Past Event: 2026 NCSBN Scientific Symposium - Impact of Employee Assistance Programs on Substance Use in Nurses Video Transcript

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- [Alison Trinkoff] Hi, everyone. I'm Alison Trinkoff from the University of Maryland School of Nursing, where I'm a professor, and I'm pleased to present this study to you today, "Findings From the Employee Assistance Providers," who I'll call EAPs from now on, "and Nurses in Healthcare."

I'd also like to acknowledge my colleagues, where if you see below, are shown. Certainly, the funding from the National Council of State Boards of Nursing, without which I couldn't have done the study. As some background, nurses endure a lot of occupational stress and burnout. The pandemic just made all of that even worse, and these factors can increase the risk of substance use disorders among nurses.

Now, as it turns out, about 90% of people that are working have some kind of access to EAP services, but we don't know a lot about how well they support nurses with substance use problems. So therefore, we were funded to conduct this study. The study had two aims. One was a quantitative aim, a survey, where we wanted to figure out what EAPs do and how they support nurses who have substance use disorders or SUDs.

And we also explored communication and collaboration among different stakeholders that work on this problem for nurses, and this was a qualitative set of interviews, and I will be actually devoting most of my presentation to those results. As you can imagine, we had an IRB Consent Form for participation in the study, and we had an NIH Certificate of Confidentiality which gives additional protections to people participating, especially if there's any sensitive data.

For the first aim, the sample came from two employee assistance professional organizations, and we received 179 responses that we were able to use for a 17.3% response rate. For some results, the EAP providers were generally in three different types of organizations. An internal EAP is one where it is part of the company, the hospital, the facility, such as at University of Maryland.

Here, we have an EAP for employees. An external EAP is one that has really no connection to the organization. It might be a separate provider group for behavioral health, and there's many other formats

that they take. It could also be an independent provider that does EAP services. And then hybrid is kind of a combination of the two.

There might be some internal services offered, but then they tie in or link with another organization if more extensive services are needed. As terms of the qualifications of the EAP providers, most were highly qualified, and part of that could be because our sample came from EAP professional organizations. In this group, 84% had some kind of professional credential, and they really do vary.

Almost all had substance use training, and 59% served nurses as clients. And of those, 43%, so a good group, said they had at least 10% or more of their caseload as nurses.

This is just an overview of what was offered. The most common services that EAPs offered were brief interventions with assessments for drug or alcohol problems, counseling, which can be part of a treatment package for people with substance use problems, referrals to other agencies or providers. And then a little, also highly prevalent but not as common, monitoring services, maybe where they check in with people as they go through treatment in or out of the workplace.

And then aftercare, people who are in recovery and returning, they link in with them. Less commonly seen were a universal screening type of activity, medical treatment, or toxicology type of drug screening activities. In terms of specific EAP services that would be used for nurses or a benefit to nurses, almost two-thirds had return to work services where they link in with employers and liaison maybe with boards to provide monitoring and oversight.

Liaison with employers, over half, and about a third are connecting with boards. Monitoring is being done and aftercare as well, and some of these services are overlapping. Now I want to go to the qualitative interviews for the rest of the talk. Our purpose for this was to find out how different stakeholders that are working to support nurses with substance use are interacting and figure out ways to improve recovery pathways for those who are recovering.

The qualitative interviews, we had a sample of 23 stakeholders. We also had four additional interviews that we used as a pilot and did not analyze those as part of the sample. The stakeholders were quite varied. The EAPs, in addition, we had board of nursing staff, Alternative to Discipline staff. Those are people in peer assistance programs or substance use programs for nurses where they can get treatment, but their license is not revoked.

They can maintain their license as long as they meet certain treatment milestones. And then employers, treatment providers, and recovering nurses. Our design was to have semi-structured interviews where we asked a certain set of questions for everyone, but they were very open-ended and you never really knew what direction they were going to take. They were always informative.

So the longest one was an hour, and we aimed for 30 to 60 minutes. We used a special data analysis called rapid coding to analyze the results. We organized it by different domains, which I'll get to in a minute, and the type of stakeholder. And that allowed us to see across the different stakeholders and as well within a stakeholder group, sort of the variety of services offered and responses.

In general, we looked from EAPs outward to the different groups and how they were interfacing, but we also heard a lot of really important and interesting information from people about how they were interfacing with others. So employers might be working with boards of nursing and Alternative to Discipline programs, as well as recovering nurses and EAPs.

So it was kind of an interesting network and mix but has a lot of potential from our point of view. In terms of EAPs and employers, just to kind of set things up, the collaboration was quite uneven. In some places, the EAPs and the employers worked really closely together and they also worked with treatment providers.

Now, other employers have a zero tolerance policy, meaning any hint or idea that there's some substance use going on just is a cause for firing the nurse, and then they have no interactions with EAP or treatment at all. The person's gone and they don't get into any of these other things. From the recovering nurse perspective, I just wanted to weave in a few things that we learned, their trust in EAPs was mixed.

People sometimes viewed an internal one that's in your workplace as possibly conflicted. Some people feel that an internal one is good because they understand the work and the situation, and they know the people to go to in leadership and who to work with to have a good, smooth effort to support nurses. But others feel like externally, at least we don't have any connection obvious with the organization, although sometimes their services are a little more limited.

In terms of available services, some nurses said they didn't know about what was offered and they didn't realize that they could have had certain things. An issue, especially in the zero-tolerance places, was real fears that they could lose their job, the stigma of having all that around it and being tied to job loss, and then just worrying about help-seeking and somehow being thought of as less than.

And the EAPs did use confidentiality agreements to ensure that they kept all of the work private and obviously, while that is excellent, if the nurse doesn't feel comfortable with that or there's a trust situation, they still may be wary. As far as findings, here were the domains that we used to assess the content.

First of all, how well the different stakeholders are communicating and collaborating. What are some challenges that they encountered? What was helpful? What kind of policies and practices made it, you know, worthwhile and seemed promising? And then stakeholder recommendations.

What do they recommend and suggest? And what's exciting about the study is we really hear in their own terms. We're not sitting there making suggestions or dropping ideas. It really came from them in terms of what they think could help make everything even better. The first domain that we looked at was communication and collaboration among the stakeholders. The confidentiality emerged as something that helps people seek help early but it also limits information sharing.

So for instance, if the EAP access is sought early by a nurse, they have a confidentiality policy, so they don't share with other agencies or stakeholders. However, there are releases, and if a nurse signs a release, then they can work with other agencies as permitted by that recovering nurse. So that gives them control over the dissemination of information related to them.

Coordination across EAPs and all these others are often fragmented. Some of the quotes, the main issue was the limited information sharing for those outside of EAP, "We start working with nurses, and we don't know what has happened so far." That was from an Alternative to Discipline person.

And from a board member, "If employers don't report, nurses can hop to other jobs and avoid treatment until something bad happens." For the second domain, treatment and recovery challenges, as I've alluded to, the termination policies often removed access to treatment resources altogether because in our workplace in the U.S., your insurance and coverage is often tied to your job.

So once you are terminated, you no longer have access to the benefits of your work, and that includes EAP. We did not find any EAP providers who were able to give services to anyone that was no longer considered an employee in the organization. Financial burdens for monitoring and testing made it sometimes hard for people to complete their contracts in terms of what they were supposed to accomplish for their recovery.

So if they couldn't pay for... Let's say there's testing that's outsourced, and it's often private and quite expensive, and they weren't working, they may have had to terminate their contract. And that's sad because it had nothing to do with their motivation or willingness to complete the milestones. Re-entry obstacles also restrict return to practice after recovery.

Some places will not hire nurses that have been known to have such problems, so that was another obstacle to overcome. Some quotes, "The whole opportunity to provide support was dismantled." As I alluded to earlier, the employees are terminated, and their insurance terminates immediately, so there's nothing they can do.

"A mark during background checks," was mentioned by recovering nurses, "which led employers to withdraw job offers." So they might have secured a job after they were in recovery, and then something comes up in a background check, and the job is withdrawn. Domain three had to do with helpful practices currently in use.

The main things that emerged were Training on how best to support people with substance use for leadership, what to do in terms of reporting, whom to report to, how to interface with EAP, etc. And for human resources people, they are often tasked with handling new employees. So if a recovering nurse is going to be employed in a new organization, it's really important for human resources to understand evidence-based treatment policies because there were some concerns that human resources folks were resistant to hiring people in recovery, even after they were cleared by the board and/or alternative programs to participate as the job was designed.

So that would be really helpful. In addition, making sure everyone knows what resources are available and the confidentiality that goes with them. Because when nurses have a problem, it can become very difficult to try to reach out and figure out what's available.

So the idea would be before anyone needs anything or early on to be proactive and present these resources to everyone on a regular basis. In terms of the stakeholder quote, "Reporting your concern should be viewed as a blessing by allowing nurses to recover instead of feeling like you're, you know, telling on somebody." Unfortunately, that gets blurred in an organization with punitive policies.

But the idea to instill for leadership that this is something you want to do because you want to help that person get care and get safer and at the very least, be assessed because maybe there are other concerns going on. They could be anything financial, mental health, and other well-being issues that can be assessed by EAP in a confidential format.

And the last one is stakeholder recommendations. They gave us many wonderful ideas as to what could be done and how to improve things, and that would be not just for them but also for the recovering nurse. First of all, non-punitive workplace policies really emerged. Even in some places where they have a punitive policy, they said, "I wish we had something else."

So replacing termination with some kind of treatment-focused response for recovery and retention. Keeping nurses employed was something people came back to. That allows them to stay in treatment and return safely to practice. Early identification and education and outreach, they kind of go hand-in-hand.

Help people know what's out there so if they or a colleague need services, they know where to go. And supervisors also need that assistance, what to do, how to refer people confidentially, especially in the punitive organizations, but really everywhere. The attempt to maintain coverage during treatment is so important because that's the main way people are going to be able to continue.

If financially it cannot work, they won't stay in the program, and you could lose a valuable resource and a valuable nurse. Structured return-to-work pathways, the clear plans of what's going to happen, that helps everyone. What's difficult is with the punitive firings, the person often cannot return to that organization, unfortunately.

But for those organizations who do engage with nurses that have these problems, they're often able to have them re-enter, practice safely, and everyone wins. As I have heard before, the saying, "Often the ones with problems are some of our best nurses," so the potential is there. And the last is strengthen cross-system coordination.

Let's have everyone have some kind of formal coordination mechanism so people know who does what. That was mentioned a few times. And a need for a structured process so everyone is not working in isolation. Obviously, we need to respect confidentiality, and recovering nurses need to know that their ability to sign releases and decide who will engage with their EAP or with other stakeholders, their treatment providers, is important.

For conclusions, we can see clearly from these interviews that workplace policies do shape the recovery pathway. Collaboration, everyone felt, improves the continuity of care. Just knowing what other people are doing, the services that have been given so far is helpful. Supportive re-entry, many would argue, benefits the workplace as well to retain good people is so important.

Many stakeholders are available, as we learned, with good intentions to support nurses and to create a support system. This is a little snapshot of the landing page of our Nurse Worklife and Wellness page, which some of the studies have been funded by NCSBN as well as others. And it also has some key findings that you can access and some other suggestions.

So I welcome everyone to have a look if it's relevant for you. And then lastly, I'll just close by saying thank you very much, and here's how you can reach me by email, and that's the link to our website. And I thank you very much for attending, and hope you enjoyed it.

- [Interviewer] Hi, Alison. Thank you for your presentation and for joining us this morning.

I'd like to ask to start things off, what would you say are the important takeaways from your findings?

- I think one of the things that energized me was that there are so many good people trying to help nurses. The only thing sometimes is maybe we're not working as smoothly together as we can, we're not aware of each other, and I think even just building a trust from being able to rely on some of the other people and knowing they're all well-intended could be very helpful.

- And then what can employees do to promote workplace policies that support the use of evidence-based approaches for those nurses misusing substances?

- I have worked with a number of employees over the years and some unions, and it seems as though they really feel that having some kind of knowledge base or evidence base such as you have been developing over the years at NCSBN is really helpful to supporting their arguments. Because unfortunately, many people did not learn about substance use and treatment and evidence base and what's successful, and they might have some myths or false beliefs about that it's not treatable and other things.

So that's hard to overcome. So people seem like they've been most successful when they've come to it positively and provided evidence. And I think the retention concerns are also helping. If people leverage that, we have wonderful employees, we want to keep them healthy and allow them to continue practicing.

That also sometimes changes minds because there is a lot of concern over nurses leaving the profession and staffing limitations. So it can also feed nicely into the issue of let's support the people we have.

- Thank you. And given the opportunity, how would you improve employee access... sorry, to employee assistant programs, EAPs for short, for nurses?

- Well, one of the things I've noticed from the EAP literature and from having a close colleague working with me on this study who is an EAP, is that they're continually finding that outreach in terms of telling people what is here, how we operate, makes a huge difference in the number of people accessing EAP services.

So it seems like it can be an early warning system and a place to kind of land, and then make a plan as to what is needed next. And by having that early on before a lot of fears and concerns develop or things escalate is really good. So it seems when organizations know what's available and work with the folks at EAP, nurses can get there and have something because I think a lot of times nurses reported that they felt isolated and didn't really know where to go, and that's sad.

But outreach apparently really helps just by broadcasting what you are, what you do, your point of view, and the vision seems to help people feel comfortable, and especially if they see that presence over time, maybe in other activities that aren't directly related to a crisis. You know, they're helping with a wellness day or something like that.

So putting that out there really helps. And it has to be kind of continual because as staffing turnover happens, newer people may need to hear that message as well. And it gives leadership a sense that they have a go-to if they are not sure what to do, so they can kind of honestly turf it to those folks who will assess and then go from there.

- Thank you. I do have a comment more so from the chat from a former board of nursing executive officer. They acknowledge that some of the most difficult information to find, or have available, is that nurses will oftentimes lose their health insurance while they are in these programs.

And so in order to meet the requirements of the programs, it's very costly for them. And so they do respect and thank you for your presentation and highlighting some of those issues that nurses face. Another question though is, how can boards of nursing work with EAPs to report nurses who have

substance misuse issues so that they can help them in APD programs, monitoring programs, so on and so forth?

- Mm-hmm, we did have some stakeholders from boards of nursing who do work with EAPs, and they had an interesting feature. They have a series of mental health professionals that the board folks feel comfortable will accurately and constructively assess a nurse in those stages, and they've been working with EAPs to, kind of, get the folks assessed by the people they're comfortable with.

And it seems like that maybe is a barrier that has been eliminated by kind of everybody knows these folks and we'll get them in. And both sides are like, "Hey, this is a good place to be." So I think that is one way to break down a barrier by kind of sharing the assessment pool of people. And even with EAP, there's often a limitation on how much treatment you can get.

Maybe there's only five sessions that are covered, and then you have to get referred anyway. So that seemed like a nice way to address that.

- Thank you. It does seem that we do not have any additional questions from our audience, but personally speaking I'd like to thank you for your time, for applying to the NCSBN Grant Program, and for your presentation today. And so with that, this concludes our Q&A session.

And for those in the audience, if you'd please return to the lobby, and you can choose your next session from there. Thank you so much.