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Don’t ask don’t tell: substance abuse and addiction among nurses

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Abstract

Aim.—The purpose of this manuscript is to illustrate the challenges faced by nurses who abuse substances and to promote international dialogue about what practitioners, administrators, health care providers and students can do when they suspect someone in the profession is abusing substances, or they may themselves be suffering from addiction.

Background.—Addiction among nurses has been recognised by professionals in the field for over 100 years, and current estimates place rates of substance misuse, abuse and addiction rates as high as 20% among practicing nurses. Unfortunately, fear of punishment and discipline may keep nurses or students from asking for help for themselves or from reporting a colleague or friend who is in need of help.

Design.—Discursive paper.

Method.—This paper synthesises the results of three previous papers conducted on substance abuse policies in the nursing profession. In the first paper, the authors reviewed the history of addiction in nursing and compared disciplinary and alternative-to-discipline policies. The second focused on the development of an alternative-to-dismissal policy for substance abuse in a school of nursing and using telephone and email interviews, and the final paper reported findings of what types of polices seem to be working to retain and rehabilitate nurses who suffer from addiction in the USA. Lastly, this paper introduces international policy for nurses with addictions.

Conclusions.—Poor or ineffective policies that mandate punitive action endanger the public by making it difficult for impaired students or professionals to ask for help. Providing early intervention and assistance is essential in helping colleagues and students recover from an addictive disorder and providing a non-punitive atmosphere of support may well be a life-saving first step for nurses and those in their care. Many territories and countries throughout the world now offer confidential, non-punitive, assistance for nurses suffering from addictions.

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Contributions

Study design: TM; data collection and analysis: TM, HK and manuscript preparation: TM, HK.

Conflict of interest

TM & HK have no conflict of interest.

Relevance to clinical practice.—Recognition of a colleague's need of treatment is the important first step in the rehabilitation process. Early intervention and assistance are essential for helping colleagues and students to recover from an addictive disorder and providing a confidential, non-punitive atmosphere of support may well be a life-saving first step for nurses and those in their care.

Keywords

alternative-to-discipline paradigm; leadership; nurse substance misuse; student nurses; substance abuse policy for nurses

Introduction

Sarah is a recovery room nurse at St. Christopher's Hospital, as urban hospital in the USA, where she has worked for 18 years since graduating from its nursing programme. Sarah has served as the charge nurse on her shift for several years and has oriented and trained many new nurses; she is well liked by her colleagues and is good at her job. In recent months, Sarah lost her husband in an automobile accident and had surgery for recurring ovarian cysts. While recovering, Sarah realised the medications she had been prescribed not only lessened her physical pain but also helped her forget the tragic loss of her husband. On returning to work, Sarah was unable to get another prescription for pain medication and began to divert medications from the recovery room. At first, she took pain pills on an irregular basis and then began to divert Demerol and Fentanyl for intravenous use. Within a few months, Sarah knew she had a problem and tried to stop, but could not. Sarah wanted help but was afraid to ask. She began to wear long-sleeved shirts daily, had a persistently runny nose and made frequent trips to the bathroom. Over the past month, her moods fluctuated and she seemed to isolate herself from the other nurses. On more than one occasion, she had broken vials of narcotics. One of her coworkers suspected something was not right, but she was fearful about reporting Sarah. Just the previous year, a nurse at St. Christopher's had been fired for substance abuse and the co-worker did not want to jeopardise her friend's livelihood and exacerbate her situation. As a result, Sarah remains at work, a threat to the public and to herself.

Aims

The hypothetical scenario above illustrates the challenges faced by substance-abusing nursing professionals. There is an ongoing initiative to promote greater dialogue about what practitioners, administrators, health care providers and students can do when they suspect someone in their profession is abusing substances, or when they may themselves be suffering from addiction (Monroe *et al.* 2008, 2009, Monroe 2009). We believe that the incidence of substance abuse among nurses and especially nursing students is both under-researched and under-reported, partly because it is considered taboo among many health care providers and nursing school faculty and staff. As our hypothetical scenario illustrates, reluctance to broach the problem results from the usually punitive approaches adopted by administrators and institutions to address the chemically dependent nursing professional. We support alternative-to-discipline (ATD) strategies that will motivate individuals to

voluntarily seek assistance for their dependency or will assist a colleague in finding the help they need.

Background: substance abuse in the nursing profession

Addiction among nurses has been recognised by professionals in the field for over 100 years (Heise 2003). Current estimates of substance abuse, misuse and addiction rates among nurses range from 14% (National Council of State Boards of Nursing 1994) – 20% (Bell *et al*. 1999). Nurses are responsible for identifying the signs and symptoms of impairment, and in most countries and territories, they are required to report peer substance abuse to boards of nursing (Canadian Nurses Association 2009; College of Nurses of Manitoba 2009; National Council of State Boards of Nursing 2004; New Zealand Nurses Organization 2007). Protecting the public from unsafe practices and workers is the primary duty of each regulatory board or agency of nursing. However, fear of punishment from the board and/or termination of employment keeps many nurses and those who would report them silent (Maher-Brisen 2007). For example, Beckstand (2005) found the odds of a nurse not reporting a co-worker for suspected substance abuse while at work were 5 to 1 (92·5%/20·4% = 4·53). This is alarming, given the critical duties nurses perform for patients every day. Those being educated for entry into professional practice are also in jeopardy; at present, nursing educational programmes do little to recognise *and assist* students suffering from addiction (Maher-Brisen 2007, Monroe 2009). Nursing schools seldom have policies in place for appropriate referral and potential re-entry (Monroe *et al*. 2009).

Method: current practice and research results for alternative-to-discipline approaches

The ATD paradigm, developed in the USA in the early 1980s (American Nurses' Association 1982, 1984), evolved its core philosophy into four tenets (Naegle 1993). First, 'assistance to colleagues and peers by advocating for rehabilitation is better than punitive regulatory discipline'. Disciplinary approaches do not advocate for nurses' recovery or return to work (Sullivan *et al*. 1990). Second, 'self-regulation, as a hallmark of a profession, is preferable to regulatory intervention and professional discipline'. Regulatory discipline results in recovering nurses being reported to the Office of the Inspector General (OIG), which insurance companies monitor – resulting in a nurse's exclusion from eligibility for liability or health insurance (Monroe *et al*. 2008); correspondingly, Smith and Hughes (1996) discovered that 69·8% of nurses reported the single biggest obstacle to returning to work was professional discipline. Third, 'public health and welfare should be protected by preventing below-standard nursing practice'. ATD programs have been shown to remove impaired nurses from practice within days to a few weeks (Monroe *et al*. 2008), while disciplinary approaches may take up three years (Sullivan *et al*. 1990). Fourth, 'policy and action that promote safety and well-being in the workplace should be pursued through collective bargaining and work-place advocacy'. Nurses suffering from addiction and who are willing and able to be rehabilitated should be treated with confidentiality and respect (Roche 2007, Monroe 2009). Imposing discipline and potential removal from practice is the only acceptable solution if a nurse cannot or will not be rehabilitated.

As we have reported elsewhere in 2008, 45 US state boards of nursing supported public safety while assisting impaired nursing professionals return to practice through the implementation of ATD programs (Monroe *et al.* 2008). More recently, we discovered that two of these states (Iowa and Missouri) have not yet implemented their programmes and Maine passed legislation approving an ATD in 2009. This means that in seven states (the three mentioned as well as Arkansas, Alaska, Georgia and Mississippi) and six USA territories (Quinlan 2003a), nurses do not yet have a confidential mechanism for entering treatment and beginning recovery without risking public disclosure.

As recently in 2003, there were no formal peer assistance programmes for nurses in England (Boyjoonauth 2003), Canada (Quinlan 2003b) or Australia (Bachman & Cusack 2003), but ATD programs in these countries are improving. Confidential programs, either wholly or in part, are now operating in Australia, New Zealand and Canada. The validity and effectiveness of these innovative initiatives are not yet being studied, but organisations in other countries (Table 1) are now offering confidential options for a nurse to receive assistance before punitive actions or disciplinary procedures are publicly reported. For example, in New Zealand, all health committee proceedings are not publically reported, and if a nurse's substance abuse issue is resolved at this level, the entire proceeding is confidential; however, if the nurse is found guilty in a professional conduct committee hearing leading to suspension or license conditions, the licensure status is updated on the NZNO webpage and the employer notified (New Zealand Nurses Organization 2009). In Victoria, Australia, a confidential Victoria Nurse Health Program (VNHP) is functioning to provide confidential peer assistance to nurses and student nurses in that territory. The VNHP provides screening, assessment, referral and support groups for nurses and student nurses seeking assistance with addictive disorders. The philosophy of the VNHP is guided by the belief that early intervention is the best way to address health problems (Victoria Nurses Health Program 2009). In Manitoba, Canada, a nurse with an addiction will go through an 'undertaking' process as part of a formal investigation. The investigation committee of the College of Registered Nurses of Manitoba has the authority to accept the 'undertaking' which is a confidential contract between the College of Registered Nurses of Manitoba and the member from between 3–5 years with conditions such as mandatory 12 step meetings, random screening and counsellor attendance. If the member is not compliant with the terms of the undertaking, they may be referred for a discipline hearing and if found guilty, this becomes public knowledge (College of Nurses of Manitoba 2005).

Researchers suggest that ATD programs may be effective in assisting nurses to recover from addiction. For example, Geiger and Smith (2003) found that ATD programs result in a 75% decrease in the overall 'problem burden' (those ancillary difficulties, such as the inability to obtain liability or health insurance, imposed by the disciplinary approach), which may help a nurse succeed in treatment and resist relapse. Other researchers have reported that moving the nurse into treatment rather than enforcing discipline (with a focus on punitive measures) ensures the best outcomes (Quinlan 2003a, National Council of State Boards of Nursing 2004, Darbro 2005). Further, participation in ATD programs appears to be the best way to retain professionals in a field that currently suffers serious shortages of experienced practitioners (Haack & Yocom 2002). For example, Hughes *et al.* (1998) found that four of five nurses in Florida's ATD program returned to practice and in other research, nurses

reported that the support they received from the state's ATD program was the most important factor in their return to work (Smith & Hughes 1996).

Conclusions

Since the turn of the century, the nursing profession has been aware of the problem of addiction among its members. Boards of nursing are charged with regulating nursing practice and protecting the public, and thus when a nurse or student is impaired, they must take action to see that such individuals are not in a position to do harm to patients. According to the American Nurses Association's *Code of Ethics for Nurses* (2001, p. 45), the nursing profession should 'mandate workplace advocacy and promotion of well-being.' Poor or ineffective policies that mandate punitive action may endanger the public by making it difficult or impaired students or professionals to ask for help and by preventing reporting that may result in a colleague losing a job or a fellow student's dismissal from school.

Currently, there are several ATD models that a regulatory board of nursing, nursing educational programme or health care facility may adopt to establish appropriate, confidential and ethical policies (Monroe 2009). We recommend inclusion of the following components to help transform perceptions about substance abuse as less a 'moral failing' than a medical disorder requiring treatment: (1) promoting open communication by discussing substance abuse in every work or school orientation; (2) encouraging an atmosphere more amenable for reporting by ensuring confidentiality;(3) providing information about the signs and symptoms of impairment; (4) conducting 'mock' interventions to help allay fears or feelings of discomfort about confronting a co-worker or fellow student about suspected chemical dependency,(5) inviting ATD experts to speak to the hospital or school administration; and (6) participating in scholarly forums about addiction among health care providers.

Relevance to clinical practice

The recognition of a colleague in need of treatment is the important first step in the rehabilitation process. While there are several symptoms of chemical dependency (Table 2), caution should be exercised if only one sign is observed; this may not necessarily indicate a problem with drugs and/or alcohol. However, the observance of multiple symptoms, especially occurring over an extended period of time, may be indicative of impairment (Roche 2007). If a nurse believes a colleague may be so impaired, a first step might involve having an honest discussion with a supervisor or professor where the nurse emphasises a desire to protect patients while assisting a fellow professional who may well be struggling with a serious disease. The hospital or school may then choose to initiate an inquiry into the circumstances. The object of a confidential intervention is to help the individual recognise that he or she may have a problem and help them enter treatment (Roche 2007, Monroe 2009). All stakeholders (e.g. nursing supervisor or dean, spouse, family and key faculty) should be involved to facilitate the best results.

We emphasise that ATD policies require considerable time from administrative leadership and accordingly, their time should be recognised. We further believe leaders who endorse

ATD policies protect the public while advocating for nurses. This means better clinical care for clients, more support for nurses and better outcomes for institutions.

Addiction has a long history in our profession and ignoring this reality may perpetuate fear, anxiety, poor outcomes for the nurse and risk for clients, as well as problems for the profession as a whole. Providing early intervention and assistance is essential in helping colleagues and students recover from an addictive disorder and providing a confidential, non-punitive atmosphere of support may well be a life-saving first step for nurses *and* those in their care.

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Table 1

International nursing regulatory and alternative to discipline organizations

American Nurses Association (ANA) [USA]
Website: http://www.ana.org
Telephone: (800) 274–4ANA
Association of Nurses in Substance Abuse (ANSA) [UK]
Website: http://www.ansauk.org http://www.ansauk.org/
E-mail: mailto:patrick.coyne@nhs.net
International Council of Nurses (ICN) [Switzerland]
Website: http://www.icn.ch/
E-mail: webmaster@icn.ch
The Royal College of Nursing (RCN) [UK]
Website: http://www.rcn.org.uk/
E-mail: webteam@rcn.org.uk
The Drug and Alcohol Services (DASC) and The Drug and Alcohol
Information Service (ADIS) [Australia]
Website: http://www.dao.health.wa.gov.au/
E-mail: DAO@health.wa.gov.au
Victorian Nurses Health Program (VNHP) [Australia]
Website: http://www.vnhp.org.au/VNHP/Welcome.html http://www.vnhp.org.au/VNHP/Welcome.html http://www.vnhp.org.au/VNHP/Welcome.html
E-mail: admini@vhnp.org.au
The Canadian Nurses Association (CAN) [Canada]
Website: http://www.cnanurses. ca/CNA/issues/position/protection/default_e.aspx
Telephone: 1–800-361–8404
The of Manitoba (CRNM) [Canada]
Website: http://wwwCollege of Registered Nurses.crnm.mb.ca/
E-mail: info@crnm.mb.ca
The New Zealand Nurses Organization (NZNO) [New Zealand]
Website: www.nature.com/reprints /
E-mail: nurses@nzno.org.nz

Table 2

Potential behaviors associated with substance use or dependency among nurses

Attendance
Excessive sick calls clothing
Repeated absences with a pattern
Tardiness
Frequent accidents on the job
Fret physical complaints
Peculiar/iquenmprobable excuses for absences
Frequent absence from clinical area
Frequent trips to rest room/locker room
Long coffee or lunch breaks
Early arrival or late departure
Presence in clinical during scheduled time off
Confusion about work schedule
Request for assignments at less supervised setting
Performance
Excessive time required for record keeping
Assignments require more effort/time
Difficulty recalling/understanding instructions
Difficulty in assigning priorities
Display of disinterest in work
Absentminded/forgetful
Alternate periods of high and low activity
Increasing inability to meet schedules
Missed deadlines
Frequent requests for assistance
Carelessness
Overreaction to criticism
Tendency to blame others
Complaints regarding poor care
Use of controlled substances
Signs out more controlled substances than other providers
Frequently breaks or spills drugs
Waits to be alone before obtaining controlled substances for assigned cases
Discrepancies between patients' charts and narcotic records
Patient complaining of pain out of proportion to medication charted
Frequent medication errors
Defensive when questioned about medication errors
Frequent disappearance immediately after signing out narcotics
Unwitnessed or excessive waste of controlled drugs
Tampering with drug vials or containers

Use of infrequently used drugs
Behavior
Unkempt/inappropriate
Poor hygiene
Mood swings
Frequent irritability with others
Poor recall
Physical abuse
Rigidity/inability to change plans
Incoherent or irrelevant statements
Drowsiness at work
Uncooperativeness with staff
Tendency towards isolation
Deteriorating relationships
Wears long sleeves all the time
Physical signs
Hand tremors
Excessive sweating
Marked nervousness
Coming to clinical intoxicated
Blackouts
Frequent hangovers
Odor of alcohol
GI upset
Slurred speech
Increased anxiety
Unsteady gait
Excessive use of breath mints

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