American Academy of Nursing on Policy

American Academy of Nursing Expert Panel Consensus Statement on leveraging equity in policy to improve recognition and treatment of mental health, substance use disorders, and nurse suicide

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ARTICLE INFO

Article history:
Received 17 August 2022
Received in revised form
2 March 2023
Accepted 9 March 2023

Keywords:
Nurse suicide
Substance use disorder
Mental health
Well-being

ABSTRACT

Rates of nurse mental health and substance use disorders are high. Heightened by the COVID-19 pandemic, nurses are challenged to care for patients in ways that often jeopardize their own health and increase risks for their families. These trends exacerbate the epidemic of suicide in nursing underscored by several professional organization clarion calls to nurses' risk. Principles of health equity and trauma-informed care dictate urgent action. The purpose of this paper is to establish consensus among clinical and policy leaders from Expert Panels of the American Academy of Nursing about actions to address risks to mental health and factors contributing to nurse suicide. Recommendations for mitigating barriers drew from the CDC's 2022 *Suicide Prevention Resource for Action* strategies to guide the nursing community to inform policy, education, research, and clinical practice with the goals of greater health promotion, risk reduction, and sustainment of nurses' health and well-being are provided.

Cite this article: Schimmels, J., Groh, C., Neft, M., Wocial, L., Young, C., & Davidson, J.E. (2023, May/June). American Academy of Nursing Expert Panel Consensus Statement on leveraging equity in policy to improve recognition and treatment of mental health, substance use disorders, and nurse suicide. Nurs Outlook, 71(3), 1–13. https://doi.org/10.1016/j.outlook.2023.101970.

Introduction

The COVID-19 pandemic exacerbated an existing but rarely acknowledged mental health crisis in the nursing profession: an epidemic of deaths of despair from suicide, drug overdose, and depression. Nurses experience problematic rates of depression, anxiety, substance use disorders, post-traumatic stress disorder, and burnout (Maqbali et al., 2021; Choflet et al., 2021 ; Melnyk et al., 2020; National Academies of Sciences, Engineering, and Medicine. (NASEM) 2019; Pappa et al., 2020 Schuster & Dwyer, 2020; Strobbe & Crowley, 2017). The problem of inequitable recognition and treatment of mental health issues among nurses exists despite an emphasis on personal health and well-being as central to professional life in the American Association of Colleges of Nursing's (AACN) *The Essentials: Core Competencies for Professional Nursing Education* (American Association of Colleges of Nursing 2021) and *Code of Ethics for Nurses* from both the International Council for Nurses (ICN) (2021) (International Council of Nurses 2021) and American Nurses Association (ANA) (2021). Indeed, nurse self-reported burnout has increased 350% since the summer of 2020 (American Nurses Foundation, 2021). An American Nurses Foundation (ANF) survey of 4912 nurses reported 35% of nurses who said they were not emotionally healthy and 42% indicate they have experienced some form of trauma. Similarly, the *National Plan for Health Workforce Well-Being* (National Academy of Medicine, 2022) recognizes burnout as a barrier to health care worker professional well-being. The deterioration of mental health of the nursing workforce with the pandemic is disturbing given that nurses were previously found to be at greater risk of suicide than the general

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https://doi.org/10.1016/j.outlook.2023.101970

population prior to the pandemic (Choflet et al., 2021 ; Davidson et al., 2020; Davis et al., 2021; Patrician et al., 2020).

The purpose of this paper is to examine the background for increased mental health concerns among nurses and provide recommendations among clinical, policy leaders, and scholars from Expert Panels of the American Academy of Nursing about actions to address risks to mental health and the factors contributing to nurse suicide. Drawing from the Centers for Disease Control and Prevention (CDC) *Suicide Prevention Resource for Action Framework* (2022), recommendations are aligned with the seven strategies for action at the individual, health system, and national levels.

Background

Nursing requires physically and emotionally exhausting work which varies over time and across settings. Persistent levels of energy expenditure at work contribute to burnout, moral distress, and a host of serious psychological consequences (ANF, 2021; Dall'Ora, Ball, Reinius, & Griffiths, 2020). In 2017, National Academies of Sciences, Engineering, and Medicine (NASEM) identified clinician well-being as a significant problem, noting an epidemic of nurse and physician suicide (Dyrbye et al., 2017). During the ensuing years, the COVID-19 pandemic has magnified the mental health crisis. The *Future of Nursing 2020-2030* (NASEM, 2021) report warns of anticipated increases rates of nurse suicide and mental health (MH) problems and substance use disorders (SUD). COVID-19 pandemic-related survey information provides a snapshot of threats to mental health which occur when nurses are stressed (ANF, 2021). As the world faces an ongoing nursing shortage, coordinated, comprehensive, multi-level initiatives are needed to support and maintain nurses' health and well-being and retain them to the profession. Three drivers of suicide in the health care workforce are stigma, access, and the job environment (American Hospital Association, 2022).

Nurses have been slow to prioritize their own individual health and well-being, evident at discipline and system levels. Although the ANA, (2015b; 2021), ICN (2021), and AACN (2021) call for nurses to improve self-care and recognize the importance of well-being, there are few evidence-based means to support these endeavors. Actions are necessary at professional, organization, and state regulatory levels to impact the drivers of suicide and nurse mental health (Liaqat et al., 2020).

Drivers of Suicide in Nursing

Research suggests drivers of nurse and health care worker suicide fall into three main categories: (a) stigma associated with asking for and receiving treatment to support mental health, (b) job-related stressors, and (c) access to mental health treatment (American Hospital Association, 2022; Davidson et al., 2021). In a longitudinal investigation of nurse suicide, Davidson et al. (2021) identified that suicide occurred in nurses with known job-related problems, almost all of whom were unemployed (94%), and their unemployment was related to untreated and under-treated mental health issues, being processed for substance use disorders, and insufficiently managed pain due to chronic illness or musculoskeletal injury. The prevalence of MH disorders (including substance use disorders) in nurses have a substantial negative impact well beyond the individual level. Depressive symptoms, poor mental health, and burnout among clinicians have been observed to contribute to medication errors, poor quality health, patient dissatisfaction, reduced productivity, high nurse turnover, substantial individual and institutional financial losses, and increased cost of health care (Hall et al., 2016; Melnyk et al., 2018; Pereira-Lima et al., 2019; Salyers et al., 2017; National Academies of Sciences, Engineering, and Medicine. (NASEM), 2019; Willard-Grace et al., 2019).

Stigma

The psychological burden derived from a career in nursing is often compounded by ongoing stigma and punitive regulatory measures that prevent nurses from acknowledging mistakes and seeking treatment for mental health and substance use disorders (Choflet et al., 2021; Kunyk, 2015) . Stigma as a primary driver of suicide stems from fear that seeking MH or substance use disorder treatment may have a negative effect on the ability to renew or retain nursing licenses or credentials; feeling judged, unsupported, or perceived as weak; or concerns about confidentiality (AHA, 2022). Stigma is a complex dynamic that negatively undermines MH help-seeking behaviors and workplace environments (Knaak et al., 2014) . For a nurse, stigma may mean not being accepted by society, fear of exposure, limits on career advancement, and potential for loss of licensure if one seeks care. Stigma can inhibit disclosure and is additionally a barrier for nurses accessing resources.

The investigation of charges related to disordered behavior results in shame, shunning, and often abandonment by peers and colleagues (Litz & Kerig, 2019; Williamson et al., 2018). Publicly reported disciplinary action lists and voluntary (yet in actuality mandatory) license surrender policies applied to nurses are not common practice in other health professions. Public criticism and the social stigma related to disclosure of MH and SUD are significant (Weston & Nordberg, 2022).

The current disciplinary and reporting practices further stigmatize and marginalize nurses in distress (Weston & Nordberg, 2022) and create major barriers to help-seeking. Inequity in managing detection and discipline of nurses versus other licensed health professionals experiencing disorders of substance use

and other disruptions of mental health has long gone unaddressed. According to the 2020 Review of Licensure Survey (Smiley et al., 2021), 78% (45) of states ask about SUD on initial licensure for registered and practical nurses, 64% (37) ask about MH diagnoses, and 21 states limit licenses based on psychological impairments. Monitoring programs that use individual assessments of nurses' rehabilitative needs, including data on workplace conditions contributing to illness, are recommended to determine non-punitive courses of action for nurses with substance use disorders (Ross, 2021). While further research is sorely needed, risks to mental health undermine justice and equity principles, and enhance the cycle of alcohol, drug use, risk taking behaviors, reduced livelihood, and potentials for increased self- and other-directed violence (WHO, 2022a; 2022b). Safety, empowerment, equity, support, collaboration, and trust; trauma-informed care core principles (SAMHSA, 2014) are compromised when fear pursuing care is a threat that undermines nurses' ability to receive mental health and substance use disorder care (AHA, 2022).

Additionally, the *National Plan for Health Workforce Well-Being* (NAM, 2022) identifies stigma associated with seeking mental health services as a key goal by addressing compliance, regulatory and policy barriers for health care workers as priority areas to reduce burnout and foster professional well-being. Maintenance of outdated stigmatizing regulatory standards that mandate public disclosure of nurses' mental health problems not only violates patient privacy laws but exemplifies the inequities in how MH and substance use disorders are stigmatized (Weston & Nordberg, 2022). We posit that loss of license and employment is indeed punitive in nature, is now known to lead to death by suicide, and should no longer be a routine first-level intervention (Davidson et al., 2021).

Job Stress

Unhealthy work environments can compromise nurse' mental health. Workplace conditions such as inadequate staffing, lack of supplies, inability to provide quality patient care, and long hours increase the stress of job performance (Giménez Lozano et al., 2021). Personal and system-related factors also drive high nurse turnover and are associated with nurses' intent to leave/resign. Fifty percent of nurses who are considering leaving their current position cite personal mental health, burnout, moral distress, staffing issues, and system-related issues such as being unable to provide quality care due to pressures from administrators or insurers to reduce costs as reasons (Fumis et al., 2017; Ohue et al., 2021; Petrișor et al., 2021; Shah et al., 2021).

Nurses report feeling unsafe at work, often because they are inadequately prepared to respond to workplace violence and bullying (Al-Qadi, 2021). Long entrenched, systemic nursing hierarchies have supported the notion that patient violence, bullying, incivility, and lateral violence are part of the culture of nursing (ANA, 2017). Bullying and incivility have become ingrained in the profession and are often seen as a 'rite of passage' in the field (Crawford et al., 2019; Edmondson & Zelonka, 2019). Violence in the health care field is a pervasive and underreported problem worldwide and the pandemic has highlighted its greater prevalence in the nursing workplace (ANA, 2015a, 2017; Crawford et al., 2019; Teo et al., 2021).

Bullying, lateral violence, incivility, prevalent in nursing environments contribute to compassion fatigue and burnout, augmenting nurses' feelings of depression, unhappiness, and loneliness (Crawford et al., 2019; Eka & Chambers, 2019; Melnyk et al., 2020; Park & Kang, 2020; Stalter et al., 2019). Evidence-based strategies for prevention of bullying remain elusive despite wide documentation (ANA, 2015b; ANA, 2016; Bambi et al., 2019). Bullying behaviors are likely to be unreported primarily due to lack of faith in the system, no centralized policy for reporting, and fear of retaliation. The lack of leadership support or standardized processes to report such incidents further enable inaction and has negative outcomes for health care teams and organizations (ANA, 2016; ANA 2017; Crawford et al., 2019). Current policies implemented by health care employers have been ineffective and insufficient to address workplace violence (Al-Qadi, 2021). Ultimately, these circumstances have negative fiscal impacts on the facilities due to staff turnover and absenteeism (Crawford et al., 2019; Green, 2021).

The ANA (2015a) and the ICN (2000) have called for zero tolerance of these behaviors. Organizational policies related to bullying need to include evaluation for root causes with appropriate action planning which may include referral tor mental health services. Additionally, the *National Plan for Health Workforce Well-Being* (NAM, 2022) identifies creating and sustaining positive work and learning environments and culture as a priority area to reduce burnout and foster professional well-being.

The psychological ramifications of COVID-19 have additionally identified the health care system as a potential source of vicarious and repeated traumatic exposure for nurses (Schuster & Dwyer, 2020). Educated with altruistic traditions, nurses and other health care workers often struggle with placing the needs of patients before their own. Without structured evaluation of burnout in the context of other associated MH issues, serious treatable conditions like depression may be overlooked, which can lead to progression of symptoms, SUD, and suicide (Zisook et al., 2022). In addition, it is imperative to teach and develop nurses' skills to mitigate the effects of vicarious trauma (Schimmels & Cunningham, 2021). To address the trauma, SAMHSA issued a guideline for second victim support services (Busch et al., 2021). Once again, trauma-informed care principles such as safety, empowerment, equity, support, collaboration, and trust (SAMHSA, 2014) are compromised when fear pursuing care is a threat that undermines nurses' ability

to receive mental health and substance use disorder care (AHA, 2022).

Access

Wide state-to-state variation in substance use disorder treatment practices further diminishes equitable treatment (Smiley, 2021). Peer health assistant programs (PHAP), developed decades ago as alternatives and/or adjunctive to state regulatory discipline are offered in some states to support nurses with substance use and mental health issues (National Council of State Boards of Nursing, 2019). These appear insufficient as Pace et al. (2020) reported barriers to help-seeking among nurses who were current or former clients of a PHAP. The programs are often not used because fear, embarrassment, and concerns about losing one's nursing license inhibits contact. When nurses engage in treatment for SUD, leave of absence vs. termination is recommended by these authors as a more humane approach towards recovery; preserving hope for re-entry into the profession as loss of job and license prior to and during treatment has been associated with suicide (Davidson et al., 2020). The expectation of licensure surrenders and resulting public exposure are discriminatory. Inconsistent standards in PHAP programs from state to state, outdated metrics, limited focus on holistic care, insufficient funding, and limited quality monitoring in these programs, result in challenges to identification and best practices standards for the profession (Pace, 2020). Untreated SUD, threat of loss of employment or nursing license is associated with death by suicide among nurses (Davidson, et al., 2021). The *National Plan for Health Workforce Well-Being* (NAM, 2022) identifies supporting mental health for health care workers by eliminating barriers to seeking services as one of their priorities to reduce burnout and foster professional well-being.

Suicide prevention saves lives and reduces risk and incidence of suicide (CDC, 2022). Current evidence helps inform policy, education, research, and clinical practice recommendations with the goals of greater health promotion, risk reduction, and sustainment of nurses' health and well-being. Improved access to care will strengthen the tenets of trauma-informed care to provide nurses with safety, empowerment, equity, support, collaboration, and trust (SAMHSA, 2014).

Recommendations

Federal policy changes are needed in addition to resources for the individual nurse. Mitigating the psychological harm experienced by nurses requires a bundled approach as suggested by the National Academy of Medicine's *National Plan for Health Workforce Well-being* (2022). Such an approach includes creating and sustaining a positive work environment; investing in measuring, assessing, and research to improve well-being; supporting mental health and reducing stigma; investing in effective technology tools; ensuring well-being is a long-term value throughout health care; and recruiting and retaining a diverse and inclusive health care workforce. Additionally, the American Medical Association's Issue Brief: *Confidential Care to Support Physician Health and Wellness* (2021) American Medical Association (AMA) 2021, the 2022 *Nurse Staffing Think Tank: Priority Topics and Recommendations*, and the Surgeon General's 2022 *Advisory on Health Worker Burnout* provide further federal policy considerations that could be adopted for nurses (Murthy, 2022). Table 1 provides a list of recommendations for policy changes for supporting nurses' health and well-being. Recommendations are outlined using the CDC's *Suicide Prevention: Resource for Action* (2022).

Strategy 1: Strengthen Economic Supports

The strengthening of economic supports for nurses encompasses numerous domains including resources/consideration for both current and future nursing workforce. Resource allocation to expand and invest in a diverse mental health workforce would not only enhance diversity and equity within the workforce but also increase the capacity within the system to provide compassionate, patient-centered care to a broader swath of nurses. Another consideration within the economic sphere resides within the stress associated with the financial ramifications potentially associated with seeking-help for mental health and/or substance use disorders such as job loss, licensure suspension/loss, and loss of future livelihood.

Strategy 2: Create Protective Environments

One important piece of legislation to support, the *Workplace Violence Prevention for Health Care and Social Service Workers Act* (2021), would require comprehensive violence prevention plans for employers in health care and social settings (Baldwin, 2022). Healthy Workplace initiatives such as the *American Association of Critical-Care Nurses Standards for Establishing and Sustaining Healthy Work Environments* (American Association of Critical-Care Nurses 2023) highlights appropriate staffing but addressing staffing issues with policy without addressing the health of the work environment is pointless (Ulrich, et al., 2022).

Additionally, mandatory reporting requirements must be reconsidered based on the negative social and psychological outcomes of public disclosure. Privacy concerns with prohibitions on public reporting could (Dr. Lorna Breen Health Care Provider Protection Act 2019) be enacted with elimination of self-disclosure of mental health issues with initial and re-licensure applications. If nursing organizations or state boards of nursing are going to ask questions regarding MH and SUD, it should be done in a manner that is American Disabilities Act (ADA) compliant (U.S. Department of Justice, 2005). The ADA requires licensure

Table 1 – – Key Recommendations by Strategy.

Strategy	Policy Changes
1. Strengthen economic supports. Includes stress related to anticipated job loss, financial repercussions of losing license, livelihood.	Increase funding and availability of mental health services for nurses. Expand and invest in a diverse mental health workforce. Pass the *Future Advancement of Academic Nursing Act* (S.246/H.R. 851) that in part provides much needed funding for increasing faculty to improve the education of nurses. Increase provision of paid mental health days. Provide economic incentives for participating in fitness and well-being programs. Preserve licenses and employment of nurses while undergoing treatment. Restrict use of license suspension/restriction to nurses who are refractory to treatment. Reconsider sanctions against license/employment for infractions occurring outside of the workplace such as driving under the influence (DUI)/driving while intoxicated (DWI). Support pipeline development programs for underrepresented minority groups in nursing. Dismantle individual state autonomy for addressing MH/SUD issues in nursing.
2. Create protective environments	Ensure licensing, credentialing, employment, and other related applications do not contain stigmatizing language that inappropriately asks about past diagnoses rather than current impairment. Provide grants for nurses to help create evidence-based strategies to reduce burnout and the associated secondary mental health conditions related to job stress. Implement non-punitive error evaluation to identify system failures vs. individual failures. Encourage nation-wide use of peer support programs for MH/SUD. Advocate for just culture concepts to focus on a healthy work environment away from blame culture. Include suicide prevention measures in the curriculum of PHAP/Alternative to Discipline programs. Support legislation such as the *Dr. Lorna Breen Health Care Provider Protection Act*, (HR 1667) and ongoing evidence-informed best practices and research for reducing and preventing suicide and burnout among nurses and other health care professionals. Support legislation such as *Workplace Violence Prevention for Health Care and Social Service Workers Act (HR 1195/S 4182)* to require health care settings to put in place engineering and work practice controls critical to safety. Establish minimum accreditation standards defining requirements for mechanisms to support health care worker mental health. Enact paid leave and rest time policies. Support national, state, and local education and awareness campaigns about well-being including mental health well-being.
3. Improve access and delivery of care	Increase funding and availability of mental health services for nurses. Develop metrics to evaluate if time frame from identification of mental health issues to appointment is helpful. Advocate and fund research to evaluate the impact of mandatory reporting and public reporting on MH outcomes in nursing. Provide national oversight for equitable (disease) treatment of nurses nationwide. Establish minimum accreditation standards for employee assistance programs. Ensure state boards and legislatures employ a non-punitive lens, offering options for "safe haven" non-reporting for licensure applicants receiving appropriate treatment for mental health or substance use challenges.
4. Promote health connections	Promote a unified strategic plan to address bullying, including bystander/upstander training. Establishing positive work norms, peer support programs, counseling, employee assistance involvement and legal counseling for victims of bullying. Provide grants for nurses to help create evidence-based strategies to reduce burnout and the associated secondary mental health conditions related to job stress. Promote peer support programs with opportunities during working hours to reflect on challenging circumstances.
5. Teach coping and problem-solving skills	Enact legislation that provides for safe haven reporting systems and wellness programs nurses can access to seek care for burnout and other stressors, as well as mental health issues. Provide grants for nurses to help create evidence-based strategies to reduce burnout and the associated secondary mental health conditions related to job stress. Prioritize, assess, and support learner well-being. Acknowledge the hidden curriculum within health professional education and address the impact is has on trainee development and well-being. Accreditation organizations can revise clinician accreditation standards to recognize and communicate the importance of health worker well-being.
6. Identify and support people at risk	Ensure laws and policies provide strong confidentiality protections for nurses seeking mental health and substance use disorder care. Screening for trauma in nursing individuals.

(*continued*)

Table 1 – (*Continued*)

Strategy	Policy Changes
	Increased awareness related to the signs and symptoms of stress, burnout, and traumatization. Support of legislation such as the *Dr. Lorna Breen Health Care Provider Protection Act*, (HR 1667) and ongoing evidence-informed best practices and research for reducing and preventing suicide and burnout among nurses and other health care professionals. Provide grants for nurses to help create evidence-based strategies to reduce burnout and the associated secondary mental health conditions related to job stress. Support a national campaign to encourage health care professionals to prioritize their mental health and use available mental and behavioral health services. Deploy anonymous encrypted screening for mental health disorders, burnout, and moral distress/injury. Provide grants for employee education, peer support programming. Create a standard dataset to routinely monitor performance of PHAP/Alternative to Discipline programs, and within this dataset monitor percent return to work with active nursing license. Limit inquiries about MH to conditions that currently impair clinicians' ability to do perform their job functions. Support a comprehensive study on the mental health and burnout of health care professionals.
7. Lessen harms and prevent future risk	Evaluate current policies re: to 12-hour shifts. Manage workload and fatigue. Eliminate self-disclosure of MH issues with licensure applications. Prohibit public disclosure of MH issues. Adapt just culture environment to focus away from blame culture. When screening for MH issues, consistent with ADA regulations, inquire about the limits on abilities to perform essential job functions rather than the presence of the MH condition. Include sanctions against license and dismissal in the definition of 'discipline'. Dismantle individual state autonomy for addressing MH/SUD issues in nursing. Create a national strategy for mechanisms nurses can use to seek treatment without jeopardizing licensure. Promote research to identify strategies to address the consequences of MH for nurses. Advocate for gun control (as firearms are a suicide risk). Discourage self-prescribing by licensed independent practitioners. Work with key stakeholders to change current payment structures to recognize the value of nurses. Support of legislation such as the *Dr. Lorna Breen Health Care Provider Protection Act*, (HR 1667) and ongoing evidence-informed best practices and research for reducing and preventing suicide and burnout among nurses and other health care professionals.

application questions to focus on the presence or absence of current impairments, not generically asking broad historical questions as to whether an applicant has been treated or diagnosed with an illness. The Federation of State Medical Boards adopted a policy in 2018 to encourage state licensing boards to only ask questions about mental and physical health conditions that impair judgement or would result in the physician presenting a danger to public health (Hengerer et al., 2018). Authors endorse the toolkit developed through the Dr. Lorna Breene Foundation to act against these intrusive questions at the institutional level with accreditation, and the state level with licensure. These intrusive questions also need to be removed from state licensing board hearings when evaluating reinstatement of a license suspended due to SUD or other mental health issues (https://drlornabreen.org/removebarriers/). The only relevant question is "Are you medically fit to practice?" (NAM, 2022).

It is important to assure that employee assistance programs and human relations policies are compliant with the Health Insurance Portability and Accountability Act (HIPAA) (United States, 2004) and ADA (U.S. Department of Justice, Civil Rights Division, Public Access Section, 2005). Policies for diversion (theft of medications) developed between state regulatory agencies and employing institutions must be re-evaluated to overtly emphasize treatment for SUD vs. dismissal and guidelines for management when an illness is refractory to treatment. Traditional approaches to investigation of work-related incidents using a just culture approach, where blame is avoided could help decrease risk (Marx, 2001). Just culture alone is not sufficient when the workplace incident involves an impairment or diverting medications, as these situations, which threaten the job and/or license, are associated with suicide (Davidson et al., 2021).

Strategy 3: Improve Access and Delivery of Suicide Care

Improving access and delivery of suicide care involves, at a fundamental level, increased funding and availability of MH and SUD services for nurses. Increasing the capacity of the MH care delivery system is

essential to improving availability of quality care. Additional strategies could include provide national oversight for equitable (disease) treatment of nurses nationwide; establishment of minimum accreditation standards for employee assistance programs; ensure state boards and legislatures employ a non-punitive lens, offering options for "safe haven" non-reporting for licensure applicants receiving appropriate treatment for mental health or substance use challenges.

Leaders must evaluate and strengthen policies, programs, processes and structures within employing organizations and licensing boards to reduce stigma associated with mental and behavioral health treatment for nurses (NASEM, 2021,International Council of Nurses 2022). (Knaak et al., 2014) validated key program elements for anti-stigma for health providers including multiple points of social contact, planned exchanges with someone knowledgeable about lived experience, teaching skills in what to say/do with others who might be suffering from mental health problems, myth-busting approaches, and recovery-oriented and person-centered focus to education about MH.

Strategy 4: Promote Healthy Connections

Nurse bullying and incivility are most often done by other nurses and suggestive of MH concerns like lack of self-confidence, anxiety, personal stress, or depression. Bullying can be rooted back to a maladaptive learned childhood behavior (Edmondson & Zelonka, 2019). Nurses who bully could benefit from individual and health system level education, and behavioral health services. Organizations should develop and promote a unified strategic plan to address bullying, including bystander/upstander training. This would help establish positive work norms through peer support programs, counseling, employee assistance involvement and legal counseling for victims of bullying.

Strategy 5: Teach Coping and Problem-Solving Skills

Self-care and resilience strategies are encouraged as a first step, but these expectations are often placed on the individual with limited support (Søvold et al., 2021). Implementing cognitive-based therapy-derived resiliency skills building has been demonstrated to decrease mental health issues in nurses and students (Melnyk et al., 2020) and mindfulness-based stress reduction programs improve mental health and resiliency (Green & Kinchen, 2021). Nurses commonly experience psychological trauma (Christie & Jones, 2014; Girouard & Bailey, 2017) and should be encouraged to engage in evidence-based trauma focused treatments. Resilience skills development in response to adversity and trauma include building coping skills, managing moods, social support, and perspective building (https://doi.org/10.1177/23333936211005). Table 2 provides an overview, a multitude of resources and links to evidence-based strategies individuals and health care systems can structure into well-being initiatives to bolster the resilience of the individual nurse. The new Essentials (AACN, 2021) have an entire domain on personal, professional, and leadership development for nursing school accreditation.

Strategy 6: Identify and Support People at Risk

Nurses deserve freedom from punishment for work related stress responses, burnout, and chronic illness and equitable support for the MH and SUD treatment they need to remain active professionals. Action on these recommendations can advance retention of our most valuable resource: nurses themselves.

Although SUD and addictions were recognized in the early 1990s as disorders which change brain function (Koob, 1992), strategies to assess and treat occupational groups like nurses who experience disorders of substance use are underdeveloped (Mahmoud et al., 2020; Smiley & Reneau, 2020; van Boekel et al., 2013). Significant challenges remain despite efforts to promote nurses' competence in identifying colleagues who may be at risk for suicide because of substance use. Those efforts include identifying interventions to prevent the progression of stress-related responses to diagnosable disorders and providing support for those in recovery from SUDs and depression (Finnell and Mitchell, 2020) . Continued labeling of substance use disorders as a moral failure and criminalization of the disease of substance use disorder perpetuates stigma. Shifting the paradigm to prevention and risk reduction, population focused treatment and monitoring programs have been demonstrated to decrease morbidity (SAMHSA, 2016).

Efforts are needed to achieve comparable treatment so nurses may return to work while receiving humane, non-punitive, long-term treatment for these chronic diseases (Gordon et al., 2021). Because of the danger of under-recognizing serious MH disorders, MH assessment should occur regularly in the context of burnout and potentially morally injurious circumstances. We suggest that a therapeutic approach to the disease of SUD be prioritized, and that, unless refractory to previous efforts, employees be given the hope of retaining employment following leave of absence for acute treatment. Further, authors suggest that screening for SUD earlier in the disease and referring for treatment may minimize disease progression resulting in episodes subject to legal action also associated with suicide.

Strategy 7: Lessen Harms and Prevent Future Risk

This final strategy addresses the need to incorporate upstream approaches to both harm reduction and health promotion when supporting the mental health and well-being of nurses. Organizational interventions that raise awareness, de-stigmatize help-seeking, and promote resilience can assist the nurse in multiple ways. Some examples are promotion awareness/

Table 2 – – Resources for Health care Worker Well-being and Suicide Prevention Programs.

Organization and Website	Recommended Use
ANA: Nurse Suicide and Prevention Resilience https://www.nursingworld.org/practice-policy/nurse-suicide-prevention/	Nurses who are depressed, burned-out and feeling suicidal. Also, helpful for those who are trying to help those who are suicidal, depressed, burned-out. Suggests interventions and recommendations for treatment.
Emotional PPE project https://emotionalppe.org/	Any health care worker can contact any licensed mental health practitioner in the directory for free sessions
ANA: Healthy Nurse Healthy Nation https://www.healthynursehealthynation.org/	Faculty or health system leaders can use this repository to locate replicable programs/interventions for enhancing mental health of the workforce/student/faculty body and suicide prevention
American Psychiatric Nurses Association (APNA) A member-driven community that advances the science & education of psychiatric-mental health nursing. https://www.apna.org/resources/well-being-initiative/	Provides nurses with information about stress and trauma and how to look for symptoms in self and others and how to seek help.
HEAR (Healer Education, Assessment & Referral) https://pubmed.ncbi.nlm.nih.gov/29300216/	Proactive, preventive program for all health care workers addresses a wide variety of mental health issues, with referral to mental health care, if needed. Surgeon General Report: https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf, p25
National Alliance for Mental Illness (NAMI) https://www.nami.org/ https://nami.org/Your-Journey/Frontline-Professionals/Health-Care-Professionals	Individuals with mental illness and their family members and friends who are seeking information and support. Resources for frontline health care workers in response to COVID, and fighting stigma against help-seeking Support groups, video resources, hotline, community events, and discussion groups.
American Foundation for Suicide Prevention https://afsp.org/	Those at risk of suicide. Those who have lost a family member, loved one or friend to suicide.
Heroes Health Initiative https://heroeshealth.unc.edu/resources-for-health-care-workers/	Health care workers and first responders.
American Medical Association (AMA) https://www.ama-assn.org/	Physician and other health care provider well-being
Center for the Study of Traumatic Stress https://www.cstsonline.org/	Veterans and their families.
American Psychological Association https://www.apaservices.org/practice/ce/self-care	Psychologist and other health care providers (open to everyone). Primarily focused on identification and early interventions.
American Psychiatric Association https://www.psychiatry.org/	Informational for individuals and health care providers.
National Suicide Prevention Lifeline 1-800-273-TALK (8255) Text HOME to 741741	24/7 help if you are in crisis right now, or are concerned that someone may harm themselves or someone else, seek immediate help by using these numbers
Mental Health America (MHA) https://www.mhanational.org/	Resources for compassion fatigue, peer support program and certification
National Academy of Medicine (NAM) https://nam.edu/compendium-of-key-resources-for-improving-clinician-well-being/	Resource compendium for health care worker well-being. Provides collection of resources and strategies based on organizational evidence-based and promising best practices for clinician well-being
Nurse Peer Support Network (NPSN) http://www.npsnetwork-mn.org/	Peer support for recovery for nurses suffering from addictions to provide non-judgmental support to nurses in Minnesota. Nursing specific.
Peer Assistance Services https://nami.org/Your-Journey/Frontline-Professionals/Health-Care-Professionals, Inc. https://www.peerassistanceservices.org/	Prevention services for health and mental health workforce across Colorado. Not nursing specific. Provides services for licensed professionals experiencing any substance abuse problems that could result in impaired practice.
International Society of Psychiatric Mental Health Nurses (ISPN) Peer Support Group https://www.ispn-psych.org/peer-support	Initiative to support nurses impacted by COVID-19 for peer support to members and non-members.

(continued)

Table 2 – (*Continued*)

Organization and Website	Recommended Use
Veterans Affairs: Provider Resilience App through the National Center of Telehealth and Technology https://apps.apple.com/us/app/provider-resilience/id559806962	Created for health care workers working in the military and veteran populations, but is free and could be used by anyone to monitor professional quality of life overtime and provide a plethora of tools to aid in well-being
Substance Abuse and Mental Health Services Administration (SAMHSA) https://www.samhsa.gov/resource/dbhis/provider-resilience	Variety of tools and education for resilience, trauma informed approaches to resiliency for individuals and the community before, during and after a disaster.
International Society for Traumatic Stress Studies https://istss.org/clinical-resources/treating-trauma/self-care-for-providers	Focused on health care professionals exposed to trauma survivors to help understand indirect trauma for self-care.

campaigns, psychological first aid, resources detailing providers and self-help options, group and individual therapy, mobile support and connection, peer-led training sessions, and resilience promoting workshops (Buselli et al., 2021) . Additionally, just culture development to extinguish a culture of blame to that of trust and safety can be implemented (van Marum et al., 2022; Marx, 2001). National campaigns and associated funding that address the importance of health care providers' prioritizing their own health and well-being, as well as addressing the stigma associated with help-seeking, would contribute to a shift in the current culture of health care.

Academy's Position

The psychological safety for all nurses is vital and the Academy is committed to a positive organizational culture that supports nurse health, mental health, substance use disorder care, and suicide prevention. Substantive change needs to occur in our health care environments where nurses are at the center of a host of potentially traumatic and psychologically demanding situations leading to burnout. This cascade of events can lead to depression, addiction, and increased risk for suicide while contributing to increased risk for errors and other concerning patient safety situations.

Conclusion

There is a tension between our obligation to safeguard the public by ensuring nurses are safe in their practice and our obligation to care for nurses who face mental health challenges. The recommendations laid out in this paper represent opportunities for significant legislative and programmatic changes in the absence of national standards. Advancing health equity and championing well-being requires that nurse leaders and health care organizations work to promote programs that support mental health and eliminate regulations that result in public shaming and perpetuate discriminatory and unethical actions against nurses with mental health issues. We must act now to ensure compassionate, equitable and evidence-based care for our professional colleagues, in recognition of known higher profession-related risks and the added demands of an ongoing pandemic. Nurses need and deserve the highest standard of care and the time to act on this is now.

Authors' Contributions

JoEllen Schimmels (Conceptualization, Writing Original Draft, Writing Review & Editing), Deborah Finnell (Conceptualization, Writing Review & Editing), Judy E. Davidson (Conceptualization, Writing Original Draft, Writing Review & Editing, Supervision), Lucia Wocial (Writing Original Draft, Writing Review & Editing), Michael Neft (Writing Original Draft, Writing Review & Editing), Carla Groh, (Writing Original Draft, Writing Review & Editing), Cara Young, (Writing Original Draft, Writing Review & Editing), Teddy Potter (Writing Review & Editing), Patricia Patrician (Writing Review & Editing), Madeline Naegle (Writing Review & Editing), Teena McGuinness (Writing Review & Editing), Elizabeth Pace (Writing Review & Editing), Elizabeth Bonham (Writing Review & Editing, Supervision), Cynda Rushton (Writing Review & Editing).

This manuscript has been reviewed and approved by the AAN Board of Directors.

Conflict of Interest Statement

The authors have no affiliations with or involvement in any organization or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this manuscript.

Acknowledgements

This consensus paper represents the partnering of five American Academy of Nursing Expert Panels:

Psychiatric Mental Health and Substance Use; Bioethics; Environmental and Public Health; Military and Veterans Health; and Quality Health Care. We gratefully acknowledge the review, editing, and expertise of Elizabeth Bonham, PhD, RN, PMHCNS-BC, FAAN; Deborah S. Finnell, PhD, RN, CARN-AP, FAAN; Teena McGuinness, PhD, PMHNP-BC, FAANP, FAAN; Madeline A. Naegle, PhD, CNS-PMC, BC, FAAN; Elizabeth Pace, MSM, RN, CEAP, FAAN; Patricia Patrician, PhD, RN, FAAN; Teddie Potter, PhD, RN, FAAN, FNAP; and Cynda Rushton, PhD, RN, FAAN.

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