Past Event: 2024 NCSBN Scientific Symposium - Nurse Substance Use: findings from the Nurse Worklife and Wellness Study 2020-2021 Video Transcript

Event
2024 NCSBN Scientific Symposium

More info: https://www.ncsbn.org/past-event/2024-ncsbn-scientific-symposium

Presenter
Alison Trinkoff, ScD, RN, FAAN, Professor, University of Maryland School of Nursing

- [Alison] You notice that the title has changed, but I felt that it's similar, but this is more specific to what I'm going to be talking about today. And we named it the "Nurse Worklife and Wellness Study" because we were reaching out to nurses for their opinions and information, and that just seemed like a more accessible way of framing the whole issue.

So that's the reason for that. I want to acknowledge my team members and co-authors. It's a mix of faculty colleagues, and also Ph.D. students. And we have a website that has many of the products that we produced over the years. And no doubt, many through NCSBN sponsorship and others.

So I have the QR code and a little link for that if that interests you for later on. Some background on this problem. We first looked at substance use in nurses years ago when I was 12, in the Nurse Worklife and Health study. And this was funded by the National Institute on Drug Abuse.

And what we found then was overall substance use rates less than or equal to the general population, and higher rates of prescription type use, and then some different relationships with work-related factors, occupational hazards, exposures, and such. So here we're also thinking in terms of 25 years going by, and how nursing has changed so much. And even the body of evidence that we have has expanded so much in no small part to this body, but also the way that we think about nursing and study outcomes, and such, per Dr.

Aiken and others. So we are overall more educated than we have been. And along with that has come much higher demands for the work, higher acuity, shorter lengths of stay, trim staffing, and all of that, contributing a lot more strain to nurses. In terms of other changes, substance use, much more of a disease model, kind of treatment-based, evidence-based approaches to addressing the problem.

And moving in the direction. And I say moving because still studying today, I'm finding that we're not there yet, but of non-blaming, reducing stigma, and all of that in a disease approach. Opportunities for diversion are still a concern. I know the board I'm going to be talking about kind of use as a whole, but

this very strong concerning portion for boards of nursing folks, the ones that end up in trouble, and also diversion issues.

More nurses have prescribing privileges, especially APRNs that are allowed to practice full scope of their authority. And then also that we need some evaluation. There's a lot of workplace wellness offerings that are being thrown out there, and some people complain they're Band-Aids for bigger problems, etc. So that's something that we're also thinking about and have some data on. So the aims.

I'm reporting today on aims one and four, which were our basic purpose to estimate prevalence, and substance use, and potential estimates of substance use disorders, relationships between those issues, and some work factors. And to try to get a handle on what do nurses know about this problem? Do they think they could identify a colleague?

And if they did see something potentially concerning, what would they think they should do about it, or do they know what to do? So that's what I'm mostly talking about today. Our framework, we use sort of this model starting for the individual, going out to the community, and state and national. But really aims one and four are in the center. I'm not good with laser pointers, but here focusing more on individual knowledge, and also some things related to the work.

So for our methods, it's a cross-sectional study, and we had mixed modes. We had online contact, and if we didn't hear after a certain amount of reminders from people, then we also sent a paper survey, and got a fair number of paper surveys as well. The data collection was from November to March in that time period.

It does coincide mostly with the Delta wave of COVID in the U.S. If you're interested, and IRB approval, of course. Our sampling method was called balanced stratified sampling. So we selected states representative of the U.S.

RN population by basically ordering them from small to large, and putting them in four chunks or strata. And then used a formula that's supposed to make the smallest standard error to how many to pick from each of the strata. So we had nine states that were selected using this process. And then once we had the states, we did a random sample of the nurses within the states.

We also had access to, thank goodness, much of the states. We had access to the nurses database. And then there were two others that we got through private contacts to get their licensure lists. The substances that we included, illicit drugs, which was mostly marijuana, and some others, and then prescription type medications in these categories.

Alcohol use we defined as three or more drinks per occasion. Usually for men, they use the cutoff of four or more. But since our sample is mostly female, we used three or more cutoff. Energy drinks, caffeinated beverages, we used four or more as the cutoff. Do you often or very often consume four beverages?

And acknowledging that there's obviously some benefit in terms of wakefulness and whatever, but we were trying to think of the more sustained regular user. Nicotine products, including everything, vaping, what have you, and then CBD. So results. Our sample looks like some of the other samples you've heard about today.

Actually a tiny bit more diverse than we've had, although could be more always. And half are working in hospitals. And that proportion has been dropping as I've been serving nurses over the years. It seems to be going down. Okay. So the substance use prevalence in nurses, these are our estimates of percentages of the different types of substance misuse.

Around 10% prescription type, alcohol use 31%. And then our substance use problems and disorders, we split. And the estimate was around 11% for substance use problems, and a little over...I guess, close to 7% for substance use disorders. And I'll go into a little bit more how we define those.

I want to go back on that slide. Okay. The way we define someone is having a problem or a disorder. If you said you had passed your use, you were asked a 10-point screening tool, so 10 items. And they were things like, do you need to cut back?

Do you have smaller effects with the same amount, which is kind of also called tolerance. Have you been under the influence at work? Fairly serious substantial thing. So if you had one or two of those, we called you a presumed problem. And if you had three or more, we defined it as a disorder. And this was from like the DAST, APA, and some other sources. So I want to go back to this.

So the other thing we did is we took that group of people and said, "Are you reporting drugs only, alcohol only, drug and alcohol together? And how do you look on the problem sort of severity scale?" Now, even though we ask those 10 items, most people said no to all of them of the past year use. "I smoke marijuana.

I don't have any of those problems," for example. But the difference in terms of the proportion that say no risk, when you get to drug and alcohol together, that's only about a third. And then there's a little over a third in the low category, and a third in the disorder category. So the basic thing about this slide is if you have the drug and alcohol use reported together, you were more likely to meet the criteria for a problem or a disorder.

Did that one already. Okay. Then this is aim four, we called it. And it's asking nurses what they know about the problem, and what they think you should do, and all of that, and some of the beliefs. And these kinds of questions have been asked before, and many posed by NCSBN.

But we thought it would be interesting to get sort of an update read on what people are thinking nowadays. So in terms of the top, what might be a potential sign of an impaired colleague, frequent med errors, often volunteers to give meds, frequent med wasting, many absences or long breaks over three quarters of the sample thought those could all be related to problems.

And we put in things like incomplete documentation, and difficulty with assignments because that could be from so many things. And if you think about the fact that we were asking during COVID, I mean... So it wouldn't necessarily be related to a substance use problem. And then the bottom is the actions and feelings, if they suspected substance use disorder in a colleague.

We were kind of sad that almost 60% thought...they worry that they could lose their job and be punished. And I will say, anecdotally, in our EAP study so far from talking to some employee assistance program professionals, they sometimes work with institutions that still say if a person is caught diverting drugs, they are just fired. That's it.

And then what happens to them? We don't know, but they're fired. So there's still this kind of thing going on in terms of employers. And that's from a system that has an EAP program that does work with people, and can pull them into treatment, and what have you. So they were saying, and I've come to think that that can be an indication of a severity of a problem.

My brain, the part that...the receptors have taken over, and just need more, need more. And I'm not using good judgment, and whatever, to me suggests someone that's in a lot of trouble in terms of this problem. I'm not trying to debate that, but that's where I am coming down. In terms of other things, being afraid to get involved was like a fifth of people.

I'm unsure what to do. Not a huge amount, but still suggests that people are needing directions. And most people said they'd report it to the supervisor, and we have 44% would report it to the board. Okay. And then in terms of nurses with substance use, what do you think that they can do or become? So some of these we thought were encouraging that acknowledge that kind of it could be anybody, that it can reflect the job stress.

Not a lot thought nurses can continue to work, most can continue to work during treatment. And now that we have so many more options, I think even telehealth and some other low-access environments, there may be more opportunity for placing someone safely in a work situation, precepted and such. And then I think, in general, the notifying someone else is fairly strong, but in terms of what they can personally do, it looks like people could use some direction in terms of what they might do.

I can identify impaired nurses at work by appearance or behavior. Maybe there's some concerns that people already are aware of, and they can pass those along. So the other thing I want to talk about is a study that we did on looking at exposure in your work, and how that relates to prescription type misuse.

So the prescription drug misuse, I feel like I didn't say what that was. I have it on an earlier slide, but on your own more than prescribed, without a prescription, or in any other way that you're not directed. That's from the National Household definition. So that's what we consider to be prescription drug misuse. So what we did for looking at exposure was took four categories, the benzos, other sleep meds, opioids, and then non-narcotic pain medications.

And anyone who reported those, we also asked about workplace exposure and related it to that. So those were things like how available is it? How often do you give these meds? What do you know about the substance? And what's the workplace controls and handling like for those? So this slide is, again, one of these busy things.

And it's just from our paper, which I have a QR code for on another slide. But basically the availability is really important. That's the first set of. And if I can point it. I didn't point to the right thing. But anyway, let's see. Okay, here we go.

It's significantly related to more likelihood of reporting prescription drug misuse. And the others are in the direction, they're not significant. We have probably fairly small numbers. But here we decided to make it index. Let's put all the variables together, and give a score, and see how exposure itself relates to the substance use.

And the first model, the top line is a continuous index. And basically what that number means is if you report good access in your workplace, you're 38% more likely to report misuse. So that's the continuous.

And then the medium to high. By the time you're in the high category of exposure, you're about three times more likely to report the substance misuse. Okay, discussion. So our summary is nurse prescription-type misuse still does exceed the general population. Nurse substance use disorder rates are similar to the U.S. population.

7.4% is what we got through SAMHSA, and it's a bit of a gender difference. So it's kind of similar, in the ballpark to our estimate. And then the workplace exposure still is a concern, and I know especially for people in the boards. And even if we show relatively small percentages out of...now we have 5 million nurses.

That's a lot of people potentially with some issues of concern. Nurses weren't always confident that they could identify colleagues with a possible problem, though they did say that they would report it to someone, supervisor or a colleague, I guess. Favorable opinions of a nurse's ability to succeed in treatment and re-enter practice.

That was kind of varied. I think it could use some help. And that's something that people reported they might be more willing to engage and to report if they thought there's something that could be done. And we've seen that in other areas, like patient safety and such. "Is there a solution at hand? And would something happen if I reported?"

Especially with the fear of people getting fired, which is the case in some institutions. And overall, we thought general supportive attitudes toward impaired nurses in terms of what could happen as a result of job stress and all that. And thinking of the COVID situation, and the data showing more stress and more difficulties since COVID, that looks like something that should be on a radar screen.

And then we had some recommendations just of giving people clear guidelines on how to and on know what to do. Sort of reminded me of that emergency handout that we got earlier today. "Here's what's going on. What should you do." Very clear steps and guidelines would be helpful.

Of course, that might need to be organization specific. Still working on the culture of safety, and not blaming, and not shaming, and that sort of thing. I was saddened to hear, "Oh, we just fire people because they happened to be in a large city, and well, then they just go somewhere else." And then what?

So what does that do for patient care safety, and what does that do for that person, and the resources that have gone into helping someone become a nurse, and training, and all that? Awareness of exposure risks. We think of it like as an occupational risk. And the other thing, I didn't present it, but we're seeing in the other settings nursing homes, home health, and outpatient, much higher rates of these things.

And we were thinking, if you look at the exposure, in hospitals, there's more with Pyxis [SP], and accountability. And I'm not saying that's infallible, but some of these other settings are very kind of wide open compared to what we think of now today's happened in hospital settings, and especially home care with end-of-life kind of things.

So there's a lot of access, and there's a lot of stress. So thinking about some of those settings as possibilities. We're not able to say someone with those issues was attracted to work in those kind of more laxed settings, or something about the setting itself.

And then there's availability or accessibility. And also, I wanted to put this AJN paper. I work in the Academy of Nursing with a group on nurse fatigue, and we did this paper for AJN, sort of, I guess, what Linda Aiken was saying to try to put things out there a little more, and about nurses being more exhausted than ever, what should we do about it?

It doesn't have a substance use focus, but it just sort of talks about the whole issue that we've been running into, and review some of the literature. So I thought that might be helpful for people that are interested in the topic. And thank you very much. I have time for questions, so look forward to it.

I know I had to go fast through a bunch of things, so if there's something I missed, or something you wanted to hear more about, I'm happy to fill in.

Oh, hi.

- [Female] Hello. Thank you so much for that. I'm obviously from the UK. And my more recent work is in the area of compassionate regulation, and this whole issue about how we confront some of the challenges that regulation presents to the workforce and the workplace, and how we change regulation for the better.

I think it's something that really, really concerns us. My question really is, you've got this vast experience in this area. Do you see a change in attitudes on this from the punitive blame culture, to the just culture, and the kind of restoration rather than retribution?

- Yeah, I think it's moved hugely in that direction. And honestly, talking about some of the exceptions, as I had, was more disappointment because I kind of thought, "Oh, we're done with that." So it's moved hugely. And the whole peer assistance movement, and NCSBN has done a lot about pointing out stigma, and what works and what doesn't.

And firing people is clearly not a solution, whether there's a shortage or not. If we don't think there is, even so. What does it say to other people still in the work environment that are also stressed when your colleague is fired? I think it's vastly different. But, of course, would like it to continue in that direction, because the evidence shows the kinds of things that can work with nurses that have these problems.

And if you go more towards that, I think then you can conserve many nurses as nurses, and not lose them. We were discussing suicide risk being high when nurses are fired that have this kind of problem, and maybe not even having resources anymore to get treated, and so forth. So, yes, thankfully it's moving in that direction.

And I think not just in nursing, but all of us, as we encounter more and more people with opioid problems, and all kinds of things, addictions, viewing them very differently from how we did before. So I think that's a welcome change. So thanks for your question.

- Thank you very much. Thank you.

- [Female 2] So to follow up on the idea, there's a welcome change because I agree, and I'm excited about it. But I arrived to Oregon after the board had voted to stop having new nurses enter into the alternative-to-discipline program. Yeah.

So there is still out there not moving in that direction. And so I'm doing everything I can to kind of do more, bring data and information to the board, and see what's next. And so I heard you just mentioned

about the peer model. And I didn't know if you could speak to what states are doing that, because it's been harder to find. And then if you can speak to what you found just from states that have alternative-to-discipline models, and states that don't.

Thanks.

- Dr. Alexander knows probably more about peer assistance models than many of us. And there are a number of states that have them. And in our EAP study, we're also talking to peer assistance providers, like in Minnesota. And what I do remember, though, is talking to nurses in states about affected nurses. And sometimes they'd say, "Oh, it's no big deal. You just call 1-800-PEER, or whatever it is, and talk to them, and they'll get you all situated and help."

And so there's some amazing models that we have here of peer assistance. And then one of the things we're going to be looking at is how peer assistance and the boards work together, or do they work together, because that also varies from state to state. So that's really important. I commend you for doing that work in Oregon, to try to turn things around.

That's tough, but really needed. Anything else? All right. Thank you again.