

SUBSTANCE USE DISORDER IN NURSING

A Resource Manual and
Guidelines for
Alternative and Disciplinary
Monitoring Programs



NCSBN

National Council of State Boards of Nursing

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National Council of State Boards of Nursing

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CHAPTER ONE

INTRODUCTION AND PURPOSE

THE TERM, SUBSTANCE USE DISORDER refers to the full range of complaints from abuse to a dependency or addiction to alcohol or drugs. The term addiction refers to the compulsive use of chemicals (drugs or alcohol) and the inability to stop using them despite all the problems caused by their use. A person with an addiction is unable to stop drinking or taking drugs despite serious health, economic, vocational, legal, spiritual and social consequences. A substance use disorder does not discriminate according to economic class, age, ethnic background, gender or any other labels. A substance use disorder is a progressive and chronic disease and if left untreated can be fatal.

It is estimated that more than 22 million people in the U.S. abuse drugs or alcohol. Three million are classified with a dependence or abuse of both alcohol and illicit drugs while 4 million are dependent on or abuse illicit drugs but not alcohol and 15 million are dependent on or abuse alcohol but not illicit drugs (SAMHSA, 2008). Several million more adults engage in a form of risky drinking that could lead to alcohol problems. These patterns include both binge drinking and heavy drinking on a regular basis. In addition, 53 percent of men and women in the U.S. report that they believe one or more of their close relatives have a drinking problem (SAMHSA, 2008).

The negative consequences of drug abuse and alcoholism affect not only individuals who abuse drugs but also their families and friends and various businesses and government resources. Although many of these effects cannot be quantified, the economic cost of drug abuse to taxpayers is a drain of nearly \$534 billion each year from increased health care, lost productivity, premature deaths, crime and auto accidents related to alcohol and drug abuse (NIDA, 2007). More deaths, illnesses and disabilities result from substance abuse than any other preventable health condition (NIDA, 2007). The Office of Drug Control Policy (2004) estimated that in 2002 illegal drug use cost America close to \$181 billion:

- \$129 billion in lost productivity
- \$16 billion in increased health care costs
- \$36 billion in other costs such as efforts to stem the flow of drugs

The American Nurses Association (ANA) estimates that six to eight percent of nurses use alcohol or drugs to an extent that is sufficient to impair professional performance.

Others estimate that nurses generally misuse drugs and alcohol at nearly the same rate (10 to 15 percent) as the rest of the population. That means that if you work with 10 nurses, one of them is likely to be struggling with a substance use disorder. Although the rates of substance abuse and dependence are similar to those of the general population, and only a very small percentage is ever disciplined, the amount is still disturbing because nurses are the medical caregivers who are most often responsible for the health and well-being of the general population (Trinkoff & Storr, 1998). Only about one-third of one percent of all actively licensed nurses are sanctioned each year for their conduct (Kenward, 2008). However, the same system made it difficult for nurses to obtain treatment.

The Substance Abuse and Mental Health Services Administration (SAMHSA) reported that only 14 percent of Americans addicted to alcohol and drugs actually seek treatment for their addictions (SAMHSA, 2008). But it was not until the 1970s and 1980s that addicted nurses were even offered treatment prior to disciplinary action (Torkelson, Anderson, & McDaniel, 1996). Although the condition, substance use disorder, was already considered a treatable disease by the American health care system, the disease concept was not widely extended to the addicted health care provider. Nurses and doctors were denied the same non-punitive approach being offered to the patients they served. Many of these providers did not receive treatment until after they had been criminally charged.

This mindset began to change when boards of nursing petitioned state legislatures to approve diversion legislation. The new legislation made it possible to offer treatment to addicted nurses without having a negative impact on their licenses as long as they continued to meet certain requirements. Forty-one states, the District of Columbia, and the Virgin Islands have since developed programs to channel nurses with a substance use disorder into treatment and recovery programs, monitor their return to work and prevent their licenses from being revoked or suspended.

Purpose of the Manual

The purpose of the Substance Use Disorder in Nursing manual is to provide practical and evidence-based guidelines (Appendix A) for evaluating, treating and managing nurses with a substance use disorder. The authors developed the guidelines by conducting an exhaustive review of the research literature on alcohol and drug abuse and surveying alternative to discipline programs to assess their current practices. The result is a comprehensive resource of the most current research and knowledge synthesized from both the literature and the field.

While the manual was developed for alternative to discipline programs and boards of nursing in an effort to enhance program content and its delivery, it also provides essential theoretical and practical guidelines for clinicians, educators, policymakers and public health professionals.

Information on prevention, detection and intervention of substance use disorder cases is presented. The manual also contains key research findings, guidelines and program recommendations and provides examples of model contracts, forms and reports.

An extensive body of scientific evidence shows that approaching addictions as a treatable illness is extremely effective financially and across the broader societal impacts. When treatments for nurses are individually tailored to meet their needs and an appropriate supportive monitoring system is in place, then recovering nurses are not impaired and can practice safely. It is the hope of the National Council of State Boards of Nursing that this manual will be a helpful tool that can be used to implement better practices in helping the healers to heal themselves and at the same time helping to protect the public.

Use of Terms

Throughout this manual the term substance use disorder is used more often instead of terms such as chemical dependency or addiction. The labels given to people with alcohol and drug problems can contribute to the stigmatization, de-medicalization and criminalization of those problems (White, 2007). For example, recent research found that when an individual was referred to as a substance abuser versus having a substance use disorder they were more likely to be thought of as personally culpable and therefore punitive rather than therapeutic measures could be taken (Kelly, Dow, & Westerhoff, 2009).

In addition, substance use disorder represents the most current and accepted terminology used by experts in the field and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (2000).

The term "impaired" is specifically not used because a person with a substance use disorder is not necessarily impaired; that is, always functioning poorly or incompetently. On the contrary, a nurse with a substance use disorder can be high-functioning and high-achieving. It's a myth that all alcoholics are skid row drunks and that all those with a substance use disorder are necessarily impaired.

The last terms that need to be clarified are confidentiality and non-public. A confidential program means that all records regarding an individual participating in the alternative program are not shared with the board of nursing, employers, treatment providers, boards of nursing in other states or the public unless agreed to by the participant through the contract or signed consent to release information.

Non-public is used in this manual to mean that all information including but not limited to reports, memoranda, statements, interviews or other documents either received or generated by the program shall remain privileged and confidential and participation in the alternative program is not disclosed to the public but is known by the board of nursing and can be required to be shared with employers, treatment providers and other state boards of nursing.

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CHAPTER TWO

SUBSTANCE USE, ABUSE AND ADDICTION

IN ORDER TO EFFECTIVELY DEAL WITH the abuse of substances among health care professionals it is first necessary to understand the components of addiction. The word addiction is often used as an umbrella term to describe a group of problems that can be broken out into drug addiction, alcoholism, substance use disorder and chemical dependence. All of these terms describe an addiction to brain-rewarding chemicals. Increasingly, addiction is also used to describe many pleasure-producing and compulsive behaviors. Members of Alcoholics Anonymous (AA), which is an international mutual-aid movement whose primary purpose is to stay sober and help other alcoholics achieve sobriety, call addiction a cunning, baffling and powerful disease.

Etiology

Drugs that are often abused are generally classified into different categories including:

- narcotics: opiates such as fentanyl, hydromorphone, hydrocodone, oxycodone
- cannabinoids: marijuana
- depressants: ethanol, barbiturates, benzodiazepines
- stimulants: nicotine, amphetamines and cocaine
- hallucinogens: lysergic acid diethylamide or LSD and ecstasy
- inhalants: toluene and nitrous oxide
- hypnotic anesthetics: propofol or Diprivan

These substances, along with alcohol, can produce a feeling of pleasure, relaxation or relieve negative feelings (Feltenstein & See, 2008). As the dependence or addiction progresses the benefits of using substances diminish and more drugs or alcohol are needed to feel the same level of pleasure.

Vulnerability to drug addiction and alcoholism depends on the individual. Both are believed to have a genetic component that is influenced by environmental and social factors. The more risk factors a person has, the greater the chance that the use of alcohol and drugs will result in addiction. The National Institute of Drug Abuse estimates that genetic factors account for 40 to 60 percent of a person's vulnerability to addiction. The estimate includes the projected effects of environment on gene expression and function (NIDA, 2008).

Other factors that can lead to addiction include the age when drug or alcohol use begins and the route of administration.

A human brain is more vulnerable during the developmental stages, which continues into adulthood. Therefore, using mind-altering substances in childhood or adolescence interferes with the normal development of brain function as well as other delicate systems.

Using mind-altering substances through injection or inhalation has an even stronger and more immediate effect. The brain receives a significant and often deadly jolt of stimulation which alters the brain neurochemistry. However, ingestion will at least give the body time to metabolize the substance and lead to a somewhat mitigated influence on the central nervous system. For nurses, the long hours, extra shifts, staffing shortages and shift rotations pose a unique challenge. The ready availability of medications and issues with the administration of narcotics can be liabilities for some nurses as well.

Overall risk factors, especially those that tend to make all individuals more susceptible to developing a substance use disorder have been divided into general categories.

These include:

Psychological factors:

- depression
- anxiety
- low self-esteem
- low tolerance for stress
- other mental health disorders (such as learning disabilities)
- feelings of desperation
- loss of control over circumstances in one's life
- feelings of resentment

Behavioral factors:

- use of other substances
- aggressive behavior in childhood
- conduct disorder (such as anti-social personality disorder)
- avoidance of responsibilities
- impulsivity and risk-taking behavior
- alienation and rebelliousness (such as reckless behavior)
- school-based academic or behavioral problems (including dropping out, involvement with the criminal justice system or the first illegal use at an early age)
- peers using alcohol and drugs
- social or cultural norms' acceptance of alcohol and drug use
- poor interpersonal relationships

Social factors:

- condoning the use of drugs and alcohol
- expectations about the positive effects of the drugs and alcohol
- access to or an availability of drugs

Demographic factors:

- male gender
- inner city or rural residence combined with a low socio-economic status
- lack of employment opportunities

Family factors:

- use of alcohol and drugs by parents, siblings or spouse
- a family dysfunction such as inconsistent discipline
- a lack of positive family rituals and routines
- poor parenting skills
- family trauma (such as a death or divorce)

Genetic factors:

- inherited genetic predisposition to alcohol or drug dependence
- deficits in natural neurotransmitters such as serotonin
- an absence of aversive reactions such as flushing or palpitations

(Sullivan & Fleming, 2008)

Neurobiology of Addiction

Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use despite harmful consequences (NIDA, 2008). People may use mind-altering substances initially because they feel good. Later, as the disease of addiction progresses they may use these substances again to feel normal or to attenuate negative symptoms of withdrawal and cravings. However, the desire to recreate the positive feelings is the primary factor behind drug dependence even though research has demonstrated that tolerance to a particular substance can develop, which requires a higher dose to achieve the same desired effect.

“Drug addiction is a brain disease that can be treated.”

Nora D. Volkow, M.D., Director, National Institute on Drug Abuse

Mind-altering substances affect the limbic system, which is a primitive system related to arousal that is located deep within the brain and is often called the pleasure center. Impulses move from the middle of the brain (limbic system) to the forebrain (the thinking center of the brain) and back again, releasing neurochemicals that influence and modulate brain activity. Dopamine is a naturally occurring, mind-altering substance and one of the essential neurotransmitters in the brain whose higher levels produce the feeling of euphoria associated with other imbibed mind-altering substances. Addiction to mood-altering substances is thought to occur as a result of decreased GABA brain function (Volkow & Fowler, 2000). GABA (gamma-aminobutyric acid) is a natural calming agent and insufficient levels of GABA can cause symptoms of anxiety, insomnia, epilepsy and other brain disorders.

The short term use of mind-altering chemicals can cause temporary deregulation of the neurotransmitters in the brain and are expressed by some unique and usually temporary behaviors. Long term use can often cause permanent changes in the neuroregulatory system in the brain with resultant negative behaviors. The neuroregulatory changes that occur in drug addicts and alcoholics serve to reset their brain reward systems outside of normal societal limits. This leads to a loss of control over the use of mind-altering substances and the development of the compulsive use of such substances despite negative consequences (Koob & LeMoal, 2008). The changes in the brain from drug addiction erodes a person’s self-control and ability to make sound decisions while sending intense impulses to use more drugs or alcohol (NIDA, 2008).

Signs and Symptoms of Addiction in Nurses

In order for addiction among nurses to be recognized and treated the nurses need to know the signs and symptoms of a substance use disorder (Pullen & Green, 1997). General symptoms of substance use problems include defensiveness, isolation, irritability and difficulty following through on work assignments. Signs and symptoms of a prescription-type substance use disorder can include coming to work on days off and volunteering for overtime. Coming to work while on vacation can suggest the need to divert prescription drugs from clinical supplies. Unfortunately, others can misinterpret these behaviors as dedication to duty by the employee which leaves the substance use disorder unrecognized. Nurses with a substance use disorder can also display suspicious behaviors surrounding incorrect narcotic counts, may consistently volunteer to administer medications, wait to be alone to open a narcotic cabinet and may lack witnesses to verify the wasting of unused medications.

Signs and symptoms of alcohol use can include:

- slurred speech
- lack of coordination
- impaired memory or attention
- leaving the workplace (to consume alcohol)
- the smell of alcohol on the breath
- frequent tardiness or poorly explained absences

(Griffith, 1999; Sloan & Vernarec, 2001).

Nurses with an untreated addiction can jeopardize patient safety because of impaired judgment, slower reaction time, diverting prescribed drugs from patients for their own use, neglect of patients and making a variety of other errors (Dunn, 2005).

Nurses who suspect a substance use disorder in co-workers need to be provided with guidelines and a clear process for reporting their concerns in a discreet and non-threatening manner (Tirrell, 1994). This will increase the likelihood that substance use problems are detected earlier and dealt with appropriately. If nurses do not have a clear process for acting on concerns about a colleague they may attempt to cover up for the person instead, which can contribute to the danger for the affected nurse as well as for patients (Serghis, 1999). Data also indicate that the likelihood of successful treatment outcomes is higher when treatment is implemented earlier in the addiction process (Martin, Schaffer, & Campbell, 1999).

Giving a staff the proper information for reporting and rehabilitation can also lead to other benefits. Torkelson, Anderson & McDaniel, (1996) found that organizations where the problem of nurses with a substance use disorder were not perceived as threatening promoted a culture of openness, participation and professionalism. In addition, such organizations were more likely to refer, reintegrate and hire recovering nurses with a substance use disorder. This was still true after controlling for hospital vacancy rate as a variable in the study. Prompt recognition and reporting also minimizes the danger impaired nursing practice can pose to patients and co-workers (Shewey, 1997).

Stages of Addiction

Mind- and mood-altering substances produce a sensation of pleasure that is important in the initial stage of dependence. Repeated and chronic administration of substances directly affects the functions in the brain and causes an intense drive in the brain to get the substance (craving). Repeated attempts to satisfy the craving are called compulsions (Volkow & Fowler,

2000). Using the substances despite negative behavioral, emotional, physical and spiritual consequences is an addiction. Different drugs produce different patterns of addiction with emphasis on different components of the addiction cycle.

There are generally five stages of addiction:

- contact (first use of drug, experiences the pleasure of using)
- experimental use (occasional, using to feel good)
- excessive use (chasing the high, getting drunk and passing out)
- addiction (use despite negative consequences)
- recovery (restoring the mind, spirit and body to health and equilibrium)

(SAMHSA, 1999)

The general pattern of the process can be described as use, abuse and addiction. Repeated and chronic administration of substances directly affects the functions in the brain and causes an intense drive in the brain to get the substance (craving). Repeated attempts to satisfy the craving are called compulsions (Volkow & Fowler, 2000). Using the substances despite negative behavioral, emotional, physical and spiritual consequences is an addiction.

It may be helpful to emphasize the difference between substance abuse and substance dependency in this section since these are the two basic criteria we refer to under a substance use disorder. It is also important to emphasize that there is a difference between nurses who have a substance disorder versus those who have a substance dependency given the natural history or progression of the disease of a substance use disorder. Carlton Erikson (2007) noted that even the American Psychiatric Association and World Health Organization now provide diagnostic criteria to differentiate those drug users who may have control over their drug use, such as substance abusers or those who do not have the disease and may achieve recovery through education, counseling, coercion, incarceration or restriction of drug availability and those who don't have control consistently and have the full-blown disease or substance dependency and require additional measures in order to attain and maintain abstinence and recovery. Erikson points out that this is possible because we are able to talk about what causes dependence (the brain disease) versus what causes the abuse of drugs. Both conditions produce serious consequences but differ in their causes and the ways they can be overcome.

Drugs that are commonly abused have a powerful influence on the brain and occur in addiction as stages. The initial stage of the addiction cycle involves the binge or intoxication stage, which gives the user an initial acute reward. Reward is defined as a positive reinforcer with some additional emotional value such as pleasure (Koob & LeMoal, 2008). It is in this initial stage that people establish a relationship or an intimacy with their drug of choice. Next is the preoccupation stage and it is characterized by a craving, which is an intense feeling coupled with an overwhelming need to obtain the substance. Dependence comes next and is the stage where people develop behavioral patterns, habits and ceremonies around the use of their particular substance. In the brain the dependence stage involves alterations of the neurochemical reactions, though some alteration also begins in much earlier stages. At this point a person could theoretically, with some degree of difficulty, walk away from the substance of choice, though for certain substances this window of opportunity is very small. The last stage is addiction when the brain has changed so profoundly and often irrevocably that a person uses the substance of choice in a feeble attempt to feel normal. There is no turning back the brain chemistry and there is no stopping the consumption without an intervention from an outside force.

Role of Family and Support Systems

Addiction is a family disease even for those in the medical profession. The effect to the families occurs because of the negative consequences that are ignored by the addict but are glaringly present for the family. Renowned expert, Claudia Black (1987) talks about the role of family, “Within families impacted by addiction, depression, chronic anger, anger avoidance, denial and shame are pervasive to spouses, partners, children, young and old and certainly the addicted person. Children, spouses and partners in addictive family systems are at greater risk for physical and sexual abuse. Alcoholism and drug addiction repeat generationally and in today’s world that generational legacy includes eating disorders, sex addiction, compulsive disorders, addictive behaviors and gambling addiction (p. 25).”

It is critical that all members of a nurse’s family or support system get help to cope with the negative feelings and destructive behaviors that characterize the person with a substance use disorder. A critical component to good recovery is emotional sobriety, which is defined as finding and maintaining our equilibrium. The essence of emotional sobriety is good self-regulation. Self-regulation means that we have mastered those skills that allow us to balance our moods, our nervous systems, our appetites, our sexual drive and our sleep. We have learned how to tolerate our intense emotions without acting out in dysfunctional ways by clamping down or foreclosing on our feeling world or self-medicating (Dayton, 2007, p. 3).

Restoring and rehabilitating families and the support systems of nursing professionals are not easy tasks but they are not impossible. Focusing on the goal of emotional sobriety for all members of an affected family is a first step toward success.

Summary

Addiction is a disease of the brain that affects the whole person. Risk factors include genetic, psychological, behavioral, social and demographic components. There are definitive signs and symptoms of addiction as well as stages. Family and support systems play a significant role in recovery for professional nurses.

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CHAPTER THREE

RISKS AND PROTECTIVE FACTORS FOR NURSES

THE PREVALENCE OF SUBSTANCE ABUSE and addiction in nurses and other health care professionals is no higher than that of the general population (Storr, Trinkoff, & Hughes, 2000), although nurses were reported to have illicit drug use rates lower than the general population (Trinkoff & Storr, 1998b). The estimates of the prevalence of addiction range from 8 to 20 percent for use and abuse combined (Trinkoff, Shou & Storr, 1999; Trinkoff, Eaton, & Anthony, 1991). A review of smoking studies also found that nurses smoked tobacco at rates less than or equal to comparable general populations (Rowe & Clark, 2000).

While overall substance abuse may be comparable for nurses and the general population, nurses report elevated rates of prescription-type drug abuse (Trinkoff & Storr, 1998b). Abuse was defined as prescription-type use without a specific script, using more than the prescribed dosage or using for indications other than those prescribed. The rate of abuse by nurses of prescription-type drugs was 6.9 percent when compared to white females as reported by the 1997 National Household Survey on Drug Abuse. The period of time that was measured for the purposes of the survey was the prior year. White females in the study had a rate of 3.2 percent (SAMHSA, 1998a). Hughes, Baldwin, Sheehan, Conard and Storr (1992) found that other medical professionals such as physicians were also more likely to abuse prescription medications. Pharmacists were believed to have substance use patterns similar to physicians but at a slightly lower rate (Coombs, 1997). In a study on the abuse of alcohol by Kenna and Wood (2004a), nurses reported less binge drinking in the previous year before the study than dentists, physicians and pharmacists but more binge drinking than the general population, age 35 and older. Nurses also comprise the largest group of health care professionals, therefore those who do develop issues with abuse and addiction are not only more visible, they are usually more stigmatized in the general health care population and receive more severe sanctions than physicians (Shaw, McGovern, Angres, & Rawal, 2004).

Different Rates of Abuse between Specialties

A nurse's likelihood to abuse substances was found to vary across specialties. Emergency room and psychiatric nurses in particular were shown to have a higher rate of abuse in the year prior to the study (Trinkoff & Storr, 1998b). Higher rates of smoking were found in psychiatric nurses and significantly higher cocaine use was found in critical care nurses as

compared to other specialties (Plant, M. L., Plant, M. A., & Foster, 1991; Collins, Gollnisch, & Morsheimer, 1999). Oncology nurses were more likely to drink alcohol (five or more drinks per occasion) than nurses who listed their specialty as administration (Trinkoff & Storr, 1998b). The specialties that were the least likely to report substance abuses during the previous year were general pediatrics, women's health and school and occupational health nurses. The American Association of Nurse Anesthetists reported that the addiction rate among anesthesiologists and nurse anesthetists exceeded 15 percent (Quinlan, 1996). An anonymous survey of drug abuse among Certified Registered Nurse Anesthetists (CRNAs) found that 10 percent of CRNAs reported abuse of the controlled drugs used in their practice (Bell, McDonough, Ellison, & Fitzhaugh, 1999). Similar patterns of increased abuse in specific specialties have also been found among physicians with higher rates in psychiatrists and emergency medicine physicians (Hughes et al., 1999) suggesting that there may be common etiologic factors among health professionals.

Gender and Substance Abuse

Nurses are at a greater risk than the overall population for developing problems with substance abuse and addiction. Many of the factors are linked to how the addiction process affects females differently coupled with the fact that the majority of nurses are women. The United States Department of Labor Women's Bureau reported that 91.7 percent of RNs in 2007 were women (United States Department of Labor, 2007). The etiology of addiction in women shows they tend to physically wear down faster and have a more virulent course of addiction. The results were the same across all drugs. This effect is known as the telescoping of symptoms and refers to the evidence that shows women tend to start substance abuse later in life, abuse fewer substances than men and yet they often present with more severe physical symptoms when they enter treatment (Goldberg, 1995; Mynatt, 1998).

Women tend to seek medical help for physical complaints such as insomnia, nervousness or depression that are often associated with substance abuse but the underlying problem often goes undetected by medical professionals because screening for abuse is not yet typically done in primary care settings. Therefore, this leads to a longer period of abuse for women in general and for women who are nursing professionals.

The path to treatment also varies widely between men and women. Men are more likely to be referred for help by outside forces because of employment or legal problems while women are referred for help for physical or mental health reasons or for family problems. Women often connect the onset of substance abuse to a stressful life event or loss, which may inadvertently assist in masking the real problem for a greater period of time (Blume, 1998). The differences in perception may also be occurring because females are presenting initial symptoms that are being confused with other maladies. For example, women have higher rates of co-morbid psychiatric disorders when entering treatment, most commonly depression and anxiety (Blume, 1998; Winick, 1992; Goldberg, 1995), which could be explained away as a result of a stressful life event or loss. Others, including family members may also be failing to recognize nurses with addiction problems if their relative's behavior does not resemble the social stereotype of an addict or alcoholic. Women with higher incomes or education such as nurses are even less likely to be identified and referred to treatment until they have reached an advanced state of addiction (Blume, 1998; Lex, 1994). Men comprise approximately only 8.3 percent of the nursing population but are overrepresented in the population of nurses in alternative programs and as disciplinary cases (Dittman, 2008).

While women tend to abuse alcohol and illegal drugs less than men, they are more likely to abuse prescription medications (Lex, 1994). Women who abuse drugs or alcohol

also experience a stronger condemnation in contemporary society. While there is a societal stigma in the U.S. toward everyone with substance abuse issues, women are often held to a higher moral standard of behavior. What may be acceptable for men may be considered unacceptable for women. In addition, sexual victimization, (i.e., women who are under the influence of drugs or alcohol being taken advantage of sexually), is an important risk factor for substance abuse (Blume, 1998; Goldberg, 1995).

The stigma of substance abuse for nurses is also still very powerful for both genders primarily because of the threat of the potential loss of one's job. The result of the societal pressures on females is that women, and therefore the majority of nurses remain the most hidden population among those who abuse alcohol and drugs (Blume, 1998).

Early risk factors for nurses include a family history of addictions, early victimization, particularly verbal, physical and sexual abuse and the experience of a loss of loved ones (Mynatt, 1998; West, 2002). Other early predictors for substance abuse include: psychological stress, low self-esteem, weak religious affiliation, emotional distance within the family, sensation seeking behaviors, a high abuse among peers and an early age of onset for the abuse of substances (Bry, 1983; Galaif & Newcomb, 1999). The age of the first abuse is also highly predictive of later substance abuse. Abuse before the age of 15 is considered early use, (DeWit, Adlaf, Offord, & Ogborne, 2000; Merlo & Gold, 2008). However, studies estimate that approximately 40 to 60 percent of the risk for substance abuse is due to genetic influences (NIDA, 2007; Schuckit, 2009).

General risk factors, which tend to make any individual more susceptible to developing a substance use disorder are:

Psychiatric such as:

- depression
- anxiety
- low self-esteem
- low tolerance for stress
- other mental health disorders (such as learning disabilities)
- feelings of desperation
- loss of control over day-to-day circumstances
- feelings of resentment

Behavioral such as:

- the use of other substances
- aggressive behavior in childhood
- conduct disorder (anti-social personality disorder, avoidance of responsibilities, impulsivity and risk taking, alienation and rebelliousness)
- reckless behavior
- school-based academic or behavioral problems (which is defined as dropping out)
- an involvement with the criminal justice system
- illegal behaviors
- poor interpersonal relationships

Social such as:

- an early age of the first abuse
- alcohol and drug use by peers
- social or cultural norms condoning abuse
- faulty expectations about the positive effects of drugs and alcohol
- an availability of drugs or alcohol

Demographics such as:

- male gender
- inner city or rural residence combined with a low socio-economic status
- lack of employment opportunities

Family such as:

- abuse of alcohol or drugs
- a family dysfunction (such as inconsistent discipline)
- a lack of positive family rituals and routines
- poor parenting skills
- family trauma (such as a death or divorce)

Genetics such as:

- an inherited predisposition to alcohol or drug dependence
- deficits in natural neurotransmitters (such as serotonin)
- an absence of aversive reactions (such as flushing or palpitations)

(Sullivan & Fleming, 2008)

Risk factors unique to a nurse's workplace can predispose them to developing a substance use disorder. Furthermore, addiction and substance abuse have even been cited as an occupational hazard for those in the health care field (Brooke, Edwards, & Taylor, 1991; Naegle, 1988).

Seven risk factors for nurses in the workplace are:

- role strain
- problems of daily living
- enabling by peers and managers
- attitudes towards drugs and drug use
- lack of education regarding a substance use disorder
- lack of controls
- physician prescribing practices

(Clark, 1988)

Role strain was defined as inadequate support at work, burnout and work overload or a feeling of insignificance in the ability to make changes. Problems with daily living included the loss of a significant other, poor coping skills and insecurity and isolation. Peer enabling included overlooking symptoms because of a misplaced loyalty for fear that the nurse would lose his/her job if the substance use problems were detected.

Five particular attitudes can be problematic and may heighten the odds of substance use problems in nurses (Clark & Farnsworth, 2006). The first attitude is when substance use is seen as an acceptable means of coping with life's problems and facilitates enjoyment, comfort and getting along. The second is when nurses are trained to develop a faith in drugs as a means of promoting healing or as a result of witnessing the positive effects of drugs on patients. The development of this pharmacological optimism can become a profound belief system. The third attitude is a sense of entitlement by a nurse that they need to continue to work and can lead to a rationalization of substance use as a means to an end. The fourth attitude deals with the special status of health care providers as being invulnerable to the illnesses of their patients. Some nurses may see themselves only as care givers and not capable of becoming the recipients of care. Finally, the last attitude is when professional training about powerful medications is used to self-diagnose and self-medicate physical pain or stress in order to enable the nurse to continue to work. The work schedule and other job demands

create adverse states such as stress and fatigue, which can lead to viewing any drug use as a coping mechanism or solution.

A lack of education about the addictive process and how to recognize the signs and symptoms remains one of the more profound risk factors for nurses.

The ready availability of medications is also an occupational hazard that is often combined with poorly managed or less than secure administration of narcotics and other controlled substances within health care facilities (Trinkoff, Storr, & Wall, 1999). A survey of 300 nurses enrolled in treatment programs showed that one-sixth had changed work sites (usually by internal hospital transfer) to have an easier access to drugs in the workplace (Sullivan, Bissell, & Leffler, 1990). On the other hand, Kenna found that lower workplace access to prescription drugs led to a greater use of illicit substances among nursing students (Kenna & Wood, 2004b). The ongoing lack of institutional controls in the storing and distribution of narcotics facilitates the diversion of drugs and the ability to conceal the diversion.

Another risk factor is the loose prescribing practices among health care professionals. In one example of this form of occupational access, nurses in the study did not seek appropriate medical care for self-diagnosed health problems. Instead, they obtained prescriptions from physician friends without receiving adequate workups (Solari-Twadell, 1988).

One of the early researchers, Charles Winick, looked into the risks for addiction and found that easy access, role strain and freedom from negative prohibitions against use will predispose certain populations to substance abuse, including nurses and physicians (Winick, 1980). Later research designed to test the utility of this model was conducted by Trinkoff, Shou, Storr and Soeken, (2000). This study supported the previous research by Winick and found that increased workplace stress, low religiosity and involvement with a social network of users were all associated with increased substance use. Prior research by William McAuliffe indicated that nurses tend to discount their own risk for addiction, are highly knowledgeable about medications and found that they thought they could experiment with medications without experiencing any harm (McAuliffe, 1984).

Top Four Risk Factors

The top four risk factors for nurses in the workplace are access, attitude, stress and a lack of education. The easy availability of drugs, training in the administration and injection of drugs, a familiarity with and a frequency of administering drugs tends to diminish negative sanctions against self-diagnosis and self-administration and increases the risk for substance abuse (Trinkoff et al., 2000, Trinkoff, Storr & Wall, 1999; Luck & Hedrick, 2004). Nursing is a highly stressful occupation particularly with staffing shortages, increased acuteness and patient ratios. One study showed a relation between work schedule characteristics such as shift rotation, weekends on, shift lengths longer than eight hours and overtime to substance abuse. In general, the more adverse the schedule was, the greater the likelihood there would be substance abuse (Trinkoff & Storr, 1998a).

The work schedule most strongly associated with substance abuse was the combination of shift rotation and longer shifts, which had multiple adverse effects. Shift work and long work hours were shown to lead to fatigue, sleep deprivation, circadian rhythm disruption and other psycho-physiological consequences (Geiger-Brown & Trinkoff, 2010). Studies of nurses' adverse work schedules, including long work hours and limited time off to recover, were shown to lead to musculoskeletal injury and pain, and an increased incidence of needle sticks (Trinkoff, Le, Geiger-Brown, Lipscomb, & Lang, 2006; Trinkoff, Le, Geiger-Brown, & Lipscomb, 2007).

Self-medication for pain is always a concern among nurses. Bugle (1996) compared a group of disciplined nurses to a group of registered nurses who were not disciplined for substance use problems and found that 40 percent of disciplined nurses used prescription medication to control chronic pain conditions (compared with 20 percent in the comparison group), and 42.5 percent of disciplined nurses used substances for emotional problems compared to 6.5 percent in the comparison group.

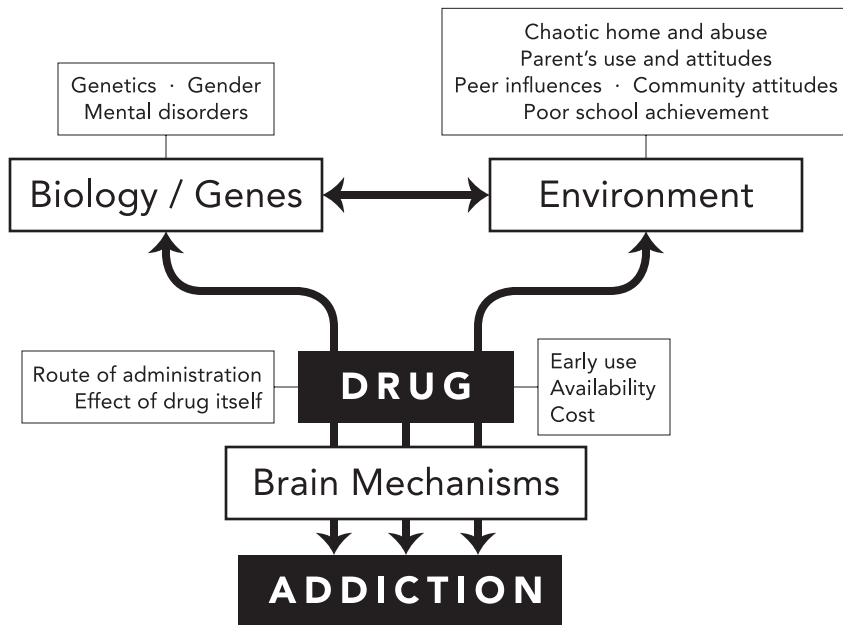
The fourth risk factor is a lack of education about substance use disorder, especially by all health care professionals, both academically and professionally, which leads to a lack of awareness about signs and symptoms and a lack of preparedness in order to identify and address the signs and symptoms. This all leads to a common yet overlooked risk factor. This lack of education also contributes to the negative stereotypes and stigma toward those with substance use disorders, again especially toward nurses and physicians (Chappel, 1992; Grover & Floyd, 1998). Health care professionals are often held to a higher standard and often it's other health care professionals who hold the most negative views toward their colleagues who develop a substance use disorder (Howard & Chung, 2000a; Howard & Chung, 2000b).

The many risk factors for addiction can be summarized in Figure 1 on page 19, which was adapted to the specific risk factors for nurses by a member of the National Council of State Boards of Nursing (NCSBN®) Substance Use Disorders Committee. The schematic is based upon the classic epidemiological triad: host (biology or genes), environment and agent (drug). Again, vulnerability to the development of a substance use disorder is multifactorial and impacted by numerous elements including genetics, family, social and work environment, age and gender. No single factor determines the overall risk for development of a substance use disorder. However, as discussed, certain workplace risk factors create a greater vulnerability for nurses to the development of a substance use disorder. But even here risk varies greatly and most nurses still cope satisfactorily with the unique stressors of nursing such as the life and death consequences of their actions, rotating shifts and constant concerns, while some nurses may find these same factors difficult or impossible to deal with and turn to the misuse of alcohol or drugs.

While most of the risk factors listed in the figure may be known to most nurses or have been discussed to some extent already, certain of the environmental factors listed in the diagram bear further explanation. Western medical practices relate to Western medicine's reliance on pharmacotherapy as first-line treatment and the resulting expectation by patients that pharmaceuticals will be prescribed for them, whether it is for pain or some other condition in order to create a quick fix. Administrative benign neglect is a term used to describe the health care administrators who fail to recognize or intervene with nurse employees who have an active substance use disorder (Gossop et al., 2001). If there is an early failure to act responsibly the disease may progress to the point where it is too late for the administration to justify retaining the nurse. Firing someone may become the only alternative for far too many nurses.

Education and stigma are two more factors in the chart below that deserve further consideration. Many of the nurses interviewed had identified a lack of education and a culture of mistreatment or stigma in their workplace, which can produce a work environment where nurses with a substance use disorder may take even greater pains to conceal their abuse and increase the risk of harmful workplace errors (Darbro, 2005).

Figure 1: Risk Factors for a Substance Use Disorder in Nursing



Adapted from NIDA Slide—2007

Protective factors are much less studied and considered in the literature yet are critical for developing adequate prevention and support not only for nurses who already have substance use issues but for those nurses who are at risk for developing substance abuse issues. Protective factors include beliefs in the values and norms of society, school and religious beliefs and strong early attachment to a parent (Simoneau & Bergeron, 2000). Other protective factors include work satisfaction, workplace social support and workplace constraints regarding use (Simoneau & Bergeron, 2000). Age is another protective factor with the highest risk for substance abuse occurring in young adulthood that declines with age (SAMHSA, 2007). Elements that support a strong recovery program can also be considered protective factors.

The following factors are predictive of a successful recovery program according to the physician health-monitoring program, Georgia Impaired Physician Program:

- a higher number of 12-step support group meetings attended each week
- a high quality and frequency of contact with a 12-step sponsor
- random, observed urine drug screens
- close monitoring of emotional reactions (such as guilt, shame, anger, depression or insomnia)
- immediate addressing of other compulsive behaviors that emerge (such as gambling, food, sex or work)
- consistent review and evaluation of treatment or medication status
- involvement, assessment and inclusion of family relationships
- support and verification of medical and physical health status
- regular questioning and support of leisure or fun activities

- intense scrutiny of compliance with all contract agreements
 - regular questioning and support of regular exercise
 - regular questioning and support of workplace stressors
 - regular questioning of financial status and any problems
 - regular questioning of any need for additional training or education
 - questioning of participant's own evaluation of his/her progress in recovery
 - identification of any weak points in the participant's recovery or support
- (Talbot & Wilson, 2005, p. 1197)

These factors have also been identified as typical components of alternative diversion programs for nurses (NCSBN, 2009). There have not been any verified best practice standards for alternative programs for either nurses or physicians even though there have been requests from many sources. Recent research seems to support the success of the common elements of both the physician health-monitoring program and the alternative diversion program for nurses such as intense and long-term treatment, aftercare, monitoring the recovery, the regular and consistent review of progress and compliance with contract stipulations (Merlo & Gold, 2008; McLellan, Thomas, Gregory, Campbell, & DuPont, 2008)

Other elements may also be: the cessation of practice as a nurse, practice restrictions and stipulations, notification of employers, monitoring the return to work by on-site supervisors or managers, verification of the compliance by the nurse in question with all contract stipulations, which may include random, observed drug screenings, attendance at 12-step or support group meetings, work with a peer sponsor, and written or regular face-to-face evaluations of the compliance with the monitoring program.

Summary

Health care professionals have specific and unique workplace risk factors that may increase their risk for the development of a substance use disorder. These include access, attitude, stress and lack of education about a substance use disorder. They share many other risk factors with the general population that also contribute to their susceptibility to developing a substance use disorder. Women have specific gender-related risk factors that also must be considered especially since 91.7 percent of nurses are female (United States Department of Labor, 2007).

A thorough consideration of the many risk factors that make certain populations vulnerable to developing a substance use disorder must be undertaken if this problem is to be addressed proactively and compassionately.

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CHAPTER FOUR

REGULATORY MANAGEMENT OF NURSES WITH A SUBSTANCE USE DISORDER

THE PREVIOUS CHAPTERS gave a basic understanding of a substance use disorder, particularly for health care workers along with the risk factors that can lead to a substance use disorder and the effects of different workplace situations on the role of nurses. Now, it's time to address the responsibility of regulatory commissions and how they impact those who are disciplined or seeking treatment.

State Nursing Practice Acts

Each state is given the power to regulate professionals such as nurses within their jurisdiction (Dunn, 2005). Boards of nursing are the administrative agencies that were created by statute. Agencies are delegated only the powers stated in the legislation that created them and these statutes frequently state an explicit duty to the board to protect the public from unsafe nursing.

These statutes are often referred to as practice acts or organic acts and generally accomplish several things: to create the board of nursing, define the qualifications and terms of its members, delegate rulemaking and adjudicative authority, define generally the practice of nursing and scope of practice and establish disciplinary procedures. The board's rulemaking function results in administrative rules, which serve to add detail to the general statutory framework and set standards for the profession as a whole. The adjudicative function of the board is concerned with violations of those standards by individual nurses.

Boards of nursing use their professional expertise to enact rules or regulations and to implement and enforce the statutes as they relate to the practice of nursing in their state (Dunn, 2005). These rules define the scope of practice for nurses and assist the nurse in determining what is considered misconduct, unprofessional conduct, incompetence or being unfit to practice (Dunn, 2005). The board will also employ these statutes and rules when they receive information alleging that a nurse has engaged in some form of misconduct.

The Traditional Disciplinary Approach

The complaint process usually begins with the receipt or generation of a complaint. Most states require that a complaint be in writing and directed to the board. Some boards require, or at least encourage, the complaint to be on a form that the board provides. The complaint

must outline certain acts or omissions that have been committed by the respondent, which the complainant or complaining party considers to be unprofessional conduct according to the rules and laws that govern the practice of nursing in the state. The board needs to know the full name of the nurse being complained about, the facts surrounding the incident, when and where the act was committed and preferably who is reporting the incident. More detail is usually better than less. The complainant must clearly describe the conduct that the complainant feels is a violation of nursing statutes or rules.

For many states, the second step in the complaint process is to provide the respondent with an opportunity to review and respond in writing to the complaint. The complaint and the response will both be reviewed by the board of nursing. Once the board of nursing has reviewed the complaint and response it generally has three options. One, if there is enough evidence indicating that disciplinary action is warranted the board may decide to initiate the disciplinary process. Or two, the board may make a determination that disciplinary action is not warranted and dismiss the complaint either with or without prejudice. Or three, the board may determine that more information is needed in order to make a determination on the complaint and may conduct an investigation. Some state laws require that each complaint against a nurse be investigated while other states leave that decision to the board of nursing (Dunn, 2005).

If the case is dismissed, the case is closed and no further action is taken. If the case is investigated, the case will be continued. It is at this time that witnesses will be interviewed, documents such as medical records and policies and procedures will be obtained and reviewed if they were not provided with the initial complaint and an investigation of the site of the alleged incident may occur. Regardless of the decision made, the board's objective is protection of the public. Throughout this process the public's right to know must be balanced with the rights of the nurse because professional discipline of any type has the potential to jeopardize a nurse's career and livelihood (Raper & Hudspeth, 2008). If the board ultimately concludes that there has been a violation of the nurse practice act that warrants disciplinary action, the licensed nurse who is the subject of the complaint will have the opportunity to request a hearing.

A license to practice nursing carries with it the ability to earn a living, which means the license is a form of property and cannot be taken away without giving the participant due process of the law as granted in the Fifth Amendment to the United States Constitution and made applicable to the states by the Fourteenth Amendment. The concept of due process of law at its most basic involves giving the nurse a notice of the charges and an opportunity to be heard by an impartial tribunal, which in the case of administrative law cases is usually a hearing examiner or other administrative official. The degree of process that is due in any given situation is a balancing of the property interest, risk of error in depriving someone of that interest and the government's interest in efficient administration (Barry v. Barchi, 1979). Hearings regarding licensure are considered administrative and investigative (Dunn, 2005). Once a decision is rendered the nurse has the right to appeal, which differs from the previous hearing. Appeals are processed in the civil court system (Dunn, 2005).

Substance use disorder within the nursing community is a major concern for agencies tasked with overseeing the public safety such as state boards of nursing and many of the complaints that come before the board involve nurses with substance use disorder issues. Substance use disorder, impairment and diversion are potential areas of concern for nurses and the board must have rules to address these concerns.

Many state regulations specifically include certain acts that are cause for disciplinary action against the nurse such as the following:

- drug diversion
- a positive drug screen for which there is no lawful prescription
- violation of a state or a federal narcotics or controlled substances law
- criminal convictions
- addiction to or dependency on a habit-forming drug or controlled substance
- illegal use of the drug or controlled substance
- use of a habit-forming drug or controlled substance to the extent that the use impairs the user physically or mentally
- failure to comply with the contract provisions of the nurses assistance program

Once the evidence against a nurse in a case alleging impairment or a substance use disorder has been presented and the board has determined that the nurse has engaged in unprofessional conduct in violation of the rules or laws with respect to the practice of nursing in that state, the board must then make a determination as to what sanctions are appropriate for rehabilitating the nurse. In these types of cases, the Final Order of Discipline would require the nurse to enroll in a monitoring program within a short period of time. Many state boards have statutory authority for implementing nurse assistance programs. These boards often implement rules for carrying out the programs such as admission criteria, program requirements and discharge criteria. The Final Order must require that the nurse sign a contract with the program as part of the enrollment process and that the nurse abide by all the terms, conditions and requirements of the program and program contract until the nurse's successful completion of the program.

The fact that discipline has been instituted against a nurse may be available to the public as soon as the discipline is taken. Disciplinary actions must also be reported to data banks such as the Nursys® data bank of the National Council of State Boards of Nursing and to data banks as required by federal law, including the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioners Data Bank (NPDB).

Challenges of the Disciplinary Approach

The value of the nursing license has led to an increasing number of nurses being represented by counsel when charged by the board. Often there is a limited ability to get the nurse to admit to a problem because the nurse and the nurse's attorney are rightly concerned with admissions, which can be used against them at a hearing. However, admitting to a substance use disorder is seen as a first step to recovery, therefore proceeding with a purely disciplinary approach to a substance use disorder presents clear challenges.

Setting out clear, enforceable conditions in a traditional disciplinary order can be problematic because orders are rather inflexible and cannot change as the nurse goes through the substance use disorder recovery process. Having a support structure such as a participant agreement imposed through a legal order, which sets rigid conditions for a certain period of time, can be beneficial for recovery. However, if it ends abruptly it can actually contribute to a relapse (Darbro, 2005).

The adversarial process can be cumbersome. Cases can often take more than a year because of lengthy investigations, a review by attorneys, drafting and editing the charging documents that start the legal process, engaging in pre-trial fact-finding known as discovery and a formal hearing before an administrative law judge or board. Although an eventual settlement before

the hearing frequently happens, it is often late in the process. If the nurse has taken a position that they have committed no misconduct, the public can be at risk for a substantial period of time until the nurse's case is heard. Even states that have the ability to take immediate action against a nurse's license still have to meet due process requirements. It is incumbent upon the boards of nursing and others involved in the regulatory process to ensure due process in a timely and expeditious manner, not only for the nurse in question but for the patients whose safety and health depend upon it.

Immediate Action

It is possible for a regulatory agency to take steps that reduce some or all of the concerns regarding whether or not to take disciplinary action against a nurse with a substance use disorder. But if a hearing is requested by the nurse, this too can become a lengthy process. There is no doubt, however, that a nurse who has been identified as having a substance use disorder must be in a monitoring program and meet that program's requirements in order to practice as a nurse. A nurse participant can still have the option, though, of dropping out of the program and could conceivably work as a nurse without being monitored. Since there is the possibility of the nurse being discharged unsuccessfully from the program, there must be a mechanism in place for ensuring that the individual is not practicing as a nurse. There are several states that have passed legislation that addresses this issue and allows the regulatory agency authority to take immediate action against the license, which would render it inactive or suspended, and then to follow up with a hearing on the issues. There are many different terms for this type of action used by the different states that have it at their disposal. Examples of such terms are: summary suspension, temporary suspension, license restriction or license suspension.

The New Mexico Board of Nursing, for example, has administrative rules that utilize a summary suspension option when it might be indicated to be necessary in order to protect the public. The New Mexico rules state that "...the board shall move for a Notice of Contemplated Action (NCA) and may summarily suspend the license of the participant for a period not to exceed ninety (90) days pending the completion of a formal disciplinary proceeding before the board of nursing for relapse or a positive drug screen." (Nurse Licensure, 2001).

Some states have a rather complicated process whereby the board petitions for an order enjoining such violation or for an order enforcing compliance with the Nurse Practice Act. Upon the filing of a verified petition in court, the court may then issue a temporary restraining order without notice or bond and may preliminarily and permanently enjoin such violation. This may or may not require involving the Attorney General for that state.

Texas (2005) has a statute which gives the board the authority to temporarily suspend or restrict the license on a determination by a majority of the board or a three-member committee of board members designated by the board, which based on the evidence or information presented, the continued practice of the nurse would constitute a continuing and imminent threat to the public welfare. The State Office of Administrative Hearings must hold a preliminary hearing no later than the 14th day after the date of the temporary suspension or restriction to determine whether there is probable cause that a continuing and imminent threat to the public welfare exists. A final hearing on the matter must be held no later than the 61st day after the date of the temporary suspension or restriction.

Montana has a similar statute that states, "If the agency finds that public health, safety, or welfare imperatively requires emergency action and incorporates a finding to that effect

in its order, summary suspension of a license may be ordered pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined.” (Administrative Procedures Act, 2001).

Washington, D.C. also has the authority through the mayor to take immediate action. According to the Licensing of Health Professionals in the Health Occupations Revision Act of 2009, the mayor may summarily suspend or restrict without a hearing, the license, registration, or certification of a person: (a) Who has had his or her license, registration, or certification to practice the same profession or occupation revoked or suspended in another jurisdiction and has not had the license, registration, or certification to practice reinstated within that jurisdiction; (b) Who has been convicted of a felony; (c) Who has been adjudged incapacitated; or (d) Whose conduct presents an imminent danger to the health and safety of the public, as determined by the mayor following an investigation. A licensee, registrant, or person certified shall have the right to request a hearing within 72 hours after service of notice of the summary suspension or restriction of license, registration or certification.

Unfortunately, going this route is not without complications. It is very resource-intensive due to the right of the nurse to have a prompt hearing and the need of the attorney to obtain evidence, prepare motions and prep witnesses in such a short amount of time. Furthermore, it often isn’t looked upon favorably because the nature of the emergency action supersedes due process.

Nonetheless, the option of having the ability to take immediate action against a nurse’s license due to the threat to the public is a valuable tool. Boards of nursing, alternative programs and employers must work to get such legislation passed in their state. If a state already has such a statute, the board can be utilizing it in order to protect the public in any situation where a licensed nurse with a substance use disorder is not being monitored by a nurse monitoring program.

The Non-Disciplinary Approach

Before the advent of alternative programs the disciplinary approach was the only way to protect the public from unsafe nurses. Since the 1970s, non-disciplinary programs, which offer an alternative to traditional discipline, have been used by a growing number of nursing boards. The process begins the same as described above for the disciplinary approach with a complaint that is reviewed by the board, however, the outcome is not the same. Recovering nurses are able to remain active in nursing while being monitored and can continue to work, which enhances their financial status, further supporting recovery (Fogger & McGuinness, 2009). Perhaps the most important benefit to the nurse and to the public when the alternative to discipline approach is used is that it enhances patient safety by early intervention and quick entry into monitoring. Nurses can also continue to provide nursing care, which is especially important as the demand for skilled nursing care grows (Fogger & McGuinness, 2009; Haack & Yocom, 2002).

The basic requirements for participation by nurses in the alternative program must be similar to those in discipline monitoring because in both the enrollees must sign a contract for participation in the program and/or have a board order. They are also required to undergo drug testing, workplace monitoring and to take part in group and individual counseling. If the nurse meets the eligibility requirements of a non-disciplinary or alternative program apart from the board, the board is still no less involved. The integrity of the process demands both transparency and accountability. This may be especially true to maintain a successful,

functioning relationship between alternative to discipline programs and boards of nursing and the public. Alternative programs must maintain a firm adherence to achieving their mission of public safety through a high level of consistency and transparency in the way they administer the core elements of their operations including organization, communication, documentation, evidence-based practice and statistical measures of performance at both a state and national level.

In short, boards and programs must be transparent to each other and the public in the way they accomplish their mission of public protection and ensuring safe patient care as they return nurses to productive roles within their professional careers while addressing their substance use disorder. Ensuring that a comprehensive and legally binding contract is in place between an alternative program that is separate from the board and the board is the first step in ensuring accountability and transparency.

Contracts between the Board and Outside Monitoring Programs

According to the 2009 National Council of State Boards of Nursing survey of states with alternative programs, almost half (47 percent) of the alternative to discipline programs are administered by the staff of the board of nursing and 11 percent are administered by a state agency other than the board of nursing (such as a department of health). Thirty-nine percent of the programs are administered by an outside entity, such as a professional association or a peer assistance program (NCSBN, 2009). A peer assistance program is a type of program that provides support and assistance to nurses helping them to remain substance-free and active in the workforce (Fogger & McGuinness, 2009). Collaboration of the board with the alternative program results in a balance between non-public monitoring of the nurse with a substance use disorder who cooperates with the program and just action of the board to meet public safety concerns. A close liaison between the alternative program and the board of nursing is necessary to fulfill the role of the board and achieve public accountability.

Regardless of the type of outside alternative program, boards must be sure to have written contracts with these programs for them to provide nurse monitoring for the board. It is vital that these contracts preserve the board's disciplinary authority. However, when a board delegates responsibility for its alternative program to an outside entity, it needs to have complete assurance in the capability and integrity of the organization. Any contract entered into must give the board adequate control and oversight. For example, a contractual relationship with the board might specify what data are shared, when those data are shared and under what circumstances. Reporting requirements may be different depending on the relationship of the contracted entities.

The agreement or contract entered into between an agency and a contractor or subcontractor for an alternative program must include certain specific components. First, there needs to be a general information section that defines and describes the purpose and description of service, an overview and background of the program, a program statement and any statutory authority. Next, there are definitions as they relate to the agreement and alternative program, which must be followed by a section detailing the expected scopes of work. This would include but are not limited to: any general or specific requirements, project personnel, number and duties of project personnel, prior experience or qualifications of personnel involved in the contract and any turnover or takeover requirement. The scope of work will explain in detail the minimum requirements for the implementation, ongoing management and the operation

of the alternative program. This must have all the components of a comprehensive substance use disorder and mental illness rehabilitative referral program that provides assessments, monitoring and consultation for health care professionals. Emphasis will always be put on the program's effectiveness or efficiency in protecting the public. Finally, the contract must include the consequences of failing to fulfill the contract requirements. California is one such state that has recently implemented the contract requirements described herein.

There are further necessary items to the agreement or contract, which must also address the following requirements:

- **The Participant's General Recovery Contract Requirements**

There must be written contracts executed between the alternative program and the participant that details the specific requirements the participant must adhere to in order to remain in compliance throughout the contract and to successfully complete the program.

- **Requirements and Description of any Drug Screening Program Testing Protocol**

A qualitative substance use disorder testing program is required for all applicants or participants enrolled in an alternative program. The testing protocol must have specific requirements and will comply with the current drug testing standards for nurses.

- **Criteria for Evaluation of Treatment Providers**

Treatment providers must incorporate the following recovery program components and philosophies:

- a. use a 12-step recovery model with 12-step group participation as a treatment expectation or comparable substitute
- b. advocate total abstinence from mood- or mind-altering drugs including alcohol
- c. offer educational components (addresses at a minimum the disease concepts, recovery process and recovery-oriented lifestyle changes)
- d. use a variety of therapeutic modalities to meet the treatment needs of clients (may include group therapy, individual counseling, lectures, family or couples therapy, written materials and written assignments)
- e. use treatment plans (reflects client-specific assessment recommendations)

Treatment facility staff and services must have:

- licensure and/or accreditation by appropriate regulatory agencies
- sufficient resources available to adequately evaluate the physical and mental needs of the client, provide for safe detoxification and manage any medical emergency
- professional staff who are competent and experienced members of the clinical staff
- treatment planning involving a multidisciplinary approach and specific aftercare plans
- means to provide treatment or progress documentation to the program contractor

Qualifications for Contractors or Subcontractors

The level of experience necessary for contracted staff must be clear. All contracted staff must have experience working with health care professionals with a substance use disorder and mental illnesses. The personnel involved in the program must hold at all times the appropriate unrestricted licenses or certifications as required in the state where the alternative program is operating. It is also important to include contractor requirements and information on such items as the schedule and format, intent, internal and external auditing processes and an evaluation process.

Outreach and Education

Any outreach or education requirements, which can include providing information to organizations and associations regarding alternative programs, explaining the program's purpose, legislation, reporting requirements, procedures, the benefits to consumers, nurses with a substance use disorder, the organization, the profession and other stakeholders must be specified. An educational plan must also include the identification of signs and symptoms of addiction, intervention, referral, recovery or identifying an impaired nurse.

A contract that is signed and contains all of the above-described items is worthless if there is no way to ensure the contract is being followed. It cannot be emphasized enough that the board of nursing must retain responsibility for oversight and evaluation of the work of monitoring program providers.

Shared Information, Communication and Data Reporting

Transparency between the program and the board is the key to ensuring that the program is functioning at a level that ensures public protection. The identities of alternative program participants may be known to the board. The board of nursing will then be able to review nurse participant files and audit the administrative records for overall compliance of nurses in the alternative program and to ensure that the program is functioning appropriately. Each participant signs a release so that the board can have access to each participant's records if necessary. To that same end, the board must notify the alternative program of any complaint and action taken by the board against one of the participants in the program. This must be built into the contract that the participant signs with the program.

The program and the board must be in agreement as to what constitutes noncompliance with the program's contract and requirements. The board of nursing must be notified in a timely manner of any identified non-compliance of each nurse participant in the alternative program based upon agreed-upon mechanisms put in place between the board and the alternative program regarding the reporting of non-compliances to the board. All alternative program records related to noncompliance, discharge or termination from the alternative program must be available to the board of nursing or the board's representative upon request and upon discharge or termination from the alternative program. The board and the program must also be in agreement as to what constitutes successful completion of the program, what documentation is required and to whom, including whether or not the program is obligated to report successful completion to the board. This is true regardless of whether the program is a monitoring or a peer assistance program. The board does not have a formal relationship with peer assistance programs and, therefore, there may be a memorandum of agreement between the program and the board, which lays out the procedures for the program to notify the board if there is a problem with one of the nurse participants.

Alternative program staff must provide ongoing reports of program activities and aggregate data regarding alternative program participant nurses to the appropriate advisory committees and the board of nursing. Regular reports to the board regarding program participants must verify compliance with all program expectations and requirements. These measures of accountability will assist the board in meeting its oversight function of the alternative program.

Statistical reports and reports of compliance or noncompliance must be provided by the alternative program on a periodic basis as required by the board to carry out its public protection mandate. It is important to track and evaluate both successes and causes for nurses to be successful in achieving their alternative program goals. Aggregate data must then be presented and analyzed at the local, state, and federal level to best achieve appropriate goals consistent with public safety. Other uses of the aggregate data may include sharing with other alternative programs, boards and other interested parties to compare the effectiveness of different approaches to monitoring or to study other contract elements.

To ensure compliance with the contract and further accountability, the alternative program must provide at a minimum the following information when reporting to the board:

- number of complaints received
- type of referral
- number of program participants
- number of participants accepted and denied entry into the program
- number of successful completions
- number of noncompliant participants
- number of participants terminated
- demographics (including age, gender, other licenses held, the area of practice, type of practice, nursing specialty or type of facility where the participant worked)
- type of substances abused

For those boards that contract with an entity to monitor its participants and that report to a third party alternative program component of the board, the reporting requirements must be extensive and detailed to achieve the necessary accountability. For those alternative programs that manage their program internally, similar reporting requirements must be established to provide the information necessary to allow the board to gauge the success of the program in terms of objective outcome data. The board is ultimately accountable to the public for doing all it can to ensure public safety.

Any statistical information that is collected is also helpful for future planning and for the evaluation of alternative program services. For example, the National Task Force on Reentry into Clinical Practice for Health Professionals in 2000 proposed that databases needed to be created to accurately measure the number of nurses reentering clinical practice (Baldiiseri, 2007). There is a lot that can be learned from the creation of such databases to assist organizations to educate, facilitate and improve on re-entry for the impaired nurse (Baldiiseri, 2007).

Audits and Evaluations

Accountability to the public and the board is critical. Ongoing evaluation provides checks and balances that policies and procedures are being implemented correctly and consistently. These also ensure the program is meeting its mandates to protect the public and can identify areas for change and improvement. The alternative program and the board of nursing shall set performance measures with respect to program requirements to foster program accountability and public protection. Evaluations are discussed in greater detail in Chapter 16.

Other Ways to Ensure Accountability

Mark Yessian (2009), former Regional Inspector General, recommends that the following parameters of program accountability and board oversight are in place:

What are the Parameters?	Putting It in Action	Questions to Ask
Program Governance: The program is established in the law and has a clearly stated mission to protect the public.	The board provides ongoing, overall direction to the program and is sufficiently informed to ensure program efficiency.	
Program Operations: Grounded in a clear and transparent set of operational rules that outline entry to the program, monitoring of participants, criteria for graduation and other key matters.	The operational rules afford sufficient internal safety valves to protect the public while facilitating the program's recovery objectives.	Is the program open and accessible? Are they being transparent?
Program Feedback: The board and the program will remain adequately informed about the performance of the program.	They share information as necessary with other state boards to protect the public from unsuccessful program participants. There are information management systems in place for getting regular, reliable feedback from the program to the board, from which comparisons can be made such as changes over time. Must be able to present data cumulatively. Data can be gained by written and telephone surveys and interviews with employers and participants, focus groups, and electronic resources such as blogs.	
Program Evaluation: There must be sufficient mechanisms to assess efficiency and effectiveness and to conduct continuous quality improvement.	Need to be able to make comparisons about participants who have successfully completed the program, not just comparisons of the numbers. There must be continuous, data-driven evaluation built into the program.	Do the program operations withstand scrutiny? How many participants relapse after program completion? Can the program engage in post-program tracking?
Internal Quality Control: The program has a system of internal quality controls sufficient to ensure the accuracy, integrity, and timeliness of program activities.		
Public Awareness: Program facilitates public awareness of the mission and makes the approaches and results of the program known to the public.	There is total transparency. Program approaches, data and results must be visible on board's website.	Why do we have anything to hide?

The goal of transparency and communication is to provide the board with as much information about the alternative program as possible. Again, the program must not be acting alone and without oversight and direction from the board. Just as the program director would be able to, the board must have certain information about all aspects of the program. In addition to statistics, the board must be as familiar with the program as each participant. The board must be familiar with the following program components:

Enrollment

- criteria for enrollment in the program
- presented in writing

Drug Testing

- frequency participants are tested
- graduated levels or frequency of testing
- program protocol for assigning testing level to participant
- employ continuous (daily) testing
- effect of relapse on the testing schedule
- the urine collectors and a list of their required credentials
- written policies and procedures for urine collection
- standards that must be followed for urine collection
- policies to ensure the urine collectors are qualified, standards are met and policies and procedures are followed
- observation of all urine tests collected
- reports of any problems getting collection sites to conduct observed testing
- collection sites and locations that provide tests
- names of the collection site workers and an outline of their required credentials
- written policies and procedures for urine testing
- standards that must be followed for urine testing
- the safeguards program to ensure that the collection sites or labs and collection site or lab workers are qualified, standards are met and policies and procedures are followed
- length of time it takes to get the sample to the lab
- length of time it takes to get urine test results back from a lab
- contact person at the lab who will communicate the results and alternate in case of absence
- out-of-state labs that are approved for traveling participants
- the methods for creating a random schedule and communications of schedule to participants
- maximum number of hours that can elapse between the call to give a urine sample and the actual taking of the sample and the average amount of time
- accommodation of vacation and travel plans by participants
- receipt of all results and whether or not this includes the non-compliant results
- creation of a written policy for reporting positive test results to the board
- policy on maintaining a chain of custody
- physician review of the test results for creatinine, pH or other markers
- physician review of the program's authorized use of prescription medicines by participants
- other types of testing used such as hair tests and oral fluids
- frequency participants must have EtG testing

- the protocol for EtG results' levels that will trigger consequences and description of actions
- cost to participant for each EtG test and cost of all other tests
- description of other testing methods including hair analysis to ensure the monitoring of use over time

Group Meetings

- program participants expected attendance at group meetings
- program meetings facilitation by trained and licensed therapists
- qualifications of group leaders
- the regional distribution of program meetings
- the costs to the participants for group meeting participation
- notification of attendance at required AA meetings

Worksite Monitors

- contact the program has with worksite monitors before approving the person
- the criteria and qualifications for worksite monitoring
- frequency of meetings between the worksite monitor and the program participant
- safeguards to ensure that the worksite monitor is not impaired by alcohol or drug use

Internal Program Controls

- safeguards to ensure the standards for discharge are consistently applied
- safeguards to ensure that the policies for reporting relapse are consistently applied
- the mechanism for communicating with the board of nursing

Program Staffing

- number of persons who work with the program
- the qualifications of each
- the number of hours and weeks each person works for the program
- the program's consultations with an addictionologist including the frequency of consultations and in what manner
- conduct of periodic interviews with the participants according to stated policy concerning frequency of interviews, interviewer, in person or by telephone or from processed and reported interviews

Program Policy and Procedures Manual

- dated approval by the board regarding the program's policy and procedure manual
- list of changes to the manual since board approval of the manual
- clear consequences of relapse
- clear procedures for managing a relapse
- clear discharge criteria, both successful and unsuccessful
- requirement by the program contact that the participant admit a violation of Nurse Practice Act as a condition for admission to a non-disciplinary program

Evidence of Program Efficacy

- program conducts a follow-up study of participants one, three and five years after discharge
- changes over time to the costs of program participation
- any external audits, the results and the board reviews
- demonstration by the program that the public is protected from chemically addicted nurses

- seminars that were provided to health care entities or classes for nursing education programs on substance use disorder and how the program works
- information and frequency of information about participants, drop-outs, unsuccessful discharges and completers that were reported to the board
- the entity that evaluates the program
- the qualifications of the evaluator
- the approval process in selecting an evaluator
- the information that is provided to the evaluator in advance
- the timelines for the evaluator's reports
- the program's system for internal evaluations or audits

Confidentiality

- the program's policy on participant confidentiality
- a distinction made between privacy and confidentiality

Education and Outreach

- ways the program makes itself known to the public, to nurses and to health care facilities
- the types of education options the program staff provides about the alternative program and substance use disorder

Re-entry to Work

- the criteria for re-entry to work
- policy to determine if a nurse can be in the program who has chosen not to work as a nurse
- policy to determine if a nurse can successfully complete the program if they have never practiced nursing while in the program

Relapses

- definition of a relapse in writing
- the relapse rates
- the standards regarding relapses in writing
- the number of allowed relapses in writing
- standards for ensuring consistency in how relapses are treated

Termination

- the criteria for termination from the program
- termination criteria as part of the written contract
- successful and unsuccessful completion rates for program participants over time
- the drop-out rates for program participants
- the recidivism rates for post-program completions

Contracts

- policy regarding the participant's admission to a violation of the Nurse Practice Act in their contract, either in the beginning or as an addendum

Contract Compliance

- how the program monitors compliance
- how compliance is being tracked
- how the program responds to non-compliances
- how long it takes for the program to respond to non-compliances

A board that knows the answers to the previous questions is a board that knows whether the alternative monitoring program is working in monitoring nurses with a substance use disorder. The board will also know whether the public is being adequately protected. Furthermore, a board with all of the above information will also be able to provide comprehensive education about the monitoring program.

Board Assistance with Referrals to Alternative Programs and Community Resources

Unfortunately, knowledge about nursing regulations is all too often gained in a piecemeal fashion (Hudson, 2008). There is little formalized training of a comprehensive nature available through most boards of nursing. Boards are well-advised to develop and provide comprehensive training programs to fill in regulatory knowledge gaps by receiving information all at once and directly from the board staff. The program content could then be repeated regularly to ensure the education of as many nurses as possible throughout the state (Hudson, 2008).

Boards can help by including articles in nursing newsletters and distributing said newsletters. Executive directors of boards can present at association meetings and specialty organizations, schools and individual hospitals and clinics across the state. They must be sure to include signs and symptoms of substance use disorder, prevention, intervention and treatment as well as the nursing assistance program in their discussion.

States need to take an active role to ensure that the disciplinary and alternative programs work more effectively. First, they must put their policies on their regulatory board home pages so they are readily available for all nurses and nursing students (Monroe, et al., 2008). They must also create mechanisms for nurses to get assistance for their peers or themselves even before a problem occurs and becomes serious enough to warrant disciplinary measures. States must be required to evaluate their programs and collect data at all phases of the process to determine what is, and what is not, working (Monroe, Pearson, & Kenaga, 2008).

Summary

The alternative to discipline programs is a successful alternative to traditional disciplinary approaches. Each state is given the power to regulate professionals such as nurses within their jurisdiction and to let boards of nursing use their professional expertise to enact rules, or regulations and to implement and enforce the statutes relative to the practice of nursing in their state. Substance use disorder within the nursing community is a major concern and many state boards have statutory authority for implementing nurse assistance programs, including alternative to discipline programs. The board is still equally involved even in situations where the nurse meets the eligibility requirements of the non-disciplinary or alternative program. Boards must have written contracts in place with these programs regardless of the type of alternative program in order to provide nurse monitoring for the board.

Transparency between the program and the board is the key to ensuring that the program is functioning at a level that ensures public protection. Alternative program policies and procedures must promote accountability to the public and assure quality outcomes by including reporting requirements to the board, information-sharing, continuous and open communication and evaluations and audits. Boards also have an important role to play in education and must develop and provide comprehensive training programs to nurses, board members, employers, nursing schools and nursing education programs.

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CHAPTER FIVE

SCREENING, INTERVENTION AND REFERRAL TO TREATMENT

THE BEST TOOL FOR NURSES who have concerns about substance misuse for themselves or someone else is information, which starts with screening. Early intervention through simple screening methods can help people in the health care profession to avoid disciplinary action by boards of nursing, as outlined in the previous chapter, and to receive an appropriate referral for treatment.

Individuals with alcohol and substance use disorders can be divided into three general categories: at-risk or hazardous drinkers, harmful, problem or abusive drinkers, or dependent or addicted drinkers (NIAAA, 2003). Those with a substance use disorder can be grouped into: at-risk or hazardous users, harmful or problem users (or abusers), or drug dependent or addicted users (Fleming, 2002).

The drinkers' pyramid identifies types of drinkers based on the screening instrument AUDIT. It identifies portions of the population as: 40 percent abstainers, 35 percent low-risk drinkers, 20 percent high-risk drinkers and five percent as probable dependent or addicted drinkers (Babor & Higgins-Biddle, 2001). Screening, brief intervention and referral to treatment (SBIRT) have been advocated as public health policy to provide early identification and intervention of many chronic medical problems and have been adapted for at-risk drinking and substance abuse.

However, the long-term use of prescription medications for anxiety, insomnia and depression as well as the use of narcotics for chronic pain can also be managed without dependence or problems. At-risk prescription drug use includes those on mind-altering drugs and pain contracts for greater than three months. It is estimated that approximately 10 to 20 percent of long-term users do experience problems and symptoms of dependence such as taking more medication than prescribed (Feldman & Christensen, 2007).

The goal of screening and assessment is to identify and refer individuals at risk for substance abuse issues in order to provide further evaluation to determine the level of symptom-severity and the appropriate level of necessary care. Screening methods may include questioning by a health care professional or supervisor as well as self-administered questionnaires, which can be done as a hard copy or online. Effective screening tools are simple, accurate and have little or no cost. Most tools and instruments are available in the public domain and are readily accessible and anonymous. Many screening instruments can be self-administered, which will

allow professionals to increase their use and availability by encouraging their clients to access them. A sample can be viewed at www.alcoholscreening.org, and www.NIDAMED.org.

Common screening instruments include:

- The Alcohol Use Disorders Identification Test (AUDIT)
- Michigan Alcoholism Screening Test (MAST)
- Short Michigan Alcoholism Screening Test (SMAST)
- Self-Administered Alcoholic Screening Test (SAAST)
- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- NIDA-modified Assist Tool

Brief Interventions

Brief interventions are designed to investigate initial client need and substance abuse severity to motivate the client to address identified areas of concern. Brief interventions are techniques that are simple to learn, easy to utilize by even non-professionals and are effective ways to communicate concern about substance use issues. Brief motivational interviewing techniques can be utilized at any time in the treatment process but were initially developed to encourage ambivalent individuals to recognize the need for treatment (Miller & Rollinick, 2002). Recently, the method has also been used to encourage initial treatment, aftercare and continuing care treatment (Madras et al., 2009; O'Farrell, Murphy, Alter, & Fals-Stewart, 2008). These techniques were based on the stages of change theory, which promotes the concept that change occurs in cycles and that individuals go through various stages of reluctance and acceptance of change (Prochaska & DiClemente, 1983). Brief interventions are considered most effective for those dealing with substance use issues or for those with earlier and fewer substance abuse symptoms rather than people dealing with more severe symptoms in the later stages of addiction.

Brief interventions can be conducted in a variety of health care or treatment settings and because they do not require extensive training the interventions can be performed by treatment staff or other medical professionals. They will nominally include the four basic components of asking, assessing, advising and monitoring (Graham & Fleming, 2003). The goals of brief interventions may differ depending upon the environmental setting in which they occur (Bien, Miller, & Tonigan, 1993).

The six basic elements of effective brief interventions known as FRAME that were developed by William R. Miller are:

- feedback is provided about risks and consequences
- responsibility for any change is translated to the client
- advice about the importance of change is given by the clinician
- menu of treatment and self-help options are provided
- empathetic style of support and understanding is used by clinician
- self-efficacy and empowerment in the client is supported

(Miller & Rollinick, 2002)

Creating a collaborative, rather than an adversarial approach is a prerequisite to successfully gain client cooperation and is the hallmark of brief motivation interviewing (Miller & Rollinick, 2002).

Patient-centered interviewing techniques can also include the use of:

- applying objective and empathetic feedback of information
- making efforts to meet the client's expectations
- expecting and working with ambivalence
- ongoing assessment of the client's readiness to change
- ongoing assessment of the client's strengths and barriers
- reframing symptoms and past experiences in terms of medical consequences
- negotiating with the client to develop a follow-up plan
- instilling hopefulness in the client

(Graham & Fleming, 2003)

Common assessments instruments include:

- Alcohol Severity Index (ASI)
- Substance Abuse Subtle Screening Inventory (SASSI)
- Composite International Diagnostic Interview (CIDI)
- Structured Clinical Interview for DSM-IV (SCID)
- Semi-Structured Assessment for Drug Dependence and Alcoholism (SSADDA)
- Alcohol Use Disorders and Associated Disabilities Interview Schedule (AUDADIS).
- Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

Many of these instruments have shown good reliability and validity in assessing dependence and co-occurring psychiatric disorders as well as identifying many associated problems that need to be addressed in monitoring programs (Samet, Waxman, Hatzenbuehler, & Hasin, 2007). The severity of substance abuse problems experienced by the general population ranges from none to mild, moderate, substantial or severe, which will also determine what type of intervention is needed (IOM, 1990; NIAAA, 2003). Brief interventions are appropriate for those with mild to moderate problems while more specialized treatment is appropriate for those with substantial to severe problems.

The ASAM patient placement criteria (Mee-Lee & Shulman, 2003), describes different levels of care that are based on need.

The following levels of services are described:

- Level 0.5 early interventions
- Level I outpatient services
- Level II intensive outpatient or partial hospitalization services
- Level III residential inpatient services
- Level IV medically-managed intensive inpatient services

Evolving approaches to assessing treatment needs have included: referring to treatment based on diagnosis only, referring to treatment based on severity of illness and level of function and the newest and yet to be fully implemented method of outcomes-driven treatment, which is based on performance measures and evidence-based treatment outcomes (Mee-Lee & Schulman, 2003).

Substance abuse is prevalent in the workplace. Nearly three-quarters of illicit drug users are employed and workers are three times as likely to be dependent on alcohol as on illicit drugs. A recent study by SAMHSA found that heavy alcohol abusers are even more likely to be employed full time than are illicit drug users (Larson, Eyerman, Foster, & Gfroerer, 2007). Abuse of prescription drugs is also a growing problem in the general population with estimates of dependence rates starting at 4.7 percent and as high as 15 to 25 percent

for hospital inpatients (Zahradnik et al., 2009). Although research shows that addiction is listed among the biggest workplace issues by 67 percent of health resources personnel, only 22 percent say they have proactive workplace policies to address substance abuse in their workplace (Hazelden Foundation, 2007). The treatment gap extends to the wider population and more than 80 to 90 percent of those who need treatment for substance use and abuse issues will not receive it and will not be identified or receive an intervention (Tighe & Saxe, 2006; SAMHSA, 2007c).

More attempts are being made to address this massive treatment gap including reducing the stigma of treatment, achieving insurance parity and supporting prevention and early identification efforts (SAMHSA, 2007a; SAMHSA, 2007b; Luoma et al., 2006). Prevention of substance abuse was one of the early goals of screening and brief interventions.

The goals of screening and brief interventions have been shown to be effective with time and research for a broad range of substance abuse problems (SAMHSA, 2007b). Intervention and interruption of potentially risky drug and alcohol use is critical since research shows more harm can be caused by risky or binge drinking than heavy drinking, (Join Together, 2009). In support of serious prevention and intervention strategies to address this issue the techniques of screening, brief intervention and referral to treatment (SBIRT) have been advocated intensively (SAMHSA, 2007b). They were initially developed to facilitate screening for abuse problems in treatment and research settings but their use has been expanded to other settings including primary care and emergency rooms (Barrett et al., 2006; SAMHSA, 2007a). Alcohol and substance abuse is implicated in a vast majority of ER visits and the use of SBIRT can reduce trauma recidivism by up to 50 percent (SAMHSA, 2007a). Results from numerous studies of SBIRT interventions indicate that almost a quarter of those screened have substance abuse problems and the percentage is much higher for college students (SAMHA, 2008). Evidence exists that screening and brief interventions also work to reduce substance abuse and motivate entry into treatment (SAMHSA, 2007b). While workplace settings are appropriate sites for conducting structured interventions for those with a substance use disorder, screening, brief interventions and referral to treatment can also be effectively utilized in the workplace with beneficial results (Webb, Shakeshaft, Sanson-Fisher, & Harvard, 2008).

Reducing the treatment gap will not be an easy task. Efforts to obtain the cooperation of primary care clinicians in primary care settings and get them to implement a screening and assessment for substance misuse have been proposed (SAMHSA, 2008). Many of the tools for screening and brief interventions are available and more are being made available online (National Institute on Drug Abuse, 2009; Anderson, Aromaa, Rosenbloom, & Enos, 2008). More than one million people already utilized an online alcohol screening tool based on AUDIT in April, 2009 (Anderson et al., 2008).

However, most alternative programs have developed their own internal policies for admission assessment criteria. Some of these may require referral to professional agencies for a full assessment and diagnosis prior to admission into the program. Other programs may admit nurses based on other criteria and utilize a formal admission assessment as corroborating information to support follow-up and monitoring requirements. Almost all programs conduct their own admission interviews to verify that minimum thresholds for admission are met. Many of these utilize various versions of formal instruments and informal interviews to obtain extensive information about the nurses' history and demographic information.

Psychosocial interviews can provide extensive information that is necessary to effectively evaluate and assess current status and treatment needs. These interviews can be conducted in structured or semi-structured interview formats and can be adapted to any program's needs. There are various forms that can be used to obtain an extensive history but most will cover an extensive history that starts from general and specific parameters. Questions can cover not only the amount and frequency of use but any negative impact from substance misuse on all life areas such as family, social, legal, employment, financial, physical and mental health.

Summary

Primary prevention strategies are understudied and underutilized just like many other tools for substance abuse intervention and treatment. Recent research into the effectiveness of screening, brief intervention and referral to treatment (SBIRT) hold a lot of promise for the earlier identification and referral to treatment of at-risk individuals and in workplace settings for nurses and health care professionals. Many tools for screening are available in the public domain and there have been recent efforts to have these tools utilized in various health care settings such as primary care offices, emergencies rooms and urgent care centers. These tools can help address the massive treatment gap that leads to 90 percent of those needing intervention and treatment not receiving it. In addition, the early intervention strategies facilitate an earlier entry into alternative programs, which enhances public safety. However, this treatment gap can only be addressed with more attention to prevention education and intervention strategies that are directed to the general public as well as toward health care professionals (Tighe, & Saxe, 2006).

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CHAPTER SIX

SUBSTANCE USE DISORDER IN THE WORKPLACE

AS PREVIOUSLY DISCUSSED, a lack of education about substance use disorder is a significant risk factor for nurses. Directors of nursing and other nursing professionals in the workplace often do not recognize or realize the warning signs of a substance use disorder in their colleagues (McKenna, 2005). Although a substance use disorder is recognized as a brain disease, the stigma surrounding the disorder continues to exist.

Developing a Culture of Transparency and Support

One way the stigma is perpetuated is through the reluctance that nurses have toward confronting another nurse when the disease is suspected or even known (McKenna, 2005). The nurses in one particular study indicated that there was a culture of mistreatment of addicts as patients in the workplace by health care professionals (Darbro, 2005). Not surprisingly, this culture or stigma was listed as a prevailing reason for the nurses' own concealment of their problem from their colleagues (Darbro, 2005). Many of the nurses in a survey of participants in Alabama's Nurse Monitoring Program identified as an issue the need for anonymity in the workplace (Fogger & McGuinness, 2009). However, the rural areas where some of the nurses work and live do not offer a nurse the opportunity to remain anonymous and dealing with the stigma of being identified as an addict only added to the stress of the work environment (Fogger & McGuinness, 2009). Fortunately, there are many things that a nurse manager can still do.

Nurse managers must be aware of their own stereotypes and encourage others to evaluate themselves for any generalizations, images and misconceptions they may hold about addiction. For example, one study discovered that male nurses with a substance use disorder issue often go unnoticed because they do not fit the stereotypical image of someone who has a substance use disorder (Dittman, 2008). Nurse managers and all classifications of nurses must begin to examine their own perspectives in relation to any stereotypes they have related to drinking, drug use and addiction along with where they learned them and begin to question their validity.

It may be necessary for the nurse manager to address the use of misleading terminology. The term, impaired practitioner is often used in literature and health care communities to describe someone with a substance use disorder. The incorrect use of this term only adds to

the stereotypical image of a nurse with substance use disorder. The presence of the disease of addiction, which is a life-long disease, does not equate to life-long impaired practice. The International Nurses Society on Addictions (IntNSA) and the American Association of Nurse Anesthetists (AANA) have spearheaded efforts to dispel the stigma around substance use disorder and have continuously provided education about substance use and the benefits of treatment (Fogger & McGuinness, 2009). In 2006, the AANA produced a video entitled, *Wearing Masks*, to enlighten nurses about the symptoms, the risks and the need for early intervention for addicted peers (Fogger & McGuinness, 2009).

Part of being a leader in the nursing community is the ability to be able to take care of ourselves and others (Naegle, 2006). Therefore, it is important that nurse managers develop and foster a culture of transparency and support. Currently, there is an absence of avenues within the health care profession to address and accept addiction as the commonplace occupational hazard that it is for health care professionals (Darbro, 2005). Implicit within this culture of understanding and support is the need for nurse managers to encourage employees to share concerns. It is critical to create cultures of safety where health care workers are able to candidly approach each other about their concerns (Maxfield, Grenny, McMillian, Patterson, & Switzler, 2005).

Nurses need to talk more among themselves and examine their complicit code of silence (the don't talk rule) that infiltrates their nursing units (Dunn, 2005). It is even necessary that nurse managers at institutions create and maintain systems that allow for reporting and tracking substance abuse incidents and provide education and support to help nurses participate in rehabilitation and avoid placing patients in harm's way (Dunn, 2005). Nurse leaders who can keep an open mind will encourage employees to share all the pertinent information and contribute ideas for system improvement, avoid punitive measures and create a culture of support marked by transparency, which in turn creates a safer environment for patients.

The nurse manager needs to assist in eliminating the code of silence and encourage feedback from staff. The medical and business leaders of a hospital or clinic can make improving crucial conversations one of their top priorities for at least a year. In order to accomplish the goal it is important to establish a baseline and a target for improvement. Nurse managers can start by conducting focus group interviews, focusing on problem areas and implementing training (Maxfield et al., 2005). Managers can assist in increasing the self-efficacy of all nurses and most notably for those nurses in treatment because there is a direct relationship between increased self-efficacy and treatment outcomes. Self-efficacy is an important predictor of lapse or relapse to substance use after treatment. Higher self-efficacy is a predictor of those who will be able to remain abstinent in high-risk situations and is associated with a greater likelihood of abstinence outcomes (Ilgen, McKellar, & Moos, 2007). Findings imply that treatment in community residential facilities influences patients' self-efficacy. Greater participation in skill-building activities such as coping skills and stress-management training seems to be uniquely associated with greater self-efficacy as well.

Nurses with substance use disorders may be required to attend 12-step groups, which is also a predictor of increased self-efficacy. The nurse manager can be supportive of attendance at 12-step groups that are requirements of alternative and discipline monitoring programs. Attendance at 12-step meetings is additional evidence of the nurse remaining transparent. The manager can then exhibit confidence in his/her employees' ability to remain abstinent. There was more confidence in a patient's ability to remain abstinent following treatment

when using more self-efficacy even after controlling for patients' baseline attributes and provider ratings of a patient's behavior in treatment (Ilgen et al., 2007).

It is important for nurse managers to realize that just because a nurse becomes educated about the disease of addiction does not mean that it is going to cease being a controversial and emotional issue at work for everyone else. Nurse managers need to keep in mind that co-workers of the nurse with a substance use disorder may also need support to deal with common feelings of anger, guilt, betrayal, frustration and resentment (Raia, 2005). When a recovering nurse returns to work, it is nursing management's responsibility to provide leadership among the team. Many staff members will have emotional reactions to the recovering nurse's behavior, which can interfere with professional relationships. It is important to create a climate of acceptance and not offer special treatment for the recovering nurse. Other than educating the staff about the process and development of a substance use disorder, nurse managers can help staff members deal with their feelings by providing them a confidential setting where they can share such feelings. Nurse managers can also reinforce the skills, value and experience of the nurse before the nurse was affected by a substance use disorder and emphasize that the disorder cannot take those things away (Raia, 2005). Finally, a nurse manager can refer the nurse to groups such as Al-Anon, which was created for the friends and families of those with a substance use disorder, as well as employee assistance programs.

Supportive Workplace Environments

Addicts rarely self-report for fear of losing their jobs, licenses and livelihoods (Copp, 2009). Creating an environment that encourages reporting is vital to reducing the stigma, maintaining transparency, rehabilitating the nurse and protecting the public. A self-report by a nurse with a substance use disorder can create an artificial rock-bottom and the nurse can then be offered treatment and rehabilitation in lieu of discipline. All of this can occur before the nurse's work has been affected (Copp, 2009). Most nurses will agree to undergo treatment and monitoring if only to save their licenses until they can get to the point where they want to stay clean and drug-free (Copp, 2009). This type of non-punitive monitoring program is consistent with a just-culture environment, which has been defined as one where the reporting of errors and near misses is supported without fear of undue retribution (Gorzeman, 2008). Similarly, in a substance use disorder situation a Just-Culture environment changes the response to the nurse's addiction while accountability for the addiction is maintained. The fact that the alternative program is not punitive does not mean accountability is ignored. Nurses who enroll in an alternative program are accountable to themselves, their program monitor, their counselors and other nurses, their work-site monitors or supervisors and are held responsible for abiding by the contract they signed upon entering the program.

Workplace interventions for substance use and abuse have been in place through employee assistance programs (EAP) for some time but these resources are historically underutilized and most workers remain unidentified and underreported, particularly nurses. Although workplace supervisors continue to be on the front line in terms of identifying employees with problems, they are still often reluctant to intervene and even refer to EAP programs. More education and direction is needed for workplace supervisors to assist them in learning to intervene with workplace substance use issues or to utilize support personnel to assist them in addressing these issues. When notified of potential problems, EAP professionals have utilized screening and brief interventions for a broad range of problems including alcohol, substance misuse and mental health problems (Ensuring Solutions to Alcohol Problems, 2008).

Lateral Violence and Stress

There are certain risk factors for substance misuse. Nurses are in a position where they are exposed on a daily basis to the numerous risk factors.

Some of these risk factors that can be linked to the work of nursing include the following:

- work demands (such as mandatory overtime and long working hours that eliminate leisure time)
- required shift changes (can lead to inconsistent sleep patterns, sleep deprivation, and fatigue)
- stress responses (while not capable of producing dependence, can lead the user to more frequent and/or excessive use so that a user who drinks regularly may begin drinking more)
- inadequate knowledge base about risks related to alcohol and drug use
- risk factors for development of dependence

There is no doubt that being a nurse is stressful. Nurse participants in numerous studies mentioned many elements of a stressful work environment such as the increase in the work load with a higher acuity of patients, expectations to work overtime due to nursing shortages and demands from the administration as well as physicians (Darbro, 2005). Unfortunately, nurses may cope with stress, anxiety and pain by misusing drugs and alcohol.

Another risk factor that is often overlooked is the treatment of nurses by their colleagues. In workplaces where nurses are bullied, the quality of patient care declines, the health of nurses suffers and the retention of quality nurses becomes difficult (Felblinger, 2008). A national survey of 13,000 physicians and nurse executives conducted by the American College of Physician Executives revealed that 97 percent of the respondents experienced unprofessional outbursts and overreactions with most saying these happened several times a year and sometimes even on a weekly basis (Sorrel, 2009). The most common complaints were degrading comments, yelling, cursing and refusing to work together, all of which are considered bullying behaviors. (Sorrel, 2009). Most verbal abuse is by physicians, yet abuse from fellow nurses is the second most common type (Felblinger, 2008). As a result, many nurses develop serious health problems and may suffer from post-traumatic stress disorder, anxiety, depression or insomnia (Felblinger, 2008). This anxiety and depression may then cause a nurse to turn to alcohol or drugs to deal with the stress of the bullying or increase a nurse's risk of relapse. To ensure a positive work environment, employees are encouraged to report bullying to their nurse manager and take immediate action against perpetrators (Felblinger, 2008). There must be a zero-tolerance policy and boundaries must be established (Felblinger, 2008). In fact, the Joint Commission now requires health care facilities to implement zero-tolerance policies that define intimidating and disruptive behaviors and to establish disciplinary procedures for the health care staff who violate the standards (Sorrel, 2009).

Another term for bullying is lateral violence, also known as horizontal violence (Sheridan-Leos, 2008). More than half of nurses surveyed by the Joint Commission on Accreditation of Health Care Organizations reported that they had been abused at work and over 90 percent said they had witnessed abusive behavior (Felblinger, 2008).

The literature defines lateral violence as nurses overtly or covertly directing their dissatisfaction toward:

- those less powerful than themselves
- themselves
- each other

(Sheridan-Leos, 2008)

It is an act of aggression that is perpetrated by one nurse against another. Members of an oppressed group of nurses display common behavioral characteristics such as low self-esteem and self-hatred. Lateral violence among nurses evolves from feelings of low self-esteem and lack of respect from others in the work environment. This has particular significance for nurses with substance use disorders, since negative or low self-esteem can generate an increased vulnerability to drug and alcohol abuse and dependency (Henshaw, 2005). Furthermore, if nurse co-workers have the attitude that addiction is a moral failure, lack of willpower or is a sign of weakness, then this leads to a lack of respect, which in turn leads to lateral violence.

Oppression theory proposes that nurses perceive themselves as powerless and oppressed in the health care setting (Sheridan-Leos, 2008). As an oppressed group, nurses feel alienated and have little control over their practice, which leads to a cycle of low self-esteem and feelings of powerlessness (Sheridan-Leos, 2008). Rather than confronting the issue, the oppressed group manifests their frustration on the nurses that are lateral to them (Sheridan-Leos, 2008). Over time, staff can come to believe that lateral violence behaviors are normal and it can become a part of a unit's culture (Sheridan-Leos, 2008). New staff may believe that this manner of relating to each other is normal and that it is just how things are done around here. The result is a group of nurses who are afraid to ask for help from their co-workers, thereby reducing the likelihood of staff reporting or self-reporting a substance use disorder problem and perpetuating a culture of silence and fear. However, professional relationships among nurses can improve if nurses make an effort to care about each other and acknowledge the part they play in the lateral violence cycle (Sheridan-Leos, 2008).

The American Medical Association has developed a policy model that calls for distinguishing between good-faith criticisms and actions that truly rise to the level of disruptive behavior (Sorrel, 2009). According to Dr. Alan Rosenstein, MD, a lead researcher on disruptive behavior, education and early graded intervention are essential. Punitive measures must be used as a last resort (Sorrel).

Some corrective measures to curb bad behaviors such as bullying and lateral violence among nurses include the following:

- create awareness of potential behavior issues so that people aren't afraid to talk about them or report problems
- put a system in place for filing complaints and allow for due process
- obtain medical staff and leadership support for the policies
- apply policies and procedures consistently and follow through on them
- institute educational training and counseling programs
- intervene early and use punitive measures as a last resort (Sorrel, 2009)
- make the education of staff and supervisors a priority

Education in the Workplace

There is a basic lack of education regarding substance use disorders. Most nurses are not educated about the disease in general. They also lack the information they need about how to recognize or intervene with a nurse who is misusing substances, which makes education a priority for nurse managers and all others who deal with nurses with a substance use disorder (Dunn, 2005; Copp, 2009). Unfortunately, while there is a lack of information, there is no shortage of misinformation. Understanding that substance abuse is a medical illness that requires treatment is the first step in removing the stigma (Dunn, 2005). Current philosophies of the American Nurses Association and boards of nursing support this position and are committed to helping addicted nurses seek treatment and rehabilitation in order to become

productive members of society and practicing nurses again (Dunn, 2005). Communication and information sharing are an essential part of the educational process. Understanding why nurses abuse substances humanizes the experience, which will ultimately prevent other nurses from stigmatizing their colleagues who have this medical illness (Dunn, 2005). Nurse managers can help by emphasizing that addiction is a human medical condition and not a personal failure (Darbro, 2005).

Nurses also need to learn common behaviors displayed by nurses with a substance use disorder problem. It is important for all employees to be familiar with the policies and procedures that are in place when impairment or diversion is suspected. Supervisors must also know when they can require alcohol or drug testing. Of course it is one thing to have policies and procedures in place but quite another to ensure that the policies are being utilized correctly and enforced. Nurse managers must schedule in-services on all aspects of substance use disorders such as the fitness for duty, impairment and documentation of the administration of controlled substances. Nurses must be encouraged to use state and federal resources for ensuring the proper storage, surveillance and administration of controlled substances and to regularly access the Internet for information on substance use disorder and drug diversion issues.

Education about substance use disorder is the key for all the staff members at the facility. The majority of nurses who enroll in an alternative to discipline program are required to have their work monitored by a supervisor who is oftentimes, and most preferably, a nurse. Another term commonly used for this person is a work-site monitor. Work-site monitors are in a position to assist recovering nurses to remain in the workforce and to ensure patient safety through a program of close monitoring (Young, 2008). They can understand the disease of addiction, be able to recognize the signs of substance use disorder and be able to respond appropriately. Organized education for professionals who serve as work-site monitors is important in order to ensure consistent reporting to boards and for effective monitoring of impaired nurses who return to practice. Successful development and implementation of these programs benefit patient safety, nurses, work-site monitors and boards of nursing (Young, 2008).

It is essential for nurse managers to include in their educational components about substance use disorder the ethical and legal obligation nurses have to report colleagues whose activities could or do harm patients. Nurses must understand that if nurses with a substance use disorder are not helped they are in danger of harming patients, the facility's reputation, the nursing profession and themselves (Dunn, 2005). Unfortunately, many nurses do not report behaviors they find suspicious because they do not believe that the incident was severe enough to report or they believe the nurse is a good care provider. Just as near misses must be reported, suspicions about another nurse's behavior must also be documented and reported to the nurse manager (Dunn, 2005). Consequences of not reporting concerns can be far worse than the feelings of guilt a nurse may have when reporting these issues (Dunn, 2005).

Many states have mandatory reporting laws that require reporting violations of the Nurse Practice Act to the board of nursing. The legal reporting requirements can mitigate the nurse from moving from job to job and state to state in order to avoid identification.

Another important component of educating staff starts with a nurse manager's recognition of the thinking processes that nurses use when making decisions to report a nurse for giving inadequate care (Beckstead, 2005). For example, in one study nurses indicated they are more likely to report a co-worker for using narcotics than for smoking marijuana and are more likely to report a co-worker for using marijuana than for drinking alcohol (Beckstead, 2005). One explanation for this is that nurses may believe that the impairing effects of narcotics are

the highest, followed by marijuana and then alcohol (Beckstead, 2005). In an earlier study, nurses' impressions of professional impairment in a fictitious co-worker were not affected when the co-worker possessed the attribute 'drinks alcohol', even though the deleterious effects of alcohol on cognitive and psychomotor skills are well known (Beckstead, 2003). As a result, it is prudent to educate or remind nurses and nursing students that although alcohol is not an illicit substance, it still has the ability to affect nurses' judgment and performance (Beckstead, 2003). Creating, distributing and implementing policies and procedures in the workplace is an important form of education.

Perhaps one of the most vital pieces for nurse managers to include in their educational components regarding substance use disorder is information about the alternative to discipline program. Nurses must be especially aware of the requirements of the program and how to refer someone to the program.

Value of Proactive Policies and Procedures

Without written policies, employees can make decisions and take action based on inaccurate information or misinterpretations. Policies are necessary to ensure a safe, organized, positive, empowering and nondiscriminatory workplace. Nurse managers must ensure that staffs are familiar with all policies and procedures regarding substance use disorder in the workplace including policies and procedures on drug testing, diversion, investigations, interventions and reporting.

The presence of detailed policies and procedures dealing with substance use disorder increases the likelihood that the nurse will be identified, reduces the opportunities for patient harm, and ensures that nurses receive the help they need and can be retained and not simply terminated. If a nurse is terminated and not reported to the board, the nurse is able to continue to get jobs at other facilities and never get help, thereby putting the public in danger.

The following ideas are central to workplace policies and procedures regarding nurses with a substance use disorder:

- a substance use disorder is a chronic disease that can affect others
- it is a treatable illness with rehabilitation as the treatment of choice
- treatment benefits, insurance coverage and sick leave benefits may be similar to other illnesses (however, implementation of parity remains an unresolved issue)
- there is a need for a written process to report suspected impairment
- confidentiality can be maintained (with the exception of mandatory reporting requirements to state and federal agencies)
- seeking treatment for a substance use disorder will not affect salary, job security, promotion or benefits
- a person in a recovery program for a substance use disorder is covered by the Americans with Disabilities Act
- written guidelines are necessary for continued employment, transfer, termination and re-entry of nurses with a substance use disorder
- a mandatory Employment Assistance Program must be part of the process
- awareness and understanding of reporting guidelines

(Raia, 2005)

The organization must have a policy addressing what is considered fitness for duty and the policies and procedures must support timely and appropriate intervention if impairment is suspected. Fitness for duty is an evaluation that determines a nurse's ability to perform essential job functions despite having a substance use disorder (Comer, 1995). It is an

assessment of the nurse's ability to work safely and ensure competence to practice. Fitness for duty can be determined by negative drug screens or by performance-based measures such as neuropsychological examinations. This policy can guide the manager in what steps to take if the manager suspects an employee is impaired, what data to collect, determine what are the lines of communication, confidentiality and legal issues. The policy can also address what to report, when to report and who to go to with the report (Ohio Nurses Foundation, 2008).

Although the specific language of the policies and procedures may vary from facility to facility, a comprehensive policy for addressing fitness-to-practice concerns can encompass the following areas:

- pre-employment and probable cause drug testing
- fitness-to-practice evaluations
- documentation expectations
- intervention procedures
- in-house and external reporting requirements
- return-to-practice guidelines (including relapse management)
- reviewing the facility's policy and procedures (this is essential prior to initiating an intervention)

It is essential to develop written policies and procedures for handling a situation where a nurse is chemically impaired or in a case of diversion long before it actually occurs, in order to ensure that all suspected employees are treated the same and communication to co-workers is consistent. Management can be notified to gain support and to ensure the agency policy and procedure is followed for the safety and rights of all concerned (Raia, 2004).

Policies and procedures can also be established for the prevention of impairment and diversion. For example, all nurses must know the policy and procedure for accepting deliveries of controlled substances from pharmacies and for the safe disposal of controlled substances, including disposal at the time of a patient's death. If there is a prevention plan in place, then all employees and potential employees can be made aware of it and it can be regularly reviewed with current employees.

Prevention of Diversion

The importance of being proactive in the prevention of diversion of drugs in the workplace cannot be emphasized enough. To prevent diversion, the institution must first establish standardized methods of documenting and handling controlled substances. Any staff members who handle controlled substances must be appropriately monitored and the seriousness of the facility's diversion program must be communicated to staff (Sobel, 2005). Diversion prevention must be supported throughout the organization with every employee being held responsible for diversion prevention.

The first step in reducing diversion is to let everyone in the organization know that a diversion prevention program is underway, controlled substances are being monitored and that diversion is being taken seriously by management. Education can even begin during orientation and continue as part of ongoing competency training. Revisiting a facility's system for medication accountability to determine its vulnerability is strongly encouraged (Shumaker & Hickey, 2006). The facility's goal is to engage in ongoing prevention. Sources of drug diversion must be tackled head-on without impeding the legal availability of opioid analgesics, the practice of medicine or patient care (Stokowski, 2008).

Most health care facilities report drug diversion as a result of an incident (such as a patient reporting that he did not receive his pain medication or a nurse is found in a bathroom unconscious from an overdose of narcotics). Regular audits of automated drug dispenser reports (such as Pyxis machines) must be conducted on a routine basis (Colorado Board of Nursing, 2003). Regular monitoring of medication records can greatly reduce or prevent these incidents. One way to reduce drug diversion in a health care facility is to prohibit the nurses from sharing or revealing their controlled substances access code to other nurses.

Regular Monitoring as Prevention

Nurses must be regularly monitoring how drugs are administered and how total or partial non-administered doses are discarded and documented.

They must be aware of and check for the following red flags:

- one nurse documents the administration of more PRN medications than other nurses
- the patient is not on the unit at the time the dose is documented
- the dose was signed out from the narcotic supply but not documented in the medication administration record or the nurse's notes
- the nurse medicates another nurse's patient
- the nurse says he/she was too busy or forgot to obtain a witness to discard the controlled substance
- the nurse signs out a larger dose of controlled substance when the ordered dose is available, then signs that the remaining medication was discarded or wasted
- the nurse says a controlled substances access code was shared with another nurse
- controlled substance withdrawal times do not correspond to administration times
- patients are reporting that the pain medication ordered does not relieve their pain on the nurse's shift
- there are inaccuracies of the controlled substance count when a particular nurse works
- controlled substances are signed out for a patient who has no order for them
- times and amounts of controlled substances signed out are not authorized by physicians' orders
- the staff signatures or initials appear to be forged

Reviewing documentation is one way to determine if a nurse is diverting medications but the medications themselves must not be overlooked. Nurses need to also check actual medications to ensure that liquid medications have a normal color, odor and consistency

If there is any concern about any medication, the nurse manager must ensure that a pharmacist inspects the medication and a determination can then be made about whether testing by a chemical or forensic lab is indicated. If it is, a sample of the medication can be sent to a chemical or forensic laboratory. It is helpful if someone also witnesses that the sample sent to the lab came from the bottle of medication in question. The nurse manager can save the bottle with the remaining medication for evidence.

Nurses can also regularly inspect controlled substance packaging for possible drug substitution. A pharmacist must inspect any medications that are returned to the facility by a nurse, such as if a nurse says they took the missing controlled substance home in their pocket by mistake. Again, a determination can be made about whether testing by a chemical or forensic lab is indicated.

Internal Investigations

The following are recommendations for conducting an internal investigation for alleged drug diversion at a health care facility.

These recommendations can supplement any facility procedures already in place:

- do not destroy any documents that contain information about possible impairment or drug diversion
- ensure that investigative documents can be found by another administrative nurse in the investigating nurse's absence (including pertinent medical records)
- document observations about the nurse (such as appearance, gait, speech, pupils, mood swings)
- obtain witness statements in writing and ensure that they are dated, timed and signed
- if the nurse admits to diverting, obtain the nurse's admission in writing with a witness present
- ask the nurse to document what drugs were diverted, within what time period and how the diversion occurred
- ensure that all documents are dated, timed and signed with the staff member's full name and title
- refer the nurse for a urine drug screen and a Breathalyzer test or blood test for alcohol, pursuant to facility policy (these are essential components of an investigation of drug diversion, drug or alcohol impairment)
- take actions to ensure the safety of patients and other staff (such as suspension or administrative leave)

After reviewing the results of the internal investigation, notify the required agencies, review the board's reporting rules and establish an intervention plan. This plan may include a referral to an alternative to discipline program, a back-to-work agreement, a complaint to the board of nursing or all three. The nurse manager can then meet with the nurse, present the plan and proceed as indicated by the nurse's response (Colorado Board of Nursing, 2003).

It is imperative that the investigative and review processes are consistent. Accusations of bias and conduct-targeting investigations can easily occur when the methodology is erratic and not reproducible (Siegel, 2007). However, judgment is still a key factor that is guided by experience in the process (Siegel, 2007). The more experience one gains in the investigative process, the easier it is to recognize patterns of diversion that raise red flags of suspicion and can help narrow down and focus the investigation (Siegel, 2007).

Managing the Nurse with a Substance Use Disorder

Nurse managers play a fundamental role in recognizing and managing nurses whose practice is impaired due to a substance use disorder. Due to the potential negative impact on patient and co-worker safety, an impaired practice can be addressed proactively in a systemized manner rather than in a blaming mode (Kohn, Corrigan, & Donaldson, 2000). To be proactive, a manager must be adequately prepared for the tasks at hand. An assessment of personal risk factors and a level of competence and comfort in addressing impairment due to a substance use disorder among colleagues is a necessary first step.

Staff can also reflect on the following important points in order to be better prepared:

- have a basic understanding of a substance use disorder as a primary disease, their course and signs or symptoms
- know the most common indicators of unsafe nursing practice due to a substance use disorder

- know the workplace policies and procedures related to substance use disorder among nurses
- know the workplace's policies and procedures pertaining to medication administration, wastage and inventorying of controlled substances
- know who the resources are in-house and externally regarding substance use disorder in any nursing staff
- recognize personal attitudes about substance use disorders as supportive or as a barrier to helping a colleague
- know how to document a problem properly
- feel confident in personal intervention skills (if a problem requires action, know the personal reporting responsibilities as they pertain to hospital administration, board of nursing and state alternative or peer assistance program)
- feel capable to coordinate re-entry to practice process for any staff nurses
- recognize the value of practice restrictions, workplace exchange and workplace monitors for such nurses
- know the signs of relapse or exacerbation of substance use disorders and how to respond appropriately

Nurse managers may be better able to intervene earlier and more proactively by assessing their preparedness both personally and professionally with nurse employees who are suspected of having a substance use disorder. Additionally, by following best practices nurse managers have the potential to assist their institutions in attaining significant financial savings when it comes to nurse employees identified with substance use disorders. In an unpublished study (Van Doren & Bowling, 2007) it was estimated that Baylor University Medical Center in Dallas, Tex. saved over four million dollars in turnover cost avoidance of RNs identified with a substance use disorder and certain psychiatric disorders over an eight-year period. Baylor worked to retain nurses whenever possible rather than summarily terminating them. Through the proactive advancement of education, identification, intervention, re-entry to practice and policies and procedures system-wide Baylor administration was able to help save the lives and careers of many employees as well as money.

Allowing for the possibility of nurses to seek treatment for their disease and resume practice whenever prudent becomes a win-win approach for employee and employer alike, enhancing patient safety through early intervention while providing the opportunity for rehabilitation and retention of valuable professionals. Such options also permit the workplace to give up its claim of immunity to nurses with addiction when in truth they have only succeeded in terminating nurses identified with substance use disorders (Kelly & Mynatt, 1990).

Identification of a Substance Use Disorder

Recognizing an unsafe practice in a nurse who has a substance use disorder can be difficult. Differentiating between the subtle signs of impairment and stress-related behavior, common among all nurses at times, is challenging. Experts agree that the earlier a problem is recognized the better the chances are for rehabilitation and retention, whereas the later the problem is identified the greater the chance of practice-related concerns. Escalating impairment is indicated by impaired cognitive functioning and memory, diminished alertness, altered motor skills, impaired judgment, difficulty making decisions and an inability to cope with stressful situations. The workplace is the source of most referrals to alternative programs (Duke & Zsobar, 1995; Smith, Taylor, & Hughes, 1998; Talbott & Wilson, 2005), therefore it is important to address the malignant denial that can exist in the health care setting and in health care professionals (Hanks & Bissell, 1992).

Nurse managers must become knowledgeable regarding the most common indicators of a problem. They also have a professional responsibility to educate their staff about signs of unsafe practice. When witnessed in isolation many of these signs may be indicative of increased stress. However, when observed as a pattern over time a more serious situation warranting corrective action becomes apparent. Keep in mind that even a single indicator may be significant enough to warrant immediate intervention. These signs may include the smell of alcohol and other overt indicators such as a staggering gait, slurred speech, witnessed diversion of drugs or any serious error in patient care.

Signs of a substance use disorder generally fall into three major categories: job performance, personality and mental status, and diversion of drugs from the workplace.

Hughes & Smith (1994) offer the following lists of these most common warning signs:

Job Performance

- excessive use of sick time, especially following days off (most common in alcohol abuse or dependency)
- absence without notice or last-minute requests for time off
- long breaks or lunch hours
- frequent or unexplained disappearances from the unit (at work but not on the job)
- job shrinkage (a nurse increasingly does the minimum work necessary for the job)
- increasing difficulty meeting schedules or deadlines
- sloppy or illogical charting
- excessive number of mistakes (frequent medication errors or errors of judgment in patient care)
- smell of alcohol on breath
- excessive use of breath mints, chewing gum or mouthwash
- elaborate implausible excuses for behavior
- denial that a problem exists (DENIAL = Don't Even Notice I Am Lying)

Personality and Mental Status

- inappropriate verbal or emotional responses (such as snapping at colleagues, uncontrolled anger or crying, unusual silences, irritability or frequent mood swings during the course of the shift)
- diminished alertness, confusion or frequent memory lapses (appearing dazed or preoccupied)
- increasingly isolates self from co-workers by eating alone, avoiding informal staff get-togethers or requesting a transfer to the night shift

Diversion

- consistently volunteering to be the medications nurse
- often signing out more controlled drugs than co-workers
- greater number of pulls or more frequent administration of controlled drugs (identified through inventory of electronic drug-dispensing system)
- frequently reporting medication spills or other non-administered or partial-dose medications
- failing to obtain co-signatures
- reports reflecting excessive use of PRN medications
- discrepancies in end-of-shift medication counts
- evidence of tampering of vials or other drug containers
- reports of the nurse waiting until no one is around to open the narcotics box or cabinet

- disappearing into the bathroom after opening the narcotics box or cabinet
- an increase in patients' complaints of unrelieved pain
- defensiveness when questioned about medication errors
- consistently coming to work early and staying late
- volunteering to work with patients who receive regular or large amounts of pain medication
- observing any combination of these behaviors with increasing regularity over a period of weeks or months
- occurrence of a critical incident (error or overt sign of faulty nursing practice) is a signal it is time to take appropriate and immediate action

Identifying and Investigating Reports of Impaired Practice

Unfortunately, many health care professionals do not receive the appropriate intervention and treatment due to the lack of proper identification of a dependency problem (Nebraska Health and Human Services Regulation & Licensure, 2005). It is essential for nurse managers to understand what a substance use disorder is so that they are able to recognize the problem earlier, intervene more effectively and so they can educate all staff members so that they too will recognize the problem. The time spent at work and the interactive nature of nursing practice means that substance abuse issues in nursing are usually first noted by staff members.

In extreme cases, it is the board's responsibility to remove a nurse from practice when the nurse has violated a professional standard for safe and competent practice (Raper & Hudspeth, 2008). However, the information gleaned during the licensure or renewal process is extremely valuable but limited in scope because it does not address the greater issues of identifying problems that occur during the licensure cycle (Raper & Hudspeth, 2008). Boards rely upon reports of these offenses from nurse managers, chief nursing officers and nurse co-workers.

Identification of traits that are apparent in the nurse with a substance use disorder is a necessary step in creating a safe nursing environment. The second step is to incorporate modifications in personal behavior and professional practice in order to identify any hazard promptly and minimize its potency whenever possible. Taking this kind of a proactive approach is essential in order to identify risk markers before the appearance of an adverse event. Ongoing monitoring for these traits may prompt a nurse to make a lifestyle change, which may decrease the likelihood of becoming substance-use dependent (Quinlan, 2003).

The most critical component in identification of a substance use disorder is to know the performance baseline from which a person normally functions (Nebraska Health and Human Services Regulation & Licensure, 2005). Negative behaviors and practices that clearly move away from the individual's performance baseline are common indicators of a substance use disorder (Nebraska Health and Human Services Regulation & Licensure, 2005). Several steps can be followed when a manager suspects an employee has a problem with a substance use disorder, which can be clearly delineated in the facility's policies and procedures.

Obviously, it is necessary to assess and observe the nurse's behavior and appearance. At least two people can conduct the assessment. The person who is assessing the nurse benefits from the support of another nurse and the second person can serve as a witness. The nurse's patients can also be assessed in order to ensure that they have received their correct medications and have received adequate pain medication pursuant to physician's orders (Colorado Board of Nursing, 2003). This may include obtaining an order for a urine drug screen for the patient from whom a drug may have been diverted to determine if the patient received the drug or if another drug was substituted for the ordered medication (Colorado Board of Nursing, 2003).

Documentation is essential to the process for potential future actions. Documentation includes, but is not limited to: trends in absenteeism and tardiness, incident reports, written complaints, charting reviews, opiate record discrepancies and evaluations. It is best to document any issues at the time a problem or incident occurs. Over a period of time the manager may be able to see patterns emerge as a result of careful documentation. A nurse manager, though, cannot wait until a crisis occurs in order to look back over the problems or incidents that may have occurred during the past year. A nurse manager can look for any patterns such as absenteeism after a scheduled weekend off, tardiness or leaving work early and habitual episodes of extended lunches or break times (Ohio Nurses Foundation, 2008).

Employees can help by documenting problems on a day-to-day basis and look for patterns in behavior. According to the Ohio Nurses' Foundation (2008), co-workers can include the following detailed information:

- specific periods of time and dates
- specific places
- persons involved (participants or observers)
- resources for additional information (chart documentation, lab data, X-ray and any additional reports)
- actions taken
- participants' responsiveness
- outcomes

If there is suspicion that a nurse may have a substance use disorder problem, then the staff can be alerted to look for patterns when reviewing the reports. The staff is in a good position to look for the following signs of a substance use disorder in the reports or complaints:

- multiple complaints of appearance
- lability of mood
- interpersonal problems with patients, staff or family
- patient complaints
- frequently absent from the unit or workplace while on duty
- charting review

When reviewing the nurse's charts the Ohio Nurses' Foundation says to look for:

- accuracy
- timeliness of entries (late entries)
- coherence (incomplete thoughts or statements)
- inappropriate terminology unexplained changes in handwriting (illegible writing if usually neat)
- opiate and medication records

Look for discrepancies such as:

- ordering medications from the pharmacy prior to the refill date
- orders for patients who have died or been discharged
- inaccurate opioid counts
- increases in charted medication administration of mind-altering drugs without appropriate cause
- unexplained changes in route of administration
- noncompliance for observing wastage of opiates
- frequent breakage or wasting of opiates

- patient reports of decreased pain relief on specific shifts despite record of medications administered
- patient comments regarding not receiving pain medication administration even though it was reported or charted
- discrepancies in the provision of controlled substances in the records of automated medication systems
- discrepancies in the provision of controlled substances through automated medication systems
- inconsistent performance evaluations
- changes in the evaluation of job performance over time with no apparent cause
- an inconsistent work history
- the way the nurse deals with others
- the ability of the nurse to take or provide feedback

Facilities must not shy away from utilizing urine screens in order to detect and prevent diversion and substance use at work. It is recommended that health care facilities establish written agreements with temporary staffing agencies to ensure that nurses who are employed by those agencies will be required to submit to urine drug testing at the request of the health care facility (Colorado Board of Nursing, 2003). The agreement can state that staff from the temporary staffing agency will come to the health care facility at times designated by the health care facility staff. The health care staff will escort the agency nurse to the collection site or lab for testing for a urine drug screen or a breathalyzer or both tests as determined by the health care staff.

Such agreements are necessary because nurses from temporary staffing agencies are seldom required to submit to drug screening. Health care facilities believe that the agency nurse is not their responsibility. However, not all staffing agencies interview the nurse about a substance abuse or diversion incident in a timely manner or require a drug screen. Therefore, many nurses with a substance use disorder who are employees of temporary staffing agencies are allowed to work in multiple facilities until someone takes responsibility for reporting them to the board.

It is also common for a nurse who is an employee of a health care facility to allege that a staffing agency nurse diverted narcotics when, in fact, the nurse who is a regular employee may have diverted the narcotics. If the identity of the nurse who diverted the narcotics cannot be ascertained, other measures can be taken. Start by identifying who had access to the narcotic stock on all three shifts and require those nurses, all nurses or all staff to submit to urine drug testing but only if the policy of the facility supports the intervention.

Recommendations for drug testing include:

- always escort the nurse with a substance use disorder to the collection site
- ensure that the chain of custody is preserved
- do not allow the nurse with a substance use disorder to drive home
- request that the lab use an expanded professional panel when testing the nurse's urine. Specify on the lab form what substance was diverted to ensure that the lab tests for that specific substance (For example, synthetic opiates are not included in routine drug panels. Therefore, if Demerol is missing and opiates is checked on the lab form, the specimen will not be tested for Demerol)
- ask the lab to test for the lower limit of quantification of all controlled substances requested on the lab request form (not just the standard cutoff levels)

- obtain the drug screen even if the nurse claims to have a valid prescription (Ask for quantified testing that will establish if the nurse is taking the medication as prescribed or supplementing the amount from facility-controlled substance stock.)
- require written verification of the prescription by the nurse's health care provider
- refer the nurse for a fitness-for-duty evaluation to ensure that the medication is not interfering with critical thinking skills such as memory or concentration (Neuropsychological testing may be indicated to assess for cognitive impairment.)
- require a breathalyzer or a blood alcohol level in addition to a urine drug screen if the nurse presents with the odor of alcohol (Breathalyzers must be administered or blood alcohol levels drawn as soon as possible because alcohol is metabolized so quickly by the body.)
- establish a urine drug screen policy and a relationship with a collection site and laboratory that has agreed to collect and test samples according to the health care facility's urine drug screen policy
- establish a plan for intervention on any shift and educate staff regarding the plan (For example, collection sites usually close in the evening. Consequently, the plan can include information such as where a nursing supervisor can send a nurse for drug testing on evening and night shifts, who will cover for the nurse, who will escort the nurse to the collection site or emergency department and how transportation will be paid.)

(Colorado Board of Nursing, 2003)

Documentation During a Workplace Intervention

Facilitating an intervention is already difficult but without adequate documentation it becomes almost impossible. The workplace has a poor track record of identifying and intervening with nurses who have a substance use disorder and that makes it even more critical to be well-trained and well-informed about intervention strategies (Beckstead, 2002; Crosby & Bissell, 1989). The importance of proper documentation cannot be overstated. Instruct the staff to record clear, concise and objective factual data when documenting concerns. It is a nurse manager's role to evaluate all documentation provided by staff and determine when and if sufficient concerns warrant formal action. In some cases the nurse manager may request the help of a trusted colleague or supervisor in determining the best course of action to take. Something as simple as written or typed notes based on anecdotal communications are useful in order to keep track of ongoing concerns. It is important to maintain some minimum organization of your notes such as the name of the staff member of concern, names of witnesses and their titles, or if they are patients the date, time and nature of their concern and the action or follow-up that was taken.

Once all of the information has been reviewed, the nurse manager who suspects a nurse with signs of a substance use disorder can compile his/her findings. In doing so, the nurse manager can consider whether or not there is a pattern of behaviors that suggest the nurse may have a problem with substance use disorder or even some other issue. The nurse manager may want to keep in mind that patterns of a substance use disorder vary depending on the stage of disease, the substances used and the nurse. There may be only one sign and symptom or many signs and symptoms. If there is any suspicion that there is a problem, the nurse can also elicit the assistance of the immediate supervisor (Ohio Nurses Foundation, 2008).

Ongoing documentation will assist greatly if counseling as part of a corrective action becomes necessary. Proper documentation is crucial to a successful plan of action, especially in the case of substance use disorder impairment with its subtle progression and chief

characteristic of denial. If a nurse suspects that a pattern of incidents may be emerging, the nurse can seek validation and consult with a supportive colleague who has experience in effectively handling a substance use disorder.

Consulting an employee assistance professional can also be a great resource for managers. However, the need for strict confidentiality in such situations cannot be overemphasized. Confidential resources outside the health care setting may also be available and may include staff within a statewide peer assistance program or alternative to discipline program. Often these resources can provide an expert opinion about the documentation that has been gathered and suggest intervention strategies. With sufficient resources and support, nurse managers can better prepare to play the role of an intervention coordinator and proceed with confidence.

If the nurse is obviously under the influence of mind-altering chemicals in the work setting the manager must immediately deal with the issue. Patients are always the first priority, which means the nurse manager must immediately remove the suspected nurse from the unit or department, obtain a drug screen and evaluate the need for emergency treatment (medical or psychiatric). If immediate treatment is needed, transport the nurse to the emergency room. Once the emergency is stabilized, the plan of action can be developed to deal with the problem (Ohio Nurses Foundation, 2008).

Action Plan

Next, the nurse manager must develop a plan of action for an intervention to effectively deal with the problem. Ideally, the manager will have time to work on this over several days. Once the nurse manager has developed a plan, the manager can rehearse what needs to be said and how to best present the information.

The nurse manager must act immediately if a nurse has demonstrated unsafe practice or is at risk for harming others. Remove the nurse from the patient care area and get the nurse to a safe, secure place. Check to make sure the nurse does not need emergency medical or psychiatric treatment. Or if the nurse is able to provide a drug screen, proceed with a test. If the nurse is not in immediate medical or psychiatric crisis, begin the intervention. If the nurse is not on-site, determine the best time to confront the nurse. This might be the next time the nurse is scheduled to work or at a planned meeting. Interventions work most effectively when the nurse is unaware of the intent of the meeting. It must be kept in mind that a nurse with a substance use disorder may not appear for a meeting if it is suspected that a confrontation about behavior is going to take place.

Ideally the most experienced and knowledgeable person in the disease of substance use disorder and intervention is the leader of the intervention. Usually the manager, supervisor and other staff providing relevant data about behaviors also attend the intervention. A union representative may be present if the nurse is in a collective bargaining unit or has been asked and requests representation. Sometimes colleagues may be asked to provide information. In addition, human resources or employee health or EAP may be present. It is also possible that a representative of the pharmacy, pharmacy board, security department or members of the police may attend.

An intervention provides the opportunity for the manager to present data to the nurse regarding the suspected substance abuse and for the nurse to explain the behavior in question. To prevent potential retaliation by a nurse with a substance use disorder, the names of people who have contributed information about behaviors can be kept confidential and not released to the nurse. Information about evaluation and treatment options need to be presented. Consequences of failure to follow through with the evaluation or treatment need

to be identified such as a loss of job or potential criminal charges. It is suggested that an agreement between the employer and employee to address the problem within a specific time frame be completed.

A confidential but safe place needs to be identified and reserved. Make arrangements for a medical leave of absence and staff coverage during the nurse's absence. In preparation for an intervention, safety is a prime consideration for the nurse and all members of the intervention team. The nurse is facing a crisis in his/her life. It includes the threat of loss of license and livelihood with possible loss of income, legal involvement, inpatient treatment and family upheaval. Another significant loss is the mood-altering chemicals that have made the nurse dependent. In order to protect all parties involved, the manager needs to find a secure area for the intervention such as an office or a conference room where they will not be interrupted but will have some privacy for the nurse in order to protect confidentiality. Someone not involved in the intervention but who is nearby can be informed so that if security needs to be called, they can do so. The manager needs to consider having security in the room during the intervention if they are aware that the nurse carries weapons such as a knife or gun. The manager can also ask the nurse prior to beginning the intervention if he/she currently has anything in his/her possession that could harm anyone.

In addition, the manager can consider the nurse's home status. Arrangements will need to be made if there are pets or children who will need care and after-school arrangements if the nurse goes directly to treatment or evaluation. Contact a spouse or family member after the intervention. These situations may interfere with the nurse's willingness or ability to go directly to treatment or evaluation. The nurse manager may realize that there is a high risk of suicide at this time and can create a plan to ensure that the employee is not left alone at any time during the intervention and post-intervention periods. Remember that the intervention, while supportive and with the nurse's well-being in mind, is still a confrontation. This is a time of crisis and family or a designated friend needs to know that the nurse cannot be left alone until the nurse is admitted into a treatment facility (Ohio Nurses Foundation, 2008).

While planning the intervention process the manager should be mindful of the rights of the nurse. Most nurses do not know that they have any legal rights. If the nurse is accused of drug theft, diversion or impairment while on duty, the manager can make the nurse aware that criminal or administrative legal action could occur. The nurse can also be advised to seek legal representation (Ohio Nurses Foundation, 2008).

Refusing treatment or being unreceptive to intervention such as a drug screen is a time of high risk. Information can be given about accessing treatment resources including employee assistance programs if a nurse refuses treatment.

Treatment for a substance use disorder does work and nurses in recovery can re-enter the workplace safely when treatment and monitoring is instituted. A nurse who is known and being monitored can be a safer practitioner than a nurse who may have a substance use disorder and goes undetected. Early termination from work actually decreases the likelihood that they can access benefits tied to employment and therefore access treatment. Termination from work minimizes the opportunity for treatment.

Zero tolerance policies resulting in automatic termination do not serve the community because the nurse with an active substance use disorder is just being passed on to another facility and that drives the issue underground. It also leads to nurses hiding and minimizing their own symptoms. In addition, blanket termination policies contribute to the stigma of addiction.

Pressure to enter treatment from employers is often the best opportunity for nurses to enter treatment and recovery. Giving a nurse a second chance is a misnomer or inaccurate term. The next ethical step in the progression of workplace intervention is to offer options to the nurse. Some options are to put the nurse on administrative leave with or without pay and give the nurse time to utilize health benefits to enter treatment and get into a solid recovery program before returning to work. Utilizing a return-to-work agreement in the workplace is highly predictive or supportive of a successful re-entry into the workplace.

Implementation

An intervention can be planned once it is determined that sufficient documentation exists to support concerns of unsafe practice. The planning and participating in an intervention is often another critical responsibility of the nurse manager. It is important for the nurse manager to consider all aspects of the work environment that are likely to be impacted. Forecasting the nurse's absence from the practice area and preparing the staffing and scheduling needs will make the transition easier for co-workers whether it is a temporary leave or a termination. Administration must be informed to garner support for the intervention and to assess the potential for retention. Human resource personnel need to be involved along with the administration in order to determine such things as the available benefits or leave time.

Prior to holding the actual intervention it is important to not just react to the situation but instead to develop a careful plan of action, which is the intervention, before the implementation. Usually, the first step is to secure help. In fact, it is never recommended to do an intervention alone, no matter what your confidence level. There are two primary reasons for this. First, the support and the witness of others are extremely useful and necessary to help create enough momentum to accept the need for assessment. Also, a group style intervention is a much more powerful message and therefore has been found to be more successful than an intervention facilitated by an individual. Denial is the chief characteristic of all addictive diseases. It is unrealistic to expect the nurse with a substance use disorder to ask for help. A solid denial system is part of the active disease of addiction. Understanding this will help lower frustration and decrease any expectation of instant acknowledgment. It is more common for the nurse with a substance use disorder to deny the problem but demonstrate willingness to comply with an evaluation process in order to safeguard employment and career. Once in a treatment process the denial normally fades and the participant can begin the process of admitting and accepting his/her part. For these reasons a group intervention is most suitable for chipping away at denial and providing additional support to both the nurse manager and identified nurse than attempting to intervene one-on-one with just the nurse.

The use of a private setting in a group format for the intervention is essential. Interveners can meet prior to the actual intervention to review documentation, in-house policy and to determine the documented facts to be presented by each intervener. Just as important as establishing the facts, interveners can also be ready to emphasize how the nurse's behavior has caused them to feel such as disappointed, hurt or worried. A course of action can also be determined (termination, reporting to a regulatory agency) in case the nurse refuses assistance. All of the interveners need to be informed of the possible consequences for the nurse such as retention or termination and a consensus achieved by all regarding the possible administrative actions.

One aspect that can't be overlooked is the possible risk of harm, whether it is self-inflicted or done to others during the course of an intervention. For this reason, whenever possible security and a safe transport needs to already be put into place. Security must be informed

that an employee counseling session will be occurring and that there may be a potential for physical harm. The nurse can be accompanied by security personnel or a responsible and knowledgeable professional after the intervention but while still on the workplace property and preferably transferred to a responsible family member, significant other or provided a taxi to an awaiting assessment. Failing this, local law enforcement (911) may need to be called especially if there is potential for public endangerment by the nurse from driving a vehicle on the roadways. Remember that a nurse who may demonstrate unsafe practice at work is just as likely to be unsafe if allowed to drive off the property.

The intervention can focus on documented facts of concerns about performance along with supportive communication. Available options for a fitness-to-practice evaluation must be identified before the intervention is facilitated. It is usually best not to reveal the exact nature of the meeting because a nurse who is tipped-off as to the nature of the meeting could build up a defense mechanism and end up refusing help. A for-cause drug test can also be included within the intervention process whenever policies permit. It is essential to ensure that the for-cause drug test includes any medications diverted or other substances and that a responsible professional of the same sex is available to provide an observed urine drug test.

Once all is in place, the identified nurse is requested to join the group. Upon the nurse's entry the nurse is asked to be seated and asked to listen to each of those present who are there because they care and are concerned. An honest, direct and caring approach by interveners is recommended. The objective of the intervention is to request that the nurse refrain from practice and obtain a fitness-to-practice evaluation as soon as possible. A referral to the state diversion program may be appropriate once the nurse agrees to follow through with the evaluation plan. Usually this contact is best made in the presence of the nurse, especially if the nurse manager has reviewed the nurse's eligibility for the program beforehand. This method of offering a non-punitive alternative to the nurse has been referred to as benevolent coercion and is considered an effective and beneficial option for all involved (Hanks & Bissell, 1992).

Practical Tips

Do:

- prepare a plan
- review documentation
- request help from others
- ensure security is readily available
- decide who will present what
- expect denial
- conduct a for-cause drug test
- provide for safe transport
- report as necessary to state alternative program and/or board of nursing
- debrief with interveners
- leave the nurse with a sense of hope that they are a good human being deserving of help
- ask the nurse to listen to everyone before responding to interveners
- stick to the job performance
- have evaluator options ready

Don't:

- just react
- intervene alone
- try to diagnose the problem
- expect a confession
- give up
- use labels

Follow-Up

After the nurse is referred and a formal evaluation is conducted, then decisions regarding the need for treatment, its type, setting and safety to practice can be made with the help of the evaluation team.

With any intervention a debriefing meeting can be scheduled for all intervention team members. This is a time for the team to review intervention strategies and look at what worked best and least. A debriefing meeting allows members to share personal feelings and reactions about an experience that is often intense and emotional. It will also help sharpen skills for future opportunities that require intervention. The debriefing meeting is a good time to formulate documentation that summarizes who was present at the intervention, what documentation was presented to the nurse and the nurse's response and outcome. At the close of this meeting members may begin to discuss return-to-practice considerations.

As a final step to the debriefing it is important to inform staff of the incident in a summary manner with everyone informed of the outcome to the intervention.

Return to Practice

A recovering nurse's return to practice also requires planning and the oversight of this process by the nurse manager is indispensable. There are many things to consider once a nurse is determined to be safe to return to practice. These include developing return-to-practice guidelines often written in what is known as a return-to-work contract. Experts also advocate initiating a return-to-work conference to provide support, review expectations (including any practice restrictions), monitor requirements and to answer any questions. There are typically two meetings that need to occur with the nurse's return: an administrative meeting that involves confirming accommodations (practice restrictions) per the Americans with Disabilities Act as well as reviewing and signing the return-to-work contract; and a clinical meeting with co-workers that involves identifying the nature of the alternative program and the restrictions involved along with the need for possible work exchange.

The prospect of returning to work is anxiety provoking for the recovering nurse and often the nurse manager as well. Discussing the plan for the nurse's return prior to the nurse's actual return will decrease misunderstanding and potential problems later. Possible participants in the administrative return-to-work conference can include, besides the recovering nurse and nurse manager, the identified nurse monitors who will be responsible for oversight of the nurse's practice, a representative from human resources, an administrative representative, an employee assistance representative, as appropriate, a supportive peer or work buddy and a representative from the alternative program. The written return-to-work agreement can be prepared and copies made for each person present at the meeting.

The National Council of State Boards of Nursing (2001) recommends that return-to-work contracts stipulate the following:

- the length of the contract
- the plan for treatment (if the contract is signed at the time the nurse's dependency is first detected) and aftercare
- practice restrictions, such as no overtime and prohibiting administration of narcotics for a period of time (Six to 12 months unless there is evidence of drug diversion, prescription fraud or harm to a patient. Then the restriction must be 12 months with no access.)
- random drug screening requirements
- mandatory attendance at support group meetings for nurses with substance use disorders

- professional standards that the nurse's job performance must meet
- provision for periodic evaluation meetings with direct supervisor
- steps to be taken in the event of relapse
- consequences of failure to comply with contract stipulations
- regular reports from supervisors or work-site monitors

Practice restrictions can be managed in a number of creative ways. A system for labor exchange is a prime example. This allows for specific tasks to be exchanged ahead of time with a designated buddy who will be assigned to work in tandem with the recovering nurse. The recovering nurse is usually prohibited from administering controlled substances early in the return-to-work period and so a labor exchange allows a buddy to administer all controlled substances for the recovering nurse while the recovering nurse completes one or more of the buddy's agreed upon assigned tasks. An arrangement like this puts planning in the forefront, promotes teamwork and removes the burden of others having to accommodate the returning nurse. Additionally, such a work arrangement may help lessen the feelings of shame, of being different and of not carrying a full load by the recovering nurse.

Another important area to consider when preparing for a nurse's return to work is the response of co-workers. If the identified nurse is returning to the same unit the staff members are probably already aware of some of the circumstances precipitating the nurse's leave of absence. As a way to minimize rumors, it is important to set up a time to hold the clinical return-to-work meeting so that the professional staff who have a legitimate need to know can openly talk about their concerns. Questions can be answered in a general way to provide necessary information to staff members while at the same time ensuring confidentiality.

This may be an appropriate time to initiate staff education as well. Basic education on substance use disorders and its prevalence in the nursing profession can help dispel myths that view substance use disorder as a moral weakness rather than a medical illness. All practice restrictions and possible work exchanges can be discussed in the clinical return-to-work meeting. This is also an opportunity for the nurse, especially if returning to the same practice area, and for co-workers to express their gratitude and make any brief comments as to their acknowledgement of their disease and the need to re-establish trust and healing over time. Additional meetings may be useful for further sharing and education once the nurse returns to work. Meetings like these are usually well received. Besides diffusing mistrust and misunderstanding, they also promote open communication and may decrease the chance of enabling behaviors occurring in the future.

In general, the ongoing management of the returning, recovering nurse can be no different than that of other employees. During any period in which access to controlled substances is in effect it is vitally important that the nurse manager ensure that all staff with a need to know be informed of this restriction. This would include any nursing float or agency staff. However, the nurse manager must also participate in the development of the return-to-work agreement and the subsequent return-to-work conference. The nurse manager will also likely have to compile regular, written performance summaries if the recovering nurse is participating in a statewide monitoring program.

It is important not to expect perfection as it may take the nurse a little while to regain a sort of comfort level upon return. Open communication providing support, clear expectations and regular feedback is crucial to success. Any concerns in performance can be communicated without delay along with expectations for improvement.

Indicators of Relapse

A substance use disorder is a chronic illness. Like other chronic illnesses, it is characterized by periods of remission and exacerbation. In general, the rate of relapse among nurses is lower than in the general population. This is due to the growth of supportive programs and strict state monitoring programs. Still, some nurses do relapse. Knowing how to manage relapse in the workplace is crucial for both the safety of patients and well-being of the nurse. A relapse is essentially a recurrence (exacerbation) of an active disease. The signs of relapse mirror the warning signs of a substance use disorder. If relapse occurs, the signs will become apparent and will progress without intervention. In recovering nurses there is usually a behavioral change noted before a break in abstinence occurs. Behavioral changes include such things as taking on more than one can reasonably handle, over-extending one's self at the expense of recovery and coping activities, withdrawing from recovery support people and meetings, isolation, resumption of denial and an eventual return to drug or alcohol use. Relapse requires a re-examination of the return-to-work contract.

The same rule of thumb for the usual employee performance assessment applies here. The nurse manager can continue ongoing monitoring of the recovering nurse's job performance, document concerns and take action when warranted. Any concerns must be addressed proactively. If performance concerns do not improve after performance counseling or if serious signs are observed the steps to re-evaluate the nurse's fitness to practice and to remove the nurse from practice can be initiated. Once re-evaluation is completed and fitness or stability is assessed the next steps can be determined. It is important that this entire process be handled in a non-punitive way. With early recognition of relapse signs and appropriate intervention or treatment, the chances of the nurse re-entering recovery (remission) are great. Decisions about return to practice can be made once the nurse is stabilized and fitness to practice is determined. A clear policy regarding the management of relapse is extremely important and it can address areas of identification, documentation, intervention, referral for fitness-to-practice assessment or treatment and parameters for return to practice.

Reporting Nurses with a Substance Use Disorder

Chief nursing officers are often in the position of making decisions that have regulatory implications. Chief nursing officers are responsible for ensuring that nurses under their direction are properly licensed and practicing safely within the appropriate scopes of practice or authorized duties as outlined by state law and regulations. Therefore, it is important for these nurses to develop both an understanding of the complexities of regulation and a working relationship with the board of nursing and nurse substance use disorder monitoring programs (Hudson, 2008). It is recommended that chief nurse orientation programs be developed in order to educate nurse managers about nursing regulation and to include such components as the mission, the scopes of practice for licensees, information about investigations, mandatory reporting for nurses and the board of nursing's program for nurses with a substance use disorder. Boards of nursing can be actively involved in these orientation programs. Research supports the need for further education and guidance for reporting workplace practice issues by nurses, which enhances public safety (Maxfield et al., 2005).

Most complaints that end up being investigated by a board are filed by nursing administrators, either chief nursing officers or nurse managers (Raper & Hudspeth, 2008). Without understanding all of the ramifications of disciplinary processes and the requirements to protect the rights of the nurse that are guaranteed under the U.S. Constitution, the final decision of the board can be totally different than anticipated and thus disappointing to

the reporting nurse administrator (Raper & Hudspeth, 2008). The complainant nurse could perceive the decision as wrong and the board as unsupportive and dismissive of his/her efforts to alert the board to a problem nurse. This unhappiness with the outcome does little to strengthen the relationship between the board and the nurse administrator.

An initial step in resolving this problem is to create a better understanding by nursing administrators of the legal procedures that guide disciplinary processes and the board. Education for nurse managers about relevant state laws and rules regarding the practice of nursing and the disciplinary process will provide more effective reporting and higher levels of satisfaction with board disciplinary decisions (Raper & Hudspeth, 2008). Although state laws mandate certain reports to the board by nurse managers, a law that most managers are familiar with, a more in-depth understanding of the law and the reasons for the mandatory reporting laws will likely ensure that reporting occurs and provide the manager greater comfort and acceptance with the board's complaint review process. For example, research reveals that for public safety reasons it is better to report a nurse if unsafe practice or diversion is suspected than to fail to report (Dunn, 2005).

Reporting Guidelines to Boards of Nursing

Many states have mandatory reporting statutes or rules and the nurse manager may face action by the board for failing to report misconduct of subordinates. Regardless of the existence of such requirements there is a moral responsibility to the public to report nurses who pose a threat to patient safety. The high demand for nurses can result in a manager, who discharges an unsafe nurse without reporting to the board or taking other appropriate action, passing the problem on to the next manager and at-risk patients.

It is important to know whether reporting a nurse to an alternative program truly fulfills the nurse's obligation to report misconduct to the board. There may be confidentiality restrictions on the alternative program's ability to pass complaints on to the board.

Nurses can examine their state's laws with respect to reporting other health care professionals. Bupport & Klein (2008) suggest that when reviewing the laws, the nurse look for the following:

- a definition of reportable events or situations
- a description of level of suspicion (must there be first-hand knowledge or is reason to believe or suspicion enough)
- direction about who to report to
- exceptions from duty to report
- consequences for failing to report

Nurse managers can work with their state board of nursing to ensure that there is a mandatory reporting law or rule in place for nurses. Mandatory reporting can require a complaint or information to be submitted to the board even if a complaint or information was filed or is going to be filed with the state's alternative to discipline program. Such a requirement would ensure that the board knows who is in the program.

Filing Complaints to the Board of Nursing

Nurse managers must be familiar with both state and federal requirements for reporting drug diversions. Health care facilities or individuals can also make a report. Health care facilities are responsible for reporting but not for filing charges. The crime is against the state. Some state statutes protect those who report diversion or theft of controlled substances to law enforcement from civil lawsuits. Therefore employers and professionals can be made

aware of their legal obligations to report diversion to appropriate criminal or administrative authorities without the threat of being sued.

Nurses and nursing management will need to know how to access a board of nursing complaint form, how to fill it out completely, who to send the completed form with supporting documentation to, and who to call if there are any questions about the form or the complaint process. All documentation must be legible.

The following information is necessary:

- the nurse's name including a middle name and any other names used by the nurse if known
- the nurse's license number and date of birth
- the nurse's address

If submitting documents from a patient's medical record, highlight information that supports the complaint, especially automated drug dispenser reports or pharmacy records.

Give specific details of the incident to answer the following questions:

- what happened?
- who was involved?
- when did it occur?
- how was it discovered?
- where did it occur?
- was there a witness?

Controlled substance diversions also require the following information:

- what drugs were diverted?
- did the nurse divert for self-use?
- did the nurse demonstrate unsafe behavior while on duty?
- did the nurse falsify patient records?
- was the nurse arrested for obtaining controlled substances by fraud or deceit, or for possession of controlled substances?
- did the nurse undergo drug testing?
- what were the results?
- was the drug test done as part of a random drug testing procedure or as part of an investigation for diversion of controlled substances?
- inclusion of all relevant documentation to the complaint, (such as drug screen results or witness statements)

(Colorado Board of Nursing, 2003)

Traditional Discipline and Alternative Programs

The nurse can be aware of whether regulations exist regarding a referral to alternative programs and the existence of mandatory reporting laws or regulations. Some states have rules that allow nurses to report directly to the nurse assistance program in lieu of a formal complaint to the board as long as certain conditions are met. Nurses can work with their state boards to implement rules that require a complaint or information to be submitted to the board even if a complaint or information was filed or is going to be filed with the state's alternative program. Such a requirement would ensure that the board knows who is in the program. It would also ensure that nurses who were previous alternative program participants (something which may be unknown to the supervisor) are not funneled into the program again when discipline is probably more appropriate. Perhaps most importantly, it eliminates the possibility of a supervisor making a referral to the alternative program

and failing to follow up to verify that the nurse did in fact enroll. The basic requirements and what is expected of the nurse participant are the same regardless of whether the nurse is in the alternative programs or the discipline program. Therefore, a co-worker does not need to have any hesitation in filing a complaint with the board as opposed to reporting the alternative program for fear that the requirements for the nurse would be stricter. Both types of participants are required to sign a contract.

Nursing management can contact the board of nursing for a listing of alternative programs and develop an open and ongoing relationship between the alternative program manager and nursing management whether or not laws and rules exist regarding alternative programs. This relationship will assist in getting nurses with substance use disorder-related issues the help they need.

Nursing management would be well advised to make contact with their state's alternative programs before facing the difficult and stressful situation of reporting a nurse with signs of a substance use disorder. These programs often maintain materials and can provide assistance to nursing management on how to handle such situations. Additionally, they often offer educational programs for management and staff.

It is important for nursing management and staff to know the regulations governing these programs, what these programs consist of, what their role will be in the monitoring of employees and the importance of continuous contact with the program coordinator and other personnel. A nurse manager who also has a greater understanding and good grasp of the interworking of the board of nursing, has knowledge about existing substance use disorder assistance programs as well as about the nursing statutes and regulations will be better equipped to educate other nurses about such things. Boards of nursing can assist nursing management in developing comprehensive educational programs for nurses.

Guidelines for nursing management:

- manage their own personal stereotypes of addiction and nurses with a substance use disorder
- develop and foster a climate of transparency and support for all nurses
- encourage nurses to break the code of silence
- educate about the disease of addiction
- manage the controversial and emotional issue of addiction among all workers
- support a Just Culture and create an environment that encourages reporting as a necessary part of reducing the stigma, maintaining transparency, rehabilitating the nurse and protecting the public
- implement and utilize workplace intervention strategies for handling substance use disorder issues
- institute educational, training and counseling programs on substance use disorder issues, bullying and lateral violence
- establish policies and procedures on substance use disorder, bullying and lateral violence
- apply them consistently and follow through

Summary

It is incumbent upon all parties engaged in the management and monitoring of nursing practice to educate themselves about substance use disorder issues. These parties must further work together to identify, document, report and generally work together to reduce complaints related to any substance use disorders in the workplace. In addition, alternative programs and boards of nursing can be cognizant of their potential role in impacting these issues through various educational materials and resources.

The nurse manager is in a unique position to play a primary role in carrying out policies and practices designed to timely address any substance use disorders in the workplace.

A nurse manager who is knowledgeable, prepared, proactive, sets clear limits and is compassionate is likely to be more successful with a staff whose practice may be unsafe due to a substance use disorder. The nurse manager who fails to act, who has a poor attitude or has unrealistic expectations can make a significant negative impact on the safety and morale of patients, co-workers and the identified nurse. Protecting patients while helping colleagues may best be accomplished by treating others as we would wish to be treated. It is critical to understand that a substance use disorder is a disease and is not a matter of will. Intervention is conducive to a better environment for patients, staff and management and for healthier outcomes for the nurse.

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CHAPTER SEVEN

TYPES OF PROGRAMS

IT WAS DURING THE 1970S AND 1980S that alternative program models for nurses with a substance use disorder were developed. Several of these models combined both the traditional model of discipline along with the peer assistance approach to treatment. The programs were created to enhance the board of nursing's ability to provide public protection by promoting earlier identification and intervention into the practice of nurses with a substance use disorder before they demonstrated unsafe practices. They were designed to refer nurses for evaluation and treatment, monitor the nurses' compliance with treatment and recovery recommendations, monitor abstinence from drug or alcohol use and monitor their practice upon return to work.

As the knowledge of addiction increased so did the evolution of alternate programs. In the late 1990s Yocom and Haack published an interim report comparing alternative programs to traditional discipline programs (1996). This research study was to determine whether alternative programs are as effective at protecting the public as the traditional discipline programs. The results of the study concluded that the recidivism rates for both approaches were the same. However, there was one important difference. The alternative programs were also able to retain or return nurses to practice without increasing the rate of return to drug use.

In 2009, NCSBN undertook a review of discipline and alternative programs and found that 41 of 59 licensing jurisdictions had an alternative program at the time. It was also found that there are several models of alternative programs that boards of nursing utilize in constructing these programs. To date some of the states have developed alternative programs that are a combination of more than one type of model. The following are descriptions of some examples of alternative models from the National Council of State Boards of Nursing (NCSBN, 1987; 2001).

Models of Disciplinary Alternatives for Nurses with a Substance Use Disorder

Alternative Program Models

Model A. Statutory Arm of the Board of Nursing

This model depicts a process that is totally under the aegis of the board of nursing. It is created by the legislature, which makes it less subject to a conflict of interest challenge for its professional advocacy aspects. The model provides for the protection of the public by triggering the disciplinary process of the boards at the time a nurse becomes noncompliant with the requirements of the program. It is assumed that those nurses who are compliant can practice nursing safely. This model also protects the rights of the nurses as long as the public is not at risk. When the actions of the nurse place the public at risk, the nurse's rights become secondary as supported by case law. If this approach does not provide educational services, an important preventive aspect is missing.

Elements of the model are:

- statutory authorization
- separate or private office and dedicated staff for the alternative program
- voluntary admissions or board referral
- non-public records as long as compliant
- assessments, treatment and aftercare monitoring (therapy, employment, sobriety) requirements
- assessment, treatment and aftercare services provided by outside agency that meets predetermined criteria
- routine disciplinary proceedings if nurse becomes noncompliant
- educational services may or may not be provided

Model B. Statutory Disciplinary Alternative under a Board of Nursing with Services Contracted to an Outside Agency

This model has the same characteristics as Model A except that when contracting with an outside agency for all services the board retains only an indirect control over the treatment specifications. Also note that as in Model A, if educational services are not provided an important prevention aspect is missing.

The contractor in this model is required to adhere to reporting requirements that may be as extensive and detailed as the board needs in order to maintain public safety and achieve the necessary accountability. When the board delegates monitoring responsibility for its alternative program to an outside entity, it needs to have confidence in the capability and integrity of the organization with a comprehensive contract or written protocol giving the board adequate control and oversight (CLEAR, 1993).

Elements of the model are:

- statutory or regulatory authorization, specific or implied
- special committee of the board with expertise in substance use disorder decides on admissions
- admission pursuant to voluntary request made to the board or pursuant to board referral
- agreement for assessment, treatment and follow-up monitoring
- services (consultation referral for treatment and monitoring) provided by contract agency

- records are non-public and reports to the board are made on all nurses referred by the board
- noncompliant nurses are referred to the board for disciplinary action
- educational services may or may not be provided

Model C. Special Committee of the Board

This model is designed only as a means to provide protection to the public from the unsafe practice of nurses with a substance use disorder without exposing the identity of the nurse in the public records of the board of nursing. It still triggers the routine disciplinary process at any time the public is at risk. There are not consultative and educational services, therefore this model does not provide for primary prevention of a substance use disorder.

Elements of the model are:

- statutory or regulatory authorization
- reports regarding substance abuse investigated and presented to committee
- committee enters into an agreement with the nurse for assessment, treatment, and aftercare monitoring to include guidelines for continued therapy, employment conditions, and relapse prevention
- reports from treatment program, employer, and evidence of sobriety sent to committee
- routine disciplinary proceeding if nurse becomes noncompliant with requirements
- records confidential as long as compliant

Model D. Peer Assistance Program of Professional Association in Collaboration with the Board of Nursing

This model offers a balance between the protection of the public and the rights of the nurse if the program is carefully planned and implemented in accordance with a formal agreement made between the board of nursing and the professional association. It also provides for consultation and educational services and is not staffed by board of nursing employees. However, the board provides a liaison staff person and statutory authorization is either explicit or implicitly implied.

Elements of the model are a formal agreement between board and association that includes:

- assurance of public protection
- protection of the privacy and welfare of the nurse
- preservation of the regulatory power of the board
- peer assistance program
- consultation and education

The association staff's program nurse enters into an agreement with the program that further details assessment, treatment, and aftercare monitoring and includes continued therapy, employment conditions and a relapse prevention agreement along with a statement that noncompliance will be reported to the board. There is also a liaison to the board program director who must send written reports to the board's liaison regarding each nurse in the program. The board's liaison reviews the reports and as long as the reports reflect compliance with the program they are placed in a confidential file. The reports that reflect noncompliance are referred to the disciplinary staff of the board and routine disciplinary proceedings are initiated.

Model E. Peer Assistance Program of Professional Association with No Relationship to the Board of Nursing

This model provides a high level of protection for the nurse's rights. However, there is no provision for protecting the public against unsafe practitioners of nursing. This program is sponsored by a professional association implying that a nurse whose practice is unsafe will be counseled into voluntarily staying out of practice for a period of time. The assumption is based on the fact that the nurse is at risk for malpractice litigation and for disciplinary action by the board of nursing if the nurse practices below acceptable standards.

Elements of the model are:

- no statutory or regulatory authorization
- staffed and operated by the association
- records are confidential (even from the board of nursing)
- services usually include intervention, referral for treatment and support
- usually no communication with board of nursing
- usually provides consultation and education

Model F. Peer Assistance Employee Assistance Program with No Relationship to the Board

This model offers the least public protection and the narrowest scope of services. Although the majority of these programs may operate similarly to the programs administered by professional associations, the private agencies may have ulterior motives for providing assistance to the nurse with a substance use disorder. Such motives may be, for example, salvaging an employee to avoid the cost of hiring and orienting a replacement for the position, providing a shelter for a nurse to escape disciplinary action by the board of nursing or even sheltering nurses from criminal prosecution.

Elements of the model are:

- no statutory regulatory authorization
- staffed and operated by a private agency
- services usually include intervention, referral for treatment and support
- records are confidential
- usually no communication with board of nursing
- may or may not provide education services

Disciplinary Models

Model G. Consent Order for a Suspension or Stayed Suspension and Probation

This model represents an official action of the board of nursing, which is usually provided for in the Administrative Procedure Act, although not specifically for handling nurses with a substance use disorder. The board has statutory authority to regulate and control the practice of nursing because the practice of nursing affects the public's health and welfare. This includes imposing disciplinary action in the form of sanctions against the licensee. Sanctions must include a term of probation or even suspension. Some boards may have statutory authority to stay or defer a suspension if the nurse meets certain conditions such as enrolling in a monitoring program. The order is designed to protect the public from unsafe practitioners of nursing and offers no primary preventive services. There is no provision for protecting the privacy of the nurse. Due to the public's interest in safe nursing practice most, if not all, states have statutes requiring that disciplinary actions be made available to the public.

The process ends in a final order or consent order and often includes:

- voluntary admission of a substance use disorder in the workplace followed by administrative complaint or employer investigation of report followed by administrative complaint
- nurse enters nolo contendere plea in district court
- nurse agrees to certain terms (such as suspension or stayed, treatment, monitoring, limited practice reports)
- administrative complaint and proposed consent order presented to the board
- the board accepts, revises or rejects terms
- if the board accepts the terms they become effective
- if the board revises the terms the licensee has the option of accepting revised terms or having a full hearing
- if the board rejects the terms the licensee is notified of a full hearing
- license may indicate probation
- records are subject to public records law

Model H. Special Disciplinary Provision for Voluntary Surrender of License to the Board of Nursing

This model protects the public from an actual or potential unsafe nursing practice of nurses misusing substances because the nurses forfeit the right to practice until it can be determined that the substance use disorder is under control. There is a minimum requirement of time and effort on the part of the staff of boards of nursing. It is not designed to provide consultative and education services. Although the property right of the nurse is not protected, it is also not violated because the surrender of the license is voluntary.

Elements of this model include:

- statutory authorization is either explicit or implicitly implied.
- staffed by the board of nursing
- voluntary admission by the nurse of a substance use disorder before or after the board receives a report from others
- license voluntarily surrendered to staff in an informal hearing
- nurse enters treatment
- license is returned after an informal hearing where the nurse presents evidence of an ability to practice
- stipulations may or may not be placed on the license

The general characteristics of each model are depicted in Table 1. Note there are different strengths and weaknesses within all of these models. The models that have the most public protection have more accountability to the board of nursing and the public in terms of entry into and reporting noncompliance to the board. Table 1 may be used as a checklist in identifying the best guidelines for a model program.

Table 1: Models of Alternative Programs for Nurses with a Substance Use Disorder (NCSBN, 2001)

General Characteristics of the Program	A	B	C	D	E	F	G	H
Specific Statutory Authority	●	●					●	
Implied Statutory Authority			●	●				●
No Statutory / Regulatory Authority					●	●		
Staffed and Operated by BON				●	●	●		
Staffed by Sponsoring Agency		●						
BON Staff w/ Contract for Services				●				●
Formal Agreement with BON				●				●
Voluntary Admissions	●	●	●	●	●	●	●	●
Board Referred Admissions	●	●	●	●	●	●	●	●
Program Services								
Consultants	●	●		●	●			
Referral for Assessment and Treatment	●	●	●	●	●	●	●	●
Monitor Re-entry into Practice	●	●	●	●	●		●	●
Education Services	●	●		●	●			
Communication with BON								
Admissions	●	●	●	●			●	
Program Reports	●	●	●	●			●	
Noncompliance	●	●	●	●			●	
Records								
Public							●	
Confidential in All Instances					●	●		
Confidential When Compliant	●	●	●	●				●
Disciplinary Proceeding								
None in Any Instances					●	●		
None if Compliant	●	●	●	●				
Action Taken and Stayed							●	●

Alternative					
Board of Nursing Programs		Professional Association		Disciplinary	
Model A	Statutory Arm of the Board of Nursing In-house Monitoring Program	Model D	Peer Assistance Program in Collaboration with the BON	Model G	Consent Order for Suspension/Stayed and Probation
Model B	Statutory Arm of the Board of Nursing with Services Contracted to Outside Agency	Model E	Peer Assistance Program of Professional Association with No Relationship with the BON	Model H	Special Disciplinary Provision for Voluntary Surrender of License to Board of Nursing
Model C	Special Committee of the Board	Model F	Peer Assistance Employee Assistance Program or EAP with No Relationship to the BON		

Regardless of the model that is used, the nurses in the alternative programs generally must sign individualized stipulated agreements with the alternative program. These contracts specify the evaluation and treatment requirements, drug screening requirements, work-site limitations, notification and practice monitoring and compliance reporting. In addition to monitoring the nurse, these programs often provide orientation for the workplace so that health team members may accept and support a recovering nurse's return to practice.

Nurses are admitted into alternative programs through a variety of methods. All alternative programs accept self-referrals, which allow nurses to report their own problem with drugs or alcohol and request admission into the program. The experience of most alternative program staff is that it is unusual for a nurse without some other external pressure such as from an employer, colleague, spouse or other family member to self-refer into the program. Most commonly, the self-referral has been precipitated by an event whether it is a work-related, family, health or legal event. Another entry point is when the nurse requests admission into the alternative program following the filing of a complaint with the board. Additionally, in some states a nurse may request admission into the program in lieu of formal board action against their license or as a condition for reinstatement of their license following a suspension or revocation.

Accountability and transparency in an alternative to discipline system requires acknowledgement upfront that it may be impossible for boards and alternative programs to pursue the many advantages of such a system without encountering some measure of calculated risk to public safety. The boards and alternative programs are working with nurses who are suffering from a substance use disorder and relapse is an expected part of the disease process. Furthermore, in time and under appropriate circumstances the nurse will be placed back into an environment where there will be access to mind-altering drugs or drugs of abuse. Some alternative programs such as New Mexico can report directly to the board of nursing when noncompliance is identified. However, in other programs the nurse may not be subject to discipline while in the program and remains a participant whose history is unknown to the public and often to colleagues as well. For these reasons, it is understandable that news reports or governmental audits that stem from controversy tend to accent these attributes of the programs.

Confidentiality from public scrutiny is an incentive for the licensee to enter the program, especially if the participant's conduct involved violations of the law when obtaining the

drugs that were used as part of the substance use disorder. This is a necessary provision because it is also not disputed that treatment for substance abuse works and the desire to get the participant into treatment is one of several important factors behind the confidentiality provision. Furthermore, there is a dearth of research surrounding the impact of formal coercion of persons entering the programs as well as the influence of perceived coercion on the outcome of nurses who enter and participate in alternative programs (Darbro, 2009a). There is also a scarcity of studies on nurse's recovery rates after re-entering the workplace (Angres, Bettinardi-Angres, & Cross, 2010). Public safety concerns must be a priority. Therefore, any noncompliance must be reported to the board for disciplinary follow-up. Participants who voluntarily enter the alternative program must admit to a violation of the Nurse Practice Act.

Perhaps a more common example of applicants who are referred to an alternative program involves nurses charged with or convicted of crimes related to their dependency who are offered treatment in lieu of conviction. Whether or not the charges or even a criminal conviction disqualifies someone from entering into an alternative program, it must still be considered as an eligibility determination requiring board approval. Controversy may be lessened or avoided by involving the board in the creation of the criteria for eligibility, which will also lead to a greater sense of accountability and transparency in the program. Administrative agency alternative to discipline programs and criminal alternative programs such as drug courts are both prevalent nationwide and are based on the disease model. Most drug courts require a finding before they will hear the case that declares, if the individual were not suffering from the disease of substance use disorder they would not have committed the crime.

The nursing alternative programs have the same fundamental premise as drug courts and are modeled similarly in many respects (Darbro, 2009b). Therefore, it may be necessary to establish more definitive standards to describe what aggravating circumstances could overcome the mitigation of the crime that is related to the substance use disorder. At a minimum a nurse applicant to the program who has pending criminal actions or prior felony convictions must have the board determine program eligibility that is dependent on the severity and consequence of the action or conviction, including non-work related substance use violations such as a charge or conviction for driving while intoxicated or a positive pre-employment drug screen for marijuana.

Felony convictions, especially when they involve violence or drug use seem to be inherently controversial, but even non-work related arrests or convictions such as the reckless operation of a motor vehicle or driving under the influence of drugs or alcohol, or the possession or use of marijuana may be an indicator of problems with judgment as it relates to the use of drugs or alcohol and the nursing practice and is a relevant consideration in any assessment of a substance use disorder and ability to practice. A single event may trigger a referral of a pattern to the board for determining eligibility in the alternative program. An example of a case in which a board might commonly permit a licensee into an alternative program would be a nurse who has a pending driving under the influence (DUI) charge and has requested entrance into the program. The board of nursing may determine that in this particular case, the nurse with a substance use disorder may be eligible for the alternative program.

However, a regulatory system holds public safety as its primary mission and a secondary responsibility to rehabilitation of those licensees suffering from the disease of substance use disorder. Therefore, when it is possible and consistent with patient safety, the program and the board must establish program eligibility requirements that close loopholes and prevents a licensee who is known to have demonstrably harmed a patient to enter or remain in a nonpublic program.

Appendix B provides an excerpt from the Texas Board of Nursing's disciplinary matrix governing practice violations related to the intemperate use of alcohol or drugs that may endanger patient safety. The matrix provides guidance for the board of nursing in determining appropriate disciplinary action including possible referral to, order to or exclusion from the board's alternative program (peer assistance program) depending upon the offense and the aggravating or mitigating circumstances. The Texas matrix is a best practice of transparency in the regulatory realm and is a public document that attempts to provide a balanced and consistent approach to determining the consequences of nurses' practice violations and relevant criminal and drug histories.

Policies and Procedures

Alternative program policies and procedures must promote accountability to the public and assure quality outcomes. They do this by including the reporting requirements to the board, information-sharing, continuous and open communication and evaluations and audits. Policies and procedures assure consistent actions by staff, clear direction to participants and accountability to the public and assure the necessary quality outcomes.

The alternative program must develop a written policy and procedure manual that contains details about the following items:

- the program's administrative and statutory authority
- the relationships and functions of entities who have administrative authority or advisory capacity over the program
- the normal business operating hours that coincide at minimum with the licensing board's business days or hours
- job descriptions and related human resource documents for program staff
- case management criteria for compliance (such as required program forms, receipt of appropriate assessment and treatment recommendations, registration, initiation, and results of drug and alcohol testing, etc.)
- the program will report what constitutes noncompliance (how, with whom, and within what time period) and communicate what the consequences are to the participant
- how continuity of case management will be maintained in the event of absences (what constitutes successful completion of the program, what documentation is required and to whom, including whether or not the program is obligated to report successful completion to the board)
- type, frequency and protocol for audits, financial and performance reports
- board review of program policies and procedures

An intake (referral) process must also be part of the written policy and procedure manual and include any required information and how it is obtained, including verification of licensure and licensure action or current board investigation coverage of the intake process when the program's primary intake staff is absent. All aspects of the office operations, including measures taken to ensure the maintenance of non-public information, procedures detailing the program's case management system and what type of communication, such as initial contact letters, noncompliance letters and by what time frame will be sent by the program.

Information Available to the Board

The board of nursing must be able to review nurse participant files and audit the administrative records for overall compliance of nurses in the alternative program.

Admission procedures must include obtaining a release of information agreement that is signed and dated by the participant nurse and authorizes the exchange of information

between the alternative program and employers, the board of nursing or designee, health care providers, support group facilitators and any treatment providers while participating in the alternative program.

Program policies and procedures must be reviewed at least annually by the program director or designated staff member as well as by a third party familiar with the program in order to ensure their currency with existing practice, laws and other requirements and objective review. It is recommended that these policies and procedures be transparent and that the board has seen and approved them and continues to review them periodically (NCSBN, 2001).

Advantages of the Alternative Program

In 2008, the results from one of the few recent studies regarding the long-term effectiveness of similar alternative programs among physicians indicated that the alternative programs that provide an appropriate combination of treatment, support and sanctions could effectively help participants manage their addiction. The results of the study showed that approximately three-quarters of U.S. physicians treated for a substance use disorder in physician health programs had favorable outcomes for five years (McLellan, Thomas, Gregory, Campbell, & DuPont, 2008).

Since many questions continue to arise regarding the effectiveness of these programs, much more research needs to be done. However, the premise that led to the establishment of these programs still stands. It is the programs' ability to quickly intervene in the practice and treatment of health care professionals who may have the potential to be unsafe due to a substance use disorder. Without these programs the licensing boards are limited in what they can do to quickly remove a potentially unsafe health care professional from practice. There are considerable legal restraints that surround a board's ability to intervene in cases where substance abuse or substance use disorder has not risen to the threshold of actual harm to the public (CLEAR, 1993).

Most regulatory boards report that the cost to intervene by temporarily removing a licensee from practice who is willing to admit to issues involving substance abuse, followed by monitoring the nurse's return to practice through an alternative program agreement is significantly less than the traditional complaint investigation and discipline process. Additionally, proponents of alternative programs often cite the timeliness of removing a licensee from practice with an active substance use disorder as compared to the traditional investigation process that may take months to years to resolve and may be limited in what can be proven without an admission by the licensee.

To operate effectively the alternative programs must establish and maintain policies directed toward assuring participants in these programs when they can be approved to return to practice, have documented evidence of their recovery and ensure that their conduct and practice is consistent with assuring patient and public safety. They must develop and maintain a positive relationship with the state licensing agency and share information freely with the regulatory authorities that have the ultimate responsibility and oversight of the nursing license.

The accountability and transparency of alternative programs can even be one of the tools used to keep boards and programs responsive to the public's needs, patient safety and to enhance vital aspects of the programs. This could also provide public awareness in understanding the powerful impact these programs are having in providing public safety while also intervening early with treatment and rehabilitation on behalf of one of the public's greatest assets, which are their health care professionals.

Controversies about Alternative Programs and Boards of Nursing

Boards of nursing and their alternative programs share a common mission to protect the public and promote the rehabilitation and return to safe practice of the nurse who is in recovery from a substance use disorder when practical. When controversy surrounds the operations of either a board or program, it by necessity impacts the other. The alternative program is an alternative to traditional disciplinary measures utilized by boards of nursing to protect the public and controversy seems to be inherent in the nature and operations of the program. News reports and critical audit findings by state governmental entities involving alternative programs have fueled questions about the effectiveness, transparency and accountability of programs and their participants, as well as the efficacy of the boards.

Problematic elements inherent within an alternative to discipline regulatory system include:

- the non-public nature of the alternative program
- failure to timely or adequately intervene when noncompliance with the program occurs
- a lack of stringent criteria to determine program eligibility
- substance use disorder as a lifetime disease process and the boards and programs inability to monitor participants through the lifetime of their practice
- nurses, ready access to drugs as a part of their job
- obtainment and use of drugs from nurses with a substance use disorder being commonly in violation of criminal laws
- a perception that professional licensing boards and alternative programs regulate themselves with minimal transparency and accountability, including sufficient consumer representation
- the stigma of drug use in society
- the complexity of nursing practice and health care in general

Boards and alternative programs must learn to function in a manner that ensures that they are sufficiently accountable to the public and inspires public confidence and support through their documented performance to address these issues. How boards and programs become more effective, transparent and accountable to the public and each other as part of their day-to-day operations may hold the answer to avoiding or responding appropriately to controversial situations.

Whether or not the criticism of boards, programs or their participants is ever justified, the skeptics view alternative programs as safe havens for nurses from public discipline rather than as a means of achieving more timely participation in treatment and monitoring for those licensees suffering from a substance use disorder. The majority of states have alternative programs for nurses with a substance use disorder and almost all of these programs do not make public the names of the individual participants within their programs. Confidentiality can serve an important purpose by encouraging timely participation in the alternative program (Darbro, 2009b). Yet, it is critical to note in any response that alternative programs are not operating in a complete vacuum of confidentiality and an absence of accountability.

While alternative programs do not generally divulge the names of participants to the public, the best operational practices of alternative programs include a requirement that the individual participant inform his/her workplace as well as states where the individual holds a license to practice or applies for one that the participant is practicing under the program's monitoring. That monitoring may include practice limitations including a limitation in the state where the program originates. Moreover, the program's contract must specify when the individual will notify the employer and other states where the individual holds a license

or applies for a license of participation and any individual noncompliance issues related to individual participation. The required reporting must be the responsibility of the program though it could be accomplished at the entry level by requiring the individual to report and ensure proper follow-up to necessary parties. Compliance with reporting requirements must be focal points to ensure that the program is living up to the collective and individual measures of appropriate functioning and must be included in performance measures for the boards and programs.

The appearance of alternative programs to the media, general public and their government representatives suffers from a public perception that the alternative programs and nursing boards are overly protective of their participants. The alternative program's guarded reserve, which is due in large part to the historical confidential aspects of its operations as established by law, may be misinterpreted as exposing the public to unnecessary risks. The boards of nursing must then by necessity keep in close communication with the alternative programs and maintain a responsible scrutiny. This gives the boards and the public an effective method to judge the success of the shared system and thereby hold the participants accountable. For example, many in the public may believe that the board must have timely access to information from the program that can assist in its own investigation of a licensee so long as the information is not subject to federal treatment provider confidentiality provisions.

However, the issue is complicated by the program's framework of confidentiality that has historically been seen as a primary impetus for entering the program even though everyone with a substance use disorder is not appropriate for entry into an alternative to discipline program. Therefore, it is possible that the board may have information that is a basis for investigation while the licensee is entering or involved with a program.

The ability of the program to share information with the board must be spelled out in the program's policies and procedures, contracts and if possible, governing statutes and rules. At a minimum, state laws must permit the board to know the names of those persons in the program. One result of this sharing of information would be that the board may better utilize its discretion in pursuing an investigation as well as avoid duplication of efforts with the program when reviewing criteria for program eligibility. In jurisdictions where statute or rule is silent or rule is prohibited by statute to govern such information sharing, the possibility of a written memorandum of understanding or contract must be explored and entered into so that the program, the board and the public are aware of how the participants in the program are managed by the board, including those jurisdictions where the peer assistance program is run by a professional association or private entity charged with oversight of nursing or multiple professions.

The extent of information permissible to be shared between the program and board must be set forth in program policies and procedures and contracts with participants so that the licensee has clear knowledge before entering the program.

Nursing boards and alternative programs must establish consistent policies regarding the types and detail of information to be kept and shared, when and with what frequency. When this is done it will allow both entities to better fulfill their common goals and avoid encountering controversy that is damaging and counter-productive to their shared mission of public safety. Failure to adhere to the requirements set forth in statutes when administering the alternative program or carrying out the mission of the board is an easily identifiable ground for criticism following on the heels of controversy. To respond by identifying a lack of adequate staffing and resources after the fact and in the face of documentation indicating noncompliance with statutory guidelines and directives or failure to track performance

measures does not adequately mitigate the damage from misfeasance. The answer to avoiding or responding appropriately to controversial situations may be found in how nursing boards and alternative programs become more effective and more accountable to the public as part of their day-to-day operations. Clearly, the public views an absence of scrutiny beyond periodic board evaluation or a governmental audit following controversy as inadequate and unacceptable for boards and alternative programs as a means to protect the public.

Therefore, the avoidance of controversy is dependent on the ability and discretion of the alternative program to properly function within the core elements of a transparent system. This transparency is defined by the ability of the nursing board to assess the performance of the program through ongoing, close scrutiny and objective performance measures. There must be follow-through or ongoing management by the board and program after the program has gathered and assessed pertinent information, especially as it relates to a participant's noncompliance with program requirements. It has been written that transparency breeds self-correcting behavior but more importantly transparency can lead to the public trust in government growing stronger (Linden, 2010).

Summary

There are several types of alternative programs that boards of nursing utilize in 41 states. All of them have the goal of promoting early identification and intervention of nurses who have a substance use disorder before their practice is impacted. Most regulatory boards report that the cost to intervene and temporarily remove a licensee from practice, and then monitor the nurse's return to practice through an alternative program agreement is significantly less than the traditional complaint investigation and discipline process. The public protection occurs more quickly and the public benefits both financially and socially. There are both advantages and controversies surrounding these programs. Whether or not the advantages outweigh the controversies of each program can only be determined by how well the program completes its primary goal of public protection and then assisting the nurse in recovery. This is accomplished by staying accountable to the public and transparent to the boards that regulate the nurse's license.

Transparency may require alternative programs to become more focused on the perception that the inherently controversial elements of the disease of substance abuse fuels debate regarding the effectiveness of these programs. Alternative programs need to show they have the ability to function within the core elements of a defined system, stress the checks and balances within the program and welcome close scrutiny. This can provide the public with the information needed to assure them that alternative programs may be successful and effective in providing public protection that is both cost-effective and timely.

Alternative programs are not only important for public protection but they are necessary to meet the growing problem of narcotic use and diversion among nurses (Sullivan & Decker, 2001) who are in a profession that reports more job stress than any other health care profession with workplace risk factors that can predispose nurses to developing substance abuse and addiction (Brooke, Edwards, & Taylor, 1991; Naegle, 1988).

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CHAPTER EIGHT

PROGRAM ENTRY

IT IS VERY IMPORTANT TO PROVIDE a swift entry into a closely supervised monitoring of recovery and the return to practice. Timely entry into an alternative program reduces delays between the identification of nurses with a substance use disorder and the start of treatment. It also reduces the extent of any unsupervised and potentially vulnerable time for nurses, the staff and their patients.

Admission Criteria for Alternative Programs

Facilitating an early entry into alternative programs is not only cost-effective but increases the likelihood of success in an alternative program. Various admission criteria are available to nurses for early entry into the alternative program.

Self-Referral

A nurse with a substance use disorder can contact the alternative program on their own. However, it is unusual for a person to self-refer without a precipitating event.

Employer, Supervisor or Colleague Referral

Alternative program staff may be contacted by supervisors, colleagues or other health care team members about individuals in the health care profession who need assistance. If the nurse with a substance use disorder does not agree to participate in the alternative program the board must be informed and the disciplinary process initiated.

Board Referral

During the processing or investigation of a complaint the investigator or the board may refer a nurse with a substance use disorder to the alternative program. If the nurse does not agree to enter or does not otherwise meet eligibility criteria, the board must be informed and the disciplinary process can continue.

Other Referral

Family members, health care providers or others may refer a nurse with a substance use disorder to the alternative program. If the nurse does not agree to participate in the alternative program or does not otherwise meet eligibility criteria, the board can be informed and the disciplinary process initiated.

Screening and Assessment Guidelines

The health care provider who is seeking admission into the alternative program is initially screened to determine if he/she meets the admission and eligibility requirements. The screening process is necessary to determine if the health care professional is appropriate and eligible for admission to that particular program. It may also help to alleviate the typical behaviors of minimization and resistance to treatment that is often encountered when nurses are identified and referred to treatment (Baldisseri, 2007). The process also emphasizes the need for treatment for the nurse with a substance use disorder who may have difficulty accepting the responsibility and entering into an alternative program.

Each alternative program is typically governed by specific statutes, regulations or policies and it may sometimes be appropriate for the state to continue with an investigation of an applicant or participant to verify that the conduct committed by the nurse does not prohibit him/her from entering or continuing in the alternative program. For example, if the nurse is prohibited from entering into the program as the result of patient harm an investigation may need to continue to substantiate the patient harm. However, the investigation can continue while the nurse moves through the screening process to prevent any delay in removal from or monitoring of the practice and to more quickly begin the evaluation and recovery process.

The eligibility screening should be brief and must occur on the same day as the intake assessment to maintain the individual's involvement and interest (SAMHSA, 2002). Staff may also have to be prepared to make emergency referrals if the nurse is in crisis.

The process can identify the specific indicators of substance abuse such as educational or job-related problems, financial and legal problems, relationship difficulties or health factors. Legal or criminal sanctions may hamper the ability or willingness of the nurse to enter or continue with the program, especially if the nurse is facing incarceration. The act or conduct that the nurse committed in order to obtain the substance must not prevent the nurse from entering the alternative program because they are a known by-product of addictive behavior.

The screening process can substantiate the reasons for concern about the nurse who has a substance use disorder and identify a need for further evaluation (Breining, 2008). The screening process will also determine whether the nurse is eligible for the alternative program and if not, refer the matter to the board for further disciplinary review and to offer appropriate treatment referrals. The referrals can be tailored to protect the needs of the public and the nurse.

The screening may go through several different processes such as the eligibility screening by the staff or the initial intake screening and assessment by an approved evaluator who has expertise in mental health and substance abuse. The evaluator can then identify the appropriate clinical assessment to give and schedule the appropriate clinical assessor as well as the in-person comprehensive clinical assessment that will be given by a licensed clinical evaluator. It is ideal if qualified professionals can do all of these assessments at one time.

An initial eligibility screening by the staff can determine if the nurse meets the requirements for admission, which include:

- holds a license in the state or in some states or is eligible for licensure
- requests admission into the program
- agrees to undergo reasonable medical or psychiatric examinations necessary for evaluation of participation in the program
- cooperates by providing medical information, disclosure authorizations and releases of liability as may be requested by the program
- admits to a problem with drugs or alcohol

- agrees to enter treatment and participate in all treatment recommendations
- agrees to cease nursing practice until approved to return to practice by the treatment professional and the alternative program
- agrees to abide by program-mandated practice restrictions including notification of current and future health care employers
- does not have prescribed medication or mind-altering addictive drugs of any kind or any substances that may render a drug screening ineffective

Not everyone with a substance use disorder is appropriate for entry into an alternative program.

Examples of ineligibility for admission include:

- the nurse is not eligible for licensure in the jurisdiction
- the nurse has not diverted controlled substances for self-administration but to illegally provide to others
- the nurse has a history of past disciplinary action that has resulted in probation, revocation or suspension (Prior approval from the board can override this exception.)
- the nurse has engaged in behavior that has an increased potential to cause patient harm such as diverting drugs by replacing one drug with another drug (This is an example of reckless disregard for patient safety.)
- the nurse has caused known and provable harm to patients
- the nurse who has any pending criminal actions or any prior felony conviction (The board of nursing may determine in some types of cases that the nurse is still eligible for the alternative program. For example, a nurse has a pending driving under the influence (DUI) charge and has had no other documented evidence of a substance use disorder. Prior approval from the board is required.)
- the nurse who has been unsuccessfully discharged or terminated from any alternative program for any noncompliance (For example, a nurse may be terminated from an alternative program for violating his/her contract by not providing self-reports, supervisor, monitor or sponsor reports. If the nurse brings his/her documentation into compliance, the board of nursing may determine that the nurse may re-enter the alternative program. Prior approval from the board is required.)

Initial Intake Assessment Procedures for Admission into the Alternative Program

The initial intake assessment involves the collection of all required eligibility and admission documents including referral information, complaint information, employment information, available investigative reports and screening information. The assessment also requires obtaining appropriate signatures and consents, collecting financial data, filling out admission forms and collecting data that relate to all required aspects of the program. There is also an initial orientation process that explains the requirements, goals and costs of the program. The initial interview by alternative program staff will include an informal assessment, which will give a clear understanding of the current status of the nurse. The review will read as a narrative of the substance use history and life story of the nurse as well as a summary of recommendations that are based on facts gathered from the interview.

The more formalized assessment that generally takes a significant amount of time and the use of standardized instruments will be conducted within the treatment setting by qualified and trained individuals. Most alternative programs will need to request the release of both

the intake assessment, results of formalized assessment and discharge assessments from the treatment program. The informal assessment interview is conducted in a semi-structured interview format in order to obtain more thorough information about a wider range of areas.

These include:

Demographics

- name, address, telephone number, Social Security number, date of birth and race
- all states the nurse is licensed in and the license number(s)
- any other professional licenses held
- gender, marital status, children and ages
- educational preparation
- referral source to alternative program

(NCSBN, 2001)

Employment history

- all work settings, including military reserve assignments
- specialty
- position
- years in the profession
- present employment status
- previous employment history (for at least five years including information about employment discipline or termination related to substance misuse or unsafe practice)
- licensure history (including a listing of all states where current or previously licensed)

Health history

- any hospitalizations within the last five years (list dates and diagnoses)
- any medications being taken (prescription and nonprescription drugs)

The alcohol and drug history must include:

- drug of choice (amount used, frequency of use, how long used, including how obtained)
- previous attempts at treatment
- other drugs used or abused
- physical manifestations
- emotional manifestations
- any legal history
- last time of illicit drug or alcohol use
- current or past medications misused or abused

The assessment is more effective if it is sensitive to the physical, emotional, intellectual, social and spiritual aspects of the individual.

Additionally, each program will have internal forms for documenting the results of the initial informal assessment. Some programs may admit the nurse prior to entrance into treatment while others may require admission into treatment prior to an admission into the alternative program. There are potential barriers to both the entry and the retention in treatment and the alternative program (National Quality Forum, 2007). These can include the degree of investment nurses have in retaining their license to practice, the degree of pressure they experience to enter the alternative program and where these pressures originate. Other barriers may include social, legal, employment, marital, child care, medical or multiple psychiatric disorders.

Comprehensive Clinical Assessment

The comprehensive clinical assessment is the critical beginning to the treatment process and determines the nature and complexity of the nurse's substance abuse and any other related problems. It is essential that the appropriate clinical assessments be done by an approved clinical assessor, also known as an evaluator, who has been provided with all collateral information from the licensing board, the alternative program, the employer and all other pertinent sources. The individual entering into the program needs treatment that is appropriate for his/her particular needs based on the assessment of the cause and course of the substance abuse or mental illness (U.S. Department of Health and Human Services, 1994). The clinical assessor must be an appropriately licensed practitioner authorized by his/her scope of practice to do the requested clinical assessment. If an inadequate comprehensive assessment is done there is a risk that the nurse will not be correctly matched to the appropriate treatment, which could result in treating the wrong set of problems or missing other problems altogether.

The assessment must probe related problem areas such as:

- medical history, including status and problems (both general health conditions and infectious diseases such as HIV, tuberculosis, hepatitis and sexually transmitted diseases)
- psychological status and psychiatric disorders
- psychosocial problems, social functioning
- family history and peer relations
- educational and job performance
- administrative, criminal or delinquent behaviors and legal problems
- types of drugs or alcohol used
- frequency and patterns of use
- severity of addiction, including history of previous treatment
- motivation to participate in treatment or readiness for treatment
- socioeconomic status and problems
- withdrawal symptoms
- other concurrent addictions (such as eating disorders, gambling, smoking, etc.)
- the nurse's needs, support systems, financial resources and insurance coverage (McLellan & Dembo, 1992; Tarter, Ott & Mezzich, 1991).

A psychiatric history can include a specific battery of tests such as the Minnesota Multiphasic Personality Inventory (MMPI 2), neuropsychological testing and a mental status exam. It must also include present and past psychiatric treatment, current medications and any suicide attempts. The assessor must observe appearance and thought processes of the nurse and evaluate for current suicidal ideation.

The family and social history must include the history of alcohol or drug use in the family and identify the specific family members.

The following areas must also then be assessed:

- present living arrangements
- social relationships and support systems
- history of trauma or family abuse.

A legal history will assess any arrests and convictions. The legal assessment must also include:

- current status of licensure
- the states in which licensed

- any actions taken by other states
- military record
- name, address and telephone number of the current probation officer, lawyer or social worker

A comprehensive assessment must use extensive procedures that evaluate the severity of the substance abuse problem and assist in developing treatment and follow-up recommendations (McLellan & Dembo, 1992).

The assessment must be done face to face and be conducted in accordance with acceptable professional standards for clinical diagnostic evaluations.

The assessment is used to determine whether the participant has a substance use disorder, mental health or dual-diagnosis problem.

The assessment sets forth recommendations for treatment, practice restrictions or other reasonable instructions related to the participant's rehabilitation and safe practice.

The assessor can also determine in his/her expert opinion whether or not the participant is determined to be a threat to themselves or the public.

If entry into the alternative program is indicated, the nurse must be asked to complete a self-assessment and sign appropriate releases of information that allow release of information from the treatment program to contact the board under appropriate circumstances. The alternative program staff or evaluation committee determine the appropriate ongoing treatment plan, which is then included in the nurse's alternative program contract.

All information gathered in the initial screening process is reviewed by the alternative program staff. The findings, recommendations and general perception of the needs of the individual nurse and information obtained can be included in the individual's alternative program treatment plan and can provide the basis for their contract and practice and monitoring requirements. A multidisciplinary assessment team is ideal for obtaining the range of information needed for comprehensive assessment and treatment planning (SAMSHA, 2002). The alternative program staff also assures that the treatment program referrals are made on the basis of identified needs of the nurse and that conflict of interest situations do not occur in the referral process.

The alternative program staff needs to be generally available to consult with nurse employers and other referring parties to discuss individual nurses who may have a substance use disorder that can potentially compromise patient care. The alternative program staff may also assist the nursing employer (such as a nurse manager or nurse administrator) in developing a strategy for any work-related situations. This consultation may include, but is not limited to, techniques for intervention, proper documentation of work-related behaviors and a plan for arranging a referral and transition to the alternative program.

All alternative programs need to provide referral information for treatment and a list of assessors as well as criteria for evaluating the quality and integrity of assessors and treatment programs.

A referral list of approved assessors can be developed and maintained by each alternative program. Some of these may be affiliated with or similar to approved treatment programs. Each alternative program needs to develop minimum education and licensure requirements for approved assessors based on the needs of the individual program. Criteria may include licensed physicians who are certified as addictionologists or psychiatrists specializing in addiction medicine. Some advanced practice registered nurses may have a specialty in substance use disorder as well. Licensed psychologists and social workers can also have a specialty certification in addiction treatment or experience that qualifies them as appropriate assessors.

Some assessors may be masters level therapists or advanced practice nurses who have either certification or advanced training in substance use disorder assessment and treatment.

The assessor must not have a financial relationship, personal relationship, business relationship or any other interest that would interfere with providing an unbiased, independent evaluation.

Maintaining Current and Effective Treatment Referrals in the Community

Boards and alternative programs must maintain current and effective treatment referrals in the community in the interest of helping to facilitate nurses to enter and maintain ongoing recovery that is consistent with patient safety. Boards can more efficiently manage the vast numbers of investigative issues dealing with a substance use disorder that potentially impact patient safety by identifying and working with programs and approved treatment providers. The boards can use the programs or treatment providers to offer timely referrals for the nurse's evaluation and treatment. It is important to note that while the alternative program does not provide the evaluation or treatment necessary to address the nurse's substance use disorder, they are still essential components to a participant's successful re-entry to nursing practice within the regulatory framework. Therefore, to maintain integrity of the system the programs must not only be able to rely on the diagnosis and subsequent treatment recommended and provided to the nurse they must also be able to effectively and in a timely manner refer the nurses to treatment. Since treatment is most effective when initiated upon entry, it follows that whatever increases the opportunity for treatment must be pursued (Darbro, 2009). It has been further suggested that to achieve the best outcome, the nurse needs to be referred to a treatment provider with an expertise in working with health care professionals (Angres, Bettinardi-Angres, & Cross, 2010).

The barriers and limitations to effective treatment referrals, whether perceived or actual, can delay or otherwise compromise evaluation and treatment and in turn endanger patient safety.

The barriers include:

- lack of communication between the entities
- lack of understanding of the required evaluation, treatment, monitoring and reporting requirements
- lack of statistical performance measures
- cost to participant
- the distance of the provider from participant
- provider understaffing or lack of providers or sufficient resources
- under- or over-referral of participants to provider

(Fickel, Parker, Yano, & Kirchner, 2007)

Therefore, it is essential that boards and programs build processes that will break down these barriers and limitations.

It is fundamental to the nurse's safe return to practice to provide patient care that has sufficient monitoring and oversight. A timely referral and effective treatment are critical components of ensuring patient safety and require that programs know and maintain a current list of available treatment providers approved for use within their programs. The list must be readily accessible, including being available on the Internet (Alexander & Wells, 2008). The nurse will benefit from having options when seeking evaluation and treatment. More importantly, studies have shown there are better outcomes for health care professionals who receive specialized treatment and aftercare.

Programs can include:

- peer group settings
- specific groups within the treatment setting that focus on work and personality variables, (for example, Caduceus group)
- a careful exploration of work re-entry issues

(Angres et al., 2010)

A wider range of treatment provider options may also improve the timeliness for obtaining treatment by lessening cost and geographic concerns for the participant while encouraging greater family involvement in the treatment process. There is a difference in motivation and capacity for treatment among many nurses due to financial cost factors (Shaw, McGovern, Angres, & Rawal, 2004). Adjusting the cost to the participant's participation in treatment or basing the cost on a sliding scale tied to the participant's financial situation is another suggestion to help break down cost barriers. The system can also benefit from addressing the cost barriers to treatment for nurse participants who are indigent by promoting the provision of basic services such as the evaluation and referral for further treatment (FSMB, 1995).

While the boards and programs do not provide the necessary treatment to the nurse program participant, the determination of whether a nurse is compliant or requires individual limitations or removal from practice lies with the boards and program and not with the evaluator or treatment provider. These determinations must be made by the programs and boards but are best made with a level of interaction with the evaluator and treatment provider to assess the treatment factors that may impact the participant's ability to practice safely, including necessary limitations and a heightened need for monitoring.

The boards and programs must ensure that the nurse obtains a long-term and coordinated management of their care over the course of their evaluation and treatment. The program's role in ensuring that the nurse satisfactorily complies with any necessary treatment recommendations becomes integral in achieving public accountability and maintaining the integrity of the alternative program. It is essential that heightened communication between the boards, programs and treatment providers be accompanied by a disclosure of what information needs to be shared concerning the evaluation, diagnosis, level of treatment required and the nurse's compliance with treatment recommendations.

Maintaining current and effective treatment referrals between the board, the program and the treatment provider requires a clear understanding of the requirements of the system by all parties including the nurse participant. Greater accountability is established if it can be shown that compliance with those aspects has been fully carried out and is communicated to the program and board through written and agreed upon terms and conditions. For example, the treatment provider must be required to have participants sign appropriate releases to monitor the participant's progress and compliance throughout the treatment continuum (FSMB, 1995). The expectations and requirements between the parties can be a contract between the various entities or a codification in statutes or administrative rules. Reducing expectations and requirements to a written contract assists communication and makes the conditions the participants are expected to operate within transparent and objective. Enacting them as the law strengthens their importance to the regulatory entities and participants.

The non-public nature of a non-disciplinary system involving professional health care licensees requires that treatment providers be required to:

- report to the programs or boards when a licensee fails to enter treatment within the specified timelines

- provide the participant with a treatment contract that clearly spells out their obligations
- provide the participant with a list of other approved treatment providers
- suspend any practice upon entry into the program
- report any failure to comply with the terms of the treatment contract during treatment or aftercare
- report to the program or board resumption of practice under the terms of the contract
- require the treatment provider report the resumption of practice to the participant's employer if it is not required to be made to the board or program (FSMB, 1995).

Programs must keep records of compliance with such requirements in order to be accountable. Record-keeping requirements must be fulfilled in accordance with state and federal laws and with the understanding of all the involved entities (State Medical Board, 2009). Statistics can further be kept to assist the boards, programs and providers on both a state and national level to measure the effectiveness of the system and processes, in which all are a critical participant. Ideally, some of these requirements can be made a part of the board and programs' performance measures.

The need for public protection demands a greater level of transparency and consistency in the operations of the alternative to discipline programs and their participants. The level of accountability is heightened because of the benefits given to the participant as part of the non-public nature of the alternative program system.

Some of the common themes of this system include:

- the philosophy and individualized treatment plan of the program is based on the disease concept
- the reliance on an abstinence-based, 12-step approach to treatment
- the treatment provider has a variety of treatment options available
- the ability of the treatment provider and board or alternative program to accept and review information collateral to the referral
- some type of state- or federal-based licensing to promote greater objectivity for the public and the program (FSMB, 1995).

To maintain current and effective treatment referrals in the community there must be a commitment between all of the parties to keep the lines of communication open and maintain an awareness and understanding of all of the issues because the board's primary mission is still to protect the public (FSMB, 1995). The integrity and accountability of the board and the program and more importantly the public safety require a high level of interaction to monitor the nurse and a corresponding level of transparency in the regulatory process.

Summary

Participating in an alternative program is not appropriate for all nurses with a substance use disorder. Alternative programs are not intended as a substitute for the more traditional investigative and disciplinary authority of licensing boards, particularly when participation in the alternative program is not in the public's interest.

The following are guidelines for eligibility to participate in alternative programs authorized by boards of nursing:

- the nurse is licensed or eligible for licensure within that state
- the nurse is eligible to maintain licensure
- the nurse admits to having a substance use or substance dependence disorder that has or can impact patient safety
- the nurse has not been terminated from any other alternative program

- the nurse is not subject to current disciplinary action and has not previously had his/her license probated, suspended or revoked as a result of substance abuse or dependence
- the nurse was engaged in prescription fraud or was diverting controlled substances only for the nurse's own use and not for the distribution to others
- the nurse has not engaged in behavior that has high level of potential to cause patient harm or has demonstrated a reckless disregard for patient safety (for example, the nurse was diverting controlled substances from patients or others but there was no substitution of the patient's medication with contaminated solutions or unauthorized medications)
- there has not been any known patient harm
- the nurse voluntarily consents to participate in the alternative program
- the nurse agrees to refrain from any alcohol or other substance use, unless medically authorized and prior notification is provided to the alternative program
- the nurse agrees to undergo evaluation and engage in treatment focused primarily on substance abuse disorders and agrees to comply with any other treatment deemed necessary by the treatment professional or team
- the nurse agrees to cease nursing practice until approved to return by the treatment program or provider and by the alternative program staff
- the nurse agrees to abide by all alternative program practice restrictions and limitations
- the nurse agrees to notify any nursing or health care-related employers of their participation in the alternative program and agrees to notify the alternative program of all nursing or health care-related employment
- the nurse agrees to limit his/her nursing practice in the state where he/she is enrolled in the alternative program (Permission to work in any other states requires written approval from an alternative program or the board of nursing in both states.)
- the nurse agrees that all noncompliance may be reported to the board for the board's review and licensure decision and may be reported to their health care employer
- the nurse agrees that if they fail to complete the alternative program or are terminated as unsuccessful from the alternative program their license is automatically suspended pending review and licensure decision by the board

Providing safe patient care is integral to the nurse's return to practice. The boards and programs must ensure that the nurse obtains a thorough and effective course of evaluation and treatment and complies with all treatment, monitoring requirements and practice restrictions. The alternative program's role in ensuring that the nurse satisfactorily complies with any necessary treatment recommendations and program requirements becomes integral in achieving public accountability and to maintain the integrity of the alternative to discipline system.

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CHAPTER NINE

ALTERNATIVE TO DISCIPLINE PROGRAM PARTICIPANT CONTRACTS

THE SUBSTANCE USE DISORDER IN NURSING MANUAL carefully outlines in each chapter the different aspects of substance abuse in the health care profession in order to assist in reaching the most reasonable outcome for the nurse, the staff and the general public. The contract is one of the most important elements and is broken down into the various aspects in order to increase the likelihood of a successful outcome.

The main purpose of the contract is to provide a strict external structure of accountability that clearly delineates the nurse's requirements and responsibilities. Contracts must specify for the participant all the terms that will result in successful completion of the program and clarify any violations that will be reported to the board for further action. Research has indicated that a close scrutiny of compliance and an application of swift and certain sanctions for noncompliance provide an incentive to the nurse to comply with the requirements in order to achieve long-term success in the program and long-term recovery.

Each nurse that enters the alternative program is responsible for meeting the requirements of the program. Therefore, the alternative program must have a written agreement that the participant must sign voluntarily upon entering the program. This agreement is considered a contract between the nurse participant and the alternative program. The contract is a legally binding, written agreement informing all the parties of what is expected for the life of the contract. Nurses will be held accountable for all the terms and conditions of the contract. It is important to make it clear that the contracts do not cover what will happen in treatment, but are there to outline how the participant will be monitored. The contract must include the terms and conditions of the alternative program, which either prohibit or define appropriate behavior for the participant. The contract must include the specific requirements of the monitoring such as drug testing, attendance at counseling and support groups and participant reports. Detailed terms of the participation may be provided separately such as in a manual since the terms are referenced in the contract for the participant to acknowledge receipt and understanding of the program manual.

The Office of Human Resources Assistant, Secretary for Administration, United States Department of Health and Human Services (2002) recommends that the terms be explicit, whether they are in the contract or handbook, particularly those elements that explain what the nurse will do in lieu of traditional discipline and the rights the nurse is waiving. They

caution that whatever is spelled out in the document frame any future argument concerning the meaning of various terms (U.S. Department of Health and Human Services, 2002). For this reason it is also important that programs obtain legal review and consultation when developing the contract.

Nurse participants have been known to criticize the monitoring program because they felt there was a lack of individualization and an impersonal approach (Fletcher & Ronis, 2005). This concern could be minimized by allowing program participants to help in developing their individual written contracts that will meet the monitoring requirements of the alternative program by providing requested information from the program staff and by mutual cooperation during the intake process. Although there are standard conditions to the contract there may be certain situations where contracts can be individualized to the specific needs of a nurse. One such example may be a nurse who wants to remain in the program but does not intend to go back to work in the nursing field for a year or more.

Cooperation between program staff and participants must assist in speeding up the intake process, which has also been identified as a concern of program participants (Fletcher & Ronis, 2005). The intake process must not be so overly cumbersome as to be overwhelming for the participant. Availability of staff, open and clear communication, providing orientation handbooks and setting target intake completion dates can result in a more efficient intake process.

It is important for the nurse participants to know before they sign the contract that any violation or non-compliance of terms in a legally binding agreement can either void the contract or lead to legal repercussions. The contract must describe the conditions for noncompliance with the alternative program contract and that such noncompliance will result in dismissal from the program and a referral to the board of nursing for disciplinary action for noncompliance with alternative program contract requirements.

Program lengths vary from state to state, which makes it difficult to determine what it is that contributes to a successful outcome (Fogger & McGuinness, 2009). Programs that are five years in length have generally been the longest monitoring periods (Fogger & McGuinness, 2009). Given the chronic, relapsing nature of the disease process, longer monitoring programs may be beneficial to promote long-term sobriety and demonstrate more successful outcomes (Fogger & McGuinness, 2009; McKay, 2005). Research has indicated that the longer the monitoring contract is the better the chance nurses have of achieving long-term success (Clark & Farnsworth, 2006). The findings from one study recommended the length for the contract for monitoring be extended from three to five years (Clark & Farnsworth, 2006).

There are many restrictions and conditions imposed upon the nurse participant, but they do not all necessarily remain the same throughout the duration of the contract. Contracts can include a gradual phasing out of contract requirements if the requirements are being met by the nurse participant and depending on the status of the nurse's recovery. Contract conditions may be gradually decreased after a minimum of one year of full compliance or evidence of other recovery parameters. However, those participants who do not have full compliance may have their contract conditions increased. Some of the conditions or restrictions can vary depending on the nurse's compliance and can include such things as the length of time that access or administration is restricted for controlled substances or any other potentially addictive medications after a return to the workplace, the frequency of drug and alcohol testing and employer or supervisor reports.

Confidentiality for the records of the program participation must be clearly articulated in

both the monitoring contract and in the policies and procedures (Dunn, 2005). It is important that the participant know who will have access to his/her records. However, the confidentiality of the nurse's participation may change based upon the nurse's compliance with the contract, making it necessary for the contract to be specific and outline under what circumstances the confidentiality of the nurse's participation can be revoked.

The participant's contract is no exception to the culture of transparency that must exist between monitoring programs and the boards of nursing. Even if it is the responsibility of the alternative program to devise the contract and ensure that it is followed, the board of nursing must still have input into the basic contents of the contract. The contract must also make it clear that the alternative program also has duties that it is expected to perform and not just the nurse. The board must have something in place such as periodic evaluations or audits to ensure that the program is meeting its obligations to the board and to the participant. Contracts and supporting data must be reviewed on a regular basis or as needed by the program coordinator and the board of nursing and can be updated as needed.

The contract must state specific requirements for work-site monitoring that are implemented at the time the nurse is ready to return to work. The alternative program staff can receive input from the treatment program, the employer, the board staff and the nurse and then determine or agree with the monitoring provisions.

Each contract or agreement must bear the witnessed signature of the nurse who is participating in the alternative program and the alternative program coordinator or designated representative.

The contract must address the following general areas:

- the voluntary and non-disciplinary nature of the program
- the program records that are non-public that have necessary exceptions for disclosure (such as to the board of nursing members, other state boards and other states' alternative programs regarding the participants in the alternative program)
- the dates and the expected length of the nurse's participation
- the requirements of drug and alcohol screens, and 12-step, support and therapeutic meeting attendance
- the requirements for work-site monitoring upon the return to work
- the consequences of relapse and noncompliance with the alternative program contract (including dismissal from the alternative program or referral to the board of nursing for disciplinary action because of noncompliance with alternative program contract requirements)
- the parameters for referral to the board of nursing (including the non-public records of program participation that are shared with the board)
- definitions of relevant terms (such as relapse)
- appropriate waivers and releases
- the period of monitoring (can be three to five years, and any flexibility within the conditions based on the participant's compliance and recovery)

There are specific duties that the contract requires of all of the parties. In order to clarify the participant's responsibilities it is critical that the contract detail each expectation that is required of the participant including any consequences for noncompliance or misconduct. This includes possible removal from practice, a referral to the board of nursing or termination from the program.

Signing an alternative program participant contract means the nurse agrees to the following statements:

- The nurse admits to a violation of the nurse practice act and that any violation of the contract is a further violation of the nurse practice act and grounds for referral to the board of nursing.
- The nurse has read and signed the contract and the terms and conditions of the program manual as well as any new policies or procedures received in writing throughout the nurse's participation in the alternative program.
- The nurse has had or is having problems with substance use or has a substance use disorder.
- Any noncompliance with the contract or termination from the program will be seen as unprofessional conduct and is in violation of the rules and laws regarding the practice of nursing and may be used to support any future disciplinary actions.
- The identity of participants and the terms of the contract are non-public but may be shared with parties who have a legal need to know, such as the state board of nursing members, other state boards, other state's alternative programs and participant's employers.
- The contract does not preclude the program from initiating appropriate action regarding any misconduct that is not covered by the contract. Such action could include reporting the offense to the board of nursing.
- Any unauthorized missed drug or alcohol testing will be considered non-compliance with the program.
- Any confirmed positive drug screen may be considered noncompliance if the program has not received the proper documentation from the prescribing practitioner.
- Any confirmed positive drug screen that the alternative program has not received prior written authorization and confirmation from an approved provider and any drug screen that is confirmed as an adulterated or substituted specimen shall result in the participant ceasing nursing practice until further evaluation and receipt of written authorization to return to practice from the alternative program.
- Noncompliance with drug and alcohol testing will result in an increased level of testing and a report to the board.
- In the event of noncompliance with any of the terms of the contract, the alternative program may require the nurse to cease practice, notify the nurse's employer and the length and terms of this contract may be extended and modified.
- In the event of any non-compliance with the terms of the contract, the participant may be discharged from the alternative program or reported to the board while still being monitored.
- If discharged from the alternative program or referred to the board of nursing for non-compliance, the board of nursing may use any misconduct that occurred while enrolled in the program during disciplinary proceedings and obtain complete records of participation in the alternative program.
- The supervisor is given a copy of the contract and any other necessary forms prior to beginning or resuming an existing position and agrees to notify the program immediately of any change in supervision. Failure to comply will result in an immediate cease-and-desist of all work-related activities from the alternative program.

Most contracts require accountability on the part of the contracting parties that include specific things to be performed or avoided. The duties or obligations of the nurse participant include:

Initial Entry Requirements

Initial entry requirements include:

- abstaining from all alcohol and alcohol-containing products without prior approval from the alternative program
- abstaining from drug use including all over-the-counter medications and other mind-altering substances unless lawfully prescribed with prior approval of the alternative program
- maintaining current state nursing licensure including meeting any continued competence and/or continuing education requirements
- completing a substance use, dependency or mental health assessment
- completing treatment, continuing care, and aftercare
- entering treatment and participating in all treatment recommendations
- ceasing nursing practice and agreeing to inactivate license until or unless approved to return to practice by the treatment professional and the alternative program.
- providing counselors with the necessary forms to complete and return to the program.
- undergoing any additional evaluation as requested by the alternative program or treatment provider

The nurse participant will also sign any releases necessary for monitoring and information exchange between:

- employer and alternative program
- health care providers and alternative program
- alternative program and board of nursing
- treatment professionals and alternative program
- other state boards and alternative programs

Mandatory Treatment and Recovery Monitoring Requirements

Mandatory treatment and recovery monitoring requirements include:

- attending at a minimum three 12-step or other approved self-help meetings per week (not including aftercare, relapse prevention, nurse support) for the duration of the contract
- submitting documentation to the alternative program at least monthly
- maintaining an active and consistent relationship with a sponsor
- random weekly drug screening for the first year, three times a month for the second year and two times a month thereafter if fully compliant with all parameters (including practice documentation by the supervisor as safe and appropriate)
- upon return to nursing practice drug screening may increase for the first 12 months of clinical practice (Drug and alcohol testing may include body fluid testing, hair testing, or any other valid and reliable method of testing such as saliva.)
- reporting any prescriptions or over-the-counter medications to the alternative program within 24 hours
- providing the contact information for one pharmacy, one health care provider and one dentist, to be used for all relevant needs, to the alternative program
- notifying any health care providers of substance use history prior to receiving any prescription

- providing a written statement from the prescribing provider that confirms the provider's awareness of the participant's history of substance use or dependence and the participant's responsibility to confirm any prescription within 24 hours of prescribing
- having practitioners complete medication verification forms and medication logs provided by the program and submit quarterly
- submitting medication forms (logs) quarterly
- providing written self-reports as specified (minimum monthly)
- obtain a reassessment by a licensed addiction counselor in the event of a relapse or suspected relapse
- abide by any further recommendations that are deemed clinically appropriate after a relapse or suspected relapse
- pay all fees and costs associated with being in the program
- appear in person for all routinely scheduled interviews or any additional interviews (reasonable notice will be given by the program)

Practice Requirements and Limitations

Practice requirements and limitations include:

- maintaining continuous employment in a nursing position for at least one year of the three-to-five-year contract in order to be eligible for successful discharge from the program
- limiting nursing practice to only one state (Permission to work in any other states requires written approval from the alternative program and the board of nursing in both states.)
- authorizing alternative program staff to release participant information to any other state of licensure or wherever participant is seeking application for licensure
- abiding by return-to-work restrictions and requirements to inform all employers or schools of participation in the alternative program and providing a copy of the contract, stipulations or final orders from the board of nursing to any prospective or current nursing position employers
- obtaining in writing proof that the supervisor is given a copy of the contract and any other necessary forms
- following up by contacting program staff to ensure that the alternative program receives the agreement form signed by the direct supervisor prior to beginning a new or resuming an existing position
- abiding by all policies, procedures and contracts of employer
- scheduling at least monthly check-in meetings with the supervisor to address any concerns of either party (documentation of such meetings may be available to the alternative program staff)
- obtaining any approved exceptions to the work restrictions in writing by the alternative program (obtain approval by alternative program prior to any position acceptance, job responsibility change, or other related employment activity)

Return to Work

Upon a return to work the participant is not allowed to work in any of the following situations for a minimum of 12 months:

- odd schedules, overtime, night shifts
- anything in excess of a 12-hour shift

- no more than three consecutive 12-hour shifts
- without direct supervision
- no access to controlled substances or any potentially addictive medications for six to 12 months after returning to work (If there is evidence of drug diversion, prescription fraud or harm to a patient the minimum time with no access is 12 months.)
- in a home health or hospice setting
- travel to other communities for work
- at a registry or agency, float or on-call (PRN) pool, tele-nursing or disaster relief nursing
- any other unsupervised nursing position

If a relapse, diversion or other violations of the work-related requirements occur, the alternative program will require the participant to immediately cease practice and the alternative program will notify the employer and the board of nursing.

Program Notification Requirements

- informing the program manager verbally and in writing of a pending relocation out of the state
- notifying and obtaining approval of any health care related position or job change prior to making the change
- notifying the alternative program when a prescription is received and provide verification for any medications within 24 hours of receipt of prescription or medication and prior to returning to nursing practice
- notifying in writing the alternative program staff of any changes to medications (including addition, deletion or changes in the dose prior to assuming any patient care duties)
- notifying the program within two days of any change in supervisor or workplace monitor
- notifying the alternative program within two days of a disciplinary meeting or employment counseling with employer
- notify within two days of any changes in residency, contact information and any termination or resignation from employment
- report within 24 hours any crimes, criminal arrests, citations, deferred sentences and convictions (including a conviction following a plea of nolo contendere)
- notify the program if a complaint is filed against the license of the participant nurse
- report any alcohol or unauthorized substance use regardless of the amount or route of administration

There are many provisions that can be included in almost any type of contract, which many would refer to as boilerplate contract language.

For example, in signing the contract, the participant agrees to the following:

- agrees to waive all rights to an appeal from any grievances or complaints or to contest licensure actions relating to alternative program participation
- waives the right to contest any discipline as the result of a breach of the agreement with the exception of contesting a determination that one or more terms of the agreement have been violated
- entry into the contract was voluntary, there was an opportunity to seek advice of legal counsel or personal representative and there was an opportunity to clarify any terms or conditions that were not understood
- if any single part, or parts of the contract are violated by the participant the remaining parts remain valid and operative

Special Contracts and Provisions for Nurses Prescribed Potentially Addicting or Impairing Medications

Nurses who are receiving medication-assisted treatment for opioid dependence are a high-risk population that requires special and ongoing consideration. Alternative programs that monitor high-risk populations such as certified registered nurse anesthetists can be guided by the specialty organization's recommendations. The board of nursing can have a written policy for approving or prohibiting this population's participation in the alternative program.

Nurse participants with a dual diagnosis must have a contract in place as well. The special considerations, which differ from other nurse participants in the alternative program, require the contract to state that the participant agrees that pain management treatment or medication-assisted treatment when indicated have the following additional or modified conditions and limitations:

- minimum five years participation in the alternative program
- obtaining a current evaluation of co-occurring conditions (e.g., psychiatric or medical disorders as indicated)
- submit to a neuropsychological or neuropsychiatric evaluation to determine fitness for duty and at any time that cognition appears to be negatively impacted as a result of illness or treatment
- obtain an assessment by a medical provider approved by the program who has a sub-specialty in addictions and pain management and sign and adhere to a pain management contract
- engage in treatment with one provider that has expertise in addictions and pain management
- maintain release of information that allows the provider to communicate directly with alternative program staff
- monthly progress reports submitted from the provider
- provide quarterly prescription profiles
- regular verification of prescriptions through prescription profile or state authorized prescription monitoring program, if available (every six months or more as determined by the alternative program)
- no more than 40 hours per week (or less depending upon provider recommendation)
- monthly reports from the nursing employer for first year (can be reduced to quarterly after one year)
- no access to controlled substances in the workplace for a minimum of 18 months (for participants with a history of diversion, prescription fraud, harm to a patient or multiple prescribers)
- submit a letter from the provider verifying the participant is safe to practice with a change in his/her medication
- random weekly drug screening for the first year, three times a month for the second year and two times a month thereafter if fully compliant with all parameters (including practice documentation by the supervisor as safe and appropriate)
- relapse prevention therapy with a provider who has expertise in pain management, addiction and relapse
- compliance with recommendations of providers and evaluators

Special Contracts and Provisions for Psychiatric Monitoring

Health care professionals with a dual diagnosis of psychiatric disorder or a co-occurring psychiatric illness are at a greater risk for relapse (Domino et al., 2005). The principles used to manage the psychiatrically-impaired nurse are the same as those used for managing a substance use disorder. (Baldisseri, 2007). Nurses who admit to also having a mental health disorder must have unique provisions in their contracts that specify an agreement to complete a mental health assessment, treatment, continuing care or aftercare.

Special Contracts and Provisions for Nurses with Chronic or Acute Pain Issues

A medication agreement (or contract) reinforces the patient's responsibility as a prerequisite for receiving controlled substance prescriptions and reassures the patient that honoring the agreement will result in continued provision of adequate amounts of pain medication (Schnoll & Weaver, 2003). However, zero-use or abstinence-based contracts are the best practice.

Other types of contracts may include prescription monitoring, detox-maintenance contracts and recovery-maintenance contracts.

Each participant though is to be evaluated on a case-by-case basis. If a participant is using prescribed or potentially addicting drugs that may cause cognitive impairment or that would render monitoring the drug screenings and therefore public protection ineffective then participation in the alternative to discipline program may not be appropriate for that nurse. Furthermore, if a participant has a coexisting diagnosis with illnesses known to increase the risk of relapse such as chronic pain, the program may not be the best option in order to ensure the public is protected.

Completion of Alternative Program

The successful completion of alternative programs by their participants can be promoted through a number of operational processes such as case management, which must be sufficiently resourced.

Six processes that programs can support are:

- contingency (behavioral) management of nurses' participations
- frequent, random drug screenings
- required attendance of 12-step, abstinence-based meetings
- an immediate, direct and therapeutic management of relapses
- emphasis of aftercare and continuing care for a chronic, relapsing disease
- the encouragement of life-long recovery.

Programs must have guidelines to ensure that nurses have met the necessary program requirements that will ensure safe practice. Thus, participants' successes are in some measure always reliant upon the continuing development and integrity of the alternative to discipline programs.

In order to verify successful completion of the requirements of the contract there are certain components that must be in place. Therefore, prior to discharge the alternative program must verify a successful completion of the program as evidenced by the following:

- all necessary program forms are on file including any subsequent participation agreements as may be required (due to relapse)
- adherence to the terms of participation for the minimum required length as established in the participation agreement
- completed treatment or therapy as recommended by approved assessor or evaluator

- maintained compliance with all drug screening and abstinence requirements
- demonstrated safe nursing practice for the minimum length of time stated in the contract.
- documented attendance at the minimum number of self-help or support group meetings required by the alternative program during the contract period
- maintained communication, electronic or face-to-face meetings with the alternative program or its designated representatives
- submitted reports within mandated time frames established by the alternative program
- developed and submitted a relapse prevention plan
- submitted a written request for program completion with other supporting documentation (such as a letter of support from supervisor, sponsor, and therapist)
- successfully addressed any other requirements stipulated by the alternative program

Student nurses will be responsible for completing the required length of the alternative program per their participation contract and may participate with the program after they have obtained licensure. Once they are licensed the nurses must continue to adhere to all applicable requirements of the alternative program.

Criteria for Success for Nurse Participants

Successful completion of an alternative program can be tied to the following documented elements:

- execution of the alternative to discipline program's participation agreement with all the necessary program forms on file (including any subsequent participation agreements due to any relapse)
- adherence to the terms of participation for the minimum required length as established in the participation agreement
- complete treatment or therapy as recommended by an approved assessor or evaluator
- maintain negative drug test results as outlined in the contract
- not exceed the minimum number of missed or dilute drug screens permitted by the alternative to discipline program
- demonstrate safe nursing practice for the minimum length of time
- attend or document the minimum number of self-help or support group meetings required by the alternative to discipline program during the contract period
- maintain communication through electronic or face-to-face with the alternative to discipline program or its designated representatives
- submit reports within mandated time frames established by the alternative to discipline program, all other required program documents and have them on file with the alternative to discipline program
- successfully address any other requirements stipulated by the alternative to discipline program

Criteria for Success for Programs

- number of referrals
- removal of nurses from practice/time period
- number of nurses participating (new and existing)/participation rates
- number of nurses returned to work (RTW) (new and existing)/RTW rates
- number of participants successfully completing alternative to discipline program or success rates
- relapses identified
- relapse rates (first or second)
- removal of nurses from practice (time period)
- recidivism rates for completers
- caseloads
- internal Q & A frequency or findings. (Case managers have addressed relapse and compliance issues. Documents are tracked and verifiable.)
- external audit findings (performance, legal or financial)

Criteria for Success for Employers

- early identification of unsafe workplace practices
- consultation intervention services rendered by alternative to discipline program
- retention
- turnover cost savings (cost–benefit for health care industry)
- improved practice/care
- identification of relapse
- education for employers
- collaborative communication about nurse participants
- closer workplace supervision

Criteria for Success for the Public

- public protection
- increased identification of nurses with a substance use disorder
- retention of safe nurses
- identification of potentially unsafe nurses or relapses
- cost savings to public

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CHAPTER TEN

TREATMENT AND CONTINUING CARE

AFTER THE CONTRACT HAS BEEN SUCCESSFULLY EXECUTED the real work begins for both the participant and the alternative program. The endeavor begins with the recommendations for treatment, which include a wide range of services such as an assessment, screening and brief intervention, psychological intervention and engagement in treatment, access to medications, wrap-around therapeutic interventions during treatment, aftercare and long-term continuing care for an adequate length of time to ensure recovery (National Quality Forum, 2007).

The goal of identification and intervention is to encourage the nurse to enter appropriate treatment and an alternative program. Early identification and referral of individuals results in a reduced severity of problems when entering a program and a better outcome when leaving treatment (Simpson & Flynn, 2009). It can also reduce the length of time health care professionals are practicing with an active substance use disorder and will enhance public protection. Treatment can also reduce or eliminate drug and alcohol use, improve social and personal functions and reduce threats to the public health and safety (McLellan, Woody, & Metzger, 1996). Treatment is an effective tool, especially when it is of sufficient intensity, is matched to the needs of the client and is followed by continued participation in therapeutic support systems (McLellan, Lewis, O'Brien, & Kleber, 2000; NIDA, 1999; Talbot & Wilson, 2005). Alternative programs are generally abstinence-based with a variety of treatment for a substance use disorder.

The different components of treatment continue to be effective in decreasing any problems associated with substance use (Merlo & Gold, 2008). Research has also shown that having employment is a major predictor of successful treatment (2008).

The specific aim of treatment is to teach the individual a healthy, drug-free lifestyle and motivate him/her to maintain a stable, long-term recovery from a substance use disorder in order to ensure he/she remains a safe practitioner. The research indicates that the effectiveness of alternative programs for nurses and physicians is very likely to be successful and will lead to a successful discharge from the program (DuPont, McLellan, White, Merlo, & Gold, 2009).

Substance use disorder treatments need to be comprehensive and personalized to the individual's needs, include the family in treatment and have a menu of behavioral therapies

and medications. NIDA (1999) has listed 13 principles of drug addiction treatment that are the basis for all other treatment approaches.

These are:

- no single treatment is appropriate for all individuals
- treatment needs to be readily available
- effective treatment attends to the multiple needs of the individual
- treatment plans must be assessed and modified continually to meet changing needs
- remaining in treatment for an adequate period of time is critical for treatment effectiveness
- counseling and other behavioral therapies are critical components of effective treatment
- medication is an important element of treatment for many clients
- co-existing disorders can be treated in an integrated way
- medical detoxification is only the first stage of treatment
- treatment does not need to be voluntary to be effective
- treatment must be monitored continuously for possible drug use
- treatment programs must assess for HIV, AIDS, hepatitis B & C, tuberculosis and other infectious diseases and help modify at-risk behaviors
- recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment

Treatment requirements are the result of an adequate assessment and usually begin with the least intensive treatments to the most intensive, depending on need.

Different types of treatment include:

- long-term residential rehabilitation services that range from six to 18 months
- short-term residential rehabilitation services that range from 28 days to three months
- intensive outpatient treatment services that range from two to six months
- outpatient services that include group and individual treatment
- medication-assisted treatment that includes methadone and buprenorphine
- aftercare treatment that ranges from six months to two years

Treatment for alcohol use disorder can include:

- brief intervention
- social skills training
- motivational enhancement
- community reinforcement
- behavioral contracting

(Miller et al., 1995)

Treatment for a substance use disorder can include:

- relapse prevention
- cognitive behavioral interventions
- supportive-expressive psychotherapy
- individualized drug counseling
- multi-dimensional family therapy
- motivational enhancement
- community reinforcement
- contingency management
- social skills training
- participation in a 12-step program

- pharmacological therapies
- multi-systemic therapy
- matrix model (for stimulants)

(NIDA,1999, U.S. Department of Health and Human Services, National Institutes of Health, 2002; NIDA, 2002)

Continuum-of-Care Model

The continuum-of-care model supports the idea of an ongoing follow-up with individuals, which starts with an early identification and continues throughout the process of treatment and aftercare (Deitch, Koutsenok, & Marsolais, 2005; McKay, 2009; White, 2008). This model recognizes that different individuals may need different levels of intervention and treatment at different times during the process of their recovery efforts. Treatment for a substance use disorder may be even more effective if it moves away from an acute care model of treatment and goes toward the chronic care model of treatment that is offered with other chronic relapsing diseases (White, 2007; White, Boyle, & Loveland, 2003). Even though addictions are seen as chronic illnesses they have been treated as acute illnesses and treatment has focused on brief, short-term interventions with high expectations of success from one-time treatments. The high dropout rates from treatment aftercare, the attrition from any ongoing participation in continuing care and the high relapse rate after completion of treatment is partially attributed to the short-term model of treatment.

Long-term recovery management seeks to improve the success rates by removing the stigma of addiction treatment and empowering the individual and his/her community to partner with treatment providers just as he/she already does with primary care providers. The principles of the recovery management model involve swift admission into further treatment, intensive case management and motivational interventions to achieve compliance with treatment objectives (Dennis, Scott, & Funk, 2003; White, 2008). The most potent component of this approach is providing recovery management checkups either in person or by phone over an extensive period of time after the discharge from treatment and beyond the typical six months of extended care that is offered in traditional treatment programs. Effective treatment programs implement these strategies in order to get clients motivated for treatment, keep them engaged in their treatment and retain them in follow-up activities after treatment (Simpson, 2002).

The continuum-of-care model for nurses has been implemented by alternative diversion programs for 20 years. The recommendations of the recovery management model have also been integral components of these programs since their inception. Both of these models represent evidence-based support for the components of effective treatment and monitoring based on long-term continuing care that is required by alternative programs.

The Change Process and the Transtheoretical Model

The Transtheoretical Model (TTM) focuses on how people change, unlike most treatment theories, which focus on the psychopathology or the problems in need of change. TTM involves emotions, cognitions and behavior and approaches change as a temporal process and not an event, much like substance disorder. TTM describes how people can modify a behavior, change a problematic behavior and acquire and create new patterns of behavior over a period of time. The method differentiates between natural change and the TTM process. Natural change occurs when people make changes based on life events such as a marriage or the birth of a child while the TTM process happens when people make changes that are based on altering their behaviors such as quitting smoking or exercising for better health (DiClemente, Bellino, & Neavins, 1999).

Elements and Stages

TTM has four general elements that include the stages of change, the processes of change, the markers of change and the context of change. These elements promote understanding of how the changes occur, which is an understanding that can be helpful in therapy.

TTM attempts to change a person's behavior by moving them through five distinct stages:

- pre-contemplation
- contemplation
- preparation
- action
- maintenance

(Prochaska, DiClemente, & Norcross, 1992).

In the pre-contemplation stage the person is not yet considering change or is unwilling or unable to change. The stage is generally six months or longer. The person does not yet fully appreciate or connect any negative consequences with his/her behavior. For example, in the 1940s and 1950s smoking cigarettes was thought to be medically beneficial. Physicians even suggested that patients take up smoking to address certain medical conditions such as anxiety. No one understood what would happen to the body as a result of the negative effects of nicotine and the carcinogens in tobacco. It was thought that a person may also be unable to change because of previous failed attempts, which have led to a belief that they cannot stop the behavior. Smoking cigarettes is again a good example of a person who quits smoking several times before the change in behavior sticks. After each relapse the person experiences another emotional reaction to the failed behavior and feelings of hopelessness are generated.

In the contemplation stage the person considers the possibility of change but remains ambivalent and uncertain. The time frame for this stage is also about six months. The person knows the pros and cons of changing his/her behavior but he/she continues to be ambivalent about the need for altering the behavior in spite of the negative effects. For example, a person who knows that he/she needs to stop drinking because his/her spouse is nagging at him/her but can't imagine being at a social occasion without drinking and yet he/she still wants his/her spouse to stop nagging. Often, the person in this stage is called a chronic contemplator because he/she is always planning to change his/her behavior. A chronic contemplator for this purpose is having the knowledge of where he/she wants to go but repeatedly not being ready to go there. For example, someone who faithfully makes New Year's resolutions every year without having a concrete plan of action could be considered a chronic contemplator.

In the preparation stage the person is finally committed to change and is planning to make these changes in the near future but is still actively deciding how to do it. Anticipated change in this stage is within one month. The person may already be making small alterations toward the target behavior. For example, they make a switch to low tar cigarettes in anticipation of a smoking cessation. Most people in this stage took some action in the past year and are now ready for recruitment into education classes such as smoking cessation or weight loss. For a person in this stage who is attempting to stop smoking, finding the smoking cessation groups would be a positive action step.

The person in the action stage is actively taking steps to change the target behavior but has still not stabilized the results. However, the behavior has changed in the past six months and therefore has lessened the negative consequences of his/her behavior. A person who has gone on a diet and has lost weight is a good example because it is not enough to just go on a diet. There is still further action that needs to be maintained such as a healthy and balanced daily plan for eating. For the smoker, a positive step in the action phase would be to throw out all cigarettes and cigars from his/her home and office.

In the maintenance stage the person has achieved change, has stabilized the results and is maintaining the new behaviors. This is the stage when a person who recently quit smoking is able to just say no to the offer of a cigarette. However, not everyone will be able to alter their negative behaviors over the long term. The maintenance stage can sometimes be tricky. Those with a substance use disorder have been known to drop out of treatment or relapse following a brief improvement. When someone does revert to an earlier stage of change then regression will follow. Relapse is one form of regression and people can regress from any stage back to an earlier one. Relapse and recycling through the stages occurs frequently as people try to modify or stop negative behaviors. A relapse can prove to be more the rule rather than the exception within addictions. The Transtheoretical Model even states that a person does not move in a linear fashion but in more of a spiral pattern, progressing back and forth through the various stages.

Stages of Recovery

Care that is oriented toward recovery seeks to improve the outcome by getting people help earlier and once they have received professional help, linking them with the services and supports that will make sustained recovery more likely (NIDA, 2009). The term recovery spans the removal of drugs from an otherwise unchanged life to a more complete and positive transformation of a person's character, identity and lifestyle. This broader transformation has been referred to as emotional sobriety and is considered an equal part of the recovery process. The chronic nature of addiction makes complete identification of the recovery path difficult. There is currently a lack of criteria that can be used to recognize or quantify remission from addiction or how that remission is best sustained.

According to the Betty Ford Institute Consensus Panel (2007), recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health and responsible citizenship. Perhaps recovery is the best word to use to summarize all of the positive benefits to a person's physical, mental and social health that can happen when alcohol and other drug-dependent individuals get the help they need (Betty Ford Institute Consensus Panel, 2007). Think of recovery as a process rather than an event and that there is no one absolute formula for the entire journey of recovery. Rather, the goals of recovery and the measurement of success can be better defined according to the individual's daily response to addiction and the continued hope for rehabilitation.

Most alternative programs require an initial period of intensive treatment through either an inpatient or intensive outpatient program with a verification of attendance and compliance that is submitted to the alternative program.

Programs need to receive all the relevant information from treatment programs including but not limited to:

- the initial intake assessment
- progress and cooperation through the treatment program
- any psychiatric and pain management assessments and recommendations
- discharge summary and recommendations

Initial treatment is followed by a specified length of aftercare set up with a treatment program, which is often six months to one year and is also verified with regular reports to the alternative program. After completion of the formal treatment and aftercare, the alternative programs need to continue to monitor attendance at support group meetings and compliance with the recovery standards. Monitoring must continue throughout the duration of the contract. This is also considered a component of the continuing-care model and this form of intensive case management monitoring has been a component of alternative programs since their inception.

The treatment program staff must work closely with the board of nursing and alternative program to assure proper implementation and administration of the policies and procedures related to the alternative program. Alternative program staff must investigate any complaints involving the quality of services provided by treatment programs and ensure conformance to the above criteria. If appropriate, the staff can assist participating nurses in the selection of a treatment facility or the services that are needed in order to access treatment services such as available treatment vouchers for those with a financial need.

Attendance at 12-step or self-support group meetings and facilitated nurse support group meetings remains a requirement of most alternative programs for the duration of the nurses' participation in the program. The number of all support group meetings required of nurses is highest in the early stages of the contract and can vary depending on the initial assessment findings. Many programs recommend participants complete 90 meetings in 90 days upon initial entry into the program. Most programs have a minimum requirement of two to three self-support group meetings a week (NCSBN, 2009), often in addition to a weekly facilitated nurse support group meeting. The recommended minimum number of 12-step or self-support meetings to achieve stable engagement is three per week. Meeting attendance can be decreased after a significant period of compliance, which is typically a minimum of one year. Although some research challenges the usefulness of support group meeting attendance (Miller, 2008), other research supports the effectiveness of support group attendance with improved outcomes from treatment and lower relapse rates (Fiorentine & Hillhouse, 2003; Laudet, Stanick, & Sands, 2007; McKellar, Harris, & Moos, 2009; Merlo & Gold, 2008). Research has also consistently supported the potent impact of social support as a predictor of abstinence and positive outcomes from treatment (Witbrodt et al., 2007; Witkiewitz & Marlatt, 2004; Zywiak, Longabaugh, & Wirtz, 2002). The size of the social support network is the most important element in providing positive outcomes and therefore increasing the number of abstinence-supporting people that are contacted daily improves treatment outcomes (Zywiak et al., 2009). More recently, online support group meetings for nurses have grown in number and may be a valuable tool when face-to-face meetings are unavailable or inaccessible such as in rural areas. These meetings do lack the valuable dimension of face-to-face interaction, evaluation and feedback and they can not be used exclusively but instead are most effective as an adjunct and under necessary circumstances.

Professional Support Groups

Nurses participating in a treatment program are required to attend a minimum of one nurse support group per week that includes nurses from the community. The purpose of these groups is to facilitate the recovery and the re-entry of nurses back into practice. The groups are structured in a way that meets the special needs of nurses with a substance use disorder. Attendance must be verified by the signature of the nurse's sponsor or the meeting coordinator and submitted to the alternative program staff. The alternative program staff is actively involved in recruiting and training support group facilitators around the state and maintaining relationships with those groups. Site visits are also conducted to groups throughout the state.

The role of the professional support group in the monitoring includes:

- sharing their experiences and providing strength, hope and support in addressing issues related to the process of recovery from a substance use disorder
- providing support for professional issues including re-entry into the workplace
- being a resource for additional supportive services

- reporting weekly attendance to the alternative program
- providing input and recommendations relative to the needs of alternative program participants

Online Support Groups and Treatment

Internet support groups may be best suited for participants with a long-term stable recovery. They must only be used as a supplement or as an adjunct to regular face-to-face support group meetings. However, Internet-based interventions do have a number of strengths such as allowing the user a high level of convenience and flexibility of use, an intervention that is not confined to a specific physical location and access that is available 24 hours a day. This allows the user to access the service as required without regard to normal business hours, set appointment times or waiting lists (Copeland & Martin, 2004). Anti-smoking Internet-based interventions were the first type of online support groups to be implemented and are generally thought to have been successful. Interventions for a substance use disorder, especially alcohol, have also enjoyed some success (King et al., 2009).

A distinction must be made between Internet-based interventions and therapy. E-therapy utilizes the power and convenience of the Internet to allow simultaneous (synchronous) and time-delayed (asynchronous) communication between an individual and a professional. E-therapy is not psychotherapy or psychological counseling because it can not diagnose or treat mental or medical disorders. However, e-therapy is flexible enough to address many difficulties that clients present to the online therapist. E-therapy can also assist a person in addressing specific concerns and learning specific skills with the same usefulness as other types of therapy such as bibliotherapy, occupational therapy and rehabilitation therapy. E-therapy private practitioners do this by working with clients in an ongoing series of emails or chats (Manhal-Baugus, 2001).

There are still no established guidelines for the use of Internet interventions or e-therapy in the recovery of health care professionals. Thus, the individual board of nursing or alternative program will have to determine if this format meets the treatment requirements for nurses with a substance use disorder. One confounding variable could be the difficulty in verifying attendance, the level of participation and the progress of nurses from the online format.

Most programs also require that nurses maintain an active and consistent sponsor relationship within the 12-step or self-support group environment. The quality and quantity of contact with a sponsor needs to be encouraged and closely monitored. Some programs will require separate sponsor reports while others will require that the sponsor sign and comment on the verification of meeting attendance form. The level of involvement and the quality of the relationship between a sponsor and a nurse in the program must be verified with a follow-up contact from the assigned case manager. Sponsors can also be invited to attend any face-to-face evaluation meetings with nurses, which will provide further opportunities to validate the quality of the sponsor relationship.

Case Management

The most standardized principles of alternative diversion programs are continued care monitoring and the close scrutiny of compliance. Case management is another integral component of continued care monitoring. It is an evidence-based practice that supports retention and ongoing contact with treatment providers, which leads to improved treatment outcomes (Metja, Bocos, Mikenberg, Maslar, & Senay, 1997; Siegal, 1998). Intensive case management provides a personal involvement and attention to each nurse from the beginning of his/her admission and throughout his/her contractual participation in the program.

Case management protocols will usually include a regular review of the written compliance with all treatment, drug screening and report protocols. Regularly scheduled evaluation meetings are included as a critical component of evaluating the current status of nurses. This continuous close scrutiny effectively identifies problem areas before they advance to reportable issues of non-compliance. It also provides a structure of accountability that allows nurses the opportunity to correct deficiencies early in their development.

Effective case management is achieved through frequent contact and open and clear communication with the nurse and all other professionals involved in the support systems associated with the nurse's recovery and professional practice setting. These ongoing lines of communication help establish clear lines of responsibility for the nurse in order to comply with his/her contract requirements. This is also how the authority of the alternative program is established, which encourages and verifies compliance. The alternative program then tracks each nurse's compliance with formalized written contracts and the precise and confidential tracking of all records for each nurse.

There are some aspects about this protocol that require some awareness on the part of the managers. Case management ratios have not been extensively researched and anecdotal evidence does not differentiate between the type and level of tasks that case managers may be required to achieve with their individual caseloads. To be effective, the case management ratios, which can range from 30 to 200, need to be low enough to allow an intense and consistent monitoring of compliance for each individual nurse. However, the sufficient ratio necessary to achieve a high quality and close scrutiny of compliance may need to be individually evaluated by each program. Some programs can achieve this with a case management load of 50 to 60 nurses. Others may even have higher case management loads of 75 to 100 nurses per case manager. However, it is clear that a lack of funding is not a good rationale for insufficient case managers because a lack of monitoring can quickly compromise the integrity of any program.

Medication Management in the Treatment of a Substance Use Disorder

Medication management is very important in the administration of detoxification and treatment as part of the treatment of a substance use disorder and yet it remains controversial when used in recovery maintenance for abstinence-based monitoring programs.

The detoxification and treatment of a substance use disorder is carried out through a process called medications-assisted management (MAT). Pharmacological treatment of addiction works best when used in conjunction with extended behavioral interventions (NIDA, 2009; Join Together, 2005).

Medications approved by the FDA for the treatment of alcohol dependence include:

- Antabuse (disulfiram)
- Revia (naltrexone)
- Vivitrol (IM naltrexone)
- Campral (acamprosate)
- Topamax (topiramate)

These medications generally do not result in mood-altering effects and are much less controversial than maintenance medications that are used for opiate addiction. Naltrexone and clonidine are available for detoxification for individuals who have abused opiates. Buprenorphine and methadone are currently used to treat opiate dependence because both suppress withdrawal symptoms and relieve the craving for the drug.

Chronic drug users can display neuropsychological impairment in the domains of executive and memory function (2008). Individual factors will influence the degree that neuropathology or changes exist in the brain. The research on the cognitive effects of MAT for the recovering health professional's use is not available at this time. However, studies are required in order to investigate the effects of methadone and buprenorphine maintenance treatment especially regarding dose-dependent effects since high to very high doses of both substances seem to have the potential to ameliorate cognitive functioning (Loeber et al., 2008).

The Center for Substance Abuse Treatment (CSAT) consensus panel recommends that medication-assisted treatment for opioid addiction, as provided in opioid treatment programs (OTPs), be conceptualized as phases of treatment so that interventions are matched to the levels of patient progress and intended outcomes (Batki, Kauffman, Marion, Parrino, & Woody, 2005). It is when patients are discharged from treatment and aftercare and then enter into a stable recovery that the question arises about medications such as buprenorphine and methadone. The controversy over the use of these medications involves the mind-altering effects that may accompany their use, including their longer term use for maintenance therapy. Currently, the use of naltrexone as maintenance therapy is encouraged when morphine, oxycodone, oxymorphone, fentanyl, and other opioids have been abused. The American Association of Nurse Anesthetists encourages the use of a third party to administer naltrexone on a daily basis to ensure consistent dosing (Hudson, 1998). However, pharmacological treatment of addiction works best when used in conjunction with extended behavioral interventions (NIDA, 2009; Join Together, 2005).

Some boards of nursing may not allow nurses to continue in the alternative program if these medications are used as maintenance medications after the initial detoxification and treatment period. Boards of nursing must offer guidelines to the alternative programs regarding the use of methadone, buprenorphine and other mood-altering medications during the continuing care phase for the recovering nurse in a clinical setting. Additionally, alternative programs and boards of nursing must ensure that they are in compliance with the Americans with Disabilities Act of 1990 (ADA) requirements, especially for reasonable accommodations.

Substance Use Disorder and Mental Health Disorders

Co-occurring or dual diagnosis issues are often a common denominator in the treatment of substance use disorder. Estimates are that 50 to 70 percent of individuals in treatment for substance use have co-occurring disorders (Flynn & Brown, 2008), although only 12 percent of people with co-occurring disorders will receive treatment for both of them (Drake, O'Neal, & Wallach, 2008). The approach to recovery for substance users with co-occurring disorders and multiple treatment episodes, through the administration of the management checkups, also recognizes that it takes an average of three to four treatment episodes over a nine year period in order to reach a solid recovery stage (Rush, Dennis, Scott, Castel, & Funk, 2008). Three types of interventions that are deemed effective in the treatment of substance use disorder with co-occurring disorders are contingency management, long-term residential treatment and group counseling (Drake et al., 2008). Most alternative programs will need to address these issues in their population even if they only accept those with a primary diagnosis of substance use disorder in their admission process.

Research on the effectiveness of this treatment has been confounded by the use of different measures of success taken over different periods of time after different types of treatment. Other issues that make assessing success difficult are high attrition, relapse to substance use or other behavioral indicators of relapse (Jacobson, 2004; Adrian, 2001). These are issues of

concern even with other chronic relapsing medical conditions and rather than be viewed as indicators of the failure of treatment they must be seen in these conditions as evidence of the need for further evaluation and referral to another level of treatment. Relapse rates for substance use disorder resemble or are often lower than those for other chronic conditions (NIDA, 2009). Treatment of substance use disorder as a chronic condition that requires long-term treatment and monitoring produces lasting benefits (Brown, Trinkoff, Christen, & Dole, 2002; McLellan, Skipper, Campbell, & DuPont, 2008).

Recovery and Relapse Issues

Recovery is marked by incremental stages of progress and like substance use disorder it develops over a long period of time that is measured in years rather than months (Valliant, 1998). Stages of recovery are marked as early, middle and late stages and these milestones are detected more accurately by the accomplishment of recovery tasks and healthy changes in lifestyle (Schaffer, 1992; Landry, 1994).

There is a more general theory of change that describes five stages of change:

- disinterest
- reluctance
- willingness
- acceptance of change
- maintenance of change

(Prochaska, DiClemente & Norcross, 1992)

Those who enter treatment and alternative programs can be in any of these stages and can present more reluctance or acceptance toward the demands of being in treatment and monitoring programs. The creation of a stable recovery can be identified by the achievement of specific tasks of recovery by the individual who will also demonstrate the development of a growing accountability and responsibility.

There are three underlying tasks of recovery. The first is the recognition of addiction as a significant and life-threatening disease. The stigma of addiction and the stereotyping of addicts make this a much more complex task than it may seem at first. The second task is the ability to maintain abstinence. This is also a significantly complex task and is at the heart of debates about what approach to recovery is more effective and what impact relapse will have on achieving long-term abstinence or recovery. The third task is the ability to develop a structured program that provides the practical and social support to stay sober (Landry, 1994).

The risk for relapse tends to be at its highest in the first two years of recovery with the highest risk occurring during the first year (Buhringer, 1995). Relapse is generally identified early and addressed quickly in alternative diversion programs due to the close scrutiny of recovery and review of compliance by programs. Relapse rates for those participating in alternative programs are generally lower than those in the general population (Talbot, 1995; DuPont et al., 2009). The risk for relapse in health care professionals has been studied extensively and has been associated with the use of an opioid, dual diagnosis and family history of addiction (Domino et al. 2005), as well as termination from work, a delay in entering an alternative program and a lack of support (Snow & Tipton, 2006).

The risk for relapse can also include the following behaviors:

- dishonesty to self and denial of a problem
- low engagement in support groups
- poor response to stress
- over-confidence

Key factors in preventing relapse include these actions:

- regular attendance at support group meetings
- personal and active involvement with a 12-step sponsor
- close contact with a case manager or monitor of an alternative program

(Long, Cassidy, Sucher, Stoeher, 2006)

Studies on the effectiveness of treatment when combined with the close scrutiny and long-term monitoring found in intensive case management within alternative diversion programs, especially for nurses and physicians, has shown results with better outcomes and higher success rates (McLellan et al., 2008; DuPont et al., 2009; Knight, Sanchez, Sherritt, Breshahan, & Fromson, 2007). In fact, the standard type of long-term monitoring of recovery and compliance parameters implemented by alternative diversion programs has been shown to be the primary component in improved effectiveness in treatment (McKay et al., 2009).

There appears to be more similarities than differences between physicians and nurses with substance abuse issues as indicated by the results from the monitoring programs, therefore the research conducted on either professional group generally applies equally to both (Shaw, McGovern, Angres, & Rawal, 2004). However, there still are differences. More physicians are male who work in private group settings, primarily abuse alcohol and are referred by a physician-assistance program to treatment. Most nurses are female, work in a hospital setting, abuse prescription medications and are referred to treatment in a more mandated manner by their employer.

Summary

Evidence-based treatments for a substance use disorder have been proven effective across a wide range of the population. When treatment has been included in a comprehensive and structured monitoring program that is offered in many states, there is an even greater likelihood of health care professionals achieving long-term recovery and abstinence and a successful discharge from the program (Dupont et al., 2009). Effectiveness of treatment involves a comprehensive menu of therapies and medications and cannot be confined to one single approach or restricted to a single episode of treatment. NIDA's thirteen principles of drug addiction treatment (1999) underscore this understanding.

The type of treatment recommended for any individual is dependent upon an adequate and thorough assessment by a competent referral source. Treatment will usually move from the least intensive model to the most intensive model depending on the history and past effectiveness of treatment. The continuum-of-care model verifies that recovery is a life-long effort and may require multiple episodes of intervention and treatment and long-term consistent care management. This model advocates long-term recovery management strategies to address the chronic relapsing nature of a substance use disorder. These strategies include rapid admission into treatment, intensive case management through regular assessments of any progress and a compliance with abstinence-based activities. Most alternative programs incorporate these strategies into their monitoring contracts. This allows for an early identification of relapse behaviors, early interventions and the application of immediate consequences, which promotes long-term recovery and compliance.

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CHAPTER ELEVEN

RETURN-TO-WORK GUIDELINES

IT IS NECESSARY FOR INSTITUTIONS to have in place a set of guidelines for the health care staff as well as the nurse who has successfully completed a program and aftercare and is deemed fit to return to practice. Institutions have a responsibility to all of their nurses and staff to provide policies and procedures for every aspect of substance abuse including a nurse's return to work.

Prevention of abuse is always preferred and education is a key component to any preventative measure as are accountability and consistent discipline measures (Quinlan, 2003). Research suggests that nurses with a substance use disorder usually worked for five years before the nurse's addiction was discovered (Booth & Carruth, 1998). Workplace mandates can also be an effective mechanism for improving work performance as well as other positive outcomes. In fact, research demonstrates that when compared to employees who are returning to work after treatment for drug or alcohol abuse without a workplace mandate, the employees who had a mandate appeared more likely to sustain a significant improvement over five years (Weisner et al., 2009).

Seventy percent of the nurses with a substance use disorder who seek treatment are estimated to successfully return to practice (Young, 2008). Therefore nursing leaders must outwardly acknowledge that substance use disorder is a treatable illness and create an environment that is supportive (Ponech, 2000). Such support is critical to the identification of nurses with a substance use disorder. Recovering nurses cited support from their colleagues as the most important factor in easing their return to work (Smith & Hughes, 1996). In a 2002 research study, nurses with a substance use disorder said that they felt let down because other nurses in the profession failed to recognize and confront their substance abuse (Lillibridge, Cox, & Cross, 2002).

Successful re-entry to the workplace is made possible by supportive colleagues and established policies. However, monitoring the recovery of nurses with a history of substance abuse and substance use disorder requires a well-informed re-entry plan that meets the Talbott criteria for re-entry and includes:

- supportive spouse or significant other
- no untreated psychological co-morbidities
- acceptance of the chronic nature of substance use disorder

- grounded in the recovery community (such as having a sponsor)
- supportive work site or department for re-entry
- willingness to commit to monitoring as recommended by monitoring program
- willingness to take medication such as naltrexone as an adjunctive therapy
- willingness to participate in toxicology screening on a random basis
- having supportive colleagues at the workplace who are familiar with history and needs (AANA, 2009)

Return-to-Work Contracts and Releases

The first action that must be undertaken is to develop a contract with the nurse and a monitoring program that will serve as a legal guideline for the recovering nurse. The contract must be compliant with federal and state laws and cover all facets of job re-entry such as monitoring, compliance and restrictions. Advanced practice nurses (APRN) as well as nurse anesthetists (CRNA) must have structured contracts that specifically address prescription privileges, restrictions on DEA licenses for controlled substances, access to medications and medication management of their substance use disorder. Prescription monitoring reports and utilization of a single pharmacy are important adjuncts as well. Other issues must be spelled out clearly so there will be no confusion.

Such issues include:

- contact information for the recovering nurse and monitoring program
- recovering nurse's legal name, address and phone numbers
- specific health care facility where the nurse is working
- workplace monitor or supervisor's name, address and phone number
- date for a return to the work setting and length of time a returning nurse is permitted to work
- work performance and conditions of employment
- abstinence and drug screens
- restrictions on practice
- employer record-keeping
- meetings with employers
- disclosure of information
- consent to disclosure of information

It is necessary to obtain signed releases so that communication can be efficient and thorough. This is essential for the recovery process.

Releases must be signed for:

- the treatment provider, the nurse and the monitoring program in order to ensure that the nurse can return to work
- the recovering nurse and the supervisor or workplace monitor and the monitoring program

Furthermore, it is suggested that there be a signed consent to disclose information between the employer and the governmental agencies about termination for noncompliance in the monitoring program. The rationale for requiring this consent is because adherence to the work contract is covered in the federal law 42 CFR, part two, which governs confidentiality issues. Without this consent, employers would not have full information about the recovering nurse if they file for unemployment or discrimination suits. The inclusion of this type of consent may be controversial for some state monitoring programs because nurses are required to provide a consent that permits employers to disclose the actual return-to-work

agreement and the nurse's related noncompliance, if it occurs. Such noncompliance would be a positive drug test and result in a termination of employment. If the nurse then applies for unemployment benefits, having a signed agreement will ensure that the nurse further agrees to a consent-to-disclose adherence in the revised work agreement.

Research has demonstrated a heightened risk for certain nursing specialties such as anesthesia, emergency departments, psychiatry and operating rooms and it is suggested that an addendum to the work contract be constructed. This would provide specific details about such issues as the handling of narcotics, orientation periods and increased random urine screenings. Some professional associations such as the American Association of Nurse Anesthetists (AANA) prohibit CRNAs from the administration of anesthesia until after one year of documented recovery and abstinence from drugs and alcohol. In some states nurse midwives, clinical nurse specialists and nurse practitioners may not have prescriptive authority for their first year of documented recovery and abstinence. It is incumbent upon the monitoring program to ensure compliance with state requirements and specialty-specific recommendations.

Qualifications for Supervisors and Work-Site Monitors

Continuous communication between the monitoring program, an alternative to discipline or discipline program and the nurse's supervisor or work-site monitor is essential in order to meet the goals of the monitoring program.

Such goals include:

- achieving early recognition and intervention with nurses with a substance use disorder
- ensuring patient safety while providing the nurse an opportunity to get into treatment and recovery
- assisting the nurse in maintaining his/her license
- assisting the nurse with the return-to-work process

Alternative to discipline programs make themselves visible and available to nurse supervisors and as a result have a constant communication that regularly includes the supervisors in the monitoring of a nurse with a substance use disorder (Quinlan, 2003). This suggests that organized education for professionals who serve as work-site monitors is important to ensure consistent reporting to boards and for effective monitoring of nurses with a substance use disorder who return to practice. In some situations, workplace monitors and supervisors are the same person and in others a separate point of accountability is named.

Return-to-work contracts must require the supervisor and often even co-workers be involved in some way in the monitoring of the nurse with substance use disorder (Griffith, 1999). Contracts must specifically require the nurse with a substance use disorder to notify employers of their participation in the monitoring program and the requirements of the program (Lowell and Massey, 1997). The supervisor and work-site monitor must be licensed to practice nursing, the license must be unencumbered and they can not be a current participant in any alternative program in order to avoid conflicts of interest that could impede the ability to objectively monitor the nurse. The supervisor and work-site monitor must have close communications with the alternative program. The supervisor and work-site monitor must be provided with any work restrictions that have been imposed upon the nurse by the program. One such restriction may be any access to narcotics for a minimum of six to 12 months. (An exception is when there is evidence of drug diversion, prescription fraud or harm to a patient. In these cases there must be a minimum of 12 months with no access.) Drugs of abuse are often obtained at the workplace, therefore facilities need to evaluate the efficacy of their own

narcotics accountability (Quinlan, 2003). In areas where there is high volume procurement such as intensive care units, operating rooms, anesthesia and emergency departments, care must be taken to ensure proper documentation. It has even been suggested that nurses in higher risk practice settings such as these consider using naltrexone as adjunctive therapy if the drug of choice is an opiate (Quinlan, 2003).

Health care facilities are encouraged to develop an action plan to diminish the likelihood of abuse of prescription drugs (Drake, Dyer, & Holzheimer, 1997).

Components of the action plan can include:

- updating the narcotics policy to include who has access to controlled substances
- developing a policy for dispensing take-home medications
- conducting random audits of narcotics
- urging the pharmacy to conduct independent and random audits of narcotics

The monitoring program may also require the employer to contact the program to verify the nurse employee's participation in the program. This is often the supervisor's first contact with the program. Many require the supervisor to fill out a supervisor agreement form that is signed by the direct supervisor prior to the nurse participant beginning or resuming a new or existing position. The supervisor needs to have face-to-face observation of the nurse in order to assess and document practice and behavior as well as to support recovery (Smith & Hughes, 1996). The supervisor or work-site monitor must be in a position to observe and report workplace performance and behavior in order to include the time and attendance, relationships with colleagues, the appearance and compliance with work conditions.

The supervisor or work-site monitor and the monitoring program coordinator must also have regular contact about the recovering nurse (Clark & Farnsworth, 2006). For example, the employer must submit work performance evaluations of the nurse with a substance use disorder to the monitoring program on a regular basis and agree to notify the monitoring program immediately of any concerns about the nurse's practice, behavior and recovery. Others suggest the supervisor schedule monthly check-in meetings with the nurse for the purpose of addressing any concerns from either party. These meetings must be documented and made available to the monitoring program upon demand. Some programs even go so far as to require the potential employer and designated supervisor to be involved in a conference call to determine whether the nurse participant may work at a particular job. However, the more contact and open communication there is, the better it is for all concerned.

A supervisor or work-site monitor agreement with the participant can include the following minimum elements:

- expectations for the nurse participant
- instructions for any supervisory changes
- education on the completion and submissions for performance report forms
- procedures for communication with the monitoring program if there is suspicion of diversion, on-the-job use or work performance problems
- process to be followed if the recovering nurse is unable to leave work for urine collections

Monitoring programs must conduct quality assurance activities on a regular basis. Many programs already conduct an employer survey in order to maintain and assure continued quality service for program participants and to improve their delivery of service. This is also a very good way to obtain feedback from supervisors about the program.

The monitoring programs must then do what they can to maintain a strong presence within the nursing community. It is vital that there is open communication between the nurse participant's supervisor and the monitoring coordinator. They must always provide information about their program to nursing management and directors and to any participant supervisor and work-site monitors.

The monitoring program can help the manager by doing the following:

- provide education and training about the recognition of unsafe practice and how to intervene appropriately
- assist in the development of policies that are fair and consistent including the issue of fitness for duty and back-to-work parameters
- assist in the coordination of back-to-work agreements
- facilitate the transition of a nurse back into the workplace, including groups with co-workers with the participant's consent
- facilitate open communication between the nurse participant's supervisor and the monitoring coordinator

Procedures for Receiving Updates from the Monitoring Program

Upon enrollment in an alternative program the nurse enrollees must be required to sign a consent form that enables the program monitor and other program personnel to speak with the participant's employer. The purpose of the release is so that the program coordinator can communicate with the employer about the nurse's recovery. Communication is essential for the nurse's successful participation and completion of the program and for their return to practice in a manner that is conducive to both the nurse's recovery and safe patient care. The participant's supervisor and work-site monitor must be educated about the signs of relapse and must report any concerns about relapse behaviors or identified relapses to the alternative program.

Return to School Rather than the Workplace

After completing a treatment program some nurses decide to go back to school rather than re-enter the work force. If the nurse is taking any clinical courses, the dean or director of the nursing program must be notified of the nurse's participation in a monitoring program (Anderson, 1994). The dean or director must identify specific faculty who can serve as monitors to assist the nurse in recovery. Procedures for continued monitoring as described above can then be followed.

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CHAPTER TWELVE

MONITORING AND COMPLIANCE

THE NEXT PHASE AFTER the nurse with a substance use disorder returns to work is an effective monitoring system in order to ensure compliance. Monitoring the level of compliance of the nurse with the contractual agreement and prescribed treatment program is essential in order to assure patient or client safety and that the nurse is competent to practice. Once the nurse has signed the alternative program stipulated agreement or contract the alternative program staff will begin to monitor the participant nurse's compliance with contract terms. This is accomplished by addressing each point of the contract to assure compliance. Monitoring aids recovering nurses by helping them regain employment and providing a process to evaluate recovery and rehabilitation. Monitoring may also provide objective data that helps to dispel undeserved accusations and can also identify behaviors that may lead to relapse. Mechanisms must be in place to identify and quickly respond to noncompliance by the participant with any of the terms in the stipulated agreement.

An important part of monitoring is the completion and reporting of pertinent alternative program information. The reports provide an accounting of compliance with recovery plans and monitoring of random drug and alcohol testing. Recommendations for modification of the recovery plan are made based on factors such as compliance, recovery status and the nurse's progress in the alternative program. The alternative program utilizes several methods and sources to monitor the progress of participant nurses.

These include:

- reports from treatment professionals
- aftercare or continuing-care reports
- individual counselor or psychotherapist reports
- meeting attendance for 12-step programs and alternatives
- work-site monitor reports
- medical care and medication reports
- drug testing
- professional support group attendance
- self-reports

Relocation out of state is not encouraged while participating in a licensure alternative program. However, if a participant nurse's circumstances require that he/she relocate out of state while participating in the alternative program, the individual must be required (as provided within the alternative program contract) to maintain compliance with the terms of contact with the alternative program regardless of their state of residence. Additionally, they must obtain written permission from the alternative program before seeking employment or licensure in another state and obtain written permission from the alternative program in that state or if there is no alternative program, the board of nursing. Alternative program contracts must include a requirement for compliance with all terms and conditions regardless of employment or residential status. If a participant nurse decides to relocate out of state and does not inform the current alternative program, the new alternative program or the board of nursing in the new state, then the nurse will be considered to be in noncompliance with their original alternative program contract and referred to the licensing board for appropriate disciplinary action.

One of the controversies surrounding alternative programs is that the participant's status in the program is not known to other states where the person may hold licensure or may be seeking to become licensed in an effort to embark on a geographical cure for his/her licensure or practice limitations. Although not currently in place at this time, it is recommended that a national database for reporting of alternative program participation be developed and that program participants be entered into the national database. Accessing information from this database would not be used for disciplinary or other public purposes in any other state or territory as long as the participant remains in full compliance with the terms and conditions of his/her participation. This database could be used for verifying information related to licensure endorsements and persons actively licensed to practice in any given state or territory.

Relapse and Program Noncompliance

Relapse is always possible with nurses suffering from a substance use disorder because addiction is a chronic and incurable but treatable brain disease. Persons with this disease often undergo recurrent cycles of relapse and recovery. Controversy surrounds the issue of relapse and the specifics of what constitutes a relapse. Relapse can be defined as a discreet event that occurs simultaneously to the resumption of drug use or as a process that occurs over time (Smith, 1992). Relapse is a term that is often used to describe the return of signs and symptoms of a disease after an apparent period of recovery. In a substance use disorder a relapse may be defined as the recurrence of alcohol- or drug-dependent behavior in an individual who has previously achieved and maintained abstinence for a period of time beyond detoxification. Relapse is also the movement away from recovery and is a progressive process that is marked by definite, predictable and progressive warning signs. Gorski, a well-known expert in recovery and relapse prevention defines relapse as a process with 10 distinct phases and recognizable warning signs (Gorski & Miller, 1986, Gorski, 2007). The final phase is marked by the actual return to use by the addict of alcohol or other drugs. Recognizing and responding to the relapse warning signs are an effective means of preventing return to substance use. The alteration of thought processes, judgment and emotional reactions precede the resumption of use. If the relapse process is not halted it leads to a break in abstinence and a renewed drug or alcohol use.

Studies reflect that health care and other professionals who are subject to a monitoring agreement with significant consequences for non-compliance have a lower relapse rate than the

general population (McLellan, Skipper, Campbell, & DuPont, 2008; DuPont, McLellan, White, Merlo, & Gold, 2009; Knight, Sanchez, Sherritt, Bresnahan, & Fromson, 2007). Nonetheless, relapse is still common. Relapse occurs more frequently during the first 12 months after entry into treatment but the prognosis improves the longer a person is able to maintain continuous recovery from substance use. Therefore, measures that are put into place to prevent, deter and to detect relapse must be intensified during the first 12 months of entry in the alternative program and can then be tapered based upon compliance and treatment recommendations. If the participants are enrolled in a state board authorized alternative program the indicators of an impending relapse or actual relapse often manifest in noncompliance by the participant with the terms of his/her alternative program's stipulated agreement.

Common signs of an impending relapse include the following:

- lack of or a decreased participation in an ongoing recovery program including a 12-step program and a lack of a sponsor relationship
- failing to comply with treatment recommendations
- lack of honesty regarding substance use and misuse history
- employment difficulties
- relationship difficulties
- unstable emotional status
- lack of a sober support system and a return to socializing with prior using associates
- failing to comply with alternative to discipline contract requirements
- late or missing monitoring reports
- missed drug screens
- dilute specimens
- altered or substituted specimens
- positive drug screens

The actual drug use can be considered one of the later aspects of the relapse dynamic and for the purposes of this model any use of unauthorized drugs or alcohol is considered a relapse. For these guidelines, two relapses are considered grounds for terminating the participant nurse from the alternative program and referring the nurse to the board for determination of appropriate licensure action. In any relapse situation the nurse would be referred to treatment professionals with an expertise in substance use disorder for further evaluation and treatment determination. Until determined as safe to return to nursing practice, a participant who has relapsed must also be immediately removed from nursing practice.

Drug and Alcohol Testing

Random drug testing is used as a preventive tool and a detection tool for unauthorized drug or alcohol use in the monitoring of participants with a substance use disorder. Urine screening is generally viewed as the preferred method for assessing substance use and may be supplemented with hair testing for some drugs to assess for drug use over long periods. A positive drug testing does not provide information about the levels of impairment but only that a drug or substance was used within the detection period and represents a significant breach of the alternative program contract. During periods of increased vulnerability to relapse, including the first 12 months of monitored compliance with treatment and alternative program requirements, random drug screening must be done at minimum of twice a month. Additionally, for a cause drug a screening must be implemented whenever there is reasonable cause to believe that a participant may have relapsed.

The alternative program requires random drug testing to provide ongoing monitoring for abstinence, early identification of noncompliance and a timely intervention if a relapse occurs, which requires a very strict procedure for obtaining and processing drug and alcohol testing. Random screenings held twice a month is the minimum requirement for at least the first year in the alternative program. More frequent screens may be requested after a return to employment or upon restoring access to drugs. The participant nurse may also be requested to submit a screen by the alternative program staff, the nurse's employer, the professional group facilitator or the treatment counselor. Upon evidence of full compliance with all terms of the alternative program stipulated agreement the drug screenings may be reduced to a minimum of once a month.

Drug testing must be performed by a certified laboratory that sends the results directly to the alternative program.

All urine or blood screens are completed according to the following procedure:

- urine collection must be observed. If unable to observe the submission of the specimen then at minimum there must be a dry room where the only source of water is the commode and the water supplying the commode must contain a dyeing agent to prevent or detect the substitution of water from the commode
- a strict chain of custody must be followed with the specimen sealed and signed by the participant nurse, collector and lab
- when indicated, a hair analysis drug test may be done
- all drug screen reports are sent directly to the alternative program staff

Drug Screening Compliance Issues and Recommendations

The two most common noncompliance issues around drug screening are positive drug screen findings and a failure to test. Additionally more programs are reporting an increase in noncompliance related to overt efforts by some participants to provide substituted and adulterated specimens in an effort to avoid substance use detection.

Recommendations for Uniform and Standardized Review

There are certain recommendations that will provide for uniform and standardized reviewing and reporting of drug screening noncompliance.

Submission of a Positive Drug Screen

A positive drug screen for any unauthorized drugs that is illegal, not prescribed or not currently medically authorized constitutes noncompliance and is reportable to the licensing board. The nurse can be notified of the results and be required to refrain from practice until further evaluation and a determination is made by the board, designee or monitoring program regarding safeness to practice and further sanctions. It is recommended that language be included in alternative program agreements, board orders, and consent agreements requiring the participant to refrain from nursing practice until evaluated and further review and action can be determined. It is additionally recommended that the state's nurse practice act contain language reflecting that failure to comply with an alternative program agreement, board order or consent agreement is grounds for disciplinary action. An example of model NPA language is, "Unprofessional conduct includes, whether occurring in this state or elsewhere, failing to comply with a stipulated agreement, consent agreement or board order." (Arizona State Board of Nursing, 2009).

Alternative program agreements can include the following requirements upon submission of a positive drug screen for an unauthorized substance:

- participant will immediately cease practicing until receiving written approval from the alternative program staff or board designee to return to practice
- participant will be required to undergo a relapse evaluation by an approved independent evaluator who has at a minimum a doctorate
- all positive drug screen results will be investigated and the investigative findings will be submitted to the board for the board's review and decision regarding any licensure action or discipline to be imposed
- the frequency of urine drug testing will increase to a minimum of weekly for three months followed by twice a month unless otherwise determined by the board

Failure to Submit a Drug Screen

Failure to submit to drug testing on the requested day constitutes noncompliance. Upon identifying that a participant has failed to submit to a drug test as required, he/she must immediately be contacted and be required to submit to testing within two hours of the contact. Contracts between the drug testing agency can include a provision that the drug testing agency notify the designated alternative program monitor within one business day of a missed drug test. Timeliness of notification is critical as one of the easiest ways to avoid detection of substance use is by failing to submit to testing.

Alternative program monitoring program policies may include the following protocols for failing to submit to drug testing:

- a drug-testing laboratory notifies the designated monitor or agency within one business day. (Contractual agreements between the laboratory and nursing board/monitoring designee can include a provision for notification of failure to test.)
- the nurse is notified of the need to submit to a urine drug screen on the day of contact and within two hours of contact
- the nurse is contacted and interviewed by the designated alternative program monitor regarding the failure to submit and to assess for indicators of relapse
- other areas of compliance must be reviewed
- additional action or evaluations may be warranted because failing to submit to testing is a way to avoid detection of drug use

In addition, any alternative program's stipulated agreements or policies must include the following requirements during the term of the program's stipulated order or consent agreement and consent order:

- a failure to submit one drug screen will result in an increase in the frequency of testing for a minimum of six months and may be reported to the licensing board
- a failure to submit a second drug screen will require the participant to cease practicing and undergo a relapse or recovery evaluation by an alternative program or board-approved evaluator and may be reported to the licensing board. The participant must comply with any resulting treatment recommendations and may not return to practice until written authorization is received from the alternative program, board or designee
- a failure to submit a third drug screen will result in the participant ceasing practice and all information regarding the licensee's participation and compliance history in the alternative program will be submitted to the board for the board's review and decision regarding licensure action or continued participation in the alternative program

Refusal to Submit to Testing

Refusal to submit to a drug screen upon request by the alternative program, its designee or any health care employer is noncompliance. Refusing to submit to a drug screen upon request must be reported to and reviewed by the board for the board's review and decision regarding any additional evaluations, continued participation in the alternative program or discipline to be imposed. Drug testing can be increased to a minimum a weekly testing, pending the completion of the investigation and final outcome by the board.

Submission of a Dilute Specimen

A dilute specimen is invalid for determining the absence of drugs in a specimen and constitutes noncompliance. However, a dilute specimen that is positive for drugs is considered to be a positive specimen for those drugs detected. Drug detection through urine drug testing is related to the quantity of metabolites present in the urine, therefore another common way for individuals to attempt to avoid detection of substance use is to overly hydrate themselves, thereby diluting the concentration of metabolites detected in the urine. Alternative program policies must require that upon receipt of a dilute specimen the participant is contacted and is required to submit to drug testing within two hours of the contact.

In addition, alternative program's stipulated agreements or policies must include the following requirements during the term of the alternative program's stipulated agreement:

- submission of one dilute drug screen will result in a warning letter to the participant and advisement to the participant that a future dilute specimen will result in an increase in the frequency of drug screening
- submission of a second dilute drug screen will result in an increase in the frequency of drug testing for a minimum of six months
- on submission of a third dilute drug screen, the nurse will cease practicing and will be required to undergo a relapse or recovery evaluation by a board-approved evaluator who is at minimum, doctoral prepared. The nurse may not return to practice until written authorization is received from the alternative program director, board or designee and the nurse must comply with any resulting treatment recommendations resulting from the evaluations
- submission of a fourth dilute drug screen will result in a referral to the board for the board's review and decision regarding any additional evaluations, continued participation in the alternative program or discipline to be imposed.

Submission of a Substituted or Adulterated Specimen

Identification of any specimen in which the temperature, pH or creatinine is outside of the acceptable parameters is indicative of a substituted specimen or an adulterated specimen and is noncompliance. Identification of any substituted specimen or adulterated specimen represents an overt attempt to cover one's continued or return to substance use. An alternative program's stipulated agreements must contain a provision requiring the participant to cease practice upon receipt and confirmation of a substituted or adulterated specimen and notification that all information regarding the licensee's participation and compliance history in the alternative program will be submitted to the board for the board's review and decision regarding continued participation in the alternative program or discipline to be imposed. Drug testing must be increased to the minimum of once per week, pending the completion of the investigation and final outcome by the board.

All alternative program stipulated agreements must contain a provision and authorization to notify any nursing employer of any failed drug screening or other noncompliance with

drug screening requirements. If the participant disputes the validity of the positive results then a medical review officer (MRO) review and a determination of the positive findings can be made available to the participant at his/her expense.

Noncompliance with Employment Limitations or Restrictions

An alternative program's stipulation agreements must contain requirements for the alternative program and participant to notify any health care employers of their participation in the alternative program and cause their employer to notify the alternative program of their receipt of a copy of the stipulated agreement and their ability to provide a work environment consistent with any practice limitations. Additionally, the stipulated agreement must contain a requirement that the participant notify the alternative program of any change in employment status. A change in employment status includes the acceptance, resignation or termination of employment.

A significant breach of the alternative program stipulated agreements occurs anytime a participant accepts nursing employment and fails to disclose to the employer or fails to disclose to the alternative program that they are employed. Not only is this suggestive of a relapse behavior but it also places the alternative program at risk of controversy when participants are able to gain employment by withholding information that may not otherwise be available to an employer. An alternative program's stipulated agreements must contain a notice that this will be reported to the board and that sanctions will include suspension or revocation of licensure.

Violating other employment-related restrictions, for example, assuming access to controlled drugs when such access has been prohibited via the alternative program's stipulated agreement, is suggestive of a relapse or an impending relapse. It is recommended that violations of employment-related restrictions result at least in the participant being removed from practice pending a comprehensive relapse evaluation by a board-approved expert evaluator. Any treatment recommendations resulting from the evaluation must be implemented and any recommendations supporting a return to work received before releasing the participant back to nursing practice. Noncompliance may be reported to the board for review and a determination of the ability to remain in the alternative program or a pursuit of licensure disciplinary action.

Noncompliance with Treatment Requirements

Alternative program stipulation agreements must contain requirements that the participant comply with all treatment requirements and participation in recovering peer support groups in addition to 12-step participation. The stipulated agreement must contain explicate parameters for reporting of attendance and completion of treatment requirements. The participant's failure to comply with attendance requirements or reporting requirements may be indicative of an impending or actual relapse.

Failure to comply with treatment program requirements (such as intensive treatment, aftercare, submitting required compliance documentation of attendance or participation) must be reported to the board for further review and determination as to the continued participation in the alternative program or a pursuit of licensure disciplinary action.

Criteria for Referral to the Board

Given the nature of addiction, it is inevitable that some participants in programs will relapse and fall short of full compliance with their contracts. When a nurse is being monitored in a program and relapses or becomes non-compliant with the contract it is important that clear

criteria exist to determine what consequences will flow from the noncompliance. There must be a clear understanding by the program staff and the board whether all noncompliance or relapse is reportable or whether only certain events are reportable to the board such as termination from the program. Guidelines for the timely recognition of non-compliance and response by the alternative program staff must be developed and implemented to protect the public and maintain the program's integrity. For example, the program can continue to monitor a nurse even after referring them to the board or the discipline program until the discipline program can begin monitoring or pending board action.

Termination Criteria

Although a nurse's recovery is important, programs primarily serve a critical public safety role. Therefore, certain conduct may be so antithetical to public safety that continued participation is unwarranted. Examples of such conduct are participants who cannot be monitored effectively. These individuals may in fact not be using but if they are not checking in with the program there is no assurance of public protection. Any lack of ability to contact a participant for two weeks or more is a good example of a clear criterion for termination or reporting to the board of nursing for noncompliance. Other examples of conduct for which termination and referral to the board for licensure disciplinary action include:

- clear and present danger to patients or self
- identified evidence of unsafe practice
- refusal to cease practice (continuing practice despite not being authorized by the program)
- active relapse by a participant who does not immediately respond to increased monitoring requirements
- failing to comply with drug screening requirements including refusal to test, submitting adulterated or substituted specimens
- rejects or is otherwise noncompliant with treatment recommendations
- participant is deemed refractory to treatment after multiple treatment episodes
- failure to inform the program of employment (A situation in which the program is unaware of a participant's employment makes the program's ability to monitor the participant impossible. It is not only a serious breach of the participant's honesty in recovery it also undermines the public's confidence in the effectiveness of all alternative programs. The importance of stressing zero tolerance for working without prior approval can be clearly spelled out in the contract and followed up consistently.)
- failing to inform another licensing board of their participation and practicing or attempting to practice in that jurisdiction

Board Responsibilities

Equally important to a program referring a participant for discipline is the board's disciplinary response to that referral. If a participant has had multiple opportunities for treatment and monitoring and has failed each time, then the board can initiate appropriate disciplinary action such as revocation or suspension. There may be a minimum period of suspension and a requirement for the nurse to establish a period of sobriety before the license is reinstated. Such an approach fits in with the well-known concept of progressive discipline and avoids the perception that participants get unlimited opportunities at recovery without consequences. All licensure disciplinary action must be reported to Nursys and the national practitioner disciplinary database.

Completion of Alternative Program

Successful completion of alternative programs by participants can be promoted through investment of a number of operational processes such as case management, which also must be sufficiently resourced.

Six processes that programs can support are:

- contingency (behavioral) management of nurses' participations
- frequent, random drug screenings
- required attendance of 12-step and abstinence-based meetings
- immediate, direct and therapeutic management of relapses
- emphasis upon aftercare and continuing care for a chronic, relapsing disease
- encouragement of life-long recovery

Programs must have guidelines to ensure that nurses have met the necessary program requirements to ensure safe practice. Thus, participants' successes are in some measure always reliant upon the development and integrity of the alternative programs.

Criteria for Success with Nurse Participants

Successful completion of an alternative program can be tied to the following documented elements:

- an execution of the alternative program's participation agreement with all the necessary program forms on file including any subsequent participation agreements that may be required (due to relapse)
- adherence to terms of participation for the minimum required length as established in the participation agreement
- completing treatment or therapy as recommended by an approved assessor or evaluator
- maintaining negative drug test results as outlined in the contract
- not exceeding the minimum number of missed or dilute drug screens permitted by the alternative program
- demonstrating safe nursing practice for the minimum length of time
- attending or documenting a minimum number of self-help or support group meetings required by the alternative program during the contract period
- maintaining communication through electronic or face-to-face meetings with the alternative program or its designated representatives
- submitting reports within the mandated time frame established by the alternative program, including all other required program documents and having them on file with the alternative program
- successfully addressing any other requirements stipulated by the alternative program

Summary

Monitoring compliance of the participant to the contractual agreement and prescribed treatment program is essential to assuring patient or client safety and that the nurse is competent to practice. Timely recognition, response, evaluation and reporting of non-compliance are critical to assuring patient safety, intervening with a potential relapse and maintaining the integrity of the alternative program with both the board and the public. It is recommended that nurse practice acts and alternative program stipulated agreements clearly identify that any noncompliance with the alternative program contract or unsuccessful

termination from the program constitutes unprofessional conduct, is in violation of the rules and laws regarding the practice of nursing, is reportable to the board and may be used to support any future progressive disciplinary actions.

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CHAPTER THIRTEEN

DRUG TESTING

DRUG SCREENING IS A RELIABLE, EVIDENCED-BASED TOOL and assists boards of nursing in monitoring individuals whose licenses are encumbered because of substance misuse or a substance use disorder and assures patient safety. Drug screening is also an important tool used in alternative program monitoring and the treatment follow-up of participants with a substance use disorder.

This chapter will present recommendations for drug screening standards for use by boards of nursing and alternative or monitoring programs.

The key parameters for drug screening are:

- random testing and for-cause testing
- frequency of testing
- who collects the specimen?
- specimen collection methods
- notification of the nurse to submit to testing
- time frame for testing
- who tests the specimen?
- what drugs to test
- specimen validity testing
- special alcohol testing issues
- compliance
- positive drug tests

Guiding Principles

The purpose of nursing regulation is mainly to protect the public. Alternative to discipline programs serve an important role for many boards of nursing in protecting the public by decreasing the time it takes from the usual investigation of a licensee with a known substance use disorder and who voluntarily acknowledges and agrees to participate in the alternative program.

They are important tools because nurses who are working under the influence of drugs or alcohol place patients, colleagues and themselves at risk of harm.

As stated in previous chapters for the purpose of this manual the term drug includes illicit drugs, prescription drugs and alcohol.

A substance use disorder is a disease process where relapse and return to drug use is not uncommon, particularly during the early phases of recovery. As stated previously, drug testing may serve as a deterrent to drug use and assists in the earlier identification of relapse.

Urine drug testing is quantitative and determines the presence or the absence of a drug in the urine at a specified threshold concentration or cutoff. A positive urine drug screen is an indicator of drug or alcohol use but not a diagnosis of a substance use disorder.

Drug testing is the most reliable indicator of abstinence. There currently exists a great variability in panels, detection thresholds and frequency of testing. As technology improves, the detection of drug use will also improve.

A drug threshold or cutoff level cannot be lower than the technology in use is capable of testing.

The increasing value placed on urine substance screening has increased the attempts to beat the test. Specimen validity is a critical component of drug testing and is used to determine whether a specimen has been diluted, substituted or adulterated.

Terminology

Drug testing may be conducted on bodily fluids such as urine, blood and saliva to detect the presence of unauthorized or illegal drugs. Drug testing may also be conducted on hair.

Two-step testing is the process used for drug testing in laboratories. The initial screen of a urine sample is commonly performed using immunoassay. Positive results, meaning those that are equal to or greater than the established threshold, are further analyzed for confirmation by gas chromatography or mass spectrometry (GC/MS), which provides specific information on the amount and kind of drug present in a urine sample. This two-step process is done to prevent false positive results from being reported and is the standard in the drug testing industry. Note that the procedures for ethanol include enzymatic initial assay and gas chromatography for the confirmation test.

False negative refers to a test that reports as negative but was actually positive. The most common cause of a false negative report is related to intentional dilution or adulterated specimens. GC/MS analysis is used to reduce or eliminate the false positive that may be detected in the initial screening immunoassay.

Dilute urine is a urine specimen with creatinine and specific gravity values that are lower than expected for human urine. A specimen that has creatinine that is greater than or equal to 2 mg/dL but less than 20 mg/dL and the specific gravity of the sample is greater than 1.0010 but less than 1.0030 is reported as dilute.

Substituted urine is a urine specimen with creatinine and specific gravity values that are so diminished or so divergent that they are not consistent with normal human urine. A specimen is reported as substituted if the urine creatinine is less than 2 mg/dL and specific gravity is less than or equal to 1.0010 or greater than or equal to 1.0200.

Adulterated urine is a urine specimen containing a substance that is not a normal constituent or containing an endogenous substance at a concentration that is not a normal physiological concentration.

A specimen is reported as adulterated when:

- the nitrite concentration is greater than or equal to 500 mcg/mL
- the pH is less than three or greater than or equal to 11
- the specimen contains an exogenous substance that is not a normal constituent of urine or an endogenous substance at a higher concentration than normal physiological concentration is usually present in the specimen

The threshold level or cutoff is a specific concentration for each drug or analyte being tested. A specimen with a concentration equal to or greater than the cutoff is reported as positive. At this time, with the exception of federally mandated testing, most laboratories establish their own threshold levels. The level may be set for technical reasons such as a particular lab technique cannot reliably detect concentrations below a certain value but there also may be clinical or business reasons. For example, a higher threshold on the initial immunoassay results in less initial positive findings and leads to less of a need for retesting and confirmation by GC/MS, which is a more expensive test to perform. However, most boards of nursing and alternative programs use a zero-tolerance approach to drug screening when monitoring sobriety, therefore the cutoff levels must be based more on the reliability of technique rather than to minimize the number of people detected.

The National Laboratory Certification Program is the U.S. Health and Human Services program that certifies laboratories to test specimens for a five-drug panel and specimen validity.

The SAMHSA (DOT) Program's five-drug test panel includes:

- amphetamine and methamphetamine
- cocaine metabolite
- marijuana metabolite
- opiates (codeine, morphine & 6-acetylmorphine)
- PCP

This panel was developed to meet the needs of most federal workplaces. Boards of nursing and alternative programs routinely test for additional drugs that nurses may have used and continue to have access to in the workplace.

The medical review officer (MRO) is a licensed physician (MD or DO) who has specialized training in interpreting and evaluating positive test results and is knowledgeable of substance use disorder.

The MRO has the following responsibilities:

- determine that the information on the chain-of-custody form is forensically and scientifically supportable
- interview the participant when required
- make a determination regarding the test result
- report the verified result
- maintain records and the confidentiality of the information
- testify if needed about the interpretation and validity of positive results

Key Parameters in Urine Drug Screening

Random drug screening as a monitoring requirement in a board disciplinary order or an alternative program agreement or contract (with limitation on the amount of time between notification and the time of submission or collection) is the best method to control against adulteration, dilution or substitution. A nurse with an encumbered license or participating in

an alternative program agreement may also be directed to submit to drug screening for cause such as a suspected or reported use or relapse.

Relapse occurs more frequently within the first year of recovery, which means drug testing must be conducted more frequently early in the treatment and recovery process. Once there is a longer period of documented recovery and compliance, the frequency of testing may be decreased. If there is a suspected use, relapse or other red flags then the frequency of testing can be increased for the time necessary to gain additional objective information. The recommended minimum frequency of drug testing during the first year of monitoring or documented sobriety may be two to three times per month and for the first 12 months of a return to clinical nursing practice.

When considering the frequency of testing, other case-by-case criteria to consider include:

- length of time without use (longer sobriety equals less frequent testing)
- identified or reported as unable to practice due to a substance use disorder
- expert evaluator findings and recommendations from the treatment program
- severity of disease
- multiple drug use history
- prior treatment history and relapse history
- work setting (supervised, observed practice equals less frequent testing; isolated, independent work setting equals more frequent testing)

Who Collects the Specimen

Individuals who have been specifically trained and demonstrate competency can be specimen collectors.

How a Specimen Is Collected

An observed collection is the preferred and most reliable method in preventing substitution or tampering with a specimen. If an observed urine collection is not available then the minimum standard is a dry room collection. A dry room requires that the only source of water available in the room is in the commode. The water supplying the commode contains a dyeing agent (most commonly blue) to prevent or detect the substitution of toilet water. An observed collection may be required if a dry room is not available or the nurse has a prior history of substitution, dilution or adulteration of specimens or if a report of the nurse substituting, diluting or adulterating specimens is received.

Notification for Testing

The nurse being tested must be assigned a color, number or other unique code. It is recommended that the nurse be required to call on a daily basis to ascertain if their color, number or code has been selected for drug screening and be required to submit to drug screening on the date that their assigned color, number or code is posted.

Time Frame for Testing

Several of the drugs of abuse have short detection time frames. The recommended standard is to require submission of a specimen on the same date as the notice to test. Depending upon the drug and the detection period, a shorter time frame may be warranted.

Chain of Custody

An important consideration for drug testing is to maintain the documentation of the collection, transportation and laboratory testing of a specimen. The chain of custody is the process and documentation of proper specimen identification and the handling from the time of collection until completion of testing. The chain-of-custody protocol assures the specimen belongs to the individual whose information is printed on the specimen bottle label (or is

associated with the identification on the chain-of-custody form and the ID on the specimen bottle), no adulteration or tampering has taken place, exactly who had possession of the specimen, when and how the specimen was transported and stored before it was analyzed, no unauthorized access to the specimen was possible and the specimen was handled in a secure manner. A chain of custody must be maintained for the drug test findings to stand up to legal challenges. (Note that the courier who transports the sealed specimen package from the collection site to the laboratory does not sign the chain of custody since they do not have direct access to the specimen because it is sealed inside a shipping container.)

Specimen Validity Testing

Testing for dilution, substitution and adulteration of the urine specimens is known as specimen validity testing, which means making sure the specimen is valid for testing. The usual parameters tested include temperature, pH, specific gravity, creatinine and oxidizing adulterants (e.g., nitrites). Every specimen must be tested for validity.

The temperature of the urine at the time of collection is recorded and verified to be consistent with the temperature of urine exiting the body. If the temperature is outside of the range of 90–100°F, the specimen must be considered invalid.

Creatinine is a normal metabolic waste product that a person excretes into his/her urine, producing and excreting about the same amount of creatinine each day. Creatinine is measured in units of milligrams per deciliter or mg/dL. The expected concentration of creatinine is equal to or greater than 20 mg/dL. If the creatinine is less than 20 mg/dL, a second test for dilution or specific gravity must be conducted. This test measures the amount of dissolved substances in the urine. (See the definition for dilute in the terminology earlier in the chapter.)

Substitution can occur by substituting urine with a non-urine fluid, by adding other fluids directly into the urine or substituting and submitting clean urine. The two most common methods for submitting clean urine is through catheterization or by placing clean urine in a small vial that may be undetected by the collection site personnel. Submission of a substituted specimen can be interpreted as refusal by the nurse to submit to a drug test, is indicative of substance use and constitutes a reportable event to the board.

Dilute specimens may be caused by ingestion of large amounts of fluids, various medications such as diuretics, antihypertensives, psychotropics or because of various medical conditions such as kidney, congestive heart failure, diabetes or polydipsia. Deliberate ingestion of large amounts of fluids or taking medications or substances with diuretic properties is a common method of attempting to avoid drug detection. A dilute specimen is an invalid specimen for determining the presence of drugs. It is recommended that a person submitting a dilute specimen be required to resubmit another specimen upon the identification of the dilute specimen. Further submission of dilute specimens may warrant a medical review to rule out any underlying medical causes and can be considered noncompliance absent a medical reason.

Adulteration occurs when a foreign substance is added to the urine specimen in order to interfere with the testing. Substances such as bleach, acids, Drano, salt and Visine have long been used to adulterate specimens. Brand names include Klear, Urine Luck, Whizzies and THC Free. The most common adulterants today are oxidants, acids and bases.

Oxidants are chemicals that react primarily to destroy marijuana metabolites in the urine and include nitrite, chromium (VI), bleach and many other compounds. Nitrites have been the most common oxidant used over the last five years. New oxidants are packaged and sold as adulterants each year making it difficult for laboratories to keep up with new oxidant products.

Acids and bases change the pH of the urine. Acids cause a low pH and bases cause a high pH value. In both cases, the drug test may not work properly. Specimens are considered

adulterated if the pH is too low (less than 3) or if the pH is too high (greater than or equal to 11.0). Submission of an adulterated specimen can be interpreted as refusal by the nurse to submit to a drug test, is indicative of substance use and constitutes a reportable event to the board.

If a specimen is dilute, adulterated or substituted, or if it is suspected that a specimen has been substituted with clean urine, the lab must notify the monitoring program. The nurse must be notified to retest on or before the next business day. In addition, the time allowed for the nurse to report for testing after notification must be reduced to two hours, which minimizes the opportunity for tampering with the results and the sample must be an observed specimen.

What Drugs Must Be Screened

See drugs listed on the recommended Minimum Basic Panel in Table 2. All drug screen panels must include the individual's known drugs of choice or use in addition to any standard panel. In addition to the usual street and prescription drugs of abuse, there are other substances that can initiate screening. For example, anabolic steroid misuse is no longer confined to professional athletes. An estimated 14 to 57 percent of anabolic-androgenic steroid users develop dependence (Talib, Fattal, Malone, 2007).

Another substance, propofol, is a hypnotic sedative widely used for sedation or analgesia and anesthesia in operating rooms, endoscopy centers, intensive care units and numerous other settings (Kirby, Colaw, & Douglas, 2009). It is not a controlled substance and has been linked to a hepatitis outbreak in 2008 and is increasingly implicated in deaths. According to a study by Adam Marcus in 2007, the incidence of propofol abuse has risen fivefold over the last 10 years. The AANA position statement on propofol administration says that it can be administered only by persons trained in the administration of general anesthesia who are not simultaneously involved in these types of surgical or diagnostic procedures (AANA, 2004). Screening procedures for propofol need to be included in all monitoring contracts where there is access to, or a history of, propofol use. Hair testing along with urine testing is the standard for testing procedures for propofol and Fentanyl.

Drug Testing Thresholds (Cutoffs)

The concentration of drug or metabolite is used to differentiate positive from negative results. The confirmation (GC/MS) thresholds are set at or below the cutoff of the initial screening immunoassay because GC/MS testing is precise, accurate and reliable. The 2006 Discipline Resources Advisory Panel (DRAP) surveyed member boards and consulted with toxicologists in recommending the following minimum thresholds on both the initial screening immunoassay and GC/MS confirmation (NCSBN, 2006).

Experts identified two appropriate cutoff levels:

- A zero tolerance approach, which is any positive test regardless of the level, confirmed by GC/MS and arguably provides the most sensitive approach to identifying drug use. (Although recent advances in technology may make this possible, it is currently expensive and not widely available.)
- Recommended cutoff values to be a negative test whenever a urine specimen value is below the established and standardized cutoff level. Arguably, this is a more practical approach because of the availability and cost effectiveness for both boards and nurses being monitored.

Table 2: Recommended Minimum Basic Panel (Urine)

Drug	Initial Drug Test Level – Immunoassay	Confirmatory Drug Test Level – GC/MS
Ethyl Alcohol	0.01% (enzymatic)	0.01% (GC)
Amphetamines ¹	1000 ng/mL	200 ng/mL Amphetamine 500 ng/mL Methamphetamine
Benzodiazepines ²	200 ng/mL	200 ng/mL
Propoxyphene/ metabolite	300 ng/mL	100 ng/mL
Barbiturates ³	200 ng/mL	200 ng/mL
Cocaine/metabolite	300 ng/mL	150 ng/mL
Cannabinoids	20 ng/mL	10 ng/mL
Opiates ⁴ (Includes synthetics)	300 ng/mL	300 ng/mL
Meperidine/ metabolite	200 ng/mL	100 ng/mL
Methadone/ metabolite	300 ng/mL	100 ng/mL
Tramadol	200 ng/mL	100 ng/mL
Ethylglucuronide (EtG)	500 ng/mL (LC/MS-MS)	500 ng/mL (LC/MS-MS)
Ethyl Sulfate (EtS)	50 ng/mL (LC/MS-MS)	50 ng/mL (LC/MS-MS)
Other Commonly Tested Substances		
Ketamine	300 ng/mL	100 ng/mL
Pentazocine (Talwin)	200 ng/mL	100 ng/mL
Butorphanol (Stadol)	100 ng/mL	100 ng/mL
Fentanyl	0.5 ng/mL	0.4 ng/mL
Meprobamate (Soma)	100 ng/mL	100 ng/mL
Nalbuphine (Nubain)	200 ng/mL	200 ng/mL
Phencyclidine	25 ng/mL	25 ng/mL
Drug of choice (if not included above)	Level of Detection using suitable technology (LOD)	Level of Detection using suitable technology (LOD)

As drug detection technology continues to improve and becomes more widely available and cost-effective, the screening and confirmation levels are likely to decrease. The threshold levels can still be re-evaluated periodically and adjusted as the industry standard changes and technology advances.

1 Amphetamines include Methamphetamine

2 Benzodiazepines include drugs such Alprazolam (Xanax), Chlordiazepoxide (Librium), Lorazepam (Ativan), Nordiazepam, Oxazepam, (Serax), Temazepam (Restoril), Triazolam (Halcion). Clonazepam (Klonopin), Estazolam, Halazepam (Paxipam), Midazolam (Versed), Diazepam (Valium), Flurazepam (Dalmane), Nitrazepam (Somnibel), Prazepam (Sentrax) and Triazolam (Halcion).

3 Barbiturates include drugs such as Amobarbital, Butalbital, Pentobarbital, Phenobarbital, and Secobarbital

4 Opiates and synthetic narcotics include Codeine, Morphine, Hydromorphone, Hydrocodone, and Oxycodone. Detecting oxycodone may require an additional synthetic opiate test and should be included in the contract between the monitoring authority and the drug testing laboratory. The Fentanyl analogs require separate immunoassay. Butorphanol, Ketamine, Meperidine, Nalbuphine and Tramadol require separate immunoassay.

The Challenge of Alcohol (Ethanol) Testing

Traditional ethanol testing utilizes breath, blood, saliva or urine. The half-life of ethanol is relatively short and thus detecting alcohol use in an abstinence-based, zero tolerance monitoring program has been a challenge. Additionally, there have been challenges in interpreting ethyl alcohol in urine tests, particularly in the diabetic population.

Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS)

Ethyl Glucuronide and Ethyl Sulfate are metabolites of ethanol found in urine. They can be detected up to 80 hours after the last ethanol use depending on the established cutoff. This offers a sensitive and specific method for a lab-based test.

Approximately 92 to 95 percent of ingested ethanol is converted to metabolites that are excreted as acetaldehyde and acetic acid (acetate). A small percentage of the ethanol is excreted from the body through urine, sweat and breath as unchanged ethanol. Only 0.02 to 0.06 percent is formed into ethyl- β -glucuronide (EtG) and ethyl sulfate (EtS).

The concentration of EtG and EtS is measured in nanograms per milliliter (parts per billion), whereas blood alcohol is measured in grams per deciliter (parts per hundred). Advances in instrumentation, including GC/MS, LC/MS and LC/MS-MS, allow for the accurate quantification and identification of the EtG and EtS metabolite in urine.

Comparison of Detection Times for Ethyl Glucuronide (EtG), Ethyl Sulfate (EtS) and Ethanol

Urinary levels of EtG and EtS are detectable from shortly after alcohol consumption to as many as three to five days following alcohol consumption. Generally, this is approximately 80 hours after complete elimination of ethanol from the body. In contrast, blood and urine ethanol can normally be detected for only a few hours after ethanol consumption. Thus, both EtG and EtS can be used to detect recent intake of ethanol even when the ethanol dose has been eliminated from the body. The studies that were conducted to reach these conclusions were carefully monitored for ethanol consumption and excretion as well as concurrent water consumption. EtG and EtS are both sensitive and specific indicators of recent alcohol consumption. They provide for a longer detection period than ethanol and thus can detect recent alcohol consumption even when ethanol is no longer measurable in body fluids (Helander & Beck, 2004).

There are numerous over-the-counter (OTC) medications that contain ethanol. Food and beverage flavorings may utilize trace amounts of ethanol. The ingestion of these products may result in detectable levels of EtG and/or EtS. For zero tolerance programs such as licensees who are subject to substance use monitoring, the use of EtG and EtS is a more reliable indicator of abstinence than urine ethanol testing. However, to avoid incidental exposure of alcohol through mouthwashes, OTC medications and other products such as alcohol-based hand sanitizers, the monitoring contract must specify that any use of any product that results in a positive EtG or EtS test because they contain alcohol shall be considered a positive drug screen for alcohol. The feature of using urinary EtG and EtS testing for detection of heavy drinking several days back is valuable for detection of relapse or consumption of alcohol in situations where complete abstinence from alcohol is agreed upon or required (Helander, Bottcher, Fehr, Dahmen, & Beck, 2009).

Evaluation of Alcohol Ingestion

The presence of EtG or EtS in a urine sample is an indication of prior use within the past three to five days. A positive EtG or EtS may also represent incidental exposure through other products. In the event the participant denies alcohol use, the participant must be required to undergo an evaluation with an addictionologist who has expertise in EtG and EtS testing and interpretation.

EtG and EtS simultaneous testing is best used for:

- documenting abstinence
- discouraging drinking
- early identification and confrontation of relapse
- to rule out false positive urine alcohol (such as with in vitro fermentation)

(Skipper, 2009)

In order to minimize excuses by those being drug tested that there was incidental exposure to products or foods containing alcohol, programs and boards need to state in their terms of participation that it is the responsibility of the nurses being drug tested to know what they are using or eating and to avoid products and foods containing alcohol.

For a zero tolerance program it is recommended that all tests include EtG and EtS testing for alcohol because of the availability of alcohol as a legal substance and the propensity to change from the drug of choice to what is available. EtG and EtS can be used to further confirm a positive ethyl alcohol urine drug screen result. At a minimum, EtG and EtS testing must be used if alcohol is the individual's drug of choice and must be used to further validate the results of any contested positive ethanol results.

Hair Testing

Some monitoring programs are using hair testing in addition to requirements for random urine screening. Drugs that can be detected through hair analysis include cocaine, marijuana, opiates (including heroin and synthetic opiates such as Fentanyl), amphetamines (both methamphetamine and Ecstasy) and phencyclidine (PCP). It takes approximately seven to 14 days post-use for the drug to be detected through hair testing which renders hair testing ineffective in situations where active use or impairment is suspected. Hair testing is most commonly used in monitoring abstinence in nurses who have access to, and a history of, using drugs that have short detection times in the urine such as Fentanyl, propofol and other similar drugs. Although it is not useful in assessing for current use and lacks the specificity to identify when and how much of the drug was consumed, it is useful for monitoring individuals in abstinence-based (zero tolerance) programs because the detection period is up to three months or longer. Unlike urine drug testing, temporary abstention will not evade the test.

Description of Services for Drug Testing Service Providers

There must be requirements and guidelines outlined for any drug testing service provider (DTSP) that provides drug testing for regulatory agencies or alternative programs. The DTSP must establish and maintain an alcohol and drug testing program that schedules, tracks, observes, analyzes and reports the test results of the participants. In addition, the DTSP or its subsidiaries must consult with the licensing agency or alternative program about the test results.

Drug testing service providers minimum qualifications include:

- possession of all the materials, equipment and technical expertise necessary to provide all the required services
- an ability to scientifically test for urine, blood and hair specimens for the detection of alcohol, illegal and controlled substances. (The DTSP must subcontract drug testing services with toxicology laboratories accredited and certified by the U.S. Department of Health and Human Services, College of American Pathology or American Board of Forensic Toxicologists.)
- provide collection sites that are located in areas throughout the testing state
- have an automated 24-hour, toll-free telephone system
- have their own or subcontract with operating collection sites that are engaged in the business of collecting urine, blood and hair follicle specimens for the testing of drugs and alcohol within the testing state
- have a secure HIPAA compliant website or computer system to allow regulatory or alternative program staff access to drug test results and compliance reporting information that is available 24 hours a day
- employ or contract with toxicologists that are licensed physicians and have a knowledge of substance use disorder and the appropriate medical training to interpret and evaluate laboratory drug test results, medical histories and any other information relevant to biomedical information

Specific services of the Drug Testing Service Provider include:

- providing a toll-free consultation and assistance to staff and participants during regular business hours, Monday through Friday (8 am to 5 pm)
- providing and maintaining an automated 24-hour, toll-free telephone system informing the participant whether or not they have been selected to provide a specimen (i.e., urine, blood or hair) for testing and analysis
- an automated 24-hour, toll-free system that can positively identify the participant by a personal identification number or license number entered by that specific participant
- a system that can record the date and time of the participant's calls
- an ability to provide collections seven days a week, 24 hours a day
- a report of non-negative test results to designated program staff within 24 hours of receipt
- immediate receipt of any information necessary to change the testing frequency of each participant or have a database system that allows designated program staff or the licensing agency to view testing schedules and change the testing frequency for each participant as necessary (Testing the same day of notification if the program or licensing agency believes the participant is a risk.)
- ability for the program or licensing agency to select a participant to test through secure access to the DTSP's system
- all the information on the participant's account is available to the licensing agency or alternative program via secure, HIPAA compliant, Internet or computer access at all times

DTSP collection services must include:

- collection sites that employ collection personnel to observe or witness the collection of urine or hair specimens and compliance by the personnel with all U.S. Department of Transportation observed collection guidelines and chain-of-custody procedures at all times
- every effort to locate and provide a collection facility that is most convenient to the participant

- making its collection site list available upon request
- for all positive test results, the maintenance of copies for each chain of custody form for five years (Each chain of custody form can contain the collector's name and collection site address and can be provided to the licensing agency or alternative program upon written request received by email, fax or letter.)
- for all negative test results, the maintenance of copies for each chain of custody form for one year (Each chain of custody form can contain the collector's name and collection site address for any individual who collects a specimen from a participant. This information must be provided to the regulatory agency or alternative program upon a written request received by email, fax or letter.)

DTSP laboratory services must include:

- services for the scientific testing of urine or hair specimens for the detection of alcohol, illegal and controlled substances (If the DTSP subcontracts these services, it must be with toxicology laboratories certified and accredited by the U.S. Department of Health and Human Services, College of American Pathologists or American Board of Forensic Toxicologists.)
- any subcontracted toxicology laboratories conducting the initial specimen and subsequent confirmation (such as urine, blood or hair) analysis by methods that meet professional standards of the forensic toxicology industry
- ensuring that only laboratory personnel handle urine or hair specimens and that the chain of custody procedures are followed at all times

DTSP Laboratory Results

The Drug Testing Service Provider must maintain a secure website or computer system for the transmission of all positive test results to the alternative program or licensing agency.

The following services related to laboratory results must be provided:

- drug cutoff levels identified on all laboratory results
- creatinine, specific gravity, pH and temperature (specimen validity testing) levels identified on all results whether they are above or below cutoff levels
- identification of the quantity level on any positive result
- confirmation testing by gas chromatography or mass spectrometer (GC/MS)
- negative laboratory results to the alternative program or the licensing agency via the DTSP's secured website or computer system within 24 to 48 hours of specimen receipt by the laboratory
- storage of all negative specimens at the laboratory for 14 days following the date of the original test
- storage of all positive specimens at the laboratory for one year following the date of the original test
- retention of any positive specimens at the laboratory for more than the scheduled one year if requested to do so in writing by email, fax or letter through the alternative program or licensing agency (The written request must be made prior to the one-year disposal period. Any specimen retained will be kept for administrative hearing purposes.)

The DTSP toxicologist specialist must:

- have access to the services of a toxicologist specialist who is a licensed physician, has knowledge of substance disorders and the appropriate medical training to interpret and evaluate laboratory drug test results, medical histories and any other information relevant to biomedical information

- not discuss results with any participant, unless directed to do so by the alternative program or licensing agency
- document the conversation about any positive test after receiving appropriate authorization from the licensing agency or alternative program (The documentation must be signed by the toxicologist under penalty of perjury and can be mailed directly to the alternative program or licensing agency within three working days along with all pertinent documentation involving the collection and results of the positive test.)
- provide to the alternative program or licensing agency any contact information and credentials on an as-needed basis (Requests can be made in writing via email, fax, or letter.)

The DTSP testimonial services include:

- providing a testimony through declaration

The DTSP provisions for online or computer access must include:

- access to a secured website or computer system to obtain and retrieve various test results and reports (If there are any changes to the electronic reporting system for test results and reports, the alternative program or licensing agency must be notified in writing within 90 days prior to the change.)
- information regarding any noncompliance or violations regarding any participant who fails to call in or report for a drug test
- access for program staff to other information relevant to participant's compliance such as case notes, testing history or personal history

Summary

Some of the unique characteristics to consider whenever monitoring health care professionals for substance use or dependency are:

- the high stakes that are involved for patients and the nurses
- health care professionals are sophisticated and knowledgeable about drugs
- health care professionals often come to the attention of state licensing authorities after some significant event has occurred whether it is a legal, personal or professional or work-related event
- health care professionals are knowledgeable about drug-screening and methods to beat the test and have access to equipment and supplies including clean urine that can be used to avoid drug use detection
- health care professionals are often reluctant to be truthful and reveal to employers and state licensing authorities their substance use or addiction
- health care professionals' drug use has great potential to affect the patients receiving their care

Drug testing is a valuable tool for monitoring compliance with board orders and alternative program agreements and in assuring patient safety in a population who have a known substance use disorder who are or will be returning to nursing practice. The panel of drugs tested must be consistent with the drugs commonly available and used by health care professionals. The panel of drugs must also include known drugs of use by the individual. Just as the panel of drugs is subject to change as new and addictive drugs become available, the detection limits of drug metabolites are subject to change with advancements and improvement in technology and availability. The guiding principle must be based upon the board's mandate of protection of patients.

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CHAPTER FOURTEEN

THE IMPORTANCE OF OUTREACH AND EDUCATION FOR ALTERNATIVE PROGRAMS

IT IS NO LONGER SUFFICIENT for alternative programs to just provide information to the larger health care profession about what it is like for the nurse with a substance use disorder and then believe that their work is done. The health care profession does need to become more aware but their failure to become not only enlightened but to also make positive strides toward identification, intervention and the retention of the nurse with substance use disorder will not be just their problem or shortcoming. Awareness needs to be followed by actions.

There are variables that impact a list of sociological phenomena. In this instance, understanding why nurses misuse substances humanizes the experience, which will ultimately prevent other nurses from demonizing their colleagues who have this medical illness (Dunn, 2005). Outreach and education therefore have to become a vital part of any alternative programs' mission. To be successful in their educational endeavors the alternative programs must be educated about what will both impact and be impacted by the human and organizational factors, venues, audiences and strategies.

Education and the Workplace Culture

Human and organizational variables in the health care setting can sometimes stonewall the best educational intentions. Certain individual factors such as a nurse's substance use history, genetics, family history, personal culture, beliefs about substance use, knowledge about abuse and access to drugs may influence the presence or absence of a substance use disorder. However, in order to fully educate others, the programs also need to assess the social and cultural fabric of the workplace by first asking a few questions. What are the details of the organization's drug administration policies and procedures? Do nurses adhere to good policies and procedures? What is the health care organization or corporation's stance regarding nurses who evidence active substance use in the workplace? What are the organization's formal and informal philosophies and policies toward nurses with a substance disorder in the workplace? Does the practice match the philosophy? Is there a history of co-dependency or complacency? Or does the organization support proactive interventions for nurses with a substance use disorder? Does the administration or corporation support the hiring or retention of identified nurses whenever prudent? What experience, positive or negative, has the organization had with the alternative program and its participants?

Any of these variables could cause the work culture to be unsympathetic to the desire to seed a change in thinking.

Alternative programs must provide an education that integrates socio-cultural factors into a true bio-psycho-social model (Chin, Monroe, & Fiscella, 2000). Educational efforts will be unlikely to succeed if the past history of the organization or target audience has not been previously assessed, much less if any ignorance or prejudice has not been identified. Programs must persevere in order to revise attitudes, since this type of reconstruction can be the foundation for behavioral change as has been discussed before in health care (Conner, Longshore, & Anglin, 2008) and other sciences (Nickerson, 2003).

Transtheoretical Model

Programs are accustomed to working with individual participants using the transtheoretical model of behavior change (Prochaska & DiClemente, 1986), which offers insight into an individual's motivation for change. However, as acknowledged, the root causes of the nurse with a substance use disorder in health care are wide-ranging and any educational activities need to take into account the motivational structure that is influencing individuals. The wide range of intervening forces causes programs to undertake at least a cursory assessment of what may be driving or inhibiting growth in the workplace. One example is the model based on Kurt Lewin's force field analysis (Swinton, 2009).

CAGE Model

A majority of nurses are probably going to be interested in learning more about just what is a substance use disorder (Deehan, McCambridge, Ball, & Strang, 2002). This finding supports the adult learning principle of providing information that the learner can apply to his/her work role. Provision of a simple but practical assessment tool can help health care workers to increase the self-awareness and the clinical competencies of any educational program.

One of the easiest and widely used tools is CAGE, which stands for:

- the need to Cut down on your drinking
- Annoyed by others' criticisms of your drinking
- feeling Guilty about your drinking
- using your drinking as an Eye-opener, (first thing in the morning)

(Ewing, 1984)

CAGE can also be modified to assess the risk of drug abuse by substituting the terms drugging and drug for drinking and drink (Brown, 1992). CAGE can be used in most adult health care settings and serves to promote positive relationships and interest when speaking to groups about what a substance use disorder is and how it relates to nurses.

Representatives of alternative programs must consider their own expertise as an asset for helping to convert knowledge into change. Program directors and staff are likely to have unique experiences and insight in the area of nurses and their substance use disorder that few others in the field of addiction can equal.

Improving access and providing alternatives to the usual didactic approaches to substance disorder education can also make a difference in nurses' ability and desire to respond positively to colleagues evidencing a substance use disorder. In the final analysis, a program's outreach activities must offer nursing peers and their employing organizations the competencies and best practices needed to effectively care for and manage the nurses who have a substance use disorder. This requires programs to match their outreach resources to the learning needs. Although every alternative program has varying degrees of limited resources, there is more of an array of educational modalities than ever for programs to accomplish positive change.

Modes of Outreach

Formal, face-to-face education such as continuing education (CE) is one type of outreach. The following list provides additional examples of outreach that can be undertaken by alternative programs as part of an educational and public relations campaign.

Online Programs

Programs on websites and related links may be the easiest way of maintaining current program information for nurses and the public. Alternative programs can use websites as a more convenient way to provide continuing education and information that is needed by practicing nurses, their managers and others. It can also be helpful for alternative programs to post their program overview and orientation material on their website in the form of a PowerPoint slide show, especially given the competing demands of more information and limited amounts of time in people's schedules. Employers and others will typically benefit from websites that contain frequently asked questions (FAQs) about the program, its mission, structure and philosophy along with information pertaining to the neurobiology of a substance use disorder, identification, referral, retention and relapse and the monitoring of participants.

Program websites can offer links to more information about many of the complex issues that make up a substance use disorder.

Some of them are:

- National Institute on Alcohol Abuse and Alcoholism
- National Institute on Drug Abuse
- Substance Abuse and Mental Health Services Administration

Posting program forms on the website makes it possible for others to easily access them and gives program staff more time for more important work. Individuals can be directed at the site to necessary forms, which reduces the amount of time and money spent on the phone and sending out information. Answering requests and questions through the website may also provide an easier way to correspond and give an opportunity to obtain more feedback about what continuing education topics or target audiences want addressed. More sophisticated programs may even have program forms and data submission including CE offerings and forms provided on a secure web-centric computer site.

Other modes of outreach are:

- presentations at formal meetings of the board of nursing's board of directors about reports or updates
- program orientation for new board members
- presentations as a guest speaker at nursing organizations' meetings and conferences
- regular face-to-face or teleconferencing between alternative program personnel and board of nursing enforcement staff (in order to keep each entity abreast of policy and personnel changes or communication needs)
- program brochures for distribution (to reach individuals with essential program information such as the mission, quotes from successful nurses, keys to identifying nurses who may be active in their substance use disorder, the mechanics of identification, referral, eligibility and participation along with monitoring requirements)
- posters and flyers for distribution to health care facilities and organizations (to heighten awareness of what a substance use disorder is among nurses, especially in the workplace)
- program newsletters distributed electronically or by mail to the necessary members of the program including participants
- providing relevant articles for publication in various state-wide nurses' organizations and associations, the board of nursing and specialty organizations

- providing positive talking points that both the program and the licensing board have agreed can be used in many different situations (such as interviews with the media in order to emphasize the benefits of the alternative program and its complementary role with the board of nursing)
- consultations with health care organizations (in order to help personnel develop policies and procedures pertaining to nurse employees with a substance use disorder or to problem-solve other needs)

Special Educational Strategies

In order to realize their true potential, the alternative programs must consider themselves more than agents for individual nurses that are being monitored. Alternative programs are also agents for behavioral changes in the workplace through education that is directed at attitudes and values (Arbuthnott, 2009). Alternative programs can lessen some of the barriers faced by nurses with a substance use disorder by using educational approaches that may induce attendees to examine their own beliefs and motivations.

Special strategies that may help to change behavioral attitudes can include:

- taking a pre-workshop assessment to help the presenter focus on the wants, needs and issues of the attendees (Appendix C provides an example of a pre-workshop assessment template for alternative programs. Taking the time for assessments can further help to minimize or eliminate any barriers to learning and improve the effectiveness of the program. Nursing education departments, human resources or nursing administration are the most likely contacts to assist in coordinating assessments for planned continuing education activities.)
- providing attendees the opportunity to complete self-assessment tools for substance misuse for their personal use or reference
- having successful recovering nurses who were former program participants tell their stories about how they became active in their addiction and what led to a successful participation and completion in the alternative program and aftercare (This can provide a powerful and moving reminder that the programs save lives and careers.)
- having nurse managers participate who can offer positive testimonials about their experiences with recovering nurses in the alternative program (Provides attendees with a perspective about the benefits to be gained by working with the alternative program.)
- having other representatives from the workplace such as EAP, HR, pharmacy, risk management and chaplaincy (The different resources will help display the breadth of problem-identification as well as the solution-set for nurses with a substance use disorder.)
- role-playing an intervention and return-to-nursing practice of a nurse whose substance use has impacted his/her practice and colleagues (This can help individuals experience what it is like to be in a difficult situation and gain additional insight into the staff who enables or stonewalls the returning nurse.)
- information on the potential cost-savings from reducing turnovers and the human savings when nurses enter into treatment
- taking the time to solicit from attendees, through discussion and the educational activity evaluation form, how they can apply the knowledge gained from the continuing education in their clinical practice (Recommended follow-up on the competencies to practice is one to six months after the program.)

These strategies are worth the extra planning and coordination that is required because they help to achieve behavioral changes through the best practices in the workplace.

Outreach modalities and special strategies that are specifically matched to the needs of the learner dramatically increase the positive results. In 2002, both the National Student Nurses Association and the American Nurses Association passed resolutions that called for greater education of student nurses about the risk of addiction and called for students to have access to such alternative programs (NSNA, 2002; ANA, 2002). Knowing who the target audience is can also ensure better outreach results because the educational needs of different populations will vary. For example, the needs of nursing students will be different from experienced nurses or the needs of critical care nurses versus ambulatory care nurses.

Target Audiences

A list of some of the target populations that alternative programs can consider for outreach includes:

- nursing management and staff who are on the front line of identification, referral, re-entry and monitoring
- nurse monitors (nurse monitors who are charged with the oversight of program participants' nursing practice are needed but often overlooked by alternative programs)
- chief nursing officers, other executive officers and health care administrators (especially corporate headquarters for health care organizations and facilities)
- state-wide nursing associations and nursing specialty organizations (including those for nurse educators who often need speakers and topics pertinent to their membership)
- long-term care, home care and specialty hospitals (especially small organizations or those located in rural areas where there may be less human resource expertise and administrative assistance or knowledge when it comes to dealing with nursing personnel with a substance use disorder)
- human resource personnel at health care facilities (an integral part of administrative interventions and the determination of available benefits, resources and hiring or firing)
- employee assistance program personnel at health care facilities (to provide initial counseling and referral to local mental health providers with expertise in assessing for a substance use disorder)
- risk management personnel at health care facilities (providing appropriate information to corporate staff and health care administration about the termination, retention or hiring of a nurse with a substance use disorder)
- pharmacy personnel at health care facilities (assist in the identification or referral process through inventory counts, medication administration audits and ensuring that proper medication administration and control procedures of controlled substances are extant)
- student nurses and schools of nursing faculty and administration (providing education through outreach about what a substance use disorder is and the need for a balance between life and work)
- board of nursing staff (especially administration, enforcement or investigation, legal and practice, as well as the members of the board of nursing's board of directors)
- state health investigators (including Office of the State Attorney General and field investigators in fraud who may be able to refer nurses within their investigations)
- health and human services investigators (Medicare fraud division)
- attorneys who specialize in criminal defense and nurses (providing information in order to better represent nurses before the licensing board)
- district attorneys (providing information about available assistance for nurses as part of sentencing or plea agreements)

- state legislators (providing essential program information, updates and talking points on a continuous basis, not just when the program's purse strings are threatened)
- alternative program staff (providing continuing educational materials to volunteers, support staff, case managers and alternative program directors about the mission and benefits of the program) provide a variety of topics for presentations that are specialized to the particular audience

Continuing Education Topics

Development of an educational activity does not need to be elaborate and can be geared to the audience's needs. Sometimes providing an overview of the alternative program's purpose, philosophy, structure and processes is enough to engage audiences in further discussion. An example of a program's educational overview is the agenda provided in Appendix D, first page, used by the Texas Peer Assistance Program for Nurses' (TPAPNs') volunteer nurse advocates who often provide continuing education to nurses in their local communities. Alternative programs can benefit by having an overview as a way of introducing the mission, structure and processes of the program to nurses and others who may be impacted by a colleague's substance use disorder. Providing a structured program that can be replicated with consistency including awarding attendees continuing nursing education hours such as the American Nurses Credentialing Center (<http://www.nursecredentialing.org/ContinuingEducation.aspx>) can be an additional benefit for attracting nurses to educational offerings.

Programs can consider these topics as part of their educational presentations:

- the program mission, vision, philosophy or structure (including how it relates to the board of nursing)
- alternative program and the board of nursing distinguishing and complementary roles
- neurobiology of addiction with up-to-date and reliable resources about the science of addiction (good resources are *The Science of Addiction: From Neurobiology to Treatment* by Carlton K. Erickson [2007] or Robert L. DuPont's *The Selfish Brain* [1997])
- risk factors for substance abuse and dependency in health care
- identification of any substance use disorder
- referral process and requirements
- eligibility requirements
- intervention processes
- drug testing requirements in alternative programs and the workplace (especially for-cause drug testing)
- treatment needs or requirements
- required participation requirements for nurses
- return-to-work requirements (including restrictions and their rationale)
- workplace monitoring needs
- signs of relapse (awareness and actions for employers, monitors and co-workers)
- requirements for successful program completion
- program data (including numbers or rates of participation, return-to-work, completion and recidivism)
- best practices for the workplace
- life and work balance

The wide range of information to present along with the unique niche in which alternative programs serve can make outreach or education seem like a daunting task. However, the growth of online resources has helped many programs to attain or maintain currency in the burgeoning field of substance use disorder and related research.

Online Educational Resources

There are a lot of resources available online to address the particular needs of nurses with a substance use disorder. However, proceed with caution before using or recommending online resources and websites. Respected government and national organizations along with trusted private online resources known and utilized by program staff are a good place to start. A few of the more notable online resources (support and treatment) are listed below. These lists do not constitute an endorsement and readers are cautioned that website domain names may be subject to change.

- Alcoholics Anonymous (AA), <http://www.aa.org>
- Cocaine Anonymous (CA), <http://www.ca.org>
- Hazelden, <http://www.hazelden.org>
- Narcotics Anonymous (NA), <http://www.na.org>
- National Institute on Drug Abuse (NIDA), <http://www.nida.nih.gov>
- National Institute on Alcohol Abuse and Alcoholism (NIAAA), <http://www.niaaa.gov>
- Substance Abuse & Mental Health Services Administration (SAMHSA), <http://www.samhsa.gov>
- Individual state substance abuse programs, <http://www.dshs.state.tx.us/sa/default.shtm>, <http://healthvermont.gov/adap/adap.aspx>

For information on how some of the issues and policies about any substance use disorder and nurses are rendered at the national level, helpful information and perspectives can be found at the following websites:

- American Association of Nurse Anesthetists (AANA), <http://www.aana.com>
- American Nurses Association (ANA), <http://www.nursingworld.org>
- International Nurses Society on Addictions (IntNSA), <http://www.intnsa.org>
- National Council of State Boards of Nursing (NCSBN), <http://www.ncsbn.org>
- National Organization of Alternative Programs (NOAP), <http://www.alternativeprograms.org>
- National Student Nurses Association (NSNA), <http://www.nsna.org>

While parts of outreach and education have been examined thus far in this chapter, it is important to also understand how programs can begin to unite individual educational needs and goals into a whole plan through strategic planning.

Strategic Planning for Outreach and Education

The alternative program and the board of nursing can have mutually agreed upon minimum expectations for outreach and education services typically established by a service contract or a memorandum of understanding. These expectations can address some of the written annual educational plans and reports that are part of the programs' annual strategic plans.

Alternative programs need to develop a budget with income and expense line items necessary for implementing the proposed outreach as part of the strategic plan. Then the rationale for educational expenditures can be understood and approved by all of the program's participants, especially the board of nursing.

The nursing profession in each state can even gain value and raise attendance by ensuring that the program is an accredited provider of continuing education through one of the national credentialing organizations for nursing education such as the American Nurses Credentialing Center. For some alternative programs such as private, nonprofit or health care organizations this will sometimes help to reimburse the alternative programs' expenses incurred from providing continuing education on-site for the organization's nurses and other

professional staff. They can also suggest to the program to request a donation in lieu of a speaker's fee. Programs that accept financial reimbursements or donations for CE need to maintain appropriate documentation in order to ensure that generally accepted accounting principles have been followed.

Human and fiscal resources are often lacking and alternative programs may also need to consider developing continuing education activities with the assistance of others in the field such as nurse volunteers, nurse educators and psychiatric mental health nurse practitioners who are capable of assisting with educational activities on behalf of alternative programs. It is important to ensure that those who speak on behalf of the program but are not paid staff understand the boundaries about what they can or cannot say.

Additional experts in the field of substance use disorder such as psychiatric or mental health nurse practitioners, MD addictionologists, medical review officers and pharmacists will sometimes speak for free and supplement the more technical information such as substance abuse treatments, prescription medications or drug testing and leave program information for program staff to address. Standardized curricula developed by the program and sanctioned for use by approved volunteers and interested parties can also be a cost-effective method for expanding program outreach.

Once the financial picture for the program's outreach efforts is understood, other aspects of planning can get started as well. Coming up with a plan is important even if there are certain aspects such as outreach activities, venues or anything that requires approval or coordination with others that still have unknown factors.

The details of each proposed activity within programs' strategic plans must be made in order to ensure the achievement of outreach goals such as:

- identified outreach goals
- types of outreach to be performed (such as CE workshop, brochures, webinars and flyers)
- deadlines for providing outreach
- locations to find CE activities or outreach materials (cities or facilities within the state)
- target populations identified (such as nursing staff, student nurses and board of nursing board members)
- type and length of CE to be provided (such as orientation versus formal workshop)
- award formal continuing education nursing contact hours
- evaluation methods for CE provided (such as formal written evaluations or individual follow-ups about updates in nurses' practices)
- resources needed to meet planned goals or activities (such as financial, material, physical and personnel)
- status of ongoing and long-term outreach resources

When a CE activity is being provided at a host site such as a hospital or school of nursing, it is important that the program not omit any planning detail. Appendix E provides an example of a checklist that can be used to coordinate between the alternative program and host facility. Various details and responsibilities of both parties involved with the continuing education are provided. Some programs may find it necessary to have a more legally binding agreement than this form can provide.

Evaluation

It is important to obtain feedback on individual presentations (CE activities) as well as the achievements and problems encountered by the program and its educational plan as a whole. Careful consideration of evaluations received about the individual outreach activities is necessary in order to identify strengths or needs and work toward improving content and

delivery. Obtaining feedback from a trusted professional mentor or colleague with experience in education can be invaluable whether one is new to teaching or has years of experience. Appendix F is an example of an evaluation form of a continuing education activity. All of the participants must take the responsibility and assess themselves using the evaluations and other feedback in order to accurately address the needs and make any improvements for future continuing education activities.

In order to improve best clinical practices for nurses with a substance use disorder, the evaluation phase must encompass any documented success for attitude and behavioral change as a result of the educational activity. Some of the changes may be in nursing practice, subsequent interventions or volunteers recruited. Additionally, the evaluation process, obtaining feedback and making corrections must accompany every outreach intervention and not just the continuing education activities provided.

Evaluation must also occur at the program level. To accomplish this goal, the alternative programs must provide, at a minimum, quarterly written reports detailing the programs' educational activities for the quarter. These reports must be directed to the board of nursing, the program's administration and the essential participants. The report must also include the activities that were provided, where, to whom, to how many and the type of participants in attendance, such as student nurses, CNOs, HR, ED nursing staff and administration. Significant achievements and problems must be noted including strategies on how to solve problems and challenges. Such documentation can assist with needed educational credentialing for presentations.

An annual evaluation of the outreach or education plan must also be completed and provided to the board of nursing, the program's administration and other identified participants. The annual evaluation must address how the strategic plan was met or not and the facilitators or barriers to success. Involving interested members of the program in the evaluation process such as representatives from the treatment providers, employers of nurses and board of nursing representatives can help ensure a more comprehensive and critical approach to the evaluation process. One model is the Plan-Do-Act-Study (PDSA) cycle originally developed by W. Edwards Deming and transposed to the health care arena (Institute for Healthcare Improvement, 2009). Alternative programs can use the PDSA tool as a means to plan and measure change. Alternative programs' willingness to take a circular and integrative approach to education evaluation, one that considers multiple views and methods will, in the long-term, help to develop better, evidence-based interventions producing improved outcomes for the benefit of all just as it did with the evaluation of medical interventions (Walach, Falkenberg, Fonnebo, Lewith, & Jonas, 2006).

Summary

It is necessary for alternative programs to set forth a reasonable and ongoing course for outreach and education for others so that their mission and merits are shared beyond the program. It is incumbent upon programs to intervene publicly and professionally in every aspect of a substance use disorder through outreach and education. Programs can be a part of the ongoing changes in the profession by starting with planning that addresses everything germane to substance disorder in nurses including needed resources and populations in need, to implementing plans and evaluation processes programs. This will give the health care profession the necessary tools to take care of their employees with a substance use disorder in a knowledgeable and competent manner. Given the growing scientific research on substance use and the ubiquitous electronic educational media, programs on outreach and education activities are more easily available for everyone.

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CHAPTER FIFTEEN

SPECIAL POPULATION GUIDELINES

THERE ARE POPULATIONS THAT MAY REQUIRE more stringent assessment, treatment, monitoring and reporting requirements because of the complexities and special needs that must be addressed by regulatory and alternative programs. Their management must be more scrutinized because of certain high risk factors for relapse.

Chronic Pain

It is estimated that a large percentage of the U.S. population experiences chronic or acute pain at any given time (American Pain Foundation, 2003). Approximately 70 million Americans will experience chronic pain and another 25 million will experience acute pain (American Pain Foundation, 2003). More than half of adults experienced chronic or recurrent pain in 2003 (Peter D. Hart Research Associates, 2003). It is unknown how many nurses suffer from chronic pain but it is likely to be at least similar to the general population. However, no research studies were found that quantified the number of nurses dually diagnosed with chronic pain and a substance use disorder. Anecdotal reports from boards of nursing about how to best manage the patient safety concerns when a participant is identified as having one, let alone both of these disorders suggests this is a growing concern for them. NCSBN recognized the complex issues of regulation surrounding the issues of pain management and addressed them in a publication entitled, *Regulatory Implications of Pain Management in 2007* (Brekken & Sheets, 2007).

The estimates of the prevalence of substance abuse in the general population with chronic pain vary across settings, depending on the definition used and the samples examined, ranging from zero to 50 percent (Hojsted & Shogren, 2007). Despite the variability in these estimates addiction and pain specialists often treat patients dually diagnosed with concurrent pain and a substance use disorder. The assessment of pain in substance-dependent populations is complicated by the lack of objective measures to assess pain. Pain management specialists and addiction specialists at times are even conflicted on how to best treat this population. Addiction specialists frequently encounter patients with antisocial behavior and in this context patient self-reports of pain and substance use status are often called into question. Conversely, the pain management community widely endorses the idea that pain exists whenever the patient says it does (Modesto-Lowe, Johnson, & Petry, 2007).

Opiates are widely accepted as an appropriate and effective method for relieving chronic pain regardless of the substance use history. The management and appropriate treatment of individuals who are dually diagnosed with addiction and chronic pain is, much like nursing regulation, controversial, complex and requires expertise and increased vigilance. They may be appropriately prescribed opioids for treatment of chronic pain but require close monitoring and assessment of safety to practice and for early signs of relapse. In a study conducted by Dunbar and Katz (1996), 45 percent of patients who had a history of chronic nonmalignant pain and substance abuse were found to show aberrant medication-taking behavior (AMTB) consistent with relapse while on opiates to manage pain. Similar to other studies of relapse, the individuals who relapsed while being treated for chronic pain were not active in a 12-step program and had less than three years of sobriety before starting opiates for chronic pain. Other risk factors included a lack of family support, a lack of active 12-step involvement, a recent history of polysubstance abuse and failure to improve the management of the chronic pain. Given the increased potential for relapse in this population, boards of nursing and alternative programs must exercise caution and increased surveillance when determining the appropriateness for acceptance of a participant with a recent active addiction into the alternative program.

Common symptoms of relapse in this population include aberrant medication-taking behavior (AMTB), which are a spectrum of behaviors that involve taking medications in a manner that is not prescribed. It includes obtaining prescription medications from multiple providers and pharmacies, purchasing prescription-only medications from a non-medical source or international sources, forging prescriptions and obtaining and using illicit drugs (Ballantyne & Mao, 2003). For nurses who have easy or ready access to controlled drugs through their workplace, the potential for misappropriation or diversion of controlled substances must be considered and appropriate patient safeguards put into place.

Urine testing is a practical and important tool for monitoring compliance with alternative-to-discipline substance abstinence requirements. Although there are obvious benefits to drug testing, there are limitations as well when the nurse is being prescribed controlled substances for a legitimate medical disorder. Therefore, for nurses who have a substance use disorder and who are dually diagnosed as having chronic pain disorder, which is being treated with controlled substances, the drug screen test results cannot be the only means to detect relapse or monitor treatment and alternative program compliance. Behavioral monitoring and drug screening for patients receiving chronic opioids or other potentially addictive medications creates a more comprehensive monitoring system than either one on their own (Dunbar & Katz, 1996). Behavioral monitoring for nurses must include workplace restrictions and supervision, regular and routine audits of the nurse's workplace access to controlled substances and the ability of the alternative program to intervene and remove the nurse from practice if there are any concerns about AMTB, relapse or if they are safe to practice.

Alternative programs may be able to monitor these individuals effectively as long as measures are implemented to decrease the potential for relapse and assure the participant is safe to practice while on these medications. These measures include neuropsychological evaluation to assess cognition, problem-solving, memory and judgment prior to return to practice.

Measures that can be taken if there are any identified practice deficits include:

- frequent random drug screening
- requiring a single prescriber with expertise in both pain management and addictions
- requiring use of a single pharmacy for filling all prescriptions
- periodic review of prescriptions obtained and pharmacy utilized through the state's electronic prescription monitoring program (EPMP)

- notification to employer and alternative program of medication changes (including medication tapering)
- relapse prevention therapy
- ongoing frequent attendance in a 12-step program

Thirty-eight states have adopted laws establishing electronic prescription monitoring programs (EPMPs) with additional states in the process of proposing, preparing or considering legislation (Center for Practical Bioethics, 2009). Under most programs the providers or pharmacies send records of controlled substances prescribed to a state-based, centralized regulatory agency, which monitors whether individuals are receiving prescriptions from multiple providers. The EPMP also allows the provider to verify whether a particular patient is receiving prescriptions from other providers. Electronic prescription monitoring programs can be a useful monitoring tool and can provide important information for providers and alternative programs in identifying drug-seeking behavior and verifying compliance with the terms of their treatment and the terms of the alternative program's stipulated agreement.

For individuals who are prescribed potentially impairing medications, whether it is to treat chronic pain, anxiety or as an adjunct to recovery through medication-assisted recovery (such as methadone or suboxone), the risk of relapse is greater and the ability to detect early relapse through drug screening is potentially compromised.

Participation in the alternative program for nurses with a substance use disorder must include the following additional requirements:

- minimum five-year participation in the alternative program
- undergo neuropsychological evaluation prior to a return-to-nursing practice and at any time that cognition appears to be negatively impacted as a result of illness or treatment
- engage in treatment with one provider that has expertise in addictions and pain management
- maintain a continuous release of information allowing the provider to communicate directly with alternative program staff
- monthly progress reports submitted from the provider
- utilize one pharmacy and provide name of the pharmacy to the alternative program
- provide quarterly prescription profiles
- regular verification of prescriptions through the EPMP if available (every six months or more frequently as determined by the alternative program)
- direct supervision
- no night shift
- no shift longer than 12 hours
- no more than 40 hours per week (less, depending upon provider recommendation)
- monthly reports from the nursing employer for the first year and if no identified issues, quarterly thereafter
- no access to controlled substances in workplace for a minimum of 12 months if there is a history of diversion, prescription fraud or multiple prescribers
- notification to nursing employer and alternative program staff of any changes to medications, including addition, deletion or change in dose prior to assuming any patient care duties
- submit a letter from provider confirming safe-to-practice with any changes in medication
- agreement to immediately cease practice upon notification by the alternative program of noncompliance or other symptoms suggestive or known to be part of a relapse

- random weekly drug screening during the first year (three times per month the second year, tapering to a minimum of two per month if fully compliant with all parameters and practice documented by supervisor as safe and appropriate)
- minimum of three times per week attendance in 12-step meeting, aftercare, relapse prevention and nurse support
- relapse prevention therapy with the provider (with expertise in pain management, addiction and relapse)

Medication-Assisted Treatment

The Center for Substance Abuse Treatment (CSAT) consensus panel recommends that medication-assisted treatment for opioid addiction (MAT) as provided in opioid treatment programs (OTPs) be conceptualized in terms of phases of treatment so that interventions are matched to levels of patient progress and intended outcomes (Batki, Kauffman, Marion, Parrino, & Woody, 2005). It is when patients are discharged from treatment and aftercare and enter into a stable recovery that the question arises about types of medications such as buprenorphine and methadone.

According to some researchers, chronic drug users can display neuropsychological impairment in the domains of executive and memory function. (Loeber, Kniest, Diehl, Mann, & Croissant, 2008). Individual factors will influence the degree to which neuropathology or changes in the brain exist. The research on the cognitive effects of MAT as applied specifically to the recovering health professional's use is non-existent at this time. Studies are required to investigate the effects of methadone and buprenorphine maintenance treatment especially regarding dose-dependent effects since high to very high doses of both substances seem to have the potential to ameliorate cognitive functioning (Loeber et al., 2008).

Nurses in MAT face unique employment challenges especially as employers increasingly impose pre-employment drug testing and nurses must wrestle with whether to disclose their status. Nurses must be advised to answer all job application questions honestly and must be counseled on ways to manage disclosure of their treatment status. A nurse who is in a documented recovery is covered under the Americans with Disabilities Act of 1988.

The legalization of medical marijuana is an emerging issue and some states have passed legislation for prescribed medical use. This presents unique challenges for the regulatory management of this population. The same stipulations and requirements that apply to those with medication-assisted treatment or chronic pain management may be applicable to this population. Until further evidence exists it is recommended that those using medical marijuana be prohibited from participating in the alternative program.

Contract Guidelines for Chronic Pain and Other Mind-Altering Chemicals

For individuals who are prescribed mood-altering medications, whether it is to treat chronic pain, anxiety or as an adjunct to recovery through medication-assisted recovery (such as methadone and buprenorphine), the risk of relapse is greater and the ability to detect early relapse through drug screening is potentially compromised.

Nurses who use such medications who are permitted to participate in the alternative program must have the following additional requirements included:

- participate in the alternative program for a minimum of five years
- submit to a neuropsychological evaluation prior to return-to-nursing practice and at any time that cognition appears to be negatively impacted as a result of illness or treatment
- engage in treatment with one provider that has expertise in substance abuse and pain management

- maintain a continuous release of information allowing the provider to communicate directly with alternative program staff
- submit monthly progress reports from the provider
- utilize one pharmacy and provide name of the pharmacy to alternative program
- provide quarterly prescription profiles
- provide regular verification of prescriptions through the EPMP if available (every six months or more frequently as determined by the alternative program)
- agree to have direct supervision
- agree to no night shift work and no work shift greater than 12 hours in length
- agree to work no more than 40 hours per week (less, depending upon provider recommendation)
- provide monthly reports from the nursing employer for the first year and if no identified issues, quarterly thereafter
- agree to have no access to any controlled substance in the workplace for a minimum of 12 months if there is a history of diversion, prescription fraud or multiple prescribers
- notify the nursing employer and alternative program staff of any changes to medications including changes in dosage prior to assuming any patient care duties
- submit a letter from the provider confirming safe to practice with any changes in medication
- agree to immediately cease practice upon notification of alternative program of noncompliance or other symptoms suggestive or known to be relapse
- consent to random drug screening weekly during the first year, three times per month the second year and tapering to a minimum of two per month if fully compliant with all parameters and practices documented by the supervisor as safe and appropriate
- attend a minimum of three 12-step meetings per week as well as aftercare, relapse prevention and a nurse support group
- engage in relapse prevention therapy with a provider who has an expertise in pain management, addiction and relapse issues

Older Populations

Although substance abuse is often considered a problem for the younger population, older adults are an at-risk population for developing a substance use disorder as well for several reasons. People are not only living longer and healthier lives, they are also managing longer retirements with the concomitant issues of having more free time, less valued work and more losses associated with children leaving home and the death of loved ones and friends (Dowling, Weiss, & Condon, 2008).

As the baby boomers age they are encountering the issues connected to being the first generation that holds more permissive attitudes toward substance use. Although it was once believed that many might outgrow their use and abuse of substances, it is now accepted that a substance use disorder initiated while young may persist throughout the lifespan (Dowling et al., 2008; SAMHSA, 1998). The nursing population is also aging and the risks associated with older adults apply to them as well. Treatment admissions for adults aged 50 years and older are steadily increasing, rising from 6.6 percent of admissions in 1992 to 12.2 percent of admissions in 2008 (SAMHSA, 2009). Alcohol continues to be the primary drug of abuse for older adults. Admissions reporting the abuse of multiple substances have nearly tripled from 13.7 percent in 1992 to 39.7 percent in 2008 (SAMHSA, 2009). Illicit drug use is also increasing in the older population with 44.9 percent of admissions using marijuana, 33.4 percent misusing prescription-type drugs and 6.1 percent misusing other illicit drugs (SAMHSA, 2009).

Between 1992 and 2008 the proportion of older admissions that reported primary alcohol abuse decreased from 84.6 to 59.9 percent, while the proportion that reported primary heroin abuse more than doubled from 7.2 to 16.0 percent. The proportion of older admissions that reported multiple substances of abuse nearly tripled, increasing from 13.7 percent in 1992 to 39.7 percent in 2008. In 2008, older admissions who initiated use of their primary substance of abuse within the past five years were more likely than those in 1992 to have reported prescription pain relievers as their primary substance (25.8 vs. 5.4 percent), (SAMHSA, 2010).

Although the abuse of illicit drugs is concerning, the primary drugs of abuse that contribute to the development of a substance use disorder for health care professionals are the same as those for the aging population. The abuse of alcohol and prescription-type medications is the primary reason for the development of a substance use disorder in older adults (Dowling et al., 2008). This can be a deadly combination because many older adults are unaware of adverse interactions that can develop when alcohol is used in conjunction with prescription medications. The abuse of alcohol alone or in combination with prescription medication can lead to an increased risk due to physiological changes of aging, as well an increase in medication interactions. In one recent study, over a third of the sample was at increased risk due to the use of alcohol alone or in combination with prescription medications (Barnes et al., 2010). Identification and referral of those either at risk or those with a substance use disorder is also lacking with health care providers less likely to ask older patients about their alcohol and prescription abuse (SAMHSA, 1998; Barnes et al., 2010). As the numbers of aging nurses and other health care providers rise, the risk for the development of a substance use disorder will also rise and result in an even greater need for identification, treatment and referral services.

Student Nurses

State boards of nursing do not monitor substance use disorder among student nurses. However, research demonstrates that nursing schools can develop alternative approaches for students that parallel and expand upon the procedures applied to practicing nurses who have a substance use disorder (Monroe & Pearson, 2009). Substance abuse is a major issue for nursing students, faculty and staff and can compromise the learning environment. An affected student, faculty member or staff person may have impaired judgment and skills, therefore appropriate identification, intervention and management of abuse and addiction is critical for nursing education and practice (AACN, 1998).

Studies have revealed that substance abuse among nurses begins before or while they are in school and that abuse of prescription drugs appears to be especially common (Monroe, & Pearson, 2009). To ensure the health and welfare of the nursing profession, care and attention must be given to the student nurse substance use disorder issues.

Anesthesia Professionals

The American Association of Nurse Anesthetists (AANA), the American Association of Nurse Anesthetists Peer Assistance Advisors (PAA) and the AANA Wellness Program all believe that the disease of addiction is characterized by a chronic, progressive and potentially fatal process that may destroy the professional, the family and the anesthesia community (AANA, 2007).

Successful re-entry to the anesthesia workplace is possible with supportive colleagues and an established department policy. Monitoring the recovery of nurse anesthetists and other nurses with a history of substance abuse and a substance use disorder requires a well-informed re-entry plan. The following recommendations are intended to provide information and education concerning these issues.

Based on over 25 years of experience with Certified Registered Nurse Anesthetists (CRNAs), the AANA Peer Assistance Advisors recommend that a good starting place for re-entry is a hiatus of a minimum of one year out of the clinical anesthesia arena and meeting the Talbott criteria (AANA, 2009) for re-entry:

- supportive spouse or significant other
- no untreated psychological co-morbidities
- acceptance of the chronic nature of a substance use disorder
- grounded in the recovery community (such as a sponsor)
- supportive worksite or department for re-entry
- willingness to commit to monitoring for a minimum of five years
- willingness to take Naltrexone where appropriate
- willingness to participate in toxicology screening on a random basis
- has supportive colleagues at the worksite familiar with history and needs

In the interest of patient safety and practitioner well-being the PAA, as a component of the AANA Wellness Program, investigates the availability and effectiveness of treatment modalities specific to anesthesia professionals and students and acts as a resource to the community regarding treatment issues.

A substance use disorder in anesthesia professionals and students can be successfully treated. The PAA are aware of the essential role that appropriate, adequate and effective treatment plays in successful treatment and return to anesthesia practice. Anesthesia professionals and students have unique treatment needs for a variety of reasons including controlled substance availability, potential loss of profession when inadequately treated, professional guilt and shame and a tendency to intellectualize the treatment process, among others (Wilson & Compton, 2009). Various treatment options exist for the disease of addiction. Success rates in the treatment of the anesthesia professional or student with a substance use disorder vary widely between treatment modalities. The PAA's function is to determine and recommend which available treatment modalities offer the highest rate of success.

The Peer Assistance Advisors recommend that all anesthesia professionals and students with any type of substance use disorder receive inpatient treatment at a Substance Abuse and Mental Health Services Administration (SAMHSA)-certified inpatient comprehensive addiction treatment center experienced in treating health care professionals. Completion of a minimum of 28 days (also termed short term) of inpatient treatment is recommended, with 90 days of treatment (also termed long term) being most desirable and offering the highest success rate.

The treatment center chosen must at a minimum include:

- comprehensive evaluation and treatment recommendations in all cases by an American Society of Addiction Medicine (ASAM) board-certified addictionologist
- evaluation when appropriate by an American Academy of Addiction Psychiatry (AAAP) board-certified addiction psychiatrist
- appropriate neuropsychiatric and or psychometric testing
- inpatient medically-supervised detoxification when medically indicated
- emphasis on a long-term 12-step model of abstinence-based recovery
- evaluation of suitability for and the timing of the return to anesthesia practice

Treatment center recommendations for aftercare and continuing care after discharge must be complied with including relapse prevention techniques, recovering professionals meeting attendance, active participation in the 12-step recovery community and monitoring

of random urine drug screens. Drug screen monitoring must be through a formal program administered by a state board of nursing or alternative program for a minimum of five years, though monitoring for the professional lifetime is more ideal.

The AANA does not advocate outpatient treatment, including intensive outpatient treatment, for the disease of addiction in anesthesia providers and students due to the high rate of recidivism. Any relapse after outpatient treatment must only be treated under the long term inpatient modality.

Summary

Special populations must also be considered when addressing any substance use disorder including the elderly and the student nurse populations. More research on student nurses increasingly indicates that many risk factors show up during nursing education and opportunities for identification and intervention of student nurses is lacking. Co-occurring issues with chronic pain also present many complex considerations. Nurses with chronic pain issues require special attention and contracts for monitoring. Anesthesia professionals have even greater work-related risk factors and have more stringent treatment and return-to-work requirements that are unique to their profession

Individuals with a substance use disorder who are actively prescribed other potentially impairing medications that may cause cognitive impairment or that would render drug screening monitoring useless must be carefully screened for appropriateness in entering the alternative program. Individuals with co-existing diagnoses with illnesses known to increase relapse risk such as chronic pain or select psychiatric illnesses may require additional screening to determine appropriateness for entry into the alternative program.

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CHAPTER SIXTEEN

ALTERNATIVE PROGRAM EVALUATION

THE GENERAL PUBLIC AND THEIR GOVERNMENT REPRESENTATIVES are often suspect of alternative programs because of a perception that the alternative programs and nursing boards are overly protective of their participants. The alternative program's guarded reserve, which is due in large part to the confidential aspects of its operations, may be misinterpreted as exposing the public to unnecessary risks. The boards of nursing must then by necessity engage the alternative programs in close communication and scrutiny to those operations and the established measures. This is how the boards and the public may judge the effectiveness of the shared system and thereby hold the participants accountable.

Nevertheless, it may be impossible for nursing boards and alternative programs to always pursue the many advantages possible in a shared system of dealing with practitioners with a substance use disorder without encountering some form of calculated risk. By definition, the boards and alternative programs are working with nurses who are suffering from a substance use disorder where relapse can be a part of the disease process. In addition, the nurse may be placed back into an environment where he/she will eventually have access to mind-altering drugs or drugs of abuse.

While in the program the nurse is not subject to discipline and remains a participant whose identity is unknown to the public and oftentimes with whom they work. Many programs permit multiple relapses before considering termination from the program or referring a nurse for discipline. For these reasons, it is understandable that news reports or governmental audits stemming from controversy tend to focus on these attributes of the programs. As a result, the avoidance of controversy is dependent on the ability and discretion of the alternative program to properly function within a defined system, the ability of the nursing board to assess the performance of the program through ongoing, close scrutiny and objective measures and the follow-through of the board after it has gathered and assessed that information.

Recent public scrutiny of alternative programs points to the need for regular program evaluation and a well thought out approach to highlight alternative programs' protection of the public. Regardless of literature showing the success of these programs and despite their cost-effectiveness and safety, there is often a tone of disbelief in media reports that

someone who has abused drugs was allowed to continue to practice. This disbelief coupled with confidentiality laws, which encourages program participation are a common criticism of alternative programs whether expressed or implied because they appear to hide misbehavior or even lead to patient harm.

Public criticism that programs lack accountability indicates a need for independent evaluations. Enacting such evaluations avoids the criticism that the profession is protecting its own or hiding impaired nurses in alternative programs. Evaluation also strengthens public protection by finding problems in processes, accountability or staff training before they result in harm to the public.

It is important that an alternative program maintains and continually improves the services it offers to the nursing community. Boards frequently develop close professional relationships with their alternative programs and come to rely on them to handle substance use disorder cases. Without regular evaluation the board may not be fully aware of what powers have been delegated to alternative programs, the decisions being made or even the definitions being used by the alternative program. For example, if the board believes that nurses will be returned after the second relapse, which the board believes means any use of a controlled substance but the alternative program defines some instances of drug use as a slip rather than a relapse, the board may be failing its public protection duty merely by lack of common definitions.

Nursing boards and alternative programs are increasingly being held to a higher standard by the public and must provide good evidence of how they are accomplishing their mission of public protection and safe patient care. These actions will achieve a shared goal of returning nurses to productive roles within their professional careers while addressing their substance use disorder (DuPont, McLellan, White, Merol, & Gold, 2009). The foundation of the effectiveness of boards and alternative programs achieving public safety is through a greater level of accountability and transparency in how they each administer the core elements of their operations. This is only met through a greater adherence to the rigors of evidence-based practice, organization, documentation, communication and statistical measures of performance at both a state and national level. Organizations that open themselves to public scrutiny and accountability by sharing substantial information with the public in order to promote informed decisions and provide balanced reports are more likely to be trusted (Rawlins, 2008).

In short, nursing boards and alternative programs must provide the public with good evidence in how they ensure public protection and safe patient care in order to achieve a shared goal of returning nurses to productive roles within their professional careers while addressing their substance use disorder.

Evaluation Components

Ongoing evaluations of the program provide checks and balances and make sure that policies and procedures are being implemented correctly and consistently. Evaluations also ensure that the program is meeting its mandates to protect the public and can identify areas for change and improvement. There must be a minimum of one evaluation of the alternative program every year. The alternative program must be accountable to itself, the board and the public, even if it is external to the board. Alternative programs were not meant to exist on their own and need to engage in some type of continuous evaluation. Program evaluation is defined as a systematic assessment of the program's efforts to measure actual outcomes against the intended outcomes of the program (Kirchner, Przybylski, & Cardella, 1994).

A program evaluation can do the following:

- discover achievement and results
- discover deviations from planned achievements
- judge the worth of the program
- identify unintended consequences
- recommend expansion, contraction, elimination or modification of the program

(Kirchner et al., 1994)

It is obvious that program evaluation is an invaluable aid in planning, developing and managing programs. However, to be effective program evaluation efforts must be placed within the broader context of program management. A flexible capacity for internal self-evaluation is fundamental to the management and ongoing improvement of programs. (Kirchner et al., 1994).

Programs that participate in evaluations will obtain information about their performance and how it can be improved. An evaluation can provide objective evidence that a program is effective, which demonstrates positive outcomes to funding sources and the community. It can help improve the effectiveness and create opportunities for programs to share information with other similar programs and agencies (BJA, 2006).

There are many types of evaluation activities including program monitoring, which continuously collects information to determine if programs are operating according to plan. Monitoring also provides ongoing information on program implementation and functioning (BJA, 2006). It is the process of developing and analyzing data to count or identify specific program activities and operations. A basic monitoring evaluation answers simple questions about a program's activities and rationale. For example, a good way to approach a problem is to ask who is doing what, when, where and how often and with what resources (Coldren, Bynum, & Thome, 1991). With respect to alternative to discipline programs, the answer would look something like this: individuals are monitoring eligible nurses with the aid of various health care professionals and others and the two basic activities are provision of treatment and work performance evaluation. These activities take place during the entire term of the participant's contract, which is typically three to five years. These activities take place in the alternative program facility and at various other settings and outside locations, such as counselor's offices and health care facilities. All of this is useful information.

Performance Measurement or Assessment

Performance measurement or assessment is the ongoing monitoring and reporting of information about whether a program is meeting its goals and objectives. Performance measurement can address project activities, services delivered and the products of those services (BJA, 2006). It focuses on whether a program has achieved its objectives expressed as measurable performance standards (USGAO, 1998). The alternative program must have these periodic performance reviews to evaluate whether or not it is supporting the overall direction of the program. This can be done by interviewing the program staff and participants or by direct observation. Exit surveys are also a good strategy for obtaining this information. The results of such an assessment can include a list of actions that need to be put in place in order to improve the overall performance of the staff and the program.

Process or Implementation Evaluation

A process evaluation can focus on program implementation and operation and can answer questions about program efforts, identify processes or procedures used to carry

out the functions of the program and address program operation and performance. Alternative program evaluations can include a periodic review of criteria, procedures, policy determinations and program direction to assure that decisions are congruent with current knowledge. The review must address compliance with legislative and board directives.

Outcome or Impact Evaluation

These evaluations focus on program success and accomplishments and answer questions about program effectiveness, address whether a program is achieving its goals and objectives and examine both positive and negative unintended consequences (BJA, 2006). When shared in the aggregate the outcome data can go far to support the value of the alternative program during budgeting, performance evaluations and sunset review. This is why it is important for an alternative program to maintain and continually improve the services it offers to the nursing community. Measuring outcomes tell the program and the evaluator what impacts or results the program has had, therefore this type of evaluation would be of great interest to the public and can be to the board as well. The real impacts are usually expressed in terms of behavior change in those served by the program by reducing relapses or increasing the understanding about the negative consequences of substance abuse. Outcomes may be divided into short-term, intermediate and long-term outcomes with the last usually being the program goal (BJA, 2006).

Cost-Effectiveness and Cost-Benefit Assessment

This type of evaluation focuses on more of a financial analysis of programs and uses the results from a sound program evaluation to assess how effective the program is relative to other program alternatives in terms of cost (BJA, 2006). Cost-benefit analysis does not answer the question of whether the program works, but uses the results of evaluations to compare the economic value of the outcomes and costs of one program with another (BJA). This type of assessment can be used to compare alternative programs with other available options or other alternative programs with respect to costs.

Evaluation of alternative programs can take many forms. A program may engage in its own internal evaluation, which may be formal or informal. Or it may contract out for an evaluation, often called an audit, to be performed externally, which is usually more formal. Participants in the program, whether past or current, can evaluate the program as well. Evaluations may be required by law in the form of performance audits or through a legislative sunset review process. Even if periodic evaluation is not required by law, they must still be done. Evaluation is an ongoing process. If all of these types of evaluations are in place, the program will benefit from feedback from a variety of sources. Regardless of the types of evaluations used, the board must also evaluate the program. The board must conduct routine audits and in-depth evaluations of the alternative programs. The results of these audits conducted by the board can be publicly reported and used to determine areas for improvement, confirm that the focus remains on public protections and if the program can continue.

Types of Evaluation Teams

One of the first issues that programs need to address when considering an evaluation is if there is an evaluation expert available and whether that person can be in-house or outside of the agency or program being evaluated (BJA, 2006). If there are funds, then a trained and experienced evaluator can be of great assistance to a program throughout the evaluation process. Before it can be done in-house, a program must weigh the particular advantages and disadvantages (BJA, 2006).

It is essential to find a qualified evaluator who is experienced in evaluating similar programs. The evaluator will need to balance the needs and concerns of a variety of decision makers including the program managers, maintain an objective evaluation and communicate with a wide variety of individuals who have an interest in the results of their work (BJA, 2006).

The decision to hire evaluators or only contract for their services can be determined by several values:

- the technical skills of the evaluators
- the evaluator's familiarity with the details of the criminal justice system (including sensitivity to the political or bureaucratic tensions that prevail)
- the disinterestedness of the evaluator
- the utility of the evaluation for the decision makers

(National Institute of Justice, 1989)

Evaluation is a team effort (KRA Corporation, 1997). Although one person heads an evaluation team and has the primary responsibility for the project, this individual will require assistance from the program staff.

An evaluation team will work together on the following tasks:

- determining the focus and design of the evaluation
- developing the evaluation plan, performance indicators and data collection instruments
- collecting, analyzing and interpreting data
- preparing the report on evaluation findings

(KRA Corporation, 1997)

There are many types of evaluation teams that can be assembled with at least three possible options. The first is hiring an outside evaluator. If the program does not have a research and evaluation staff it will probably need to hire one. The evaluator would be supported by in-house staff and serve as a team leader. The evaluator could come from a research institute or a consulting firm (KRA Corporation, 1997).

The second type of evaluation team would be made up of an in-house evaluation team supported by an outside consultant and program staff. If the program has sufficient staff resources to implement the evaluation but needs assistance with the technical aspects, it may be a good idea to hire an outside consultant. In this situation, an in-house evaluator would serve as the team leader and be supported by both program staff and the outside consultant. If there are research resources within the program, this may be a good option to consider. A consultant could support the evaluation by developing the evaluation design, conducting data analyses, and selecting or developing questionnaires. This person can also help develop the evaluation plan and performance indicators (KRA Corporation, 1997).

The third style is very similar and uses an in-house evaluation team supported by program staff. If resources are available within the alternative program (there is research staff, evaluators or program personnel who can assist with the evaluation), the program could recruit these individuals to serve as evaluation team members (KRA Corporation, 1997).

Someone from the program can become part of the team no matter what team option is chosen. Even if their role is limited to overall evaluation management, the staff person will want to participate in all phases of the evaluation effort. This decision will be based on the resources and capabilities of the program. To determine what internal resources are available, the program staff can examine their staff's individual skills and experience in planning an evaluation, designing data collection procedures and questionnaires and collecting and analyzing information (KRA Corporation, 1997).

A checklist is provided to help decide what type of team is needed. If the program doesn't have any of the resources listed, then the program may want to consider postponing the evaluation until there are sufficient funds to hire an outside evaluator. It may be necessary to consider budgeting funds for an evaluation in future program planning efforts (KRA Corporation, 1997).

If the program does have the first item but none of the rest, then an outside evaluator with in-house support is needed and the program will need maximum assistance in conducting the evaluation and option one is probably the best choice.

If the program doesn't have the first item on the list but has most of the other resources, then option three with only in-house staff may be an appropriate choice. If the program does have the first item but only some of the other items, then either option one or option two can be effective (KRA Corporation, 1997).

Checklist of Resources for an Appropriate Team Selection

- program has funds designated for evaluation purposes
- successfully conducted previous evaluations of similar programs, components or services
- existing measures or indicators of performance currently in place
- existing program practices and information collection forms useful for evaluation purposes
- collected evaluation information as part of your regular intake of participants
- program staff who have training and experience in evaluation-related tasks

(KRA Corporation, 1997)

Internal Evaluations

Internal evaluations must be an ongoing process for the alternative program staff. Due to the need to maintain transparency with the boards and the public, program staff must know the evaluation plan, which is a written document that states the objectives of the evaluation, the questions that will be answered, the information that will be collected to answer these questions and when collection of information will begin and end (KRA Corporation, 1997). An objective of an evaluation is a specific and measurable condition that must be attained in order to accomplish a particular program goal. There are many different ways to specify objectives. The program and evaluator can choose the method that works best for each situation. (BJA, 2006). The evaluation plan can be thought of as the instructions for the evaluation and can be used to guide program staff through each step of the evaluation process because it details the practices and procedures for successfully conducting the evaluation (KRA Corporation, 1997). Staff must also know the program goal, which can be a broad statement of what the program hopes to accomplish or what changes it expects to produce. Once the program staff is familiar with the identified goals and objectives, they need to specify the major activities or processes that will be undertaken in order to get to these goals and objectives.

Continuous, data-driven evaluation must be built into every alternative program. For example, data will tell how quickly participants who are referred to the program actually sign up to participate. These data also reveal whether the program is working the way it was intended (Yessian, 2009).

Most programs collect some information that is potentially useful for evaluation. At the outset, the evaluation needs to assess what data already exist, what the quality of the data is and whether it is readily available in a useable form. The answers to these questions will help to determine whether existing data can be used or whether new data must be collected (BJA, 2006).

When planning an evaluation, the evaluator must determine whether existing or new data will be used in data analysis. The advantage of using new data is the greater control an evaluator has over the measures, procedures and data collection staff, which can contribute to greater reliability and validity of the data (BJA, 2006).

Sometimes evaluators are able to use information that already exists without going through the expensive and time-consuming process of collecting new data. Information collected by the program for a variety of purposes may have value for performance measurement and evaluation. Evaluators can often make relatively small changes in the program's practices and procedures that will result in data that can be more readily used for evaluation.

Examples of existing data on program participants that might be used for evaluation include:

- attendance records
- counseling forms and progress notes
- discharge summaries
- other agency investigation reports
- psychological testing and other classification information

(BJA, 2006)

A highly accountable program would have look-back mechanisms built into it. These could include random monitoring of case files, and could serve as a check that the program staff is carrying out the program appropriately (Yessian, 2009).

Finding and Hiring an Outside Evaluator

Careful selection of the right outside evaluator can mean the difference between a positive and a negative experience. A good place to start is to consider using someone that the program or another alternative program has worked with successfully on another project and interviewing them. Other public agencies within the community may also be good sources for a referral (KRA Corporation, 1997).

Some of the criteria for hiring an evaluator can include:

- the level of experience in program evaluation
- any experience conducting evaluations in addictions and monitoring
- ability to offer assistance in the full range of program evaluation activities (including research design, data collection, data analysis, data interpretation and dissemination of the results)
- useful presentation of the information cost of the project
- the program staff's involvement in the evaluation
- willingness to work closely with the program staff and other necessary personnel

(KRA Corporation, 1997)

A good outside evaluator won't dictate to program staff how the project will proceed but instead will work in a collaboration to conduct a successful evaluation. The program manager can also have input into determining the purpose of the evaluation, research questions and performance indicators (KRA Corporation, 1997).

A good evaluator has:

- a willingness to work collaboratively to develop an evaluation plan that meets the program's needs
- the ability to communicate in simple, practical terms
- experience evaluating similar programs and working with similar levels of resources
- experience with statistical methods
- consideration of cultural differences

- the time available to do the evaluation
- experience developing data collection forms or using standardized instruments
- the willingness to work with any national evaluation team
- the willingness to treat data confidentially

(KRA Corporation, 1997)

Managing an Evaluation Headed by an Outside Evaluator

Often when the decision is made to hire an outside evaluator, the program managers and staff believe that the evaluation is out of their hands. This is not true. An outside evaluator cannot do the job effectively without the cooperation and assistance of program staff and program participants. An evaluation is like any activity taking place within the program because it needs to be managed (KRA Corporation, 1997).

Creating a Contract

One mechanism for effectively managing the evaluation is to prepare a written contract specifying the evaluator's roles and responsibilities. Both the evaluator and the program staff will need to sign the contract (KRA Corporation, 1997).

The contract is a legally binding document that specifies the evaluation activities to be performed, the amount of time to complete the evaluation and the cost. This document offers protection by specifying who is expected to conduct the work and how the data that has been collected will be used.

Every evaluation contract must include:

- who will perform evaluation tasks (Some evaluators delegate many of their responsibilities to less experienced staff and have little contact with the client once the contract is signed. To protect the program from this scenario the contract must specify what percentage of time the evaluator and his/her staff will devote to the evaluation.)
- who owns the evaluation data (In the contract specify who has ownership of the data and to whom the information can be given. Release of information to outside parties must always be cleared with appropriate program staff. Any plans for publishing the evaluation results must be discussed and cleared before articles are written and submitted for publication.)

Expectations about Contacts between the Evaluator and Alternative Program

It is very important for an outside evaluator to keep the program manager, program staff and participants informed about the status of the evaluation. Regular communication allows the program and other concerned parties to make important changes on an ongoing basis. A contract must specify expectations about the frequency of meetings and ongoing reporting requirements (KRA Corporation, 1997).

Participant and Employer Evaluations

Alternative program participants and their employers can be an effective way to evaluate a program. This must be done on a regular basis such as bi-annually. This type of evaluation can be conducted in the form of a written survey, a telephone survey or a personal interview. The information can serve as important feedback to ensure continued quality service for alternative program participants and improvement in service delivery. Larger scale surveys of alternative program participants in different states have resulted in valuable information about what is and what is not helpful to a nurse's recovery. Every alternative program must have some sort of mechanism in place for participants to conduct their own evaluations of the program.

Legislative Sunset Review Process

Sunset laws schedule entire programs for elimination by a certain date unless they successfully complete the sunset evaluation process and justify their continued existence. Under some sunset provisions agencies will be abolished on a specific date, which is generally 12 years after creation or renewal unless the legislature passes specific legislation to continue its functions.

Under the sunset process each agency that is subject to the sunset laws must perform a self-review of its roles and responsibilities. There are usually dates by which the self-review must be completed.

Evaluation Constraints

Every evaluation is carried out under certain constraints or limitations. These constraints must be identified as part of the planning process for the evaluation. Two major evaluation constraints are time and cost. Evaluation results that aren't timely are not useful to program managers and funding agencies. When evaluation information is needed quickly, the evaluation ends up addressing fewer questions. Similarly, the financial resources available for the evaluation help to determine its scope. Therefore the strengths and weaknesses of various evaluation approaches can be considered in conjunction with the level of available resources (BJA, 2006).

Due to the public safety aspect of monitoring programs, an alternative program is in many ways different. A regular evaluation is usually not undertaken on one aspect of the program, but with an alternative program the evaluation needs to encompass the inner-workings of the entire program, especially since the goal of most alternative programs is to offer eligible participants the opportunity to enter a monitoring program and subject themselves to close supervision in order to continue working or regain licensure as a nurse. Simply maintaining and reporting data on the number of participants and program completers is not sufficient for determining program success. It's also not sufficient for satisfying the public that the nurses in the community are safe practitioners. A number of factors then must come into play in determining whether the program is operating effectively, is meeting its goals and objectives and is successful, which means that the gathered data are necessary and thorough.

Reporting and Using Evaluation Results

Communicating and disseminating the evaluation findings is a critical step in building support for a program. Evaluators must plan the reporting process as carefully as the evaluation and build in opportunities to share findings with key participants such as program managers and staff prior to the final report (BJA, 2006).

While evaluation findings must be objectively reported, interpreting those findings and reaching any conclusions can be a challenging process. The evaluator can include key participants in this process by reviewing findings and preliminary conclusions with them prior to writing a formal report. Circulating an interim or draft report and meeting to discuss it also provides a means of obtaining feedback. Discussions with staff can provide new perspectives on the meaning and interpretation of the findings. These perspectives can then be included in the final report (BJA, 2006).

Briefings on the findings of the evaluation may be more useful for participants outside the program that do not have time to read an interim report. The briefing can be used to generate ideas and feedback in much the same way as an interim or draft report. It can also be used to obtain feedback on how findings can be presented (BJA, 2006).

Writing a Final Report

The product of most evaluations is a written final report. Final reports must be concise and nontechnical in nature. An executive summary, which is a condensed summary of the main points of the report can be included with the final report. Technical material that is not of interest to a general audience can be included in appendices or in separate volumes.

A final evaluation report must include:

- review of the findings of previous evaluations of similar programs
- discussion of why the evaluation was conducted and questions the evaluation sought to address
- program description, including goals, objectives and activities
- explanation of the methods and the procedures undertaken to collect and analyze data including a description of output and outcome measures and the evaluation design
- presentation of the results
- interpretation of the results and conclusions
- limitations of the evaluation methodology
- recommendations for future steps including short- and long-term suggestions for program improvement

The findings from the annual evaluation of the program must result in specific details being reported to the board, which allows the board to determine whether the program is meeting necessary performance, financial and legal needs or requirements.

The findings can include the following specific pieces of data:

- number of referrals
- length of time the program receives the referral to the execution of the agreement
- length of time to determine eligibility for participation in the alternative program
- number of nurses participating (new and existing)
- return-to-work rates of the number of nurses returned to work (RTW) (new and existing)
- success rates of the number of participants successfully completing alternative program requirements
- success rates of the number of nurses removed from practice in timely and appropriate fashion
- identified relapse rates (first or second)
- length of time it takes to remove a nurse with a substance use disorder from practice
- recidivism rates for completers
- caseloads of managers
- internal quality assurance frequency or findings
- case managers have addressed relapse and compliance issues
- documents are tracked and verifiable
- review of policies and procedures
- policy recommendations to the board of nursing
- program direction to assure that decisions are congruent with current research, knowledge, best practices and compliant with legislative and board directives
- educational plans and reports

Evaluation information can be a powerful tool for a variety of participants. Program managers can use the information to make changes in their programs that will enhance their effectiveness. Decision-makers can ensure that they are funding effective programs. Grant monitors can ensure that programs are developed as intended and have sufficient resources to implement activities and meet their objectives.

Ideally, evaluation is an ongoing process that is embedded in the process of program planning, implementation and improvement. Evaluation findings can be used to revise policies, procedures, activities and objectives to allow programs to provide the best possible service to their clients (BJA, 2006).

Each program must have readily available metrics to be able to tell people something about its success (Yessian, 2009). The board and the department can respond to the findings in the audit report.

Evaluation Concerns

Despite the advantage of evaluation it may not happen for a variety of reasons. The following is a list of common concerns program managers often have about conducting a program evaluation, along with corresponding responses to such concerns:

- an evaluation will divert resources away from the program (An evaluation will take some upfront resources. Typically about 10 to 20 percent of an overall program budget is needed to conduct a process and outcome evaluation, but what a program can learn from an evaluation can help streamline its resources to focus on what works for program participants and improve the outcomes.)
- an evaluation will be too complicated (While some evaluations are complex, evaluation designs can be simple and straightforward. An independent evaluator or consultant can help develop an evaluation design that is most appropriate for a program given the program's service model, the evaluation questions the program wishes to address and the program's resources for conducting an evaluation.)
- an evaluation will be an additional burden on staff (In order to minimize the potential burden on program staff the evaluation activities can be incorporated into ongoing program management activities. Also, when feasible and appropriate the evaluation data can be collected by an outside evaluator.)
- an evaluation will produce negative results (Finding out what does not work is as important as finding out what does work.)
- an evaluation is just another form of program monitoring (Program monitoring assesses whether a program is in compliance with specified performance standards such as the number of participants served, while an evaluation assesses whether expected outcomes were achieved.)

Measuring Success

For most programs the statistical significance will be less important than other considerations such as if the program effect was large enough to make a substantial difference and if enough benefits were derived from the program to justify its existence (Institute for Law & Justice, 1997). One measure of alternative program effectiveness is the participant nurses' success. In addition to tracking participant success, it is also important to track causes for why nurses are unsuccessful in achieving their alternative program goals. Given the public scrutiny of alternative programs, it is important to include measures to show the alternative programs' role in protection of the public. Alternative programs need to demonstrate their ability to address substance abuse promptly and to effectively prove their value to the public as well as the participants.

One common and appropriate measure of alternative program effectiveness is the participant nurses' success or graduation rates. Alternative program providers are motivated by a sincere desire to help nurses safely return to practice, and success stories of shattered lives returned to health and productivity are common. While these stories are important

successes, it is a mistake to make this the emphasis of messaging to the media and the public. It must be remembered that public support for alternative programs is enhanced only by showing how these programs can protect the public by quickly addressing substance abuse issues in a responsible way. Therefore, in addition to tracking participant success, it is also important to track causes for nurses to be unsuccessful in achieving their alternative program goals and how quickly those failures are detected and resolved. Alternative programs need to demonstrate their ability to address substance abuse promptly and effectively to prove their value to the public as well as the participants.

Summary

An alternative program must be accountable to itself, the board and the public. Alternative programs must engage in continuous data-driven evaluation. Evaluation can provide objective evidence that a program is effective, demonstrating positive outcomes to funding sources and the community. It can help improve program effectiveness and can create opportunities for programs to share information with other similar programs and agencies. There are many decisions to make when establishing evaluation protocol such as what type of evaluations will be conducted, what types of evaluation activities will take place, what types of evaluation teams will be formed, how the evaluation will be managed and what will be included in any relevant contracts. Communicating and disseminating the evaluation findings is a critical step in building support for a program. The findings from the annual evaluation of the program must result in specific details being reported to the board, which allows the board to determine whether the program is meeting necessary performance, financial, and legal needs or requirements. The findings must include certain specific pieces of data. It is important to note that in terms of measuring the success of most programs that the statistical significance will be less important than other considerations such as if the program effect was large enough to make a substantial difference and if enough benefits were derived from the program to justify its existence.

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CHAPTER SEVENTEEN

SUMMARY

THIS MANUAL PRESENTS THE MOST CURRENT EVIDENCE for proposed guidelines. The material offers a path to recovery for nurses with a substance use disorder so we can retain them in the workforce and avert harm to the public or the nurse with a substance problem. The specific guidelines for the identification, treatment and monitoring of the nurse with a substance use disorder are listed in Appendix A. The guidelines present an explicit and transparent set of operational rules concerning entry to the program, monitoring of program participants, criteria for graduation and other key matters. The operational rules afford sufficient internal safety valves to protect the public while facilitating the recovery objectives of the program.

Too often the approach taken with a nurse with a substance use disorder is to ignore his/her performance or productivity problems. Though studies have found that helping employees to recover is more cost-effective than termination, some employers still believe that firing an employee with a substance use disorder is easier than providing rehabilitation. Of course, concern for public safety is the primary concern. Co-workers may overlook or cover up for the employee with a substance use disorder or pick up the additional workload created by a nurse with a substance use disorder. Fear of confrontation aids in ignoring the problem. Doing these so-called favors will mean that the nurse with a substance use disorder is ultimately not helped. For the employer there is an increased likelihood the employee will engage in risky or inappropriate behavior, a higher chance the person will be involved in on-the-job accidents and a higher turnover rate and replacement costs. If the substance use disorder is not addressed, the nurse is able to seek and obtain employment in another setting, thereby jeopardizing patients in those settings and progressing in a potentially deadly disease.

The problem of substance use disorder is too important to ignore. Nurses generally use drugs and alcohol at about the same rate as the rest of the population. That means that over 300,000 nurses have a substance use disorder. It is frequently asked, why must we give a second chance to nurses? The answer is because substance use disorder is a health care issue rather than a moral issue. It can be responsive to treatment and can successfully restore a nurse to safe practice. It is not good public policy to dismiss or permanently revoke the license of every nurse with a substance use disorder. But it is also not feasible to have mandatory drug tests before nurses begin work each day in order to ensure the public is protected. This would be a very time consuming, cost prohibitive and a completely unreasonable exercise.

What is practical is to get the nurse with a substance use disorder into treatment and monitor his/her progress. Research shows that early intervention, treatment and monitoring are the best public protection there is against unsafe practice by a nurse with a substance use disorder. Studies conclude that 80 to 90 percent of those health care practitioners who seek treatment and enroll in a monitoring program stay in recovery.

Effective monitoring of a substance use disorder can be addressed in a number of ways. One approach is the discipline monitoring process that can result in probation, practice restrictions, suspension, or revocation of a nurse's license to practice. In some states a license can be suspended or revoked, but with a stay of action that places the individual on probation. The nurse must then comply with the terms of probation (treatment and aftercare) and is placed under close monitoring. Under this model, all disciplinary actions become public record. Some states now require hearings and a finding by the board prior to entry in diversion programs, which requires reporting of the administrative hearing's finding into state and federal disciplinary databanks. And, some states now treat administrative pleadings of *nolo contendere* as admissions of guilt in nursing licensure cases, which once again requires reporting of the action to state and federal databases.

Alternative programs are similar to discipline monitoring programs because they provide oversight of the participant during the period that the participant seeks treatment and follows a plan of recovery away from the dependency, except that no disciplinary action is taken against the nurse's license, the information remains non-public and the violation is not entered into the nurses' record. While nurses are participating in the program they can continue to practice as long as they are not a threat to patients, without receiving disciplinary action by the nursing board.

Alternative programs are criticized for not protecting the public because they are thought to be confidential programs that allow nurses to continue working while shielding them from discipline and public exposure. These criticisms do not recognize that the alternative approach actually provides better patient safety because it identifies nurses with a substance use disorder sooner and removes them from practice in a timely and accelerated manner. The traditional discipline method can require in some instances up to a year and a half of documentation, investigation and hearings before the nurse is removed from practice. A nurse with a substance use disorder can often be identified, treated and re-entered to safe practice under a rigid monitoring program within the same time frame. Thus, alternative programs can facilitate earlier entry into treatment and monitoring programs and longer periods of monitoring than discipline monitoring programs.

The proposed guidelines recommend that alternative programs be non-public rather than confidential. While the general public would not know who was in the program, the board of nursing, employers, treatment providers and other states of licensure need to know who is in the program. This approach would provide protections for the public without ending the nurse's career.

Despite the spread of the concept that a substance use disorder is a disease of the brain, this condition is still often treated unfavorably and compared in a poor light to other conditions. People with alcohol and drug dependence often face discrimination from individuals, employers and other institutions. Many still believe that addiction is a character flaw or weakness that probably can't be cured. The stigma against people with addictions is so deeply rooted that it continues even in the face of the scientific evidence that addiction is a treatable disease. There are many people in our families and communities living well-rounded lives who are in long-term recovery.

If a professional is diagnosed with a life-threatening condition such as cancer the public is very supportive of the whole recovery process. Family, friends, clients and customers are kept informed and regularly offer to help out in any way that they can. It is acceptable for a nurse to be on leave for cancer or a heart attack. However, if a nurse leaves her current position to receive treatment for a substance use disorder there could be a different reaction. Unfortunately, it is too risky for a nurse to reveal he/she has a substance use disorder and has sought help.

When a board or alternative program fails to adequately monitor the licensees practicing under its shared responsibility to the public, the resulting media attention and public anger fosters the same misconceptions and disparate treatment as experienced by those with other diseases of the brain. One concern is that alternative programs are convenient places for nurses with a substance use disorder to hide out in secret and avoid disciplinary action. The guidelines are a mechanism to begin to change those negative perceptions. However, to be effective the boards and programs must work together rather than independently. Our efforts must also be more transparent going forward to achieve accountability from the public.

These guidelines offer a focused attempt to set forth practical, effective public safety practices for use by boards and programs. They are standards grounded in an evidence-based practice to ensure public safety while preserving the opportunity for nurses who have a substance use disorder to practice under appropriate monitoring and supervision.

Screening and Assessment

Alternative programs are not treatment programs. They must, however, require the nurse to undergo formal assessment and treatment from substance use disorder professionals. The goal of screening and assessment is to identify and refer individuals at risk for substance use and abuse issues and, if identified as such, to provide further assessment to determine the level of symptom severity and the level of care needed. A complete history needs to be collected for the nurse including demographic information, employment history, health history, alcohol and drug history, psychiatric history, family or social history, legal and financial history.

The length of time spent in these programs varies. The recommendation is that the nurse spend a minimum of three (preferably five) years during which he/she is monitored in his/her practice setting.

Contracts

The purpose of a contract is to document the obligations of both the nurse and the alternative program. Nurses who are admitted into the program must sign a contract that states the nurse agrees to be monitored by the program for a specified period of time.

Treatment

More recent research on evidence-based components of treatment has verified that treatment continues to be effective in reducing substance abuse and problems associated with substance abuse. Treatment needs to be comprehensive, personalized to the individual's needs and includes family involvement in the treatment.

The goal for those who are dependent on alcohol and drugs is total, complete and permanent abstinence from alcohol, drugs and mind-altering substances. Any goal that falls short of complete abstinence such as controlled drinking or drug use is thought to be detrimental, fosters a continuation of denial and delays the participant's need to accept the reality that moderate use of any substance is a myth.

Most alternative programs require an initial period of intensive treatment, either inpatient or intensive outpatient, with verification of attendance and compliance submitted to the alternative program.

Programs need to receive all relevant information from treatment programs, including but not limited to:

- the initial intake assessment
- progress and cooperation through the treatment program
- any psychiatric and pain management assessments and recommendations
- discharge summary and recommendations

Initial treatment is followed by a specified length of aftercare with a treatment program, which is often six months to one year and is also verified with regular reports to the alternative program. After completion of formal treatment and aftercare the alternative programs continue to monitor attendance at support group meetings and compliance with recovery standards throughout the duration of the contract. This is also considered a component of the continuing care model and this form of intensive case management monitoring has been a component of alternative programs since their inception.

Continuing Care

In order to keep the disease in remission there is a need for continued care and ever-present vigilance. Attendance at 12-step or self-support group meetings and facilitated nurse support group meetings remains a requirement for alternative programs for the duration of the nurses' participation in the program. The number of all support group meetings required of nurses is highest in the early stages of the contract and can vary depending on the initial assessment findings. Many programs recommend participants complete 90 meetings in 90 days upon initial entry into the program. Most programs have a minimum requirement of two to three self-support group meetings a week often in addition to a weekly facilitated nurse support group meeting. The recommended minimum number of 12-step or self-support meetings a week to achieve stable engagement is three meetings per week. Meeting attendance can be decreased after a significant period of compliance, which is typically a minimum of one year.

Research has consistently supported the potent impact of social support as a predictor of abstinence and positive outcomes from treatment. More recently, research has indicated that the size of the social support network is most important in providing positive outcomes and that increasing the number of abstinence-supporting people contacted daily improves treatment outcomes. More recently, online support group meetings have become more widely available and may be a valuable tool when face-to-face meetings are unavailable or inaccessible such as in rural areas. Because these meetings lack the valuable dimension of face-to-face interaction, evaluation and feedback, they cannot be used exclusively but as an adjunct under necessary circumstances.

Participant nurses are required to attend a minimum of one professional or nurse support group made up of nurses in the community per week. These groups exist to facilitate the recovery and the re-entry to practice. The groups would be structured to meet the special needs of nurses with a substance use disorder. Attendance is to be verified by a signature from the meeting coordinator and submitted to alternative program staff. Alternative program staff is actively involved in recruiting and training support group facilitators around the state and maintaining relationships with those groups. Site visits are conducted to groups throughout the state. After completion of formal treatment and aftercare, the alternative programs continue to monitor attendance at support group meetings and compliance with recovery standards throughout the duration of the contract.

Drug Screening

Random drug screening or testing is used to detect the use of unauthorized or illegal drugs for the purpose of ensuring patient safety. Although drug testing may be conducted on other bodily fluids and hair, urine testing is most commonly used.

Drug screening must occur on a random basis so that the nurse does not know when testing will occur. The frequency of testing may initially be more than once a week and later reduced to several times a month.

The collection of alcohol and drug samples must be performed by a certified laboratory. Each drug test collection needs to be directly observed. An observed drug test is when the collector of the same sex as the donor accompanies the donor to the bathroom and observes the urine collection directly from the nurse. This is to verify that the specimen was provided by a particular nurse and was not diluted, substituted or tampered with in any way. A strict chain of custody must be followed so that samples are handled in a scrupulously careful manner to avoid later allegations of tampering or misconduct.

In order to effectively monitor the nurse participant, it is critical that the alternative program be notified of any positive, adulterated, substituted, diluted, failure to submit or noncompliance within the same business day of the identification. The alternative program in turn must notify the board of nursing regarding the identity of the noncompliant nurse and the reason for noncompliance.

Return to Work

Before entering the alternative program the nurse's license is placed on inactive status. The license will become active once the alternative program recommends and the board of nursing approves the nurse's return to work. While the alternative program and the board of nursing generally yield to the recommendations of the treatment providers, it is the board of nursing that is ultimately responsible for deciding whether licensees are able to practice safely and competently. Upon returning to work, the nurse continues to be monitored. Random and observed testing continues throughout the time the nurse remains in the program.

During the first 12 months of the program or longer the nurse is subject to certain workplace and practice restrictions. The nurse is not allowed to work in high risk areas such as where there is a frequent need to access and handle controlled substances. Other high risk situations where the nurse may have practice limitations include situations where there is minimal or no direct supervision such as homecare or travel nursing, night shifts, or where they have to work more than 12 hours at a time or more than 40 hours in a week. The practice and workplace restrictions may be reduced with documented compliance and recovery of a minimum period of time.

Once the nurse returns to work he/she is also monitored by a worksite supervisor or monitor who provides the program with reports on the nurse's performance and behavior. Documentation regarding attendance, job performance and compliance with practice restrictions provides some assurance the nurse is acting in a manner that is consistent with recovery and adhering to his/her contract and the limitations placed on his/her practice.

Outreach and Education

Outreach and education are key functions for programs and boards to fulfill. Without an informed and enlightened profession and public, the recovering nurses are likely to be subject to continued misunderstanding and stigmatization. Programs themselves also need to convey to the profession, nursing students and the public how their missions promote public safety and professional accountability. Programs must identify and document their

outreach goals, strategies, methods and outcomes on a regular basis. These include first-hand accounts of how nurses were initially identified and then succeeded through their participation in alternative programs as well as the presentation of formal workshops that provide information on such topics as the risks and signs of a substance use disorder in nurses, referral, retention in the workplace and relapse. Through these methods, outreach can be the catalyst for positive change and the reduction of harm.

Program Evaluation

Each program needs readily available metrics to be able to tell people something about its success. Data need to be convincing and compelling so that a case can be presented to the legislature, the media and others to show the value of the program. A good yardstick to use in order to measure success is the percentage of participants who successfully completed the program. Another important statistic that needs to be collected is the percentage of participants who remain recovered after graduation.

Accountability

Who is in the alternative program is non-public but the existence of the program is not confidential. The purposes of the program, the protocols, the rules and operations are to be totally transparent with the board of nursing and the public.

Accountability occurs in a number of different ways as outlined in the guidelines. One way is through audits. Is the program doing what it says it is doing? Does it have the documentation to show that it is doing what it says it does?

Another way alternative programs are accountable is by identifying a relapse quickly through monitoring, testing and taking people out of practice within 24 hours of a complaint. In addition, when there is a relapse the participant starts the program over again, beginning with treatment.

Nursing needs to face the issue of the unsafe and disruptive nurse more rigorously. We must study it, confront it and become more transparent in dealing with it. We need to do this to help those at risk and in so doing help our patients as well.

Conclusion

This manual has presented a number of guidelines and suggestions for the evaluation, treatment and monitoring of nurses with a substance use disorder. It is recognized that resources and circumstances may preclude use of all the guidelines to the fullest extent. However, it is important to stress the desirability of following these guidelines as a way of improving responses to a substance use disorder problem. It is also recognized that in order to adopt these guidelines it may be necessary to make changes in state laws, regulations and policies.

However, these guidelines are not intended to inhibit the development or utilization of new approaches. In fact, as new research and evidence becomes available in the future this manual and guidelines will be revised to be kept current and even more useful.

A P P E N D I X A

GUIDELINES FOR ALTERNATIVE PROGRAMS AND DISCIPLINE MONITORING PROGRAMS

THE PURPOSE OF THESE GUIDELINES is to provide practical and evidence-based guidelines for the regulatory management and monitoring of nurses with a substance use disorder. The guidelines are based on a review of the most current research and knowledge synthesized from the literature and from the field.

These guidelines were developed and written with the primary focus on alternative programs for nurses with a substance use disorder. The programs are known as alternative or diversion programs because nurses are directed into treatment and early monitoring rather than to the disciplinary process. These programs rest on the rationale that they can quickly remove someone from practice and provide a path to recovery for nurses with a substance use disorder. With proper monitoring they avert harm to the public and once the nurse is determined to be safe to practice, they help to retain nurses in the workforce. The guidelines underlying principles, however, are applicable to traditional discipline monitoring programs as well.

Implementing these guidelines presents a number of opportunities such as best practices so that the public can have confidence that the nurses in these programs are safe to practice. Guidelines also set benchmarks for standardization, performance and quality measures for alternative and discipline monitoring programs. However, in order to adopt these guidelines it may be necessary to make changes in state laws, regulations and policies.

Responsibilities of the Program

Programs operate as agents of the board to enforce statutes and rules designed to protect the public.

To meet this charge of public protection, the programs have the following functions and responsibilities:

- to protect the public while monitoring the nurse to ensure safe practice
- encourage early identification, entry into treatment and entry into a contractual agreement for monitoring of compliance with treatment and practice monitoring
- identify, respond to and report noncompliance to the board of nursing in a timely manner
- to facilitate nurses to enter and maintain an ongoing recovery consistent with patient safety

- to be transparent and accountable to the public by providing information to the public, which also includes:
- policies and procedures of the program
- annual reports, audits and aggregate data
- educational materials and other resources
- conferences and continuing education offerings
- to provide adequate resources and staffing to implement policies and procedures and all contract requirements
- all nurse participants or nurse licensure applicants in alternative programs can be reported to a non-public national database that gives access to all states

Eligibility Criteria

Not everyone with a substance use disorder is an appropriate candidate for entry into the alternative program and may be referred instead to the disciplinary monitoring program of the board of nursing for further review, investigation and a board decision.

Those who are ineligible for the alternative program may include:

- the nurse who has diverted controlled substances for other than self-administration (For example, when it has been determined that the nurse engaged in prescription fraud with the purpose of selling or distributing to others.)
- the nurse who has caused known provable harm to patients
- the nurse who has engaged in behavior that has high potential to cause patient harm such as diverting drugs by replacing the drug with another drug (This is an example of reckless disregard for patient safety.)

Those who need approval of the board by policy or case by case prior to admission to the alternative program include:

- the nurse who has a history of past disciplinary action that is not related to substance use and resulted in probation, revocation or suspension may still be eligible for admission (For example, a nurse's license was previously suspended for administering medications without an authorized order but the board of nursing determined that in this particular case the nurse was eligible for the alternative program.)
- the nurse who has any pending criminal actions or a prior felony convictions may still be eligible for admission (For example, a nurse with a pending criminal charge or conviction related to a substance use disorder but the board of nursing determined that in this particular case the nurse with a substance use disorder was eligible for the alternative program.)
- there is information available indicating that incidents have occurred where the nurse may have caused harm, abuse or neglect to patients (However, the nurse is determined not to pose significant risk for the health care consumer as determined by alternative program staff or a representative of the board.)
- nurse actions are suspected to cause harm to the patient (For example, a patient's pain may have been inappropriately treated because the nurse took the patient's medications.)
- the nurse who has been unsuccessfully discharged or terminated from the same or any other alternative program for non-compliance (For example, a nurse may be terminated from an alternative program for violating his/her contract by not providing self-reports, supervisor, monitor or sponsor reports. If this nurse brings her documentation into compliance the board of nursing may determine that the nurse may re-enter the alternative program.)

- individuals on medication-assisted treatment or therapy
- individuals who are prescribed controlled substances for dual diagnosis or chronic pain
- the applicant is not eligible for licensure in the jurisdiction (For example, a student nurse who has yet to be licensed.)
- the applicant who has had previous and unsuccessful participation and substantial noncompliance with the contractual agreement in the last five years

Screening and Assessment

To ensure individuals entering into the programs are appropriate and qualified for an alternative option, it is essential that appropriate screening and assessment take place.

A nurse seeking admission into the alternative program is initially screened by staff to determine the nurse's motivations for entering the alternative program and whether the nurse meets admission requirements and is willing to participate. The alternative program includes in the participant agreement, the licensee recommendations from approved substance use disorder evaluators regarding a substance use disorder treatment plan for all nurses participating in the alternative program.

All pertinent information related to the nurse is to be gathered from the employer, nursing board investigator and all others who have information related to that case in order to complete the admission information and to determine program eligibility.

Demographic assessment data includes:

- name, address, telephone number, Social Security number, date of birth and race
- all states in which the nurse has been licensed
- license numbers and the status of the license
- any other professional licenses held
- history of licensure disciplinary action or pending action in any state or territory
- gender, marital status, children and their ages
- educational preparation
- referral source to alternative program
- any previous participation in an alternative program

Employment history data includes:

- all work settings, including military reserve assignments
- specialty area of practice
- employment position
- years in nursing
- present employment status
- previous employment history for at least five years including information about employment discipline
- current employment
- dates of employment
- supervisor contact information

Academic history for unlicensed student participants or licensed nurses who are currently in or entering into a nursing academic program the data includes:

- years in program
- overall grade status
- expected graduation date
- number of course hours currently taking or to be taken
- clinical rotations (access to controlled substances)

- clinical instructors and mentors and their contact information
- program director, dean or administrator with oversight and their contact information

Health history can include any hospitalizations and treatment providers within the last five years (list dates and diagnoses) and any medications being taken (prescription and nonprescription drugs) and contact information for current treating and prescribing medical providers.

The alcohol and drug history can include the following:

- age of first use of any drug or alcohol
- drug of choice (amount used, frequency of use, how long used and how obtained)
- previous attempts at treatment
- other drugs used or abused
- medical complications of use including physical and emotional manifestations
- last time of drug use, last time of alcohol use and longest period of abstinence
- withdrawal risk and assessment
- current medications

Psychiatric history must include present and past psychiatric treatment, current contact information for providers and prescribers, current medications and any suicide attempts.

The family or social history must include the history of alcohol or drug use in the individual members of the family.

The following areas must also be assessed:

- present living arrangements
- social relationships and support systems
- any history of trauma or family abuse
- other substance use within the living environment

A legal history will assess any present or past arrests, convictions and actions on any license, registration or certification. The legal assessment must also include current status of any professional license in any state that they are currently or previously licensed, any actions taken by other states, adverse military record, and the name, address and telephone number of current probation officer, lawyer or social worker.

A financial history must determine any present or past financial problems and whether or not the nurse has health insurance including the length of time the coverage exists.

Contracts

The contract is a legally binding written agreement informing all parties of what is expected of them. Nurses will be held accountable for all terms and conditions of the contract.

The alternative program must have a written agreement, which the participant must sign voluntarily upon entering the program. Each contract or agreement must bear the witnessed signature of the nurse participating in the alternative program and the alternative program coordinator or designated representative.

The contract must address the following areas:

- the voluntary and non-disciplinary nature of the program
- the program records that are non-public and have necessary exceptions for disclosure such as to the board of nursing members, other state boards and other states' alternative programs regarding the participants in the alternative program
- the dates of the nurse's participation and the expected length of participation
- the requirements of drug and alcohol screens, 12-step, support, therapeutic meeting attendance and self and supervisory reports

- the requirements for work-site monitoring upon return to work
- the consequences of relapse and noncompliance with the alternative program contract including a dismissal from the alternative program or referral to the board of nursing for disciplinary action because of noncompliance with alternative program contract requirements
- the parameters for referral to the board of nursing including the non-public records of program participation that are shared with the board
- definitions of relevant terms such as relapse
- appropriate waivers and releases
- the period of monitoring can be three to five years (Contract conditions may be gradually decreased after a minimum of one year of full compliance or evidence of other recovery parameters. Those participants who do not have full compliance may have their contract conditions increased.)

The terms and conditions set forth in the contract are outlined in various categories.

Initial Entry Requirements

The participant is expected to:

- abstain from all alcohol and alcohol-containing products without prior approval from the alternative program
- abstain from drug use including all over-the-counter medications and other mind-altering substances unless lawfully prescribed with prior approval of the alternative program
- obtain a current evaluation of co-occurring conditions such as psychiatric or medical disorders as indicated
- maintain current state nursing licensure including meeting any continued competence or continuing education requirements
- cease nursing practice and agree to inactivate their license until or unless approved to continue or return to practice by the treatment professional and the alternative program

There are releases that are necessary to sign for monitoring and consents to information exchange between:

- employer and alternative program
- healthcare providers and alternative program
- alternative program and board of nursing
- treatment professionals and alternative program
- other state boards and alternative programs

Further points of the contract are:

- enter treatment and participate in all treatment recommendations
- provide counselors with the necessary forms to complete and give back to the program
- obtain an assessment by a medical doctor who is approved by the alternative program and has a sub-specialty in addictions and pain management
- sign and adhere to pain management contracts if there are pain issues as well as addiction issues
- undergo any additional evaluation as requested by the alternative program or treatment provider
- complete substance abuse, dependency or mental health assessment, treatment, continuing care and aftercare

Recovery Monitoring Requirements

The participant is expected to:

- attend three 12-step or other approved self-help meetings a week and one peer support group per week and submit documentation to the alternative program at least monthly
- maintain an active and consistent relationship with a sponsor
- select and provide the contact information for one pharmacy for prescription needs, one health care provider for health care needs and one dentist for dental needs to the alternative program
- report any prescriptions for mood-altering drugs as well as over-the-counter medications within 24 hours of receipt of prescription to the alternative program and prior to returning to nursing practice
- notify any and all health care providers of substance use history prior to receiving any prescription
- provide a written statement from the prescribing provider that confirms the provider's awareness of the participant's history of substance abuse or dependence and the participant's responsibility to confirm any prescription within 24 hours of prescribing
- have practitioners complete medication verification forms and medication logs provided by the program and submit quarterly
- submit medication forms (a log) quarterly
- provide written self-reports as specified (minimum is monthly)
- submit to random drug and alcohol testing at a minimum of two to three times per month for the first 12 months of participating in the alternative program.

Drug and alcohol testing may then be gradually reduced in frequency. Upon return to nursing practice, drug screenings must increase for the first 12 months of clinical practice. Drug and alcohol testing may include body fluid testing, hair testing or any other valid and reliable method of testing such as saliva.

Practice Requirements and Limitations

Requirements and limitations must include:

- limit nursing practice to one state only (Permission to work in any other states requires written approval from the alternative program and the board of nursing in both states.)
- if licensed in another state or seeking licensure in another state, authorize alternative program to release participant information to any other state of licensure or where seeking application for licensure
- maintain continuous employment in a nursing position for at least one year of the three-to five-year contract in order to be eligible for successful discharge from the program
- notify and obtain approval of any health care related position or job change prior to making the change or relocating
- abide by return-to-work restrictions and requirements
- abide by all policies, procedures and contracts of employer
- inform all employers or schools of participation in the alternative program and provide copy of contract, stipulations or final orders from the board of nursing to any prospective or current nursing position employers
- ensure that the supervisor is given a copy of the contract and any other necessary forms
- ensure that the alternative program receives the agreement form signed by the direct supervisor prior to beginning a new or resuming an existing position

- schedule at least monthly check-in meetings with supervisor for the purpose of addressing any concerns of either party (Documentation of such meetings shall be available to the alternative program staff if requested.)
- notify the program within two days of any change in supervisor, workplace monitor or employment
- any exceptions to work restrictions are approved in writing by the alternative program. (Obtain approval by alternative program prior to any position acceptance, job responsibility change or other related employment activity.)
- discontinue access to and administration of controlled substances or any potentially addictive medications for a minimum of six months of returning to work

Program Notification Requirements

Programs must require notification parameters in the contract that include:

- notify the alternative program within two days if participant has a disciplinary meeting or employment counseling with employer
- notify within two days of any changes in residency, contact information and for any termination or resignation from employment
- report within 24 hours any crimes committed, criminal arrests, citations, or deferred sentences and conviction including a conviction following a plea of nolo contendere.
- notify program if a complaint is filed against the license of the participant nurse
- report any and all alcohol or unauthorized substance use regardless of amount or route of administration
- obtain a re-assessment by a licensed addiction counselor in the event of relapse or suspected relapse
- abide by further recommendations in the event of a relapse or suspected relapse as deemed clinically appropriate
- appear in person for all routinely scheduled interviews and any additional interviews with reasonable notice given by the program
- inform the program manager verbally and in writing of a pending relocation out of the state
- pay all fees and costs associated with being in the program

By signing the contract the participant agrees to the following:

- The nurse has had or is having problems with substance use or has a substance use disorder.
- Admit they have violated the nurse practice act and that any violation of the contract is a further violation of the nurse practice act and grounds for referral to the board of nursing.
- Entry into the alternative program was voluntary, there was an opportunity to seek advice of legal counsel or personal representative and there was opportunity to clarify any terms or conditions that were not understood.
- Read, sign and abide by the terms and conditions of the program handbook or manual as well as any new policies or procedures received in writing throughout participation in the alternative program.
- Waive all rights to appeal, grievances, complaints or otherwise contest licensure actions arising out of alternative program participation. Waive the right to contest the imposition of discipline arising from a breach of this agreement with the exception of contesting a determination that one or more terms of the agreement have been violated.

- Identity of participants and the terms of the contract are non-public but may be shared with parties who have an official need to know such as state board of nursing members, other state boards, other state's alternative programs and participant's employers.
- The supervisor is given a copy of the contract and any other necessary forms prior to beginning a new or resuming an existing position and agrees to notify the program immediately of any change in supervision. Failure to comply will result in an immediate cease and desist of all work-related activities from the alternative program.
- Any noncompliance with the contract or unsuccessful termination from the program is unprofessional conduct, is in violation of the rules and laws regarding the practice of nursing and may be used to support any future progressive disciplinary actions.
- If any single part, or parts of the contract are violated by the participant, the remaining parts remain valid and operative.
- Any unauthorized missed drug or alcohol testing will be considered non-compliance with the program.
- Any confirmed positive drug screen may be considered noncompliance if the program has not received the proper documentation from the prescribing practitioner.
- Any confirmed positive drug screen for which the alternative program has not received prior written authorization and confirmation from an approved provider and any drug screen that is confirmed as an adulterated or substituted specimen shall result in the participant ceasing nursing practice until further evaluation and receipt of written authorization to return to practice from the alternative program.
- Noncompliance with drug and alcohol testing will result in an increased level of testing and will result in a report to the board.
- In the event of any non-compliance with any of the terms of the contract in any respect, the alternative program may require the nurse to cease practice, notify the nurse's employer and the length and terms of this contract may be extended and modified.
- In the event of any non-compliance with the terms of the contract, the participant may be discharged from the alternative program or reported to the board while remaining in monitoring.
- If discharged from the alternative program for non-compliance or referred to the board of nursing for non-compliance, the board of nursing may use any misconduct that may have occurred while enrolled in the program in disciplinary proceedings and the board of nursing may obtain complete records of participation in the alternative program.
- The contract does not preclude the program from initiating or taking appropriate action regarding any other misconduct not covered by the contract. Such action could include reporting the offense to the board of nursing.

Special Contracts and Provisions for Nurses Prescribed Potentially Addicting or Impairing Medications

Individuals with a dual diagnosis of psychiatric disorder or a substance use disorder as a result of chronic pain are a high risk population for relapse. Nurses who are receiving medication-assisted treatment for opioid dependence are a high risk population that requires special and ongoing consideration. Alternative programs that monitor high risk populations such as CRNAs must be guided by the specialty organization's recommendations. The board of nursing can have a written policy for approving or prohibiting this population's participation in the alternative program. The contract can be negotiated and include the following:

The participant shall engage in pain management treatment or medication assisted treatment when indicated. The contract shall specify that the participant will comply with recommendations of the evaluator and that it may be amended to include the following requirements in addition to the other standard eligibility and monitoring requirements:

- minimum five-year participation in the alternative program
- submit to a neuropsychological or neuropsychiatric evaluation to determine fitness for duty at any time that cognition appears to be negatively impacted as a result of illness or treatment
- obtain an assessment by a medical provider approved by the program who has a sub-specialty in addictions and pain management if there are pain issues, as well as sign and adhere to a pain management contract
- engage in treatment with one provider that has expertise in addictions and pain management
- maintain release of information allowing the provider to communicate directly with alternative program staff
- direct supervision
- no night shift
- no shift greater than 12 hours in length
- no more than 40 hours per week (or less depending upon provider recommendation)
- no access to controlled substances in the workplace for a minimum of 18 months if there is a history of diversion, prescription fraud or multiple prescribers
- monthly progress reports submitted from provider
- monthly reports from the nursing employer for the first year and if there are no identified issues, the reports can be reduced to quarterly thereafter
- utilize one pharmacy and provide name of the pharmacy to alternative program
- provide quarterly prescription profiles
- regular verification of prescriptions through prescription profile or state authorized prescription monitoring program, if available (every six months but may be done more frequently as determined by the alternative program)
- notification of nursing employer and alternative program staff of any changes to medications including addition, deletion or change in dose prior to assuming any patient care duties.
- submit letter from the provider verifying safety to practice with any change in medication as outlined above
- agreement to immediately cease practice upon notification of alternative program of non-compliance or other symptoms suggestive of a relapse
- random drug screening weekly during the first year, three times monthly for the second year and tapering to minimum of two per month if fully compliant with all parameters including practice documentation by the supervisor as safe and appropriate
- minimum attendance in 12-step meeting not including aftercare, relapse prevention and nurse support of three times per week
- relapse prevention therapy with a provider who has expertise in pain management, addiction and relapse

Standards for Treatment Programs

Nurses with a substance use disorder must be offered long-term, coordinated management of their care for substance use disorder and any co-existing conditions and this care management must be adapted based on ongoing monitoring of their progress. In order to

work effectively with the alternative program, there are criteria that must be in place for any treatment program to be approved to provide services for participants.

The minimum standards for approved treatment providers include:

- licensure by the state
- provide a geographically convenient location for treatment to encourage the participation of family members in the nurse's primary treatment
- offer family involvement in the treatment
- adhere to an abstinence-based program
- adhere to a 12-step philosophy
- require frequent random and for-cause drug screening with positive results reported to the alternative program
- development of an individualized initial treatment and a minimum 12-month aftercare program to meet the specific needs of the nurse client, based on evaluation by a multidisciplinary team
- provide information to the alternative program staff on the status of referred clients after appropriate consents to release information are obtained including immediate reports on significant events that occur in treatment that are related to the nurse's ability to practice safely (Information that needs to be communicated includes assessments, diagnosis, prognosis, discharge summary, follow-up recommendations and compliance with treatment.)

Nurse Support Groups

The nurse support groups are an essential component of monitoring compliance and facilitating safe and appropriate re-entry into the workplace in addition to the 12-step or other approved self-help group meetings.

Nurse support groups that participate in the monitoring program are required to:

- adhere to the total abstinence model of recovery and the 12-step program model
- have the participant sign a release of information form permitting disclosure of known or suspected relapse or a threat to self or others
- be prepared to respond to crisis situations by either intervening or referring
- organize at least weekly meetings which are conducted by a qualified facilitator
- provide a facilitator-to-nurse ratio that is not to exceed 12 participants per facilitator (It is recommended that support groups include graduates of the program.)

A facilitator for the nurse professional support group can:

- be a licensed nurse or a health professional in good standing with the board of nursing or other licensing entities
- have demonstrated expertise in the field of substance use disorder as evidenced by having worked in the area for at least one year within the last three years and having at least 30 hours of continuing education in the area or have certification or eligibility for certification in substance use disorder
- have a minimum of six months experience facilitating groups
- if recovering, have a minimum of four years' continuous recovery
- not have any current complaints pending with the board of nursing or other regulatory board
- not be a current participant in the alternative program
- not have a current license encumbrance

Drug and Alcohol Testing

An objective measure of abstinence and compliance is frequent, random and observed drug and alcohol testing that states:

- drug and alcohol testing must be random
- drug and alcohol testing can be requested for cause at any time and within any time frame
- random drug screening is recommended three times a month with a minimum of twice monthly for at least the first year in the alternative program (Gradually decrease the frequency of random drug screens for the duration of the contract depending upon compliance and recovery status.)
- the participant is required to submit to drug and alcohol testing on the same business day or within two hours for-cause drug screen
- when indicated, a blood alcohol test or breathalyzer may be done as well as a urine drug screen (This is of critical importance if the odor of alcohol is present on the participant.)
- testing for alcohol includes EtG and EtS testing
- when indicated, a hair analysis drug test may be done in conjunction with urine tests (Hair testing cannot be the sole means of testing.)

Drug testing must be observed and include:

- if an observed collection is not available, the minimum standard is a dry room collection (A dry room requires that the only source of water available in the room is in the commode. The water supplying the commode contains a dyeing agent, most commonly blue, to prevent or detect the substitution of toilet water. An observed collection can be required if a dry room is not available or the nurse has a prior history of substitution, dilution or adulteration of specimens or if a report of the nurse substituting, diluting or adulterating specimens is received.)
- a strict chain of custody must be followed (An observed collection is a sealed specimen that is signed by participant, collector and lab.)
- the participant is responsible for payment of charges for the drug and alcohol testing
- all screens must be performed by a certified laboratory and the laboratory sends results directly to the alternative program
- the alternative program will be notified by the lab of any positive, adulterated, missed or noncompliant tests within the same business day of the identification

Strict guidelines for selecting drug testing service providers (DTSP) must be followed and include:

- the DTSP must possess all the materials, equipment and technical expertise necessary to provide all the required services
- the DTSP must be able to scientifically test for urine, blood and hair specimens for the detection of alcohol or illegal and controlled substances (The DTSP must have or subcontract drug testing services with toxicology laboratories accredited and certified by the U.S. Department of Health and Human Services, College of American Pathology or American Board of Forensic Toxicologists.)
- the DTSP must provide collection sites that are located in areas throughout the testing state
- the DTSP must have an automated 24-hour toll-free telephone system
- the DTSP must have or be subcontracted with operating collection sites that are engaged in the business of collecting urine, blood and hair follicle specimens for the testing of drugs and alcohol within the testing state

- the DTSP must have a secure, HIPAA compliant website or computer system to allow regulatory or alternative program staff access to drug test results and compliance reporting information that is available 24 hours a day
- the DTSP must employ or contract with toxicologists that are licensed physicians and have knowledge of substance use disorder and the appropriate medical training to interpret and evaluate laboratory drug test results, medical histories and any other information relevant to biomedical information

Return to Work

Upon entry into the alternative program, the participant agrees that their license will be placed on inactive status until return to work is recommended by the alternative program.

In order to ensure patient safety, the nurse's practice must be monitored through the following:

- the participant's supervisor and whenever possible at least one nurse monitor must be identified in the participant's return-to-work contract
- supervisors and work-site monitor (must be licensed to practice nursing) or supervisor whose license is unencumbered, is not a current participant in any alternative program and avoids any conflicts of interest that could impede the ability to objectively monitor the nurse
- supervisors and work-site monitors are nurses who have assumed responsibility for overseeing the participant's practice (At least one monitor or the supervisor must be available on-site in order to intervene if there is a concern or an incident involving the participant.)
- supervisors and work-site monitors must be knowledgeable of the participant's nursing role (job description) and the nurse's participation in the alternative program including the nurse's return-to-work agreement and any associated practice restrictions
- nurse monitors or supervisors must provide to the alternative program regular and as-needed reports on the nurse's ability to practice safely
- nurse monitors, supervisors and program staff must have continuous and ongoing communication to ensure the nurse's compliance with the contract and workplace policies and procedures
- periodic face-to-face visits with the nurse, work-site monitor or supervisor
- nurse employers must make reasonable accommodations for nurses with a substance use disorder under the Americans with Disabilities Act of 1990
- the employer shall have the authority to request a for-cause specimen for drug testing when warranted or when requested by the alternative program
- it is recommended a meeting be held with the nurse's co-workers who have a legitimate need to know regarding the nurse's work restrictions

Upon return to work, the participant is not allowed to work any of the following for a minimum of 12 months:

- odd schedules such as overtime, night shift or anything in excess of a 12-hour shift
- more than three consecutive 12-hour shifts
- without direct supervision
- with limited or full access to controlled substances
- in a home health or hospice type of setting, travel, registry or agency, float or on-call PRN pool, tele-nursing and disaster relief nursing
- in any other unsupervised nursing position

If relapse, diversion or other violations of the work-related requirements occur, the alternative program will require the participant to immediately cease practice and the alternative program will notify the employer and the board of nursing.

The program will continue to monitor the nurse even after referring the nurse to the board of nursing or the discipline program until the discipline program can begin monitoring or pending board action.

Return to Academics

A nurse participant can return to academics if the program has the authority to monitor unlicensed personnel.

In order to ensure patient safety, the unlicensed student nurse's academics, including clinical, must be monitored through the following:

- the student's clinical rotation schedule and potential for access to controlled substances is provided to the alternative program
- student must have approval of his/her substance use treatment provider prior to working in a clinical setting, academic-related or other, that involves working with patients with a substance use disorder
- clinical monitors are identified to the program such as the nurse faculty or clinical nurse mentor prior to each clinical rotation (The clinical monitor must have an unencumbered nursing license and must not be a current participant of any alternative program.)
- at a minimum, a student must check-in face-to-face with his/her clinical faculty before and after each clinical.
- the ongoing status, passing or failing, of the student nurse is to be made known to the program by the end of each quarter or semester
- self-reports are provided to the alternative program
- all drugs including over-the-counter medications and prescribing providers or advanced practice registered nurses are to be made known to the alternative program
- student nurse and the nursing academic program agree that the student's course and clinical work hours combined with any employment hours do not exceed an average of 40 hours per week
- if unacceptable academic or clinical performance occurs including relapse or other violations of the re-entry to academics, the student will be required to cease academics, including a clinical setting and obtain re-evaluation
- if student is dismissed from the nursing academic program, the student will also be dismissed from the alternative program

Monitoring

Monitoring compliance of the nurse participant with the contractual agreement and prescribed treatment program is essential to ensuring patient or client safety. Close scrutiny of contractual compliance including the timely identification and program response to noncompliance is essential to ensure the nurse is competent to practice.

Monitoring can assure that nurses comply with all the contract requirements such as:

- initial assessment, treatment and aftercare
- drug screening requirements
- support group attendance
- all practice stipulations in the contract
- all monitoring reports

- work-site reports
- self-reports
- verification of all prescribed medications

Program Completion

In order to verify successful completion of the requirements of the contract certain components must be in place.

Prior to discharge, the alternative program shall verify successful completion of the program as evidenced by the following:

- all necessary program forms on file including any subsequent participation agreements as may be required due to relapse
- adherence to terms of participation for the minimum required length as established in the participation agreement
- completed treatment or therapy as recommended by approved assessor or evaluator
- maintained compliance with drug screening and abstinence requirements
- demonstrated safe nursing practice for the minimum length of time as established by the contract
- documented attendance at the minimum number of self-help or support group meetings required by the alternative program during the contract period
- maintained communication through electronic or face-to-face contact with the alternative program or its designated representatives
- submitted reports within mandated time frames established by the alternative program, along with all other required program documents that are kept on file with the alternative program
- developed and submitted a relapse prevention plan
- submitted written request for program completion and other supporting documentation (such as a letter of support from supervisor, sponsor, and therapist)
- successfully addressed any other requirements stipulated by the alternative program
- student nurses will be responsible for completing the required length of the alternative program per participation contract and thus may participate with the program after they have obtained licensure (once licensed they must continue to adhere to all applicable requirements of the alternative program)

Relapse and Program Noncompliance

For the purposes of uniform regulatory standards, noncompliance is the failure to adhere to any of the terms of the program contract and relapse is defined as any unauthorized use or abuse of alcohol, medications or mind-altering substances. Patient safety is jeopardized if a relapse is not identified early. Consistent monitoring and immediate identification of relapse is critical as it puts the nurse's health in immediate jeopardy and may be fatal.

Some of the issues with relapse are:

- any relapse is considered noncompliance and shall be reported to the board
- one relapse is considered noncompliance and participant must immediately cease nursing practice until receiving written approval from the board of nursing or its designee and a written recommendation from the alternative program staff to return to practice
- substantial noncompliance can be evaluated and reported to the board

Substantial noncompliance can include:

- violating any practice or work-related restrictions

- failure to complete treatment
- failure to attend meetings as required
- failure to submit required reports as defined by the program
- criminal convictions
- the unauthorized use of any medications
- use of multiple prescribers and pharmacies
- failure to report prescription medication use to the alternative program

Policies and Procedures

Policies and procedures assure consistent actions by staff, a clear direction to participants, accountability to the public and assure quality outcomes.

The alternative program must develop a policy and procedure manual that must contain details regarding the following items:

- the program's function per administrative and statutory authority
- relationships and functioning of entities having administrative authority or advisory capacity over the program
- the normal business operating hours that can coincide at minimum with the licensing board's business days or hours
- job descriptions and related human resource documents for program staff
- the intake (referral) process including the required information and how it is obtained including verification of licensure and licensure action or current board investigation
- coverage of the intake process when the program's primary intake staff is absent
- all aspects of office operations including measures taken to ensure the maintenance of non-public information, procedures detailing the program's case management system and what type of communication will be sent by the program such as initial contact letters, noncompliance letters and the time constraints
- case management criteria for compliance (For example, the required program forms, receipt of appropriate assessment and treatment recommendations, registration, initiation and results of drug and alcohol testing.)
- the program will report noncompliance of how, to whom and within what time period, and communicate what the consequences are to the participant (There must be clear criteria for acts of noncompliance and how noncompliance will be reported to the board for possible disciplinary action.)
- how continuity of case management will be maintained in the event of absences
- what constitutes successful completion of the program, what documentation is required and to whom, including whether or not the program is obligated to report successful completion to the board
- type, frequency and protocol for audits, financial and performance reports

Program policies and procedures must be reviewed at least annually by the program director or designated staff as well as the board or its designee in order to ensure their currency with existing practice, laws and other requirements and objective review. The board of nursing must be notified of any identified non-compliance and the identity of each nurse participant in the alternative program.

All alternative program records related to noncompliance, discharge or termination from the alternative program can be available to the board of nursing or the board's representative upon request and upon discharge or termination from the alternative. The board of nursing must be able to review nurse participant files and audit the administrative records for overall

compliance of nurses in the alternative program. Admission procedures must include obtaining a release of information agreement signed and dated by the participant and authorizing the exchange of information between the alternative program and employers, the board of nursing or designee, health care providers, support group facilitators and any treatment providers while participating in the alternative program.

All nurses entering the alternative program can be asked to sign informed consents, which outline all terms, requirements and conditions for participation.

Programs must keep records of the following data, compile and analyze those data and share with the board of nursing to verify compliance with all program expectations and requirements:

- referral and entry into the program
- demographics of participants
- program requirements
- relapses
- other program violations
- referrals to the board
- non-completers (participants who did not successfully complete the program)
- participants who sign new contracts due to noncompliance
- recidivism rate of participants who successfully completed the program and relapsed
- completers (participants who successfully complete the program)
- all programs need to provide new participants with an orientation handbook

Program Education and Outreach

An important role of alternative programs is to educate and inform all participants such as nurses, the public, educators, students, facilities and agencies in order to improve early identification and referral and reduce risk factors.

Alternative programs can have education or outreach services that are mutually agreed upon with the board of nursing. For example, through service contracts that require alternative programs to provide written annual educational plans and reports that include:

- education or outreach goals
- target audiences for educational activities
- dates of proposed educational activities or offerings
- locations (cities or facilities within the state)
- type and length of education to be provided such as orientation versus formal workshop
- means by which the education or outreach will be provided such as on-site by program staff, e-media based continuing education, flyers or brochures
- any formal contact hours in nursing to be awarded
- methods by which the programs will be evaluated (For example, formal written evaluation or individual follow-up about changes in the nurses' practices that have occurred.)
- status of the resources both material and manpower

Program Annual Evaluation and Reporting Requirements to the Board of Nursing

Accountability to the public and the board is a critical, ongoing evaluation that provides checks and balances so that policies and procedures are being implemented correctly and consistently. These also ensure that the program is meeting its mandates to protect the public and can identify any areas that need to change and improve.

The alternative program and the board of nursing can set performance measures of the program requirements to foster program accountability and public protection.

The annual evaluation of the program can include the following reporting requirements to the board of nursing:

- number of referrals
- length of time between when the program receives the referral to the execution of the agreement
- length of time to determine eligibility for participation in the alternative program
- participation rates (number of new and existing nurses participating)
- return-to-work rates (number of new and existing nurses who returned to work [RTW])
- success rates (number of participants who successfully completed the alternative program requirements and the number of nurses removed from practice in a timely and appropriate fashion)
- relapse rates and number of relapses
- length of time it takes to remove a nurse with a substance use disorder from practice
- recidivism rates for completers
- caseloads of managers
- internal quality assurance frequency or findings
- case managers have addressed relapse and compliance issues
- documents are tracked and verifiable
- external audit findings of performance, legal or financial components as directed by the board of nursing
- review of policies and procedures
- policy recommendations to the board of nursing
- program direction to assure that decisions are congruent with current research, knowledge, best practices and compliance with legislative and board directives
- educational plans and reports

A P P E N D I X B

TEXAS BOARD OF NURSING DISCIPLINARY MATRIX

TO DETERMINE AN APPROPRIATE disciplinary action, including the amount of the assessment of any administrative penalty, the board will have to consider the threat to public safety, the seriousness of the violation and any aggravating or mitigating factors. The board currently lists factors to be considered in Rule 213.33, published at 22 Tex. Admin. Code §213.33. The matrix may list additional aggravating or mitigating factors, which must be considered in addition to the factors listed in Rule 213.33. Furthermore, any aggravating or mitigating factors that may exist in a particular matter but are not listed in this matrix or Rule 213.33, must also be considered by the board, pursuant to the Occupations Code Chapters 53 and 301.

Additionally, the board can consider whether the person is being disciplined for multiple violations of either Chapter 301 or a rule or order adopted under Chapter 301 or has previously been the subject of disciplinary action by the board and has previously complied with board rules and Chapter 301. Furthermore, the board will consider the seriousness of the violation, the threat to public safety and any aggravating or mitigating factors.

If the person is being disciplined for multiple violations of either Chapter 301, or a rule or order adopted under Chapter 301 the board shall consider taking a more severe disciplinary action than the disciplinary action that would be taken for a single violation including revocation of the person's license.

If the person has previously been the subject of disciplinary action by the board, the board shall consider taking a more severe disciplinary action including revocation of the person's license than the disciplinary action that would be taken for a person who has not previously been the subject of disciplinary action by the board.

The board may assess administrative penalties as outlined in 22 Tex. Admin. Code §213.32.

Although not addressed by this matrix, the board may also seek to assess costs of a contested case proceeding authorized by the Occupations Code §301.461.

Although not addressed by this matrix, the Occupations Code §301.4521 authorizes the board to require an individual to submit to an evaluation if the board has probable cause to believe that the individual is unable to safely practice nursing due to physical impairment, mental impairment, chemical dependency or abuse of drugs or alcohol. Section 301.4521 also

authorizes the board to request an individual to submit to an evaluation for other reasons such as reported unprofessional conduct, lack of good professional character or prior criminal history. The board's rules regarding evaluations are published at 22 Tex. Admin. Code §213.29, §213.30, and §213.33.

This matrix is also applicable to the determination of an individual's eligibility for licensure under the Occupations Code §301.257.

APPENDIX C

TEXAS BOARD OF NURSING DISCIPLINARY MATRIX CHART*

§301.452(b)(9) intemperate use of alcohol or drugs that the board determines endangers or could endanger a patient.		
First Tier Offense: Abuse of drugs or alcohol without patient interaction and no risk of patient harm or adverse patient effects. No previous history of abuse and no other aggravating circumstances.	Sanction Level I: Referral to a board-approved peer assistance program for nurses pursuant to board rules and policy on alcohol or substance abuse. http://www.bon.state.tx.us/disciplinaryaction/dsp.html	Sanction Level II: For individuals receiving a diagnosis of no chemical dependency or no substance abuse, a warning with stipulations that may include remedial education; supervised practice; perform public service; abstain from unauthorized use of drugs and alcohol to be verified by random drug testing through urinalysis; limit specific nursing activities; a periodic board review. Appropriate when individual declines participation in peer assistance program or they are otherwise ineligible for the program.

* Excerpted from <http://www.bon.state.tx.us/disciplinaryaction/pdfs/discp-matrix.pdf>

§301.452(b)(9) intemperate use of alcohol or drugs that the board determines endangers or could endanger a patient.		
Second Tier Offense: Abuse of drugs or alcohol without patient interaction and no risk of patient harm or adverse patient effects. However, individual has a previous history of peer assistance program participation or previous board order.	Sanction Level I: Board ordered participation in a board-approved peer assistance program for nurses pursuant to board rules and policy on alcohol or substance abuse. Includes individuals with non-disciplinary history of peer assistance participation. http://www.bon.state.tx.us/disciplinaryaction/dsp.html For individuals receiving a diagnosis of no chemical dependency or substance abuse, a reprimand with stipulations, which may include remedial education; supervised practice; perform public service; abstain from unauthorized use of drugs and alcohol to be verified by random drug testing through urinalysis; limit specific nursing activities; periodic board review.	Sanction Level II: Suspension of license until treatment and verifiable proof of at least one year sobriety. Thereafter a stay of suspension with stipulations that may include remedial education; supervised practice; perform public service; abstain from unauthorized use of drugs and alcohol to be verified by random drug testing through urinalysis; limit specific nursing activities; periodic board review. Includes individuals with prior disciplinary history with peer assistance participation. For individuals receiving a diagnosis of no chemical dependency or substance abuse, suspension of license, which can be probated, and stipulations that may include remedial education; supervised practice; perform public service; abstain from unauthorized use of drugs and alcohol to be verified by random drug testing through urinalysis; limit specific nursing activities; periodic board review. Emergency suspension of nursing practice in light of violation that may be a continuing and imminent threat to public health and safety pursuant to the Occupations Code §301.455 or §301.4551, which may ultimately result in revocation..

§301.452(b)(9) intemperate use of alcohol or drugs that the board determines endangers or could endanger a patient.

<p>Third Tier Offense: Abuse of drugs or alcohol with a risk of patient harm or adverse patient effects. Abuse of drugs or alcohol and other serious practice violation noted.</p>	<p>Sanction Level I: Referral to a board-approved peer assistance program if no actual patient harm, no previous history of drug or alcohol abuse, and no other aggravating circumstances. Board ordered participation in an approved peer assistance program if no actual patient harm or other aggravating circumstances. For individuals receiving a diagnosis of no chemical dependency or substance abuse, warning or reprimand with stipulations that may include remedial education; supervised practice; perform public service; abstain from unauthorized use of drugs and alcohol to be verified by random drug testing through urinalysis; limit specific nursing activities; periodic board review. Denial of licensure until applicant establishes they have received treatment and demonstrates one year of verifiable sobriety followed by a license with stipulations that include supervision; limited practice; abstention from drugs or alcohol; and random drug testing through urinalysis.</p>	<p>Sanction Level II: Suspension of license until treatment, verifiable proof of at least one year sobriety and a stay of suspension with stipulations that may include remedial education; supervised practice; perform public service; abstain from unauthorized use of drugs and alcohol to be verified by random drug testing through urinalysis; limit specific nursing activities; periodic board review. For individuals receiving a diagnosis of no chemical dependency or substance abuse, a suspension of license, which can be probated and stipulations, which may include remedial education; supervised practice; perform public service; abstain from unauthorized use of drugs and alcohol to be verified by random drug testing through urinalysis; limit specific nursing activities; periodic board review. Emergency suspension of nursing practice in light of violation that may be a continuing and imminent threat to public health and safety pursuant to the Occupations Code §301.455 or §301.4551, which may ultimately result in revocation.</p>
<p>Fourth Tier Offense: Abuse of drugs or alcohol with serious physical injury or death of a patient or a risk of significant physical injury or death.</p>	<p>Sanction Level I: Denial of licensure, revocation or voluntary surrender.</p>	<p>Sanction Level II: Emergency suspension of nursing practice in light of violation that may be a continuing and imminent threat to public health and safety pursuant to the Occupations Code §301.455 or §301.4551, which may ultimately result in revocation.</p>

Aggravating Circumstances for §301.452(b)(9):

actual harm; severity of harm; number of events; illegal substance; criminal action; criminal conduct or criminal action involved, criminal justice probation; inappropriate use of prescription drug; unsuccessful or repeated treatment; concurrent diversion violations. Ineligible to participate in approved peer assistance program because of program policy or board policy.

Mitigating Circumstances for §301.452(b)(9):

self-remediation including participation in inpatient treatment, intensive outpatient treatment, and after care program. Verifiable proof of sobriety by random, frequent drug or alcohol screens.

APPENDIX D

PRE-WORKSHOP ASSESSMENT

THE PURPOSE OF THIS ASSESSMENT is to better address the individual and organizational needs of the continuing education by the alternative program. Please answer the questions that are relevant to you as succinctly as possible. Return the assessments to the program at least one week before the scheduled CE. Appropriate respondents include: CNOs, nurse managers, nursing staff, nursing education, pharmacists, HR, EAP and risk management. **NO NAMES OR PERSONAL IDENTIFIERS ARE NEEDED.**

What questions do you have about the alternative to discipline program as represented by the following areas?

- For yourself or the practice area (Please identify your department or practice area.)
- Nursing staff or other health professionals, such as what are the colleagues' roles with the alternative to discipline program
- Nurse managers or department heads including how to handle the re-entry to practice under the alternative to discipline program, drug administration or wastage policies of controlled substances
- HR/EAP, especially policies related to hiring, identification, intervention, termination and retention
- Nursing administration and others within administration:
- Pharmacy, especially controlled substances, administration and wastage, inventory controls and drug administration audits

What specific information or educational needs do you or others have regarding the following:

- intervention or for-cause drug tests
- referral
- participation requirements
- return to work or ADA
- monitoring or relapse intervention
- facilitated support groups
- program staff and volunteers
- other

To the best of your knowledge, have there been any critical incidents or learning needs leading to this CE request? If so, please succinctly describe.

Briefly, to the best of your knowledge, what is your facility's policies pertaining to nurses who are suspected or identified as having: a) any substance use disorder (abuse or dependency); b) any psychiatric disorders? Note that having knowledge of existing policies may help the alternative to discipline program guide attendees in making best practice decisions within their institution. The alternative to discipline program does not discredit any facility's policies.

Does your facility intervene or manage a nurse employee with possible impaired practice differently depending upon whether the nurse has been:

- diverting, such as theft of patient medication (narcotics or other meds that can be abused)
- misusing personal prescription medication or misusing alcohol?

If yes, explain briefly how?

If not already described, what positive or negative personal experiences pertaining to a substance use disorder or the alternative program and recovering nurses can you report?

If applicable, are there nurses employed at your facility who are volunteers with the alternative to discipline program? If so, do you know how are they utilized by your facility?

Please offer any suggestions or requests not already covered about your facility's upcoming alternative to discipline CE presentation.

A P P E N D I X E

ALTERNATIVE PROGRAM CONTINUING EDUCATION OVERVIEW

Title: An Overview to Substance Abuse in Nursing and the Alternative Program

Presenter: Alternative program staff or designated volunteer

Goal: To enhance one's competency when working with the alternative program and nurses with a substance use disorder.

Objectives:

- Outline how the alternative program's mission complements the licensing board's mission.
- Relate at least three risk factors that may cause nurses to be at-risk for a substance use disorder.
- Recognize at least three signs that may indicate a nurse is in need of referral to the alternative program.
- Identify the essential steps to take when making a report or referral to either the licensing board or to the alternative program.
- Identify at least three requirements for participating in the alternative program.
- State the primary responsibilities of an employer as an alternative program participant.

Topical Agenda:

- Welcome and Introduction
- Substance Use Disorder: A Public and Professional Health Problem
- Risk Factors for Nurses
- Recognizing Nurses with a Substance Use Disorder
- How Nurses Are Reported or Referred to the Alternative Program
- The Alternative Program's Relationship to the Board of Nursing
- Resources and Their Roles within the Alternative Program: Employers, EAP, HR, Assessors, Treatment Providers and Licensing Board
- Participation and Return-to-Work Requirements of Program Participants
- Employer Monitoring Requirements of Alternative Program Participants
- Recognizing and Addressing Indicators of Relapse
- Staff and Volunteers of the Alternative Program
- Summary and Evaluation

A P P E N D I X F

**ALTERNATIVE PROGRAM AND HOST
FACILITY AGREEMENT TO PROVIDE
CONTINUING EDUCATION**

This agreement is between the continuing education activity provider and the host facility:

Title of CE Activity: _____

Location: _____

Date(s): _____ Scheduled from _____ to _____ for _____ contact hours.

Presenter(s): _____

Each item below must be agreed to and checked to reflect as being the responsibility of the appropriate party.

Item	ATD	Host
1. Arrangement of Physical Facilities		
2. Printing		
Brochure		
Program format		
3. Advertising		
Mailing list		
Hand distribution of brochures		
4. Postage		
5. Supplies		
Name tags		
Packets and handouts		
6. Educational Design		
Provider of CE activity or contact hours		
Determination of objectives and content		
Selection of faculty		
Determination of number of contact hours		
Number of contact hours to be awarded		
Evaluations		

Item	ATD	Host
7. Administration of Budget		
8. Record Keeping (Secretary)		
9. Awarding Contact Hours or CE Certificates		
10. Special Equipment		
Audiovisual		
Sound System		
Room set		
11. Summary of Evaluations		
12. Travel Arrangements		
Air/Auto (Private Rental)		
Map or Directions to facility		
13. Reimbursements		
Travel (Private Auto)		
Lodging		
Meals		
Requested Donation in lieu of Speaker Fee		
14. Registration		
Fee (if charged): Outside Attendee: \$_____ / Host Employee: \$_____		
Attendee Roster		
On-site registration		
15. Arrangement for Workshop Meals		
Breakfast		
Breaks		
Lunch		
16. Payment of Workshop Meals		
Breakfast		
Breaks		
Lunch		
17. Collection of CE Applications and Evaluations		

Program Director (Signature)

Date

Host Facility Rep. (Signature)

Date

Name/Title (Please print)

Date

Email

Telephone

Mailing Address

APPENDIX G

**EDUCATION ACTIVITY
SUMMARY EVALUATION**

Activity Name	Activity Date
---------------	---------------

Site	Contact Hours
------	---------------

Number in Attendance

Successes:
Problems:
Recommendations or Follow-Up:

Submitted By: _____

Complete this form within 30 days following activity. File with completed documentation
after review by RN Planner _____ (Initial) or Program Administrator _____ (Initial).

A P P E N D I X H

DEFINITIONS

Abstinence. Refraining from the use of non–medically prescribed and currently authorized drugs, including alcohol.

Addiction (Substance Use Disorder). A medical disorder marked by the compulsive use of chemicals (drugs or alcohol) and the inability to stop using them despite all the problems caused by their use. A person with addiction is unable to stop drinking or taking drugs despite serious health, economic, vocational, legal, spiritual and social consequences. (also referred to as abuse)

Administrative Procedures Act. In most jurisdictions this is the statute that provides uniform processes for administrative agencies including rule-making and hearing procedures.

Aftercare. Ongoing substance abuse treatment after the initial intensive phase of treatment. This part of the treatment process continues to provide structure for the person with a substance use disorder and most commonly focuses on relapse prevention strategies.

Alcoholics Anonymous (AA) and 12-Step Programs. Self-help groups, or fellowships, which provide support for persons with a substance use disorder, promoting sobriety and recovery.

Alternative Program. A voluntary, non-public and non-disciplinary program, which offers an alternative to traditional discipline authorized in statute and rule by nursing or other regulatory boards.

Americans with Disabilities Act. Federal legislation designed to protect disabled persons from discrimination in employment, transportation and other aspects of everyday life.

Cease Practice. The Nurse Practice Act in each state offers regulatory guidance over standards for nurse monitoring programs. Generally, monitoring contracts stipulate that a nurse agrees to cease practice immediately for failure to comply with the terms and conditions set forth in the monitoring contract. In some instances, a nurse is asked to surrender or inactivate their license during the cease practice period. This reduces the potential that the nurse with an active substance use disorder will obtain employment as a nurse when not otherwise authorized to practice. Return to practice and reactivation of a nurse’s license involves collaborative statements from treatment providers and monitoring or alternative program staff attesting that the nurse is safe to practice.

Chemical Dependency (Substance Use Disorder). A medical disorder in which an individual experiences a compulsion to take a drug, either continuously or periodically, in order to experience its psychic effects or to avoid the discomfort of its absence.

Chemical Dependency Evaluation. Assessment by a professional evaluator with expertise in substance use disorder for the purpose of assessing, diagnosing and providing recommendations for treatment, monitoring and safety to practice.

Chemical Dependency Treatment. Formalized and structured treatment for persons with a substance use disorder. Treatment often consists of group therapy, individual therapy and education. Treatment goals are directed toward facilitating individuals to obtain the insight and skills needed to understand and deal with their illness, problems associated with their alcohol and drug use and obtain and maintain abstinence from drug use. Treatment may occur in a variety of settings including outpatient, inpatient and residential.

Confirmation Assay. Confirmation of drug test results by gas chromatography or mass spectrometry (GC/MS), which provides specific information on the amount and kind of drug present in a urine sample. This two-step process is done to prevent false positive results from being reported and is the standard in the drug testing industry.

Continuing Care. The phase of treatment post-acute treatment. Common elements of continuing care include aftercare, relapse prevention treatment and 12-step meeting attendance.

Controlled Substances. Those drugs which fall under the provision of the Controlled Substances Act of 1970, which classifies drugs into one of five schedules. Three basic criteria are considered in the classification of drugs: potential for abuse, currently accepted medical use and the likelihood of either physical or psychological dependence (Readling and Sells, 1992).

Craving. Urge for drugs after ceasing drug use. Craving is both a physiological response as well as a conditioned response to people, places and things previously associated with drug use. Although cravings are very common in the early days of abstinence and are usually experienced more intensively and frequently during the detox process, they can persist over the long haul, or stop and then return periodically.

Detoxification. Structured medical treatment to overcome the withdrawal symptoms of physical dependence in the process to become drug free. Fear of withdrawal can be worse than the actual experience.

Disciplinary Process. Consists of the regulatory procedures and activities involved in the receipt, review, investigation, prosecution, decision-making and case resolution.

Drugs. Chemicals usually taken by ingesting, smoking, snorting or IV injection to produce a rapid rise and spiking brain levels of the substance with the goal of getting high rather than to get relief from an illness.

Drug Addiction (Substance Use Disorder). A chronic relapsing brain disorder characterized by neurobiological changes that lead to a compulsion to take a drug with loss of control over drug intake. The compulsive use of drugs and the inability to stop using them despite all the problems caused by their use. A person with addiction is unable to stop drinking or taking drugs despite serious health, economic, vocational, legal, spiritual and social consequences.

Drug Diversion. Drug diversion is a term used to describe a variety of activities used to obtain drugs illegally. It is most commonly used to refer to the misappropriation of drugs from a patient, health care employer or other source.

Emergency Action. Disciplinary action authorized to many boards of nursing through the Nursing Practice Act or other statutes that allows the board to take immediate action in situations that put the public at high risk of harm. Statutes authorizing emergency action provide for the nurse's due process by requiring a hearing within a specified time period. Types of emergency action include summary suspension, temporary and emergency suspension.

Enzyme Immunoassay (EIA) and Radioimmunoassay (RIA). Lab screening tests that use sensitivity and specificity of antibodies to indicate type and quantity of drug metabolites present in urine. Cross-reaction of compounds can occur, making this procedure less specific than GC or GC/MS. Commonly used for screening because the procedure is less complex, widely available and less expensive. The initial screen of a urine sample is commonly performed using immunoassay. Positive results, those that are equal to or greater than the established threshold, are further analyzed for confirmation by gas chromatography or mass spectrometry (GC/MS) which provides specific information on the amount and kind of drug present in a urine sample. This two-step process is done to prevent false positive results from being reported and is the standard in the drug testing industry.

False Negative. An erroneous result from the absence of a drug that actually is present. A false negative is reported if the drug is not presenting a high enough concentration to exceed the cutoff point. False negatives can result when copious amounts of liquids have been consumed or when donors use adulterants that interfere with the test.

False Positive. An erroneous result indicating the false presence of a drug. A false positive usually occurs when a harmless substance causes the same reaction as an addictive drug and is reported as a drug positive. Confirmation of drug test results by gas chromatography or mass spectrometry (GC/MS), which provides specific information on the amount and kind of drug present in a urine sample is done to prevent false positive results from being reported and is the standard in the drug testing industry.

Federal or State Controlled Substance or Drug Statutes, Rules and Regulations. Those federal and state laws and rules or regulations which govern the prescribing, dispensing, movement, control and use of mood-altering drugs.

Intervention. A formal, structured and planned meeting of family and friends that is often led by a trained professional, which is designed to break through the denial of the person with a substance use disorder. Participants share personal observations about the person that has led the participants to believe that the person is dealing with an addiction. The desired outcome of the intervention is typically admission of the person with a substance use disorder to an addiction treatment program.

Limited or Restricted. Board disciplinary action to confine the parameters of a nurse's scope of practice as provided for in the jurisdiction's Nursing Practice Act, Uniform Discipline Act or other applicable statute.

MTR (Medication Treatment Record). The medical treatment records in client medical or health records used to track ordered medication and administration.

Monitoring. Ongoing assessment of the nurse in recovery by alternative program or board staff using a variety of methods including reports and body fluid testing to track the progress of the nurse. Monitoring is essential to assuring patient or client safety and that the nurse is competent to practice.

Narcotics Anonymous. Self-help groups modeled on the principles of Alcoholics Anonymous but with a focus on a broader range of drug problems.

Nursing Administrative Rules or Regulations. Most boards of nursing are authorized to promulgate rules or regulations to further interpret and implement the Nursing Practice Act. Rules or regulations cannot conflict with law and once adopted have the force and effect of law.

Nursing Practice Act. Statutes governing the regulation of nursing practice in a jurisdiction that typically empower a board of nursing to license individuals who meet specified requirements. The board may be explicitly or implicitly authorized to use an alternative program for nurses with a substance use disorder as well as have the authorization to take disciplinary action against those nurses who violate specified grounds.

Polydrug Use. Use of more than one drug. While most persons with a substance use disorder have a drug of choice they are also likely to use multiple drugs.

Probable Cause. Having a reasonable belief in the facts, which may therefore warrant further investigation and disciplinary action.

Conditional Probation. Board disciplinary action that allows a nurse to continue to practice a full scope of nursing but with certain requirements and under scrutiny or monitoring of the board of nursing as provided for in the jurisdiction's Nursing Practice Act, Uniform Discipline Act or other applicable statute.

Professional Nurse Support Groups. Professionally facilitated support group that is most commonly limited to nurses, in order to support a nurse's recovery and re-entry into practice.

Rational Recovery. An alternative to 12-step programs used by individuals to overcome drug and alcohol dependency. The program focuses on rational-emotive therapy (RET) and attempts to teach individuals to think about life from a practical perspective.

Recovery. The process for a person with a substance use disorder to get well (getting well does not mean a cure but it does mean regaining control of one's life). It is marked by acceptance of having a substance use disorder and abstinence from alcohol and all unauthorized, non-prescribed drugs.

Rehabilitation Act of 1973. Federal legislation requiring protection of persons with disabilities that applied only to organizations that receive federal funding.

Relapse. Relapse is the return to drug or alcohol use after a period of abstinence. A relapse may last for a few days or for many years. Relapse is not a simple, singular event; rather, it is a long process that usually begins with a distancing from participation in meetings and results in the re-emergence of denial. A person loses sight of the benefits of recovery and becomes re-absorbed in his/her addictive substance.

Relapse Prevention. Involves the education, treatment and planning to prevent or interrupt the relapse process.

Residential Treatment Program. Addiction treatment in a hospital or residential treatment center (the typical private sector addiction treatment program has been the 28-day residential program pioneered in Minnesota and known as the Minnesota Model).

Return-to-Work Contract. An agreement between a recovering nurse and employer, which specifies the terms and conditions for the nurse to resume or continue work as a nurse.

Revocation. Board disciplinary action to remove a nurse's license as provided for in the jurisdiction's Nursing Practice Act, Uniform Discipline Act or other applicable statute.

Screening Assay. An analysis used to screen a sample for the presence of drugs. Samples testing positive with a screening assay can be followed by a confirmation assay to ensure that the result is not false positive. Screening assays are generally immunoassays and therefore exhibit cross reactivity with several substances, but are not specific.

Sobriety. The state of abstinence from mind-altering drugs and alcohol.

Substance Abuse. Any use of drugs in a manner deviating from medically approved or socially acceptable patterns of use either on a single occasion or episodically. For example, a nurse who uses on duty, on one occasion is exhibiting poor judgment and putting clients at risk but is not necessarily addicted.

Substance Use Disorder. The state of dependency on mind-altering chemicals with continuing use that persists despite negative consequences. Substance use disorder can be diagnosed with physiological dependence, evidence of tolerance or withdrawal or without physiological dependence according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

Suspension. Board disciplinary action to discontinue for a period of time, sometimes indefinitely of an individual's authority to practice nursing as provided for in the jurisdiction's Nursing Practice Act, Uniform Discipline Act or other applicable statute.

Tolerance. The phenomenon of needing to use larger amounts of drugs to attain the same effect of a non-user using a much smaller amount of the drug.

A P P E N D I X I

ADMINISTRATIVE LAW

ADMINISTRATIVE LAW IS A BRANCH of civil law that has developed in response to an increasingly complex society. Administrative agencies are usually created to deal with serious social problems. Early federal agencies like the Interstate Commerce Commission and the Federal Trade Commission were created in an attempt to control the anti-competitive actions of some corporations. Periods of strife such as wartime or the Depression typically see the establishment or enlargement of administrative agencies.

Compared to the legislative process or the judicial process, the regulatory process offers more flexibility and the specialized staffing needed to accomplish control of complex activities and functions in order to protect the public. If a field is rapidly changing, legislators may be unable to specify detailed requirements and standards. An agency with flexible decision-making policies and ongoing responsibility for a limited subject matter may be better able to develop sound policy. The administrative process must aim to maintain flexibility while providing adequate legal procedural checks to prevent unrestrained government power.

Authority

Administrative agencies have no inherent authority. They are created by statute and have only those powers granted by the statute. Many agencies function under broad delegated powers that authorize combined legislative, executive and judicial powers.

Legislative statutes govern administrative agencies and typically contain enabling clauses that authorize the promulgation of rules or regulations as deemed necessary for implementation of the governing statutes. Rules cannot conflict with existing law or go beyond the delegated rule-making authority. Properly adopted rules or regulations have the force and effect of law.

Executive authority gives the authority to issue licenses and to investigate and prosecute alleged violations of statutes and rules within the agency's jurisdiction.

Judicial authority is a means to resolve disputes regarding compliance with statutes and rules within the agency's jurisdiction.

General Principles for Investigations

- the investigation must be legally authorized and undertaken for a legitimate purpose
- the information being sought must be relevant to a subject within the agency's jurisdiction
- investigative demands must be sufficiently specific and not overly burdensome
- information obtained must be protected and maintained in accordance with jurisdictional requirements

An investigator's report can fairly and accurately set forth the facts and the statements of the parties in order to facilitate an informed decision. It can not include the investigator's suppositions or opinions.

Due Process Considerations

- Adequate notice of the case against an individual
- Opportunity to respond to allegations

Adjudication of Administrative Cases**Informal Negotiated Settlement**

- Consent Orders
- Summary Suspension (hearing typically after the suspension taken to provide due process protection)
- Other Informal (warning letters, public advice, supervision or other measures short of an agency order)

Formal Negotiated Settlement

- Notice
- Limited Discovery
- Hearing (typically follows the jurisdiction's Administrative Procedures Act)
- Decision
- Appeal (right to appeal must be expressly stated in governing statute)

Judicial Review occurs when a court reviews the agency's governing statutes to determine if it acted within its authority. Court cannot retry the matter but must determine whether or not the agency properly exercised powers conferred upon it by the statute. The court cannot substitute its own decision in judicial review.

Ethical Considerations

- Duty of Confidentiality
- Duty of Impartiality and Honesty
- Duty to Respect the Administrative Process and Organizational Structure
- Duty of Continuous and Exclusive Service
- Duty of Loyalty

Relevant Federal and State Laws

Some of the important laws that have implications for how boards of nursing manage substance use disorder cases are outlined below.

Rehabilitation Act of 1973 (Section 503)

- Defines alcohol and drug abuse as a handicap or disability.
- Protects alcohol- and drug-dependent people from discriminatory employment practices when employer receives federal financial assistance or contracts with the federal government.

- Employer must base employment and promotion decisions solely on the potential for job performance. Interview questions and tests such as drug screens must be used consistently for all applicants and employees. Active, or practicing alcohol and drug abusers are excluded if employment could constitute a threat to patients' or employer's safety, diversion or stolen property or violation of an established conduct code.

Examples of conduct violations are:

- working under the influence of a drug or alcohol; theft of hospital or agency property; or alteration of patient records or other records kept in the course of providing care.
- protects confidentiality of treatment records or other records kept in the course of providing care.

Employers are responsible to provide reasonable modifications in the workplace for recovering individuals. Reasonable modifications may include such things as limited access to controlled substances, stable shift assignment or no overtime.

Americans with Disabilities Act of 1990 (ADA)

Prohibits discrimination by an employer whether or not federal funds are received because of a handicap or disability. The illegal use of drugs or alcohol is not included within ADA's definitions of a disability. An employee is considered handicapped and receives protection by the ADA if the employee:

- has successfully completed a drug rehabilitation program and is no longer engaging in the illegal use of drugs or alcohol
- is participating in a supervised rehabilitation program and is no longer engaging in the use of drugs or alcohol (case law now developing which addresses timing and length of time in program may be relevant)
- is erroneously regarded as engaging in the use of drugs but is not engaging in such use.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules says that a substance abuse treatment program¹ include:

- submission of claims to health plans
- coordination of benefits with health plans; inquiries to health plans regarding eligibility, coverage or benefits or status of health care claims
- transmission of enrollment and other information related to payment to health plans
- referral certification and authorization (such as requests for review of health care to obtain an authorization for providing health care or requests to obtain authorization for referring an individual to another health care provider)

The HIPAA Privacy Rule is a federal law that gives a person rights over their health information and sets rules and limits on who can look at and receive an individual's health information. The Privacy Rule applies to all forms of individuals' protected health information whether it is electronic, written or oral. At the same time the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

Part two of the Privacy Rule protects any and all information that could reasonably be used to identify an individual and requires that disclosures be limited to the information necessary to carry out the purpose of the disclosure. See 42 CFR §2.11 and 2.13(a).

The Security Rule specifies a series of administrative, physical and technical safeguards for covered entities to use to assure the confidentiality, integrity and availability of electronic protected health information.

1 A substance abuse treatment program is defined as an individual or entity that provides alcohol or drug abuse diagnosis, treatment or referral. For the purposes of this document, the term "program" includes both individual substance abuse providers and substance abuse provider organizations.

State Laws (Nurse Practice Acts)²

- Provide for a disciplinary process.
- Identify grounds for disciplinary action, including those related to chemical use or abuse.
- Provides the authority for a board to require upon probable cause that a nurse submit to a substance use disorder, mental health or medical evaluation.
- Authorizes a board to develop a non-disciplinary alternative program for nurses with a substance use disorder.
- Authorizes a portion of licensure fees to be used to support alternative programs.

² Jurisdictions vary as to whether all or some of these elements are included in the Nursing Practice Act.

A P P E N D I X J

FREQUENTLY ASKED QUESTIONS

Why can't an employer just fire a nurse who has problems with alcohol or drug abuse?

Addiction is a disease of the brain and is treatable. Rather than termination, consideration can be given to placing the nurse on sick leave or leave without pay that allows the nurse to access a facility's benefits and obtain treatment. Boards of nursing, alternative programs and literature on the treatment of substance abuse disorders support the return to work for nurses who successfully engage in treatment and participation in an authorized recovery and monitoring program. A nurse who has a strong recovery program that includes accountability and monitoring have a lot to offer to patients and the profession.

In addition, the Americans with Disabilities Act (ADA) protects those nurses with a substance use disorder who are in recovery, from discrimination. While the illegal use of drugs or alcohol is not included within the ADA's definition per se, a person is covered when he/she is participating in a supervised rehabilitation program and is no longer engaging in the abuse of drugs or alcohol or is erroneously regarded as engaging in the use of drugs. Consult with the human resources department or the agency attorney for specific guidance.

What is the likelihood of recovery for nurses with a substance use disorder?

Treatment for substance use disorder does work and nurses in recovery can re-enter the workplace safely when treatment and monitoring are instituted. Research demonstrates that substance use disorder is treatable and that successful, long-term recovery is possible for all who maintain a rigorous relapse prevention program. A nurse who is known and being monitored can be a safer practitioner than a nurse who may have a substance use disorder that has not yet manifested or that has thus far gone undetected.

What about relapse and how does relapse have an impact on a successful recovery?

Substance use disorder is a chronic illness. Like other chronic illnesses, it is characterized by periods of remission and exacerbation. In general, the rate of relapse among nurses is lower than in the general population. This is due to the growth of supportive programs and strict state monitoring programs. Still, some nurses do relapse. Knowing how to manage relapse in the workplace is crucial for both the safety of patients and well-being of the nurse. A relapse is essentially a recurrence or exacerbation of an active disease. The signs of relapse

mirror the warning signs of a substance use disorder. If relapse occurs, the signs will become apparent and will progress without intervention. In recovering nurses there is usually a behavioral change noted before a break in abstinence occurs. Behavioral changes include such things as taking on more than one can reasonably handle, over-extending one's self at the expense of one's recovery and coping activities, withdrawing from recovery support people and meetings, isolation, resumption of denial thinking and eventual return to drug or alcohol abuse. Relapse requires a re-examination of the return-to-work contract.

The same rule of thumb for usual employee performance assessment applies here. The nurse manager can continue ongoing monitoring of the recovering nurse's job performance, document concerns and take action when warranted. Any concerns must be addressed proactively. If performance concerns do not improve after performance counseling or if serious signs are observed, steps to re-evaluate the nurse's fitness to practice and to remove the nurse from practice can be initiated. Once re-evaluation is completed and fitness or stability is assessed, next steps can be determined. It is important that this entire process be handled in a non-punitive way. With early recognition of relapse signs and appropriate intervention or treatment the chances of the nurse re-entering recovery or remission are great. Once the nurse is stabilized and fitness to practice is determined, the decisions about return to practice can be made. A clear policy regarding the management of relapse is extremely important and can address areas of identification, documentation, intervention or referral for fitness to practice assessment or treatment and parameters for return to practice.

Is it safe for patients if an employer hires or retains a nurse who:

- **Has a history of a substance use disorder or drug abuse and is in recovery from a substance use disorder?**
- **Is currently participating in an alternative program for a substance use disorder?**
- **Is currently under a board order that addresses the substance use disorder or drug abuse?**

There are many factors to be considered in making these decisions. The most important factor is patient safety. Boards of nursing, alternative programs and literature on the treatment of the substance use disorder support the return to work for nurses who successfully engage in treatment and participation in an authorized recovery and monitoring program. A nurse who has a strong recovery program that includes accountability and monitoring has a lot to offer to patients and the profession.

Safety considerations are also an important part of the employment decision for the recovering nurse and other health team members.

Some elements to consider in determining whether a potential employment opportunity is a safe place and time for the nurse to practice include:

- the type of work environment
- the level of supervision and interaction with other professionals
- the intensity and stress of both physical and emotional aspects of the role
- the access and exposure to drugs
- the level of support for the nurse

What recommended policies or procedures can an employer have in place to guide decision-making concerning issues of drug use in the workplace?

The language and format of policies or procedures varies from agency to agency. Look for a comprehensive policy for addressing fitness-to-practice concerns that include but are not limited to:

- pre-employment
- drug testing
- fitness-to-practice evaluations
- expected documentation
- intervention
- employee assistance programs
- reporting expectations (both internal and external)
- return-to-practice guidelines
- relapse management

What quality assurance steps can an employer take to monitor the system for signs of potential drug issues? What tools could assist in this evaluation?

The first and most important step is to have in place appropriate policies and procedures. Planning for a variety of possible scenarios will increase the likelihood that you and your staff will be prepared to identify and deal with drug issues. Work with your pharmacy department to conduct routine audits as a regular quality assurance activity. Provide periodic education and policy review. It is better to plan for potential problems than to wait until you are facing an actual crisis. Nursing boards, alternative programs and organizational policies must provide the public with good evidence in how they accomplish their mission of public protection and safe patient care in order to achieve a shared goal of returning nurses to productive roles within their professional careers while addressing their substance use disorder.

What are possible signs of drug diversion?

Signs of drug diversion can be exhibited in a wide array of circumstances ranging from behavior to discrepancies in medication administration and documentation to missing drugs.

Behavior: Signs can consist of mood swings, a change from normal emotional patterns, changing patient assignments for no apparent reasons, giving narcotics to other nurses' patients, leaving the unit frequently without explanation, pinpoint pupils, needle marks on arms, blood stains on shirt or front of slacks.

Documentation: Signing out narcotics and not charting as administered, not having a witness for wastage, forging other person's names, patients complaining of pain after they have received suitable narcotics, excessive use of narcotics when other nurses have not had to give patients as much medication.

What are frequently abused drugs in various practice settings?

Sometimes what drugs are abused depends on the setting. Specialty settings like the OR lend themselves to drug abuse of Fentanyl, propofol and other anesthetic agents especially by practitioners administering such drugs. In acute care settings meperidine, oxycodone, benzodiazepines and propoxyphene still top the list of drugs that are more readily accessible to the nurse diverter. PCA pumps still provide opportunities for diversion if wastage is not carefully monitored. Home care and other community settings may provide opportunity for a variety of different drugs to be abused depending on the particular types of patients and their needs. Drug abuse can be opportunistic and someone who prefers one type of drug may switch to whatever is available at the time and place.

When is the right time to confront an employee?

Practically speaking, this is a most challenging question for employers and nursing management. Some signs and symptoms could have many different causes. Is it stress or behavior caused by other issues or really an indication of a substance use disorder? When a nurse's behavior or substandard practice jeopardizes patient safety, then that can be enough to take steps necessary to address the behavior or practice concerns. Setting forth clear policies and standards regarding medication administration and documentation, waste protocols, periodic Pyxis review, work attendance requirements, drug-free employment and drug testing in the workplace are ways for the employer and management to let nurses know how much is enough and that risky behavior and practice will be addressed promptly.

Identifying traits apparent in the nurse with a substance use disorder and making known to employees ahead of time what behavior will be scrutinized if it occurs, is an essential first step in creating a safe nursing environment. The next step is to integrate changes in personal behavior and professional practice promptly and minimize its potency whenever possible. Timely intervention with a comprehensive approach is essential in order to identify risk markers before the appearance of an adverse event. Ongoing monitoring for problematic traits may prompt a nurse to modify his/her lifestyle, which may decrease the likelihood of becoming substance use dependent (Quinlan, 2003).

What questions can be asked regarding drug abuse or a substance use disorder when questions arise regarding whether a nurse employee is showing signs of drug use or abuse?

If an employee is exhibiting signs or symptoms of drug use or abuse, patient safety must be the first consideration. Nurse managers and supervisors can follow the organization's policies and procedures on any substance use disorder in the workplace.

Generally, the nurse can be removed immediately from patient contact and the patient needs can be addressed immediately. Comply with any mandatory reporting requirements by state or federal regulators and direct the nurse to comply with any drug testing procedures that can be in place per policy of the practice or facility. If you do not have organization policies and procedures in place, consult administrative leadership and legal counsel for assistance before proceeding.

The importance of proper documentation cannot be overstated. Instruct staff to record clear, concise and objective factual data when documenting concerns. It is a nurse manager's role to evaluate all documentation provided by staff and determine when and if sufficient concerns warrant formal action. In some cases the nurse manager may request the help of a trusted colleague or supervisor in determining the best course of action to take. Something as simple as written (typed) anecdotal notes can be utilized to keep track of ongoing communicated concerns. It is important to maintain some minimum organization to your anecdotal notes such as the name of the staff member of concern, names of witnesses and their titles or if they are patients, date, time and nature of concern and action or follow-up taken.

Once all of the information has been reviewed, the nurse manager who suspects a nurse with signs of a substance use disorder can write down his/her findings. In doing so, the nurse manager can consider whether or not there is pattern of behaviors causing the nurse manager to think that the nurse may have a problem with substance use disorder or some other issue. The nurse manager can keep in mind that patterns of substance use disorder vary, depending on the stage of disease, substances used and the nurse. It can also be kept in mind that there may be only one sign and symptom or many signs and symptoms. If there is suspicion that there is a problem, the nurse can elicit the assistance of the immediate supervisor (Ohio Nurses Foundation, 2008).

Ongoing documentation will assist greatly if counseling for corrective action be necessary. Proper documentation is crucial to a successful plan of action, especially in the case of substance use disorder impairment with its subtle progression and chief characteristic of denial. When a nurse suspects that a pattern of incidents may be emerging, it is helpful to seek validation and consultation of a supportive colleague with experience in effectively handling any substance use disorder. Consulting an employee assistance professional can also be a great resource for managers. The need for strict confidentiality in such situations cannot be overemphasized. Confidential resources outside your health care setting may also be available and may include staff within a statewide peer assistance program or alternative to discipline program. Often these resources can provide an expert opinion as to the documentation and provide suggested intervention strategies. Nurse managers can better prepare their likely role as intervention coordinator when they have sufficient resources and support so that implementation of the intervention can effectively proceed.

When can an employer direct a nurse to be drug tested?

With a policy in place it is possible to direct a nurse to be tested when the person exhibits behavior described in the policy: confusion, unsteady gait, inability to focus or manage expected performance, slurred speech or any other signs that could be consistent with an active substance use disorder.

What are common substances screened in for-cause testing? What establishes cause?

Drug use testing may be conducted on bodily fluids (urine, blood and saliva) to detect the presence of unauthorized or illegal drugs. Drug use testing may also be conducted on hair.

Common substances that can be in a screening panel include: benzodiazepines, amphetamines, propoxyphene, cocaine, cannabinoids and opiates. Alcohol screening by breathalyzer is preferred to screening urine for alcohol. All drug screen panels can include the individual's known drugs of choice or abuse in addition to any standard panel.

For-cause drug testing is described in an organization's policies and procedures. In addition to behavioral signs (confusion, unsteady gait, inability to focus or manage expected performance, slurred speech), some organizations require testing when narcotic discrepancies are noted. Establishing cause ahead of time makes it easier to enforce the policies and obtain timely testing when needed.

What policies or procedures are recommended to address drug testing in the workplace?

Drug testing policy can include a clear statement that employees are subject to drug testing for cause. Cause can be spelled out so that the employee understands that certain behaviors that suggest unsafe practice will cause the employer to require drug testing. The policy can also include the confidentiality that will be maintained for the employee and how the employee will be apprised of the results. Finally, the policy can address the consequences of a positive drug test result and the employee's options.

Random drug testing is used as a preventive tool and a detection tool for unauthorized drug or alcohol use in the monitoring of participants with a substance use disorder. Urine screening is generally viewed as the preferred method for assessing substance use and may be supplemented with hair testing (for some drugs) to assess for drug use over long periods. A positive drug testing does not provide information regarding levels of impairment but rather that a drug or substance was used within the detection period and represents a significant breach of the alternative program contract. During periods of increased vulnerability to relapse, and including the first 12 months of monitored compliance with treatment and alternative program requirements, random drug screening must be done, at minimum, twice

a calendar month. Additionally, for-cause drug screening must be implemented whenever there is reasonable cause to believe that a participant may have relapsed.

The alternative program requires random drug testing to provide ongoing monitoring for abstinence, early identification of noncompliance and timely intervention if relapse occurs, in order for the testing to be effective there must be a very strict procedure for obtaining and processing drug and alcohol testing. Twice monthly random screening is the minimum requirement for at least the first year in the alternative program. More frequent screens may be requested after a return to employment or upon restoring access to drugs. The participant nurse may also be requested to submit a screen by the alternative program staff, the nurse's employer, the professional group facilitator or the treatment counselor. Upon evidence of full compliance with all terms of the alternative program stipulated agreement, the drug screening may be reduced to a minimum of once monthly thereafter.

A certified laboratory must be used to perform drug testing to ensure the integrity of the process. The laboratory sends results directly to the alternative program to preserve proper chain of custody, an essential legal requirement. All urine or blood screens are completed according to the following procedure:

Urine collection must be observed. If unable to observe the submission of the specimen, at minimum, there must be a dry room with the only source of water the commode and the water supplying the commode contains a dyeing agent to prevent or detect the substitution of water from the commode.

A strict chain of custody must be followed with the specimen sealed and signed by participant nurse, collector and lab. When it is indicated, a hair analysis drug test may be done. All drug screen reports are sent directly to the alternative program staff.

How do you prepare to participate in an intervention?

An intervention can be planned when there is sufficient indication that behavior and documentation is not within the expected norms. Facts can be objective and descriptive so that the nurse is presented with concrete information. The importance of proper documentation cannot be overstated. Instruct staff to record clear, concise, objective and factual data when documenting concerns. It is a nurse manager's role to evaluate all documentation provided by the staff and determine when and if sufficient concerns warrant formal action. In some cases the nurse manager may request the help of a trusted colleague or supervisor in determining the best course of action to take. Something as simple as written (typed) anecdotal notes can be utilized to keep track of ongoing communicated concerns. It is important to maintain some minimum organization to the anecdotal notes such as the name of the staff member of concern, names of witnesses and their titles or if they are patients, date, time and nature of concern and action or follow-up taken. Participants who are directly aware of the situation can be invited to attend the intervention, are able to protect the confidentiality of the nurse and can include management and human resources personnel. The intervention can take place away from where the nurse works in a private and confidential area.

Once all of the information has been reviewed, the nurse manager who suspects a nurse with signs of a substance use disorder can write down their findings. In doing so, the nurse manager can consider whether or not there are patterns of behaviors causing the nurse to think that the nurse may have a problem with a substance use disorder or some other issue. The nurse manager can keep in mind that patterns of substance use disorder vary depending on the stage of disease, substances used and the nurse. It can also be kept in mind that there may be only one sign and symptom or many signs and symptoms. If there is suspicion that there is a problem, the nurse can elicit the assistance of the immediate supervisor (Ohio Nurses Foundation, 2008).

When can the board of nursing be involved?

The nurse practice act and regulations in your state stipulate the board of nursing's involvement in an alternative program. Some states have reporting requirements for individuals or agencies. Forty-one states and the District of Columbia have alternative programs available for nurses who meet program requirements. It is important to be aware of and understand the applicable laws in the nurse's state.

It has been observed that when a nurse is confronted and realizes that his/her source of drugs is being cut off, there is an increased possibility of suicide. What is the nurse manager's next action if a nurse is confronted?

The nurse manager must realize that there is a high risk of suicide for any nurse undergoing an intervention. Managers can create a plan to ensure that the employee is not left alone at any time during the intervention and post-intervention periods. Suicide is one of the reasons that it is so important to plan the intervention before implementation and garner professional support as needed. That plan can include possible actions after the intervention. If the nurse admits to a problem, it is best to get the person into treatment immediately. Refusing treatment or being unresponsive to intervention (such as drug screen) is a time of high risk. If a nurse refuses, treatment information can be given about accessing treatment resources including employee assistance programs. If the nurse is in denial, and especially if there are employment repercussions for the denial, the nurse can be released to trusted family or friends.

What recommendations are available for employers and nurse managers regarding what to say to staff members when a nurse:

- **Goes into treatment voluntarily?**
- **Is referred and agrees to participate in an alternative program?**
- **Is reported to the board of nursing and the board takes disciplinary action?**

Nurse managers must first deal with their own personal stereotypes of addiction and nurses with a substance use disorder. They can develop and foster a climate of transparency and support for all nurses that will encourage nurses to break the code of silence if a nurse shows signs of substance use or practice problems. Managers can educate themselves and their staff about the disease of addiction and manage the controversial and emotional issue of abuse among all workers. They can create an environment that encourages reporting because this is vital to reducing the stigma, maintaining transparency, rehabilitating the nurse and protecting the public. Nurse managers can implement and utilize workplace intervention strategies for handling substance use disorder issues. They can institute educational, training and counseling programs on substance use disorder issues, bullying and lateral violence. Finally, they can establish policies and procedures on substance use disorder, bullying, and lateral violence and apply these policies consistently and follow through on implementation procedures.

How can management deal with anger issues toward the substance-misusing nurse among staff members?

Co-workers will demonstrate many emotions after a colleague is identified as having a substance use disorder. There may be feelings of anger, hurt, betrayal and even guilt when a colleague is identified as having a drug problem. Other staff may feel used or put at risk because of their colleague's illness. After educating the staff on the prevention, treatment and recovery for a substance use disorder the best approach is to be open and allow opportunity for an expression of feelings in order to build support for the recovering nurse. If certain staff members are having difficulty accepting the situation then some individual counseling

will be needed. Community resources such as treatment centers and employee assistance programs can provide the needed assistance for staff.

What can management do to assure a supportive environment for the nurse to return to practice? What safeguards? What precautions?

Returning to practice after treatment is anxiety provoking for the nurse, for the staff and for the nurse manager. Planning is essential. Successful re-entry to the workplace is possible with supportive colleagues and established policies. If the identified nurse is returning to the same unit, the staff members are probably already aware of some of the circumstances precipitating his/her leaving. As a way to minimize rumors, it is important to set up a time to hold the clinical return-to-work meeting so that professional staff who have a legitimate need-to-know can openly talk about their concerns. Questions can be answered in a general way to provide need-to-know information to staff members while at the same time ensuring confidentiality. This may be an appropriate time to initiate staff education as well. Basic education on substance use disorder and its prevalence in the nursing profession can help dispel myths that view a substance use disorder as a moral weakness rather than a medical illness. All practice restrictions and possible work exchanges can be discussed in the clinical return-to-work meeting. This is also an opportunity for the nurse especially if returning to the same practice area and co-workers to express their gratitude and make any brief comments and acknowledgement of his/her disease and the need to re-establish trust and healing over time. Once the nurse returns to work, additional meetings may be useful for further sharing and education. Meetings like these are usually well received. Besides diffusing mistrust and misunderstanding, they also promote open communication and may decrease the chance of enabling behaviors occurring in the future.

In general, the ongoing management of the returning recovering nurse can be no different than that of other employees. During any period that access to controlled substances is in effect, it is vitally important that the nurse manager ensure that all staff with a need-to-know be informed of this restriction. This would necessarily include any nursing float or agency staff. However, the nurse manager must also participate in the development of the return-to-work agreement and the subsequent return-to-work conference. The nurse manager will likely have to compile regular, written performance summaries if the recovering nurse participates in a statewide monitoring program.

What questions can be asked regarding drug abuse or a substance use disorder prior to employment?

During an employment interview, employers and managers can be aware that persons with a history of a substance use disorder and currently in documented recovery are protected by the Americans with Disabilities Act (ADA) with respect to the extent an employer may question an applicant concerning his/her past history. Consult with the Human Resources Department or the agency attorney for specific guidance.

Does an employer need to obtain written consent from a recovering nurse to have access to recovery information? If so, what does the consent need to address? How long is the consent effective?

Obtaining written consent from the recovering nurse will facilitate access to important information for nursing management to consider in monitoring the recovery and practice of a nurse with a substance use disorder. The Health Information Portability and Accountability Act of 1996 (HIPAA) Rules set forth protection of individually identifiable health information. Consult with the hospital administration and legal counsel as to content, format and duration.

What resources can help an employer or nurse management learn more about a substance use disorder?

There are many sources of information about substance use disorder. Reading the entirety of the NCSBN Manual on Substance Use Disorder is a great place to start. You can contact your State's Alternative Program or state board of nursing. Government agencies such as the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the Substance Abuse and Mental Health Services Administration (SAMHSA) provide research data and teaching materials on the subject. Private sources and well-known treatment centers such as Hazelden or Talbott Recovery have catalogs of products and written and audio-visual materials on the topic. Local treatment programs and hospitals for chemical dependency treatment have professionals who can provide advice and guidance. Employee assistance programs are also an excellent source of information and support.

References

Ohio Nurses Foundation. (2008). *Guidelines for managers working with impaired nurses*.

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Quinlan, D. (2003). Impaired nursing practice: A national perspective on peer assistance in the US. *Journal of Addictions Nursing*, 14, 149-155.

APPENDIX K

COMMONLY ABUSED DRUGS

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule* How Administered**	Intoxication Effects or Potential Health Consequences
Cannabinoids			Euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination or cough, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety, panic attacks, tolerance, addiction
Hashish	Boom, chronic, gangster, hash, hash oil, hemp	I swallowed, smoked	
Marijuana	Blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed	I swallowed, smoked	
Depressants			Reduced anxiety, feeling of well-being, lowered inhibitions, slowed pulse and breathing, lowered blood pressure, poor concentration or fatigue, confusion, impaired coordination, memory, judgment, addiction, respiratory depression and arrest, death Also, for barbiturates there is sedation, drowsiness or depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness, life-threatening withdrawal For benzodiazepines there is sedation, drowsiness or dizziness For flunitrazepam there is visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug's effects
Barbiturates	Amytal, Nembutal, Seconal, Phenobarbital; barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, V injected, swallowed	
Benzodiazepines (other than flunitrazepam)	Ativan, Halcion, Librium, Valium, Xanax; candy, downers, sleeping pills, tranks	IV swallowed	
Flunitrazepam***	Rohypnol: forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	IV swallowed, snorted	

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule*	Intoxication Effects or Potential Health Consequences
		How Administered**	
Depressants (continued)			GHB: drowsiness, nausea or vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death Methaqualone: there is euphoria or depression, poor reflexes, slurred speech, coma
GHB***	Gamma- hydroxybutyrate: G, Georgia home boy, grievous bodily harm, liquid ecstasy	I	
		swallowed	
Methaqualone	Quaalude, Sopor, Parest: ludes, mandrex, quad, quay	I	
		injected, swallowed	
Dissociative Anesthetics			Increased heart rate and blood pressure, impaired motor function or memory loss; numbness; nausea or vomiting Ketamine (at high doses): delirium, depression, respiratory depression and arrest PCP and analogs: possible decrease in blood pressure and heart rate, panic, aggression, violence or loss of appetite, depression
Ketamine	Ketalar SV: cat Valiums, K, Special K, vitamin K	III	
		injected, snorted, smoked	
PCP and analogs	Phencyclidine; angel dust, boat, hog, love boat, peace pill	I, II	
		injected, swallowed, smoked	
Hallucinogens			Altered states of perception and feeling, nausea, persisting perception disorder (flashbacks) LSD and mescaline: increased body temperature, heart rate, blood pressure, loss of appetite, sleeplessness, numbness, weakness, tremors LSD: persistent mental disorders psilocybin: nervousness, paranoia
LSD	Lysergic Acid Diethylamide: acid, blotter, boomers, cubes, microdot, yellow sunshines	I	
		swallowed, absorbed through mouth tissues	
Mescaline	Buttons, cactus, mesc, peyote	I	
		swallowed, smoked	
Psilocybin	Magic mushroom, purple passion, shrooms	I	
		swallowed	
Opioids and Morphine Derivatives			Pain relief, euphoria, drowsiness or nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death codeine: less analgesia, sedation and respiratory depression than morphine
Codeine	Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine: Captain Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	II, III, IV, IV	
		injected, swallowed	

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule* How Administered**	Intoxication Effects or Potential Health Consequences
Opioids and Morphine Derivatives (continued)			heroin: staggering gait
Fentanyl and fentanyl analogs	Actiq, Duragesic, Sublimaze: Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	I, II injected, smoked, snorted	
Heroin	Diacetylmorphine: brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse	I injected, smoked, snorted	
Morphine	Roxanol, Duramorph: M, Miss Emma, monkey, white stuff	II, III injected, swallowed, smoked	
Opium	Laudanum, paregoric: big O, black stuff, block, gum, hop	II, III, V swallowed, smoked	
Oxycodone HCL	Oxycontin: Oxy, O.C., killer	II swallowed, snorted, injected	
Hydrocodone bitartrate, acetaminophen	Vicodin: vike, Watson-387	II swallowed	
Stimulants			Increased heart rate, blood pressure, metabolism; feelings of exhilaration, energy, increased mental alertness or rapid or irregular heartbeat; reduced appetite, weight loss, heart failure, nervousness, insomnia amphetamine: rapid breathing or tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction, psychosis cocaine: increased temperature or chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition, panic attacks MDMA: mild hallucinogenic effects, increased tactile sensitivity, empathic feelings or impaired memory and learning, hyperthermia, cardiac toxicity, renal failure, liver toxicity
Amphetamine	Biphetamine, Dexedrine: bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II injected, swallowed, smoked, snorted	
Cocaine	Cocaine hydrochloride: blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II injected, smoked, snorted	
MDMA (methylenedioxy- methamphetamine)	Adam, clarity, ecstasy, Eve, lover's speed, peace, STP, X, XTC	I swallowed	

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule*	Intoxication Effects or Potential Health Consequences
		How Administered**	
Stimulants (Continued)			methamphetamine: aggression, violence, psychotic behavior or memory loss, cardiac and neurological damage; impaired memory and learning, tolerance, addiction nicotine: additional effects attributable to tobacco exposure; adverse pregnancy outcomes; chronic lung disease, cardiovascular disease, stroke, cancer, tolerance, addiction
Methamphetamine	Desoxyn: chalk, crank, crystal, fire, glass, go fast, ice, meth, speed	II	
		injected, swallowed, smoked, snorted	
Methylphenidate (safe and effective for treatment of ADHD)	Ritalin: JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II	
		injected, swallowed, snorted	
Nicotine	Cigarettes, cigars, smokeless tobacco, snuff, spit tobacco, bidis, chew	Not scheduled	
		Not scheduled or smoked, snorted, taken in snuff and spit tobacco	
Other Compounds			
Anabolic steroids	Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise: roids, juice	III	No intoxication effects or hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; in adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics
		injected, swallowed, applied to skin	
Dextromethorphan (DXM)	Found in some cough and cold medications; Robotripping, Robo, Triple C	Not scheduled	Dissociative effects, distorted visual perceptions to complete dissociative effects or for effects at higher doses see ‘dissociative anesthetics’
		swallowed	
Inhalants	Solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexyl): laughing gas, poppers, snappers, whippets	Not scheduled	Stimulation, loss of inhibition; headache, nausea or vomiting, slurred speech, loss of motor coordination, wheezing or unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death
		inhaled through nose or mouth	

* Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (not refillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in six months, and may be ordered orally. Some Schedule V drugs are available over the counter.

** Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis and other organisms.

*** Associated with sexual assaults.

APPENDIX L

PRESCRIPTION DRUG ABUSE CHART

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule*	Intoxication Effects or Potential Health Consequences	
		How Administered**		
Depressants			Reduced pain and anxiety, feeling of well-being, lowered inhibitions, slowed pulse and breathing, lowered blood pressure, poor concentration or confusion, fatigue, impaired coordination, memory, judgment, respiratory depression and arrest, addiction	
Barbiturates	Amytal, Nembutal, Seconal, Phenobarbital; barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, V injected, swallowed		
Benzodiazepines (other than flunitrazepam)	Ativan, Halcion, Librium, Valium, Xanax; candy, downers, sleeping pills, tranks	IV		barbiturates: sedation, drowsiness or depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness benzodiazepines: sedation, drowsiness or dizziness
		swallowed		
Flunitrazepam***†	Rohypnol: forget- me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	IV	flunitrazepam: visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug’s effects	
		swallowed, snorted		
Dissociative Anesthetics			Increased heart rate and blood pressure, impaired motor function or memory loss; numbness; nausea or vomiting Ketamine: at high doses, delirium, depression, respiratory depression and arrest	
Ketamine	Ketalar SV: cat Valiums, K, Special K, vitamin K	III injected, snorted, smoked		

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule*	Intoxication Effects or Potential Health Consequences
		How Administered**	
Opioids and Morphine Derivatives			Pain relief, euphoria, drowsiness or respiratory depression and arrest, nausea, confusion, constipation, sedation, unconsciousness, coma, tolerance, addiction codeine: less analgesia, sedation, and respiratory depression than morphine
Codeine	Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine: Captain Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	II, III, IV, IV	
		injected, swallowed	
Fentanyl	Actiq, Duragesic, Sublimaze: Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	II	
		injected, smoked, snorted	
Morphine	Roxanol, Duramorph: M, Miss Emma, monkey, white stuff	II, III	
		injected, swallowed, smoked	
Opium	Laudanum, paregoric: big O, black stuff, block, gum, hop	II, III, V	
		swallowed, smoked	
Other opioid pain relievers (oxycodone, meperidine, hydromorphone, hydrocodone, propoxyphene)	Tylox, oxycontin, Percodan, Percocet; oxy 80s, oxycotton, oxycet, hillbilly heroin, percs, Demerol, meperidine hydrochloride; demmies, pain killer, Dilaudid; juice, dillies, Vicodin, Lortab, Lorcet; Darvon, Darvocet	II, III, IV	
		swallowed, injected, suppositories, chewed, crushed, snorted	

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule*	Intoxication Effects or Potential Health Consequences
		How Administered**	
Stimulants			Increased heart rate, blood pressure, metabolism, feelings of exhilaration, energy, increased mental alertness or rapid or irregular heartbeat, reduced appetite, weight loss, heart failure amphetamines: rapid breathing, hallucinations or tremor, loss of coordination, irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction cocaine: increased temperature or chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition methamphetamine: aggression, violence, psychotic behavior or memory loss, cardiac and neurological damage, impaired memory and learning, tolerance, addiction methylphenidate: increase or decrease in blood pressure, psychotic episodes or digestive problems, loss of appetite, weight loss
Amphetamines	Biphetamine, Dexedrine; bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II injected, swallowed, smoked, snorted	
Cocaine	Cocaine hydrochloride; blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II injected, smoked, snorted	
Methamphetamine	Desoxyn: chalk, crank, crystal, fire, glass, go fast, ice, meth, speed	II injected, swallowed, smoked, snorted	
Methylphenidate	Ritalin: JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II injected, swallowed, snorted	
Other Compounds			
Anabolic steroids	Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise: roids, juice	III injected, swallowed, applied to skin	No intoxication effects or hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunk testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics

* * Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (can not be refilled) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in six months and may be ordered orally. Most Schedule V drugs are available over the counter.

** Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis and other organisms.

*** Associated with sexual assaults.

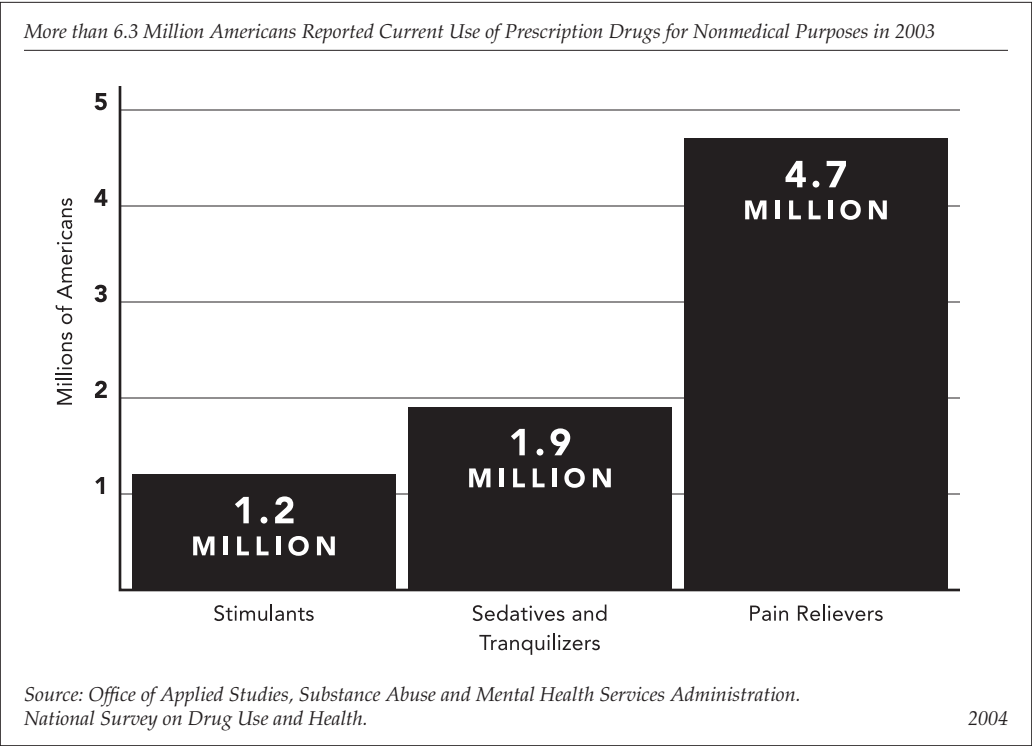
† Not available by prescription in U.S.

APPENDIX M

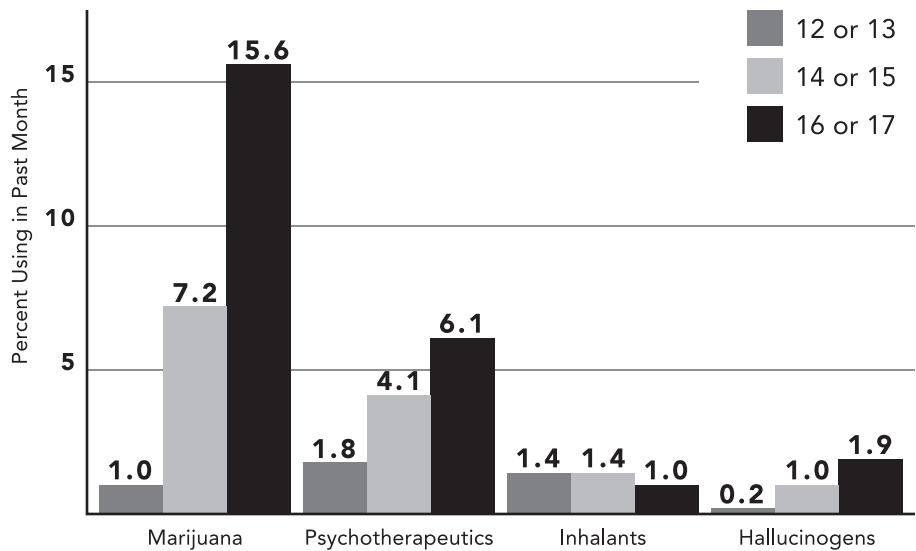
FACTS ABOUT PRESCRIPTION
DRUG ABUSE

MEDICATIONS ARE EFFECTIVE when they are used properly but some can be addictive and dangerous when abused. This chart provides a brief look at some prescribed medications that when used in ways other than what they are prescribed for have the potential for abuse and even addiction.

Fortunately, most Americans take their medications responsibly. However, an estimated 48 million people, ages 12 and older have used prescription drugs for nonmedical reasons in their lifetimes. This represents approximately 20 percent of the U.S. population.



Past-Month Use of Selected Illicit Drugs among Youths, by Age in 2003



Source: Office of Applied Studies, Substance Abuse and Mental Health Services Administration.
National Survey on Drug Use and Health.

2004

What types of prescription drugs are abused?

Three types of drugs are abused most often. They are opioids, which are prescribed for pain relief, CNS depressants, which are barbiturates and benzodiazepines prescribed for anxiety or sleep problems, which are often referred to as sedatives or tranquilizers, and stimulants, which are prescribed for attention-deficit hyperactivity disorder (ADHD), the sleep disorder narcolepsy, or obesity.



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