Seán Collins (00:01):
Our podcast has its roots in an oral history project that shares its name. Over the past several years, more than 500 pairs of people have had conversations with each other and allowed us to record them. They've talked about everything -- about healthcare and about being a patient and about being a caregiver. They've talked about loss and illness and frustration and treatment, and their commitment to take care of others. Today's podcast starts with an excerpt from one of those conversations.

Kirsten Lavery RN (00:35):
Hi, my name's Kirsten Lavery, and I'm the manager of Addiction Recovery Services at Swedish Ballard. And I get to work with a fantastic population. I also know somebody that I get to work with in different advocacy settings, and today I'm gonna have the opportunity to hear a little bit more about her story.

Jennifer Justice (00:54):
Thank you, Kirsten. My name is Jennifer Justice. Before anything, I am a mother of four, but I am a parent ally with the First Legal Clinic, and I get the amazing honor of being a parent ally, a parent advocate, a friend, and a mentor to mothers like myself, who happened to have been, or currently using substances while pregnant.

Kirsten Lavery RN (01:19):
So, Jennifer, today as being somebody in recovery, I'd love to hear a little bit about your journey.

Jennifer Justice (01:26):
Yeah, so I grew up in a very, very large family, very much a village. The whole thing takes a village to raise a child. That was my family. My parents had us very, very young, and so weren't always capable of parenting us. And so family members, aunts, uncles, mainly grandparents, stepped in a lot of the times. We were loved, loved more than any children could possibly be loved. But addiction also ran really heavy in my family. And

that doesn't have to necessarily mean drugs. It could be gambling, eating, shopping relationships, bad relationships. And so kind of the skills that we were taught growing up were those things to become very dependent on people and things, to get through really tough situations. I never wanted to have children, but I ended up having children in my early twenties.

(02:22):
And when I became a mom, that was it for me. I was mom. I was blessed that the father of my older children, his father owned a business. And so I was very fortunate to be able to stay home and parent my children. And I became super mom. And that's not bragging. I literally dedicated my life to being the mom you saw on tv. I nannied for my sisters and my friends, and just my house six days a week was minimum four to five children under the age of three. And I just loved every minute of it. In 2006, 2007, their father and I separated, and it came very much outta nowhere for me and devastated my life. I attempted to be a single mom. I started looking for work, and I found that very difficult because I was very apprehensive of daycares. And so I ended up bartending.

(03:17):
It was something I was good at. It allowed me to be home with my children during the day. And as I became a bartender, these health problems that I had I have a hip problem and became, started becoming an issue. And so I was seeing a doctor and went to a pain clinic and started on opiates as a way to dealing with that so that I could work these long 10 hour shifts. And as time went on it was easier to leave my children with my parents because I, you know, picking them up at three o'clock in the morning to get up in the morning was just, didn't seem very like the right thing to do. And so my children ended up spending more time with my parents. And my doctor ended up deciding me that me going to the pain clinic wasn't going to you know, be the best option.

(04:06):

And so I, I did some other things, but ultimately it ended up with me turning to street drugs, opiates, heroin, as a way to cope with my pain. And so you fast forward a couple of years and I'm in a new relationship with somebody else, and I, I just, I thought I was doing the right thing. I, but this time I was no longer a bartender. I owned my own business. I was very successful. I had a home, very nice cars. My children wanted for absolutely nothing. And I thought all of those things were making me a really good parent still. My parents were having to step up more and more to help me with my children. And I got pregnant with my now eight year old. And my family was not aware of my use. Nobody was, I was very, very good at hiding it.

(04:56):
I was a, what you would call a functioning addict completely, but my kids were missing school. And so they started staying with my parents more. And it just became this, I guess maybe people may have under thought something was, you know, a little different, but definitely not related to drugs by any means. And so, towards the end of my pregnancy, I told my OB who was the most wonderful doctor. He was my doctor for all of my children had been since the day they were born, if not right after they were born, delivered one of my children. And I really trusted him. And I had lied to him about almost my entire pregnancy. And so finally towards the end of my pregnancy, I decided to tell him that I had been using, and you could see just the hurt that I had, not been honest, and the disappointment because this man, I mean, my mother worked for him in his office.

(05:52):
All my sis siblings and my friends went to his office. He sent birthday cards to my children. Like he, he was more family than he was even at my doctor. And so he decided, you know, we talked about, you know, options that would help me get into treatment or whatever afterwards. But I, I don't think at the time I was really interested. I, I still could not see my own addiction as a problem yet. And so my son was delivered by emergency C-section. That's the beginning of probably the worst period of my life. And I do apologize you guys, 'cause I do get emotional. They had me on Dilaudid to

help manage my withdrawals after my son was born. And my son went through terrible withdrawals for, for quite a long time. My family stepped up in ways that I'm truly grateful for.

(06:41):
They would be there for him day and night in the nicu. So, let's see, three days into my, after delivering my son the doctor came in and said, you know, C p Ss wants to see you. And they're not willing to wait anymore. 'cause I had been putting it off and I could not even sit up myself. I was so heavily on medication that Dilaudid. And and so I had asked the nursing staff could they please not give me a couple doses so that I could make it to this interview the next day. I had to be wheelchaired in. I was still so out of it. I could barely stay awake the whole entire time and really not having any support, no legal support just me and the father of my child. And we're sitting there and we're listening, and they're telling me that they're gonna create this plan that's a safe plan, that's just gonna protect myself and my children.

(07:33):
And of course, as a mom, that's all I wanted. And so I agreed to it. I had no idea what I had signed. Two days later, I found out that I had basically signed my son to the state and that a dependency had been filed. They had had a court hearing even before I got out of the hospital that I had no idea that I was just marked as not showing up to. But what I remember is leaving the hospital on day five without my son, because he was still in the nicu on morphine, withdrawing from opiates and meth. And I schedule, go call to my doctor's office to schedule a c-section follow up. And they tell me that he has discharged me as a patient. And I just remember feeling so betrayed, betrayed that he called c p s on me in the first place. Betrayed that he discharged me as a patient without even talking to me about it. Just added to my, to my problems and my addiction.

Seán Collins (08:30):

Jennifer Justice in conversation with Kirsten Lavery in Seattle. Kirsten is the nurse manager for Addiction Recovery Services at Swedish Medical Center, Ballard. We'll be hearing more of their conversation ahead on the program,

(08:54):
(THEME MUSIC) Substance use and pregnancy.

Jennifer Justice (08:57):
We aren't just addicts, right? We did not grow up as Gina Wassemiller says, we did not grow up playing Barbie dolls, imagining that we were going to be addicts one day and giving birth to children addicted to drugs

Seán Collins (09:07):
In an environment where stigma and fear are the norm. Remarkable caring goes on when compassion and kindness guide the clinical approach.

Collin Schenk MD (09:17):
I certainly think that we're on the right track and making the cultural shift that is needed so that a hospital feels like a safe place for someone with a substance use disorder to receive comprehensive medical care and maintain their dignity and, and humanity in the process.

Kirsten Lavery RN (09:35):
There's such a big need for it. We've had a wait list that can be 20 to 30 patients long. And the problem with that is by the time we're able to get back to them, that's already been an eternity. And their lives have changed. And so we miss out on being able to connect people with the treatment that's so needed.

Seán Collins (09:54):
Substance use and pregnancy today on the Hear Me Now podcast. Stay with us.

(10:15):
Hi, it's Sean Collins. I'm glad you're listening. We started today's program with the voice of someone who has lived through the experience of substance use during pregnancy, and we'll hear more from Jennifer Justice coming up. But I want to turn back to Kirsten Lavery, who was Jennifer's conversation partner. Kirsten is the Nurse manager of Addiction Recovery Services at Swedish Medical Center, Ballard. That's where she works with Dr. Collin Schenk, an addiction medicine physician and associate program director of the Swedish Addiction Medicine Fellowship. Really glad to welcome the two of you to the podcast. Thanks for being with us.

Kirsten Lavery RN (11:00):
Hi, Sean. Thanks for having us.

Collin Schenk MD (11:02):
Hey, Sean. Thank you.

Seán Collins (11:05):
I think I wanna start with a really general question, which is, can you give us a sense of how substance use complicates a pregnancy?

Collin Schenk MD (11:16):
I would say the way that substance use complicates a pregnancy is most related to the lived experience in the pregnancy and not actually the impact of the substance on a medical or, or biochemical level. People that are using drugs in general and including in pregnancy, are much more reluctant to engage in, in the healthcare system, often related to past traumas that they've experienced in healthcare settings and a lot of the judgment and stigma that they, they may experience. So our, you know, our number one priority when someone engages with us and cares to express our gratitude and appreciation for their bravery and courage and, and seeking out care because of all of the fear that might be there. And when somebody comes in with substance use and pregnancy the majority of what we're focusing on is, is getting their pregnancy care up

to date and helping them have the healthy pregnancy that, that they want. And simultaneously we're, we're helping take care of their substance use disorder. But it's really about treating them as a complex and whole person first and foremost, and, and then fitting addiction into that. With that said, there are some risks associated with each different substance that we'll talk about with patients and try to reduce the potential harms associated with those. But far and away there, our priority is helping them engage in, in prenatal care in a way that will help them have the safest, healthiest pregnancy that they can.

Seán Collins (12:45):
Yeah. Kirsten, what's your perspective?

Kirsten Lavery RN (12:48):
You know, and I agree, we talked a little bit about this. Jennifer had a good understanding of, of her experience in the healthcare system, encountering providers who might've been fearful of treating somebody who was pregnant with a substance use disorder. She also was able to identify how women tend to be less forthcoming with a substance use disorder for fear of stigma. And this is just amplified in the, in pregnant and postpartum women. Many of our women who come in report fear of seeking out prenatal care 'cause they're also afraid of the judgment, the stigma, and the, the fear of the criminalization of, of substance use in pregnancy.

Seán Collins (13:34):
I am fascinated by the cultural shift that you all are capable of or potentially have the capacity to affect in a hospital. Dr, you mentioned earlier the sort of treating someone as a whole person, a complex person, and making sure that they feel that the stigma that attaches to their situation is not part of your thinking. You would hope that would be the attitude throughout the hospital. And I, my sense is that you might be in a leadership position here.

Collin Schenk MD (14:08):

I certainly think that we're on the right track and making the cultural shift that is needed so that a hospital feels like a safe place for someone with a substance use disorder to receive comprehensive medical care and maintain their dignity and, and humanity in the process. I know that Swedish has had tremendous growth in that regard, and I'm hopeful that our addiction medicine team has been a big part of that transition because we put a large emphasis on it. And the way that we talk about patients when we get called about a new consult in the hospital, when we talk to a subspecialists, when the way we document in our notes trying to prioritize that everything is, is patient-centered, that the person in front of us is far more than just the substance use disorder. That they have many adaptations in the way that they engage in care that are meant to protect themselves based on their, their lived experience. And what may feel hard for a healthcare provider to engage with them on is actually something that has helped them stay alive among often very traumatic circumstances. And I, I think that healthcare providers mostly across the board are very open and willing to view people in those terms. But these are really tough cases in many circumstances and a little bit of extra support from an addiction medicine colleague. Nurses physicians, counselors can go a long way to helping reframe the situation for other staff.

Kirsten Lavery RN (15:39):
By the time people reach our doorstep, they're at one of the most vulnerable times in their lives. A story that I hear often is I was at a place where I wasn't able to care about myself, but it was my baby or my pregnancy that gave me the motivation to step in the door. Initially we will help somebody with the medical stabilization, either medical or prenatal care and withdrawal management. And after a few days, patients transition to our intensive inpatient program. And this is where they get to participate in group therapy education about recovery principles birth prep, parenting, lactation classes. But this is really where we have the time to work with somebody on planning for transition outta the hospital, hospital and addressing parts of their environment that supported substance abuse or substance use. By the time they get here, they're often coming in with a, a lot of shame or fear.

(16:36):
And so many times I've heard women talk about expecting judgment or lecturing preemptively, they say, you can't say anything worse to me than I've already said to myself, which is heartbreaking. Often they've developed these protective defenses or behaviors that have truly helped them survive in the settings that they were existing in. And we understand that people with a long history of trauma have needed these responses to be able to survive. So we'll validate how, how useful that response must have been. They get a chance to see that we aren't offering judgment, but we're offering compassion and support. And so about 50% or more of our patients come in with unstable housing and or others have young children that have prevented them from seeking treatment for lack of childcare. So we partner with different community resources. There are six month residential treatment facilities where pregnant and parenting women can bring young kids or supported housing or sober living. And we can work with anything that's going on in somebody's lives, whether it be legal challenges or even just connecting them to different supports such as TANF or, or SNAP or the Parent Child Assistance Program, which provides extended case management services. And these services in the community are, are vital. But what was missing or what's missing is the opportunity to get people connected. It's that starting point. It's to get people medically stable so they can access these different resources. And that's really what we provide. We provide that beginning. (musical Interlude)

(18:29):
Kirsten Lavery RN (from conversation with Jennifer Justice) What would be your advice to healthcare providers based on the experiences that were supportive and helpful of your recovery? What advice would you give to us or to other healthcare providers?

Jennifer Justice (18:42):
Well, first, most importantly is that we're people. That we, we aren't, we aren't just addicts, right? We did not grow up as Gina was. Larry says, we did not grow up playing Barbie dolls, imagining that we were going to be addicts one day and giving birth to

children addicted to drugs that are substance. That is not what, what we thought, right? So we're people, and we're scared and nobody's gonna be harder on us than we are. So when we come in, having that compassion and that respect to not talk at us, to talk to us, but also to be knowledgeable, because had I walked into somewhere and them not have any resources, which they did a lot of the times, didn't have resources, didn't have options for me, I it would've been, it makes it that much more difficult to get help.

(19:29):
Right? And not only that, so when you're not, every mom's gonna be ready. Not every person is going to be ready to get clean when they're in front of you as a healthcare worker. But if you are kind and you are compassionate, you are respectful, and you offer them all the knowledge that you have and leave that door open, when they are ready, they'll come back. But even when you say, I've had a nurse say something to a, a patient of mine, a client of mine that says, you know, don't you care about your baby at all? Don't, you know, you're just trading one substance for another? She never went back to that hospital and she ended up delivering in a really bad situation because of it. It is not, that's not fair. The, if this, what you, one, one smile can change one hug, one, one kindness can change the outcome for a mom in ways I cannot, ima I cannot tell you, and hugely in part, by doctors and nurses, because for one, when we walk in, we are trusting that you're going to take care of us, and that you're going to be kind to us.

(20:36):
And that is not always the case. And even if you're going to have to be a mandated reporter, even if you're going to have to share what you've, you know, that this person has used during their pregnancy, be honest, be transparent, explain that and explain what they can do about it. Again, knowledge and options make all the difference.

Seán Collins (20:54):
That's Jennifer Justice. She's a parent ally with First Legal Clinic, the medical-legal partnership in Seattle. You can hear an extended excerpt of her conversation with

Kirsten Lavery. There's a link on our website, HearMeNow,Podcast.org Back now with my conversation with Dr. Collin Schenk and with Kirsten Lavery, who is the nurse manager of Addiction Recovery Services at Swedish Medical Center. Ballard.

Kirsten Lavery RN (21:23):
One of the benefits of working in this program is we have the opportunity to connect with other community partners, either as referral sources or people just calling to, to seek information. And we have a team that really helps to walk people through if they encounter somebody a healthcare provider on the line who's reporting, like, I'm not, I'm not getting a, a response that I'm looking for. I don't know how to appropriately help this person. Often nurses are able to walk them through just some of the, the language again, is important, making sure that we're connecting with understanding what the person's, what the person's goals are, ultimately in seeking care. So many of them have reported fear of if they're coming in for another medical condition that this might not be heard, or this might be overlooked in relation to their substance use disorder as being primary where they feel that they might not get believed or get something else addressed and treated.

Seán Collins (22:33):
Can you give me an example of that language shift that you're talking about of, of how you might reframe the conversation to make sure that the person that you're working with is feeling seen and respected, and what are those language differences?

Kirsten Lavery RN (22:52):
One of the questions that had come up from an an outside agency is they were referring a mom for treatment who had just delivered and asking about, is it okay for this person to be able to administer breast milk or breastfeed? And there was a question just because of a lack of understanding saying, well, we didn't teach this mom how to use the breast pump because she will likely not be using it. She's not able to because she's taking methadone or buprenorphine. And so part of what we do is, is educate and just provide information and help patients to understand that yes, we're

gonna support you in every way possible to be able to, to bond with baby or to be able to care for a baby.

Seán Collins (23:40):
Yeah.

Kirsten Lavery RN (23:40):
If that's your goal. Often moms may come in with different, different for the pregnancy, and I wanna make sure it's important that we do normalize all aspects of that. Pregnancy is a con, it's part of the criteria for admission. But if even patients as they're coming in may misunderstand that if they lose a pregnancy or choose to terminate or even if they deliver that they will no longer be eligible for the program. And so just working with everybody in their unique scenarios and situations and letting them know that we're gonna support them through every aspect of that process and helping them make the best choice for them and their family.

Seán Collins (24:27):
So I wanna make sure I understand the sort of scope of the work you're doing. There's, there's one level at which your concern is the sort of immediacy of healthcare for the pregnant person. And at another level, you're concerned about prenatal care and making sure that the person is sort of up to speed as much as you can get them up to speed. And then, is detox part of the formula? I mean, is that explicitly part of it or is it something that you're holding in re reserve? If, if it seems appropriate.

Collin Schenk MD (25:05):
I think detox is a great example of, of the language shift that we talk about. And we, and detox is still a, a really common term that even we use on, on occasion. And we've shifted more towards withdrawal management services because of the connotations around detox. And now that's, that's kind of one of the softer ones that is up for more debate. But going back to your question about some of the shifts in language that we've been working with over time, you know, it's often just the terms that people use

to describe each other. Things like addict or substance abuse, drug abuse. It can be things like, like staff or providers feeling manipulated by people rather than recognizing the person's attempting to having, having their needs met in terms like clean versus dirty in terms of their, their urine admitting to substance use or suspecting substance use.

(25:59):
Things that feel like we're participating in a, in more of the surveillance process of people rather than as caregivers for them. And that we're using really technical terms that are very specific to what we are trying to say as we would in any other medical circumstance. 'cause Addiction is very prone to a lot of colloquial terminology that comes with a lot of judgements and feelings latent within that. And so the question about withdrawal management or detox, when people come in, that is absolutely the, the first stage when people enter our program. And that's where we really, I think, where our, our doctors and our nurses shine. But of course, we're doctors and nurses are helping through the group treatment phase of the program as well. So when people come in into the withdrawal management side of our program, if they're coming for opioid use disorder, we will help them stabilize on medications if that's their choice.

(26:55):
And just about every person ops to stabilize on either buprenorphine or methadone, buprenorphine. The other name for that is Suboxone or Subutex. And that's because those medicines are far and away the most effective way for entering recovery and maintaining recovery. They significantly reduce the risk of relapse, the risk of overdose. And they're strongly recommended by about every medical society out there from the from the addiction medicine body, the WHOACOG, the obstetrical group the CDC, it is the standard of care. And usually that takes us, you know, anywhere from three days to, to two weeks depending on what the person needs. Mm.

Seán Collins (27:38):

All the while providing other immediate care with an eye towards prenatal stabilization or prenatal concern, or how would you describe it?

Collin Schenk MD (27:48):
Absolutely. Trying to play a little bit catch up in their prenatal care, but also taking what I like to think of as the harm reduction approach to prenatal care that many of our patients ha we wanna engage with them on their terms and, and their pregnancy. And so some people have major aversions to having their blood drawn, or they have a really hard time providing urine samples with frequency. And they come in and they're exhausted. They've been awake for three days straight, or they're coming out of a really vulnerable living situation or a relationship that they've been in. And so, you know, ideally we would get everything done all at once, but we also have to make them feel like they have some autonomy in how their, their care is being delivered and, and received. And so things can be paced based on what they feel up for, what our team feels able to provide and, and also getting them to the specialist care that they, that they need.

Seán Collins (28:45):
Is it worth us talking about substances in, in particular and like what you see most frequently and any differences that you see?

Collin Schenk MD (28:54):
Certainly opioids and stimulants are far and away the most common substances that we see along with tobacco. Alcohol is a much less common one, which I'm grateful for because alcohol is, has far more serious negative effects on fetal development and child development than any of the other substances that we may talk about.

Seán Collins (29:17):
It's remarkable how that message got through to Americans, you know, 40 years ago that drinking during pregnancy was not a good thing to be doing.

Collin Schenk MD (29:27):
Yeah.

Seán Collins (29:27):
I mean, they, everyone, everyone seems to, to know that

Collin Schenk MD (29:31):
The message definitely came through loud and clear. Of course, there are still people who are struggling with addiction, and despite that knowledge, it demonstrates how severe the addiction is when there's ongoing alcohol use in, in the pregnancy. Yeah. whereas, you know, I think the message around crack cocaine and the, the supposed crack baby epidemic that didn't ever exist is something that I think was attempted to be delivered to the public. And fortunately was I think we've moved past that where we recognized that it was had racist origins in trying to pathologize black pregnant people, black families and, and black children as being a biological underclass. And recognize that that does, has no foundation in, in the scientific evidence. And fortunately our response to the opioid epidemic has been much more centered around what's going to be best for the pregnant person as well as for, for the baby.

(30:34):
And so the, the primary opioid that we deal with now is fentanyl. And it continues to escalate in the amounts that people are using because that's what happens as people develop more tolerance over time. And this has really been a transition over the last five years, and especially escalating over the last two to three years. And fentanyl has made treatment significantly more challenging because the withdrawal from fentanyl is typically much more intense. It comes on faster. People have a harder time tolerating the withdrawal to get started on buprenorphine or methadone. So it makes it harder for them to feel like they're getting adequately cared for in treatment and to stay engaged enough until they get stable. Buprenorphine or Suboxone seems to be less effective for people who have high tolerance of, of fentanyl. So we have more people needing to be on methadone, which is perfectly fine. But it may not meet the, the person's goals

when they came into treatment. And then their methadone doses these days tend to be significantly higher than what they were in the pre fentanyl era.

Seán Collins (31:39):
For a person who's using fentanyl, is there any assurance of dosage that they are receiving? I mean, it seems like it's a little bit of a crapshoot what dose someone has acquired.

Collin Schenk MD (31:52):
That's certainly one of the scary parts about the unregulated drug supply out there. And one of the reasons why so many people in addiction medicine are in favor of a safe supply source as exists just north of us in Vancouver. So fentanyl in the Pacific Northwest tends to come in two forms. They're either tablets that are pressed to look like Percocet, 30 milligram doses, they call them blues here. And those tend to be less potent than the, the Fentanyl powder. And people who tend to smoke a lot of the blues eventually may have to progress onto the fentanyl powder because of just they can't stay well anymore by, by smoking the blues. The withdrawal is, is too intense. And so, you know, there been limited studies on the potency, and a gram of fentanyl powder could be anywhere equivalent of 50 of the blues to 150 of the blues. And that's why part of why the overdose risk is so high, because each new batch that you get, you have no idea how potent it's gonna be. And one of the things that we recommend for harm reduction is if you're trying a new batch do a small sample of it first so you can get a sense of what the, the potency is.

Kirsten Lavery RN (33:06):
One other piece to consider with fentanyl is often people or finding that people whose primary substance of choice isn't even opiates. It could be stimulants, and they may not realize that they're using or ingesting opiates in any form. And, and we're finding this in other substances. It's, it's just so pervasive in the community.

Seán Collins (33:29):

I wanna shift gears a little bit to your experience in this work. Can you tell me about something that you've experienced with patient care that surprised you, that amazed you about someone's effort to recover? Yeah.

Kirsten Lavery RN (33:46):
You know, Sean, I got to join this program. I had the privilege of joining this program at the end of 2021, and one of my first experiences here. Now, I've worked in primary mental health or substance use disorder in other settings where pregnancy was exclusionary criteria. And so I hadn't had much opportunity to work with a pregnant population. And we had gotten a report from a hospital in a postpartum setting. And the questions around working with this mom was they were noticing that mom wasn't engaging in care at the time, or wasn't feeding consoling. And they, the thought was, maybe mom is not open to to parenting baby at this time, and, and that's okay too, and we can work with her around that. When her team was able to connect with, with mom and speak with her directly and talk about some options and to recovery and to continue to be able to parent baby, she was shocked. She, she didn't understand. She said, what do you mean I I'm gonna be allowed to parent my baby? And, and she said, you know, I was just protecting my heart. I wasn't engaging because I didn't think I would be able to. And it was really that moment I just knew I was in the right place and I was lucky to be able to work with women and hear their stories.

Seán Collins (35:17):
Yeah, Collin?

Collin Schenk MD (35:19):
Yeah, I would say that on a daily basis, I feel inspired by what I see, but I think the level of inspiration took a step up when I had my own child about six months ago. And I had this new insight into how unbelievably hard it was to care for a newborn, despite having every resource under the sun, including a very capable spouse, grandparents on both sides being a doctor myself that it just it blew my mind that our patients who are under such enormous stress, feeling so physically ill with such often such little

support, that they're able to step up and care for a newborn despite having roadblocks in front of them that I don't know how I would imagine I would get through the, the go in on the bus for 45 minutes each direction with a newborn to a WIC appointment, and then to a, an outpatient newborn appointment, and then to their methadone clinic appointment.

(36:25):
That it's just extraordinary that people are able to make it happen. And so many birthing people are able to make it happen. There's so much hope for so many of them. And I have my own, you know, biases that I'm constantly trying to work on. And one of them is when we have patients who, who come for treatment several times in pregnancy, for example, we're caring for one right now who I think has been in treatment eight times in pregnancy. And I have to reframe it for myself and remember how remarkable it's that this person keeps on trying that they're not giving up, that they still wanna be in treatment, they're still trying to care for themselves and care for their child. And I am often appreciative and grateful when even I have my own internal kind of my, my risk assessment for engaging in care is, is not optimistic that they surprise me so often and they just take off and do incredibly well. And you just never know when that point is is gonna happen for them. And so just continuing to keep the doors open, keep your heart and mind open for them, and be ready for when that moment comes, because they will inspire you when you least expect it.

Seán Collins (37:39):
What's your census? How many people are you looking after? Any one time?

Kirsten Lavery RN (37:44):
We've recently had a census reduction, so we can take up to 12 pregnant patients currently. And I say pregnant patients 'cause we, we do also, we do offer gender inclusive services.

Seán Collins (37:56):

I'm really grateful for the two of you taking the time to help me understand what you're doing. It's really impressive. And I don't know what the word I'm, I'm, I'm casting around for the right word. I wanna say poignant, but that's not really what I wanna say. I think I wanna say that there's something quite holy about what you're doing. I mean it's the only language I can fall back on that accurately expresses my admiration for, for the work you do. So I appreciate you coming and talking about it with us.

Kirsten Lavery RN (38:33):
I do appreciate that, Sean. I, I do wish that our, our services were not unique in that sense. And I, I do feel like we are getting a lot of support from WISHA and the Department of Health to really expand and, and make substance use disorder access for pregnant people available in any setting and be it needs to be, we need to have the ability to treat this as we would any other medical condition If somebody shows up on your medical unit and your emergency department,

Collin Schenk MD (39:04):
Yeah, I would love to believe that we could be obsolete, but both pregnancy and substance use are as old as humans are. So I think that this is gonna be an eternal thing that we work with and care for pregnant people and postpartum people who have used and also caring for their children. So we take care of the newborns of people who have used during their pregnancy and we support them through the withdrawal experience and the newborn period and help connect them to care afterwards. And one thing we always wanna make clear to the pregnant or the birthing people as well as their families, but also to the community, is that these children have every opportunity as other children to grow up with the same neurocognitive development, the same behavioral development. What matters far more than in utero exposure to substances is the environment that they're raised in.

(40:00):
So being able to protect them from adverse childhood experiences is what's actually gonna have the most profound difference on their their development into adults. Now

they do experience withdrawal from opioids, less significant patterns with stimulants or benzodiazepines, but opioid withdrawal is a real thing in the, in the newborn. One thing we always wanna make clear is that newborns are not born addicted to a substance. They're not addicted to opioids. Addiction is the combination of physical dependence plus behavioral patterns. And newborns don't have behavioral PA patterns. So new newborns may have a dependence on opioids, but they're not born addicted. It doesn't mean that they're gonna become addicted later in life because of their in utero exposure. So we call it neonatal opioid withdrawal syndrome. It used to be called neonatal abstinence syndrome, but the name was changed because newborns can't become abstinent after having previously used because they never used.

(41:01):
So nows are neonatal opioid withdrawal syndrome is the, the name. And we use a protocol called Eat Sleep Console that has really been a game changer across the, the country. And it's allowed us to treat babies like babies. The idea is that they should be able to eat and sleep and console like every other baby does. And that model really empowers the family caring for the baby to not have their baby be as pathologized or worry that it's really sick or needs to be treated differently. That if they just focus on caring for it as a baby, they can get through the withdrawal period. And the withdrawal can be a little hard to see sometimes for families, but when you have a newborn in your arms a lot of that, that goes away because of how much how much love can come from those moments. And still some babies do need morphine to help complete the withdrawal process, but our length of stay for hospitalizations from babies has dropped from multiple weeks long. Oftentimes three plus weeks in a NICU setting down to something more in that five to seven day range to discharge. So babies are getting, getting discharged home with their families very early on to have something resembling the pretty, pretty standard newborn home experience that every other family gets to have.

Seán Collins (42:15):
Collin Schenk. Kirsten Lavery, thank you for taking the time to talk with me today.

Kirsten Lavery RN (42:20):
Great, Sean, thank you for having us on.

Collin Schenk MD (42:23):
Yeah, thank you so much for inviting us.

Seán Collins (42:25):
Kirsten Lavery is the Nurse Manager of Addiction Recovery Services at Swedish Medical Center Ballard. Dr. Collin Schenk is an addiction medicine physician and associate program director of the Swedish Addiction Medicine Fellowship. Earlier we heard from a conversation between Kirsten and Jennifer Justice, you'll find a link to an extended excerpt of that conversation on our website. Hearmenowpodcast.Org

(42:54):
The Hear Me Now podcast is a production of the Providence Health System and its family of organizations. The program is produced by Scott Acord and Melody Fawcett. We have research help from medical library staff, Carrie Grinstead, Basia Delawska-Elliot, Sarah Viscusso, and Heather Martin. Our theme music was written by Roger Niell. The executive producer is Michael Drummond.

(43:19):
Join us in two weeks when we'll be talking about the future of hospice. Some thought-leaders in the field say It's time to reclaim the mission of hospice to make it meaningful in the future. That's on our next episode. Make sure you subscribe at HearMeNowPodcast.org

(43:35):
I'm Sean Collins. Thanks for listening today. Be well.