Accessibility and Financial Barriers in the Utilization of Alternative to Discipline Programs in the United States

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Article

Abstract

Nurses are facing increased mental health issues, substance use, and even suicide since the novel coronavirus pandemic arrived in the United States. Nurses with substance use disorder (SUD) may enroll in alternative-to-discipline (ATD) programs to retain their license during initial treatment with the goal to return to practice, but this process is not without challenges. For example, previous analyses have shown that the time surrounding disciplinary/regulatory process regarding substance use disorder (SUD) by either employers or licensure boards was a trigger for nurses who died by suicide. Internet searches are a common approach to find information on health-related topics. This limited critical review sought to replicate and evaluate a simple internet search that a nurse seeking information on their state ATD program may complete. Google searches for information on ATD programs were completed on the 50 continental states and Washington, DC between April and September 2022. States with ATD programs were evaluated for evidence-based components and barriers to accessing program information. Publicly available ATD program information ranged from requirements for contact information to obtain details to websites that outline the entire program, including associated costs. While ATD programs offer a significant improvement over traditional disciplinary responses to nurse substance use, a significant barrier is program cost, which can often exclude participation. In this article, we discuss the detailed results of our critical review and offer implications for practice that include opportunities for research and a national database to track ATD program components and target outcomes to support return to practice for nurses with SUDs.

Key Words: Substance use, alternative to discipline, licensure, regulatory, substance use disorder, alcoholism, drug addiction, mental health, Nurs*, peer support program

Professional nurses are in a vulnerable space. Prior to the novel coronavirus pandemic, it was reported that nurses have higher rates of mental health issues, substance use, and suicide compared to the general population (Choflet et al., 2021; Davidson et al, 2020; Melnyk et al., 2021). Peri-pandemic, Cuccia et al. (2022) reported a significant change of nurses' mental health for the worse. The American Nurses Foundation (ANF) (2021) reported that one third of nurses currently working in healthcare indicated that they were emotionally not healthy. During the pandemic, in a study of nearly 10,000 nurses in 2021, one of five nurses reported an increase in alcohol consumption, and three percent noted an increase in substance use (ANF, 2021).

A recent cross-sectional survey of 1170 registered nurses using balanced stratified sampling found that 18% of respondents had problematic substance use and 6.6% screened positive for chemical dependency (Trinkoff et al., 2022). Internationally, substance use is the primary reason cited for nurses taking leaves of absence or having formal disciplinary procedures (Covell et al.,

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One attempt to address SUD and mental health issues from a professional perspective has been the use of alternative-to-discipline (ATD) programs, which began in the 1980s (Bettinardi-Angres et al., 2012). ATD programs attempt to decriminalize addiction through non-punitive pathways to promote recovery with the goal of the nurse returning to practice. This approach differs significantly from the traditional approach to SUDs in nursing which included punitive measures and criminalization of SUD, often accompanied by public shaming, such as publishing a nurse's SUD status with their nursing license (Smiley & Reneau, 2020). Currently, the nurse is removed from the workplace while retaining their license during initial treatment until deemed safely sober by the board (National Council of State Boards of Nursing [NCSBN], 2022).

ATD program components include case management services, substance use assessment, random substance use testing, and documentation of structured support groups built into an individualized practice contract or agreement with the nurse in recovery as a method for monitoring (Bettinardi-Angres et al., 2012; Russell, 2020). Although data regarding the effectiveness of substance use monitoring programs for nurses have been sparse, a retrospective analysis reported three key elements associated with successful completion of monitoring programs: 1) monitoring for at least 3 years, 2) bimonthly random substance use tests, and 3) daily check-ins. Structured group meetings and mutual support meetings were also found beneficial for participants (Covell et al., 2020; Smiley & Reneau, 2020).

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While best practices in ATD programs are known, it is unknown if the state boards of nursing in the United States (US) have been implementing these elements. This is because there is no structured national system for data collection or monitoring of ATD programs. Although efforts have been made to increase support and accessibility of treatment, most nurses with SUDs do not receive any form of treatment (Fauteux, 2022).

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Once problematic substance use is identified, connecting to resources is critical. Help-seeking behaviors by nursing professionals who have SUDs often result from complex interactions among friends, colleagues, and management. It is often very difficult for the individual access to needed resources without external help or guidance (Kunyk, 2015; Kunyk et al., 2016). For this reason, easing the pathway to help nurses and their colleagues access information about SUD treatment has been an effective method for increasing enrollment in ATD programs (Benson & Ingels, 2020).

It is imperative that SUD treatment resources are non-punitive, confidential, and easily accessible so that help is readily available when necessary (Kunyk, 2015). Internet searches have become one of the primary methods for researching health-related topics, especially for women and individuals who are university-educated (Bach & Wenz, 2020; Purcell et al., 2012). When individuals seek assistance on stigmatized issues, they often look for help using an internet search, valuing the ability to seek information anonymously and confidentially (Pretorius et al., 2019).

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It is unknown how nurses considering self-referral find out about ATD options in their state and it is fair to consider they may begin with an internet search. It is also reasonable to consider that demands on providers during the pandemic, and the associated concerns related to mental health described above, may mean that even more nurses seek information about ATD options to manage a stress related SUD. The purpose of this limited critical review was to replicate and evaluate the experience of a nurse with SUD completing a simple internet search for a state ATD program prior to self-reporting.

Methods

In this critical review, we sought to collect a brief "snapshot" of program accessibility using specific search terms to navigate to the appropriate site. Our search was not intended to be an exhaustive review, but rather was completed using multiple search terms that a nurse with a SUD may conduct. A standardized Google search ("alternative to discipline nurse [name of state]") was completed for the 50 continental U.S. states and Washington DC from April 2022 to September 2022. The review was purposefully limited to Google as it is currently the most used search engine (Davies, 2021). If the first page of the Google results did not have a link to the state ATD program, the NCSBN (2022) website, *Alternative to Discipline "Find a Program"* search tool was used to review program content. States without ATD programs were noted.

If a search resulted in needing to call, email, or fill out a web-based form to receive further information, the search was stopped and noted as a barrier to seeking information. Guiding questions of this limited critical review included:

Our search…was completed using multiple search terms that a nurse with a SUD may conduct.

- Did the search results lead to information about the state's ATD program?
- Does the ATD information have evidence-based components on the website?
- Were there obvious barriers to accessing ATD program information and possible enrollment?

…the publicly available information was evaluated on the use of evidence-based practices…

If the Google search or NCSBN website resulted in information about the state ATD program, the publicly available information was evaluated on the use of evidence-based practices as reported by Smiley et al. (2020). In addition to the evidence-based components of the program, additional information about the ATD program is available in the Supplemental Data link below.

Institutional Review Board approval was not indicated because there was no interaction with human subjects.

Supplemental Data

Results

Internet Search Results

Of the 51 states evaluated, 43 (84%) states currently offer ATD programs; 30 were found using a google search and 13 through the NCSBN website. Of these 43 states, 19 websites contained no specific information about the ATD program and 5 required making contact for information. The majority of programs do not provide direct recovery services but instead provide case management to supervise contracts that specify routine recovery reports and random substance use screening. Most ATD programs were operated through the state board of nursing and at least six were operated by third party vendors.

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Some state programs had fully-enabled websites rich with detailed information, while other program websites directed potential participants to a single webpage, or sometimes a document outlining only the state statute governing practice for nurses with substance use issues. For example, a nurse seeking SUD services in West Virginia, where further contact is required for additional information, would have a very different experience compared to a nurse seeking SUD services in Massachusetts, where detailed information about the ATD program is provided. More examples of these differences are noted in the Supplemental Data linked above.

Evidence-Based Program Components

Of the 43 websites with ATD programs, 26 stated that the program was for nurses only and 13 websites indicated that the program was available for more than one type of healthcare professional. Four websites did not describe what types of healthcare providers can enroll. There were 27 ATD program websites with enough information to evaluate the program for evidence-based care. These aspects included monitoring for at least 3-years, random substance use screenings, and daily check-ins (Smiley et al., 2020). Of these 27 websites, 24 contained at least one evidence-based component, but only 3 had all 3 components of the components listed above as part of their ATD program.

Potential Barriers to Access of Program Information and Enrollment

During the review and evaluation of states with ATD program websites, potential barriers to access of program information and enrollment were both clearly stated and latent. Of the websites reviewed, five states required further contact to receive information that would require leaving at least a name and contact information. Three websites outlined out of pocket expenses to participants in the ATD programs, 2 of which included all types of healthcare providers as participants. Websites also stated that there may be a conditional acceptance based on legal actions against the nurse. Many state websites listed eligibility criteria for the ATD program, such as the nurse could not be undergoing pending legal action because of substance use. Some states disqualified nurses with previous felony convictions or who have previously enrolled in an ATD program.

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Two latent barriers to information access were noted during this limited critical review. One was the lack of an explicit statement of the state stance on mandatory reporting of substance use disorder or drug diversion to the board of nursing. As a result, a nurse would not be able to tell whether this state required mandatory reporting and it was not clear if a nurse would be able to continue the program if reported by others for a criminal event (e.g., driving under the influence, diversion of medications).

The second latent barrier noted was availability of several links on the first page of search results that recommended against participation in ATD programs. Nurses were cautioned against the use of self-report because, though labeled non-punitive, ATD programs were perceived as punitive. For example, these pages included a link to a slide presentation about potential tricks and/or traps of programs, created by a lawyer recommended that people referred to ATD programs seek legal representation and do not provide any information to the investigating bodies. Other examples included a blog post asking about personal experiences with a state ATD program with several responses recommending against self-referral (Allnurses, 2015) and a newspaper article from Oklahoma describing "addicted nurses" as manipulative people who "...use their position of trust to feed their addictions even when they aren't on the clock." (Knittle, 2014, section 3).

Specific Costs and Structured Support Requirements

One of the less discussed details of enrollment in an ATD program is the significant out-of-pocket costs incurred by participants (summarized in the Table). Websites state that the cost of treatment, substance use screening tests, and any referrals required by the ATD program are the sole responsibility of the program participant. In many states, participants are also required to pay a service fee directly to the ATD program to cover costs associated with monitoring compliance with the program itself. For example, service fees can range anywhere from $0 to $175/month. The cost of random substance use screening tests range from $35/test to over $100/test, and some states require testing twice per week during the first year of monitoring. Additional treatment, referrals, and type of treatment required vary by state, which may cost thousands of dollars to the nurse.

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Table. *Estimates of Financial Burden of ATD Programs*

Treatment	Costs
Monitoring Fees	$0-175/month
Initial evaluation	$0-$1500
Treatment–Intensive Inpatient	$6,000/month*
Treatment–Intensive Outpatient	$5,000/3 months*
Treatment–Individual Counseling	$100-200/session**
Treatment–Group Therapy	$0-40/week
Substance Use Screening (24 tests/year)	$35-$100/test (average cost)
Transportation to testing sites, missed work, childcare	Unable to determine

Unless otherwise noted, all costs directly taken from ATD program websites

*National Center for Drug Abuse Statistics NCDAS) (2022) cheapest rates

**Lauretta, A. (2022)

Of the ATD programs that offered detailed information about program components, 11 websites mentioned structured support groups. These included peer support, 12-step programs, and structured support meetings. Peer assistance includes any programs that utilize mutual support from participants who share similar experiences and come together to work towards healing and recovery (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). In some states, peer support is incorporated into the recovery program (e.g., California) while in other states, peer support is offered as a completely separate support service (e.g., Minnesota).

For states with peer assistance programs that are separate from the ATD program, it is difficult to understand their relationship to the boards of nursing from the website information. On the surface, peer support programs appear as separately administered programs, but a deeper search may indicate that they are actually be linked to the state board. Many programs utilize a third-party for-profit monitoring company for substance use screening and other administrative tasks. Some programs initiate referrals through the program while others simply recommend/require nurses who self-refer to engage in therapy and provide proof of routine visits and progress.

Discussion

Many programs utilize a third-party for-profit monitoring company for substance use screening and other administrative tasks.

Substance use disorder is one aspect of mental health that is especially important to the nursing profession. While it is unknown how many nurses are affected by SUD, the issue is prevalent. Substance use disorder is known to be associated with death by suicide in nurses, further emphasizing the importance of addressing proactive early treatment (Davidson et al, 2021). SUD among nurses has never been a more pressing concern than in the current peri-pandemic moment, as front-line healthcare workers continue to struggle with mental health issues (ANF, 2021). The Centers for Disease Control and Prevention reported the alarming trend of 40% of U.S. adults who struggled with mental health substance use in June 2020. The American Medical Association (AMA) also reported an increase in drug overdose and deaths during the COVID-19 pandemic (AMA, 2022; Czeisler et al., 2020).

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The COVID-19 pandemic, while a significant and profession-altering event, did not create the conditions in which nurses are suffering, although it has quantifiably worsened the mental health of the workforce (ANF, 2022; Hanley, 2021). Specific occupational hazards are well-known within the healthcare professions and the typical response is to create a system of universal education that provides the employee with personal safety information combined with structural safeguards to prevent harm from occupational exposures. The difference between needlestick safety and PTSD as a result of workplace trauma seems to lie with the assumed responsible party. We posit that while nurses are required to attend mandatory universal education regarding bloodborne pathogens and fire safety, in the past well-known occupational risks (e.g., mental health and SUD issues) are not included as routine critical topics for universal education.

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This limited critical review of publicly available information regarding ATD programs for nurses reveals important nuances that may make the programs inaccessible to persons in the nursing workforce. While ATD programs offer a significant improvement over traditional disciplinary responses to nurse substance use, structural barriers may make it impossible for less economically privileged nurses to take advantage of this pathway. The cost of the program to individual participants is significant, especially considering the common requirement to voluntarily relinquish the participant's nursing license for an unspecified amount of time until cleared by the ATD program.

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Financial strain for nurses in recovery is not a new problem; researchers in 2003 found that 45% of nurses in ATD programs who were surveyed reported financial problems as the most common problem they were facing (Geiger-Brown et al., 2003). Depending on the situation necessitating referral to treatment, participants may be left without employment or access to affordable insurance. Most states offer no assistance to find employment for participants, either during the initial period of license surrender or during the period of monitored return to work, when nurses are often working with significant practice constraints. It has previously been reported that the financial despair caused by the burden of treatment for substance use disorder while unemployed is associated with nurse suicide (Davidson et al., 2021).

While consequences to the individual nurse related to unemployment can be dire, an even more complex picture emerges when considering the effect on a family unit. The cost of caregiving is a long-understood financial strain (Body, 2020). A nurse who is also a primary caregiver for dependents has additional unmet financial obligations during the initial period of unemployment within the profession. Even a temporary exit from the workplace can have long-lasting and often devastating consequences for a worker (Body, 2020).

The situation of worsening mental health of the nursing workforce, coupled with the exodus of nurses from the profession during the COVID-19 pandemic, has resulted in such severe economic pressures on the system that new seminal documents were developed advocating that healthcare leaders overtly address the mental health of the workforce. These documents call to attention for the first time the specific obligation of employers to address untreated mental health issues in healthcare professionals (Murthy, 2022; National Academies of Sciences, Engineering and Medicine [NASEM], 2019). Traditionally and by design state boards of nursing (BON) have had no responsibility to support transition into board-

approved employment situations for nurses in acute treatment for substance use disorder. Given the data surrounding death by suicide among unemployed nurses with substance use disorder (Davidson et al., 2021), we posit that there is an opportunity for BONs to collaborate with employers to develop referral lists. With such collaboration, once a nurse's license is suspended or the nurse is provided with a license with stipulations regarding conditions of employment, the process of finding a suitable position is case-managed.

While some monitoring programs are free and/or covered by state licensing fees, others require a monthly or annual fee to cover the cost of monitoring alone. Importantly, these services often cover only the assessment and administrative components of a participant's contract. All required treatments, including random screening tests, are the financial responsibility of the participant and represent costs upwards of several hundred to several thousand dollars per month with no evidence of financial support opportunities for participants. Substance use treatments are offered in several iterations, ranging from inpatient treatment with 24-hour care and costing in the tens of thousands, to outpatient treatment with daily check-ins costing a few thousand dollars for a 30-, 60-, or 90-day program (NCDAS, 2022). Availability of funds often dictates the length of stay in various treatment programs in the absence of a specific court order. One for-profit treatment center suggests that potential patients consider a personal loan from friends and family or setting up a "GoFundMe" site to pay for treatment (Moore, 2022).

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In addition to finding a way to pay for and complete treatment, participants must find an employer willing to allow them to leave work to submit mandatory blood, hair, or urine samples at a specified collection site. Payment for drug screening is due at the time of sample collection and a participant who does not have sufficient funds to cover the cost of testing is considered noncompliant with monitoring. During the COVID-19 pandemic, collection sites have become more difficult to locate and less widespread, often leaving ATD participants with no choice but to skip work or risk becoming noncompliant with their contract. In this light, it would improve the system if the state BONs facilitated the process of job placement and encouraged employers to participate in hiring nurses in recovery while being monitored.

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Another potential problem is the issue of driving under the influence convictions as they may either be processed as a misdemeanor or a felony; this varies from state to state. If a nurse has a compact state license when they enter treatment, the multi-state license is deactivated and they become single-state licensed in the state in which they are being treated. Most ATD programs do not allow participants to transfer to another state, or allow participants from out of state ATD programs to transfer in. Once a nurse is enrolled in a contract, the programs usually require permission for travel so that the participant maintains compliance with daily check ins and random substance use screening protocols.

While most ATD programs referenced the three evidence-based interventions shown to correlate with long-term recovery (Smiley et al., 2020), the level of adherence to these recommendations could not be determined from an internet search. Specifically, the frequency of random substance use testing, length of the program, utilization of daily check-ins, and specific utilization of structured support groups are often not specified. Further, there is no consistent reference to evidence-based substance use therapies or language supporting the incorporation of evidence-based practices in recovery.

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Increasingly, many states have subcontracted third party monitoring companies to manage the administrative component of the monitoring requirement. This places an additional layer of administrative burden between the nurse and the monitoring agency. Use of third-party services makes it extremely difficult to find relevant information from a basic internet search without providing personal contact information, thereby decreasing the safety of fact-finding and introducing a barrier to health-seeking behavior. Additionally, third-party services may not be indicated solely for nurses struggling with SUD, but for a wide variety of healthcare professions.

For example, the daily exposure to high-schedule drugs is more prominent in the nursing field than in dentistry, and thus the plan of care may require different restrictions. It is also unknown how these third-party vendors are vetted or audited for quality control. In a personal communication (K. Russell, personal communication, September 28, 2022) with representatives from the NCSBN, it was identified that there is no aggregated data regarding mandatory reporting processes within or between states. This appears to be a fruitful area for future research and advocacy.

The need to find primary care and mental health treatment providers, often a requirement in ATD programs, may represent an unachievable burden for some participants. Even before the COVID-19 pandemic, professional organizations reported cautionary signals about a looming primary care, addiction treatment, and psychiatry shortage throughout the United States. The average wait time to see a primary care physician in the US is currently 20 days with significant regional

differences (AMN Healthcare Services, 2022). A study of psychiatrist distribution across the US in 2018 revealed that there were significant differences in psychiatrist availability between rural and urban counties, with over 50% of U.S. counties reporting no available psychiatrists (University of Michigan, 2018).

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Recommended length of monitoring varied by state and many states did not publicize a range of possible program lengths, indicating instead that monitoring contracts are individualized and will be adjusted based on participant progress. Emerging evidence points to a linear relationship between length of monitoring and positive outcomes, with longer programs yielding better results (Olivarez, 2021; Smiley et al., 2020), though the longer the program, the higher the cost to the participant. Another significant factor emerging from literature is return to practice while enrolled in a monitoring program, which is not a requirement in all programs. In a study of nurses involved in the North Carolina ATD program, participants were more likely to complete the ATD program if they returned to practice during the program (Griffith, 2021). However, this is a double-edged sword. From personal anecdotes, we have learned that nurses may desire to return to practice, but limits on the type of practice permitted and unavailability of willing employers may prevent them from achieving this goal or meeting the terms of the ATD program. This again presents an opportunity for BONs to expand their current scope to include developing partnerships with local employers to develop pathways for gainful employment of nurses in recovery. It is also unknown whether the presence of an ATD program that serves multiple disciplines would make a program appear more or less accessible to a nurse seeking treatment.

The question of long-term outcomes as a result of ATD programs has not yet been answered. Attempts to measure recovery rates are hampered by variation in definitions of recovery, differences in the timing of when "the clock starts' (i.e., at completion or initiation of therapy), and a limited ability to follow outcomes after the monitoring period has ended. Additionally, there is no national data repository or mandated reporting expectations to guide programs in determining success. A meta-analysis of ATD programs that included all healthcare professionals revealed that approximately 75% of participants enrolled in ATD programs are abstinent and employed by the end of their program, but even these findings were undermined by variability in measurement principles from one program to another (Geuijen et al., 2021).

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Exemplar

Nurses may enter into board-monitored substance use disorder programs through several mechanisms: self-enrollment, report by an employer after being found impaired, or as a result of criminal action (usually diversion of medications or found impaired while driving). Further, self-enrolling may be encouraged by an employer in return for maintaining employment when the employer identifies that a nurse has a substance use problem. The nuances on how the situation is handled at the BON level may vary depending on how the board learned of the problem. The following case study, an aggregate exemplar drawn from lived experiences and anecdotal information, is presented to depict the experience of a nurse navigating through the system in a state that advertises an ATD program.

Figure. *Recovery Case Study*

This case study is an anonympus account of one nurse's personal story. Sally is a registered nurse in State A. She is 37 years old, divorced, and has 2 young children. She has been a nurse for 16 years and was considered a role model by peers and an excellent nurse by managers. Sally was caught diverting Fentanyl from the hospital. No one had any idea she was struggling with substance use. Her substance use started with alcohol when she was young, to manage anxiety and depression. In her early 30s, she was prescribed opioids for pain following a surgical procedure. Once she was no longer in pain, she found opioids worked to relieve her anxiety and depression symptoms. While going through a difficult personal issue a few years later, she began diverting controlled substances that should have been wasted. The first time she took fentanyl, she immediately craved more. Sally had no idea that there was an ATD program through State A's Board of Nursing that she could have joined for help.

Sally began stealing fentanyl from floor stock and soon after was caught diverting. She was terminated and per hospital policy, the police were notified. Sally was ultimately charged with 26 felony offenses, one for each ampule of fentanyl with evidence of diversion. Sally lost her insurance and could not pay for Consolidated Omnibus Budget Reconciliation Act (COBRA) insurance. She did qualify for state insurance, being the mother of two children. She could not afford a lawyer and was assigned a public defender to handle legal proceedings. After months of waiting, Sally became insured through the state and began an intensive outpatient treatment program with twenty other participants. The program offered individual therapy, and Sally continued to see her therapist after the treatment program. Sally's therapist helped her get through some of the darkest days of going through court proceedings and trying to find employment. She ended up taking a factory job that she found through a staffing agency and making minmum wage. When she took the factory job, she lost her state insurance. After months of court appearances, Sally pleaded guilty to a misdemeanor and received probation.

After Sally began probation, she was notified that the State A BON had suspended her nursing license, but she could petition the nursing board for reinstatement. She could not hire a lawyer, but she applied for reinstatement. One requirement was completing a monitoring program that included daily check-ins for urine drug screening, biweekly 12-step meetings, continuing to a therapist, and quarterly reports. The monitoring program was paid out of pocket; because Sally lost her health insurance, she had to beg friends and family for money to complete the program and make ends meet. A few months later, she received an email that confirmed her license reinstatement with restrictions and limitations.

After a few months, Sally found an employer willing to accommodate the restrictions and limitations at a dialysis center. Some restrictions included no access to controlled substances; no 12-hour shifts, night shifts, weekends, holidays, or overtime; and a work site monitor (i.e., someone with her at all times while working). As Sally progressed through the monitoring program, the restrictions and limitations were reduced. Sally was in the monitoring program for 5 years before she petitioned the State A BON for full reinstatement of her license. She had no idea there were about 300 other nurses in the program. Although her license was reinstated with no limitations or restrictions, her progress through the monitoring program is public record. She again struggled to find work but accepted a position at a behavioral health hospital. She continues to work on her recovery daily and to work on relationships that have been harmed as a result of her substance use.

In this situation the nurse was reported to the BON for criminal activity, which resulted in public disclosure of her record despite the ATD framework. We could find little literature-based evidence regarding the downstream financial situation imposed by suspending the nursing license during initial investigation and treatment. However, we felt it was important to document that barrier through this case exemplar. Research that has analyzed death narratives of nurses with job problems, who die by suicide, has suggested that financial ruin precedes death and is associated with the process of investigation by the employer and/or the BONs (Davidson, 2021). Thus, it is reasonable to assume that each cumulative barrier to treatment we have noted as a result of this critical review has the potential to inform the most serious outcome that could befall a nurse struggling with an SUD.

Further Advocacy and Policy Implications

This review focused on the topic of ATD programs. There are other issues of concern that are under-evaluated in the extant literature. For instance, there is stigma associated with seeking mental healthcare by licensed professionals when licensing boards ask probing questions routinely about mental health diseases and treatments of the individual upon licensure. These questions are often posed in a way that is unlawful and non-compliant with the Americans with Disabilities Act (Foreman et al., 2000). The most up to date data available informed us that nearly half of jurisdictions within the United States use these unlawful questions; this was reported in 2018 and bears replication (Halter et al., 2019)

It is known that in medicine, despite required reporting of mental health conditions in many states, when queried, only 6% of physicians told the truth to respective boards for fear of retaliation (Gold et al., 2016). This study informs us that required reporting of mental health issues to licensure boards does not work as intended and may actually add barriers to health-seeking behaviors. Replication of this study among nurses is indicated. As each state is regulated independently, the NCSBN may not enforce the best practice at the individual state level. Change requires local advocacy, one state at a time. Readers are referred to resources located on the Lorna Breen Foundation website for instructions regarding how to enact local change (Dr. Lorna Breen Heroes' Foundation, 2022; Halter et al., 2019).

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Limitations/Implications for Future Research

There were several limitations of this critical review. First, the review was intentionally limited in scope to a standardized internet search phrase and single search engine. This approach almost certainly returned less information, resources, and opportunities than those that are currently available in each state. It was impossible to determine whether information lacking in each state was due to issues with search engine optimization or issues with website navigation and accessibility. It was not possible to fully analyze the uptake of ATD program best practices from a website review and it is not known whether nurses with SUD consider the utilization of best practices when deciding whether to self-report.

It could not be determined what implications mandatory reporting has on the process of ATD. One author's query to the NCSBN disclosed that an aggregate summary of this information is not available at the time of this writing (K. Russell, personal communication, September 28, 2022). It is not known, and could not be determined in our critical review, whether nurses who work in states that do not have mandatory reporting seek treatment earlier than in states where reporting is required. Similarly, no information can be reported regarding the differences in the process for a nurse who is reported by an employer or the judicial system versus self-report.

A case study was presented because we have had numerous nurses anecdotally report the issues described. However, there is no research evidence to draw from to quantify proportionally how often the process of regulation and discipline results in negative outcomes such as financial ruin, delayed employment, and suicide attempt or deaths of despair. Future research is needed. First steps might be to interview nurses who experience substance use disorder and treatment to further identify best practices and opportunities within this area of practice, followed by a survey of those enrolled in programs. Such a survey would require design of an instrument created through the gleanings of qualitative research.

Implications for Nursing

As leaders in the nursing profession struggle to keep qualified nurses in patient-care positions, it is imperative to provide equitable, safe access to substance use recovery services. Routine universal education about the importance and availability of substance use treatment for nurses

Routine universal education about the importance and availability of substance use treatment for nurses is essential.

is essential. Education regarding the dangers of risky substance use and the implications on licensure and employment is needed to promote early treatment and encourage health-seeking behaviors prior to the development of substance use disorder.

Access pathways to programs, program components, and program outcomes should be standardized and the information about these options made publicly available. Information about self-enrollment processes should likewise be standardized and evaluated for ease of use. We posit that a holistic approach which provides case management and positive support to assist nurses to secure appointments with providers would streamline the process. Strategies to provide financial resources to support nurses in recovery are a critical need.

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Given the lack of standardization and transparency found from this search, we suggest that a national set of metrics are constructed to monitor outcomes from board monitoring programs and that contracts for third-party vendors include the requirement for reporting these metrics. A similar strategy of case management is needed for work/license preservation during recovery and return to work in a licensed position when the license has been temporarily suspended. Standards or incentives for retaining or hiring nurses in recovery are indicated.

A clearinghouse of employers willing to serve as recovery employment sites might make a huge difference to nurses in recovery.

A clearinghouse of employers willing to serve as recovery employment sites might make a huge difference to nurses in recovery. Finally, in addition to the measures reported previously by Smiley et.al. (2020), proactively tracking national data regarding percent suspended license, time to return to work in licensed position, and death by suicide are recommended.

Conclusion

The decision to self-report substance use disorder is life-altering for a nurse. The ability to find adequate information using a confidential search strategy should not be a barrier to seek and receive desperately needed help. The ambiguity of posted information may prevent a nurse who needs treatment from taking the next step towards sobriety. Action is needed to simplify the process of self-report, make treatment and monitoring affordable, and standardize the manner in which non-punitive programs operate. Critical needs are support for nurses with employment issues as well as substance use treatment; the ability to track outcomes, and public availability and transparency of identified outcomes to inform best practices.

The decision to self-report substance use disorder is life-altering for a nurse.

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