Nurses with Chemical Dependency: Promoting Successful Treatment and Reentry

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Nurses with chemical dependency pose a threat to patient safety, their own health, and the reputation of the nursing profession. To achieve the best possible outcomes for all involved, they must be identified promptly, treated appropriately and, when appropriate, allowed to reenter the workplace with stringent monitoring. Nurses and physicians in chemical dependency treatment programs tend to show similar clinical characteristics, use comparable medical services, and function similarly at follow-up. However, nurses report more frequent and severe work-related sanctions stemming from their chemical dependency (Shaw, McGovern, Angres, & Rawal, 2004). In 1982, the American Nurses Association (ANA) first defined "impaired nursing practice" as the presence of dysfunction related to alcohol and other substance use or psychological problems that interfere with judgment and the delivery of safe care (ANA, 1982).The literature on chemical dependency in nurses lags far behind that for other health-care professionals, especially physicians. However, with nurses on the front lines of patient care, it stands to reason that their risk of chemical dependence is at least as high as that of other health-care professionals.This article draws on our 25 years of experience working with chemically dependent health-care professionals in specialty treatment and aftercare settings tailored to these professionals.

Mary, a 36-year-old single mother of two young children, is an intensive care nurse who began using hydrocodone when it was prescribed for a back injury she sustained while moving a patient. Eventually, she found herself needing more and more of the drug despite a negative work-up for her back problem. Initially, she found it eased her pain, improved her mood, and raised her energy level.

When she could no longer find physicians willing to prescribe increasingly higher amounts of hydrocodone, Mary began diverting it from her unit. At that point, she knew she was in trouble and made several attempts to quit, which failed because of the withdrawal symptoms she experienced. When she was caught diverting, the hospital offered her a last-chance agreement and referred her for treatment.

Identification and Intervention for Chemically Dependent Nurses

The first steps in successful treatment of chemically dependent nurses are accurate identification followed by knowledgeable treatment referrals. Chemical dependency can manifest in the workplace through a wide range of behaviors and physical signs (see Table 1).

Intervention: The Who, What, When, and How

Intervention should be implemented by professionals who are trained and experienced in the required techniques and can remain nonjudgmental.

For the best outcome, a professional treatment program or an interventionist with expertise in working with health-care professionals should be consulted. Chemical dependence in health-care professionals is a specialized treatment area, and an appropriate referral will lead to a better outcome for the nurse who enters a rehabilitation program (Angres, Talbott, & Bettinardi-Angres, 1998).

A nurse identified as chemically dependent may be asked to make an appointment with employee assistance personnel (EAP). Available at most health-care organizations, EAP can provide professional counseling, education, and referral services for employers as well as confidential crisis intervention services, evaluation and assessment, brief interventions, screened referrals, and follow-up services for chemically dependent employees. Alternatively, the employee's supervisor may arrange an intervention in advance.

In some cases, an intervention must be done quickly. For instance, a nurse who is working while under the influence or actively diverting opioids must be removed from patient care immediately.

Nurses with chemical dependence typically fear they will lose their jobs and possibly their nursing license, suffer financial loss, and face criminal or other legal consequences. Interventionists need to consider these concerns before the intervention begins. Ideally, they should take a nonpunitive approach that focuses on relieving the nurse's suffering and emphasizing that a nurse who is willing to accept help may avoid potential harm. They also should be prepared to address questions and concerns the nurse is likely to raise.

Post-Intervention Referral Options and Practices

Typically, chemically dependent nurses are referred to a treatment program after they have been caught diverting controlled substances

(most often opioids). The referral source expects the treatment provider to determine if the nurse needs to go through a detoxification program, and if so, to arrange for this.

In detoxification (which precedes treatment), the nurse typically is hospitalized in a detox unit for 2 to 14 days. Detox usually is uncomfortable and the patient is focused on symptom management, so psychotherapeutic interventions tend to be superficial during this time.

The treatment provider also is expected to provide treatment of an appropriate length, offer family services, and determine aftercare recommendations. After the nurse is given the option of entering a rehabilitation program, the employer typically postpones the decision regarding work reentry until the nurse has been sober for an appropriate time and has completed rehabilitation successfully. However, recently we have seen a trend to terminate nurses after they have successfully completed rehabilitation, rather than offering a last-chance agreement (discussed below). Unfortunately, terminating nurses with a history of chemical dependency is likely to drive the dependency problem underground, making it harder for nurses to recover. Hospitals and other employers that opt to terminate chemically dependent nurses should be fully informed of the Americans with Disabilities Act. This act protects nurses who are seeking treatment or are in treatment from discrimination (Equal Employment Opportunity Commission, 1992). Even when a nurse is terminated, most employers still refer him or her to a treatment program. Programs specializing in treating chemically dependent health-care professionals are adept at making practice and reentry recommendations that promote the best chance of success.

Treatment

Two major treatment approaches are used with chemically dependent health-care professionals:

- Intensive outpatient treatment (full-time treatment while the nurse lives at home)
- Full-time treatment in a residential setting, sometimes called *boarded partial treatment.* This is a day hospital setting with the provision of independent living (Angres, Talbott, & Bettinardi -Angres, 1998)

Nurses considered at risk for harming themselves or others in the workplace are candidates for a full-time program that specializes in treating nurses. Typically, their history includes opioid diversion, working while impaired, and/or missing a substantial number of work days. Whether the full-time program should be in a residential setting varies with the individual; for instance, a nurse who has not diverted drugs and has financial constraints may be eligible for nonresidential intensive outpatient treatment.

Although many recovering nurses can return to higher-risk settings over time and with proper precautions, reentry decisions must be made on an individual basis by a treatment team familiar with chemical dependency in health-care professionals. Chemically dependent nurses sometimes are being allowed to enter outpatient treatment settings while they continue to work in the same environment where they had diverted drugs or worked impaired. This carries a substantial risk—both to the nurse trying to remain sober and to patients. Research on cue-induced craving (an involuntary craving for mood-altering substances on exposure to specific cues) underscores the risk of prematurely placing nurses back in units where they diverted drugs (Goldstein & Volkow, 2002). Especially during the first year or two of recovery, recovering addicts are vulnerable to visual and other sensory cues, such as the sight of a syringe or handling of substances they previously used. These involuntary cues can occur suddenly, serving as powerful triggers that can lead to relapse (see Table 2).

TABLE 1

Physical and Behavioral Signs of Chemical Dependence

Coworkers and supervisors must be able to identify the various ways chemical dependence can manifest in the nurse. Any of the following can occur, alone or in combination.

- Cognitive impairment
- Excessive tardiness or absenteeism
- Mood swings
- Appearance changes
- Increase in personal problems (such as financial difficulty or divorce)
- Increase in physical complaints
- Dilated or pinpoint pupils
- Excessive weight loss or gain
- Wearing long sleeves all the time to avoid needle-mark detection (in nurses with intravenous drug dependence)
- Spending excessive time around opioids
- Working too many hours (for greater access to opioids or to avoid withdrawal symptoms)
- Asking physicians for prescriptions
- Colleagues noting opioids missing in the workplace
- Isolation from work-related social events (Angres, Talbott, & Bettinardi-Angres, 1998).

Low-intensity treatment programs, such as part-time evening programs, may be appropriate for nurses whose dependence has not affected their work performance or raised other workplace issues. A good candidate for an evening program might be a nurse who, for instance, meets the criteria for alcoholism, binges only on days off, and has a supportive family or other social support person who has been educated and involved in the recovery process.

Family involvement in treatment is essential to a good outcome. Family members should receive education and therapeutic interventions while the chemically dependent nurse undergoes treatment. An intensive family week is nearly always part of the recommendation in a health-care professional's treatment program, along with family sessions to include and empower families to be a part of the solution (Angres & Bettinardi-Angres, 2008).

Specialized Treatment

Studies demonstrate much better outcomes for health-care professionals who receive specialized treatment and follow-up. These treat-

TABLE 2

Causes of Relapse

Even after appropriate treatment and during intensive aftercare monitoring, a recovering nurse may relapse. Causes of relapse include:

- failure to understand and accept that chemical dependence is a disease
- feelings of denial and uniqueness ("That recommendation may be fine for other nurses, but not for me.")
- dishonesty, commonly exhibited as lies of omission
- a secret held by the chemically dependent nurse that causes anxiety
- specific family dynamics, such as lack of family support or loved ones who disagree with the diagnosis or enable or rescue the addict and thus limit the consequences of substance use
- isolation
- lack of participation in a spiritual program
- repeated stress within or outside the workplace, with no awareness of the possible resolution or communication of that stress to others who could help
- untreated post-traumatic stress disorder
- exposure to cues that induce involuntary craving
- cross-addiction with another substance (for instance, an opioid addict may start to drink alcohol, rationalizing that she has never had a problem with alcohol) or an addictive behavior (such as gambling or compulsive sexual behavior).

ment programs include the following elements:

- Peer-group setting. In full-time treatment settings with supervised independent-living peers, the presence of other health-care professionals provides a source of empathy and can help the chemically dependent nurse confront feelings of uniqueness. Many health-care professionals also experience an inordinate amount of shame over their chemical dependency, believing they should have known better. Realizing they are not alone and that others with the same disease have overcome it is important to recovery. In contrast, when health-care professionals are placed in general-population treatment programs, they tend to become "experts" for others' aches and pains and are less likely to share the experiences they had while under the influence of chemicals, for fear of exposure and financial ramifications.
- Specific groups within the treatment setting that target occupational and personality variables, such as a Caduceus group that meets weekly to discuss professional issues related to health care only. Health-care professionals tend to have specific personality profiles that are familiar to staff in these specialized programs and can be addressed readily. For instance, Gabbard & Menninger (1988) found that physicians tend to be compulsive—a characteristic that can make them successful at work but cause lack of intimacy in relationships.
- A treatment plan that includes reentry to professional practice and extended aftercare monitoring. Typically, this plan includes involvement in a health-care professional program.
- Regular attendance at Alcoholics Anonymous meetings.
- Careful exploration of work reentry issues, such as whether and when the nurse should return to work and if so, whether he or she should be allowed to work in a position that involves handling addictive substances. Treatment providers at specialized programs are familiar with the reentry process and, in many cases, with those who determine reentry eligibility (such as members of state boards of nursing).

Last-Chance Agreements

For nurses who have followed all treatment recommendations, employers most commonly offer a last-chance agreement (Chatton, 2004). Essentially, this is a contract between the employer and nurse stating that the nurse will not be terminated but must agree to follow in good faith all stipulations in the agreement. The nurse signs the contract after successfully completing the treatment program and before reentering the workplace. Many last-chance agreements stipulate that the nurse seek a position without access to controlled drugs for 6 months to 1 year (Smith, 1996).

Based on our experience and practice, hospitals do not always report nurses who have accepted last-chance agreements. The last-chance agreement usually stipulates that the nurse successfully complete an addiction treatment program qualified to treat nurses, undergo urine monitoring with frequent and random screens, and follow through on all recommendations made by the treatment program for continued recovery (including regular involvement in a 12-step program and work with a sponsor). Terms of the agreement must last for 2 years and the nurse's job performance must meet generally accepted professional standards. Violating any part of the agreement results in job termination.

Offering last-chance agreements and letting recovering nurses return to work (with stipulations) can benefit employers in several ways. This approach allows them to show appreciation for loyal and valued employees. Also, in many cases it "may be less expensive than recruiting, hiring, and orienting a replacement. It can boost morale by demonstrating that the institution supports its employees. And it affirms that chemical dependency is a treatable disease, which makes it more likely that other chemically dependent employees will come forward and seek help" (Smith, 1996).

Caduceus After-Care Agreement

Near the end of treatment, many nurses are asked to sign a Caduceus aftercare agreement, similar to the American Association of Nurse Anesthetists' (AANA's) Model Reentry Contract (American Association of Nurse Anesthetists, 2009). This agreement outlines recommendations for the nurse's continuing recovery, including specific practice recommendations. On successful treatment completion, this contract is sent to the hospital's EAP, the state monitoring program and, in many cases, the nurse's work supervisor.

The goal of a Caduceus contract is to help the nurse succeed in the health-care workplace and empower the nurse by including him or her in the process of developing the contract; without the

nurse's direct involvement in contract development, some recommendations may seem punitive. The contract's workplace stipulations and restrictions are designed to foster a stable work environment, give the recovering nurse sufficient time to attend required 12-step meetings and meet with a sponsor, help the employer feel comfortable allowing the nurse back to work, and convince the regulatory agency that the nurse is not a threat to public safety and should be allowed to continue to practice.

In the Caduceus contracts our group develops, workplace stipulations for reentering nurses commonly include:

- a workplace monitor (usually the nurse supervisor)
- attendance at weekly meetings with the nurse supervisor and at monthly meetings with the EAP counselor
- no night shifts, overtime work, rotating shifts, and/or work on other units for at least 6 months (to be renegotiated at the end of that period by the nurse and supervisor)
- in most cases, no access to controlled substances for 6 months to 1 year (Sullivan & Decker, 2001)
- in most cases, working in a position other than the former one, with no access to controlled substances. If a nurse recovering from opioid addiction will return to a position that provides access to these drugs, a daily regimen of naltrexone 50 mg may be initiated and urine screens (which also can assess naltrexone compliance) should be done more frequently.

A Caduceus contract also may include requirements that *do not* pertain to the workplace, such as:

- attending individual therapy sessions
- attending marital therapy or workshops
- attending workshops on anger, codependency, shame, or other issues (depending on the individual)
- attending a gender issues group, with separate male and female groups
- attending at least three 12-step meetings per week
- weekly contact with a sponsor
- frequent random and observed urine screens
- in some cases, placement in a recovery residence (such as a halfway house)
- attending a counselor-facilitated Caduceus aftercare group or nurses' support group (preferably counselor facilitated). Such groups have been a critical component for recovering health-care professionals, increasing the chance for a successful long-term outcome (Maher-Brisen, 2007).

Continuing Care

Continuing care during recovery from chemical dependence is just as essential as initial treatment. Various studies show the benefits of extended monitoring for health-care professionals (Angres, Talbott, & Bettinardi-Angres, 1998). Such monitoring should continue for at least 2 years and may be done in conjunction with a health-care professional program with 5-year monitoring.

Usually independent of the treatment program, a health-care professional program (sometimes called a professional health program) follows recovering nurses, physicians, and other health-care professionals to ensure they stay sober. The recovering professional pays the program to advocate for his or her sobriety and to participate in necessary membership requirements (such as weekly support groups and random urine monitoring).

Reentry to the Workplace

Specialized treatment teams should provide guidance on whether, when, how, and where the recovering nurse should reenter clinical practice. Each hospital setting presents certain challenges; working directly with the nurse manager can ease the nurse's reentry and reduce anxiety among all parties involved.

In general, experts believe a nurse who has diverted opioids or has worked impaired for at least 1 year should not return to a clinical setting where opioid exposure exists. The science supporting this decision involves the impaired response, inhibition, and salience attribution of cue induction (Hyman, 2005).

Also, it is well-documented that chemically dependent persons are at higher risk for cross-addiction, especially during the first 6 months of sobriety, due to endorphin imbalances caused by withdrawal from their drug of choice. In cross-addiction, other mood-altering substances or behaviors (such as gambling) artificially correct the endorphin imbalance, thus "answering" the craving (Blum, Cull, Braverman, & Comings, 1996). For this reason, nurses who have abused alcohol, for example, are strongly encouraged to avoid working around opioids for at least 6 months. Many addicted persons have a history of problems involving food, gambling, spending, or sexual/relationship issues; unless addressed, these can threaten recovery. Cross-addiction is officially termed *addictive interaction disorder* (Carnes, Murray, & Charpentier, 2004).

Mary, mentioned earlier, recognized that although the desire for pain relief initially triggered her hydrocodone use, she later used the drug for its calming and energizing effects. She also had a strong family history of alcoholism. It was recommended that she enter a residential intensive outpatient program for chemical dependence specializing in treating health-care professionals. She successfully completed the program in 6 weeks, participating in family week with her oldest daughter and sister (her main family supports). She agreed to attend weekly Caduceus meetings with random urine monitoring for 2 years.

The treatment program supported her return to a nonpatient care position for 1 year, provided she would not have access to opioids or other mood-altering addictive substances. Because of Mary's previous long-standing track record as an excellent employee, the hospital agreed to employ her in its quality assurance department. She was able to return to patient care after demonstrating 1 year of solid recovery and complying with a structured aftercare plan that increased her chance for successful reentry to a position with access to controlled drugs. Her return to work was conditioned on continuing an intensive long-term monitoring program. Her strict at-work monitoring program gave her minimal opportunity to divert drugs. These terms were outlined in a Caduceus aftercare agreement by the health-care professional treatment program she attended.

Defining Successful Reentry

Few reliable studies exist on nurses' recovery success rates (abstinence after 2 years) after reentering the workplace. The California Nurse Diversion Program includes 1,000 nurses who successfully returned to work (Grauvogl, 2005). According to Diana Quinlan, MA, CRNA, chairperson of the AANA peer assistance program (2003), "programs that are put together well have an 80% recovery rate and some have a rate as high as 95%" (Trossman, 2003).

DuPont, McLellan, Carr, Gendel, and Skipper (2009) described the excellent outcomes for chemically dependent physicians monitored by several state medical society programs: 78% maintained complete abstinence over 5 years in 900+ physicians studied. This is far better than outcomes in the general population, where relapse rates typically range from about 40% to 60% (Angres, Talbott, & Bettinardi-Angres, 1998). The authors suggest that the following elements were crucial in the physicians' positive outcomes: extended intensive treatment; long-term monitoring; inclusion of colleagues, family, and employers in the monitoring process; appropriate reentry planning; and involvement in a 12-step recovery program. These elements were integrated into a contractual agreement in which failure to comply could lead to job termination or licensure problems. We believe that with appropriate treatment and aftercare, nurses and other health-care professionals can have similar positive outcomes (Shaw, McGovern, Angres, & Rawal, 2004).

Conclusion

Chemically dependent nurses jeopardize the standard of patient care as well as their own health. A nurse with suspected chemical dependence should be confronted in a formal, empathetic manner by a qualified interventionist or EAP, and should receive appropriate treatment recommendations. Treatment is more likely to bring long-term success if the nurse enters a specialized program for health-care professionals, followed by a strict aftercare program.

With proper assessment, intervention, treatment, and aftercare, chemically dependent nurses can safely reenter the profession. A nonpunitive approach gives the nursing profession the opportunity to model compassionate, effective peer assistance. What's more, experience and research support the success of recovering nurses in the workplace (Angres, Talbott, & Bettinardi-Angres, 1998).

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