Past Event: 2026 NCSBN Scientific Symposium - Nurses in Recovery: A Grounded Theory Study Video Transcript

Event
2026 NCSBN Scientific Symposium

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- [Dr. Foli] Hello, welcome. My name is Karen Foli. I'm professor and the Louise Harrington Endowed Chair for Mental Health Nursing at Baylor University. I'll be joined later for the live Q&A on this study with Dr. Wang, my associate who was instrumental in conducting this study.

I'll be speaking today on Nurses in Recovery, a Grounded Theory Study. My learning objectives for today are to discuss a brief overview of substance use in nurses and the regulatory context of nurses in recovery. I'll explain the themes and steps in nurses' recovery process that was derived from the data I collected. I'll talk about an emerging theory of nurses in recovery, including global themes that were uncovered.

Importantly, I'll assert implications for nurses' unique recovery process. And again, we'll have about 10 minutes of live Q&A after the recording is finished. So let's talk a little bit about funding and the study team. This was a large study that I could not have conducted by myself. It was sponsored by the National Council of State Boards of Nursing Center for Regulatory Excellence.

And we're so grateful for this funding and sponsorship. In addition to myself and Dr. Wang, we had two colleagues that were also co-investigators and part of our advisory panel, which I'll talk about a little bit later, Drs. Nicole Adam and Jeffrey Coto. Many thanks to those individuals.

So this is almost embarrassingly brief overview of substance use in nursing, but Trinkov's seminal study in 2022 gave us some current indications of what rates of nurses and substance use we had. 18% in her study of the participants screened positive for substance use problems, and of those 6.6% screened positive for a substance use disorder, where you consider the numbers of nurses practicing in the United States, it becomes a troubling total number.

We know that there are alternative to discipline programs, which are instrumental in nurses' recovery, and I'll talk about those in depth when I describe the findings from the study. We know that the charge of the Board of Nursing is to protect public safety and enforce the Nurse Practice Act.

I'll talk about the role of the Board of Nursing, again, revealed from the study participants' lived experiences. We'll talk in depth about recovery monitoring agreements, those contracts that are forged between either alternative to discipline programs or state boards of nursing and the individual nurse. And finally, I don't want to underdescribe the influence of stigma and shame.

If you look at the very brief but powerful piece that was authored by Leah Curtin in 1987, I'll refer to it now and at the very end of the presentation is that her recommendations are still very valid today and even within the context of this study.

So the overall question is very highly, highly qualitative study, where I used an interpretive approach to the data was what are the social patterns embedded in the individual nurses' narratives and behaviors related to substances, their employment, exiting the organization and their attempts to re-enter the profession, as well as licensure regulation.

I used a constructivist approach and symbolic interactionism, which means that I based the reality on what they told me their reality was and the symbolic interactionism was part of the interpretive process in that I looked at their realities from the vantage point of who they were interacting with and the symbolic nature of those interactions between themselves and the board of nursing, themselves and the recovery monitoring agreement companies that were making sure they were adherent to their family and friends, to their peers, to their recovery coaches and so forth and so forth.

We used the standards for reporting qualitative research and it did receive IRB approval. This study challenged me like no other study in terms of recruitment. It's commonly a challenging step in any investigation, but this one brought me to my knees. I was in the grant application planning on using the National Council of State Boards of Nursing alternative to discipline program website, but that did not pan out to be very successful and in a good way because a lot of those programs were very protective of the nurses in their programs and their identity.

Recovery groups that I was sent to from that website, again, very limited, a good way because they were protective of the nurses. What I really found the most success with, I had my network of folks that I asked for help to, but it was when they said, well, have you tried SheRecovers on Facebook?

There are a lot of nurses that belong to that group and that's where I really found an influx of nurses that I could reach my saturation point, if you will, and interview them. Again, we had a review panel of experts that really Drs.Cotto, Adams and Dr.

Wang really helped me keep on track so it wasn't the world according to Karen Foli. I would give them preliminary interpretive results and they would say, well, "Have you thought of this?" or "This might mean that." Very, very helpful. I think the trustworthiness of our findings. So the methods and procedures that I used, we collected data for about 13 months. Again, it was very challenging to do so.

I was so grateful I didn't have a failed study. I was able to complete it and I think it's become a really important study. As an aside, you can find the findings of this study in detail in a publication in the Journal of Nursing Regulation. Many thanks to them and the editorial staff. We did incentivize our participants.

We had pre-interview data to avoid collecting sensitive data during the interview. We designed a very brief pre-interview survey, which included some demographic information and also employment information as well as their drug of choice, how long they've been in recovery, what their license status was.

And then we asked them to complete a resiliency tool, a post-traumatic growth tool and organizational support. And these tools are described more in depth in the publication that I just talked about. I conducted all of the interviews, which is in alignment with methodology when you use an interpretive approach.

I used the Zoom platform. I offered the participants or informants the ability to have their camera off or on to help them feel as comfortable as possible during the interview. Our inclusion criteria was that they could have or not have a restricted nurse's license, but they were in an active current recovery from substance use disorders, having engaged with state boards of nursing and a monitoring alternative to discipline program and that they could read and speak English.

Those that were using substances were excluded from the study. In total, I conducted 41 in-depth interviews that lasted approximately one hour each. Some were a bit shorter, some were a bit longer, but really that's an accurate average of the length of time that I spent interviewing folks. This is just a brief outline in terms of the demographics information.

You can see their age was about 43 years of age, the gender predominantly women, educational level we had the majority of the bachelors or under. The income was kind of divided. Many had reported real hardships related to finances.

I'll get to that a little bit more. We talk about the cost of the recovery monitoring agreements. Some had declared bankruptcy, some had moved in with family, etc., etc.. And you can see the RN license and the number that were probationary or suspended and then the length of current recovery.

Just real quick back on the RN license status, even though we had 41% unencumbered, that is somewhat misleading in that some of those individuals that I interviewed with an unencumbered license had been reported to the boards of nursing and were waiting for action to be taken from those boards of nursing.

So they could have been reported for diverting opioids, but still passing narcotics in an ICU. So the categories of primary substance use, you can see that alcohol was the drug of choice, but followed by opioids and stimulants was far less. There was a lot of combination of alcohol used and you can see the breakdown there with alcohol, benzodiazepine, THC, opioids, and so forth.

So what were our findings in this study? Again, this was based on 41 nurses interviewed for approximately an hour in length. These were very raw interviews that were, I believe I am changed as an individual having conducted these interviews.

I was struck by the bravery of the individuals who I spoke with, how difficult it was for them to share what they had, what their journey had consisted of, to share what they had done and were doing to get a livelihood and their licenses back. So what were our findings?

The global themes of the board of nursing, "The Great and Powerful Oz," the tangible and intangible costs of monitoring, finding their way, what is needed, and then again that trauma, shame, and guilt and

stigma was very, very prevalent in everyone I spoke with. And then there are eight steps to the recovery process. I'm going to go through all of this in more detail.

Here is the emerging theory, if you will, of themes and the steps that I just gave an overview of. If you look at the bottom, we have a line that symbolizes time, so that's particularly important as far as the steps go. You can see steps one through eight from the confrontation and contact with employer, boards of nursing, all the way to giving back.

And these aren't necessarily all that different from non-nurses recovery process, but I would draw your attention to steps one and two as being different. Steps one and two, they are confronted oftentimes, they have the organizations, the state boards, they've been referred to the state boards of nursing, there's something that triggers them into this whole process.

And that is different from non-nurses. And I'm going to talk a little bit more in depth on that specifically towards the latter part of the presentation. The four global themes, again, are cutting across the data that bubbled up in all of the interviews in a very profound and consistent way. So let me talk about the themes, The Great and Powerful Oz The boards of nursing, and there's such statewide variation right now between how states' boards of nursing operate in their communications, but a lot of these nurses had experienced very difficult communications with them, very delayed communications.

Many of them weren't there within, they didn't know what was coming, they knew something was coming or they were waiting, waiting, waiting. And they felt that they were just out of control as far as this mysterious entity of the board of nursing. They also talked about at the hands of the boards of nursing sometimes being very humiliated and subjected to shameful interactions.

Publicly streamed experiences were not uncommon, as well as just this mystery that was surrounding the boards of nursing. Theme two had to do with The Tangible and Intangible Costs of Monitoring. They spoke widely about how much the laboratory testing costs and the screening tests and how often they had to go.

They talked about how difficult it was to navigate, what to do, especially in the new weeks and days when they received their recovery monitoring agreements, and how they had to unpack all of that, how they weren't sure they could do it, especially if they were employed. And so, you know, they said it feels punitive. I really had problems with that.

And again, it was a me issue, but you have to check in every day. So, there's an app that they would have to use commonly that they would check in. Some of them wanted to take a little bit of a respite and go on a vacation. And so, they would have to get special accommodations. And it was very, very hard and sometimes dehumanizing for them to do that. So, eventually they found their way in what was needed, at least the ones I spoke with.

And so, these were on a successful trajectory, which is something I think to keep in mind. They would ask other nurses who were in recovery, and that was something that I want to emphasize as a real secret sauce. Finding a peer who had gone through this, not just any nurse, any peer, but a nursing peer who had gone through this was really, really important to them and their success.

It also reduced their feeling of swimming in an ocean and being all alone and trying to figure it all out, how to get to that lab when you're on a 12-hour shift if you're lucky enough to be employed, how to do

that successfully so that they could be compliant with their recovery monitoring agreement. And then lastly, that Trauma, Shame, and Stigma.

I don't know how many times across the 41 interviews, the individuals would say, I never thought it would happen to me. This was one nurse who worked in the emergency room of a rural hospital who would take babies who had been stillborn down to the morgue, and eventually she just couldn't take it anymore and started to divert opioids as a maladaptive coping mechanism.

But she said the people she worked with never helped her debrief or anything like that. They also talked about nurses being held to a higher standard in terms of how dare you stumble and fall, and weren't we all called heroes during the pandemic. So they talked about how they were held to this higher standard and if they didn't meet that standard, how it was very difficult for them.

So as I mentioned, there are eight steps to the nurses' recovery that were derived from the narratives. Again, the first two steps are unique to nurses in recovery due to that lack of ability to, hey, I've got this. They may still be in a little bit of denial and certainly in crisis. Step number three is important to note when they might be vulnerable to relapses.

They're trying to get grounded into that recovery monitoring agreement, getting their bearings on how do I do this? What do I do and when do I do it? And then that resentment and fear might sink in a little bit, that anger of where they're at and so forth. But again, you can read these steps in detail in the publication as well.

So when I talk about those first steps being different, I would refer you to the Brophy concept analysis of recovery for nurses being a process with goals and objectives for life improvements, person-centered, individual process. Not so much with the recovery monitoring agreement, although I shouldn't say that one is a substitute for the others.

I think nurses in recovery need to be reminded of this and encouraged to make these lifelong goals and person-centered processes. The Transtheoretical Model is also something that is commonly applied to recovery. And again, for those first two steps that were derived, that pre contemplation and contemplations, those stages might be absent for the nurse.

And so they may not follow the traditional Transtheoretical Model stages. So something to consider and hopefully something that state boards of nursing will take note of as well. So in conclusion, very similar recommendations to Curtin, although I think we've come a long way in terms of understanding nurses in recovery.

She recommends allowing nurses sick leave, an enlightened state board of situating substance use in nurses as a chronic, highly treatable disease. Having them referred for inpatient treatments, limits on reentry, which we have now built into a lot of agreements.

For example, limitations on hours worked in a week, limitations on specialty areas worked, limitations on passing medications, etc, etc. The secret sauce, as I mentioned before, as well, nurse peer support groups and nurse peer coaches were highly, highly valued by these nurses. It made such a tremendous difference in terms of their stigma, their shame, their isolation, as well as their success.

Here's how you do it. Here's how you get to that lab. Well, hey, here's an approved lab that's closer to your workplace, that kind of thing. I would also strongly assert that the bifurcation of nurses in recovery

and supporting their well-being and protecting patient and public safety, the separation of those two goals is unnecessary. We achieve them both simultaneously by making it a little bit less fearful for nurses to admit to substance use earlier, certainly protects patients in the public safety.

There is tremendous progress being made in states such as Washington, which has passed legislature to start a fund to help offset some of the costs of the recovery monitoring agreements and the lab testing. It also allows nurses who have successfully completed those contracts to have their names removed from various websites.

Another serendipitous finding in this study was that nurses would want to seek gainful employment and get to the interview stage, only to have be canceled because their employer did a search on their license and found out that they were involved in substance use and have that interview canceled. It was heartbreaking for them. So I would also say that a lot of states, and I'm just going to name Texas as another state, I interface and have a lot of dialogue with Brittany Meschewski and the alternative to discipline program in Texas.

So these are just two examples of states, but I know there's many, many others. And I'm very much encouraged by the strides we have made in the area of nurses and substance use. This concludes my presentation. Thank you so much. I think it's time for the live Q&A.

- [Jen] Hi, Karen, Yitong. Thank you for joining us after lunch. I hope you had a wonderful break.

And thank you for this presentation. I did want to ask you, what makes mid-level nurses a unique group to study and compared with frontline nurses or senior nurse leadership?

- [Dr. Wang] Thank you so much, Jen. This is a great question. I think middle-level nurse managers, they're unique because they serve as the bridge between senior leaderships and the frontline care nurses. So they are accountable for staffing, quality, safety, personnel, and also union operations. But very sad, they often have limited authorities or the resource needed to meet those expectations.

So their role is distinct because they remain close to the clinical practice while also carrying substantial organizational responsibilities.

- So then based on your findings, what aspects of this role put them at a particular risk for stress, burnout, or substance use risk?

- I think that they have this double barrel, if you will, of emotional labor. They're hearing pressures from above, as Dr. Wang just described, in terms of budget and resources and staffing. And then at the same time, they're also receiving feedback from the bedside nurses about the pressures they're experiencing, the difficulties that they're...

So they really have it coming at them in both ways. As we described in the recording, they also... Some of the novel implications or novel findings that give us some implications and insight into these areas is the fact that it's just a 24/7 responsibility. There's no relief.

They're constantly on. That intense responsibility is just unrelenting. They mentioned that they really wanted mental health services nearby. They would take advantage of those. They wanted better benefits, better pay, better compensation at the level of their responsibility. And then in terms of substance use, they also wanted more education in that area so that they could perhaps identify nurses who might be

struggling sooner or even down the path that they could identify nurses who were struggling with coping with some of these stressors that they were having.

So it was really... They were clear about what they wanted. And in all of the studies I've done through the years, nurses are very clear about what they want and will hand you the implications, if you will, if you ask the right questions.

- So one final question to lead off of that. What organizational supports may be most important for helping mid-level nurses manage the work and the stress before it contributes to turnover, intention to leave, or unhealthy coping?

- Do you want to take that, Dr. Wang, or would you like me to?

- I can take it, but if there's any add-ons, Dr. Foli, you can add. Yeah. So thank you so much for these questions. I think the organizations, from my point of view, should reduce the excessive workload, improve staffing, and also the administrative support, give managers some meaningful decision-making authorities, and also provide those confidential mental health and substance use resources.

I think that's the key point. And also the resilience programs should be supported, but not replace the system level improvements. What do you think, Dr. Foli?

- I agree with all that. I think you did a great job of summarizing and highlighting those important points. The only minor thing I would add is that their direct supervisors understand the pressure that they're under. There's a saying, you don't quit your job, you quit your supervisor. And I think that that's kind of true for many, many roles, but I think that's especially true with this one.

And so, that their supervisors understand that dual responsibility, that sandwiching that they experience day in and day out, I think that that would go a long way as far as retention and their ability to cope.

- So thank you both for your insightful findings, your words of wisdom, and for your research. That does conclude the Q&A session for today. Please make your way back to the lobby and then choose your next session to join.