Received: 15 April 2019 | Revised: 29 July 2019 | Accepted: 12 September 2019

DOI: 10.1111/jonm.12874

ORIGINAL ARTICLE

WILEY

Experiences and outcomes of nurses referred to a peer health assistance program: Recommendations for nursing management

Elizabeth M. Pace[1] | Chris Kesterson[1] | Katherine Garcia[1] | Jean Denious[2] | Deborah S. Finnell[3] | Sara Douglass Bayless[2]

[1]Peer Assistance Services, Inc., Denver, Colorado

[2]OMNI Institute, Denver, Colorado

[3]Johns Hopkins University School of Nursing, Baltimore, Maryland

Correspondence
Deborah S. Finnell, Johns Hopkins University School of Nursing, Baltimore, MD.
Email: dfinnell@jhu.edu

Funding information
Colorado Department of Regulatory Agencies, Division of Professions and Occupations, State Board of Nursing.

Abstract

Aim: To provide recommendations for nursing management based on the experiences of current and former nurses who were served by a peer health assistance program (PHAP).

Background: Providing help for nurses with impaired practice is critical to their health and well-being, assuring patient safety and public trust, as well as returning competent nurses to the healthcare workforce.

Methods: Nurses (n = 268) who were current clients or former clients of a PHAP were surveyed about their experiences.

Results: Nearly half of nurses were referred by the board of nursing with 69% reporting the referral was due to substance use, alcohol being the most common. Most (62%) did not believe that their substance use affected their practice yet relayed that recognition of their emotional or physical condition could have led to earlier identification. Key barriers to seeking assistance were fear and embarrassment, along with concerns about losing their nursing license.

Conclusions: Nurses in management are in key roles to identify and intervene with nurses who are at risk for impaired practice.

Implications for Nursing Management: Nurses in management and nurse colleagues would benefit from workplace education on the warning signs of impaired nursing practice and how to address it.

KEYWORDS

nurses, patient safety, substance use, workplace

1 | INTRODUCTION

Nurses have a legal and ethical duty to provide safe and effective care for patients. Yet a nurse's use of alcohol and other drugs; mental health conditions such as depression, anxiety and stress; and manifestations of a mental disorder can impair practice and put patients at risk. Ideally, the risk is identified by the individual nurse, their significant others, colleagues or supervisor. Whether a real or potential harm to the patient is manifest, once identified the nurse should be guided to appropriate treatment. Impaired practice may result in discipline up to and including loss of their license to practice. Peer health assistance programs (PHAP) emerged in the 1980s created to enhance public protection by promoting earlier identification and intervention before the professional demonstrated unsafe practices. These PHAPs, developed as alternative to discipline (though there may be discipline but permitted to practice if monitored) for nurses and other licensed

professionals, provide evaluation, referral to treatment, case management and monitoring of the professional throughout treatment and recovery. It should be recognized that nurses, like the general population, can experience substance use and mental health-related problems. PHAPs were developed so that referred nurses could be supported through recovery and retained in the profession while safeguarding the health of the nation.

There is significant variance in PHAPs from state to state. In part, this depends on whether programmes are codified by the state practice acts, regulated by the state board of nursing, the levels of nurses (i.e., licensed practical, registered) and the reasons for referral (e.g., substance use, mental health and physical health). According to the National State Boards of Nursing (NCSBN), 44 states including the District of Columbia have alternative to discipline programmes. The NCSBN defines alternative to discipline programmes as, 'programs to enhance a board of nursing's ability to quickly assure public protection by promoting earlier identification, requiring immediate removal from the workplace, and evidence-based treatment for nurses with substance use disorder (NCSBN, 2019).' While others have described PHAPs (e.g., Stone, Quinlan, Rice, & Wright, 2016), published data on the prevalence of nurses enrolled in these programmes (e.g., Monroe, Kenaga, Dietrich, Carter, & Cowan, 2013) and have reported on studies focusing on experiences of nurses in them (e.g., Fogger & McGuinness, 2009) and re-entry into the workplace (Cook, 2013; Mumba, 2018), there is a limited body of evidence on nurses who have participated in a PHAP. One exception is a 2010 survey of nurses participating in the PHAP (Cares, Pace, Denious, & Crane, 2015) which is the focus of the current survey. This PHAP is one that provides outreach to nurses and the various settings in which they work, for example, presentations at hospitals, clinics, small practices and schools of nursing. There are regular advertisements in the statewide nurse newspaper distributed to 80,000 nurses each quarter. Exhibits are staffed at numerous professional meetings where nurse educators and professional association members attend. Collateral information is disseminated that highlights the signs of impaired practice along with accessible resources. The programme staffs a 24-hr information line so that the programme can be accessed statewide at any given time. Given the gap in data on PHAPs and the decade since that survey was completed in 2010, this study describes the experiences of current and former nurses licensed by the State Board of Nursing or students of nursing who were served by a PHAP over more than a 6-year period (1 April 2010–31 January 2017). The results of this study highlight the important role that nurse managers have in detection of and intervention with nurses exhibiting early signs of impairment, assisting and supporting them in accessing treatment, case management and monitoring, and returning to professional practice.

2 | METHOD

2.1 | Design, participants and procedure

This descriptive study utilized a survey to assess the experiences of the PHAP clients.

The study was approved by the Institutional Review Board of the University of Colorado, Boulder. The target population included nurses (registered nurses including nurse practitioners, licensed practical nurses, certified nurse aids and nursing students) who were enrolled in the PHAP between 1 April 2010 and 31 January 2017, and who at a minimum, completed a comprehensive evaluation. There were 849 nurses who were either current clients (n = 311) receiving services from the programme at the time of the survey or former clients (n = 538) who had completed their participation prior to the survey.

The PHAP, (name redacted) is in a U.S. state (name redacted) in which the nurse practice act includes statutory requirements to designate a peer health assistance program. This non-profit organisation established for nurses by nurses in 1984 contracts with the State's Department of Regulatory Agencies to provide a PHAP to licensed nurses and other professions. The contract is funded by license fees. The original model of services was based on the Employee Assistance Program: assessment, referral, monitoring and follow-up. In the late 1980s the Nurse Practice Act was amended to include a statutory peer health assistance program. The PHAP assists licensees to deal with physical, emotional, psychiatric or psychological problems, behavioural, mental health or substance use disorders that may be detrimental to their ability to practice. These health concerns may lead to potential practice violations. The programme objectives include public protection and rehabilitation of the licensee. The programme model includes comprehensive evaluation, referral to appropriate levels of treatment and case management that includes the daily monitoring of compliance with rehabilitation contract requirements. These rehabilitation contracts are typically 5 years in length.

An email was sent to clients to relay the purpose of the evaluation and that they would be contacted to request their participation in the survey study. The email address of the client from the PHAP database was used to send a unique link to access the survey. Clients were informed of the 30-day deadline for completing the survey. Given the length of the survey and amount of time to complete, the ethics of participant payment were considered (Gelinas et al., 2018) and approved by the IRB. The payment included a $10 e-gift card and entry into a raffle for one of three $250 gift cards. Reminder emails were sent only to clients who had not yet completed the survey. The first reminder was sent two weeks after the survey was deployed. A second reminder was sent two weeks later, and the incentive was raised to $20. A third follow-up was sent at the initial deadline date with a one-week extension of the deadline.

2.2 | Measures

Demographic characteristics were obtained from the programme's client database. Additional questions were asked about their involvement in the programme, such as if they received an evaluation only or if they received both an evaluation and signed a rehabilitation contract; what concerns brought them to the programme (e.g., substance use, mental health and/or physical health); and their referral source. The nurses' current participation status (active/inactive),

whether they were ordered by their board to participate in the programme, and their programme discharge status were derived from the programme's client database.

Surveys administered in a previous evaluation of the programme were expanded upon to address additional objectives. Specifically, in addition to replicating the past evaluation questions and aims, the current evaluation (and revised survey) included new questions to understand clients' health outcomes since leaving the programme; and the impacts of public disclosure of programme involvement. Face validity was established through a review by two individuals, each with expertise in the content area and expertise on question construction. Further validation testing was not conducted. The final surveys were used to assess the experiences of current and former clients. Both survey forms included questions about clients' (a) history of substance use, mental health and physical health conditions prior to receiving services from the programme; (b) current licensure and employment status and obstacles to obtaining or maintaining employment; (c) perceived barriers to seeking assistance; (d) perceived obstacles to maintaining compliance with a rehabilitation contract; and (e) satisfaction with services received through the programme. Both survey forms were designed so that respondents only received follow-up questions relevant to their experiences and perceptions. The survey for former clients included questions about their experiences following programme participation. A four-point Likert-style response scale was used for most closed-ended questions. Open-ended questions were utilized to obtain data on how having to disclose participation in the PHAP affected them personally and professionally.

The number of survey items varied by client status (current vs. former) and was based on participants' individual responses to certain questions. Former clients received additional questions about their health, effects on practice, employment status and consequences of programme participation on employment opportunities since their participation in the programme ended. Reports of substances used prior to the programme also affected survey length for all participants. For example, if a participant indicated never having used a substance prior to the programme, no further questions were asked about that substance. If a participant reported ever having used a substance prior to the programme, they received a follow-up question regarding the frequency of use.

2.3 | Analyses

The analyses were conducted by three members of the research team at including the fourth and sixth authors who verified the findings. Univariate analyses were used to obtain descriptive statistics (i.e., number, frequencies, mean and standard deviation) based on the level of data. Thematic analysis was used for qualitative data.

3 | RESULTS

There were 268 surveys returned for a 32% response rate. Summarized below are the characteristics of the respondents, factors related to their entry into and engagement in the programme, and programme outcomes.

3.1 | Participants

Based on the client records, respondents (except students) were licensed by the State Board of Nursing. Most respondents were registered nurses (n = 234; including four nurse practitioners) followed by Licensed Practical Nurses (n = 28), Certified Nurse Aides (n = 4) and students of nursing (n = 2). Most respondents were White (86%; n = 230) and female (83%; n = 222) ranging in age from 22 to 68 years (mean = 43.05; SD = 10.69).

3.2 | Programme entry and engagement

3.2.1 | Reasons: Substance use, mental health and/or physical health

The majority (72%) of nurse respondents came to the PHAP because of substance use. Of the 183 nurses who specified the type of substance, 77% reported alcohol use, 43% opioid use, 17% benzodiazepines, 16% recreational marijuana and 10% each for cocaine and amphetamines. The remaining 15% reported using tramadol (8%), medical marijuana (4%) or Soma (3%). The majority (67%) of nurses using alcohol reported a 5 year or longer history of use. Half of those with medical marijuana use reported use of 5 or more years before receiving services. On average, nurses reported shorter durations of use (<6 months) for cocaine (47%), benzodiazepines (35%) and amphetamines (28%). Those reporting opioid use reported use of <6 months (23%) or 5 or more years (26%) before receiving services. Oral routes of ingestion were dominant (76%). Smaller proportions reported administering intravenously (14%), with 96% of these using a sterile technique for administration. Even smaller proportions reported inhaling or smoking (6%) or snorting (3%) substances. Thirty-two per cent of nurses reported obtaining substances in an illicit way. Of these, 20% kept a portion of patient medication for their own use, 6% replacing medications with other medications or normal saline, 5% obtaining waste from the sharp's container and 3% via forged prescriptions. A proportion of nurses (13%) reported ordering drugs for their own use.

The remaining third of nurses surveyed reported coming to the programme because of both substance use and mental health problems (13%), mental health problems alone (10%), physical health problems (3%), a combination of substance use, mental and physical health (2%) or a combination of mental and physical health reasons (<1%). Three per cent of respondents did not provide the reason for coming to the programme.

The majority (61%) of nurses who used a substance prior to coming to the programme indicated that they experienced a trigger that led to escalation of that use. The most common reason was divorce or separation (24%) closely followed by trauma (22%). Other factors included death of a loved one (17%), undiagnosed or untreated

mental disorder (16%), workplace stress (16%), physical illness or injury (15%) and financial issues (12%).

3.2.2 | Impact on practice

Substance use

Nurses were asked to report about their substance use at work and the impact on their professional practice prior to entering the programme. A small percentage of nurses reported using alcohol at work (6%); however, 23% reported using other drugs at work. Most (62%) did not believe that their substance use affected their practice, but 21% agreed that their substance use affected their practice in a way that put patients at risk.

While 45% of nurses relayed that they could have recognized their substance use as a concern earlier, 37% suggested that a spouse/partner could have identified their substance use as a problem earlier. Other people who could have identified their substance use earlier included other family members (27%), friends (25%), coworkers (17%), employers (12%) and a therapist (11%). Primary workplace indicators that could have led to earlier identification of substance use were changes in emotional or physical conditions (35%). Other signs included increased absenteeism or tardiness (16%), documenting more pain medication administration (16%), decreased dependability (12%) and increased drug waste or breakage (10%).

Mental health

Of the 20% of nurses who came to the programme due to mental health concerns, 58 of 60 reported on how these impacted their professional practice. Over half (53%) reported that their mental health concerns negatively affected their job performance. A small percentage (9%) indicated that their mental health concerns affected their practice in a way that put patients at risk.

The majority (64%) of these respondents believed that earlier recognition of their mental health concerns was possible, with 41% rating themselves as the primary person who could have done so. Other early identifiers included a spouse/partner (35%), other family member (38%), friends (35%), coworkers (24%), a professional colleague (19%) or a therapist (22%). More than half (52%) of nurses reported that low energy or fatigue were key indicators that could have led to earlier identification of mental health symptoms. This was followed closely by depressed or euphoric mood (45%) and decreased interaction or isolation (43%).

Physical health

A small percentage (3%) of the nurse respondents came to the programme because of physical health concerns. Of these nine nurses, 44% agreed that their physical health affected their job performance. Less than one-quarter (22%) believed that their physical health affected their practice in a way that put patients at risk.

One-third (33%) of the nurse respondents believed that earlier recognition of their physical health concerns was possible. More than half (56%) endorsed low energy or fatigue as the most common indicator that could have been recognized.

Seeking assistance: Barriers and facilitators

Table 1 displays the reported barriers to seeking assistance and responses among all nurses. The most common reason was that nurses felt they could resolve their problems on their own (65%). Nurses were also concerned about confidentiality (59%) and fear of losing their license (57%). Over half (55%) relayed that embarrassment was also an influential barrier to seeking assistance. Fewer (<20%) relayed that lack of insurance and lack of a health care provider were barriers.

Table 2 displays potential facilitators to help reduce barriers to seeking assistance. Personal and professional networks were key mechanisms for overcoming their barriers, particularly support from friends (65%), a spouse/partner (62%) and colleagues (61%). A majority (62%) also relayed that family or colleagues intervening would have been helpful, as well as assurance of confidentiality (63%).

Impact of disclosure

Nurses with a license that was active with conditions, suspended or surrendered/relinquished (n = 115) were also asked how having

TABLE 1 Barriers to seeking assistance (n = 226)

Potential Barrier	Not at all	A little	Somewhat	A lot
Thought I could resolve it myself	34%	9%	20%	36%
Concerned about confidentiality	41%	5%	14%	40%
Too scared	43%	9%	13%	35%
Afraid to lose license	44%	8%	11%	38%
Too embarrassed to seek assistance	45%	7%	12%	35%
Unaware of programme	53%	9%	14%	24%
Did not think of it as a health problem	57%	12%	14%	17%
Too ill to seek assistance	63%	12%	12%	14%
Could not pay	72%	8%	9%	11%
No insurance	82%	3%	5%	9%
No health care provider	84%	4%	5%	6%

TABLE 2 Facilitators to reducing barriers to seeking assistance (*n* = 221)

Potential Barrier	Not at all	A little	Somewhat	A lot
Support from friends	35%	11%	25%	29%
More confidentiality in process of seeking assistance	37%	7%	14%	42%
Intervention by family/colleague	38%	16%	25%	21%
Support from spouse/partner	38%	11%	19%	32%
Greater knowledge of treatment services	39%	14%	21%	25%
Support from colleagues	39%	11%	20%	30%
Greater understanding of Practice Act	43%	11%	21%	26%
Lower treatment costs	45%	12%	16%	27%
Insurance coverage for treatment	45%	12%	13%	30%
Knowledge of programme	48%	13%	19%	20%
Identifying mental health symptoms	48%	16%	17%	19%
Knowing signs & symptoms of substance use	53%	16%	17%	14%

discipline as a public record affected them personally and professionally. The vast majority (93%) of these respondents provided open-ended responses to these questions. Thirty-nine per cent of the respondents indicated that disclosing to potential employers was stigmatizing, embarrassing and disturbing. An illustrative response was, '(It was the) worst experience of my life and incredibly embarrassing to tell employers I had depression and anxiety when it really is my own private business.' Similarly, 46% of nurses indicated that having a public record was stigmatizing, embarrassing and disturbing. One nurse stated the following.

> *I cannot even begin to state how humiliating and horrifying it is to be shamed publicly for having a DISEASE! I suffered depression, suicidal ideation and shame as a result of having my career taken from me and having it displayed to the public as if I had been convicted of homicide.*

A percentage of nurses (28%) reported that disclosing to potential employers made it more difficult to secure a job, advance in their position and do their work well. Forty per cent of nurses indicated that having the public record made it more difficult to secure a job, advance in their position and do their work well. This nurse's response illustrated the impact of disclosure.

> *It was demeaning. I was no longer seen as a professional. I was seen as an alcoholic and a liability. I was not treated like a person who has an illness that needs treatment but as a person who [was] no longer 'qualified' to work in my chosen field. I had to take jobs that I absolutely hated just to get work at all. This was a most undeserved consequence that felt and continues to feel like punishment. It ruined me professionally.*

Another respondent described the impact of disclosure.

> *I couldn't get a job. It's extremely difficult if not impossible to sell yourself in a job interview when your past is thrown on the internet for everyone to see.*

Some nurses (30%) reported having no negative experiences related to disclosing to employers or that their employer was supportive. One nurse relayed, 'I have not changed employers, my current employer has been super supportive, understanding, and amazing!' Another stated,

> *Personally, this has not dramatically affected me this far. I am transparent about my recovery, and for any prospective position, I explain my case in a face to face meeting. Therefore, I have not been directly notified from a professional or a potential employer that this is a barrier.*

Twelve per cent of nurses reported no negative experienced related to the public record.

3.3 | Programme outcomes

3.3.1 | Satisfaction

Respondents (*n* = 277) were asked to rate overall satisfaction with the programme and specific aspects (i.e., help maintaining professional practice, service timeliness, case management effectiveness, responsiveness to needs, help stabilizing personal life, opportunities to provide feedback, programme responsiveness to feedback, quality of referrals and overall satisfaction with referrals). More than half (58%) of respondents rated overall satisfaction as somewhat or very satisfactory. Somewhat/very satisfactory ratings for all other aspects ranged from 55% to 62%.

Of services provided by the programme, the highest rating (somewhat/very helpful) was reported for case management (65%), followed

by peer education meetings (57%), evaluation (53%), relapse prevention plan (45%), employment referrals (41%) and self-status reports (35%). In ratings of the helpfulness of programme referrals and requirements, nurses rated individual counselling/therapy as the most helpful (79%).

Nurses (*n* = 268) also provided responses about the programme as a resource, its effectiveness, and any reasons that would prevent them from referring a colleague. Over one-third (37%) viewed the programme as a meaningful resource. Highlighting the integral role that the programme had in success, one nurse relayed, 'I think (the program) is fantastic! They helped me completely change my life…Couldn't have stayed clean and sober without them.' Over one-third (34%) relayed that the programme helped them and provided a significant value to their life. 'I am still sober 9 years later and I owe part of that to (the program). I am very connected in my Recovery community and am stable. I am a better nurse because of (the program).' When asked about referring a colleague, 37% indicated they would do so. Of those who indicated they would not refer a colleague, the most common reason (provided by 25%) was that they felt the programme was not helpful to them. Other respondents relayed that the requirements were too inflexible and not tailored appropriately to their situation (16%) or did not feel that the programme treated them as individuals (16%).

3.3.2 | Licensure status

Nurses were asked to report the current status of their licenses with the State Board of Nursing. Current clients (*n* = 130) were more likely than former clients (*n* = 133) to have a license that was active with conditions (50% vs. 5%, respectively). Former clients were more likely than current clients to have an active license without conditions (61% vs. 25%, respectively), but they were also more likely to have surrendered or relinquished their license (17% vs. 2%, respectively).

Among those who surrendered or relinquished their license (*n* = 25), the most common reasons were that they chose relinquishment over revocation (44%) and the requirements of the rehabilitation contract were too expensive (44%). Other reasons included: requirements of the rehabilitation contract were too burdensome (36%), humiliation of the discipline being public was overwhelming (24%), could not go through another rejection when seeking employment (12%), working with practice restrictions was too stressful (12%), found a different career path (8%) and being singled out by colleagues was too stressful (8%).

3.3.3 | Employment status

Most of the respondents who were current clients (*n* = 133) and former clients (*n* = 129) were employed in their licensed profession (66% and 61%, respectively). Half of the 50 nurses who were employed outside of nursing or seeking employment outside of nursing reported that their license status (e.g., suspended, interim cessation of practice) was the reason that did not allow them to practice. Of these 50 nurses, 14% reported that employers would not hire them because of their public discipline; 12% had rehabilitation contract restrictions that limit their practice; and 8% had restrictions that prohibit them from working as a nurse.

Among former clients who were employed or seeking employment in nursing (*n* = 82), 21% experienced challenges returning to practice. Specifically, 18% reported that employers were not willing to hire them due to participation in the programme; 41% because of public discipline; and 41% because of some other complication based on their participation in the programme, such as having to explain a lapse in work history.

3.3.4 | Substance use status

All survey respondents were asked about their post-programme substance use. Less than one-quarter (24%) reported using alcohol since completing the programme; in contrast, 76% of the survey respondents reporting using alcohol prior to the programme. Similarly, only 4% of nurses reported using opioids since leaving the programme, compared with the 47% of nurses who reported using opioids before the programme. Tramadol use increased from 6% before the programme to 8% after.

4 | DISCUSSION

This comprehensive survey provides important information about one PHAP. The nurses surveyed were most likely to seek services due to substance use concerns. Given the fact that 51.2% of Americans aged 12 or older reported alcohol use in the past month (Substance Abuse & Mental Health Services Administration [SAMHSA], 2018), it is not surprising that alcohol was the dominant substance used by the nurses prior to programme participation. This finding also parallels that of a survey of Canadian nurses, drawn from the general nursing population, wherein self-rated prevalence of 12-month alcohol use was higher than 12-month drug use (Kunyk, 2015). There is enough evidence of adverse effects on functional capacity the day after a heavy drinking session (Gunn, Mackus, Griffin, Munafò, & Adams, 2018; Scholey et al., 2019), highlighting why alcohol use among nurses, whether at work or outside of work is problematic.

Many nurses believed they could have self-identified their substance use concerns earlier and even more believed they could resolve their problems on their own. In the study by Kunyk (2015), 121 of 243 nurses who were actively practicing self-identified as having problems with substance use, yet 77% had not sought treatment. National population data reveal a similar pattern. In 2017, among the estimated 18.2 million Americans aged 12 or older who needed substance use treatment, 94.3% did not feel they needed treatment (SAMHSA, 2018). Thus, assuming nurses are like the general population, a majority who could benefit from substance use treatment will not receive it, and untreated or undertreated, their symptoms will persist or worsen potentially leading to impaired practice.

Barriers to seeking assistance for nurses in this study were like those identified by Cares et al. (2015) who relayed that fear and embarrassment and concerns about losing their nursing license were

among nurses' greatest barriers to seeking assistance for substance use and mental illness. The poignant statements provided by the nurse respondents highlight the negative impacts of disclosing their problems and participation in the programme. Strategies to reduce stigma include education and advocacy (National Academies of Sciences, Engineering, and Medicine, 2016). A first step may be for individuals to become aware of their own perceptions and biases and how they are grounded on understanding the neural pathways that fuel stigma (Finnell, 2018). Another key strategy for addressing stigma is understanding the neurobiology of substance use and substance use disorders, scientific evidence which is summarized in the report from the U.S. Surgeon General on alcohol, drugs and health (United States Department of Health & Human Services; USDHHS, 2016). This evidence-based information is helpful in realizing that substance use is not a character flaw, but rather a chronic illness that requires the same skill and compassion with which providers approach persons with heart disease, diabetes and cancer.

Nurses did not view their practice as impaired. It may be that the nurses did not experience any problems in carrying out their responsibilities or, if the nurses did experience consequences related to patient care, did not associate them with their substance use, mental health or physical conditions. From this survey study, nurses' personal and professional networks appeared to be key mechanisms for overcoming barriers to seeking help. Thus, if nurses do not view their practice as impaired, the nurses responding to this survey suggest that coworkers and employers are instrumental in earlier recognition of their problems. These colleagues and supervisors may be reluctant to do so; however, a study by Mumba (2018) suggests otherwise. Specifically, nurses who had participated in peer assistance programmes for a substance use disorder reported 'gratitude for being caught' (Mumba, 2018, p. 564). In describing this phenomenon, nurses articulated the power of addiction and their feelings of powerlessness (Mumba, 2018) and thus seem to value the identification of their problem by others as helpful.

The favourable outcomes related to reduced rates of substance use, retention of license in the profession and employment as a nurse point to the value of nurses participating in the programme. The challenges that nurses faced in returning to practice could be overcome by greater understanding of the chronic health conditions experienced by the nurses that treatments are effective, recovery is possible and return to work agreements support the nurse and protect patients. The profession has a long-term challenge in retaining nurses. Nurses in management have key roles in helping nurses return to the workplace by appreciating the efforts they have taken to regain their health and mitigating the embarrassment and shame they feel as they resume their patient care responsibilities.

The National Council of State Boards of Nursing (NCSBN) has developed and disseminated educational material outlining the roles and responsibility of the nurse manager, particularly for situations involving substance use (NCSBN, 2018). Bowler (2018) conducted a quality improvement project with nurse managers who completed an online programme developed by the NCSBN. The goal of the educational programme is to promote nurse managers' proactive prevention, detection and intervention when a nurse is exhibiting signs suggestive of substance use. From Bowler's (2018) findings, most nurse managers (94.1%) strongly agreed that the education intervention was worthwhile for their professional practice and enhanced their knowledge and skill as a unit-based leader. Additionally, more than three fourths (76.5%) of the nurse managers believed the programme should be offered to all bedside nurses (Bowler, 2018). The results of this quality improvement project by Bowler (2018) are promising in terms of the value of the programme for these nurse managers, particularly since nurses in the study by Mumba (2018) reported inconsistencies regarding perceived support from their employers, ranging from no support at all to the best support imaginable. Widespread dissemination of this educational programme to nurse managers and nurses in general may promote prevention and early identification of substance use problems and this programme may be generalized to mental health and physical problems that can lead to impaired nursing practice.

4.1 | Study limitations

Except for the demographic and service characteristic data, the findings of this study are based on respondent self-report and rely on the willingness of respondents to disclose sensitive information. Some findings rely on respondents' memories from the time they received services from the programme, some who may have participated up to eight years prior to completing the survey. This study is descriptive in nature, and thus, conclusions cannot be drawn regarding associations or causations. The findings are from one PHAP and thus may not be generalizable to others.

4.2 | Conclusions and implications for nursing management

The results of this survey from about one-third of the nurses who were engaged in the PHAP highlight the positive outcomes for nurses participating in a PHAP in terms of satisfaction, licensure, employment and substance use status. More that half of the respondents to the survey reported satisfaction with the PHAP. Satisfaction was highest for case management and individual counseling or therapy. However, qualitative data revealed general dissatisfaction with public shaming and the punitive effects on licensure and continued employment as a nurse. Their entry into the PHAP was predominantly because of substance use with the majority experiencing a personal crisis that triggered the escalation of that use. While the majority did not believe that substance use affected their practice, nearly half thought they could have recognized their substance use earlier. In the work setting, respondents identified that coworkers and employers could have identified their substance use as a problem earlier than it was pointing to the importance of educating nurses in management and nurses about signs that may be indicative of nurses who are experiencing problems associated with substance use or problems affecting their mental and physical health. Importantly, however, are how these problems are brought to the attention of the nurse to ensure that the nurse is not demeaned. Compassion and

care must be extended to the nurse with impaired practice, resulting from physical, substance use and/or mental health disorders to stop the stigma that may prevent that nurse from seeking help. A PHAP that provides comprehensive case management and monitoring supports the nurse to safely and skilfully return to the health care workforce. Warranted is the promotion of a national standard for providing non-punitive holistic health assistance services to nurses.

4.3 | Significance for nurses in management

Nurses in management are in key positions to promote and provide education for nurses about substance use. The U.S. Surgeon General's report (USDHHS, 2016) can serve as a key source document for this education as it provides details that nurses should know in providing care to their patients as well as information that is scientific and not moralistic. Building on the review of the regions of the brain in that report, the publication by Finnell (2018) could be used to guide education about the neural and structural areas of the brain that are the underpinnings of disgust, bias, prejudice and discrimination that fuels stigma. Further discussion could centre on the recommendations to reduce stigma, outlined in the National Academies (2016) report.

The NCSBN online programme described earlier is another educational resource for any nurse in a management role. While the programme can be completed individually, engaging in a peer discussion group with peers provides the opportunity for these nurse leaders to apply what they are learning to their day-to-day experiences. Lastly, nurses in management roles should be informed of PHAPs in their area including the types of services provided and the outcomes of nurse clients from these programmes. Raising awareness through education may help to reduce stigma and associated barriers for nurses with impaired practice seeking treatment. Further, policy efforts are needed to address consequences associated with licensure and public shaming of those successfully abstaining from substance use and receiving treatment for mental health issues.

ACKNOWLEDGEMENTS

The authors gratefully acknowledge the nurses who disclosed information about their experiences and perceptions during the engagement in the peer health assistance program.

ETHICAL APPROVAL

University of Colorado, Boulder #18-0195.

ORCID

Deborah S. Finnell https://orcid.org/0000-0001-7678-9640

REFERENCES

Bowler, F. (2018). *A program for unit-based nurse leaders to mitigate the impact of impaired nursing practice in the workplace*. (Unpublished Doctor of Nursing scholarly project). Johns Hopkins School of Nursing, Baltimore, MD.

Cares, A., Pace, E., Denious, J., & Crane, L. A. (2015). Substance use and mental illness among nurses: Workplace warning signs and barriers to seeking assistance. *Substance Abuse*, *36*(1), 59–66. https://doi.org/10.1080/08897077.2014.933725

Cook, L. (2013). Can nurses trust nurses in recovery reentering the workplace? *Nursing*, *43*(3), 21–24. https://doi.org/10.1097/01.NURSE.0000427092.87990.86

Finnell, D. S. (2018). A call to action: Managing the neural pathway of disgust, bias, prejudice, and discrimination that fuels stigma. *Substance Abuse*, *39*(4), 399–403. https://doi.org/10.1080/08897077.2019.1576091

Fogger, S. A., & McGuinness, T. (2009). Alabama's nurse monitoring programs: The nurse's experience of being monitored. *Journal of Addictions Nursing*, *20*(3), 142–149. https://doi.org/10.1080/10884600903078928

Gelinas, L., Largent, E. A., Cohen, I. G., Kornetsky, S., Bierer, B. E., & Fernandez Lynch, H. (2018). A framework for ethical payment to research participants. *New England Journal of Medicine*, *378*(8), 766–771. https://doi.org/10.1056/NEJMsb1710591

Gunn, C., Mackus, M., Griffin, C., Munafò, M. R., & Adams, S. (2018). A systematic review of the next-day effects of heavy alcohol consumption on cognitive performance. *Addiction*, *113*(12), 2182–2193. https://doi.org/10.1111/add.14404

Kunyk, D. (2015). Substance use disorders among registered nurses: Prevalence, risks and perceptions in a disciplinary jurisdiction. *Journal of Nursing Management*, *23*, 54–64. https://doi.org/10.1111/jonm.12081

Monroe, T., Kenaga, H., Dietrich, M., Carter, M., & Cowan, R. (2013). The prevalence of employed nurses identified or enrolled in substance use monitoring programs. *Nursing Research*, *62*(1), 10–15. https://doi.org/10.1097/NNR.0b013e31826ba3ca

Mumba, M. N. (2018). Employment implications of nurses going through peer assistance programs for substance use disorders. *Archives of Psychiatric Nursing*, *32*(4), 561–567. https://doi.org/10.1016/j.apnu.2018.03.001

National Council of State Boards of Nursing (2019). *Alternative to discipline programs for substance use disorder*. Chicago, IL: NCSBN. Retrieved from https://www.ncsbn.org/alternative-to-discipline.htm

National Council of States Boards of Nursing [NCSBN] (2018). *A nurse manager's guide to substance use disorder in nursing*. Chicago, IL: NCSBN. Retrieved from https://www.ncsbn.org/Mgr_SUDiN_Brochure_2014.pdf

Scholey, A., Benson, S., Kaufman, J., Terpstra, C., Ayre, E., Verster, J. C., … Devilly, G. J. (2019). Effects of alcohol hangover on cognitive performance: Findings from a field/internet mixed methodology study. *Journal of Clinical Medicine*, *8*(4), 440. https://doi.org/10.3390/jcm8040440

Stone, L., Quinlan, D., Rice, J. A., & Wright, E. L. (2016). The evolution of a peer assistance network for nurse anesthetists' substance use disorder. *Journal of Addictions Nursing*, *27*(3), 218–220. https://doi.org/10.1097/JAN.0000000000000138

Substance Abuse and Mental Health Services Administration (2018). *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSDUH Series H-53)*. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

U.S. Department of Health and Human Services (USDHHS), Office of the Surgeon General (2016). *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS.

How to cite this article: Pace EM, Kesterson C, Garcia K, Denious J, Finnell DS, Bayless SD. Experiences and outcomes of nurses referred to a peer health assistance program: Recommendations for nursing management. *J Nurs Manag*. 2019;00:1–8. https://doi.org/10.1111/jonm.12874