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Alabama's Nurse Monitoring Programs: The Nurse's Experience of Being Monitored

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Over the last 25 years, nursing regulatory agencies have developed programs for nurses recovering from substance use disorders. It is estimated that over 250,000 nurses are affected by substance use disorders. Recovery rates for nurses are higher than the general public due, in part, to the regulatory agency oversight. Within the State of Alabama, the Board of Nursing manages both voluntary alternative to discipline and disciplinary monitoring programs. Both programs allow nurses in recovery to return to work with supervision. This project sought to evaluate recovering nurses' attitudes about the monitoring program. Nurses actively involved in both monitoring programs (N = 173) were asked complete an anonymous survey to evaluate and share perspectives of the experience. The participants reported that the monitoring process was cumbersome, yet the structure assisted nurses to remain in recovery.

Keywords Substance use, Nurses, Recovery, Monitoring

Substance dependence impairs cognitive function, undermining interpersonal relationships, work, physical health and spirituality. Within the United States, "current estimates are that 22.5 million Americans (9.4%) aged 12 or older were classified in the past year with substance dependence or abuse" (Substance Abuse and Mental Health Administration, 2005, p. 17). Clearly, the effects of substance dependence (a term we use interchangeably with *addiction* and *chemical dependency*) take a great toll as the disorder not only affects the user, but also the lives of individuals touched by that person. The negative impact of substance use does not spare the nursing profession. The untreated substance dependent nurse puts patients at risk, as well as jeopardizes the nurse's health.

Incidence of Substance Abuse in Nursing

Statistics concerning the number of nurses affected by substance use are difficult to accurately assess since few studies in the past 10 years have addressed this issue. It is believed that the number of nurses impacted by chemical dependency is approximately that of the affected general population (Shaw, McGovern, Angres, & Rawal, 2004; Trinkoff, Eaton & Anthony, 1991). The volume of nurses potentially impaired is staggering, taking into account that there are an estimated 2.4 million RNs and 720,000 licensed practical and vocational nurses in the United States (Department of Labor, 2007, Table 1). This figure represents a combined workforce of 3.1 million nurses. Calculating the impact on nursing by using the disease rate of the general public suggests a quarter of a million nurses within the United States are impaired by substance use disorders. If left unrecognized or ignored, this can have a significant negative impact on patient care. To protect the public, many state boards of nursing have instituted programs to assist nurses to recover. The purpose of this paper is to share results of a survey of participants in Alabama's monitoring programs for impaired nurses.

Boards of Nursing and Chemical Dependency

Active chemical dependency within the nursing population is a major concern for agencies tasked with overseeing public safety such as state boards of nursing. Prior to the 1980s, these agencies viewed chemical dependency as a criminal act and managed the impaired nurse through a punitive disciplinary approach. Scientific breakthroughs demonstrating the biochemistry of disease were pivotal in the recognition of substance use disorders as an illness by many agencies. Highlighting this issue, the American Nurses Association (ANA) issued a statement in 1984, rallying the membership in favor of treatment rather than punishment for nurses with chemical dependence. This statement was reaffirmed in 2002, when the ANA's House of Delegates issued a policy statement that renewed the organization's commitment to treatment rather than criminalization of the addicted nurse. Although the ANA advocates for treatment of addicted nurses, each state's governing body has the legislative power to determine how the impaired nurse will be managed once identified.

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Two types of alternative to discipline programs have emerged within the United States: peer assistance and monitoring programs. Peer assistance programs are often contracted to agencies outside of the nursing licensing board (Finke, Williams & Stanley, 1996; Fletcher, 2004; Sisney, 1993). Peer assistance programs provide support and assistance to nurses helping them to remain substance-free and active in the work force. The process is designed to encourage early identification and treatment for the nurse with chemical dependency. Additionally, peer assistance programs are staffed by case managers and peer advocates (nurses with chemical dependency training who have frequent contact with the nurse in recovery). The advocates act as a liaison between the nurse and the caseworker to communicate issues related to nurse recovery. The peer assistance programs keep the management of recovery from addictions out of the board of nursing (BON) disciplinary arena.

The second type of alternative program is the monitoring program. These programs are often managed within BONs, as is the case in Alabama. Other alternative to discipline programs are separate from the BON or are contracted by the BON to provide monitoring. The degree of BON involvement depends on how each state legislature established the program. BON-based monitoring programs have a twofold agenda: (a) early identification of the illness and, (b) protection of the public. Although these programs may guide the nurse to enter and remain in recovery, the monitoring program's primary purpose is to ensure public protection through a process of early identification as well as supervision for continued sobriety. They generally do not provide treatment or peer support. Some monitoring programs may be collaborative with other disciplines and manage the professionals for regulatory boards within the state such as nursing, dentistry and medicine (Monroe, Pearson, & Kenaga, 2008).

The alternative to discipline process can quickly remove an impaired nurse from practice and limit the effects of the disease process. Nurses cannot return to practice until they are in recovery, and permitted to return to work by their treatment team. The earlier the impaired nurse is identified and engaged in treatment, the greater the benefit to all.

The disciplinary arm of the BON becomes involved when the nurses do not meet criteria for the voluntary program, or refuse to admit the extent of their illness. (See Figure 1 for Alabama's requirements for VDAP and Probation).

Guidelines for Alternative to Discipline Monitoring Programs

Providing regulatory guidance for the development of alternative to discipline monitoring programs, the National Council of the State Boards of Nursing (NCSBN) gathered nursing leaders in the field of addictions and policy in 1996. The task force created a template for monitoring program development. These guidelines were based on T. Gorski's relapse prevention model and were updated in 2002 into the *Chemical Dependency Handbook,* providing nursing boards with suggested structure for starting up individual state programs. Most monitoring programs continue to follow this recovery model.

Recovery Rates

Recovery rates for chemical dependency are similar to other chronic remitting illness in which relapse is considered part of the process. Schroeder (2005) examined recovery rates at 1 year for remission and found a 40–60% rate of recovery for alcoholism and drug abuse; additionally, recovery rates for addiction exceed that of many other conditions (such as gliomas and pancreatic cancers) that are routinely and aggressively treated (Schroeder). The National Institute on Drug Abuse (NIDA; 1999), as well as the National Institute of Health (NIH) support ongoing, long term treatment. The Director of NIDA, Dr. Nora Volkow, (2007) issued a statement supporting treatment:

> Diabetes, asthma and hypertension all have relapse rates (50–75 percent) similar to those for drug addictions. As with other chronic diseases, many people suffering from drug addiction require a level of continuous care or support in order to be successful. (p. 4)

One of the troubling aspects of public beliefs about substance treatment concerns perception of chemical dependency. "Substance use disorders are seen as volitional, while aggressive cancers are not" (Schroeder, 2005, p. 1008). This skepticism concerning benefits of treatment may delay many nurses from seeking help earlier or color co-worker's perception of the nurse returning to work.

The International Nurses Society on Addictions (IntNSA) and the American Association of Nurse Anesthetists (AANA) have spearheaded efforts to dispel the stigma around chemical dependency. IntNSA's mission is to advance excellence in addictive nursing practice through advocacy, collaboration, education, research and policy development. (IntNSA, 2008, p. 3) The organization's leaders have an ongoing effort to educate nurses about substance use and the benefits of treatment. The AANA produced a powerful video entitled *Wearing Masks: the Series,* (2006) to enlighten colleagues about the symptoms, risks, and the need for early intervention for addicted peers. Trossman (2003) summarized the importance of treatment for nurses: "We should care about nurses with addictions because they are our colleagues. We'd care about them if they had heart disease, fragile diabetes, or any other chronic disease" (p. 27). Nurses with chemical dependency issues have valuable skills and experiences that are invaluable given an increasing need for nurses.

Background and Significance

Prior to 2000, the majority of literature on nurse recovery and alternative to discipline programs centered on the need for identification of impairment and treatment. (Green, 1989; Griffith, 1999; Naegle, 2003; Trinkoff, Eaton & Anthony, 1991, Trinkoff & Storr, 1998). Although the term *impairment* applies

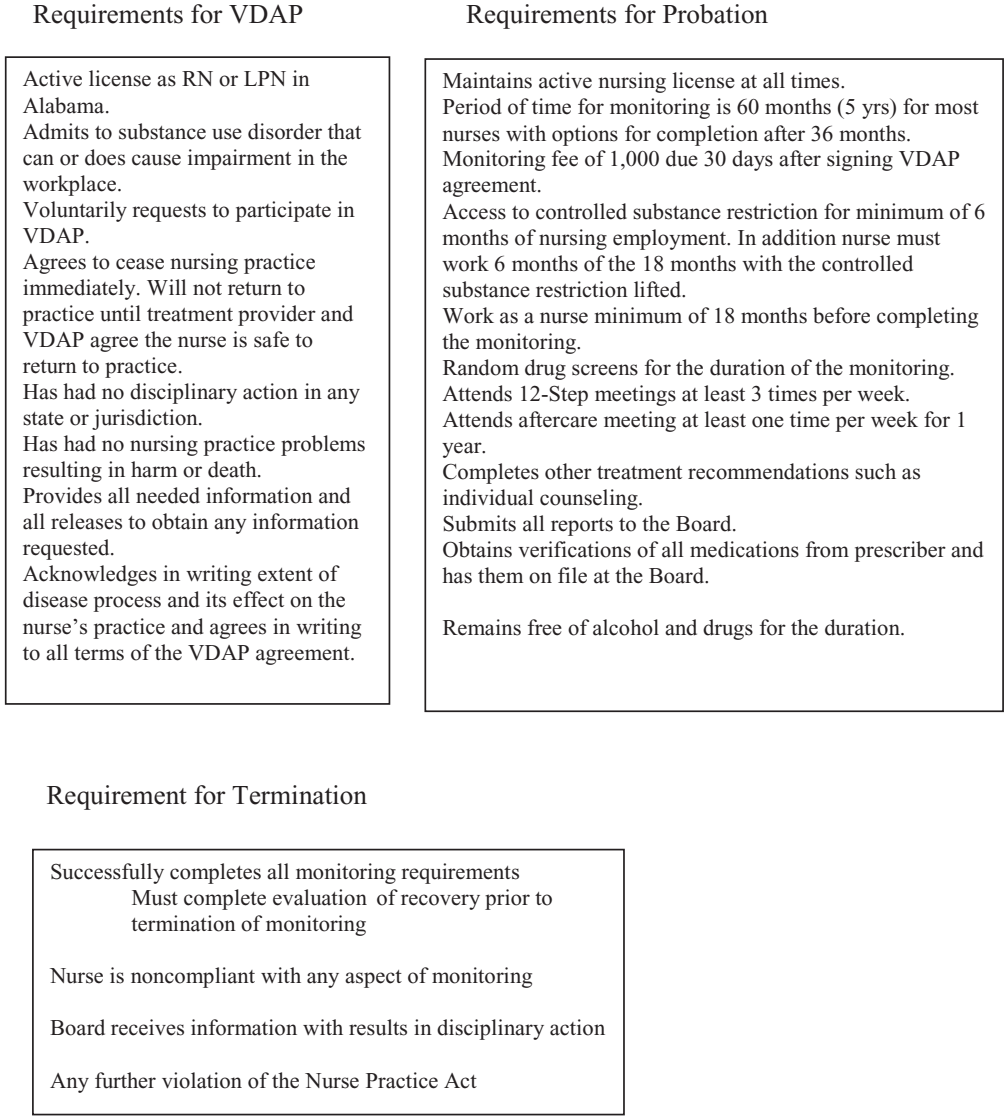

FIG. 1. Requirements for The VDAP and Disciplinary program.

to substance abuse as well as mental illness, all the studies focused on the nurse with a chemical dependency issue (Brown & Smith, 2003; Clark & Farnsworth, 2006; Darbro, 2005; Darbro, 2009; Fletcher, 2004; Fletcher, & Ronis 2005; Green, 1989; Griffith, 1999; Haack, & Yocom, 2002; Lazarus & Morocco, 2000; Monroe et al., 2008; Naegle, 2003; Quinlan, 2003; Smardon, 1998; Tipton, 2006; Trossman, 2003; Trinkoff, & Storr 1998; West, 2003). A small number of studies in the past 10 years focused on the outcomes of alternative to discipline programs or how the program was helpful in recovery from nurses' personal perspectives (Clark & Farnsworth, 2006; Darbro, 2005; Fletcher, 2004; Fletcher, & Ronis, 2005, Haack & Yocum, 2002; Monroe et al., 2008). The Monroe et al. (2008) study summarizes these works as well as incorporates communication from alternative program directors to offer an examination of the outcomes of several programs.

Nurse Recovery Rates

Data on nurse recovery rates while being monitored are limited to a few outcome studies published in the last 5 years. Monroe et al. (2008) found ranges for completion of monitoring to vary from a low of 61% successful completion to a high of 95%. They highlighted the need for standardization of the definitions of the term "successful completion," as terms vary from program to program making comparison difficult.

Although the rate of addiction of nurses is similar to that of the general population (Trinkoff, Eaton, & Anthony 1991; West

2003), the type of substances that nurses use may be different. The primary substance of abuse for the general public historically has been alcohol (U.S. Department of Health and Human Services, n.d.) and alcohol is the number one reason for chemical dependency treatment in Alabama (SAMHSA, 2007). However, the majority of studies found narcotic use to be the predominant drug of choice for nurses enrolled in the monitoring process (Clark & Farnsworth, 2005; Darbro, 2005; Fiske, Williams, & Stanley, 1996; Haack & Yocom, 2002; Tipton 2006). Recovering nurses may be in a vulnerable position when they return to work as the factors inherent to nursing practice may include continued access to their substances of abuse. Moreover, the chronically stressful working environments add to the probability of relapse. Domino and colleagues (2005) identified stressors such as being fired from work, having an underlying psychiatric illness and using a specific drug (hydrocodone) as contributing to relapse. The most significant risk factor identified for relapse was a co-occurring psychiatric illness such as major depression or bipolar disorder.

Success of Monitoring Programs

One of the primary benefits of the alternative to discipline approach is a rehabilitation process. Recovering nurses were able to remain active in nursing, and continuing to work enhanced their financial status, further supporting recovery. They continue to provide nursing care, which is especially important as the demand for skilled nursing care grows. Both disciplinary and monitoring programs allow the nurse to continue to practice once they have been through treatment. "At two months, 43% of the participants in the discipline group and 75% of those in the alternative group reported employment in nursing" (Haack & Yocom, 2002, p. 93). The monitoring process supports continued recovery through employment within the profession.

The one commonality of the monitoring process is the use of random frequent urine drug screens (UDS). Random drug screens coerce individuals to follow a prescribed plan towards recovery or deal with the consequences of using. Frequent UDS can identify early return to substance use (Heit & Gourlay 2004; Myrick, Henderson, Dansky Pelic, & Brady, 2002) or be a deterrent from returning to drug use.

Program lengths vary from state to state making determination of what contributes to successful outcomes difficult. For example, nine programs in the United States (including Alabama) are 5 years in length, representing the longest monitoring periods (Tipton & Van Doren, 2007). However, 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 (Dennis & Scott, 2007; McKay, 2005).

Alabama Monitoring Programs

In the early 1990s, the Alabama State Nurses Association (ASNA) advocated for impaired nurses and supported the creation of an alternative to discipline program. Corresponding legislation was passed in 1994, making the program a reality. Management of the program was established at the BON when the Alabama BON accepted the task of administering the program instead of the ASNA.

Entry Into the Monitoring Programs

Alabama law requires the nurse enter monitoring as a mandatory entry to keep their license once impairment is determined. The initial contact with the BON may have been through supervisors or peers reporting of the nurse's impairment or the nurse volunteering once they have entered treatment. Nurses may enter either the disciplinary program (Probationary Program) or the alternative program (Voluntary Discipline Alternative Program; VDAP). The disciplinary program (Probationary Program) may have conducted an investigation of the nurse following a complaint. A list of names of those disciplined is published each quarter for public knowledge.

The VDAP program participants must voluntarily request entry into the program and are protected from public knowledge by having done so. They can achieve a clean record with the BON provided they complete the monitoring process. Both the VDAP and probationary program stipulate that a participant follow a contract to remain eligible to work. During this time, the nurse is responsible for all costs of recovery including frequent urine drug screening tests. In addition, she/he pays a onetime fee that assists in covering the cost of the program to the BON. If an impaired nurse does not enter into monitoring, she/he must surrender their license. Student nurses are not eligible for either program as they do not fall under the Alabama BON jurisdiction until they apply for licensure (Genell Lee & Mary Ed Davis, personal communication, August 9, 2007). An overview of both programs is presented in Figures 1. The monitoring programs create an environment that requires the nurse with substance use disorder live a life of recovery to keep their license.

Upon entering either of the monitoring programs in Alabama, the nurse will encounter similar components. Both programs are 5 years in length. The exception is if the nurse stays substance free and adheres to program guidelines, the nurse may request an early evaluation and discharge at the 3 year mark. In addition, the nurse must complete a final evaluation prior to discharge from monitoring. The recovering nurse meets with the treatment team to review her/his plan for continued sobriety before they are discharged from the program.

Purpose of the Research

This study will help fill a gap knowledge related to the lived experience of the monitoring process within the State of Alabama. In addition, although Alabama's programs are unique, the basic structure of the monitoring process can be identified throughout programs across the United States and territories. The goal of the study was to evaluate the Alabama VDAP and Probationary monitoring program's effectiveness though feedback from program participants. The data assists to fill a knowledge gap related to the nurses' experience of being monitored.

METHODS

Initial project development required cultivation of a working knowledge of Alabama's monitoring process. Understanding the process demanded understanding resources as well as the roles of key personnel. A collaborative effort with the VDAP and Probation Director produced a confidential postal survey that included both qualitative and quantitative questions of the monitoring. Examples of quantitative items included demographic variables, length of treatment program and time in monitoring process, rating of the urine screening process, cost of program, and attendance at support groups. Examples of qualitative questions included items such as, "If you could propose changes in work restrictions, what would they be?" Another question was, "What would improve the monitoring process?" The survey was then validated for program elements as well as readability. Several nurses in long term recovery also reviewed the questionnaire and provided helpful suggestions to the draft. After approval by the BON, the project and survey were submitted to and approved by the University of South Alabama's Institutional Review Board (IRB). The survey was sent to the Alabama BON for a confidential mailing to monitoring program participants.

Sample Selection

All nurses in monitoring for substance use disorders were included (both those who were enrolled in VDAP as well as in the Probationary Program); those not selected were being monitored for reasons other than substance use. The participants' time in the program ranged from the newly identified, to the almost complete but not yet discharged. The survey packet contained letters from the BON's executive director as well as the author requesting participation. The introduction included IRB instructions, the 46 item survey, a stamped, self addressed return envelope and one dollar as an incentive. Limitations of the confidential mailing and time constraints restricted the study to one mailing without follow-up reminders.

RESULTS

Within VDAP, surveys were sent to 267 nurses. Within the Probationary Program, 115 surveys were mailed. Of 382 sent, a total of 173 surveys were completed and returned, representing a 45% response rate. The response rate for VDAP was 48% with a lower rate for the Probation Program at 38%. This is consistent with Fletcher and Ronis's (2005) response rate of 43% and 45% with mailed surveys. Further comparison between the two groups revealed one significant difference (with an alpha level of .05). The length of sobriety was greater for the probationary group was an average of 4.4 years with the VDAP group's mean at 2.5 years ($z = -2.438$, $p = .015$). However, there was no significant difference in the age of the nurses in each group (average age for the probation group was 44.3, with the VDAP's group's mean age at 40.7 ($z = -1.688$, $p = .091$). Additionally, there was no significant difference between the groups on years of experience in nursing: $z = -1.167$, $p = .243$ (see Table 1).

TABLE 1
Demographic variables

	Mean VDAP	Mean Probationary	*Mann-Whitney Test Z*	*P*
Length of sobriety	2.5	4.4	−2.438	.015
Age	40.7	44.3	−1.688	.091
Years in nursing	15.85	18.08	−1.167	.243

The treatment programs' utilization demonstrated that different levels of treatment were necessary or were chosen based on what the nurse could afford. Long term inpatient treatment was the most expensive and utilized when the illness severity demanded intensive treatment. Often nurses used more than one type of treatment (see Table 2). A considerable number of the nurses in VDAP (41%) and Probation (42%) attended long term treatment. Of the VDAP nurses, 15% used halfway houses; within the Probation program, 18% used halfway houses to remain in a safe environment while learning to live without substances.

Both the VDAP participants and the Probationary Program participants were currently employed at high rates (90% and 96%, respectively). Additionally, 94% of the nurses reported no relapses since they entered monitoring. A very small percentage had one relapse. This is one definition of success within the monitoring program.

Registered nurses comprised the highest proportion of participants at 77% and 78%, respectively, in the VDAP and Probationary programs; licensed practical nurses and advanced practice nurses represented much smaller numbers of the sample (13% and 18%, respectively in VDAP; 18% and 4% in Probationary) (see Table 2).

TABLE 2
Description of responses from nurses in monitoring

Categories	VDAP	*n*	Probation	*N*
Employed in nursing	90%	127	96%	45
Prior treatment	24%	127	42%	45
Type of licensure				
LPN	13%	17	18%	8
RN	77%	99	78%	35
APRN	8%	10	4%	2
Type of treatment utilized				
Short term residential	24%	31	31%	14
Long term residential	39%	50	42%	19
Partial program	38%	48	33%	15
Intensive outpatient	41%	53	42%	19
Halfway house	15%	19	18%	8
Health care coverage	71%	91	53%	24

Within the VDAP program, 71% reported having health care coverage, whereas only 53% of participants from the Probationary program reported having health insurance. Health insurance or the lack of health insurance may be a byproduct of the illness. Often the nurse is fired or may leave their position when their chemical dependence is discovered. Job loss and the subsequent loss of insurance may mean the difference between quality treatment and no treatment at all. Without receiving treatment, the nurse is not eligible to return to practice.

Qualitative Findings

Hand-written responses of the participants were voluminous. Most surveys included comments about their experiences with suggestions to improve the monitoring process. All participants completed the entire eight page survey. Many wrote extensive responses to program improvement questions.

Return to Work Issues

Nurses consistently identified the narcotic restriction and the inability to work overtime as major problems they felt that added to the burden of initial monitoring. The Narcotic restriction is a criterion that forbids the nurse from handling or giving narcotics for 6 months once they return to work. The nurse must find another nurse to give their patient's meds. This complaint was consistent with findings by Fletcher and Ronis (2005). Nurses reported not being able to administer narcotics for 6 months was a hardship to provide timely care and increased stress on themselves and their patients. Many felt that the restriction should be limited to those who had abused narcotics rather than applied to all. The most prevalent drug of choice for nurses in Alabama was the Opioid class of drugs at 36%, which varies from the general public as alcohol is the drug of choice in Alabama and the United States. Most participants requested consideration of individualized monitoring contracts and suggested that the narcotics restriction be implemented on a case-by-case basis.

When a nurse is in a monitoring program, no overtime is permitted during the monitoring. Consequently, participants reported the overtime restriction as limiting. Several suggested that this restriction be negotiated so that several shifts per month could be authorized based on success with the monitoring process. This increased allowance would help to offset the economic burden related to the expense of monitoring such treatment cost paid out of pocket.

Anonymity

Many nurses identified difficulty with anonymity at the work place as an issue. Anonymity in rural areas is almost impossible for nurses, who must have UDS done within their organization as it is the only health care facility for miles. Some found there was no anonymity as everyone knew about their being monitored because of the frequent urine drug screens and inability to administer narcotics. "Anything that would help maintain my anonymity at work" was seen as being helpful. The rural areas where some of the nurses work and live do not offer the nurse the opportunity to remain anonymous. Dealing with the stigma of being identified as an addict added to the stress of the work environment.

A number of nurses wrote about being grateful for monitoring programs. They added "no changes need to be made" as well as wrote heart felt thanks for the opportunity to begin to recover.

> I am grateful for the VDAP, I used to think I would lose my nursing license forever, if I got caught. VDAP helps me keep my license. I didn't feel grateful at first, but now I'm glad the Board of Nursing got involved and helped me back on the road to recovery.

The monitoring structure was viewed as contributing to continued sobriety by 92% of the nurses. They either strongly agreed, or agree the rigor and discipline of the program was a helpful and needed element.

DISCUSSION AND RECOMMENDATIONS

One limitation to this study is that the data were obtained via self-report and response bias may be present. Additionally, the two groups of nurses differed significantly on their length of sobriety (see Table 1).

The high percentage of nurses utilizing long term treatment suggested severe illness. Unfortunately, treatment options for long term treatment are very limited within Alabama as currently there are only two centers approved through the BON. A treatment resource that may be underutilized is the halfway house. Very few nurses in either program used halfway houses as part of their treatment. However, this figure may not adequately reflect the need as the availability of recovery-focused halfway houses is quite limited in Alabama.

Although Alabama's monitoring program(s) have parallel requirements, there are significant differences between the two groups concerning length of sobriety of the participant. This may be a factor of self reporting or the effect of only those participants with more recovery time and doing well in the disciplinary program choosing to participate. LVNs were underrepresented in the sample as LVNs represent 29% of Alabama's nurse workforce. This may be related to the expense of monitoring and the cost of treatment to maintain licensure. LVNs may choose to surrender their licenses rather than receive treatment and enter monitoring.

The high rates of employment in both programs may mirror each program's requirement that the nurse work within nursing for 18 months of the monitoring. Additionally, high rates of employment may reflect the sample as those who chose to reply may be actively engaged in recovery and committed to remain in nursing. Those not doing well simply did not respond. Fletcher and Ronis (2005) focused on satisfaction with the monitoring process by polling nurses in two states examining satisfaction of monitoring practices. They found the higher the level of satisfaction with the monitoring program, the more likely nurses rated themselves as doing well in recovery and abstaining from substances.

The nurse being monitored pays all evaluation and treatment costs, as well as a onetime fee of $1,000 due within 30 days of signing the monitoring contract. It is unknown how many nurses may choose to surrender their licenses rather than attempt to borrow money to pay for treatment and the monitoring fee. Changes to procedure would allow payments over several months rather than in a lump sum at the beginning of the monitoring. Although the nurses in VDAP were in a non-punitive program, many felt the fee was a punishment as both the probation and VDAP pay the same amount.

The study results were presented to the Alabama Board of Nursing during a quarterly meeting in November of 2007. Recommendation for stipulation revisions concerning supervision, and overtime were offered based on the evidence presented. Monitoring program revision suggestions were based on participants' comments regarding a more responsive individualized program. Currently all the requirements must be met until the nurse reaches the termination stage. The nurses' concern centered on the monitoring process that remained constant even when they were successful with recovery. Some felt that the program rigidity may place the nurse at high risk for relapse after years of highly structured environment. When the nurse is released from monitoring, participants reported they were concerned about being suddenly autonomous in their own recovery. The nurses' recommendations included changes that would allow those who successfully completed the first year of monitoring be eligible to negotiate for a decrease in monitoring requirements. A slow graduated return of autonomy while continuing to be monitored with urine drug screens for signs of relapse was seen by some nurses as optimal. Provided this change could be approved, it would more closely reflect a chronic illness model which the recovery process is a life long change process and ongoing. The monitoring process should continue to provide needed structure for early recovery and ensures the safety of the public. As addiction is a chronic remitting illness perhaps infrequent ongoing monitoring might be an option for nurses. This would more closely follow the chronic illness model in which relapse over time is a given.

CONCLUSION

Further research concerning effectiveness of these programs will help to standardize and improve the monitoring process while decreasing barriers and stigma of nurses returning to work. Alabama's nurse monitoring programs are effective in helping nurses remain in recovery. However, the structure of monitoring long term recovery needs further evaluation to promote as well as define regulatory best practice. Establishing best practices for alternative programs remains in the process of development.

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