Substance Use Disorders and Accessing Alternative-to-Discipline Programs

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Alternative-to-discipline programs (ADPs) are monitoring programs developed in the United States in the 1980s for nurses with substance abuse disorder (SUD). These programs enable health care professionals to avoid disciplinary action and return to work under strict guidance and supervision that ensure public safety and hold the health care professional accountable. Knowledge and understanding of the process of accessing an ADP in one's state can be an elusive and confusing process for the nurse with SUD or those with an interest in helping nurses with SUD. This article addresses SUD among nurses and how complaints against nurses are handled by the board of nursing, and discusses ADPs, including their availability, eligibility, benefits, and challenges.

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Learning Objectives

- Compare disciplinary and nondisciplinary approaches used by boards of nursing (BONs) for substance use disorder cases.
- State the benefits of alternative-to-discipline programs (ADPs).
- Describe the ADP process, including referral, eligibility, and treatment.
- Discuss the relationship between ADPs and BONs.

The Substance Abuse and Mental Health Services Administration (2008) reports that only 14% of Americans addicted to alcohol and drugs seek treatment for their addictions. Substance use disorder (SUD) has been considered a treatable disease by the American health care system for many years, but the concept of SUD as a treatable disease in health care providers has not always been widely accepted. In the past, nurses and doctors were denied the nonpunitive approach offered to the patients they served. Many of these providers did not receive treatment until they were criminally charged.

This approach began to change as boards of nursing (BONs) petitioned state legislatures to approve alternative legislation. This new legislation enabled treatment to be offered to addicted nurses without negatively affecting their licenses, as long as they continued to meet certain requirements. To date, 41 states, the District of Columbia, and the Virgin Islands have developed programs to channel nurses with SUD into treatment and recovery programs.

Today, nurses with SUD can avoid disciplinary interventions by the BON if they understand the progression of SUD and promptly act to interrupt it with treatment and aftercare. Most nurses admit a lack of knowledge regarding the steps necessary to access help for themselves or other nurses with SUD. The process of obtaining help and advocacy is not common knowledge among nurses. To intervene effectively, nurses must know the available treatment resources, and the process a nurse with SUD undergoes from the time of a complaint or referral to treatment, to monitoring, to aftercare. With professional help and support, nurses can recover from SUD, improve their overall state of well-being, and return to the safe practice of nursing, while steps are taken to ensure public protection. This article addresses SUD among nurses and how complaints against nurses are handled by BONs, and discusses the alternative-to-discipline approach, including availability, eligibility, benefits, and challenges.

Substance Use Among Nurses

The prevalence of SUD among nurses is conservatively estimated to be the same as the prevalence among the general population (10%), or about 250,000 nurses (Fogger & McGuinness, 2009; Shaw, McGovern, Angres, & Rawal, 2004). Between 67% and 90% of disciplinary actions taken by nursing BONs are related to SUD (Haack & Yocum, 2002).

SUD includes addiction, which is defined as the continued and compulsive use of mood-altering, addictive substances despite adverse consequences (Bettinardi-Angres & Angres, 2010). Though alcohol is the drug of choice for the general population, narcotics are the most common drugs of choice for nurses enrolled in a monitoring process (Clark, Parker, & Gould, 2005; Darbo, 2005; Fogger & McGuinness, 2009; Haack & Yocum, 2002; Tipton, 2005).

Nurses are susceptible to SUD in the workplace, and the disorder can harm both nurses and patients. Workplace risk factors include easy access, role strain, enabling behavior by peers

and managers, lack of education, and attitudes towards drugs and drug use. Certain attitudes may heighten the odds of substance use among nurses:

- Seeing drugs as an acceptable means of coping with life's problems
- Developing an overarching faith in the ability of drugs to promote healing
- Rationalizing drug use on the basis of needing to continue working
- Feeling invulnerable to illnesses
- Developing a permissive attitude toward self-diagnosing and self-treating physical pain or stress (Clark & Farnsworth, 2006; Luck & Hedrick, 2004).

Reviewing and Investigating Allegations

BONs are created by state legislation to protect the public, and states give BONs the power to regulate nurses in their jurisdiction (Dunn, 2005). BONs enact and enforce rules and regulations related to the practice of nursing in their state. These rules and regulations define what constitutes misconduct, unprofessional conduct, incompetence, and unfit to practice (Dunn, 2005). BONs employ the rules when they receive an allegation that a nurse has engaged in misconduct.

To understand alternative-to-discipline programs (ADPs), nurses must comprehend what happens when a complaint is submitted. The BON handles all allegations or complaints against nurses, typically by following a process of review, investigation, hearing or proceedings, and resolution of the complaint. Table 1 describes a typical complaint process for any allegation.

SUD in the nursing community is a major concern for state BONs. When a nurse is suspected of or admits to substance abuse, the offense falls under the general category of unprofessional conduct. State regulations cover certain acts that are cause for disciplinary action against the nurse, including the following:

- Drug diversion
- Positive drug screen without a lawful prescription
- Violation of a state or federal narcotics or controlled substances law
- Criminal convictions including driving under the influence
- Illegal use of drugs or controlled substances
- Use of habit-forming drugs, controlled substances, or alcohol to the extent that the use impairs the user physically or mentally
- Failure to comply with the contract provisions of the nurse's assistance program

After the evidence against a nurse in a case alleging impairment or SUD has been presented and the BON has determined that the nurse has engaged in unprofessional conduct in violation of the nurse practice act in the state, the BON must determine which sanctions are appropriate for rehabilitating the

TABLE 1

Complaint Process from Complaint to Resolution

When a complaint is filed against a nurse, the board of nursing (BON) follows a process of review, investigation, hearing or proceedings, and resolution. Though the exact process may differ among states, typically it follows the path described below (National Council of State Boards of Nursing, 2010b).

Review and Investigation

First, a determination is made as to whether or not the alleged act violates existing laws or regulations that govern the nurse's practice. If it is found to violate the nurse practice act (NPA), evidence is gathered, and interviews are conducted. The process used to investigate and act on a complaint may vary, depending on the seriousness of the allegations (was there actual or potential harm to a patient, or was the alleged behavior minor in nature?) and on the timeliness of the complaint. Investigation can include requesting additional documents or information from complainants and the licensee, visiting pertinent sites, and interviewing witnesses.

Proceedings

When sufficient information is gathered, the nurse is given an opportunity to respond to the allegations. BONs vary in the methods used to obtain the nurse's perspective on the situation. Nurses are informed of methods used to obtain information through informal proceedings, and the implications for licensure and the ability to continue to practice nursing. The nurse has the right to obtain legal advice and advocacy at her or his own expense.

State laws vary as to the standard of proof (degree of certainty) required in administrative law cases. If the BON determines that disciplinary action is warranted, it must then decide on the type of action. Factors such as the level of risk, the underlying cause, the question of whether the nurse should be out of practice for a time, and mitigating or aggravating factors are considered.

Complaint Resolution

If, after hearing the evidence, the BON decides the nurse violated the NPA, the BON must determine the appropriate sanctions for disciplining the nurse. The types of actions available to BONs vary according to state law. Although terminology may differ, BON action affects the nurse's licensure status and ability to practice nursing in the state taking action. BON actions may include:

- Fine or civil penalty
- In the case of substance abuse, referral to an alternative-to-discipline program for practice monitoring and recovery support
- Imposition of requirements for monitoring, education, or other provision tailored to the particular situation
- Limitation or restriction of one or more aspects of practice (e.g., limiting role, setting, activities, hours worked)
- Separation from practice for a period of time (suspension) or loss of license (revocation)

nurse and whether a disciplinary or nondisciplinary approach is appropriate.

Disciplinary Approach

In the traditional disciplinary approach, the Final Order of Discipline resolution requires the nurse to enroll in a monitoring program within a short period of time. Many state BONs have statutory authority for implementing nurse assistance programs; others work closely with independent programs. The BON implements rules that often include admission criteria, program requirements, and discharge criteria.

The Final Order will 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 contract until successfully completing the program. There is no provision for protecting the privacy of the nurse. The Final Order also usually includes:

- voluntary admission of the SUD and a no-contest plea
- agreement to certain terms, such as suspension of licenses, treatment, monitoring, and limited practice reports
- presentation of administrative complaint and proposed consent order to the BON
- BON acceptance, revision, or rejection of terms
- possible coding of license as "Probation," Limited," or some similar indication of probation
- provision that records be subjected to public access (may not apply in all states).

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

Before the advent of ADPs, this disciplinary approach was the only way to protect the public from nurses with SUD. Since the 1980s, ADPs have been used by a growing number of BONs.

Alternative-to-Discipline Programs

The first ADP started in Florida in the 1980s in response to the need to compassionately but effectively protect health care professionals and the public. The American Nurses Association (ANA) and NCSBN were pivotal in promoting recovery and reentry to practice for health care professionals. In 1984, the ANA (1982, 1984) adopted a resolution calling for nonpunitive state assistance programs and treatment before disciplinary action. In 1996, an NCSBN task force created a template for ADPs that is widely used in the United States. In June 2002, a resolution before the ANA House of Delegates on workplace advocacy recommended advocacy for the retention of nurses who experience addiction and psychiatric disorders and efforts to educate the public and professional nurses on the prevalence of addiction disorders as diseases for which society and registered nurses are at risk. Today, 43 of 59 jurisdictions have ADPs (Bainer, 2010).

ADPs enhance the BON's ability to provide public protection by promoting early identification of nurses with SUD and intervention before they demonstrate unsafe practices. The programs were designed to refer nurses for evaluation and treatment, monitor the nurses' compliance with treatment and recovery recommendations, and monitor their abstinence from drug and alcohol use.

ADPs offer an opportunity for nurses who meet specified criteria to remain active in nursing while in treatment and being monitored. Thus, they can continue to work, which enhances their financial status, further supporting recovery (Fogger & McGuinness, 2009).

When a nurse is referred to an ADP or self-reports, the investigation does not last long, as it often does with the traditional disciplinary model, which allows the nurse to practice during this period, placing patients at risk. In ADPs, compliance with treatment and aftercare recommendations is required immediately, and return to or continuation of practice is carefully monitored to ensure public safety (Geiger & Smith, 2003).

Relationships between BONs and ADPs

The majority of states have ADPs affiliated with or recognized by their BONs. As of 2008, 45 BONs in the Unites States had some form of ADP (Monroe & Kenaga, 2010). According to the 2009 NCSBN survey of states with ADPs, 47% are administered by the staff of the BON, and 11% are administered by a state agency other than the BON, such as the department of health. The rest are administered by an outside entity, such as a professional association or a peer-assistance program (National Council of State Boards of Nursing [NCSBN], 2010c). An example of an ADP administered by an outside entity is the Illinois Professional Health Program (IPHP), which works with other health professionals, such as physicians and pharmacists. IPHP works with the BON after the identified nurse grants legal consent for them to communicate.

Collaboration between BONs and ADPs results in a balance between nonpublic monitoring of the nurse with SUD and just action of the BON to meet public safety concerns. Outside ADPs must preserve the BON's disciplinary authority. However, when a BON delegates responsibility for its ADP to an outside entity, it needs to have complete assurance in the capability and integrity of the ADP. Any contract entered into should give the BON adequate control and oversight. A contractual relationship should specify which data are shared, when data are shared, and under what circumstances.

Referral

A nurse may be referred to an ADP in several ways:

- Self-referral. A nurse with a SUD may contact an ADP.

- Work-related referral. An employer, supervisor, or colleague contacts an ADP about a nurse who needs help. If the nurse with SUD does not agree to participate in the ADP, the BON will be informed, and a disciplinary process may begin.
- BON referral. While a complaint is being processed or investigated, the BON or the investigator may refer a nurse to an ADP.
- Treatment program referral.

Eligibility

A preliminary screening process has usually substantiated that the nurse has been diagnosed with SUD and identified a need for further evaluation (Breining, 2008). The screening process also determines whether the nurse is appropriate and eligible for the ADP.

If the nurse is not eligible, the ADP refers the matter to the BON for further review and offers other appropriate treatment referrals. An ADP is not available to a nurse who diverted drugs for sale or distribution to others, caused harm to a patient because of his or her abuse, or engaged in behavior with a high potential for causing harm, such as substituting patients' drugs with placebos (NCSBN, 2010c).

To enter an ADP, a nurse must sign an individualized contract specifying evaluation and treatment requirements, drug-screening requirements, worksite limitations, and compliance reporting. The nurse also admits to having problems with substance use and agrees to waive all rights to appeal, file grievances or complaints, and contest licensure actions relating to or arising from the ADP.

Noncompliance with the ADP is unprofessional conduct and may result in a cease-to-practice order, notification of the nurse's employer, extension or modification of the contract, discharge from the ADP, report to the BON, or automatic public discipline. The BON may obtain complete records of the nurse's participation in the ADP. Participants and terms of the contract are nonpublic but may be shared with parties who have an official need to know (NCSBN, 2010d).

Further, because a nurse has the option of dropping out of an ADP and because the program has the option of discharging an unsuccessful nurse, several states have passed laws giving the BON the authority to take immediate action against the license and then have a hearing on the issues. Depending on the state, this action may be called a summary suspension, temporary suspension, license restriction, or license suspension.

Benefits of ADPs

ADPs offer a voluntary, nonpunitive opportunity for impaired nurses to begin recovery (National Organization of Alternative Programs, 2012), which benefits the recovering nurse, the BON, and the public:

TABLE 2

Peer-Assistance Programs

In peer-assistance programs, nurses help nurses with their recovery. The primary goals are to help the nurse reenter the workforce safely and competently and to restore a healthy continuum of personal growth. A peer-assistance program is an advocacy and support group, not a treatment program. After some time in an alternative-to-discipline (ADP), most nurses begin participating in a peer-assistance program as they continue with their ADP.

Treatment centers and ADPs encourage attendance at peer support-group meetings. The groups, which are usually free, operate on the principles of anonymity and confidentiality. A nurse in recovery for several years or a nurse knowledgeable about substance use disorder facilitates meetings. All participants are nurses, which enhances camaraderie.

A pivotal focus of these meetings is assistance in the process of reentry into the workplace, including when and where to apply for employment. In the early stages of recovery, some nurses do not understand that an immediate return to an environment similar to the one in which they used mood-altering substances would be detrimental to their recovery. Nor do they understand the difficulty of reentry into a hostile or an indifferent workplace.

Not all states have peer support-group meetings for nurses, and most groups exist in metropolitan areas. A need for more peer-assistance programs exists, especially more peer-assistance programs in rural areas.

- By complying with the BON recommendations, the nurse can continue to practice nursing and earn a living instead of losing his or her license and livelihood.
- The nurse has the advantage of building a record of recovery in a recognized and approved program. Regular reports to the BON regarding program participants should verify compliance with all program expectations and requirements. These measures of accountability assist the BON and the recovering nurse.
- Guidance and expertise of ADP professional support and advocacy for the recovering nurse are ongoing. (See Table 2.)
- The ADP approach, which includes early intervention and quick entry into monitoring and treatment, enhances patient safety. The traditional disciplinary method often requires 6 to 18 months of documentation, investigation, and hearings before the nurse is removed from practice (Foster & Jordan, 1994). During that time, the nurse may continue to place patients at risk.
- In that same 6 to 18 months, an ADP can identify a nurse with SUD, implement treatment, and have the nurse safely reenter practice with rigorous monitoring and aftercare.
- Most BONs report that the cost to intervene, temporarily remove a licensee from practice, and monitor the nurse's return

TABLE 3

Standards for Treatment Programs

Nurses with substance use disorder must be offered long-term, coordinated management of their care, and the care management should be adapted based on ongoing monitoring of their progress. The following criteria must be in place for a treatment program to be approved to provide services:

- Licensure by the state
- Adherence to an abstinence-based program
- Development of an individualized initial treatment plan with a 12-month aftercare program based on evaluation by a multidisciplinary team
- Adherence to a 12-step philosophy
- Provision for family involvement in treatment
- Provision of a geographically convenient location for treatment to encourage the participation of family members in the nurse's primary treatment
- Requirement for frequent random and for-cause drug screening and reports of positive results
- Requirement for immediate reports of significant events in treatment that are related to the nurse's ability to practice safely

to practice through an ADP agreement is significantly less than the cost of the traditional discipline process.

Recovery and Retention

ADPs have the highest rate of long-term recovery for the successfully treated nurse (Griffith, 1999; Hughes, Smith, & Howard, 1998), and their retention rate is high (Haack & Yocum, 2002). Darbro (2003) found that even most of the nurses who viewed the ADP requirements as punitive remained in recovery.

Florida's ADP, which is the oldest, estimates that 80% of impaired nurses return to practice, and fewer than 25% relapse (Hastings & Burn, 2007). To participate in the Florida program, a nurse must refrain from practice until cleared by the ADP, comply with all treatment and monitoring recommendations for a minimum of 3 to 5 years, and participate in a weekly nurse support group in his or her local area (Hughes et al, 1998).

Along with participation in ADPs, studies show better outcomes for health care professionals who receive specialized treatment and aftercare, including peer-group settings, specific groups that focus on work and personality variables (for example, the Caduceus group), and careful exploration of work reentry issues (Angres, Bettinardi-Angres, & Cross, 2010). Peer-assisted programs, on the other hand, consist of nurses helping other nurses and do not qualify as treatment or professional support systems. They should not replace treatment or an ADP. However, they can contribute to the ongoing sobriety and personal growth of the recovering nurse. These groups are especially helpful in the process of reentry.

Anecdotally, recovering nurses report their ADPs were the most important factor in their successful return to work (Smith & Hughes, 1996). Additionally, the higher the level of satisfaction with the ADP, the more likely the nurse will do well in recovery (Fogger & McGuinness, 2009), although as stated earlier, even a disgruntled nurse in an ADP has a greater chance of maintaining sobriety (Darbro, 2003).

Confidentiality and Public Protection

The image of ADPs to the media, the general public, and government representatives has suffered from the perception that the ADPs and BONs are overly protective of their participants. The programs' confidential aspects may be interpreted as exposing the public to unnecessary risks. Because nurses with SUD have violated their nurse practice act, some see confidentiality as an unwarranted benefit. However, the assurance of confidentiality is an incentive to encourage timely participation in the program and helps nurses begin their recovery (Darbro, 2009).

BONs must engage the ADPs in close communication and scrutiny with respect to their operations and standards, so BONs and the public can judge the effectiveness of the shared system. (See Table 3.)

Although the majority of ADPs do not make the names of participants public, they require the nurse to report participation to their employer (NCSBN, 2010a). ADPs are required to notify the BON when a nurse enters the program, when a nurse substantially fails to comply with the terms of the program, and when a nurse leaves the program (NCSBN, 2010a). When the BON is not notified of a licensee's participation or status in the ADP, other jurisdictions cannot be notified, thus allowing the licensee to move to multiple jurisdictions without detection.

All ADP records related to monitoring, noncompliance, discharge, or termination from the program should be available to the BON. The original agreements should authorize the exchange of information among ADP employees, employers, the BON, health care providers, support-group facilitators, and treatment providers.

Transparency between the ADP and the BON is key to ensuring the program is helping to ensure public protection, even though communication between the program and the BON may decrease the level of confidentiality.

Conclusion

The nursing profession must work toward a positive outcome for nurses with SUD that protects nurses and the public. SUD cannot be eradicated, but the nursing profession can guide nurses with SUD toward an approved and successful course.

ADPs do not guarantee recovery and successful reentry into the profession, but statistics thus far prove this approach, along with professional treatment, aftercare, and peer assistance, offers a nurse with SUD the best chance of success.

References

American Nurses Association. (1982). *Action on alcohol and drug misuse and psychological dysfunctions among nurses. Resolution #5*. Retrieved from http://nursingworld.org/MainMenu Categories/ThePracticeofProfessional Nursing/workplace/ImpairedNurse/ Response.aspx

American Nurses Association. (1984). *Addictions and psychological dysfunctions in nursing: the profession's response to the problem*. Retrieved from http://nursingworld.org/MainMenu Categories/ThePracticeofProfessional Nursing/workplace/ImpairedNurse/ Response.aspx

Angres, D. H., Bettinardi-Angres, K., & Cross, W. (2010). Nurses with chemical dependence: Successful treatment and reentry. *Journal of Nursing Regulation, 1*(1), 16–20.

Bainer, J. K. (2010, April). *Comparison of discipline & alternative program survey results.* Presented at the National Council of State Boards of Nursing Annual Substance Use Disorder Forum, Chicago, IL.

Bettinardi-Angres, K., & Angres, D. H. (2010). Understanding the disease of addiction. *Journal of Nursing Regulation, 1*(2), 31–37.

Breining, B. G. (2008). *The addiction professional: Manual for counselor competency.* Orangevale, CA: Breining Institute.

Clark, C., & Farnsworth, J. (2006). Program for recovering nurses: An evaluation. *Medsurg Nursing, 1*(4), 223–230.

Clark, C., Parker, E., & Gould, T. (2005). Rural generalist nurses' perceptions of the effectiveness of their therapeutic interventions for patients with mental illness. *Australian Journal of Rural Health, 13*(4), 205–213.

Darbro, N. (2005). Alternative diversion programs for nurses with impaired practice: Completers and noncompleters. *Journal of Addictions Nursing, 16,* 169–186.

Darbro, N. (2003). A guide for healthcare professionals—behavioral problems. *Nursing News & Views*, New Mexico Board of Nursing. Retrieved from http://epubs.democratprinting.com/display_article.php?id=918855

Darbro, N. (2009). Overview of issues related to coercion and monitoring in alternative diversion programs for nurses: A comparison to drug courts: part 2. *Journal of Addictions Nursing, 20,* 24–33.

Dunn, D. (2005). Substance misuse among nurses—Defining the issue. *AORN Journal, 82*(43), 573–594.

Fogger, S., & McGuinness, T. (2009). Alabama's nurse monitoring programs: The nurse's experience of being monitored. *Journal of Addictions Nursing*, 20 (3):142-149.

Foster, F. D., & Jordan, L. M. (Eds.). (1994). *Professional aspects of nurse anesthesia practice.* Philadelphia, PA: F. A. Davis.

Geiger, J., & Smith, L. (2003). Nurses in recovery: The burden of life problems and confidence to resist relapse. *Journal of Addictions Nursing, 14,* 133–137.

Griffith, J. (1999). Substance abuse disorders in nurses. *Nursing Forum, 34*(4), 19–28.

Haack, M., & Yocum, C. (2002). State policies and nurses with substance use disorders (profession and society). *Journal of Nursing Scholarship, 34,* 89–94.

Hastings, J., & Burn, J. (2007). Addiction: A nurse's story. *American Journal of Nursing, 107*(8), 75–77, 79.

Hughes, T. L., Smith, L., & Howard, M. J. (1998). Florida's Intervention Project for Nurses: A description of recovering nurses' reentry to practice. *Journal of Addictions Nursing, 10*(2), 63–69.

Luck, S., & Hedrik, J. (2004). The alarming trend of substance abuse in anesthesia providers. *Journal of PeriAnesthesia Nursing, 19*(5), 308–311.

Monroe, T., & Kenaga, H. (2010). Don't ask don't tell: Substance abuse and addiction among nurses. *Journal of Clinical Nursing, 20,* 504–509.

National Council of State Boards of Nursing. (2010a). Alternative to discipline survey findings. Retrieved from www.ncsbn.org/3013.htm

National Council of State Boards of Nursing. (2010b). Board of nursing complaint process. Retrieved from www.ncsbn.org/2105.htm

National Council of State Boards of Nursing. (2010c). *Model nursing act and model nursing administrative rules.* Retrieved from www.ncsbn.org/Model_Nursing_Practice_Act_081710.pdf

National Council of State Boards of Nursing. (2010d). *Substance use disorder in nursing: A resource manual and guidelines for alternative and disciplinary monitoring programs.* Chicago, IL: Author.

National Organization of Alternative Programs. (2012). *Bylaws*. Retrieved from www.althernativeprograms.org/bylaws.html

Shaw, M. F., McGovern, M. P., Angres, D. H., & Rawal, P. (2004). Physicians and nurses with substance abuse disorders. *Journal of Advanced Nursing, 47*(5), 561–571.

Smith, M. F., & Hughes, T. (1966). Re-entry: When a chemically dependent colleague returns to work. *American Journal of Nursing, 96,* 32–37.

Substance Abuse and Mental Health Services Administration. (2008). *National household survey on drug abuse: Detailed tables.* Rockville, MD: Office of Applied Statistics.

Tipton, P. (2005). Predictors of relapse for nurses participating in a peer assistance program. *Dissertation Abstracts International, 66*(11).

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CE Posttest

Substance Use Disorders and Accessing Alternative-to-Discipline Programs

If you reside in the United States and wish to obtain 1.4 contact hours of continuing education (CE) credit, please review these instructions.

Instructions

Go online to take the posttest and earn CE credit:

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If you cannot take the posttest online, complete the print form and mail it to the address (nonmembers **must** include a check for $15, payable to NCSBN) included at bottom of form.

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Contact hours: 1.4
Posttest passing score is 75%.
Expiration: July 2015

Posttest

Please circle the correct answer.

1. Which statement about substance abuse disorder (SUD) among nurses is correct?
a. The prevalence of SUD among nurses is higher than the general population.
b. The prevalence of SUD among nurses is lower than the general population.
c. Alcohol is the most common drug of choice for nurses.
d. Narcotics are the most common drugs of choice for nurses.

2. Of all disciplinary actions taken by boards of nursing (BONs):
a. less than a quarter relate to SUD.
b. fewer than half relate to SUD.
c. as many as 90% relate to SUD.
d. as many as 40% relate to SUD.

3. Which statement about the Final Order of Discipline for nurses with SUD who have been found to have engaged in unprofessional conduct is correct?
a. Disciplinary actions are reported to data banks.
b. Records are kept private.
c. No signed contract is needed.
d. Entry into a monitoring program is voluntary.

4. An alternative-to-discipline program (ADP):
a. allows nurses who meet specific criteria to continue to work.
b. requires that nurses change shifts.
c. has a longer investigation time compared to traditional discipline.
d. takes a punitive approach.

5. The most common model for administration of ADPs is:
a. a state agency other than the BON.
b. the BON.
c. the board of medicine.
d. an outside entity such as a professional association.

6. Which statement about the relationship between a BON and an outside entity providing ADP is correct?
a. The BON's contract with the ADP must give the BON adequate control and oversight.
b. Outside ADPs typically assume the BON's disciplinary authority.
c. The ADP does not share data with the BON.
d. The ADP communicates with the BON as soon as the nurse enrolls in ADP.

7. Which statement about referrals to an ADP is correct?
a. An employer cannot refer a nurse.
b. An employer can refer a nurse after dismissal.
c. A nurse may self-refer to an ADP.
d. A nurse cannot self-refer to an ADP.

8. Which nurse is eligible for ADP?
a. A nurse who diverted drugs for sale
b. A nurse who distributed drugs
c. A nurse who substituted placebos for drugs
d. A nurse with a diagnosis of SUD

9. Which statement about noncompliance with an ADP is correct?
a. The contract is automatically extended by 6 months.
b. The nurse's employer may not be notified.
c. Noncompliance may result in a cease-to-practice order.
d. No reports related to noncompliance can be shared.

10. The rate of return to practice for nurses in the Florida ADP (the oldest in the United States) is:
a. 25%.
b. 50%.
c. 65%.
d. 80%.

11. Which statement characterizing ADPs is correct?

a. ADPs cost more to administer than traditional discipline processes.
b. ADPs cost less to administer than traditional discipline processes.
c. ADPs take longer than the traditional discipline process to remove a nurse from practice.
d. ADPs take longer than the traditional discipline process to return nurses to practice.

12. A peer-assistance program:

a. focuses on reentry into the workplace.
b. focuses on a 12-step program.
c. is a mutual help group.
d. is a treatment group.

13. When does a nurse typically enter a peer-assistance program?

a. 1 month after completing an ADP
b. 3 months after completing an ADP
c. While in an ADP
d. Before entering an ADP

14. Which statement about confidentiality and ADPs is correct?

a. Confidentiality is an unintentional benefit of ADPs.
b. Communication between the ADP and BON should be limited.
c. Most ADPs do not make the names of participants public.
d. ADPs are not required to notify the BON when a nurse enters the program.

15. If a nurse leaves an ADP:

a. the BON can notify other jurisdictions.
b. the ADP cannot share the information with the BON.
c. the nurse cannot be readmitted.
d. the exit will not affect recovery chances.

Evaluation Form (required)

1. Rate your achievement of each objective from 5 (high/excellent) to 1 (low/poor).

- Compare disciplinary and nondisciplinary approaches used by boards of nursing (BONs) for substance use disorder cases.

  1 2 3 4 5

- State the benefits of alternative-to-discipline programs (ADPs).

  1 2 3 4 5

- Describe the ADP process, including referral, eligibility, and treatment.

  1 2 3 4 5

- Discuss the relationship between ADPs and BONs.

  1 2 3 4 5

Rate each of the following items from 5 (very effective) to 1 (ineffective):

2. Were the authors knowledgeable about the subject?

   1 2 3 4 5

3. Were the methods of presentation (text, tables, figures, etc.) effective?

   1 2 3 4 5

4. Was the content relevant to the objectives?

   1 2 3 4 5

5. Was the article useful to you in your work?

   1 2 3 4 5

6. Was there enough time allotted for this activity?

   1 2 3 4 5

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