

ABN



**MONOGRAPH
2000**

**Evaluation of the Alabama Board of Nursing
Recovery Programs for
Chemically Dependent Nurses**

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Montgomery, Alabama
April 2000**

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Evaluation of the Alabama Board of Nursing Recovery Programs for Chemically Dependent Nurses

INTRODUCTION

This research was authorized to provide scientific input to facilitate decision making by the Alabama Board of Nursing regarding the regulation of chemically dependent nurses. Chemical dependency, substance abuse, addiction are terms that are often used interchangeably. Individual differences may be declared but there is general agreement that a problem exists when any human's physical and mental capacities are adversely affected by excessive use or abuse of chemicals. Hutchinson (1986) and Kabb (1984) described dependency as alcohol or drug usage, which causes continuing problems in one or more areas of an individual's life. Six components of dependency or addiction have been delineated by the Substance Abuse and Mental Health Services Administration (1995) [as individuals who have experienced]: (1) trying to cut down on use, (2) failing attempts to cut down, (3) needing a larger amount to get the same effects or to get high, (4) using daily or almost daily for at least two weeks in a row, (5) feeling withdrawal symptoms, or (6) feeling the need for the drug. When these components exist, problems have been identified that range from depression to domestic violence, irritability, decreased work productivity or impaired work performance and inability to make sound decisions. Hughes, Smith & Howard (1998) state "When a nurse misuses or becomes dependent upon alcohol or other drugs (AODs), there is a great likelihood that nursing practice will be adversely affected. Boards of Nursing are challenged to assure the public's safety and welfare. This challenge is compounded when dealing with chemically dependent nurses. Currently, the Board exercises three options in the regulation of chemically dependent nurses: revocation of the nursing license, executing discipline by imposing probation of the license with specific stipulations aimed at recovery, and allowing admission to a non disciplinary recovery program.

A 1915 statute commonly referred to as the "Nurse Practice Act" established a board to examine and register nurses. The law also gave authority to the board to "revoke any certificate of registration for incompetency, dishonesty, intemperance, immorality or unprofessional conduct..." (*Alabama General Laws Regular Session 1915 § 11 No. 207*). A few letters prior to the 1940s reflect concern about the conduct of nurses, but no mention of formal action due to substance abuse. One may only make assumptions that these violations were handled quietly but firmly by an authority figure. Minutes of the May 9, 1942 Board meeting named two nurses about whom a nonspecific complaint was considered. An investigation was authorized to determine if the State Board of Narcotics knew of a record against the two. Since that time, however, as societal changes have occurred, and particularly beginning with the 1970s, numerous cases have been filed against licensees with substance abuse problems. The earlier quiet ways of managing the occasional cases in which licenses were revoked or considered relative to how repentant a nurse behaved, have transitioned into hundreds of formal charges leading to revocations, suspensions, or probation with closely monitored stipulations. Only recently (1994), with an opening of society to recognize substance abuse as manageable disease, has the Board initiated, with legislative authority, a non disciplinary approach for those nurses who were willing to enter an agreement for treatment and monitoring for recovery.

The Board of Nursing as the regulatory agency for nursing practice, is challenged to keep the trust of promoting public protection, health and welfare. To offer a disciplinary or non disciplinary program for those individuals who are seeking recovery from addiction of alcohol or other substances may be considered a risk for public safety. Yet a recent study (Mann, et al., 1999) evidenced consumers' willingness to allow an individual to be on probation if in treatment for substance abuse. Even so, the Board is very conscious of its responsibility to assure that the programs that are offered for recovery are effective, and are in keeping with the intent of the law. There is need to evaluate the overall success of the programs, their strengths, weaknesses, and the level of expected outcomes. If either program is to be retained, there must be data to evidence their value and to evidence agency accountability.

Purpose

This purpose of this project was to determine the effectiveness of two recovery programs regulated by the Alabama Board of Nursing for chemically dependent licensed nurses: (1) a voluntary non-disciplinary program in which Board action has not been taken against the license, and (2) a disciplinary program in which Board action has been taken against the license. Specifically, this project intended to:

- (1) systematically describe demographic, physical and behavioral characteristics of the two populations in the two programs;
- (2) determine success and failure rates of the licensees in their respective recovery programs;
- (3) synthesize the study populations' perceptions of interventions and substantive components which facilitate adherence to stipulations in the recovery programs;
- (4) determine the effects of demographic and other salient characteristics of the study groups on outcomes within and between the disciplinary and nondisciplinary groups, and
- (5) discover, describe and name the variables that affect recovery.

Gains

Anticipated gains from the research included: (1) developing of a comprehensive data base on licensees with chemical dependency problems, (2) gaining insight into the process of recovery in chemical dependency under the auspices and supervision of a regulatory agency, obtaining data about effectiveness of interventions as currently stipulated in disciplinary and nondisciplinary programs, (3) obtaining data about the influence of demographic and other salient characteristics on success in meeting stipulations in the disciplinary and nondisciplinary programs. Finally, (4) a desired gain was to be able to utilize the findings of the study to improve the existing programs for recovery of chemically dependent licensees. A major intended gain was the addition of data about minorities including women and African Americans who are undergoing recovery and males who are included in both types programs.

Extent of the Problem and Need for the Study

Cohen and Morrison (1993) state that "estimates of alcoholism generally cluster around ten percent of all drinkers." This accounts for approximately 13-15 million of adolescents and adults in the United States (U.S.). Taking care to differentiate between drug "use" and "dependence" and referencing the estimates from the Institute of

Medicine, they provide an estimate of drug dependency at 2.5 per cent of the overall United States adolescent and adult population. In a given month over twenty years of tracking, as many as 25 million individuals are estimated to use some kind of illicit drug.

The management of drug and alcohol abuse is very costly to society. The National Institute on Drug Abuse (NIDA) (Swan, 1998) provided estimates, from a 1992 study by the Lewin Group, that the economic cost to U.S. society of drug abuse was \$97.7 billion. The parallel cost to society for alcohol was estimated at \$148 billion. Projections from NIDA in 1995, revealed that inflation and population growth have increased the cost by 12.5 per cent or \$109.8 billion since 1992. The report emphasizes that "substance abuse brings consequences and costs in three categories: first, health consequences and their impacts on the health care system; second, criminal behavior either as a livelihood, participation in the drug trade, or violence related to drug abuse; and finally, job losses, family impoverishment, and subsequent reliance on welfare or other elements of society's safety net." (pp. 1,12) The report also emphasized that drug abuse can be treated and that treatment reduces cost.

Reliable statistics on numbers of chemically dependent health care professionals are not available, only estimates. Smith and Seymour (1985) stated there are an estimated 17,000 practicing physicians with substance abuse problems. They quoted the American Medical Associations' estimate that 6% to 8% of practicing physicians are subject to developing alcohol related problems and about 1% to 2% will abuse nonnarcotic and narcotic drugs. Estimates for substance abusing nurses range from 2% to a high of 12%. In a 1990 comparative study by Trinkoff, Eaton and Anthony, registered nurses reported substance abuse rates less than or equal to a matched sample of non-nurses. The reader was cautioned, however, that the study involved only 143 working registered nurses and that the findings should not be generalized. The American Nurses Association estimated that 6% to 8% of nurses have substance problems with 1% to 2% specific to drugs and approximately 6% to alcohol (Green, 1984; Addictions and Psychological Dysfunctions, 1984; Hughes, 1994; Trinkoff and Storr, 1998). This figure is considerable when one realizes that there are more than 3 million licensed registered nurses and over 900,000 licensed practical nurses (NCSBN, Inc. 1998). A spokesperson from the National Council of State Boards of Nursing, Inc. (NCSBN) stated, in June 1995 that an estimated 80% of the total disciplinary actions taken by boards of nursing are related to chemical dependency (1994, N =3,263). These figures, however, do not reflect the numbers of licensees who may be in treatment or in non-disciplinary programs, nor do they reflect cumulative statistics of cases that have previously been processed. Lewis, Snodgrass and Larkin (1990) provided data showing that there is a disproportionate number of complaints against men in nursing. In 1990, the male nurse population was approximately 6% of the total nursing population. Eighteen percent of the national population, however, had complaints issued for substance abuse by boards of nursing.

At the start of this research project in 1995, there were approximately 250 active files of individuals whose Alabama licenses were affected due to substance abuse at the Alabama Board of Nursing, with an equal number of licensees whose licenses were restored to an active status and or revoked. The nondisciplinary program had only 40 entries at that time. In 1999, there were over 500 actively monitored files. These figures indicate in Alabama, an approximate 1 percent of nurses are active with

substance abuse (being monitored) and a similar number who had had their licenses restored. This is reflective of national figures.

Regulatory agencies have long recognized an inherent danger in chemical dependency and drug abuse in the work place. Accordingly, when confronted with individuals whose lives have become compulsively driven to unsafe behaviors by use of controlled substances and/or alcohol, regulatory bodies have been spurred to exercise their power and invoke disciplinary action in the interest of public welfare. For a period of time, simply revoking the license seemed to be the legally responsible action to take. Professionals have, however, been bound to an ethical mandate to seek ways of helping their colleagues seek recovery from the destructive processes of addiction or abuse of drugs/alcohol. Because of the nature of addiction, the confrontation with a formal charge by the regulatory agency may be the first time that licensees are awakened to the reality of major problems for their own health and livelihood (Supples, 1995; Hutchinson, 1987). While revocation is a common practice, regulatory bodies have sought ways and means of allowing the retention of the license when possible through probating the license. Usually probation of a license is allowed only after there is evidence of treatment and evidence of continuing efforts for recovery. In nursing, probation has included a variety of stipulations to monitor abstinence from drugs or alcohol and to promote continued recovery (Crume & Mann, 1994).

Over the past decade, as information has been generated about chemical dependency, regulatory agencies have initiated peer assistance or non-disciplinary programs for recovery (Bissell, Haberman & Williams, 1989; Baldwin, 1994; Farley & Hendrix, 1993 and Smith & Seymore, 1985). In such programs licensees are allowed to retain their licenses provided they adhere to specific intervention contracts for recovery. Additionally, confidentiality of the identity of the program participant is maintained.

While a number of studies have been conducted on substance abuse, and chemical dependency or addictive diseases and interventions (Hutchinson, 1987), only recently have licensing/regulatory agencies begun to consider formally studying the effectiveness of interventions generated through their recovery programs. A literature search has revealed few studies regarding program evaluation sponsored by Boards of Nursing. Studies involving minorities of gender and race are also limited. Factors of influence have only recently begun to emerge relative to cause, relapse and to recovery. There is a tremendous deficit of evaluation research related to treatment programs. There is a call for continued research in numerous areas of deficit (Snow, Jewell & Anderson, 1997; Innis, 1997; Trinkoff, Eaton & Anthony, 1991). This study addressed some of these in relation to the evaluation of the two recovery programs conducted the Board of Nursing.

Regulatory Agencies and Substance Abuse

With national focus on increasing problems of substance abuse and greater consumer interest in quality of health care delivery, those professions who have been privileged to self-regulate have been challenged to acknowledge that those in their own ranks are subject to chemical dependency in percentages similar to the general public. Trinkoff, Eaton and Anthony (1991, p. 173) concluded, "the prevalence among nurses of substance abuse and depression was less than or equal to corresponding prevalence estimates for a sample of non-nurses." While alcohol plays a significant part in chemical dependency for the nursing population, other substances are also implicated.

It is known that nurses tend to obtain their supplies, other than alcohol, from their places of work rather than from "the streets" (Lee, 1990).

Regulatory agencies in nursing have been at the forefront of program development for discipline and recovery of the licensees, in order to meet their primary responsibility of public protection and to meet a professional ethical mandate. In the interest of public welfare, state regulatory agencies including boards of nursing, exercise their disciplinary powers to either remove licensees from practice or to allow practice under probation with stipulations. Usually probation has been allowed only after there is evidence of treatment and continuing efforts for recovery. Stipulations on probation have included a variety of strategies to monitor abstinence from drugs or other addictive substances such as alcohol (Crume & Mann, 1994). This particular type program has been in effect in Alabama for over ten years (Copy of Order is found in Appendix 1-C). The effectiveness of specific stipulations in this type program, however, has not been determined.

In 1993, the Alabama "Nurse Practice Act" was amended to give to the Board of Nursing authority to implement a voluntary non-disciplinary program named Alabama Nurses Nondisciplinary Alternative (ANNA) for nurses who meet criteria for supervised recovery for properly diagnosed problems of physical and mental health (§34-21-25, Code of Alabama, 1975). While the program does not prohibit access by individuals with other physical and mental health problems, most licensees enrolled are chemically dependent. On October 7, 1994, the first licensee was admitted. At the initiation of the study, there were 40 licensees enrolled in the program. As of the writing of this report, 198 licensees were enrolled in the ANNA program; 118 had been discharged. Forty-one (13%) of the total number ever admitted (N=316) had formal actions taken against their licenses for failure to uphold one or more of the stipulations in the agreement. Approximately 18 per cent of the first 40 admissions were taken to formal hearings for failure to adhere to criteria for the nondisciplinary track. Stipulations for retention in the program require considerable effort on the part of the licensee (Baldwin, 1995). A copy of the contract is found in Appendix 2-C)

Conceptual Support for the Study

Conceptual support for this project has been derived from studies using grounded theory (Hutchinson (1987, 1987b), Wing, (1995) and Supples (1995, currently in process)). All are based on psychosocial processes or theories. Hutchinson propounds the recovery process as moving from a self-annihilation trajectory to self-integration. Wing emphasizes denial of the addiction as a defense mechanism to be transcended in the recovery process, and Supples contends that recovery is not possible without dealing with underlying phenomena. All indicated that there is limited research on recovery and interventions. Other researchers have used statistical models (McLellan, Arndt et al., 1993) to study the effects of interventions on recovery.

Specific exploration of concepts of addiction and recovery facilitated the structuring of research questions. "Addiction is considered to be a condition in which a person develops a bio-psycho-social dependence on any mood altering substance..." (Gorski & Miller, 1986, p. 39), and is "characterized by compulsion, loss of control and continued use in spite of consequences" (Smith & Seymore, 1985, p. 713). Although there is debate on the classification of addiction as a disease, such debate stems from

concerns about failure to include the bio-psycho-social aspects of the condition with the physical. In such cases recovery may be viewed as synonymous or adjunct to medical intervention whereas the comprehensive definition allows for medical treatment to be a fragment, although significant, in the interventions required for promoting healing as part of recovery. Gorski and Miller (1986) resolve this by describing addiction as a disease, properly classified with heart disease, cancer and diabetes with long term physical, psychological and social damage.

In Taber's 16th edition (1989), recovery is defined as "the process or act of becoming well..." Recovery then may be viewed as more than an end action or terminal outcome to interventions for acute illness. In addictive disorders, recovery is necessarily considered as a chronic disease. Gorski (1989, pp. 2-3) describes recovery as "a progressive process that unfolds through six stages...learning to live a meaningful and comfortable life without the need for chemicals... more than not using alcohol or other drugs. The model that he asserts is primarily psychosocial in nature and deals fractionally with the acute condition of withdrawal which is in the second stage of recovery, and may overlap into the third stage. In acute withdrawal concern exists for life saving maintenance interventions (Antai-Tong, 1995). Withdrawal, which may extend into the third stage, may also need acute care intervention but should be carefully planned to avoid creating dependency on other drugs. Further, there is need to recognize that most formal intervention programs end at a time when individuals may need support (Murphy, 1993). That time frame is usually 24 months, when the "aftercare" programs end. Relapsing is common, and according to Supples (1995) there are critical points in recovery when relapse is likely to occur. In Alabama it is estimated that currently approximately 25% of the licensees in the disciplinary program experience at least one relapse in the first year. Reasons for relapse may be shared by the licensees but have not been formally accounted.

Pragmatically, there are some concrete indicators observed in recovery processes which serve as benchmark for success, that is operational definitions of recovery that regulatory agencies may use when considering release of a licensee to reenter practice. Sisney (1993, p. 108) says that "ongoing recovery ...the number of months a subject was a peer assistance program participant without having experienced more than one relapse." Others, such as participants in a chemical dependency interest group at the 1995 National Council of State Boards of Nursing, inc. meeting, said success in recovery is simply being drug free or maintaining abstinence from chemically addictive agents. Still others contended that success in recovery is adherence to recovery program criteria, "with only a relapse or two." In all of the rhetoric, there is an acknowledged deficit of intervention effectiveness. This study proposed that answering the following questions could contribute to filling the identified deficit and, accordingly meet the aims of the study.

Research Questions

The research questions emanated from the purpose and aims of the study. Stated broadly at the initial planning of the study, they were later amplified into taxonomy of questions so that they actually served as the guide for interviewing the participants.

1. Are there any differences between the disciplinary and nondisciplinary groups in compliance with the Board's stipulations across time?

2. What are the demographic and other salient characteristics that influence compliance with the Board's stipulations?
3. What are the participants' perceptions, across time, of significant life events, nature of the disease, effectiveness of their treatment programs, and effectiveness of Board stipulations?
4. What are the differences among treatment modalities when moderated by membership in disciplinary and nondisciplinary programs.

METHODOLOGY

Study Design

The research was conducted as a longitudinal descriptive, evaluation project, using a quasi-experimental nonequivalent control group design with post test measurement. Five distinct phases were designed to promote validity prior to implementation of the comprehensive project: (1) formation of a research team, (2) implementation of a pilot study that included defining the study sample and developing methods for data collection, (3) selecting the study sample, (4) developing and refining instruments for data collection (5) and designing a plan for (a) organization of collected data and (b) analysis of data.

Research Team

The research team initially consisted of a planning team of three Board staff members and one outside advisor who was an authority on evaluation research. The Board staff consisted of a coordinator of research and the two practice consultants who managed the two recovery programs. From this initial planning team, recommendations were made and approved for advancing to a core research team to conduct both a qualitative and quantitative study.

Invitations were submitted to two doctoral prepared researchers with knowledge of chemical dependence and experience in interviewing. One was an authority on qualitative research and ethnography with a background in nursing who was actively engaged in research involving chemically dependent nurses, and one was a counselor with experience in research activities directed to chemical dependence as well as research evaluation for refinement of the design, data gathering, evaluation, and statistical analysis. These two researchers and the three Board staff members composed the core research team for the project. The untimely death of the outside consultant required a regrouping and determination of action to take regarding the project. (*Dr. Joanne Supples, the external consultant on the projects died suddenly in August of 1995. Her expertise in qualitative research and support for continuing the project were significant factors in the decision to continue the project using her recommendations to the extent possible.*)

A decision was made to add the professionals needed to proceed with the project. A projected timeline of activities was proposed to begin the formal project in April 1996. The proposed time frame was adapted to accommodate recruitment of qualified interviewers for the research team, bureaucratic procedures for contract approval, and developing a schedule of meetings for orientation of the team to the project and planning for interviews. Three doctoral prepared nurse researchers and two master's prepared practitioners with experience in interviewing and qualitative research experience were hired under contract following standard procedures of legislative contract review and gubernatorial approval. All were experienced in counselor interventions with chemically dependent individuals. One of the first tasks of the research team was to develop and interview guide that could be employed in the pilot project, and then edited for the major study. Broad research questions were used to serve as the framework for development of the interview guide.

Summary of the Pilot Study

The pilot study was conducted to:

- analyze strategies to assure a representative sample from the disciplinary and non disciplinary programs that are sponsored by the Board of Nursing;
- develop and refine a code book for collection and organization of demographic data and other variables that would be subjected to quantitative analysis;
- design a plan for the collection of qualitative data; this included a plan for conducting interviews and identifying commonly occurring themes from the interviews of the pilot population.
- identify from the interviews, any areas that should be addressed in the project interviews (i.e., information necessary to meet objectives of the project), and
- reevaluate the potential to meet all study objectives.

The pilot study revealed that archival data were limited and often inaccurate. Further, limitations were imposed by the small population used for the pilot study. Consequently, plans were projected for the comprehensive study to select only those data from archival files that could be relied upon for valid results. For the pilot, of the three individuals signed the Informed Consent; two of the three participants were in the non-disciplinary program, one male, registered nurse and one female licensed practical nurse. The other nurse participant was a registered nurse enrolled in the disciplinary track. The interviews conducted with these individuals helped establish the codes for future analysis of qualitative data. Due to the small group, advanced statistical methods were not used, however, a decision was made to apply the quasi-experimental nonequivalent control group design with post test measurement for the full study. Also, the pilot evidenced that securing a broader population was highly dependent upon willingness of program individuals to give of their time with a stipend included. The sample was therefore limited to one of convenience. A full report of the pilot study is included as Appendix B.

Study Sample

The study sample was derived from two distinct populations: The first group consisted of 12 licensed nurses who were participants in the disciplinary program, by Board Order for probation, with an acknowledged problem of chemical dependency. The second group was composed of 38 licensed nurses who were participants in the alternative (non-disciplinary) program who entered voluntarily after evidencing that they met a predetermined criteria for admission and whose identities were unknown to all except the program director.

Delineation of the population was dictated by study design that required collection of quantitative and qualitative data. This particular delineation included for the quantitative component 100 percent of the licensees admitted and still active in both programs from October 1, 1994 through March 31, 1998 for comparative analysis. For the qualitative component all licensees who met the inclusion criteria as outlined below, were solicited by invitation through the program directors. At the initiation of the research project, there were 50 participants in the voluntary program, with approximately one admission per week. Of these, approximately 30% were males. In the disciplinary program, there were approximately 200 who met the inclusion criteria. Approximately 10% were males. While figures fluctuated, an estimated aggregate of

30% of the licensees in both programs were African-American. Initially 40 of the total population of the alternative program signed informed consents to participate. Attrition due to individual decision to leave the study and relapse resulted in a loss of the original two participants.

While the plan had been to have equal groups with a stratification of type program, age, gender, and race, a sample of convenience emerged. A representative sample of individuals across age and gender volunteered but there were unequal numbers in type group and race. The final number who accepted the invitation to participate were 12 participants in the disciplinary program and 38 participants in the non disciplinary program.

Summary of Inclusion Criteria:

- (1) Current participants in one of the two recovery programs for chemically dependent nurses sponsored by the Alabama Board of Nursing, (Admitted between October 1, 1994 March 31, 1996).
- (2) Signature on Informed Consent
- (3) Licensed in Alabama as a Registered or Licensed Practical Nurse.
- (4) Alabama resident.

Summary of Exclusion Criteria:

- (1) Any condition that would impede the interview process, as determined by the program coordinator, in consultation with the external consultant and principal investigators.
 - (2) Any evidence that would indicate a legal prohibition to participation as validated by the Attorney to the Board.
- Methodology for data gathering includes inviting all admissions to the two recovery programs within the specified time frame and up to the desired sample number to participate with assurances of anonymity through exercising appropriate actions for the protection of human subjects.

Instrumentation and Data Collection

Two software packages were available for data analysis; SPSS (Statistical Packages for the Social Sciences) and Excel for Windows. A trial run on one aspect of the study was attempted on a population of 69 disciplinary licensees. Specifically, the question was whether type work in a hospital evidenced a relationship to type substance abuse. Frequency analysis evidenced that the Chi Square test of significance could not be run on this group due to the cell size being too small, again supporting the need to focus on descriptive and summative data first, then to evaluate the most appropriate statistical methods to apply.

Limitations

As with any quasi-experimental design, potential problems in data collection existed. Securing an adequate number of participants was of concern. While the total population provided sufficient numbers across license type, gender, race and program type, there was no assurance that the licensees would accept the invitation to

participate. The outcome of solicitations was a greater number of participants from the voluntary program and fewer from the disciplinary program. Only two blacks elected to participate.

Mortality of study subjects was also considered as a strong possibility and a contingency plan was established to promote population stability. In reality, of those who volunteered, all except one person granted at least one interview. Because of the sensitivity of the subject matter and the licensee's relationship to the regulatory agency, developing trust between the interviewer and the participant in order to have reliable data was essential. Controls included careful selection and education/training of interviewers who were able to commit to the project over the 18 to 24 months for qualitative data collection. Interviewers were also selected on the basis of experience in interviewing and knowledge of substance abuse. Usual concerns about technological failures also existed. Of all interviews, two tapes were partially damaged or did not record adequately for transcribing.

Quantitative Data:

Data gathering methods included obtaining archival information from files of the sample in the two recovery programs for the quantitative component of the study. Demographic data were also obtained from the licensing files using numbers rather than names of participants. The instrument for archival data was developed in codebook format to accommodate data entry and analysis (see Appendix C). Page one of the instrument consists of instructions necessary for maintaining confidentiality and methods for coding. Page two provides the case identifier, and page three established the keys for license data. The body of the instrument was established using a traditional format for coding of variables, i.e., Software Name (SPSS, SAS, EXCEL), Variable Name, Value. The named categories for archival data included: (1) Demographic Variables, (2) License Data, (3) Employment Data, (4) Socio-cultural Variables, (5) Substance Use History and (6) Substance Abuse history). A total of 283 variables were initially identified and coded under their respective categories. Unfortunately, three areas of deficit in archival data were identified, all under the socio-cultural category: information of religious orientation, information on sexual identity and background and history regarding legal involvement of self or family. Interviewers were asked to consider ways and means of securing this information directly from the licensees on interview. All quantitative data were entered into a Statistical Package for the Social Sciences (SPSS) using the code book.

Qualitative Data

Under strict protocols for the protection of human subjects, qualitative data were derived from interviews with the study sample. Informed consent statements were issued to each potential participant. The program directors responded to questions about the project and the licensees' role. Once the Informed Consents were signed, appointments were made between the interviewer and the licensee. Interviews were recorded on audiotape and transcribed by court recorders. All tapes and transcripts were retained in a secure file in the Board of Nursing Office. Only the interviewers and co-investigators had access to the raw data. Only the co-investigators had access to coded data for the entire population. The participants were allowed to use aliases. Names, however, were protected and never referenced in data analysis. Questions for

interviewing the program participants were constructed and validated by the interviewers during the pilot project. While somewhat redundant, a step-by-step process for obtaining the qualitative data follows:

1. Development of an interview guide using the research questions.
2. Development of procedures for procuring the population and conducting interviews.
3. Development of codes by the core team and the interviewees in response to research questions.
4. Letter of invitation to be sent by a Board of Nursing contact (recovery program directors) to potential participants.
5. Follow-up call by contact person to licensee.
6. Licensee returns call and/or signed informed consent.
7. Files for volunteers were established.
8. Call made by interviewer to licensee.
8. Interview time established.
9. Interview conducted by tape; as interview ends the licensee was directed to next interview and potential subject matter to be covered.
10. Interviewers using ethnographic methods coded transcripts.
11. Coding concerns were resolved by consensus of co-investigators.
12. Concerns were resolved and codes assigned per consensus of co-investigators.
13. Codes were entered into the computer using Ethnograph 4.0, a software package compatible with Windows 95 and made available only to the co-investigators. Evaluation of sufficiency of data in relation to research questions. Plans were made to obtain additional data as needed, e.g.; new codes established Interviewers fashioned questions on second and third interviews to obtain and code the needed data.
14. Co-investigators then entered the codes into the Ethnograph 4.0. Complete X 3.
15. Following completion of all three interviews (when all three were conducted), the interviewer terminated the process.
16. Follow-up by Board contact on project completion.

Participants were evaluated for program compliance and interviewed for perceptions at three designated intervals over a period of 18 months.

Interview Guide

The following questions were formulated to assist the interviewers in obtaining data relative to the purpose of the project. (The interview guide was established using the broad research questions.

- 1.0 What are the characteristics of the two recovery system study populations? Upon Admission? At one year? At termination of the project or upon discharge?
 - 1.1 What are the demographics of the two study populations (age, gender, residence, type license, marital status employment status)?
 - 1.2 What are the physical characteristics of the individuals in the two study groups (body type, health status, major diseases, health history)?
 - 1.3 What are the behavioral characteristics (communication patterns, receptiveness to intervention, stipulations, appearance, compliance with stipulations)?

- 1.4 What are the socio-cultural characteristics (religion, sexual orientation, living arrangements, who in relationships uses(ed) drugs/alcohol (family members, friends, co-workers)?
 - 1.5 What is the psychiatric history (major problems, any treatment, any suicide attempts, family psychiatric history, other)?
 - 1.6 What is the drug/alcohol use history (when began, how long used, what drugs/alcohol, how much, frequency)?
 - 1.7 What is the current drug/alcohol usage? (actively use, last time used, current prescriptions, any non-prescription use)?
 - 1.8 What was the precipitating event to initiate contact with the Board of Nursing Recovery Program (point of time in connection with the program; reporting person to Board, e.g., self, employer, friend, family, criminal justice system)?
 - 1.9 What is the work history of the population (where worked, type agency, facility, usual time to stay on job, multiple jobs at one time, shifts worked)?
- 2.0 What are the perceptions of the study populations regarding chemical dependency and the recovery programs upon admission and during interviews two and three.
- 2.1 How is chemical dependency perceived (disease which is treatable, curable, manageable; is not a disease or a problem that exists for self, weakness in moral character, God's will, punishment for sins; other)?
 - 2.2 What life events are perceived as influencing the development of chemical dependency (even if the person does not perceive of her/him self as being chemically dependent) (abandonment as child, abuse, heredity, party, peers, death/loss of loved one, being a female, a male or female in the dominate different sex occupation, sexual orientation, physical appearance, poverty, wealth, divorce/loss of parents, friends, self; history of sexual abuse such as rape or incest; loss of job; economic depravity; religious disenchantment; other)?
 - 2.3 What event(s) is/are perceived of as having precipitated intervention by or through the regulatory agency? (employer reporting, fear of self harm, loss family/friends, other)
 - 2.4 How do the study participants perceive the recovery program in which they are participating (as a punishment, as a help such as life saving, as a way to retain or lose dignity, as a means to have a license to work, as a way to enter/seek recovery, as a pattern to follow for a cure, other)?
 - 2.5 What factors influenced the type of treatment program selected by the study participant (proximity, holistic care, stipulations only, family, money, lack of knowledge of any other, age, friends, other)?
 - 2.5 Which stipulations are perceived of (in each agreement or order) as most helpful? least helpful?
 - 2.6 Which substantive activities are perceived of as facilitating compliance or non-compliance with stipulations? (drug screens, personal contact with program coordinator/manager, coordinator's demeanor/approach, family or friends, support groups, counseling, work restrictions, exercise, diet, fear of loss of license, other).

- 3.0 What is effective treatment and what is recovery as perceived by the study population?
- 3.1 How does the participant describe an adequate or "good" recovery program?
 - 3.2 What does the term "recovery" mean as perceived by study population
 - 3.2 What is "effective treatment" as perceived by the study population?
 - 3.3 What factors are believed to be harmful or ineffective in treatment or promoting recovery from chemical dependency?

Data Analysis

Quantitative Analysis

Descriptive and inferential statistical methods were applied to quantitative data at intervals and at the termination of the project to describe the study population's characteristics, and when possible, to show relationships between selected variables and outcomes. Both between and within group analyses were employed. Between group statistical strategies was used for assessment of differences between the disciplinary and voluntary groups. Within group statistical strategies were used to determine demographic and characteristic differences that existed within the disciplinary and voluntary groups. Specific attention was given to determining differences (if any) in responses of minorities, women, and to responses relative to treatment programs in which licensees are attached.

Qualitative Analysis

Qualitative analysis was initially conducted in the pilot project using the constant comparison method adopted by Supples (1995). This method required careful reading and verification of transcriptions, identifying and sorting facts and incidents into code segments. The code segments were then sorted into categories and resorted into more general categories and subcategories as the research progressed. Categories were derived from substantive codes in the data. Refinement of categories occurred over time as the previously delineated processes are repeated following each of three interviews and transcriptions. A variety of techniques such as diagramming was employed to facilitate coding, linking of themes and categories, identifying trends and analytical schemes and eventually, positing theoretical explanations. Definition and refinement of categories and their properties led to a description of participants' perceptions of interventions required by the regulatory agency which were considered to be or not be helpful in recovery and other factors which are perceived to impact their recovery.

This hand driven method was essentially adapted into the technologically driven Ethnograph 4.0 coding methods. Analysis essentially begins through the coding process, in this case by the interviewers. The investigators finalize it after codes are entered. The Ethnograph 4.0, is a software package created by Seidel, J., Friese, S., & Leonard, D. C, that "facilitates the management and analysis of text based data such as transcripts of interviews, focus groups, field notes, diaries, minutes, and other documents. The basic unit is the segment. Each segment can be identified by up to twelve code words. Segments can be nested and overlapped seven levels deep, and search results represent these levels." In Review of *The ethnograph. Journal of Industrial Teacher Education*, 33(4), 78-82, (Satchwell, R. (1996), the author stated that the

Ethnograph software is designed to enhance and assist the process of noticing items of interest in data, collecting instances, and reasoning about those items. Prior to coding a data file must be created from text. This procedure can be developed using any word processing program that has the ability to save a file in the American Standard Code for Information Interchange (ASCII) format. The completed data file is imported into the program and is automatically formatted into a 40 character, single spaced line numbered file. The following is an example of the imported file that has been coded for this project.

CODING DATA FILE: 55

+FORM

Well I guess that my family life had	11		SUBTHX
deteriorated to such a point that I	12		
was forced to do something about myself.	13		
So I went to my minister and asked him	14		
to help me. He simply said that my job	15		
was to be a good mother and pray that God	16		REL
would deliver me from the devil and sin	17		
and I did pray, but when I got to work	18		
I was shaking so bad that I knew I'd	19		
Never make it to the end of the shift	20		
without at least some lortab. So when	21		PROCUR
Mr. Jones called for his medication	22		

+Editing

	24		
That's when they caught me - the	26		EVENT
Supervisor and aide. She - Ms. Elzy	27		
called me in and told me to go for	28		
a urine screen. It was terrible. Of	29		
course it was positive. All I could.	30		
think of was how am I goin' to tell	31		
my kids. I've been trying to get my son	32		FAMC
to stop usin' and here I was!!How was I	33		

Coding Methods Using Ethnograph 4.0

Once the file is created and coding has been initiated, new codes may be entered as various themes emerge through memos or additional coding of segments. Data are then explored and analysis conducted both quantitatively and qualitatively.

In this study, court recorders transcribed interviews from tapes. The transcripts were prepared using the ASCII format and were later imported into a Word processor. Once the transcript was converted to the appropriate format, they were returned to the interviewers for their analysis and hand coding. As stated previously, the research questions formed a framework for the interviews and the research team identified specific code words from the questions. Sub categories were identified for coding within the broader categories. These categories were identified first by the interviewers and coded in segments. Then subcategories were coded within the segments. Example: The term "recovery" was a broad category in which one could identify a segment or pattern within the interviews. Within this broad category, several themes could be

identify a segment or pattern within the interviews. Within this broad category, several themes could be coded such as "recovery problem" or "recovery strategy." As the coding occurred over time, other themes emerged and were added to the list of coded terms. The following is the master code list used by the interviewers.

Master Code List based on the research questions

Step I for Ethnograph.coding

Health History:	HLTHHX
Mental	MHHX
Physical	PHYHX
Substance Abuse History	SUBTHX
Substance Procurement Strategies	PROCUR
Relationships	RELATSHP
Family	FAM
<i>add a suffix from the following to FAM</i>	
<i>only if there is a major recurring theme involving a family member or significant other. M=</i>	
<i>Mother, F= Father, B= Brother, S = Sister, C = Child, SP = Spouse, SIG = Significant Other, MX =</i>	
<i>Mixed (i.e. step family or parents or any mixture of individuals constituting "family")</i>	
Board	BRD
Patients	PAT
Friends	FRND
Work Related	WRKREL
Event	EVENT
Recovery	RCOVRY
Strategies	RCOVRY S
Problems	RCOVRY P
Treatment	RX
Strategies	RXSG
Stipulations	RXST
Prescriptions	RXR X
Compliance Strategies	RXCSG
Self Concept	SLFCSPT
Work Choice	WRKCHC
Work Concept	WRKCSPT
Work Environment	WRKENV
Work History	WRKH X
Legal	LEGAL
religion	REL
Economic	ECON
Education	EDUC

Once the major codes were delineated, definitions were created to promote consistency in coding and to minimize problems in the coding processes. Those that were of particular concern are as follows.

Definitions:

Event:: any significant positive or negative occurrence.

Work Environment: the work setting, which includes place, people, attitudes described, atmosphere described.

Procurement: deliberate strategies used by licensees to obtain drugs either legally or illegally.

Work Choice: Decision to enter nursing.

After coding of the cases, the investigators entered the code, identified new themes or categories, added new codes if evident and initiated summary output of the data . The data were generated in three different ways, depending upon the questions to be answered: (a) as segments of text by displaying the actual text of each segment, (b) as frequency counts of the coded segments, and (c) as summary output that simply lists the line number coordinates of the different segments.. For example, the project allowed quantification of selected segments that related to family relations, e.g., spousal abuse, or family members' substance history. It also allowed descriptions of procurement methods. These processes eventually led to conclusions and recommendations relative to the programs, their effectiveness and needs.

FINDINGS

Findings are presented according to the taxonomy of research questions. Analysis is primarily summative with some frequency determinations of associations.

Characteristics of the Two Recovery Program Samples

The Board of Nursing administers two groups of nurses identified as substance abusers. Group 1 consisted of 252 nurses under Board Order for disciplinary action. Group 2 was composed of 224 nurses in an alternative, non-disciplinary substance abuse program (ANNA) at the time of completion of data analysis of the study. Thus a total of 476 nurses was involved in treatment for substance abuse and under the Board's jurisdiction at the time of data analysis. The 12 who volunteered from the Disciplinary group were designated as Group 3, and the 38 who volunteered from the non-disciplinary program (ANNA) were designated as Group 4. Three additional groups were identified as reference groups for the study. Group 5 consisted of all nurses in the Disciplinary group, who did not volunteer for the study, and Group 6 consisted of nurses in the ANNA group who also did not volunteer. The third reference group, designated as Group 7, consisted of 600 randomly selected nurses from the registry of active nurses who did not have a record of substance abuse problems noted in their files. The total number of nurses who were compared for demographic data from directory information was 1,076.

Demographic Characteristics

For Group 7, the random sample of 600 active nurses in Alabama, ages ranged from 20 to 77 with a mean of 41.95 years. Age ranges in the other groups in the study were more restricted. Notably, the age range in Group 3 was the most restricted with only a range of 14 years. This feature was reflected in Group 3 having the smallest standard deviation of all the other groups. An analysis of variance was computed on Groups 1, 2, and 7 to determine if there were differences in mean ages.

Table 1

Mean age, standard deviation and number in each group 1999

GROUP	MEAN	Range	SD	N
1 All Disciplinary	*39.06	23-63	7.51	252
2 All ANNA	*39.92	24-62	7.56	224
3 Study Disciplinary	41.75	34-48	4.94	12
4 Study ANNA	41.16	26-57	8.03	38
5 Non Study Disciplinary	38.92	23-63	8.01	240
6 Non Study ANNA	39.67	24-62	8.00	186
7 Random 600	*41.95	20-77	10.97	600

F (2,1073)= 9.223, p< .001

The mean ages in Groups 1 and 2 were statistically smaller than Group 7, but not different from each other. It was concluded from these data that volunteers in the study were about the same age as nonvolunteers in the recovery programs.

The national and state percent of females and males in nursing is estimated between 92-94% and 6-8% respectively (Hughes, Smith, & Howard, 1998; Lewis, Snodgrass, & Larkin, 1990). These figures were approximately the same in the random sample group of 600 taken from the population of licensed nurses in Alabama where 7% of the nurses were males and 93% were females. However, the percent of males in Groups 1 and 2 (all known substances abusers) was approximately 22%, more than twice as many as were expected. This over representation of males has been documented in other studies of addicted nurses (Hughes, et. al, 1998).

When the two volunteer samples were examined for gender representation, males comprised 9% of the total in Group 3 (Disciplinary) and nearly 18% in Group 4 (ANNA program). Groups 5 and 6 (nonvolunteers) had nearly the same proportion of males (17%-18%). Chi Square analysis for Groups 1,2, and 7 was significant at the .01 level ($\chi^2 = 31.438, df=4$)

Table 2.
Number and Percent of Males And Females in Each of Group.

Group	Female	Male	Total*
1. All Disciplinary	208 (83%)	42 (17%)	250
2 All ANNA	180 (81%)	42 (19%)	222
3 Study Disciplinary	11 (91%)	1 (9%)	12
4 Study ANNA	31 (82%)	7(18%)	38
5 NonStudy Disciplinary	197 (82%)	41 (18%)	240
6 Non Study ANNA	149 (83%)	35 (17%)	186
7 Random 600	552 (93%)	41 (7%)	600

8
17 cases of missing data among all groups.

Marital status data of participants were classified as either married, singled, divorced, or widowed. The data for marital status are displayed in Table 3 on the following page. Of significance is the rate of divorce among study participants as compared with the random sample of licensees.

Table 3.

Marital status for groups 1 through 7.

Group	Married	Single	Divorced	Widowed	Total*
1.All Disciplinary	138	39	53	8	247
2 All ANNA	132	29	52	6	223
3 Study Disciplinary	5	1	5	1	12
4 Study ANNA	20	3	12	3	38
5.NonStudy Disciplinary	133	38	48	7	235
6 Non Study ANNA	112	26	40	3	185
7 Random 600	393	62	92	13	570

23 missing cases for marital status

There was an ordered increase in per cent of licensees who were married of 56%, 61%, and 69% in Groups 1,2, and 7 respectively. Chi Square analysis was significant at the .01 level ($\chi^2 = 19.69$, $df=8$). The per cent of nurses who were divorced for Groups 1,2,3,4,5,6, and 7 was 22, 24, 45, 32, 21, 23, and 16 per cent respectively. The divorced rate in Group 3 was significantly different from the divorced rates in the other groups at the .01 level ($\chi^2 = 32.057^a$, $df = 16$).

Type license under consideration was categorized as either RN or LPN. Those with dual licenses were grouped with RN. Table 4 below displays the number of individuals for each license type and the per cent they represent within group membership.

Table 4

License type for each of the 7 groups.

Group	LPN	RN	Total
1.All Disciplinary	96 (38%)	156 (62%)	252
2 All ANNA	44 (20%)	180 (80%)	224
3 Study Disciplinary	3 (25%)	9 (75%)	12
4 Study ANNA	6 (16%)	32 (84%)	38
5.NonStudy Disciplinary	93 (39%)	147 (61%)	240
6 Non Study ANNA	38 (20%)	148 (80%)	186
7 Random 600	197 (33%)	403 (67%)	600

It was noted that LPNs were over-represented in Group 1 (substance abusers on probation/all disciplinary). The per cent of LPNs in Group 1 was 38% as compared to 20% in Group 2 and 33% in Group 7. The per cent of LPNs in the study population, Groups 3 and 5 was 25 % and 39% respectively and the rate in Groups 4 and 6 were 16 and 20 per cent respectively. For LPNs in Group 7, the Chi Square was significant, $\chi^2 (2, N = 1076) = 19.60, p < .05$. Registered nurses account for 41, 699 licensed nurses in the state. Of these 156 (62%) in Group 1 as compared to 189 (80%) in Group 2 and 403 (67%) in Group 7. The Chi Square was significant, $(\chi^2 = 32.057^a, df = 16), p < .001$.

The residences of nurses involved in the study were classified as either urban or rural. Urban areas were identified by zip code associated with the four cities with the greatest population in Alabama. The overall number of nurses claiming rural residence was 410 (38.1%) and overall urban was 666 (61.9%). Table 5 provides the breakdown by group.

There was a significant difference among Groups 1, 2, and 7 with respect to their residences. $\chi^2 (2, N = 1076) = 8.48, p < .05$. A greater percentage of nurses in Groups 1 and 2 lived in urban areas than nurses in Group 7.

Table 5.

Urban and rural residence for each of the 7 groups.

Group	Urban	Rural	Total
1.All Disciplinary	152 (61%)	100 (31%)	252
2 All ANNA	158 (70%)	66 (30%)	224
3 Study Disciplinary	7 (64%)	5 (36%)	12
4 Study ANNA	27 (69%)	11 (31%)	38
5.NonStudy Disciplinary	145 (60%)	95 (40%)	240
6 Non Study ANNA	131 (70%)	55 (30%)	186
7 Random 600	356 (59%)	244 (41%)	600

Table 6 provides a breakdown of ethnic distribution of all groups for comparative data. The composition of racial mix is geographically reflective. The majority of participants were either Caucasian or African American with few claiming memberships in the other classification. The number of African-Americans in Groups 3 and 4 combined was 6 of 50 (12%), while there were 67 of 420 (16%) African-Americans in Groups 5 and 6. The per cent of chemically dependent African-Americans was comparable to the random sample of licensees (16%).

Table 6.

Racial composition of Groups 1 through 7.

Group	AFA	Cau	Hisp	Native	Asia	NK	Total
1.All Disciplinary	47	164	0	0	0	36	247
2 All ANNA	26	171	0	1	0	25	223
3 Study Disciplinary	0	12	0	0	0	0	12
4 Study ANNA	6	32	0	0	0	0	38
5.NonStudy Disciplinary	47	153	0	0	0	36	236
6 Non Study ANNA	20	139	0	1	0	25	185
7 Random 600	93	399	1	1	4	72	570

Location of employment references the region of the state in which the study sample worked during the time of the study. Table 7 shows the frequencies of employment location when broken down by six geographical categories.

A total of 42 participants indicated that they were employed while eight claimed that they were unemployed. For the two groups taken together, 16 worked in rural areas of the state and 30 in urban areas. This compares favorably with the employment of the general nursing population's work location. Specifically, in Group 4, 19 (49%) classified themselves as urban and in Group 3, seven of 11 (63%) indicated that they worked in urban locations.

Table 7

Location of Employment for Groups 3 and 4.

Location	Frequency	Percent	Cumulative Per Cent
Unemployed	8	16.0	16.0
Rural north	2	4.0	20.0
Rural south	7	14.0	34.0
Rural central	7	14.0	48.0
Urban north	10	20.0	68.0
Urban south	4	8.0	76.0
Urban central	12	24.0	100.0
Total	50	100.0	

Physical Characteristics of the Study Group

Table 8 provides data relative to the physical characteristics of the participants in two samples. Interviewers were asked to rate participants on several dimensions of physical characteristics on a scale from 1 to 9 with a midrange designated between 4 and 6. For height a mean estimate of 5.14 was given indicating average height for the group. There was however, a range from 2 to 9 on this dimension. Weight likewise was rated in an average range for the groups with 20 of the 50 participants rated between 4 and 6 on the scale. It was noted that 18 were described as being overweight with two being classified as obese, 9 as very heavy, and 7 as heavy.

Health status based on observations and assessments during interviews indicated that 33 of the 50 participants were of average health. Four were described as healthy and 13 were assessed as in poor health. Numerous physical conditions were described qualitatively about the health status of the participants. These conditions will be addressed more fully under the ethnographic analysis.

Interviewers assessed the general appearance of participants over three interviews. Characteristics describing general appearance related to the overall impression the interviewers had of the interviewees. The range was from neat (1) to unkempt (9). For the 50 participants, 36 were rated average in appearance, 19 were described as neat and five as unkempt. Qualitative comments by raters spoke to weight gains of up to 25 pounds during the interviews. By contrast appearance of one changed from unkempt to an average of neat during the interviews.

Table 8

Mean and SD for Groups 3 and 4 for Height, Weight, Healthy, and General Appearance.

<u>Group</u>	Height		Weight		Health Status		General Appearance	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Disciplinary	4.92	1.73	5.75	2.38	5.75	1.22	4.75	2.49
Nondisciplinary	5.21	1.66	5.37	2.10	5.45	1.54	3.97	1.53

When Groups 3 and 4 were compared, no significant difference was found for height ($F=1.280$, $df=1,48$, $p=.299$), weight ($F=.283$, $df=1,48$, $p=.597$), health status ($F=.387$, $df=1,48$, $p=.537$), and general appearance ($F=1.70$, $df=1,48$, $p=.199$).

In addition to the physical characteristics described above, mannerisms were also rated using the same scale. Mannerisms, indicative of body language, ranged from excited (1) to subdued (9) with more even activity between four and six. The mean for the Disciplinary Group was 4.82 and a standard deviation of 1.78. The mean for the Nondisciplinary Group was slightly lower at 4.61 with a standard deviation of 1.75 ($F=.287$, $df=1,48$, $p=.595$).

Behavioral Characteristics (communication patterns, receptivity to intervention, stipulations, appearance, compliance with stipulations)

Receptivity was rated as participants' behavior exhibited in responding to questions about their recovery programs. Interviewers rated six bi-polar descriptors of participants' behavior on a 1 (negative) to 9 (positive) scale. The descriptors were cold-hot, angry-friendly, hostile-cooperative, withdrawn-outgoing, closed-opened, and resistive-forthcoming. Ratings were summed to create a score assessing each participant's degree of receptivity. Scores ranged from 19 to 52 with a mean score of 35.98 for the combined groups 3 and 4. Participants were generally rated as being receptive in the interviewers. Less than 20% of the participants were rated as below the average band expected from the group. Mean scores for Groups 3 and 4 did not differ as shown in Table 9.

Table 9.

Means, Standard Deviation and Number for Groups 3 and 4 on Receptivity

Group	N	Mean	Standard Deviation	Std. Error Mean
Disciplinary	12	36.25	9.72	2.81
Non Disciplinary	38	35.89	8.25	1.34

$t = .125, df=48, p = .899$

Interviewers were also requested to comment qualitatively on their impressions of the interviewers' degree of receptivity of the treatment programs and the interview process. One interviewer described a participant as "guarded during the interview. Hugged me after the interview-said that she was that kind of person. She was the coldest, most aloof of the participants I saw." This participant scored 24 on the Receptivity Scale, one of the lowest scores in the group, and unknown to the interviewer, the participant's license was revoked.

Additionally, qualitative assessments by interviewers provided insight into the ratings. An example of a positive comment was "pleasant, assertive, and cooperative." "This woman seemed to be the most put together of all the individuals I interviewed." Several negative comments provided information on the participants. One interviewer stated that "interviewing this guy was like pulling teeth." When his score on the Receptive Scale was computed he obtained a 19, the lowest in the group. Several comments addressed anger as participants progressed through the interviews. One interviewer remarked that the interviewee seemed angrier at third interview than at first interview. Another said, however, the interviewee began very angry, hostile and resistive, but much more forthcoming during the third interview. Another was rated as friendly on the first, but became less friendly in the last interview. Yet, another comment describes the interviewee as being more able to express anger at the third interview than she was during the first.

Socio-cultural Characteristics

Socio-cultural characteristics were restricted to levels of nursing education and certification, religion, sexual orientation, living arrangements, and drugs use among

family, friends and associates. Education in this study references only the preparation for nursing practice. Two primary divisions were designated for educational preparation; one for LPNs and the other for RNs.

Education

LPNs earn a certificate or diploma in technical schools and RNs earn diplomas or degrees in post secondary educational institutions or institutions of higher education. Registered nurse educational programs are connected with a variety of private and public educational institutions. Diploma programs (DIP) are generally connected with private hospitals while associate degree programs (ADN) are associated with community and four year colleges or universities. Baccalaureate degree programs (BSN) are conducted in institutions of higher education. Masters (MSN), CRNP, CRNA and CNM are also reflected in RN education programs. Table 10 displays a breakdown by educational preparation for LPNs and RNs for each group of participants.

Nine of the 50 participants' education was identified as certificates for license as practical nurses. This represented about 18% of the nurses in both groups. Specifically, 25% of the nurses in Group 3 were LPNs while 16% of nurses in Group 4 were LPNs.

Table 10

Frequencies of Educational Preparation: Groups 3 & 4

Group	LPN EDUCATION	RN EDUCATION						
	LPN Certificate	ADN	DIP	BSN	MS	CRNP	CRNA	CNM
3	3	5	1	3	1	1	0	0
4	6	22	2	7	1	1	1	1

When the percentage of all nurses who had substance abuse problems (Groups 1 and 2) were calculated, it was found that 30% were LPNs. This percentage is representative of the LPN population of nurses licensed in Alabama. However, there was a difference in LPN composition in the Disciplinary (38%) and Nondisciplinary groups (21%). In this study sample 22 of 38 (58%) registered nurses were AD graduates as compared to 41% in the general population of nurses in Alabama.

Religion

From a socio-cultural context religion encompasses both structured and unstructured situations in which an individual's spiritual or emotional attitudes express the recognition of a superhuman power or powers. Using the Ethnograph program, 382 references to religion were identified over all interviews. Forty-seven of the 50 participants mentioned religion in some form at least one time. The range of references was from 1 to 23 coded segments. Frequency of religious experiences mentioned did not

necessarily correlate with the extensiveness of expression. For instance one individual described religious experiences three times over 256 lines of dialogue. And another person made 23 references over 179 lines. Typically religious experiences were stated within five to six lines.

Marital Status

Marital status, as previously described, showed that the majority (N=25) lived within heterosexual marital unions. Seventeen of the 50 participants were divorced although two revealed involvement with a significant other and four were widowed. Two female nurses acknowledge a homosexual orientation. Four were single, never married females.

Family History and Substance Abuse

Family history of substance abuse was assessed during the three interviews. Here, family relationships were confined to abuse in the immediate family including spouse or significant other, father, mother, sisters, brothers, aunts, uncles, and grandparents. Table 11 (Appendix 1-A) provides a breakdown of family members who stated, during interview, as having abused drugs and/or alcohol.

Out of the 50 cases 7 gave no mention of family substance abuse history. Eleven identified at least one family member or significant other as having abused alcohol or drugs and 32 identified at least two and up to as many as 7 family members/significant other as abusing drugs or alcohol. Twenty-two participants identified grandparents as having a history of substance abuse, primarily alcohol. From these cases involved 18 grandfathers and seven involved grandmothers. In three cases both grandmother and grandfather were jointly abusers. Aunts were mentioned in five cases and uncles in 12.

Fathers were mentioned most frequently in 31 out of 50 cases (62%) while mothers were mentioned in 15 cases (30%). There were 13 cases with a history of both mothers and fathers abusing substances. Two mothers were independent of their spouses in having substance abuse problems while seven cases mentioned stepmothers as having substance abuse problems. Four of the seven of these cases were linked to the father as abusers. There was only one mentioned as an abusing stepfather. Eighteen participants identified brothers as having a history of substance abuse and 16 identified sisters as having a history of substance abuse. Only one significant other was identified in this study as an abuser while 18 spouses were identified (36%) as having a history of substance abuse. Some of these cases were active in their abuse. As shown in Table 11 multiple family members were involved with drugs while there were only three cases in which one family member was identified. In nine cases brothers who abuse substances also had fathers who abused. This is contrasted with seven sisters whose fathers also were abusers. These data may help explain the participants' belief in the heredity linkage to their involvement in substances.

Psychiatric History

Mental health history was assessed during the interviews with participants. For Group 3, 9 (75%) of 12 participants stated that they had availed themselves of mental health counseling and/or other therapeutic regimes contrasted with 24 (63%) of 38 non-disciplinary participants. Table 12 (Appendix 2-A) provides a breakdown by group of

the problems that led to need for mental health interventions as well as the type treatment interventions.

Nearly half (23) of the participants reported a history of depression with treatment. Of these seven were in the disciplinary program and 16 were in the ANNA program. Of those reporting depression nine stated that they were planning and/or attempted suicide and an additional five who did not report depression revealed receiving treatment for attempting suicide. Other mental health problems ranged from anxiety to compulsive eating disorders, sexual abuse, rape, "bad marriage", and post traumatic stress syndrome. In two cases, participants coupled physical and sexual abuse with mental health history. One case included needing mental health treatment when her husband sexually abused their daughter.

The intervention that the participants received for mental health problems was varied. Six of the participants specifically mentioned being treated by a psychiatrist, one of these combined the intervention by a psychiatrist with treatment in a psychiatric hospital. Five others admitted to being treated inpatient with two being committed for treatment. Other types of providers included therapists, counselors, psychologists, and physicians. The majority was treated in outpatient settings with two being treated in general medical or intensive treatment. Antidepressants were the primary drug used in treatment although some of the participants were diagnosis with anxiety and forms of barbitol were prescribed in these situations. Only five indicated a family member was treated with mental health interventions.

Drug/alcohol Use History

Questions 1.6, 1.7, and 1.8 were concerned with drug and alcohol histories of participants in Groups 3 and 4. Drug history, the type substances used, length of treatment and the number of relapses were considered defining issues for these questions. No attempt was made to quantify the actual frequency of use, rather a qualitative picture typical of progressive and intensive drug use was drawn from the interviews. Frequency of use ranged from admitted one time use of a prescription drug to an undefined continuous usage. Table 13 (Appendix 3-A) provides an individual breakdown of the drug history of both groups combined. There appeared to be no differences between Groups 3 and 4 regarding initiation into drugs and alcohol, types of drugs used, and duration.

Drug use for more than a third of the participants was initiated during adolescence. The range of duration of drug use was from one to more than 20 years. While some reported initiation into drug and alcohol was the result of adolescent experimentation, many stated that they were heavy users of substances during their teenage years. The most commonly used substances during adolescence were alcohol and marijuana, although a few stated that they used narcotics for migraine and headache pain. Very few reported that they indulged in "hard drugs" such as cocaine, crack, or heroin during their formative years. Comments during the interviews revealed that some participants reported a hiatus of substance use for periods in their lives such as high school transition to college or proceeding or immediately after childbirth.

Substances used by participants were catalogued as prescription, street, alcohol, or mixed (alcohol with other drugs). As shown in Table 14 in Group 3, six

(54.5%) reported prescription drug use, and five (45.5%) mixed. Participants in Group 4 eight reported (20.5%) alcohol use, 9 (23.1%) prescription drugs use, 21 (53.8%) mixed substances use and one (2.6%) involved solely with street drugs.

Table 14.

Number and Percent of Substance by Group Use.

Group	Alcohol	Prescription	Mixed	Street	Total
3 Disciplinary	0 (0%)	6 (50%)	6 (50%)	0 (0%)	12 (100%)
4 ANNA	8(21%)	9 (24%)	20 (53%)	1 (2%)	38 (100%)
Total	8(16%)	15 (30%)	26 (52%)	1 (2%)	50 (100%)

The most commonly mentioned street drugs used were marijuana and cocaine. Few reported using crack, crank, heroin, or LSD. Thirty-eight prescription drugs were identified by their manufacturers' names as commonly used by the participants. Those most frequently mentioned were in the analgesic family including Demerol, Dilaudid, Lortab, Darvocet, Morphine, and Lorcet. Next most common were those in the sedative family such as Phenobarbital, Tranxene, and Fiorinal. Also mentioned were Xanax, Ativan, and antidepressants. Additionally diet pills, non-specific "wasted drugs" and drugs associated with "ventilation patients." Nurses that admitted to taking the wasted drugs were not discriminating in their drugs of choice. Availability and accessibility were more critical in the drug use.

Procurement.

The overwhelming majority of substance abuses eschewed street drugs and procured their drugs by diversion from the workplace or from illegal acquisition of prescription drugs. A pattern emerged from the sample regarding procurement of drugs. Initial procurement during adolescence was from friends, pilfering money or drugs from family medications. This may or may not have been associated with illegal use of alcohol. Some of this drug-taking behavior may be accountable to adolescent experimentation. In adulthood, the initial use usually began following some emotional crises, physical pain, or associations with other drug users. Several of the participants describe their procurement as calculating. They sought work environments known to have a high availability and disbursement of controlled substances such as emergency rooms, intensive care units, post surgical units, obstetrics and home health agencies that deal with pain management. Further, they were aware of agencies or departments known to have more relaxed record keeping and accountability as well as those facilities rumored to employ drug users.

In the work place several nurses engaged in particular behaviors to obtain drugs and to ensure protection from discovery. Use of code words served as keys to drug sources particularly among users. In several cases women participants would comment that they had headaches or cramps and work peers would shared where and

how to obtain drugs for relief of these "illness" and would suggest that the "afflicted" nurse take a few minutes to get some relief. In some measure peers, who may not have been abusers themselves, were complicit in drug use. A significant number of advanced users took advantage of narcotics to be wasted. Almost all shared that their injectable drugs were procured through declaring that drugs were wasted or that they gave a partial dose of a drug to the patient and the remainder to themselves. In some less regulated units the participants admitted to wasting saline as a cover up or pilfering full vials of drugs in hurried times saying that it was administered to the patient. Further oral medications were obtained by searching for patients with large supplies of dose packs and stealing small quantities. Some of the participants scanned the census and diagnosis as well as doctors orders for those patients receiving controlled substances and volunteered to take care of them. By doing this it put them in close proximity of drugs.

Associated with these behaviors was the tendency to seek out environments where physicians readily prescribe controlled substances. Several participants admitted to be manipulative with doctors in order to obtain prescription drugs. This behavior would include faking pain and other illnesses, enticing them into personal relationships, and striking up friendships. By doing this they were able to not only obtain legal prescriptions for their drugs, but also to steal prescription pads and DEA codes. This information enabled them not only to write prescriptions to several different drug stores and but also to call in prescription. A few of the participants actually sought employ in doctors' offices to enhance their abilities to obtain prescription drugs. This allowed them to access prescription pads and samples of controlled substances. In some cases, they even made contacts with drug salespersons as well as having quasi-legal channel to pharmacists. Most of the participants who forged prescriptions did so at several pharmacies and used multiple consumers' names. Some struck up friendships with pharmacists to enhance their drug supply without being discovered. A few mentioned that they were aware that the pharmacist "was suspicious" of their activities. In one case a romantic relationship with a pharmacist was developed to secure drugs for the participant.

A favorite tactic to ensure a steady supply of drugs was to use several physicians as sources for prescriptions. Usually this was accompanied by selecting physicians with little opportunity to share in the knowledge of their medical regiments. Additionally, much energy went into seeking out physicians who prescribed painkillers freely.

A common feature of participants was being vigilant in pursuit of drugs. This would include looking into medicine cabinets of friends and family, checking medications of family members, and the aforementioned surveillance of patients on pain medications. Often they would use husbands', mothers', and fathers' children's and friends' prescriptions to obtain drugs. In summary, these participants created a reticulum for drug procurement that circumscribed their lives.

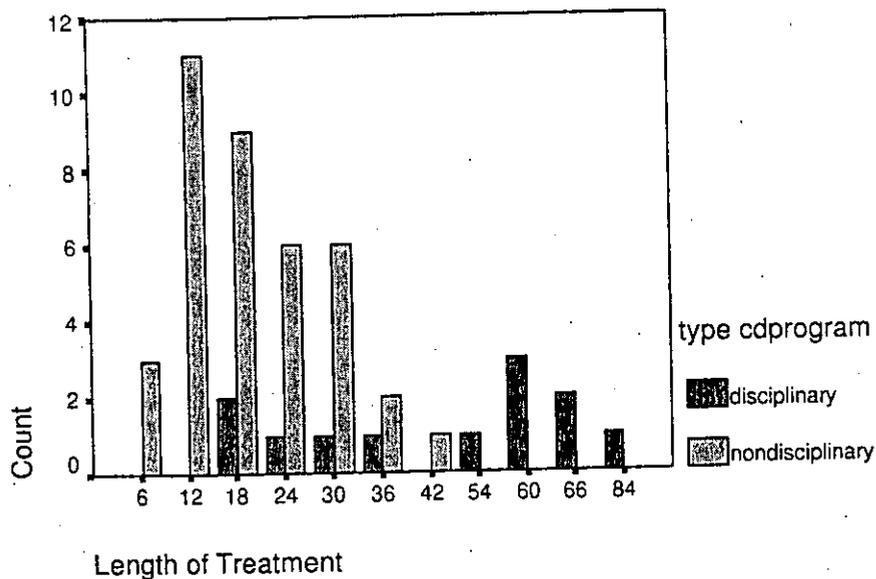
Length of Treatment

Length of treatment was defined as the number of months participants reported at the time of the first interview. The time in recovery was however defined as the time a significant event occurred in the life of a nurse that initiated contact with the Board of Nursing. Although a few of the participants may have had previous treatment, they

were not considered to be in recovery according to Board standards. Length of treatment was measured in months. The range of treatment for Group 3 was from 15 to 84 months with a mean of 46 months. On the other hand the length of treatment for Group 4 ranged from 2 through 39 months with a mean of 17.37 months. Group 3 had a broader range of treatment spanning 58 months. Those who were at the upper end of the range may have relapsed or were not working as a nurse. The difference between

Figure 1. Length of Rx in Months

Groups 3 and 4



the two means was significant ($F = 42.626$, $df = 1, 48$, $p < .001$). One of the stipulations in a recovery program is that a nurse must be working in nursing during recovery in order to meet the stipulations for recovery. Work time in other occupations is not considered to meet the time requirement for probation. Figure 1 shows the length of treatment by six-month intervals for participants in both groups.

The diverse range of program participants shows in part the point of entry into the two different programs. Ordinarily one may anticipate an average treatment plan of 36 months. When the treatment plan exceeds this time frame, it often reflects a relapse. Both study groups had relapses among participants. Additionally 17 of the 50 participants indicated during the interviews that they had at least one relapse. For Group 3 four participants say they had no relapses, while seven of eleven (63.7%) claimed at least one relapse with two claiming two relapses. Group 4 had nine of 39 (23%) who had at least one relapse with one relapsing two times and another five times.

Work History

All of the participants reported having multiple jobs throughout their nursing careers. The majority held staff positions at the time of the study although some were unemployed and seeking jobs. This situation in some part was precipitated by their being on probation and employers' lack of receptiveness to working with people with a

history of addiction. Also, it was related to stipulations requiring no more than 40 hours a week or an eight-hour day, and certain restrictions on shift or type employment (e.g. home health care).

Work Choice From Historical Perspective

From an historical perspective several patterns were identified regarding the participants choice of nursing for a career. Several stated they wanted to be nurse for as long as they could remember and an occasional comment was made that a family member such as an aunt had influenced their decision. Two stated they were influenced as adults to enter nursing after kind nurses during a hospitalization or health crisis had cared for them. Two declared accidental "getting hooked" following secretarial jobs in a health related environment. One of these said she "had never wanted to be a nurse but got hooked anyway." Three entered nursing through an inductive process e.g. couldn't be a businessperson, "had to do something to support my baby," "couldn't get a job as an aircraft mechanic so, became a paramedic and then a nurse." Within these decisions a number of choices occurred. There was a tendency to drift toward high tech, high stress areas such as emergency or intensive care nursing initially. Then as addiction became eminent job shifting occurred to facilitate procurement or to get a job after being fired.

At the time of the study there was a tendency to shift focus from the acute intense areas of nursing for most of the participants to more routine care areas. Some were not happy in this situation because it removed them from the more exciting work environment. Others said they have learned to love long term care and adjusted to the slower pace these areas provided. Still a few were vacillating about changing professions completely.

Work Schedule

Stipulations and treatments drove the work schedules of the participants. Previously, however, work schedules were driven by the degree to which procurement and use of substances were facilitated. Nearly 75% revealed the particulars of their work schedules at the time they came in contact with the Board. All worked atypical schedules. Fifteen identified night shifts without specifying hours in the hours involved, six stated they work from 7:00 o'clock in the evening (p.m.) until seven o'clock in the morning (a.m.), five worked 16 hours shifts usually involving nights, and three indicated 3:00 p.m. until 11:00 p.m. Six described working extra odd hours such as noon until midnight and odd schedules such as multiple shifts in one week's time and several worked extra hours. Eight of the participants working 7 days on and 7 days off most often 12 hour days. These too were more often nights. Several of the participants linked the hours of work with procurement opportunities. For instance, one person said, "I was working a night shift because it was even more available...there was less people to watch you". Another stated, "Because you work with different doctors on different shifts on different days" drugs were more available. Still another said, "Because when you work night shift a lot of times by yourself you forget to waste the medication and find it in your pocket when you get home, " or, "I would go in during the middle of the week of the week off when working seven on and seven off...just to get the drug."

Additionally the workers on the 3-11 p.m. shift stated that after work they would go out and drink or used drugs. The shift ending at 11:00 p.m. may have facilitated their going out to public bars.

In summarizing the work history of participants their work identity was always as a nurse even those who were vacillating between staying or leaving the profession. Their decisions to seek treatments for their addictions were predicated on keeping their licenses. Their concerns at the time of the study often centered on work limitations established in the stipulations.

Perceptions Of Chemical Dependency

Perceptions of the study participants regarding chemical dependency were examined qualitatively. Throughout the interviews a number of ideas emerged but there was no indication of the licensees' changing perceptions. Their ideas often emerged as insights to be added to their current perceptions.

Themes Regarding Perceptions of Chemical Dependency

Each interviewee was asked to describe or share their perceptions of chemical Dependency. The interviewers were especially keyed to listen for anticipated themes Based primarily on past research or literature (disease that is treatable, curable, manageable; is not a disease or a problem that exists for self, weakness in moral character, God's will, punishment for sins; other).

Thirty-seven of the participants provided information in the interviews that were categorized into six themes that described their perceptions of chemical dependency: (1) moral issue, (2) heredity, (3) disease, (4) personality type, (5) chemical imbalance and (6) emotional deficits. Table 15, found in Appendix 4-A, provides examples of summaries of their perceptions.

Moral issues centered on a concept of sin and character defect. Genetics as a cause, in these situations, was generally averted or denied. Heredity received considerable support as a perception. Family members were identified to validate this assertion (see Table 12). In relation to the disease concept, one individual stated that she was actually pressured to "think that way." She had entered treatment with an idea that it was a moral sin. She did not appear to truly accept the disease concept but felt bombarded by peers in treatment groups to change her views. Disease was often coupled with heredity. In some situations disease was clarified as being a "disease of the mind, not a physical disease." Another's perception was described as "a physical allergy." Only one participant who said chemical dependency is a disease, perceived of it as curable. All others stated that it is an incurable disease.

Personality was never described in positive terms when addressing the subject of perceptions about chemical dependency. Seven identified themselves as "addictive personalities" with assertions of obsessive, compulsive, and perfectionist ideation. Drugs and alcohol were not declared as chemical imbalancing agents. Rather, they were described as "something" causing an imbalance so that alcohol and or drugs were used as remedies. Most commonly, conditions such as "adrenaline seeking", depression and introversion were cited as imbalances.

Emotional deficits were presented as lack of spirituality, low self esteem, compulsive and obsessive behavior. Often the themes were amalgamated to produce a multiple explanation of the cause of chemical dependency. Prominent among these was a lack of coping ability.

Life Events and the Development of Chemical Dependence:

Forty-two participants spoke of life events influencing the development of chemical dependency. Some events were acute, dramatic, and had an immediate influence on chemical dependency while others were more chronic resulting in a progressive route to dependency. Nurses reported physical, mental, psychological and sexual abuse in their lives. Some of these incidences occurred when they were children, some occurred when they were adults and in some cases abuse continued throughout their lives, but with different perpetrators. While it is difficult to posit a causative role of abuse in addiction, there appeared to be an established relationship between childhood abuse and later substance abuse. This relationship is especially powerful when child sexual abuse is a part of individual's experience. As was previously mentioned the participants reported 8 cases of child sexual abuse. Since this variable was not solicited directly from the participants rather it emerged from the interviews and since child sexual abuse is generally recognized as being underreported, it is possible that the number of nurses who experienced child sexual abuse was greater than the 8 (20%) reported. All cases of child sexual abuse reported in this study were by female nurses. The impact of this event on substance abuse in adulthood and involvement with mental, physical, and substance abuse by their partners is supported by the data in this study.

Of interest was the relationship of participants' substance abuse to spouses' or significant others' substance abuse. In thirty cases (60%) participants' spouses or significant others also abused substances. In some cases, where there were multiple marriages, participants' remarried spouses who abused substances. This was also true in lesbian relationships where physical, mental and substance abuse by partners was reported. Nurses who volunteered that they were sexually abused as children reported that they often married spouses who abused them and who were substance abusers. In these situations there were multiple types of abuses including sexual, physical, and mental.

Female nurses were often involved with spouses or significant others as vehicles for procuring drugs. They frequently developed relationships with pharmacists or doctors who were in positions to provide them with drugs. On the other hand, all male nurses in this study except one were in relationships that were helpful and supported. It should be noted that the number of male nurses who volunteered for the study was very small and any inferences drawn from this data must be done with caution. A number of female nurses reported that their spouses or significant others were in recovery or met them in rehabilitation programs. Female nurses in this study appeared to have made poor choices in the personal relationships. Their involvement with men who abused them and in some cases their apparent lack of ability to learn from bad relationships may have propelled them into serial abusive and sometimes-violent relationships. Male nurses reported no case of this phenomenon. Male nurses' spouses were supportive in the sense that they were employed in professions and did not abuse substances (with the exception of the one case previously reported). By marrying nonusers it may have facilitated the façade of normalcy in the marital relationship and

it may have contributed to their addiction by providing a stable base for the abuser. No attempt was made in this study to explore further the nature of this relationship.

Physical abuse was the most often reported form of abuse. Incidences of beatings included striking the female nurse during her pregnancy and beatings combined with death threats. In one case a nurse had to flee the state because her husband threatened to kill her and burn down their house. There were 20 cases of physical abuse reported by the participants. When the eight male nurses were extracted from the calculation nearly 50% of the female nurses report incidences of physical abuse. Physical abuse was almost always combined with sexual or mental abuse creating a complex of multiple abuse experienced by the nurses. The role that substance abuse plays in spousal abuse and domestic violence is well-documented and since there was a large number of spouses who were also substances abusers, a possible volatile mix was present in the life of participants in this study. Table 16 (Appendix 5-A) provides qualitative descriptions of the events, which may have influenced their chemical dependency.

Significant life events influencing the development of chemical dependency included physical, mental, and sexual abuse. Nearly 36 % (15) reported beings abused either as children or as adults in marriages or relationships. Child sexual abuse by family members including mothers, fathers, uncles, stepbrothers, and cousins, were stated in 8 (16%) of the cases. One case of sexual abuse as an adult was divulged. Ten of the 15 indicated physical abuse, eight mentioned mental abuse by spouses or a significant other as adults, and one identified herself as a lesbian who was involved in a battering situation.

Environmental influences, peer pressures, professional work environment and social associations, and cultural context, was cited by 15 (30%) of the nurses. Professional work environment included doctors who proscribed drugs easily, and work associates whom "partied" together after work hours. Family social environment was also influential including exposure to substance abuse during childhood and later marital or live-in partners who were abusers. In one example a male nurse reported that his wife was a drug addict and he saw his choice as either joining her or getting a divorce. Another mentioned parents encouraging her to drink when she was very young.

An example of an immediate influencing precipitant was a case involving the death of a child with SIDS coupled with desertion of the husband. Another example involved two cases in which husbands committed suicide.

Thirteen (26%) cases reported that medication for pain control, such as back pain, molar pregnancy, and various surgeries, often lead to substance abuse. In addition pain medication was taken to control migraines in 10 cases. The nurses cited long histories of migraine headaches. Often respondents stated that the medications not only relieved the headaches but also created a sense of well being and energy in the persons. In some cases medication for both physical pain and migraine headaches were cited.

In some cases individuals took drugs to be energized to compensate for the overload they were experiencing. The sense of being overwhelmed by the multiple roles some nurses engaged in was reported by five nurses. Understandably, female

nurses claimed their roles as mothers, nurses, and wives, and in some cases caretakers for elderly parents, created a large amount of stress which was ameliorated by their abuse. Diet pills such as amphetamines were often used for this purpose. Unspecified medications were taken to fit or to fill a void or to relieve self loathing.

Event Precipitating Intervention by a Regulatory Agency

Each participant's story included descriptions of their relations with the Board of Nursing. The precipitating events were diversified as shown in Table 17 (Appendix 6-A).

Nearly every case (49 out of 50 cases) related the event that placed them in contact with the Board of Nursing. Seven were actually contacted by the Board after having been reported by another entity such as the courts, arrests, or treatment programs. Twenty-five were reported by someone in the employing agency usually the Director of Nursing or the supervisor. Nine were detected on drug screens. Of these, six were mandated by employers, six had records of arrest with DUIs, cocaine possession, and felony prescription fraud. Nineteen self-reported and eight were reported by other individuals most often in the health related profession (physicians, colleagues, attorneys, counselors, and pharmacists. Several stated that they were given the option of self reporting or being reported by the employer. Study participants who self-reported were accepted into the ANNA program.

Perceptions of Board of Nursing Recovery Programs

Table 18 (Appendix 7-A) provides insight into the study sample's perceptions of their recovery program. Six of the disciplinary group provided comments regarding this question, as did 21 of those in the non-disciplinary program. Two thirds of the disciplinary program were positive about the influence it had on their lives. Reasons appear on the surface to be simple: "it was a way to keep my license", yet three of six saw it as a way of 'getting their lives back or building new lives." One perceived the program as punishment for his/her behavior.

Of those in the non-disciplinary program, two indicated that the program was perceived as punishment, one of these was resentful and although she had met the requirements of the program to this point she stated she would never recommend it to anyone. Others saw the restrictions as too stringent, while others were positive stated that the program taught them about themselves, changed their lives, gave them a second chance, and provide structure to keep watch over them. One person as with those in the disciplinary group stated that she would just "play the game" to save her license". Another saw the ANNA program as focusing too much on loss of license instead of the person.

Stipulations Perceived of as Most Helpful and Least Helpful

Participants differed on their perceptions of the stipulations that were most and least helpful, as shown Table 19 (Appendix 8-A). For example the nurse support group was seen as essential in treatment because it gave nurses an arena to be cathartic with like-minded professionals. This was contrasted with some nurses' impressions that in other groups, such as NA, they were "thrown in" with crack heads and street people. On the other hand, some nurses felt the nurse support group deteriorated into gripe

sessions and added little to their treatment. Additionally, there was a feeling that information shared in the support group would not be confidential and this could jeopardize their treatment program.

Drugs screens were seen as a necessary component in treatment. Many thought that without this device successful treatment was unlikely. Only one person indicated that screens were not helpful because it made her feel like a criminal. The random process of selecting when drug screens would be given to nurses also got mixed reviews. Some claimed that it kept them in line while others thought it imposed severe restriction in their lives. While drug screens were endorsed frequently as being helpful the cost associated with the process was a drawback. Five mentioned that the expense caused a financial hardship to them.

The structure that the stipulations imposed on the participants was viewed as most helpful. Addicted nurses noted that it was essential to have a well-defined set of rules and regulations associated with their treatment. As with other stipulations there were nurses whose feeling were at variance with this view. Some thought that the structure was too severe and did not allow for individual differences. Additionally, restrictions, such as the key restriction, should have a procedure that would ease the restriction over time. It was felt that there should be a general easing of all the restrictions based on the length of time people were in treatment. Added to this was the concern that being on their own after all restrictions were lifted was frightening. Concerns were expressed that some mechanism should be in place to ease the transition from Board control to program completion.

There was some concern that the restrictions imposed on them prevented them from being hired by employers. It was their impressions that organizations were not willing to go through the hassles of dealing with recovery nurses and it would put the organization at risk to hire a nurse in treatment.

A few cited concerns centering on safety and scheduling of meetings. Issues for female nurses were that some groups met in locations that were deemed as not be safe and that these meetings took place at night. Often meeting times conflicted with family responsibilities placing the nurse in a position of having to go to the meeting or neglecting her family. Travel to meeting also impinged of family obligations. One person stated that 36 miles one way to her meetings.

Factors Influencing Selection Of Treatment Programs

In choosing an initial treatment program, 25 participants indicated either the type program entered, the reason chosen, or both. The unique finding here had less to do with quality of treatment than economics or felt obligations to family. Insurance was the driving force for the type of program chosen. Participant chose inpatient or outpatient treatment usual based on family responsibility and insurance benefits. In general availability of treatment facilities, insurance allowances and family considerations limited treatment choices. Individuals influencing treatment choices were employers, physicians, counselors, friends, and to some extent family. In some cases self-referrals was the main agent of choice.

Facilitators of Compliance and Non Compliance

Analysis revealed 477 substantive items to be helpful or not helpful. These items were consistent with factors believed to be harmful, ineffective or supportive to recovery. The findings from these two research questions are presented simultaneously with findings relative to question under the following section.

Effective Treatment And Recovery

Descriptions Of "Good" Recovery Programs

In describing a good recovery program, some of the participants were very clear with no ambiguity, others identified desirable components then qualified their statements with contrasting impression. Still others disagreed with the value of some of participants' ideas of a good program. For instance, some felt many meetings were required while thought that there were too many meetings. A major concern was expressed several times regarding group mix of some of the treatment programs. Participants were distressed about the group composition, which often include criminals, heavy "crackheads, and "street people". Apparently the differences in language, cultural experiences, gender, levels of indigence, and social orientation created an element of fear for safety particularly among the female participants. Males and females stated they were not like "them".

Five specific modalities were stated to be essential by most of the respondents. Inpatient and outpatient treatment substance abuse programs were mentioned jointly or independently. One individual stated that "outpatient treatment is a joke", another stated that it was the best for them. Inpatient treatment received mixed reviews but the majority gave positive assessments of its value. One participant indicated the need for at least six months of inpatient program. The third program modality was the nurse support group. Several of the participants indicated that the nurse support group was essential to their recovery, some however, did not perceive them as part of good recovery program. Reasons for this included poor leadership, "gripe sessions", and lack of confidentiality. Some stated that anything shared got back to the Board.

The 12-step program was identified several times as an example of a good recovery program. Qualifying that several times was the essentiality of a good sponsor. The next and final modality in a good recovery was simply a broad general called structure. Structure included having a strict program, frequency of urine testing, and close monitoring of stipulation compliance.

In any and all programs a number of components were identified as critical to recovery programs. Although not exclusive, the following list capsules the comments :

- Strong spirituality emphasis
- Good counselors who are in recovery
- Good sponsor
- Excellent aftercare program including anything from a halfway house to outpatient continuing care
- A program that supports total health including diet and exercise.
- Family counseling

A program that gives attention to gender issues for men and women. One male stated that there is a need to treat the whole person and not just the addict.

Additionally, one component was identified as requiring special attention. That related to women's issues in recovery. Factors needing consideration encompassed the family, economics, safety, domestic violence, and women's sexual concerns such as rape, incest, sexual abuse and gynecological issues.

Finally, relations with the Board were identified as a significant component in a recovery program for nurses. Several of the participants identified a positive relationship with the Board, but most including these, identified areas of concern. One person claimed that the Board is a black hole, a secret entity that doesn't respond to letters, calls, or individual concerns. Others see the need for the Board structure but stated the need to lessen restrictions in a progressive as the licensee moves toward program completion. Several mentioned the need for the Board to individualize the recovery program to meet individual needs to be less punitive and more facilitative. Publishing the names of individuals who have been disciplined by the Board in its newsletter was considered to be a problem in recovery particularly because it effected employment opportunities. Table 20 (Appendix 9-A) provides comments from the participants describing a "good" recovery program.

Descriptions of Effective Treatment

Participants in this study described treatment mostly in structural terms. These were concrete components of total recovery programs that stood out in their perceptions. Twenty-four of the 50 provided statements about the meaning of effective treatment. Terms such as continuing care, 12 step program, different types of therapies, individual counseling, inpatient care, and good after care were used by participants to describe an effective treatment. Regarding inpatient care, some individuals specified time frames such as six months and six weeks - "long enough to get over the game-playing" that was so much of the addict's personality. Specific components of inpatient programs that were desired included individual counseling, balance of recovery and non-recovering staff, or one-on-counselors to get issues out. Participants also stated that there is a need for counseling during inpatient and outpatient treatment settings. They amplified this statement by saying that consideration should be given to the following: individual counseling, domestic violence, recovering counselors, substance abuse specialist, availability of family and marriage counseling. Treatment programs should include good support from family, friends and employers. Comments from individual cases that described components of effective treatment including strategies for compliance and prescriptions may be found in Table 21, Appendix 10-A.

Interviewees described a qualitative difference in the transition from treatment to recovery. Treatment seemed to provide a framework. One participant stated "...treatment showed me what I could do. They kinda of forced fed me, you know, made me do what they said. And then recovery is doing on it on my own". Another individual said, "I think treatment is ---What I felt was total lack of control over my life. And recovery is ...We get that control back and learn to live life sober without drugs or alcohol." Several others while not defining the difference between treatment and recovery describe a crossover point in their lives when they no longer find a need

or satisfaction in using substances. One stated "Something clicked...no longer wanted to play games such as having someone else switch urines".. Another described her turning point as being in treatment for months before she realized she had self-destructive behaviors and she was dangerous to patients. Among reasons given for their turning points were accepting their addiction, taking personal responsibility for their recoveries, and realizing that consuming substances no longer provided adequate solutions to their problems.

Meaning of Recovery

Participants defined recovery less in clinical terms than in terms meaningful to their own personal experiences with managing their addictions. High on the list was the development of spiritual wellness. Frequently used terms were "recovery was a personal spiritual journey, closeness to God, trusting in God to provide for you, and a peace and serenity that comes with submission". Nurses frequently mentioned that they were calmer now and had a greater sense of inner peace. Another meaning for recovery centered on personal emotional processes and outcomes. Change was often the defining characteristic of a more positive emotional development. This included developing coping skill apart from drugs to deal with life problems, accepting self, no longer feeling like a victim, emotional wellness, taking adult responsibilities, expressing feelings in more positive ways, being honest with self, and more accurate in apportioning blame for their problems. One individual capped the definition by saying that it was a life long commitment to staying clean and sober. In only one case was recovery spoken of as a concrete process of attending meetings and staying in treatment. Even this person acknowledges needing "sunshine in your life". See Table 22 Appendix 11-A for individual case examples.

Given participants' concepts of recovery they further revealed strategies, which they utilized to facilitate their recovery process. The interviewers coded 699 individual segments as containing recovery strategies. These strategies ranged from substantive "things to do" to personal inner reflections. Both groups had similar strategies for dealing with recovery problems and progressing in recovery. Within the structural activities most frequently mentioned were the Board levied stipulations, working the 12 steps, attending AA, NA, and nurse support groups, and "working the stipulations". Several identified specific components of the 12 step program such as depending on a higher power, giving up control, taking a personal inventory, forgiving others in their lives, and acknowledging their addictions. Other activities that facilitated their spiritual journey and served as strategies in recovery were Bible study, formal prayer, talking with God, talking with others about addictions, and helping others in the community especially those people who have problems with drugs.

Personal strategies employed in recovery included being open and honest with self, recognizing triggers to drug use, monitoring stress and realizing the level at which help maybe needed. Refocusing on life rather than the addiction along with adopting a less self-center worldview was mentioned as facilitative, even necessary in the recovery process. An example of becoming less self-centered included listening to others rather than consistently talking out their problems. Exercise, prayer, meditation, physical wellbeing, and diet management took on added importance in recovery. Almost all of the participants identified outside supportive agents or individuals they depended on to assist in addressing problems of addictions or personal concerns. These included counselors to address anger, and physicians, chiropractors, acupuncturist, and

pharmacist to assist in pain management without causing relapse. Ministers and recovery addicts were called upon to assist in addressing spiritual issues. Family, friends, sponsors and coworkers were consulted for support in personal matters such as work, children, and management of recovery issues.

A specific strategy for recovery particular to the female nursing population was attending meetings with recovering women. Addressing women's concerns in addition to recovery issues was important. Finally, a significant outside source in recovery for some of the participants was the Board of Nursing contact person.

Less frequently, strategies for recovery included limiting the self to what can be managed, looking to the present not to the future, changing work location, and learning to work with spouses on personal and recovery matters. In cases where spouses were in recovery, two participants stated that they had to learn how to work separate programs.

Recovery Problems

Twelve themes emerged from the interviews regarding recovery problems. These were interpreted as helpful and harmful or ineffective to recovery.

Factors Not Helpful to Recovery

Several structural components relative to the stipulations were identified as problems. These included problems with support groups (both nursing and AA or NA), urine screens required meetings, and notification. Specific problems associated with nursing support groups included inadequate leaders or facilitators, lack of confidentiality of information shared, too much "whining, bitching, and complaining" with not enough focus on recovery, information shared would get back to the Board, inconvenience of meeting location and distances traveled. Problems emerging from AA and NA included concerns as "type" people attending meetings ("crackhead", drunks, ex-cons, "street people") Many of the nurses felt alienated from members of groups while some felt fear for their safety and well-being. AA tended to be older males making it difficult for some of the female nurses to bond. Some perceived a negative attitude from AA members toward people with drug abuse problems. Meetings created problems by the numbers required in beginning, scheduling of work and personal responsibility around meetings, inconvenient times and locations to attend creating long distances and late night returns. These concerns were especially noted among women with small children. Women often stated that it was difficult to relate to others when the membership of groups were overwhelmingly males. This feature created problems in at least two regards. Women felt uncomfortable in discussing topics dealing with gender issues. Additionally, many females experienced sexual, physical, and mental abuse at the hands of males. Discussing these problems in groups consisting of a majority of males was not considered helpful. Conversely, male nurses expressed concerns that nurse support group membership was mostly females creating an uncomfortable environment for them.

Monitoring by urine screens and blood tests created numerous recovery problems. Most frequently mentioned as a concern relative to this stipulation was cost of the screens. The financial burden of drug screens placed on some of the nurses created tremendous stress on family budgets. Some verbalized that they were forced to go into debt or had to borrow money from family and friends to meet their

obligations. This situation was exacerbated for those who were unable to obtain a job because of employment restrictions. The location of laboratories was described as being inconvenient to their residence of work and at times interfered with their work schedules. In some cases participants described situations in which they knew individuals who faked the screens because of poor monitoring. This situation favored noncompliance.

Interactions with the Board were often described as strained, stressful, and demeaning. Well after admission into the program individuals commented on the lack of support of some of the staff. These comments more often were generated from individuals on probation rather than from the ANNA program. The magnitude of stipulations was experienced as being overwhelming. This included paperwork required, urine screens, mandatory meetings, notifications, and additional counseling or treatment when required. A common comment was that all this was "thrown at them" with no help or compassion and the Board was not receptive to the frustration of managing stipulations. Anger toward the Board was a result of these perceptions toward the Board. Some nurses perceived the Board applying sanctions inconsistently further increasing anger towards the Board. Additionally, nurses felt that the standard approach taken by the Board mitigated against individualized program. The one size fits all approach failed to be helpful in recovery. One individual described the Board as "that dark hole" where information was lost and no response was given regarding efforts made toward recovery. Another person described it as "the dammed Board of Nursing" while still another claimed that the Board "rides on my shoulders everyday". A comment was made that the "Board interfered in individual's private life not just the drinking and drugging life". A number of nurses felt that they would like a greater role in managing their lives. There was an expressed need to taper off in some stipulations as recovery progressed rather than having an unchanging set of stipulations. This approach allowed for easier transition to a life unregulated by the Board.

Publishing the names of nurses in the Board of Nursing Newsletter creates disadvantages for those on probation regarding jobs, personal relationships and relationships in the community. Several nurse commented on the embarrassment experienced when their names appear in the Newsletter. The confidentiality allowed in the ANNA program regarding publishing names has been perceived as unfair.

Economic matters were a real concern in recovery. Most of the time it centered on the cost of treatment, urine screens, logistics effecting travel, and lack of employment. Work concerns centered on work choice (having to take a job outside of the preferred area), restriction of shifts that can be worked, poor pay, having to work part time rather than full time due to work restrictions, loss of full pay and benefits, time away from work because of screens, no time to devote to adequate recovery activities, and restrictions on work duties. For those on probation obtaining employment was difficult because probation was stamped across their license cards. Impressions by addicted nurses were that employers were not willing to take a chance on them and often discriminated against hiring them. Because of the restrictions placed on work duties by the Board, employers were reluctant to hire these nurses for fear of the additional monitoring that would be required and from stigma created by being on probation. Nurses also felt that they were under a cloud of suspicion when on the job. Unfair labor practices were also described, such as being required to work on holidays.

Aftercare programs were characterized as not good, conducted haphazardly, and not helpful because of the composition of the groups. Being thrown in with street people was not conducive to recovery. Counselors leading aftercare programs were criticized for not understanding if they were not in recovery. Many expressed the belief that if the counselor was not in recovery it limited his/her effectiveness.

While the above problems addressed structural concerns, a major theme emerged that dealt with self-concept, emotional needs, and managing life crisis. Publication of names in the newsletter, having probation stamped on licenses identifying them as an addict, simply knowing that they have a drug problem were cited as self-concept problems by nurses. These particular issues were demeaning to nurses who were already vulnerable and were not characterized as helpful in recovery. One applicant stated that treatment programs focused more on the drugs than on the person. The implication of this statement was that participants did not properly develop life skills to cope when they were released from their treatment programs. Dealing with life's crises centered on developing new associations, the urge not to use again when placed in a situation of temptation, the loss of significant persons in their lives, developing healthy and supportive relationships, and how to live a life not filled with chaos.

Pain management was a major recurring theme. Several nurses were introduced to drugs through the use of painkillers. When confronted with surgery, birthing, or unexpected injuries, considerable anxiety was experienced. The questions were raised as to whether they could bear pain without medication or if they had to have medication, would their addiction be fully reactivated. One person repeatedly said that he was told that it would be o.k. after having a local anesthetic, but it wasn't. "The pain was unbearable." This situation was worsened by the reluctance of nurses to report to the Board for fear of the Board not understanding the need for medication and resultant punitive actions.

A theme outside of the Board's control that emerged was the participant's identified lack of self-discipline as a factor interfering with recovery. There appeared to be a fear of relapse and temptation "not to work the program", to want to rush through the program as if time were the main factor in recovery. Time in context of Board requirements is not seen as an important factor in recovery. The lack of transition was also a major concern of the individuals. The sudden end to the treatment program does not guarantee a life without relapses. Nurses were very concerned about being left alone when the treatment programs ended and the Board requirements were met.

Factors Helpful in recovery

It was obvious from the content analysis that several of the factors that were described as helpful in recovery were qualifiers to those factors that were described as not helpful. For the number that describes the support group as not helpful nearly an equal number described them as helpful and an important component to recovery. Likewise a group that described NA and AA as helpful balanced those that describe them as not helpful. The Caduceus group was the one group that received nearly

uniformly high praise as being helpful. The need to be with other professionals in recovery was deemed to be important to the participants.

The structure of the 12 step program AA and NA was acknowledged as critical to recovery. A major focus to recovery under the 12-step program was admitting the problem, and another was having a sponsor. Support groups were seen as places to talk out problems and participate with others in recovery. They also provided opportunities to give back to others. Structure was seen as imperative lives that were in chaos.

A disciplined structure program was mentioned frequently as an asset to recovery. Several of the individuals stated that initially they resented structure imposed on them and the demands created by the stipulations of both programs, but later acknowledge, particularly by the third interview, that the structure was critical to recovery. This included everything from drug screens to work restrictions.

Relationships included facilitative sponsors, availability of counselors who shared similar experienced of sexual and other abuse, who have a history of substance abuse themselves and supportive friends, family and coworkers. In marital situations, good spousal support was deemed as very important. Within those relationships it seemed important to have someone to listen without judgement and give direction to what the participant needed to hear. Associations with people who were trying to achieve true recovery not just with people concerned only with obtaining.

Helpful factors included needs that were not readily identified but were perceived of as very significant to recovery. Examples included needing to share experiences, becoming a sponsor, giving service through AA or the community, association with different groups to gain a broader view of life, and having quiet time to meditate.

Driving forces at times were somewhat negative. Two of the most poignant and helpful center on fear. The participants complied because of fear of losing their license and their professional identity. These were mentioned as highly motivated. Being a nurse was crucial in the recovery process. Participants clung to their professional status as a life raft. Some of the activities favored by some but not others included drug screens, numerous meetings of all types, close monitoring by the Board, all stipulations, including work restrictions, halfway houses, aftercare, monitoring systems in hospitals and long term treatment.

Inpatient treatment was the preferred mode of treatment even though it could cause economic and family hardships A few stated that the loss of a job was a necessary eye opening. Others however stated that keeping the license and making a good living was essential to recovery. Broader but less defined elements included variables such as church and religion, spirituality including emotional, physical and spiritual inventory of the self, honesty with the self. Meetings, monitoring, Board accessibility, grief support groups, and changing the total work environment. Mentoring after probation seemed to be one of the most frequently mentioned needs. Table 23 (Appendix 12-A) provides a synopsis of factors that were helpful and harmful to recovery.

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to determine the effectiveness of two recovery programs regulated by the Alabama Board of Nursing for chemically dependent licensed nurses: (1) a voluntary non-disciplinary program in which Board action has not been taken against the license, and (2) a disciplinary program in which Board action has been taken against the license. In seeking to meet the purpose, the following objectives were established:

- (1) Systematically describe demographic, physical and behavioral
- (2) Determine success and failure rates of the licensees in their respective recovery programs;
- (3) Synthesize the study populations' perceptions of interventions and substantive components, which facilitate adherence to stipulations in the recovery programs;
- (4) Determine the effects of demographic and other salient characteristics of the study groups on outcomes within and between the disciplinary and Nondisciplinary groups, and
- (5) Discover, describe and name the variables that effect recovery.

The literature has not recorded a specific "effectiveness" barometer to measure success of recovery programs for nurses that are sponsored by regulatory agencies. Although research has shown mechanisms that facilitate an on-going recovery of substance abusers, unbiased measurements of success for recovery programs are generally nonexistent. Indeed, success as related to addiction, is not clearly defined by researchers. For some, success means staying drug or drink free; to others, success is measured by a full embracement of life without alcohol or drugs. Still others say it is unreasonable to expect substance abusers to not relapse, but that the evolving process of recovery is evidenced by other elements such as dealing with personal problems.

Regulatory agencies typically have not dealt directly with the problems of substance abuse on a therapeutic level. Rather, in an effort to support their duty of public protection, a disciplinary approach toward substance abusing nurses has been instituted. In recent years societal changes have made a difference in how the "Board" treats the substance-abusing individual. Several state regulatory agencies have initiated non-disciplinary approaches for recovery. In Alabama, the Board of Nursing has implemented both disciplinary and non-disciplinary approaches. Recognizing that program success is contingent upon individual success, it seemed reasonable to evaluate the programs not only from an operational basis, but also on an outcome basis.

The purpose of this section is to cull out elements from the findings that respond directly to the purpose and objectives of the study. Objectives 1, 2, 3, and 5 were readily met through quantitative and qualitative methods. Objective # 4, however, indicated a need for analysis of relationships or effects. Cell numbers were too small to effect valid test results between the study's samples' characteristics and program outcomes; therefore group characteristics have been incorporated into the discussion about the programs.

The Two Programs and their Operations:

Disciplinary Program

When a licensee either self reports or is reported to the Board of Nursing for use of or addiction to alcohol or drugs or theft of drugs, an investigation is initiated by the Board. Upon completion of the investigation a determination is made regarding a need to institute disciplinary proceedings. At times, an individual is referred to the alternative program for intervention. At other times, a licensee may choose to surrender the license. The Board may, however, elect to revoke the license or have it placed on a probationary status. In situations where the license is surrendered or revoked, the licensee may request reinstatement of the license. The Board may deny the request or may allow reinstatement on probation. Whatever the situation leading to probation, the licensee is issued a Board Order that specifies stipulations to be met in order to hold a license on probation. It is disciplinary in nature and requires considerable monitoring. Focus is on public protection with respect that the public may best be served when the licensee is placed in a probationary status while being allowed to retain a license under the supervision of the Board.

There are at least 33 stipulations included in a standard chemical dependency Order. Among the first considerations is whether to require treatment for chemical dependency. In situations where there has been diversion of narcotics/controlled substances at work or when there has been an arrest for illegally writing prescriptions for drug procurement, treatment is required. When these criteria are missing, the Board may require a chemical dependency evaluation. If the chemical dependency evaluation indicates a need, then the licensee must enter into a formal treatment program. This is followed by requirements for an aftercare program for at least one full year, attendance at alcoholics anonymous three times per week and once a week participation in an approved nurse support group. Another stipulation includes random drug screening. More frequent screening is required when there is a history of diversion or if the individual is working in situations where controlled substances must be administered. Other stipulations include abstinence from alcohol and mind altering drugs, self reports of rehabilitation, supervision under practice by a registered nurse, restrictions on employment such as hours of practice, work with a travel agency or home health, restrictions on administration of controlled substances for a period of time, and updates on demography (see Appendix C).

Individuals who accept the consent order are then entered into a strict monitoring program with the Board of Nursing. A call-in color code system has been developed for licensees with substance abuse problems. Here the licensee calls in daily to obtain the color code for the day. If their color is relayed, a urine or blood specimen must be collected at an approved laboratory site within less than 24 hours and a report forwarded to the board office. The program director makes contact with the licensees on a random basis or on a follow-up basis when problems are detected. Individuals involved in the disciplinary program have been described as resistant to the stipulations but generally make an effort to retain their licenses by acquiescence particularly in the early phases of discovery and admission of substance abuse. Denial and discursive hostility are often characteristic behaviors. Most of the interviewees complied under duress early in the process, however, later they complied with intent to remain sober or drug free, and some with a valuing approach, others

with an angry determination. Within the general population of "probationers" some elect to voluntarily surrender their licenses rather than go through the numerous stipulations. Because the program is highly structured, subject to public scrutiny and requires intense monitoring by staff, it may propel some nurses to surrender their licenses rather than to adhere to the stipulations. Failure to comply with all aspects of the consent order may lead to revocation of the license.

Non-Disciplinary Alternative Program (Alabama Nondisciplinary Nursing Approach (ANNA))

The Alabama Nondisciplinary Nursing Approach (ANNA) is a program developed to identify and assist nurses whose abilities to provide nursing care are compromised by dependency on drugs or alcohol, or by a mental or physical illness, so that they can return to competent practice. ANNA's foundation is that substance abuse and physical or psychiatric conditions are treatable, and that recovery and return of a nurse to competent nursing practice is in the best interests of the profession and the public. Of course, the responsibility of the Alabama Board of Nursing remains unchanged: to protect the public's health, safety and welfare.

The ANNA program emphasizes a belief that a nurse should not lose a job or license due to substance abuse or mental or physical illness. The program emphasizes hope, opportunity and education rather than punitive action against the nurse and is administered with compassion, confidentiality and concern for the dignity of the nurse. Even with this compassionate philosophy as foundation for the program, the stipulations for being accepted into the program are extensive. They are, in essence, the same as those for the disciplinary program and the monitoring is as intense. The outcome for failure to comply is written and is implemented when required, even revocation of the license. Licensees who are participants in ANNA may express frustration about the tremendous number of stipulations, but are less discursive in their frustration.

Program Differences

Differences between the two recovery programs lie first in the conceptualization of punitive vs. non punitive actions by an official body, in confidentiality of status and records with no imposed probation nor publication of membership in the program. While opinions may vary, the general impression derived from the study is that the ANNA program focuses on recovery with education, treatment, protecting the confidentiality of the licensee while the disciplinary program centers on monitoring for compliance with treatment as a requirement.

Differences are also found in operational methods. First, intake of licensees into each program varies. ANNA's admissions are voluntary. A program director interviews the licensee and after case history and diagnostic interventions a decision is made as to whether the individual will qualify for admissions. Referrals may come from employers, or from the Board investigators. The disciplinary program's admissions are generated after a formal complaint if filed with the legal division of the Board. A formal investigation is conducted and the licensee is confronted by the investigative staff with a formal Board complaint. The licensee is given the options available, formal hearing with a potential for an Order for probation or for revocation, voluntary surrender of the license or informal settlement with a consent order.

In conducting the study, a codebook was developed based on previous research of known factors associated with substance abuse histories and known factors in recovery. The instrument could only be used for obtaining directory information. Because of due process considerations and the inconsistent information contained in files, data relevant to individual prescriptions for recovery were not retrievable using a single instrument. Critical factors that were inconsistent or missing included sociological data such as preferred life style, family histories of substance abuse, other types abuse and medical histories. While each record included data about the charges related to substance abuse, a pattern of abuse history or personal drug history that included drugs of choice was inconsistent or not clear. These data were obtained during the interviews. The difficulty in obtaining the information via interviews and the study's findings indicate a need for a formal intake instrument to be administered to all substances abusing nurses upon admission to either program. The individuals in the disciplinary program raised questions of protecting the confidentiality of the licensee in the ANNA program.

Program Similarities

Both programs have the same goals: Protecting the public and recovery of nurses with a substance abuse problem. Although some of the licensee participants stated that the programs have been a means to an end - keeping their licenses and a job, comments from a majority of the participants indicated that the programs have had a positive impact toward recovery. Each program has allowed the licensees to retain their licenses while seeking recovery within a structured set of stipulations. Even so, each program has similarities that should be critically examined for improvement and advancement of treatment and recovery of substance abusers.

In essence, they are programs of acquiescence that have consequences for failure to comply. Neither program provides for a transition from completion of requirements under supervision to an unencumbered license. Repeatedly, the licensees who participated in the research project stated that they were frightened about being alone after completing program requirements. "Where will I go? Who shall I talk to when the going is rough?" Will I be able to stay drug or alcohol free without being monitored.

While a desired outcome may be to have the licensee value sobriety and abstinence, the majority acquiesced to the requirements, doing what they must to keep the license rather than valuing a way of life. The redundancy of their statements of what they wanted in life and from life was to be unencumbered from Board restrictions. Time spent in the programs, however, led some to admit to the need for structure to avoid being controlled by drugs or drink. These individuals seemed to have moved into a more valuing mode, seeking spiritual growth as they advanced through their programs. Even these licensees did not discuss at any length events in their personal lives for which resolution may be needed in order to reach the spiritual growth that may make a difference between acquiescence and valuing. It was impossible to uncover personal events in the lives of the licensees that were the catalysts for them to move from acquiescence to spirituality.

While each program may have allowed some alternative within the stipulations that specified counseling, there was no single requirement that facilitated the diagnosis of intervening variables and treatments that could impact recovery on a long-term basis. For instance, one of the licensees described the sexual and physical abuse administered by her father. During interview she said she felt sorry for him because he had had a hard life. It was her duty to take the abuse because she was the oldest and the others needed a life. She did not mention her needs as related to the abuse. One of the program directors stated that the programs within the recovery program should give the licensees the foundation to seek solutions for on-going recovery. The licensees often questioned the quality of the required programs, such as the "28 day" treatment programs, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). If there are identified deficits in such programs within the recovery programs, how long will the licensee last in recovery before Hutchinson's (1987) theory of self-annihilation reemerges? This area will be explored more as characteristics of the population are described.

Study Participants and Program Concerns

The licensees in each program, in this study were similar in age, education and gender. All had similar long-term histories of substance abuse. Although some indicated on first interviews that they had only started "using" in recent years, further explorations led to revelations of "trying out" marijuana in teen years or drinking "a little" in earlier days. Most, however, admitted to initiation into drug use and drinking during the teen years. Often they would make statements that they did not consciously select nursing as a means of acquiring drugs, but at this point in their lives, they may have. Others openly admitted to an early realization that this was a way to procurement. As the interviews unfolded, the emergence of "reticular visioning" became paramount to procurement for the licensees. There was a consistent "cruising," looking for opportunities to obtain drugs engaged in by these nurses. Examples include the selection of nursing as a profession, volunteering to work nights, volunteering to care for sick family members who had recently had surgery, or working home health for cancer victims, becoming involved in relationships with physicians or pharmacists, and working for physicians known to prescribe drugs easily. This information was revealed across time in the interviews.

The phenomenon of reticular visioning is not new. Naming it in relation to substance abuse in nursing is. What the concept of reticular visioning, means in relation to substance abuse and subsequent recovery has not been formally researched, to the knowledge of the investigators, and is open for exploration through future research. Could this same phenomenon be directed to a more positive behavior?

Although the invitation to participate in the study was exactly the same, for both groups, the ratio of participation was 1:3 of disciplinary to non-disciplinary. Their reasons for participation varied but the general theme was a stated willingness to share their story in the hopes that it would help contribute to the body of knowledge about substance abuse and recovery. Racially the groups were representative of the total nurse population in Alabama. Licensed practical nurses were underrepresented in both groups (approximately 16%) as compared to the total population (33%) of LPNs, and in relation to the RN population. Of significance is the fact that the LPN's composed 38% of the population of participants in the disciplinary program as

compared to 21% in the non-disciplinary program. Are there less (percentage) LPNs with problems of substance abuse or are the LPNs less aware of the options available until discipline is immanent. Although the ANNA program has been "advertised" in the *Newsletter*, it is conceivable that the advertisement may need to be evaluated as to its ability to be noticed by all members of the profession, and/or that another means of disseminating information about ANNA is needed.

Physical characteristics of the participants were as diverse as in any population. One trait, weight gain, emerged in several instances as the study progressed. Some recognized it as a substitute for other type abuse and were examining ways to lose weight. Behaviorally, there was a fairly consistent pattern of anger on initial admission of substance abuse and on initial contact with the Board. There was resistance to meeting the stipulations in each program. Although the agreement in the ANNA program and the Consent Order in the disciplinary program were very similar, the disciplinary group expressed resentments about their programs considerably more than the non-disciplinary group. Of prime concern was the publication of their names in the *Newsletter* when they "knew" of some of the ANNA group who laughed about how they were fooling the Board. Interviews revealed behavioral characteristics of the two populations were similar in active usage. Educationally, the participants, held the equivalent of a high school education followed by preparation in technical schools for practical nurses, and hospital diploma education (some higher education courses), associate degree and baccalaureate degree education. Only two of the study population held higher degrees. Growth in the recovery programs was not related to the level of education. Indeed, at least two of the individuals (RNs) who relapsed held baccalaureate degrees. Perhaps the significance of this finding lies in whether educational level should be considered as one of the recovery program's elements.

The majority of the study participants were women (84%). This rate fell within a national estimated percentage of nurses who abuse substances. Males nurses were over represented as abusers when compared to their numbers in the general population of nurses in Alabama. This is also true for the national data where a disproportionately higher number of males abuse substances. The majority of both males and females had histories of multiple marriages. The women participants most often married or chose a significant other who were abusers of substances or who also demonstrated other abusive characteristics. The males, however tended to marry women who were usually professional, self supporting and self-sustaining individuals. Some of this population were dating abusers and married them during the time of the study. At no time was there, during the interviews, any indication that counseling was sought in relation to continuing intimate involvement with substance abusers. These facets of the population deserve consideration as related to each of the recovery programs.

The participants described concerns about meeting some of the stipulations. One that emerged frequently was the issue of personal safety regarding the locations and times of NA and AA meetings. Since the nursing profession consists largely of females, this is a particularly salient issue. Some described the meeting places as being in poorly lighted areas with meeting times after 7:00 p.m. Some of the women described the group members as predominately male often having criminal backgrounds who attend the meetings as part of the requirements for their rehabilitation. The discussions are male oriented and the women did not always feel

free to speak especially as some issues may relate to abusive male spouses or significant others. A major issue that was voiced several times related to gender specific needs. The women did not feel comfortable in sharing issues that affect their lives differently from men, "girl things."

Men nurses, on the other hand, addressed issues as individual matters in their interviews such as the "Macho image." They too, however, had misgivings about the effectiveness of some of the AA and NA groups' populations. The men were specific in their identity as professionals and the noticeable cultural and professional differences of many of the attendees.

To date, no incidents of physical harm have been reported. Even so, Board liability in event of harm to the licensees needs to be considered. If fear of harm is a concern, site visits may need to be considered and alternative sites recommended if this particular stipulation is essential. Even more encompassing in evaluating the recovery program is asking, "Is this component or stipulation essential for effective treatment and or recovery?" If it is, where can it be obtained without fear of harm and do these meetings comprised mostly of males have the resources to address issues relevant to women? If the group members are a threat to image, what is the Board's responsibility to the licensee and the public in such matters? Is it important for recovering nurses to perceive themselves positively as in a "professional image?" If the members of the group are not gender sensitive, should this be a concern to the Board? With the current focus on women's' health issues and the differentiating role that gender plays in addiction, this may bear exploring.

The questions raised above are not intended to dampen the value that might be derived from these programs. Indeed, the value of the meetings was described positively by some of the participants. Some stated that when they skipped the meetings, there was a tendency to relapse into the previous drug thinking and seeking behavior. Some even relapsed and equated their situations with failure to be consistent in attending the meetings. What made these experiences positive for these participants as opposed to those whom experienced problems needs to be identified and used to the greatest advantage.

Treatment interventions prior to making contact with the Board ranged from admissions to full inpatient programs as far back as 20 years, to outpatient (often incomplete interventions) and episodes of assistance with various physical problems. Among the most frequently mentioned were various surgeries, migraine headaches, pregnancies, and mental health problems, especially depression. In several instances the treatments for physical illnesses were cited as the introduction to drugs. This was especially true for migraine headaches. At the time of contact with the Board, prior treatments for substance abuse had not proven to have lasting success.

Few comments were made about the quality of the in-patient and outpatient programs that they had previously experienced. None of the participants gave a reason on interview as to why they had relapsed after completing or participating in the programs. With the advent of the ANNA program, a criteria for treatment providers was established. The criteria includes elements such as assessment and medical care for safe detoxification interventions, follow-up care, ability to provide for psychiatric and neuropsychological testing by qualified persons, referral potential, willingness to cooperated with the Alabama Board of Nursing information necessary to facilitate recovery and attention to physical, educational, psychological and spiritual

aspects of the illness (full list attached as Appendix D). The Board of Nursing has established a list of approved treatment programs that meets the criteria. Licensees may select from the list in accordance with their assessed needs (i.e. inpatient or outpatient prescriptions).

In this study, recent individual experiences were skimmed over with little reference made to quality of care about their treatment programs. Modalities of intervention were varied and were described only in general terms. One individual stated, "outpatient is a joke." Some of the participants stated they selected their treatment program based on available financial resources -not what they "thought they really needed. Some of the participants, however, supported the criteria by stating a need for inpatient, halfway house and after care programs as essential to treatment. From a qualitative perspective, the researchers concluded from this group of participants that while there are criteria for approved treatment programs, there is a variance in the perceived quality of treatment within the programs. Evaluation of the quality of care as related to the effectiveness of the programs is somewhat limited. Failure of a program to cooperate with the Board in matters of reporting necessary information can result in removal from the list of approved providers.

Because treatment in either inpatient or outpatient programs are requirements of both recovery programs, it seems that prescribing the desired elements of the programs, and having some assurance that these elements have been experienced should be a priority for consideration in the future. It seems critical to systematically evaluate the licensees' experiences in the programs and to quantitatively evaluate the success ratio of the licensees to the programs in their overall recovery progress.

Contact with the Board of Nursing usually occurred under duress and threat of loss of licenses. Even those in the non-disciplinary programs revealed that they "voluntarily" approached the Board only under threat or fear of being reported and losing their licenses. The relationship with the Board of these two groups of participants was both positive and negative. Some admitted they were going or went through the programs only to retain their licenses. Others expressed gratefulness at being given a chance to rebuild their lives. Dissatisfactions with the Board centered first around what was perceived as least helpful stipulations. Costs and stipulations surrounding drug screens were high among those identified as least helpful. While many endorsed drug screens as essential for recovery, costs and frequency were major concerns. For instance some of the participants said they could understand the need for close monitoring early on in the program, but believed it would be most helpful if they could be tapered off to assist in transition to a non-monitored situation. Other stipulations that created concern related to requirements for attending large numbers of AA/NA meetings at times that compromised family life and relations, potential opportunities for work and other variables described in preceding paragraphs. Again, in a profession where the majority of members are women, issues of family have pronounced saliency. On the other hand, some said, while inconvenient, these meetings were most helpful and still others said that the structure of screens was critical to success.

Variables That Effect Recovery

Variables that have or may have an effect on recovery for the nurse who abuses drugs or alcohol are numerous. First there are those that the participants themselves

specifically identified as helpful and harmful to their recovery. Then there are the variables that the researchers propose based on findings from the interviews.

Most of the variables identified by the licensees related to the recovery programs themselves. Few mentioned personal, professional or demographic variables as affecting or having an effect on recovery. In such cases the personal variables were indirectly approached such as stating a need for recovery programs to have counseling available to deal with personal problems. Residence was mentioned by several who were required to travel some distance in rural areas to attend AA/NA or nurse support group meetings. Some addressed their marital and family situations as being stressed due to the requirements imposed by the stipulations in the agreements for ANNA or the Consent Orders. Indeed the socio-cultural environment led to at least one person dropping out of the ANNA program.

Apparently family demands led to an inability to meet the stipulations, so she/he relinquished her/his license. No follow-up has been done to determine if the person has continued on a course of recovery or has relapsed in to drug/alcohol abuse. The aforementioned concerns about AA/NA were listed among the "least helpful" variables to recovery.

As shown in the section on "Findings" relative to recovery, variables were described or named that were helpful to recovery. These were comparable to what were found in a "good recovery program" as well as "effective treatment." These are "named" in order to show some measure of meeting the objective.

1. Inpatient substance abuse treatment programs that include attention to physical health as well as substance abuse, individual counseling, one-on-one counseling, domestic violence counseling, a balance between recovering and non recovering staff "to get issues out." Time frames of six to eight weeks up to six months (time enough to get over the game playing). Inclusion of family and friends and employers in the treatment program.
2. Outpatient substance abuse treatment programs with the same type counseling opportunities as identified under #1, inpatient programs.
3. Follow-up treatment programs that support peace and serenity.
4. Strong spirituality emphasis for all treatment programs as well as those that give attention to gender issues.
5. Emphases on total health diet and exercise in treatment programs.
6. Staffed with good counselors who are themselves in recovery.
7. Good working relations with sponsors.
8. Support from family, friends and employers.
9. Treatment modality includes the whole person and not just the addict.
10. A 12-Step program.

11. Structure including urine screens.
12. Positive relationship with the Board, especially a program director or contact person on whom the licensee could rely for guidance and assistance in managing the substance abuse.

This last variable was mentioned several times in the interviews. Two revealing concepts emerged as to the study group's perceptions about "the Board." One, a member of the disciplinary group, saw "the Board" as "the office" or "black hole" that never responded to their calls, never gave feedback on their diaries or reports. Paperwork was just "sent in" and that's the last they heard unless they tried to call - then there was little hope of a response. Some participants said they knew of some of the licensees in both groups who saw the "Board" as something to be manipulated. The other concept was of "the Board" as that unknown and unfeeling body that passed judgements on them and their lives - something to be feared. Various interviews revealed that the participants perceived the Board as having conflicting roles as both regulator and nurse advocate. They also verbalized the need to have a program director or contact person who could offer guidance and encouragement when they were under stress or threat of relapse, and could give positive reinforcement for compliance when there were adverse circumstances with which they had to deal. There is an apparent need to resolve the conflicting roles. Is the Board strictly a regulatory agency or an advocate for the nurse? Is it possible to be both? Is there an advocate role for the Board? How can this be managed without compromising the integrity of its monitoring role? Regardless of the need to resolve the conflicting roles the Board, there is a press to ameliorate the communication between the Board and its constituents. In this study the problems were with substance abusing nurses in treatment programs. However, the problem may be larger and it may be of a problem with Board's general method of communication. Further, there is a political problem in that some legislators have voiced opposition to the State's providing therapy for substance abusers.

The researchers looked beyond the obvious and examined the interviews for specific variables that may have an effect on recovery. It was often the unsaid that raised questions about potential success of the recovery of the participants, such the licensees' anger that either was not detected or unresolved at the time of discharge from the program. Also there were relationship problems in personal lives that were not resolved. These include the tendency for women to become involved second and third or more times with substance abusers or ones who were physically or mentally abusive. Indeed, the matter of support systems was rarely addressed other than what or whom might be found in nurse support groups, AA/NA or prescribed counselors. Weight gain was acknowledged by some as a substitute addiction but no guidance was given or sought for its management. Then there were serendipitous findings that could potentially effect a positive outcome. One was an observation that there was a lack of any meaningful help from the nurses professional organizations mentioned in any of the interviews. Is there a need or do professional organizations have any role in providing treatment facilities, education, treatment program evaluation, financial assistance or other support? Another was that the interviews revealed that the licensees mentioned a dearth or no education in nursing education programs about substance abuse. Do entry into practice programs pose any obligations on institutions regarding prevention and or intervention related to substance abuse? If so is there is need for interaction with the Board of Nursing. All of these variables

have the potential of having some effect on recovery. If they are not part of the recovery programs, then they should be examined as to having a potential value in enhancing the programs and the desired outcomes.

Finally there is a need to examine those variables that were identified as harmful to recovery: The following list includes several variables that were not mentioned in the previous paragraphs.

1. The amount of information that licensees are expected to absorb and implement upon entry into ANNA or probation is overwhelming.
2. Dealing with the publication and posting of their names in the NEWSLETTER and on the bulleting board is very stressful.
3. Having counselors who do not understand substance abuse and recovery is not helpful.
4. The Board's inconsistent management of violations of the agreements and Consent Orders is a problem. Some get away with violations, others do not.
5. The Board "doesn't listen, no matter what."
6. Work restrictions are a problem. (Cannot work in home health, nights, and in some acute care areas).
7. Paperwork is excessive.
8. Nursing support group is awful. If you complain you are labeled as not making progress.
9. Managing pain if you are in the program is a problem.
10. Having probation stamped on the license is a problem.
11. Confidentiality is not respected.
12. The monitoring system for "urines" is imperfect; nightly call-ins are difficult.

These concerns may, by some individuals, seem insignificant in relation to the overall expectation of meeting the program's requirements, particularly when one considers the privilege of retaining a nursing license. One licensee, said, "There should be less emphasis on loss of license and more on the individual." A regulatory agency must always, however, be vigilant to public protection. Allowing a nurse who abuses substances to practice nursing with a license on probation or while in a nondisciplinary program carries a certain risk to public safety and welfare. If the regulatory agency is to sponsor such programs, then there is an obligation to consider those components that have an effect on program success. This includes examining those variables identified by the participants and harmful or not helpful.

Conclusions on Program Effectiveness and Recommendations

So, how effective are the two programs for recovery that are sponsored and administered by the Alabama Board of Nursing? The licensees by majority gave numerous indications of a positive outcome in their situations. Almost every item identified by the licensees as necessary for a good recovery are included in the stipulations of the agreements for the ANNA program and in the Consent Orders for the probationary program. The concerns lie not in most of the requirements but in a perceived lack of individualization and inadequacies in various programs such as AA/NA and Nurse support groups, restrictions to work, and economic hardships.

Two of 12 (17%) of the licensees in the disciplinary program have since completion of the study had their licenses revoked due to relapse, and one (8%) had their probation extended due to failure to meet a monitoring requirement. In the non-disciplinary program, five (13%) relapsed and voluntarily surrendered their licenses (treated as revocation), two (5%) relapsed and their licenses were revoked, and one (2.6%) voluntarily surrendered his/her license due to personal pressures creating problems in meeting stipulations. Whether the recovery programs, as designed, contributed to the outcomes is not known. Questions will always be raised about the effectiveness of the treatments. Cohen and Morrison (1993) addressed the effectiveness of treatment programs by saying that whether treatment works is not always straightforward in that it varies. "Treatment effectiveness "depends" upon the treatment goals by which success is measured, and treatment effectiveness "varies" across treatment methods, client population and competence of clinical management." Any time an agency seeks evaluation, there is a risk of finding out something that is undesirable. Here, the findings were generally positive, but there are sufficient findings that indicate a need to seek alternatives to certain stipulations or to take measures to enhance the effectiveness of some of the other stipulations.

Accordingly, several recommendations, summarized in the next paragraph, were made to the Board for consideration. The major recommendation was to determine if the programs were conducive to public safety and welfare, if so to state the justification and take measures necessary to fulfill the intent of each program and reduce liabilities to the Board of Nursing. Within this recommendation, three sub sets addressed internal structural mechanisms, programmatic components and issues of Board responsibilities for continuing licensure.

Internal structural mechanisms included conducting a cost analysis for the return on investment, developing a non-ambiguous data base that umbrellas selected study variables, structuring concrete admission processes, clarifying confidentiality for the non-disciplinary program, comprehensively addressing stipulations for total health needs of participants, and clarifying parameters of relapse. Specific program issues encompassed evaluating the quality of support groups in recovery, assessing counseling needs of the participants such physical, sexual and mental abuse, evaluating the quality and effectiveness of drug detection programs, clarifying the role of the Board for licensees, and determining if the Board should continue monitoring the probation and ANNA programs or if they should be outsourced. Recommendations about issues of Board responsibilities and continuing licensure of program participants included defining program "success," making decisions about the potential for extended or life-long monitoring, possibly permanently lapsing licenses for habitual noncompliance, clearly delineating the role of program monitors,

reevaluating relapse parameters as related to licensee recovery and public safety, and designing educational programs for nurses regarding substance abuse. A final recommendation was to establish an on-going research agenda to address issues of substance abuse including interventions for success and long term outcomes.

Finally, this project was developed to determine effectiveness of the two recovery programs. The researchers are well aware that this evaluation, although conducted over time, has a time limited value. The various deficits identified in the research process whether from interviews, or from in agency search indicate a need to expediently make some decisions that are cogent to the Board of Nursing's Mission. There is, based on numerous comments from the licensees, a need to immediately establish an on-going monitoring program with outcome indicators that serve as a barometer for public safety and welfare.

Post Note: Since the completion of the study, the Board has established a task force to study the recommendations. The Task Force has verified the validity of the findings and recommendations through a thorough investigative process, graphed processes of the two programs, identified gaps that may impact public safety and welfare, and is currently drafting proposed changes through regulations, policies and procedures. Additionally, the Task Force has confirmed strengths and successes in the programs as delineated through the research process.

SELECTED REFERENCES

- Alabama Common Laws. Regular Session 1915. §No. 207.
- American Nurses' Association Task Force (1984). Addiction and Psychological Dysfunction in Nursing: The Profession's Response to the Problem. Kansas City: ANA Publishing Company: Author.
- Angres, D.H., (1994) The disease of chemical dependency. The Bar Examiner, 2, 6-14.
- Antai - Otong, D. (1995). Helping the alcoholic patient recover. AJN, 95 (8), 22-30.
- Baldwin, L. (1994). Guidelines and Procedures for the Alabama Recovery Program for Nurses. Montgomery, Alabama: Alabama Board of Nursing.
- Bissel, L., & Jones, R.W. (1981). The alcoholic nurse. Nursing Outlook, 29, (2), 96-100.
- Bissell, L., Haberman, P., & Williams, R. (1989). Pharmacists recovering from alcohol and other drug addictions: an interview study. American Pharmacy, N529 (6), 19-30.
- Cohen, R.A., & Morrison, R.D., (1993). The regulatory management of the impaired practitioner: a discussion. Resource Briefs, 93 (4), Council on Licensure, Enforcement & Regulation, 1-9.
- Committee on Chemical Dependency Issues (1994). A comparison of two regulatory approaches to the management of chemically impaired nurses [abstract]. Delegate Assembly Book of Reports National Council of State Boards of Nursing, Inc. Chicago, 49-50.
- Compton, M. (1996). Innovative roles addictions nurse researcher. Journal of Addictions Nursing, 8 (3), 99-101.
- Crume, J., & Mann, J.B. (1994). Stipulations for probation of licenses. In National Council of State Boards of Nursing: 1994 Concurrent Educational Sessions (pp. 19-40). Chicago: National Council of State Boards of Nursing, Inc.
- Farley, P.B. & Hendrix, M.J. (1993). Impaired and nonimpaired nurses during childhood and adolescence. Nursing Outlook, 41 (1) 25-31.
- Gorski, T. & Miller, M. (1986). Staying Sober: A Guide for Relapse Prevention. Independence, MO: Herald House/ Independence Press.
- Gorski, T. (1989). The Relapse/Recovery Grid. Hazel Crest, IL: Hazelden.

Green, P., (1989) The chemically dependent nurse. Nursing Clinics of North America (24, (1) 81-93.

Hughes, T.L., Smith, L., & Howard, M.J. (1998) Florida's intervention project for nurses: a description of recovering nurses' reentry to practice. Journal of Addictions Nursing 10, (2), 63-69.

Hutchinson, S. (1986). The chemically dependent nurse: Trajectory toward self-annihilation. Nursing Research, 35 (4), 196-201.

Hutchinson, S. (1987). Toward self-integration: The recovery process of chemically dependent nurses. Nursing Research, 36 (6), 339-343.

Innis, J. (1997). Relapse and Alcoholism: the need for nursing research. Journal of Addictions Nursing 9, (4), 164-166.

Johnston, L.D., O'Malley, P.M. & Bachman, J.G. National survey results on drug use from the monitoring the future study, 1975-1993 (NIH Publication No. 9403809) Rockville, MD: U.S. Department of Health and Human Services.

Lee, S. (1990). The chemically dependent nurse: A management issue. Journal of Intravenous Nursing, 13 (3), 190-192.

Lewis, J.D., Snodgrass, M., & Larkin, F.H. (1990) Men in nursing: some troubling data. American Journal of Nursing, 90 (8), 30.

Mann, J.B., Permaloff, A., Howard, G., Albert, Y., Dickson, C.J., Scharath, B.J., Sewell, J. (1999). Consumers' perceptions of competence in nursing. Issues, 20 (3), 7-12.

Mark, B.A. (1995). Patient outcomes research - a black box? Image: Journal of Nursing Scholarship, 27 (1), 42.

McClellan, T., Arndt, I.O., Metzger, D.S., Woody, G.E. & O'Brien, C.P. (1993). The effects of psychosocial services in substance abuse treatment. JAMA, 269 15, 1953-1959.

Murphy, S. A. (1993). Coping strategies of abstainers from alcohol up to three years post treatment. Image: Journal of Nursing Scholarship, 25 (1), 29-35.

Nurse Practice Act. Volume 18, Code of Alabama, 1975. Section 34-25-21 (as amended 1993).

Sisney, K.F. (1993). The relationship between social support and depression recovering chemically dependent nurses. Image: The Journal of Nursing Scholarship, 25 (2), 107-112.

Smith, D.E. and Seymour, R., (1985). A clinical approach to the impaired health professional. The International Journal of Addictions, 20 (5), 713-722.

Snow, D. & Gorman, M. (1999). Working with relapse. American Journal of Nursing, 99 (7), 69.

Snow, D.M., Jewell, D., & Anderson, C. (1997). How recovering addicted women succeed. Journal of Addictions Nursing, 9 (4), 182-188.

Supples, J. (1995, July 5). Telephone conference regarding the Colorado project and findings. Montgomery, Alabama: Board of Nursing.

Swan, N. (1998). Drug abuse cost to society. NIDA Notes, 13 (4), National Institute on Drug Abuse, U.S. Department of Health and Human Services, National Institutes of Health. 1; 12-13.

Thomas, C.L. (ed.) (1989). Taber's Cyclopedic Medical Dictionary (16th ed.). Philadelphia: F.A. Davis.

Trinkoff, A.M., Eaton, W.M. & Anthony, J.D. (1991). The prevalence of substance abuse among registered nurses. Nursing Research, 40 (3), 172-175.

Trinkoff, A.M., Storr, C.L. (1988). Substance abuse among nurses: differences between specialties. Journal of Addictions, 10 (2) 77-84. (Reprinted with permission from Am J Public Health, 1988, 88; 581-585)

Wing, D.M. (1995). Transcending alcoholic denial. Image: Journal of Nursing Scholarship, 27 (2), 121-126.

U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration (1994). National household survey on drug abuse: population estimates 1993 (DHHS Publication No. (SMA) 94-3017). Rockville, MD: Author.

Walzer, R.S., & Miltimore, S. (1994). Proctoring of disciplined health care professionals: implementation of model regulations. Federation Bulletin 81 (2), 79-93.

APPENDICES

APPENDIX A

Tables 11-23

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Table 11 Continued

Case	Father	Mother	MX	Bro	Sis	Spouse	Unc	Aunt	GF	GM	Cou	Sig
1314	x		x						x	x		
1324				x		x					x	
1334		x			x			x				
1344				x	x				x		x	x
1354	x	x				x						
1364	x	x			x	x						
1374				x					x			
1384	x			x		x						
1394	x			x	x			x	x			
1404	x	x				x		x	x			
1414							x				x	
1424	x			x	x							
1434	x	x				x			x			
1444						x					x	
1544	x	x			x	x					x	
1744	x	x							x	x		
1844												
1944	x			x								
2004												
2014	x											
2024	x	x		x							x	
2034			x			x						
Total	31	15	7	18	16	18	11	6	19	7	8	3

Appendix 2-A

Table 12

Summary of Mental Health History, type of Intervention and Family

CASE	MENTAL HEALTH PROBLEM			TYPE INTERVENTION		FAMILY
	Depression	Suicide threat	Other	Resource	Medication	
1003	x	x		Psychiatrist	Prozac	x
1023	x		Overeating	Therapist	Buspar	x
1033	x			"doctor"		
1053			Behavior	ICU Med Uni	Phenobarbital, Dilantin, Thorazine	X
1083	x			Counselor and outpatient RX		
1093			Physical abuse and rape	Psychiatrist and Psychiatric Hospital	Desyrel	
1103	x	x		Mental health center, group counseling		
1113	x	x				
1123	x	x				
1164	x		Addictive personality, spousal abuse	Mental health center-inpatient		
1174	x			Counselor, doctor, grief support	Paxil	
1194	x	x		Committed to state psych hospital	Librium, Prozac	
1234	x	x	Headaches	"doctor"	Welbutron	
1254		x	PTSD			
1264	x		"breakdown"	inpatient		
1284		x		Committed mental health center		
1304	x	x	PTSD	Psychologist and psychiatrist		
1314	x		X	psychiatrist		

Table 12 continued

Case	Mental Health Problem			Type Intervention	Medication	Family
1334	x			Mental health hospital		
1354		x		counseling		
1364	x	x	"nervous breakdown" migraine, sexual abuse	Therapist, psychiatrist	Antidepressant, Xanax, Luvox	
1374	x		Sexual abuse	counselor	Valium	
1384			"fragile state emotionally" Husband sexually abuse daughter	counselor	Antidepressants, Valium, Zoloft, Xanax	
Case	Depression	Suicide	Other	Resource	Medication	FAMILY
1424	x			Counselor		
1434	x					
1544	x	x	Bad marriage, anorexic	Physician	Prozac	
1844		x		Counselor		
1944	x		Anxiety	Psychologist	Dalmane, Klonopin, Zoloft	
2004		x		Mental health counselor, inpatient RX		
2010				counselor		Husband
2024			Anxiety	Outpatient therapy. Psychiatrist, physician	Paxil, Desyrel, Xanax	son
2034	x			counselor	Paxil	

Appendix 3-A

Table 13

Drug And Alcohol History Of Nursing In Both Programs

CASE	WHEN STARTED	DURATION (YRS)	DRUGS	FREQUENCY
1003	24	8	Zanax, Darvocet	Daily
1023	22	25	Narcotics-vicodin, demerol	Daily at night when child was asleep
1033	17; also used undergraduate		Demerol, morphine, alcohol	Alcohol daily
1043	18-20 used in college	About 15	Pain pills, cocaine, quaaludes, alcohol	Daily
1053		5 years (1991)	Iv drugs, lorcet, lortab	
1063	20 (1991)	5	Dilaudid, -marijuana in college	Every other day
1083	19		Darvocet, lortab, hydrocodone	Daily
1093	16 experimented	15	Narcotics, IVs	
1103		12-15	Percocet, some alcohol	Daily
1113	Drinking at 15	6	Alcohol, cocaine	Daily
1123	About 20	6	Florinal, Lorcet	Daily
1143	23	15	Cocaine	Daily
1154	15 experimented	On and off 20	Phenobarb, marijuana, alcohol, cocaine	Daily
1164	Since 1989	5	Lortab, hydrodone alcohol	Daily
1174	Began drinking at 15	About 15	Alcohol	Daily
1184	16	At least 10	Inhalants, binge, alcohol, lortab, vicidan	Daily

Table 13 continued

CASE	WHEN STARTED	DURATION (YRS)	DRUGS	FREQUENCY
1194	Starting drinking at 20	20	Alcohol	Daily
1204	15	About 20	Alcohol	Daily
1214	15	20	Alcohol,mj, opium	Daily
1224	20	25	Iv morphine, xanax, marijuana, Isd	Daily
1234	15		Alcohol, stadol marijuana	Daily
1244	About 21		IV drugs	Daily
1254	21	15	Opiates, valium, darvocet, Fiorinal	Daily
1264	21	13	Alcohol, tranquilers	Alcohol daily
1274	17	20 +	Alcohol, opiates, Darvon	Daily
1284	About 25	20 +	Alcohol	Daily
1294	About 22	4	Lorcet, hydrocodone	Daily
1304		6	Lortab, Vicodan, Darvocet	
1314	23	1	Lortab	Daily
1324	Around 25	15	Alcohol, Xanax, Ativan	Daily
1334	38	10	Valium, Demerol cocaine	Daily
1344	14	20	Marijuana., alcohol, amphetamines	Daily
1354	15	About 15	Alcohol IV, Morphine Demerol ,Dilaudid	Daily
1364	16	About 16	Demerol, butalbital, alcohol	Daily
1374	16		Marijuana, alcohol	
1384	About 22	15	Valium Demerol	Daily
1394	16		Mj	Daily
1404	17		Alcohol, Fioricet	

Table 13 continued

CASE	WHEN STARTED	DURATION (YRS)	DRUGS	FREQUENCY
1414	About 17	18	Fiorinal, Percodan esgic+	Daily
1424	18	About 10	Alcohol	Daily
1434	18	18	Alcohol	Daily
1444	46	6	fenetanyl	
1544	1976		Alcohol	
1744			Codiene hydrocodone	
1844		20	Demerol phenergan	Daily
1944	12-15		Pills and pot cocaine alcohol	Daily
2004			Lortab alcohol	Daily
2014	20	3	Alcohol	Daily
2024			Xanax antidepressants	Daily
2033			Lortabs lorcet alcohol	

Table 15

Groups 3 and 4: Perceptions of Chemical Dependency (N = 37)

Case	Perceptions of Chemical Dependency
1003	It is not a disease. It a coping strategy for depression and low self-esteem
1023	A disease as learned through treatment program, however was brought to think it was a moral issue
1033	It is a combination of genetics, chemical imbalance (biochemical) and environmental interaction
1042	It is a disease that is not curable but treatable and manageable. Rejects the moral issue
1053	Disease that is partly genetic and not curable but treatable but also thinks that it is a sin that is related to illness
1062	It is a disease
1083	Learned from parents as a coping strategy. Low self-esteem with genetics playing a role it addiction. Women become addicted to pills become socialized to taking a pill.
1103	It is a coping mechanism for depression. A disease that is curable and treatable. A genetic component "born with the disease."
1113	Genetic-it runs in families as a disease.
1123	First saw it as a moral issue, now sees it a disease that can't be cured.
1154	Physiological and genetic components combined with psychological problems and family dynamics.
1164	Born with an addictive personality and it is non-curable.
1174	It's a disease that people can't stop on their own. Some heredity but also social biological. It is treatable.
1184	It's a progressive illness
1194	Heredity
1204	It's a disease like a physical allergy to alcohol and a mental obsession..."You take the first drink and you're gone".
1214	It is genetics combined with obsessive-compulsive behavior disease. "It controlled me I didn't control it.
1244	Disease with genetics playing a role
1254	Born with it (heredity)
1264	People have a genetic propensity but hesitant not to call it a disease because of pressure in the addiction community. It's a weakness, indifference to self.
1294	Not necessarily a physical disease. It's the way we are brought up. Think of it as a sin and was bombarded in NA meeting for saying that. Not genetic, may be a mental disease, character defect.

Table 15 Continued

Case Perceptions of Chemical Dependency

- 1314 No segments noted
- 1334 First saw it as a moral issue now sees it as a disease with heredity playing a part.
- CASE How is Chemical Dependency Perceived?
- 1344 It is a disease
- CASE How is Chemical Dependency Perceived
- 1374 Mental illness, disease of the mind, a compulsion to adrenaline seeking people and can't live their lives without anger in it.
- 1384 Addictive personality-running from something not happy with themselves. Largely introverts use drugs to be extroverts. Some physical causes, body doesn't process chemicals like everyone else, but a bankruptcy of spirituality (low self-esteem). Some genetic role in the 'disease process. Personality of perfectionism/obsession/compulsion.
- 1394 Defective gene thought it was a moral problem but now thinks it is a disease.
- 1404 A disease
- 1414 A disease with more than one cause, a predisposition, lack of coping skills and something in the brain that can't put it down as others can.
- 1424 No segment found
- 1434 A disease with chemical imbalance for depression. First thought it was a problem in living but now thinks it is a disease.
- 1444 Two causes 1 physical 2 emotional. Different personalities are addicted to different substances
- 1744 A progress disease passed down through generations. Addictive personality.
- 1844 A disease process, people are born with it.
- 2004 Chemical disease and lack of coping skills. A "longing of the heart" rather than a bodily disease. Genetics play a part.
- 2012 Way of coping with problems. Both emotional and physical
- 2033 Started if a mental process to feel good and to be popular. No genetics play a role.
-

Table 16.

Influencing Life Events and the Development of Chemical Dependency?

Case	What life events are perceived as influencing the development of chemical dependency?
1003	In nursing school roommate had easy access to drugs and introduced her to them. Doctor prescribed Xanax after she wasn't eating and she liked it. Took diet pills to keep up at work. Molar pregnancy and depression started her dependency; prescribed Darvocet for headaches.
1023	Sexually abused by father, step brother and uncles. Took medication for weight. Started out as an experimenter. Wanted to see how they made her feel. The hospital environment was conducive to her use.
1033	Never happy in childhood. Mother very sick and died when she was 17 and father did not set limits. Was tired of her mother being sick all the time. Overwhelmed by work, husband and baby.
1043	Experimented in school; later used pain pills for a slipped disc.
1053	Abused physically and sexually by father.
1063	Self medicated for pain associated with parasites; later took for pleasure.
1083	Abusive marriage to an Iranian who threaten to take child; took pain medication for headaches.
1093	Experimented through peer pressure. Used drugs to energized herself. Identifies self as lesbian.
1103	Self-medication for physical problems. Mother physically and mentally abusive. Husband physically abused her, burned house down, and threatened to kill her. Self medicated for depression. Sexually abused as child
1113	Experimented in high school. Physically and verbally abusive husband. Husband died in car accident and she was lonely.
1123	Treated for migraines. Worked in ER with doctors who prescribed medication freely
1143	Making a lot of money and ran with a fast crowd using drugs; husband used also.
CASE	Events (continued)
1154	Began drinking and drugging to feel confident when he went out on dates
1164	No specific event-method of coping; series of physical problems and used pain medication.
1174	To escape from a bad marriage; drank heavily after divorce. Series of losses: mother , father, sister died in a short period of time.
1184	Took wife's prescription for hydrocodone.
1194	Drank during idle times Significant other molested daughter

Table 16

Case	Influencing Events...
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1204	Experimented at age 15 with friends. After divorce began to drink heavily. Involved in an abusive relationship and binged
1214	Used as a coping mechanism.
1224	Learned from parents that it was o.k. to medicate. Took drugs to fit in.
1234	Only affection she received was from her father who was an alcoholic.
1244	Experimented with drugs. Self-conscious. Drugs filled the void
1254	Working environment was very lax about drug accountability; treated for migraines.
1264	Dated a man who introduced her wine. Instantly felt warm and wonderful feeling.
1274	Started to take narcotics because of menstrual cramps also to cover up inadequacies.
1284	Difficulty in relationships which are often abusive (lesbian). Self loathing.
1294	Initially for pain then to get through the day.
1304	Pain killer for back pain.
1314	Self medication for depression
1324	Escape from life's problems
1334	Found husband in bed with best friend; self medication for migraines.
1344	Abusive and jealous husband who often tied her up at home.
1354	Alcoholic household growing up; Lost son, depressed, drank.
1364	Self medication for migraines.
1374	Sexually abused by father.
1384	To deal with pain.
1394	Male anorexic did drugs to ameliorate self loathing
1404	Parents encouraged her to drink and had peer pressure; medicated for migraines.
1414	Sexually abused by uncle. Insecure and uncomfortable around people. Husband committed suicide and she began abusing more; medicated for migraines. Initially took pain medication for extraction of wisdom teeth and liked it.
1424	Parents died when she was in her 20s. Found out she could not conceive began drinking.
1434	Child died of SIDS. Was in a bad marriage husband left for younger woman.
1444	Wife was a drug addict and he joined to get along with her.
1544	Lost job during consolidation, new house payment due, mother had congestive heart failure. Worshiped her father, only love she ever knew, who was an alcoholic. Mother abused her children badly.

Table 16 Continued

Case	Influencing Events...
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- 1744 During third month of pregnancy she had to have an appendectomy and later gall bladder surgery and became addicted to pain killers
- 1844 Used drugs to cover up pain. Overweight, nine major surgeries, lots of pain medication and husband mentally abuse her. Self medicated for migraines.
- 1944 Started to take medication for bad headaches and found that they energized her.
- 2004 Molested at 13, raped at 15, several miscarriages, attempted suicide, and doctor prescribed medication for chronic back pain.
- 2014 Assumed care taker role for mother (sick) and began drinking.
- 2024 Stress, overload, married at 17, overwhelmed.
- 2033 Sexually abused at 5 by cousin. Female problems, back problems.
-

Table 17

Events Perceived as Precipitating Board of Nursing Intervention

CASE	BOARD INTERVENTION
10031	Someone reported to Board-thinks that her pharmacist did. Started taking Darvocet for headaches
10231	Confronted at work (94) and fired for diverting drugs. ---weight problems child sexual abuse by father, uncle and stepbrother --spousal abuse-got drugs form doc for made up headaches-claims stressful hospital env caused her to use
10331	Confronted by co-worker(1989)used in school, overwhelmed by work, husband, baby
10431	93 tested positive in random drug screen-began using pain pills for slipped disk and other drugs recreational
10531	Drug screen positive-Abused physically and sexually
10631	Caught diverting drugs. Self medication for pain and parasites and later for pleasure
10831	Arrested for forging prescription-abusive relations with spouse started to take pills for headaches
10931	Asked to go home by supervisor. Identifies herself as lesbian
11031	Caught at work-used drugs because she was depressed-many physical problems
11131	Busted for buying cocaine-spouse was alcoholic ,mj, beat her and killed in car accident. Used because of loneliness
11231	Husband called ABI to get control of kids. Doctors prescribed pain killers for migraines
11431	Caught by police for buying m.j. for maid in a sting. Husband also used
11541	Self notification to board after going into treatment when tested positive for cocaine and opiates after care accident.
11641	Caught calling in prescription-began using after series of physical problems
11741	DUI caused her to self report to board
11841	Resigned before being caught for missing drugs at work
11941	Hospitalized for suicidal depression and was reported for alcohol abuse by supervisor who wrote letter to board--boyfriend sexually abuse daughter
12041	Supervisor smelled alcohol and had her tested.
12141	Self reported to board
12241	Caught by the Medatarol computer system for ordering more drugs than patient needed
12341	Caught at work by supervisor

Table 17 Continued

Case	Event and Board Intervention
12441	Caught at work by DON, terminated then turn self in to Board
12541	Caught at work-began using after treatment for migraines
12641	Doctor called employee assistance program and it turned her in
12741	Caught at work-started to self medicate for menstrual pain.
12841	After a suicide attempt mental health professional turned her in. Started drinking to deal with abusive husband. Lesbian relationship was also violent
12941	Self reported to Supervisor Pain killers for illness ,then for energy and then recreational
13041	In car accident was tested positive. Pain killers for back pain
13141	Confronted by supervisor-self medicating for depression
13241	Caught diverting drugs at nursing home
13341	Went into Tx and then self reported. Self medicating for migraines. Started to use as a result of seeing husband in bed with best friend
13441	Self reported after going into TX Abusive & jealous husband (often tied her up to control her
13541	Diverting drug-first time DUI-second time
13641	Caught writing scripts-self medicating for migraines
13741	Tested positive for mj at work-sexually abused by father
13841	Told to take drug screen which was positive
13941	Drug screen at work positive for mj-male anorexic
14041	Physician persuaded her to get tx. Medicating for migraines
14141	Fired from work. Self medicating for migraines
14241	Self reported after getting into TX
14341	Nurse friend counseled her to go into tx. Brd notified
14441	Self reported after getting into TX. Began to take drugs because wife was an addict and was a way to cope with her

Table 17 Continued.

Case	Event and Board Intervention
15441	DUI
17441	Caught taking patient drugs
18441	DON suggested she go in tx because of missing drug count. Self medicating for migraines
19441	Turn self in to rehab. Self medicating for migraines
20041	Self reported to DON. Self medicating for back pain
20141	Charge nurse confronted her on the job and had her tested
20241	Confronted by day nurse about missing medications
20331	Supervisor caught her calling in prescription

Perceptions of the Board of Nursing Recovery Programs

Case	Perception of recovery program
1003	Turned out to be the best thing to happen in my life; "I'll do what ever it takes to keep my license."
1002	It was the best to happen in my life-showed me another side (to addiction CAPs; a public treatment center). I would be dead or worse.
1033	Loss of license was the main incentive
1043	It has given me a second chance
1053	At first I thought it was punishment, but I now want my license back and my life back
1103	Being punished because she is sick and can't work; resents the ANNA people
1154	Feels the ANNA program is the better approach
1164	"in her best interest"-resentful at times in the beginning, but more peaceful with it now. Grateful for not losing license and grateful for the ANNA program
1174	Treatment taught her about herself. Motivated to keep license and in the ANNA program you get a second chance
1184	At first she didn't like the limitations, but got past that stage in about 3 months
1194	Very pleased with the program
1204	"I'll go out to play the game. I'm doing this to save my license
1214	Program places more focus on loss of license than the person
1234	Feels lucky to be in the program
1264	Will do what ever she has to do to meet the requirements
1284	Resentful that she went for help and was punished and would never tell anyone to go to them for help
1304	Very grateful for what they do for her
1334	Program has been wonderful
1344	Loss of license but realizes that recovery is more than that
1364	At first do to keep my license, but realized that recovery was more than that
1414	Provides structure to keep watch over you
1444	It was a way to get my life straighten out
1544	Feels a little like punishment, though there are a lot of requirements she agrees with. Not flexible enough. ANNA restricts what she can do.
2004	Changed her life-never looked at it as punishment

Table 18 continued

Case	Perception of recovery program
2014	Program forced her to go into treatment, but one has to reach a certain point to make any difference
2024	A relief it happened-grateful that Board was willing to work with nurses on this problem
2033	Great program-it was a second chance

Table 19.

What stipulations are perceived as most helpful, least helpful

Case	Most helpful	Least helpful
1003	Drug screen, nurses support group	AA meetings-didn't fit in and not helpful, a deterrent-just talk, talk
1023	Meetings keep you busy, keeps from the old stuff	The paperwork
1033	Nurse support group	Going to meetings at night, going for urines, suspension was harsh
1043		If you're in the disciplinary program and you are on probation you can't get a job; nobody wants to hire you.
1053	Safety net of the drug screens	Being in AA group with "street people"
1063		Finances of the drug screens
1123	Aftercare is very important, attending AA meetings, nurses support groups	
1154	Nurses support group	
1164	Drug screens, but expensive	Nurses support group-Times not convenient, locations are few and far between and a lot of bitching goes on
1174		Drug screens are a pain and expensive
1184	Structure-addicts need structure	
1244	Drug screens, meeting requirements, good in the beginning not to work overtime, nurse support group, and narcotic restrictions for 6 months	
1264	AA meetings were helpful	Nurse support group helpful at first, but later a pain
1274	Having to be accountable, having structure	
1284	Urine and drug screens	The meetings have not been helpful
1294	Go to meeting where you can sit and talk with people you identify with. NA and aftercare	

Table 19 Continued

Case	Most Helpful	Least Helpful
1304	Key restriction was useful, drug screens, group sessions and aftercare	Being put on key restriction should be from the time you begin working
1314	AA meetings	Aftercare and nurse support
1334	Nurse support	NA (didn't get a lot out of it) the people not like me
1344	Drug screens	Financial burden of drug screens; easing of the restrictions a little at a time
1364		Having other treatment options
1384	Structure is vital	
1394	AA, nurse support group	NA (nothing in common), lack of counseling component in program
1424	Nurse support group	
1434	AA meeting, nurse support group	Drug screens-makes you feel like a criminal. Not being able to administer narcotics for 6 months (worked on med/surg floor) also nurses are denied a job because of this restriction.
1544	Continuing care, AA	
1884	Nurse support group	
1944	Nurse support group, counseling	Outpatient group (traveled 36 miles), nothing in common with people, drug screens
2004	Nurses support group	AA-people were there because they had to be
2024	Inpatient treatment	

Descriptions of a Good Recovery Program

Case	Comment
1003	It has to be different for everyone (individualized) Don't have an institutional atmosphere for spiritual recovery you need to examine nature and sunshine-no distraction, easy access to personal counseling
1022	To be in with "street people"
1043	A good 12 step program A good recovery is growing spiritually Half way through the program you can meet with Board to go over your program and progress
1063	The Board is too secretive
1083	Variety of meeting places (availability) Having counselors familiar with domestic violence
1093	Inpatient program, pay attention to physical aspects (body & exercise) Be encouraged to express feelings; do something about our unhappiness
1103	A good sponsor is the key. A good program helps you work through your feelings
1113	A good halfway house
1154	A good continuing care unit. Time set aside for personal counseling and a quiet setting
1164	Educate the public and health professionals about addiction. Make requirements of the Board less stressful on us
1174	Good nurse support group
1184	Have recovery people in with each other. Spend too much time indoors; need outdoor activities. Need intensive group therapy
1194	Long term inpatient (6 months). Lots of structure
1214	Structure and in-depth group sessions
1254	Work on spirituality and discipline
1304	Individualized program
1324	Learn to get touch with yourself
1334	Need more structure, especially after being released

Table 20

Case	Descriptor of a Good Recovery Program
1344	Lessening of Board restrictions as time program progresses
1374	Structure, intensive therapy, but consideration of time for people with families
1384	First two weeks inpatient, then outpatient Having recovering counselor, build self-esteem Program expressly for prescription drug abusers (NA is for street people) Follow-up with monitoring
1394	Inpatient, then halfway house, a lot of monitoring and follow-up Family counselor component with counselors who are in recovery
1404	Nurse support group component
1414	Strict program, strong spiritual component, strong support system
1424	A good 12 step program, a good sponsor, individualized
1434	A lot of meetings-contact, family meeting, relationship with God
1444	Inpatient treatment
2004	Individualized with regard to inpatient or outpatient treatment
2024	More support groups, inpatient treatment, intense treatment, group and individual counseling sessions, "outpatient treatment is a joke:"
2023	Group sessions to open up the addict

Table 21

Components of Effective Treatment: Stipulations, Strategies, Prescriptions and Compliance

Case	Comments
1002	Continuing care, when you look to peace and serenity first A good 12 step program-doing the 12 steps
1023	Discipline 12 Step program-stability and consistency
1033	Different types of therapy
1043	Individual counseling; 12 Step program; A program that has a spiritual component
1063	Having recovery counselors in program. Inpatient and good aftercare. Accountability that's in the program
1083	Inpatient then outpatient then aftercare. Individual counseling. Balance of recovering and non-recovering staff. lasting at least 3 weeks. Outpatient would have therapist on call. Domestic violence specialist
1093	Good solid 12 step program
1154	Recovery counselors, inpatient to break the cycle
1164	Needs to be beaten into submission
1174	Inpatient; programs with nurse support group and attending meetings-aftercare doesn't make any difference
1184	Nondisciplinary program so as not to be labeled
1194	Six months inpatient
1204	Six weeks inpatient-need that long to get over the game playing. One-on-one counselors to get the issues out. Female groups
1264	Individualized more one-on-one
1284	Personal counselor for your individual problems
1324	To have recovering persons on its staff
1374	Counselors you can trust and who are available at all times
1384	Integrate all the professional staff so that they know what the problems of patients are
1424	Inpatient is effective treatment
1544	Being able to have a private A & D counselor
1944	Family/marriage counseling available
2004	A strong support group
2024	Good support; family, friends, and employers
2033	Counselors who are in recovery

Table 22

Responses Regarding the Meaning of Recovery

Case	What does recovery mean
1003	Without feeling the need to alter mood in order to be successful Peace and serenity; being honest with yourself and others; emotionally and spiritually secure
1033	Recovery is spiritually based
1043	Having a strong spiritual life; developing different coping skills for live Recovery is a journey, treatment is discovering
1063	Lifelong commitment to stay clean and sober; spiritually oriented
1083	Learn to develop your own coping skills; being at peace with yourself
1113	Recovery is staying in treatment and going to meetings. "You have to have sunshine in your life
1154	Overcoming self-centeredness
1164	Learning a new way of life without drugs; learning a better way of life
1184	Recovery is for life. Being aware and considerate of others
1204	Recovery is more that detox, more that not using. There is a solution to problems that drinking
CASE	What does recovery mean?
1214	Accept yourself as you are, love is unconditional, learning to love Change your lifestyle; making choices and decisions
1244	Taking care of yourself
1254	Learning how to live different; how to deal with problems without medicating
1264	It's a process, find for yourself (an individual process); personal, spiritual journey, when you no longer feel like a victim
CASE	What does recovery mean?
1274	Being able to feel feelings good and bad
1324	Learning to deal with life on life's term
1344	It's all about changing, and adapting and dealing with reality and life on a daily basis. It is an awesome journey
1354	learning how live life
1364	Changing, Changing, changing. Honesty

Table 22 Continued

Case	What Does Recovery Mean
1424	Rebirth of emotional, spiritual wellness
1434	Accepting you have the disease. Being able to be happy and close to God
1441	Growing up and taking adult responsibility. Learning to accept your feelings and express them. Going with the flow without fighting in every direction
1544	With recovery comes peace
1744	To look out and see all that God made to see that it is beautiful without griping
1844	When you think of yourself as a worthwhile individual
1944	Being able to trust God to take care of you
2024	Not a point. It's how you deal with yourself and how you accept things. Comes from an inner spirit.
2033	Knowing you don't have to please anyone. To find yourself

Table 23

Factors Identified as Helpful and Harmful to Recovery

Case	Comments	
	Positive	Negative
1003		In the beginning too much is thrown at patients. Overwhelming. Measures are too extreme for most violations. Putting names in the Nursing Bulletin is embarrassing (had to work through a lot of therapy to accept that). Calling in everyday is a pain. Don't feel comfortable in AA meetings because there are a lot of males who have done crimes-Need for an all women group. Need counselors who are in recovery
1023		Finding a job if you are on probation. Work restrictions. Paper work is a pain. Board doesn't listen no matter what you say. Some people get away with violations, Board is inconsistent in enforcement. Nurse support group is awful. If you complain you are labeled as not making progress
1033		Going to meetings at night at dark places. Managing pain if you are in the program. Aftercare and nurse support groups are time consuming. Monitor system for urines is imperfect. We are being punished for it. Taking away license places a financial burden on families. Probation stamped on license is a problem with employers. Concerned about making it after monitoring is gone. Board make you feel like a bad person.
1043	A strict, discipline treatment program	Name published in the newsletter Employers treat them differently-make them work on holidays
1053	A structured program Attending meetings, becoming a sponsor, nurse support. Someone to talk to.	Paperwork Tough to get a job when you are on probation Home health care should be allowed. Having to have urines after you have been in the program for a long time is unfair. Paperwork is too detailed. Board doesn't respond to letters. The Board is a big dark entity in Montgomery

Table 23 Continued

CASE	Comments Positive	Negative
1083	A program for women	Calling to get your drug screen. Too many reports to fill out
1093		Paperwork
1103		After progress the number of meetings can be reduced. Paperwork is too much. Taper off the number of drug screens.
1113	Having someone to talk to. Cont' care	Getting a job. Decrease drug screens over time.
1154	Continuing care and monitoring	Nurse support group-mostly women (nurse is male)
1164	Urines are incentives as is keeping your license	Economic hardship. Nurse support group is least helpful-bitching sessions. You are always under a cloud of suspicion on the job. Requirements are stressful for many who are single parents
1174	Nurse support group and attending meetings on a regular basis	Aftercare not helpful because are mixed in with street people in some groups. Confidentiality is not respected. Board not sympathetic/caring and harsh
1184	Longer treatment. Enforce contract more rigidly	Members in AA an older group-didn't identify with them
1194	Longer Treatment. Structure is good	Difficult to find a job
1214	Good monitoring system after probation. Board stipulation keeps you in line	Less interest in loss of license and more on the individual.
1254		Pain management when nurse has physical problems. Stigma of being an addict-can't be trusted
1264	Urine screens Nurse support group	

Table 23 Continued

Case	Comments Positive	Comments Negative
1284		Board is punishing to nurses
1294	Alumni group is helpful	
1304	Individual counseling	Aftercare is haphazardly structured
1314		Driving to drug screens in impediment
1354	Having nonjudgmental people is very important	Paperwork Name published in newsletter
1374		Treatment that focus on problems and not on the solution. Too many meetings interfere with family
1384	Monitoring after probation (not just left out in the cold)	
1442	long term treatment program	Tough to get hired, addicted nurses are shunned
1434	Aftercare and nurse support	Board doesn't know what it is like
1544	Individualized program	
1744		AA meetings. Mostly men in group Aftercare was not good
1844		Confidentiality in group is violated Probation for 3 years is too long
1944	Women's group	
2004	Strong support group	

APPENDIX B

Pilot Study Report

Evaluation of Two Alabama Board of Nursing Recovery Programs for Chemically Dependent Nurses: A Pilot Project

Progress Report: August 1997 and revised in October 1, 1999 to reflect past tense to August 1997 decisions.

Jean B. Mann

Purpose and Objectives

The purpose of this pilot project was to refine the research plan for an evaluation of two Board of Nursing recovery programs for chemically dependent nurses. Specific emphasis was placed on meeting the following objectives:

- analyze strategies to assure a representative sample from each program;
- refine the codebook for collection and organization of demographic and other variables which would be subjected to quantitative analysis;
- identify commonly occurring themes from the interviews of the pilot population,
- identify from the interviews, any areas which should be addressed in the next interview (i.e., information necessary to meet objectives of the project), and
- reevaluate the potential to meet all study objectives.

Background

In 1995, a plan was developed to evaluate the effectiveness of the two recovery programs which the Alabama Board of Nursing sponsors for nurses who have been identified as, or who have self admitted to being chemically dependent. The planning team initially consisted of three Board staff members and one outside advisor who was an authority on evaluation research. The Board staff consisted of a coordinator of research and the two practice consultants who managed the two recovery programs. From this initial planning team, recommendations were made and approved for advancing to a core research team to conduct both a qualitative and quantitative study. A decision was also made to seek funding from an outside source.

Invitations were submitted to two doctoral prepared researchers with knowledge of chemical dependence and experience in interviewing: (1) an authority on qualitative research with a background in nursing who was actively engaged in research involving chemically dependent nurses, and (2) a counselor who has specific research activities directed to chemical dependence. These two researchers and the three Board staff members composed the core research team for the project. The principal investigator drafted a basic proposal for the core group to use as an initial working implement. At an organizational meeting, project aims were revised and methodology clarified for a pilot. The proposal for the pilot was included in a proposal for funding to the National Institute of Drug Abuse (NIDA). The proposal encompassed processes for the protection of human subjects. Although not funded, an invitation to resubmit was issued. A decision was made to not resubmit until the pilot could be completed. A full copy of the grant application and the protocols for the institutional review board are on file. The informed consent form and "Protocols" are attached as Appendix A. The methodology as described in the "Protocols" and the "Narrative" for the grant proposal was applied in the pilot.

The pilot proceeded initially with four participants. One dropped, leaving three. First interviews from these three led to an initial identification of variables using the constant comparison method. The untimely death of the outside consultant required a regrouping and determination of action to take

regarding the project. A decision was made to proceed with the project, and add the professionals needed to interview the participants as outlined in the protocols and grant proposal.

Synopsis of Project

This research addressed the evaluation of the Alabama Board of Nursing's recovery programs for chemically dependent nurses. A major focus of the project was on determining effectiveness of treatment interventions stipulated by the Board as a regulatory agency: Project objectives are specifically to:

- (1) systematically describe demographic, physical and behavioral characteristics of the two populations in the two programs;
- (2) determine success and failure rates of the licensees in their respective recovery programs;
- (3) synthesize the study populations' perceptions of interventions and substantive components which facilitate adherence to stipulations in the recovery programs;
- (4) determine the effects of demographic and other salient characteristics of the study groups on outcomes within and between the disciplinary and non-disciplinary groups, and
- (5) discover, describe and name the variables that effect recovery.

Anticipated gains included: developing a comprehensive data base on licensees with chemical dependency problems, gaining insight into the process of recovery in chemical dependency under the auspices and supervision of a regulatory agency, obtaining data about effectiveness of interventions as currently stipulated in disciplinary and non-disciplinary programs, obtaining data about the influence of demographic and other salient characteristics on success, such as gender, race, and ethnicity in meeting stipulations in the disciplinary and non-disciplinary programs, and utilizing the findings of the study to improve the existing programs for recovery of chemically dependent licensees.

PURPOSE

This purpose of this project was to determine the effectiveness of two recovery programs regulated by the Alabama Board of Nursing for chemically dependent licensed nurses: (1) a voluntary non-disciplinary program in which Board action has not been taken against the license, and (2) a disciplinary program in which Board action has been taken against the license. Specifically, this project intends to:

- (1) systematically describe demographic, physical and behavioral characteristics of the two populations in the two programs;
- (2) determine success and failure rates of the licensees in their respective recovery programs;
- (3) synthesize the study populations' perceptions of interventions and substantive components which facilitate adherence to stipulations in the recovery programs;
- (4) determine the effects of demographic and other salient characteristics of the study groups on outcomes within and between the disciplinary and nondisciplinary groups, and
- (5) discover, describe and name the variables that effect recovery.

GAINS

Anticipated gains from this research include: (1) developing of a comprehensive data base on licensees with chemical dependency problems, (2) gaining insight into the process of recovery in chemical dependency under the auspices and supervision of a regulatory agency, obtaining data about effectiveness of interventions as currently stipulated in disciplinary and nondisciplinary programs, (3) obtaining data about the influence of demographic and other salient characteristics on success in meeting stipulations in the disciplinary and nondisciplinary programs. Finally, (4) a desired gain was to be able to utilize the findings of the study to improve the existing programs for recovery of

chemically dependent licensees. A major intended gain was the addition of data about minorities including women and African Americans who are undergoing recovery and males who are included in both types programs.

As of the date of this writing, there are approximately 200 licensees on probation and enrolled in the disciplinary program, and 140 in the in the non-disciplinary program. With the original success of 33% participation of both groups and the exercise of the recommendations for improvement in recruitment, good results are anticipate.

Research Questions

Broad research questions were originally proposed as a framework for formulating the final draft of research questions.

1. Are there any differences between the disciplinary and non-disciplinary groups in compliance with the Board's stipulations across time?
2. What are the demographic and other salient characteristics that influence compliance with the Board's stipulations?
3. What are the participants' perceptions, across time, of significant life events, nature of the disease, effectiveness of their treatment programs, and effectiveness of Board stipulations?
4. What are the differences among treatment modalities when moderated by membership in disciplinary and non-disciplinary programs.

Methodology for Obtaining Data

The study proposal which described the study design as a longitudinal descriptive, evaluation research project was implemented in the pilot project. In the conduct of the pilot, the proposal methodology was not altered. Both qualitative and quantitative data collection methods for data gathering and analysis were employed. Due to the small group, advanced statistical methods were not used, however, plans are to apply the quasi-experimental nonequivalent control group design with post test measurement for the full study.

Data gathering methods include obtaining archival information from all files of individuals in the two recovery programs for the quantitative component of the study. A stratified random sample of participants from both programs will be sought to address the qualitative component. A designated time frame of admission from October 1, 1994 to the current date will be utilized for basic parameters in issuing invitations to participate. Also, within the sample, effort will be made to stratify across race, gender and geographical variables while maintaining respect for anonymity and the protocols for the protection of human subjects. The goal is to have 60 participants with 30 in each type recovery program. Archival data will be collected from existing data sources. Questions for interviewing the program participants will be constructed and validated. Participants will be evaluated for program compliance and will be interviewed for perceptions at designated intervals over a period of 18 months. Interrater reliability determinations will be conducted where appropriate, however, consensus is to be achieved on coding of qualitative data. A qualitative analysis will be conducted following coding of data. Co-investigators arbitrated discrepancies in coding. Descriptive and inferential statistical methods were applied at intervals and at the termination of the project to describe study characteristics, and when possible, to show relationships between selected variables and outcomes. Specific attention was given to

determining differences (if any) in responses of minorities, women, and to responses relative to treatment programs in which licensees are attached.

Limitations

As with any quasi-experimental design, potential problems in data collection existed. Mortality of study subjects was considered as a strong possibility and a contingency plan established to promote population stability. Each interviewer was asked to conduct one to two additional interviews in event of need. Because of the sensitivity of the subject matter and the licensee's relationship to the regulatory agency, developing trust between the interviewer and the participant in order to have reliable data was essential. Controls included careful selection and education/training of interviewers who were able to commit to the project over the 18 to 24 months for qualitative data collection. Interviewers were also selected on the basis of experience in interviewing and knowledge of substance abuse.

Instrumentation and Data Collection

Instrument for Archival Data

The instrument for archival data was developed in codebook format to accommodate data entry and analysis (see Appendix). Page one of the instrument consists of instructions necessary for maintaining confidentiality and methods for coding. Page two provides the case identifier, and page three established the keys for license data. The body of the instrument was established using a traditional format for coding of variables, i.e., Software Name (SPSS, SAS, EXCEL), Variable Name, Value. The named categories for archival data are: (1) Demographic Variables, (2) License Data, (3) Employment Data, (4) Socio-cultural Variables, (5) Substance Use History and (6) Substance Abuse history). A total of 283 variables were identified and coded under their respective categories. The research team agreed by consensus that all items on the instrument were essential to answer the research questions, however, three areas of deficit were identified, all under the socio-cultural category: information of religious orientation, information on sexual identity and background and history regarding legal involvement of self or family.

Interviewers were asked to consider ways and means of securing this information on interview. Also, some consideration was given to determining if the information could be obtained during program admission.

Two software packages were available for data analysis; SPSS (Statistical Packages for the Social Sciences) and Excel for Windows. A trial run on one aspect of the study was attempted on a population of 69 non-disciplinary licensees. Specifically, the question was whether type work in a hospital evidenced a relationship to type substance abuse. Frequency analysis evidenced that the Chi Square test of significance could not be run on this group due to the cell size being too small, again supporting the need to focus on descriptive and summative data first, then to evaluate the most appropriate statistical methods to apply.

The Qualitative Component

The second and third sets of questions must be answered using qualitative methods. For this study, the research questions serve as the guide for interview.

Procedures for Obtaining Qualitative Data

1. Letter of invitation to be sent by Board of Nursing contact (recovery program directors).

2. Follow-up call by contact person to licensee.
3. Licensee returns call and/or signed informed consent.
4. Set up file
5. Call made by interviewer to licensee.
6. Interview time established.
7. Interview conducted; as interview ends the licensee will be directed to next interview and potential subject matter.
8. Transcript of tape.
9. Code Transcripts by Co-Investigators, External Consultant, and interviewers.
10. If arbitration is needed to resolve concerns in coding, internal consultant will be called; consensus must be reached for coding.
11. Enter data.
12. Evaluate data obtained relative to questions for plan for additional data needed.
13. Complete X 3.
14. Terminate the interview process.
15. Follow-up with Board Contact.

Interview Guide

The research questions served as the framework for interviews

- 1.0 What are the characteristics of the two recovery system study populations? Upon Admission? At one year? At termination of the project or upon discharge? (The time frame for this question has necessarily been adjusted to accommodate the participants schedule time, and their admission dates into the program.
 - 1.1 What are the demographics of the two study populations (age, gender, residence, type license, marital status employment status)?
 - 1.2 What are the physical characteristics of the individuals in the two study groups (body type, health status, major diseases, health history)?
 - 1.3 What are the behavioral characteristics (communication patterns, receptiveness to intervention, stipulations, appearance, compliance with stipulations)?
 - 1.4 What are the socio-cultural characteristics (religion, sexual orientation, living arrangements, who in relationships uses(ed) drugs/alcohol (family members, friends, co-workers)?
 - 1.5 What is the psychiatric history (major problems, any treatment, any suicide attempts, family psychiatric history, other)
 - 1.6 What is the drug/alcohol use history (when began, how long used, what drugs/alcohol, how much, frequency)?
 - 1.7 What is the current drug/alcohol usage? (actively use, last time used, current prescriptions, any non-prescription use)? to Board, e.g., self, employer, friend, family, criminal justice system)?
 - 1.8 What is the work history of the population (where worked, type agency, facility, usual time to stay on job, multiple jobs at one time, shifts worked)?
- 2.0 What are the perceptions of the study populations regarding chemical dependency and recovery programs upon admission, and during interviews two and three.
 - 2.1 How is chemical dependency perceived (disease which is treatable, curable, manageable; is not a disease or a problem that exists for self, weakness in moral character, God's will, punishment for sins; other)?

- 2.2 What life events are perceived as influencing the development of chemical dependency (even if the person does not perceive of her/him self as being participant (proximity, holistic care, stipulations only, family, money, lack of knowledge of any other, age, friends, other)?
 - 2.3 Which stipulations are perceived of (in each agreement or order) as most helpful? least helpful?
 - 2.4 Which substantive activities are perceived of as facilitating compliance or non-compliance with stipulations? (drug screens, personal contact with program coordinator/manager, coordinator's demeanor/approach, family or friends, support groups, counseling, work restrictions, exercise, diet, fear of loss of license, other).
- 3.0 What is effective treatment and what is recovery as perceived by the study population?
- 3.1 How does the participant describe an adequate or "good" recovery program?
 - 3.2 What does the term "recovery" mean as perceived by study population?
 - 3.3 What is "effective treatment" as perceived by the study population?
 - 3.4 What factors are believed to be harmful or ineffective in treatment or promoting recovery from chemical dependency?

Analysis and Considerations for the Pilot Project

Quantitative Component:

Plans made during the pilot project regarding analysis of data for the comprehensive study, included conducting between and within group analyses. Between group statistical strategies were used for assessment of differences between the disciplinary and voluntary groups. Within group statistical strategies were to be used to determine demographic and characteristic differences that may exist within disciplinary and voluntary groups. Discriminate analysis was planned to assess the predictive values of the variables under consideration.

Findings from Archival Data:

The pilot study revealed that archival data were limited and often inaccurate. Further, limitations were imposed by the small population used for the pilot study. Consequently, plans were projected for the comprehensive study to select only those data from archival files that could be relied upon for valid results. For the pilot, two of the three participants were in the non-disciplinary program, one male, registered nurse and one female licensed practical nurse. The other nurse participant was a registered nurse enrolled in the disciplinary track.

Qualitative Component:

The constant comparison method adopted by Supples (1995) was utilized for analysis of data obtained through qualitative processes in the pilot. This method requires careful reading and verification of transcriptions, identifying and sorting facts and incidents into code segments. The code segments are then sorted into categories and resorted into more general categories and sub-categories as the research progresses. Categories are derived from substantive codes in the data. Refinement of categories will occur over time as the delineated processes are repeated following each of three interviews and transcriptions. A variety of techniques such as diagramming were considered to facilitate coding, linking of themes and categories, identifying trends and analytical schemes and eventually, positing theoretical explanations. Definition and refinement of categories and their properties led to a description of participants' perceptions of interventions required by the regulatory agency which are or are not helpful in recovery and other factors which are perceived to impact their recovery.

Findings Regarding the Qualitative Component

Content analysis was applied to six interviews (two per three pilot participants) by the total team including the consultant. As with the consultant study, categories were identified through recurring themes. These are summarized in the following Table. Additionally, consideration was given to the potential of adding religious orientation. In the pilot, however, this did not occur as a recurring theme.

Table: Categories of Commonly Recurring Themes in Interviews of Chemically Dependent Nurses

CASE NUMBER	001	002	003
CATEGORY : COMMON THEMES			
Family	Family wonderful, happy family, father spend life depressed, husband is alcoholic drinking, two sisters married to addicts, parents not substance abusers; "sure know how to pick them [husbands].	Parental stress, father dominance, power in the father, controlling, uncle with problem, parents control over drink is good, lives at Lake xx, wife, no children, wife supports him.	Father dominant, Mother couldn't believe it (SA); Husband-father who was good enough to help me out (as related to recovery) He abused her but helped her out by keeping 10yo son while she is in recovery; 17yo child, Parents want her do be the best she can; first husband has gotten "real" religious
Social/Societal/religion	family is "spiritual"; Lost her spirituality, lost zest for life, spiritual music vs. Rock and role. Public stigma—"everybody will know..." [as related to reg. Agency].	upper middle class, social drinker, [no mention of religion.	Middle class family (parents); two husbands, one abused her, one religious. Parents were deacons, church going, Southern Baptist. Licensee "goes to church."
Legal	Didn't think I had broken a law.	?	?
Treatment and Recovery	not an addict; Who Rx's? prayed; Females are worst—they confront. Doesn't want to be told-you're not okay; She was to do as told-not think, Had to let someone else think for her. Physician enabler into addiction—gave scripts.	Doesn't like AA; Likes recovery support group (nurses); Has had two relapses; 14 months now dry and clean; 24yo, first effort; Physician enabler in to (recovery?)	Withdrawal: shock, not ready, surprise, no preparation for formal treatment. Friend identified need for help, self reported, got lawyer, economic factor is hard, financial burden, One year medallion (sponsor feels good); 12 step program, pride, recovery group

Table : Categories of Commonly Recurring Themes in Interviews of Chemically Dependent Nurses

CASE NUMBER	001	002	003
CATEGORY : COMMON THEMES			could report her. What she said...doesn't think this is right this tattletale thing. Physician enabler into addiction (gave scripts) convenience for meetings (day, time, geography) hardships "needs to be with people for whom this works.
			could report her. What she said...doesn't think this is right this tattletale thing. Physician enabler into addiction (gave scripts) convenience for meetings (day, time, geography) hardships "needs to be with people for whom this works.
Self Authentication; Self Differentiation	I'm still a good person (hope). Honor? Striving to maintain a professional appearance. Been a pleaser. "If I can make a difference..."; Worked hard to become a "bad boy". Insecure, self-medicated	"I have a point" (hope). Honor/or denial. Never took from a patient, Structure abuse. Depressed, Prozac helps p. 31-32. Been a Pleaser.	Hope.. 14. Did not divert. From middle class family. Not an addict "that way." "Never did street drugs.: Been a pleaser.
Education	Went to religious school for 2 years; nursing school (2 years?)	Bachelors Degree; CRNA	Nursing school? Other

Conclusions and Recommendations:

The core research team concluded, after conducting the pilot the following:

- The research design is basically sound and can be implemented with the original aims intact.
- The research questions could be answered by the methodology described in the study proposal.
- Immediate implementation of the project was essential to secure the study population as expediently as possible, however, the recommendations regarding personalizing the invitations must be initiated.
- Four seasoned researchers, educationally qualified with knowledge and skilled in interviewing were to be secured. (Also be knowledgeable about chemical dependency.)
- The schedule for initiating the study and for completion should be revamped to accommodate interviews, organization, tabulation and analysis of data.
- Funding should be secured from an outside source i.e., NIDA if possible.

APPENDIX C

Consent Order
SAMPLE

Agreement

ANNA

ALABAMA NONDISCIPLINARY NURSING APPROACH
ALABAMA BOARD OF NURSING
RSA Plaza, Suite 250
770 Washington Avenue
Montgomery, Alabama 36130

AGREEMENT

For Treatment, Rehabilitation, and Monitoring for Chemical Dependence

IN THE MATTER OF
LICENSE NO.: _____

CASE NUMBER: _____

ISSUED TO: _____

Pursuant to §34-21-25, Code of Alabama, 1975 and §610-X-13 of the Alabama Board of Nursing Administrative Code, the Alabama Board of Nursing has the authority to enter into the following agreement and pursuant to §34-21-25 J(1), has the authority to enforce the following agreement.

On _____, «PROFPRACT» Nurse License No. «LICENSENO», admitted that «HESHE» is chemically dependent and in violation of Section 34-21-25(b) and on _____, voluntarily entered an «OUTORIN» Board approved treatment program at _____

I, «FULLNAME», recognize that I am chemically dependent. During my recovery, I agree to abide by the terms of this Agreement as established by the Alabama Board of Nursing.

1. During the period of this agreement, I agree to maintain a **current Alabama Nursing license** and to abide by the Statutes and Rules of the Alabama Board of Nursing.

2. I (the "Participant") agree to participate in the Alabama Nondisciplinary Nursing Approach (the "Program") for a period of three (3) years.

3. I agree to notify the Board in writing of **any change of address**.

4. I agree to notify the Program staff of **any change in my employment status**.

5. I agree to remain **free of alcohol** and all unprescribed **mood-altering substances** including **over-the-counter** medications containing mood-altering substances. I agree to inform my **health care provider** regarding my alcohol and drug problem. In the event such medication is needed, I will take responsibility to ensure that my health care provider submits, within seven (7) days, appropriate documentation to the Program staff explaining the choice of treatment and duration of prescribed mood-altering substances. I will give permission for my personal health care provider to release information to the Program staff and for the Program staff to communicate with my health care provider. I agree not to seek or receive drugs from any source other than the following: My health care provider(s) is _____

_____. In the event of the need for emergency treatment requiring mood-altering drugs, I agree to submit a copy of the emergency treatment record to the Program staff.

15. I agree to the following conditions for nursing employment:

- a. Shall practice only under the on-site supervision of a registered nurse in good standing with the Board. The supervising RN is not required to be on the same unit or ward as Participant, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The Participant shall work only regularly assigned, identified, and predetermined units. The supervising nurse shall be primarily one (1) person. The Participant shall not be self employed or contract for services.
- b. Shall not work for a nurse registry, traveling nurse agency, nursing float pool, home health agency, temporary employing agencies, or any other practice setting in which supervision is unavailable.
- c. Shall not seek employment as a supervising nurse.
- d. Shall not administer or have access to controlled substance medication for a minimum of the first _____ months of this Agreement, and I further agree to this condition until such time that I receive a letter from the Program staff acknowledging I may administer controlled substances.
- e. Shall not schedule my work to interfere with attendance at continuing care activities; shall not schedule work to exceed 40 hours in one week and/or 80 hours in two weeks; shall not work double shifts and will agree, if I desire to request a review of this condition in six months.
- f. Following two (2) years satisfactory compliance with stipulations, may request to work areas which have limited supervision. If granted, certain conditions will apply.

16. I agree to voluntarily submit to **random controlled drug screens**, which may be observed, inclusive of blood and/or urine, as may be directed by the Program staff, and shall be submitted at a Board approved collection site or laboratory. The drug screen will be a Board-approved drug screen and may include testing of chemicals beyond the base drug screen panel. Failure to submit to a random drug screen on the designated date may result in non-compliance, discharge from the program, and subsequent reporting to the Alabama Board of Nursing. A minimum of once a month testing shall be done and may be more frequent as requested by the Program staff.

17. I agree to execute all release of information authorizations in order for the Program staff to communicate and receive the reports from the primary treatment program, the aftercare facilitator, counselor/therapist, nurse support group facilitator, health care provider, and employer.

18. I agree to report any occurrence of a **relapse** to the Program staff and upon the request of the program staff will agree to cease nursing practice until it is determined I am safe to practice. I also agree to an evaluation by my original treatment program or the appropriate treatment provider and agree to follow recommendations made by the treatment program including long-term care.

19. I agree to appear in person for an **interview** upon request from the Program staff and given reasonable notice.

20. I agree to notify the Program staff of pending **relocation** out of the state of Alabama, and

#1-Standard Chemical Dependency/Treatment

BEFORE THE ALABAMA BOARD OF NURSING

IN THE MATTER OF:

XXXX

LICENSE NO. **XXXX**

)
)
)
)
)

CONSENT ORDER

The Alabama Board of Nursing, hereinafter referred to as Board, having evidence that **XXXX**, hereinafter referred to as Respondent, is in violation of the Code of Alabama 1975, §34-21-25, and of the Alabama Board of Nursing Administrative Code, §610-X-8-.05; and Respondent, desiring to avoid the necessity of a formal hearing, do hereby enter into this Consent Order in lieu of proceeding with further disciplinary action. Respondent understands that he/she has a right to a formal hearing in this matter and hereby knowingly waives such right. Respondent further understands and agrees that this a non-appealable Order.

FINDINGS OF FACT

I.

On xxxxxx-xx-19xx, Respondent was licensed by the Alabama Board of Nursing as a **XXXXX** Nurse (**XXN**) and was so licensed at all times relevant to matters stated herein.

II.

CONCLUSIONS OF LAW

Respondent's conduct constitutes sufficient grounds for the imposition of sanctions against his/her licensee to practice as a **RN/LPN** in the State of Alabama pursuant to the Code of Alabama 1975, §34-21-25, and the Alabama Board of Nursing Administrative Code, §610-X-8-.05(c)(e).

ORDER

Respondent's Alabama RN/LPN License, No. X:XXXXXX, is hereby placed on PROBATION for a period of THIRTY-SIX (36) MONTHS subject to the following terms and conditions:

1. Return of Wallet ID Card

Within ten (10) days of the effective date of this order, Respondent shall return his/her wallet ID card to the Alabama Board of Nursing office in order to have it indicate probationary status.

2. Fine

Respondent shall pay a fine in the amount of \$XXXX. This fine must be paid within thirty (30) days of the effective date of this Order. Respondent understands that failure to pay the fine is cause for additional disciplinary action by the Board of Nursing.

3. Primary Physician – Drug Use Exception

The Respondent will have only one primary physician/group during the period of this probation. Any other physician, other than in a documented emergency, must be referred by the primary physician. All mood altering medications must be prescribed to Respondent by this primary physician for a bona fide medical condition, or if prescribed by a referring physician, must be immediately reported in writing by the Respondent to the primary physician. Respondent must notify the Board of the name, address, and telephone number of the primary physician within 10 days of the effective date of this Order. The primary physician, within 10 days of entering into the practitioner/patient relationship, must inform the Board in writing of knowledge of Respondent's drug abuse history and provide a list of all medications prescribed for Respondent. Respondent shall cause any subsequent prescription to be verified to the Board by prescribing practitioner on a Board provided form at the time of the issuance of a prescription. The Board or its designee may, at any time request the practitioner to document the continued need for prescribed medications.

Respondent shall keep a written record of medications. Respondent shall keep a written record of medications taken, including over-the-counter drugs, and produce such record upon request by the Board. This is required regardless of whether Respondent is employed in nursing.

4. **Rehabilitation Program**

Within ten (10) working days of the receipt date of this Order, Respondent shall cause the director of the treatment program to submit to the Board or its designee proof of Respondent's scheduled assessment and subsequent entry into a primary intensive alcohol/drug treatment program. The program must be a Board-acceptable chemical dependency rehabilitation program. Respondent shall also cause the program director to provide the Board with documentation concerning Respondent's successful completion of the program and recommendations and arrangements for appropriate follow-up. Should Respondent, for any reason, fail to comply with this stipulation such will be grounds for termination of this Order and revocation of license. This is required regardless of whether Respondent is employed in nursing.

5. **Aftercare Program**

Within one (1) week of the completion of the rehabilitation program, Respondent shall enter and complete a Board acceptable chemical dependency aftercare program with said program to extend for a minimum of one (1) year. Upon entry, Respondent shall execute the appropriate release of information forms allowing the program to inform the Board, in writing and on the Board-approved form, of Respondent's entry into the program. Respondent shall also cause the program to submit to the Board, in writing and on the Board-approved form, evidence of satisfactory participation and progress in the program. Such reports are due beginning thirty (30) days after entering the counseling program and quarterly thereafter, according to schedule, for the remainder of the probationary period or until completion of the aftercare program. This is required regardless of whether Respondent is employed in nursing.

6. **Participation in AA/NA**

Throughout the term of this Order, Respondent shall participate three (3) times weekly, or as determined by the Board or Board designee, in Alcoholics Anonymous and/or Narcotics Anonymous meetings and shall submit to the Board, in writing on Board-approved forms, quarterly attendance reports. The first report is due commencing the month after the effective date of this Order and quarterly thereafter. Respondent must also maintain a sponsor relationship at all times throughout the terms of this Order. This is required regardless of whether Respondent is employed in nursing.

7. **Individual/Group Counseling**

Respondent shall participate regularly in a Board-acceptable counseling program contingent upon the recommendations of the original treatment program. Respondent shall continue in counseling for as long as deemed necessary by the counselor/therapist. This stipulation is in addition to meeting the stipulation requiring aftercare participation. Respondent shall have the counselor/therapist notify the Board when continued counseling is no longer indicated and Respondent is discharged or when there is a failure to complete or comply with the course of therapy. Respondent shall also cause the program to submit to the Board, in writing and on the Board-approved form, evidence of satisfactory participation and progress in counseling. Such reports are due beginning thirty (30) days after entering the counseling program and quarterly reports thereafter, according to schedule, as long as indicated during the probationary period. This is required regardless of whether Respondent is employed in nursing.

8. **Nurse Support Group/Caduceus Group**

Respondent shall participate weekly or as directed by Board or Board designee in a Board-acceptable Nurse Support Group or Caduceus Group and shall cause the group facilitator of the Nurse Support Group to submit to the Board, in writing on the Board-approved form, evidence of satisfactory attendance and participation during the remainder of the probationary period. A self-report documenting attendance in the Caduceus Group shall be submitted. The

first report is due commencing the month after the effective date of this Order and quarterly thereafter.

9. **Rehabilitative Progress Report**

Respondent shall submit a written progress report to the Board on the basis of one (1) time each month on a Board-approved form, containing a self-assessment of rehabilitative progress and status. This report is required regardless of whether Respondent is employed in nursing.

10. **Drug Screening**

Respondent shall participate as directed in a Board-acceptable program for random biological fluid testing. The drug screen will be a Board-approved drug screen and may include additional chemicals as designated by the Board or its designee. A minimum of one (1) random testing per month shall be done and may be required more frequently as requested by the Board or its designee. Further, the Board or its designee may at anytime require the Respondent to undergo additional drug screening of a type specified by the Board to ensure the Respondent is free of chemical substances as provided in this order. Refusal to provide a urine drug screen within the requested time frame constitutes a violation of this Order and such will be grounds for termination of this Order and revocation of license. Respondent waives any argument as to chain-of-custody of the sample or validity/accuracy of its testing regarding any positive screen received by the Board from an approved testing facility. The report of a positive drug screen which is not a result of prescribed medications as provided for herein shall be considered a violation of this probation. This is required regardless of whether Respondent is employed in nursing.

11. **Abstain from Alcohol Use**

Respondent shall abstain completely from the personal use of any substance containing alcohol.

12. **Abstain from Drug Use**

Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the Alabama Uniform Controlled Substances Act, dangerous drugs as defined by law, mood altering substances, or any drugs requiring a prescription (legend).

13. **Employment - Practice Under Supervision**

Respondent shall practice only under the on-site supervision of a registered nurse in good standing with the Board. The supervising RN is not required to be on the same unit or ward as Respondent, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The Respondent shall work only regularly assigned, identified, and predetermined units. The supervising nurse shall be primarily one (1) person. The Respondent shall not be self employed or contract for services.

14. **Employment-Increased Autonomy**

Following two years of satisfactory compliance with stipulations, Respondent may request to work areas which have limited supervision. If such is granted, said employment will be with specified conditions as set forth by the Board. In no event may Respondent engage in unsupervised practice without written authorization from the Board.

14. **Restricted Employment**

Respondent shall not work for a nursing registry, traveling nurse agency, nursing float pool, home health agency, or temporary employment agency without prior written approval from the Board or its designee.

16. **Employment-Supervision Restriction**

Respondent shall not seek employment as a supervising nurse.

17. **Employment -Access to Drugs**

Respondent shall not administer or have access to controlled substance medications for a minimum of six (6) months of employment on probationary status, and shall not have access to or administer controlled substance medications until a letter is received from the Board stating this stipulation no longer applies.

18. **Employment - Hours of Practice (Optional)**

Respondent shall not be scheduled to work more than three (3) consecutive 12-hour shifts in seven (7) days, and shall not be scheduled to work more than forty (40) hours in one (1) week or more than eighty (80) hours in two (2) weeks.

19. **Employment - Notification of Probationary Status**

Respondent shall provide any health care employer(s) and/or school of nursing with a copy of this Consent Order and cause each employer or school of nursing to acknowledge to the Board, in writing, that a copy of the Consent Order has been provided to the employer and/or school of nursing. The letter, on employer and/or school of nursing letterhead stationery, acknowledging receipt of a copy of this Consent Order shall be received by the Board no later than fourteen (14) days after the effective date of this Order or within fourteen (14) days of Respondent's employment.

20. **Employment - Change in Status**

Respondent shall notify the Board, within one (1) week, and in writing, of any change of employer or employment status. This is required regardless of whether Respondent is employed in nursing.

21. **Employment - Evaluation of Performance**

Respondent shall cause the employer to provide the Board, on a Board-approved form, a written evaluation of Respondent's nursing performance every three (3) months. The receipt of an unfavorable report may be considered to be a violation of probation. If Respondent is not employed as a nurse, Respondent is required to submit the employer evaluation form on the date it is due and indicate on that form that current employment is not in nursing.

22. **Not Employed in Nursing**

Periods of time in which Respondent is not employed as a practicing nurse shall be excluded from computation of time to be served on probation, unless determined otherwise by the Board of Nursing or its designee. Employment in fields other than nursing does not relieve Respondent from compliance with all other terms and conditions of this Order.

23. **Alabama Licensure Status**

Respondent must maintain a current license at all times during the period of probation. If for any reason Respondent allows the nursing license to lapse/expire during probation, such would be grounds for immediate revocation thereof. This provision includes obtaining continuing education contact hours as required for licensure.

24. **Notification of Board**

If Respondent is arrested by any law-enforcement agency or is admitted as a patient to any institution in this state or elsewhere for treatment regarding the abuse of or dependence on any chemical substance, or for treatment for any emotional or psychological disorder, Respondent agrees to cause the Board to be notified immediately.

25. **Change of Address**

Respondent shall immediately notify the Board, in writing, of any changes of address.

26. **Personal Interview**

Respondent shall appear in person for interviews at the request of the Board or Board designee.

27. **Obey the Laws**

Respondent shall refrain from violation of any federal, state or local law or rule or Order of the Board.

28. **Release of Records**

Respondent agrees to provide the Board with releases that authorize release of any and all records necessary to comply with the stipulations of this Order.

29. **Probation Violation**

Any deviation from the requirements of this probation without the written consent of the Board shall constitute a violation of this probation.

30. **Subsequent Practice Act Violation**

In the event that supplemental cause for disciplinary action should arise during the period of this probation or that Respondent should violate any of the aforesaid terms and conditions of the probation, the license of Respondent shall be subject to revocation.

31. **Fraudulent Acts During Probation**

Submission of fraudulent documents or reports or misrepresentation of facts relating to the terms and conditions stated herein shall constitute a violation of this probation.

32. **Termination of Probation**

The probationary period shall terminate only upon receipt of documents to satisfy all terms and conditions of this Order and the Board notifies Respondent in writing that all terms and conditions have been met and probation has been completed.

33. **Public Information**

This Order is public information and can be disseminated.

34. **Effective Date**

The effective date of this order shall be the documented date of service or attempted service by certified mail or personal service.

35. **Final Order**

This Order is subject to full Board consideration and acceptance before it shall be final.

EXECUTED on this the _____ day of _____ 20____.

XXXX

APPROVED AND ACCEPTED by the ALABAMA BOARD OF NURSING on this the _____ day of _____ 20____.

N. GENELL LEE, RN, MSN, JD
EXECUTIVE OFFICER
ALABAMA BOARD OF NURSING