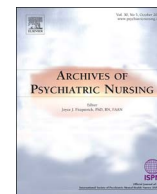




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## Employment Implications of Nurses Going Through Peer Assistance Programs for Substance Use Disorders

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### ABSTRACT

Nurses constitute approximately 36% of all healthcare providers, and 2% of the labor force in the United States (American Nurses Association [ANA], 2016). However, about 8% of nurses suffer from substance use disorders ([SUD]; Kunyk, 2015) and must participate in peer assistance programs to maintain their licenses (Darbro & Malliarakis, 2012). The purpose of this study was to describe the lived experiences of nurses with SUD participating in peer assistance programs and the subsequent employment implications. A Phenomenological approach was used to answer the research questions. Ten nurses were recruited from local support meetings and a thematic inductive approach was utilized to develop four overarching themes, which included stress from restriction, guilt and shame, gratitude for being caught, and keeping up with recovery. Understanding the challenges recovering nurses face when being incorporated into the workforce is important in implementing policies that facilitate a smooth transition.

### Introduction

Nurses constitute approximately 36% of all healthcare providers and 2% of the labor force in the United States (American Nurses Association [ANA], 2016a). However, about 8% of nurses suffer from substance use disorders ([SUD]; Kunyk, 2015) and must participate in peer assistance programs to maintain their licenses (Darbro & Malliarakis, 2012). Most nurses who participate in peer assistance monitoring programs, although able to return to work after a probationary period, may have restrictions placed on their licenses (Texas peer Assistance Program for Nurses [TPAPN], 2016). These restrictions may include inability to administer narcotics, inability to work in certain departments such as critical care and emergency rooms, and limitations on shifts the nurses with impaired practice are able to work (Bettinardi-Angres, Pickett, & Patrick, 2012). Consequently, employment prospects for nurses suffering from SUD are limited, thus influencing their nursing practice, and subsequent satisfaction with their present employment.

Substance use disorders affect individuals irrespective of age, gender, race, and socioeconomic background (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). For example, an estimated 2% of the adult population in the United States is dependent on drugs and approximately 10% are alcoholics (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2016). Furthermore, a significant number of individuals with SUD do not seek

treatment due to various reasons (SAMHSA, 2015). One of the most cited reasons is the stigma associated with substance abuse and mental health disorders in general (Evans-Locko, Brohan, Motjabai, & Thornicroft, 2012; SAMHSA, 2015). This stigma is compounded among nurses especially that nursing as a profession has consistently been ranked as one of the most trusted professions in the United States (ANA, 2016a; Dittman, 2012).

Interestingly, a significant number of insurance companies minimally cover alcohol and other drug related rehabilitation programs, which then shifts the financial burden for treatment onto the patients (SAMHSA, 2016), in this case, the nurses. This only exacerbates the inherent costs of participating in peer assistance monitoring programs. Examples of inherent costs of participating in peer assistance monitoring programs for substance abuse include random drug screen test, transportation for attendance of mandatory meetings, and costs associated with receiving therapy (TPAPN, 2016). Because most nurses participating in these programs may be facing other financial and legal problems (Tipton, 2006), the added stress of job insecurity may result into exacerbation of subjective stress and a downward spiral back into substance abuse (Darbro & Malliarakis, 2012).

Substance abuse among nurses has poor consequences for both nurses and patients. Nurses with impaired practice have decreased productivity, increased absenteeism, and have increased turnover rates (Epstein, Burns, & Conlon, 2010). Substance abuse in the workplace can additionally result in conflict with managers and colleagues (Jordan,

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Grissom, Alonzo, Dietzen, & Sansland, 2008), which does not promote a healthy work environment conducive for professional growth. Additionally, SUD are linked to workplace injuries, incorrect charting, and decreased quality of care (Epstein et al., 2010). Consequently, understanding the plight of nurses going through peer assistance monitoring programs and the subsequent effects on their psychosocial wellbeing and employment status is imperative. This is particularly important considering that a significant number of nurses report depressive symptoms and anxiety while practicing nursing in various setting (Letvak, Ruhm, & Gupta, 2012; Welsh, 2010). Therefore, having a SUD with comorbid psychiatric mental health problems is expected to exacerbate these findings (Tipton, 2006).

Several studies exploring the phenomenon of substance abuse among nurses have been conducted. For example, nurses going through peer assistance programs can be characterized as either completers or non-completers (Darbro, 2005). Characteristics of completers include a commitment to nursing, understanding of the value of alternative programs, and non-alienation from other impaired nurses (Darbro, 2005). These are contrary to characteristics of the non-completers of peer assistance monitoring programs (Darbro, 2005). Furthermore, in a review of literature comparing alternative and disciplinary programs, Monroe, Pearson, and Kenaga (2008) found that alternative programs had higher retention rates compared to disciplinary programs and nurses in alternative programs returned to work faster than those in disciplinary programs. Additionally, longer time spent in alternative monitoring programs is associated with higher chances of recovery (Clark & Farnsworth, 2006; Darbro, 2011). Other studies have focused on predictors of relapse in nurses participating in a peer assistance program, which include poor advocacy early in recovery, psychiatric co-morbidities, stress, and noncompliance with attendance in self-help group (Tipton, 2006). Having a SUD as the primary diagnosis in treatment, job termination, and using narcotics as a drug of choice are other additional predictors of relapse among nurses in alternative monitoring programs (Tipton, 2006).

In a qualitative study aimed at describing recovering nurses' experiences, nurses with impaired practice recognized that the stipulations of their contracts, which include attending 12-step programs and providing random urine samples, foster a sense of accountability that would otherwise not be present (Horton-Deutsch, McNelis, & Day, 2011). This sense of accountability provides motivation for sobriety, without which they would be less likely to maintain recovery (Horton-Deutsch et al., 2011). It is also important to recognize that there is a need for individualized treatment protocols that include support for psychosocial problems such as depression and anger as means to improve the chances for recovery (Horton-Deutsch et al., 2011). Although some studies have been conducted among nurses with SUD going through peer assistance programs, no studies were found that examined the employment implications of nurses with SUD who participate in peer assistance programs. The purpose of this study therefore, is to describe the lived experiences of nurses with SUD participating in peer assistance programs and the subsequent implications for employment.

## Methodology and Procedures

### Design

This was a qualitative research study that employed a phenomenological approach to understand the employment implications of nurses participating in a peer assistance monitoring program for SUD. This study was approved by the Institutional Review Board (IRB) at the researcher's institution. Phenomenology was utilized because it is concerned with understanding the lived experiences of individuals, the meanings attached to their experiences, and thus aims to explain the essence of being: what it means to be in a particular context (Philips-Pula, Strunk, & Pickler, 2011).

### Sample and Recruitment

Potential study participants in the community were approached and screened for eligibility to participate in the study. All the participants in this study were recruited from one location. Recruitment occurred over six weeks at the local support group meetings. The researcher attended the weekly support group meetings that nurses with SUD participating in TPAPN were required to attend. Prior permission was obtained from the group facilitators to recruit nurses at the end of each of the weekly meetings. Individuals interested in participating were required to provide informed consent prior to any data collection procedures.

Inclusion criteria for this study were that participants should be adult nurses, at least 18 years of age, who are participating in peer assistance programs for SUD. These participants should be willing to talk to the researcher about their experiences in peer assistance programs for extended periods, at least 30 min at a time. Participants were expected to understand, communicate, and express themselves in English. No translation services were offered for this study. Ten nurses were included in the study. The sample size was determined by the point at which the data saturation was achieved.

### Data Collection

Semi-structured interviews were utilized but the interviews were not audio-recorded. An interview guide was utilized. This interview guide was developed by the researcher based on the review of literature on chemical dependency among nurses. The interview guide contained nine questions that were used to elicit responses from the subjects. The subjects were further provided with extra paper that included the interview questions to write any additional comments related to the interview. The researcher used field notes as an additional safeguard to record some emotional responses, facial expression, and other non-verbal communications that might otherwise be missed by simply analyzing the interview transcripts. Subjects could talk about other emerging thoughts related to the topic and probes were utilized to allow the subjects to clarify their thoughts. The researcher's notes and the comments that were written on the additional papers provided were transferred into a word document within 48 h of conducting the interview.

A demographic data sheet was also administered to assist the researcher in obtaining data that would aid with describing the sample for the study. Data were collected over a period of 10 weeks, although all participants were recruited at six support group meetings. Data collection was only concluded when data saturation was achieved. Subjects were further encouraged to talk about other topics closely related to their substance abuse and participation in the peer assistance monitoring program whenever they were relevant to their employment implications. The duration of the interviews ranged from 45 min to 60 min. The researcher made sure to check own biases while conducting the interviews and throughout the data analysis procedures.

### Data analysis

The responses to the interviews were transcribed verbatim into a word document. These responses were then entered into NVIVO software for qualitative data analysis. The seven steps to procedural data analysis in phenomenological studies were utilized (Philips-Pula et al., 2011) to examine meaning and construct the emerging themes. The data were analyzed using the inductive thematic analysis. The researcher took the time to "dwell" with the data, which allowed for interpretation of meanings of the experiences as provided by the subjects. As the data were analyzed, formulation of meaning was promoted through contemplation, which further provided for the clustering of themes, thereby leading to the identification of the four overarching themes. These themes were stress from restrictions, guilt and shame, gratitude for being caught, and keeping up with recovery.

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