Work Reentry for RNs After Substance Use Disorder Treatment: Implications for the Nursing Profession

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Introduction: This grounded theory research study was conducted with the purpose of explicating a theoretical model that describes the basic social processes present in successful work reentry of registered nurses (RNs) after substance use disorder (SUD) treatment. **Methods:** Semistructured interviews were done with a purposive sample of 22 participants from various regions of the United States who met the research inclusion criteria. **Results:** Using constant comparative analysis, the core variable of the theoretical model emerged as "self-redefinition," described as acceptance and internalization of self as a person and a nurse with SUD. Factors contributing to successful work reentry were recovery support, use of healthy self-care strategies, strong professional nursing identity, compliance with regulatory mandates, and honesty about SUD and recovery status. Underlying factors to the beginning of "self-redefinition" included taking adequate time off to establish a solid foundation of recovery before reentry to work. Barriers to successful work reentry were stigma, reluctance to change behaviors or the view of self, knowledge deficits about SUD among work colleagues, financial stressors, and lengthy wait times for license status decisions from state boards of nursing. **Conclusion:** Future research is recommended to address the multiple issues associated with the topic of SUD among nurses to augment these findings.

Keywords: Grounded theory, qualitative research, registered nurse, self-redefinition, substance use disorder, work reentry

Approximately 3 million registered nurses (RNs) are licensed in the United States (McMenamin, 2015). Up to 10% of nurses are estimated to meet diagnostic criteria for substance use disorder (SUD) (Monroe, Kenaga, Dietrich, Carter, & Cowan, 2013). Nurses are a unique subgroup in the SUD population as most have access to and are knowledgeable about pharmacologic agents. When a nurse develops an SUD, there are negative consequences to patient safety, the nurse's personal health, the profession of nursing, and health care systems. Furthermore, SUDs in nurses have considerable impact on state boards of nursing (BONs) and their regulatory capacity, as it is estimated that up to two-thirds of all disciplinary cases involve SUDs and/or related psychiatric impairments (Smith, 2013). Current nursing shortages in the United States (American Association of Colleges of Nursing, 2014) make early identification, effective treatment, and support of reentry to the workplace desirable.

Early research focused on understanding characteristics of nurses with SUDs. More recent research has focused on state alternative-to-discipline (ATD) programs and their effectiveness; however, comparisons between states are inconclusive because each ATD program is unique (Monroe, Vandoren, & Smith, 2011). Other themes about nurses with SUDs include (a) the concept of stigma towards nurses with SUDs who face judgmental responses from inside and outside of the profession (National Council of State Boards of Nursing [NCSBN], 2011), and (b) the need for greater education about SUDs for all nurses (Cook, 2013; NCBSN, 2011).

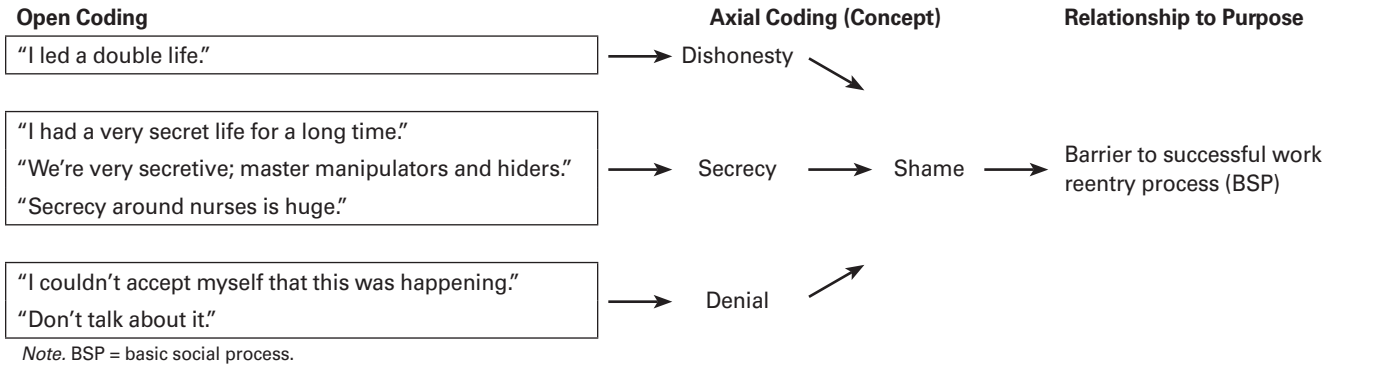
The nursing profession has long endorsed the scientifically accepted view that SUDs are chronic, treatable disorders. In the 1980s, the American Nurses Association and the NCBSN initiated a shift in addressing SUDs from punishment and nursing license suspension/revocation to that of promoting SUD treatment (many states use ATD programs) and career preservation (Darbro, 2013).

The majority of research on nurses with SUDs fails to fully give voice to the nurses with SUD; quantitative research limits full understanding of this personal complex issue by not having a rich, descriptive account generated through qualitative processes (Chenitz & Swanson, 1986). This study was conducted to fill this gap.

The purpose of this grounded theory (GT) study was to explicate a substantive theory/model that describes the basic social processes (BSPs) present when an RN successfully reenters the workplace following completion of SUD treatment. To accomplish this purpose, the researchers believed that focusing on supports and barriers to workplace reentry was central to explicating the

FIGURE 1

Process of Analysis Through Coding: Representation of One Concept



Note. BSP = basic social process.

BSP. From this perspective, a semistructured interview guide was developed and piloted with participants.

Theoretical Application: Symbolic Interactionism

The theoretical foundation that guides the GT methodology of Strauss and Corbin (1990, 1998) and Corbin and Strauss (2008) is symbolic interactionism, a theoretical perspective that views human beings as active participants in the social environment. Symbolic interactionism is built on three theoretical assumptions: (a) individuals act toward things in their lives (objects, other people, institutions) on the basis of their attributed meanings; (b) meanings originate from interactions with others; and (c) individuals modify meanings through an interpretive process used to make sense of the social environment (Blumer, 1969). These assumptions support explication of BSPs that are present when a nurse returns to work after SUD treatment because nurses use interpretive processes and create personal meanings of human interactions within the social context of the work environment.

Methodology

GT methodology is a qualitative research approach that explores and explicates social processes experienced by persons that lead to development of a model or theory grounded in the data collected in the field (Creswell, 2013). The study of human behavioral processes within challenging social contexts is suited to a GT approach when minimal knowledge exists about a topic area (Wuest, 2012). GT was used for this study because of its fit with the study's purpose, its emphasis on social interactions, and the societal impact of the topic. Researchers used an integration of theoretical approaches to GT (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998).

Institutional Review Board Approval

Institutional review board (IRB) approval for this study was obtained from the University of North Dakota. Because of the highly stigmatized content of this study, a waiver of signed consent was sought in the original IRB application to protect confidentiality and anonymity of participants. The consent form was presented and explained to each participant before conducting the interview. Understanding of informed consent was ascertained verbally and a written copy of the consent form was provided to each participant.

Participants

Purposive sampling, characterized by choosing participants who have knowledge and experience with the research topic, is recommended for use in GT studies (Morse, 2010). All participants met the following inclusion criteria: (a) held an RN license, (b) had completed at least one SUD treatment at a state licensed/approved SUD treatment facility, and (c) had reentered the workplace at the participant's professional level of entry in a work setting that required an RN license.

Recruitment

Participants were recruited through written announcements placed in various venues, including printed newspapers and recovery websites, Alcoholics Anonymous meeting sites, a recovery-focused church, and alumni websites of SUD treatment facilities. Snowball sampling (participants suggest or recruit subsequent participants who voluntarily make contact with the researcher for study inclusion) (Polit & Beck, 2012) was highly effective.

Data Collection

On the basis of the research purpose, demographic questions and a semistructured interview guide were created. Pilot interview findings suggested the addition of two demographic questions: Did the participant have preexisting medical conditions or history of trauma/abuse? Did the participant have leadership work expe-

riences? After demographic data were collected, the researcher began the audiotaped dialogue (personal story telling) with the statement, "Tell me about your experience of returning to work after [SUD] treatment." Eighteen (81.8%) of the 22 interviews were done face-to-face and four interviews were conducted via telephone. Length of interviews ranged from 45 to 90 minutes. All sessions were transcribed verbatim.

Analysis

Constant comparative analysis (Flick, 2014) was utilized to analyze transcribed data because it supports the researcher's ability to remain grounded in the data while moving between the micro and macro levels of data (Wuest, 2012). Constant comparative analysis examined relationships of shared experiences from participants' work reentry, the focus of the research (see Figure 1), a dynamic, interactive, and nonlinear process. Multiple sources of data were analyzed, including transcribed audiotaped interviews, discussions with content experts, and researcher-generated memos/notes with emerging tables/diagrams.

Three types of coding recommended by Strauss and Corbin (1990, 1998) for GT analysis were used in this study: (a) *Open coding,* a process of line-by-line examination of the transcribed data to identify categories; (b) *Axial coding* (conceptualization) and the use of subcategories to systematically think about relationships among categories focused on work reentry; and (c) *Selective coding*, the process of identifying the emerging core variable and linkages among the categories leading to a theoretical model (Strauss & Corbin, 1990, 1998; see Figure 1). The constant revisiting of multiple data sources supported the emerging core variable. Content experts agreed the emerging core variable was relevant. Rigor was enhanced through confirmation of preliminary findings by select participants (Polit & Beck, 2012).

Results

Study findings are categorically presented as: (a) demographic data, (b) findings based on the research foci (facilitators and barriers), and (c) the emergent theoretical model.

Demographic Data

Participants (N = 22) resided and worked in four different regions of the United States (the Midwest, the Southeast, the Southwest, and the South). The majority (81.8%, n = 18) were licensed in states of the Upper Midwest. The mean age of participants was 48.6 years, slightly older than the national mean age of RNs (44.6 years); four male participants accounted for 18.2% of the sample, two times higher than the national workforce statistic of 9.1%; over 85% of study participants were white, a higher percentage than the national statistic of 75.4% white RNs (Health Resources and Services Administration [HRSA], 2013).

TABLE 1

Participant-Identified Drug(s) of Choice

Drug (single)	%	*n*	Combination	%	*N*
Alcohol	22.7	5	Alcohol/ benzodiazepines	4.5	1
Opiates	41	9	Alcohol/opiates	9.1	2
Cocaine	4.5	1	Alcohol/THC	4.5	1
Methamphetamine	9.1	2	Methamphetamine/ cocaine	4.5	1

Note. THC = tetrahydrocannabinol.

Study participants were well educated, with over 40% (n = 9) having earned a graduate degree in nursing (nationally, the average is less than 11%) (Health Resources and Services Administration, 2013). Nineteen (86.3%) had worked as an RN for 11 years or longer. Leadership experiences included 17 participants (77.2%) having held management, administrative, or charge nurse positions in nursing.

Table 1 depicts participant self-identified drug(s) of choice. Central nervous system depressant use was predominant, as only three participants (13.6%) self-identified a drug other than alcohol or opioids as their drug of choice, a finding consistent in the literature (NCSBN, 2011). Opioid diversion from the worksite often resulted in the employer filing charges of theft that led to legal consequences for participants who were often terminated from employment. These charges, part of a public record, are viewed negatively by future potential employers.

Nineteen of the 22 study participants (86.3%) disclosed a concurrent or co-occurring medical disorder or history of trauma/abuse that occurred before the development of the SUD. (See Table 2.) Of these 19 participants, eight disclosed a mental health disorder or trauma/abuse history. The literature confirms that psychiatric disorders are known risk factors for SUDs (NCSBN, 2011).

Slightly over half (54.5%; n = 12) of the participants had been sober/abstinent from all drugs/alcohol for 5 years or less; five (22.7%) had long-term sobriety of 11 years or more. At the time of the interviews, 50% were currently being monitored by a state ATD program or the state BON, while two participants were monitored by two different state programs simultaneously. Eight participants (36.4%) had completed monitoring. Participants shared monitoring experiences from ten different states in the United States.

Findings Based on the Research Foci

The core variable and model of the BSP for successful work reentry emerged during analysis of all data sources. Embedded categories emerged from the personal stories of participants and evolved to the theoretical model. Findings related to facilitators and bar-

TABLE 2

Self-Disclosed Medical Conditions or Trauma History (*n* = 22)

	%	*N*
Present	86.3	19
Chronic pain	4.5	1
Headaches	13.6	3
Insomnia/sleep-related condition	13.6	3
Physical condition (unspecified)	13.6	3
Mental health disorder (depression, anxiety, PTSD, ADHD)	27.3	6
Childhood trauma/abuse	9.1	2
Combination of childhood abuse/PTSD and ADHD	4.5	1
Absent or not disclosed	13.6	3

Note. PTSD = posttraumatic stress disorder; ADHD = attention-deficit/hyperactivity disorder.

riers to work reentry are categorically discussed as external or internal.

External Facilitators to Work Reentry

Most of the five identified external facilitators to work reentry related to the importance of support during recovery and early reentry, reenforcing new positive behavioral patterns for participants:

- Most commonly discussed was the use of aftercare strategies and support, which stressed *"put recovery first."* Some participants who had been through treatment more than once voiced that putting in place extended treatment and multilayered aftercare services helped them keep their primary focus on recovery/sobriety as they planned a return to work. Recovery support systems were described by participants most frequently in terms of involvement in 12-step programs. When asked, "What advice would you give to other nurses who return to work after treatment?" participants often spoke of engagement in recovery programs: "Go to meetings." "Stay in touch with somebody else, with other recovery peers and talk about how it's going." "[Find] support in other people who are in recovery; other nurses and people who are in [a similar] kind of field, where there's support and understanding."
- Another external facilitator, *setting healthy boundaries,* was actualized in finding the means to take adequate time off between treatment completion and work reentry. One participant stated: "Take the time to get into good recovery." For others, healthy work boundaries entailed returning to work part time during the early phase of reentry so as to keep one's primary focus on recovery.
- For many, SUD treatment completion and keeping a major focus on recovery meant *reevaluation of their nursing career trajectories*. Some made the decision not to return to nursing positions in high-stress, fast-paced, acute-care settings, voicing the belief (often in hindsight) that finding a less stressful nursing position was vital to successful work reentry.
- Participants discussed the significance of meeting individuals who became important to their recoveries, termed by one participant as *turning point people.* These individuals often facilitated work reentry by pointing the participant to a job they ultimately obtained or by offering other critical support during early recovery.
- Some participants indicated that *positive encounters with staff employed at state BONs and ATD programs* impacted their self-worth in affirming ways, supporting courage and perseverance in reentering the workforce.

Internal Facilitators to Work Reentry

Internal facilitators focused on strong professional nursing identity, acceptance of the SUD disease process, openness and honesty, hope and perseverance, and valuing the importance of self-care strategies are presented below. The following points explicate their significance:

- *Deep pride in, commitment to, and strong identity with the profession of nursing* sustained some participants during periods of license suspension and the search for employment. Participants stated: "My career as a nurse is one of those things that gives me purpose and value." "Nursing was more than just what I did. It really was a big part of my identity…. It was also a source of great pride for me." "I love what I do…. I never thought I wasn't going to go back to it. I guess it really is a part of my identity."
- Many participants reflected on internal processes within themselves related to *acceptance of viewing themselves as an "addict."* Participants who had failed at work reentry before subsequent successful work reentry were particularly articulate in identifying positive behavioral changes made based on internalization and acceptance of viewing themselves as a person with SUD.
- Enhanced *willingness to being open and honest* about their SUD was identified by many as being closely tied to their individual programs of recovery; it was part of the internal process of confirming who they were as a person. Furthermore, nearly one-third of the participants shared that *personal honesty and accountability* were enhanced by mandated monitoring after SUD treatment and were important factors for successful work reentry.
- Coming to *value the importance of healthy self-care* was cited by participants as an internal facilitator and included diligent management of coexisting medical and/or psychiatric conditions.
- Presence of *hope and perseverance* during early recovery was also communicated as significant to successful work reentry. Participants voiced that these values are reinforced in the spiritual aspects of 12-step program support. A participant stated:

"I'm evidence you can come out the other side. It doesn't mean it's going to be easy, but there's hope."

External Barriers to Work Reentry

External barriers identified most often related to financial concerns, lack of education about SUDs among colleagues, prolonged regulatory management, and difficulty finding employment:

- There were *many financial stressors* experienced by participants because of SUDs. Commonly cited were the loss of jobs and health insurance, and the costs incurred by treatment, urine toxicology testing, and legal fees and/or representation. For some, these financial needs factored into the decision to return to work almost immediately following completion of SUD treatment. Returning to work before sound recovery was in place led to relapse and subsequent job losses for some participants.
- *Lack of education about SUDs* and observing or participating in discriminatory behaviors by nurses toward patients with SUD complicated workplace reentry. SUD educational deficits were noted among nursing peers, human resource staff, nurse managers, and worksite monitors and were identified as barriers to smooth transition to reentry.
- Participants often *waited many months for the state BON* to complete investigations, decide on disciplinary actions, and reach regulatory decisions about nursing license status. For many participants, these months of waiting intensified financial and emotional stressors.
- Finally, *difficulty finding a nursing position* after SUD treatment was common. This challenge was especially prevalent for nurses seeking positions in acute-care settings in large health care systems. Several participants could only find employment in small agencies providing mental health or addiction services despite having past experience in specialized acute-care areas of nursing.

Internal Barriers to Work Reentry

The interrelated concepts of stigma, shame, and fear were discussed most frequently by study participants as internal barriers to work reentry. The following bulleted points describe these findings:

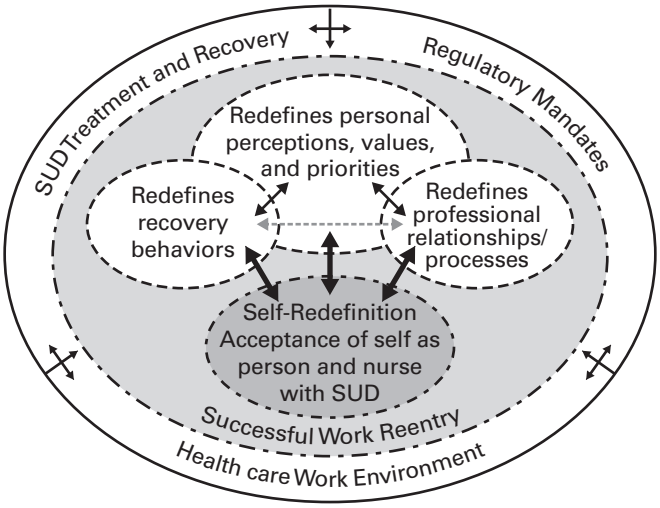
- Every participant discussed the negative impact of *stigma.* Public stigma was viewed as pervasive in the profession towards patients and nurses with SUD. Internally directed negative thoughts and feelings about being a part of a stigmatized group describes self-stigma. Both types of stigma led some participants to hide their abuse of substances and hindered them from getting help in a timely manner. Stigma was also a factor in not honestly disclosing one's SUD status at work, fearing adverse reactions from colleagues.
- Many participants discussed the hard work done in addressing *shame* during SUD treatment and early recovery. Participants especially found it difficult to deal with the shame of having violated their personal moral code and the professional *Code of Ethics for Nurses* (American Nurses Association, 2015). A participant stated:

  > I carried shame with me for a very long time. I did not buy into the disease concept. I thought it was a cop-out and that people in recovery were just using that as an excuse, that … if I just had more willpower, I wouldn't have done what I did. It took me a long time to get to the point where I could forgive myself and move forward.

- *Fear* was closely tied to stigma and shame for some participants and contributed to delays in getting treatment for SUD. Fear of losing one's nursing license and job was a concern voiced by a majority of the participants.

FIGURE 2

Theoretical Model of Successful Work Reentry



Note. SUD = substance use disorder.

The Emergent Theoretical Model

The distinct external and internal dimensions of facilitators and barriers, which emerged early in analysis, melded into a theoretical model that explicated: "What is the BSP an RN experiences in successful workplace reentry after completion of SUD treatment?" *Self-redefinition* was the core variable, defined as the perception and acceptance of self as a person *and a nurse* with SUD. This self-redefinition required a redefining of one's: (a) professional career, (b) recovery behaviors, and most significantly, (c) personal perceptions, values, and priorities. Use of internal and external facilitators while overcoming barriers supported participants' work of self-redefinition as "a nurse living in recovery," and supported successful reentry to the workplace. Reconciliation of this new identity with one's professional nursing identity was both challenging and necessary in order for participants to actualize successful work reentry.

Participants spoke of the struggle to find a balance between identity as a nurse and the emerging/changing self-identity as a person in recovery. A key factor in the success of self-redefinition was a willingness to redefine recovery behaviors and the perceptions toward them (i.e., positively initiate and practice recovery-based strategies that affect personal behaviors) while maintaining a positive professional view of self. This was voiced by one participant as: "I know I'm a good nurse."

Furthermore, values of hope for and perseverance in redefining one's self and professional roles connected with promising changes for participants, such as improved health and healed personal relationships. The presence of hope was an internal process driving self-redefinition and successful work reentry. This significant internal element grew as participants actively engaged in recovery activities; it also supported a change in self-appraisal of personal and professional identities from negative to positive.

The lines of the model (see Figure 2) depict porous boundaries and represent the flow between all model components of redefiniton. The three outer contextual foci are: (a) the SUD treatment and recovery environments, (b) regulatory mandates, and (c) the health care work environment. When participants held positive perceptions and values, and actively engaged in and adhered to role expectations of these contextual environments, the processes of behavioral and professional redefinition were more fully actualized, facilitating a positive work reentry outcome.

Discussion

Participants in this study shared examples of the pervasive nature of SUD and how it affects all aspects of a person's life. Experiences shared by participants and represented in the model illustrate that a holistic approach to living one's life as a person in recovery helped regain balance and changed one's definition of self. Attention to the emotional, physical, and spiritual aspects of health involved practicing self-care strategies and putting one's recovery as a priority focus. Placing "recovery first" supported self-redefinition and also resulted in participants viewing themselves as more effective nurses.

Today's complex nursing practice environments (social contexts) are often experienced by nurses as stressful. Many participants shared the widespread stigma towards SUDs within the culture of health care (perceived as stemming from lack of knowledge), citing that it contributed to workplace stress. Results of this study found greater work reentry success when participants were able to be open and honest about their SUD status at work. However, attempts to educate individual colleagues and reduce workplace stigma were challenging for most participants.

The nursing literature strongly endorses education as an effective strategy to change nursing and health care cultures related to stigma about SUDs (NCSBN, 2011). The critical need of expanding education about SUDs is a key implication derived from the findings of this study. Regularly scheduled continuing education on this topic for all nurses within health care systems is recommended. Additionally, curricular offerings on the topic of SUD in nurses for academic nursing education programs are needed. The vulnerability of nurses to SUDs due to stressful work environments (i.e., significant responsibilities in dealing with the unpredictable) should be one of the educational foci for such offerings. Promotion of stress management in the nursing practice workplace and support for use of healthy self-care strategies are also essential components for curricular offerings on this topic.

The role played by the state BON in the lives and experiences of nurse participants who successfully returned to work was significant. Participants voiced understanding and acceptance of the BON's regulatory role in enforcing protocols. Regulatory mandates and monitoring after SUD treatment provided structure and were viewed by some participants as a way to strengthen personal accountability and actions. Yet, participants from nearly every state represented in the study voiced frustration that decisions made by BONs took more time than participants anticipated, significantly increasing personal financial burdens. Study findings support the need for state BONs to evaluate their processes and timelines regarding disciplinary actions in order to design systematic protocols that operate more efficiently.

Policies and regulations of BONs and ATD programs vary greatly across the United States. These differences create difficulties in ascertaining common concerns, issues, and strategies from a national perspective. This inability to reach conclusions about the effectiveness of policies, treatment modalities, and monitoring strategies enacted in individual states blocks sharing of information nationally (Monroe et al., 2011). To further our understanding of nurses with SUD and to streamline policies, there is a need for greater communication among BONs, ATD programs, professional nursing organizations, and health care systems. Such communication would promote a greater capacity for regional and national exchange of research data. Furthermore, an increase in national dissemination of information about these issues into the nursing literature may support the development of recommendations to be implemented nationally and lead to enhanced understanding of how best to treat and support nurses with SUD.

Limitations

There was homogeneity among participants, as a majority of them (81.8%, n = 18) were licensed in one region of the country, thereby limiting maximum variation of location, which could be realized had this study accessed more participants in a wider territorial range. There was also homogeneity among study participants related to self-reported co-occurring medical conditions (physical and/or psychiatric) and history of trauma/abuse; this high percentage (86.4%) of comorbidities may have implications for SUD treatment facilities and the nursing profession and points to a need for further investigation. Inclusion criteria of the participants (only RNs with SUD treatment completion and a work reentry

experience in nursing) provided a boundary to the study and participant selection. Different perspectives could be noted with the inclusion of nurses who have left the nursing profession or who have failed to achieve and/or sustain sobriety/abstinence after SUD treatment.

Conclusion

This study is one of the first to examine work reentry processes from the experiential perspective of nurses after SUD treatment. Study participants were able to return to work successfully after adequate time was taken to formulate a solid foundation of recovery through self-redefinition as a person and nurse with SUD. Participants discussed numerous barriers and facilitators that influenced setting priorities and making choices about recovery and the reentry to work.

Stressful work environments and a workplace culture that stigmatizes patients with SUDs led to nurses internally feeling shame and hiding their own issues regarding SUDs, resulting in not accessing help in a timely manner. Additionally, return-to-work issues were challenging because reentry often occurred when the nurse was early in SUD recovery.

Additional work is needed from the nursing profession and health care systems to expand education about SUDs to all nurses and health care professionals. Development of strategies to support nurses with SUDs returning to the workplace after treatment is also recommended. Research is needed to elucidate and expand evidence-based programs for the unique treatment and recovery needs of nurses. The authors recommend that research be expanded across the United States for greater understanding of the intrinsic and extrinsic forces impacting the lives and careers of nurses desiring to reenter the workplace after SUD treatment.

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