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AANA Helpline Resource: Signs & Behaviors, Intervention Essentials, Treatment Recommendations, and Re-entry Criteria for Anesthesia Professionals

Signs & Behaviors to Identify Impairment and Drug Diversion

When behaviors are *significantly different* than a previous norm it may indicate the clinician has a substance use problem or another issue, which should be addressed sooner rather than later to reduce associated risks. The collective changes may be observed in behaviors or physical signs. Physical signs while more apparent, may not be visible until later in the disease progression because professionals hold high standards in the workplace.[3] Stigma, bias, fear of loss of licensure and career, and financial repercussions all contribute to a clinician's reluctance to use resources for help with at-risk substance use.[4] Unwillingness creates delays but similar to other diseases, early treatment offers the best possible outcomes.[4] Therefore, it's important for education across all disciplines in every healthcare workplace to know the signs and behavior indicating a problem and be ready to respond with a process of reporting when situations occur.[2,3,4] Some examples of signs and behaviors: [2,3]

- Behavior change: Decline in competence, questionable judgement, change in attendance, unprofessional communications or boundaries, new onset of severe mood swings, aggressiveness, defensiveness; isolation, avoids direct eye contact, disappearing during shift, changes in work schedule, i.e., coming in late or frequent absences may indicate drinking; arriving early or staying after everyone is gone may be drug diversion.
- Observed signs: Deterioration in appearance, i.e., newly disheveled appearance or starts wearing only long sleeves, unexplained weight loss/gain. Tremors or shaky hands, alcohol odor, bloodshot eyes.
- When drug diversion is occurring: Inconsistent recording of waste, increased use of medications compared to other providers, inappropriate drug choices and doses for patients, extended delays between pulling medications to dispensing and unnecessary intervals between use and wasting, facial bruises/fractures (specific to Propofol injection, sudden unconsciousness), refuses relief for lunch or break but frequent bathroom trips, discovered comatose or dead.

In the event suspicion or observation occurs, call the AANA Helpline 800-654-5167 for a full list of signs and behaviors and guidance on what to do next.

Conducting a Safe Intervention

In the event of suspicion or observation, a timely, safe, non-punitive, solution directed, and planned intervention provide the most appropriate response.[2,3,4] The planned intervention includes common components to collect the evidence, utilize a non-threatening multidisciplinary team approach, and provide follow-up after the meeting with the impaired and/or diverting clinician who is struggling with at risk substance use and requires external motivation to seek professional help. [2] In a planned intervention, securing a treatment provider with supportive details, such as financial and insurance aspects to facilitate admission can be factors in a successful outcome of the clinician getting the needed care.[2] But gathering information should not delay acting when concern arises for provider or patient safety leading to an immediate/crisis intervention. [2] Either approach should be non-punitive, compassionate, and empathetic, supporting the afflicted clinician to take steps toward healing and well-being.[2,3] Whether planned or immediate, the AANA Helpline 800-654-5167 provides guidance and support for safe interventions. The Helpline can also share resources to develop a facility wide workplace policy and procedure to build a culture of well-being, mitigate drug diversion, and be ready to address situations as they occur. The following page provides basics on planned and crisis interventions and a table of intervention essentials.

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Planned Versus Crisis Intervention[2]

Call the AANA Helpline 800-654-5167 for guidance and assistance.

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

Intervention Dos and Don'ts[2]

What to Avoid	***What to Do***	***Rationale***
Conducting an intervention alone	Utilizing a multidisciplinary team approach	For your safety, the safety of the provider, and the integrity of the discussion, utilize a team approach.
Be accusatory and threatening in tone	Utilize an empathetic and understanding tone	Avoid cultivating a situation where the provider will become defensive
Leaving the provider alone	Develop a plan for family or friends to be notified after the intervention	Suicide and self-harm feeling are possible during this very vulnerable peri-intervention time frame
Explaining the suspicious activity in detail	Be general in your description of the events leading up	Asking the provider to "explain" your suspicions will likely not result in a truthful answer and will not reveal all your information
Avoid diagnosing and speculation "We think you may be an addict/alcoholic"	Utilize a general concern of "fitness for duty."	By keeping the concern general, the stigma associated with mental health and addiction can be avoided
Allowing the provider to quit the job and walk out of the intervention	Preempt the participant from quitting or walking out by informing them of the reporting requirements if they do so.	The provider is much more likely to participate if the alternative will result in an adverse outcome

After the intervention can be an especially stressful time for colleagues, especially a whistle-blower, be sure they address their own well-being and seek emotional support as needed.

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Treatment Recommendations for an Anesthesia Professional[1]

Due to their direct access to potent drugs and knowledge of pharmacology, anesthetists present unique challenges for treatment and recovery compared to other practice specialties. They also face potential loss of profession, professional guilt and shame, and a tendency to intellectualize the treatment process. Because returning to use with highly potent anesthetic drugs has such a high risk of a drug related death, it's important to get treatment right the first time.[8]

The most desirable treatment program has:

- Experience treating healthcare professionals' personality styles and "other nuances." [7]
- Offers a minimum of 28-30 inpatient or partial hospitalization with residential programs available, followed by aftercare program of at least 60 days.[7]
- Approval by the state board of nursing.
- A cohort-specific option where peer understanding can help bring about adequate self-disclosure to address past substance-related behaviors.[7]
- A comprehensive evaluation and treatment recommendations by an American Society of Addiction Medicine (ASAM) member certified by the American Board of Addiction Medicine (ABAM) who is committed to evaluating and treating anesthesia professionals in abstinence-based recovery models in accordance with other safety sensitive occupations such as aviation, department of defense and department of transportation.
- Evaluation by an American Academy of Addiction Psychiatry (AAAP) board-certified addiction psychiatrist where appropriate
- Appropriate neuropsychiatric and or psychometric testing
- Medically supervised detoxification, when clinically indicated.
- Treatment for mental health comorbidities.
- Family program, family/loved one's support.[7]
- Emphasis on a long-term 12-step model of abstinence-based recovery
- Evaluation of suitability for, and timing, of the return to anesthesia practice

Reentry to Clinical Practice[1]

"The path to recovery is individualized. It is greatly impacted by the severity of the SUD and the recovery capital available."[5]

According to recent studies, following completion of treatment course for SUD, once abstinence and recovery is well evidenced and risk of return to use is assessed, discussion can begin for a safe return to practice following considerations.[6] Recent studies indicate a factor for success is when monitoring for accountability is included, and a rigorous relapse prevention program can make long-term recovery possible. [5]

Intensive treatment following recommendations specific to anesthesia professionals (listed above) and subsequent participation in aftercare for healthcare professionals as well as the state's alternative to discipline monitoring program are the most important factors for consideration for an individual's return to work in anesthesia supportive of their continued recovery**.** Upon meeting these factors, a safe return to work in anesthesia can be facilitated on an individual basis. Not all practitioners will be able to return to practice.

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The readiness for reentry is a collaborative decision of the state licensing board, the state monitoring program, an addiction professional from the current aftercare program, and the employer. The following criteria should be considered prior to re-entering practice:

- Evaluation by a licensed provider with experience treating substance abuse and dependency.
- Successful completion of a treatment program and commitment to follow aftercare recommendations. [6]
- Acceptance of the chronic nature of substance use disorder.
- Evidence of a supportive spouse, significant other, or other supportive individuals
- Willingness to take Naltrexone, if appropriate, under direction and supervision of medical professional
- Having no untreated psychological comorbidities
- Participation in a monitoring program with random drug testing.
    - Recovery is improved when random drug testing occurs because of the consequences of a positive test.
    - Five-year duration of monitoring with the potential of monitoring for the duration of clinical practice
    - Having supportive colleagues in a recovery friendly environment; administrators and supervisors at worksite are familiarized with history and needs.
    - Grounding in a recovery community, such as Anesthetists In Recovery
    - Participating in a 12-step program
- Because anesthesia professionals are engaged in safety-sensitive work with considerable consequences when errors occur, abstinence-based recovery and refraining from substitute treatments such as buprenorphine are recommended.

There can be many barriers for the provider to return to work, knowledge of the challenges and a recovery friendly workplace with education, acceptance, and established boundaries can reduce encountering stigmatization, guilt, remorse, or shame and lessen the threat of relapse.[5]

References:

1. Excerpted from American Association of Nurse Anesthesiology (AANA) Position Statement and Policy Considerations, Addressing Substance Use Disorder for Anesthesia Professionals, May 2021 with additional updates as noted by citations.
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7. Early PH. Persons in Safety-Sensitive Occupations. In: Mee-lee D, ed. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.* 3rd ed. Carson City, NV: The Change Companies; 2013:340-349.
8. American Association of Nurse Anesthesiology (AANA) Position Statement, Addressing Substance Use Disorder in Anesthesia Professionals, August 2021.

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