NCPD 2 HOURS
Nursing Continuing Professional Development

The Impaired Nurse

A guide to recognizing and treating substance-related disorders among colleagues in the workplace.

ABSTRACT: Substance use disorders (SUDs) do not discriminate. Anyone can be affected regardless of age, sex, ethnicity, socioeconomic status, or profession. Nurses with SUDs present serious risks to both their patients and the nursing profession. Frontline nurses' responsibility to provide patients with safe, high-quality care may be too great a challenge for those with SUDs, resulting in adverse consequences. Early recognition and treatment of nurses with SUDs promotes patient safety and retention in the profession. For this reason, all nurses and other health care professionals should be able to recognize behaviors associated with SUDs and should be familiar with the available treatment modalities.

Keywords: impairment, intoxication, substance abuse, substance-induced disorders, substance-related disorders, substance use disorders, withdrawal

Substance-related disorders are a major cause of death and disease in the United States.[1,2] They include substance use disorders (SUDs), a term denoting prolonged use or misuse of a substance such as alcohol or drugs that impairs a person's health or ability to meet personal, social, or occupational responsibilities,[1] as well as substance-induced disorders, such as intoxication or withdrawal.[2] According to a cross-sectional study of boards of nursing discipline data collected in 2019, they are among the most common reasons for a state board of nursing to take disciplinary action against a nurse.[3]

Health implications associated with substance-related disorders include the following[4]:

- injuries (motor vehicle accidents, falls, drownings, burns)
- propensity for violence (intimate partner violence, suicide, homicide, assault)
- risky sexual behaviors
- fetal demise in pregnant women
- chronic illnesses (cardiac and liver diseases, digestive issues, cancers, weakened immune response, and mental health disorders such as depression and anxiety)

SUDs are sometimes referred to as "brain diseases" because they change the brain's reward circuitry.[5,6]

The *Diagnostic and Statistical Manual of Mental Disorders, fifth edition, text revision (DSM-5-TR)*, categorizes SUDs by the substances used.[7] Although we address SUDs globally in this article, in practice it is important for health care providers to specify the substance a patient is misusing—for example, as alcohol use disorder, cannabis use disorder, or opioid use disorder.

SUBSTANCE USE AMONG U.S. RESIDENTS AGES 12 AND OLDER

Alcohol use. According to the 2020 National Survey on Drug Use and Health, 138.5 million Americans ages 12 and older used alcohol that year.[8] A total of 61.6 million (44.4%) reported current binge drinking, and, among these, 17.7 million—28.8% of current binge drinkers and 12.8% of current alcohol users—were heavy drinkers.[8]

SUD prevalence. About 40.3 million people ages 12 and older (that is, 14.5% of this population) had an SUD, including 28.3 million who had an alcohol use disorder, 18.4 million who had an illicit drug use disorder, and 6.5 million who had both an alcohol use disorder and an illicit drug use disorder.[8]

The illicit drugs used most commonly were reported as follows[8]:

- marijuana (49.6 million)
- prescription pain relievers (9.3 million)
- hallucinogens (7.1 million)
- prescription sedatives (6.2 million)
- cocaine (5.2 million)
- prescription stimulants (5.1 million)
- methamphetamine (2.5 million)
- inhalants (2.4 million)
- heroin (902,000)

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RISK FACTORS FOR SUBSTANCE-RELATED DISORDERS

Although genetic influences account for 40% to 60% of a person's vulnerability to substance-related disorders,[5] nurses have distinctive risk factors associated with the work environment that may increase the probability of developing SUD.[9] These occupational risk factors include[9-14]

- a stressful work environment in which nurses may witness the effects of trauma or violence, which may in turn produce anxiety and depression.
- work stressors such as an increased workload; 12-hour shifts; mandatory overtime; the lack of necessary resources; and caring for high-acuity patients with the potential for transmission of infectious agents—all of which can be emotionally and physically taxing.
- feelings of inadequacy due to heavy workloads, insufficient staffing, and a lack of support.
- ease of access to medications in the workplace and the tendency to self-medicate.
- knowledge of the therapeutic benefits of medications.
- fatigue related to shift work and work-related physical pain.

The ongoing COVID-19 pandemic. The advent of the pandemic confronted health care providers with many additional work-related stressors, both physical and psychological, which increased the prevalence of anxiety, depression, posttraumatic stress disorder, and exhaustion in nurses who treat patients with COVID-19.[15-18] Taylor and colleagues developed a five-factor COVID Stress Scale that includes danger and contamination fears, social and economic stressors, traumatic stress symptoms, reassurance-seeking behaviors, and xenophobia, suggesting that these factors form COVID Stress Syndrome.[19] Each of the five factors increases the risk of developing an SUD.[20] Given the negative psychological impact of COVID-19 on health care providers and the continued uncertainty associated with the virus, there remains a critical need to identify nurses at risk for SUD and to provide access to care.

SUBSTANCE USE AMONG NURSES

Nursing is the largest sector of health care providers in the United States, with approximately 4.2 million active RNs and more than 920,000 practical nurses.[21]

Establishing the prevalence of SUDs in nursing has been challenging, but an analysis of survey responses concerning substance use and abuse from a nationally representative sample of 1,170 randomly selected RNs from nine states indicated that SUD prevalence varied with the nurses' practice environment[22]:

Prescription drug misuse, reported by 9.9% of nurse respondents, was highest among nurses working in

- home health or hospice, in which 19% reported misuse.
- nursing homes or assisted living, in which 15.8% reported misuse.
- government, community, or military settings, in which 15.2% reported misuse.

Alcohol use, reported by 30.9% of nurse respondents, was highest among nurses working in

- nursing homes or assisted living, in which 42.9% reported use.
- hospital and ambulatory care, in which 31% reported use.
- multiple workplaces, in which 34.4% reported use.
- government, community, or military settings, in which 26.1% reported use.
- home health or hospice, in which 22.6% reported use.

Illicit drug use, reported by 5.7% of nurse respondents, was highest among nurses working in

- hospital and ambulatory care, in which 9.5% reported use.
- nursing homes or assisted living, in which 8.8% reported use.
- multiple workplaces, in which 8.2% reported use.

Compared with the prevalence of substance use among U.S. residents ages 12 and older, prescription drug misuse was found to be higher among nurses, and illicit drug use was found to be lower.[22]

The analysis of these survey results revealed that 18% of RN respondents had substance use problems and one-third of these (6.6%) screened positive for an SUD. Nurses in administrative positions (staff and charge nurses, coordinators, and nurse managers) were nine to 12 times more likely to have an SUD than nurse educators and researchers. Nurses younger than age 45 reported using illicit drugs at twice the rate of their older counterparts (8.2% versus 4.2%, $P = 0.007$) and were significantly more likely to use alcohol and nicotine.[22]

The primary substances found to be used by nurses in a retrospective descriptive study of Texas nurses with SUDs were as follows[23]:

- opioids (29%)
- alcohol (25.5%)
- stimulants (5.6%)
- amphetamines (3.5%)
- cannabinoids/marijuana (3.3%)

CRITERIA FOR SUD DIAGNOSES

Diagnostic criteria for SUD include physiological, behavioral, and cognitive symptoms; two or more symptoms occurring within a 12-month period are required to make the diagnosis.[7]

Physiological symptoms of SUD include[6, 7]

- *tolerance*, the need for increased amounts of a substance to obtain the desired effect, or a diminished effect with the same amount of the substance.
- *withdrawal*, the experience of unpleasant physical sensations accompanying substance cessation or decreased use; withdrawal varies greatly among commonly misused substances.

Alcohol use withdrawal must include two of the following symptoms: diaphoresis; nausea; vomiting; tremors; insomnia; agitation; anxiety; seizures; or transient visual, tactile, or auditory hallucinations.[7] Opioid use withdrawal is often described as producing flu-like symptoms and includes three of the following: emotional distress, nausea, vomiting, diarrhea, muscle aches, lacrimation, rhinorrhea, yawning, diaphoresis, elevated temperature, and insomnia.[7]

Behavioral symptoms of SUDs include[7, 22, 24-27]

- substance craving.
- consuming more than intended.
- difficulty trying to stop or reduce use.
- continued use despite related health, social, occupational, and interpersonal problems.
- spending significant time securing, using, and recovering from substance use.

PSYCHOLOGICAL SYMPTOMS, PREDICTORS, AND CO-OCCURRING DISORDERS

Approximately 50% of people who develop an SUD also have a co-occurring mental disorder such as anxiety, depression, or bipolar disorder.[28, 29]

In a survey-based study that explored the predictors of SUD in 1,478 nurses, psychological trauma, depression, and anxiety were associated with the use of alcohol, tobacco, and other substances, with depression being the psychiatric disorder most commonly reported (by 40% of the nurses surveyed).[28]

Comorbid mental illness in substance-related disorders is associated with poor clinical, social, and occupational outcomes. It is therefore necessary to develop integrated policy approaches to better support mental health in the workplace, while promoting rehabilitation and a safe return to practice.

THE CHRONIC NATURE OF SUD

Neurobiological research suggests that SUD should be considered an acquired chronic illness, which, like hypertension or type 2 diabetes, may have periods of remission and exacerbation.[30] A relapse, therefore, should not be viewed as a treatment failure, but as a sign that underlying issues and comor-

bidities may warrant reevaluation. According to the *DSM-5-TR*, substance misuse often continues despite harmful substance-related consequences.[7] SUD symptoms cause significant distress and impair the person's health and other aspects of life.

THE DUTY TO ACT

The American Association of Nurse Anesthesiology, the National Council of State Boards of Nursing, the Drug Enforcement Administration, and the state of Florida have all independently called on nurses to act on suspicions of impairment in their colleagues and have identified the following behaviors and visible signs an impaired nurse may exhibit[24, 25, 27, 31]:

- inconsistent work performance
- difficulty concentrating
- unkempt appearance
- inaccurate record keeping, such as discrepancies in the administration of opioids and instances of controlled drug wastage
- mood swings
- interpersonal conflicts with colleagues
- frequent disappearances from work areas and long breaks
- frequent tardiness and unexplained absences

RECOGNIZING AND REPORTING IMPAIRMENT

It is not uncommon for nurses and other health care professionals to experience substance use impairment in the clinical work environment. Recognizing signs and symptoms of impairment and differentiating these peer behaviors from responses to job stress and clinical demands may assist in improving patient safety and result in better outcomes for everyone. Nurses often demonstrate enabling behaviors by rationalizing their colleague's impairment, providing excuses for their actions, assisting them with patient care, and shielding them from detection. Fear of the consequences of reporting someone may cause nurses to discuss their suspicions of an impaired colleague with each other but often refrain from reporting them.[32]

Given the potential consequences of SUDs among nurses, it is essential that organizations have policies and procedures in place for nurses to follow when suspecting an impaired colleague and resources available through which nurses with a substance-related disorder can seek treatment. Addressing colleagues who are suspected of being impaired in the work setting should be viewed as supportive rather than punitive.

SCREENING FOR SUBSTANCE-RELATED DISORDERS

Two widely used evidence-based screening tools for alcohol and substance-related disorders are the CAGE questionnaire (cut down, annoyed, guilty, and eye-opener) for detecting alcohol use disorder and the Drug Abuse Screening Test (DAST).[33, 34] Nurses suspected of impairment may be asked to be evaluated by a fellow health care professional, and these readily available screening tools can be administered in minutes, prompting referrals based on scoring. Both the CAGE questionnaire and the 10-item DAST, or DAST-10, have reported validity and reliability for screening SUDs.[35, 36]

INTERVENTION FOR NURSES

Substance-related disorders are unpredictable, progressive, and chronic, with episodes of relapse and exacerbations that can be characterized by overpowering, mind-altering substance seeking. Loss of control over substance use can negatively influence brain function, including thought, memory, coordination, and judgment. Impaired nurses are thus incapable of providing competent patient care and safely performing their job responsibilities. Consequences of nurse impairment can lead to medication errors, problematic communication, and other health-related mistakes.[37]

To facilitate the appropriate course of action when there is concern about impairment, it is the nurse colleague's ethical and legal duty to act immediately to intervene and report the impaired nurse to their supervisor or risk management depending on institutional policy.[38]

Depending on state laws, treatment teams or the disciplinary committee are obligated to report impaired nurses to the state licensing board or initiate a referral to an SUD assistance program. To ensure that safe and competent care are delivered to all patients in a variety of health care settings, each state board of nursing has a nurse practice act that outlines the circumstances by which the governing board can order an evaluation of a licensee.[38]

Health care workers must be versed in the current practice standards and rules outlined in their state's nurse practice act.[39] State management and monitoring programs have been developed through legislative action to protect public safety and provide helpful mechanisms through education, monitoring, and continuing support. Although the state board of nursing has the final authority over whether the nurse can continue to practice, program procedures aim to protect public welfare while maintaining or restoring the ability of nurses with SUDs to work and practice safely and ethically.

In 1983, as a response to the American Nurses Association's call for action to assist nurses with SUDs, the state of Florida established the first Intervention Project for Nurses (IPN) as an alternative discipline program for nurses with SUDs.[40]

The IPN is confidential and voluntary. IPN staff collaborate with the state's department of health,

board of nursing, employers, and nurses to ensure public safety and monitor licensees rather than take disciplinary action.

The IPN facilitates recovery by[37,41]

- collaborating with employers to ensure public safety through early detection.
- offering appropriate treatment and close monitoring.
- advocating for nurses to promote adherence.
- providing the support needed for sustained recovery through a nonpunitive public process.

EVALUATION AND TREATMENT PROGRAMS

A leading Healthy People 2030 health indicator focuses on preventing SUDs and helping people with these disorders obtain appropriate treatment.[42] Programs for nurses with SUDs provide a path that saves nurses' careers and promotes long-term recovery.

State boards of nursing have the authority to propose professional disciplinary options to nurse licensees. In most cases, nurses are mandated to withdraw from practice until they are in stable recovery and return to practice if they comply with the contracted requirements. Most states monitor and oversee recovery programs, program intervention, evaluation, and treatment setting; however, these options may differ across states.

Treatment programs include accredited and state-approved residential or inpatient programs, intensive outpatient programs, partial hospitalization programs, institutions, and employee-mandated programs. Admission can be voluntary, required, or mandated by a court or medical board or can result from colleagues, family, and friends supporting the person's treatment.

Treatment options may include

- voluntary or mandated peer-assistance programs through state boards or professional organizations.
- assigned evaluations with a trained SUD peer specialist.

Peer-assistance programs generally consist of multidisciplinary teams that manage individuals voluntarily seeking assistance, whereas state licensing boards operate programs for nurses who are at high risk for inflicting harm because of substance-related impairment.[27] A trained SUD peer specialist, by contrast, does not provide treatment, but rather informs the nurse of interventions; recommends evaluations; and initiates referrals for ongoing management and monitoring by a multidisciplinary team that may include state-licensed psychiatrists, psychiatric mental health NPs, counselors, and SUD peer specialists who specifically treat nurses.

NURSE MONITORING PROGRAMS

It's difficult to determine the effectiveness of specific nurse monitoring program components, interventions, and return-to-work rates owing to a lack of consistency and uniformity among such programs. However, one longitudinal study of more than 7,000 nurses in SUD programs across 13 states between 2007 and 2015 reported an average program completion rate of 61.5%.[43] Bimonthly random drug testing, daily check-ins, a minimum program length of three years without relapse, and bimonthly peer-support meetings were associated with the highest program achievement rates, according to the researchers.[43] High program dropout rates were associated with family histories of SUD and other psychiatric comorbidities. It is essential that contracts clearly delineate expectations, practice restrictions, and monitoring requirements. If a nurse does not adhere to the requirements, each state board of nursing has the obligation to enforce its nurse practice act and respond accordingly, such as possibly notifying the state's department of health.[44]

BARRIERS TO TREATMENT

Shame, guilt, denial of symptoms, loss of professional confidentiality, and fear of discrimination or stigmatization as an "addict," may discourage nurses from seeking or continuing care. Structural barriers to care include[45,36]

- the costs related to legal fees or frequent urine drug screens, which are paid by the nurse out of pocket.
- loss of health insurance, as some states and employers require nurses with SUDs to stop working during treatment.
- the inconvenience of treatment.
- the fear that reaching out for help will destroy their careers.

Nurses with substance-related disorders may face an additional barrier to treatment compared with other professionals, because society may view them, like they view physicians, as healthy people who treat and care for patients, rather than as people who may need help themselves.[47]

FRAMEWORKS THAT FACILITATE TREATMENT

Low retention and disengagement across the treatment continuum highlight the need to help nurses with SUDs initiate, pursue, and sustain long-term recovery and overcome the obstacles they may face from substance-related problems.[48] High rates of attrition are associated with increased relapse, unemployment, and mortality.[48,49] SUD frameworks that emphasize respect for diversity and provider understanding of the varied impact that adversity, ethnicity, and culture have on treatment expectations and experiences can facilitate treatment and promote sustained recovery.[50]

Patient-centered approaches can be universally applied across treatment settings and providers. Such approaches integrate a holistic or biopsychosocial methodology that focuses on clients' unique needs, goals, and preferences, with the nurse and prescribing clinician forming a therapeutic alliance in which they share power and responsibility.

For nurses who have been identified as having their practice impaired by SUD, nonpunitive alternative programs such as state-supported IPN programs provide support during recovery and promote early recognition and interventions for optimal outcomes.[37]

Respect, empathy, and understanding are attributes that build a strong, nonjudgmental, therapeutic alliance; foster a sense of patient empowerment; and promote respectful and trusting relationships. Through dialogue and discussion with the patient, the provider can obtain a better understanding of the patient's personal needs, goals, and expectations and promote a dynamic and active, holistic decision-making process.[50] Positive interactions with health care providers promote optimal use of services, satisfaction, perceived quality of care, adherence to treatment recommendations, and favorable patient-reported outcomes.

SUD treatment strategies vary depending on the misused substance. Aligning evidence-based treatment options with the person's specific needs is critical to facilitating optimal functioning in the workplace.[6] Nurses seeking potential treatment options should ensure the program they choose incorporates the latest research findings. (See Table 1 for national SUD resources.)

The primary goal of any SUD treatment is to return the person to their ideal level of functioning, to reduce symptoms of the disorder, and to decrease risk factors for recurrence.

For alcohol use disorder, treatment often combines behavioral therapies, cognitive behavioral therapy, motivational enhancement therapy, and participation in support groups, such as Alcoholics Anonymous and Al-Anon Family Groups.

In some cases, pharmacological agents, such as disulfiram, may be necessary to deter the person from misusing alcohol. A person treated with disulfiram who consumes alcohol will experience nausea and vomiting. Another negative reinforcement strategy is naltrexone, which, by blocking opioids from attaching to opioid receptors, reduces the urge to drink alcohol.[51]

For treating opioid use disorders, the gold standard is medication-assisted treatment (MAT).[52] MAT is evidence based and is used in conjunction with behavioral therapies, counseling, and support groups, such as narcotics anonymous (NA).[53] MAT includes the use of either a full opioid agonist (methadone) or a partial opioid agonist (buprenorphine), which reduces the pleasurable response when opioids are consumed.[51] Once a person is opioid free for seven to 10 days, an opioid antagonist, such as naltrexone, may be prescribed to maintain abstinence and to block the pleasurable effects of chemicals at the opioid receptor sites.[54]

Although the evidence-based strategies of medication-based programs and 12-step–oriented programs are effective in supporting recovery from SUD, MAT options continue to be a divisive topic owing to differences in program approaches and philosophy.[55, 56] Monico and colleagues studied 300 opioid-dependent individuals in an outpatient program who were prescribed buprenorphine and attended at least one NA meeting per week. The study revealed that each additional NA meeting attended was associated with a 2% increase in opioid treatment retention and a 1% increase in opioid abstinence at six months.[56] Despite data demonstrating superior recovery rates in long-term studies and that MAT reduces illicit opioid use, risk of overdose, and patient use of costly hospital and emergency care, many treatment centers do not allow certain types of MAT (such as buprenorphine) to be prescribed in their programs.[55, 56] MAT may not be the best treatment for everyone with opioid use disorder; however, for nurses suffering from opioid use disorder with severe features, it can be a vital resource for those struggling with intense cravings and relapse.

The behavioral and pharmacological treatment strategies in current use for SUDs may not be effective for everyone. New studies indicate the benefits of using noninvasive neuromodulation techniques, including repetitive transcranial magnetic stimulation, transcranial direct current stimulation, and deep brain stimulation, in the treatment of SUDs.[57] Song and colleagues conducted a meta-analysis of the effects of single- versus multisession invasive brain stimulation on cravings and consumption in individuals with drug addiction, eating disorders, or obesity and concluded that noninvasive brain stimulation specifically targets the dorsolateral prefrontal cortex, reducing cravings and substance use.[58]

NURSING IMPLICATIONS

Nurses may have negative attitudes toward patients with SUDs.[59] People who have SUDs report feeling stigmatized by health care providers, which may make them reluctant to seek care and treatment.[60, 61] Health care provider discrimination may negatively affect care of people with SUDs and result in poor treatment outcomes.[62, 63] A systematic review by van Boekel and colleagues found that health care providers' negative attitudes toward patients with SUDs led to poor communication, less provider empathy, and suboptimal therapeutic interactions.[62] Nurses reported feelings of frustration, apathy,

Table 1. National Resources for Substance Use Disorder

Agency	Purpose	Contact Information
National Institute on Alcohol Abuse and Alcoholism (NIAAA)	Leads national research on alcohol abuse and translates findings into practice	www.niaaa.nih.gov or call 301-443-3860
National Institute on Drug Abuse (NIDA)	Leads national research on substance use disorders	https://nida.nih.gov or call 301-443-1124
National Institute of Mental Health (NIMH)	Leads national research to improve the understanding and treatment of mental illness	www.nimh.nih.gov or call 301-443-4513
Substance Abuse and Mental Health Services Administration (SAMHSA)	Goal is to reduce the impact of substance abuse and mental illness.	24-hour National Treatment Referral Hotline (1-800-662-HELP) or https://findtreatment.gov
Center for Substance Abuse Treatment (CSAT)	Supports treatment services through a block grant program and disseminates research findings. Provides hotline referral services.	Call 988 for 24-hour Suicide and Crisis Lifeline www.samhsa.gov/about-us/who-we-are/offices-centers/csat

disappointment, and fear of being manipulated during interactions with patients who had SUDs.[64] The absence of literature about discrimination and bias among nurses toward peers with SUDs presents a challenge when trying to address the unique relationship between nurse colleagues. Nurses' lack of knowledge about SUDs and SUD treatments may foster a bias toward people with SUDs.[62]

Continuing education on SUD epidemiology, neurobiology, pathophysiology, and treatments may reduce health care provider bias and discrimination that negatively affect the treatment of patients with SUDs.[59] Currently Delaware, Florida, and West Virginia are the only states that require nurses to complete continuing education on SUDs.[65-67] Educational programs on SUDs that were provided to undergraduate and graduate nursing students indicate that education can positively alter knowledge and bias about individuals with SUDs.[68-70] Researchers found a positive shift (less bias) in the attitudes of nurses who provided care for patients with SUDs following an eight-hour educational workshop on the subject.[59]

Challenges of treatment. One of the biggest challenges for clinicians when treating nurses with substance-related disorders is helping them break through the resistance and denial they often develop as defense mechanisms during their disease process; balancing empathy, compassion, and accountability is crucial for this work. Understanding the physiological processes and neural adaptions that occur with repeated substance misuse can promote such a balance and a positive attitude toward treatment.[71] The brain's bidirectional stress and reward systems are intricately linked to substance use behaviors, and drug dependency is mediated by a cycle of spiraling dysregulation of brain reward and antireward mechanisms.[72] In other words, in dependency, the motivation for substance use changes; instead of using substances for pleasurable effects (positive reinforcement), the driving force shifts toward removal of an aversive stimulus (negative reinforcement) or drug withdrawal effects.[72-74]

The importance of self-care. Nurses care for others daily but may neglect self-care, which is a conscious process of taking care of oneself physically, mentally, and emotionally. Self-care programs for nurses should be available in all health care systems and university nursing programs to prevent stress, compassion fatigue, disengagement, burnout, posttraumatic stress disorder, and suicide.[12] Suggested content may include mindfulness, meditation, conflict resolution, relaxation and stress management techniques, deep breathing exercises, visualization, nutrition, exercise, and gratitude journaling.[75] By recognizing the value of the physical, mental, emotional, and spiritual aspects of their lives, nurses can effectively prepare for the ongoing demands of the profession and may avoid the risks of developing SUDs. ▼

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