Podcast Transcript

Intrusive Licensure Questions: Are We Violating Our Nurses' Rights to Privacy?

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At Colibri Healthcare, we developed this educational content with a genuine approach to bringing attention to mental health from a healthcare professional's perspective. This podcast contains content that may be unsettling for some listeners. The episodes may discuss suicide, depression, and other sensitive topics. We do our best to discuss sensitive topics such as these with discretion and sincerity. Because of the sensitive topic being discussed, we recommend this podcast for adults only.

Content warnings: Mentions of alcoholism, anorexia nervosa, death, depression, and suicide

Guests

Judy Davidson, DNP, RN, MCCM, FAAN

- Nurse scientist
- Editor of a nursing journal
- Educational consultant
- Researcher
    - Focus includes workplace wellness, mental health issues, suicide prevention among healthcare professionals, suicide of healthcare professionals, and second victim syndrome
- Thought leader
    - Led the development of the first suicide prevention program for nurses, which was awarded Edge Runner status, or a model for replication, by the American Academy of Nursing

Margaret Halter, PhD, APRN

- Nurse editor
    - Edits a leading psychiatric nursing undergraduate textbook

- Educator
    - Expertise includes undergraduate and graduate psychiatric nursing and program development
- Volunteer
    - Serves on several volunteer mental health–focused boards
- Advocate
    - Has held local, state, and national leadership positions as an advocate for the profession of nursing and patients
    - Research focus has long been on mental illness stigma

Marie Manthey, PhD (hon), MNA, FAAN, FRCN

- Founder and president emeritus of Creative Health Care Management
- Multi-award-winning author
- Credited with the development of the primary nursing care model
- Recognized in 2015 as an American Academy of Nursing Living Legend
- Participated in the development of the Minnesota Nursing Peer Support Network

Host

Leana McGuire, BS, RN

- Extensive expertise with leadership development and executive coaching and a background in content development, visual performance, speaking, and podcast hosting

Transcript

Episode 1 – Do I Have to Share My Mental Health or Psychiatric History for Licensure?

SOUNDBITE OF MUSIC

LEANA MCGUIRE, HOST: Hello. And thank you for joining in to listen to a thought-provoking and, dare I say, controversial conversation today. I'm Leana McGuire, your host for this Elite Learning podcast by Colibri Healthcare.

We want to discuss something today that has been brewing for years. Should nurses have to share their personal information regarding their mental health and/or their psychiatric history for licensure or renewal? Let's allow a moment for you to consider that a little bit. What are your initial thoughts? Is there any kind of gut feeling leaning one way or another? If you're a nurse preparing to take your nursing board exam or if you have been a nurse for any length of time, what would you do if you look at your information for obtaining a license or renewing an existing license and see a question about divulging your personal mental health history? In some states, this is an issue that nurses face.

One of the purposes for this podcast is to analyze and better comprehend the issue of disclosure of nurses' psychiatric history or current mental health information as connected to licensure. Through the podcast episodes, we will review the current controversial issue about disclosure, discuss how the Americans with Disabilities Act, or ADA, might weigh in on this conversation, and consider reasons for and against collecting this

kind of information. We're joined by three experts today who are definitely top choices for discussing these issues: Dr. Judy Davidson, Dr. Marie Manthey, and Dr. Margaret Halter.

Some may recognize Dr. Davidson and Dr. Manthey as the influential nurse leaders from Nurse Suicide and Substance Use Disorder: The Shocking Truth, another of our Elite Learning podcasts by Colibri Healthcare. We have the privilege of also talking with Dr. Margaret Halter, who you go by Peggy, correct?

DR. MARGARET (PEGGY) HALTER, GUEST: Correct.

MCGUIRE: And we're thrilled to have all of you here. Here is a brief introduction of each of our subject matter experts today.

Dr. Judy Davidson is a nurse scientist and thought leader whose research has centered on suicide of healthcare professionals, suicide prevention, workplace wellness, and second victim syndrome. A nurse scientist, editor of a nursing journal, and educational consultant, she has a wealth of information to share with us today.

Dr. Marie Manthey has many claims to nursing prominence. She was a founder of primary nursing care delivery who was named a living legend of the American Academy of Nursing in 2015. She is currently president emeritus of Creative Health Care Management and spends much time talking and spreading awareness about mental health and substance use disorders.

Dr. Peggy Halter is a PhD-prepared advanced practice registered nurse. Her expertise includes undergraduate and graduate psychiatric nursing and program development. Dr. Halter currently edits a leading psychiatric nursing undergraduate textbook and serves on several volunteer mental health-focused boards. Health policy is another area of interest, and she has held local, state, and national leadership positions as an advocate for the profession of nursing and our patients.

Dr. Davidson, is there anything you would like to add by way of introducing yourself?

DR. JUDY DAVIDSON, GUEST: No, I think you captured it. I think the work on suicide and suicide prevention that our research team focuses on will surely give us a little bit of special information for today's program.

MCGUIRE: Excellent. Dr. Manthey, anything you would like to add?

DR. MARIE MANTHEY, GUEST: For the last ten years I’ve been really significantly involved in helping nurses overcome the stigma and shame that's associated with substance use disorder.

MCGUIRE: Fantastic. Dr. Halter, is there anything you would like to add to introduce yourself to the audience?

HALTER: I'm really glad to be here today. Thanks for having me. I'd like to add that my research focus has long been on mental illness stigma. So, today's topic is quite a passion for me.

MCGUIRE: Fantastic. Great. So, there's been a developing issue that has been brewing over the years, as we discussed. As nurses, we understand the importance of HIPAA and the value of personal and private health-related information. There's a certain amount of privacy and confidentiality that patients and their healthcare providers respect to help enable truthfulness in discussing health, behavior, and illnesses.

Privacy is valued for encouraging provision of care, treatment, and patient education. On the other hand, the National Council of State Boards of Nursing describes how it was established over a century ago to help protect the public by interventions such as regulating nursing practice, administering nursing licensure, checking for compliance issues, and oversight needed to help ensure that licensed nurses are held to professional standards and that unlicensed, even non-healthcare persons can't easily masquerade as licensed professionals.

However, between these two ends of the spectrum is a gray area. How much information should licensing boards have access to when it comes to personal health information, and how much personal information should nurses supply in the interests of public and professional good? We have a lot of questions here, so let's discuss.

We'll start with Dr. Davidson. Your research interest is on suicide and suicide prevention. Why is this issue related to your research?

DAVIDSON: Well, we didn't go about looking to find this. In fact, we were shocked when we found this. But we found a direct link between the fear of losing your license and suicide. We found this same thing occurring in nurses, doctors, and pharmacists. Our team takes the NVDRS, National Violent Death Reporting System, data from the CDC. And, we read through the death narratives of every nurse, doctor, and pharmacist who has died by suicide.

We read all the narratives since 2003, and far too often those death narratives include an account of the struggles that a health professional goes through when they think they're going to lose their license because of a mental health issue, um, that may include substance use disorder. So, the two are linked in a way that we had not known in the past.

In fact, many of you might be aware of a very, very highly publicized case of Dr. Lorna Breen, who died within the last couple of years, during the pandemic, suffering from depression. Her family describes that her fear of the medical board finding out that she had depression prevented her from receiving adequate treatment. And they attribute this, the intrusive questions on medical boards, like what we're talking about today in nursing to be one of the factors associated with her death.

So, there's many issues that get stigmatized against nurses seeking mental healthcare. One of them, just one of them, one of the many issues, is what we're talking about today, the intrusive questions on licensure. A second problem is mandatory reporting of mental health conditions to the state boards. And, a third problem is the way that we treat and process nurses with substance use disorder or other mental health conditions.

But today, we're going to focus on just that issue of intrusive questions regarding mental health asked by some states on licensure. I want the audience to know that the Joint Commission and the Surgeon General have both issued reports stating outright that we need to remove these stigmatizing questions from use by the licensing boards. But, it has not happened yet.

MCGUIRE: Okay, interesting. There are some discussions and comments online of different nurses who reported various information about psychiatric treatment or mental health issues and then say how it became publicly noted after working through issues with the board of nursing or court or other ways that information came to light. Have you heard of anything like this?

HALTER: This is Peggy Halter. I am personally not aware of any cases in which mental health conditions were made public. I suppose they could be, especially if a malpractice case goes to court.

MCGUIRE: Okay. Now there's a thought-provoking article from 2019 titled State Nursing Licensure Questions about Mental Illness and Compliance with the Americans with Disabilities Act by Halter, Rolin, Adamaszek, and Ladenheim and Hutchens. By the way, this is Dr. Halter, whom we are privileged to have on this podcast today.

As of 2018, the authors said 30 of 51 licensing boards inquired about nurses' statuses with regard to mental illness in some shape or form. The article used the term "mental illness" to refer to what it found from those boards. How long has this been an interest of yours? And can you tell us about why you did this study, Dr. Halter?

HALTER: Yes, sure. Mental health stigma, that is the perception that someone is flawed based on having a mental illness, was the focus of my doctoral dissertation in 2003. Specifically, I explored the connection between stigmatizing attitudes and its impact on future *help-seeking* for depression. From there, my research included *stigma by association* whereby family members, friends, and even mental health workers are stigmatized simply by their association to the individual with mental illness. I found that topic fascinating.

Being a faculty member, I began to recognize a third type of stigma that is a structural stigma over a decade ago. It began with a senior nursing student who approached me at the university where I taught. She explained that she was completing the application to take the state board examination. "They're asking about treatment for psychiatric conditions," she said, "and I've been treated for a bipolar disorder." She became tearful, hardly able to talk. She says, "After four years of hard work, I'm not going to be able to be a nurse." I felt so bad for her. I acknowledged her fear but assured her that treatment would not be a barrier to her nursing candidacy. But, that experience put me into action. I thought, "What can I do about this?" I mean, what possibly can the state board be doing with the answers to these questions?

I contacted the State Board of Nursing and asked for the rationale behind asking if a person had ever been treated for a mental illness. Their first response was, "Well, we do that, because that's what the medical association does. We use the same wording." And I said, "That doesn't sound right." Okay. I said, "But what is the purpose of the question?" The board member responded, "To protect the public." Although I pressed the issue, I didn't receive a reasonable response on how collecting information about psychiatric treatment and collecting records protect the public. After all, is not getting treatment a safer approach?

I recognize these types of questions as a sort of organizational or structural stigma. After all, the highest law of the land in nursing is suggesting to students who receive treatment that they are flawed. Disturbingly, on my state's renewal application, the question about mental illness appears right before "Are you required to register as a sex offender?" Questions are right next to each other.

MCGUIRE: Wow.

HALTER: Sends a message, doesn't it?

MCGUIRE: It certainly does.

HALTER: So, I worked with my state's association, that is Ohio Nurses Association, to bring my concerns to the board. And we actually had an agenda item on the quarterly meeting agenda, and we were in fact awarded with time to speak at the meeting. And, we did. They listened, and nothing changed. Around the same time, the US Department of Justice was alleging that the Louisiana Bar Association violated the Americans with Disabilities Act by asking discriminatory questions.

Subsequently, psychologists conducted a systematic study on their applications. After that time, James Jones, a professor of law from the University of Kentucky, contacted me in 2017. He sent an email, and he'd heard of my interest in eliminating stigmatizing questions from state board applications. He shared his work as a legal consultant, along with physician colleagues, on a study that evaluated all medical state board applications for compliance with the ADA. I was so excited by this email. I realized that the path to conduct my own study had already been forged. I got to work doing that right afterwards. I recruited a couple of nurse colleagues, along with an attorney, and the work began.

MCGUIRE: Wow. What an interesting story! In regard to the 2019 study, it had to have been very difficult to obtain all that data.

HALTER: Well, it could have been. However, graduate nursing assistants are a precious commodity. These students collected all of the U.S. and the District of Columbia Board of Nursing prelicensure applications. They were pretty easy to get actually. They gathered most of them online. A few they had to request by mail, because they weren't available electronically.

MCGUIRE: Are there? It sounds like most boards of nursing are asking for this kind of information. Are there plans to update this to see if we are making any progress?

HALTER: Yes. Let me just give you a little background of what I found in my study. As of spring of 2018, 30 of RN licensing boards ask questions about mental illness on prelicensure applications. Of the 30 schools that asked questions, eight focused on current disability, and you're allowed to ask questions under the ADA about current disability by the way.

That left 22 states that were not compliant, not in compliance with the ADA. I recently found a 2021 survey by the National Council of State Boards of Nursing from 2020, yeah, 2021: that's when they did it. They found that 37 state boards of nursing ask about, listen to this, it's kind of tricky, they ask about "sound physical, and/or mental health," and that's how NCSBN reported the data.

So, I'm not sure how to tease that out when they mix physical and mental health. It seems like if you look at their data, that with 37 state boards asking questions, that it looks like the number of questions have actually increased over the four years, but I can't really tell for sure. But, what's been interesting to me is over the years I've received feedback about our article from a few nursing boards, and it's mostly been positive!

Hopefully this information shined a light on a real problem, and that the problem was addressed in some cases. The only way to know if changes have been made in the intervening years is to repeat the study. And, actually one of my colleagues and I are in the early stages of making this happen, but we face a hurdle in collecting licensure applications that wasn't there in 2018.

I think we will act to actually get paper copies of the application. Otherwise, the nursing graduate students will have to actually make accounts in Wyoming, Mississippi, etc. and have their names and information all out there, if it would even work, I don't know. Anyway, it will be done again.

MCGUIRE: Anything to add, Dr. Davidson?

DAVIDSON: Yes, thanks. There's more to this than meets the eye. Dr. Halter studied the use of the questions for licensure and relicensure in normal situations. However, the questions are also asked for a third purpose, for the reason of disciplinary hearings, when it's being considered whether a nurse should keep their license or whether it should be reinstated after a period of being suspended.

I actually hear from nurses who are going through this and the pain that is associated with actually looking at those questions and wondering what the state board is going to do with it and whether answering truthfully will result in them not receiving their license. So even if your state's in the clear from Dr. Halter's report, we still need to evaluate whether the ADA noncompliant questions are being used for disciplinary evaluations and hearings.

And I'd like to propose that this be something we track as a profession. Why should we need to do a study repeatedly, over and over? Can't we take the baseline and put it up on the NCSBN website and then have it tracked at a national level over time? … maybe even rewarding states for making the changes towards healthier practices that are less stigmatizing? … create some kind of award system and best practice and shine light on exemplars that are doing the right thing. Wouldn't that be the way to go in the future? And I'm hoping we can stimulate that kind of change.

MCGUIRE: It certainly would. Yes, I agree. Do you have any data on the prevalence or how common it is for adults in general in the United States or even nurses specifically to have been diagnosed already with any kind of mental health issue? Are we talking about a small portion or large percentage of either group who would be affected by the questioning of licensure?

HALTER: I'll just start off with some general data. The sheer numbers of people with mental illness is very high, and nurses likely mirror, if not surpass, these numbers. According to the World Health Organization in 2019, one in every eight people in the world were living with a mental illness, with anxiety and depressive disorders being the most common. In the U.S., estimates are even higher, with one in five people estimated having a mental disorder. That's a lot of people.

MCGUIRE: Yeah, it really is.

HALTER: And then, you know, due to the COVID-19 pandemic in 2020, the number of people living with anxiety and depressive disorders rose significantly. Estimates indicate they vary. But one that I got was, there was a 27% increase for both anxiety and major depressive disorders in that one year alone.

DAVIDSON: Yeah, I'd like to take this a little further. Did you know that the CDC reports that one in five Americans is taking a medication to treat a mental health condition? Google that up. It's really easy to find. So, what benefit would it be to the boards to know this? If the nurses actually disclose this information truthfully, what would they do with all this information?

How would it be helpful? Somewhere between one in seven and one in ten Americans have substance use issues, and there's no reason to believe that it's any different in nurses. So, stigmatizing these conditions to the masses and encouraging them to be in a situation where they either have to lie or be in fear ... it just doesn't seem like the right path to take.

Think about our code of ethics. What does our code of ethics teach us in nursing? We should not put nurses in a situation that we know can stimulate moral distress, moral distress: being prevented from doing the thing that you think is right. And, these stigmatizing questions do just that. I want to lean on the American Nurses Foundation study that's been done over the pandemic.

In 2021, they asked over 9500 nurses about their mental health. A third of them, a third, had sought treatment over the last year, but only 80% could find the treatment they needed. Of those that did not seek treatment, a full half of those thought they needed treatment, but something prevented them. So, all in all, about 60% of our workforce who answered this survey had mental health issues that the nurses themselves perceived needed treatment.

Now, this is going to shock you, four percent had suicidal thoughts in the last two weeks prior to the survey, that's hundreds of nurses; 1% had actually harmed themselves; 3% had substance use issues that they disclosed on the survey. And, substance use disorder, I have to remind the audience, is a mental health disorder that's treatable, but untreated can lead to suicide. So, these are staggering numbers, staggering numbers that we definitely need to pay attention to. So, this concern of stigmatizing nurses against seeking treatment for the questions we ask on licensure, is a very important topic.

MCGUIRE: Well, it certainly is. Let's also consider the stress of being a healthcare worker, a nurse in the trenches provider of care, so to speak. Caring for persons in life-or-death situations can take a toll on nurses over time. Most of the time, a person seeks treatment, medical or psychiatric, related to an issue or problem of some kind. Usually, people don't come in to be seen, because they feel like their health is great or “A-plus.”

So, just the stress and emotional aspects of caring for people experiencing disease, chronic health concerns, or other matters of maladaptive health require a lot of energy. A nurse can easily be drained with multiple responsibilities, both at work and at home. Would reporting information to a board help? What is something that helps nurses before treatment is needed or when treatment is needed accomplish more than reporting? Or, is that the purpose of reporting, to facilitate treatment?

DAVIDSON: That's why the wording of these questions is so important. Let's get into specifics like a bad question will ask about specific diagnoses or whether you have received mental health treatment. Now let's consider a revised question. This one was recently drafted by a group called the Lorna Breen Foundation to be used by the medical boards for physicians. And when I contacted the Lorna Breen Foundation, they told me there is no reason that the profession of nursing cannot adopt these same strategies to take action and improve our situation as nurses.

So, the question drafted for use by medical boards is, “Are you currently suffering from any condition for which you are not appropriately being treated that impairs your judgment or that would otherwise adversely affect your ability to practice … in a competent, ethical and professional manner? (Yes/No)” (AMA, 2018). Right. So that you see the difference there. It's not about whether you receive treatment or have a treatable condition, but instead whether there is something right now that would make it dangerous for you to be a nurse.

However, unless it's for the purpose of a disciplinary hearing, I don't see why this question should be asked at all. What are they going to do with this information? And would a person whose truth of the matter is yes, would they actually disclose it? Asking the question routinely without due cause decreases the perception of safety, increasing stigma. I think Dr. Halter would agree with me that this only increases stigma if the question is asked routinely, stigma against seeking the healthcare that these people need.

MCGUIRE: Right. Dr. Manthey, do you think reporting helps facilitate treatment or connecting people to resources?

MANTHEY: You know, I wish I could say yes, it's a wonderful thing, and it always works and gets people the help that they need. But quite the contrary, in the area that I've spent most of my life in lately, the substance use disorder issue in particular, it carries with a person. Whatever action is taken is carried with the person's career throughout their lifetime; actually, because it becomes part of a permanent record and is available to anybody who's looking at the license of a person.

It terrifies nurses, when, especially when, they are already getting treatment. Maybe they've gone to a treatment facility on their own nickel, and they've gotten the help that they need. And they're in a program process of recovery, and it's time to answer that question. And, they know if they say yes, truthfully, they're going to be asked to explain it. And that'll become part, in the state of Minnesota, that becomes part of their permanent license record.

MCGUIRE: Right.

MANTHEY: If they say no, then they are being dishonest, which we learn pretty quickly in recovery, totally jeopardizes the recovery. Secrecy is dangerous to people in recovery.

MCGUIRE: Yeah.

MANTHEY: So, the issue of reporting regarding substance use disorder and chemical dependency is fraught with danger for nurses, and it totally terrifies nurses.

MCGUIRE: Yeah.

MANTHEY: It is very difficult. And then on the other hand, take the nurse who is in recovery and is doing really well. And, now she wants to expose a conspiracy of silence. She wants to open that up to a process of recovery of a disease. And she decides to start talking about her recovery. If she's interested in a promotion later on in her career, that's going to follow her, and it's going to impact the kind of decisions that her potential employers will make. So, it's fraught with danger both ways.

MCGUIRE: Yeah, I can see that.

SOUNDBITE OF MUSIC

MCGUIRE: It's time to conclude episode one of this podcast. Please return for episode two as we continue discussing possible issues surrounding sharing mental health and psychiatric history information with licensing boards. The sincere thank you to Dr.'s Davidson, Halter, and Manthey for joining me. This is Leana McGuire for Elite Learning by Colibri Healthcare.

SOUNDBITE OF MUSIC

Episode 2 – State Boards, Nursing Experiences, Stigma, and the Possibility for Change

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MCGUIRE: Welcome back. So now that we know there are problems with these questions and that the questions can make the situation unintentionally worse than better, what can be done about it?

DAVIDSON: Well, I think anyone interested in this should go to the NCSBN, the National Council of State Boards of Nursing, to their website and study their suggestions on how to handle nurses with substance use and other mental health issues. They've collated great guidance, but because of the 10th Amendment, each state has the right to govern themselves. They cannot mandate the change, which I find to be absurd that the profession of nursing at the very top of the profession, the national councils and the ANA, cannot mandate a change. Right? We have to wait for each state, one state at a time, to decide that this is something that they want to take action on. That it has the priority, this year, of all of the other things in the judicial system … and the process that they want to take action on. So, the leaders in our organization, even though they know the right thing to do and they endorse the right thing to do, cannot mandate that the right thing happen.

Also, I think anyone interested in this, if you've been enlightened today and awakened or shocked the same way that I have been over the past couple of years learning about this, I mean, this has been Dr. Halter's life. I just learned about this by accident and could not believe it was happening. But, if you're interested, Google up the Lorna Breen Toolkit, and you'll find it easily online.

There's strategies that anyone can take in their state to start raising awareness and creating a call for action and asking that the State Board of Nursing make a change. This was developed in response to the death of the physician, Dr. Lorna Breen, I discussed earlier, who died by suicide. And, again, her family felt it was this stigma associated with the medical questions that were integral factors in her death, exactly what we are talking about today, the relicensure questions. So, the toolkit gives us the words that could be used that are not stigmatizing and the references to support the change. But it's not as easy as that. Just call up the state board and ask them to make a change.

Well, Dr. Halter's already said what her experience was. This bona fide scientist with the data to support the need for change contacted the board of nursing, went through all the proper steps years ago, and nothing has

happened since. I have at least a dozen research reports published on suicide in the professions, and I have asked all of my colleagues, and they said, “Well, one person contacting the board of nursing is not going to get this change to happen.”

We need more than that. We need concentrated, organized effort. Right? So, you're probably going to need more than just you. You're going to have to create a team to address this situation. And I think, Marie, you've been working on this in your state. You've started since we've learned about this. And you're an integral, key player in the recovery of nurses in your state through the programs that you've developed. You decided to take action. What have you tried so far and how far have you gotten?

MANTHEY: Well, we have certainly, we're certainly in the process of raising awareness. And, our next step is going to be putting our heads together, about a half a dozen people really engaged in this issue, including the dean of the school of nursing and some other notable folks like the former A.D. of the board of nursing. (It's Minnesota, who also was chairperson of the National Council of State Boards of Nursing.) So, we got a fair number of people.

In fact, one organization I just want to mention here is, we have developed an organization called the Nursing Peer Support Network. And, that's because we discovered, I discovered about ten years ago after 40 years of recovery, not being aware of what was really happening in my own field, I discovered that the stigma and shame involved with chemical addiction and alcoholism is so great that it isolates nurses. And, nurses are isolated from each other while they're drinking, while they're in recovery, and while they're in treatment, and then while they come back to work and to work again. The secrecy requires them to not talk about where they work. So, the stigma and shame is a horrific barrier that nurses seem to have, in my opinion, much stronger than even physicians, dentists, and pharmacists.

That organization has been in existence for about almost ten years now, and we have thousands of nurses who have been through it. They've gotten over the stigma and shame. They're willing to speak out even about their own process too much, sometimes to their detriment. They need to understand what it means to your career in the future if you start speaking out.

So, we are potentially the organization that will make the communication to state board of nursing about the need to change the language, particularly with chemical use. The chairperson of the state board of nursing has told me that I'm sorry, she's the executive director, has told me that they have already gotten the approval of the attorney general's office to change the language on mental health, but that the language regarding specifically substance use disorder has not been approached yet.

So, we're gathering our forces right now, and the precise next step hasn't been decided yet. We want to do what we're going to do with the executive director with us, if possible. Just one more piece of really good news. They invited me to come to the practice specialist committee meeting, those are the people that investigate nurses, and they allowed me to tell my entire story of alcoholism and recovery, the impact on my career, and what recovery is all about, including the difference between recovery and treatment. And, it had an impact on them that tells me the story needs to be told so much more than it is now.

MCGUIRE: Absolutely.

MANTHEY: So, yeah, opening it up, talking about it, and then getting the board to change those questions, I think, is going to make a tremendous amount of difference in the recovery of nurses from substance use disorder.

DAVIDSON: Dr. Manthey was explaining to us how she was taking some initial steps with her state board of nursing towards raising awareness about the licensure questions with the goal of, some day, deleting those questions from the licensure process in her state. And, she described that there's even another twist on this that the state boards might address mental health questions in general, but there might be more stigma or more challenges associated with addressing questions that are focused on the topic of substance use disorder. Now, Marie, you're working with lawyers, too, right? You've teamed up with a group of nurses

MANTHEY: Yes

DAVIDSON: who are going to help you on the process. I think what I learned about policy in nursing is that the state boards function under the auspices of the state judicial system, and they're tied to the attorney general. Right?

MANTHEY: Right.

DAVIDSON: Yeah. Yeah. So when you take up a challenge like this, it really is important to have lawyers on the team that move forward to challenge the questions at the board level.

MANTHEY: And, here we have five or six attorneys who were nurses first and attorneys second. So, they call themselves nurse attorneys. And they are a niche, they have a niche practice. They specialize in helping nurses with licensure problems, negotiate those tricky waters without getting themselves in more trouble. Oftentimes, they use the wrong words, but the board increases the discipline. So, they get a lot of help.

DAVIDSON: And, there's less sympathy surrounding making the changes for people that have drug use issues. Right? Like it's not, it's more difficult, It's more difficult to gather the sentiment about that change. But what I, what I found on the death report of these nurses with drug use problems is often that the report starts something with she had cancer; she was being treated with an opiate. Then she developed a dependency. Her proximity to these drugs in the workplace led to diversion. She had uncontrolled, relentless pain, became addicted and then ended up diverting, and once found in the workplace diverting, then the process happened towards the sanctions against the license and could not handle that emotionally or psychologically, leading to death by suicide. And I've also seen this with nurses with fibromyalgia, with uncontrolled pain, cancer ... uncontrolled pain, car accident ... uncontrolled pain.

So, these are not, we need to kind of put it in perspective. These are sometimes the best and brightest amongst us who are going through life situations that are just traumatic, horrific situations to no fault really of their own through the process of this poor health and pain and ended up with an issue of addiction that could be treated. And, if we had a better process in place, I think those, all of those deaths, could have been prevented. So, I think, I really think it's important to put this situation in perspective, to be able to garner the support we need for both handling mental health issues or substance use issues, drugs and alcohol, and tackle them all together. Yes.

MCGUIRE: It seems like between the tool kit created by the Lorna Breen Foundation and the NCSBN, the answers to this problem have been outlined for us. I feel your frustration. Why isn't this just mandated at the national level and changed?

DAVIDSON: We've kind of alluded about the fact that these states have the right to govern themselves. It sounds counterintuitive that the ANA, the Academy of Nurses, or the NCSBN cannot set the standards for each state to follow. But when I tried to find out about how did this get this way, I was told it goes back to the 10th Amendment.

And now are they interested? Are our governing bodies in the profession of nursing interested? The answer is yes. I serve on the mental health and substance use expert panel through the academy. We led, we put together a board proposal this year to address this issue. The proposal was accepted, and a group was formed to write a white paper to raise awareness.

So, that's the very beginning of action, is raising awareness. And that paper is now under review at the journal. And, we're hope hoping, praying that it be published in a timely manner. So, we did have a group from the academy write this paper and to to hopefully stimulate the change that's needed in our country today. A white paper raises awareness. But, it does not again make the change happen. And, it cannot mandate the change. Right. All it will do in the end is say that the Academy of Nurses supports this message.

MCGUIRE: Right. Gotcha. And, is this issue just a nursing issue or do other licensed professionals face the same problem?

DAVIDSON: Oh, it's not just a nursing issue! All licensed healthcare professionals are working through this in different stages of taking action and creating change. In nursing, we're far behind our colleagues in medicine. The profession of medicine is beginning to track their progress through their national council, that's called the FSMB. And, sadly, it took that widely publicized death of Dr. Lorna Breen to stimulate the activity.

They were working on it well before then, but now they've got really some momentum around it, and it would be my hope that someday our national councils would be able to publicly track our progress as well. Take the great work of Dr. Halter, who's on the call with us today, and use that baseline, and start tracking it. We, the profession of nursing, we have not started an organized approach for change, even though this has to happen one state at a time.

I think that to get it done in our lifetimes, we would have to get a group together, and then check it like you would if you were polling working in an office, in the office, supporting somebody for the office of the president. Right? And, you check off one state at a time and who's got the votes, right? So, we need that kind of organized effort to make this happen at a national level and not let it look like the elephant is too big to tackle. Right? 50 states, District of Columbia, is that too big to tackle? I say no, but we do need an organized effort around it.

MCGUIRE: Right.

DAVIDSON: So, policy change happens along a very long continuum. We're still at the very left end of this, raising awareness. It's an important step, but we've got a long way to go. We're barely out of the starting gate.

MCGUIRE: Hmm, so, we said this issue was controversial. Has there been a board who had to stop asking for this kind of information, or is this a growing trend to ask for the information from nurses?

HALTER: Well, I don't know of any board that has had to stop asking this type of information. This whole ball got rolling with the U.S. Department of Justice alleging that the Louisiana Bar Association violated the ADA. And, after that time, this resulted in changes to their state board questions. And, physicians and psychologists have also addressed the problem, mainly in the form of providing model questions from the national level, not mandating, just providing a model that state boards can follow.

MCGUIRE: Okay. Do you think nurses should HAVE to share their personal information regarding their mental health and or psychiatric history for licensure or relicensure?

HALTER: I've never seen a news headline that read, “This tragedy could have been averted if only the state board of nursing had collected information about her mental health.” It’s just ludicrous. The presumption

seems to be that the state boards possess the clinical skill, the labor force, and the focus to follow up on concerns regarding mental illness. And, we know that they don't.

Yes, words do exist to protect the public. If there are rules that are broken, as in the case of individuals with felony convictions or sex crimes, then the public should be protected by the board through denial of licensure. Educational institutions also do background checks, and we screen out individuals who are ineligible to eventually sit for the board of nursing examination.

I want to talk a little bit about where I think the "protect the public" angle really can be accomplished in terms of mental health and physical impairment or other types of impairments.

MCGUIRE: Please.

HALTER: In terms of health, educators really are the first line of safety in terms of protecting the public. They are capable of assessing and intervening with students who are exhibiting behavioral or physical health problems that may impact care somewhere down the road.

For example, I remember I had students at a state psychiatric hospital, and one of my students had anorexia nervosa. And, she came to the clinic, clinical area one day, and she was just in a really bad shape. She was dehydrated, you could tell by her skin that she was dehydrated, and she was like getting weak. And, you know, obviously, I said, you cannot stay in the clinical today. You need to go home and take care of yourself, get into some treatment, and come back and see me, and let me know how you're doing. So, I'm a psychiatric nurse. And, so that is an area that I would definitely assess. But, I mean, nurses with other expertise would pick up on other things.

MCGUIRE: Sure.

HALTER: Fortunately for that student, she did get treatment and was ultimately successful and became a bachelor's-prepared nurse. Now that's the first line of safety. The second line of safety comes from the area of employment. So once a nurse, a graduating nurse, passed boards and gets a job, it is the employer whose job it is to provide oversight for employees. If a nurse is unable to provide comprehensive and competent care due to a health condition, be it mental, be it physical, hopefully management will intervene.

Fellow nurses are also invested in safe patient care. I recall a nurse, I started working with who drank soda the whole shift she was on. She never was parted from that bottle. Turns out she had alcohol in that bottle, because I could tell. Her mood was changing, and we did do some reporting, and she eventually got into treatment, and she came back and worked as an RN. In both cases, the story of the nursing student with anorexia and the nurse with an alcohol problem, it was the actual presence, physical presence, of professionals that made a difference. A question or two on an application would likely not prevent potential harm in the same way.

MCGUIRE: Now, if someone were to say, What's the big deal, just disclose the info to the board, it's private. What thoughts do you feel that that person should consider?

DAVIDSON: Well, I'd like to tackle that one, if I may. The question is problematic, because if you don't report mental health problems in a state where mandatory reporting is required, you're breaking the law. And, if you do not answer the questions honestly that you're asked, you can lose your license, right?

MCGUIRE: Right.

DAVIDSON: We already talked about the fact that the state boards of nursing are connected to the state judicial system through the attorney general. It's kind of a double-edged sword. I actually witnessed this in process. Right? Nurses contact me who are survivors of suicide attempt, and now I'm receiving calls from nurses who attempted suicide because of this process and survived their way through it. ... found the papers that we published, and they want to do something about it, and they want to be connected to change. And, I have one nurse volunteering on my research team. My research is unfunded. She gets no money for it, but she volunteers to feel as though she's in the process of making change happen. So, she was going through a disciplinary hearing and contacted me about it, and her state board asked the questions about whether she had been treated for a mental health problem.

And, she talked me through the dilemma, and she was crying, tormented, you know, in tears. I could just hear the torment in her voice. She's like, "I, I did, but what are they going to do with that? Do they want to know that I did and that I was serious about my recovery, so I went to treatment? Or, did they, are they going to use this against me, because I'm a weak person who needed mental health treatment?"

They don't tell you why they want the information or what they're going to do with it. The questions just come in. And, you cannot get through the disciplinary process of the hearing without answering them. I knew that she had had a previous suicide attempt before, and I was quite concerned for her personal safety. Just reading those questions unraveled months of therapy.

MCGUIRE: Wow.

DAVIDSON: I'm sure the boards don't realize how dangerous those questions are.

MCGUIRE: No.

DAVIDSON: My research is on suicide among nurses, and I hear from these people who have survived attempts at suicide, and they confirm that what we are trying to do here is critically important. We need nurses to be able to obtain treatment for their diseases without shame.

MCGUIRE: Amen. Dr. Halter?

HALTER: You know, I'd like to piggyback on what Dr. Davidson was talking about. And, boy, that was a really touching story. Thanks for sharing it. Civil rights really are a big deal. They're the pillar of the American government, the American experiment, really. In this case, we have safeguards in place to protect the civil rights of "would be" professionals from invasive questions on state applications.

Unfortunately, not all boards are ADA compliant. I didn't go through what some of my students have gone through in terms of having passed with psychiatric treatment, but I can't imagine how devastating it would be to choose between two scary options. And, Judy brought this up earlier, and the first would be lying by omission and fearing reprisals. And, I know some students did that, ended up doing that.

The second is admitting to a stigmatizing condition and then fearing unknown reprisals. I sure would be interested in seeing a study that demonstrates the questions about mental health in any way protects the public, something empirical. The term mental illness connotes danger and unpredictability. And, who wants a dangerous and unpredictable person caring for patients? No one, let alone boards entrusted with the public safety. However, the diagnosis of and treatment for mental illness and the absence of criminal behavior is not a board of nursing concern.

MCGUIRE: Yeah. We've really honed in on the fact that nurses may feel uncomfortable seeking mental health or substance use disorder treatment, even though they have every right for this care. Are there any suggestions you have for nurses who might be listening and need help?

DAVIDSON: Well, I would point the individual nurse to the mental health resources made available by the American Nurses Association on their website. If you Google up just “ANA suicide,” put those two words in your search browser, you'll come up to a whole collated rough set of resources and references on how to prevent suicide, how to access mental health treatment.

DAVIDSON: And they've actually collated a list of free resources that nurses could access outside of their work environment. Now I have another strategy that we talked about on the last podcast that we did together related to the suicide prevention work that we do. We've tested a suicide prevention program at UCSD based on the American Foundation of Suicide Prevention Interactive Screening Profile, which is an anonymous encrypted screening for mental health risk.

So, you can actually if you work in partnership, if your organization works in partnership, with the AFSP, American Foundation of Suicide Prevention. It only costs about two grand a year. It's nothing in the scheme of things. You can set up anonymous encrypted screening, and that gets around the whole issue of mandatory reporting, because what happens is that the nurse will take the screening, it goes through encryption, it's scored.

If you're moderate or high risk, a therapist contacts you back through encryption, through the computer, offers to talk to you and start a dialogue and communication, and can even refer you into treatment without even knowing who you are. If the therapist doesn't know who you are, you can't be reported, right?

MCGUIRE: Right.

DAVIDSON: It gets around the whole issue!

MCGUIRE: Right.

DAVIDSON: So, I think that program is being recognized, has been recognized by the Academy of Nurses as an edge runner, a model for replication. And, I think until we can get past all of these archaic policies and practices that are increasing stigma against seeking care, the anonymous encrypted nature of this screening program is needed.

We'll need that for many years to come until we get past this, until we're mature enough as a profession and mature enough as a country to openly accept the fact that mental health treatment is needed by many.

MCGUIRE: Well, we've been discussing the issue of reporting to licensing boards. Can you think of another option for reporting that nurses would be more comfortable reporting to?

MANTHEY: Well, you know, if we take the issue, again, specifically focused on substance use disorder, particularly alcoholism, which is a 10% rate in our nursing as in the whole rest of the population. So, 10%, I always like to say this to a chief nurse who needs a wake-up call about what's going on in her own department, 10% of the people in your department are either using a substance or in recovery from a substance. Which would you like it to be?

How about how about hiring some nurses who are in recovery instead of letting it be a blindfolded question? Specifically, what I set out to say is that, in a substance use disorder, there is a capacity of full blown recovery without ever going into treatment. And, I saw the classic example of that when I was fired from my position at

Yale-New Haven. I was totally devastated. I cannot begin to tell you what that was like. I can go into that more later if you want. But specifically, I did not go to treatment. Oh no, I did go to treatment, I take that back. I went to treatment as a way of getting out of society for a while and getting my head screwed on right.

I've known many nurses, however, who got into good, good recovery simply by finding a guide, someone in recovery they could get help with and going to meetings. There are all kinds of meetings that are off the record. They are confidential meetings. No names are taken. There's no sign-up sheets. And, it's an opportunity for that group support that the research that John Kelly at Harvard has definitely shown that group support over time in recovery is by far the most successful form of of recovery. And, that includes all treatment centers and all different approaches to treatment.

MCGUIRE: Okay.

MANTHEY: So that's possible. There is certainly a way, a way to thread the needle into one's own recovery that does not require "treatment" for that ugly question on state boards.

MCGUIRE: Got it.

SOUNDBITE OF MUSIC

MCGUIRE: Well, this is a fascinating conversation that we want to have continue. So, we are going to move forward to a third episode. Please come back and listen to this conversation with Dr.'s Davidson, Halter, and Manthey. I am Leana McGuire, your host for Elite Learning with Colibri Healthcare.

SOUNDBITE OF MUSIC

Episode 3 – The Americans with Disabilities Act, Intrusive Licensure Questions, and Dr. Manthey's Story

SOUNDBITE OF MUSIC

MCGUIRE:

Welcome back to episode three. We're having a really in-depth conversation with Dr. Davidson, Dr. Halter, and Dr. Manthey, and we will continue that discussion now. Okay. The Americans with Disabilities Act, known as the ADA, yields some important influence on this discussion that we've been having. Before we get into specifics, Dr. Halter, can you tell us some of the history about this act? It goes back to the nineties and is actually civil rights law, correct?

HALTER: That's right. The Americans with Disabilities Act was modeled after the Civil Rights Act of 1964, and this act prohibited discrimination on the basis of race, color, religion, sex, or national origin. The ADA of 1990 expanded this prohibition to include individuals with disabilities, and disabilities refer to any physical or mental impairment. This law ensures that people with disabilities have the same opportunities as everyone else.

MCGUIRE: Okay. And does the ADA say that organizations can't ask about a nurse's psychiatric history or mental health?

HALTER: Professional boards are subject to the ADA, because they are empowered by the state. The specific regulation that is related to your question is that a "public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of

disability ….” (Title 28 CFR 35.130[b][6]) A more specific response to your question is psychiatric history is not acceptable, but current impairment is, so they are allowed to ask that under the ADA.

MCGUIRE: Okay. So, it's more about how the question or questions are worded then, as Dr. Davidson was explaining earlier in episode one. There are questions that are lawful to ask and some that aren't. Can you explain more about that to us?

HALTER: Yes, I'd be glad to. So not asking any questions at all about mental illness is preferable, and that's what we would like to see on all the board questions in nursing, law, psychology, and medicine. And there are other professions we haven't talked about. As previously stated, asking you about current impairment is acceptable. For example, Nevada's 2017 application read, “Do you currently,” that's the keyword, “Do you currently have a medical or psychiatric/mental health condition which in any way impairs or limits your ability to practice the full scope of nursing?” (Halter et al., 2019, p.19) That's okay. I mean, you kind of want to find that out, maybe even let the applicant think about doing something about what they just answered, maybe getting some help for that. But questions that go beyond current impairment and ask candidates to disclose psychiatric history in the absence of present limitation are not acceptable.

These historical type questions typically require the person to look back for a specific, specific period of time, such as 2 to 5 years. Another no-no are predictive type questions. These are hypothetical incompetence questions. They ask applicants to predict how their condition may impact future practice. For example, “Do you have a physical, mental, or emotional condition that could impair your ability to practice nursing...with reasonable skill and safety?” (Halter et al., 2019, p.19)

Other predictive terms besides “could” include, “may impair,” “may interfere,” and “might affect.” Applicants with psychiatric conditions and histories are required by many states to undertake (this is awful) the laborious task of collecting documentation about their conditions and their treatment. These documents include dates, locations, and circumstances, along with statements in many cases from healthcare providers indicating their ability to safely practice nursing.

One nursing student from Michigan that I had, and again I'm in Ohio, had to travel, she thought she did, travel back to her state and get all this documentation. ... and just so inconvenient for her at the end of her nursing senior year.

MCGUIRE: Wow. And Dr. Halter, you mentioned that psychology had also addressed prelicensure applications. What is an example of how psychology boards are progressing with this situation? ... since the way other professions conduct themselves could influence professional nursing matters in this regard.

HALTER: Ah! So, I had a good friend named Fred Frese, who's quite famous in the area of stigma. He's a psychologist. He was part of the study conducted by Jennifer Boyd and some of their other colleagues. They scrutinized psychology applications in 2016. They found that 28 states, 28 states ask no questions about mental illness. You may recall that only 21 nursing applications asked no questions.

HALTER: So, the psychologists seemed to be doing a little bit better, maybe because that's their profession's focus. They drew the same conclusion that we did, namely that states should eliminate mental illness questions or simply screen for current impairment.

MCGUIRE: Well, the medical community, at least in part, has responded to this issue of which questions can be asked. What is going on in the medical community about this?

HALTER: Like their psychology colleagues, in 2014, after two suicides by medical residents, the American Medical Association put forward a policy to eliminate mental illness and substance use questions. That’s 2014.

My study didn't take place 'til 2018, but the American Medical Association urges states that wish to retain questions about health to focus again on current functioning. As of 2018, their recommended wording was as follows, "Are you currently suffering from any condition for which you are not appropriately being treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)." (AMA, 2018)

MCGUIRE: Got it. Okay. Let's return to talking about the nursing side of this issue. If questions about current issues (are current things that interfere with one's practice of nursing) are allowed, rather than past issues or future assumptions, then we still have the issues related to nurses' concerns of future negative effects. If a nurse disclosed a current interference with practice, and the nurse receives help, that info could potentially affect the nurse in the future. Right?

MANTHEY: If it stays as public information, which is what our notations are, answers on state boards are. Then, the potential is there for the rest of that person's life.

MCGUIRE: Hmm. Wow.

MANTHEY: So, how does it, how do we get those, those answers? How do we get that information expunged from the record? ... or not put there in the first place, of course?

MCGUIRE: Now, the 2019 article raises another concept for consideration. It says something about how the National Council of State Boards of Nursing or the NCSBN did not, at the time of the article, gather or keep track of information related to a tally of disciplinary interventions related to mental health issues. So, it seems we don't know at this time whether increased reporting to boards is actually going to provide more help to nurses or who could benefit from treatment of some sort. What do you think, Dr. Halter?

HALTER: Well, I absolutely believe that board reporting requirements are a huge detractor for getting nurses into treatment.

MANTHEY: I agree.

HALTER: Tracking disciplinary actions is done at the state level and sometimes available on state board websites. I just went to mine recently to see what it looked like. As with my previous article, what I said in that, I cannot find any information about national tracking. The NCSBN does report that the current rate of discipline on a nursing license is less than 1%.

MCGUIRE: Wow.

HALTER: That's pretty low! Tracking these conditions and trying to correlate them with mental health would be quite tricky. In Ohio, only the name and type of license, for example, RN or LPN, are available under a general heading of disciplinary actions. So, it used to list what they'd done in general terms. Now they don't.

To review the infraction, you have to do a specific records search for each individual. Even when more information was available, I had never seen a disciplinary action associated with a mental health condition. I don't remember seeing that anyway. One research question that might generate some information could be, "Is the diagnosis in the treatment of mental illness in nurses associated with higher rates of disciplinary action in registered nurses?"

I'm curious, is there really an effect on people in terms of that less than 1% a discipline?

MCGUIRE: Right.

HALTER: Maybe we could do something like a confidential survey link. ... could be sent to a sample of registered nurses. Maybe we could get a feel for the answer to this question that way.

MCGUIRE: Hmm. Good point. Anything to add, Dr. Manthey?

MANTHEY: Just in the state of Minnesota, there is one organization that monitors for all health professionals known as the Health Professionals Services Program, and so they monitor for every licensed health professional. And that's under the attorney general's office as well, having nothing to do with the professional boards, of boards of directors. And so, that organization has a lot of statistics they collect and report on all the time. Nursing makes up 50% of the total N, generally speaking, of all the health professions, and then nursing. So that makes 100%; nursing is 50%. And, that is becoming more controversial, certainly, more controversial due to medical marijuana and other forms of medication treatment for substance use disorder. Suboxone® is a very popular drug ordered by physicians for reducing craving and allowing the person to join a normal life.

However, it contains heroin, and so the health professional board is going to ask for urine specimens, periodically, blood specimens. And, if they're showing a positive result, that is going to have a major impact, at least in nursing on that nurse's license. So, there's a, there's a lot of uncertainty going on right now within not only the boards but also the licensing, the monitoring agencies.

MCGUIRE: Right.

DAVIDSON: So, what Marie brought up, two new points of concern that we haven't discussed previously. The first is that some of the questioning and the tracking by the boards can actually discourage medication-assisted treatment for substance use disorder, which is a known evidence-based practice. Right, so we're shooting ourselves in the foot there. The nurses would not be able to, in certain situations in some states, engage in that evidence-based treatment because of what the board would do with the information.

MCGUIRE: Right.

DAVIDSON: Yeah. Then she also brought up the fact that of everything reported, even though there's seven different professions that are licensed healthcare professionals, 50% of those cases were attributed to nurses, meaning a disproportionate amount of nurses were in disciplinary action. And, we did a cursory review in our state of the same thing, and found, and we had to patch data from different places together, because it's not all housed in one place. And we found the same thing that nurses were disproportionately being disciplined. And, you can't imagine that doctors have any less issues with alcohol or drugs than nurses do, right?

MCGUIRE: Right.

DAVIDSON: Right. Even in the situation of a DUI or DWI, depending on what state you're in .... In the state where I practice, that board, the Department of Motor Vehicles is linked directly to the board of nurses. Those records are automatically sent over a year or two after your DUI, you may be picked up by the board of nursing. You may have already gone through treatment and recovery. But, at that point, the clock stops when the board knows the clock starts there, and then they start working on this issue of protecting the public and suspending your license during the investigation. And, then you have to go through their board-mandated recovery program and system, pay for everything out of pocket and all the lawyers associated with that.

It could probably cost you somewhere between 15 and $20,000 to maintain your license on a period of probation where you may or may not be able to keep your job. Most employers will let you go at this point, once this happens. I'm trying to find exemplars of organizations that keep their nurses through recovery. If you

happen to be listening and you're one of those places, please contact me, because we need to shine a light on best practice examples of organizations that understand that substance use disorder is a, is a disease, and it can be effectively treated. And, we don't need to discard these employees, these health professionals, who are often the best and brightest among us. There is no reason to discard these people from the profession or to treat them as criminals instead of people with a disease.

MCGUIRE: Great point.

MANTHEY: Another, another part of this is that in the state of Minnesota, it is possible to self-refer. So, a nurse who is concerned about her own recovery wanted to get help, wanting to do the right thing, really dedicated to using all things that's available to her can report herself to the HPSP, go into a monitoring program based on a contract that's created.

It may last for two years or three years. During that time, as long as she adheres to the contract, she will not be reported to anybody. However, by law, a positive screen, failure to achieve some aspect of that contract will result in a reporting to the board of nursing, which will then start the disciplinary action on that person's license.

And, I think that there's more self-reporting of nurses than there are of other health professions within HPSP. So, that's just an interesting other piece of this one about the nurse who really does self-report. And, third thing I want to ask about this, before I forget to say it, is what do we know? Most of us in the field, what do we know about the compact?

What is the state association, the licensing compact that now has 37 states agreeing to administer something about the boards of nursing in the same way? I don't know what they're saying about this? I was hoping, Dr. Halter, that you would have your finger on that pulse. That's a question about what does a compact say about boards of nursing, the compact that holds 37 boards of nursing as one, allowing for nurses to practice across state lines without needing to reapply.

HALTER: I was trying to find information about that very question that you've asked, and I couldn't find anything.

DAVIDSON: Yeah, you won't find anything in writing, but the purpose of the compact is to facilitate the ability of nurses to work in more than one state without undue burden on applying for these individual state licenses. So, when I asked the national council this very question, could the compact, if we engage the compact in making this change, it could get us to a tipping point really quickly. Wouldn't it? Sounds like an efficient strategy, doesn't it? Well, but I think the answer was a little discouraging. That it was felt that the compact ... this would not be a priority for the compact because of their other priorities and the work it took to put the compact together for the purpose of facilitating the movement of nurses between states where there's a critical need. I do think, though, that we shouldn't lose sight of this idea, even if it looks discouraging on the surface, just like we can't say the elephant's too big, we can't change this in 50 states, right? I think the idea of gaining momentum within the compact has ... there's a great allure to that. Now, we just have to see, could we set up an organized approach to make that happen?

MCGUIRE: That would be great. Yes, absolutely. Now, the article we keep referring to discussed prelicensure situations, but I've heard that some states might be asking about mental health-related information for relicensure or renewal as well. Have you heard anything about this in your states?

HALTER: Well, I definitely have, and I definitely looked it up in preparation for this podcast. So, the state of Ohio, I was surprised to see they've made some changes. They are not asking historical type questions anymore on

renewals, or … or on prelicensure applications. Let's see, they've cleaned up the question by modifying them somewhat in measurable legal terms. And, I think you guys will be interested to hear the way they've changed it. So, in this renewal application, it says, "Since you filed your last renewal application, … have you been found to be" (ooh, listen to this term) "a mentally ill person …"

MCGUIRE: Oh, dear.

HALTER: I know, I know. We could talk … it would be another podcast. You've "been found to be a mentally ill person subject to hospitalization by court order, been found to be mentally incompetent by a probate court, or been found incompetent to stand trial by a court?" (Ohio Board of Nursing, 2021). Presumably, if an applicant responds in the affirmative to that statement, the board would have to follow up. Hopefully this is a *protect the public* issue and not so much of as a *protect the board* issue.

MCGUIRE: Right. Okay. And Dr. Davidson, you're in California?

DAVIDSON: Yes. California does not ask the questions on licensure or relicensure, but the questions are, the questions are definitely asked during disciplinary hearings and in a way that is non-compliant with the ADA.

MCGUIRE: Okay. And Dr. Manthey, Minnesota.

MANTHEY: Yeah. In Minnesota, it's a relicensure. I'm not quite sure. I think you, I think everybody has to relicense every three years showing, sometimes showing continuing education units acquired. And, the question is always there.

MCGUIRE: Okay, got it.

DAVIDSON: You know, I'd like to sneak something in on you, you're not expecting now. I hope you don't mind.

MCGUIRE: Not at all. Not at all.

DAVIDSON: There's yeah, there's, there's a research study that was done by a Dr. Katie Gold. Katherine Gold. She's a physician on what, what do people really do with these questions in the field of medicine? And, she did this great study that we have to replicate in nursing. And I am, I'm sure I can find nurses to replicate this. She actually used Facebook, a protected Facebook group that she was a part of or had privilege to, and sent out a list of 24 questions about these issues of mental health and physicians and the licensing board questions and asked them how many of them felt that they had, um would self-diagnose with that they had met criteria for a mental illness. And, 50% of the women that they studied had met the criteria for mental illness but had not sought treatment. 50%! And then also, they said that the reason why they had not was, one of the reasons, was these licensing questions. But then when asked the question, did they disclose the fact that they had mental health condition?

Did they answer yes to the question? Only 6% of those who felt they had the mental health condition had answered truthfully to their medical boards. 6%! So, this really tells us that these questions don't do anything except for increased stigma, right? If only 6% could answer truthfully, is that really giving the board anything useful to work with? Right? And, can we extrapolate this data in research? We call it using indirect evidence. Right? Can we use this indirect evidence that was gathered amongst physicians and assume that it might be applicable to nursing? And, I would say yes, but of course, we need to replicate this study. And boy, wouldn't it be fun to do?!

MCGUIRE: Wouldn't it?

DAVIDSON: Right. Yes.

HALTER: It would. It would. But, you know, in the case that you just brought up, Judy, the person had not gotten help. And, the question is, "Did you get treatment? Have you been diagnosed and treated?" No, they hadn't. So, they answered no.

MCGUIRE: Right. Right, exactly. So, speaking of research, Dr. Halter, I'll bounce this question to you. What do you think are the gaps in the literature or areas of particular interest for future research related to this topic?

HALTER: Are you sure you want to ask me this? I have got a lot to say about it. First, I mean, the easiest answer that I've got is we need to replicate those studies that I've already talked about, just any progress that has been made in any of the fields. And like I said, I plan to replicate my own study. Second, I'd like to visit the *protecting the public* issue. I want to see if states with more invasive mental health questions actually protect the public more. But, designing a study to get this information would be tricky. Maybe the proxy for protecting the public would be more disciplinary actions or less. I'm not sure. We'd have to work on that one.

MCGUIRE: Right.

HALTER: Finally, I think it would be helpful to look at the other more positive side of the coin. I'm curious as to whether ADA-compliant states' application questions improve psychiatric care-seeking. Isn't that the bottom line? That's what we all want to know.

MCGUIRE: Sure.

HALTER: I think the question is central to today's topic.

MCGUIRE: Yeah, I would agree. So now that we know more about how there are lawful ways to ask nurses about their practice, let's have a pros and cons discussion. There are beneficial reasons for disclosing some information to the board of nursing, and there are reservations for disclosing that kind of information. Dr. Manthey, I feel like you could say a lot here about pros and cons. Before we start naming some of them, could you tell us some of your story as it pertains to this issue?

I know you could probably take the whole hour or more to share all of the details of your journey. But, in a nutshell, can you give us a few of the main points through time as to your story and how disclosing helps and may also hurt for some.

MANTHEY:

I'm happy to do that. I spent the first half of my life as a non-using person, nonalcoholic, non-using drugs. I got into a point in my life where I was experiencing a great deal of stress, and I didn't know how to handle it. I didn't understand about self-care. And, while we haven't mentioned that today, I would like at some point in time for those of us who are in these topics to start talking about self-knowledge, self-awareness, and self-choosing how life balance can be best achieved.

I think we oftentimes can blame other people for it. And, I was doing that. I was certainly victimized by some circumstances. But at this point, I had already developed primary nursing. My career was on a very forward upward trajectory and then chief nurse of two hospitals here in Saint Paul and then Yale-New Haven. But, my drinking escalated throughout that time, and I went from one drink before work, I mean after work, *never before*! One drink, after work, before dinner, and then it moved forward over time, ten years until I was *not able* to not drink, I was totally *unable* to have any control over whether or not I had a drink after work. And so, I drank a blackout or passed out every single night, and I knew what position I was in. I knew the responsibilities of it. And, what I haven't yet said is I wanted to be a nurse since I was five years old. Something really powerful happened at that time, and that's never been a question for me at any point in my life. It has always been the

right thing. So, when I was fired for acute alcoholism, with the understanding that if I, if I would go to inpatient treatment, I could save my job, I went into inpatient treatment, and they fired me while I was there. So, at that point in my life, I was totally devastated, and I had nothing. I certainly couldn't afford treatment. I had three months of severance. I had two children, a house with a mortgage, a lot of responsibilities financially. And, I had no job and no hope of getting one in any field that I was prepared for. So, my life after that for the next 40 years has been a life of recovery, very staunch recovery. I have engaged in recovery processes for a long time. I've gone to international meetings. I've sponsored people. I've attended meetings on a regular basis. I have a home group, and I have support that is, that is never going to go away. It's phenomenal. And, I know from John Kelly's research that that is the most successful treatment for substance use disorder, having a support group that you have stayed, stay connected to. It wasn't until ten years ago that two and two became four. And, I'm so embarrassed and so angry that I am in the situation that I am, am in where I did not understand what was happening in the nursing profession to nurses like me who had succumbed to a substance use disorder. The conspiracy of silence is so powerful in nursing. It results in stigma and shame that oftentimes in and of itself is enough to keep nurses from getting any kind of help. The shame is profound! The stigma is profound! Stigma comes from the outside. Shame comes from the inside. And, both of them are barriers to recovery.

I knew instinctively that I needed to be honest. I also knew that I could not be honest in public. So, I developed a consulting practice, and I always told every client the truth about my recovery. Everybody who ever worked with me worked for me in the company that I developed, everybody knew, and we incorporate, incorporated some of those principles of life health into the work.

Ten years ago, I had an occasion to be with the nursing advocates of Texas. Texas Nurses Association has a huge program, a peer support and case management, etc. And, I realized that I was with a group ... I was there to do a keynote speech on relationship-based care, which sometimes I want to get that incorporated into this work, because it's so relevant.

And, I was talking about the work of my company, and I realized these people all knew about recovery. And so, at the break, I took a break, and I came back from the second half of the keynote, and I started off with my name is Marie, and I am an alcoholic. Now, I have been speaking nationally and internationally. I had written my book on primary nursing, I co-authored several other books in those years of recovery.

And I had never said to my colleagues in public, I am Marie Manthey, I am an alcoholic. I said it a thousand times to people who are in AA meetings and other meetings but never to my own colleagues. And, it was like I was on fire on the inside. And all of a sudden, I realized the shame, the stigma that it kept, that conspiracy of silence so profound that I, I don't mean to sound arrogant here, but I will, I've been active in the profession of nursing for by that time, 50 years. And, I have been active in recovery for close to 40 years at that time. And, I had never put two and two together. I had never seen what we do about the stigma and shame, which up to that point in Minnesota had been nothing. And so, we began to, to address that directly and created something called the Nursing Peer Support Network. We have eight meetings going on around the state now. A couple of them are online meetings, and they are opportunities for nurses to talk to nurses. Nurses talking to nurses is absolutely, is absolutely the essential way to relieve stigma and shame.

Therapists can't help with that. Counselors can’t help with that. It takes a nurse talking to a nurse who has gone through that process to really help. And again, William L. White, I don’t know what you think of him, but we've read a lot of his literature, a lot of his wisdom about peer support as a form of therapy and really find that nurses who go to peer support meetings immediately feel connected. They immediately begin to feel a reduction in stigma and shame. That organization now has become somewhat strong in Minnesota, because we are right in between the board of nursing and HPSP, that monitoring program. They are independent of each other, both under the Attorney General. We stand in between them, a freestanding 501(c)(3) obligated to

neither, to no one actually. We are an entity unto ourselves, and that gives us a strength in this particular situation that I see as the mechanism that if we don't, if the board, if the other potential leaders in this process aren't willing to take a hand in it, we can carry it forward.

SOUNDBITE OF MUSIC

MCGUIRE: Dr. Manthey, that was an incredible story! I thank you for sharing that and for the work that you're doing as a result. It's very profound. We are going to wrap up episode number three and move to a fourth episode to continue this discussion. It's a very important discussion. I'm thrilled that we're getting the opportunity to do this with Dr. Manthey, Dr. Halter, and Dr. Davidson. I am Leana McGuire, your host for this podcast from Elite Learning and Colibri Healthcare.

SOUNDBITE OF MUSIC

Episode 4 – Reasons and Reservations for Sharing Personal Health Information

SOUNDBITE OF MUSIC

DAVIDSON: In episode three, Dr. Manthey was describing a model situation where in the state of Minnesota there are the state board of nursing, the monitoring program for nurses going through monitoring for substance use, and then there's a peer support program in the middle that's 501(c)(3) that's not connected to either but supports the nurses.

Does the Board of Nursing recognize your program officially for nurses that are going through monitoring? And, do you have to report a list of names to them?

MANTHEY: No, we have an arrangement that contains the principal of confidentiality, we don't collect names. So that means we don't have good statistics, and that kind of breaks my heart. But the safety and security of no name-taking, I think has, has just helped it to be a very honest, open conversation. We have actually developed a statement about reportable, mandated reportable material. If that, if that comes up in a peer support meeting, we know how to deal with it. So, we have, we really developed a strong program, but we are not, it's not considered treatment. We're not licensed for treatment. We don't use any therapists. It's peer support. It's staff nurses working with staff nurses or nursing leaders. Any license from LPN up to practicing advanced practice nurses.

DAVIDSON: So, Marie, if a nurse wanted to, themselves, disclose to the board that they were using your program as part of their recovery, can they do that? And, would the board accept that?

MANTHEY: I don't know. I don't think we would want them to accept us as a program of recovery. We are a support group that helps just get through the rough spots, but we don't proclaim to be a recovery program. We also have a 30-day residential recovery program in the Twin Cities called The Retreat, and that is licensed as board and room that has no therapists, no licensed therapists. And, it does not accept insurance. And so, that is not a treatment program so defined by the courts, by law, and it's extremely successful.

DAVIDSON: The cost of the board monitoring programs is very expensive. They're usually dictated. And, if you go outside of their network, it doesn't count towards getting your license back.

MANTHEY: But we're not, we're not into recovery. I think that we've managed to place ourselves in a position of pretty strong recognition of a positive value. But we are not, we're not treating the disease.

DAVIDSON: And, I think what we've heard Marie disclose here is that it's working, it's helpful, but it's not a formal .... The thing that is working, the thing that is helpful is not part of the formal recovery process, correct?

MANTHEY: Absolutely. Yeah.

MCGUIRE: Well, I'd like to thank Dr. Manthey again for sharing her impactful story in that last episode. So, Dr. Manthey, could measures to ask for self-reporting of any mental health issues actually hinder nurses from seeking treatment? Do you think that that is a valid concern?

MANTHEY: Currently, I think it is a valid concern, very definitely. When we move into ADA language and when the results of information released on one's own state board no longer becomes a permanently available public record, I think that we can, we can really see the benefit then of self-reporting it.

MCGUIRE: Okay. And is it possible to name one benefit of self-reporting to a state board like a nurse's current issue that negatively affects their practice. What's a good thing that can come from self-reporting?

MANTHEY: Well, the self-reporting that a nurse refers herself to the monitoring program, HPSP, provides her with a structure for the next year or two or three that requires certain mandated activities which will demonstrate a consistent recovery.

MCGUIRE: Got it.

MANTHEY: It demonstrates no relapse. And, a nurse who chooses that can go to her employer if the employer as an employer gets involved, but they do not necessarily get involved at all, it's for a nurse's own security. And what they say time after time after time at these meetings is, "Because I had that structure, even though I hated it the first year, because I had that structure, I was able to go three years, and by the time my contract was finished, I was okay."

MCGUIRE: Great.

MANTHEY: And I was in the program, and I was able to handle it the rest of my life. So, they, they do use it for their own support when they fear relapse.

MCGUIRE: Right. Right. Okay. Dr. Halter, anything to add from your perspective?

HALTER: ... about a positive aspect of reporting to the board of mental health or substance use disorder condition? I hadn't thought about what Dr. Manthey was talking about. Maybe, you know, just self-reflection and just saying, I'm going to bite the bullet, and I'm going to report, and then I'm going to get myself into treatment whether I want to or not? That is a good outcome.

Otherwise, I think that the questions on the board of nursing applications results in fear of help-seeking and unnecessary anxiety. The nursing board may have a benefit of asking that question by showing to the public that they are asking that question. I mean, that's the only benefit I can think of. And, the proof is in the pudding in that a lot of states don't ask those questions!

MCGUIRE: Right. Right. Good point.

HALTER: They seem to be doing okay.

MCGUIRE: Yeah. Okay.

MCGUIRE: And now let's talk about reservations about self-reporting. We've talked about a lot of this, a lot of reservations. But, Dr. Manthey, can you add anything to what is a reservation or con of self-reporting.

MANTHEY: Only if one fails to honor the contract, then one is going to be reported to the board of nursing and potentially their own employer. The board may decide in investigation that the situation is so serious that they feel they need to report it to the employer as well.

MCGUIRE: Got it.

MANTHEY: None of that is protected in self-reporting if one relapses.

MCGUIRE: Sure.

MANTHEY: The problem with relapsing right now, as most treatment places are saying, relapse is part of recovery.

MCGUIRE: Right? Okay. Yeah. Dr. Davidson, could you name a concern that we haven't discussed yet that could arise from self-reporting?

DAVIDSON: Well, we do see from the institution level that an institution may take action saying if you self-report, you may be able to retain your position, whereas if you don't and we need to report, you will be dismissed. Okay? So there is that angle as well, whether or not the organization is encouraging the self-reporting to assure that the person gets the treatment that they need and use it as leverage there. You can see, as in Marie's case, she was asked to go into treatment by her employer and under the guise that she would be able to retain her position.

And, then when she was in treatment, she was fired. So, nothing is guaranteed here. And, I'd like to even bring up at this point that I'm kind of veering a little off topic, but the conversation is naturally leading in this direction, the term *alternative to discipline* program, right? So, many states are very proud of the fact that they have *alternative to discipline* programs; so that, they monitor and move nurses towards recovery without what they are labeling as discipline.

And, they do not include suspending the licenses as discipline. That's not discipline in their eyes. Discipline is whether we're going to press criminal charges or this will remain on your criminal record. Right? The act of diversion, right?, or similar acts. So, the term *alternative to discipline* can be deceiving, and the nurses that I hear from who have been through these processes definitely feel as if the process is punitive, is disciplinary in nature, even though it's labeled *alternative to discipline*.

So, back to the self-reporting. Self-reporting could in some situations help you to retain your employment if the employer is asking you to self-report or be fired. Right? Yeah.

That's the only benefit that I can see from this. And because, as we discussed in the other three episodes, that these situations are handled independently state by state. None of us can tell you what to predict if you self-report, because it's handled differently, in each state, one at a time, right? Whether or not you retain your job happens independently, one organization at a time within each state. So no two, no two institutions will handle this the same way.

MCGUIRE: Dr. Halter, any concerns related to self-reporting that you have? Something we haven't discussed yet?

HALTER: I just have a couple of anecdotal kinds of comments.

MCGUIRE: Sure.

HALTER: People aren't comfortable talking about this topic. I mean, mental illness itself, substance use disorders, they're not comfortable. And, you know, go back to the topic of structural stigma. You see this in our institution and organizations. And, it's sad that we've had to work so hard to get such a simple thing accomplished, i.e., getting rid of those questions. I would tell you the anecdotal was this. When I complained to the board of nursing and I think it was 2014 about the questions, for the very first time since becoming a nurse in 1986, my CE's were audited. Now, was that a coincidence?

MCGUIRE: Oh, interesting!

HALTER: I don't know, but I had to come up with all the documentation on my CEs. This is kind of interesting too. When my colleagues and I developed this paper. We thought, “Man, we're going to do a great presentation at our professional association.” That year was the first year I was denied a speaking position at my national conference, and while I was on an elevator, I was around a higher-ranking person in the organization. I said, “My presentation didn't get accepted.” And, she goes, “Oh yeah, I heard about how controversial it was.” And, I'm going, “What?”

MCGUIRE: Interesting!

HALTER: So, those are my two anecdotes. And, I'd like to comment also that while I'm thrilled with the incremental change that's been occurring with these licensure applications, or at least I think they have, I think we can do more. And, if you look back, this is probably going to be controversial by the way, if you look back to 2014 challenge by the Louisiana, to the Louisiana Bar Association about their applications, the lawyer sued, and that's what ended up changing the system. And I don't know, maybe we should encourage applicants who feel like they've been unduly hurt to do something about it. Maybe?

MANTHEY: Let me talk to our nurse attorneys.

DAVIDSON: You know, Peggy, I would challenge, the thought has crossed my mind that we could conduct action research in this realm and have the people that have been most affected by the process drive the research forward and study ways, best practices towards creating this change and making it happen. And wouldn't that be a rewarding process to gather together people who had been affected by the process, had somehow made it through it, and had a passion to make the change so that this doesn't happen to others in the future?

HALTER: That would be wonderful.

MCGUIRE: Yes, it would. Can either of you think of a way state boards could monitor nursing practice for the safety of nurses and the public without the concerns of some of the reservations or ramifications of self-reporting? Dr. Davidson?

DAVIDSON: I think about a year ago I would have answered this question completely differently, but then we had the case of RaDonda Vaught. Right? So, for the audience, listening audience, who's not familiar with that case, a nurse made a mistake, pulled a medication. Based on what happens in the brain, when you see the first three letters of a word and your brain completes the end of that word falsely in your head ... and she pulled out one medication that she thought was a sedative, and it was not. It was a neuromuscular blocking agent, gave it to the patient and the patient died, was not intubated.

And, she was tried in a court of law for murder on this medical error that she had reported herself. Right? So, I definitely think that the board's monitoring for safety is fraught with hazard. Now anyone monitoring for safety is fraught with hazard now, because nurses across the country are afraid to report their errors and problems. So, I think it, it, it, it eeks into this whole topic of how do we protect the public from nurses who are incompetent to perform?

And, I think the best, the best process, the best public safety is to encourage nurses into treatment without punishment and shame. Right? If we encourage nurses into treatment without punishment and shame, then, and it's not punitive, nonpunitive in any way, shape, or form, then we have the public would be better protected. I talked to a nurse today as I'm looking around the country for examples of best practices where an organization might allow a nurse to go out on leave of absence to get the acute treatment that they need for substance use disorder and come back into the organization, right? Without any punishment towards the treatment of this mental health issue. And, I asked her about the logic of not allowing these people to work or firing them when you find out they have a substance disorder or other mental health condition. And she said, you know, if a nurse is being monitored, those are probably the safest nurses amongst us, because they have to have mandatory drug and alcohol testing on a routine basis.

MCGUIRE: Right.

DAVIDSON: Those are probably the safest ones. If you think that one in ten, one in ten Americans has a substance use disorder problem, you've probably got … if you've got 100 nurses on your staff, you've got ten people out there that are not being monitored, that are having the issue, that's not being treated. It's safer to hire and retain these nurses that are going through the actual treatment and being monitored. You'd be better off with those at the least they're known, right? And, you know that they're getting the treatment they need.

MCGUIRE: Right.

DAVIDSON: So, protecting the public? Hire these nurses that are going through recovery. That's another controversial yet I think would be a positive strategy that we have not tackled. Do you know that I've found throughout this whole process of discovery that the veterans association, the VA at a national level, at a federal level, discards these nurses. Go … anyone with a sanction against their license, cannot work. So, they are let go if they're on probation with the state board of nursing.

MCGUIRE: Wow.

DAVIDSON: So, yes, you cannot work. It's, I saw it in writing, and it's … so … they're let go. These kind of policies need to be addressed and changed so that we can have a healthier community, a healthier workforce.

MCGUIRE: Yeah, good, good point. Dr. Halter, thoughts?

HALTER: So, you asked about whether there is a way that state boards can monitor nursing practice for the safety of nurses without the concerns that we've been sharing today.

MCGUIRE: Correct.

HALTER: I believe that the state boards are already monitoring nursing practice for safety based on their statutory authority. They're responsible for reviewing complaints and acting on them. In cases with sufficient evidence, the nurse's license may be impacted, and they handle complaints that have to do with practice issues, drug issues, boundary violations, sexual misconduct, abuse, and fraud. And, they also look into positive criminal background checks. And, I believe that most states' boards of nursing are doing an excellent job with these areas.

MCGUIRE: I gotcha. Dr. Manthey?

MANTHEY: I really support what you were saying, Judy, about employing nurses in recovery, exactly the same point I've made to audiences over and over and over again as nurse executives, nurse administrators, locally.

The point being you got 10% of your staff, exactly what you said. Wouldn't you rather have that 10% in recovery than in addiction? And, the answer generally is yes. That makes a lot of sense.

MCGUIRE: Sure, absolutely.

MANTHEY: And, nothing ever happens, because HR, HR and EAP need to be brought on board in this change process to facilitate the structural changes that need to happen, that will support what we're trying to do here with changing the way nurses' mental health, mental health and substance use disorders are treated by the profession.

MCGUIRE: Excellent point.

MANTHEY: So, I really think that nurses in recovery, nurses in treatment for mental health issues, we need to have a pathway to employ them. And, then I'm thinking that with the post-COVID exodus of staff and the terrible staffing situations that occur around the country, that this would be a great time to create what I've been calling a pathway to employment of nurses in recovery, a pathway to employment of nurses in mental health. And, somehow we don't have ... just seems like to those of us in the field of recovery, it makes common sense. But, it feels to me like we still don't have the safety net in the hospital that would allow a director of nursing or a chief nurse to take a risk on this.

MCGUIRE: Got it. Yeah.

MANTHEY: HR people have to change. I think our biggest problem sometimes is policies in HR. They are so afraid and they are so risk aversive that they have unfortunately hard and fast rules that prohibit the employment of nurses in recovery.

MCGUIRE: Okay. Good point. Excellent point. Now, there are states that aren't asking for past psychiatric or mental health history in connection with licensure. Why do you think some states started asking and some didn't?

HALTER: I don't think it's an issue of why did they start asking them. I believe that they probably all used to ask those questions.

MCGUIRE: Sure.

HALTER: And, I think the Americans with Disabilities Act came about. Many states stopped asking the question.

MANTHEY: Yeah, yeah. Good point, I agree.

MCGUIRE: If a nurse is in a situation where personal mental health-related information is being asked through questions that the nurse feels are too probing or even unlawful, do you have any suggestions about how to proceed? Dr. Davidson mentioned that if reporting is a state requirement, then you have to report. You don't want to break the law, right?

HALTER: You don't. You don't. And that, that's tricky. And when a nursing student would tell me, I'm not going to say that I had a problem, I just, you know, do so at your own peril. But, nurses complete these applications. And, on the applications, there's a disclaimer alerting them to the fact that misinformation can be prosecuted for perjury. While I've never actually heard of anyone being legally charged for omitting details of psychiatric care, I recommend that applicants respond truthfully. In addition, I recommend that they become part of the solution by protesting intrusive and overly broad questions about mental health. Grassroots movement.

MCGUIRE: Well said.

HALTER: Thank you.

MANTHEY: Can I just add one more comment here? One of the things that I think nurses should do is assume responsibility for their own liability insurance.

MCGUIRE: Right.

MANTHEY: Because a lot of liability is fairly reasonably priced, and it does provide for at least partial payment of an attorney.

MCGUIRE: Right.

MANTHEY: Having a nurse attorney present when people are being interrogated by the state board of nursing in our case is always helpful.

MCGUIRE: Excellent.

MANTHEY: There's language in problems that nurses don't understand, to use certain words that mean certain things to the board that it doesn't mean to the average nurse. And, just having someone who can explain that and help them understand a different way to answer the question can be really helpful.

MCGUIRE: Gotcha. I think it's important to discuss Dr. Lorna Breen again in the context of the Dr. Lorna Breen Heroes Foundation. Can you tell us something about that, Dr. Davidson?

DAVIDSON: Well, earlier I talked about how the foundation began after the death of Dr. Lorna Breen, and the Lorna Breen Act is, was put into place to provide funding for people that wanted to start a project to make change, to decrease stigma against seeking mental health amongst healthcare professionals, but even further .... So, there's federal money available now for people who want to take action. Okay?

But, there is also, the Lorna Breen Foundation teamed up with the Schwartz Center in Boston, and they will also be providing grants for people that want to start work on projects like these to decrease stigma amongst healthcare professionals. So, there are two different seemingly pots of money available for people that want to form groups, to take action that might cost money.

MCGUIRE: Gotcha. Okay, excellent. Well, this has really been an informative conversation, all, all of the episodes involved in this discussion. Are there any final thoughts you'd like to share before we conclude? Dr. Halter?

HALTER: So, the article that I did about state nursing licensure questions and non-ADA compliance was the only research that I ever did that was not connected with my employment. That is, I had no goal of promotion or tenure by publishing. This issue is extremely important to a subset of licensure applicants. This issue is also vital in reducing organizational stigma and its damaging effects. Hopefully non-compliant boards will hear our message and make changes.

MCGUIRE: Excellent. Anyone else?

DAVIDSON: I want to thank you for bringing this up today. It was so timely for you to approach us on this. As I said at the beginning, my research was not looking for this. It was a complete shock and a surprise to find that these things were linked to suicide amongst healthcare professionals. It is time to take action.

Wish me luck! I've been asked to address the Tri-Regulatory council, the council of medicine, nursing, and pharmacy soon, and I'm hoping I can present this in a way that won't alienate our colleagues but instead stimulate some action.

MCGUIRE: Well, good luck! Absolutely, absolutely.

MANTHEY: That's wonderful.

HALTER: Congratulations!

MCGUIRE: And this has been a shock. It was a shock to me to hear that relationship too during this conversation. I hadn't put that together at all. It's, it's a fascinating discussion, and the work you're doing is incredible. So, keep it up. Thanks to all three of you for participating in this conversation. We really appreciate your insight and your experience and willingness to spread awareness about, about this topic. It's, it's admirable.

So as a recap, one of the purposes of this podcast was to analyze and better understand the issue of disclosure of nurses' psychiatric history or current mental health information as connected to licensure or relicensure. This has really made me aware of the many aspects of this topic. As I mentioned, sometimes in trying to solve one problem we can cause another.

SOUNDBITE OF MUSIC

MCGUIRE: In trying to collect information, we must be careful not to cause harm for those providing the information. There is a lot to think about as we do want nursing boards to protect the public and help nurses. And, we also want to protect nurses. We thank you all again, as I said, for joining us. Another sincere thank you to Dr. Judy Davidson, Dr. Marie Manthey, Dr. Margaret (or Peggy) Halter. This is Leana McGuire for Elite Learning by Colibri Healthcare.

SOUNDBITE OF MUSIC

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