Clinical Quicknotes
on Substance Use Disorders

Substance Use Disorders
Center of Excellence

Impaired Healthcare Professionals: Risks, Recovery, and Resources

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Quick Takes

- Impaired healthcare professionals (HCPs) are clinicians who are unable to adequately fulfill work responsibilities in the context of unstable mental health disorders, substance use, burnout, unresolved trauma, or poor coping.
- Workplace trauma and vicarious trauma increase the risk of impairment.
- Licensed HCPs should support impaired colleagues in seeking help.
- HCPS are often reluctant to seek help due to fear of losing their employment or compromising their licensure.
- Most professional licensing boards have "safe haven" programs that allow HCPs to avoid board reporting and action if licensees voluntarily seek treatment and agree to monitoring following treatment.
- In some circumstances, it may be necessary to report impaired colleagues to their specialty licensing board. Licensed HCPs should familiarize themselves with their specific board's safe haven programs and any requirements that may exist for mandatory reporting.

This QuickNote (QN) describes the various types of impairment that professionals experience, primarily concentrating on burnout, substance use disorders (SUDs), and mental health disorders. Although help and professional support are often readily available, stigma and institutional barriers can negatively impact their willingness to ask for help. Our goal in this QN is to support communication amongst professionals, to inform and educate about where to turn for help, and to support and guide HCPs through the recovery process.

Case History:

> *Crystal, a 20-year nurse and a 17-year psychiatric nurse practitioner, believes in providing service to patients regardless of their ability to pay. She is well-respected and has a strong personal mission that is fulfilled at the federally qualified health center where she's worked since 2019. COVID changed many of the workflows and increased her patient volume significantly. She's unable to pinpoint exactly when she started to feel burned out, but it was sometime after Ohio's COVID lockdown. She finds herself ruminating throughout the day with thoughts like: "I just cannot do this anymore, I cannot hear what my patients are saying to me," and "I need to get some help, but how can I make time for that?"*

Professionals struggle with various issues they face at their jobs, homes, and personal lives that can create emotional chaos, overwhelming their ability to be fully present while at work. As clinicians, we are certainly not immune to the same pressures that our patients experience. We are trained to be caring for others, which may at times discourage us from engaging in the very practices that we encourage in those we treat. We may neglect self-care, limit time to reflect, and avoid preventive practices until it is too late.[1] The research suggests that healthcare systems are concerned about the consequences of professional impairment on patient care practices, providers, colleagues, and healthcare centers themselves.[2-5]

According to the National Association of Social Workers (NASW), "Professional impairment occurs when something in the professional's life interferes with their ability to perform their job to the best of their ability, sometimes in a manner that can be unethical. Professional impairment does exist, though it is difficult to measure its prevalence."[6] According to NASW, impairment can happen to professionals for a myriad of reasons, including poor coping strategies, unresolved grief and trauma, burnout, self-medication of mental health symptoms, and unstable mental health conditions.[6]

The issues most commonly associated with provider impairment are burnout, SUDs, and mental health issues. Burnout, though not technically a medical diagnosis, is problematic for providers of all disciplines and is characterized by emotional exhaustion, interpersonal detachment, cynicism, and a decreased sense of personal accomplishment that is driven by chronic work-related stresses.[7] Burnout is exceedingly common, with almost one-third of physicians and one-half of nurses working in a hospital setting reporting high levels of burnout.[8] The rate of SUDs in these groups is also significant, with estimated rates of 10-15% in physicians and 20% in nurses.[9,10] Depression and anxiety are also significant in physicians, with notably higher rates in women than men. Regrettably, many physicians, nurses, and other HCPs do not seek help with any of these issues, a problem that also exists in the general population.[11] This does not imply that all HCPs experiencing these issues are necessarily impaired. Impairment is a problem of functioning, not diagnosis. Many HCPs experiencing one or more of the previously mentioned issues continue to function at a high level.[12]

> *Crystal begins to experience mild symptoms of depression with impaired sleep and unintentional weight gain. She feels guilty over her detached feelings toward patient care and her organization. Missing meetings and appointments become customary. She feels like she is running out of excuses and fears that it will soon be evident to her colleagues that something is wrong. To combat her ruminating thoughts, she drinks more than usual, drinking a bottle of wine per night. She finds herself thinking about wine while at work and craving a drink between patient visits. She experiences increased fatigue, abdominal upset, frequent nausea, diarrhea, and headaches most mornings.*

Multiple risk factors increase the possibility of impairment in HCPs. Exposure to patient trauma, chronic workplace stress, and ready access to medications all increase the likelihood of impairment,[13,1] and HCPs with prescriptive authority and/or ready access to medications are particularly vulnerable to mental illness and substance use.[2,4] Demographic risks for impairment include male gender and single or divorced status.[3] Psychological and social contributors include untreated mental illness, accepting attitudes about drug use, concurrent use of multiple substances,[14] and unhealthy lifestyle habits.[3] Family histories of addiction or trauma, chronic pain, and long-term illness also heighten risks.[15] Fortunately, some factors are protective and decrease the likelihood of impairment, including having dependent children, maintaining a healthy lifestyle, and being subject to robust workplace drug-monitoring policies.[3]

Virtually all HCPs experience substantial stressors at work. Unmanageable workloads, repeated exposure to patients who have experienced traumatic events, and even workplace violence contribute to this stress, at times leading to burnout, vicarious trauma, compassion fatigue, depression, and SUDs. Compassion fatigue and burnout are strongly influenced by workload and exposure to workplace trauma. Research indicates that stress and trauma exposure increase compassion fatigue, while job resources—such as supportive supervisors, coworkers, and organizational backing—are protective influences that mitigate these effects.[16]

Access to medication is a recognized and important risk factor for the development of SUDs in HCPs. Provider education and active surveillance of medication usage and diversion within healthcare settings can reduce misuse and create a safer work environment.[17,18] According to the state physician health programs, opioids and alcohol are the most commonly implicated drugs in physicians with SUDs.[19] Nursing professionals who have ready access to controlled medications also face a higher

risk of SUDs than the general population.[17,20] Although the effects of burnout, SUDs, and mental health issues in HCPs have been noted for decades, they became increasingly problematic during the COVID pandemic. For example, a 2021 survey of 1,452 Ohio pharmacy professionals (pharmacists and technicians) revealed a 360% increase in daily emotional exhaustion during the COVID-19 pandemic, with a lower commitment to patient outcomes, diminished sense of accomplishment, more depressive and hopeless feelings, higher rates of suicidal thoughts, and greater concern about their own use of substances.[21]

Another statewide survey of 13,532 licensed healthcare professionals, including nurses, physicians, pharmacists, behavioral health providers, dentists, psychologists, and veterinarians, showed similar trends with respondents reporting increasing rates of mental-health impairment, suicidal ideation, and worries about personal substance use.[22] Despite this, fewer than 24% sought emotional support services, and nearly 81% reported no formal screening or monitoring for stress or mental health during the pandemic.[22] In yet another study of 1,600 Ohio physicians assessed before and during the pandemic, mental distress rose, and work efficacy declined, with 6.2% of those surveyed reporting suicidal thoughts and 4.3% expressing concern about personal substance use.[23]

> *Crystal finds it increasingly difficult to function and arrives at the clinic at least 10 minutes late most workdays. Her colleagues have noticed her decreased performance and choose to cover for her rather than address the issues that they recognize as being unlike her. Her morning patients have started to notice her symptoms and ask her if she's feeling OK. She has emotionally detached from her husband and kids, but is still able to fulfill her family responsibilities of making dinner and school pick-up. She thinks she might have a problem, but is unsure what to do or who to tell. She learned at a professional conference that colleagues are responsible for reporting issues like the ones she is experiencing at the workplace, and she finds herself hiding her pain, leading to feelings of isolation that impair her even more. She cannot afford to lose her job and be reported to the board.*

Denial and stigma are major obstacles to seeking help for HCPs who are experiencing emotional distress,[24,19] with fear of job loss, disruption of insurance coverage, board action, and confidentiality concerns being prominent.[25,19] During a 2021 survey across 13 Ohio licensing boards, fewer than 25% of professionals sought help through an Employee Assistance Program (EAP), citing time constraints, stigma, and privacy concerns as barriers.[26] Nurses who have diverted medication in the face of an active substance use disorder are even more reluctant to self-report due to potential licensure action.[20] Additionally, co-workers are also hesitant to address potential impairment of their colleagues due to stigma, fears that it may be embarrassing to their peers, or a concern about a potential need to report to licensure boards.[25,19]

Awareness of professional impairment dates to World War II and the early development of Alcoholics Anonymous (AA).[2] In fact, Dr. Robert Smith, one of the founders of AA, was a physician himself, and his role in its founding was because of his own alcoholism, not his role as a medical professional. Since then, professional assistance and monitoring programs that address provider impairment have become commonplace and operate utilizing an advancing evidence base on how to best engage, assess, treat, and monitor impaired professionals, facilitating their successful return to professional life. Such professional assistance organizations are available throughout the United States. In Ohio, this organization is the Ohio Professionals Health Program.[27]

Most HCPs have concerns about board reporting and action. To allay some of these concerns and encourage treatment, all HCP licensure boards in Ohio have established "safe haven" programs. Safe haven programs are confidential pathways that allow professionals who may be experiencing burnout, substance use, or mental health difficulties to avoid board reporting by voluntarily seeking treatment from an approved provider. Usually, this involves monitoring of the professional during and following treatment. In some circumstances, board reporting is still required either by law or board rules, but overall, safe haven programs have helped many individuals enter treatment that they may have previously avoided due to regulatory fears. Providers should acquaint themselves with their board's safe haven programs (Table 1) and any requirements that may exist outside the safe haven program that would require reporting.

Crystal knows she is impaired but is unsure of where to turn and continues to work. Her husband begins to express feelings of neglect and finds he is handling most of the priorities at home. He confronts her with these observations and implores her to seek professional help. She minimizes his observations while continuing to fall further into depression and escape through alcohol. She finds herself retreating to her car often for breaks and occasionally takes a few drinks to "settle her nerves" so she can continue her day. A colleague comments upon her return that she smells alcohol on her breath, which she denies. "I had some wine last night before heading to bed. It must still be lingering."

Crystal considers this colleague a friend and becomes overwhelmed with guilt for her response. She asks "Emily" to go out after work to let off some steam. Emily agrees and looks forward to the break herself. At dinner, Crystal has a few drinks and becomes obviously inebriated. Crystal shares that she has been drinking to the point of intoxication regularly and, on one occasion, consumed alcohol while at work. Emily, who had not consumed alcohol, felt confused and was unsure of what to do with this disclosure. Emily proposes that she drive Crystal home, but she declines, insisting she is "fine."

TABLE 1. OHIO HCP BOARDS OFFERING SAFE HAVEN PROGRAMS THROUGH THE OHIO PROFESSIONALS HEALTH PROGRAM (AS OF OCTOBER 1, 2025)

State Medical Board of Ohio	Ohio Speech and Hearing Professionals Board
Ohio Board of Nursing	Ohio Veterinary Medical Licensing Board
Ohio Board of Psychology	Ohio Vision Professionals Board
Ohio Chemical Dependency Professionals Board	Ohio Board of Pharmacy
Ohio State Dental Board	Ohio State Chiropractic Board
Ohio Emergency Medical, Fire, and Transportation Services	Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

Emily returns home, troubled, and searches for professional impairment guidelines, learning about the safe haven program for Ohio nurses. When Crystal arrives at work (late as has become her habit), Emily tells her about the availability of confidential help and offers her support in seeking it. Crystal is angry with her and indicates that she can handle any problems that she has on her own. Emily informs her that her impairment is placing patients at risk, and if Crystal declines to pursue the safe haven option, she is obligated to report her to the nursing board. Crystal questions Emily's loyalty and friendship, and Emily responds that she is doing this because she is a friend—one who is concerned for her well-being, for her professional future, and for the safety of her patients. After a long pause, Crystal agrees with Emily and shares that she has been at a loss for what to do about her distress for some time. This now provides an impetus for her to deal with her difficulties and a pathway to do so. Crystal and Emily called and arranged an intake for the safe haven program the following day.

"The profession, health care institutions, and organizations should promote practice environments in which patient safety is prioritized and physician [and other health care provider] wellness and well-being are addressed."

-Candillis, et al. 2019 (Annals of Internal Medicine)

Emily arranged patient coverage for the day, and Crystal informed human resources (HR) at the clinic that she needed to go home and may be off work longer. That day, she shared the difficulties she was experiencing with her parents, husband, and children; none of them were surprised by her problems, and all were pleased that she was seeking help. The following morning, she went for intake and, due to concerns about alcohol withdrawal, was promptly admitted to a residential program for withdrawal management. She remained in treatment following medical stabilization, where she addressed her SUD, depression, and stress. She entered into a confidential monitoring agreement, and no board report was ever required. She has since returned to work at the clinic and feels that she is functioning better at work and outside of work than she has in years.

Workplace stress, burnout, SUDs, and mental health issues can seriously affect HCPs and undermine their ability to practice effectively and safely. The path to affected individuals receiving help is often a circuitous one, fraught with all the same issues that hinder non-HCPs' treatment entry, including denial, stigma, and financial concerns. Additional areas unique to HCPs, such as fears about board action or clinical privileging, make willingness to seek care even more problematic. Fortunately, licensure boards recognize the importance of clinicians receiving treatment and have made active steps to improve treatment entry by decreasing stigma, developing treatment pathways, and introducing monitoring that protects the confidentiality of the HCP receiving treatment and avoids board involvement. The prognosis for HCPs who receive SUD treatment and subsequent monitoring is quite good, with 72% maintaining total abstinence and 77% successfully returning to practice. [28]

Many healthcare organizations are now providing services that prevent or address burnout, substance use, and mental health by providing Employee Assistance Programs (EAP) services for mental and physical health, and by actively supporting treatment when needed.[17] Additional efforts may lower the impact of the stresses of the healthcare system by encouraging mutual support among peers, addressing stigma, and minimizing workplace stress itself. As individual HCPs, we too can be impactful by engaging in self-care activities that allow us to be more understanding and supportive of our peers and to function better ourselves. To assist our peers who are struggling and potentially impaired, offering support and being aware of options for confidential treatment is helpful. Connecting with our colleagues honestly and openly can lessen the burden of secrecy and shame that they may be experiencing and influence them to seek needed treatment that will improve their lives, the lives of their families, and their ability to provide care.

For Additional Information on This Topic

- Ohio Professionals Health Program. Free continuing education on safe haven for multiple disciplines.
- How Doctors with Addiction Heal and Return to Practice. Medscape.
- Physician Well-Being Resource Center. Ohio State Medical Association.
- Addressing Health Worker Burnout. Office of the Surgeon General, United States Department of Health and Human Services.

Upcoming Training on Substance Use Disorders

- Ohio Substance Use Disorders Center of Excellence. Multiple trainings on various topics in the coming months, throughout Ohio and online.
- American Academy of Addiction Psychiatry Annual Meeting. November 6–9, 2025. San Francisco, California.
- Association for Multidisciplinary Education and Research in Substance Use and Addiction (AMERSA) Conference. "Building Stronger Communities through Addiction Care Innovation, Research, Education and Advocacy." November 13–15, 2025. Portland, Oregon.
- American Society of Addiction Medicine Annual Conference. "Innovations in Addiction Medicine and Science." April 23–26, 2026. San Diego, California.

At the SUD COE, we are committed to bringing you resources and trainings that meet your needs in providing care to patients with substance use disorders. Please let us know what suggestions you have for improving Clinical QuickNotes, or topics that you would like addressed by clicking here: QuickNotes Feedback Survey.

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This QuickNote is an overview only and is not intended to be the sole resource about impairment in healthcare professionals. The reader is encouraged to seek additional information from sources listed in "For Additional Information on This Topic."

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