PROMOTING EVIDENCE-BASED TREATMENT APPROACHES FOR NURSES WITH SUBSTANCE USE DISORDERS

Report and Recommendations

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Authors and Contributors

Jonathan Chapnick, JD, CPHR; Director, Human Resources and Labour Relations, RainCity Housing

Deborah Charrois, LLB, LLM; Co-ordinator of Professional Practice and Advocacy, BC Nurses' Union

Cheyenne Johnson, RN, MPH, CCRP; Director, Clinical Activities and Development, BC Centre on Substance Use

Samantha Robinson RN, MPH; Clinical Programs and Development Lead, BC Centre on Substance Use

Charlotte Ross RN, RPN, PhD; Faculty, BSN Program, Faculty of Health Sciences, Douglas College

Karen Urbanoski, PhD; Canadian Institute for Substance Use Research, Public Health and Social Policy, University of Victoria

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Executive summary

Employers of individuals in safety sensitive positions have an obligation to create a safe workplace that protects co-workers and the public in circumstances where health issues may compromise workplace performance. This is true of safety sensitive workers with substance use disorders, however, policies employed in these circumstances have not been subjected to scrutiny. In recent months, a number of high profile cases in British Columbia and elsewhere have highlighted a number of serious incongruences between what is considered best practice in the clinical management of substance use disorders and the treatment and care pathways that nurses with a suspected or confirmed substance use disorder are able to access.

This report provides an overview of the current approach, evidence of its associated harms, and recommendations to improve the pathway for nurses diagnosed with a substance use disorder to receive comprehensive, evidence-based approaches along the full continuum of care. Broadly, these recommendations aim to:

1. Promote evidence-based, patient-centered treatment approaches

Despite recent advances in addiction medicine and availability of evidence-based treatments, nurses are routinely mandated to treatment plans that include modalities that have either proven unsafe or ineffective while precluded from using evidence-based care.

2. Reduce opportunities for harm and coercion, including addressing conflicts of interest that may exist

There are a number of inconsistencies between existing practice in caring for nurses with substance use disorders and the scientific evidence, including mandatory/coercive attendance at support group meetings that have not proven to be effective and may increase the risk of relapse[1]. Further, conflicts of interest that exist, between physicians who conduct independent medical examinations and the medical monitoring companies that are often a central component of resulting treatment plans, should be explored and addressed. If an independent medical examination is required, this should be performed by a health care provider that does not have any relationship to a monitoring company.

3. Promote individualized risk management

Like other chronic, complex conditions, substance use disorders are heterogeneous with vastly different trajectories and progressions. A one-size-fits-all approach to risk management is often applied, regardless of severity of substance use disorder, job environment and work duties.

When subjected to critical review, common workplace policies fail to provide evidence-based substance use disorder care and, as a result, do not effectively protect the public as they leave nurses with a substance use disorder at high risk of relapse.

This document puts forward several proposed actions for the British Columbia College of Nursing Professionals and the British Columbia Nurses Union, that when implemented, would better protect the public through strategies that would support employees to seek timely assistance and receive individualized, evidence-based treatment approaches that support recovery and relapse prevention.

Summary of Opportunities, Recommendations, and Proposed Actions for Improvement

Opportunity 1. Promote evidence-based, patient-centered treatment approaches	
Recommendations	**Proposed Actions**
1. Promote individualized, patient-centered evidence-based treatment plans, including pharmacotherapies that evidence has shown to significantly improve outcomes of substance use disorders (SUDs), based on the substance(s) used, individual disease severity, previous treatment attempts, co-occurring conditions, and the medical and/or social consequences of use. 2. Offer accommodations similar to other return-to-work approaches for nurses with other health issues or injuries. 3. Base return-to-work decisions upon evaluations by nurses' primary care provider or chosen addiction treatment provider and systematic assessment of risk. 4. Enhance research of nurses with SUDs (e.g., evaluation, monitoring, and quality improvement projects) and make findings of these studies accessible in the scientific literature to the general public. 5. Develop a mechanism to fund and procure extended release naltrexone (XR-NTX) to be offered to nurses with alcohol use disorder (AUD) and/or opioid use disorder (OUD) and evaluate health outcomes of nurses on this treatment modality.	• Develop a position statement that promotes reform for institutional policies related to substance use and the workplace, and promotes evidence-based approaches to SUD • BCCNP and BCNU work in concert to develop a clear and publicly available pathway for nurses with SUDs. This would include: o Developing standardized, comprehensive forms and supports for general practitioners and addiction specialists to use in evaluating nurses with SUDs. o Funding and procuring XR-NTX for nurses with AUD and/or OUD, work with BCCSU to develop robust evaluation of health outcomes of nurses on this treatment. • Fund and establish a peer-navigation program, to support nurses accessing treatment for SUDs. • Develop a mechanism for collecting data on nurses engaged in substance use-related processes, for evaluation and monitoring of care trajectories and quality improvement; partner with substance use research organizations to increase research of nurses with SUDs.
Opportunity 2. Reduce opportunities for harm and coercion, including addressing conflicts of interest that may exist	
Recommendations	**Proposed Actions**
1. Encourage nurses with SUDs to retain control over the choice of qualified health care providers, including publically funded first-line diagnostic care providers, treatment providers, and other health care providers. a. If an IME is required, ensure there are no	• Develop and broadly disseminate guidance for employers when developing workplace substance use policies that promote therapeutic and evidence-based approaches, recovery, employee collaboration, inclusion, cultural

conflicts of interest by having this performed by a health care provider that does not have any relationship to a monitoring company. b. Remove barriers to access second opinions, including costs incurred by nurses if second opinion accords with initial assessment. c. Remove mandated support group attendance 2. Encourage nurses with SUDs to retain control over individually tailored choices of evidence-based treatment options, including choices to move between multiple care approaches and treatment options that match their needs and preferences. 3. At each stage of the care pathway, ensure that nurses with SUDs are free to give, refuse, or revoke consent on any grounds; and be fully involved in all case planning and decision-making and have the information that a person would reasonably require to understand the proposed health care plan. 4. Implement supportive workplace policies alongside educational activities that destigmatize substance use and SUDs a. Remove wording from policies that emphasize punitive sanctions and replace with therapeutic and evidence-based approaches that promote recovery. b. Eliminate harmful coercive practices and non-evidence-based compulsory interventions in the SUD care system. 5. Cultivate a safe work environment for nurses by maintaining employee privacy. a. Ensure that the personal health information of a nurse with a SUD is collected or disclosed only on a "need to know" basis with the knowledge and consent of the nurse.	competence, health promotion and maintenance of employee privacy. • Explore conflicts of interest, between physicians who conduct independent medical examinations and the medical monitoring companies that are often a key part of treatment plans • Develop and maintain an expanded list of practitioners who can complete independent medical examinations • Develop an educational toolkit for workplaces that clearly outlines processes for employees experiencing problematic substance use or a substance use disorder, describes available supports and evidence-based treatment options, and engages employees in activities that aim to destigmatize substance use and substance use disorders.
Opportunity 3: Promote individualized risk management	
Recommendations	**Proposed Actions**
1. Wherever possible, decouple treatment from risk management. Apply evidence-based standards to each. 2. Determine the requirement for medical monitoring on a case-by-case basis for nurses with SUDs 3. Align the approach to risk management for nurses with SUDs with risk management approaches for nurses with other conditions that may result in performance impairment. For example: a. Individually assess workplace hazards based on physical work space, job duties and potential for	• Support the development of a standardized evidence-based risk management strategy that considers individual factors, including the specific risks, duties, and competencies of each nurse as well as each individual's SUD. • Whenever it is not appropriate or necessary remove the requirement for medical monitoring

risk/adverse events b. Where an individual nurse's substance use disorder and workplace environment intersect to create real risks for safety, take appropriate, individualized steps to assess and manage safety risk, through medical evaluation, analysis of workplace duties, and effective risk mitigation. c. Where workplace risks exist, provide temporary accommodations to specific nursing tasks and activities or move the nurse to a more suitable role or physical location.	• Develop and share an evidence-based workplace safety checklist.

Introduction

According to the Health Professions Act, health professionals (registrants of any health profession college under the Health Professions Act) have legal and ethical obligations to report in writing to the appropriate regulatory body when they have reason to believe that the public might be in danger, due to any physical or mental health condition (including drug or alcohol addiction) that may impair another health care professional's ability to practice competently. Regulatory bodies then have a responsibility to investigate such concerns and take action as necessary and appropriate to protect the public. When concerns are brought to the BCCNP regarding a registrant's potential addiction, a typical pathway for investigation and action unfolds. In these cases, nurses are typically mandated to undergo an independent medical exam (IME), which is often carried out by one of a small number of physicians many of whom have a financial interest in a monitoring company. Once diagnosed with a SUD, nurses are often offered a non-individualized return-to-work plan regardless of the type of SUD or severity. A typical plan generally involves an initial period of inpatient residential treatment in a private facility, followed by mandatory routine (e.g. 3-4 day per week) attendance at 12-step fellowship group meetings, abstinence from all psychoactive substances (other than tobacco and caffeine), and ongoing compliance monitoring (e.g. random urine drug screens) to ensure abstinence. Despite the widespread application of this approach, several elements of these programs are not supported by evidence. In some instances, evidence based interventions are withheld and interventions associated with higher rates of relapse are required.

Current estimates for SUD prevalence nationwide among health care providers are lacking, however, an SUD prevalence rate of 7.9% was found in Alberta nurses, which is similar to the prevalence in the general population.[2] Individuals with SUDs face social marginalization and stigma,[3] which are associated with feelings of helplessness, shame, anxiety, and fear.[4] Individuals with SUDs have also been found to have higher rates of major medical conditions (e.g., chronic pain, hypertension, injuries, poisonings, and overdoses),[5] morbidity, and mortality.[6,7] Despite an abundance of evidence supporting the clinical management of SUDs as complex, chronic, relapsing disorders affecting brain neurochemistry, these disorders are still often framed as an individual's choice and a moral failing by society at large, including by health care providers and administrators.[8] This conceptualization contributes to the perpetuation of harmful stereotypes about who develops SUDs and increases the stigma those with SUDs experience. Health care providers with SUDs likely face additional challenges, including compounded feelings of stigma and guilt associated with working in a helping profession, as well as experiencing stigma in the workplace from colleagues and administrators as a barrier to disclosure.[9-11]

This report focuses specifically on the current standardized regulatory approach to nurses with suspected or diagnosed SUDs, however, the evidence and issues outlined in this report can be extrapolated to a variety of other health care professionals or other safety sensitive industries where employees face similar challenges. As explained below, this approach is not supported by evidence and has the potential to do harm to nurses by limiting choice of physician and treatment, preventing access to treatment tailored to individual needs and circumstances, preventing nurses from moving along the care continuum as necessary and appropriate, reinforcing stigma against those with SUDs, and mandating risk management strategies that may be experienced as overly onerous and lack evidence to support them.

The Current Approach

The current regulatory approach to managing and providing clinical care to nurses with SUD in British Columbia has not been subjected to any kind of scrutiny or evaluation. However, physician Health Programs (PHPs) and alternative-to-discipline (ATD) programs in the United States, guide the course of action for physicians (PHPs) and nurses (ATD) with suspected or diagnosed SUDs and are similar to the current approach in BC. Historically, nurses found to be impaired on the job faced termination, license revocation, public disclosure and, for many, prosecution and imprisonment.[11] In 1982, the American Nurses Association's House of Delegates passed a resolution urging the creation of non-disciplinary (also called "alternative-to-discipline" programs) peer-assistance programs by state boards of nursing.[12] In 1987, the National Council of State Boards of Nursing published model guidelines for ATD programs.[13] Although case studies and descriptive reports of ATD programs exist,[12, 14] they do not offer rigorous evidence demonstrating the efficacy of this model.[15]

Similar to PHPs, general ATD program requirements include random drug-testing, coercive 12-step group participation, total abstinence from all mood-altering drugs, compliance monitoring, and requirements for group and individual counselling.[16] Documents that tout the effectiveness of ATD programs for nurses with SUDs frequently cite the same methodologically problematic PHP literature discussed below.[16]

PHPs do not provide comprehensive addictions treatment.[8] Rather, PHPs exist to support and monitor physicians with medical conditions that may impair their work. For physicians with SUDS, this includes making arrangements for assessment, treatment, long-term monitoring and relapse detection, and documentation of abstinence.[17] The current approach to nurses with SUDs in BC, like the standard PHP approach, begins with a medical evaluation once identified (through self-report or employer, union, or regulatory college intervention), and is followed by mandated residential treatment.[8] Residential treatment is followed by monitoring, typically for 2 or more years.[8] Monitoring contracts generally mandate abstinence from all psychoactive substances, mandatory attendance at self-help groups like Alcoholics Anonymous or Narcotics Anonymous, random provision of biological samples (e.g., urine drug testing), and documentation of abstinence before returning to work.[17] Remarkably, especially since mandatory 12 step meeting attendance is associated with high rates of relapse[1, 18-20], evidence-based interventions in the case of opioid addiction (e.g. buprenorphine/naloxone) are not available to nurses who want to return to work.

The current approach (as outlined above) for nurses diagnosed with or suspected of an SUD or problematic substance use[1] could be improved by incorporating an evidence-based approach to SUD. In

[1] If an employee is diagnosed with an SUD during an IME, they are generally subject to mandatory medical monitoring and Last Chance/Return to Work Agreements. If an employee is not diagnosed with an SUD during an IME, then standard discipline strategies are employed to address the behaviour that triggered the process.

fact, the incorporation of more evidence-based addiction care, based on the fact it is associated with lower rates of relapse, would also improve workplace safety. Further, the current approach may inadvertently perpetuate stigma among those who use substances, which can in turn create barriers for employees to return to work. The inflexible, "one-size fits all" nature of the current approach may prevent employees from actively participating in their treatment plan and outcomes. Consequently, opportunities for early identification and voluntary self-disclosure may be missed.

Like other chronic, complex conditions, SUDs are unique to the individual and may have vastly different trajectories and progressions.[21] It follows that SUDs may or may not affect work performance or attendance and may or may not require employee accommodations. Despite advances in the medical understanding of SUDs, the current approach to managing workplace outcomes related to SUDs in BC is not based on the best available evidence and has significant consequences—both potential and real. The current approach results in significant financial burden to nurses and the system, has the potential to do significant harm, and may inadvertently further stigmatize individuals with SUDs, thus making it more challenging for individuals to seek support earlier or successfully return to work.

Evidence gaps and overall quality of evidence

Physician Health Programs (PHPs)

Physician health programs (PHPs) emerged as an alternative to disciplinary action in the United States after the American Medical Association Council on Mental Health published a report in 1973 ("The Sick Physician"[22]) that identified problematic substance use among physicians as a frequent problem.[23, 24] Studies evaluating PHPs to date show very positive results, with significantly higher completion and abstinence rates than commonly seen in studies of addiction treatment.[8, 25-27] However, the evidence supporting the use of Physician Health Plans suffers from methodological issues.[28] Studies evaluating PHPs consist of uncontrolled, descriptive studies—considered among the weakest forms of evidence. This is due to the lack of a comparison (or control) group of physicians receiving another type of intervention (which makes it possible to determine whether outcomes are due to the specific intervention). Additionally, the evaluations of PHPs in the US to date have included less than 40% of eligible programs, with inclusion based on availability of data.[27, 29] Although the programs excluded from the evaluation appeared to have similar clinical and administrative services to those included, due to the lack of detail provided, it is not possible to confirm that significant differences did not exist in factors (such as funding, leadership, results and length of existence) that may have resulted in a biased sample. Varied methodological problems plague study designs used to evaluate employer-mandated treatment in general,[30] making determinations about the efficacy of employer-mandated treatment difficult. Given these limitations, PHPs cannot be said to be evidence-based[28, 31].

Medical Monitoring Programs

Medical monitoring (also referred to as compliance monitoring) is often a requirement following residential treatment. Monitoring contracts typically stipulate abstinence from all psychoactive substances, attendance at self-help group meetings, random biological testing (e.g., urine screening), and documentation of abstinence prior to resumption of medical practice.[13] It should be noted that medical monitoring has typically been utilized for the purpose of tracking adherence to return-to-work requirements (such as abstinence from psychoactive substances), rather than as part of a comprehensive addiction treatment plan and, as such, may be better understood as a form of risk management.

Though widely utilized, the efficacy of mandated PHP-type medical monitoring is not well-established. Research on compulsory monitoring is scant and the evidence supporting the use of PHPs is generally

of poor methodological quality.[28, 32] It is difficult to determine the therapeutic efficacy of medical monitoring, given the scarcity and low quality of evidence either supporting or refuting.[28] Although medical monitoring has been hailed as showing significantly improved outcomes over other treatment approaches, this evidence relies on the same studies evaluating PHPs and thus suffers the same methodological issues. More high-quality research is needed in order to determine the efficacy and utility of this approach.

Substance use disorders and workplace risks

PHP-type approaches operate with a baseline assumption that all SUDs among health care providers, regardless of the specifics or severity, present a safety risk to patients, rather than focusing on impairment in the workplace. This approach assumes that health care providers with SUDs are uniquely unsafe, which is a position not supported by evidence.[33] Rather, this assumption is likely based on the ubiquitous societal stigmatization of people with SUDs as being poor decision-makers and a danger to others.[34]

One of the assumptions underlying the perceived utility of PHPs is that medical monitoring, including urine drug testing, reduces risk. However, as outlined above, the evidence supporting the use of PHPs and medical monitoring suffers from methodological issues. Moreover, the efficacy of urine drug testing as a workplace safety measure is unproven.

A 2014 systematic review on the efficacy of urine drug testing for workplace safety found the evidence base supporting drug testing to reduce workplace accidents and injuries to be of poor methodological quality.[35] Urine drug testing is an imperfect science, making it difficult to determine when substances were last used or if use resulted in workplace impairment. Additionally, a 2013 qualitative review of the evidence related to drug testing for workplace safety highlighted some of these challenges, including that a positive urine drug test only indicates relatively recent use.[36]

An additional gap in the evidence is the lack of direct comparison between treatment modalities under the current approach and other approaches to SUD treatment. Because the current approach to treating nurses with SUD in BC has not been compared to any other approaches, it cannot be said to be superior to other approaches, including comprehensive, evidence-based approaches to care.

I. Coercive 12-step-based Approaches

Overall, research on the success rates of abstinence-based treatment and fellowship approaches is mixed. While many individuals benefit from voluntary Alcoholics Anonymous (AA), other 12 step or peer support group meeting (e.g. SMART recovery) attendance, the research regarding coerced peer support meeting attendance does not support the practice of mandating it. For instance, in a study published by Brandsma *et al*. involving subjects who were randomly assigned to 1 of 4 treatment interventions (most of them court-ordered) or a control condition where they were encouraged to use community resources, it was found that those coerced into AA had significantly worse abstinence outcomes at 12 months and higher dropout rates (77% for AA vs. 50-64% for the other treatment conditions).[18] In a study published by Ditman *et al*. involving offenders with alcohol use disorder who were randomly assigned to Alcoholics Anonymous, a community alcohol treatment clinic, or no treatment as a condition of their probation, it was found that coerced AA attendance and coerced alcohol treatment had no statistically significant effect on recidivism rate, number of subsequent arrests, or time elapsed prior to re-arrest compared to no treatment.[19] Finally, in a study published by Walsh *et al*. involving workers who were newly identified as abusing alcohol and randomly assigned to compulsory inpatient treatment, compulsory attendance at Alcoholics Anonymous meetings, or a choice of options, it was found that the coerced AA group had the worst outcomes on the various study

measures of drinking and drug use.[20] As a result of these findings, reviews such as a meta-analysis of 21 controlled studies of AA which specifically examined the impact of coerced support group attendance concluded that the research to date indicates that coercive AA attendance results in **worse** outcomes for persons with addiction (i.e. higher rates of relapse).[1] For this reason, the published literature clearly does not support coercive attendance regimes.[37]

II. Opioid Agonist Treatment in Health Care Providers

Historically, in BC, workplace addictions policies for safety sensitive workers have often precluded health care professionals from using buprenorphine/naloxone. As described below, this policy has emerged without a firm evidence base and has become a convention that has not been appropriately scrutinized.[38] In fact, there are jurisdictions elsewhere in Canada (e.g. Quebec) that allow for the use of full opioid agonists like methadone (even among physicians). This distinction is important as the job description for a family physician, for example, can involve a diverse array of highly complex tasks (e.g. diagnosis, interview, treatment, report and prescription writing, medical procedures) that are not always relevant to other health professions where the tasks are more limited and defined. While some nursing roles may be considered safety sensitive it is helpful to note that most experience and literature in this area comes from physician's health programs in the U.S.

In the United States, some states allow health care providers receiving buprenorphine-based opioid agonist treatment to return to work.[38] A 2012 study examined such policies contacted all relevant state bodies (boards of medicine or nursing, physician health programs, and alternative to discipline programs) in all 50 states and the District of Columbia.[38] Of those bodies that were willing to share their policies, 11 (48%) of 23 physician programs and 13 (37%) of 35 nurse programs allowed health care providers to return to work while on buprenorphine under most circumstances. While international literature outside North America is scare, some European settings allows physicians and nurses to return to work while receiving buprenorphine/naloxone.[39] A review of the literature was not able to identify any studies associating use of buprenorphine/naloxone among health care providers with medical errors or other concerns.

In fact, no studies have demonstrated negative impacts of buprenorphine on cognitive function in health care professionals. Instead, many of the studies evaluating the impact of opioids on cognitive performance have examined long term heroin addicted persons and use automobile driving-related tests to evaluate impairment rather than activities that would be relevant to a health care professional. The biggest limitations of these studies is that findings of predominantly street heroin users may not be relevant (i.e. a range of co-morbidities not found in health care providers) to this population and they tended to lump together patients on full opioid agonists (e.g. morphine, methadone) and not restricted to patients on buprenorphine. Nevertheless, a 2003 structured evidence-based review concluded that the majority of reviewed studies indicated a lack of impairment in opioid agonist therapy patients tasked with driving simulation or on-the-road driving.[40] Similarly, a 2013 systematic review of driving ability that included patients on full opioid agonists more cautiously concluded: "At least some opioid maintenance therapy patients are observed having only slight impairments of relevance to driving."[41] Individual studies restricted to buprenorphine/naloxone have concluded: "Patients receiving a stable dose of sublingual buprenorphine showed no significant impairment of complex psychomotor or cognitive performance as compared to healthy controls."[42] A 2018 systematic review of the effects of opioid agonist therapy on functional outcomes essentially concluded that weaknesses in the literature prevent any strong conclusions from being drawn on the impacts of opioid agonist therapy on functional outcomes including full opioid agonist medications like methadone.[43]

Based on the above, the literature has failed to identify consistent and clear motor or performance gaps for individuals on chronic opioids including full opioids and, if an impact exists, that buprenorphine/naloxone likely has less impact on these domains. Further, as noted above, buprenorphine/naloxone is integrated into the treatment of health care practitioners in a number of jurisdictions in the U.S. and Canada.

Opportunities to improve healthcare for nurses with SUDs

There are a number of opportunities to improve treatment outcomes and to enhance patient-centered care for nurses with SUD. Each opportunity presented below is accompanied by recommendations that, if enacted, would help to align the current regulatory approach with standards of care for SUD and would promote evidence-based, situation-specific risk management. This will ensure that nurses receive evidence-based, trauma-informed, patient-centered, and culturally safe care while also taking necessary steps to protect the safety of patients through case-specific risk mitigation strategies.

1. Promote evidence-based, patient-centered treatment approaches

It has long been recognized in BC that there is an urgent need to develop a coordinated, evidence-based substance use system of care for all patients and families.[44] This system of care should represent a continuum of care that facilitates movement between multiple approaches of varying intensities and promotes long-term recovery.

The existing process for identifying and treating health care providers with SUDs does not reflect the available evidence, which informs the treatment of SUDs more broadly.[28] The last decade has seen significant attention from the medical and scientific community that has resulted in an abundance of scientific evidence that supports the identification, assessment, and management of SUDs. For example, the recently published BC Centre on Substance Use/Ministry of Health *Guideline for the Clinical Management of Opioid Use Disorder* recommends buprenorphine/naloxone as first line pharmacotherapy for the treatment of opioid use disorder. In contrast, while specific numbers are not available, the current regulatory approach stipulates that the overwhelming majority of nurses in BC with opioid use disorders are currently offered primarily non-pharmacological and abstinence-based approaches, including referral to psychosocial treatment interventions which are not evidence-based,[45, 46] and short detox periods which, for people who use opioids, increase the risk of relapse and fatal and non-fatal overdose.[47-49]

In the current approach, nurses are often advised to abruptly stop using the substance(s) they have been using and are often offered only 12-step support/meetings, despite there being a number of evidence-based public outpatient services and medical treatments available. Generally, nurses are not referred to or made aware of these treatment options. Depending on the substance(s) used, this may represent a significant risk to a nurse's health and safety. For example, medically unsupported alcohol withdrawal can be very dangerous, even fatal,[50] while medically unsupported rapid withdrawal of opioids is associated with relapse and increased risk of overdose once tolerance is lost.[51] The focus of the current approach on complete abstinence extends to the mandatory requirement to attend abstinence-oriented 12-step treatment such as Alcoholics/Narcotics Anonymous, as required in many Return to Work and Last Chance Agreements and many Medical Monitoring and Relapse Prevention Agreements used in BC. 12-step, AA, and other peer support groups are not evidence-based approaches to addiction[52] and mandating coercive attendance in these groups has been linked with worse outcomes and higher rates of relapse in individuals with addiction[19, 20, 53].

Another pharmacological option, extended-release naltrexone (XR-NTX), an opioid antagonist that fully blocks the effects of opioids, has shown some promise in the United States in treating nurses and

other health care providers with opioid use disorder, with no study participants (n=49) relapsing to opioid use disorder requiring withdrawal management or resulting in overdose or death during two years of treatment.[54] XR-NTX has also been shown to enhance abstinence from alcohol and decrease heavy drinking.[55, 56] At present, XR-NTX is only available in Canada for clinical and research purposes or through Health Canada's Special Access Programme. This may represent another point on the care continuum that is appropriate for some nurses with opioid use disorder and/or alcohol use disorder and should be available to those who, with their care providers, decide it is the best approach for them.

The current standardized approach for treating health care providers with SUDs represents a generalized "one size fits all approach." Because this approach is not individualized, it can prevent the collaborative creation of a patient-focused plan that accounts for substance(s) used, individual disease severity, previous treatment attempts, co-occurring conditions, and the medical and/or social consequences of use. It should also be noted that the current approach is not aligned with the individualized, evidence-based, culturally safe and appropriate care nurses provide their patients with SUDs.

This focus on abstinence-only approaches rather than the full continuum of care for healthcare professionals with SUDs also extends to relapse, where non-compliance with monitoring requirements results in negative professional, employment, and reputational consequences.[8] However, in the general public, relapse is extremely common, with studies showing 91-94% of participants relapsing after withdrawal management ("detox") for opioids,[51, 57] 43-83% of participants relapsing at one year after treatment for alcohol use disorder,[58, 59] and 25% of participants in Washington State's Physician Health program reporting having at least one relapse to opioid use at 5 years.[60] Given that employment has been shown to be a predictor of successful completion of treatment for SUDs,[61] interruption or termination of employment due to relapse may negatively impact treatment outcomes for employees.

Recommendations:

1. Promote individualized, patient-centered evidence-based treatment plans, including pharmacotherapies proven to improve outcomes of substance use disorders (SUDs), based on the substance(s) used, individual disease severity, previous treatment attempts, co-occurring conditions, and the medical and/or social consequences of use.
2. Offer accommodations similar to other return-to-work approaches for nurses with other health issues or injuries.
3. Base return-to-work decisions upon evaluations by nurses' primary care provider or chosen addiction treatment provider and systematic assessment of risk.
4. Enhance research of nurses with SUDs (e.g., evaluation, monitoring, and quality improvement projects) and make findings of these studies accessible in the scientific literature to the general public.
5. Develop a mechanism to fund and procure extended release naltrexone (XR-NTX) to be offered to nurses with alcohol use disorder (AUD) and/or opioid use disorder (OUD) and evaluate health outcomes of nurses on this treatment modality.

2. Reduce opportunities for harm and coercion, including addressing conflicts of interest that may exist

When a blanket approach is applied to any chronic condition, there are risks of inappropriate care (for example, treatment options not being matched and tailored to level of severity), coercion, and lack of culturally appropriate and safe care. Additionally, this approach may act to prevent the application of evidence-based treatment modalities. For example, the requirement of abstinence from all

psychoactive substances, including evidence-based pharmacological agents, may prevent those in need from receiving life-saving treatment. This approach is also inconsistent with the provincial clinical guidelines for clinical management of opioid use disorder, which recommends buprenorphine/naloxone as the first line treatment option.[62] Literature on patient-centered care in general has found it to be positively related to patient satisfaction and well-being, with generally positive relationships between patient-centered care and both intermediate and longer-term oucomes.[63]

Addiction treatment under the current regulatory approach in BC lacks alignment with many of the practice standards that nurses themselves are required to deliver in their own practice. These include, for example, from the BC College of Nursing Professionals, evidence-based practice, client-centered care, collaborative care, and the recognition and promotion of the client's right to make informed decisions.[64] This lack of alignment has potential to do harm by preventing informed consent and patient choice in treatment options, by allowing real or perceived conflicts of interest to exist, by preventing physician choice and widening the scope of who receives private medical information, by inadvertently reinforcing stigma, by creating financial hardship due to the high costs of medical monitoring, and by preventing early voluntary self-disclosure.

I. Ensure choice and consent in determining treatment options

In a system where every nurse, regardless of their individual circumstances, is mandated a similar plan of intensive and prolonged treatment, it is likely that some will receive care that is not well-matched to their needs and preferences. The current approach may be perceived as coercive due to restrictions placed upon choice of physician and treatment modality. For some nurses, this sense of coercion may make it nearly impossible to engage in or see the benefits of care.

The use of IMEs and medical monitors, both of which are provided by a small number of private health care providers and come with significant financial costs, limits patients' choice of qualified healthcare professional as well as opportunities for second opinions. As nurses' continued employment is contingent upon meeting the requirements of their medical monitors and fulfilling the prescribed treatment plan, these monitors have an immense amount of real and perceived power. This raises the question of whether nurses can provide full and informed consent to the proposed treatment plan (including when there is a lack of alignment between the treatment plan and the nurse's health goals) when often only one plan is offered and there are limited options for second opinions.

The abstinence-based model of care may match the priorities of some nurses; however, others will not experience this approach as patient-centered. As discussed above, there is considerable heterogeneity among SUDs, requiring an individualized, case-by-case approach to care. Under a patient-centered approach, nurses with SUDs would be offered information regarding, and reasonable access to, a variety of treatment options, including pharmacological management and recovery-oriented modalities along the continuum of care. Nurses would also, in most cases, be allowed choice of care provider and be able to easily seek a second opinion when needed.

II. Avoid conflicts of interest (wherever possible)

With the current approach, there are concerns about potential conflicts of interest, as the number of medical monitors in BC is small. Due to the small number of medical monitors, there is potential for overlap between physicians who provide assessment and those who perform monitoring (monitors may work for or have financial interest in the same company as the physician from whom they receive referrals). This overlap may create a real or perceived conflict of interest. Replacing IMEs by a small number of physicians with assessments by employees' primary care provider (or an addiction specialist

when necessary) and removing the requirement for medical monitoring will reduce the opportunity for potential or real conflicts of interest.

III. Ensure physician choice and privacy of health information disclosed

Certain aspects of the current approach to care for nurses with SUDs are unnecessarily invasive in terms of patient privacy and prevent nurses from receiving care and assessment from the physician of their choice. For instance, under the current approach, first-line diagnostic care must be provided by a medical practitioner (IME provider) other than the nurse's treating physician, with whom the nurse does not have a relationship of trust and confidence. The IME provider collects the nurse's health information and medical records as a matter of course. Thus, nurses' private medical information is shared with a widening scope of practitioners, regardless of the relevance and the nurse's wishes. Moreover, IME reports are typically provided directly to the third-party ordering the examination (e.g., professional regulatory body, employer), whereas under most circumstances, it is up to the individual who has access to their personal health information. This provision of IME results to the third-party ordering the examination may constitute an unnecessary invasion of the employee's privacy, as the employer may only need and be entitled to some of the information in the IME report for workplace purposes.[65]

There are two additional concerns with employee privacy with the current approach. The first is the practice of some employers to require employees in safety sensitive positions to disclose past or present substance use disorders. This requirement to disclose current or past alcohol/drug dependency problems regardless of severity or whether work is being impacted may be considered overly broad and requires disclosure of personal information that employers may not reasonably need for workplace purposes. Second, per The Canadian Human Rights Commission's *Impaired at Work: A guide to accommodating substance dependence*, treatment plans are confidential agreements between a patient and their treating physician. Return to work agreements "should not include treatment expectations or any other details of an employee's confidential treatment plan."[65] However, in contravention of this guidance, the current approach commonly includes treatment expectations, including a requirement for total abstinence from all substances (including over-the-counter medications), and a minimum number of AA/NA meetings to be attended weekly.

Since IMEs are required as a matter of course, nurses' choice of physician is routinely restricted upon entry into the standard care pathway. It is further restricted by the fact that nurses may only be assessed by a BCCNP-approved IME physician. Removing the requirement for IMEs and allowing nurses to be evaluated by their primary care providers, with whom they have existing therapeutic relationships, or an addictions specialist of their choice when necessary, will ensure that nurses with SUDs retain choice in physician. This will also limit the number of people who have access to their private medical files.

IV. Reduce Stigma and Encourage Voluntary Early Disclosure

The current regulatory approach mandates all nurses to similar treatment plans regardless of substance(s) used, severity, and other relevant factors. This "one size fits all" approach and its blanket assumption of safety risk treats SUDs as uniquely impairing and harmful, which may reinforce stigma that harms both employees with SUDs and other patients seeking care, who suffer when stigma goes unchallenged.[34] Although there is little evidence on the factors that support or inhibit voluntary disclosure of an SUD at work[10], literature on disclosure of mental health problems exists and may be a reasonable substitute, given the high rate of stigma and discrimination, as well as the frequent overlap of mental health disorders and substance use disorders. Factors associated with a reduced likelihood of disclosure include concerns about losing one's job, fears of stigma and discrimination, decreased

confidence in ability to maintain professional status, and pressure to fit in with colleagues.[66] Additional factors reducing the likelihood of disclosure include stigmatizing stereotypes, a perceived lack of knowledge about mental health disorders from their employer, past experiences of being treated differently or rejected after disclosure, and fear that they will be "marked" with the label of having a mental health problem, which will lead to their opinions being devalued and dismissed.[67]

Meanwhile, a systematic review found the following factors to be associated with an increased likelihood of disclosure: high perceived rates of emotional support in the workplace, knowledge of legislation that protects those with disabilities, longer period receiving psychiatric mediation, and decreasing ability to complete work tasks.[66] A qualitative study on disclosure beliefs and experiences of people with mental health problems identified the following needs prior to disclosure: the establishment of trust, establishing performance and personality prior to disclosing, and the ability to introduce information slowly and gauge reactions.[67] The most important aspect identified in the timing of disclosure is the need for reasonable accommodations.[67] Additional factors include the confidence that disclosing would not result in negative repercussions, that employment is secure, feeling appreciated by supervisor, and supervisors and coworkers are perceived as supportive.[68]

Aligning policies on nurses with SUDs with current evidence would likely help reduce stigma and encourage voluntary early disclosure, allowing nurses to seek treatment earlier in the course of their SUD, as those disclosing would be given choice in their treatment options and would be reassured that their ability to continue working would be based on analysis of their particular situation, tasks, abilities, and risk, rather than the stigmatizing belief that nurses with SUDs present a unique and inherent danger.

Recommendations:

1. Encourage nurses with SUDs to retain control over the choice of qualified health care providers, including first-line diagnostic care providers, treatment providers, and other health care providers.
    a. If an IME is required, ensure there are no conflicts of interest by having this performed by a health care provider that does not have any relationship to a monitoring company.
    b. Remove barriers to access second opinions, including costs incurred by nurses if second opinion accords with initial assessment.
    c. Remove mandated support group attendance
2. Encourage nurses with SUDs to retain control over individually tailored choices of evidence-based treatment options, including choices to move between multiple care approaches and treatment options that match their needs and preferences.
3. At each stage of the care pathway, ensure that nurses with SUDs are free to give, refuse, or revoke consent on any grounds; and be fully involved in all case planning and decision-making and have the information that a person would reasonably require to understand the proposed health care plan.
4. Implement supportive workplace policies alongside educational activities that destigmatize substance use and SUDs
    a. Remove wording from policies that emphasize punitive sanctions and replace with therapeutic and evidence-based approaches that promote recovery.
    b. Eliminate harmful coercive practices and non-evidence-based compulsory interventions in the SUD care system.
5. Cultivate a safe work environment for nurses by maintaining employee privacy.

a. Ensure that the personal health information of a nurse with a SUD is collected or disclosed only on a "need to know" basis with the knowledge and consent of the nurse.

3. Promote individualized risk-management

The current approach operates on a baseline assumption that all problematic substance use and SUDs among health care providers, regardless of the specifics or severity, present a safety risk to patients, rather than focusing on impairment in the workplace. This approach treats substance use as uniquely risky, which is a position not supported by evidence.[33] Rather, this assumption is likely based on the ubiquitous societal stigma around SUDs that views individuals with SUDs as dangerous.[34] An internet survey of registered nurses in Alberta (n=4064) found 121 (3%) self-identified as fitting an SUD diagnosis. Only three of those 121 nurses had been reported to their employer or regulatory body due to their alcohol and/or drug use.[2] An American study of 904 physicians who had completed a Physician Health Program found that 29% (261 physicians) had at least one recorded relapse, with only one episode of patient harm identified (overprescribing).[8] While any episode resulting in patient harm is problematic, and the data that exists is not of the highest methodological quality, the very low rate of patient harm reported in the studies above suggests that the safety risk attributed to health care professionals with SUDs may be overstated.

All nurses are required by their regulatory colleges to provide "safe, competent and ethical care to their clients."[64, 69, 70] There are many factors unrelated to substance use that could impact a nurse's capacity to provide safe, ethical, and competent care, including chronic or acute illness, social and relationship instability, or intractable insomnia. Further, there are also instances where substance use may not impact a nurse's ability to provide safe, ethical, and competent care, including use that occurs outside of work hours. Cases where substance use does prevent a nurse from providing safe, ethical, and competent care must be considered seriously and within an individual approach and include an evaluation by a trained and qualified addiction treatment provider.

Where risk does exist, it should be managed through medical evaluation, analysis of workplace environment and duties, and risk mitigation strategies based on the severity, type, individual factors, and social supports. Effective safety risk management involves systematically assessing workplace hazards based on physical work space, job duties, and potential for risk/adverse events, rather than making a blanket assumption based on stereotypes. Where the particular circumstances of a nurse with an SUD suggest a potential inability to provide safe, competent, and ethical care, appropriate steps must be taken to assess and manage safety risk, through medical evaluation (by a trained and qualified addiction treatment provider), thorough analysis of workplace considerations, and effective risk mitigation measures. Rather than imposing universal, blanket restrictions across multiple life domains and social contexts (e.g. mandated abstinence from all psychoactive substances) risk mitigation measures should be individualized and focused on the specific tasks and activities required in each nurse's practice.

As outlined above, research on compulsory monitoring is scant and the evidence supporting PHP-type approaches is of generally poor methodological quality.[28, 32] In addition, medical monitoring agreements frequently have requirements that may be experienced as onerous depending on the severity of SUD and other individual considerations. These include weekly monitoring sessions; total abstinence from all psychoactive substances other than caffeine and nicotine; a minimum of three documented mutual self-help group meetings per week; finding a sponsor of the same sex; and abstinence from a variety of ethyl alcohol-containing products (e.g., certain mouthwashes, non-alcoholic beer and wine, and wine for communion).[71] These requirements are in addition to the

treatment the employee receives from their primary care provider and/or other specialists, and have significant costs associated, with monthly costs frequently exceeding $1000.

There may be employees who identify a potential benefit from receiving medical monitoring, including long-term monitoring and relapse detection, and wish to pursue it in addition to addiction treatment and other appropriate interventions. Employees should be supported to pursue medical monitoring when they have identified it as a therapeutic strategy of interest. However, given the lack of high quality evidence to support the use of medical monitoring to improve treatment outcomes or reduce risk, it should not be required of employees in order for them to return to work once their primary care provider or an addiction specialist has determined them capable of returning to modified or full work duties.

Recommendations:

1. Wherever possible, decouple treatment from risk management. Apply evidence-based standards to each.
2. Determine the requirement for medical monitoring on a case-by-case basis for nurses with SUDs
3. Align the approach to risk management for nurses with SUDs with risk management approaches for nurses with other conditions that may result in performance impairment. For example:
    a. Individually assess workplace hazards based on physical work space, job duties and potential for risk/adverse events
    b. Where an individual nurse's substance use disorder and workplace environment intersect to create real risks for safety, take appropriate, individualized steps to assess and manage safety risk, through medical evaluation, analysis of workplace duties, and effective risk mitigation.
    c. Where workplace risks exist, provide temporary accommodations to specific nursing tasks and activities or move the nurse to a more suitable role or physical location..

Proposed action plan

Outlined in this document are a number of recommendations and proposed actions organized into four key opportunities to improve care for nurses with substance use disorders.

1. Promoting evidence-based patient-centred treatment approaches;
2. Avoiding harm and coercion, including addressing conflicts of interest that may exist; and
3. Promoting individualized risk management.

Key proposed actions to improve the processes for nurses with problematic substance use and addiction include:

1. BCCNP and the BCNU each develop position statements that promote reform for institutional policies related to substance use and the workplace, and that promote evidence-based approaches to SUD.
2. BCCNP and BCNU work in concert to develop a clear and publicly available therapeutic pathway, which promotes evidence-based treatments along the continuum of care, individualized approaches, and institutional policies that foster safe and supportive work environments.
3. BCCNP and the BCNU each develop, where appropriate, guidance, position statements, and education toolkits

4. BCCNP and the BCNU support the development of a standardized evidence-based risk management strategy based on the specific risks, duties, and competencies of each nurse.

Conclusion

There are tremendous opportunities to improve care for nurses and other health care providers with SUDs in BC by reforming the current regulatory approach and promoting evidence-based SUD care. In order to address stigma and support employees in seeking treatment early and voluntarily, SUDs should be assessed and treated in a manner similar to other complex chronic conditions that have the potential to impact job performance, behavior, or safety. Given the considerable heterogeneity of substance use issues (including substance type, severity, previous treatment attempts, co-occurring conditions, and the medical and/or social consequences of use), a one-size-fits-all approach is inadequate and may cause harms in some cases.

Promoting public safety and minimizing potential risks are of paramount importance, especially in the health care sector. When nurses with SUDs are clinically stable and advised to return to work by their general practitioner or addiction specialist, risk assessment and accommodation should be based on individual workplace environments and job duties, rather than blanket assumptions that all nurses with SUD pose inherent safety risks.

Institutional policies should be updated to reflect and promote current evidence-based approaches to treatment, with mandatory medical monitoring removed. A patient-centered approach should be promoted, where the employee has access to a range of local treatment options, including evidence-based pharmacotherapies, where indicated. These policies should emphasize the importance of individualized treatment plans, carefully crafted in a collaborative manner and based on the severity of SUD and other individual factors. Workplace policies should use supportive language and institutional educational activities should be developed to combat stigma related to substance use, thereby encouraging earlier and voluntary disclosure of potential workplace problems.

Taken together, the information and discussion outlined above represents an urgent call to action. Meaningful reform of the current regulatory approach to nurses with SUDs in BC cannot wait. A new approach is needed to ensure timely assistance and individualized, trauma-informed, culturally competent, and collaborative care that is confidential, supports recovery, and offers avenues to remain at or return to work.

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