when they start arriving on time and begin going to therapy regularly. I highlight changes in their lives that they've told me about and tell them how proud I am of them. Being a source of encouragement builds rapport with all patients, but it's especially helpful with patients struggling with addiction.

No life is a throw-away life

Not every patient addicted to opioids who comes in contact with the healthcare community is going to be ready for help, but every patient is worth the effort of trying. If it were my daughter seeking assistance, I would want her to be assigned that once-in-a-lifetime nurse at just the right time. If my son reached out from the depths of his sixth overdose, I would want resources to be offered to him when he woke up. There are times when these patients can be emotionally and physically exhausting. I have a secret weapon that I use when working with patients who may cause compassion fatigue: I remind myself *no life is a throw-away life*. I believe in the potential of all my patients and that my job is to nurture their greatest selves. As healthcare providers and exemplary nurse leaders, we must rally together to be a force to change the tides of the opioid epidemic in our communities. NM

REFERENCES

1. Jalal H, Buchanich JM, Roberts MS, Balmert LC, Zhang K, Burke DS. Changing dynamics of the drug overdose epidemic in the United States from 1979 through 2016. *Science.* 2018;361(6408). pii: eaau1184.
2. Centers for Disease Control and Prevention. Opioid overdose. 2017. www.cdc.gov/drugoverdose/index.html.
3. Indiana Professional Licensing Agency. INSPECT purpose and goals. www.in.gov/pla/inspect/2451.htm.
4. McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. *JAMA.* 2000;284(13):1689-1695.
5. American Society of Addiction Medicine. Access to medications talking points. www.asam.org/docs/default-source/advocacy/mat-talking-points-final.pdf?sfvrsn=0.

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