

Addressing Substance Use Disorder for Anesthesia Professionals

Position Statement and Policy Considerations

Table of Contents	
Position	1
Purpose	1
AANA Peer Assistance Advisors Committee	2
Definitions of Common Terms	2
Background	2
Considerations for Creating a Substance Use and Drug Diversion Policy	3
Fitness for Duty and Maintaining Health and Wellness	4
Identify Those at Risk	5
Signs and Behaviors of Impairment and Drug Diversion	5
Harmful Consequences of Drug Diversion and Substance Use Disorder in the Workplace	6
Drug Diversion Prevention	7
Drug Testing	8
Reporting a Colleague to Supervisor or Appropriate Chain of Command	10
Conducting a Safe Intervention	10
Legal Reporting	12
Treatment Recommendations for Anesthesia Professionals	12
Reentry to Clinical Practice	13
Conclusion	15
References	15

Position

The American Association of Nurse Anesthetists (AANA) recommends that facilities address an important element of patient and provider safety through a comprehensive program and non-discriminatory policy that includes education to identify signs and behaviors and strategies to minimize drug diversion and substance use disorder. Substance use disorder should not be ignored, for patient and provider safety. The policy applies and is communicated to employed staff, contracted providers and students training at clinical sites.

If you are reading this document before a policy is in place to address a current situation, call the AANA Peer Assistance Helpline 800-654-5167 and if there is concern due to risk of imminent harm, call 911 immediately.

Purpose

The purpose of this document is to provide a resource for healthcare facilities, nurse anesthesia education programs, and healthcare professionals, including anesthesia professionals, to develop evidence-based policy regarding substance use disorder before a situation occurs.

AANA Peer Assistance Advisors Committee

Since 1983, the AANA Peer Assistance Advisors Committee (PAAC) has provided proactive support for issues related to substance use disorder. The PAAC is committed to educational endeavors and prevention of substance use disorder through informational support and resources. The AANA Peer Assistance Helpline 800-654-5167 responds to nurse anesthetists and students seeking help for substance use disorder, as well as a supervisor, colleague, or family member with concerns, by offering resources and support to help individuals be evaluated for appropriate, life-saving treatment.

To get help for yourself or a colleague, visit www.aana.com/gettinghelp

To view all PAAC resources, visit www.AANAPeerAssistance.com

Definitions of Common Terms

Substance-Use Disorder: Substance use disorder is a disease of the brain characterized by the recurrent use of substances (e.g., alcohol, drugs) that cause clinical and functional impairment such as health problems, disability, and failure to meet major responsibilities at work, school, or home as defined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).^{1,2} The disease involves a circuit of reward, withdrawal, memory and motivation and can be classified as mild, moderate or severe depending on the level of impairment.

Addiction: The most severe, chronic stage of substance use disorder, in which there is a substantial loss of self-control, as indicated by compulsive substance use despite the desire to stop using.^{1,3} Addiction recruits memory systems and motivational systems, weakens inhibitory systems and continues to stimulate use of substances. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Drug diversion: The transfer of any substance from the purpose for which it is intended for any illicit use (e.g., personal use, sale).^{4,5}

Impairment: The inability or impending inability to engage safely in professional and daily life activities as a result of a physical, mental or behavioral disorder (e.g., substance use, abuse, or addiction).^{3,6}

Background

In the United States approximately eight to ten percent of people ages 12 or older are addicted to alcohol or other drugs.¹ Substance use disorder, addiction, drug diversion and related impairment present threats to health and safety of the individuals misusing alcohol and drugs that may result in harm. An increasing concern is the deaths from overdose in the general population, which have more than quadrupled over the past 15 years.⁷ Overdose causes are complex, but most often include the over prescription of pain medications, which can lead to using medications in higher quantities or for another purpose than prescribed, using medications prescribed for someone else, or turning to the less expensive and readily available illicit drugs such as heroin and some containing highly toxic fentanyl.⁷⁻¹⁰

Substance use disorder is an occupational hazard of disproportionately greater risk among the anesthesia profession than in other practice specialties due in part to stresses of working in a demanding profession, increased availability of highly addictive medications, and possible environmental sensitization to the effects of such medications.^{4,11-14} An estimated 10 to 15 percent of all clinicians, including anesthesia professionals, will misuse drugs or alcohol at some time during their career.^{13,15} The full scope of the problem is likely underestimated due to the many factors that discourage disclosure such as stigma, potential for licensure restriction or loss, potential for legal action, and implications for patient care.^{13,11}

Substances such as opioids (e.g., morphine and fentanyl), inhalational anesthetics and volatile agents (e.g., sevoflurane, nitrous oxide), and intravenous (IV) anesthetic agents (e.g., propofol, which is not classified as a controlled substance) are readily available to anesthesia professionals to provide anesthesia services. Even with medication dispensing and audit controls in place, drugs may be diverted for misuse. Drug diversion may occur through procurement of medications directly from pharmacies, automated dispensing units, retrieval from sharps waste containers of medications remaining in syringes, diversion directly from patient medications, or indirectly through dilution of a medication to appear that nothing is missing from the original container.

Regardless of the substance abused (e.g., alcohol, opioids), impairment on the job can adversely impact patient and provider safety.¹⁶ Facility policy and education that address symptom awareness, prevention, reporting, safe intervention, and reentry to the workplace, when appropriate, may minimize the risk of substance diversion and minimize adverse outcomes. Policies that advocate for fair and uniform management of providers with suspected or diagnosed substance use disorder supports a safe environment for prompt reporting, appropriate treatment, and the possible reentry of the anesthesia professional into clinical practice.

Substance Use Disorder is a Disease not a Choice

Research has provided strong evidence that substance use disorder is a disease of the brain, for which there is no cure and that achieving short term and lifetime recovery is possible and the goal.^{1,16-18} Building and enhancing knowledge of risk factors and preventative coping mechanisms, as well as recognizing the signs and behaviors of impairment and drug diversion can help prevent patient and provider harm.¹

Considerations for Creating a Substance Use and Drug Diversion Policy

A policy that includes the following elements may discourage diversion and substance use, identify possible substance use to intervene to prevent death, and promote the well-being of employees and patients

- Promotes healthy behaviors to support professional responsibility to be fit for duty.
- Builds awareness of individual risk factors.
- Identifies behaviors and symptoms of substance use disorder and drug diversion.
- Acknowledges harmful consequences of substance use disorder, drug diversion and impairment in the workplace.
- Utilizes drug diversion prevention strategies
- Optimizes drug testing modalities (e.g., pre-employment, random, for-cause) to include testing for anesthesia drugs.

- Outlines safe reporting processes of impaired individuals through the appropriate chain of command.
- Facilitates a safe intervention for appropriate treatment evaluation.
- Addresses specific treatment considerations for anesthesia professionals.
- Clarifies reporting obligations to authorities and/or licensing boards.
- Requires specific criteria before consideration for reentry into practice.
- Assists with safe transition back to anesthesia practice that includes a return to work contract and monitoring plan.
- Maintains a safe, stigma-free workplace environment.

Visit AANA www.aana.com/SUDWorkPlaceResources for additional resources.

Fitness for Duty and Maintaining Health and Wellness

Overall well-being is the foundation of practice for nurse anesthesia professionals. Professional self-care to maintain fitness for duty is an essential underpinning to best practice to deliver high-quality, safe anesthesia care. Recognizing vulnerabilities and managing stress that puts individuals at risk for developing substance use disorders can help deter the use of harmful substances.¹⁰ Acknowledging personal vulnerabilities, taking precautions to reduce stress, and seeking help can mitigate the risk of developing unhealthy behaviors and destructive choices that can trigger substance use disorder and addiction.¹⁵

The nurse anesthetist is responsible and accountable for his or her actions, including self-awareness and assessment of fitness for duty.¹⁹ Healthy lifestyle choices can help maintain work/life balance and wellbeing to support coping mechanisms for effective resilience. The AANA Health & Wellness Committee provides education and resources that recognize personal and professional risk factors (such as substance use disorder, workplace and personal stress, physical and mental disorders) and promotes a balanced and fulfilling personal and professional life. For more information and resources, visit www.AANAWellness.com.

The following are some examples of healthy mind, body, and spirit lifestyle choices and coping mechanisms that can help anesthesia professionals maintain fitness for duty:

- **Physical:** manage health through regular, nutritious meals, physical recreation, and healthy sleep; take appropriate time off after injury or illness; avoid tobacco and drug use, limit alcohol consumption; protect yourself from disease and injury, and manage pain appropriately.
- **Emotional:** take vacation time when needed and enjoy life, practice stress reduction, mindful meditation, and positive reframing of the situation,¹⁶ be realistic, adjust expectations to prepare for changes,¹⁶ vent in moderation without ruminating on the issue,¹⁶ build resiliency, recognize and seek help for depression and suicidal ideation, manage finances.
- **Social/Spiritual:** build and cultivate relationships and support from friends, family, colleagues,¹⁶ connect to a spiritual community, practice volunteerism and altruism.
- **Workplace:** cope with critical incidents, disruptive behavior/bullying, ergonomics, career transitions, financial stress, safety, remain positive and make suggestions for improvements.

Identify Those at Risk

Access to highly addictive drugs is a significant risk factor for substance use disorder among anesthesia professionals and all healthcare professionals who have access to addictive medications. The anesthesia professional's risk is increased as he or she may have several of the general risk factors along with anesthesia-specific risk factors described below in Table 1.

Table 1. Risk factors for developing substance use disorder

General Risk Factors ^{13,17,20}	Workplace-Specific Risk Factors ^{4,11-13,20}
<p>Psychological</p> <ul style="list-style-type: none"> • Depression/anxiety • Low self-esteem • Low stress tolerance • Feelings of resentment • Addictive personality • Underlying psychological disease <p>Behavioral and Social</p> <ul style="list-style-type: none"> • Personal history of alcohol or medication misuse • Risk-seeking behavior • Maladaptive coping strategies • Trauma, isolation, abuse, lack of support system • Stressful work, home, community environment • Victim of bullying (e.g., work place, school) • Family history of substance use disorder and addiction • Family dysfunction • Unnecessary prescriptions of addictive medications, including opioids <p>Physical</p> <ul style="list-style-type: none"> • Acute or chronic pain <p>Genetic</p> <ul style="list-style-type: none"> • Inherited predisposition • Deficits in natural neurotransmitters • Absence of adverse reactions 	<ul style="list-style-type: none"> • Heightened stress of working in high-intensity environment (e.g., operating room) • Production pressure • Fatigue and burnout • Irregular work hours • Role strain • Inadequate work-life balance • Lack of education or resources about substance use disorder and curbing addiction <p>Anesthesia-specific</p> <ul style="list-style-type: none"> • Possible sensitization to the effects of opioids and anesthetic agents • Access and availability of opioids, benzodiazepines, IV and inhalational anesthetics in workplace • Unregulated, readily available propofol

Signs and Behaviors of Impairment and Drug Diversion

Early identification of substance-using anesthetists reduces the risk of harm to themselves, colleagues, and patients (see harmful consequences described in Table 3).¹³ Colleagues may be the first individuals to notice changes in behaviors, but may not be equipped to recognize the signs and behaviors that may be associated with substance use or impairment.^{16,21} Healthcare providers are often successful at disguising their issues or their signs are ignored because they are popular, respected, and intelligent.²¹ Suspicious or significant changes in behavior in the workplace may have many causes, and if subtle signs and behaviors of substance use disorder and drug diversion are left unrecognized, the provider may be placed in danger, patient safety may be compromised, and the organization may be placed at risk for liability. Signs and behaviors of impairment and drug diversion are described below in Table 2.

Table 2. Behaviors and signs associated with substance use disorder and drug diversion

Impairment ^{3,17,22,23}	Drug Diversion ^{*4,16,23,24}
<p>Behaviors</p> <ul style="list-style-type: none"> • Severe mood swings, personality changes • Frequent or unexplained tardiness, work absences, illness or physical complaints • Elaborate excuses • Underperformance • Difficulty with authority • Poorly explained errors, accidents or injuries • Wearing long sleeves when inappropriate • Confusion, memory loss, and difficulty concentrating or recalling details and instructions • Visibly intoxicated • Refuses drug testing • Ordinary tasks require greater effort and consume more time • Unreliability in keeping appointments and meeting deadlines • Relationship discord (e.g., professional, familial, marital, platonic) <p>Signs</p> <ul style="list-style-type: none"> • Physical indications (e.g., track marks, bloodshot eyes) • Signs indicative of drug diversion* (see right column) • Deterioration in personal appearance • Significant weight loss or gain • Discovered comatose or dead 	<p>Behaviors</p> <ul style="list-style-type: none"> • Consistently uses more drugs for cases than colleagues • Frequent volunteering to administer narcotics, relieve colleagues of casework, especially on cases where opioids are administered • Consistently arrives early, stays late, or frequently volunteers for overtime • Frequent breaks or trips to bathroom • Heavy wastage of drugs • Drugs and syringes in pockets <p>Signs</p> <ul style="list-style-type: none"> • Anesthesia record does not reconcile with drug dispensed and administered to patient • Patient has unusually significant or uncontrolled pain after anesthesia • Higher pain score as compared to other anesthesia providers • Times of cases do not correlate when provider dispenses drug from automated dispenser • Inappropriate drug choices and doses for patients • Missing medications or prescription pads • Drugs, syringes, needles improperly stored • Signs of medication tampering, including broken vials returned to pharmacy

Harmful Consequences of Drug Diversion and Substance Use Disorder in the Workplace

Healthcare professionals are responsible for the safety of patients, which includes the duty to deliver care without impairment.^{6,12} Impairment and drug diversion in the workplace can create an environment of disorganization, demoralization, and promote feelings of betrayal among staff, which can adversely impact patient safety and quality of care.²⁵ There are significant harmful consequences when substance use and drug diversion occurs in the workplace for patients, professionals, colleagues, family, friends, communities, and the facility. The consequences directly related to the workplace are described below in Table 3.

Table 3. Harmful consequences of drug diversion and substance use disorder in the workplace

Consequences ^{4,23,26}	
Patient	<ul style="list-style-type: none"> • Undue pain, anxiety, and side effects from improper dosing • Allergic reaction to wrongly substituted drug • Communicable infection from contaminated drug or needle • Victim of medical errors (e.g., medication, procedural) • Loss of trust in the healthcare system
Impaired Professional	<ul style="list-style-type: none"> • Adverse health effects (e.g., respiratory depression, organ failure, death) • Chronic health effects (e.g., liver impairment, heart disease) • Communicable infections from unsterile drugs, needles, injection techniques • Accidents resulting in physical harm • Familial and financial difficulties • Loss of social status • Decline in work performance and professional instability • Felony prosecution, incarceration and civil malpractice • Actions against professional license • Billing or insurance fraud
Colleagues	<ul style="list-style-type: none"> • Injury or infection from blood borne pathogens due to improperly stored equipment (e.g., needle sticks) • At risk for medico-legal liability secondary to shared patient-care responsibilities with an impaired professional, resulting in adverse patient outcomes • Stress due to an increased workload from impaired professional absence • Disciplinary action for false witness of leftover drugs disposal or failure to report impaired professional
Facility	<ul style="list-style-type: none"> • Costly investigations • Loss of revenue from diverted drugs or reimbursement from adverse events due to impaired provider • Poor work quality or absenteeism of the impaired healthcare worker and paying overtime to cover the worker's shifts • Civil liability for failure to prevent, recognize, or address signs of drug diversion or of an impaired provider • Civil liability for patient harm • Damaged reputation due to public knowledge of mandatory reporting or highly publicized drug diversion instances, especially those that led to patient harm • Increased worker's compensation costs

Drug Diversion Prevention

Vulnerability to drug diversion exists when a provider is free to engage in drug procurement from central stores, drug preparation, drug administration to patients, and disposal of drug waste.^{5,27} System-wide initiatives that prevent and identify diversion of controlled substances allow healthcare facilities to promptly intervene when diversion is occurring. These systems require close cooperation between multiple stakeholders, such as departments of pharmacy, safety and security, anesthesiology, nursing, legal counsel, administration, and human resources.

In an effort to discourage drug diversion, inform all employees, contractors and students practicing at clinical sites that protocols are in place to detect and prevent drug diversion, with the primary objective of preventing patient harm. Policies that advocate for fair and uniform management of providers with substance use disorder help create a safe environment for prompt reporting, appropriate treatment, and the potential for the reentry of the anesthesia professional into clinical practice. Practices that may be implemented to help prevent diversion in the workplace are described below in Table 4.

Table 4. Considerations for drug diversion prevention strategies

<ul style="list-style-type: none"> • Institute random drug testing • Install automated drug dispensers to control excess amounts of drugs from being administered^{4,23} • Return all unused medications to a centralized location⁴ • Secure return bins so that unused portions of drugs could be submitted for subsequent random quantitative drug assays before destruction⁴ • Audit anesthesia records to identify outliers using excessive drugs, particularly opioids • Witness disposal of excess waste from medications dispensed and randomly assay waste • Collaborate with other departments (e.g., pharmacy, supply chain management) to create systems to reconcile waste volumes with the dispensing records and patient anesthesia records⁴ • Investigate medication discrepancies (e.g., automated information management)^{4,23} • Withdraw substances for only one patient at a time and administer immediately to patient²³ • Implement policies and procedures for investigations and for managing the many possible outcomes of a confirmed diversion⁴ • Create a safe environment for prompt reporting, including self-reporting, which may result in less punitive outcomes, can discourage continued drug diversion

Drug Testing

Facilities that implement random, for-cause and pre-employment drug testing, within the limits of applicable federal (e.g., Americans with Disabilities Act), state, and local law, as the basis of an effective policy may prevent, deter and detect misuse of substances and drug diversion.^{12,21,28-31} A description of various drug testing modalities is provided below in Table 5. Please consult legal counsel for legal review of drug testing policies and processes.

Table 5. Description of pre-employment, random and for-cause drug tests

<i>Pre-Employment</i>	<ul style="list-style-type: none"> • Predictably scheduled, typically as a condition of employment. • Misses drug use that begins after employment.³² • May deter individuals from using substances, however the predictable, scheduled time makes it easier for impaired individuals to deploy strategies to subvert the test.^{21,33}
<i>Random</i>	<ul style="list-style-type: none"> • Unpredictably scheduled • Administered in a non-discriminatory manner to individuals regardless of whether there is reason to suspect substance use disorder.³² • Compared with pre-employment and for-cause testing, the value of drug testing is improved because individuals do not know when they will be tested, which may deter misuse of substances and drug diversion, especially first-time use, for fear of being caught.^{34,35}
<i>For-Cause</i>	<ul style="list-style-type: none"> • Administered when there is reason to suspect substance use disorder. • While the test may confirm suspicion of substance use, it is not effective in preventing use of harmful substances and impaired individuals may deploy strategies to subvert the test.³³

Facility policies can optimize the validity of testing processes with the following practices:

- Provide pre-employment notification with individual’s signed acknowledgement of facility drug testing policy.
- Select individuals for random testing without human interference.
- Notify individuals of an immediate testing time with escort to an observed testing site for specimen collection.³⁶
- Request disclosure of any legal prescribed drugs or substances they are using that may impact test results.
- Consider privacy in all drug testing settings.³⁶
- Use testing protocols and an extended panel, especially for anesthesia providers that identify anesthesia drugs not commonly detected on standards tests (e.g., fentanyl, propofol).³⁷
- Collaborate closely between the laboratory and medical review officer to help ensure that the best test is being ordered and the results will be interpreted appropriately.³⁷
- Ensure proper chain of custody and prevent tampering of sample.
- Implement protocols for handling false positive and true positive results, including processes to challenge results.
- Provide opportunity for appropriate intervention and treatment arrangements.³³
- Refer impaired individuals for evaluation for substance use disorder by a properly trained addiction professional, without jeopardizing employment, in the event of a positive result.

Facility policies detailing drug testing should be in compliance with practices outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines and all applicable laws, and use a lab that is certified by the U.S. Department of Health and Human Services or an equivalent state agency.³⁸ Practices outlined by these organizations can help alleviate concerns of a false-positive test damaging careers.²¹ Seeking legal consultation in the development of drug testing policies will help ensure compliance with legal and regulatory requirements and mitigate common concerns with drug testing, which are described below in more detail.³⁹

- Variable detection windows depending on dose, sensitivity of the test method, route of administration, duration of substance use, and variability between individuals.¹²
 - May miss infrequent substance use
 - Standard drug tests do not test for anesthetic substances such as propofol and fentanyl, which are often drugs of choice due to availability⁴⁰
 - Substances such as propofol have short half-lives and require testing via blood draw promptly after use⁴⁰
- Time consuming, expensive and a personnel-intensive procedure
- Potential for issues with regards to the chain of custody of samples by the laboratory
- Time lag between sample collection and test results, making it difficult for a timely intervention.

Reporting a Colleague to Supervisor or Appropriate Chain of Command

Ideally, the anesthesia professional will acknowledge his or her condition, seek help voluntarily, and not require intervention. However, this is often not the case due to denial of condition, stigma, fear of job loss, and other ramifications. Therefore, colleagues play an important role in helping the impaired provider get into treatment.^{22,41} Colleagues are often reluctant to report a suspected colleague for a variety of reasons, such as believing someone else is addressing the issue, it is not their responsibility, the individual will be punished excessively; fear of retribution and being responsible for their colleague's loss of job or license; or lacking knowledge of how to properly report or intervene.³² The AANA Peer Assistance Helpline (800-654-5167) is available for administrator or colleague concerns and questions related to the safe handling an individual struggling with substance use disorder.

Communication forums where individuals can safely and confidentially voice their concerns can empower them to report an individual suspected of substance use disorder and potentially save a life by preventing death from overdose. Maintaining regular departmental operations and promoting confidence among affected staff after a colleague has been removed from practice and placed into treatment can facilitate the provision of optimal and safe patient care.¹⁶

Colleagues may have certain legal responsibilities in identifying and reporting providers to their supervisor or appropriate chain of command.^{6,16} States may have reporting laws which hold colleagues responsible for harm to patients if they fail to report a coworker in whom substance use disorder is suspected. Outline proper steps in facility policies to help guide informants on how to report an impaired colleague, ensure confidentiality of the informant, and offer guidance for investigating and evaluating the credibility of the allegation.⁴² More information on reporting is described in the section below, *Legal Reporting*.

Conducting a Safe Intervention

Critical components involved in an effective intervention need to be in place prior to confronting the individual, which means coordinating a large number of variables. If an individual is suspected of impairment or drug diversion, the facility should follow all appropriate laws and conduct a thorough, objective investigation and plan an intervention to facilitate transition into a treatment program for proper evaluation for treatment. Ideally the intervention will be planned, although some situations may warrant conducting a crisis intervention, (e.g., impaired during patient care, threats to harm themselves). Details on how to proceed with a planned or crisis intervention are described in Table 6. Simulating interventions (e.g., during grand round presentations) may help to train staff to be better prepared to intervene, whether in a planned or crisis situation.²¹

Assistance for safely handling an individual struggling with substance use disorder is available by contacting the AANA Peer Assistance Helpline 800-654-5167.

Gathering Evidence

Suspicious or significant changes in behavior in the workplace may have many causes; therefore, it is important to have proper evidence that supports the notion of substance use disorder or drug diversion.²⁹ Ensure evidence is documented and convincing, sequential and substantiated, including specific dates and occurrences and accounts from multiple witnesses, if available.

A thorough, nondiscriminatory investigation of the individual suspected is accomplished by:

- Reviewing work behaviors and performance evaluations
- Analyzing utilization of controlled substances
- Documenting changes in appearance and suspicious behaviors, including dates and times
- Collaborating with various departments (e.g., surgery, nursing, pharmacy) to gather evidence

When evidence supports a case of substance use disorder or drug diversion, arrange an intervention and remove the individual from clinical practice.^{43,44}

Assembling an Intervention Team

Assemble an intervention team with a common goal of supporting the individual using people who care about the individual's well-being.⁴⁵ Best practice is to involve a trained interventionist during all points of the intervention; however, during a crisis intervention where there is little time to act, this may not be possible. If possible, contacting an interventionist to coordinate the process should be the first course of action. Sensitivity to the needs of the individual being confronted (e.g., gender, age, ranking) and involving individuals who will make them feel the most comfortable is important to creating a supportive environment.²⁹ Recommendations of individuals to be present during the intervention include:

- Trained interventionist
- Colleagues in recovery (if available)
- Supportive family, friends, and colleagues
- Clinical supervisor
- Administrative supervisor
- Representative from human resources and/or employee assistance program
- Member of security department may be available if there is a particular safety concern

Facilities may have a designated individual or group (e.g., employee assistance programs) with sufficient expertise to assist in interventions.²⁹ Confirm the scope of these services before utilizing them for interventions.

During the Intervention

The intervention is an opportunity to present organized and irrefutable evidence in an atmosphere of care and concern for the individual, where the individual can be empowered to admit their problem, accept help and transition into treatment. These situations are extremely sensitive and must be handled with caution and without coercion to avoid further harm.²⁹ Handle all interventions in a professional, uniform, nondiscriminatory manner. It is important to confront the individual who is suspected appropriately and in a safe environment to facilitate an effective intervention.

Individuals may become suicidal once the gravity of the situation becomes apparent. Avoid cornering the individual and questioning him or her about suspicious behaviors, and refrain from removing the individual from practice without any plan for treatment evaluation. Never leave the individual alone until evaluation for treatment, and do not allow leaving the intervention unaccompanied.²⁹ Facilitate transfer to a facility for proper treatment evaluation. Table 6 provides an overview of how to facilitate a safe intervention, whether it is planned or conducted in a crisis.

Table 6. Overview of facilitating a safe intervention²⁹

Planned Intervention	Crisis Intervention
1. Assemble an intervention team, including a trained interventionist.	1. Do not let the person out of your sight! Do not let them drive!
2. Gather all the evidence.	2. Get a properly collected drug test.
3. Invite the individual into an intervention meeting. Do not let the person out of your sight! Do not let them drive!	3. Include a trained interventionist, family, spouse, and colleagues.
4. Get a properly collected drug test, if necessary.	4. Bring all evidence.
5. Have a bed in a treatment facility ready.	5. Have a bed in a treatment facility ready.
6. Do not let the impaired individual decide treatment. Remember, they are sick.	6. Do not let the impaired individual decide treatment. Remember, they are sick.
7. Only when all else fails, threaten to call the police. Often, this will cause the individual to admit that he/she has a serious problem.	7. Only when all else fails, threaten to call the police. Often, this will cause the individual to admit that he/she has a serious problem.

Legal Reporting

Since the priority is to get the impaired individual evaluated and into treatment safely, reporting to the proper state medical or nursing board can usually wait until after the individual is safely in treatment. Most states have programs that promote treatment and rehabilitation of impaired providers as an alternative to disciplinary action.^{22,46} Programs vary by state; some programs are housed within the board of nursing, while others are not. Although it is important that facilities are aware of their state’s reporting process, the priority is to get the impaired individual safely into treatment.^{16,22}

- Not every state requires reporting unless patient harm has occurred. Therefore it is important to review state law to determine responsibilities in reporting an individual, versus the impaired individual self-report to the state’s alternative program and/or state board of nursing.^{20,29,45}

- State requirements should not preclude filing a complaint if it is believed the impaired individual presents danger to themselves or others.²⁹
- Confidentiality must be exercised with disclosure only to appropriate authorities.^{29,45}

Treatment Recommendations for Anesthesia Professionals

Due to their direct access to potent drugs and knowledge of pharmacology, anesthetists present unique challenges for treatment and recovery compared to other practice specialties.⁴⁰ They also face potential loss of profession, professional guilt and shame, and a tendency to intellectualize the treatment process.^{20,40,46}

The most desirable inpatient rehabilitation treatment program has experience treating healthcare professionals, specifically anesthesia professionals.²⁹ Completion of a minimum of 28 days inpatient treatment with at least 90 days of treatment total (inpatient or outpatient) offers the highest success rate.²⁰ An ideal treatment center for anesthesia professionals includes:

- Approval by the state board of nursing⁴⁰
- A comprehensive evaluation and treatment recommendations by an American Society of Addiction Medicine (ASAM) member certified by the American Board of Addiction Medicine (ABAM) who is committed to evaluating and treating anesthesia professionals in abstinence based recovery models in accordance with other safety sensitive occupations such as aviation, department of defense and department of transportation^{13,20,29,45}
- Evaluation by an American Academy of Addiction Psychiatry (AAP) board-certified addiction psychiatrist where appropriate^{20,45}
- Appropriate neuropsychiatric and or psychometric testing²⁰
- Medically supervised detoxification, when clinically indicated²⁰
- Treatment for mental health comorbidities^{20,29,47,48}
- Emphasis on a long-term 12-step model of abstinence-based recovery^{13,49,50}
- Evaluation of suitability for, and timing, of the return to anesthesia practice²⁰

Reentry to Clinical Practice

Intensive inpatient treatment and subsequent follow-up care increases possibility of recovery for healthcare professionals with substance use disorder.³ Upon completion of a rehabilitation program, a safe return to work in anesthesia can be facilitated on an individual basis. Not all practitioners will be able to return to practice. Reentry challenges an anesthesia professional may encounter include stigmatization, shame, working with choice substances, and unresolved pain, all contributing to the threat of relapse.^{13,51,52} Furthermore, the Americans with Disabilities Act (ADA) provides limited protection from employer discrimination against individuals in recovery, further compounding the issue.³⁰

Readiness for reentry is a collaborative decision of the monitoring program, a certified drug and alcohol counselor, and the employer.⁴⁸ A minimum of one year in recovery before returning to the clinical anesthesia arena is recommended.^{13,48,49} The following criteria should be met prior to considering re-entering practice:

- Evaluation by a licensed provider with experience treating substance abuse and dependency^{13,47,48,53}
- Successful completion of a rehabilitation program^{13,48}

- Acceptance of the chronic nature of substance use disorder
- Evidence of a supportive spouse, significant other, or other supportive individuals⁵⁴
- Willingness to take Naltrexone, if appropriate, under direction and supervision of medical professional^{29,46,47}
- Having no untreated psychological comorbidities^{48,50}
- Participation in a monitoring program with random drug testing.^{49,51}
 - Recovery is improved when random drug testing occurs because of the consequences of a positive test.¹²
 - Five-year duration of monitoring with the potential of monitoring for the duration of clinical practice^{29,49}
- Having supportive colleagues, especially administrators and supervisors, at worksite familiar with history and needs^{20,52}
- Grounding in a recovery community, such as [Anesthetists In Recovery](#)^{46,48}
- Participating in a 12-step program⁵⁴

Because anesthesia professionals are engaged in safety-sensitive work with considerable consequences when errors occur, abstinence-based recovery and refraining from substitute treatments such as buprenorphine are recommended.⁵⁵

Disclosure and Return to Work Contracts

Disclosing recovery status to an employer or potential employer is important to gain support and obtain protection from legal repercussions.⁴⁸ Open disclosure may remove the stigma of shame and gives colleagues the opportunity to extend the same care and compassion to a recovering colleague as they do their patients.⁵⁴ Recovering anesthesia professionals may have a difficult time gaining employment after disclosure of their history and managers may not be willing to monitor them in practice.⁴⁰ Various state laws may impact the anesthesia professional's ability to return to full scope of practice in their state.

A return-to-work agreement is highly predictive and supportive of successful reentry into the clinical workplace.²⁰ Include the following stipulations in contracts defining terms of practice reentry:

- Length of the contract
- Phases of the clinical reentry plan, which outline practice restrictions and milestones
- Consequences of failure to comply with contract stipulations
- Plan for treatment (if the contract is signed at the time the anesthesia professional's substance use disorder is first detected) and aftercare⁴⁹
- Practice restrictions, such as no overtime or extra call and limiting administration of narcotics for a period of time^{13,40}
- Supervision requirements⁴⁸
- Random drug testing requirements⁴⁷
- Mandatory attendance at support group meetings
- Job performance standards
- Provision for periodic evaluation meetings with direct supervisor
- Steps to be taken in the event of relapse
- Regular reports from supervisors or work-site monitors
- Monitoring with state board of nursing

Relapse Prevention

Job dissatisfaction and overall stress may be an indicator of potential relapse, especially for the anesthesia professional who is working with substances they formerly abused. Managing stress, and maintaining healthy lifestyle habits (e.g., fitness, nutrition), and support of peers can help prevent relapse.⁵² Additionally, managing triggers to substance use can also help mitigate incidents of relapse.^{52,56} A scale to measure job satisfaction can give the employer and practitioner a score for job satisfaction and alert employers and practitioners of potential relapse due to the level of stress or burnout.⁵¹

Conclusion

Substance use disorder and impairment in the workplace can result in harm to the impaired individual, their colleagues or patients. Education, random drug testing, and drug diversion prevention can help deter substance use disorder and get individuals safely into appropriate treatment. Not all practitioners will be able to return to clinical practice. Those who do return to practice may encounter stigmatization, shame, and work with their choice substances, all contributing to the threat of relapse. Developing facility policies that address awareness, prevention, reporting, and safe intervention and management of impairment in the workplace is a key step in the prevention of adverse outcomes. Policies that advocate for fair and uniform management of providers with substance use disorder help create a safe environment for prompt reporting, appropriate treatment, and the potential for reentry of the anesthesia professional into clinical practice.

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The *Substance Abuse and Chemical Dependency* position statement was adopted by the AANA Board of Directors in 1984 and revised in 1998, 2007, and November 2011. In July 2016, the AANA Board of Directors archived the position statement and adopted *Addressing Substance Use Disorder for Anesthesia Professionals*.

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