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Nurses' Experiences and Perspectives Caring for People With Substance Use Disorder and Their Families: A Qualitative Descriptive Study

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ABSTRACT

Substance use disorder is a public health crisis that is a financial strain to many healthcare systems and communities, but more importantly, it costs lives. Nurses interact with people experiencing substance use disorders and their families in many settings. Nurses can provide insights into the experiences of working with this population. This descriptive qualitative study aimed to examine nurses' experiences and perspectives on caring for people with substance use disorder and their families. After receiving institutional review approval, purposive sampling was used to recruit registered nurses ($n = 16$) who worked in a variety of settings, and interviews were conducted. Constant comparison analysis was conducted concurrently with data collection until saturation was reached. Code development and refinement was an iterative process. Three themes were generated from the data. *Personal Experiences Affect Professional Practice* represented participants varied personal experiences and included two subthemes: *Reflecting on Personal Experiences* and *Seeing the Person Beyond the Substance Use Disorder*. A second theme is *Professional Experiences Affect Professional Practice*, which included two subthemes: *Professional Experiences are Stressful and Rewarding and Substance Use Disorder Education Increases Confidence*. Finally, *Stigma Affects Substance Use Disorder Care* is the third theme. Future implications range from the individual engaging in self-reflection, to nursing leadership establishing a framework to incorporate reflection and creating a culture that supports and reinforces these activities. The findings of this study support the need for stigma awareness/reduction education starting in undergraduate nursing programmes, throughout practice, with extension to inter-professional groups and the community.

1 | Introduction

Substance use disorder (SUD) is a public health crisis. Globally, an estimated 39.5 million people were diagnosed with drug use disorders in 2021 (United Nations Office on Drugs and Crime 2023). Two years prior, in 2019, 600000 deaths were attributed to drug use, of which 25% of those deaths were caused by opioid overdose (The World Health Organization 2023). Before the COVID-19 pandemic, there were significant strides in impacting SUD and overdose death rates. However, the COVID-19 pandemic impacted this progress, this is attributed to several factors including reduced access to interventions and treatment, stress from isolation, change in mental health services and change in drug sources and patterns of use (Ghose, Forati, and Mantsch 2022). There is a high individual and societal cost to SUD. Combatting SUD is a global priority (Office of Disease Prevention and Health Promotion n.d.; The World Health Organisation n.d.).

Registered Nurses (RNs) and Advanced Practice RNs (APRNs) [nurses] are on the frontlines, practicing in many roles including direct care, care coordination, leadership and executive roles, and are well positioned to impact this crisis from both the healthcare aspect and the societal view (American Nurses Association [ANA] 2018). Coupled with the ethical responsibility to care for these individuals (ANA 2018; International Council of Nurses [ICN] 2021) understanding the nurses' experiences and perspectives of caring for individuals experiencing SUD and their families could build on the evidence of Antill Keener et al. (2023), who identified barriers to treatment, opportunities to support individuals, families and nurses and identify education opportunities. Antill Keener et al. (2023) noted the lack of hospital and community resources, including alternative pain therapies and nurse-driven strategies, which could improve SUD care.

2 | Background

The SUD epidemic has broad impacts ranging from the person to the family and society including babies born with neonatal abstinence syndrome, disrupted families, participation in the criminal justice system and changes in the workforce creating an ever-expanding rippling effect (Centers for Disease Control [CDC] 2023; Ducharme et al. 2021; Paris, Rowley, and Frank 2023; Winstanley and Stover 2019). Nurses are on the frontline encountering people and families in multiple settings from acute care settings to the community including the emergency department, healthcare provider offices, specialty settings and schools. Given the reach of this crisis, nurses may also have personal experience caring for or interacting with people with SUD.

Nurses recognised the emotional toll of caring for people experiencing SUD. One aspect was the need for constant vigilance when interacting with people with SUD. Johansson and Wiklund-Gustin (2015) described the overarching theme of multifaceted vigilance with balancing between understanding and frustration, being supportive, safeguarding the healthy and protecting self in the caring relationship as subthemes. Another study examining the experiences of critical care nurses revealed four themes; feeling empathy and a wish to provide dignified care, dreading caring and feeling a lack of empathy for people with SUD, feeling frustrated and questioning the care or if the patient outcome was temporary and lacking knowledge about the complex and challenging situation specifically care after discharge from critical care (Wedin et al. 2020). These studies demonstrate the emotional impact on nurses in these settings and caring for people with SUD.

Nurses need specialised knowledge and skills to care for this population. In their scoping review, examining nursing's contribution to the management of people with pain and opioid use disorder, Van Cleave et al. (2021) uncovered two key themes balancing effective pain management and patient safety, and the quest for solutions to providing quality care for people with pain and opioid misuse. Using a summative approach, Van Cleave outlined the breadth of expertise needed to manage this population; and as such, identified a gap in the literature surrounding education for healthcare consumers and professionals. This gap presents future opportunities for education and research (Van Cleave et al. 2021). Education is needed in undergraduate nursing programmes (Lewis and Jarvis 2019; Selby and Trinkoff 2023). While some nursing programmes have incorporated education related to SUD, these programmes demonstrate knowledge acquisition but lack evidence-informed development, implementation or the data to support the impact of knowledge acquisition to improve health outcomes (Lanzillotta-Rangeley et al. 2020). These studies support the need to gain nurses' perspectives on knowledge, experience and ability to provide care for people experiencing SUD.

Despite the toll that nurses face, nurses are legally and ethically bound to care for the people who may also be living with SUD, and in some cases, nurses care for the family members in settings such as the neonatal intensive care unit, the paediatric unit, and in the school setting (ANA 2018; ICN 2021). Nurses see first-hand the challenges this population faces. Nurses balance feelings of responsibility and conflict when caring for this population (Johansson and Wiklund-Gustin 2015; Wedin et al. 2020), nurses may experience stigmatising behaviour towards the person and family (Hoover et al. 2022); therefore, self-examination is necessary before caring for any person. Yet, while self-examination of personal experiences and views is often considered when discussing the nurse–patient relationship (Rasheed, Younas, and Sundus 2019; Younas et al. 2020) and cultural awareness (Kaihlanen, Hietapakka, and Heponiemi 2019), this practice must be expanded to all populations and interactions, especially people with SUD. Dowdell et al. (2022) studied compassion fatigue and its impact on job satisfaction, the authors recommend several strategies including self-awareness. The purpose of the larger study was to uncover the nurses' perspective of caring for people experiencing SUD and their families including challenges to securing and maintaining treatment, stigmatising behaviours and its impact, opportunities to facilitate treatment access and participation, and the professional impact of caring for this population. This manuscript reports a portion of the study findings. The participants in the study referred to people experiencing SUD as ‘patients’.

3 | Methods

3.1 | Design

A descriptive qualitative design, guided by inductive reasoning was used to capture nurses' experiences and perspectives on caring for people with SUD and their families (Doyle et al. 2020). This method is used for research focused on the ‘who, what, and where of events or experiences…from informants’ (Kim, Sefcik, and Bradway 2017, 2). In consideration of the method and after a review of recent qualitative studies examining the experiences of nurses, an interview guide was developed (Almomani et al. 2022; Kim 2018; Pariseault, Copel, and McKay 2022). The interview guide contained prompts such as experiences caring for this population, challenges for the individual and their families, memorable caring experiences, stigma observed and experienced, personal SUD experiences, a message for nurses caring for this population and a word(s) to describe their experiences. University IRB approval was obtained. A completed COnsolidated criteria for REporting Qualitative research checklist accompanied this manuscript submission (Tong, Sainsbury, and Craig 2007). The authors are PhD-prepared female, nurse researchers who have conducted three previous research projects together related to SUD, have published and presented together on this topic and have expertise in qualitative research and SUD.

3.2 | Setting and Participants

Purposive sampling was used to recruit nurses with experience caring for people with SUD and their families. Recruitment flyers were distributed via listservs to colleagues and alumni at the university. Colleagues and alumni were asked to distribute the flyer to nurses in their network who care for or interact with people who experience SUD. The recruitment flyer asked potential participants interested in participating in the study to email the second author. Coercion was not a factor as the second author did not have a dependent relationship with colleagues and alumni who were asked to distribute the flyer or the participants who participated in the study.

The second author contacted potential participants to determine eligibility and provide additional information about the study including its objectives and the researchers' credentials. The second author read the informed consent verbatim and gave potential participants time to ask and have their questions answered. The interview was then scheduled.

3.3 | Data Collection

One-on-one interviews were conducted by the second author in person, via phone or Zoom based on the participant's preference. In-person interviews were conducted in a quiet, private space selected by the participant. The second author was in a quiet, secure space for phone and Zoom interviews. The study information and consent were reviewed at the outset of the interview. Demographic data were collected before initiating the audio recording. Participants were interviewed using the semi-structured interview guide. The interview guide was created through a collaborative process where the two authors examined the current evidence and identified current gaps in nurses' perspectives and experiences of caring for people with SUD. Interview guide questions were designed and refined until a consensus was reached between the two authors. At the interview's completion, a $25.00 gift card was handed or mailed to each participant. The interviews were conducted during May and June 2023.

3.4 | Data Management and Analysis

Within 48 h after the interview, the audio files were transcribed by the IRB-approved transcription service. Transcripts were verified, de-identified and uploaded to NVivo 14. Once verified, the audio recordings were destroyed. Interviews ranged from 10 to 45 min. Concerning the 10-min brief interview, the interviewer used several interview strategies to elicit more elaborate, detailed responses; however, despite these efforts, the interviewee answered questions with short responses. All interviews were included in the data analysis as each participant provided a unique perspective and contributed to the dataset. Data collection and constant comparison analysis were done concurrently until data saturation was reached and no new information or ideas emerged (Leech and Onwuegbuzie 2011). Constant comparative analysis method was selected as it is an iterative and inductive process that reduces the data through constant recoding; data are coded and compared across categories, patterns are identified and these patterns are refined as new data are obtained (Glaser and Strauss 2017). After the first two interviews, open coding began, and a preliminary codebook was generated by the co-investigator. The authors tested the codes on the original two transcripts used to create the preliminary code book and two additional transcripts independently. Discrepancies were discussed and the codebook was refined until a consensus was reached. The final codes and respective definitions of each code were used to code all transcripts ($n = 16$) independently. Again, the researchers met and discussed discrepancies until a consensus was reached. An audit trail was created to document the process. The researchers reviewed the final coded transcripts and themes were constructed in collaboration. The researchers reviewed the themes and exemplary quotes of coded text were extrapolated to illustrate and support each theme. The process adhered to analysis as described by Doyle et al. (2020); transcribe, sort, apply codes to initial data, add comments/reflections, identify similar themes/patterns, use this information to inform ongoing data collection and develop data sets that cover consistencies in data.

4 | Results

4.1 | Participant Characteristics

All nurses ($n = 16$) were from one state in the Mid-Atlantic region of the United States. Participants' ages ranged from 24 to 66 years ($\mu = 41.31$ years; SD = 11.03). The participants' years as a nurse ranged from 3 to 40 with an average of 17.69 years (SD = 10.53) (Table 1). Participants worked in 11 distinct zip codes with six zip codes classified as metropolitan, two classified as micropolitan and three unclassified (Health Resources and Services Administration 2022). The years the participant worked in their current practice setting ranged from 1 to 21 years with an average of 8.84 years (SD = 5.69). Two participants reported working in both inpatient and outpatient

TABLE 1 | Participant demographics.

		Age (years)		Degree	
Gender					
Female	15	24–29	2	Diploma	1
Male	1	30–39	6	Associate	1
Race		40–49	4	Baccalaureate	7
White	15	50–59	3	Master's	3
Pacific Islander	1	60–66	1	Doctoral	4
Ethnicity					
Non-Hispanic	15				
Hispanic	1				

TABLE 2 | Participant work settings.

Setting type	
Emergency room	4
Medical/Surgical	2
Intensive care	1
Paediatric intensive care	2
Behavioural/Mental health	3
Obstetrics/Gynaecology	2
Home health	1
School	1

locations and 14 participants worked exclusively in an outpatient or inpatient setting, respectively. Participants worked in several different units or departments; some worked exclusively in one setting while four worked in more than one unit/department (Table 2).

Most of the participants ($n=10$) did not have specialised training such as mental health or addiction certification. Six participants reported having specialised training including de-escalation training ($n=3$), Medication Assisted Treatment training ($n=2$) and detox training (n=1). One reported having specialised training but did not report what type of training and another reported two distinct types of training.

4.2 | Themes

Three main themes and subthemes were derived from the analysis, and the themes included: Personal Experiences Affect Professional Practice, Professional Experiences Affect Professional Practice and Stigma. The overarching themes were generated from the participants' rich descriptions of their personal and professional experiences and the stigma perceived or experienced as they provide care for people experiencing SUD and their families. The participant quotes were not edited to remove emotive or stigmatising language.

4.2.1 | Theme: Personal Experiences Affect Professional Practice

All but three participants personally knew someone with SUD (i.e., family member, friend and neighbour). All who reported having a family member or knowing someone with SUD noted that this experience changed their personal perspective about people with SUD. Participants' perspectives varied and some reported an increased understanding, compassion towards or level of comfort (e.g., confidence), while others expressed feelings of stress, anger and frustration. Some participants reported feelings that included understanding and levels of comfort, stress, anger and frustration. One final note is that the interview questions allowed the participants to reflect on their experiences of caring for people with SUD. However, before this interview, many noted that they had not considered how their personal experiences had impacted care. Participants acknowledged the connections, whether positive or negative, to how these experiences shaped their care for people with SUD.

4.2.1.1 | Subtheme: Reflecting on Personal Experiences. Several participants reflected on their personal experiences of knowing someone with SUD and how these individual experiences have shaped their perspectives and practices. One participant discussed working in a rehabilitation facility and some of their co-workers were in recovery. The participant was impacted in a way that changed her perspective on her work.

> I think my personal relationships that I've developed since working there has really… just grounded me, and that compassion. I just look at it completely different now.
>
> (Participant #7)

Another participant discussed how personally knowing someone with SUD shaped their emotional response when providing care to people with SUD and now reframes her care to acknowledge that the patient they are caring for is the family member of another person.

> … I might really be uncomfortable with the situation or it's making me angry or feel a certain way. But then I remember that you know, my friend's father is suffering from addiction and…this is somebody's father, somebody's mother, somebody's someone.
>
> (Participant # 14)

In addition, more than half of the participants reflected that other physical or mental health issues played a role in the SUD, including a history of physical or emotional trauma and/or a family history. Several acknowledged that the person with SUD shared no fault in experiencing the trauma or family history and therefore, see them as casualties of their circumstances. One participant who had a brother with PTSD shared her reflection as she supported her brother with SUD and how recognising them as a person lessens anger and judgement.

> I was a nurse when my brother was addicted…I remember at first, I was really angry and my attitude was just like, “Well, you should just quit,” because I didn't really understand a lot about it…But as we went through it with him and we struggled with him, it made me realize that all of the things that he had underlying, all the depression, all the anxiety, all the extra stress, he also had PTSD from being in the military, that he just used this as a resource to just forget about all the bad things that had happened throughout his life, … And it makes you look at another side of a person.
>
> (Participant 1)

Another participant shares her experience of having a parent who had SUD and alcohol was used to cope with the loss of a child.

> My mom also was an alcoholic… She lost her firstborn child at the age of five and her coping mechanism was to just drink and to forget… that was her coping mechanism. So, I think that sometimes you just have to dig a little deeper and you have to see if people need help or they need counselling because a lot of times, they just don't know.
>
> (Participant #1)

Finally, personal experience influences the care of patients with SUD and noted, '…taking these personal encounters, they do impact your professional experience and how you provide care as well'. Others expressed their thoughts with these exemplary quotes:

> …I've had members of my own family that were alcoholics or addicts…being involved with them and seeing the personal struggles. I think it's hard to take care of patients that come in under the influence…I think that definitely plays a role in how I take care of them. You want to provide them with the utmost respect and care and you want to give them the resources because you want to see them succeed.
>
> (Participant 4)

> We had a lot of experiences personally in a family on how manipulative that some of them can be and how you have to learn to work with people with addiction and learning how to handle not just addiction, but depression that leads to the addiction.
>
> (Participant 1)

4.2.1.2 | Subtheme: Seeing the Person Beyond the SUD. Some participants noted that SUD can affect anyone and any family despite socioeconomic status or class, education level or geographic location. This notion was tied back to the fact that all but three of the participants had a family member or friend with SUD, which opens the possibility that anyone, including their own family, could be affected. One participant noted that a family member with SUD had no previous risk factors or warning signs. The participant noted,

> I have an adult cousin who went through drug addiction…it can happen to anyone, and it can happen to people who don't have a drug history, … can be good, hard-working, educated people…grew up with excellent morals, … work ethic, and standards…So, that has kind of opened my eyes and made it a lot more easy for me to be open-minded about caring for these people.
>
> (Participant 15)

In addition, instead of stigmatising people with SUD, one should recognise that any individual with SUD holds the potential to enter remission and be productive members of society. One example noted that a family member with SUD went on to earn a college degree and gain employment as a police officer.

> I had an uncle who suffered from IV drug use…he was very stigmatized because of it…He went on to go to college, make a career for himself…He actually became a cop…But that definitely shaped the way that I see people with substance abuse disorders because I know that everyone has the potential to do more and to do better and to want to improve.
>
> (Participant 9)

4.2.2 | Theme: Professional Experiences Affect Professional Practice

Professional experiences interacting with people with SUD affected nurses' feelings and actions towards the people with SUD and their families. Three subthemes emerged from the broader theme *Professional Experiences are Stressful and Rewarding*, *Professional Experiences Impact Professional Response* and *SUD Education Increases Confidence* and are described below.

4.2.2.1 | Subtheme: Professional Experiences Are Stressful and Rewarding. Several participants acknowledged that their professional experiences could be both stressful and rewarding, and in many cases, oscillate throughout the day or even in one interaction as they provided care to this population. In some settings, participants would see the same individuals regularly, creating an opportunity to be well acquainted with the person. These repeated interactions and professional relationships created a sense of stress as the nurse was invested in the person's remission success. One example that demonstrated this is noted by

> It's stressful at times. I mean, I do enjoy it…I feel I know them, a lot of the patients on a personal level at this point… I see them in the community… I take care of these patients on a regular basis. So, when they come in, it's kind of you know them on a one-to-one kind of level… So, it's rewarding at the same time, but it's just stressful helping them get to that point where they can break through and overcome everything that they're going through.
>
> (Participant 4)

4.2.2.2 | Subtheme: Professional Experiences Impact Professional Response. Participants also acknowledged that their professional experience impacted their feelings towards patients with SUD by describing their interaction with patients with SUD. For nurses who work in non-mental health or SUD treatment centres, repeat exposure to people who test positive for an alcohol or drug screen desensitises the nurses to the individual's care needs. Some examples of this included people who had positive drug screens and were mothers who were pregnant and/or delivering their babies and people who were admitted to the emergency department because of potential drug or alcohol use and monopolised acute care resources instead of mental health resources.

> My overall experience treating them was actually very impactful for me... [At my previous job] I was a hospital supervisor. I felt that I had become, I would say, almost calloused to patients that would come into the emergency room that were intoxicated or using. That environment caused me to...lose a little bit of my compassion. And that was something that was very important to me as a nurse, was my compassion level...
>
> (Participant 7)

Not all professional experiences promoted negative perceptions or care practices. Some acknowledged that SUD is a disorder and not the person and could separate the disorder from the person. Embracing the person and demonstrating that as a professional you respect their personhood, can enhance the care that is provided.

> [I] do love this patient population...it's like any other disease...You treat the patient, and you treat them the way you would treat anyone else...I think just taking a non-judgmental approach is really important for these patients and showing them that someone actually cares, I think can go a long way.
>
> (Participant 3)

4.2.2.3 | Subtheme: SUD Education Increases Confidence. The participants who received comprehensive training ($n=6$) appeared to reflect that their training and previous interactions better prepared them to care for this population in comparison to their peers. The training was thought to be both comprehensive and necessary to support their professional practice and provide them with the confidence they needed to care for people with SUD. As a result of this training, one participant explains her abilities,

> ...I do feel like I can handle some of the behaviours that come with patients who have substance use disorders maybe better than some of my peers...but I have gone through pretty extensive de-escalation training...And I think that that's something that I got that has influenced the way I practice more than anything in my personal life.
>
> (Participant 2)

> As my crisis nurse role, we respond to behavioural de-escalations, which a lot of that population is people withdrawing and coming on the CIWA [Clinical Institute Withdraw Assessment] for alcohol use. So, I've had a good amount of interaction with patients and families from substance use and abuse.
>
> (Participant 3)

4.2.3 | Theme: Stigma Affects SUD Care

Many participants acknowledged that 'stigma is real'. Stigmatising behaviours were noted in the language used by nurses, the treatment received by people with SUD, and the culture created on the unit. Stigma and stigmatising behaviours were expressed in a variety of ways and some acknowledged that they had or currently have a stigma against people with SUD. Stigma and stigmatising behaviours affected their interactions with patients including the language used and the treatment they provided. Despite recognising stigmatising behaviours in self and others, some participants continued with stigmatising language during the interview. This can be seen in several of the quotes reported throughout the text and include references to the people with SUD as 'addicts', 'alcoholics' and 'crack babies'. Some nurses have seen and heard fellow nurses using stigmatising language and reported,

> I think stigma is very real, ... but in the individual's own community... But I think it's really hard for many healthcare providers, who just...you hear horrible terminology, like drug seeking, or crack babies, and things like that... And I think... our words have so much power.
>
> (Participant 11)

Participants also reported seeing stigmatising behaviours towards people with SUD because of their stigma. This was captured as,

> I definitely see that in practice. I've witnessed nurses may be withholding medication or having an opinion about a dosage of a medication, even though that's not really in their scope of practice to decide upon... Very abrupt, almost intense language and tone. They think they're setting boundaries, but really they're just being mean... I know of nurses that don't want patients that are known to have drug addictions... Patients that are actively withdrawing, nurses are very frustrated by the care of those patients.
>
> (Participant 2)

Stigma was noted to have an effect not only on the patient treatment but also on the participants. Although participants did not report standing up to the person who was using the stigmatising language, they did report that they felt bad about the stigma towards people with SUD.

> So it always makes me feel bad when people stigmatize these patients, because listen, it's still a disease process. They're still people, they're still human. They still deserve empathy and care and support just like every other patient here because, ... technically diabetes can be self-induced too, and we don't treat those people with stigma.
>
> (Participant 9)

5 | Discussion

Findings revealed the personal and professional experiences of nurses and how their experiences shape their professional practice as they provide care for people experiencing SUD and their families. Most of the participants personally knew someone with SUD, which influenced not only their personal perspective but also their professional practice. These findings support previous research about nurses' experiences impacting their interactions with people with SUD. From these findings and through these interviews, it was evident that many nurses have not previously reflected on their interactions with people with SUD and their families.

Kratovil et al. (2023) reported that nurses' personal beliefs and experiences inform care and in some cases are in a negative way (e.g., judgmental attitudes). These practices could be changed for the better and were described as increased compassion or empathy, or practices could be to the detriment of the person with SUD, such as expressed anger and frustration. While no studies directly supported these findings, Recto et al. (2020) reported that nurses experienced ethical distress, moral distress and compassion fatigue while caring for families impacted by neonatal abstinence syndrome (NAS). In addition, nurses reported challenges (e.g., pain management and personal safety) in caring for patients with SUD (Antill Keener et al. 2023). In caring for this population, nurses expressed feelings (e.g., anger, frustration, exhaustion and inadequacy) that influenced their care. In the model proposed by Vottero, Schuler, and Kratovil (2023), the internalisation stage is described as a process where the nurse integrates their knowledge and prior personal and professional experiences, which was reinforced in this study where participants acknowledged their increased understanding and impact on patient care. These experiences, positive or negative, inform care and potentially impact patient outcomes (Vottero, Schuler, and Kratovil 2023). In addition, study findings demonstrated the nurse's varied feelings related to levels of compassion, confidence and stress.

Nurses' prior personal experience of substance use (e.g., alcohol and/or drugs) with a family member, and familiarity with opioid use problems and people experiencing them revealed higher levels of motivation to care for the population (Mahmoud et al. 2021). Findings from a Scandinavian research group noted that caring for this population has been researched using the concept of 'core of love'. Thematic findings revealed love as the driving force, searching for the human being, faith in the inner power and love as the movement of giving and receiving (Thorkildsen, Eriksson, and Råholm 2014).

Professional experiences affected nurses' feelings and actions towards people with SUD and their families. These feelings were expressed as push–pull between rewarding and frustrating. Petersén, Thurang, and Berman (2021) supported these findings and reported that providing care for people with SUD was perceived as difficult, and noted a lack of resources and knowledge were barriers to their professional work. The participants with more clinical experience caring for people with SUD or who received comprehensive training on best practices to care for this population reported being more prepared and confident as they provided care. Experience and education are critical. Antill Keener et al. (2023) reported that nurses with < 1 year of experience reported more significant challenges as they care for people with SUD (e.g., managing pain and knowing protocols) and indicated the need for comprehensive education for all nurses, especially novice nurses. Mahmoud et al. (2021) reported that nurses' experience caring for the population in addition to receiving continuing education and having access to educational resources increased their motivation to care for this population.

Given the current global shortage of mental health nurses and the predicted need for additional nurses to enter this specialty, efforts for workforce retention must be addressed (ICN 2022; Westervelt-House 2023; U.S. Bureau of Labor Statistics 2024). Caring for this population can contribute to 'compassion fatigue' and job dissatisfaction which in turn can contribute to job turnover (Dowdell et al. 2022). Additionally, nurses with a specialty in substance use disorder or mental health have been stigmatised by other nurses outside of the specialty, making this nursing specialty less desirable (Searby, Burr, and Abram 2024). To ensure a robust workforce in this specialty, awareness must be raised about this specialty, and stigma towards these specialised nurses must be addressed (Searby, Burr, and Abram 2024). Individuals and organisations should embrace strategies to prevent stigma, compassion fatigue, and the potential impact on job satisfaction.

Stigma was another concept that was mentioned by every participant. It is well documented that stigma is one of the pressing and most influential areas of healthcare professionals when caring for people with SUD (CDC 2022). Hospital-based providers and people with SUD shared perspectives about their past experiences in healthcare propagating stigmatised relationships, stigmatising documentation and that addiction consultation reduced enacted and internalised stigma (Hoover et al. 2022). Similarly, participants in this study discussed their responses to people and families that return for care to the facilities and encounter these individuals in the community, participants also spoke to the responses of coworkers. Another study noted mothers of infants with NAS reported they were often ostracised, excluded and shamed (Recto et al. 2020). Not only are stigmatising behaviours directed at the person with SUD, but also at family members supporting the person with SUD. (McCann and Lubman 2018). Research surrounding stigma has been examined in the context of response to educational interventions and reported a change in attitude and perceived stigma post-educational intervention (Dion and Griggs 2020; Jackman et al. 2020). In fact, one study compared attitudes of nursing students across four different countries. Nursing students with the training of SUD in nursing education had more positive attitudes to individual alcohol use disorder (Diaz Heredia et al. 2021). To reduce stigma, there is a great need for educating nurses caring for patients extending beyond the pathophysiology of SUD (Kratovil et al. 2023). Training programmes about SUD issues that are interprofessional should be offered to all staff including nurse residents (Antill Keener et al. 2023). Adopting strategies to moderate the effect of stigma can help support not only the person with SUD but also the family member who is supporting them (McCann and Lubman 2018). These educational programmes should be offered at regular intervals and continuously so that new staff are prepared to provide care and current staff has the opportunity to learn about updates and best, current practices (Antill Keener et al. 2023).

6 | Conclusion

This project builds on the evidence that nurses should participate in self-awareness strategies and recognise their personal and professional bias and how their experiences shape the way they care for people with SUD and their families. These findings demonstrated the nurse's varied feelings related to levels of compassion, confidence and stress. Individuals, employers and organisations should embrace strategies to prevent compassion fatigue for nurses, especially those who can work with people with SUD. It also supports the critical need for additional research related to creating, implementing and evaluating education related to SUD stigma for healthcare professionals, including nurses.

7 | Relevance for Clinical Practice

The findings of this study reveal how personal and professional experiences impact nurses' care of healthcare consumers. Acknowledging and examining experiences through interprofessional education, storytelling or testimonials can humanise individuals with SUD is an important first step in combatting stigma. Additionally, cultivating a workforce prepared to provide consistent, high-quality care to people with SUD in any setting, with organisations that establish an inclusive culture of care, including using stigma-free language is essential. General education on SUD and stigma-reduction education for all healthcare professionals, especially nurses who have the potential to interact with people SUD can enhance care practices and support, and mandating or embracing stigma-free language is also essential.

Author Contributions

All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors. All authors agree with the manuscript.

Ethics Statement

This research study was approved by the University's Institutional Review Board.

Consent

The authors have nothing to report.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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