

EVALUATION OF THE NURSES ASSISTANCE PROGRAM
IN MONTANA

by

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A project submitted in partial fulfillment
of the requirements for the degree

of

Master of Nursing

MONTANA STATE UNIVERSITY
Bozeman, Montana

December, 1994

P378

P2895

ii

APPROVAL

of a paper submitted by

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This paper has been read by each member of the graduate committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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ACKNOWLEDGMENTS

I wish to thank the members of my project committee, Ms. Jane Scharff and Ms. Carol Sem for their guidance and assistance in this project. A special thanks to Dr. Kay Chafey, for her guidance and patience as chair of the committee.

I extend my thanks to the nurses and employers who participated in this project, and the constructive comments provided. To my wife, Joyce, I offer a very special thanks for all the support she provided during the most trying of days.

With all the support and assistance provided, my greatest thanks go to my Lord and Savior Jesus Christ. His provision of knowledge and understanding through His grace permitted the completion of this project.

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ABSTRACT

Assisting individuals who are substance abusers through the recognition, treatment, monitoring, and re-integration into society will benefit both the substance abuser and society. The profession of nursing has assumed the responsibility of helping nurses who have substance abuse problems through understanding and providing direction for alternatives to the abuse of substances.

This project was established to provide a basis for accountability for the Nurses Assistance Program by measuring the monitoring effectiveness of the Nurses Assistance Program for those nurses who are participating in the program. Specific aims of this study were to describe the following: 1) Nurses Assistance Program participants, perceived satisfaction with the program, 2) perceived helpfulness of the nurses assistance Program to nurse participants, 3) perceived employer satisfaction with the Nurses Assistance Program and non-Nurses Assistance Program monitoring, and nurses' ability to return to work. In addition, potential impact of rurality on program access and satisfaction was assessed.

The participants were asked to respond to quantitative and qualitative statements to assess perceptions of participant satisfaction and helpfulness of the program. The statistical package SSPS was used to analyze the quantitative data, and the investigator analyzed the qualitative data through content analysis.

Findings of the project suggest that nurse participants and employers view the monitoring provided by the Nurses Assistance Program as meeting the established goals and objectives of the program. The areas of support, monitoring, urine testing procedures, counseling and established work restrictions were supported. Both nurses and employers commented that the cost of urine testing should be considered for change. Recommendations as a result of this study to the NAP include exploring mechanisms to facilitate increased contact between NAP management and participants. Another consideration is assessing tactics which may be perceived as intimidating to participants

CHAPTER 1

INTRODUCTION

Statement of the Problem

The purpose of the professional project was to evaluate aspects of the Montana State Board of Nursing's Nurses Assistance Program (NAP). In 1993, the Montana State Board of Nursing established the NAP to address the problem of substance abuse among practicing nurses. An evaluation of the program was requested by the NAP program consultant. Therefore, the aim of this professional project evaluation was to evaluate the effectiveness of the NAP in monitoring substance abuse treatment of selected nurses licensed by the Montana State Board of Nursing.

Significance of the Project

Society expects high levels of performance by health care professionals because of their advanced education, clinical expertise and access to personal aspects of citizens' lives (Naelge, 1989). The role expectation of nurse infallibility promoted by health professionals tends to contribute to denial of problems by nurses in health care settings (Brenner, 1991), and when nurses practice at levels below minimal competence for licensed professional nurses, standards of professional practice are seriously threatened (Naegle, 1989). Furthermore, numerous complications can occur with individuals who are influenced by substance abuse. Impairment may be manifested in the individual's

judgment, behavior, memory, interpersonal relationships, technical skills and even hygiene (Marquis & Huston, 1992). Therefore, it is important that nursing leaders and managers recognize the employee who is a substance abuser as early as possible and offer the appropriate interventions. These interventions include treatment and a plan to monitor the progress of the substance abuser in rehabilitation.

According to the Montana State Department of Institutions (1981), "prevention of alcohol and drug abuse in Montana is predicated on the philosophy that each individual is responsible for his or her own actions and, given accurate and sufficient information and education, [the individual] will make responsible decisions" (p. 4). In general, the purposes of treatment and rehabilitation programs are to "minimize identifiable problems caused by alcohol and drugs for individuals, while increasing abuser participation in socially acceptable activities as an alternative to dysfunctional abuse" (Montana State Department of Institutions, 1981, p. 33).

The devastating effects of alcohol and drug abuse cause serious problems for the health, safety and quality of life for all Americans and those who live in Montana including its nurses (Comprehensive Chemical Dependency Plan, 1989). Montana nurses need to be aware of the potential for substance abuse. Substances abused are both legal and illegal. Alcohol, amphetamines, marijuana, depressants, opiates, and multiple drug usage patterns, as well as cocaine, hallucinogens and inhalants make up the ingredients of Montana's drug problem (State Department of Institutions, 1981).

The profession of nursing must be accountable to those served as well as to those with whom nursing works. Evaluation of drug treatment and monitoring programs has

gained interest in the day of cost containment, and redistribution of finances. Proper evaluation and assessment of programs whether controlled by the employer, government agency or an independent facility is critical in determining program effectiveness. The evaluation of the areas of cost-effectiveness, prevention, referral, and follow-up care will measure the success of the program. It is important that the nursing profession fully acknowledge, and formulate standards and guidelines to advance knowledge and understanding of the problem of substance abuse programs (Hughes & Sullivan, 1989).

The profession of nursing needs to offer patients nurses who are able to perform their work, without being under the influence of substances that may endanger those patients. Proper evaluation and monitoring of nurses who have substance abuse problems will provide the potential to enhance the professional image of those nurses involved with the program, and provide credibility to the program's goals.

The Montana State Board of Nursing has established the NAP to deal with alcohol and drug abuse. The stated purpose of the NAP is to "offer eligible licensees the opportunity to enter a care management rehabilitation program and subject themselves to close supervision in order to continue working as a licensed nurse" (Department of Commerce, 1993, p. 2). In order to rehabilitate nurses with substance abuse problems, the NAP provides monitoring, counseling, evaluation, and support, enabling them to return to work. Since the NAP's beginning, approximately thirty nurses have enrolled in the program.

Objectives of the Study

This project was undertaken for the Montana State Board of Nursing to evaluate the effectiveness of the Nurses Assistance Program. The overall goal of the project was to improve understanding of the ways the NAP is helpful to nurses. The project results were to provide a basis for accountability for the program by measuring the monitoring effectiveness of NAP for those nurses who are participating in the program. Specific aims of this study were to describe the following: 1) NAP participants' perceived satisfaction with the program, 2) perceived helpfulness of the NAP to nurse participants, 3) perceived employer satisfaction with NAP and non-NAP monitoring, and nurses' ability to return to work. In addition, potential impact of rurality on program access and satisfaction was assessed.

CHAPTER 2

LITERATURE REVIEW

Identification of Substance Abuse in Nurses

Scope of the Problem of Substance Abuse

Substance abuse in health professions was first documented in studies by Modlin and Montes in the late 1940's (Marquis & Houston, 1992). Research conducted in the area of substance abuse in nursing suggested that health professionals, particularly nurses and physicians, experience an abuse rate disproportionately higher than the general public (Haack & Hughes, 1989). Sisney (1993) reported that approximately 420,000 registered nurses in the United States abuse alcohol or drugs. These numbers were based on a study by Jacobs and Stringer in 1983 of the general population that is chemically dependent (Sisney, 1993). Data presented by the National Council of State Boards of Nursing indicated that in 1984, "67% of disciplinary cases were abuse related" (Green, 1989, p. 82). In the State of Montana disciplinary actions related to substance abuse is estimated between 65% - 75% of the total case load (J. Ballantyne, member, Montana State Board of Nursing, personal communication, October 25, 1994). These facts are of concern to health care professionals as well as the prospective patient population.

Contemporary Problems

The American Nurses Association estimates that six to eight percent of nurses have a substance abuse problem (Green, 1989). Green, Haack and Hughes (1989) found in a survey of State Boards of Nursing, 35 out of 37 reported substance abuse an increasingly serious problem. Brenner noted similar findings in a 1991 report. Curtin (1987), and Haack and Hughes (1989) reported that approximately three-quarters of disciplinary actions and licensure problems have resulted from substance abuse problems. Weisner and Schmidt (1993) reported that "thirty-three percent of the interviewed health care providers (physicians, nurses, and social workers) had one or more substance abuse symptoms" (p. 827). Weisner and Schmidt (1993) conducted interviews to measure alcohol and drug related problems in health and social service agencies. Their sample included over twelve thousand individuals from the following areas of employment: alcohol treatment, emergency rooms, mental health, drug treatment, primary health care, criminal justice and welfare. Results indicated that consumption of drugs by primary health providers (physicians and nurses, and social workers) was greater than the general population sampled, and seven percent of the primary health providers were multiple drug users (Weisner & Schmidt, 1993).

In the State of Montana, approximately 100,000 individuals suffer from some type of substance abuse (Comprehensive Chemical Dependency Plan, p. 23). The prevalence of substance abuse among nurses in both the United States and Montana is roughly proportional to the general population, or approximately six to eight percent (State Department of Institutions, 1989). In the State of Montana, substance abuse consisting of

both legal and illegal drugs, has the potential to affect “approximately 1,200 nurses some time during their career” (Department of Commerce, 1993, p. 4). Messner, Banonis, and Van Horn (1991), offered that drug addiction in health care providers is thirty to one-hundred times higher than the general population, and is considered an occupational hazard (p.7). Green (1989) proposed that a lower percent of nurses, (approximately 6 to 8%) have substance abuse problems.

Recognition of Substance Abuse

Messner et al. (1991), maintained that basic signs for addiction can be observed, and early recognition and treatment permits nurses to return to a “comparable excellence of nursing practice” (p. 6). The identification of nurses who are substance abusers is an important task of the nursing profession. Nurses need to be cognizant of the potential problems that result from substance abuse among practicing nurses. The knowledge gained from understanding the etiology of substance abuse will aid in substance abuse identification, subsequent treatment, monitoring and re-entry into the work place.

Messner et al. (1991) stated that early signs and symptoms of addiction include:

1) Increased absenteeism, 2) diminished quality/quantity work, 3) increased errors or accidents, 4) patient complaints of ineffective medication relief when a suspected nurse is on duty, 5) progressively illegible handwriting throughout the shift, 6) personality changes, and 7) frequent trips to the bathroom or off the nursing unit. (p. 6).

Green (1989) reported other signs include odor of alcohol, emotional lability, withdrawal, and reports of illness. Messner et al. (1991), concluded that because nurses are knowledgeable about drug effects they erroneously believe themselves to be protected from the dangers of addiction.

Alvin and Silverstein (1991), stated that the “stages of substance abuse which may range from months to several years are: 1) Experimental, 2) casual, 3) progressive, and 4) terminal” (p. 38). Alvin and Silverstein (1991) further state that behavioral changes that may indicate drug problems include: “1) Extreme mood changes, 2) secretive behavior, 3) irresponsibility at work or at home, 4) lack of ambition, 5) changes in friends and hangouts, 6) sudden sloppy dressing, and 7) deteriorating health” (p. 39). Nurses who monitor and/or supervise nurses who are substance abusers need to be aware of these characteristics in order to provide proper assessment, intervention, and aftercare to those nurses (Green, 1989).

Attitudes of Nurses Towards Substance Abuse

Nursing has traditionally stigmatized nurses who are substance abusers, making restoration of self esteem and dignity difficult (Selbach, 1990). A randomized study was conducted by Spencer-Strachan in 1990. Her study involved eighty-six senior nursing students to examine: 1) Awareness of substance abuse in the profession, 2) attitudes toward education specific to substance abuse, 3) attitudes toward substance abusers, and 4) attitudes toward education as a possible deterrent to drug addiction. The author reported “99% of the nurses interviewed felt that substance abuse was affecting the nursing profession, and that 86% of interviewed nurses were aware of the influence that substance abuse has on the nursing profession” (p. 28). Conclusions from this research included the following:

- 1) A course in substance abuse should be in the professional nursing curriculum,
- 2) the course may deter substance abuse,
- 3) respondents were supportive of substance abusing peers,
- 4) nurses returning back to work prior to completing

rehabilitation were not looked at favorably (Spencer-Strachan, 1990, p. 30).

Cannon and Brown (1988) conducted a study of five-hundred nurses in the Northwest United States using the Chappel's Substance Abuse Attitude Survey to assess nurses' attitudes toward impaired colleagues. The authors reported that "nurses are more tolerant of patients being substance abusers than they are of colleagues who abuse substances" (p. 97), and further noted that 76% of the nurses questioned would confront an impaired colleague, 54% would favor a nurse's return to practice after rehabilitation, and 73% of the nurses would accept nurses who have abused substances as co-workers. When attitudes toward alcohol and drug abusers were compared in the Cannon and Brown study (1988), their results were more favorable for alcohol abusers than for drug abusers in the work place. Cannon and Brown (1988) concluded their research with the suggestion that programs "should alert nurses to deviant behavior, early detection, avoidance of premature labeling, and to provide information regarding prognosis and recovery" (p. 100).

Professional organizations should include professional well-being of the organization's members as part of their responsibility (Selbach, 1990). Selbach (1990) suggested that boards of nursing should focus on rehabilitation, not punitive actions only. Green (1989) recommends that information and referral services, formal peer assistance programs, peer support groups and education and consultation services can assist nurses who abuse substances as well as their peers. Courses provided by nursing education and training in drug abuse, intervention, and recovery "would help in the understanding of the substance abuse process" (Selbach, 1990, p. 541).

Treatment and Prevention of Substance Abuse in Nurses

Historically, the problem of substance abuse was handled primarily by ignoring the problem, and/or passing on the problem to another employer, or terminating the employee (Green, 1989; Truan, 1993). Ignoring the problem of substance abuse provided little support or opportunity for assistance in rectifying the problems that promoted the abuse of substances. Methods of professional assistance must be balanced with a commitment to preserve the rights of a professional colleague (Naegle, 1989). It is also helpful if the nurse's co-workers have a positive attitude toward recovering nurses (Green, 1989). If a nurse returns to the same work environment in which she or he worked while impaired, it may be helpful to have a group process to allow colleagues to discuss their feelings (Green, 1989). Peer assistance programs such as employee assistance programs could provide clearcut guidelines for substance abusers (Ashton & Bay, 1994).

Drug use can cause physical damage to the user's body, an overdose can be deadly, and a drug user may suffer from "mental confusion, impaired judgment, and loss of physical coordination and the ability to respond quickly in demanding situations" (Alvin & Silverstein, 1991, p. 35). To have effective interventions, the nurse must understand defense mechanisms and distorted perceptions of the substance abuser (Williams, 1989). Weisner and Schmidt (1993) concluded that more precisely targeted screening tools will assist in the determination of those who have, or have the potential for substance abuse. Mayer (1992) reported that some of the most successful programs involve family, friends, and other community resources.

According to the State of Montana Department of Institutions, Alcohol and Drug Abuse Division (1980), two philosophies exist on the subject of substance abuse. First, prevention of alcohol and drug abuse in Montana is established on the philosophy that individuals are responsible for their own actions. Second, given accurate and sufficient information and education, individuals will make responsible decisions. The purpose of treatment and rehabilitation services is to recognize and reduce identifiable problems caused by abuse of substances, and redirect substance abusers to participate in activities that are socially acceptable (Comprehensive Chemical Dependency Plan, 1989).

Treatment Models

Substance abuse treatments tend to vary in approaches to substance abusers and substance abuse. Lippman (1992) notes that although physicians are sent to rehabilitation programs, "RN's lose their jobs, licenses and dignity" (p. 37). Miller and Pechacek (1987) stated that treatment programs that teach reinforcing alternatives to substance abuse are found to be more effective than traditional drug-focused approaches. To provide treatment, Johnston (1991) suggested five conditions to be changed to decrease the popularity of drug use. These five conditions involve the following aspects of drug use: "Awareness of side effects (both negative and positive), ease of access, motivation to seek the rewards of drug intoxication, reassurance of availability, and willingness to violate social norms in order to obtain the drug" (Johnson, 1991, p. 99). Alteration of an individual's concept of substance use is also important in changing behaviors. Monitoring an individual's behavior by considering those "five conditions" can assist in overcoming the abuse problem and provide guidance to those who are in the

position of monitoring abusers.

Four philosophical models for treatment as described by Truan (1993) provide guidance for treatment. These four philosophical models include: moral, disease, spiritual or enlightenment, and bio-psycho-social models. The moral model posits that people are responsible for themselves. The disease model states that abuse has an underlying disease and cannot be treated without medical intervention. The spiritual or enlightenment model relies on a higher power for healing. The bio-psycho-social model focuses on prevention and relapse prevention, and group interaction as an effective means to this end.

In addition to the philosophical models described above, treatment modalities must be considered for use. There are three reported modalities for treatment and rehabilitation for substance abuse (The Department of Defense, 1973; Selbach, 1990; Hutchinson, 1987). The first of these is a five phase process that provides: 1) Identification of the individual, 2) detoxification, 3) psych-evaluation, 4) behavior reorientation, and 5) follow-up support (The Department of Defense, 1973).

The second reported type of program holds individuals in treatment to the following criteria: 1) No psychoactive drugs, 2) weekly meetings, 3) after care, 4) twelve-step meetings, 5) support groups, 6) random urine collection and evaluation, 7) sponsorship with the twelve step program, 8) drug therapy, and 9) a primary physician who specializes in substance abuse for appropriate treatment (Selbach, 1990).

A third reported type of program is known as peer assistance. Peer assistance programs have been found helpful and offer assistance through specific guidelines for

substance abusers (Hutchinson, 1987).

Treatment Methodology

Although high rates of relapse occur following addictive behavior treatment, there is also reason for optimism about treatment effectiveness (Miller, 1992). In his review of treatment research, Miller found that two-thirds of those in alcohol treatment showed favorable outcomes at the end of three months. However, at one year, only one-fourth of those treated had favorable outcomes. Miller also reported that twenty percent of individuals who go without treatment will also improve, and summarized as follows: "Interventions should be tailored to the needs and characteristics of individuals, with regard to the optimal length, setting, and methods of treatment" (1992, p. 99).

Performance during, and length spent in treatment were found to have had positive effects in areas such as attitude change and social needs of nurses participating in substance abuse treatment programs (Simpson & Sells, 1982). McLellan, Grissom, Brill, Durell, Metzger and O'Brien (1993) conducted a study to evaluate four different substance treatment programs. A population of two-hundred adults, with each program containing approximately one-fourth of the sample was evaluated. These programs included: two inpatient programs, one rural, one suburban; two outpatient programs, one urban and one suburban. The authors evaluated the programs for differences in the treatment programs. The findings reported: 1) Effectiveness existed in the outpatient programs in drug abuse improvement scores, and 2) improvement was found in all programs regarding drug abstinence (McLellan, Grissom, et al, 1993, p. 251).

McLellan, Arndt, Metzger, Woody, and O'Brien (1993) conducted a study to determine whether the addition of counseling, medical care and psychosocial services improved patient outcome. The sample population consisted of ninety-two intravenous opiate users in methadone maintenance treatment. The results indicated that substance abuse treatment programs can be effective in relieving substance abuse, medical, social, psychological and family problems. Substance abuse patients who received the most services during treatment had the best outcomes and the addition of counseling, medical care and psychological services improved the treatment outcome of opiate-dependent patients (McLellan, Arndt, et al., 1993). Simpson and Sells (1982) also reported that there is a more favorable outcome for individuals that spend longer periods in treatment.

Regardless of which treatment modality is used, treatment must be flexible and individualized. Consideration of the individual's psychological state, attitude, motivation, gender, religious background and ethnicity is part of the treatment process (Selbach, 1990). Prochaska, DiClemente, and Norcross (1992) stated that "consideration of adequate motivation, resistance to therapy, defensiveness and inability to relate to program objectives may alleviate problems of treatment failure" (p. 1103). In summary, treatment programs need to address cognitive and affective dimensions of addiction as well as structural and functional support to provide attitudinal change to chemically impaired nurses (Gefland et al., 1990).

Prevention

Prevention consists of increasing knowledge regarding substance abuse, identifying existing substance abuse prevention services, and formulating a plan of action to decrease stresses on substance abusers (State Department of Institutions, Alcohol and Drug Abuse, 1980). Basic concepts that must be considered are educating educators, leaders, potential drug abusers, health care personnel, and family members (The Department of Defense, 1973), and helping individuals to realize that they are responsible for the decision to use drugs.

Drug treatment and rehabilitation programs require that individuals have proper information on drug education and drug prevention (The Department of Defense, 1973). These individuals should also understand methods of prevention relating to substance abuse treatment and drug treatment. Staff involved in rehabilitation must have desire, persistence, motivation and a sense of loyalty to the goals of the group (The Department of Defense, 1973). Training programs should promote the following concepts: “1) Awareness of the problem of impaired practice, 2) recognition of signs of impaired practice, 3) helpful methods of intervention, 4) awareness of treatment resources; and 5) understanding of disciplinary processes” (Gelfand, Long, McGill, & Sheerin, 1990, p. 78).

Substance Abuse Monitoring Programs

Monitoring programs are essential in program evaluation (Brekke & Wolkon, 1988). Monitoring, or process evaluations are designed to provide: “1) An empirical description

of services delivered and mode of service delivery, 2) data to describe population served, and 3) comparison of these data to the intended target population served" (Brekke & Wolkon, 1988, p. 426).

There were several methods for monitoring nurses with substance abuse problems reported in the literature. These methods provide supervisors and managers access to the progress of the nurse in substance abuse rehabilitation (Adersberg, 1993; Buxton, 1990; Green, 1989; Huba, 1990; Robbins, 1987). Re-entry programs, employee assistance programs, case management, and follow-up of substance abuse treatment monitoring are presently used.

Gelfand, et al. (1990) noted that historically, "nurses have ignored problems of substance abuse in colleagues" (p. 77). Moore and Hogan (1987), stated that "nurses should be advocates for humane treatment of addicts" and Lindell (1987) recommended that the profession of nursing has a responsibility to "regulate and control members and its own professional practice by providing a network of supportive peers" (p. 377).

Carefully monitored re-entry at the worksite is considered part of treatment and continuity of care for the substance abuser and is especially important for the health care provider (Seymour & Smith, 1990). Seymour and Smith (1990) noted that there is twice the compliance of recovering individuals with a monitored re-entry than those who are not monitored. Seymour and Smith (1990) concluded that provisions should be made for relapse, periodic reevaluation and flexibility as the patient moves thorough the recovery process. There is a need to incorporate appropriate social support and job maintenance strategies to provide a basis for potential success in the reintegration of the substance

abuser into the workplace (Renwick & Krywonis, 1992). Personal characteristics, cognitions, behavior patterns and environment play an important part in substance abuse intervention (Renwick & Krywonis, 1992).

Green (1989) reported that monitoring was found to be helpful in rehabilitation by making the "consequences of relapse clear and immediate" (p. 90). Each nurse should be monitored in the early phases of recovery to "verify that the nurse is in recovery, to protect patients, and provide documentation in case the recovering nurse's drug-free status is questioned" (Green, 1989, p. 90). Green (1989) also suggested that monitoring can be done by the employee assistance program or supervisor at the workplace, by the State Board of Nursing, or by the nurse support group. Dimensions of individual and population characteristics, time and environment also influence the recovery process (Tomko, 1988).

Tomko (1988) suggested that recovery is a multidimensional process, a holistic approach in the plan of care. Sutherland (1991) noted that treatment attrition occurs in the early phases of treatment, and clients should be encouraged during this time to remain in treatment with continuous assessment and active participation by staff. The use of case management in substance abuse treatment can involve coordinating the care and monitoring of individuals over long periods.

Case management can address problems of accessibility to services outside the drug treatment system (Bokos, Mejta, Mickenberg, & Monks, 1992; Dennis, Karuntos, & Rachal, 1992; Rapp, Siegal, & Fisher, 1992; Ridgely & Willenbring, 1992; Woodwind, 1992). Consideration of the advantages of case management has useful goals.

Bokos et al. (1992) suggested that case management can provide oversight of a patients' overall treatment, and case managers develop, or have access to networks of available resources to use on behalf of the client.

Ridgely and Willenbring (1992) noted that treatment and monitoring programs need to enhance continuity of care, comprehensive and coordinated services, continuance over time, and be accessible, accountable, and efficient. Dennis et al. (1992) reviewed a training and employment program study involving four programs in the United States that evaluated an individual's ability to have interaction in the areas of job preparation, assessment, vocational counseling and resources for vocational needs. The results disclosed that seventy-two percent of participating individuals had contact with existing community resources through case management services (Dennis et al., 1992).

Although there has been success with case management, Ridgely and Willenbring (1992) suggested that barriers such as limited case management studies involving substance abuse, and philosophical conflicts about the nature of addiction and goals of treatment effect the case manager and services for the client. Inciardi, Isenberg, Lockwood, Martin, and Scarpitti (1992) held that problems on how to link individual outcomes and the abilities of the case manager need consideration for proper assessment of the case manager methodology. The case manager model should be catered to individualized needs to facilitate the client in functioning as normally as possible (Bokos et al., 1992).

Regardless of which method of monitoring is selected for or by the substance abusing nurse, there should be a process to follow in order to evaluate compliance.

Green (1989) suggested the following:

1) Written return-to-work contract, 2) release form for monitor/employer talks, 3) documentation of support group participation, 4) documentation of follow-up plan of aftercare, and 5) random urine drug screens, with stipulation of consequences if urine is positive (p. 90).

Buxton (1990) reported that assistance networks are important adjuncts to primary chemical dependency care. Networks include state regulatory agencies, professional associations, employee assistance programs, and support group networks (Buxton, 1990). Monitoring provides a structure for the patient's recovery as well as documentation of the recovery process and Buxton (1990) stated that the following areas should be included in a full recovery program: "1) Recovery maintenance activities and adjuncts, 2) work-site assessment and reentry recommendations, 3) random body fluid analysis, 4) relapse management and consequences, and 5) financial responsibility" (p. 449). Buxton (1990) concluded that substance abuse monitoring and re-entry guidance in health care professional's workplace would benefit both the recovering professional and those who are receiving health care.

Program Evaluation

In 1989 the State of Montana recommended that state agencies involve themselves in establishing standards for service delivery and quality assurance (Comprehensive Chemical Dependency Plan, 1989). Evaluations are an integral part of any drug and alcohol program. Measuring the accomplishments of a program provides a basis for explaining the failure or success of that program. It is important to consider how and why evaluations are done, and how the results weigh against the program outcomes.

Ditzler (1983) and Fisher (1983) recommended that program evaluation should not be ignored, and the results should provide usable information for program managers.

Assessment of substance abuse program accomplishments will judge program validity, and provide realistic recommendations (Evaluation of Drug Education Programs, 1972).

Larsen, Attkisson, Hargreaves, and Nguyen (1979) found that although many evaluators and researchers are seeing the importance of client satisfaction surveys, there are problems in collecting satisfaction data such as the lack of standardization of scales, assessment, and obtaining unbiased samples. Larsen et al. (1979) developed the Client Satisfaction Questionnaire, which has proven to be a reliable tool used in evaluations of health and human service systems.

Attkisson (1980) acknowledges that managers can employ program evaluation as an ongoing formative process to elicit "program stability, adaptation, growth, development and accountability" (p. 82). Attkisson (1980) stated that "The ability of a health or human-service agency to accomplish its mission depends on its ability to function effectively within four functional areas: 1) Service delivery, 2) program management, 3) planning, and 4) evaluation" (p. 85). Furthermore, Attkisson and Greenfield (1994) stated that "A client satisfaction or service satisfaction evaluation tool will provide efficient, sensitive, and reasonably comprehensive measures of patient satisfaction with services received" (p. 402).

Rural Influences in the Treatment of Substance Abuse

Turner and Gunn (1991) stated that “despite advances in the overall improvement of health status in the country . . . severe problems such as substance abuse in rural areas still exist” (p. 106). The need for rural hospitals to diversify in order to care for substance abuse has been hindered by marginal finances in rural hospitals (Fuszard, Slocum, & Wiggers, 1991). Nurco and Balter (1990) reported that in less populated areas, training of existing health care and other professionals, and providing strategically located facilities could enhance emergency, management, and treatment services, as well as support and referral for substance abuse. The informal network could also act as a community information service by providing consultation and educational programs to support both abuser and supervisor (Nurco & Balter, 1990).

Investigation into rural hospital health promotion by Hendryx (1993) determined that rural hospitals are especially limited in the types of services that are provided. A survey of mid-western rural hospitals conducted by Hendryx (1993) indicated rural hospitals only occasionally offered or scheduled substance abuse programs, in contrast to their urban counterparts who had scheduled substance abuse programs offered to their staff. Hendryx (1993) also found that 41.5% of rural hospitals needed promotion programs in substance abuse but the programs were not offered. Recommendations for resolution of this problem centered around: “1) Increasing staff commitment to certain areas of health promotion, 2) improving mental health services relating to substance abuse problems, and 3) conducting investigation into cost effectiveness of programs already in use” (p. 248).

Summary

The problem of substance abuse extends into many areas of society. The profession of nursing exhibits abuse patterns similar to the general population and the nursing profession considers the impairment of nurses to be a serious problem. The profession of nursing must be accountable to provide assistance to colleagues who abuse substances. Nurses who are provided assistance in resolving their substance abuse problems have the potential to return to being productive members of society.

CHAPTER 3

METHODOLOGY

Project Design

This study was designed to evaluate satisfaction with and helpfulness of monitoring by the Nurses Assistance Program (NAP). Participants of this study were NAP nurse participants and employers of those participants presently involved with NAP monitoring. The study investigated the following: 1) NAP participants' perceived satisfaction with the program, 2) perceived helpfulness of the NAP to nurse participants, 3) perceived employer satisfaction with NAP and non-NAP monitoring and nurses' ability to return to work. In addition, potential impact of rurality on program access and satisfaction was assessed.

Many tools were found to evaluate client satisfaction with substance abuse programs. The lack of tools dealing directly with the area of monitoring led the investigator to develop tools specifically for this project evaluation. The evaluation instruments were constructed to reflect the evaluation goals and objectives of the NAP. Internal validity was assessed by committee members regarding the content of the questions. The questionnaires examined NAP nurse participants' and employers' satisfaction with and helpfulness of the NAP monitoring program. Data collection tools for nurse participants (see Appendix A) and employers (see Appendix B) included questions regarding support, monitoring, urine testing, and work support issues.

The employer questionnaire was developed with input from actual employers of nurses in recovery. The questionnaires also included a qualitative section inquiring about the participants understanding of various areas of the NAP. These included: 1) Understanding of NAP purpose, 2) helpfulness of NAP, 3) understanding of the relationship between the NAP and the Board of Nursing, 4) improvement needed to make the NAP a better program, 5) referral approaches to the NAP, and 6) perceived difference of the NAP to other monitoring programs.

Description of Data Collection Methods

Data were collected using a questionnaire mailed to nurse participants in the NAP. Employers experienced with nurses involved in substance abuse treatment programs also received questionnaires regarding program monitoring satisfaction. Enclosed with each questionnaire was a letter from the investigator explaining the project and assuring anonymity of the participant. A letter stressing the importance of the project was also included from the NAP Consultant. Nurse participants and employers were mailed questionnaires for completion at their choice of time and location. Completed questionnaires were mailed back to the investigator in self-addressed stamped envelopes. A follow-up letter was sent to participants who did not return the questionnaire by the predetermined date in the original mailing. This follow up letter was sent to encourage participation.

The questionnaire used a Likert-type scale and required approximately twenty minutes to complete. A similar scale assessed employer opinions of NAP and non-NAP

monitoring programs. Both questionnaires asked a series of open-ended questions to solicit opinions and suggestions for the program. Demographic data were also collected.

Methods of Analysis

A statistical package (SPSS) was used to analyze quantitative data and the investigator summarized and analyzed the qualitative data from nurses and employers. The major subdivisions of concern were: NAP monitoring, support by the NAP, urine testing, work status, and counseling. A mean and standard deviation for each response was calculated for each question and for each major subdivision. Correlational analysis was used to explore NAP satisfaction and helpfulness as perceived by nurse participants in regard to: Distance from facility, time in program, track, and population of the community in which they lived. Qualitative analysis was used to analyze open-ended responses of the nurses and employers regarding their opinions and suggestions for the NAP. Descriptive statistics were used to summarize the demographic data.

Rights of Human Subjects and the Consent/Review Process

Nurses Assistance Program participants, and employers who had contact with nurses being monitored for substance abuse problems made up the sample population for this study. To assure anonymity of the participants, at no time was the name or other identifiers known to the investigator nor did the investigator have access to the mailing list. The questionnaires were coded, and sent with separate letters of introduction from the investigator and the NAP consultant. All material was mailed from the NAP office;

participation was voluntary, and the return of the questionnaire implied agreement to participate in the study.

Questionnaires were returned to the investigator through the College of Nursing at Montana State University, Bozeman, so that the NAP did not have access to the raw data. Follow-up for purposes of timely response was coordinated between the investigator and the NAP consultant. The coding was destroyed after data had been retrieved from the individual questionnaires. The completed questionnaires remained in a locked file cabinet in the researcher's residence during data analysis. When data analysis was completed, the completed questionnaires were stored in a locked file cabinet in the College of Nursing, where they will reside for two years before being destroyed.

CHAPTER 4

PROJECT OUTCOMES

Demographics

Of the twenty-five questionnaires initially mailed, twelve nurses returned the questionnaire. An additional three nurses responded to the second request. Nine employers initially returned the completed questionnaire, and five employers responded to the second request.

Demographic data collected for nurse participants included: 1) Area of employment, 2) size of facility (beds), 3) licensure action (probation, suspension, and revocation), 4) other monitoring programs the nurses participate in such as Alcoholics Anonymous and Narcotics Anonymous, 5) how nurses learned about the NAP, 5) referral source, 6) time in the NAP, 7) track (voluntary or disciplinary), 8) number of relapses, 9) number of prior treatment experiences, 10) population of community in which they live, and 11) distance to treatment facility. Table 1 displays responses to all of these questions.

Table 1. Demographic Characteristics of the Sample Population of Nurses (N=16)

Variable	f	% of nurses
Areas of Current Nursing Practice		
MED/SURG	4	25.00
ICU/ER	5	31.25
OR/Anesthesia	1	6.25
CDU	1	6.25
LTC	2	12.50
Home Health	1	6.25
None	2	12.50
Facility Size (number of beds)		
5 to 40	5	31.25
75 to 100	4	25.00
101 to 120	3	18.75
None	2	12.50
Not reported	2	12.50
Learning of the NAP		
Board of Nursing	8	50.00
Director of Nursing	2	12.50
Employee Assistance Program	2	12.50
Other Nurse	3	18.75
Medical Doctor	1	6.25
Referral Source to the NAP		
Board of Nursing	7	43.75
Director of Nursing	2	12.50
Employee Assistance Program	1	6.25
NAP Consultant	1	6.25
Self	3	6.25
Medical Doctor	1	18.75
No Response	1	6.25
Prior Actions Against Nursing License		
Probation	3	15.00
Suspension	4	20.00
Revocation	1	5.00
No Priors	12	60.00
Time (in months) in the Nurses Assistance Program		
Six or less	2	12.50
Seven to Twelve	6	37.50
Thirteen to Twenty	5	31.25
Twenty-one to Twenty-four	3	18.75
Population of Community in Residence		
100 to 3,000	2	12.50
3,001 to 50,000	7	43.75

(Table continued)

50,001 to 100,000	4	25.00
No Response	3	18.75
Number of Relapses While in the Nurses Assistance Program		
None	13	81.25
One	3	18.75
Number of Prior Treatment Experiences for Drug/Alcohol		
None	8	50.00
One to Three	7	43.75
Seven	1	6.25
Previous Substance Abuse Monitoring		
Yes	3	18.75
No	7	43.75
No Response	6	37.50
Distance (in miles) from Treatment Facility		
1 to 4	4	20.00
16 to 50	4	20.00
90 to 120	3	18.75
No Response	5	31.25

Descriptive Data

Nurse Participants

Data analysis reflected the aims of the project, which for the nurse participants included: 1) NAP participants' perceived satisfaction with the program, and 2) perceived helpfulness of the NAP to nurse participants. Potential impact of rurality on program access and satisfaction was also assessed.

The instructions with the questionnaire requested participants respond as follows: If the participant strongly agreed with the statement a "5" was placed in the appropriate space in front of the question. If the responder strongly disagreed with the statement "1" was the appropriate choice. The response of "4" or "2" indicated a "somewhat agree" or

“somewhat disagree” respectively. A score of “3” indicated a neutral value was attached to the question.

Sample question:

Strongly agree ←————→ Strongly Disagree
5 4 3 2 1

- ☐ 15. I see my urine testing as necessary to protect me from false accusations of relapse.

NAP Participants Perceived Satisfaction with Program Monitoring

The nurses involved in the evaluation of the NAP generally reported that overall, they were satisfied with the monitoring program with a mean (M) value of 3.68 and a standard deviation (SD) of 1.19. To provide a clearer presentation of the data, responses to specific questions have been grouped in the following manner: Support provided by the NAP and other groups (#'s 1, 9, 10, 13, 14, and 15); monitoring conducted by the NAP (#'s 3, 4, 6, 7, and 8); urine testing (#'s 2, 12, 16, 17, 19); and work status in relation to restrictions imposed by the NAP (#'s 5, 11, and 18).

Support

Support offered by the NAP was thought to be positive. Nurse participants apparently felt that the NAP gave a nurse a good name to “fall-back” on when seeking employment, and provided a voice behind the contract. Other comments included “humane treatment”, “positive support”, and being a “potential advocate if needed”.

Table 2. Nurses' Perceived NAP Support

Variable	<u>M</u>	<u>SD</u>
1. The NAP is approachable when there are problems I need to discuss.	3.65	1.62
9. I believe having a "Nurse Advocate" (another recovering nurse) would be helpful to me in returning to work and to maintain abstinence/ recovery.	3.56	1.36
10. I believe that support groups are helpful	3.81	1.37
13. I believe that the NAP is supportive of the nurse in the program.	4.43	.81
14. I see my peers at work as supportive when returning to work after treatment.	3.35	1.59
15. I see UA's as necessary to protect me from false accusations of relapse.	4.06	1.18

Monitoring

Monitoring by the NAP had an overall mean of 3.78 on a scale of 5.00. Two of the nurse participants noted that the NAP was better than the Board of Nursing, "the contract was more detailed with the NAP than other previous monitoring programs," and "the NAP provides flexibility with monitoring requirements over time."

Table 3. Monitoring of Nurse Participants by the NAP

Variable	<u>M</u>	<u>SD</u>
3. The NAP provides fair and adequate monitoring.	3.87	1.14
4. The NAP provides appropriate follow-up.	4.06	1.06
6. I am satisfied with the interaction I have had with the NAP.	4.37	1.02
7. I see monitoring by NAP as punitive.	3.40	1.63
8. Contact with the NAP has been helpful.	4.00	.81

Urine Testing

The subject of urine testing proved somewhat controversial with the nurse participants, the mean for this subgroup being 3.36 on a scale of 5.00. Issues raised about

the method of specimen collection included responses of violation of privacy, cost, lack of randomness of random samples (“one could set your calendar by them”). Questions were also asked as to why do individuals with alcohol addictions need to have so many urine specimens given, and fears that reports on the results of urine testing would be lost. The nurse participants suggested that the NAP considered decreasing urine collections with length in the program and with “clean urines.” Because the nurses pay for urine tests, they requested less expensive labs be used to process urine specimens.

Table 4. Urine Testing Procedures and Protocol

Variable	<u>M</u>	<u>S D</u>
2. I am satisfied with the urine testing collection arrangements.	3.00	1.46
12. Random urine testing presents problems in coverage when on duty.	3.56	1.50
16. Urine testing should be conducted more frequently	3.47	.74
17. I believe that Urine testing is an invasion of privacy.	3.87	.88
19. I should be allowed more than six hours to submit to urine testing	2.93	1.61

Work Status

The nurse participants reported that they were satisfied with work conditions established by the NAP with the mean of this subgroup being 3.33 on a scale of 5.00. Supportive comments made by the nurse participants included: “The NAP allowed suspension instead of revocation of my license,” and “The NAP allowed me to continue to work”. An interesting response by the majority of the nurse participants (94%) reported they did not feel that they could ever return to administering narcotics without supervision.

Table 5. NAP Imposed Restrictions of the Nurse Participants Work Status

Variable	<u>M</u>	<u>SD</u>
5. I see the NAP contract as a tool I can use to gain back professional integrity.	4.00	1.09
11. Work restrictions imposed by the NAP contract are appropriate.	3.62	1.36
18. I believe a nurse who has diverted drugs from work for her or his own use can return to nursing and administer controlled substance without restrictions.	2.93	1.30

Perceived Helpfulness of the NAP to Nurse Participants

Responses from nurses regarding perceived helpfulness of the NAP indicated that nurses find the NAP generally helpful. Participants were requested to evaluate the questions in this section in the following manner. If the participant strongly agreed with the statement a "5" was to be marked in the space provided. If the responder strongly disagreed with the statement a "1" was to be indicated. A response of "4" or "2" indicated a somewhat agree or somewhat disagree respectively. A response of "3" was evaluated as neutral. If the participant had not participated in a certain area they were to indicate the question was not applicable by annotating a zero in the space provided.

Sample:

Most Helpful <=====> Least Helpful Not Applicable
 5 4 3 2 1 0

☐ 30. Quarterly Work Reports

In order to provide a clearer subject relationship the questions have been grouped in the following manner: Counseling (#'s 1, 2, and 3); Support (#'s 4 and 8); Monitoring (#'s 6, 7, 9, 10, 11, and 12); and Urine testing (# 5). The overall mean (M) for perceived helpfulness was 2.84. An overall standard deviation (SD) for perceived

helpfulness was 1.17.

Counseling

The Nurse participants reported inpatient counseling most helpful ($\underline{M} = 4.66$). To a lesser extent, outpatient and aftercare counseling were reported to be helpful as well ($\underline{M} = 3.84$ and 3.57 respectively).

Table 6. Counseling Provided by NAP and Others

Variable	<u>M</u>	<u>SD</u>
1. Counseling-inpatient treatment.	4.66	.70
2. Counseling-outpatient treatment.	3.84	1.21
3. Counseling-aftercare.	3.57	1.28

Support

Nurse participants reported that support groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) were found helpful ($\underline{M} = 3.65$). Traditional meeting groups such as AA and NA were complemented by other means of support such as family and religious activities.

Peer support was found helpful by thirteen of sixteen responders ($\underline{M} = 3.66$), with peer support ranging from adequate to very helpful. Three responders indicated that they did not receive any peer support. The 6 month evaluations conducted by the NAP were generally found helpful ($\underline{M} = 3.33$). Approximately 30% of the nurse participants criticized the evaluations for “lack of timeliness in response”, and “blaming nurses if evaluations were late”. Supportive criticism noted that nurses should have more input into the evaluation process, and the nurses should meet with the NAP staff bi-annually.

Perceived helpfulness of quarterly reports conducted by the NAP were reported to be less than satisfactory ($M = 2.81$), but there were no suggestions regarding how to improve this problem. The worksite monitor was thought to be helpful ($M = 3.50$), but work restrictions imposed by the NAP were not thought to be not helpful overall ($M = 2.80$). Only 40% of nurse participants found the work restrictions favorable.

Table 7. Support for Nurse Participants

Variable	<u>M</u>	<u>SD</u>
4. Support Group Meetings (AA, NA, Other)	3.64	1.64
8. Peer support.	3.66	1.63

Other Monitoring Activities

The nurse participants reported an overall mean of 3.07. Participants requested more nurse/case manager interaction. One nurse participant criticized that “only the contracts told the nurse what to do”. No other specific nurse participant responses were noted.

Table 8. Other Monitoring Activities

Variable	<u>M</u>	<u>SD</u>
6. Contact with case manager.	2.76	1.23
7. NAP contract.	3.43	1.31
9. Six month NAP evaluations.	3.33	1.63
10. Quarterly work reports.	2.81	1.72
11. Work site monitor.	3.50	1.72

Urine Testing

Nurses' responses to urine testing procedures ranged from being helpful and keeping them on track to the urinalysis being an invasion of privacy. The mean for this

response was 3.62 with a standard deviation of 1.45 suggesting that most nurses reported random urine testing helpful. One nurse commented that “the urine collections keep me straight!”. Comments that indicated dissatisfaction with urine collection included: “Make the random urine collections random,” “You could set your clock or calender by them,” “I don’t like someone watching me use the bathroom,” and “less frequent urinalysis should occur with length in the program.”

Correlational Analysis

Correlation coefficients were calculated for each question to compare satisfaction with, and helpfulness of the NAP with distance to treatment facility, and time in the program. Table 9 represents the correlations between nurses' satisfaction with NAP monitoring and the independent variables. Items which demonstrate a correlation of .30 or greater or -.30 or less are worthy of discussion. These values are indicated with an underline on Table 9.

Table 9. Perceived Satisfaction of Nurses with NAP Monitoring in Relation to Distance, Time, and Population

Items	Distance	Time	Population
1. The NAP is approachable when there are problems I need to discuss.	.20	.15	-.64
2. I am satisfied with the UA collection arrangements.	-.80	-.09	.26
3. The NAP provides fair and adequate monitoring.	-.29	-.10	.01
4. The NAP provides appropriate follow-up.	.03	.04	-.34
5. I see the NAP contract as a tool I can use to gain back professional integrity.	.11	.04	.58
6. I am satisfied with the interaction I have had with the NAP.	.22	-.10	-.22
7. I see monitoring by NAP as punitive.	.01	-.51	.13
8. Contact with the NAP has been helpful.	.02	-.46	.07
9. I believe having a "nurse Advocate" (another recovering nurse) would be helpful to me in returning to work and to maintain abstinence/recovery.	.07	-.15	-.04
10. I believe that support groups (AA, NA, others) are helpful	-.03	-.11	-.19
11. Work restrictions imposed by the NAP contract are appropriate.	-.20	.14	-.25
12. Random Urine testing presents problems in coverage when on duty.	-.28	-.34	.34
13. I believe that the NAP is supportive of the nurse in the program.	.07	-.12	-.31
14. I see my peers at work as supportive when returning to work after treatment.	-.14	.27	-.07
15. I see urine testing as necessary to protect me from false accusations of relapse.	-.11	.09	.03
16. Urine tests should be conducted more frequently.	-.19	-.22	-.23
17. I believe that urine tests are an invasion of privacy.	.66	-.45	.00
18. I believe a nurse who has diverted drugs from work for her or his own use can return to nursing and administer controlled substance without restrictions.	.34	-.44	.54
19. I should be allowed more than six hours to submit to a urine test	.09	.22	-.03

Distance to Treatment Facility

A strongly negative correlation was reported with distance and urinalysis collection arrangements ($r = -.80$). This finding suggests that as distance increases to treatment facilities, the greater dissatisfaction the nurse participants have with urine collection

requirements. Furthermore, the greater the travel distance by the nurse participant, the greater the belief that urine tests invaded their privacy ($r = .66$). A weak correlation was reported with administration of controlled substances ($r = .34$). The nurse participants' responses implied that with a greater distance to travel to treatment, upon return to work, nurses were more likely to believe they could administer narcotics without supervision.

Time in Program

A moderately negative correlation was reported by nurse participants regarding NAP monitoring and time in the program ($r = -.51$). The responses support a conclusion that the longer the nurse participants are in the program, the less punitive they perceive the NAP to be. A negative correlation was also found between time in program and contact with the NAP ($r = -.46$). In other words, as nurses participate in the program longer, NAP contact becomes less helpful. A weakly negative correlation was found for the relation of time and staff coverage during random urine collection ($r = -.35$). This finding suggests that time in the NAP and random urine testing coverage while on duty has a slightly negative effect on staffing requirements. Time in the NAP and urine testing as an invasion of privacy was reported as being weak to moderate ($r = -.45$), meaning the longer the nurse is in the program, the less urine tests tend to be perceived as an invasion of privacy. The relation between time and restrictions on administration of controlled substances was a weak to moderate correlation ($r = -.44$), implying that the longer the nurse is in the program, the less confidence they have in returning to administering controlled substances without restrictions.

Size of Community

A strongly negative correlation was reported for NAP approachability and population ($r = -.64$). This finding suggests that the greater the population area in which the nurse participant lives, the less approachable the NAP is to discuss problems the nurse may have. Furthermore, nurse participants considered NAP follow-up less appropriate as population density increases ($r = -.64$). A strongly positive correlation was found for the NAP contract and population ($r = .58$). This finding suggests that with increasing population densities, the more the NAP contract can be used to help the nurse participant gain back professional integrity. There was slight indication that finding coverage at work for random urine testing presents greater problems in larger populated areas ($r = .34$).

Table 10. Nurse Participant Perceived Helpfulness of the NAP

Variable	Distance	Time	Population
20. Counseling-inpatient treatment.	<u>.55</u>	.28	<u>-.30</u>
21. Counseling-outpatient treatment.	<u>.35</u>	-.06	.08
22. Counseling-aftercare.	.17	-.05	<u>.41</u>
23. Support group meetings (AA, NA)	-.03	-.28	.00
24. Urinalysis	<u>.37</u>	-.13	.04
25. Contact with case manager.	<u>.49</u>	.05	<u>-.44</u>
26. NAP contract.	-.08	<u>-.46</u>	.11
27. Peer support.	.14	.00	.09
28. Six (6) month NAP evaluations.	.14	.10	-.25
29. Quarterly work reports.	-.11	-.06	-.28
30. Work site monitor.	.08	.07	<u>-.60</u>
31. Return to work restrictions.	.42	-.15	<u>-.71</u>

Perceived Helpfulness

Distance and Helpfulness

A moderately positive correlation was reported for inpatient treatment and distance ($r = .55$) suggesting that counseling in inpatient treatment facilities is perceived as being helpful when distance to the treatment facility is longer. A weakly positive correlation for outpatient treatment counseling supports this response ($r = .35$). In other words, counseling in an outpatient treatment setting is less helpful than an inpatient setting when distance is longer. A modest correlation was also found for distance and urine testing ($r = .37$), suggesting that urine testing is perceived as helpful by nurse participants when distance is a factor. Furthermore, this finding suggests that the farther the treatment facility is from the nurse participant the more helpful is contact with the case manager ($r = .49$). A weak to moderate correlation was reported with work restrictions and distance ($r = .42$), indicating that return to work restrictions are perceived as more helpful with increased distance to treatment facility.

Size of Community

Larger populations centers had a slightly negative influence on perceived helpfulness of inpatient treatment counseling ($r = -.30$). In fact, aftercare tends to be perceived as slightly more helpful by NAP nurse participants in larger population centers ($r = -.40$). A weak to moderate correlation was demonstrated between the population and case manager contact ($r = -.44$), suggesting that the larger the population in which the nurse participant resides, the less helpful is contact with the case manager. On the other hand,

a strongly negative correlation between population and the work site monitor ($r = -.60$), indicated worksite monitors were viewed less helpful to NAP nurse participants in larger populated areas. A strongly negative correlation between work restrictions and population ($r = -.71$) lends support to the idea that NAP nurse participants in larger communities perceive the NAP return to work restrictions as less helpful than their counterparts in smaller population settings.

Perceived Employer Satisfaction with NAP and non-NAP Monitoring,
and Nurses Ability to Return to Work

Table 11. Demographic Characteristics of the Sample Population of Employers (N = 14)

Variable	f
Position of Supervision	
Charge Nurse	6
Director of Nursing	7
No Response	1
Number of NAP Nurses Supervised	
One	7
Two	2
Three	3
Four	2

The questionnaire requested the participants to respond to the following options:

If the participant strongly agreed with the statement a “5” was indicated. If the responder strongly disagreed with the statement that a “1” was indicated. The response of “4” or “2” indicated a “somewhat agree” or “somewhat disagree” respectively. A score of three (3) indicated a neutral response

Questions related to employer satisfaction have been grouped in the following manner: Support that the NAP and groups provide to Nurse Participants (#'s 1, 9, 10, 13, 14); NAP monitoring and evaluations (#'s 3, 4, 6, 7, and 8); urine testing required by the nurse participants (#'s 2, 12, 15, 16, and 17); and work status restrictions imposed by the NAP (#'s 5, 11, and 18). "Helpfulness" questions related to: Counseling by treatment facilities (#'s 1, 2, and 3); support by NAP and other groups (#'s 4 and 8), monitoring and evaluations by the NAP (#'s 6, 7, 9, and 11); and urine testing for drug screening of the Nurse Participants (5).

Sample question:

Strongly Agree $\longleftrightarrow$ Strongly Disagree
 5 4 3 2 1

☐ 3. The NAP provides better monitoring than other monitoring methods

Support

Employers perceived support of nurses as slightly above average ($M = 3.44$). Employers reported that they were pleased with the overall progress of the NAP nurses, (for example, "one of the best nurses I have"). They tended to be pleased with the positive experience and support they had with the program.

Telephone support ranged from contact twice monthly to a response that the supervisor was not aware of the number of telephone contacts. Notification of support group attendance ranged from just once, to once a month. The work evaluations conducted by supervisors/employers conducted ranged from every month to quarterly to biannually.

Recommendations for improvement consisted of the following: 1) NAP to give out more information about the program to employers, 2) more direct contact rather than phone calls, 3) provide instruction on how to “handle supporting the nurse that is under pressure from the NAP,” 4) the NAP should be more willing to work with peer assistance programs and employers in the facility, 5) the NAP should also be concerned with “work relationships” and not just the client, and 6) employers “have a lot to offer and should be more involved in the monitoring process.”

Table 12. Employer Satisfaction with Support for Nurses and Employers

Variable	<u>M</u>	<u>SD</u>
1. The NAP is approachable when there are problems with the nurse I need to discuss.	3.92	1.44
9. I believe having a “nurse Advocate” (another recovering nurse) would be helpful to the nurse to help in returning to work and to maintain abstinence/recovery.	3.46	1.19
10. I believe support groups (AA, NA, Others) are helpful to the nurse in recovery.	4.30	1.19
13. I believe the NAP is supportive of the nurses in the program.	4.15	.98
14. I see the nurses’ peers at work as supportive when returning to work after treatment.	3.69	.94

Monitoring and Evaluation

Monitoring by the NAP was found to be generally acceptable by employers. The mean of this subgroup was 3.36. When comparing employer satisfaction with NAP and non-NAP monitoring some employers noted that the NAP is superior and is easier for supervisors. Other respondents stated that the NAP did not come across as punitive, and did not monitor as closely as other programs.

Negative comments regarding the NAP included: 1) “Poor or inadequate due to time and continuity,” 2) the need to be more “flexible in their contracts for rural areas,” 3) difficulty of rural areas that have smaller facilities and cannot meet all the established NAP requirements, 4) “improve its image as being helpful, and not make nurses fearful of reprisals from the NAP,” and 5) a need for increased phone contact between NAP and supervisors. A final comment was that an employer felt that it was difficult to follow staff when “care provided was so fragmented.” This response lacked any supportive examples regarding what was fragmented.

Table 13. Monitoring and Evaluation by the NAP

Variable	<u>M</u>	<u>SD</u>
3. The NAP provides better monitoring than other monitoring methods.	3.45	.82
4. The NAP provides appropriate follow-up on nurses enrolled in the NAP.	3.92	.86
6. I am satisfied with the interaction I have had with the NAP.	3.76	1.16
7. I see the monitoring of the nurse by the NAP as punitive.	4.07	1.18
8. Contact with the NAP has been helpful.	3.76	1.09

Urine Testing

The response from the employers regarding urine testing was a positive 3.8 on a scale of 5.0. The employers felt that the urine testing did not provide a problem with staffing. The employers were more concerned with the cost of the test as well as the potential of nurse reprisal if the employer was at fault for not being timely with the urinalysis report. The comments regarding dissatisfaction with cost were noted by both employers and the nurse participants.

Table 14. Urine Testing Procedures and Protocol

Variable	<u>M</u>	<u>SD</u>
2. I am satisfied with the urine testing collection arrangements for the nurse.	3.69	1.37
12. Random urine testing present problems in coverage when nurses are on duty.	3.37	1.31
15. Urine testing should be conducted more frequently.	3.63	1.03
16. I believe urine tests are an invasion of the nurses' privacy.	4.30	.94
17. I believe the NAP monitoring is too severe.	3.92	1.18

Work Restrictions

The employer mean for this subgroup of questions was 3.56. Employers felt the NAP provided adequate contractual agreements and restrictions imposed on the nurse participants were manageable in the worksetting. The employers also felt that NAP staff were very firm about restrictions.

A comment that was common to both nurses and supervisors was that nurses should not be allowed to return to administration of controlled substances without restrictions (Nurse mean = 3.68; Employer mean = 3.61 respectively). In light of the satisfaction that both supervisors and nurses have with the program, this was an interesting comment. This response suggests that the NAP is delivering a message about addiction and recovery that is realistic, and there will always be limitations.

Table 15. Work Restrictions Imposed on Nurse Participants by the NAP

Variable	<u>M</u>	<u>SD</u>
5. I see the NAP contract as a tool a nurse can use to gain back professional integrity.	4.38	.65
11. Work restrictions imposed by the NAP contract are appropriate.	3.84	.98

(Table continued)

18. I believe a nurse who has diverted drugs from work for her or his own use can return to nursing and administer controlled substances without restriction.	3.61	1.26
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Employer Perceptions of NAP Helpfulness

Participants were asked to respond in this section by indicating a (5) for strong agreement with the question, (4) for mild agreement, (3) for a neutral response, (2) for mild disagreement, and (1) for strong disagreement. A (0) response was allowed for those participants who have not had any experience with those areas.

Sample item:

Most Helpful $\longleftrightarrow$ Least Helpful Not Applicable
 5 4 3 2 1 0

☐ 6. Contact with the case manager.

Counseling

Results indicated that counseling in aftercare was found to be the most helpful by nurse participants. However, approximately 20% of the employers reported that they were not aware of counseling or support groups in which the nurse participants were involved.

Table 16. Helpfulness of Nurse Participant Counseling as Perceived by Employers

Variable	<u>M</u>	<u>SD</u>
1. Counseling-inpatient treatment.	3.88	.78
2. Counseling-outpatient treatment.	3.88	1.05
3. Counseling-aftercare treatment.	4.40	.84

Support

Employers reported that the NAP was very supportive. A mean of 3.96 was reported in this subgroup of questions. Employers also reported a positive experience with the NAP and that the NAP would have a positive influence of the Board of Nursing regarding the monitoring of the nurses in the Nurses Assistance Program.

Table 17. Perceived NAP Support to Nurse Participants

Variable	<u>M</u>	<u>SD</u>
4. Support group meetings (AA, NA, other)	4.00	.94
8. Peer support.	4.00	.95

Contracts, Evaluations, and Reports

Employers felt that the NAP was helpful in the realm of monitoring the nurse participants. A mean for this subsection was found to be 3.58. Employers found NAP staff personable and willing to help. Recommendations for the program included comments that employers would like to see a faster turn-around time in licensing decisions as well as have the NAP improve its image as being helpful to nurses. Employers also suggested that they be more involved in the evaluative process of the nurse participant.

Table 18. Contracts, Contacts, and Reports with Nurse Participant

Variable	<u>M</u>	<u>SD</u>
6. Contact with Case manager.	4.18	1.16
7. NAP Contract.	3.75	1.13
9. 6 month NAP evaluations.	3.63	.92
10. Quarterly work reports.	3.36	.92
11. Work-site monitors.	3.00	0.00

Urine Testing

Urine testing was seen as being helpful with a mean of 3.83 and a standard deviation of .93. There were no additional comments regarding urine testing in regard to helpfulness for either the employers or the nurses under their supervision.

Influences of Rurality

Areas of concern in the realm of program satisfaction consisted of several comments. The smaller the community, the more approachable, supportive, and helpful the NAP was perceived. Nurses reported that they had to travel from one to one-hundred-twenty miles for treatment, and therefore there should be more frequent contact with the NAP for support. Phone contact was perceived as a problem because of the answering machine. As one participant put it “there should be a person there.”

Time and financial factors possibly excluded more frequent travel to the individual sites. Although Montana is considered a rural/frontier state, the same situation may exist in any area where limited staff covers large areas.

Employer comments regarding rurality consisted of only one “rural” response. There was a need for the NAP to be more flexible in contract agreements for rural areas due to lack of services, or distance related problems.

Summary

The Montana State Board of Nursing’s Nurses Assistance Program was found to be generally satisfactory and helpful in monitoring nurse participants, by both the nurse

participants and their employers. Although there are several problem areas such as contractual agreements, person to person contact, and urine test collection protocol and cost, the responses and comments suggest that the program is meeting its objectives.

Implications and Recommendations for Further Study

It is hoped the Montana State Board of Nursing, Nurses Assistance Program, and consumers of NAP services will benefit from this study. The results should provide a basis for needed changes and/or modifications to the program, and for conducting further evaluation studies.

Because the present population of nurses and employers evaluated was small, results are only generalizable to the sample population. However, future comparisons could be made with larger populations. Cooperative evaluation with other rural states with similar substance abuse monitoring programs would allow for a larger data base and potential for further improvement of all programs involved.

This investigator recommends the following to enhance the NAP. The urine testing procedure should consider a less expensive testing facility, as well as making random collections truly random. Reduction in frequency of random urine specimens should be considered over time (point common to nurse participants and employers). Another recommendation is the reduction of "intimidation" by the NAP if test results are late. A supervisor stated that a late report may be the fault of the supervisor, and the nurse should not be held accountable for that action. The individuals involved with the

program, whether nurse or employer, should be assured that the NAP is there to monitor the individual. Supervisors stated that they should know the nurse advocate and be more involved in the program.

Contact with the nurse participant and the employer should occur more frequently, and the nurse and the employer should have greater input into NPA evaluations of the nurse participants. There should also be an easier method of contact; for example, a frequent comment was that the answering machine was a element of dissatisfaction for both nurse participants and employers.

Recommendations for further study are based on these points. First, the NAP should conduct an evaluation of the expectations of nurses who will be participating in the program. This would provide a foundation to compare nurse participants and NAP goals and objectives. The evaluation would also provide a basis for follow-up evaluations and meeting of goals and objectives that the nurse participant may have.

A second recommendation is that longitudinal study is conducted at six month intervals and yearly after graduation to assess long term effectiveness of the NAP or other supportive programs. Because the first NAP participants will not complete the program for another year, it is important to assess the opinions of those nurses at that time. Follow-up of graduates and those participating in the program is important to continue monitoring outcomes of the program. This could be accomplished in one year intervals for several years.

Finally, conducting audio-taped interview or teleconference by a neutral third party may provide a richer data base than with a written questionnaire alone. This conference

could include past NAP members as well as present members. A type of follow-up evaluation group meeting was suggested by some of the study participants. Conducting a client satisfaction survey (not limited to monitoring) might also provide data for future program assessment.

This investigator makes one final recommendation regarding the evaluation of the NAP. Program evaluation of other monitoring programs similar to the NAP should be conducted for analysis and comparison of programs, methodologies and outcomes. This type of analysis could provide other substance abuse programs with data for evaluation of their programs, and to expand the rural nursing substance abuse monitoring knowledge base.

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APPENDICES

APPENDIX A

Nurse Participant Questionnaire

NURSES ASSISTANCE PROGRAM
PARTICIPANT SATISFACTION SURVEY

Please complete the following questionnaire in order to assess the monitoring functions of the Montana State Board of Nursing's Nurses Assistance Program.

Respond to the statements by indicating to the extent that you strongly disagree (#1) or strongly agree (#5) with the questions listed below.

Strongly agree $\longleftrightarrow$ Strongly disagree
 5 4 3 2 1

- ☐ 1. The NAP is approachable when there are problems I need to discuss.
- ☐ 2. I am satisfied with the UA collection arrangements.
- ☐ 3. The NAP provides fair and adequate monitoring.
- ☐ 4. The NAP provides appropriate follow-up.
- ☐ 5. I see the NAP contract as a tool I can use to gain back professional integrity.
- ☐ 6. I am satisfied with the interaction I have had with the NAP.
- ☐ 7. I see monitoring by NAP as punitive.
- ☐ 8. Contact with the NAP has been helpful.
- ☐ 9. I believe having a "nurse Advocate" (another recovering nurse) would be helpful to me in returning to work and to maintain abstinence/recovery.
- ☐ 10. I believe that support groups (AA, NA, others) are helpful.
- ☐ 11. Work restrictions imposed by the NAP contract are appropriate.
- ☐ 12. Random UA testing presents problems in coverage when on duty.
- ☐ 13. I believe that the NAP is supportive of the nurse in the program.
- ☐ 14. I see my peers at work as supportive when returning to work after treatment.
- ☐ 15. I see UA's as necessary to protect me from false accusations of relapse.
- ☐ 16. UA's should be conducted more frequently.
- ☐ 17. I believe that UA tests are an invasion of my privacy.
- ☐ 18. I believe a nurse who has diverted drugs from work for her or his own use can return to nursing and administer controlled substances without restrictions.
- ☐ 19. I should be allowed more than six hours to submit to a UA.

Respond to the following statements by indicating to the extent that you strongly disagree (#1), strongly agree (#5) or (#0) no exposure, with the statements listed below.

Please complete the following statements in this section with the following scale

Most Helpful $\longleftrightarrow$ Least Helpful Not Applicable
 5 4 3 2 1 0

- ☐ 21. Counseling-inpatient treatment.
- ☐ 22. Counseling-outpatient treatment.
- ☐ 23. Counseling-aftercare.
- ☐ 24. Support group meetings (AA, NA, Other); [which group(s)]? _____
- ☐ 25. UA's.
- ☐ 26. Contact with case manager.
- ☐ 27. NAP contract.
- ☐ 28. Peer support.
- ☐ 29. Six (6) month NAP evaluations.

- ☐ 30. Quarterly work reports.
☐ 31. Work site monitor.
☐ 32. Return to work restrictions.

Please answer this set of questions by filling in the blanks with the appropriate response.

1. What is your understanding of the purpose of the NAP? _____

 _____.
2. Has the NAP provided any assistance to you? _____. If yes, how have they helped? _____
 _____.
3. What is your understanding of the relationship of the NAP and the Board of Nursing? _____

 _____.
4. Additional comments about your experience with the NAP. _____

 _____.
5. Suggestions for improvement. _____

 _____.

Demographic responses

1. Area of nursing: _____ 2. Size of facility (Staff/beds): _____.
3. Prior probation/suspension/revocations of nursing license due to drug/alcohol issues:
 [No] _ [Yes] _; number of times: Prior probation; __, Suspension; __, Revocation; __.
4. Have you ever been monitored by employer or board of nursing before? [No] _ [Yes] _.
5. If yes to #4, how does your previous monitoring compare with the NAP monitoring program? _____
 _____.
6. How did you learn about the NAP? _____
 _____.
7. Who referred you to the NAP? _____.
8. How long have you been in the NAP? _____.
9. Voluntary Tract: ____ 10. Disciplinary tract: ____.
10. Have you experienced any relapse(s) while in the NAP? [No] __, [Yes] ____.
 If yes, number of relapse(s)? _____.
12. Number of previous treatment experiences for drug/alcohol in your lifetime? _____
 _____.
13. What has been the biggest help in your recovery? _____
 _____.
14. Community population where you live _____. 15. Distance to a treatment facility: _____.
15. Do you anticipate on continuing with substance abuse treatment? [Yes/No] ____.
 Why? _____.
16. Are you anticipating on continuing with NAP monitoring [No/Yes] _____. Why? _____
 _____.

APPENDIX B

Employer Participant Questionnaire

NURSES ASSISTANCE PROGRAM EVALUATION
EMPLOYER SATISFACTION SURVEY

Please complete the following questionnaire in order to assess the monitoring functions of the Montana State Board of Nursing's Nurses Assistance Program.
 Respond to the statements by indicating to the extent that you strongly disagree (#1) or strongly agree (#5) with the questions listed below.

Strongly agree $\longleftrightarrow$ Strongly Disagree
 5 4 3 2 1

- ☐ 1. The NAP is approachable when there are problems with the nurse I need to discuss.
- ☐ 2. I am satisfied with the UA collection arrangements for the nurse.
- ☐ 3. The NAP provides better monitoring than other monitoring methods.
- ☐ 4. The NAP provides appropriate follow-up on nurses enrolled in the NAP.
- ☐ 5. I see the NAP contract as a tool a nurse can use to gain back professional integrity.
- ☐ 6. I am satisfied with the interaction I have had with the NAP.
- ☐ 7. I see the monitoring of the nurse by the NAP as punitive.
- ☐ 8. Contact with the NAP has been helpful.
- ☐ 9. I believe having a "nurse Advocate" (another recovering nurse) would be helpful to the nurse to help in returning to work and to maintain abstinence/recovery.
- ☐ 10. I believe support groups (AA, NA, Others) are helpful to the nurse in recovery.
- ☐ 11. Work restrictions imposed by the NAP contract are appropriate.
- ☐ 12. Random UA testing present problems in coverage when nurses are on duty.
- ☐ 13. I believe the NAP is supportive of the nurses in the program.
- ☐ 14. I see the nurses' peers at work as supportive when returning to work after treatment.
- ☐ 15. UA's should be conducted more frequently.
- ☐ 16. I believe UA tests are an invasion of the nurses' privacy.
- ☐ 17. I believe the NAP monitoring is too severe.
- ☐ 18. I believe a nurse who has diverted drugs from work for her or his own use can return to nursing and administer controlled substances without restriction

Please complete the following statements in this section with the following scale
 Respond to the statements by indicating to the extent that you strongly disagree (#1) strongly agree (#5), or (#0) no exposure with the statements listed below.

Most Helpful $\longleftrightarrow$ **Least Helpful** **Non-Applicable**
 5 4 3 2 1 0

- ☐ 19. Counseling-inpatient treatment.
- ☐ 20. Counseling-outpatient treatment.

- ☐ 21. Counseling-aftercare treatment.
- ☐ 22. Support group meetings (AA, NA, other); [which group in particular] _____.
- ☐ 23. UA's.
- ☐ 24. Contact with Case manager.
- ☐ 25. NAP Contract.
- ☐ 26. Peer support.
- ☐ 27. 6 month NAP evaluations.
- ☐ 28. Quarterly work reports.
- ☐ 29. Work-site monitors.

Please answer this set of questions by filling in the blanks with the appropriate response.

31. What is your understanding of the NAP? _____

32. How do you refer a nurse to NAP? _____

33. What is your understanding of the relationship of the NAP with the Board of nursing? _____

34. Have you had to supervise nurses returning to work after treatment for alcohol/drug abuse/ addiction before your contact with the NAP? _____

35. If yes, was there monitoring (either by yourself or by your facility) of counseling attendance, AA/NA/support group attendance, work performance, and UA's? (indicate which one of these were monitored and by whom) _____

36. How often were the following done:

- a. follow-up phone calls documenting attendance at counseling sessions. _____
- b. documentation of support group attendance (AA, NA, other) [indicate the group(s)]. _____
- c. evaluation of work performance. _____
- d. U/A collection. _____
- e. Other body fluid analysis for alcohol/drugs [note whether drugs and/or alcohol] ? _____

37. Please compare methods of monitoring used before with the NAP's monitoring. _____

38. Addition comments about your experience with the NAP.

39. Suggestions for improvement _____

Demographic responses

Position of supervision. _____

How many nurses involved in substance abuse treatment have you supervised? _____

Population of community in which your facility is located _____

Size of facility in which you work (staff and/or beds) _____

APPENDIX C

Letter of Introduction to the Nurse Participant

Dear Nurses Assistance Program evaluation participant:

Purpose

You are being asked to participate in an evaluation of the Nurses Assistance Program (NAP). In the State of Montana approximately 1,200 nurses have the potential to be affected by substance abuse during their career. This project's intent is to evaluate how nurses that are participating in substance abuse rehabilitation perceive how the monitoring by the NAP has assisted in their rehabilitation. In order that monitoring programs reach the needs of their clients, periodic evaluations are conducted to assess the satisfaction that their clients have with monitoring of their substance abuse rehabilitation. The enclosed questionnaire will provide you with the opportunity to voice your opinion regarding monitoring, helpfulness of the program and how the rurality of Montana affects the opportunity, ability or inability to receive assistance.

Benefits

Participation in this study will provide monitoring programs such as the Montana State Board of Nursing's Nurses Assistance Program increased guidance in the monitoring of substance abuse treatment.

Procedures, Risks

Your participation is voluntary. If you choose to participate in this study, the completion and return of the questionnaire will indicate your consent to participate in the study. If you choose to refuse to participate in this study, it will **NOT** affect your status with the Nurses Assistance Program or the Montana State Board of Nursing.

For this study, only one questionnaire is required to be completed. Upon completion of that questionnaire no further involvement is required. Completion of the questionnaire should take you 15 to 20 minutes. The questionnaires will not require names or identification other than a code to follow-up responses. The questionnaire will be coded in order that I may remind you to complete the questionnaire if I have not received it in a timely manner (to be returned no later than 10 September, 1994). Please note that once I receive the questionnaire, the code will be destroyed and your individual questionnaire will **NOT** be able to be identified. **Your anonymity will be honored.**

Results of this study will be reported as grouped data. Individual data will not be shared with any Board of Nursing personnel. There will not be any financial reimbursement for participation in this study.

Your participation is greatly appreciated. If you have any questions regarding the study, please feel free to call me at 585-8709. Thank you.

Sincerely,

William J. Pawlyshyn, RN, BSN
Graduate Student
MSU College of Nursing

APPENDIX D

Letter of Introduction to the Employer Participant

Dear Nurses Assistance Program evaluation participant:

Purpose

You are being asked to participate in an evaluation of the Nurses Assistance Program (NAP). In the State of Montana approximately 1,200 nurses have the potential to be affected by substance abuse during their career. This project's intent is to evaluate how nurses and employers that are participating in substance abuse rehabilitation perceive how the monitoring by the NAP has assisted in rehabilitation. In order that monitoring programs reach the needs of their clients, periodic evaluations are conducted to assess the satisfaction that their clients have with the monitoring of their rehabilitation. The enclosed questionnaire will provide you with the opportunity to voice your opinion regarding monitoring, helpfulness of the NAP and how the rurality of Montana affects the opportunity, ability or inability to receive assistance.

Benefits

Participation in this study will provide monitoring programs such as the Montana State Board of Nursing's Nurses Assistance Program increased guidance in the monitoring of substance abuse treatment.

Procedures, Risks

Your participation in this study is voluntary. If you choose to participate in this study, the completion and return of the questionnaire will indicate your consent to participate in the study. If you choose to refuse to participate in this study, **it will NOT** affect your status with the Nurses Assistance Program or the Montana State Board of Nursing.

For this study, only one questionnaire is required to be completed. Upon completion of that questionnaire, no further involvement is required. Completion of the questionnaire should take you 15 to 20 minutes. The questionnaires will not require names or identification other than a code to follow-up responses. The questionnaire will be coded in order that I may remind you to complete the questionnaire if I have not received it in a timely manner (to be returned no later than 10 September, 1994). Please note that once I receive the questionnaire, the code will be destroyed and your individual questionnaire will **NOT** be able to be identified. **Your anonymity will be honored.**

Results of this study will be reported as grouped data. Individual data will not be shared with any Board of Nursing personnel. There will not be any financial reimbursement for participation in this study.

Your participation in this study is greatly appreciated. If you have any questions regarding the study, please feel free to call me at 585-8709. Thank you.

Sincerely,

William J. Pawlyshyn, RN, BSN
Graduate Student
MSU College of Nursing

APPENDIX E

Follow-up letter to program participants

Dear Nurses Assistance Program evaluation participant:

Several weeks ago I sent you a letter and a questionnaire regarding evaluation of substance abuse treatment monitoring in Montana. I realize that sometimes time can get away from people. As of this date I have not received any response from you. I have received some impressive data from those who have responded, and would greatly appreciate your contribution to this study. Please find enclosed another questionnaire and self-addressed stamped envelope for return of the questionnaire. Please take some time now to complete and return the questionnaire by 4 October 1994. Your participation is greatly appreciated and will assist in the evaluation of substance abuse program monitoring in the State of Montana.

Sincerely yours,

Bill Pawlyshyn, RN, BSN

APPENDIX F

Project Introduction Letter from the Nurses Assistance Program Director

NURSES ASSISTANCE PROGRAM
Carol R. Sem RN, CCDC, NCAC II
111 N. Higgins, #206
Missoula, Montana 59802

To: NAP participants and employers/supervisors
From: Nurses Assistance Program
Date July 31, 1994

The NAP has been in operation for one and a half years and it is time we evaluate our program. We need your help to do this. Montana State University School of Nursing graduate student Bill Pawlyshyn has taken on this project and I encourage you to return the enclosed questionnaire.

To assure confidentiality, names or addresses of participants or supervisors have NOT been shared with Bill or MSU. Sealed envelopes containing the questionnaire and our letters were given to the NAP from Bill and the NAP sent out the envelopes using our confidential mailing list. The questionnaire is to be mailed directly to Bill at the Montana State University School of Nursing so the NAP will not be involved in the evaluation process. This is your opportunity to express your opinions without the NAP knowing who said what.

Enclosed is a letter from Bill, the questionnaire, and a stamped, addressed envelope for the return of the questionnaire.

Sincerely,

Carol R. Sem RN, CCDC, NCAC II
NAP Consultant