

The Throwaway Nurse Syndrome: Examining the Lived Experiences of Nurses who Divert  
Opioids

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## **Abstract**

This dissertation explores the lived experiences of nurses who have engaged in opioid diversion for personal use. Interpretive phenomenological analysis, a qualitative methodology, was utilized to gather data through private interviews with nine nurses residing in Canada and the United States. This research draws upon the theoretical concepts of taboo and stigma as found in the work of Freud, Goffman, and other scholars. Analysis of the transcripts revealed five key themes. This study contributes to the limited understanding of nurses' encounters with opioid addiction, diversion, and participation in alternative to discipline programs, highlighting the long-term effects on their personal and professional lives. In addition, the findings underscore the importance of acknowledging and addressing diversion, promoting a better understanding of addiction and combatting its social stigma, critically evaluating the public image of nurses and its impact on nurses' lives, and probing into the relationship between substance misuse and the profession of nursing. Finally, this study underscores the need to increase support for nurses, raise awareness of support programs that do exist, and improve the alternative to discipline programs to better facilitate a return to meaningful work in the nursing profession.

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On a different note, and I realize this may be a bit unorthodox, I find it important to express gratitude to myself for getting through such a challenging experience. I cannot put into words how difficult this journey has been. Yet, I somehow managed to get through something almost impossibly painful and turn it into something positive. My experiences were unfortunately worsened as during my PhD journey I was simultaneously dealing with litigation surrounding a medical procedure. During this case, my history was heavily scrutinized, used as a ploy to discredit me as a person and devalue the harm I endured. While I anticipated this, I can't deny the shame and guilt that it brought forward. Immersing myself in this study, however, and meeting others who had lived through similar events, helped me beyond measure. I was able to see the magnitude of the problem and better understand the occupational hazards that nurses face. I am learning to let go of the past and am proud of how far I have come.

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## **The Throwing Nurse Syndrome: Examining the Lived Experiences of Nurses who Divert Opioids**

Addiction is a serious health issue that can have potentially fatal consequences (Dunn, 2005). This is a condition whereby individuals use substances compulsively, continue to use despite harm, and suffer withdrawal effects if they stop (Hyman, 2005). Addiction can result from the misuse of licit substances such as alcohol, tobacco, cannabis, and prescription medications, as well as illicit substances including cocaine, heroin, and methamphetamines (Kiepak & Baron, 2019; Stewart & Mueller, 2018). When the consumption of these substances is inappropriate, excessive, and results in harmful effects to one's health, well-being, and social functioning, it is considered misuse (Brennan, 1991; Health Canada, 2022). Substance misuse is distinct from typical use which adheres to prescribed dosages or socially accepted norms for moderate and responsible substance use.

The vast majority of individuals who use substances do not misuse them, nor do they become dependent upon them, however rates of addiction are rising in North America and beyond (Baird, 2021; Volkow et al., 2019). Addiction impacts people of all backgrounds and social classes. This includes healthcare workers, who are not immune to issues with substances despite their unique skills and knowledge surrounding addiction (Perry & Vandenhouten, 2019; Ross et al., 2018; Talbert, 2009). Nurses are thought to misuse substances and develop addiction at the same rate as the public, estimated to be between 6 – 20% (Dunn, 2005; Kuyk et al., 2016b; Patrick, 2010; Ross et al., 2018; Shaw et al., 2004; Smentkowski & Primas, 2014; Talbert, 2009; Watson, 2009).

Although there are various substances that can be consumed in a harmful way, this research will focus on opioid misuse by nurses, focusing on the diversion of opioids by nurses

to sustain their consumption. Drug diversion is the unlawful misuse or misdirection of any medication by healthcare workers from their places of work (Clark, 2020). Opioid misuse entails that the opioids are either not prescribed to the user, are not being taken as prescribed, or are being used for reasons other than they were intended (Volkow et al., 2019; Vowles et al., 2015). While not all those with opioid addiction engage in diversion, opioids are accessible to nurses working in tertiary care, as well as other settings, and their diversion is well-documented (Braquehais et al., 2015; Carpenter, 2014; Clark & Farnsworth, 2006; Hastings & Burn, 2007). There is no data which can fully explicate the extent of drug diversion as it is engaged in covertly and can occur undetected (Baldisseri, 2007; Berge et al., 2012). The sparse research that does focus on this issue is dated and has been conducted on small non-representative samples (Collins et al., 1999; Patrick, 2010). Drug diversion is, however, a well-known and documented concern that can have catastrophic consequences upon nurses, patients, colleagues, healthcare facilities, and the profession of nursing (Berge et al., 2012; Collins et al., 1999). According to Berge et al., (2012) some diversion does take place for financial gain, but most diversion occurs for individual use. Within the context of this research, the use of the term diversion will imply the misdirection of opioids by nurses for their personal misuse, and it will be regarded as a behaviour resultant of addiction.

Historically, punitive measures such as termination, license loss, criminal charges, and even incarceration were used to address diversion by nurses (Baldisseri, 2007; Brennan, 1991; Daprix, 2003; Darbro, 2009; Monroe & Pearson, 2009; Pullen & Green, 1997; Sidlinger & Hornberger, 2008). As diversion was perceived as delinquent behaviour, the response from employers and regulatory bodies was purely disciplinary, and there was little consideration of the need to advocate for or treat healthcare workers with addiction (Baldisseri, 2007; Monroe et

al., 2008). There was also a lack of support for affected nurses from their colleagues and unions (Patrick, 2010). The overwhelmingly negative response and severance of ties was dubbed the “throwaway nurse syndrome” by Bissell and Jones (1981). This term elucidates the shunning of nurses seen to lack the moral tenability long associated with this profession and conveys the predominant lack of compassion and concern for nurses grappling with addiction (Heise, 2003).

In 1984, the American Nurses’ Association (ANA) was pressured to take action after increasing numbers of nurses were reported and disciplined for substance misuse and diversion (Dabney, 1995; Trossman, 2003). Around this time, it was found that between 67% to 90% of disciplinary actions against nurses by nursing boards were in response to substance misuse (Darbro, 2005). This led to the creation of various alternative to discipline (ATD) programs in the United States (US) managed by regulatory bodies in individual states (Darbro, 2005; Monroe & Kenaga, 2010). These programs lagged somewhat within Canada where their provincial implementation commenced in 2010 (Monroe & Kenaga, 2010).

ATD programs, also referred to as nonpunitive return to work programs, currently exist throughout North America albeit in different capacities. These programs present nurses with an opportunity to re-enter nursing practice, moving away from a strictly punitive approach (Mumba et al., 2019). ATD programs focus on early detection and treatment with an aim to safeguard the public while also providing support and assistance for nurses (Monroe et al., 2008). Persistent nursing shortages combined with the time and resources required for training supports the need for nurse retention through these programs (Darbro, 2005; Monroe & Pearson, 2009). ATD programs assert that they possess both financial and social benefits, and statistics indicate these programs are highly successful. Trossman (2003) found that between 85% - 90% of nurses who participated in ATD programs were able to cease substance use, a rate far greater than that of the

general population. The high recovery rates observed can be attributed to a variety of factors within the programs, with some studies indicating these positive outcomes are associated with the mandatory treatment and monitoring components inherent within the ATD programs (Clark & Farnsworth, 2006).

While it is indeed promising to learn that long term sobriety is both possible and sustainable, and that many health care workers successfully return to practice following addiction and diversion, it is essential to look deeper into experiences of addiction within the nursing profession. Recovery rates alone fail to provide a complete understanding surrounding the experience of diversion and return to work (Darbro, 2005). Despite the development of the ATD programs and the potential benefits they can provide, there is a need for a comprehensive exploration of the implementation and experience of these programs. While they are presented as non-disciplinary, it is important to understand how they unfold in practice. There exists a significant gap in knowledge regarding the experiences of nurses who participate in these programs and the challenges they encounter during their return to work. This includes questions surrounding the requirements placed upon nurses, the type of support they are provided, and how they are integrated back into the workforce. Indeed, while ATD programs have expanded opportunities for nurses to maintain their employment and nursing licensure following diversion, there has been little research focused explicitly on understanding the unique experience faced by nurses in these circumstances.

Moving beyond the structure of the ATD programs, it becomes imperative to delve into the lived experiences of nurses grappling with addiction and diversion and how they experience the ATD programs. A comprehensive understanding can be gained by exploring their personal narratives, encompassing substance use histories, influential factors upon their misuse, and

personal and professional stressors. These facets can provide valuable insights into the challenges they have faced. Furthermore, it is crucial to investigate the enduring impact of opioid addiction and diversion on nurses, as the consequences often extend well beyond the completion of the ATD programs. They can affect career trajectories, family dynamics, social connections, and self-identities. Finally, exploring nurses' encounters with stigmatization, a pervasive issue in addiction, is essential. Unraveling the nature and repercussions of this stigma in the healthcare system and society at large can shed light on the journeys of these nurses. Transitioning from removal from practice to the return-to-work process presents numerous challenges for nurses dealing with opioid addiction, and sharing their stories can foster understanding and reveal the meanings drawn from this complex journey.

### **Terminology**

Prior to delving into the issue at hand, it is crucial to address the language surrounding what is commonly referred to as *addiction*. While there are numerous terms that are used to describe individuals who misuse drugs and alcohol, many of these terms are offensive and stigmatizing. The term addiction is used most frequently within the literature and is the term that each participant organically chose to describe their condition within the interviews. While I was hesitant to adopt this term, its acceptance, and its self-descriptive use by those who participated in this study provided rationale for its use. This research will, therefore, utilize the term addiction. The terms *chemical* and *opioid dependence* will also be used when relevant. Dependence indicates physical and/or psychological reliance upon substances to function in day-to-day life or to manage uncomfortable emotions (Baldisseri, 2007).

Some literature utilizes the brain disease model, which refers to addiction as an *illness* or a *disease*. This type of language can elicit negative thoughts and beliefs as it insinuates that the

person's brain is damaged. This approach can potentially increase stigmatization (Meurk et al., 2014). Within this study, the terms *condition* or *issue* will be used to avoid a sole medical model approach. Furthermore, the act of consuming drugs or alcohol in a maladaptive or harmful way will be termed substance *misuse* to avoid using the term *abuse*, which is associated with violence and carries judgmental undertones. Research suggests that use of this term can increase punitive treatment of patients by their healthcare providers (Szalavitz et al., 2021). Finally, the term *addict* will be avoided when referring to individuals with addiction. This term is often associated with the stereotypical portrayal of dishonest and immoral substance users (Dunn, 2005; Ferentzy & Turner, 2013). Moreover, it implies that addiction defines the entirety of the individual, solely reducing them to their condition. This language can contribute to stigmatization and elicit negative reactions such as judgement and blame. This study will make use of language *a person with addiction* as it is person-first language and emphasizes that the individual has a problem, rather than is the problem (National Institute of Health, 2021).

If any direct quotes from studies include alternate wording, it will be reflected in italics or quotation marks. As many of the studies included in this literature review were written over a forty-year period, the accepted terminology varies between studies and sources. The aim is for the language used in this study not to contribute further to the stigmatization surrounding addiction and individuals who misuse opioids.

### **Operational Definitions**

Clarifying the terminology used in this study is necessary to ensure common understanding. This clarification will include terms related to substance use as well as terms that pertain to nurses in particular. These terms are addiction, *addict*, chemical dependence, diversion, impaired nursing practice, opioid dependence, opioid use disorder, recovery, re-entry

to practice, stigmatization, substance use, substance misuse, substance use disorder, and tolerance. Each will be addressed within this study and the following definitions will be used:

**Terms:**

**Addiction:** The continuous and compulsive use of substances despite harm to oneself and/or those around them, including family and friends. Involves excessive time devoted to procuring and using substances and powerful cravings to use the substance of choice (Baldisseri, 2007; Health Canada, 2022).

**Addict:** A person with an addiction or a diagnosis of substance use disorder (SUD). Carries a negative bias and has stereotypical associations (National Institute of Health, 2021).

**Chemical Dependence:** Physical or psychological dependence upon drugs or alcohol for day-to-day functioning or to manage uncomfortable emotions. The symptoms include the need for increasing amounts of the substance to obtain desired effects and withdrawal symptoms if stopped. (Addiction Centre, 2023; Baldisseri, 2007)

**Diversions:** The unlawful channeling of a controlled substance, including prescription medications, often by healthcare professionals for non-medical purposes such as self-administration (Tanga, 2011).

**Impaired Nursing Practice:** The inability of a nurse to perform their job in a safe and skillful manner due to mental illness or a dependency on drugs or alcohol (Dunn, 2005; Baldisseri, 2007).

**Opioid Dependence:** Physical or psychological dependence upon opioids for day-to-day functioning or to manage uncomfortable emotions. Physical dependence is often associated with withdrawal symptoms when opioids are not used (Addiction Centre, 2023).

***Opioid Use Disorder:*** A diagnostic term for a problematic pattern of opioid use that leads to significant impairment. Marked by a variety of characteristics including cravings, excessive time and energy spent to obtain and use opioids, continued use despite social/interpersonal problems, development of opioid tolerance, and experiences of withdrawal (American Psychiatric Association, 2013).

***Recovery:*** The process of achieving and maintaining a substance-free life, often involving physical, psychological, and social aspects of personal health and wellness (NIH, 2021).

***Re-Entry to Practice:*** The stage in which nurses who have engaged in diversion are able to return to their nursing careers following treatment and meeting necessary regulatory body requirements (Matthias-Anderson & Yurkovich, 2020).

***Stigmatization:*** The process of labeling, stereotyping, or discriminating against individuals who share an attribute or a behaviour that is socially undesirable. This includes individuals who misuse substances, leading to a variety social, emotional, and legal problems (Goffman, 1963; Sleeper & Bochain, 2013).

***Substance Use:*** Controlled and limited drug or alcohol consumption without adverse consequences (Dunn, 2005).

***Substance Misuse:*** Excessive alcohol or drug use that leads to social consequences and psychological or physical harm. Also termed as “abuse” in the literature (Baldisseri, 2007; Dunn, 2005).

***Substance Use Disorder:*** A diagnostic term for a neuropsychiatric disorder that impacts behaviour, cognition, and brain functioning, and is often marked by relapses (American Psychiatric Association, 2013).

**Tolerance:** Occurs when an individual who uses drugs or alcohol over time becomes accustomed to a particular dose and needs higher amounts to obtain the same effects (Bartlett et al., 2013; CDC, 2021; Government of Canada, 2023; Kosten & George, 2002).

### **Statement of the Problem**

Opioid diversion is an ongoing issue within the nursing profession that remains largely unacknowledged (Baldisseri, 2007; Johnson & Borsheski, 2019; Watson, 2009). The historical refusal of nursing regulatory bodies to acknowledge addiction in nurses, despite the danger it poses, has contributed to its taboo nature within the profession (Boulton & Nosek, 2014; Brennan, 1991; College and Association of Registered Nurses of Alberta [CARNA], 2017; Patrick, 2010; Hendrix & LaGodna, 1986; Stewart & Mueller, 2018). Taboo acts in nursing include the actions or behaviours that are strongly discouraged and socially unacceptable by its members, which includes the misuse of substances by nurses. For years this was deemed a “conspiracy of silence” within the nursing community where diversion and substance misuse were known to take place, but not discussed (Baldisseri, 2007, p. 111; Brennan, 1991; Dunn, 2005; Quinlan, 2003). Regardless of the development of dedicated programs to manage this ongoing concern, the acknowledgement of diversion is still skirted by the healthcare system (Monroe & Kenaga, 2010). There is a culture of mistrust and judgement surrounding addiction within the healthcare field (Baldisseri, 2007; Kiepek & Beagan, 2018). Today few healthcare institutions have open conversations about the risk for substance misuse and it is frowned upon to openly admit that diversion occurs (Johnson & Borsheski, 2019; Monroe & Kenaga, 2010; Watson, 2009). Drug diversion is regarded as a threat to the professional image of nursing, and it remains a workplace matter most often managed behind closed doors (Johnson & Borsheski, 2019; Kynyk, 2015). Yet there is a need to draw attention to this issue because of the particularly

large risk it poses (Shaw et al., 2004). These effects can be far reaching with potential implications to the lives of nurses, the safety of patients, the reputations of healthcare facilities, and trust in the nursing profession (Dunn, 2005; Hendrix et al., 1987). Despite knowledge of diversion within the nursing profession for many years, it remains a taboo topic and there exists a paucity of research exploring this issue (Clark & Farnsworth, 2006). In order to effectively address opioid diversion, it is essential to first recognize that addiction, and its associated behaviours, are issues that affect nurses and the nursing profession.

Illuminating the lived experiences of nurses who divert opioids is also important to challenge and address popular misconceptions surrounding substance misuse. Addiction is among the most highly stigmatized health conditions (Corrigan et al., 2014; Darbro, 2009). This stigma acts as a significant barrier in both addressing and treating the issue, especially for healthcare workers who can face increased scrutiny and professional repercussions. There are varied contributors to this enduring stigma including its association with disenfranchised groups including racial minorities and people of lower socioeconomic status (Ferentzy & Turner, 2013). Yet it is important to recognize that addiction can affect anyone, regardless of their background, education level, or socioeconomic status. In addition, there is a lingering belief that addiction is due to personal failing, weakness, or the result of some sort of moral deficiency (Dion, 2019; Dunn, 2005, Livingston et al., 2012; Sleeper & Bochain, 2013; Taylor et al., 2021). Historically people who suffered from addiction were thought to possess poor self-control and there remains entrenched social perceptions of drug or alcohol misuse as a choice or a lack of willpower (Bartlett et al., 2013; Dunn, 2005; Trossman, 2003). Additionally, opioid diversion is viewed as a criminal or immoral act, rather than being understood as a symptom of addiction which is a complex health condition requiring holistic treatment and care. The pervasive stigma

surrounding addiction plays a powerful role in the experiences of this population and can have isolating effects on nurses (Berge et al., 2012; Kozicki & Strickland, 2014; Trossman, 2003). It can also act as a barrier to disclosure and seeking help (Stewart & Mueller, 2018; Zimlich, 2018). A deep-seated examination of the sources, manifestations, and encounters with stigma can assist in raising awareness and promoting a better understanding of addiction (Stewart & Mueller, 2018; Zimlich, 2018).

Public opinion of nurses is another important consideration in relation to opioid diversion and misuse. Nurses occupy an elevated position within society where they are often regarded as virtuous, trustworthy, and altruistic (Fealy, 2004; Heise, 2003; Kiepek & Beagen, 2018; Stewart & Mueller, 2018). However, when nurses engage in the misuse of substances, it violates the societal expectations and reverence they are typically afforded (Stewart & Mueller, 2018). Indeed, while society generally frowns upon substance misuse, the reactions are heightened when directed at nurses (Darbro, 2009). This may be in part due to their historical association with sobriety. For instance, in the US new nurses once recited the Nightingale Pledge which emphasized purity and abstinence from harmful drugs (Florence Nightingale Pledge, 1985; McBurney & Filoromo, 1994). Later this pledge became a part of the Code of Ethics by the ANA (Lachman, 2009; McBurney & Filoromo, 1994). This early focus on sobriety has contributed to an enduring image that is at odds with nurses who misuse opioids. This culture of intolerance also stems from within the profession as negative reactions from colleagues often arise when nurses fail to meet the expectations and assumptions regarding proper nursing character (Dunn, 2005; Ross et al., 2018; Tanga, 2011). Moreover, when members of the nursing profession are struggling with substance misuse, they often lack support and solidarity from their employers and regulatory bodies. This quick severance of ties to struggling nurses has led some authors to

comment that “nursing is an army that shoots its wounded” (Quinlan, 2003, p.154). The prevailing view is that nurses must strictly follow their code of ethics, and that substance misuse is incompatible with professionalism (Kiepek & Baron, 2019). As these images can increase scrutiny, this study aims to shed light on how these discourses impact the experiences of nurses who divert and misuse opioids.

Finally, while nurses are thought to experience addiction at the same rate as the general population, there is evidence to suggest that they may be at increased risk to misuse substances due to the nature of their work and their ease of access to opioids and other mind-altering substances (Dunn, 2005; Baldisseri, 2007; Hastings & Burn, 2007; Kunyk & Austin, 2012; Kunyk et al., 2016b). As a result, drug diversion and misuse has been identified as an occupational hazard for nurses (Darbro, 2009; Patrick, 2010; Quinlan, 2003; Smentkowski & Primas, 2014). Despite the perception of infallibility in nurses, they are not immune to the health conditions and issues that affect the wider society (Brennan, 1991; Smentkowski & Primas, 2014). In fact, the nursing profession may perpetuate substance misuse by rewarding competitiveness, self-sacrifice, and endurance, creating stress within the workplace that can impact the mental health of nurses (Quinlan, 2003). Some have even referred to nurses as the "casualties of caring" due to the challenges they face (Bailey, 1985; Plant et al., 1992). There is also a lack of acknowledgement that nursing is saddled with stressful work, decreasing autonomy and control, and experiences of moral distress and injury (Kunyk & Austin, 2012; Patrick, 2010; Perron, 2013). The relationship between the profession of nursing and substance misuse by its members is a critical consideration, and research with a focus on the experiences of nurses with opioid addiction is an underexplored, yet timely and relevant issue in contemporary nursing practice.

## **Research Questions**

What is the lived experience of nurses who have engaged in opioid diversion and misuse? How do these nurses experience their return to work following participation in an alternative to discipline program?

## **Chapter 2: Literature Review**

### **Search Strategy**

A literature review was performed to examine the state of knowledge regarding opioid diversion and misuse by nurses. Preliminary searches used the University of Ottawa's OMNI database along with searches of Google scholar which helped to identify key terms. The literature was then searched using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) as well as searches of PsychInfo, ProQuest, and Medline. Major keywords included "addiction or substance abuse or drug abuse", "impaired health professional", "diversion", "risk factors", "stigma", "taboo", "recovery", and "nurse, nurses or nursing". Articles were also handpicked by reviewing reference lists and by searching authors who had published studies on this topic. Inclusion criteria included articles focusing on the experiences of nurses and had been published in English. The literature review did not distinguish between various types or classes of nurses, including registered nurses (RNs), registered practical nurses (RPNs), and nurse practitioners (NPs). No date range was set to capture the evolutionary nature of this issue. Several themes were noted in the literature which include an overview of opioid misuse, stigma, drug diversion, addiction in nurses, contributing factors, and ATD programs. Each of these themes will be discussed below.

## **Overview**

### ***Substance Misuse, Dependence, and Addiction***

Addiction is a complex issue that affects numerous individuals in Canada, the US, and worldwide. Drugs and alcohol can be used for a variety of reasons including religious or ceremonial purposes, personal enjoyment, performance enhancement, curiosity, and to cope with stress and anxiety (Government of Canada, 2023; National Institute of Health, 2020; Patrick, 2010). Although moderate and responsible use of legal substances is quite common, some individuals who experiment with different substances end up misusing them (Robinson & Berridge, 2003). As described, misuse is the harmful and excessive consumption of substances (Brennan, 1991; Health Canada, 2022).

At times, the terms addiction and dependence are used interchangeably, however there are distinct and important differences between the two. Drug dependence is a broad term that refers to an individual's need for a drug in order to function normally and effectively in their day-to-day life (Addiction Centre, 2023; Baldisseri, 2007). This may be due to physical dependence whereby the body has adapted to the presence of a drug in the system (Centers for Disease Control and Prevention, 2021). This is an expected consequence when certain medications are taken for an extended period. Physical dependence is associated with symptoms of withdrawal (Szalavitz et al., 2021). Withdrawal symptoms can occur if an individual is unable to obtain the substance that they are dependent upon or if they are trying to abstain from substance use (Canadian Centre for Substance Use and Addiction, 2023). It can also occur if an individual has developed tolerance. Tolerance occurs when an individual begins to experience a reduced response to medication over time, thus prompting the need for increased doses (Bartlett et al., 2013; Centers for Disease Control and Prevention, 2021). Withdrawal symptoms can be

physical or psychological in nature and can involve body aches, muscle weakness, nausea/vomiting, profuse sweating, and experiences of anxiety and depression (American Psychiatric Association, 2013; Government of Canada, 2023). These symptoms can further fuel the drive to continue substance use (National Institute of Health, 2020). One can be physically dependent on a substance, for example a prescription medication, but not use it in a way that has negative repercussions on their health (O'Brien et al., 2006). Drug dependence can also be associated with psychological dependence. This occurs when an individual has an emotional reliance upon a medication and feels like they need the drug to do certain activities. This could be to sleep, socialize, or to cope with different uncomfortable emotions including stress, anxiety, or depression (Raypole, 2020). Individuals with psychological dependence may not experience any physical symptoms of withdrawal, however they can have strong emotional cravings for drugs and their effects (Eddy et al., 1965). While the initial decision to use drugs or alcohol is typically voluntary, one's ability to control their use becomes progressively impaired with continued misuse due to physical and psychological dependence (Addiction Centre, 2023; National Institute of Health, 2020). This loss of self-control can culminate in addiction. Addiction is a more severe form of drug dependence with specific criteria (Szalavitz et al., 2021). While drug dependence is a term that references physical and psychological reliance upon a drug, addiction represents a severe and chronic form of drug dependence. It affects the brain and is widely recognized as both a chronic and progressive condition with far-reaching implications (Maly, 1993). It is possible to be drug-dependent and not addicted, however addiction can develop from dependence (Szalavitz et al., 2021). The key characteristics of addiction will be discussed below.

Addiction is a state of severe psychological and/or physical dependence and is associated with continuous and compulsive substance use (Health Canada, 2022; National Institute of Health, 2020). As discussed, addiction has defining characteristics. The Centre for Addiction and Mental Health (CAMH) describes addiction using the following criteria: loss of control of amount or frequency of use, compulsion to use, ongoing cravings, and use despite consequences (Centre for Addiction and Mental Health, 2023). Indeed, one of the hallmarks of this condition is the impairment of self-control (National Institute of Health, 2020). Individuals with addiction may make numerous attempts to cut down or stop using substances without success (Centre for Addiction and Mental Health, 2023). In addition, it is important to clarify that addiction is greater than an urge to use drugs or alcohol. Rather, it is an overwhelming, relentless, and uncontrollable compulsion to find and use one's drug of choice (Baldisseri, 2007; Bartlett et al., 2013). This can include risky behaviours that an individual would not otherwise have engaged in, for example drug diversion. Addiction is also characterized by powerful cravings (Szalavitz et al., 2021). Intense and persistent cravings are common, and these can be triggered by various cues including one's environment or their emotional state (National Institute of Health, 2022). These cravings are so intense that they can render individuals helpless in controlling or discontinuing their substance use (Bartlett et al., 2013). Finally, use despite harm is a feature of addiction. It involves substance use at the expense of most other activities and responsibilities in a person's life (Robinson & Berridge, 2003). Individuals with addiction become consumed by the pursuit of their substance of choice, prioritizing it regardless of consequences and adverse outcomes (Bartlett et al., 2013; Hyman, 2005; Lillibridge et al., 2002). This is often to the detriment of their personal relationships, professional obligations, and their overall health and well-being (Maly, 1993). Despite these defining characteristics, it is important to recognize that addiction

is a complex condition. Not all people with addiction will have the same symptoms and experiences as it affects individuals in different ways.

There are numerous substances that can lead to addiction, including both licit and illicit drugs, alcohol, and nicotine (American Psychiatric Association, 2013; Bartlett et al., 2013). Although there are similarities between these substances, there are also distinct differences in terms of legality, potential for harm, associated stigma, and acceptance within society. Social attitudes and laws regarding the use of different substances have shifted over time in North America (Ferentzy & Turner, 2013; Kiepek & Baron, 2019). Alcohol, for example, was demonized during prohibition yet is now culturally accepted when used in moderation. Nicotine is often viewed as separate from illicit substances, although it can still be considered a type of gateway drug into the misuse of other substances (Ferentzy & Turner, 2013). The shifting of standards for substance use over the past century has seen social judgment first associated with alcohol, then altered to be primarily associated with illicit drugs. Generally, there is stigmatization towards individuals who use any substances illegally or those who live with substance dependence or addiction (Canadian Centre on Substance Use and Addiction, 2023; Taylor et al., 2021). Unfortunately, the massive influx of opioid misuse has increased negative attention surrounding drug addiction and the stereotypical *drug-addicted junkie* is often the illustrative figure for this issue within contemporary society (Ferentzy & Turner, 2013). As a full overview of addiction is beyond the scope of this study, the focus will be opioid addiction.

Opioids are the subject of this research for several reasons. Firstly, opioid-related deaths have risen dramatically due to the opioid crisis, particularly due to the increase in illicitly manufactured fentanyl (Szalavitz et al., 2021). In the US, opioids are a leading cause of preventable death (Centers for Disease Control and Prevention, 2022; Rudd et al., 2016;

Vashishtha et al., 2017). This is due to overdoses, but also through accidents and violence (McLellan, 2017). Canada is the world's second-largest prescriber of opioids, after the US (Belzark & Halverson, 2018). The number of Canadians struggling with opioid addiction has continued to grow through illegal use and prescription misuse, with the provinces of Ontario, British Columbia, and Alberta being disproportionately affected (Belzark & Halverson, 2018; Government of Canada, 2023; Nosyk et al., 2013). In 2022, 7328 deaths were attributed to opioid-toxicity in Canada, double the rate prior to the Covid-19 pandemic (Government of Canada, 2023). The US statistics are alarming where close to 100,000 opioid-related deaths occurred in 2020 (Centers for Disease Control and Prevention, 2022).

Opioids will also be the focus of this research because of their frequent use in tertiary care for the management of acute and cancer pain, as well as during operative procedures. Morphine, fentanyl, and oxycodone are among the opioids used in hospital environments. As a result, many nurses working in tertiary care have regular access to these medications within their professional practice (Matthias-Anderson & Yurkovich, 2020). Opioid diversion and misuse are known to occur by nurses and other healthcare professionals (Berge et al., 2012). Their use as pain management must be balanced with the risk of misuse, both by patients and healthcare workers (Webster, 2017). Although focusing on a specific class of drugs is a limitation of this research, opioids are responsible for the current public health crisis and are being misused by many individuals, including nurses.

While this study specifically examines opioid addiction, it is important to nuance the harms associated with other substances. For instance, alcohol is the substance most misused by nurses and physicians (Berge et al., 2012; Trossman, 2003), and studies have shown that it is the most harmful drug to individuals and society as a whole based on categories such as drug-related

mortality, damage, dependence, and loss of relationships (Nutt et al., 2010). Despite the known effects of alcohol, it remains legal, celebratory, and socially acceptable to engage in alcohol consumption in North America, and there is a tendency to highlight the harms of illicit substances, including opioids (Single, 1996). This could be tied to legality and beliefs that illegal substances are more dangerous or harmful. This may also be because illicit drugs can be sources of harm to others through criminal activity including drug-smuggling and drug-dealing (Wilkinson & Ritter, 2021). This is especially true in countries where the manufacture and trade of illicit drugs have been linked to extreme violence and corruption (Wilkinson & Ritter, 2021).

### ***Substance Use Disorder – Disease Model vs. Choice Model***

Addiction can be viewed from different lenses. From the biomedical disease model, a framework used in healthcare to approach and understand diseases, substance misuse and resultant chemical dependence and addiction are attributed to substance use disorder (SUD). This is defined in the DSM-5 as a neuropsychiatric disorder that impacts behaviour, cognition, and brain functioning, and is often marked by relapses (American Psychiatric Association, 2013; Everitt & Heberlein, 2013). The symptoms and severity of SUD can change over time as individuals move in and out of problematic substance use (Pycroft, 2015). This can result in relapse after long periods of sobriety. SUD is marked by adverse social, occupational, legal, and interpersonal consequences (Maly, 1993). This can include repeated absences from school or work, criminal charges, and marital and relationship issues (Dunn, 2005).

SUD can be linked to a variety of substances including opioids, alcohol, other prescription drugs (e.g., benzodiazepines), and illicit drugs (Stewart & Mueller, 2018). SUD is classified as a chronic and progressive disorder (NIH, 2020). While death is the most significant risk of opioid misuse, there are other risks including localized and systemic infections (for

example endocarditis and cellulitis), organ damage from long term drug use, and anoxic injuries to the brain, heart, and other organs related to respiratory depression (Berge et al., 2012; Government of Canada, 2021; Health Canada, 2019; National Institute of Health, 2020). The use of contaminated equipment can also put individuals at risk for the transmission of Hepatitis C and HIV (Hatia et al., 2015; National Institute of Health, 2020). Additionally, the actions taken by individuals while intoxicated, such as driving or unsafe sex, can increase the likelihood of injury or death (Health Canada, 2022; National Institute of Health, 2020). There is also a connection between drug use and mental illness. These issues often co-exist, and, at times, drug use can trigger or worsen mental health conditions including anxiety, depression, and schizophrenia in those with vulnerability (National Institute of Health, 2020; Kelly & Daley, 2013).

SUD is characterized by impaired brain functioning. To better understand why opioids are misused so frequently, it is important to understand how the brain responds to opioids on a physiological level (Everitt & Heberlein, 2013). When opioids are consumed, they stimulate the release of dopamine, a neurotransmitter that induces feelings of intense pleasure (Patrick, 2010). This initial feeling of euphoria can serve as a powerful incentive for repeated opioid use (National Institute of Health, 2020). However, continued misuse of opioids can lead to significant changes in the brain, resulting in opioid dependence. Firstly, individuals with opioid dependence are no longer able to experience the same levels of pleasure without these drugs because their dopamine receptors become depleted (Patrick, 2010). In addition, their brain adapts to the presence of opioids, functioning normally when drugs are present and abnormally when they are not (Kosten & George, 2002). At this stage, the driving force behind opioid consumption transitions from the pursuit of pleasure to the avoidance of withdrawal symptoms (Kosten &

George, 2002). Opioid tolerance is another development that results from ongoing and escalated opioid use. This condition necessitates increasingly higher doses of opioids to prevent symptoms of withdrawal (Robinson & Berridge, 2003). As discussed, withdrawal symptoms can be psychological and physical in nature such as anxiety, restlessness, jitters, and gastrointestinal discomfort (Kosten & George, 2002).

The changes in the brain resulting from drug use are central to understanding SUD. Indeed, when an individual reaches a point where they cannot function without opioids, it marks the critical turning point whereby drug misuse evolves into a neuropsychiatric disease. The brain's reward system becomes essentially hijacked, and individuals find themselves trapped in a cycle they can no longer control (Meurk et al., 2014; Patrick, 2010). Loss of control over drug use is one of the hallmarks of SUD, profoundly affecting a person's brain functions and their desire to continue using (Bartlett et al., 2013). These neurological changes contribute to the persistent and compulsive use of substances in the face of potential risks and negative consequences (Patrick, 2010).

Arguments in favour of the disease model assert that ongoing substance misuse is a symptom of SUD, which significantly impacts behavior and decision-making (Everitt & Heberlein, 2013). This biomedical perspective emphasizes that substance misuse is not a matter of willpower or moral failing, but rather the result of a complex interplay between biological, psychological, and environmental factors (which will be discussed further below). While SUD does have lasting impacts on the brain, it is crucial to recognize that recovery is attainable. Recovery approaches may include abstinence or harm reduction strategies, which can include medications such as methadone or buprenorphine to alleviate cravings and deter further use

(Braquehais et al., 2015). Nevertheless, it is important to acknowledge that relapse remains a possibility as individuals strive for long-term sobriety.

The classification of drug and alcohol addiction as a neurological disorder is a topic of debate (Branch, 2011). Some reject the disease model and find fault labelling addiction a medical condition. There are suggestions that this classification is an attempt to excuse individuals' behaviour while obtaining substances or under the influence of substances (Meurk et al., 2014). Holden (2012) goes as far as describing the disease model as a way for *addicts* to shirk personal responsibility for their actions. Others believe that continuous substance misuse reflects poor morality or character (which will be discussed later in this chapter).

An alternate approach is the choice model, and Heyman's book, *Addiction: A Disorder of Choice* (2009), offers a controversial perspective whereby he sees life choices and consequences as the primary motivators for substance use. Heyman (2009) argues that while individuals may not choose to be *addicts*, their addiction is the byproduct of life decisions they have made. For example, when faced with life stressors, *addicts* may have chosen substances for their immediate mood-altering effects rather than options that would provide delayed gratification, such as exercise, meditation, or therapy. He sees addiction to be the result of a series of life choices driven by a desire for emotional comfort rather than the result of a disease process. Furthermore, Heyman (2009) challenges the notion that addiction is a medical condition requiring treatment. He points out that while up to 30% of adults will meet the criteria for addiction at some point in their life, most individuals are capable of recovering without medical intervention, thus indicating that addiction is not a true disease (Heyman, 2009). Holden (2012) echoes Heyman's argument, asserting that true diseases will worsen without medical attention thus classifying addiction as a behaviour rather than a traditional disease. These perspectives

offer a counterpoint to the disease model of addiction and emphasize the role of personal choices and consequences in the development and resolution of substance use disorders. While these arguments challenge the contemporary understanding of addiction, they also shed light on the intricate and multifaceted nature of this issue including the social controversy and deep-rooted stigma associated with addiction.

### ***Contributory Factors***

In addition to the neurological factors discussed above, there are numerous psychological and environmental factors that can play pivotal roles in the development of addiction. Certainly, some individuals will experiment with substances out of curiosity, however there are often other elements involved when substance use evolves into misuse or addiction. These factors encompass a wide range of conditions and experiences, further underscoring the complexity of addiction. Some of the influential factors can include traumatic experiences, mental health conditions, stress, family circumstances, and economic factors.

There are a variety of psychological experiences that can be connected with substance misuse. Individuals who have undergone or been exposed to traumatic events, such as physical or emotional abuse, accidents, or violence may suffer profound emotional repercussions (Nehls & Sallmann, 2005; Wiklund, 2008). Some individuals are able to process these emotions by utilizing healthy coping strategies which could include receiving support from family and friends or engaging in therapy (Elman & Borsook, 2019). Others, however, may turn to substance use in an attempt to cope with the discomfort and distress associated with these events (Dabney, 1995; Lutz & Kieffer, 2013). Opioids can provide temporary relief from this emotional discomfort, however this can create an association between difficult feelings and opioid use, and individuals can learn to rely on opioids to regulate their emotions (Elman & Borsook, 2019).

This can culminate in addiction if individuals continually seek out opioids to cope with uncomfortable emotions rather than developing skills to manage psychological discomfort and distress.

Mental health issues, including anxiety and depression, can also be associated with substance misuse (Nehls & Sallmann, 2005; Volkow, 2005). Research indicates that more than half of those with addiction to drugs or alcohol have also suffered from mental health problems in their lives (Centre for Addiction and Mental Health, 2023). Individuals with mental health issues can suffer from painful symptoms and, for some, substance misuse is employed as a means to change their emotional state (Patrick, 2010; Wiklund, 2008). In these cases, substances are employed as mechanisms to self-soothe or to avoid uncomfortable emotions (Crowley, 1972). If mental health problems remain untreated, individuals are more likely to develop addiction as they use substances to feel better and relieve their symptoms (National Institute of Health, 2020).

Stress can be a motivator for substance misuse whereby opioids serve to temporarily alleviate suffering (Wiklund, 2008). Stress can be attributed to numerous aspects in a person's life including social stressors, including social rejection. Exclusion, alienation, and feelings of inadequacy are painful experiences, and individuals in these situations may use substances to alleviate the discomfort resulting from social isolation. Stress can also be tied to experiences of self-consciousness or poor self-regard. Under the influence of drugs or alcohol, self-perception can be profoundly altered whereby feelings of inferiority can be temporarily replaced with enhanced self-confidence and a sense of power (Wiklund, 2008). Individuals who struggle with their sense of self can become reliant upon substances to participate in social activities, including attendance at school or work. Stress can also be associated with work life, especially if individuals work in environments with great pressure and responsibility (Bozimowski et al.,

2014). Individuals may turn to substances to manage professional demands such as heavy workloads or complicated duties. In these cases, substances can be used to increase attention and stamina.

Biological and environmental factors can also play a role in the development of addiction. Beyond individual predispositions, troubled family relationships can influence susceptibility to addiction (Brennan, 1991; Meurk et al., 2014). Dysfunctional dynamics within households, coupled with a genetic history of addiction within the family, can elevate the risk for individuals (Kenna & Lewis, 2008; Patrick, 2010; Ross et al., 2017). Moreover, socioeconomic factors, including financial stability and economic struggles, can exert influence over the initiation and continuation of substance misuse among individuals. These various factors collectively contribute to risks surrounding addiction, demonstrating the relationship between biology, family relationships, and socioeconomic environments in the misuse of substances.

Comprehension of the neurological aspects of addiction as well as its contextual factors is necessary to increase awareness, reduce stigmatization, and create more effective interventions and support systems. It is essential to understand that while addiction is driven by neurochemical changes from the brain's exposure to substances, it is a combination of factors that can lead to the initial substance misuse (Bartlett et al., 2013). The experiences described above cannot cause addiction, but rather they can lead to substance misuse to relieve distress or provide a temporary escape. Understanding these varied contributors and the multifaceted nature of addiction identifies the need for comprehensive care. Recovery from addiction is achievable when an individual receives care that supports their overall health, including physical, psychological, and social well-being (Health Canada, 2022). In addition, treatment is more likely to be successful when a person comprehends the root cause of their substance misuse.

## **Stigma**

### ***Historical Roots of Drug Stigma***

There is a deep-seated stigma surrounding substance misuse, which can be traced back to racist and classist sentiments in North America. An example includes the discriminatory perception of opium and cocaine use among marginalized communities the late 19<sup>th</sup> century (Bailey, 2005). Asians, who faced discrimination due to their dominance in the labour market, were associated with opium use, thus fueling prejudice (Ferentzy & Turner, 2013). Similarly, when Black Americans in the Southern States used cocaine, it was demonized yet was culturally accepted when used as a medical treatment by physicians, even being prescribed as a “cure” for opium addiction (Ferentzy & Turner, 2013). The continued use of both cocaine and opium by members of lower class and disenfranchised groups at this time has contributed to the enduring stigma and misconceptions surrounding addiction (Ferentzy & Turner, 2013). This problem was exacerbated with the invention and marketing of the hypodermic needle in the mid-nineteenth century. This new route to ingest substances, as well as the over-prescribing of habit-forming drugs, worsened the problem of substance misuse (Cazales, 1971). The stigma was further perpetuated whereby newspapers in the US vilified minorities and accused Blacks, Chinese, and Mexicans of corrupting young men and women into addiction (Heise, 2003).

This stigma is also based on misconceptions surrounding addiction that reject the notion that it is a health condition (Stewart & Mueller, 2018). Dominant views in society perceive the misuse of substances as indicative of poor character and moral failing, thus evoking negative feelings and associations (Bartlett et al., 2013; Brener et al., 2010; Dunn, 2005; Trossman, 2003). In addition, it is associated with delinquent personality, criminality, self-indulgent behaviour, and a lack of willpower (Dunn, 2005; Lovi & Barr, 2009). As substance misuse is commonly

believed to be a choice made by an individual, it leads to blame for repercussions from use (Brener et al., 2010). In such cases, less pity, less concern, and less helping behavior toward members of the stigmatized population is elicited (Weiner et al., 1988). This stigma is apparent whereby only half of Canadians report they would feel comfortable disclosing addiction to others (Centre for Addiction and Mental Health, 2023; Dunn, 2005). The stigmatization of individuals who misuse substances can be perpetuated by the labels used in everyday conversations, negative beliefs about the *type of people* who misuse substances, and a lack of attention or interest in addiction within societal programs and processes (Health Canada, 2022). Health Canada (2022) points to a need to reduce this stigma within society to ensure people with addictions can get help when they want or need it.

### ***Social Stigmatization***

The stigma directed at nurses that divert and misuse opioids is connected to societal perceptions of the qualities and characteristics a nurse is expected to possess. Nurses are a valued group. The contributions of nurses during wartime helped solidify their position of high public esteem, and their perceived devotion to “duty, self-sacrifice, heroism, and willingness to serve the medical profession” (Fealy, 2004, p.651). Popular and persistent narratives image the nurse in a white uniform, a metaphor for purity and angel-like features (Trossman, 2003). The profession of nursing continues to be defined by stereotypical images with respect to gender, illustrating nurses as caring maternal figures (Fealy, 2004; Hoeve et al., 2014; McAllister et al., 2017). The expectations for nurses to act as moral agents in service to the public have been molded by these narratives (Gordon & Nelson, 2006; Kunyk et al., 2016a). While there have been numerous advancements within the profession over the past century because of higher education including post-graduate and specialty nursing programs, the characteristics of virtue,

compassion, kindness, and service are still associated with the profession (Kunyk et al., 2016a; Ross et al., 2018). Nursing is stereotypically understood to be a female profession imbued with caregiving, with the feature of caring forcibly ingrained within individual nurses (McAllister et al., 2017). These narratives contribute to the social status, trust, and esteem bestowed upon nurses (Kiepek & Beagen, 2018; Ross et al., 2018; Stewart & Mueller, 2018).

When opioid diversion by nurses becomes known, it leads to outcry evident by the strong public and legal reactions in the media (Kunyk et al., 2016a). There is a stark lack of pity, concern, or sympathy for these nurses (Brener et al., 2010). These powerful responses occur as nurses are subject to greater scrutiny than the public, likely due to their portrayal as trustworthy and infallible beings (Darbro, 2005; Dunn, 2005; Trossman, 2003). In addition, the responses are related to the ethical responsibilities of nurses (Tanga, 2011). Nurses are subject to a code of ethics and there is a belief that substance misuse is incompatible with professionalism (Kiepek & Baron, 2019). Nurses are expected to be teachers of healthy lifestyles, and models of self-regulation and social values, and those who engage in diversion are seen to breach their ethical duties and damage the sacredness of the nursing profession (Collins et al., 1999; Kiepek & Baron, 2019; Ponech, 2000; Rush et al., 2005; Rutherford, 2014).

### ***Medical Stigmatization***

Addiction is known to be an uncomfortable topic within health care settings where its associated stigma is widely acknowledged (Bartlett et al., 2013; Kiepek & Beagan, 2018). Research indicates that many health care workers have poor views of patients with drug or alcohol dependence, or that are exhibiting behaviours often referred to as *drug-seeking*, seeing their situations as hopeless with little chance of recovery (Bartlett et al., 2013; Howard & Chung, 2000). Most physicians receive minimal training, some as little as a few hours, on addiction

medicine over the course of their education (Szalavitz et al., 2021). Nurses also lack adequate education on this subject within their nursing training, and even those with an intellectual conceptualization of this health condition can harbour negative feelings towards it (Kunyk et al., 2016b). Nurses have been reported to use terms such as *low-class*, *uneducated*, *addicts*, and *junkies* when discussing their chemically dependent patients (Ross et al., 2018).

Amongst all health professionals, nurses have been found to be the most judgmental about addiction, and this scrutiny is heightened when it affects members of their own profession (Bartlett et al., 2013; Harling, 2017; Lovi & Barr, 2009). Negative attitudes are often based on moralistic and stereotypical beliefs about substance misuse that disregard the nature of chemical dependence (Harling, 2017; Kunyk et al., 2016b). There is a belief that nurses who misuse substances cause damage to the reputation and credibility of the profession. Indeed, it is an expectation of nurses that they protect their professional image (Baldisseri, 2007; Tanga, 2011). The College of Nurses of Ontario (CNO) states, “nurses have a duty to uphold the standards of the profession and conduct themselves in a manner that reflects well on the profession.” (College of Nurses of Ontario, 2019, p.11). For this reason, some nurses have reported being advised to conceal their own personal experiences with substance misuse or addiction (Oates et al., 2017).

When diversion is revealed, it can result in feelings of anger, shock, and betrayal amongst nurse coworkers who have high expectations of themselves and others in the profession (Haugh, 2009; Trossman, 2003). Research into the attitudes of colleagues found those who divert and misuse opioids are seen to “let their profession down” (Haugh, 2009, p.265). When nurses fail to meet their expectations, their colleagues can engage in stigmatization, regarding them as unfit for the profession, and can dismiss or devalue them (Bos et al., 2013; Peterson, 2017; Ross et al., 2018; Tanga, 2011). Colleagues can also engage in exclusionary practices whereby these

nurses are treated as different, less valuable, and less worthy of empathy (Canales, 2000; Jacob et al., 2021; Ross et al., 2018). “The stigma is she’s a bad person, she’s got this disease, and we don’t want anything to do with her.” recalls a nurse of her experience with colleagues after her substance misuse became known (Contenta, 2019).

Blame, fear, and a refusal by colleagues to recognize the stories of nurses who misuse substances has been described in the literature, however it should be clarified that these reactions are not solely based on judgment and condemnation (Peterson, 2017). The literature indicates that feelings of betrayal and grief can also be experienced by colleagues on the unit when they become aware that diversion has occurred (Tanga, 2011). Some colleagues may feel duped as they have been in denial about possible substance misuse by their colleagues, or they have reluctantly accepted excuses to satisfy potential suspicions (Quinlan, 2003). Colleagues may also be concerned about how the diversion has impacted patient care (Haugh, 2009). Preserving the integrity of nursing is voiced as important to colleagues, and they are thought to go through a type of grieving process when they become aware that diversion has occurred close to home (Haugh, 2009).

### ***Stigmatization in the Media***

The mainstream media’s portrayal of chemically dependent health care workers, as seen in TV shows like Nurse Jackie and House, has been found to contribute to the stigmatization of this population (Bartlett et al., 2013; Knyk & Austin, 2012). Such television shows that exploit this issue in healthcare workers can significantly influence how society perceives nurses who misuse opioids. Beyond the fictitious portrayal of this population, news reporting is also responsible for shaping the narrative around diversion by nurses. Unfortunately, media coverage often focuses solely on the individual nurse without examining any contributing factors or

influences that may have contributed to their acts (Ross et al., 2018). This approach also overlooks the neurological changes that occur due to chemical dependence, which are necessary for understanding the nature of this condition (Kozicki & Strickland, 2014). This was reflected in a critical discourse analysis undertaken by Konyk et al., (2016a) which examined the language used in the media regarding two Canadian nurses accused of unprofessional conduct related to drug diversion. The study revealed that within media reporting addiction was framed as a choice and not a health condition, nurses' characters were called into question, and personal and systemic factors were not discussed (Konyk et al., 2016a). Media reports repeatedly used terms such as *choice*, *actions*, and *consequences* to describe the diversion, framing it as a criminal behaviour by blameworthy individuals. Indeed, dominant discourses focus on nurses' personal shortcomings, poor decision-making, unprofessional conduct, and even immoral characters (Konyk et al., 2016a; Ross et al., 2017). The reporting on this issue often lacks a deeper understanding of why nurses engage in diversion, and this approach can contribute to the public scrutiny and blame surrounding nurses with addiction (Konyk et al., 2016a).

## **Drug Diversion**

### ***Substance Misuse in the Nursing Profession***

Substance misuse was first acknowledged as a problem for nurses by the ANA in 1984 (Dabney, 1995). Prior to this time, it was treated as a taboo issue affecting only a minority of nurses (Boulton & Nosek, 2014). However, at the turn of the twentieth century, health care workers were among the most affected by addiction because of their stressful work and easy access to self-medicating substances (Heise, 2003). An example in the literature tells a story of a group of nurses found using alcohol to sleep after stressful and tiring shifts. When this was discovered, it resulted in their termination along with the tarnishing of their reputations (Hobbs,

1907). Yet increasing cases of substance misuse among nurses forced nursing organizations to concede that this issue was more than a few isolated incidents (Boulton & Nosek, 2014). As the magnitude of this issue became clear, concerns emerged regarding the potential loss of nurses and the impact on the profession. This led nursing organizations to shift from punishment to treatment for affected nurses (Heise, 2003). The ANA's recognition of addiction as a health issue rather than a character flaw was an important step in addressing this issue within the profession (Sidlinger & Hornberger, 2008). In Canada, individual provinces have created programs modelled on programs found in the US to assist nurses with addiction.

As mentioned, addiction is believed to affect health care workers equally to the general population (Smentkowski & Primas, 2014; Talbert, 2009; Watson, 2009). Research suggests that between 6% to 20% of all nurses struggle with drug or alcohol dependence, with estimates varying depending on the publication year (Dunn, 2005; Kulyk, 2015; Perry & Vandenhouten, 2019; Patrick, 2010; Ross et al., 2018; Stewart & Mueller, 2018; Talbert, 2000). Previous figures from the ANA in 1984 estimated that 6% to 8% of nurses suffer from drug or alcohol dependence (American Nurses' Association, 1984), while more recent studies place this number closer to 14% to 20% (Monroe & Pearson, 2009). A Canadian study conducted in 2015 found a 1.9% annual rate for drug dependence amongst nurses (Kulyk, 2015). A study conducted by Pilgrim et al. (2016) analyzing drug-related deaths among healthcare practitioners in Australia found that nurses were the most significantly impacted healthcare group, accounting for 62% of the deaths. Among these cases, approximately 20% involved drugs that had been diverted from the workplace and nearly half were associated with a diagnosis of mental illness and personal or professional stress (Pilgrim et al., 2016).

### ***Diversion***

As described, drug diversion is the illegal acquisition of medications (Clark & Farnsworth, 2006). Despite the health care system's denunciation of diversion, it is known to occur (Braquehais et al., 2015; Carpenter, 2014; Johnson & Borsheski, 2019). Dabney's (1995) analysis shed light on nurses' attitudes towards diversion, revealing that 92% of nurses admitted to stealing supplies like dressings, toiletries, and over the counter (OTC) medications such as acetaminophen. Many nurses condoned supply theft and felt entitled to the stolen items, with some justifying the theft of OTC analgesics to cope with the stress and headaches of their job. Yet there was a clear distinction between the theft of supplies and the diversion of opioids. Drug diversion remains widely condemned, and those that engage in diversion are considered liabilities within their profession (Tanga, 2011).

Data from Health Canada indicates that Canadian healthcare facilities experienced more than three thousand incidents of lost or stolen controlled medications from 2015 to 2019, the majority of which remain unexplained (Glauser, 2019). Within these settings, diversion predominantly occurs for personal misuse by staff members, with opioids being the most frequently diverted medications (Berge et al., 2012). Diversion methods can include taking the "wasted" or unused portion of a medication dose, administering partial doses and diverting the remainder, or diverting full doses of medications and administering substitutes (such as normal saline) to patients (Perry & Vandenhouten, 2019).

### ***Risks to Patients***

The literature emphasizes the ethical obligation for nurses to provide safe and competent care to their patients (Johnson & Borsheski, 2019; Tanga, 2011; Watson, 2009). Nurses are responsible for advocating for their patients, and safeguarding their well-being is both a legal

and an ethical requirement (Talbert, 2009; Watson, 2009). The implications of opioid diversion can be far-reaching. Patient harm is a significant concern when nurses engage in opioid diversion and misuse (Clark & Farnsworth, 2006; Kynyk, 2015; Stewart & Mueller, 2018). Misusing opioids can impair a nurse's critical thinking skills, thus jeopardizing patient safety (Sullivan et al., 1990; Watson, 2009). A nurse under the influence of opioids may be unable to perform their job properly, hindering their ability to provide quality and safe care (Blair, 2002; Sidlinger & Hornberger, 2008; Talbert, 2009). This can be evidenced by unclear cognitive functioning, inappropriate clinical judgment, and impaired motor skills (Clark, 2020; Collins et al., 1999; Dunn, 2005; Johnson & Borsheski, 2019; Ross et al., 2018; Stewart & Mueller, 2018; Valdes, 2014). In addition, patients may be left with untreated pain and anxiety if their needed opioids are diverted (Berge et al., 2012; Evans, 2015). They are also at risk of bloodborne pathogens if medications are tampered with (Berge et al., 2012). Moreover, patients and their families may lose trust and feel vulnerable and angry if they fall victim to diversion (Berge et al., 2012; Perry & Vandenhouten, 2019). Some authors suggest that most nurses with opioid addictions are not identified until after patient care and safety have been put at risk (Clark & Farnsworth, 2006; Talbert, 2009; Zimlich, 2018).

### ***Risks to Organizations***

There are varied risks and costs to healthcare organizations resulting from opioid diversion and misuse amongst their employees. Some of the risks are monetary, with financial costs stemming from use of sick time, health benefits, theft, decreased productivity, and turnover (Dunn, 2005; Sidlinger & Hornberger, 2008). Dunn (2005) reported that individuals who misuse drugs or alcohol are more likely to miss work, to resign or be terminated, and have increased involvement in workplace accidents. Drug diversion by staff can also put facilities at risk for

litigation (Berge et al., 2012; Johnson & Borsheski, 2019; Perry & Vandenhouten, 2019; Tanga, 2011). This is especially true in the cases where patients have experienced iatrogenic harm due to drug diversion (for example patients who have contracted Hepatitis C). The latter is a prime example of both costs and risks of diversion (Berge et al., 2012; Hellinger et al., 2012). Other non-monetary costs come in the form of low morale among colleagues and strained communication on clinical units following cases of diversion (Berge et al., 2012; Dunn, 2005). There are also risks to colleagues who may have unknowingly assisted the nurse in their diversion by signing off the waste of medication doses that they did not witness based on trust between colleagues (Berge et al., 2012). This could impact colleagues as they may have disregarded formal policies regarding drug wasting. The reputations of co-workers and the facility brand can also be damaged when diversion occurs and attracts negative publicity (Berge et al., 2012; Evans, 2015; Johnson & Borsheski, 2019; Perry & Vandenhouten, 2019). Another consideration is the time devoted to investigation following suspicion or detection of diversion. Indeed, the responsibility to manage diversion is often left to the managers on individual units, whereby they have an obligation to address the legal, ethical, regulatory, and practical considerations when drug diversion occurs (Tanga, 2011).

## **Addiction in Nurses**

### ***Psychological Impacts***

The literature touches on the emotional impacts and repercussions faced by nurses who struggle with addiction. These responses can be experienced both during periods of opioid diversion, as well as during their journey to sobriety and when transitioning back into nursing practice (Smentkowski & Primas, 2014). The stigma associated with substance misuse plays a

significant role in exacerbating the adverse psychological effects experienced by these nurses (Ahern et al., 2007).

Nurses grappling with addiction encounter a myriad of emotional struggles that can affect their personal well-being and mental health. Feelings of shame are common among these healthcare professionals, often linked to incidents of deception involving patients, colleagues, employers, and the nursing profession (Baldisseri, 2007; Hughes et al., 1998; Kunyk et al., 2016b; Lillibridge et al., 2002). Shame is also linked to a violation of the nurses' own morals leading to negative self-thoughts and beliefs (Matthias-Anderson & Yurkovich, 2020). One nurse interviewed by the Toronto Star described her diversion as "soul-destroying", believing it unethical, yet viewing it as a last resort (Contenta, 2019). Shame can also be tied to personal beliefs about addiction. One nurse with lived experience stated, "I carried shame with me for a very long time. I did not buy into the disease concept. I thought it was a cop-out and that people in recovery were just using that as an excuse..." (Matthias-Anderson & Yurkovich, 2020, p.30). Negative beliefs about addiction can influence how the nurses view themselves and their acts. Persistent feelings of shame damage the self-image of these nurses and can delay, or prevent, the return to nursing for this population (Valdes, 2014; Zimlich, 2018).

Nurses who divert opioids may also experience fear (Monroe & Kenaga, 2010; Peterson, 2017; Shinebourne & Smith, 2011). This response can be related to potential judgment or rejection from colleagues and the public should the diversion become known (Matthias-Anderson & Yurkovich, 2020). Nurses may worry about losing their nursing identity and the social standing they have garnered because of their profession (Lillibridge et al., 2002). It is also based on more practical concerns including loss of livelihood (Matthias-Anderson & Yurkovich, 2020). Fear can also stem from the potential for discipline, punitive actions, and serious

professional risks, including investigations into their fitness to practice (College of Nurses of Ontario, 2020; Johnson & Borsheski, 2019; Quinlan, 2003). These fears are well-founded as even when nurses admit to their actions and seek help, they may still face public shaming, criminal charges, civil action, loss of employment, and threats to their professional licensure (Berge et al., 2012; Kunyk et al., 2016b). Additionally, there may be significant personal costs including damaged relationships with friends and family, an altered self-perception, and decreased moral and ethical worth (Owens, 2015; Patrick, 2010). Living with these fears can significantly impact nurses' health and well-being.

It is challenging to locate research that provides in-depth insights into the experiences of nurses who have diverted opioids and how this experience has impacted them. Currently available research primarily focuses on risk factors for substance misuse, the dangers of practicing while under the influence, signs of impairment, and information about return-to-work programs. There is a significant lack of research that delves deeply into the personal experiences of nurses who have diverted opioids

### ***Social/Physical/Financial Impacts***

Although research suggests that up to one fifth of nurses may be struggling with substance misuse in some capacity, those who have been identified represent a small fraction of those affected (Dunn, 2005; Kunyk et al., 2016b; Ross et al., 2018; Smentkowski & Primas, 2014; Talbert, 2009; Watson, 2009). The impact of addiction on nurses can be devastating. Those with this condition may face a myriad of risks and repercussions up to and including loss of life (Ross et al., 2018). This includes damage to their reputations, negative impacts on their health, and financial burdens.

Nurses who struggle with addiction face significant risks to their social standing. The stigmatization of nurses with this condition is considerable. This was noted by Ross et al., (2018) in their institutional ethnography exploring substance use practices among nurses whereby, “Many of our nursing colleagues have lived with substance-use problems, either in secret or, if discovered, in disgrace.”. Known addiction can damage the reputations of nurses, and they may no longer be considered suitable for nursing practice. They are viewed to be flawed, with their acts deviating from professional expectations. This social judgment is painful, and nurses have reported feeling broken because of their health issue (Smentkowski & Primas, 2014). Societal scorn and disdain are not only hurtful for nurses with addiction but have been cited as a barrier to seeking help (Zimlich, 2018). Nurses may delay or choose not to return to practice as regaining professional credibility in this culture of blame and judgment is so challenging (Pastorius, 2007). If these emotional repercussions are not appropriately addressed, it can lead to loss for the nursing profession. It is essential to recognize that these nurses are individuals who once sought to care for others, and they require support to reintegrate into nursing practice successfully (Hospital Employee Health, 2017). Despite these challenges, many of these nurses highly value their nursing careers and overcome addiction in order to reclaim their position in the profession (Quinlan, 2003).

Substance misuse not only has social and professional consequences for nurses, but also places them at risk for physical harm. Nurses who misuse opioids are especially vulnerable to morbidity and mortality resulting from unintentional overdose (Pilgrim et al., 2016). Overdose can lead to respiratory depression, leading to anoxic injuries to the brain, heart, and other organs (Berge et al., 2012). Moreover, there is a risk of infections or bloodborne illnesses from use of unsterile equipment (Berge et al., 2012). Beyond the physical risks to this population, addiction

can harm a person's mental health by triggering anxiety, depression, aggression, paranoia, and hallucinations (Health Canada, 2022; National Institute on Drug Abuse, n.d.).

Financial implications can also result from opioid diversion. Addiction can negatively affect work attendance and contribute to lost earnings through missed shifts (Bartlett et al., 2013). It can also lead to legal costs related to the potential for criminal charges of theft, possession of drugs, or driving while under the influence of drugs (White et al., 2021; Health Canada, 2022; Monroe & Pearson, 2009). There are also costs associated with the ATD programs that are the sole responsibility of the participants. There are many aspects of these programs requiring payment such as fees for urine testing, treatment programs, and for Caduceus (support program for health professionals in recovery) group attendance (Matthias-Anderson & Yurkovich, 2020). Fees listed on the ATD program websites in the US detail the extent of these costs. Some examples include service fees (paid directly to the ATD program to cover program costs) that can be up to \$175 per month, group counselling of \$40/week, and initial evaluation costs that can be upwards of \$1500 (Choflet et al., 2023). The greatest costs surrounded treatment. These costs varied based on programs, however inpatient treatment programs were in the range of \$6000/month (Choflet et al., 2023). Other treatments, referrals, medications can create additional costs for program participants.

The Canadian Nurses' Association (CNA) states that substance use by nurses is considered problematic when it impairs work performance so that the standards of professional practice are not met (Canadian Nurses' Association, 2009). It must be noted that not all nurses who divert opioids are impaired or are engaging in opioid misuse while at work. That being said, the literature indicates this does occur and many nurses that consume opioids during working hours can continue practicing without arising suspicion (Ponech, 2000). Nurses who engage in

diversion are often not the stereotypical substance misusers that are portrayed in media and movies. In fact, they are more likely to be overachievers, many possessing several degrees, and are regarded as dedicated, hard-working, highly skilled, bright, and capable by their colleagues (Clark, 2020; Dittman, 2015; Johnson & Borsheski, 2019; Patrick, 2010; Ponech, 2000).

Affected nurses can become very skilled in concealing their diversion and intoxication (Berge et al., 2012; Johnson & Borsheski, 2019). In addition, despite assumptions that a nurse under the influence of opioids is engaging in impaired practice, some nurses who have misused substances have reported feeling like a better nurse while intoxicated (Ross et al., 2018). Indeed, substance misuse so often goes unreported because individuals can perform adequately at work, or even excel at their jobs, while under the influence of substances (Baird, 2021; Quinlan, 2003). Substances can increase the ability to cope with both the physical and emotional demands of nursing, either through providing energy when at work or better sleep while at home (Kiepek & Beagan, 2018). Unfortunately, the ability to continue working while intoxicated can feed the false narrative that these individuals are in control of their substance use (Baird, 2021). In addition, some nurses have rationalized the theft and justified their drug use by believing they were working harder than their colleague, speaking to the demands of their work and a need to cope with work-related stressors (Ross et al., 2018). Often it is only when a nurse is deep into misuse that signs begin to show at work (Quinlan, 2003). Unfortunately, one of the first signs may be something as serious as an overdose, attempted suicide, medical errors, or death (Johnson & Borsheski, 2019; Pilgrim et al., 2016).

The method of diversion is also an important consideration. Although many nurses who divert opioids believe their actions are wrong, many remained dedicated to their profession and are concerned with providing safe patient care (Kunyk et al., 2016a). Some nurses use diversion

methods that are less likely to impact their patients, such as through medication wastes or refused doses (Kunyk et al., 2016a). In the minds of these nurses, this was a key difference regarding the ethical implications of their acts. Knowing that they did not deprive their patients of medications or risk patient safety by tampering with medication vials or syringes was an important distinction. They were then able to justify their acts by viewing these medications as needed to treat their own suffering (Lillibridge et al., 2002).

## **Contributing Factors**

### ***Individual Risk Factors***

There are a variety of risk factors that are thought to place nurses at increased risk to develop addiction. Interestingly, individual risk factors are the focus of the literature, often at the cost of a broader consideration including contextual and structural factors that may have contributed (Kunyk et al., 2016b; Ross et al., 2018). Some of these individual factors include the presence of psychological conditions such as anxiety and depression (Wright et al., 2012), which are notably higher in nurses than the general public and are deemed to be the result of ongoing and repeated occupational threats to psychological safety (Stelnicki et al., 2020). In addition, traumatic events experienced in childhood, including sexual abuse, have been identified (Ross et al., 2018; Wiklund, 2008). A family history of addiction is also a cited risk factor (Dunn, 2005; Talbert, 2009). Beyond the genetic link, studies have shown that people with a hereditary connection may be more likely to choose nursing as a career (Kenna & Lewis, 2008). Some authors estimate that up to half of all people who work in jobs where they care for others were raised by parents with substance misuse issues, possibly related to the nurturing role they developed in their upbringing (Dunn, 2005; Patrick, 2010). Finally, there is the suggestion that

nurses with sensation-seeking characters and those who seek perfection, with unattainable standards, are also at risk to misuse substances (Dunn, 2005; Patrick, 2010).

### ***Nursing Education***

A distinct lack of focus on substance misuse and the risk for addiction within nursing education has been voiced as a contributing factor to drug diversion in this population (Compton, 2020; Hastings & Burn, 2007; Howard & Chung, 2000; Kiepek & Beagan, 2018; Stewart & Mueller, 2018; Ross et al., 2018). This is not only a missed opportunity to provide education to combat the stigma surrounding addiction, but it also prevents nurses from being aware of signs of dependence, in themselves and their colleagues, and from being equipped with the proper skills to address substance misuse when it does occur (Pullen & Green, 1997; Stewart & Mueller, 2018). In addition, this lack of education influences how nurses who misuse substances are perceived by their colleagues. When nurses lack education on addiction, they are more likely to have negative attitudes towards it (Darbro, 2009; Patrick, 2010). Without a comprehensive understanding of chemical dependence, the narrative that individuals who misuse substances are morally corrupt or unethical can be perpetuated. Increasing knowledge on chemical dependence can assist in a shift of attitudes whereby it is recognized as a health issue as opposed to a moralistic failing (Stewart & Mueller, 2018). Nursing school is an ideal time to provide this education as students do not only learn skills, but they also pick up on the norms and informal ways of being in a profession (Kiepek & Beagan, 2018). Lacking adequate education on this topic can allow new nurses to be unduly influenced by their workplace culture, especially if substance misuse is a taboo topic within their place of work.

### *Healthcare Organizations*

There are structural and systemic factors within health care organizations which are understood to influence substance misuse by nurses, yet these are rarely acknowledged in the literature and are often completely missing from mainstream reporting (Kunyk et al., 2016a; Ross et al., 2018). While nurses do not share the same genetic history or individual risk factors, they do share similarities through their membership in the profession of nursing, and certain structural policies and practices within organizations place nurses at risk.

Firstly, there is a lack of attention to this issue within healthcare organizations. Few facilities have staff training and open conversations about the risk for substance misuse (Watson, 2009). Effective policy within healthcare organizations can influence how addiction is both understood and managed, and it can improve the treatment of those affected by increasing awareness and reducing the associated risk and stigma (Kunyk, 2015). Orientation is an opportune time to ensure all workers, not just those with access to controlled substances, are aware of the nature and scope of the problem (Berge et al., 2012). Processes to follow should diversion be suspected are also important to share with staff (Clark, 2020). Finally, this topic should be frequently revisited throughout the careers of all staff members both to discourage diversion, but also to share available resources for staff affected (Berge et al., 2012). This can raise awareness, reduce stigma, increase opportunities for early detection, and support return to work (Kunyk, 2015).

There are several possibilities which may account for this paucity of education and action. Leaders within health care organizations may refuse to accept the presence of addiction and diversion within their facility (Dunn, 2005). This could be based on mistaken beliefs about the prevalence of addiction within healthcare workers, a focus on more pressing administrative

functions, or a lack of time or resources to dedicate to this issue (Brennan, 1991; Johnson & Borsheski, 2019). Fears surrounding liability may also contribute to active ignorance on behalf of healthcare organizations and their hesitancy to openly acknowledge drug diversion (Brennan, 1991; Quinlan, 2003). If these organizations admit to being aware of the issue, they open themselves up to complaints and concerns from patients, families, and funders, as well as perceived culpability (Evans, 2015). Finally, there is the suggestion that healthcare organizations neglect this issue as they perceive their employees to be assiduous and infallible (Brennan, 1991). When leaders expect faultlessness in their staff, reinforcing dedication and perseverance, it reduces opportunities for self-disclosure (Brennan, 1991; Dunn, 2005; Quinlan, 2003). This type of organizational culture can create unrealistic expectations, enhance shame and guilt, and encourage denial which can further perpetuate the problem of diversion (Darbro, 2009; Evans, 2015).

Work-related stress resulting from poor policies and practices is another factor that can contribute to substance misuse in nurses. While healthcare organizations have an ethical and moral responsibility to staff because of the risks of drug diversion, this is seldom put into practice (Kunyk & Austin, 2012; Quinlan, 2003). Improvements could be made through an increase in education and an emphasis on staff well-being, with appropriate medical leave and employee assistance programs available and open dialogue surrounding risks for diversion (Quinlan, 2003).

There are other structural issues within healthcare organizations that can influence substance misuse. This includes poor working condition which are often absent in discussions surrounding drug diversion (Pilgrim et al., 2016). Point of care nursing is known to be physically taxing work with higher rates of musculoskeletal injuries (Talbert, 2009; Trinkoff et al., 2001;

Watson, 2009). Pain from work-related injuries can be a segue into opioid dependence and diversion (Dunn, 2005; Hospital Employee Health, 2017; Watson, 2009). Other issues can include frequent changes in managers/leaders, accreditation processes, and the high expectations placed on nurses (Jarrad et al., 2018). Structural procedures to decrease diversion are also a necessity. The need for healthcare facilities to implement committees dedicated to the prevention of diversion including staff from pharmacy, security, and nursing is discussed in the literature (Glauser, 2019). Making diversion challenging or impossible can be a protective factor for nurses at risk of engaging in the misuse of substances they have accessed in their workplace. Finally, a lack of assistance from hospital leaders and administrators to deal with problems occurring within healthcare organizations has been reported as a factor that has impacted substance misuse in nurses (Dabney, 1995; Kunyk, 2015; Trossman, 2003). Although health care organizations often escape accountability, they do play a role in drug diversion by nurses whilst simultaneously participating in the discourse that singularly blames nurses when it does occur (Kunyk et al., 2016b).

### ***Occupational Hazards***

Occupational stress is repeatedly cited as a contributing factor to the misuse of substances by nurses (Dunn, 2005; Lillibridge et al., 2002; Talbert, 2009; Jarrad et al., 2018; Patrick, 2010; Plant et al., 1992; Pousa & Lucca, 2021; Trossman, 2003; Watson, 2009). Trauma in the workplace can contribute to poor mental health, including experiences of anxiety and depression (Magnavita et al., 2021). Mind-altering substances, such as opioids, can be perceived as mechanisms to manage work-related stress and anxiety (Wright et al., 2012). When nurses use drugs or alcohol to cope with exposure to occupational stress, it can lead to chemical dependence and addiction in those predisposed to this condition (Dunn, 2005). Indeed, most nurses who have

experienced opioid misuse describe it as a means to escape from stress rather than a pursuit to experience a high (Patrick, 2010; Wiklund, 2008).

There are varied occupational hazards in nursing that can contribute to substance misuse. One factor is physical fatigue which can result from shift work, fluctuating sleep schedules, long hours, intense work demands and pace, high absenteeism, and overtime (Dunn, 2005; Kiepek & Beagan, 2018; Kynyk, 2015; Pousa & Lucca, 2021; Ross et al., 2018; Schalk et al., 2010; Trinkoff & Storr, 1998; Watson, 2009; Wright et al; 2012). Physical fatigue can also result from challenging working conditions within nursing. This was particularly difficult during the Covid-19 pandemic as nurses were burdened with ongoing use of PPE that caused excessive sweating, dehydration, skin breakdown, and physical discomfort (Erdagi et al., 2022). Feelings of exhaustion and being physically incapable of keeping up with nursing duties can encourage the use of analgesia, with some nurses describing feeling like a better nurse as they had more energy and were more able to accomplish their tasks while intoxicated (Kiepek & Beagan, 2018).

Stress and emotional fatigue are other occupational hazards for substance misuse in nurses. These factors are often beyond the control of nurses in their daily work. Work-related stress can be caused by institutional factors such as deteriorating care environments, chronic staffing shortages, cutbacks, being floated to unfamiliar units, increasing patient acuity, high patient to nurse ratios, lack of supports including stress management resources, and a level of responsibility disproportionate to power (Bozimowski et al., 2014; Horner et al., 2019; Jarrad et al., 2018; & Austin, 2012; Perron, 2013; Plant et al., 1992; Schalk et al., 2010; Stelnicki et al., 2020; Talbert, 2009; Wright et al., 2012). Bullying and verbal, physical, and sexual assault in the workplace are other occupational hazards described in the literature (Magnavita et al., 2021; Michelle-Rowe & Sherlock, 2005; Ross et al., 2018).

Finally, the emotional nature of nursing work is an occupational hazard. The literature spoke to different factors inherent in the job. This includes work that focuses on the needs of others while neglecting one's own, which can increase the risk of developing substance misuse in nurses (Lillibridge et al., 2002; Ponech, 2000). This emotional toll can be exacerbated by nursing scheduling whereby nurses can be distanced from their friends and family, due to their irregular working schedules, therefore reducing their ability to seek social support (Dunn, 2005). There is also the issue of moral distress for nurses when they cannot act in the way they believe is appropriate and right based on obstacles (Patrick, 2010). Nurses struggling with these workplace issues may turn to substances to manage their work-related pain and distress (Patrick, 2010).

### ***Access***

Access to opioids within healthcare settings has been repeatedly proposed as a major contributor for opioid misuse (Dunn, 2005; Evans, 2015; Hastings & Burn, 2007; Ross et al., 2018; Talbert, 2009; Wright et al., 2012). While the implementation of strict policies to deter diversion are prudent within health care organizations, it is important to clarify that access does not in itself cause diversion and substance misuse. Some have argued that this is an overly simplistic explanation, and it erroneously assumes causation as opposed to correlation (Ross et al., 2017). Few studies looking at this phenomenon have even inquired if substance misuse by nurse participants began before they had access within their workplace, or if the access preceded their misuse (Ross et al., 2017). The discourse surrounding access to opioids remains framed in terms of the unethical behaviour and suggests that theft by nurses is the actual issue, disregarding the contextual and organizational factors that have led nurses to no longer being able to cope with daily living and/or working without the use of opioids (Ross et al., 2017; Ross et al., 2018).

## **Alternative to Discipline (ATD) Programs**

### ***Program Characteristics***

A shift to what has been deemed nonpunitive return to work programs took place in North America four decades ago in response to rising rates of substance misuse in nurses and pressure to provide treatment rather than punishment (Clark & Farnsworth, 2006; Sidlinger & Hornberger, 2008). Through early intervention, treatment, and a return to nursing practice, ATD programs have transformed the trajectory for nurses with addiction to drugs or alcohol (Hughes et al., 1998; Monroe & Kenaga, 2010; Monroe & Pearson, 2009). While these programs differ based on province or state, they share many common features including a goal of career preservation (Matthias-Anderson & Yurkovich, 2020). ATD programs are organized around requirements to fulfill to return to work, known as *treatment*, then undertakings to follow once back in the workplace, referred to as *aftercare* (Quinlan, 2003). Some of the requirements of treatment can include attending a rehabilitation program (inpatient or outpatient), assessment and clearance from a physician with specialized training, and ongoing evidence of sobriety through biological testing (Monroe & Pearson, 2009). Treatment focuses on abstinence and often involves participation in a 12-step program (Quinlan, 2003). Once the nurse has successfully completed treatment, some of the terms of aftercare can include long-term drug testing, restricted work areas and shifts, limited access to narcotics, and the need for a workplace monitor (Hospital Employee Health, 2017; Monroe & Pearson, 2009; Trossman, 2003). Another obligation can include attendance at a Caduceus group which is a private recovery support group specifically for health care workers (Hastings & Burn, 2007). Aftercare programs can range from three to five years (Hospital Employee Health, 2017). The literature indicates that the success of recovery

for nurses is often based on the rigour of treatment and the quality of the aftercare (Quinlan, 2003).

### *Advantages of Programs*

The creation of ATD programs has been a positive development for nurses and the profession, especially as studies show that disciplinary actions have more negative consequences than non-disciplinary approaches (Kunyk et al., 2016b). There are numerous benefits to the ATD programs for nurses beyond the public health implications of retaining valuable health care workers. The speed at which nurses receive treatment for addiction is one of the primary assets of these programs (Patrick, 2010). While disciplinary processes are so lengthy that nurses may not be directed to treatment for a year or longer, nurses in ATD programs receive immediate referral and treatment (Monroe & Pearson, 2009).

These programs tout other benefits. ATD programs allow more opportunities for reporting (Monroe & Pearson, 2009). Nurse colleagues have voiced hesitancy to report nurses with suspected substance misuse issues of fear this could lead to license loss (Glauser, 2019; Ross et al., 2017). Understanding that treatment, rather than punishment, is provided may encourage earlier reporting, thus reducing the length of time that a nurse engages in drug diversion and misuse (Patrick, 2010; Pullen & Green, 1997; Trossman, 2003). This can aid in the safety of nurses and patients under their care (Trossman, 2003).

There are other benefits to ATD programs including the maintenance of employment, nursing licensure, and health benefits. Prior to the introduction of these programs, the potential for job and license loss were barriers to self-disclosure (Kunyk et al., 2016b). Maintaining employment and health benefits is especially important as there are costs associated with ATD programs including rehabilitation programs not covered by provincial/private insurance, fees for

urine toxicology testing, and potential legal costs (Matthias-Anderson & Yurkovich, 2020). The maintenance of nursing employment and license also benefits both the individual nurse and the public as it ensures nurses can return to practice once they have recovered, thus protecting the profession from further shortages (Hospital Employee Health, 2017; Patrick, 2010). In addition, when affected nurses are aware that there are opportunities to return to practice following diversion, it can encourage truthfulness and act as a motivator for recovery (Darbro, 2005). Finally, by moving away from punishment for nurses with behaviours related to addiction, it can help break down social stigmas, raise awareness, and contribute to safer nursing practice (Kunyk et al., 2016b).

Maintaining the confidentiality of the nurse is one of the greatest assets of certain ATD programs. Pronounced fear of addiction becoming public knowledge has been a sentiment shared by many nurses who have misused substances (Kunyk et al, 2016b). In the United States, most ATD programs will not reveal the nurse's name to the public if they successfully complete the full three-to-five-year program (Clark & Farnsworth, 2006). In Ontario, nurses' names were revealed to the public on CNO's website up until 2019 when the Nurses' Health Program (NHP) was developed (College of Nurses of Ontario, 2022; Nurses' Health Program, 2023). The NHP reports it will benefit nurses by providing "confidence that your name will not be disclosed to the public if you follow the terms of your contract" (Nurses' Health Program, 2023).

A final benefit of the ATD programs is the holistic care nurses receive so they can return to practice armed with plans and strategies to avoid relapse and recidivism (Monroe & Pearson, 2009). In addition, these nurses may be able to offer more compassionate care to patients with chemical dependence, and they may feel an affinity for other nurses with similar lived experiences (Darbro, 2005; Monroe & Pearson, 2009). Some factors found to positively impact

a nurse's chances of recovery include a commitment to nursing as a profession, relationships with other nurses in recovery, and a positive view on the program they went through (Darbro, 2009). Personal motivation for treatment has been a good predictor of long-term success (Darbro, 2009).

### *Disadvantages of Programs*

While the ATD programs have been a positive step towards aiding nurses with addiction, the literature alludes to aspects of these programs that have been more harmful than helpful. One study by Shaw et al., (2004) found remarkable differences between the treatment of nurses versus physicians who had gone through these programs. Nurses were more likely to have stricter sanctions when they returned to work, to return to work in areas with more inherent environmental triggers, and they had less access to primary treatment (Shaw et al., 2004). A Grounded Theory study by Darbro (2005) looked at the experiences of nurses who were unsuccessful in completing ATD programs and found one of the barriers to completion was that the nature of the program felt coercive and punitive (Darbro, 2005). Nurses described their treatment within the program as “demeaning” and that “it was like they were just waiting to find something wrong to punish you with” (Darbro, 2005, p.174). Another issue was a perceived lack of support from those who administered the programs (Darbro, 2005). Many participants felt that the program was of no value and it was adding to their stress, thus putting them at risk of relapse (Darbro, 2005).

The financial implications of ATD programs have also been reported as a barrier to a successful return to work. This is related to the costs of assessments, rehabilitation programs, Caduceus group fees, urine toxicology testing, and counselling sessions (Clark & Farnsworth, 2006; Darbro, 2005; Matthias-Anderson & Yurkovich, 2020). The burden of these fees can be

significantly more taxing if the nurse lacks or has lost access to health insurance. A descriptive study examining the ATD programs found the financial burden of urine screens and treatment programs was a factor in unsuccessful completion (Clark & Farnsworth, 2006). The time-consuming nature of the program has also been described as a barrier to completion, with one participant pointing out the overwhelming responsibilities of working full-time, participating in AA groups, and frequent laboratory visits to provide urine samples. Other factors that were found to negatively impact program completion included a lack of buy in by nurse participants (Darbro, 2005).

Finally, the largest disadvantage of ATD programs is the continued focus on the individual nurse and their personal risk factors. This, unfortunately, dismisses the current public health practices whereby the focus should be on creating positive physical and social environments (Ross et al., 2017). Solely blaming nurses without consideration of outside factors can further perpetuate the stigmatization of nurses with this health condition (Ross et al., 2017). It is important that structural factors, including work conditions and workplace policies, are also taken into account, especially as they are argued to be more significant than the individual factors that are often the main focus (Rhodes, 2009).

### **Chapter 3: Theoretical Approach**

Theory is essential when conducting research and can be used in different ways. Researchers may use existing theories to guide the research process and provide a framework to interpret, explain, and make sense of the collected data (Sandelowski, 1993). Theory can also be used as a lens to approach and understand collected data. This helps to make sense of the data, identifying relationships, patterns, and themes. Theory works to develop deeper understandings

of phenomena and contributes to knowledge in the area of study. Bourdieu and Wacquant (1992) aptly note that “research without theory is blind, and theory without research is empty” (p.162).

In this study, theory was used to conceptualize the phenomena under investigation, and to analyze and interpret research findings based on the meanings and experiences described by study participants in their own words (Lyons & Coyle, 2007; Sandelowski, 1993). The theoretical concepts of taboo and stigma, as well as the related concept of othering, provided the foundation for this research.

### **Taboo**

The term taboo was first introduced to the English language in the eighteenth century, originating from the Polynesian word “tabu” that had strong religious associations, prohibiting certain acts and practices (Fershtman et al., 2011; Freud, 1913). According to Merriam-Webster’s dictionary, a taboo is a social prohibition imposed by custom or a type of protective measure associated with religious beliefs. The contemporary understanding of taboo is the social processes that are restricted, prohibited, or considered unacceptable within society (Nicklas, 2010).

Taboos vary among cultures and evolve over time, with some becoming more powerful while others disappear (Fershtman et al., 2011). They function to promote social expectations, highlight shared values, and illustrate rules of acceptable conduct (Fershtman et al., 2011). As taboos guide both the thoughts and beliefs of society members, they exert a great deal of influence on human behaviour (Chiauzzi, & Liljegen, 1993; Fershtman et al., 2011). In his work *Totem and Taboo*, Sigmund Freud (1913) examined cultural conformity and contributed to an understanding of taboo as a product of socialization. Freud believed that although taboos could lack reasoning, they are frequently accepted without consideration and can function as unwritten

laws (Freud, 1913). Some examples of the taboo found in Freud's work include stipulations on sexual behaviours (e.g., incest) and dietary restrictions followed by religious or cultural groups (Freud, 1913).

Taboos are often associated with undesirable characteristics, beliefs, and behaviours. In North American culture, there are several health-related taboos including obesity, HIV, mental illness, and addiction, which is the focus of this research study (Ziliotto & Marcolan, 2013). The acceptance of substance use within Canada and the US has shifted over time, and while alcohol use can be seen as prestigious and celebratory, the use of many drugs remains taboo. This is especially true when use crosses over into misuse (da Silva et al., 2021; Room, 2005; Ziliotto & Marcolan, 2013). The taboo nature of addiction affects how individuals who misuse drugs and alcohol are viewed in society.

Taboos not only serve to regulate human behaviour, but also help maintain the interests of certain groups, often those in positions of power, by promoting conformity through the fear of social punishment (Chiauzzi & Liljegren, 1993; Douglas, 1966; Fershtman et al., 2011). Taboos surrounding addiction, for instance, serve the vested interests of various groups, including the health care industry and public health departments, by deterring individuals from behaviours that threaten their health and that of the community (Chiauzzi & Liljegren, 1993). Substance misuse, and other taboo acts, can be considered dangerous or unclean, setting apart persons and things from the rest of society (Chiauzzi & Liljegren, 1993). As a result, taboos can lead to myths and prejudices towards those perceived as defying social norms (Ziliotto & Marcolan, 2013). This is evidenced by prejudicial and discriminatory beliefs towards individuals who misuse substances. Freud (1913) posited that taboo individuals possess a dangerous power that can be transmitted to others, almost like an infection, which may explain why individuals

with addiction face such potent social reactions. Isolation and exclusionary practices can occur as others attempt to avoid individuals who engage in taboo acts.

In the context of this study, understanding and acknowledging the taboo nature of addiction both within and outside of the healthcare field was essential. The topic of nurses misusing and diverting opioids is a sensitive subject to explore and had potential implications throughout the study. Both the secrecy and the potential social, professional, and legal consequences associated with opioid diversion were relevant considerations regarding the experiences of these nurses. This taboo may also have led to hesitation to participate and engage in open and honest disclosure during the interviews. Ensuring this phenomenon was approached with sensitivity and empathy fostered an environment of safety and trust and contributed to deeper reflections and expressions of the participants' lived experiences.

### **Stigma**

Stigma is a complex concept that can be approached from various levels and perspectives. One seminal text on the topic is Goffman's (1963) *Stigma: Notes on the Management of Spoiled Identity*. Goffman's work examined the presence and manifestations of stigma towards individuals within society, highlighting that people are categorized by their place in society, and each category has expected norms and characteristics (Goffman, 1963). These categories are relied upon to make assumptions about others, and individuals with attributes that are discrediting or different from others within their category would be socially discounted. Stigma, therefore, is not a result of a particular characteristic or condition, but rather the social response to an unexpected or unwanted attribute as collectively agreed upon by society. This social response causes the individual to be viewed as tainted and not fully human by the rest of society (Goffman, 1963).

Link and Phelan (2001) built upon Goffman's ideas and argued that stigma is marked by a power differential which creates an *us* and a *them* mentality and leads to a loss of status. They suggest that stigma arises when society confers a label onto an individual, and this label becomes the dominant way that they are defined or identified. This label can be applied to any attribute, including medical conditions. The labeled individual then experiences social and structural disadvantages including exclusion, discrimination, and limited access to opportunities and/or resources (Link and Phelan, 2001).

Stigma can negatively impact how individuals see themselves and their place in the world. Goffman (1963) observed that internalization of stigma can occur when an individual absorbs the negative perception of themselves held by others. This can lead to what some authors call self-stigmatization, resulting in feelings of shame, self-hate, and self-degradation (Goffman, 1963; Link & Phelan, 2001; Peterson, 2017). Self-stigmatization can arise when individuals are socialized to view certain traits or characteristics as undesirable (Peterson, 2017). To cope with these negative feelings, individuals may attempt to address their perceived deficit by going to great lengths to prove they have overcome their weakness or character flaw (Goffman, 1963).

Stigma does not only affect those individuals who are seen to possess undesirable attributes. It can also be directed at individuals in close proximity to the stigmatized. This can include family and close friends. This transferability of stigma is identified in Goffman's work where it is described as a courtesy stigma (Goffman, 1963). In this case those who are connected to the stigmatized persons are also marked through their association. The suggestion is that the caliber of one's companions can be a reflection of the individual themselves, although the resulting stigmatization of these associated individuals can occur at a less intense level.

While stigma does exist in social relations and interactions, it also exists as a structural component within social institutions including cultural values, policies, practices, and discourses (Bruckert & Hannem, 2012). This perspective moves beyond individual and interpersonal levels to examine how discredited individuals are managed on broader levels through social controls. These institutions reflect the values and beliefs of the dominant groups and condemn those that challenge this order (Canales, 2000). Of relevance to this particular study is the systematic devaluation of certain identities within institutions including hospitals (Muncan et al., 2020). Hospital policies can guide what types of individuals or groups are stigmatized within the healthcare system. Punitive responses to addiction towards patients and employees alike can reinforce the notion that substance misuse is merely a social or criminal problem, and those who resist or who engage in these behaviours are labeled and discriminated against. It can also be evident through policies that restrict opportunities for stigmatized groups or that result in undesirable consequences (Muncan et al., 2020). This can include a lack of dialogue and continuing education surrounding substance misuse, reporting nurses to the police rather than the programs that are designed to provide them with treatment, and removing nurses with chemical dependence from clinical practice for extended periods. The institutional culture within the health care system concerning addiction can reinforce exclusionary practices and create a power division between groups.

When members of society learn to devalue those who fail to follow established social norms, it leads to stereotypical beliefs and negative reactions towards them (Bos et al., 2013). This response has been captured in a concept called *othering* (Canales, 2000). Othering occurs when a person or a group are seen as different, less valuable, or not belonging (Canales, 2000). Although these resulting collective beliefs about particular persons or groups are often not

accurate reflections, they are linked with exclusion and can result in marginalization and ostracism (Bruckert & Hannem, 2012; Room, 2005). As the misuse of substances is strongly condemned, nurses with addictions can suffer prejudicial beliefs, unequal treatment, dehumanization, and social rejection including repulsion, disapproval, and judgment (Bos et al., 2013; Room, 2005). These discriminatory behaviours are the observable evidence of stigma (Bruckert & Hannem, 2012). Stigma can also be less overt, operating below the surface through avoidance or by creating tension in social interactions (Bruckert & Hannem, 2012). For nurses regarded as other by their peers, this can result in having their work and decision-making questioned, and being micromanaged.

The widespread disapproval of nurses who divert opioids is a manifestation of the divergence between behaviour that is permitted and that which is forbidden within society. Indeed, the stereotypical assumptions made about nurses combined with misconceptions about addiction are at the crux of this issue. Using the concepts of taboo, stigma, and othering will provide a theoretical approach to view and better understand the experiences of nurses who divert opioids. This will help to illuminate how deeply embedded the concept of taboo is within the experiences of this population and how stigma and othering are located in the policies, discourses, and social processes that affect this population of nurses.

## **Chapter 4: Methodology**

### **Interpretive Phenomenological Analysis (IPA)**

This study utilized the research methodology of Interpretive Phenomenological Analysis (IPA). This is a qualitative approach that sets out to examine the human lived experience and the meanings people attribute to experiences in their personal and social worlds (Smith et al., 2009; Smith & Osborn, 2003). IPA is grounded on the assumption that everyone perceives the world

in their own unique way as influenced by their history, personality, and motivations (Smith & Osborn, 2004). It is an excellent methodology to make sense of ambiguous, complex, or particularly emotional research questions as it considers how individuals make sense of significant or important life experiences (Smith & Shinebourne, 2012). This can be understood as moments in individuals' lives where "everyday ordinary experience becomes 'an experience'" (Smith et al., 2009. p.33).

IPA has three primary philosophical underpinnings. Firstly, like all forms of phenomenology, the focus is on the lived experience of the participant (Creswell & Poth, 2018). IPA is interested in the human experience, with a specific focus on the aspects that hold personal significance or meaning (Smith et al., 2009). IPA is committed to exploring how humans understand their experiences in the world (Smith et al., 2009). Smith et al., (2009) acknowledge that the concept of experience is complex. Simply put, experiences are the moments in an individual's life that are especially important or meaningful. While humans are continuously immersed in the world around them, frequently moments go unnoticed and fail to leave any lasting impression. When an event holds importance, and an individual is attuned to it, it can transcend from experience to what Smith et al., (2009) define as "an experience". Smith et al., (2009) describe hierarchical and multilayered structures to experience. This draws upon the work of Dilthey (1976) who characterized an experience as a moment in time that, either independently or in conjunction with other moments, possesses significance. As an example, Smith et al., (2009) describe a day at the beach and the awareness of warm pebbles underfoot as the smallest unit of an experience. While an IPA study could be conducted on such, more often these studies are centered on how small units of experience fit together to become events in one's life that have great significance. In this example, the feeling of the pebbles could be one experience

within “an experience” of swimming for the first time following a surgery. This example helps define the range of events or encounters that can be captured within the IPA methodology.

The second theoretical underpinning of IPA emerges from hermeneutics, the theory of interpretation (Smith et al., 2009). IPA acknowledges that making sense of participants’ subjective life experiences requires the active interpretation of the researcher (Peat et al., 2019; Smith & Osborn, 2003). As it is not possible to directly observe the thoughts and emotions of research participants, the researcher plays a pivotal role in interpreting the data to help create an understanding (Anderson et al., 2015; Smith & Shinebourne, 2012). This is dubbed a “double hermeneutic”, whereby the participant tries to make sense of their own world, and the researcher tries to make sense of the participant’s sense (Smith & Osborn, 2003). Engaging in interpretation requires researchers to consider their own perspectives about the subject matter. Charmaz (1990) wrote that in qualitative research, including phenomenological studies, researchers must bracket their beliefs and assumptions about the area of study, while acknowledging that a total lack of knowledge or familiarity with the topic is neither expected nor necessary. This viewpoint diverges from the standpoint of Smith et al., (2009) whereby researchers utilize reflective practices as an alternative approach. Rather than attempting to close off any preconceived notions, it is crucial for researchers to be aware of how their own experiences and expertise influence their understanding. By acknowledging their own position, researchers can then refocus attention onto the participant, fostering a more genuine understanding of the participants’ subjective experiences.

Finally, IPA is idiographic in that it is committed to the detailed examination of each participant as individuals (Smith & Osborn, 2015). Smith et al., (2009) describe this as a “commitment to the particular” (p.29). This is in terms of the level of detail sought out through

deep analysis, but also in terms of how an event is experienced by an individual in their unique circumstance. Participants are situated in their personal contexts and there is an emphasis on their views and perspectives (Smith et al., 2009). This approach differs from more common research methods in psychology that aim to establish laws about how humans behave (Smith & Osborn, 2003). Rather, idiography is concerned with the specific over the general and recognizes that life experiences and meaning making are incredibly diverse (Miller & Minton, 2018). For this reason, IPA is concerned with bringing forth rich data about a particular phenomenon as opposed to making claims that can be easily generalized (Smith & Osborn, 2003). Some IPA studies will make use of single case analyses while others will make use of small sample sizes. Yet the aim is always to engage in deep analysis to get at the meaning of an event, process, or relationship for a given person (Smith et al., 2009).

### **Theory in IPA**

As described, IPA is fundamentally concerned with understanding the subjective experiences of individuals. An important consideration within this methodology is that participants have the opportunity to articulate and reflect on the phenomena in their own words and from their own perspectives (Smith et al., 2009). This approach allows the participants to express themselves organically which can better capture the richness and the depth of their lived experiences. This contrasts with some other research approaches that may impose predefined categories within established theoretical frameworks onto participants' experiences.

The core principles of IPA support an adaptable and open stance regarding theory. As described, data collection and analysis unfold through a collaborative process whereby both participants and researchers actively engage in sense-making of the phenomena of study. Participants are encouraged to co-create knowledge by sharing their unique perspectives and

interpretations, while researchers are tasked with actively listening to participants and reflecting on their own perceptions of the stories shared. Through reflexivity, researchers can critically consider their own preconceptions, fostering self-awareness and sensitivity in the interpretive process.

Reflexivity was a core feature of this study in various ways. For example, while a particular theoretical framework was not utilized, I was able to leverage lived experience as well as the reflective process to identify theoretical concepts pertinent to the study. Concepts are understood as abstract representations or, more simply, ideas about situations, human behaviours, or processes (Larsen & Adu, 2001). The concepts of taboo, stigma, and othering were identified as relevant and meaningful in the context of this study. These concepts are used as a guide within the data collection process as well as a lens through which to engage in data analysis.

From a data collection perspective, these theoretical concepts were instrumental in developing an interview guide that would capture rich and meaningful data. This included questions that focused on the reactions of others, including colleagues, friends, and family members, once the participants' opioid diversion and misuse became known. There were also questions about how this experience shaped the participants' perception of self as a nurse and what the personal and professional impacts have been. This approach helped to gather detailed insights and understand the bigger picture of individual stories within wider societal constructs surrounding addiction.

During the analysis phase, the concepts were employed to draw out themes and make connections between the participants' experiences. By using these concepts as a theoretical lens, it allowed me to engage in deeper interpretation, giving a clearer picture of how the themes

converged and diverged between participants. This was particularly relevant when considering the impacts on self-identity and how the nurses experienced the ATD programs. The concepts also helped to navigate the interpretation process and identify underlying meanings in that participants' narratives. This assisted me to move beyond surface level observations and pick up on the subtle nuances in their stories. Overall, the theoretical concepts helped to enrich the data analysis and contribute to a richer and more holistic understanding of opioid diversion and misuse among nurses.

### **Sensitive Research**

This study is situated within the realm of sensitive research. Lee and Renzetti (1990) are credited with developing a comprehensive definition of what sensitive research entails. They described sensitive topics as those which “potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding, and/or dissemination of research data” (Lee & Renzetti, 1990, p.512). Sensitive research is known to encompass a wide range of topics, can be approached using different methodologies, and often applies to the investigation of social issues (McCosker et al., 2001). Lee and Renzetti (1990) suggested key areas that contribute to sensitivity in research, including studies that intrude into the private or intimate details of participants' lives. This is because they examine personal, emotional, and stressful experiences, and they also place participants in vulnerable positions, potentially generating emotional distress (Lee, 1993; Lee & Renzetti, 1990). In addition, research that focuses on acts of deviance, and where there is a risk of identification or incrimination, is considered sensitive (Lee & Renzetti, 1990).

This study is situated in the realm of sensitive research as the topic matter is not only private, but is also illegal, taboo, and breaches nursing codes of ethics (College of Nurses of

Ontario, 2019; Kiepek & Beagan, 2018; Lachman, 2009). IPA was an appropriate research design for this study because of its ability to navigate the complexities within sensitive research. Given the nature of drug diversion and misuse among nurses, there was a need for a methodological approach that respected the privacy and dignity of the participants while also addressing the legal and ethical implications surrounding this topic. Conducting sensitive research also requires careful consideration and planning due to the difficult methodological and technical challenges that may occur (Lee & Renzetti, 1990). These challenges encompass various aspects, including securing access to participants and effectively recruiting them. Additionally, ensuring participant comfort and safety during data collection requires a consideration of cultural norms and social dynamics that may impact participants' willingness to engage with the research process. Finally, there is a need for stringent measures to protect the data as well as the confidentiality of the participants. Addressing these considerations will allow the researcher to engage in sensitive research while upholding ethical standards and promoting the well-being of those involved. The methods employed to address these issues, and the sensitive nature of this study will be discussed further below.

### **Sample**

IPA focuses on small sample sizes as the analysis is detailed, heavily immersive, and labour-intensive (Smith & Osborn, 2003). Recommendations suggest a range of three to ten participants (Creswell & Poth; 2018; Pietkiewicz & Smith, 2014; Smith & Osborn, 2003). Such sample size is congruent with sensitive research studies as recruitment is often challenging, yielding smaller sample sizes. Some considerations for choosing sample size in IPA includes the depth of the analysis at hand and ensuring a thorough analysis is feasible (Pietkiewicz & Smith, 2014). For the purposes of this study, the aim was to sample between twelve to fifteen

participants. While this is a higher than average sample size for an IPA study, this decision was made with the belief that sampling a larger number of participants would be beneficial to understanding a poorly researched topic. Despite this goal, the total number of participants in the study ultimately amounted to nine nurses stemming from challenges encountered with access and during recruitment.

The study sample comprised nine nurses residing in North America, all of whom had returned to nursing practice following experiences with opioid diversion and misuse. There were similarities and differences in the sample based on geographical location, regulatory body, age, area of practice, and so on. All the participants were registered nurses. Three nurses were from Canada and six lived in the United States. All of the Canadian nurses resided in Ontario. The American nurses were from different states including Florida, Iowa, and Ohio. The study was dominated by female nurses with the involvement of a single male nurse participant. The ages of the participants ranged from 32 – 61 years. All the nurses were Caucasian. No other demographic data was obtained.

Purposive sampling ensured the participants were able to provide insight into the phenomenon of study (Smith et al., 2009). All nurses who had diverted and misused opioids, regardless of job training, job class, and education level, were invited to participate in the study. This included all types of nurses, for example, registered practical nurses, registered nurses, and nurse practitioners. In addition, no particular area of practice was specified although it was expected that most would be employed in acute care environments during their opioid diversion as access to these medications is less likely to occur in other healthcare settings. The nurses were from a variety of clinical backgrounds, but the majority reported working in hospital settings during the time of diversion. This included work in the ICU, ER, cardiac telemetry, and surgery.

An important consideration of this sample is that it only included nurses who had re-entered practice. Nurses who subsequently left the profession following diversion were not actively sought out for this study. Their exclusion stems from the fact that they would not be able to provide insight on the experience of re-entry to practice, nor would they be able to share the significance of their experience as a current nurse. In addition, only those nurses who had participated in regulatory board run return-to-work programs were included in this study. While there are likely nurses who have privately sought treatment following opioid addiction and diversion unbeknownst to their regulatory board and employer, those individuals were not included. Not only would it have been extremely difficult to locate and recruit these nurses, but also those that maintained their anonymity would likely have experienced their return to work differently than nurses who were known to their employers and regulatory boards.

### **Recruitment**

Recruiting participants can be challenging in sensitive research studies (Lee, 1993). This is understandable as when investigating sensitive issues, such as those surrounding addiction and diversion, participants may have a greater desire to hide their involvement (Lee & Renzetti, 1990). People who engage in taboo behaviours, those that are disapproved of in society, may naturally hesitate to share their stories (Hall & Osborn, 1994). In the case of nurses who have been involved in opioid diversion but have subsequently returned to practice, concerns about maintaining their anonymity and avoiding further scrutiny may have led to reluctance to participate.

The anticipated challenges with recruitment proved to be accurate within this study and there were a variety of factors that deterred nurses from joining. One nurse refused to participate citing concern that this study was a type of ploy by the regulatory board for nurses to incriminate

themselves. In addition, several nurses were at first highly motivated to participate in the study, but later voiced that they had changed their minds, or they suddenly stopped responding without explanation. While the exact reasons for these actions remain unclear, they could potentially stem from concerns about jeopardizing anonymity, fear of potential negative repercussions from participation, or a general reluctance to divulge details about such a sensitive topic.

Accessing potential participants for this study also posed significant challenges, largely due to the involvement of gatekeepers. Gatekeepers serve as intermediaries between researchers and participants and their role can, at times, impede researchers' efforts to reach participants, especially in sensitive studies (Johnson, 2018; Lee & Renzetti, 1990). Within organizations, gatekeepers hold the authority to either grant or withhold access to individuals or information for research purposes (Andoh-Arthur, 2019). In the context of this study, the provincial and state-run regulatory boards as well as leaders of caduceus groups served as such gatekeepers.

Requesting lists of nurses who had engaged in diversion from the regulatory boards was not a viable option for this study due to privacy considerations. Diversion is often associated with SUD, and regulatory boards do not disclose the private health information of their members. For this reason, regulatory boards were not utilized within the recruitment process. Instead, I pursued an alternative approach which involved connecting with leaders of Caduceus groups to access potential participants. Unfortunately, each group immediately declined this request citing confidentiality concerns. Even when I reiterated that the request was not to have access to members' names or information, but rather for the leaders to pass along information about the study and offer the opportunity to participate, all groups refused. I also communicated with the Nurses' Health Program in Ontario and shared the study information with a team leader there. Once again, this organization refused to share the study details with the nurses enrolled in this

program, citing confidentiality concerns. Ultimately, the initial recruitment was only successful by contacting the leader of a local Caduceus groups who was known to me. One participant was recruited through this method, and this person was able to recruit two others through snowballing. A total of three nurses joined the study through the initial recruitment strategy.

Recruitment stalled at this point prompting a review of strategy. I connected with my supervisors to brainstorm new techniques for engaging participants and a discussion was held to decide if I should reveal personal experiences with the subject of study to aid in recruitment. While I harboured concerns about the exposure of my health information, ultimately a choice was made to reveal this aspect to those nurses who expressed interest or confirmed their intention to participate. This decision was rooted in principles of kinship and solidarity, as well as a belief that this would garner richer data. By revealing my own lived experiences, I aimed to establish a sense of trust and connection with potential participants that could potentially elicit more meaningful and candid responses. Beyond the encouragement of more open and honest sharing, sharing this detail was also important within the context of this study. This disclosure was in line with the hermeneutic approach to data analysis whereby the experiences of the researcher are both acknowledged and integrated into the interpretive process.

At this time, a strategy was developed to utilize social media, specifically Facebook, as a tool to recruit other nurse participants. In addition, the geographical area was expanded to include nurses residing in the US. This decision was guided by the understanding that ATD programs in Canada are modelled upon those in the US, thus sharing similar characteristics. It was also made with the aim of reaching a larger pool of nurses due to the higher population in the US as compared to Canada.

Following these decisions, an amendment was filed with the Research Ethics Board to gain approval to include American nurses and to use the Facebook platform to connect with nurses who might be willing to share their stories. Two private groups catering to nurses with addiction were identified. To gain access to these groups, I affirmed that I fulfilled the requirement for group membership. Other rules in the online groups surrounded mutual trust and privacy whereby information shared in the group was required to stay in the group. There were also guidelines to ensure group members did not discuss specific patients.

The use of social media allowed me to connect with a wider audience and engage individuals who may have otherwise been difficult to access through the initial recruitment methods. Shortly after requesting to join the two groups, I received notification that my request was approved. At this time, online posts were crafted to share details about the study and to invite members of the groups to connect either through the comment section or via Facebook's private messenger service. This approach ultimately provided fruitful, resulting in the recruitment of six additional nurses who met the inclusion criteria and were willing to participate.

I encountered difficulties in reaching potential participants and these challenges persisted when it came to engaging them to participate in this sensitive research study. As described, despite initial expressions of interest from many nurses who verbalized excitement about the project or reached out with questions, a considerable number ultimately declined to participate. This trend, while frustrating, underscored the complexity of engaging individuals in sensitive research studies. It was important, however, that throughout this process, I ensured that all participants that did engage did so willingly, and without any form of pressure or coercion (Perron et al., 2014). Despite the setbacks encountered, maintaining ethical integrity, and respecting the autonomy of the potential participants was paramount.

I employed several effective strategies to secure participants, especially those who displayed interest but expressed hesitancy. Being flexible, demonstrating genuine concern for the participants, and addressing their questions were key approaches recommended by Perron et al., (2014). For example, I was able to engage one particularly concerned individual by verbalizing understanding of their reservations and offering additional documentation to reassure them that this was a verified study. This was done by directing the participant to view publicly available information published on the CNO website that confirmed my own enrollment within an ATD program. This was a method to secure trust in myself and in the study. Sharing this information was aimed at making the participants feel safe and act as a reassurance that they could disclose their experiences without fear of judgment or blame. The characteristics and design of this study were also tailored to encourage tentative individuals to join. The study allowed participants to speak freely, sharing as much or as little as they felt comfortable. This empowered the participants to control the extent of their disclosure. Finally, offering an incentive can help to engage participants. Some researchers have expressed concern about not being able to compensate participants for their time and energy (Johnson & Clarke, 2003). In this study, I offered fifty-dollar gift cards to the participants as a token of gratitude for their time and their stories. All these aspects contributed to the successful recruitment of the nine nurses who participated in this study.

It should also be noted that this study presented the participants with a unique opportunity. One asset of this study was that it provided a safe space for nurses to discuss difficult experiences that they may have otherwise been without. When designing this study, I was hopeful that the nurses would see the interviews as an opportunity to discuss experiences that were likely lonely and isolating. Indeed, not all sensitive research results in negative responses.

Despite discussing intimate details of their lives, participants in other sensitive research studies have reported a therapeutic effect from sharing their stories (McCosker et al., 2001). This sentiment turned out to be true as at the end of the interviews several nurse participants expressed relief from sharing their experiences.

### **Data Collection**

Data collection in IPA studies encourages rich, thoughtful, first-hand recollections of lived experiences (Smith & Shinebourne, 2012). Establishing a connection and a rapport with participants is essential (Smith et al., 2009). To share sensitive details, participants must feel comfortable and have a sense of trust (Smith et al., 2009). In this study, questions and concerns regarding trust were brought up by most of the participants. Some participants asked for reassurances about their privacy. Others requested certain information be redacted including information about where they lived and the names of their current employers. All the participants chose to use a pseudonym. This helped create a trusting relationship and allowed the participants to speak openly and without fear of reprisal.

I had hoped to conduct some of the interviews in person, however, this was ultimately left up to participant preference and feasibility. All interviews were ultimately conducted using online platforms. Eight interviews were done on Teams, and one was on Zoom. Basic demographic information was collected from the participants including their age, gender, race, area of practice (pre and post diversion), and years of nursing practice. The interviews were expected to last between 60 – 90 minutes, however, some were as short as 35 minutes and the longest was 75 minutes. This was due to the willingness of participants to share their experiences and their ability to articulate their experiences and what they meant to them. All participants were asked to commit to two interviews, but only one interview took place with each participant.

It was possible to gather all the information in one interview, however, leaving it open to schedule a second interview allowed space to return to participants if clarification was needed or to re-visit data that may have needed more analysis.

Semi-structured one-to-one interviews are the most common method of data collection in IPA studies and sensitive research, and they were utilized in this study (Creswell & Poth, 2018). This style of interview is preferable as it allows participants to describe their experiences in their own words (Smith & Osborn, 2004). As data collection in IPA aims to elicit detailed stories, feelings and experiences, semi-structured interviews use multiple open-ended questions that encourage the participants to tell their stories in their own way (Smith et al., 2009). Questions often are geared toward how participants experienced events rather than the events themselves (Miller & Minton, 2018). Researchers have found that framing questions in a casual conversation style is more successful than adopting a more formal, back-and-forth style (Perron et al., 2014). This method was utilized in the study as it helped participants share in a more organic way and allowed me to respond to their answers. This was important as I was at times surprised by the direction the discussion took (Smith & Osborn, 2003). For example, many of the participants spoke at length about the factors that led up to their diversion. Detailing these events was a greater priority for the participants than I had anticipated.

The literature does allude to specific risks to participants partaking in sensitive research because of the nature of semi-structured interviews. The concern is that by asking participants to share their stories, they may share especially intimate and revealing matters and potentially regret their perceived over-sharing post interview (Corbin & Morse, 2003). An opposing view, however, is to consider that semi-structured interviews give participants considerable control over what they chose to share (Corbin & Morse, 2003). In addition, it is reasonable to assume

that participants who do not want to share details will refuse to do so, or simply will not agree to participate in the study (Corbin & Morse, 2003). This semi-structured interview approach wound up being successful as the majority of the nurses shared their stories freely and organically. Participants expressed appreciation for being able to share as they pleased. Following the interviews, none of the nurses voiced any regret about sharing their experiences and, instead, several described a sense of relief and a feeling as though a burden had been lifted.

An interview guide was developed and used as a reference to varying degrees within the interviews. One participant did not engage with the conversation style, preferring to answer the questions as presented. The other participants engaged more freely, and the interview guide was only referenced once or twice. The guide served as a useful tool, ensuring that discussions stayed focused and highlighted topics of interest, while still allowing participants to share their experiences in their own preferred manner.

With regards to setting, Smith and Osborn (2003) suggest performing interviews in places where the participants feel comfortable and that provide the needed privacy, intimacy, and confidentiality with minimal interruptions. This could include the participants' homes or other private settings. Interviews in the workplace were not suggested as this could impact the participants' level of comfort while also being potentially distracting. All interviews took place virtually while the participants were in their homes. One participant sat in her backyard away from her family who were inside. The rest of the participants were at home alone at the time of the interviews. Recordings of the interviews were essential for accuracy, depth, and trustworthiness within data analysis. As a result, all interviews were video recorded using the online platforms (Teams/Zoom). The recordings were transcribed and then proofread and edited to redact any identifying information. The recordings were then deleted.

## Consent

Researchers must be extra vigilant when designing sensitive research studies, especially regarding free and informed consent, confidentiality, and privacy (Hall & Osborn, 1994). Researchers must balance these concerns and participants' rights with furthering knowledge in the area of study (Haggerty & Hawkins, 2000). Ensuring that participants fully understand the risks and benefits of their participation and have every opportunity to ask questions is necessary to obtain informed consent (Corbin & Morse, 2003). In this study, the consent form was provided to participants in advance of the interview, so they had ample opportunity to review the information. In addition, verbal informed consent was obtained before all online interviews began. This included the purpose of the study along with its risks and benefits. These factors were reiterated to the participants prior to commencing the interviews.

Protecting the confidentiality of the data is an ethical component in all research studies. Confidentiality refers to issues surrounding data handling, storage, and ownership (Perron et al., 2014). It is an agreement between the researcher and participant that any information obtained will only be used for the study (Sieber, 1984). Researchers can offer anonymity by sharing the experiences of the participants while protecting their privacy (Lee & Renzetti, 1990; Smith et al., 2009). One tactic considered in this study was to use a false project title that did not include sensitive terms such as diversion (Haggerty & Hawkins, 2000). This proved to be unnecessary, however, as the title of the study was only shared with the participants and the study details were shared via personal email addresses. Pseudonyms were assigned to all participants to protect their identity (Perron et al., 2014). To provide participants further control over the research process, they were offered the opportunity to review their interview transcript and to decide if I could use direct quotes (Perron et al., 2014; Smith et al., 2009). Only one participant chose to

review their transcript, and it was sent to their preferred email address as a password-protected document. The participant was then given two weeks to review the document and email the revised or edited document back. No changes to the transcript were requested. All other participants declined the opportunity to review their transcripts.

Despite strict rules, there are instances when researchers must break confidentiality due to mandatory reporting, for example in cases where a participant discloses child or elder abuse, or if they intend to harm themselves or others (Haggerty & Hawkins, 2000). A particular concern in this research is that participants could have potentially breached the Personal Health Information Protection Act (PHIPA) if they were to disclose names or identifying information of patients (Personal Health Information Protection Act, 2004). While this would not require mandatory reporting, it could violate the terms of the Act as custodians of health care information. For these reasons, research participants were advised not to identify patients. This did not occur, however if it had, it would have been redacted from the transcript.

### **Protection of Participants**

While the opportunity for participants to share experiences proved beneficial in this study, proactive measures were implemented to minimize the likelihood of harm. One of the greatest considerations in research is the need to protect participants, and this is especially the case with sensitive topics. Yet engaging in discussions about distressing events can evoke strong emotions, regardless of whether the dialogue occurs with researchers or with others (Corbin & Morse, 2003). Thus, it was my obligation was to ensure that the risks were reduced or eliminated. In instances when this was not possible, I took care to ensure that such risks were never greater than what participants would typically encounter outside the research setting.

As participants were asked to share highly personal details in this study, it could have been emotionally taxing and led to experiences of discomfort, embarrassment, and distress (Cowles, 1988; Lee, 1993). All researchers must avoid inflicting needless suffering on the participants (Kavanaugh & Ayres, 1998). To this end, I anticipated and created a plan to identify, address, and mitigate the risk of psychological harm prior to commencement of the study (Corbin & Morse, 2003; Hall & Osborn, 1994). Various strategies were carried out, such as directing the interview in and out of sensitive areas, and being flexible with the interview format (Brackenridge, 1999; Perron et al., 2014). One way this was done was by asking the participants how they wished to start the interview. This approach fostered a sense of comfort among participants, starting off slow and enabling them a level of control as they discussed topics that they were more at ease addressing. In addition, I navigated back and forth between more difficult topics of discussion. When participants became emotional or exhibited difficulty speaking about a topic, I would change the direction of the interview and ask about more neutral topics such as employment histories or professional pathways. Respecting rhythm and silences and offering to pause or stop the interview if the participants expressed distress, were other protective strategies. The choice to cease an interview occurred in a single case. This interview ended slightly earlier than planned due to a poor internet connection near the end which disrupted the flow.

Interventions post data collection were planned which included debriefing post-interview (Brackenridge, 1999; McCosker et al., 2001). In this study, I sent a message via email or Facebook messenger to each participant in the days following the interview to check in with them. None of the participants expressed a need for a verbal debrief, nor did any of the participants request resources, although different services were included on the consent form. The information was provided to all participants prior to the study included the Rapid Access

Addiction Medicine (RAAM) clinic, AccessMHA, AA/NA, and employer-funded EFAP programs. In fact, several nurses expressed a sense of well-being, describing relief and comfort following the sharing of their stories.

### **Protection of Researcher**

Lee and Renzetti (1990) point out that sensitive research can also pose a threat to researchers. Oftentimes researchers are preoccupied considering potential effects of their study on the participants and do not consider how they could personally be impacted (Zurbriggen, 2002). This type of research can pose both physical and psychological dangers. The physical safety of researchers could be threatened if interviews are performed in unsafe locations. Researchers may, for example, have their safety jeopardized by conducting an interview in a violent home (McCosker et al., 2001). The risk of physical harm was not identified for this study due to its online nature.

There are also psychological risks for researchers, and many have voiced challenges in obtaining, analyzing, and processing sensitive data which caused emotional distress (Johnson & Clarke, 2003; McCosker et al., 2001; Zurbriggen, 2002). There was some concern that this study could present particular challenges due to my relatively recent experience with the matter of study. Some strategies implemented to protect myself from psychological harm included limiting the number of interviews per week, analyzing data for a set amount of time then taking a break, debriefing with supervisors, and relying on my personal support system (Brackenridge, 1999; McCosker et al., 2001). While at times I acknowledged feelings of regret and sadness that were provoked by the participants' stories, overall, the experience was positive. There were no triggers to misuse substances. Rather, I experienced feelings of solidarity and a greater comprehension of the prevalence of this issue within the nursing profession.

## **Trustworthiness**

Jonathan Smith and colleagues have acknowledged that IPA can be a challenging methodology to utilize due to its lack of a prescribed method for data analysis (Smith et al., 2009; Rodham et al., 2015). This can challenge trustworthiness as the analysis process is open to interpretation. Yet all IPA studies share a common element in that participants interpret and voice their experiences in a way that the researcher can make sense of (Rodham et al., 2015).

Ensuring the trustworthiness of the research was a consideration throughout the process. It began by ensuring the sampling was appropriate and that all participants had lived experience with the phenomenon of interest (Alase, 2017). One way I enacted trustworthiness was by ensuring the focus of the research remained on the participants.

Reflexivity was also a key aspect of trustworthiness. To address this, I engaged in self-reflection on my own experiences, understandings, and assumptions about the subject of study. This included rereading journals that were kept and examining photographs taken during this period of my life. This assisted me to address my own recollections and beliefs surrounding the topic of study. This act of reflexivity was necessary to be aware of my own values and beliefs as I was situated both inside and outside of the research (Goldspink & Engward, 2019). As a nurse who had lived through the subject matter, I had a unique insider perspective. Through reflexivity, emerged experiences with stigma, taboo, and othering, which helped to provide direction for the theoretical basis of this study. Yet, as a researcher aiming to understand how other nurses had experienced and made sense of drug diversion, it was necessary to also situate myself outside of the subject. One way this was achieved was by ensuring the analysis was deep and thorough. This was addressed by re-reading the interview transcripts numerous times, following leads in the data, probing participants, and reflecting on the data with my supervisors and committee.

Alase (2017) described the importance of being aware that conducting phenomenological research is entering another human's private life and space. This was an ongoing consideration which contributed to trustworthiness through the lengthy and thoughtful analysis of the data.

## **Chapter 5: Results**

### **Data Analysis Process**

Smith et al., (2009) describe IPA as possessing a healthy flexibility with regards to data analysis. Analysis began by immersing myself within the data (Pietkiewicz & Smith, 2014). This was done through several readings of the transcribed interviews (Smith et al., 2009). Next the perspective shifted between emic and etic approaches as reflexive notes were added to areas of interest (Pietkiewicz & Smith, 2014). Emic refers to the views of the insiders while etic refers to the views of outsiders (Creswell & Poth, 2018). I was able to engage in both approaches due to my unique position of being both inside and outside of the research.

Wide margins on the transcripts were used to jot down notes on significant findings including questions, comments on the use of language, and any other insights about what the participants shared (Smith & Osborn, 2003). This was a thoughtful and deep analysis (Smith et al, 2009). Each transcript was read three or more times to truly capture what the participants were verbalizing and how they understand the impact of the phenomenon on them (Alase, 2017). Emergent themes were developed through a combination of the transcripts and my reflexive notes. The focus was on capturing the central meaning of the lived experience. This is otherwise described as the central meaning of the lived experience, that which the participants are attempting to share. The themes that emerged reflected both the dialogue between the participants and myself, along with my own interpretation (Smith et al., 2009).

This process of analysis was completed for the data from each participant, ensuring that each transcript was approached individually. Once the themes emerged, I developed a system of how the themes fit together (Smith et al., 2009). This was done by cutting out examples of the themes from the transcripts and clustering the connected themes together. I looked for patterns to determine which themes were the most prominent and how they were related. Some themes were dropped at this phase as they were singular and did not fit in well with the others (Pietkiewicz & Smith, 2014). In IPA the results can be presented in different ways. In this study they will be reported in narrative format which lists the themes and includes examples.

## Themes

Five themes were identified during the data analysis process. Each of these themes are reflected in Table 1 and will be described and exemplified below.

### Figure 1

#### *Themes and Sub-Themes in Data Analysis Process*



### *In Search of Quiet – Beginnings and Backstories*

During the interviews the nurses demonstrated a powerful desire to break their silence and candidly share their personal experiences as healthcare providers struggling with addiction. While the taboo nature of this topic commonly restricts nurses from speaking openly about substance misuse and cultural norms within the health care industry shun nurses from engaging in any self-disclosure, the participants in this study were eager to describe their journeys which eventually culminated in their diversion of opioids.

While exploring these backstories, the nurses articulated the events and experiences that preceded and ultimately converged into this pivotal moment in their lives. The experiences varied between participants, however common threads of similarity emerged in the narratives with mental health conditions and/or physical afflictions standing out as the prevailing influences on their addiction and diversion. Additionally, long-standing histories with substance misuse were shared that hinted at a familiarity with the effects of drugs or alcohol. These histories also shed light on the potential roots of the participants' struggles whereby substances had previously been used as a means of self-medication, offering a temporary refuge from pressure or difficulties at different times in their lives.

Mia openly recounted her prior encounters with substance misuse. "Honestly, I've had issues with [substance misuse] in the past. It's not the first time..." (Mia). This admission acknowledged her ongoing battle and illuminated Mia's vulnerability to the effects of substances. David also described the use of numerous substances beginning in college that followed him into adulthood. Chemical dependence plagued another participant since her adolescence. "I've been struggling with addiction for the vast majority of my life... I probably started binge drinking when I was like 15." (Katie). Katie's story offered a glimpse into substance

misuse in her formative years and the trajectory this placed her on. Beth's recollections surrounded experimentation with substances in her high school days which evolved to more frequent and varied use as she grew older. Each of the nurses' narratives emphasized the entwined relationships between mental well-being, physical health, and the influences of substances within the course of their lives.

**When Healing Hurts.** Four of the nurse participants traced their experiences with addiction and diversion back to encounters with physical pain and discomfort. In these cases, opioid analgesics were prescribed to them as a remedy by their healthcare providers, only to morph into intense struggles with misuse and dependence. Some participants recalled experiences of acute pain resulting in temporary treatment with these medications. Others suffered chronically, leading to prolonged opioid use. While their pain experiences varied, these participants attributed their eventual addiction and diversion to their exposure to these powerful medications.

The pharmaceutical treatment and the mechanism which led to dependence varied between those who were treated acutely versus chronically. The nurses who were treated with opioids on a short-term basis described their introduction to a class of medications that offered relief far beyond physical discomfort. While their physical ailments were relieved with opioid use, so was any psychological distress they were experiencing. The participants in this study shared the profound relief from these medications for their injuries, but also for mental suffering within their personal and/or professional lives. Such was the case for Katie who reflected upon her development of opioid dependence. After tearing her ACL, Katie underwent surgery and was prescribed opioids to manage post-operative pain. She soon began to misuse these opioids because of the outcomes they generated, becoming accustomed to their effects and resulting in

both physical and psychological reliance. Katie spoke of varied life stressors at this time, including family tensions, which the opioids soothed for her. After her prescription ran out, Katie alluded to purchasing opioids on the street. She continued to obtain drugs this way but found it challenging to secure the quantities she required to prevent discomfort and withdrawal once she reached a state of dependence. Desperately craving relief, Katie soon resorted to diverting opioids from her workplace. “But I came back to work after [surgery], and I started diverting and it went downhill from there.... Other places dried up, so then that’s the next step...” (Katie). In Katie’s experience her prescription medications became a mechanism to cope with stressors. This led to prolonged use and paved the way to opioid dependence, leaving her unable to function without opioids and ultimately leading to addiction and workplace diversion.

Other participants recounted similar experiences in their initial encounters with opioids. Diana was first exposed to opioids during her teenage years as treatment for an injured knee. She recalled the psychological effects of these medications, commencing a long relationship with substance misuse that included pilfering medications from family members and eventually progressing to the diversion of opioids from her workplace. She shared, “I dislocated my knee and was prescribed the medication, which was nice to have, and when that was all gone, it was all gone. But after that I realized that my dad had medicine and I would take some of his sometimes. And then, you know...” (Diana). Diana's misuse of opioids persisted over the years and escalated significantly after a series of personal stressors, including the death of her grandmother and her husband’s cancer diagnosis. During this challenging period, she began to divert narcotics, recalling their effectiveness in soothing mental distress. Her desperation for relief from her grief and anxiety drove her to seek out the familiar feeling of opioids and engage in workplace diversion. Sara, too, connected her substance misuse to physical injuries and

described having multiple surgeries where she “got her taste for opioids”. In her case, again, opioids were prescribed for acute pain but opened unexpected awareness of their capacity to reduce psychological distress and invoke experiences of calmness and relaxation. These responses encouraged Sara, and others in this study, to continue their use. The paths varied for the participants, but at some point, their misuse escalated, causing physical and psychological dependence on opioids, and resulting in their workplace diversion.

For the nurse who suffered with chronic pain, her dependence occurred over time as she developed opioid tolerance, thus requiring higher and higher doses to achieve adequate pain control. Once dependence took hold, continued use was required to control pain and stave off experiences of withdrawal. Such was the case for Darby who suffered prolonged and intense pain from an injury she sustained in adulthood. She was prescribed opioids, however as her tolerance grew, her pain would no longer be controlled. Over time, she became physically dependent on these medications and described the difficulty managing her ongoing symptoms and achieving adequate pain control. She found it challenging to live with the burden of chronic pain and to navigate an adequate treatment plan with her chronic pain physician. “The pain level would start to climb again. And I think out of an active desperation... The opportunity came at work one night that I could.... Basically, if I saved a wastage then I could pocket it. I remember feeling really guilty and swearing I would never do it again. But with that came relief, and it was so easy to do.” (Darby). Opioid tolerance is expected in long-term use, yet it can present challenges for patients who require increasingly higher doses of these strictly regulated medications. Darby struggled immensely with daily pain and eventually resorted to workplace diversion to control her ongoing discomfort and function inside and outside of the workplace.

Within the interviews the participants delved deeply into the trajectory of their misuse, charting their journey from pain management into full-blown opioid addiction. Their stories revealed the progression of opioid use, leading to their eventual reliance upon these medications to navigate daily life. Each of the participants was initially prescribed opioids to mitigate pain from physical injuries, acquainting them with the varied effects of these medications. For some, the misuse of opioids stemmed from their dual ability to provide relief from physical discomfort while simultaneously inducing psychological responses including anxiety reduction, relaxation, and a sense of well-being. For others, the development of opioid tolerance with prolonged use necessitated higher doses to achieve the same level of pain relief and their evolving reliance upon opioids created a compulsion to exceed their prescriptions. However, once opioid addiction took hold, the participants found themselves incapable of functioning without the aid of these medications. This factor was important for the nurses to emphasize whereby the physiological changes resulting from persistent opioid consumption acted as a key driver in perpetuating their continued usage. When opioids were not available, symptoms of withdrawal would manifest which made their lives unbearable. David spoke to his personal ordeal, stating, “I went through severe withdrawal three or four times. And that is a special kind of hell.”. At this point the nurses struggled immensely to navigate their personal and professional lives under the burden of their dependence. Some sought out opioids from friends or family, while others resorted to street purchases. Ultimately, all the nurse participants were driven to diverting opioids from their workplace and their stories shed light on their profound struggle with opioids and the cycle of opioid misuse and dependence.

**Escaping the Pain.** Mental health and wellness issues were identified as the primary contributor to addiction for four of the participants, while one participant considered it a co-

contributor. These nurses described using opioids to alleviate the symptoms associated with their psychological conditions. Jennifer revealed that her substance misuse was directly related to untreated mental health issues. “I started doing that [diverting] in 2015 when my mental health was really struggling... It was a way to self-medicate when I wasn't receiving proper treatment from my physicians.” (Jennifer). At the time of the interview, Jennifer had recently received a bipolar disorder diagnosis and she reflected on the challenges she faced before understanding her condition. This included resorting to substance misuse from the age of sixteen to twenty-six to manage her manic episodes. In Jennifer’s case, she couldn’t understand what was happening and why she was experiencing extreme shifts in mood and energy. She discovered that substances could provide symptom management and relied on them for years until she was able to get a formal diagnosis and appropriate pharmaceutical treatment. Diversion provided a means of access to medications which were used as a band-aid for the symptoms she experienced, eventually leading to her dependence upon opioids.

Jessica had an almost identical experience, sharing she has had “mental illness my entire life” including a misdiagnosis which resulted in nearly a decade of ineffective pharmaceutical treatments. Ultimately, she sought relief through substance misuse which progressed from alcohol and marijuana to more powerful drugs including oxycodone and heroin. Diversion provided her with access to opioids which she used to relieve her ongoing symptoms. She described her use of these medications to quell racing thoughts and hyperactivity. She was later diagnosed with ADHD and finally was prescribed medication and treatment that addressed the symptoms that had been plaguing her for years. Mia was hesitant to delve into the specifics of her mental health diagnosis, however she did share that she “has a few issues with her mental health” and was under the care of a psychiatrist. For these nurses, opioids and other substances

provided a temporary reprieve from their ongoing psychological discomfort. For two of the participants, their distress was exacerbated by difficulty in obtaining accurate diagnoses of their mental health conditions.

Other participants shared their experiences of opioid misuse as a means to cope with psychological distress, not necessarily tied to diagnosed mental illnesses. David, for instance, discussed his mental well-being and his foray into the misuse of substances as a response to loneliness and a desire to fit in during his college years. During the interview David spoke about a series of moves and transitions following his completion of nursing school where he found himself isolated and unhappy as he attempted to settle and lay roots in different cities. This included struggles to make friends due to his shift work schedule and the amount of overtime he was working. At some point during this time David was introduced to ecstasy and spoke of his enjoyment not only of this drug, but also of the rave scene where he felt a level of acceptance that he lacked elsewhere. Eventually he began misusing opioids and reflecting on the impact of these substances, he remarked, "Maybe I am being a bit dramatic here, but I felt like I was normal for the first time in my life." (David). While he eventually settled in his home state and found a partner, David spoke of various personal issues that influenced his ongoing substance misuse. Some of these contributors included a troubled and unsatisfying marriage, strained relationships with extended family, financial difficulties, and challenges with his children. His emotional pain was evident during the interviews, particularly when he spoke about feeling different from others in his youth and the unhappiness he continues to experience in adulthood.

Not all the participants connected their substance misuse to one of the two categories, pain or psychological conditions, exclusively. In contrast to the other nurses, Sara viewed both physical injuries and mental health concerns as equal contributors leading up to her diversion.

Sara spoke of her introduction to opioids following surgery, however she also reflected on her lifelong mental health struggles. A history of debilitating anxiety had left her with fragile mental health. Feeling trapped in her distress, opioids introduced a peace and calm that Sara did not believe was attainable. She eloquently described the effect opioids had on her, stating, “It was the first time in my life that my brain was just quiet... Those pills, those injections... All of that just quieted something I’ve worked my whole life battling.” (Sara). Sara spoke of the immense relief that opioids provided, leading her to misuse her prescriptions that she had from various surgical procedures. She then progressed to pilfering medications from her husband, and eventually engaging in workplace diversion when she no longer had access to opioids but couldn’t cope with daily life without them.

These participants described their misuse of opioids as a form of self-medication, aiming to alleviate uncomfortable or distressing psychological symptoms. They engaged in opioid misuse to provide temporary relief from stress and emotional discomfort by dulling pain or inducing feelings of euphoria. Two of the participants explicitly linked their opioid misuse to mitigating symptoms associated with undiagnosed or misdiagnosed mental illnesses. When under the influence of opioids, the nurses were offered a brief reprieve from their discomfort. In their cases, opioids provided a respite when medical practitioners and their treatment plans failed to help. This prompted ongoing use that eventually culminated in their workplace diversion. Other participants spoke of opioid misuse to cope with and combat mental stressors including social anxiety, emotional turmoil, and in response to life stressors and difficulties. The nurses relied on opioids to manage their mental health and wellness, and diversion provided a means of ongoing access to these medications when they felt unable to cope without them.

**Nature versus Nurture.** Physical and psychological issues dominated the stories of the participants regarding their foray into addiction. One participant, however, shared an alternate viewpoint seeing her dependence as a hereditary condition that was bound to occur regardless of career and life choices. “I know that my dad was a terrible alcoholic. And I do think there's, like, a genetic predisposition.” (Beth). When she was asked to elaborate, she shared her belief that this path was inevitable for her. “I think I would have used. ... I think I was gonna be a drug addict.” (Beth). Beth shared examples of the passage of this condition within her family, speaking at length about the way it has affected her relatives, her grandson in particular. She became tearful when describing his struggles with alcoholism and her belief that he was genetically predisposed to live his life this way.

As Beth recounted her experiences, she presented instances to support her opinion that she had a hereditary predisposition towards addiction. This included a discussion on her body's physiological response to opioid ingestion. During the interview, Beth recalled trying Vicodin, a synthetic opioid, and her response to this drug. In her case, this medication induced a substantial burst of energy which improved her ability to deal with daily tasks including housekeeping and childcare.

And I remember I was at work one day and I was a nurse, and I had a headache, and I took Vicodin. And my headache went away. And not only did my headache go away, but I went home. I did like a million loads of laundry, gave the kids a bath. I had so much energy from that one Vicodin, and everybody would say oh, they make you so sleepy. Well, it had the opposite effect on me. And so I think that's when I... I mean I of course diverted that Vicodin because I took it from a patient's drawer. And I just started... (Beth)

Feeling energetic and able to cope with the seemingly never-ending tasks associated with rearing children and maintaining a home acted as a motivator for Beth to continue consuming opioids. Indeed, Beth's exploration of how opioids affected her yielded a finding that applied to all the participants. When considering how they responded to opioids, it was observed that all the nurses in this study experienced pleasant side effects such as increased energy, euphoria, and enhanced ability to cope with life stressors. These effects deviate from other common experiences of opioids, which can typically induce drowsiness, confusion, nausea, and vomiting. The nurses all had powerful physiological responses to opioids that encouraged their continued use. None of the nurses reported uncomfortable side effects from their opioid use and many spoke of the swiftness with which they became chemically dependent upon these medications.

While Beth felt strongly that addiction was part of her genetic makeup, the personal experiences she discussed echoed the stories shared by the nurses who attributed their addiction to mental distress or mental health conditions. While Beth denied any type of psychological assessment, diagnosis, or care, she spoke of a lifetime of racing thoughts and hypervigilance, stating, "I feel like I'm always up all the time anyways.". She turned to substances to calm her mind and body. Beth spoke of experimenting with different substances over the years including quaaludes. She shared her enjoyment of "downers" and described how stimulants exacerbated her baseline symptoms. Once she discovered opioids, they became her drug of choice and she rotated through different types of opioids, moving to something new once tolerance had been achieved and she was no longer experiencing the effects she craved. Beth spoke about the effects of opioids, stating, "It gave me more energy, made me feel smarter, made me feel prettier...". The impact of opioids on her mental health and the positive psychological responses they elicited indicated there may have been a psychological component at play within her opioid misuse.

### *A Series of Small Traumas - The Dark Side of Nursing*

The nurses collectively expressed that they had traced back their initial experiences with opioid misuse to physical, psychological, and/or genetic factors. Nevertheless, all nine of the participants described work-related factors that played a role in their ongoing misuse and acts of diversion. The interviews delved into the interplay between nursing work, access to opioids, and substance misuse. There was an acknowledged connection between nursing work and opioid misuse as the participants recognized that their demanding work environments and the inherent challenges within the profession was responsible for either triggering or intensifying pre-existing struggles with substance misuse.

**High Cost of Stress.** Among the contributing factors discussed, stress emerged as the predominant contributor for substance misuse within the nursing sphere. The participating nurses reflected on the multifaceted nature of this stress, attributing it to numerous factors within the workplace. Some of these work-related stressors revolved around scheduling, notably the rotating schedules that force nurses to alternate between day and night shifts. This type of scheduling, common for many nurses working in acute care, contributes to fatigue and exhaustion. Such conditions have a profound impact on nurses' well-being, influencing their performance within and beyond their professional duties. The nurses described the toll of this stress on their bodies and its impact on their nursing work and their activities outside of the workplace.

Mia, for instance, shared that working twelve-hour shifts for four days on and off, and then switching night and day schedules, was confusing for her body. She grappled with this schedule within her professional role and spoke of constant weariness and the challenges to acclimate from daytime work to nighttime work. She struggled deeply with getting adequate rest

so that she could be alert in the workplace to provide safe and competent care. Her personal history with substance use had created an awareness that different drugs could be used to encourage sleep or increase performance when tired. In her case, opioids acted as stimulants and, consequently, she began using opioids to help her stay awake at night when her fatigue threatened her work performance. Another nurse echoed a parallel narrative, albeit with a different approach. Diana recounted the impact of opioids on her, invoking feelings of relaxation and calm. Her personal struggle centered around pre-night shift restlessness, making it difficult for her to obtain proper rest. In response, Diana turned to opioids to induce slumber, enabling her to function overnight while at work. These coping strategies illustrate how workplace stress, such as fatigue, encouraged opioid use for some of the nurses in the study.

Another nurse spoke of how her opioid use was directly impacted by the shift work she performed. In Sara's case, she found the fatigue associated with her schedule had far-reaching impacts beyond the length and quality of her sleep. For Sara, shift work impacted her family life and her relationships with her children and partner. She spoke of not feeling present when at home. The ongoing exhaustion she experienced made it challenging for her to spend and enjoy quality time with her family. She reported being tired during her sets of shifts, but also on her days off as she recovered from her work hours. This fatigue was compounded by the "push to work long hours and to keep going." (Sara). This was her reality as a nurse, but also as a mother and partner. Again, being aware of her body's response to opioids prompted their misuse to manage the impacts of her work schedule on her personal life.

Stress in the workplace was not just related to issues surrounding scheduling. There were numerous other factors discussed in the interviews that touched on the specialized work that nurses perform. Some of the stressors that were addressed in the interviews included the pressure

for nurses to perform, workplace gossip and conflict, lack of debriefs following critical events, dealing with hostile patients and families, experiences of verbal and physical aggression, work-related musculoskeletal injuries, and the psychological pressure of working with acutely ill people. Although the nurses came from different specialties, these stressors were voiced collectively. The nurses spoke of their experiences and shared memories of the workplace stressors that stayed with them to this day.

Examples were provided to illustrate the challenges in their day-to-day work. One of the nurses reflected on dangerous nurse-patient ratios and lack of management support. Jessica explained that on night shift she was regularly assigned nine patients on her med/surg unit and worked in fear of the potential repercussions on the health and safety of her patients, as well as her nursing license. Jessica shared, “Yeah, it's like here's nine acute patients on the night shift. Good luck. Any poor outcomes, that is your responsibility, and you get reprimanded. It's sad.”. Feeling overwhelmed by the heavy workload and unrealistic expectations led to fear and psychological distress for Jessica.

Workplace stress was prevalent in the emergency departments. Katie reflected on what life was like as an ER nurse whereby she felt overworked and underappreciated. “Both the ER jobs that I was at for multiple years, I ended up leaving... You know they will take my hard work. They take the fruits of my labour. But at the end of the day, I just.... I didn't matter...” (Katie). In Katie's experience stress was due to the volume and intensity of her work, but also the absence of appreciation from her employer. Despite being tasked with providing ongoing care to her patients, Katie verbalized a lack of support and gratitude for the amount and type of work she performed. Over time, Katie grew despondent, eventually leaving in search of new areas of work that would value her as a nurse as well as the contributions she made.

The nurses shared the effects of work-related stress and how it influenced their substance misuse. Diana described the psychological impact of her work in the ICU, stating, “I think that being a critical care nurse and probably being a nurse of any kind is a series of small traumas. Like every week”. Critical care environments often house the most acute patients and, therefore, can be the site of profound human suffering. Nurses who work in these environments can regularly witness the loss of life. Diana acknowledged the repeated assaults on her mental health from witnessing the ongoing sickness and pain of patients and their families. While Diana acknowledged that she hadn’t fully mentally processed her opioid misuse and diversion, she reflected that working in this environment and the cumulative stress it provoked was likely one of the things that she “couldn’t handle”.

Jessica was employed as a nurse on a med/surg unit during her diversion and she recounted the job-related stress and workplace politics she endured there. Jessica spoke of a culture of gossip and drama, and she was particularly affected by incidents of nurse-to-nurse bullying on her unit. She spoke of how the nursing culture can be “really nasty” and recalled the psychological impact of working in this type of environment (Jessica). At one point she became so distressed by the bullying she had endured that she began experiencing suicidal thoughts, “I had a plan that I was going to go into the narcotic dispenser and steal a bunch of dilaudid to go to my car and drive somewhere to take it all and kill myself.” (Jessica). Fearing for her safety, Jessica reached out for help and wound up admitted as an in-patient on a psychiatric unit. As time moved on, Jessica searched for ways to cope with the stress in her workplace. While Jessica had used a variety of substances throughout her life, she reported that her substance misuse increased dramatically once she began working as a nurse. Craving the comfort that opioids provided, they became her drug of choice during this time.

Sara spoke at length about work-related stressors which included experiences with trauma codes that created painful images and memories. She spoke of the weight of these memories. The effects were cumulative as the images built up inside of her. She lacked an outlet because, as a nurse, Sara was bound by confidentiality and unable to discuss her patients outside of the workplace. While at work, she lacked the time and setting for debriefs to help her process these experiences. To illustrate the pain she carried, Sara shared memories of events that had profoundly impacted her.

It was trauma after trauma after trauma... And I still to this day, I remember this.

There was a car crash victim that came in. I went to move her arm to put an IV in. It was just like a limp noodle. I will never forget that feeling. I will never forget the look of it. I will never forget any of it. And you go home, and you can't talk about your day... (Sara)

Sara spoke of other events in her nursing career that weighed on her including performing CPR on a drowning victim. She described the feeling of his ribs breaking under her hands as she performed compressions. Despite her best efforts, she was unable to resuscitate the young victim and described reliving this event and picturing his face when she would be trying to sleep at night. The stress from these events and others compounded, and Sara described her desperate search to escape from these feelings. She connected her opioid misuse to stress caused by her work, recalling it as an attempt to quiet her mind and block out disturbing memories.

**Occupational Hazards.** It was important for the nurses to acknowledge the relationship between their substance misuse and the realities of their nursing work. Opioids were used by the participants to manage the physical and emotional repercussions from working in a high-stress environment, in addition to outside life stressors. The nurses described searching for ways to

cope with the pain and stress associated with their jobs, and ultimately turning to substances. While the participants did not attribute their opioid use solely to nursing, all identified the role that nursing work played in their use.

During the interviews, the nurses were asked to share their thoughts about their access to opioids and their misuse of opioids. Regarding this link, the nurses emphasized they did not misuse opioids merely because they were in proximity to them, nor did access to opioids serve as motivation for their misuse. This was an important finding as there is little research examining sequence of events, for example if substance misuse precedes diversion or if access to opioids prompts substance misuse.

When Jessica was asked about the role of access in her chemical dependence, she shared, “The addiction definitely came first. The access did not push me to do drugs.”. Diana echoed this statement, stating, “I think access allowed me to avoid the street drugs... But if it weren’t for the access to narcotics, I would have been drinking alcohol. If it weren’t for the access to drugs at work, I would have been stealing more from family members.”. Mia described substance use outside of work, but anxiety related to nursing work increased her opioid use, “When you start using, I feel like you get more anxious, so whatever happens at work gets to you a lot more. So that didn’t help you know...”. She found herself caught in a cycle whereby she needed to use increasingly larger amounts of drugs to combat this mental discomfort and to stave off experiences of withdrawal. She shared that her escalation to workplace diversion was because, “At a certain point you have like no choice to keep yourself going.” (Mia). At this time her use quickly escalated, leading to an abrupt end when she overdosed at work and was taken to the ER department. David also shared that he was misusing substances before he began to divert, however he wondered aloud what his life would have been like had he not chosen nursing and

“never worked in an environment where he was surrounded by controlled substances.” Beth spent many years of her nursing career engaging in the misuse of substances she obtained outside of the workplace. Once she crossed the line to diversion, however, she sought out nursing work that would allow her access to greater amounts of opioids. “And it's funny how, you know, like I worked on a med/surg floor, and we didn't have a lot of narcotics. So, I had to switch to either intensive care or emergency because I needed more narcotics. So that's kind of my career.” (Beth). Beth’s career path was heavily influenced by her drug dependence and in her case, access was not the cause of her misuse, but her misuse led her to seek out greater access. For these nurses, workplace access was a means of obtaining the substances they were misusing but was not identified as the primary cause of the misuse.

When considering the relationship between drug diversion and nursing knowledge, the participants rejected the notion that they should be immune to addiction because of their specialized skills and knowledge. In fact, they spoke of the nature and risks inherent within this profession and felt that their work was a contributor to their ongoing and increased substance misuse. They perceived the societal judgment that nurses should “know better” to be naïve and unfair, especially when considering the effect nursing work had on them. Despite the expectation for nurses to have an in-depth knowledge of addiction, they remain susceptible to substance misuse. David spoke to this and expressed that the public’s understanding of drug diversion overlooks the unique challenges nurses face, including their proximity to substances that can be habit-forming. Katie echoed this sentiment, addressing how stress in the workplace and access to opioids intersect to increase the risks for nurses, “And the thing that's crazy is that nurses, we're at risk because we have very stressful jobs and other people who have stressful jobs don't have access. Right? So, if they did...” (Katie).

Finally, beyond the fatigue and stress associated with this work, one nurse commented on the characteristics of individuals that enter this profession. As a career forged upon caring and compassion, it is not surprising that some nurses may become emotionally overwhelmed by the weight of their role. Diana shared this perspective, stating, “I know a lot of health care providers that are in recovery and that have gone through all of this, they're all the good ones ... I think they're just people who took too much on and have too much on them, and then end up looking for relief from that weight of the world.”. Diana’s suggestion moves beyond the notion that the risk for opioid misuse among nurses stems solely from the nature of their profession. Instead, it sheds light on the interplay between the demands of nursing work and the personal disposition of those who choose nursing as a career. This powerful insight made during the interviews acknowledges the multifaceted risk factors for nurses to engage in substance misuse.

#### ***A Scarlet Letter - Stigma, Self-Perception, and Identity***

The experiences of addiction and drug diversion profoundly affected the nurse participants’ self-perception, triggering powerful shifts in their self-concept and their place within society. Their accounts provided insight into the true aftermath of drug diversion and the repercussions which extend far beyond the immediate effects. The participants explored the various factors contributing to this change, most notably societal attitudes towards addiction which is plagued by stigma. The participants discussed the negative beliefs and stereotypes that are tied to substance misuse. Each participant reflected on their experience with stigma during their interviews where it was either referred to directly or alluded to.

The language surrounding individuals who misuse substances is relevant here as it contributes to stigmatization. When conducting this research, I hesitated to use the term *addiction* due to the perceived stigma embedded into this term and a fear of offending the

participants. A surprising development, however, was that addiction was the term that was chosen and utilized organically by each participant to describe their relationship with substance misuse. One nurse, Jennifer, explained that she only uses the term SUD when speaking with her care team at medical appointments, finding this term lengthy and overly formal. Another nurse, Diana, spoke of the importance of embracing the term addiction, stating she didn't want to separate herself from others struggling with the same issue. As an active member of the NA community, Diana felt that addiction was the common thread that held the group together and she believed that referring to it as SUD was pretentious and would imply a belief that she was better than others.

While the term addiction was accepted amongst the participants, there was further discussion about the term *addict* which several of the participants used in reference to themselves. When asked if they thought this was a stigmatizing term, the participants agreed that it was. This was confirmed when one of the nurses stated that she calls herself an addict, but she would never use this term to describe someone else. This term has specific discriminatory meanings embedded in it, but it also violates the movement within health care that adopts person-focused language. For example, the term diabetic has been replaced with a person who has diabetes. This follows suit for addiction although the participants were encouraged to use whatever terms they felt best described themselves in the context of the interviews.

Regarding the stigma of addiction, the nurses spoke of its social prevalence and reach, "I mean, there is such a stigma about addiction" (Katie). "Addiction in general is still a stigma" (Jennifer). They also discussed society's link between substance misuse and low socioeconomic status. As Sara articulated, "There is such a stigma about what an addict is and what an addict looks like.". Mia echoed this thought, stating, "You know as soon as you talk about something

like that [drug use], people put you in the same box as everybody else, you know, like they're on the street." Pre-conceived notions and biases were referenced, including society's idea that there is a certain kind of person who misuses substances. The nurses also discussed how society responds to individuals with addiction which included disappointment, judgement, and a lack of understanding.

The social perception of people who misuse substances clashed with the realities of the nurses yet contributed to the negative reactions they received. Judgmental beliefs about addiction led to negative reactions in the participants' social and professional spheres. Familial, professional, and social reactions to their misuse challenged the identities of the nurses and reshaped their self-perception and sense of worth. There were varied changes that ensued following their diversion, and many participants expressed difficulty reconciling these adjustments in status and standing. Their intimate accounts underscored the complex interplay between stigma, personal experiences, external perceptions, and the shaping of individual identity.

**The Weight of Personal Shame.** Living through addiction and engaging in workplace diversion powerfully affected the nurses' self-regard. Shame was a prominent emotion that was experienced by the nurse participants both during and following their diversion. They expressed persistent negative self-concepts, including feelings of disappointment, regret, and guilt. Mia, for instance, shared the long-term impacts of her acts, stating,

I feel really disappointed with myself. When I had this issue with the substances, that was before I got my [nursing] license. So, I thought like, when I got sober, I'm not gonna go through that again. You know, I'm gonna be a nurse.

Everything's gonna be perfect. And then I fell back into this. I'm still not looking at myself the same way that I was. (Mia)

Later she described her experience with addiction as “embarrassing” and something she conceals about herself whenever possible (Mia). Other participants shared the way they had been affected. Beth, who was eight years sober at the time of the interview, said, "It is what it is... I'm still ashamed.". Despite this lengthy period of sobriety, Beth revealed lasting impacts to her self-esteem and self-worth following her misuse. Participants like Katie suffered visceral reactions to memories of her diversion. Katie described how she felt during her suspension from work, stating "When I wasn't practicing as a nurse, I felt like I was just so lost... And I would get sick to my stomach.". The nurses openly conveyed the profound impact of their addiction and the enduring pain it has caused them. They described long-lasting shame and sadness, even in the face of recovery and sobriety.

The behaviour of the participants while in active addiction played a powerful role in their altered self-perception. Looking back on their diversion years later was an emotionally challenging task and many participants avoided speaking directly about incidents of diversion. Rather, they would acknowledge they had engaged in diversion but chose not to discuss the details and methods within the interviews. This avoidance was evidence of the level of shame they carried as they were provided with a safe and judgment-free place to recall these memories. A few of the participants, however, felt compelled to openly discuss acts of diversion and memories of specific incidents. They reflected on these times with profound regret and a level of disbelief. Jennifer was one participant who looked back on her actions and shared her memories of her opioid misuse in the workplace. The severity of her acts engulfed her as she admitted, “I can't believe I would be squirting liquid morphine into my mouth in the bathroom

and then going out and taking care of patients." (Jennifer). She looked back on this time in horror as she reflected on the dangers that she placed herself and her patients in. The stark contrast between her past behaviour and her current sober mindset made it impossible for her to rationalize her previous actions. Her story reflects her transformation since she ceased substance misuse and the clarity she now has regarding the gravity of her past acts. While she displays accountability and a dedication to safety and sobriety, Jennifer remains haunted by her past behaviours.

Other participants explored their ways of thinking during times of diversion and explained how they were able to engage in an act that they knew was wrong. For Beth, her engagement in diversion was a product of what she referred to as her "addict mind thinking". She emphasized that she does not condone or support this behaviour, but in the grips of addiction, she had developed a distorted perspective that allowed her to justify her actions. She described skewed thoughts processes, driven by her dependence on opioids, that challenged her understanding of right and wrong. This created a powerful shift in her priorities and her decisions became heavily influenced by the need to obtain and use substances. Years later Beth reflected on the decisions and acts that occurred while she was in active addiction, and she continued to struggle to reconcile her past acts with her values and morals.

Darby also grappled with reconciling her past actions related to diversion in the face of her current understanding. She spoke of how she would find ways to excuse her acts while in the midst of active addiction, explaining, "I justified it in my head by saying, 'Well, I didn't do it at work. This was going in the sharps container anyways.'". She engaged in this self-justification in an attempt to minimize the guilt and moral conflict that she felt about her actions. It was only when Darby was no longer in a state of opioid dependence that she could acknowledge she had

“crossed a line” and was able to fully recognize the dangers associated with her use. This led to powerful remorse and guilt which was evident in her experience returning to work. At that time, Darby reported being unable to go near the floor where she used to work, “I couldn't go on to that floor in general, the whole floor, even though I wasn't going on to that unit, without having like a visceral reaction.” (Darby). Darby’s narrative highlights the depth of her shame and underscores the long-lasting emotional consequences of actions committed during addiction. For Darby, shame and guilt have been powerful obstacles when trying to let go of her past and move toward a healthier future.

Not all the participants chose to speak about the specifics of their diversion, but they all shared how they have been affected by it. This experience has had lasting impacts on the individuals’ self-assessments, and many hold critical self-beliefs, feeling themselves forever changed. Some believe their behaviour has left a permanent mark on their character. Others described feeling exposed and different from others following this experience, “It's almost like a scarlet letter, basically is what it feels like. Like I'm Hester Prynne sort of thing.” (Katie). This sense of guilt and shame affected the overall beliefs, attitudes, and opinions the nurses hold about themselves, both personally and professionally. Lingering critical self-assessments among the participants were vividly apparent during the interviews, including common threads of remorse, shame, and guilt. It has forever altered their social identity, and many found it challenging to reconcile these feelings, even after years of sobriety.

**The Toll of Disapproval.** The nurses spoke of how their sense of self had been impacted by their own feelings of shame and guilt, however this wasn't the sole factor responsible. Their self-perception was also impacted by their interactions with others. Within the interviews, the participants described how they have been influenced by responses from close friends and family

members following their experiences. Throughout the interviews, the nurses shared instances where their chemical dependence, and at times their diversion, became known to their loved ones, and the negative reactions that followed.

The participants recalled familial responses during these pivotal moments. The responses they received varied in intensity, but they all experienced forms of judgment and blame. Mia reflected on her experience and how her loved ones responded. She described the reactions of her parents when they found out about her addiction, something she had previously hidden from them. She recalled, “It was a shock. I think they were really upset... More disappointed than anything.” (Mia). In Jessica’s case, it was the relationship with her mother that was most heavily impacted. She shared, “My mom, she is my best friend, but she doesn’t even know the extent of what all I was doing. And she told me that she doesn’t want to know... She admitted that she doesn’t get it and she never will understand why I did all that. And that’s hard.” (Jessica). She reflected on her mother’s wish to be spared the details of what occurred. This distancing of her mother and Jessica’s inability to confide in her has created a lasting chasm between them and has led to experiences of pain, regret, and self-doubt.

Several participants experienced damaged marriages due to their substance misuse. Diana’s husband distanced himself when her dependence was revealed, leaving her feeling vulnerable and alone.

He [Diana’s husband] doesn't have the emotional capacity to deal with this all.

He just really doesn't. So, he just says just do whatever you need to do and...

Whatever you need to do. So early on it was very isolating. Like the loneliest....

Gosh, I'm really sorry I'm dumping this on you... The loneliest... [sobs] The

loneliest place in the world for me was in my bed laying next to him. (Diana)

Diana became very emotional when sharing what life was like at this time, stopping to cry and then collecting herself. She described how her experience and recovery were hers to bare on her own as her husband was unwilling or unable to be there for her. While she has been sober for several years, she referenced the lasting impact that has had on her marriage and her ongoing desire for love and support.

Other examples of impacted relationships include David, who ultimately attributed the downfall of his marriage to his wife's resentment and lack of understanding surrounding his substance misuse. The lack of trust in their relationship became obvious during the interviews when David twice removed his headphones and went over to the bedroom door to ensure his wife, who he was still cohabitating with, was not listening in at the door. He was motivated to share openly during the interview but was concerned that his wife was eavesdropping. He justified this concern by stating she does not understand his addiction and has used it against him in different ways in the past. In this case, David's sense of security and safety in his home was disrupted by his wife's reaction to his addiction. Another participant, Sara, described how her marriage broke up for several years, although the couple ultimately reconciled when she achieved stable sobriety. She spoke about their time apart, "He left... which I cannot blame him. He didn't understand my addiction." (Sara). Beth also suffered familial losses because of her substance use, with nobody in her family speaking to her, and even ending up homeless at one point. She spoke about the repercussions her substance misuse has had on her family relationships.

I stayed high all the time. I just didn't care. My mom died. She was my worst enabler, but my best friend. When she died, I just didn't care. I completely lost my family. Nobody was speaking to me. I ended up homeless. I mean, it was a

mess. I mean, it took me hitting bottom to get clean. Like sometimes your bottom isn't that low. Mine is that low. Mine was that low. (Beth)

These losses ultimately led to Beth's desire for sobriety, but the effects on her family relationships have been immense and long-lasting.

It was not only immediate family that the participants were concerned about. In Jennifer's case, her parents disclosed her dependence to numerous friends and extended family without her consent, leading to frustration and unwanted attention. Jennifer attributed her parents' involvement in her situation to her young age, suggesting that their intervention was a result of her perceived immaturity or lack of experience. Jennifer expressed annoyance that so many people were informed about her substance misuse, stating, "And it sucks when you're kind of young, like 26. Your parents also disclose to their friends and family... Which I didn't ask them to do, but... It was done, and then everyone in my family and close friends all know that I had a problem." (Jennifer). Other participants referenced marred friendships. Diana shared that she lost one of her closest friends when her addiction was revealed. Her friend found fault in what she described as a lack of authenticity and honesty, seeing Diana's substance misuse as a lie between friends. Several months later, this individual ended their friendship stating that she was no longer emotionally invested. Sara also spoke about the temporary loss of her best friend during this time. She described her friend pulling away from her as well as Sara's own self-isolation as she worked through her issues.

When exploring these reactions from friends and family, many participants expressed that the negative responses were based on a lack of understanding about chemical dependence. Some family members and friends responded with shock and fear, others reacted with anger. Some also responded with disappointment, seeing substance misuse as indicative of a poor

character. Mia expressed frustration with this, sharing, “I feel like people should know more about it... It's being sick, you know?”. These responses led to lasting changes in the participant's relationships and family-based hierarchies. David shared his experience of how this issue can impact family relationships, citing his NA home group where “95% of people there are divorced” as an example.

The nurses shared how they were impacted by their families' negative responses to their substance misuse. Some described a loss of their identity as a good mother, with partners expressing distrust of their ability to safely care for their children. Darby shared how her substance misuse impacted her family, with her children becoming aware that something was wrong. Darby explained, “The kids knew something was up because Mom kept nodding off at home.”. Other participants shared incidents involving their children including Diana who recalled the particularly heartbreaking experience of her ten-year-old son finding her unconscious in their home after an overdose. This had far-reaching effects on perceptions of trust and safety within her home. Mia spoke of the loss of confidence from her husband, and his ongoing fear that she is using substances while at home caring for their baby son.

My husband's still gets paranoid. You know, it's been like four years, I think. And sometimes he gets home, and he's like, ‘Are you OK?’ Like, ‘Your eyes are red’ or ‘Why are you acting like this?’ And I'm like, ‘What's wrong with you? Like, I'm not doing anything’. But I can't blame him either, you know? (Mia)

Mia mourned the loss of trust with her husband while acknowledging his continued concern for her safety and that of their child.

Others felt they had let down their parents, losing their respect and altering their perceptions. This was the case for Katie, whose substance misuse remains an unspoken topic in

her family. She shared, “Oh, they [parents] know and we don't.... It's kind of one of those things. Nobody in my family is an addict. So, we don't really talk about it. But you know, they know about it.” (Katie). The pressure of disappointing her parents weighed heavily on Katie, and she feared that she had forever damaged their perception of her.

Some of the nurses also described how they were impacted by the responses of their partners. In David’s case, his wife’s lingering resentment and lack of trust has created a palpable imbalance of power within their home. Adding to the complexity of the situation, his wife is a chronic pain patient who relies on opioids. This dynamic has presented unique challenges for David as the presence of these medications in his home has become a constant struggle for him. David shared the toll this has taken and the ways it has been used to manipulate him.

I had a relapse when she left her safe open, I think on purpose, in 2019. I took a bunch of her pills. And I think she was already having an affair at that time with one of her coworkers. And I think me taking her pills made her think it was okay for her to do this. So that went on for about nine months. And I was like, you’re obviously not coming back to me. I’m filing for divorce... The resentment for my years of drinking and using have never gone away from her standpoint. (David)

While the participants mainly shared these stories with sadness and regret, there were moments within the interviews when they expressed frustration with the judgment and reaction reactions that they had been exposed to. Some shared the feeling that the level of condemnation directed towards them was excessive, considering the level of suffering they had already endured. Katie verbalized the profound effect that opioid addiction has had on her. She stated, “I can tell you that I will not relapse... I know this is gonna sound macabre, but I would kill myself before I allow myself to relapse just because I can't go through it again”. Other

participants shared similar sentiments of the pain that they endured, and they believed that no amount of social blame or judgment could be worse than how they saw themselves and what they had been through.

The personal accounts of the nurses shed light on the impacts of addiction on personal relationships and the challenges faced by individuals as they navigate their journey to sobriety. The actions of the nurses had profound effects on their home and family lives, leading to a significant diminishment in their familial and personal standing. As a result, they have faced ongoing challenges in trying to reconcile these changes in their identities. The nurses expressed their struggles in navigating these emotional and relational fallouts, and their efforts to adapt to changed relationships with their loved ones while simultaneously carrying the weight of shame and remorse.

**Professional Scrutiny.** The nurses explored their experiences and spoke to the stigma of addiction, particularly around the use of opioids, which they identified as prominent within the healthcare industry. Darby drew attention to this issue when recalling an encounter with her chronic pain physician. Prior to her involvement in diversion, Darby was prescribed opioids to manage her chronic pain. However, her doctor strongly recommended she keep this opioid use confidential, despite her genuine need for these medications to manage a chronic condition. Reflecting on this, she shared, “My specialist at the time made very well sure for me not to tell anybody. He said, you know, if you tell anyone that you're taking anything [opioids], there's this culture within the healthcare system, you know, so just keep it to yourself. Even if you go to ER. So, he felt strong about it.” (Darby). Her doctor was acutely aware of the existing stigma of opioid use within the healthcare field, and he cautioned Darby about the potential consequences of disclosure.

The participants also acknowledged the healthcare industry's culture of judgment and distrust surrounding addiction within the patient population. The nurses reflected on this with one participant recounting how poorly tolerated it is in the ER where she used to work. Katie recalled the degrading treatment of these patients, "When I [worked in the] ER, it was horrible.... Calling addicts worthless and stuff like that. They have absolute disdain for anybody who was in addiction.". Other participants shared similar accounts of witnessing derogatory terms used to describe these patients. They noted that these individuals were often referred to as "frequent flyers" and were subjected to rushed or inadequate care and poor treatment. Beth recounted an experience in her nursing training whereby her preceptor refused to give personal care to a patient who came into the ER highly intoxicated. Beth recalled, "And she [the patient] was in the ER, and she was so aggressive. And she was really dirty. And I said, well, why don't we just put her in the shower? That will make her feel better. And I remember my preceptor saying, I'm not getting near that filthy whatever she called her...". Beth spoke about this event sadly, recalling how assistance with basic hygiene was denied to this patient because of her drug use. These experiences shed light on the pervasive culture within healthcare settings that reinforces and perpetuates the stigma surrounding chemical dependence.

While the weight of stigma surrounding opioid use is potent on its own, it becomes magnified when there is an element of misuse involved. This magnification is even more pronounced when that misuse is attributed to healthcare professionals. This was another dimension that was explored in the interviews. Mia explored this sentiment, sharing, "I feel like there's a lot of stigma around drug and substance abuse, especially with nurses.". Her words highlight the heightened level of societal judgment that often accompanies substance misuse, particularly when it involves those seen as responsible for the well-being of others. Jessica

further elaborated on the extent of public reaction to opioid misuse within the healthcare realm. She spoke of an online article she had come across which detailed the diversion of opioids by a nurse. The responses from the public were deeply vitriolic, suggesting the nurse should engage in self-harm or be punished with lifelong incarceration. These harsh responses emphasize the intensity of the stigma surrounding opioid misuse by healthcare professionals and the severe judgment they face from the public.

This social stigma played a powerful role in the nurses' experiences. It impacted their perception of themselves as nurses, leading to a profound shift in how they viewed their professional identities. For some, a sense of alienation, otherness, and a feeling that they no longer belonged within the profession of nursing was experienced following their diversion and subsequent removal from practice. This led to self-criticism, whereby they questioned their worth both as individuals and as nurses.

Some felt they were no longer worthy of the nursing profession. Mia, for instance, stated, "I was so proud of this work and now I feel like I don't really deserve this profession" (Mia). These types of statements were significant for several reasons. Firstly, the participants highlighted clear connections between their nursing duties and their substance misuse and diversion. Despite this, they clung to traditional ideals of nursing, expressing doubts about their worthiness for the profession following their acts. In addition, feelings of failure were apparent, although some participants' actions suggested otherwise. Many continued to prioritize patient care, even in the face of active addiction, finding ways to divert medications they thought would not compromise patient safety or risk contamination. Others used opioids to boost their energy levels and allow them to enhance their nursing performance. Though they continued to prioritize

the wellbeing of their patients while struggling with opioid addiction, the nurses remained focused on their shame and disappointment in themselves.

Coming to terms with this change in self-perception posed a significant challenge for many participants, considering the significant role nursing had played in their lives. Several nurses spoke of a desire to self-harm because this shame was so potent. The sense of pride and fulfillment they once felt in their work as nurses was replaced by doubt, shame, and feelings of unworthiness. This created an internal struggle as the participants grappled with their identities as healthcare professionals while reconciling their past diversion.

The nurses detailed other influences on their self-perception. Many identified instances when their diversion had become known to their colleagues. The nurses anticipated poor reactions from others in their field. Jessica spoke to this, revealing, "It's like a very shameful thing in the community. You know, even in my nursing support groups, most of the nurses there were not open about being in recovery or admitting that they were in the program." The disapproval and disappointment the participants received profoundly impacted their self-image. Jennifer shared a distressing incident where her manager filed a complaint with her regulatory college. This complaint included shocking quotes from former colleagues about her conduct. The existence of such quotes was enough to deeply upset Jennifer, to the point where she refused to read the rest of the document. This disapproval from her colleagues further exacerbated her emotional turmoil. David experienced a negative response when he disclosed his opioid dependence to his dentist, prompting him to conceal this information from his other care providers. The lack of understanding and support from another healthcare professional intensified his reluctance to reveal his struggles, fearing similar judgment and potential repercussions from others in the field. Beth described a sense of being looked down upon once

her colleagues became aware of her opioid dependence. She elaborated, “I think the non-addict nurses judge the addict nurses really harshly.” (Beth). Her experience reinforced the division and stigma within the profession of nursing, and further contributed to her diminished self-perception. Sara reported her humiliation upon returning to practice in the same hospital where she had engaged in diversion. To her surprise, individuals that she expected to be supportive turned their backs on her, “They were my partners and they totally shunned me.” (Sara). Her exclusion by colleagues intensified Sara’s feelings of shame and isolation. Mia shared an alternate concern, finding it hard to tell if her former colleagues truly supported her. She explained, “People are really two faced, you know, especially like in this profession, they're gonna act like everything's gonna be OK... Like to my face anyway.” (Mia). Mia expressed her frustration that colleagues would put on a face of acceptance, while potentially harbouring judgment behind her back.

Shame weighed heavily on the participants and was amplified when their diversion became widely known through workplace gossip. Katie vividly recalled the exclusion she experienced as news of her diversion spread, “I remember how ostracized I was... I could just tell the absolute disdain people had for me... Nobody will say it to my face. But you know, there’s all the whispers, and people talking about you, and the things you hear.” (Katie). While no one addressed her diversion directly, Katie was able to sense the dialogue about her within her workplace. A similar sentiment was shared by Jessica when the news of her diversion was revealed, “They made-up a lot of things about me. It went around the hospital pretty quickly. Like every single person in the hospital knew. It was the biggest story...” (Jessica). As the information was spread around her workplace, Jessica unwillingly found herself the center of attention. Beth’s lived experience mirrored these sentiments. She described the profound sense

of being excluded and labelled a deviant by her colleagues, “I mean, they ostracized me. And, you know, I was a villain. None of them would talk to me...” (Beth). The nurses’ narratives revealed a range of negative responses from colleagues and other health professionals.

Being the subject of workplace gossip and suffering the disdain of coworkers was deeply distressing for the nurses in this study. The impact of these reactions was profound, causing feelings of isolation, rejection, a diminished sense of self-worth, and exacerbating the sense of shame they were already grappling with. Jennifer expressed her frustration with these negative reactions, citing stigmatization and the lack of understanding about this condition, “I mean, there is such a stigma about addiction, especially in the ER because people just think it's for attention or whatever. But I believe it's an actual disease and I didn't actively want to live my life that way. It just turned out that way.” (Jennifer). Moreover, the nurses felt that their colleagues viewed nurses who engage in diversion as damaged, further perpetuating the lack of understanding and compassion. Katie remarked, “I felt very other. I felt... I have constantly felt like I had a dirty secret.”. The responses from colleagues were disheartening and left the participants feeling excluded and inferior.

The lack of genuine support from colleagues stood out in the interviews, especially as nursing is a profession based on the concept of caring for others. Only one nurse shared that she had a supportive manager who showed true concern for her. Darby spoke of the day she was sent home from work, stating, “My manager made sure that I texted her as soon as I got home... That I got home safely, and she kept checking in on me to see how I was doing.”. The rest of the participants detailed their lack of support and compassion from colleagues and leaders within their places of work. This was made more difficult by their unique situation as they belonged to both the nursing and patient populations yet couldn’t fully identify with either group. They faced

challenges in receiving the respect and inclusivity they needed from their colleagues. Moreover, as individuals in need of care themselves, they lacked the compassion and care they felt should have been extended to them. This treatment highlighted the stigma of addiction, and social beliefs about the *particular kind* of people that are worthy of compassion and care. This poor treatment from other nurses, at a time when the participants could have greatly benefited from the same, was saddening and had long-lasting effects. Overall, the neglect and lack of emotional support from their professional communities had profound and long-lasting repercussions on the nurses.

### ***Public Shaming and Pointing Fingers - Experiences with the ATD Programs***

The participants spoke at length about the period following their removal from the workplace. This encompassed the duration of their absence from work as well as their reintegration into the workplace through the ATD programs in their individual provinces and states. Throughout their time away from work, all the nurses underwent either in-patient or out-patient rehabilitation to address their opioid dependence. Only after completing treatment and demonstrating a sustained recovery were the participants granted permission to resume their professional duties. On average, the nurses were away from work for one year, although two participants faced additional difficulties in accessing care and maintaining a stable state of sobriety which resulted in significantly longer absences. The nurses encountered a series of frustrations and setbacks during this pivotal phase of their lives. These setbacks manifested as they confronted the difficulties associated with withdrawal symptoms, psychological distress, and the intricate demands of the ATD programs.

**Entry into the ATD Programs.** Each participant was promptly removed from nursing practice once their opioid diversion became known to their respective employers. Following this,

the nurses voluntarily enrolled in their local ATD programs to prevent the permanent loss of their nursing licenses. As described in chapter two, the ATD programs had a series of criteria that had to be fulfilled before the nurses could resume their professional duties. During the initial phases of the program, the nurses were prohibited from engaging in any nursing-related responsibilities. This restriction remained in place until they were able to demonstrate active participation in treatment along with stable sobriety.

The first concern raised regarding the ATD programs was the lack of awareness of their existence. None of the nurses had received formal education about the ATD programs and most were unaware that such help was available to them. As a result of this, the nurses felt trapped in their situations with nowhere to turn for assistance. David agreed, stating, “I didn’t see a way out.”. Darby also was uninformed that her nursing board could aid her and stated this was “fueling her secrecy”. Katie believed she would lose her job and license if her opioid addiction was revealed to her employer and board, “They pulled me in, and they said, ‘Katie, do you need help?’ And of course, I would say no, because they wouldn't provide me any answers on what help was and I was almost 100% sure that help did not include keeping my job.” (Katie). In this case, Katie quit her job to avoid her substance misuse from being investigated. This occurred several times before she was caught diverting, and only then was she made aware of her local ATD program. Sara also lacked knowledge of the available support and described feeling “absolutely alone” when she was put off work. Only Jessica had heard about the programs, but it was through workplace gossip, and she had no verified information on how they worked. This systematic failure to provide awareness and education to nurses left them largely naïve to the ATD programs offered by individual nursing boards, thus acting as a significant barrier to disclosure.

Upon entry into the programs, the participants struggled with the change in their professional lives. Being prevented from nursing was painful, especially as nursing was described as an integral factor in the lives of participants at this time. It was repeatedly described as more than employment, but rather a calling and a way of life. Deep admiration and respect for the profession emerged from the majority of the participants. Most described their love for their work with two participants sharing their passion for working in emergency medicine, “ER was my first love... I would say I was a master in my field too.” (Katie). A call for work in the nursing profession was also described, “It's what I was meant to do. I know that... It just comes natural and I'm good at it.” (Beth). Nursing was described as a vocation and a source of personal achievement. It was also a source of professional pride, drawing on its links with strong moral and ethical values. For most of the participants in this study, nursing was not merely their employment, but instead it was described as a part of who they are. Only one nurse was clear that nursing was a part of her identity, not the sum of who she was. Jennifer shared, “Everyone’s like, ‘I'm a nurse’. ‘I'm a nurse’. Like, I just say, ‘I work as a nurse’. Like, I am a sister. I am or whatever... Like to me, nursing isn't my whole identity where it is to a lot of people.”

Losing the ability to practice nursing due to drug diversion was crushing. The nurses described their experiences of being removed from nursing practice, with many expressing feelings of shame and distress. In addition, they shared a longing for nursing work while away from practice. Katie recalled how she felt when she was prevented from nursing, “It's when I was clean and then I wasn't practicing nursing, which was such a part of my being for such a long time. Yeah, it was devastating. Just absolutely devastating.”. This experience, and the void it left, negatively affected the mental health of the participants. Some had thoughts of self-harm. Suicide was contemplated by several of the nurses when they were removed from the workplace.

They described ambiguity if they lived or died. Others considered plans. Darby shared, “I was devastated.... I remember thinking as I was driving past the bridge.... I don’t think that bridge is tall enough for me to jump off because I wanted to literally die.” (Darby). Beth shared that she experienced hopelessness that affected her will to live. These poignant admissions illuminate the profound influence of the nursing profession on the participants’ sense of self. This was particularly clear when the nurses described being removed from nursing practice and the prolonged period of absence required. Instead of a hiatus from their employment, the participants described this period as a loss of self. They were emotionally devastated by the separation underscoring how deeply nursing was intertwined with their identity and existence.

A desire to hide away was common for the nurses following their removal from practice. Many expressed great personal shame as well as fear of the judgment of others. Several coped during this time by attempting to shroud themselves away and conceal their acts. Darby, for example, suspended contact with all her colleagues, some of whom she considered close friends, when she was removed from her workplace. She said, “I just did the whole avoidance. I disappeared... I didn’t tell anyone because there was too much shame with that.” (Darby). Similarly, Jessica isolated herself from many former coworkers to mitigate the psychological impacts of the shame she felt. She reported deleting people on social media so she would not be reminded of their possible negative opinions about her, “I guess it was a shame thing. Like, if I don't see it, it’s not going to affect me.” (Jessica). Sara echoed this sentiment whereby she “didn’t even leave the house for many months” out of fear of running into someone who knew about her addiction and diversion. The nurses greatly feared social scrutiny. Many attempted to avoid situations and people that would reignite feelings of shame within them which resulted in their experiences of isolation and confinement.

**Biological Testing.** The ATD program's obligations were voiced as onerous and unsustainable at times. Biological testing was an ongoing requirement throughout the program to ensure the nurses were maintaining their sobriety. The urine testing frequency, especially during the initial year of the program, was demanding. This requirement posed difficulties, particularly for the nurses in the US. The format varied between the two countries with the testing of Canadian nurses managed by their individual care providers, while an app regulated the random testing schedule for those in the US.

For the nurses living in the US, biological testing caused significant financial strain. Urine testing fees were approximately one hundred dollars per test and some nurses reported having to test up to five times per month. This was a significant expense over the years it took to complete the program. Beth, for instance, revealed that she incurred fees close to five thousand dollars for testing over a five-year period to participate in the program in her state. Adding to the strain, her case manager at the nursing board emphasized, "If you say at any point that you're going to have to stop because of financial reasons, we won't work with you again. This is your last chance." (Beth). Such statements placed additional pressure as financial capabilities determined the nurses' participation in the program and subsequent future within the nursing profession.

All the nurses reported long wait times to perform their tests that were challenging on a day-to-day basis. This was especially cumbersome for nurses who lived outside of urban areas and had to regularly travel long distances or miss work to attend testing. Beyond the associated costs and inconvenience of random testing, missing a test could mean removal from the program for all the nurses, leading to much anxiety. As an example, Katie shared that she went to a public lab to provide a urine sample in the height of the pandemic, despite having an active Covid-19

infection at the time. She recognized the risk this posed to her community but was fearful a missed test would be considered a failed test by the board, “I was very sick with it [Covid-19]. I was incredibly sick... And I'm embarrassed to say this, but I strapped on an N95, and I went in for a test because I didn't have a choice.” (Katie). This example demonstrates the fear surrounding urine testing and the ongoing challenges it created during the lengthy program.

Another particularly compelling example was when Beth was admitted to the ICU with kidney failure. She reached out to her contact at the Board of Nursing to advise she may be unable to perform her urine tests as she was at risk of being intubated if her medical condition deteriorated further. At that time, Beth was instructed by her program manager at the nursing board to have a family member call them daily if she was too sick to check her daily app. Beth's daughter balked at this request, feeling this was inappropriate and an overstepping of the Board's power. While Beth agreed with her daughter, she agreed to the Board's request as this was necessary for her livelihood. Although she was never actually intubated, this was a distressing consideration when she was already burdened with serious health concerns. Furthermore, it created stress that her illness would negatively impact her ability to continue within the ATD program and therefore nursing. The amount and frequency of tests performed by the participants varied, but many found it challenging to balance work responsibilities, personal commitments, and the requirements set out by their regulatory colleges.

**Protecting Privacy.** Feeling a blurring between the demands of the regulatory boards and the rights to privacy was another concerning aspect of the ATD programs. Katie shared that her regulatory college requested all her medical records including documentation for health issues unrelated to her opioid use. This included information about a childhood sexual trauma that she had been the victim of, “It feels very invasive. I don't know. It felt violating... That's not

their business. They have no right.” (Katie). Diana shared that she must share “all my health information” with her nursing board, including a form her family doctor must fill out after every medical appointment which indicates the reason for the visit, regardless of the nature. The demands for access to medical information was perceived as unethical and coercive as nurses would otherwise be prevented from entering and participating in the program.

There were other concerns regarding privacy of health information when confidential information was shared by the boards through their websites or quarterly reports. Katie’s restriction on narcotic access and handling as well as her need for a workplace monitor were published online and she described this as “devastating”. While the restrictions do not specifically state that diversion took place, it is clearly implied. David spoke about the process in his state where nurses who are disciplined are published in a quarterly report. David agreed it is obvious when the discipline is related to substance misuse, “When you see suspended and then probation, you know what it is.” (David). Darby also described her experience with her regulatory college and the publishing of her narcotic restrictions. She agreed that it made her addiction public knowledge and felt that her personal medical information was being broadcast against her will, “And anybody that checks it, you can read between the lines...” (Darby). She went on to describe this experience, “It was brutal. I was quite upset with the college.... I just felt like for something that was considered medical... to post it on the page for everyone to see.” (Darby). Jennifer also felt her narcotic restriction revealed her personal health information, “So, when I returned to work, it was apparent because I can’t handle or administer controlled substances and I don’t know any other illness that can’t do that.”. The excessive requirements for medical information and the publishing of narcotic-related restrictions were concerning parts

of the ATD programs.<sup>1</sup> The nurses wondered at the necessity of publishing these restrictions as they were already mandated to advise their employers of these terms, seeing the true intent to shame nurses under the guise of protecting the public. Their stories also revealed contradictions between how their health information was not protected in the same manner as that of patients in healthcare settings.

**Restricted Returns.** The participants were permitted to return to nursing practice once they had established stable sobriety and met the terms of their contract with their local nursing boards. Permission to return to work was at the discretion of their addiction doctors. This period away from work was a year or longer for all the participants. While the nurses described relief at the prospect of returning to work, many found it deeply upsetting that they were unable to return to nursing practice in a way they found meaningful. For many, this was due to restrictions on narcotic access and handling. The interpretation of this restriction, along with its necessity considering the concurrent urine screening requirement, created great challenges in the nurses' return to work.

Sara shared that her employer would not immediately provide her with nursing work because of her narcotic restriction. In her case, she returned to work as a personal support worker (PSW) while awaiting a fitting position to become available. Her employer refused to allow her to work as a nurse in any clinical areas where narcotics were stored, even if she was not given access to administer them. Interestingly, she was able to work as a PSW in these same areas. Beyond the inconsistencies with this rationale, Sara suffered psychological effects from this process. She described it as an incredibly challenging experience, sharing, "That was really hard

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<sup>1</sup> Since the introduction of the Nurses' Health Program in 2019, the restrictions on the licenses of Ontario nurses who participate in this program are no longer made public so long as nurses meet the program obligations. Other North American programs vary by province and state, and many continue to publish restrictions related to narcotic access and administration.

going from an ICU RN to walking back in there and showing my face for the first time since, you know, basically stealing drugs from the hospital to work as a PSW. It took everything in my power to go to work that first day. I think I almost had a meltdown.” Sara found issue that her restriction led to a return to work in a position beneath her level of skill and knowledge. This increased her shame and humiliation, but also may have affected patient care by preventing a skilled nurse from caring for patients in a specialized area.

Jennifer shared her struggles whereby she was returned to work in a job in Occupational Health that required a completely different set of skills and knowledge. In Jennifer’s case she participated in a return-to-work meeting where her new manager stated, “You’re never going to work in the ER again.”. Feeling rejected by her former area of work, Jennifer described feeling “stuck” in her new non-clinical nursing role. She also spoke of her anxiety of finding a workplace monitor which was a necessity for her return to work. She recalled asking her new manager to be her monitor, stating, “I was super anxious, but to them [her manager] it was like nothing. It’s not a big part of their life, where my whole life depends on people saying yes.” (Jennifer). Jennifer’s experience highlighted her profound vulnerability and a sense of powerlessness and dependence upon her manager for her professional livelihood. Her reliance on this agreement and support from her leader to return to work, and therefore earn an income, caused her significant mental distress. She expressed profound vulnerability as she was at the mercy of her employer. This created a sense of helplessness and dependency and illustrated the power dynamics at play within the return-to-work programs. Darby shared similar feelings whereby she was barred from working in many clinical areas of her hospital despite a professional history in surgical nursing, “I feel like this has held me back professionally. You know, just doing the simple things of applying for a job...” (Darby). Darby found it challenging to be permitted to

return to work yet prevented from working in most nursing roles. She lacked permission to work in areas that she was trained and specialized in, and this was a significant stressor for her.

The nurses described frustration that they were unable to work in areas that they desired and found personally gratifying. They feared the loss of their clinical skills and knowledge. They also found fault in the explanations of their employers whereby they were unable to work in any clinical areas where narcotics were stored, even if they were unable to administer them. This was a sticking point for several of the nurses. Although their specialists had cleared them to return to work and they were participating in ongoing biological testing, their employers continued to facilitate returns to work in undesirable areas and the nurses had little or no input on what type of nursing they would return to. Some nurses perceived this as an overstepping of authority as employers were free to interpret restrictions on narcotic access, thus preventing a return from most patient-facing nursing for lengthy periods of time.

**Support or Surveillance.** A perceived lack of support from nursing boards and a feeling that they were constantly under the radar was identified by the nurses during the interviews. Rather than believing the ATD programs were designed by the boards to help nurses, the participants felt they were there to ensure they didn't slip up. Beth shared, "The Board of Nursing is definitely on my back all the time". Others believed the regulatory boards did not truly care about the health of its members. Jennifer described her impression of her nursing board stating, "Oh yeah, I'm just a number to them. They don't care about me at all. They just care about XY and Z."

Some took this further, feeling that the programs were designed to punish nurses. Mia stated, "I feel like we are... it's like getting punished. You know, you have to do this. You pay for that. But people have issues. It's not really a choice to do something bad. So, it feels sad that

we have to pay for this. We were sick.” This was echoed by Katie who shared, “They probably put me backwards with the public shaming and the pointing fingers and the making me want to hide myself... I mean everything they've done seems to be directed at punishment...”. David also mentioned his belief that the program was punitive in nature instead of rehabilitative. One example used to illustrate the perceived punitive nature of the programs was shared by Sara, who was required to attend a caduceus group despite having to regularly travel over seven hours to participate.

The true nature of the ATD programs were considered during the interviews. Some nurses expressed suspicions that the ATD programs were designed to publicly shame nurses in an attempt to deter other nurses from diverting, “They want to publicly shame and punish you in front of all these other nurses” (Katie). Darby concurred, adding, “The college though... I found that the way the wording was in the undertaking... It just felt like it was such a shameful thing I had done... They were gonna watch me and there was no way around it.”. Others felt that the regulatory boards piled requirements onto the nurses to increase their likelihood of leaving the profession, to weed out those who don't measure up and protect their “Florence Nightingale white hot image” (Katie). Some participants were skeptical that supporting nurses to return to work was the true intention of these programs based on the number and severity of the requirements imposed. These beliefs contributed to distrust for the ATD programs processes.

The role of workplace monitors was also broached as a significant concern within the context of the ATD programs. Each nurse was required to have an appointed monitor within their place of work that they check in with on a daily basis. While these individuals have been touted as support persons in the workplace, they were unable to instill a sense of trust. The participants perceived the monitor's role was primarily focused on keeping an eye on the nurses.

Most often the monitors functioned as another level of suspicion and surveillance, and participants saw them as watchdogs for the hospitals as well as the regulatory colleges. When asked if they felt comfortable discussing any challenges related to their sobriety and potential triggers with their workplace monitors, the resounding response from the nurses was that their monitors would be the last people they would open up to. The nurses reported feeling minimal support from these individuals and did not perceive them as true support persons within their recovery. The nurses shared that they lacked authentic opportunities to be open and for much of their experience they were tasked with presenting themselves as healthy and *all better* to avoid the risk of being removed from the workplace. Many also expressed a sense of humiliation during workplace check ins with their monitors where they felt under the microscope as their monitors assessed for signs of intoxication. Darby referenced the way her monitor used to stare directly into her pupils and how much discomfort this would cause her.

Several of the nurses shared their experience with their workplace monitors. Darby spoke about this, and, in her case, her manager served as her workplace monitor. Unfortunately, there was little consistency in her situation. Due to frequent turnover in this role, she had to disclose her situation to four different leaders during her contact period. This repeated disclosure, combined with the dynamics of the workplace, hindered Darby's sense of comfort and safety, making it difficult for her to confide in others, "Disclosing to each one of them [her managers] been like 'Well, you know, if you ever feel like you're struggling, you can come to me.' And I'm thinking there's no way.... I mean, that's great. Nice as that is, there's no way I'm going to go tell my boss. 'Hey, I'm craving today.'" (Darby). Jennifer agreed that she would never confide in her monitor, who was her manager as well, stating, "Because then they [her manager] would be like, 'Oh, maybe she's gonna go on sick leave again or she's doing unwell.'" Jennifer felt unable to

be truthful about issues related to her recovery from addiction and was compelled to prioritize her image as a reliable and high-performing employee. In these cases, having managers act as monitors created conflicting priorities and prevented the supportive relationship they are proposed to be.

Finally, a lack of support regarding workplace accommodation also impacted the experiences of the nurses. Some participants shared the difficulties they experienced when submitting workplace restrictions. As an example, many nurses could not return to night shifts or 12-hour shifts because fatigue was identified as a trigger to misuse substances. These restrictions were part of the contracts to return to work, but staff felt pushback from their individual managers. Mia described a return to work on reduced hours which made her boss “really upset” because of the scheduling issues it caused. This increased Mia’s stress and guilt, ultimately leading her to return to a lengthy medical leave. Facilitating supportive, successful, and safe returns to practice was sorely lacking for the nurses in this study.

**Lack of Buy In.** The early experiences of the nurses in the ATD programs were filled with a range of overwhelming emotions, including devastation, exasperation, and despair. These sentiments arose as the nurses grappled with the extensive requirements and stringent monitoring associated with the program. Due to this, some individuals exhibited a distinct lack of commitment, failing to fully engage with the programs. Jessica, one of the nurses, candidly expressed her skepticism, saying, “For the first year, I thought it was bullshit. I felt like a prisoner.” Her words reflected her disillusionment and resistance towards the program’s expectations. Similar concerns were voiced by others who felt that demands imposed on them were excessive or exaggerated.

There were varied issues that were approached by the participants to illustrate their skepticism. One source of frustration emerged from the nurses' observation that while their opioid use was subjected to rigorous scrutiny, there were numerous instances of fellow nurses indulging in other self-destructive behaviours. Sara, for instance, highlighted the prevalent wine culture within nursing and the sanctioning of alcohol as a coping mechanism for work-related stressors. Sara shared, "There's nurses that go home and eat their way through the evening. There are nurses that go home and drink bottles of wine and show up to work. But people don't know.". Some nurses felt the judgment surrounding opioid misuse was discriminatory and hypocritical considering the slew of unhealthy behaviours being engaged in by colleagues including smoking, excessive alcohol intake, and overeating.

Another concern was shared regarding the rigidity of the programs and the lack of individualized approaches. Jennifer spoke of how strict the nursing regulatory colleges are when compared to that of physicians. She explained that when doctors engage in drug diversion, many can return to unrestricted practice. Nurses who engage in diversion, however, are subjected to uniform restrictions on narcotic access, hours of work, and areas of work. In addition, many nurses are required to join Narcotics Anonymous (NA) or Alcoholic Anonymous (AA). These programs have a religious basis and some of the participants in this study found their messaging and the requirement to attend problematic. They reported discomfort with a spiritual approach to their health condition and were upset that they were unable to choose treatment options that were in line with their beliefs and values. Jessica shared her experiences whereby, "I had tried NA... I did the steps. They didn't do anything for me. It wasn't helping my recovery. It was only making me feel more guilt and shame." Katie shared that in her state nurses are required to attend NA, but she was opposed to participation, stating, "I feel very other... I feel very weird and dirty

from 12 steps” (Katie). Some of the participants verbalized that NA was not only interfering with their recovery but causing them further harm, and they were opposed to this requirement.

Beyond the NA requirement, there are standard restrictions on all substance use for the duration of the program. Despite dependence on opioids, the nurses in this study were prohibited from any substance use. Some participants took issue with the fact that they were barred from all substances, including legal substances such as alcohol and marijuana, outside of working hours. This requirement increased the nurses’ sense of feeling singled out and being unfairly controlled. It increased their overall frustration, exacerbating their lack of buy in to the program. Indeed, Jennifer vocalized that her opioid dependence was adequately controlled by care from her doctors. She found the other requirements, especially those lacking scientific basis such as NA, imposed upon her to be stringent and excessive.

The monetary aspects of the program were also broached, with the nurses highlighting the significant financial difficulties associated with the ATD programs. While nurses residing in the US faced more profound financial burdens associated with treatment programs and ongoing fees related to biological testing, all nurses participating in the programs experienced financial implications. These fees resulted from attendance at Caduceus groups, treatment programs, and biological testing. Most participants suffered financial hardship during this time because of their removal from practice. As such, many were compelled to take up low-wage employment in various fields such as cleaning homes, factory work, performing PSW work, or working in a gas station in order to make ends meet. For some, the financial strain was compounded by monetary fines resulting from legal charges. David shared his personal experience of being criminally charged with obtaining a prescription medication by fraud, resulting in two years’ probation along with a thousand dollar fine. This aspect was particularly concerning as the ATD programs

are intended to manage drug diversion without involving the legal system. The financial impacts following their diversion affected the participants to varying degrees.

The early thoughts of the nurses were primarily dominated by their inability to practice which was a devastating blow for emotional and financial reasons. The nurses described impatience as they awaited permission from the nursing boards to return to practice. Upon their return to practice, these feelings transitioned to frustration and resentment as they had lost the autonomy to work where they were trained and knowledgeable. These negative feelings were shared by the nurses, particularly those who were still in the early phases of their return-to-work program, and they struggled to find meaning in their lengthy removal from work followed by their unsatisfactory return.

***If You're Going to Live, You Have to Keep Moving Forward - Evolving Meanings and Empowered Perspectives***

Each participant indicated that their life path had been vastly altered by their experience with opioid diversion. Beyond the professional and psychological implications, monumental life changes have ensued. The results have included changes within their personal relationships, newfound perspectives on the meaning of this experience, and a reevaluation of the role nursing played within their lives. In addition, some of the participants have engaged in roles of advocacy to bring attention and awareness to this issue within the profession of nursing.

**Repairing the Damage.** Following their experiences with addiction and diversion, a strong desire to rebuild relationships permeated the participants' lives. Initially, the nurses sought forgiveness from all those that had been impacted, including their colleagues, employers, friends, and families, and they shared personal efforts they had made both at home and in the workplace to mend and restore these relationships. Over time, however, the nurses shifted their efforts and

energy to focus on the people in their lives who were the most important to them. Through this, they were able to accept the loss of other connections. Ultimately, this experience impacted a variety of relationships, leading some to become stronger while others became less of a priority.

Diana expressed the importance of her family relationships and spoke of her acts to reduce the impacts this has had on her children. She reported working to be “a better mom for them than I ever have” (Diana). Diana spoke positively about her newfound sobriety and her improved ability to care for her children. Beth shared a similar perspective. She spoke of her need for sobriety for her livelihood, but also to maintain the relationships she has fought to rebuild with her family members, “I'm sixty-one. It took me a long time to get to where I am, but you know, I've got too much to lose.” (Beth). Katie also spoke about how her life was damaged by opioid addiction and the effects upon her family. She shared,

It was just not a life. Like you can't live a life on substances, looking for substances, obtaining, paying for them. That's what it was. It took over. And I had two little kids I was trying to raise, and I wasn't even focusing on them. I was thinking about other things. I was driving impaired. Like it was out of control. You know, it's insane to think about. And now it seems like a different life. (Katie)

Katie spoke of a calmer and simpler life now that she has achieved sobriety. While she expressed her current lifestyle can be monotonous at times, she has a strong desire to maintain her abstinence from substances to prevent it from returning to its former chaos.

The participants acknowledged that their relationships with others had been powerfully impacted, yet most were able to mend the relationships with the people around them that mattered most. For many, family emerged as the primary concern, and the nurses emphasized the importance of nurturing and preserving connections with their loved ones. While they did

discuss the loss of relationships with others, including colleagues and friends, repairing these connections ultimately played a lesser role in their long-term experiences. Some nurses described a process of acceptance and letting go, acknowledging the loss of friendship with these individuals. They found the strength to come to terms with these losses and redirected their focus towards the people who held greater significance in their lives. In all these cases, family connections and close friends were the priority and they acted as motivators for the nurses to continue their journeys with sobriety.

**New Perspectives.** While feelings of anger and resentment dominated during the early years in the program, the nurses with more years of sobriety discussed changes in the way that they viewed their experience. Some found solace in the biomedical approach to their condition that was being adopted. David remarked that he was “encouraged that we are in a place in the world where there is this thing called substance use disorder” and he was hopeful that it would one day be seen no differently than other mental health conditions such as depression and anxiety. Others expressed gratitude for the opportunity to return to nursing practice. Even frustration over ongoing urine testing, monitoring, and being followed by specialized physicians was reframed by some of the nurses as something that helped them to get well. All the nurses expressed thankfulness that they had overcome their opioid addiction. Some even foresaw their own deaths had they not received help. “Probably getting caught saved my life.” shared Beth. Sara agreed stating, “I don't want to say I'm lucky. I'm far from lucky, but my story could have been a lot worse.”.

As the time since diversion increased, the nurses reflected on the newfound meanings they had garnered from this experience. Some meanings that emerged included increased self-awareness and a desire for a better life. Self-growth was described by some of the participants

when reflecting upon their journey through addiction. “I’ve grown a lot and learned a lot about myself.” (Jennifer). Darby stated, “Well, there’s been a lot of growth from it. Of course. When you hit rock bottom like that, you can’t help but self-reflect on how you got to this point.”. Learning about themselves was an important takeaway and many were able to channel this new knowledge into forms of self-improvement.

Jessica explored her journey to sobriety and how she has grown. She felt that her former “addictive behaviour” was to run from problems, whereas now she is able to face life issues head on. She shared an example of revealing the truth to colleagues who had unknowingly and unwittingly assisted her with diversion. Facing these nurses was one way she was able to work through this experience. Jessica had a desire to be truthful and open, stating, “The one step from NA that I did take to heart was making amends with people... You know, I could have gotten them in trouble.”. She revealed the truth to individuals, knowing it could lead to a loss in friendship, out of a desire to right her wrongs and take ownership of her behaviour.

Sara spoke about her personal growth after ceasing substance use and facing her mental health issues, stating, “I realize how much better I am as a mom, a friend, a person.”. She also embraced healthy ways to manage stress including through home improvement projects, gardening, and art. Diana spoke of self-forgiveness and an acceptance that she is an imperfect human. Katie shared that she is working through the shame. When she becomes fixated on what others are saying about her, she tells herself, “If you’re going to live, you have to keep moving forward.” (Katie). Healthy coping mechanisms, self-kindness, and improved mental health were some positive outcomes for the participants following their experiences.

**Thriving in Sobriety.** Permanent changes to the participants’ relationships with mind-altering substances were acknowledged in the interviews. Darby described how her physical

dependence on her prescription for opioids morphed into misuse. She followed by acknowledging, “And now when I think about how that changed me, I would say that is for life.” Darby expressed the importance of this realization and the necessity to keep it in mind moving forward. Beth also confirmed that this experience has helped her come to terms with her own substance misuse. “I tried everything and always went back to drugs and so, you know, I definitely know that I’m a drug addict. And it’s OK... It’s who I am.” (Beth). Sara described her own struggles, as well as the recent loss of her stepdad to alcoholism, and how this has contributed to her realization that she has “been an addict my whole life”. She went on to say, “I’m an addict. I will always be an addict. Every day for the rest of my life, I will be an addict.” (Sara). This recognition was important for her to be cognizant of the lifetime battle she would be fighting with substances.

The participants described ways they adapted their lives to prevent relapse. Jennifer spoke of safety plans during triggering events, such as always driving herself to weddings, so she is able to leave whenever she desires. She also connects with friends or her care providers if she is considering substance use. Jessica shared her plans for a future without substances and gave a recent example whereby she made sure those who surrounded her would support her sobriety. When friends invited her to partake in marijuana use, a previous drug of choice, following the completion of her five-year program, Jessica’s dedication was made clear. “Like, I’m not risking this ever again. I know it’s just weed, but I have an addiction to it. I understand that people can use it recreationally or medicinally and responsibly, but I’m not one of those people.” (Jessica). Declaring her desire to remain substance-free to those around her was an important act to affirm and help maintain her sobriety.

An acceptance of their vulnerability regarding all substances and a need to prioritize their sobriety moving forward also resulted from the nurses' experiences. As Jessica shared, "I do have a disease. And this is a disease that is never going to go away." Mia described that she had previously rationalized her use of substances, but she now understood that it was substance misuse. She shared, "Now I can see that it's an issue... Before I went to treatment, I felt like it was normal. Like I'm working a lot of hours. I would give myself excuses, you know, like it's fine. It's just to keep me awake... But now that I look back, I know it's wrong." (Mia). The nurses all developed a need and a desire to move forward with their lives without the use of substances and felt this was a significant meaning from what they had been through.

**New Paths.** While all the participants continued to respect and were dedicated to working in the profession of nursing, a shift in priorities was born out of their experiences. All the participants were working in acute care at the time of diversion, areas they thought they would stay in for the rest of their careers. These areas included the ER, ICU, and cardiac units. Since then, all have adopted new roles in less acute areas. While many spoke nostalgically about their previous work in critical care, they have now found work that is less physically and psychologically demanding. Jennifer shared, "I kind of romanticize working in the ER and being a really good nurse, but that was so long ago... I do feel sometimes like I miss my calling. I loved critical care. But, you know, probably now I wouldn't even want to go back to that." Diana also described her reluctance to return to critical care, stating, "I'm a really good nurse. And I have a lot of skills and a broad knowledge base. But I don't know that I want to go back to that." The transition out of critical care was challenging for these participants, but they were able to shift their focus to appreciate the benefits within their new roles.

Beyond the changes in their areas of work, there were also changes to their schedules. Most of the participants now work daytime hours exclusively, feeling that their shift work and associated fatigue contributed to their substance misuse. An example is Sara who is now employed as a diabetes educator. She raved, “It’s fantastic. No shift work, no stress. I’m home every night with my family.” (Sara). The participants reported feeling healthier and found it hard to believe they had spent so many years flipping back and forth from day to night shift. Changes in nursing roles also impacted the physical health of the participants with reduced incidents of musculoskeletal pain and injuries associated with bedside nursing. David shared, “I really don’t feel like wiping butts and boosting patients anymore. My back hurts... I don’t want to deal with that anymore.”. The nurses were now employed in a variety of areas including occupational health, ambulatory care, substance use programs, and long-term care. The nurses spoke highly of the perks associated with these roles in less acute areas. While at times they were remorseful that their work situations had changed, many expressed gratitude for the consistency, stability, and work-life balance provided by their new roles. Many participants’ beliefs about the nursing profession, and where they belonged within this field, were profoundly altered by their experiences. These newfound perspectives, particularly the way that the participants spoke about their altered career paths, was a relevant finding as their early thoughts in the programs were focused on returning to their former roles. The transition in their nursing roles and new appreciation for jobs they otherwise would not have considered was an important finding.

**From Struggle to Strength.** Another particularly interesting meaning that emerged was the idea of new strengths that the participants now possessed and could incorporate into their nursing work. They could now practice in a gentler and kinder manner following their experiences and the learning that came with it. Jessica shared, “I know I’m a better nurse than I

was. I'm a lot more compassionate, a lot more patient. I care about my patients more.”. Diana added that her own experiences have given her a "superpower of compassion" allowing her to provide care with greater empathy. The impact on their nursing care was a positive development that emerged following their experiences.

Some of the nurses also shared that their personal experiences have given them an increased ability to care specifically for patients who misuse substances, forging deep and trusting relationships with them. This was relevant as most described minimal training on addiction within nursing school that prevented a thorough understanding of this condition. While many admitted that their previous views of addiction were narrow, they now have a better understanding which has contributed to higher quality care and better patient connections. Sara spoke of coming in the motto of “I really try to turn my pain into power” and how her experience has enabled her to help others who are struggling with substances. Beth, who works in a substance use facility, also spoke of how she can better empathize with her patients due to her own lived experiences. Jessica shared a deepened ability to understand this patient population, seeing herself in them. She recognized that the only difference between them was luck, whereby “I could have been that person. If I hadn’t had my parents for support, I would have been homeless after I lost my job... I realized I am not that far away from these people at all.” (Jessica). The nurses were humbled by their vulnerability and were able to channel this insight into their work.

Finally, the ability to manage incoming stressors without being overwhelmed was a power that some of the nurses developed. Beth reported she is now able to practice nursing without allowing the associated stress to impact her mental health. She has found a sense of peace in sobriety, allowing her to manage personal and professional issues in healthier ways.

Mia shared a similar sentiment whereby she is aware of the need to manage stressors and not try to escape them. “And I had to tell myself... It was me and I have to deal with it. I’m not going to run away from my problems, you know? So, I have to deal with them.” (Mia). These insights suggest that the nurses' personal experiences have not only contributed to their own growth and healing but have also positively impacted their nursing practice and patient care.

**From Silence to Speaking Out.** Over time, several of the nurses became engaged in activities aimed at education and advocacy. They spoke of their efforts to challenge the stigma of addiction and increase awareness of its prevalence and risks. Speaking about their experiences in this study was one way to draw attention to this issue. Openly sharing what they had been through was significant for the nurses, especially as they had been conditioned within their profession to keep their substance misuse secretive. Jessica challenged this culture of secrecy, stating, “Why did we have to be quiet about it? I think it should be talked about because it’s more prevalent than we know.”. Entering onto dialogue on this topic was important to challenge misconceptions about addiction and increase understanding.

Indeed, the widespread occurrence within the nursing community was a topic of reflection among the nurses and was a motivator for the participants to share their stories. Many touched on the severity of the issue during their interviews, with Diana sharing a compelling example. She recalled the day she was taken to the hospital by ambulance after an opioid overdose. On this day, the nurse assigned to her care in the ER was actively misusing substances. In fact, this nurse had an intravenous line in her ankle for opioid use when Diana arrived in the hospital. It was only later, during a support meeting, that the two nurses reconnected and realized what had happened. “I met her maybe three or four months later in the treatment program that I

had been to. I was telling my story to her, and she was like, ‘Oh my God, that’s you.’ She didn’t recognize me until I was telling her. And then she told me...” (Diana).

Other nurses also shared their thoughts on the magnitude of the problem including Beth who remarked, “I know that there’s a lot more of us out there.”. David agreed, stating, “I don’t know how many nurses there are in the US, but I do know there are a lot of addicts in the US.”. Several participants revealed that they personally knew nurses who had diverted opioids, some of whom had been caught, while others continued to practice undetected by their employers and regulatory boards. Jessica shared, “There are a lot of us out there who aren't getting caught and who are using.”. Mia revealed that she had engaged in diversion with a colleague who was never discovered. She also shared her suspicions of other former colleagues stating, “I feel like even other people I've worked with at the hospital, I'm sure they had issues too. I could see some people acting strange and when you did the[narcotic] count, you know, they would want you to walk away.” (Mia). These thoughts and firsthand accounts helped illustrate the prevalence of this issue within the nursing profession.

The nurses shared their personal experiences in the interviews, and they also shared how they draw attention to this issue in other ways. On a small-scale level, Katie spoke of educating others within her field who demonstrate narrow views about addiction. She spoke of the negative comments she hears from colleagues when there are issues of substance misuse within their patient population. The message she gives to those nurses in her workplace is, “addiction leads you to very dark places and to do things that you know crosses lines and boundaries”. Katie shares this message to challenge the culture of judgment within the healthcare system and educate other workers who may lack a thorough understanding of the implications of chemical dependence, including its impacts on behaviour and decision-making.

Two of the nurses proactively adopted roles of advocacy and were passionately involved in spreading awareness. Sara and Diana both spoke of their desire to educate others and their choice to publicly share their stories, despite the potential risks this presents. Their work involves participation in community support meetings, sitting on the boards of substance use committees, and actively supporting other nurses in similar situations through online platforms. Sara spoke about her advocacy within her workplace to foster better understanding and care for individuals with addiction. In addition, speaking out as a participant in this study was meaningful for her. While at times she found participation in the study challenging, due to the emotion it evoked, Sara expressed a personal responsibility to tell her story, stating, “If it just helps one person, it's all worth it.” Helping others was important for Sara as she described an epidemic of addiction in the town where she works. Living through addiction and witnessing its devastating impact firsthand motivated Sara to share her story.

Diana spoke of her work, including within the NA community where she plays an active role as a facilitator and shares her story. While some participants expressed skepticism about the usefulness of NA, Diana reported much solace and belonging from her group. She spoke of her involvement and how it has influenced her recovery. “I've been a really active member of NA and it's one of just the foundational things that when my story can help other people, then I want to. I want to do what I can to help.” (Diana). Diana viewed her work in NA as an opportunity to help herself while also helping others. She expanded on this, stating, “One in ten people are in active addiction. And that's too many for me to keep my mouth shut.” (Diana). For Sara and Diana, sharing their stories was an integral part of their recovery. Both these participants were highly motivated to create positive outcomes from their experiences. They hoped to

counterbalance the negative consequences of their actions, seeing advocacy as an opportunity to both help others and try to make things right.

Not all the participants chose to engage in such vocal acts. Several of the nurse participants remained more stagnant, continuing to isolate themselves and showing little interest in acts of advocacy and awareness. This could be due in part to the variation in years of sobriety. In general, the nurses with more years of sobriety demonstrated a greater willingness to speak about their experience, desiring to help others with the same issue. Those nurses who were earlier in their recovery seemed to be stilted by their experiences of shame and were focused on minimizing the damage that addiction and diversion could inflict on their personal and professional lives.

**Need for Change.** Finally, a need for change emerged from the lived experiences of the participants. The nurses reflected on their experiences and had valuable feedback to provide. This included suggestions to raise awareness of this issue, increase support for nurses within the workplace, and improve the functioning of the ATD programs.

The lack of attention to this issue affecting the health of nurses was concerning for the participants. Mia stated, “They don’t talk about it in nursing school or even in institutions. Like they don’t tell you you’re at risk. And it’s easy too.”. David echoed this sentiment stating, “We spent maybe thirty minutes on this topic in nursing school and that was it.”. When Katie was asked if she learned about these risks in nursing school or at work, she responded, “Not at all.”. Nursing school curriculums and workplace education sessions have been described as favorable times to draw attention to risks for substance misuse, but this is not occurring. All the participants reported being unaware of their risks or the magnitude of the problem. David described the necessity of making nurses fully aware of their risks. He spoke about life stressors and the need

to warn nurses about using substances to combat these issues, stating, “I think nursing students need to be warned about it in a big way. Because life gets hard. And when you are 22 and you’ve graduated college and you don’t have a relationship and three kids and a house payment, you don’t think about these things...” (David). Mia agreed, stating, “There could have been, like, more classes on that. Definitely. It wasn't that much on the impacts that it has on society and how many people are actually dealing with this. I think there should be a lot more. A lot more information to nurses and whatever people in healthcare.”. The meager information that was shared with nurses about substance misuse did not address the magnitude of the issue, nor did it focus on the risks for nurses themselves. Increasing awareness of the problem, but also helping nurses understand their true vulnerability were important take away messages.

In addition, the participants emphasized the need for the nursing boards to make ATD programs more effective in supporting nurses, while having fewer negative impacts. To achieve this, they first highlighted the importance of making nurses aware of the programs. When nurses are unaware that there is help available to them, it reduces opportunities for disclosure. Spreading the message that there is help available is tantamount to reaching nurses who are already in the midst of addiction. They also felt strongly of the need to increase education about this condition to prevent further stigmatization. Katie spoke to this stating these negative beliefs “just makes addiction worse and it separates people”. Furthermore, the nurses shared various concerns with the ATD programs, finding some processes to be more harmful than helpful in facilitating a successful return to work process. These concerns included demanding obligations, a lack of support, challenges for nurses outside of urban areas, extensive documentation needs, and a lack of individualized programming. Being unable to take over the counter medications to deal with minor ailments was another issue broached. Katie spoke about the disappointing response of her

nursing board and how the program could be geared to better help nurses while also protecting the public. She explained, “Protecting the public would have been them folding me in... Bringing me into the nursing community. Plugging me in for recovery resources.” (Katie). Instead, Katie felt thrown away, and she struggled fiercely to make her way back into the profession.

A need to provide truly supportive environments for nurses and other health care workers was also broached. Jennifer spoke of her employer which was a large acute health center. She reported being offered the Employee Assistance Program (EAP), which is free, but offers a very limited amount of mental health support such as counselling. She felt health care facilities had a responsibility to recognize this issue and create long-term programs such as hospital-based 12-step meetings for employees. She stated, “They need to be more supportive and not just offer EAP programs. Because I've tried those, and they don't work very well” (Jennifer). Mia also felt that hospitals should offer special treatment for health care workers, stating “we obviously don't fit in the same box as everyone else”. Other suggestions included offering staff mental health days, absorbing the cost of private therapy to reduce absenteeism, and focusing on staff wellness to prevent staff turnover and attrition.

The ATD processes impacted the lives of the participants to varying degrees. A telling fact was that several participants revealed they would not refer other nurses in active substance misuse to the program. In fact, despite attributing her current sobriety to the program, Beth stated, “I would never turn anybody in.”. When asked why this was the case, she reported “They saved my life. But they've also made my life really hard.” (Beth). Sara agreed stating, “I can't honestly say I would rat them out...” if she knew a colleague was diverting. While many of the participants were thankful for the opportunity to return to practice, they felt a strong need for the

ATD programs to be assessed and reconfigured by feedback from those who had lived through them.

Great changes in the lives of the participants ensued following their experiences with opioid addiction and diversion. For many, particularly those with more years of sobriety, they were able to reframe their thinking to focus on the way they have grown and developed. Improvements to their personal and professional lives resulted and the nurses demonstrated great individual growth which included goals of long-term sobriety. In addition, the nurses were able embrace nursing roles that were outside of the acute care they used to perform. One of the nurses described a new passion for work in long-term care, despite previously looking down upon this type of work. Beyond changes to their work settings, the nurses vocalized changes to the way they perform their jobs and establish relationships with their patients. Increased understanding and compassion for others resulted from their lived experiences. Finally, acts of advocacy and changes to the ATD programs emerged from the stories of the nurses. As stated by Katie, “This is a voice... We have not been given a voice.”. The need for change and for input from those who had lived through the ATD programs was an important finding in this study.

## **Chapter 6: Discussion**

### **Taboo in Nursing**

Throughout this study the theoretical concept of taboo was used as a critical lens to both interpret and explain the data collected (Sandelowski, 1993). As described, social norms and taboos impact human behaviour. Shared standards and cultural values function in combination with laws to guide how individuals act in their daily lives (Chiauzzi, & Liljegren, 1993; Fershtman et al., 2011). Social norms steer behaviour by encouraging acceptable conduct and promoting behaviours that are in line with dominant thoughts and beliefs (Bicchieri et al., 2018).

In contrast, taboos encompass acts and behaviours that are discouraged or prohibited within a given society (Bos et al., 2013). Social norms and taboos have a powerful influence on humans in almost every aspect of their lives, and this dynamic is not only confined to broader society (Fershtman et al., 2011). Taboos also exist within smaller subcultures, including professional groups like nursing (Cody, 1993). In these types of specialized communities, social norms and taboos play a crucial role in fostering cohesion and encouraging behaviours that align with professional principles and values (Dixon, 2013). For this reason, the examination of taboo was particularly important in this study to understand its subtle and explicit influence on the experience of the participants as nurses who engaged in opioid diversion and misuse.

To understand the significance of taboos within this study, it is necessary to consider the underlying social norms embedded within the profession of nursing. These norms constitute the expectations that are imposed on the behaviours and attributes of its members. Norms are a product of socialization within nursing education and training whereby practitioners learn the behaviours, knowledge, and ways of being that reflect the core values of the profession (Dinmohammadi et al., 2013; Dixon, 2013). In nursing, these can include a commitment to morality, strong ethical foundations, and dedication to honesty and trustworthiness (Kunyk & Austin, 2012; Watson, 2009). Moreover, the profession places high value on traits that are assets in navigating the challenging realm of nursing work such as stamina, devotion, and selflessness (Fealy, 2004; Sadler & Snively, 2023). Other norms exist via expectations on how nurses should perform their jobs. These norms are rooted in dominant discourses within the nursing community whereby “nurses have long been socialized to believe that the virtue of nursing care lies within nurses’ humble disposition, sacrifice, and servitude” (Perron, 2013, p.156). Truly caring for patients, thereby offering a part of oneself to one’s work, is an integral aspect of nursing practice

(Nistelrooik, 2024). Alongside this requirement to be self-sacrificing and submissive, nurses are held to a standard where they are expected to be teachers of healthy lifestyles, and models of self-regulation and social values (Collins et al., 1998; Ponech, 2000; Rush et al., 2005).

These professional norms act as stringent requirements upon those who enter the field, impacting their lives by cementing the values and expectations of the nursing profession within them (Dinmohammadi et al., 2013). This extends beyond clinical practice. These norms carry over into the identity of those employed as nurses through the internalization of the profession's values, customs, and responsibilities (Mooney, 2007). These expectations placed upon individual nurses mold their professional identity and foster conformity (Mooney, 2007). In addition, nursing norms serve to safeguard the image of the profession (Kunyk et al., 2016a). Consequently, nurses enjoy favourable public opinion, and trust and respect in the profession is preserved. These norms lead to a complex interplay between social expectations, personal characteristics, and the values and reputation of the nursing profession.

Alongside the social norms and values upheld by the nursing profession, there also exists a variety of taboos. These include a spectrum of behaviours and attributes that are either frowned upon or actively discouraged within the profession. Taboos further enforce social norms by identifying acts that are considered dangerous, impure, or dirty (Douglas, 1966). In general, taboo acts pose a threat to the established order as they stand in direct opposition to what society values (Fershtman et al., 2011). In the realm of nursing, these taboos represent elements that are undesirable or in direct opposition to the profession's principles and ethical standards. Taboo elements within the profession of nursing unfold on various levels. They impact how nurses perform, discuss, and feel about their work. They also impact how nurses conduct themselves inside and outside of the workplace.

In nursing, taboos encompass personal traits as well as specific behaviours, creating prohibitions within the profession. Some taboos can be universally applied to all nurses, and there are others that have varying degrees of relevance in differing nursing environments. Examples can include taboos surrounding the sensitive nature of nursing work. Nursing care involves “crossing social boundaries, breaking taboos and doing things for people that they would normally do for themselves in private if they were able” (Lawler, 2006, p.32). Nurses often engage in physical care of their patients, acts that would be prohibited in any other setting. This can include things like bathing and toileting patients. At times, this nursing work can provoke feelings of discomfort within practitioners (Holmes et al., 2006; Perron & Rudge, 2016). Peri care, wound care, and the care of cadavers can evoke experiences of disgust and abjection, yet it’s considered inappropriate and in poor taste for nurses to react to these aspects of their work (Perron & Rudge, 2016). Nurses are expected to maintain their professional composure and are discouraged from acknowledging emotions such as repulsion and disgust (Holmes et al., 2006). These types of taboos create boundaries around what nurses are supposed, and allowed, to feel.

These types of taboos in nursing became evident in the interviews when the nurses discussed their work. At first, the participants focused on their pride at being part of the profession and they were less upfront about its negative aspects than anticipated. This was a significant finding. I had formed assumptions about how the nurses would describe their work, expecting them to openly address stressors within their practice. In reality, it took some gentle probing to persuade the nurses to speak about nursing work in anything other than positive terms. There was a focus in the interviews on the emotional impacts of being removed from practice and the burdensome journey to return to nursing care. The lack of attention to the nature of

nursing work led to questions about what the nurses felt comfortable discussing and I wondered if there was a possibility that they were self-censoring. This potential censorship could have been because I was also a nurse, and there may have been a concern about professional judgment. There was also the possibility that the nurses spoke about their work in a particular way because it was the language they had been accustomed to using. It was only when I created comfortable spaces and opened the discussion to explore the taboo aspects of nursing work that the participants spoke freely and revealed numerous parts of their work that they were grateful to escape. The narrative changed as the interview proceeded and the participants were able to divulge the true nature of their feelings about their work. For example, some shared great relief at no longer having to perform nursing care in acute environments. Jennifer spoke of how she was nearing the end of her contract period, but no longer wished to return to work in the ER. While she had previously been committed to getting back to her specialty, time away weakened her desire to return to hands-on work in this chaotic environment. Diana expressed a similar sentiment. As a highly experienced critical care nurse with broad skills and knowledge, she spoke of how her experience prompted her to step away. David also spoke of leaving bedside nursing. He acknowledged the taboo nature of bedside nursing and his desire to no longer “wipe butts”. This comment stood out as it surrounded an aspect of nursing work that is generally shrouded in sensitivity and not spoken of. While David’s comment was made in a light-hearted manner, it was noteworthy because it contrasted with the way that nurses were conditioned to only speak of nursing work in terms of its nobility, being prohibited from acknowledging its inherent challenges.

There are other taboos within the nursing profession surrounding the appropriate personal impact and emotional responses to nursing work. Nurses can witness a multitude of horrors in

their daily work including violence, patient deaths, suffering and agony, and exposure to traumatic injuries (Perron & Rudge, 2016). There exist, however, taboos about acknowledging these workplace challenges. There is an expectation for nurses to quell their human responses to upsetting workplace events, thus contributing to a culture of silence surrounding these aspects of nursing. This silence highlights an unspoken agreement within the profession that psychological reactions to certain facets of nursing work should be suppressed, rarely spoken of, and never openly acknowledged (Perron & Rudge, 2016). This stems from the requirement for nurses to maintain distance and objectivity in their work, thus reinforcing a culture whereby emotional responses are seen as unprofessional and signs of weakness (Perron & Rudge, 2016).

During the interviews the nurses spoke of the impact of this taboo on their nursing work, shedding light on its influence within their experiences. Sara highlighted the lack of debriefs following critical events coupled with an expectation for nurses to quickly resume their duties. She spoke of lying in bed at night and replaying horrific events from her workday over and over in her mind. The lack of open dialogue within the workplace forced her to bring all these unresolved emotions home with her at the end of the day. She did not have an outlet as there was no support in the workplace, but she was also prohibited from addressing these confidential events elsewhere. Diana referenced the mental trauma she had accumulated over the years from being consistently surrounded by death and dying in her workplace. She expressed a feeling of restraint whereby she was prohibited from openly acknowledging her human reactions to such profound and painful experiences. The suggestion was that expressing any type of vulnerability or emotional reaction to workplace events could be interpreted as vulnerability and a lack of professionalism.

Beyond the taboos within clinical practice, there are taboos related to nurses themselves. Taboos regulate the behaviours of nurses and set rigid standards for the characteristics that nurses should possess, thus perpetuating stereotypical images of the profession (Brennan, 1991; Trossman, 2003). Beyond the prevailing image of nurses as gentle maternal figures, there are also demands on how nurses should look (Fealy, 2004; Hoeve et al., 2014; McAllister et al., 2017). Taboos restrict many aspects of nurses' lives, including their physical appearances whereby nurses are encouraged to maintain a healthy weight to set a good example for their patients (Katz, 2014). There are also rules regarding how nurses should behave. Nurses are expected to be truthful and committed to those under their care (College of Nurses of Ontario, 2019). In addition, nurses are expected to adhere to a code of conduct not only in the workplace, but also within their personal lives where there are social expectations for nurses to behave in an agreed upon manner (Lilly, 2015). The taboos function to protect the image of nurses. Portraying nurses to have elevated morals and virtues maintains the trust and respect of the public (Lilly, 2015). As nurses are tasked with providing sensitive care to people at their most vulnerable, this sense of trust persuades the public to submit their bodies, privacy, and dignity to accept nursing care (Rutherford, 2014). Ensuring the public believes that nurses are moral, ethical, and trustworthy gives them confidence in the care they will receive. People trust individual nurses because they trust the profession of nursing (da Raeve, 2002; Stewart & Mueller, 2018). Taboos, therefore, are not confined to the work nurses perform, but also seep into their personal lives where they regulate nurses' behaviours and characteristics.

Mental health issues and addiction in nurses are examples of taboos that are particularly relevant in the context of this study. This includes experiences with mental illness and chemical dependence. Studies examining the mental health of nurses have exploded since the Covid-19

pandemic. Even prior to the pandemic, unrealistic expectations and the workloads of nurses was contributing to burnout and emotional exhaustion in this population (Akoo et al., 2024; Stelnicki et al., 2021). The effects of the pandemic have worsened this problem, yet despite the prevalence of mental health issues in this population, nurses have described being actively encouraged to conceal this type of information about themselves from those in their care (Akoo et al., 2024; Oates et al., 2017; Peterson, 2017). Several nurses in the study disclosed that they suffered from diagnosed mental health conditions, issues that they attempted to keep hidden within their workplaces. Jennifer shared how she has battled with her mental health, yet she felt shunned from talking about this in her work. She referred to unspoken rules forbidding this type of self-disclosure by nurses.

The misuse of substances is another taboo behaviour for nurses, and it remains an issue that is heavily frowned upon within nursing practice. Addiction continues to invoke stereotypical and judgmental beliefs in society. This can be traced back to nursing's origins whereby the recitation of the Nightingale Pledge promoted nurses as pure in character (McBurney & Filoromo, 1994). While this pledge is no longer a part of nursing initiation in the US, it has been adapted, at least in part, into the Nursing Code of Ethics by the ANA (McBurney & Filoromo, 1994; Lachman, 2009). Conversations about abstaining from substances both govern nurses and perpetuate a professional image of nurses as morally superior. This is connected to prominent social beliefs towards addiction, creating a misconception that nurses who engage in the misuse of substances lack the ethical fortitude necessary to work in this role. This prevailing image has created a persistent belief that substance misuse conflicts with the expected conduct of nurses (Kiepek & Baron, 2019).

Opioid addiction in nurses is a particularly powerful taboo, one that is intricate and multifaceted. There remain prominent misconceptions surrounding addiction and it is often considered a sign of moral weakness or flawed character. These prevailing beliefs hinder a genuine understanding of addiction, undermining its ability to impact all individuals, regardless of their background, profession, or socioeconomic status. Consequently, the nursing profession endeavours to distance its members from any association with substance misuse, recognizing the powerful social admonishment that addiction can invoke.

As evidenced within this study, however, there is a connection between nursing work and the misuse of substances. Taboos within the profession extended into the daily lives of the participants surrounding their workplace tasks and their doing and being of a nurse. From workplace stressors and challenges that they felt unable to openly acknowledge, to constraints on their ways of being, thinking and speaking, participants felt suffocated by rigid professional expectations. The nurses described histories of substance misuse, but also shared that their professional experiences had either provoked re-entry into misuse or aggravated ongoing misuse. The result of this dynamic is a daunting cycle. Nurses grapple with the impact of their work on their mental health and well-being yet are inhibited by workplace taboos from acknowledging these issues or seeking support. This predicament is then further exacerbated by taboos surrounding substance misuse. This results in a dilemma where nurses cannot openly discuss their mental health concerns due to these prevailing taboos, only to face criticism and condemnation when they resort to using substances as a coping mechanism.

While substance misuse and addiction are already taboo within the profession of nursing, this issue is exacerbated when there is an element of diversion. Diversion adds a layer of complexity whereby it is regarded as professional misconduct that harms the relationship nurses

have with their employers and their patients (College of Nurses of Ontario, 2023). Nurses who engage in taboo behaviours are seen to violate their ethical duties and the aspects of nursing that society views as sacred, including notions of virtue, morality, and trust (Rutherford, 2014). It also worsens the responses associated with addiction, being interpreted as a dishonest act and a breach of trust (College of Nurses of Ontario, 2023).

There is powerful judgment when incidents of diversion by nurses occur. This was evident when the nurses in the study spoke of the responses they faced, including workplace exclusion, othering, gossip, and the loss of friendships and relationships with colleagues and other nurses. Feeling discarded by their profession was a common experience among participants as they described no longer feeling wanted or included within their profession. This was especially true among nurses who felt that the ATD programs were designed to dissuade re-entry. In their view, these programs were created to give the impression of support while numerous restrictions and costly requirements acted as deterrents to program completion and re-entry. In addition, participants' experiences of shame and guilt were amplified through uncomfortable interactions with program administrators and excessive demands for personal health information. Feeling thrown away by their profession, either through a lack of support or through punitive programs was a significant finding in this study and it had lasting effects on participants' sense of self and how they viewed nursing as a profession.

The negative responses that the nurses received was not limited to their professional sphere. Opioid addiction also impacted their personal lives and they reflected upon damaged friendships and relationships with their loved ones. As nurses are often subject to greater scrutiny than the public because of their special status in society, there were repercussions when their experiences became known to those around them (Darbro, 2005; Dunn, 2005). Beyond the

general social stigma surrounding addiction, the aspect of diversion amplified the negative responses. As discussed, the nurses felt pushed away or at times abandoned by those around them. Some lost friends while others felt their parents and partners withdraw from them. Others felt that they were offered support but in an insincere way. This desertion by loved ones was disappointing and painful for participants. It increased the shame surrounding their addiction and solidified a desire for many to conceal this information from others in their lives. Even when their addiction became known, they refused to disclose their diversion, and several of the nurses shared that their loved ones were still unaware that diversion had taken place. Keeping this information secretive has added to the emotional distress of the nurses. Indeed, for several participants, the element of diversion was the most concerning part about their addiction becoming known. Jennifer, for example, discussed how protective she has been about keeping the diversion factor a secret. While many around her are aware of her issues with substances, she worked to keep her diversion private after the negative responses it evoked in those that were aware. Similarly, Darby spoke of how she successfully concealed her diversion from her family members for years, including her own husband. Even years after their experiences with addiction and being presented with a safe and judgement-free place to discuss what had occurred, diversion was still regarded as unclean behaviour and was painful for the nurses to openly acknowledge. Only a few nurses delved deeply into their diversion techniques and methods. The rest of the participants acknowledged that diversion had occurred but appeared distressed when the interview steered in this direction. This was especially relevant to Diana who demonstrated an element of denial, sharing that she would not allow herself to “dig around in her brain hard enough” to truly reflect on her diversion and its potential impacts within her workplace.

Examining the presence and function of these taboos within the nursing profession was an important consideration within this research. Taboos in nursing function to uphold the stereotypical image and reputation of the profession, reinforcing notions of virtue, purity, and moral standing. Nurses are persistently perceived as subservient professionals, with an emphasis on their caring nature (Godsey et al., 2020; Hoeve et al., 2014). They are known for being nice, self-sacrificing, and obedient (Glasdam et al., 2023; Gordon & Nelson, 2005). While these notions of the profession and discipline of nursing are prevalent, they are often antiquated and do not accurately reflect the true nature of this work.

Nursing continues to be one of the most respected professions that exist. Surveys in the United States have consistently ranked nurses as the most honest and ethical profession for more than twenty years (Saad, 2022). This type of professional admiration has followed nursing almost since its inception and yet nursing is rarely described so favourably by those that perform the job. A study in Germany found great discrepancies between how patients and nurses regard nursing work and conditions. While the public values the image of nurses, those within the profession describe dissatisfaction with their jobs (Isfort, 2013). In addition, the public's perceptions of nursing is different than those held within the profession itself and is greatly based on stereotypes and misconceptions about the work nurses perform (Morris-Thompson et al., 2011). Within this study, the nature and reality of working as a nurse was a significant finding. The participants shared the challenges that they faced within their profession on an ongoing basis. Examples included musculoskeletal injuries, fatigue, and an array of stressors upon their mental health. They shared how their lives were dramatically impacted by the work they engaged in. This included having to shift from working during the day to working at night, ruminating on traumatic workplace experiences, and not feeling present when spending time with their friends

and family. The nurses described how their substance misuse issues were exacerbated by their jobs and spoke of opioid use as a way to escape the impacts of their work.

Despite social trust and admiration for nurses, consumers of the healthcare system have been more vocal in recent years about nursing's flaws and failings. Importantly, feedback has come from nurses who have had personal experiences as patients. In 2019, the *International Journal of Nursing Studies* published an article entitled, 'Shitty Nursing' - The New Normal?' in which the authors, nurses themselves, pointed out their own lived experiences of abysmal nursing care as well as their professional opinions on the matter (Richards & Borglin, 2019). In this work the authors moved beyond antiquated and stereotypical views of nursing care to focus on how nursing care is truly unfolding in practice. They reported a lack of assistance with care needs including bathing and toileting, poor communication, neglect, and untreated pain. The authors referenced an abundance of issues within nursing that contributed to the poor care they received including staffing shortages, cost cutting, delegation of traditional nursing tasks to poorly trained workers, as well as a mass exodus of nurses (Richards & Borglin, 2019). Their firsthand experiences along with their perceptions of how nursing care has changed begs the question of whether the image of nursing care, and the social contract that it feeds, has been broken.

In the midst of this exposure, it forces readers to think about why nursing is holding so tightly to its past. What is nursing trying to uphold and why? Dissecting contradictions within nursing taboos was essential to understand why they exist and who they benefit. Some authors suggest it is a matter of branding (Godsey et al., 2020). Nursing holds onto taboos to promote their unique values and characteristics and to shape their image. This differentiates them and their unique role from others within the healthcare field, namely physicians (Godsey et al., 2020).

Nursing work is distinctive as it is thought to provide holistic care with an understanding of how social factors can influence health (Godsey et al., 2020). This approach allows nurses to directly impact those in their care who are at risk for either developing or exacerbating health-related conditions (Godsey et al., 2020). Furthermore, the positive public image and social respect of nurses also fosters trust and communication which are especially important when considering their role in caring for the health of society (Yalcin et al., 2023). Yet from the viewpoints of the participants, nursing's enduring image can be harmful as it upholds anachronistic views in the public opinion, leading to unrealistic social expectations of how nurses should perform their jobs (Gill & Baker, 2021).

The image of nursing is perpetuated in different ways. Campaigns orchestrated by the nursing profession often make use of outdated and virtue-based messaging. An illuminating instance was the "We Answer the Call" by the Canadian Nurses' Association that was promoted during the Covid-19 pandemic (Canadian Nurses' Association, 2022). This campaign lauded nurses for their perceived strength and resilience amid the pandemic, emphasizing their altruistic calling to help others during times of fear and uncertainty. A similar sentiment was reflected by infamous street artist Banksy depicting a child playing with a caped nurse toy, rather than other more traditional superheroes (Mohammed et al., 2021). These examples illustrate the tendency of society and the profession to perpetuate an idealized image of nurses, obscuring the harsh realities they face. In actuality, nurses confronted a multitude of challenges during this time including a shortage of personal protective equipment (PPE) and other essential supplies, unprepared deployment to ICUs and other specialty units, burdensome workloads that impeded optimal care, and experiences of burnout, anxiety, and depression (Akoo et al., 2024; Garcia-Vivar et al., 2023; Mohammed et al., 2021). Poignant images circulated, serving as reminders of

how nurses suffered during the pandemic, including facial wounds caused by prolonged use of N95 masks, makeshift PPE solutions such as garbage bags, and exhausted staff sitting on hallway floors. Their experiences were worsened by the narrative that emphasized nurses' willingness to be *heroes* when they were desperate for support to perform their work in a safe manner. Another example includes the campaign "Clap for Carers" where the public would stand outside and clap for nurses during times that are typically shift change (Mitchell, 2021). Many nurses found this initiative insulting, as it not only diminished their professional knowledge but also reinforced the invisibility of a workforce that was struggling immensely (Mitchell, 2021).

These types of campaigns downplay the urgent need for support and safe working conditions for nurses. Despite advancements in the profession, there is a powerful pull to maintain idealistic virtues and embed them upon nurses. These campaigns, which are intended to influence both the public and nurses alike, create a feedback loop that reinforces taboos and stereotypical images (Gordon & Nelson, 2003). The effects are numerous. A study in Sweden found that one of the main reasons nursing students dropped out of their programs was due to the incongruity between their perceptions of nursing versus actual nursing work during their student placements (Glasdam et al., 2023). In addition, taboos create a dialogue that is inherited by nurses, who promote these messages by incorporating them into how they discuss their work (Gordon & Nelson, 2005). This becomes the message that is sent out to the public and inevitably projected back onto nurses. By practicing as a nurse, an individual is claiming to embody the values of this profession (Rutherford, 2014). These discourses and expectations of nurses can be thought of as "emotional weapons" (Fealy, 2004, p. 654) whereby as nurses they reap the benefits of membership in a prestigious profession yet are denied the opportunity to be vulnerable and fallible humans.

It is essential for the nursing profession to reconsider its messaging, ensuring that they accurately reflect the difficulties faced by nurses. Perpetuating outdated hero narratives and promoting nurses as infallible beings sets patients, the general public, healthcare administrators, decision makers, and elected officials up for unrealistic expectations in the context of the current healthcare system. They do not benefit patients who enter the healthcare system with ideas of care that are swiftly reduced as they are exposed to hallway nursing, unanswered call bells, lack of basic care, and little to no communication (Richards & Borglin, 2019). In addition, they place pressure upon nurses as they suggest that good nurses should be capable of individually and professionally managing the fatigue, pressure, and responsibility of their work in ways that seamlessly preserve the provision of care. This creates rules about what nurses are allowed to speak of and even what the nurses are supposed to think, forcing individual providers to question themselves and their fit for this job if they are unable to perform to the standards that are socially expected. Finally, taboos regulate how nurses are allowed to act, what attributes they can possess, and how they should manage themselves inside and outside of work.

### **Stigma and the Reshaping of Identity**

Stigma was another theoretical concept that was used to make sense of the collected data in this research study. Stigma functions within social environments to discredit and devalue individuals who fail to possess the attributes demanded of those within their social position. Goffman's (1963) work on stigma examined the presence of assumptions and expectations made upon individuals within society. When individuals fail to meet these demands, it can lead to their stigmatization, marking them as different or tainted (Goffman, 1963). This can result in experiences of discrimination and exclusion as stigmatized individuals suffer social and structural disadvantages (Link & Phelan, 2001). In addition, stigma can create power imbalances

and lead to social demotion (Link & Phelan, 2001). Essentially stigma is understood to be a trait or characteristic that results in widespread disapproval, creating insiders and outsiders within a society (Bos et al., 2013). Stigma exists within the nursing profession and in the work that nurses perform. Its influence on the participants was multifaceted and followed them from their opioid misuse to their return to work and beyond.

Stigma in nursing is manifested in different ways, including through the conflicting social status of nurses. This surrounds the work that nurses perform whereby despite being lauded for their role as caregivers and healers, certain aspects of the profession make it susceptible to stigmatization. A key element of stigma in nursing stems from the nature of nursing work. Nursing duties, particularly those involving physical care, is an uncomfortable topic. Tasks related to the human body, including washing, feeding, and toileting, are fundamental to patient care however are often thought of as “dirty” work and fall outside of the bounds of social norms (Lawler, 2006). The intimate nature of these responsibilities can lead to feelings of horror and disgust when contemplated by the public (Lawler, 2006; Perron & Rudge, 2016). For this reason, these tasks are often performed discreetly, hidden from public view behind closed curtains or in private spaces. In addition, nurses are routinely in the presence of bodily fluids and substances that are socially viewed as dirty or unsanitary. This includes matter such as vomit, melena, and sputum. They also provide care to individuals that are socially discredited due to stigmatized qualities, such as those with obesity or mental illness (Ziliotto & Marcolan, 2013). This creates a system whereby the work nurses perform makes marks them as different or dangerous. A recent example occurred during the Covid-19 pandemic whereby some nurses were socially ostracized, thought to be dangerous because of their proximity to the virus (Taylor et al., 2020). Not only were the nurses socially excluded, but the stigma impacted their families as some were asked to

remove their children from daycare over fears from other parents and providers of virus transmission (Taylor et al., 2020). These factors illustrate the dichotomy within nursing whereby the profession is esteemed for its social value but stigmatized for the discomfort it evokes.

Gender also plays a pivotal role in perpetuating the stigma surrounding nursing. Within patriarchal societies, caregiving is often considered women's work (Lawler, 2006). This reinforces traditional gender roles and devalues aspects of the work that nurses perform. This dynamic is particularly powerful as nursing is a profession that is overwhelmingly dominated by women. It remains associated with femininity, aligning with social perceptions of women as nurturing and suited to the caretaking of others (Balkin et al., 2023). In the US, for example, 85% of those employed in nursing, psychiatric care, and health aides are female (Cheeseman & Chrisnacht, 2019). However, despite the overwhelming presence of women in the workforce, only 25% hold leadership positions (Dhatt & Keeling, 2021). This could be correlated to a lack of socialization for females to exert influence over others (Manojlovic, 2007). The issue of gender in nursing is significant as women experience increased societal, ethical, and sexual stigmatization (Paivinen & Bade, 2008; Stanford, 2018) and the feminine view of nursing, and the traditional tasks and roles associated with it, contributes to stigmatization toward the profession.

Stigma in nursing is also related to power dynamics and professional hierarchies. The public image of nursing work often revolves around the provision of hands-on care and the development of patient relationships (Rodriguez-Perez et al., 2022). Yet there is a lack of clarity on what it is that nurses do. Nurses are frequently defined through their comparison with other healthcare workers, most notably physicians. In general, nurses are regarded as inferior to physicians, both socially and professionally (Terry et al., 2020). This is not only in regard to the

work they perform, but also the power they hold. Nurses are thought to be obedient and humble, and many nurses have little power in their places of work despite being accountable to physicians, patients, administrators, and regulators (Elsberry, 1972; Lee et al., 2022; Manojlovic, 2007; Sepasi et al., 2016). Critical aspects of nursing practice, such as staffing ratios, patient assignments, scope of practice often fall outside of nurses' control. There are additional expectations for nurses to participate in continuing education and stay informed on research and best practices. This can put nurses in untenable positions as they attempt to manage conflicting expectations without the skills, confidence and position to exert power and advocate for themselves (Elsberry, 1972; Lee et al., 2022; Manojlovic, 2007). These observations are not new, having persisted in the literature for more than fifty years which underscores the enduring nature of these challenges within the nursing profession. Furthermore, the devaluation of nursing work, particularly the intimate and traditionally private nature of caregiving tasks, reinforces the perceptions of nursing as less financially productive and inherently inferior to physicians (Lawler, 2006). In essence, the stigma surrounding nursing is intertwined with power differentials that marginalize nurses, limit their autonomy, and undermine their contributions to the health of society.

Stigma within the nursing profession is a complex issue, yet it was compounded for the participants in this study. Nurses already exist in precarious social positions, and the study participants grappled with heightened challenges due to societal perceptions surrounding addiction. The impact of stigma upon the participants was profound, partially stemming from institutional attitudes towards addiction within the healthcare system. The nurses shared how poorly regarded addiction was in their places of work, giving examples of the of use labels such as “drug-seeking” to refer to patients who misuse substances. This type of language is

commonplace despite its contribution to stereotypes and negative attitudes toward those with addiction (Valdez, 2021). The participants spoke of the impacts of stigma within their workplaces, demonstrating how clinical care of patients with addiction were influenced by their labelling (Weiner et al., 1998). This included examples of those with addiction being accused of acting out for attention and being denied physical care because of negative reactions from hospital staff. The nurses also spoke of the broader social responses to addiction, particularly when it affects healthcare workers. As discussed in the findings, the nurses shared the vehemence directed toward them, responses that were exacerbated by the factor of diversion. This required them to navigate complex dynamics within their families and social circles and they described long-lasting repercussions including alterations to family structures, loss of trust, and beliefs that they were no longer good parents, partners, friends, or children. The sensitive nature of this research became clear when this topic was broached and many of the participants became emotional as they described the altered perceptions now held by their loved ones. The nurses not only faced external judgment, but also internalized negative perceptions which resulted in the process of self-stigmatization. For most, this change in their identity was the most powerful and painful part of their experience. The intersection of these stigmatized views greatly influenced their lived experiences and had enduring consequences, powerfully altering the nurses' sense of self and identity. Their stories vividly illustrated the formidable power of stigma within society.

Stigma loomed large in the narratives and was especially relevant for the participants because of their work. For the participants, nursing was not just a job. Rather, it played an integral part of their lives. The issue of identity was rooted in the experiences of the nurses as they viewed their work as a cornerstone of their personal identity, shaping and influencing various facets of their self. Nursing is consistently identified as one of the most honourable and virtuous

professions and the nurses' held beliefs about themselves that were in line with society's images of their profession (Stanford, 2018). The participants internalized these social constructs and perceived their role as nurses to be fundamental parts of who they were. Yet when they experienced addiction and diversion, it disrupted their social illusion of nursing, leading to the devaluation of self by the participants. This illustrates how the individuals internalized negative societal perceptions associated with addiction, leading them to believe negative things about themselves (Goffman, 1963). In this case, the pervasive social stigma surrounding substance misuse triggered a powerful reconstruction of the nurses' confidence, self-concept, and their place in the world. Many felt their reputations and characters were forever damaged. Despite voicing a slew of stressors within nursing work and no inclination to return to acute care, the nurses still expressed remorse that they were no longer the person and nurse they once felt they were. As they shared their stories, it became evident that each nurse had undergone a significant change in their self-perception and self-concept following diversion. The intertwining of professional identity and personal identity made the experience even more challenging, and their lingering shame was palpable within the interviews.

The issue of stigma and a spoiled identity created a vulnerability that shaped the nurses' behaviour following their addiction and diversion. For many, working through changes in their self-concept involved an element of social redemption. There was the suggestion that their addiction had broken a social contract and the nurses spoke of acts and behaviours to try to atone for their misdeeds. This linked back to notions of purity and self-giving within the profession. Indeed, traditional nursing ideals influenced the behaviours of the nurses, and religious undertones appeared within their narratives, evoking image of a time when nursing was closely associated with Catholic morals and values. This imagery became even more evident when

nurses spoke about their *calling* and *devotion* to nursing work, terms often used in religious contexts in which individuals express their divine calling to serve God. This type of language and approach to nursing work demonstrated the power of these dominant discourses upon contemporary nursing practice, as well as its influence on the participants as nurses. Furthermore, this theme persisted with notions of forgiveness woven into their stories. During the interviews, the nurses discussed the condemnation of people who misuse substances, and what followed was a deep desire for redemption as they engaged in actions in an attempt to repair their image and regain their social standing.

The notion of being *good* following their experiences with diversion was one method for the nurses to manage stigma. This was attempted in different ways, including their behaviour during the ATD programs as well as in their return to work. Being good was relevant to how the nurses tolerated the ATD programs whereby despite their extensive and demanding nature, all the nurses participated with an absence of complaints or criticism. The nurses largely kept their reservations about the programs to themselves. One nurse described this as her “penance” for engaging in diversion. Their reluctance to voice any concerns about the ATD programs stemmed from multiple fears intertwined with their altered identities. Some expressed fear that any form of questioning or challenging the requirements of the program might be misconstrued as a lack of humility. More importantly, many of the nurses had internalized beliefs that they did not deserve the privilege to voice complaints or any discontent about the programs. Their sense of tainted status, arising from the stigma of addiction and diversion, permeated their perception of self-worth, hindering them from feeling entitled to express grievances about the programs. This emotion perpetuated their compliance despite concerns and reservations. Consequently, a pattern emerged whereby many of the nurses opted to follow all the program requirements, even those

that they were fundamentally opposed to, to avoid further scrutiny or attention. Mandatory attendance at religion-based support groups is one such example whereby several nurses reluctantly participated despite concerns about the underlying message embedded in the programming. The feeling that they were no longer valued members of society intensified their hesitancy to address problematic components of the program, emphasizing the complex nature of social stigmatization and its effects on self-identity and self-expression.

The attempts to escape the stigma of addiction and repair a polluted identity was also addressed within the nurses' relationships with others. For the participants, this was an arduous task as they navigated both the cognitive and emotional labour of this reconstruction. Many of the nurses attempted to repair the damage this stigma had inflicted on their identity and social status. Professionally, the participants described a loss of respect from their peers and a sense of not belonging. They cited examples of workplace ostracism and gossip. This led to feelings of otherness, and the nurses grappled with beliefs that they were no longer valid and respected members of their profession. In addition, their professionalism was questioned, and they spoke of feeling devalued, dismissed, and thrown away. The nurses felt this separation fiercely. They attempted to overcome their perceived flaws to reverse this stigma, with some working harder and longer than colleagues to prove themselves. Within their personal lives, the nurses worked to be better parents, partners, and children, sharing their efforts to repair friendships and prioritize the rebuilding of trust. These attempts hinted at a belief that the nurses owed something to society, their actions a paying of debt. Yet despite great efforts, the desperate pursuit to shake off the stigma that followed them proved to be futile. Many attempted to revert to their pre-addiction selves, however they ultimately realized that while identity is easily spoiled, it is challenging and perhaps impossible to fully repair. Goffman (1963) spoke to this whereby,

despite much work and dedication, individuals are unable to fully erase their stigmas. Participants spoke of permanently altered family relationships, the loss of friendships, exclusion from their professional circles, and the tarnishing of their reputations.

The participants' experiences vividly illustrate the power of the stigma surrounding substance misuse, overshadowing all other facets of their identities. Despite the nurses' myriad of qualities and accomplishments, addiction and drug diversion became their defining features, and they were unable to erase this stigma. Being reduced to this single factor was a long-term struggle for the participants. Through their narratives they conveyed the profound effects of stigma and how difficult it has been to come to terms with their substance misuse. The nurses expressed disbelief at how addiction had controlled their behaviours, particularly surrounding workplace diversion, as well as actions whilst in active addiction.

While highlighting the power of addiction was crucial, there was also a noticeable element of justification whereby the nurses explained the circumstances leading to their diversion. Each interview revealed a significant amount of time recounting the life events and experiences that precipitated their opioid addiction. They cited physical, psychological, and genetic factors, as well as workplace stress and fatigue which impacted their health and their relationships. This effort seemed aimed at challenging the identity that was imposed on them by themselves and others. By rationalizing their substance misuse, the participants distanced themselves from others who are socially condemned for their addiction. The creation of a separate category for them highlighted their opioid addiction as different, and perhaps more *valid*. While possibly an unconscious attempt to protect themselves or reclaim their former identity, it underscored the participants' sensitivity to stigma surrounding addiction and diversion.

This response of differentiation and setting themselves apart was significant as it simultaneously maintained the stigma and reinforced the societal belief that substance misuse indicates moral deficiency. This dynamic was particularly intriguing given that the interviews took place in a supportive environment, devoid of judgment and blame. This was unlike settings they might experience otherwise when discussing diversion and addiction, yet there was still a move for the participants to clean up their image which has been tainted as a result of this experience. This illustrates the enduring influence of stigma. Despite being a significant factor in the experience of the nurses from various perspectives, their inclination to continue stigma management in a non-stigmatized setting highlights its longevity and influence.

The impact of stigma varied among the study participants. Some displayed a greater capacity for self-forgiveness and had sought counselling and support to move forward. Others were overcome by shame, struggling to accept their altered self-concept. This was tangible in the interviews whereby despite lengthy periods of sobriety, some nurses were still actively grieving their former identities. Their sense of division became strikingly clear through a poignant metaphor shared by one nurse. Mia vividly likened her situation to being stained, symbolizing not only a visible difference, but also suggesting a blemish or smear that marked and tainted her entire identity. Her acknowledgment of the perceived inability to remove this stain was a heartbreaking admission, highlighting the deep internalization of their differences by the participants. Ultimately, the nurses found themselves viewing their identities through a different lens following their addiction. Despite their efforts at action, justification, or self-forgiveness, they have been unable to fully restore their previous sense of self.

## Chapter 7: Conclusion

This study has addressed a notable gap in the literature by delving into the experiences of nurses involved in opioid diversion and misuse. Rather than concentrating solely on individual risk factors or optimal management strategies for such individuals, this study has uniquely allowed nurses with personal experience to share their stories. This approach offers a much-needed comprehensive understanding that is often absent in discussions about diversion. Despite the sensitive nature of this topic, there is a need to recognize and acknowledge the prevalence of this issue within nursing practice. Addiction and diversion place nurses at risk for morbidity and mortality, and they can have far-reaching consequences upon community health, the reputation of healthcare facilities, and trust in the profession of nursing. Therefore, it is essential to recognize this persistent and sensitive issue.

Exploring addiction and diversion within healthcare facilities was an important aspect of this research as these remain significantly under-addressed. The reluctance to openly acknowledge addiction stems from its taboo nature, influencing the way this problem is approached. This was demonstrated in the interviews whereby the nurses shared the lack of comprehensive formal or continuing education on this issue. The pervasive silence surrounding addiction, coupled with inattention to diversion within healthcare environments, exacerbates the issue. Failing to recognize and openly acknowledge drug diversion within the profession can intensify the problem by fostering continued silence and hindering opportunities for self-disclosure. Moreover, this lack of dialogue contributes to the perpetuation of misconceptions about addiction. Many participants spoke of an alarming lack of understanding of chemical dependence, and the persistence of moralistic beliefs surrounding substance misuse. This was especially relevant in this study whereby the social intolerance of opioid addiction was worsened

by stereotypical images and beliefs about nurses. The absence of open and honest discussions about addiction fuels prejudices and discrimination toward individuals grappling with this issue. Finally, there are dangerous repercussions to this silence as opioid addiction and diversion are issues that threaten the health and safety of nurses. When cases of diversion do occur, nurses are swiftly removed from practice under a veil of secrecy. This leads to missed chances to address diversion in a candid way and preventing opportunities for nurses to be open and seek support. This silence also leads to a lack of awareness of the ATD programs, leaving nurses to feel there is nowhere to turn and no way out.

Comprehending the nature of addiction is crucial to move beyond views of diversion solely rooted in blame. The study highlighted the need for better awareness of the power and potency of opioids and other mind-altering substances. This includes their ability to alleviate both physical and psychological distress, along with the formidable challenge of discontinuing their use once addiction or dependence takes hold. The condemnation surrounding diversion emerged as a key focus of this study, whereby it drew backlash and criticism from numerous angles including regulatory boards, employers, colleagues, family and friends, and the public. Outsiders were primarily concerned with the act of diversion, often questioning the nurses' suitability for their profession. The study revealed a lack of recognition that diversion was a consequence of addiction. It was crucial for the nurses to communicate to others that their involvement in drug diversion directly stemmed from their addiction, compelling them to engage in behaviours that contradicted their ethical principles and personal beliefs. The need to encourage a true understanding of addiction, both inside and outside of the healthcare field, was an important finding.

This study shed light upon the inherent demands and ongoing challenges within nursing profession, and how they affect the health and safety of nurses. The nurses described conflicting priorities such as requirements to discharge patients promptly, meet budgetary constraints, and simultaneously achieve high levels of patient satisfaction. This relentless pace often left them feeling stretched thin, contributing to fatigue and burnout, and the nurses struggled to find ways to cope. There were also concerns regarding the way nurses treated one another in the workplace. The lack of peer support was broached as well as workplace bullying, shaming, gossiping, and incidents of nurses “eating their young”. They shared the emotional struggles they experienced due to their work and highlighted how the culture within nursing can neglect the psychological health of its members. The nurses emphasized these types of emotional responses were shared by many others in their profession, painting a picture of a profession filled with individuals who are exhausted, discontented, and are engaging in overeating, overspending, smoking, and other unhealthy behaviours as they try to cope with the psychological burden of nursing work. This includes managing an ongoing flood of emotions such as resentments, fears, and traumas. In fact, a key revelation from this study was how nursing work contributed to their addiction and diversion.

Within the existing nursing literature, there is a growing suggestion that substance misuse should be redefined as an occupational hazard. This is not only due to environmental factors, such as ongoing access to various medications, but also in relation to the unique nature and stressors inherent in nursing work. Importantly, none of the study participants had been informed about the heightened risks of substance misuse associated with their occupation and were previously unaware that drug diversion posed a specific hazard within their field. Drawing attention to this issue was a theme that was presented time and again. Identifying and addressing

these professional risks is critical as the study participants acknowledged the link between their nursing duties and their substance misuse. There was a lack of safe spaces for nurses to express their vulnerabilities and imperfections and they were discouraged from sharing concerns about their work or voicing their reactions to emotionally burdensome encounters. The connection between the nature of nursing work and the misuse of substances was apparent in this study. Feeling the weight of the expectations upon them and being prevented from sharing the load of these burdens contributed to mental distress within their profession. This proved to be true as several of the participants in this study shared that their workplace stress was a factor in their misuse of substances. The participants also reflected on the underacknowledged responsibility of employers to support staff, speaking to the need for resources such as peer supporters, on-site addiction support meetings for staff, improved access to counselling, and work environments that foster respect and appreciation for staff. Other suggestions surround improvements to structural factors within the healthcare system including ongoing vacancies, lack of vacation time, low autonomy, adequate health insurance, use of sick time, and wage concerns (McMillan et al., 2021; Stelnicki et al., 2020).

The way in which nurses experience the ATD programs was also a key finding. Beyond recovery rates, this study looked more deeply into how nurses return to the profession following opioid diversion. Undoubtedly, the establishment of the ATD programs has been a step in the right direction and the recognition of addiction/SUD as a health condition has assisted nurses to return to practice. Yet, from the stories of the participants, these programs could be greatly improved upon. There were numerous concerns raised regarding the ATD programs which spanned from the start of their experiences to their return to work and beyond. Early on, the nurses felt barred from providing any sort of feedback about their experiences. Instead of

leveraging their expertise to offer feedback and insights to help others, the nurses were compelled to return to work in a humble and unquestioning way. This suppressed their potential contribution to addressing addiction-related issues within the profession.. In the context of these interviews, a notable transformation occurred as the nurses were able to freely share their concerns and suggestions without the fear of repercussions. This was important as, while their experiences with the programs were either over or close to completion, they were concerned about others to come. This environment allowed them to share their honest perspectives and engage in constructive dialogue in a way that advocated for the well-being of those in their profession. Initially, many nurses were not informed about the existence of ATD programs and had to proactively seek out assistance, leading to missed opportunities for early support. Most assumed that revealing their addiction and diversion would inevitably result in job loss and license revocation, fueling a culture of secrecy. Upon entry into the programs, the nurses expressed profound dissatisfaction with various aspects and requirements including demands for excessive medical information, urine testing challenges and costs, lack of individualized approaches, and prolonged treatment programs. The five-year program period held great importance for the nurses, and many spoke of their anticipation of the end date. This stood out as addiction is a chronic health condition and it was expected to span beyond program completion. In reality, it was an end to the program itself that the nurses truly desired. In addition, despite the programs' stated intention to be nonpunitive, some of the nurses described being terminated from their positions, fined, and even facing criminal charges. The nurses were motivated by their own struggles to advocate for changes to alleviate the challenges and financial burdens associated with the ATD programs.

Beyond the varied program concerns addressed by the nurses, there was a strong emphasis on the lack of support within the ATD programs. The nurses pointed to elements within these programs that suggested rehabilitation and reintegration were not their genuine intent. This increased their feelings of being discarded by the profession. While the programs are touted to support nurses with addiction with their re-entry to practice, many of the participants viewed these efforts as mere tokenism. They voiced skepticism that the ATD programs were truly designed to help nurses, finding the processes punitive and detrimental to their recovery. In addition, although not all nurses went to this extreme, some perceived the programs as vehicles for humiliation and public shaming. In these cases, there was a belief that the programs were intentionally designed to make nurses fail, casting doubt on the sincerity of nursing boards in their purported goal of reintegrating affected nurses. This study identified areas of the ATD programs that could be improved upon to foster safe returns to work for affected nurses. Genuine support and assistance could target the fear and apprehension toward regulatory boards that was frequently described in the interviews. While ATD programs have been meaningful progress within the domain of addiction, they require restructuring to ensure they do not harm or penalize nurses. This study pointed out the importance of ensuring addiction is acknowledged as a health condition by regulatory boards and the response is centered on therapeutic measures.

The manner in which nurses experience opioid addiction and diversion was another key feature of this study. The results were numerous including legal, professional, social, and financial impacts. The psychological impacts, however, were the most prominent within the nurses' narratives. As discussed, the concepts of taboo and stigma significantly influenced the nurses throughout their experiences. Taboos exerted an effect on their work dynamics, dictating not just their responses to workplace challenges but also the extent to which they were supported

and allowed to reintegrate into their professional roles. Furthermore, the taboo nature of substance misuse and diversion by nurses had powerful repercussions on how the nurses belonged in the world. What was termed the throwaway nurse syndrome by Bissell and Jones (1981) held true for the nurses in this study decades later. Stigma cast a shadow over the nurses' sense of self, fundamentally altering their self-perception in the wake of opioid diversion and addiction. The nurses were shunned, othered, devalued, ostracized, and excluded. Their morality and characters were called into question and their reputations were forever altered. These responses impacted the participants' sense of belonging, leaving them feeling like outsiders at work and in their personal lives. The nurses demonstrated ongoing guilt and shame and spoke of feeling isolated, alone, and different from others.

The culture of blame towards individuals who misuse substances was a significant influence on the nurses. While the stigma surrounding addiction was already present, the participants' experiences with addiction were unique because of their specialized profession. Nurses are expected to uphold a certain image and conduct themselves in an appropriate manner, inside and outside of the workplace. As drug diversion and addiction are contradictory to their professional expectations, this led to profound effects as their identities were deeply intertwined with their professional roles. The study shed light on how the nurses confronted external judgment. In addition to outside sources of stigmatization, the nurses also grappled with changes in how they viewed themselves after addiction. Reflecting on their acts of diversion proved challenging for the nurses. Many participants shared their stories with disbelief and horror, vocalizing a deep disconnect between their actions and their personal principles and values. Many struggled to reconcile their actions with their core beliefs, underscoring the pervasive

nature of this stigma and the deep-seated tendency to associate addiction with moral and ethical failure.

Finally, while each nurse had their own experience, there were common threads of similarity in their narratives including personal histories and experiences that culminated in addiction and diversion. In addition, this study revealed the way each individual was irreversibly changed by their experience. Prior to their diversion, many were caught up in the doing and the being of a nurse, fixating on this role within their identity and wondering who they were otherwise. Losing the ability to practice nursing was a devastating blow when their opioid diversion became known. However, with time and healing, many were able to shift the focus of their identity away from their work, encompassing other important aspects in their lives. With this came the realization that nursing was a job they held, not the sum of one's identity.

Their journeys varied and were impacted by their years of sobriety and other factors, yet all the nurses spoke of some altered perspectives, lessons learned, and changes made. Of relevance were their reflections on the nature of nursing as a profession and the risks inherent in the work. For the participants, workplace stress activated or provoked their underlying issues with substances and opioids were sought out to improve their psychological state and provide a brief respite from the ongoing physical and emotional exhaustion associated with their work. As the nurses described their lives, their pain was palpable. The true toll of nursing work on the participants was visible when they spoke of their new lives away from acute care. They were happier and healthier in lives away from acute care which included regular sleep schedules, more time with family and friends, consistency in their daily routines, less musculoskeletal pain and injuries, less conflict with colleagues, and more sustainable workloads. They spoke of positive outcomes in terms of their mental and physical health, their relationships with friends and family,

and their enjoyment of their new nursing roles. Although many had previously believed their jobs would remain unchanged, these experiences led them to embark on new professional pathways. Their time away from their work gave them a space to think more critically about their profession, which ultimately brought them into better places both personally and professionally. They detailed various factors that had previously impeded their progress, including entrenched beliefs about the nature of nursing and which roles were deemed most significant or valuable. The nurses were able to gain clarity, including letting go of some of these more restrictive aspects and ideas about nursing. For many, this involved acknowledging that being away from acute and/or direct patient care did not diminish their status as a nurse. A greater perspective emerged from a rethinking and reconciling of the role of nursing in their lives, allowing them to see the effects more clearly. In addition, with time came levels of self-forgiveness, a crucial step to healing and moving forward. This was a challenging process marked by loss and distress. The theme of being thrown away by the nursing profession when they were at their most vulnerable was particularly painful. Yet through resilience and efforts, the participants successfully reevaluated and altered long-held beliefs about their nursing identity.

All nine nurses were in stable long-term recovery at the time of the interviews and continued to practice nursing. Each described the changes to their lives that had followed their experience. This included professional changes, such as Beth who was working in a substance *abuse* facility where she described deep connections with the individuals in her care. Darby was months away from completing her contract and was considering the pursuit of post-graduate education to advance her career. Jessica found employment in long-term care and had developed a deep appreciation for this type of nursing, one she had previously looked down upon. The nurses also recounted positive changes that had transpired within their personal lives which they

attributed to what they had been through. Some considered their experiences with addiction and diversion essential in enhancing their personal lives and overall health. The nurses shared their personal progress and achievements. Sara, for instance, received help through years of counseling, psychiatric assistance, and medication changes, which enabled her to make positive changes. This included improved relationships with her partner and close friends. David shared plans to pursue personal happiness and the decision to leave an unfulfilling marriage. Other nurses spoke of changes to their families including Mia who was on parental leave and enjoying the opportunity to be home with her baby son. Jessica shared that her struggles with infertility resolved in sobriety, and she gave birth to two children during her five-year ATD program. She shared gratitude not only that she was able to conceive, but also to have substance-free pregnancies. Furthermore, she found peace and simplicity in daily life with her family and acknowledged that her struggles were necessary to get better. She summarized that she “had to go through it all to end up here” (Jessica).

Despite the challenges they faced, these participants were grateful for the opportunity to confront and overcome unhealthy cycles. These developments demonstrated how the nurses had been transformed by their experiences, gaining new perspectives and priorities. For the nurses, sharing their stories required tremendous courage. Many became visibly emotional when recounting their ordeals, and their ongoing shame and guilt was evident. Nevertheless, their unfiltered honesty and willingness to open up provided valuable insight into a dangerously underacknowledged issue within nursing practice. While many of the nurses have managed to derive positive outcomes from challenging experiences, it is important to emphasize their stories are not over. This study has captured a moment in time, recognizing that addiction will be an enduring challenge for the participants. While the ultimate trajectory of their stories remains

uncertain, there is hope that these individuals will continue to lead fulfilling lives and successful nursing careers in sobriety.

Finally, when considering the nurses as a group, what stood out was a profound need to be understood. Drug diversion is an extremely sensitive subject and most participants lacked opportunities to speak freely about their lived experiences. Although some voiced a cathartic effect from being able to speak openly about their experiences, these interviews delved into deeply personal and distressing territory. As they shared their stories, many expressed false narratives had followed them in their recovery from opioids and they appreciated the opportunity to correct these mistruths. As the nurses spoke about this time in their lives, what resonated was the profound transformation brought on by their drug use. They described the deep and distressing changes that accompanied their substance misuse until they were unrecognizable to themselves. They spoke of the darkness they lived in whilst in active addiction, and how they were driven to unthinkable acts. This included crossing the line into drug diversion, an act that the nurses were ethically opposed to. In the interviews, the nurses recounted their altered priorities, dangerous behaviours, and skewed beliefs during this period. Retrospective horror and disbelief at their diversion and other drug-related acts was evident as they described how they were slowly consumed by their addiction. Their narratives challenge the notion that addiction stems from inherently bad individuals engaging in wrongful actions. Instead, the study portrays addiction as a manifestation of fallible humans coping with life's stressors in their best way possible given their available resources. It also challenges the discourse that flawed nurses are the problem, drawing attention to the erroneous perception that drug diversion is merely a matter of theft by individuals unsuitable for the profession. This common perception places the focus on the acts, diversion and opioid misuse, minimizing the complexity of this issue and concealing

what led to these taboo things in the first place. The social judgment they experienced was painful and many nurses found it unfair and unjustified. In addition, rather than being cast aside or thrown away by their profession, they hoped for themselves, and others suffering with addiction, to be folded in. This study demonstrates the need for support and understanding in these cases because nurses can, and do, get better and return to the profession. The participants demonstrated their strength and resilience as they battled personal shame and social judgment and fought to return to their profession. Finally, above all, they had a powerful desire to simply be heard and sharing their lived experiences was a way to promote a more compassionate and nuanced understanding of addiction and diversion within the nursing profession.

### **Chapter 8: Limitations and Recommendations for Future Research**

This study was limited by the female-dominated participant sample as only one male nurse participated in the study. In addition, there was an absence of BIPOC participants. This study also looked at nurses in Canada and the US based on the similarities between the return-to-work programs in these two countries. Nurses from outside these locations were not recruited and this limited the global perspective of opioid diversion in nurses. In addition, nurses who sought private treatment for addiction unbeknownst to their employer were not included. This was related to concerns that they would not have participated in the ATD programs and therefore would be unable to provide their reflections on how these programs are experienced.

Some recommendations for future research are to delve deeper into the stigma surrounding addiction within healthcare facilities, particularly the perpetuation of this stigma. In addition, further investigation into the ATD programs is required to determine the most successful way to help nurses return to safe and meaningful work. Highlighting the reality of working in the nursing profession is another recommendation for future research. The nurses in

this study spoke at length about workplace stressors, identifying their lack of space to engage in these conversations otherwise. Looking directly at how nurses experience their work can identify methods to better support nurses and suggestions for changes to improve the work for this within this profession.

Finally, it should be noted that since the commencement of this study, Ontario has launched the Nurses' Health Program which seems to have a more supportive orientation, designed to help nurses rather than penalize them. It offers the benefits of confidentiality and prevents the public posting of restrictions on licenses. However, it remains unclear if their programming has similar restrictions and requirements as their website does not provide details on program operation.

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## APPENDIX A – Recruitment Poster

## Nurse Participants Required for Research



**Nurses who have engaged in  
opioid diversion are being sought  
to share their stories**

### Why are we studying this?

Drug diversion is an ongoing concern in North American healthcare institutions and impacts the lives of nurses who divert. Despite the prevalence of this issue, drug diversion is taboo and is rarely acknowledged by the nursing profession. For this reason, this population of nurses often lack the space to share their experiences.

### What does this study involve?

Participating in a private interview to share your experiences (approximately 60 – 90 minutes in length) and the possibility of participating in a follow-up interview.

### Who can participate?

All nurses who have diverted opioids from their workplace and have since returned to nursing practice are invited to join this research study. Participants will be given a gift card of \$50 as a token of gratitude.

This study will be conducted in English. All participants will be selected on a first come basis up to a maximum of 15 participants.

**For more information or to join this study, please contact the primary investigator:**

**Natasha Gordon, RN, MScN, PhD(c)**

**University of Ottawa, Faculty of Health Sciences, School of Nursing**

This study is supervised by Dr. Brandi Vanderspank and Dr. Amélie Perron and has been reviewed by and received ethics clearance through The University of Ottawa's Health Sciences and Science Research Ethics Board.

## APPENDIX B – Consent Form



Université d'Ottawa  
Faculté des sciences  
de la santé  
École des sciences  
infirmières

University of Ottawa  
Faculty of Health  
Sciences  
School of Nursing

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## Consent Form

“The throwaway nurse syndrome: Examining the Lived Experiences of Nurses who Divert Opioids”

**Principal Investigator:**

Natasha Gordon, RN, MScN, PhD(c)  
Faculty of Health Sciences, School of Nursing  
University of Ottawa

**Supervisors:**

Brandi Vanderspank-Wright PhD RN CNCC(C)  
Associate Professor  
Faculty of Health Sciences, School of Nursing  
University of Ottawa.

Amelie Perron  
Full Professor  
Faculty of Health Sciences, School of Nursing  
University of Ottawa

**Funding:** No funding has been received for this study

*Participation in this study is voluntary. Carefully review this information sheet and consent form before making a decision to participate. The research team is available to answer all of your questions related to participation in this study.*

**Purpose of the Study:** Drug diversion is an ongoing issue in healthcare institutions. This study aims to explore and describe the lived experiences of nurses who have returned to nursing practice following experiences with opioid diversion. This study is being conducted as part of the principal investigator's PhD Thesis.

**Invitation to Participate:** You are invited to participate in the above-named research study conducted by Natasha Gordon, Dr. Brandi Vanderspank-Wright, and Dr. Amelie Perron if you have returned to nursing practice following opioid diversion.

Brandi Vanderspank-Wright, and Dr. Amelie Perron if you have returned to nursing practice following opioid diversion.

**Participation:** Your participation in this study will consist of an audio-recorded in-person and/or online/telephone interview lasting approximately 60 to 90 minutes. During the interview you will be asked to reflect and describe your experiences surrounding diversion, removal from practice, and subsequent return to nursing practice. You will have an opportunity to review your transcript upon request.

**Benefits:** In partaking in this study, you will be able to share your experiences that you may have lacked a space to openly discuss in the past. The findings from this study will contribute to developing a better understanding of substance misuse by nurses and how stigma affects their experiences.

**Risks:** It is possible that the discussion elicited during the interview may evoke painful thoughts or memories specific to your substance misuse. If you are feeling emotional and/or fatigued from sharing your experiences, the researcher conducting the interview will offer to take rest periods as needed and will ascertain your willingness to continue with the interview and will seek to terminate the interview should your emotional integrity be compromised. In addition, resources will be offered should you find yourself triggered to misuse substances. These resources include AA/NA groups, the Rapid Access Addiction Medicine (RAAM) clinic, AccessMHA, and employer-funded EFAP programs.

**Confidentiality and Anonymity:** The information that you will share will remain strictly confidential and will be used solely for the purposes of this research. Only the researchers will have access to the research data. It is possible that quotes from your interview will be used in

future publications and presentations related to this research. In this instance, your anonymity as a participant will be protected with a use of a pseudonym.

*I agree to be quoted but all personally identifying information shall be removed or altered and contents of the quote shall not be revelatory of my identity. \_\_\_\_\_*

*I do not wish to be quoted at all. \_\_\_\_\_*

**Conservation of data:** All data (digital recordings and electronic copies of the researcher's notes and transcribed interviews) will be kept securely, stored in password protected electronic files and a secured cabinet in the researcher's office for a minimum period of five years at which time they will be destroyed.

**Compensation (or Reimbursement):** A \$50 pre-paid VISA gift card will be offered as a token of gratitude for participation in this study. You will still receive this compensation should you choose to withdraw from the study. All costs of telephone interviews will be incurred at the expense of the researcher.

**Voluntary Participation:** You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw your data will not be used. The electronic files of your audio-recorded interview and transcribed interview will be deleted.

**Information about the Study Results:** Information about the study results will be made available to the participants upon publication of the results. If you have any questions or require more information about the study itself, you may contact the primary researcher or the supervisors at the number mentioned herein.

**Telephone Consent****Person reading the telephone script and consent form:****Researcher/Research Assistant Name:** \_\_\_\_\_**Researcher/Research Assistant Signature:** \_\_\_\_\_**Date:** \_\_\_\_\_

I [insert name of interviewer] have explained to the research participant the contents of the informed consent information letter and I have answered all their questions.

Do you [insert name of participant] agree to participate? Yes \_\_\_ No \_\_\_

Participant name: \_\_\_\_\_

Telephone number: \_\_\_\_\_

**Acceptance:** [Insert name of participant], agrees to participate in the above research study conducted by Natasha Gordon (Nominated Principal Investigator) of the School of Nursing, University of Ottawa, and Drs Brandi Vanderspank and Amelie Perron (Co-Supervisors) and has provided verbal consent.

Should you have any questions about the study, you may contact the researcher at the telephone number and/or email provided herein.

A copy of this consent form has been sent to you by email for your personal records.

If you have any questions with regards to the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON, K1N 6N5, tel.: (613) 562-5387 or ethics@uottawa.ca.

**APPENDIX C – Interview Guide**

1. Tell me about your experience of opioid misuse and diversion?
2. How did people react when they found out about your diversion and misuse?
  - a) at work (manager, peers)
  - b) in personal circles
4. How did you experience the return-to-work process?
  - a) what worked well in the process?
  - b) what parts of the process could be improved?
5. How has the regulatory college/healthcare institution responded to your diversion?
6. How has this experience shaped your perception of self as a nurse?
7. What have been the personal and professional impacts?
8. Do you disclose your diversion and misuse?
  - a) If not, how so? What would happen if people found out?
  - b) If yes, with whom, in what contexts? Are there any aspects of your experience that you still prefer not to disclose?
9. What would you do if you were struggling in your return to work?
10. What is next to come in your career and personal life?
11. How do you make sense of your experience with substance misuse?