



Arkansas State Board of Nursing

UNIVERSITY TOWER BUILDING, SUITE 800
1123 SOUTH UNIVERSITY AVENUE
LITTLE ROCK, ARKANSAS 72204-1619
Telephone 501.686.2701 • Facsimile 501.686.2714
www.arsbn.org

BOARD STRATEGIC PLANNING MEETING MINUTES

TIME AND PLACE:

May 9, 2018
Comfort Suites Hotel Conference Room;
11 Crossings Court in Little Rock, AR

MEMBERS PRESENT:

Ramonda Housh, MNSc, APRN, CNP, C-PNP; Yolanda Green, LPN; Haley Strunk, LPN, Rachel Sims, BSN, RN; Stacie Hipp, MSN, APRN; Pamela Leal, RN, Representative of the Older Population; Michael Burdine, RN; Renee Mihalko-Corbitt, DNP, APRN, ACNS-BC; Melanie Garner, LPN, CLC; Janice Ivers, MSN, RN, CNE; Kaci Bohn, PhD, Consumer Representative; Lance Lindow, RN

MEMBERS ABSENT:

Neldia Dycus, BS, MHSM, MHRD, RN

STAFF ATTENDING AT VARIOUS TIMES:

Sue A. Tedford, MNSc, APRN, Executive Director
Fred Knight, JD, General Counsel
Mary Trentham, JD, MNSc, MBA, APRN, CNP, Attorney Specialist
Karen McCumpsey, RN, MNSc, ASBN Assistant Director
Susan Lester, Executive Assistant to the Director
Tammy Claussen, MSN, RN, CNE, Program Coordinator
Debra Garrett, DNP, APRN, Program Coordinator
Lisa Wooten, MPH, BSN, RN, ASBN Assistant Director
LouAnn Walker, Public Information Coordinator
Jim Potter, Regulatory Board Chief Investigator
Albert Williams, Information Systems Coordinator

President Ramonda Housh called the meeting to order at 9:00 a.m. A flexible agenda was declared.

I. BOARD STRATEGIC PLANNING MEETING AGENDA

A copy of the agenda for the day along with a copy of the corresponding hand-outs are attached.

ASBN MINUTES

May 9, 2018

Page 2

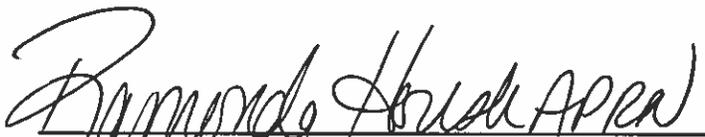
The Board discussed various options of names for the new alternative to discipline program and decided to call it "Arkansas Nurses Alternative Program (ArNAP).

Policies and procedures were reviewed and revised as attached as indicated by the attached copy wherein changes are marked using red strike-through font.

The use of Naltrexone was discussed. The Board members decided it is not a controlled substance; therefore, there is no need to monitor its use by nurses participating in ArNAP. A copy of Dr. Kaci Bohn's presentation is attached.

Documents regarding PEER support groups and CRNA guidelines were provided to Board Members, but discussion regarding these topics was tabled until future meetings.

There being no further business, the meeting adjourned at 4:20 p.m.



Ramonda Housh, President



Susan Lester, Recording Secretary



Date Approved

**2018 ASBN
STRATEGIC PLANNING MEETING**
*Comfort Suites Meeting Room
11 Crossings Court in Little Rock, AR
May 9, 2018*

- | | |
|---------------|--|
| 9:00 – 9:15 | Overview of the Alternative to Discipline Program-
Sue Tedford, MNSc, APRN, ASBN Executive Director |
| 9:15 – 9:45 | Brainstorming Session- Program Name |
| 9:45 – 10:15 | Review Policies and Procedures: I – VII and IX – XV |
| 10:15 – 10:30 | Break |
| 10:30 – 12:00 | Policies Continued |
| 12:00 – 1:00 | Lunch |
| 1:00 – 1:30 | Policies Continued |
| 1:30 – 2:00 | PEER Support Groups |
| 2:00 – 2:30 | Use of Naltrexone |
| 2:30 – 2:45 | Break |
| 2:45 – 3:30 | CRNA Guidelines |
| 3:30 – 4:00 | Review Mission and Objectives |
| 4:00 – 4:15 | Wrap Up- Sue Tedford, MNSc, APRN, ASBN Executive
Director |



Arkansas State Board of Nursing

1 State of Arkansas
2 91st General Assembly
3 Regular Session, 2017
4

A Bill

HOUSE BILL 1413

5 By: Representatives Boyd, Pilkington
6 By: Senator Files
7

For An Act To Be Entitled

8
9 AN ACT TO CREATE THE ALTERNATIVE TO DISCIPLINE ACT;
10 TO PROVIDE FOR TREATMENT OF NURSES LICENSED IN
11 ARKANSAS WHO SUFFER FROM IMPAIRMENT; AND FOR OTHER
12 PURPOSES.
13
14

Subtitle

15
16 TO CREATE THE ALTERNATIVE TO DISCIPLINE
17 ACT; AND TO PROVIDE FOR TREATMENT OF
18 NURSES LICENSED IN ARKANSAS WHO SUFFER
19 FROM IMPAIRMENT.
20
21

22 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
23

24 SECTION 1. Arkansas Code Title 17, Chapter 87, is amended to add an
25 additional subchapter to read as follows:

26 Subchapter 8 – Alternative to Discipline Act
27

28 17-87-801. Title.

29 This subchapter shall be known and may be cited as the "Alternative to
30 Discipline Act".
31

32 17-87-802. Purpose.

33 The purpose of this subchapter is to:

34 (1) Provide for the identification and treatment of nurses
35 licensed by the Arkansas State Board of Nursing who suffer from impairments;

36 (2) Promote public health and safety; and



1 (3) Ensure the continued availability of the skills of highly
2 trained nursing professionals for the benefit of the public.

3
4 17-87-803. Definitions.

5 As used in this subchapter:

6 (1) "Alternative to discipline program" means a plan approved by
7 the Arkansas State Board of Nursing for intervention, treatment, and
8 rehabilitation of an impaired nurse;

9 (2) "Impairment" means the inability or significant potential
10 for inability to practice with reasonable safety and skill as a result of a
11 diagnosed substance use disorder or any diagnosed mental or physical health
12 condition;

13 (3) "Participant" means an applicant or licensee who:

14 (A) Self reports an impairment to the board;

15 (B) Is referred to the alternative to discipline program
16 by the board; or

17 (C) Signs an initial agreement with the program
18 coordinator to oversee the impaired nurse; and

19 (4) "Rehabilitation" means the process whereby an impaired nurse
20 advances in an alternative to discipline program to an optimal level of
21 competence to practice nursing without endangering the public.

22
23 17-87-804. Alternative to Discipline Program – Program coordinator
24 duties – Board review.

25 (a) The Arkansas State Board of Nursing shall create an alternative to
26 discipline program which shall:

27 (1) Serve as a diversion program to which the board may refer
28 licensees when appropriate in lieu of or in addition to other disciplinary
29 action; and

30 (2) Be a source of referral for nurses who, on a strictly
31 voluntary basis, desire to avail themselves of its services.

32 (b) The board may perform the following duties and powers while
33 operating the alternative to discipline program:

34 (1) Approve addiction evaluators and treatment programs
35 available through the alternative to discipline program;

36 (2) Contract with providers of treatment programs;

1 (3) Receive and evaluate reports of suspected impairment,
 2 regardless of the source of the report;

3 (4) Intervene in cases of verified impairment;

4 (5) Refer impaired nurses to the program coordinator of the
 5 alternative to discipline program or another treatment program, or both;

6 (6) Monitor the treatment and rehabilitation of impaired nurses
 7 and the post-treatment of impaired nurses who are rehabilitated; and

8 (7) Perform other activities deemed necessary to accomplish the
 9 purposes of this subchapter.

10 (c)(1) The board shall employ a program coordinator to organize and
 11 administer the alternative to discipline program.

12 (2) The program coordinator shall:

13 (A) Review and evaluate nurses who request participation
 14 in or are recommended for the alternative to discipline program;

15 (B) Review and designate treatment facilities and services
 16 to which nurses in the program may be referred;

17 (C) Receipt and review of information relating to the
 18 participation of nurses in the program;

19 (D) Preparation of reports for the board; and

20 (E) Other duties as deemed necessary by the board.

21 (3)(A) The board shall review the activities of the program
 22 coordinator.

23 (B) As part of this evaluation, the board may review files
 24 of all participants in the alternative to discipline program.

25 (C) The board shall also resolve complaints voiced
 26 regarding the alternative to discipline program.

27
 28 17-87-805. Reporting procedure.

29 The Arkansas State Board of Nursing shall develop rules and procedures
 30 for:

31 (1) Reporting to the board:

32 (A) The names and results of any contact or investigation
 33 regarding an impaired nurse who is believed to be an imminent danger to the
 34 public or to himself or herself;

35 (B) An impaired nurse who:

36 (i) Fails or refuses to:

1 (a) Cooperate with the program coordinator; or

2 (b) Submit to treatment;

3 (ii) Exhibits professional incompetence; or

4 (iii) Does not have alleviation through treatment

5 for his or her impairment; and

6 (C) A participant of the alternative to discipline program

7 resuming the practice of nursing;

8 (2) Informing each participant of the alternative to discipline

9 program regarding the program requirements, program procedures,

10 responsibilities of the participant, and consequences of noncompliance; and

11 (3) Performing other activities as necessary to implement this

12 subchapter.

13

14 17-87-806. Program requirements.

15 (a)(1) Eligibility to participate in the alternative to discipline

16 program is at the sole discretion of the Arkansas State Board of Nursing.

17 (2) A person is not entitled to participate in the alternative

18 to discipline program.

19 (b) To establish eligibility, a nurse shall:

20 (1) Have a license issued or an application for licensure in the

21 State of Arkansas;

22 (2) Acknowledge that the nurse has a drug or alcohol abuse

23 problem or addiction; and

24 (3) Meet any other requirements determined by the board.

25 (c) A participant in the alternative to discipline program shall:

26 (1) Agree to:

27 (A) Complete an evaluation conducted by a board-approved

28 evaluator in order to outline the treatment required;

29 (B) Place his or her nursing license on inactive status

30 until a treatment provider determines that the participant can safely

31 practice nursing;

32 (C) Comply with:

33 (i) The written terms of the agreement to

34 participate in the alternative to discipline program; and

35 (ii) The terms and conditions of any contract

36 between the board and participant;

- 1 (D) Pay all costs for treatment and monitoring;
2 (E) Select from board-approved evaluators, treatment
3 facilities, counselors, and laboratory facilities before utilization of
4 services;
5 (F) Admit in an affidavit to violations of § 17-87-101 et
6 seq.; and
7 (2) Perform other activities as determined necessary by the
8 board.

9
10 17-87-807. Failure to comply.

11 (a) Participation in the alternative to discipline program under this
12 subchapter is not a defense to any disciplinary action that may be taken by
13 the Arkansas State Board of Nursing.

14 (b) This subchapter does not preclude the board from commencing
15 disciplinary action against a nurse who is terminated from or fails to comply
16 with the alternative to discipline program.

17
18 17-87-808. Liability.

19 (a) A person acting on behalf of the Arkansas State Board of Nursing
20 in the alternative to discipline program under this section is considered an
21 officer or employee of the State of Arkansas for purposes of:

22 (1) Immunity from civil liability under § 19-10-301 et seq.; and

23 (2) Payment of actual damages on behalf of state officers or
24 employees under § 21-9-201 et seq.

25 (b)(1) Except as provided in subdivision (b)(3) of this section, all
26 participant records shall be confidential and shall not be subject to public
27 inspection except under an order of a court of competent jurisdiction.

28 (2) However, the records may be introduced as evidence in any
29 relevant proceedings before the board and shall be produced upon board
30 request.

31 (3) The records regarding an impaired nurse or a participant of
32 the alternative to discipline program shall be available to:

33 (A) The board;

34 (B) The staff of the board;

35 (C) An employer;

36 (D) A treating healthcare provider;

(E) Nursing education programs; and
(F) Other states' nursing boards.

APPROVED: 03/02/2017

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36

ARKANSAS STATE BOARD OF NURSING RULES

CHAPTER TEN ALTERNATIVE TO DISCIPLINE

SECTION I QUALIFICATIONS FOR ADMISSION

In order to be eligible for admission to the ATD program the licensee or applicant for licensure shall:

- A. Hold an Arkansas nursing license or be eligible for licensure;
- B. Otherwise be eligible for continued licensure under the Arkansas *Nurse Practice Act*;
- C. Admit in writing to a Substance Use Disorder (SUD) including alcohol; and
- D. Voluntarily request participation in the ATD program.
- E. A participant may transfer from another state's alternative program if it is substantively similar and approved by the ATD program director.

HISTORY: Adopted: January 1, 2018

SECTION II DENIAL TO PROGRAM

Licenseses or applicants for licensure will be denied participation in the ATD program if they:

- A. Do not meet the qualifications listed in Section I;
- B. Diverted controlled substances for reasons other than self-administration;
- C. Engaged in behaviors resulting in patient harm;
- D. Have prior discipline by any board of nursing for substance abuse or diversion; or
- E. Demonstrated unsuccessful participation resulting in termination from the Arkansas ATD program or similar program offered in another jurisdiction.

HISTORY: Adopted: January 1, 2018

SECTION III REQUIREMENTS FOR PARTICIPATION

The participant shall:

- A. Agree to immediately place licensure on inactive status;
- B. Complete an in-depth psychological and addictive evaluation by a Board approved evaluator;
- C. Agree to complete all treatment recommendations, if any, of the evaluator;
- D. Admit, in writing, to violation of the Arkansas *Nurse Practice Act*;
- E. Enter into an ATD program contract;
- F. Execute any release necessary to give the ATD program director access to records, including but not limited to medical, employment and criminal records; and
- G. Agree to not practice nursing without written authorization from the ATD program director.

HISTORY: Adopted: January 1, 2018

SECTION IV STANDARDS FOR APPROVED EVALUATORS AND TREATMENT PROVIDERS

- A. Board approved evaluators shall meet the following standards:
 1. Be a physician, psychiatrist, psychologist, or mental health certified Advanced Practice Registered Nurse who is engaged in the treatment of substance use disorder, including alcohol;
 2. Demonstrate the ability to perform an examination to include a detailed history with the appropriate testing i.e. drug screens and other psychological testing as indicated;

ARKANSAS STATE BOARD OF NURSING RULES

3. Cooperate and communicate with the ATD program director; and
 4. Submit evaluation reports according to Board approved criteria.
- B. Board approved treatment providers shall meet the following standards:
1. Provide outpatient and/or inpatient treatment;
 2. Cooperate and communicate with the ATD program director;
 3. Submit individualized written plan of care to include, but not limited to, assessment, diagnosis, treatment goals, discharge criteria, and recommendations for continuing recovery; and
 4. Meet all regulatory requirements in their respective state.

HISTORY: Adopted: January 1, 2018

SECTION V DISCHARGE FROM PROGRAM

- A. A participant shall be discharged from the ATD program upon:
1. Successful completion of all terms and conditions of the ATD program contract; or
 2. Demonstration of noncompliance with the terms and conditions of the contract.
- B. If discharged from the ATD program for noncompliance, the licensee shall immediately surrender their licensure, accept a consent agreement, or be scheduled for a Board hearing.
- C. Participation in the ATD program does not preclude the Board from commencing any disciplinary action against a participant who is discharged from the ATD program or receives additional complaint(s).
- D. A participant may transfer to another state's alternative program if it is substantively similar and approved by the Arkansas ATD program director.
- E. If the participant voluntarily withdraws from the program, he/she shall immediately surrender his/her nursing licensure.

HISTORY: Adopted: January 1, 2018

SECTION VI REPORTING TO THE BOARD

The ATD program director shall make the following information available to the board:

- A. Names and results of any contact or investigation regarding an impaired nurse who is believed to be a danger to the public;
- B. Names of participants who:
 1. Fail to comply with the terms and conditions of the contract;
 2. Refuse to cooperate with the ATD program director; or
 3. Voluntarily withdraw or involuntarily discharge from the program;
- C. An annual evaluation of the program; and
- D. Other information and data as requested by the Board.

HISTORY: Adopted: January 1, 2018

Mission

The mission of the Recovering Arkansas Intervention for Nursing (RAIN) program is to protect the public by providing education, consultation, referral, monitoring, and support for chemically dependent and recovering individuals licensed by the Board of Nursing.

Objectives

In order to protect the public, the objectives of the RAIN program are:

1. To identify, support, and closely monitor licensees who are unsafe or potentially unsafe to practice due to chemical impairment;
2. To facilitate rapid intervention thereby decreasing the time between the licensee's acknowledgement of the problem and entry into a recovery process;
3. To provide an opportunity for licensees to be rehabilitated in a therapeutic, non-punitive, and non-public process;
4. To develop a statewide resource network for referral of licensees to appropriate services;
5. To provide outreach and education to healthcare facilities, professional nursing organizations, and nursing programs throughout the state of Arkansas.



ARKANSAS STATE BOARD OF NURSING

1123 S. University Avenue, Suite 800, University Tower Building, Little Rock, AR 72204
Phone: (501) 686-2700 Fax: (501) 686-2714 www.arsbn.org

DATE: May 9, 2018
TO: Board of Nursing
FR: Sue A. Tedford, MNsc, APRN
Executive Director
RE: Program Name

Board Action Requested: Select a name for the ASBN Alternative to Discipline program.

Background: The program was named RAIN by the consultants. This acronym is used across the nation for the Regional Aids Interfaith Network. The next page is a list of potential names for the program. The list is intended to start your creative juices flowing and help you come up with a few more ideas.

Possible names for ATD program

We will have a brainstorming session to identify a name for our ATD program. Below is a list of ideas that various individuals have suggested. Use this list to engage your creative juices for more ideas that you can offer at the meeting.

1. Recovering Arkansas Intervention for Nursing (RAIN)
2. Monitoring Intervention for Nurses in Arkansas (MINA)
3. Arkansas Assistance with Monitoring Program (ArAMP)
4. Arkansas Returning to Nursing Practice (ArRNP)
5. Arkansas Nursing Recovery Monitoring Program (ArNRMP)
6. Monitoring Arkansas Nurses in Recovery (MANIR)
7. Arkansas Secondary Chemical Dependency Cooperative – ASCDC
8. Arkansas Chemical Dependency Reformation Program – ACDRP
9. Arkansas Dependent Activity Program – ADAP
10. Arkansas Dependent Activity Prevention Program – ADAPP
11. Arkansas Dependency Readjustment Training Program – AD RTP
12. Arkansas Discipline Cessation Program – ADCP (AR tobacco cessation program)
13. Arkansas Chemical Dependency Intercession Program – ACDIP
14. Arkansas Adjunct Anti-Dependency Program – AAADP
15. Arkansas Alternative to Discipline Cooperative - AADC
16. Monitoring Arkansas Impaired Nurses - MAIN
17. Choice for Arkansas Nurses – CAN
18. Arkansas Disciplinary Alternative Program - ArDAP
19. Arkansas Nurses Alternative Program - ArNAP
20. Arkansas Alternative Discipline Program - ArADP

* Adapt is a good way to describe the transition for nurses entering the program.

*Cooperative – group with common interest or pursuit

*Intervention – the act of intervening

*Intercession – attempt to bring to agreement



ARKANSAS STATE BOARD OF NURSING

1123 S. University Avenue, Suite 800, University Tower Building, Little Rock, AR 72204
Phone: (501) 686-2700 Fax: (501) 686-2714 www.arsbn.org

DATE: May 9, 2018
TO: Board of Nursing
FR: Sue A. Tedford, MNSc, APRN
Executive Director
RE: Policies

Board Action Requested: Review attached policies and provide input on content. You will not be "approving" these documents at this meeting.

Background: The consultants developed the attached policies and procedures. The ATD Ad Hoc Committee (Ramonda, Kaci, Pam, Mike and Yolanda) have worked with staff to revise the policies according to current ASBN practice. Following your review, the documents will be divided into Policy and Procedures and Guidelines. For an example of current guidelines, DG-1, DG-5 and DG-7 can be found in Appendix A.

Assessment and Evaluation Requirements

POLICY: Individuals referred to the RAIN program shall be nurses licensed in Arkansas or eligible for licensure in Arkansas and shall be provided guidelines for enrollment and participation in the RAIN program. Participants shall place all licenses on inactive status and agree to not practice as a nurse in any jurisdiction until written authorization is received from the RAIN staff.

PROCEDURE:

1. Upon contact with an individual seeking admission into the RAIN program, information about the program, referral process, and monitoring process shall be provided. A face-to-face meeting shall be scheduled with the individual within forty-eight (48) business hours.
2. At the time of acceptance of RAIN services the participant shall:
 - a. Complete and submit a release of information to:
 - i. Employer (current or most recent)
 - ii. ASBN
 - iii. Evaluator or treatment provider, if applicable
 - b. Sign a notarized eligibility agreement; and
 - c. Place all Arkansas nursing licenses on inactive status and agree to not practice as a nurse in any jurisdiction.
3. The participant shall be required to either:
 - a. Undergo an evaluation with an ASBN approved addiction evaluator who is familiar with the RAIN program, substance use disorders, and ASBN requirements; or
 - b. Admit directly to an ASBN approved treatment facility.
4. Initial Diagnostic and Treatment Evaluation
 - a. The evaluation appointment and interview conducted by an ASBN approved addiction evaluator should occur after the participant has officially requested the RAIN program services.
 - b. The focus of the evaluation is to determine if the participant has a substance use disorder.
 - c. The purpose of the evaluation is to gather information regarding the evaluator's diagnostic impression, recommend an individualized treatment plan, and any monitoring parameters.
 - d. All evaluations shall be conducted through an in-person assessment.
 - e. The evaluation does not establish a patient/provider relationship.
 - f. The evaluator shall provide RAIN staff with a written report providing recommendations.
 - i. RAIN staff shall review the evaluation report upon receipt.
 - ii. RAIN staff shall contact the participant and provide the recommendations, if any, to the participant. An evaluation recommendation letter shall be mailed (certified and regular) to the participant. The letter shall establish a timeline for compliance with the recommendations.
 - iii. The participant shall comply with all treatment and monitoring recommendations.

5. Treatment
 - a. An individual who recognizes the need for treatment may bypass the RAIN program diagnostic and treatment evaluation requirement and report directly to a treatment facility approved by the ASBN.
 - b. The treatment facility staff shall conduct an assessment to determine if the individual shall benefit from treatment and the appropriate level of treatment.
 - c. When the treatment facility staff have determined the level of treatment, the individual may seek treatment at that facility or another as long as the treatment is consistent with the recommendation and the facility is approved by the ASBN.
 - d. If already admitted in a treatment facility at the time of referral, the individual shall sign a release allowing the treatment facility and RAIN staff to correspond about the admission evaluation and ongoing treatment to ensure the care is comparable to those facilities approved by the ASBN. There is no assurance that the RAIN program shall accept non Board-approved treatment facility's evaluation and treatment plans.
6. No diagnosis of a substance use disorder
 - a. Participants shall submit to RAIN staff a reinstatement of licensure and return to nursing practice request with a safe-to-practice statement by an ASBN approved addiction evaluator.
 - b. Participant shall enter into at least a one (1) year contract to include at a minimum:
 - i. Drug screening
 - ii. Self-reports
 - iii. Reports from treatment providers, if applicable
 - iv. Other employment conditions outlined in Policy VI
7. Addictive evaluation
 - a. Prior to return to nursing practice, the participant with a diagnosis of substance use disorder shall complete an addictive evaluation by an ASBN approved addiction evaluator.
8. Declined Service
 - a. The file shall be closed, and the participant shall be referred to the ASBN for further action, if any, when an individual who has requested participation in the RAIN program fails to complete the enrollment and intake process.
9. Public Safety
 - a. The ASBN shall be immediately notified when RAIN staff has concern for an individual's immediate safety or the safety of others.
 - b. The RAIN staff may continue to offer services to the individual unless otherwise directed by the ASBN.
 - c. Prior to program completion if a participant has not returned to active nursing practice, the participant shall have a safe-to-practice statement by an ASBN approved evaluator.
10. Demographic information, including, but may not be limited to the following shall be collected from the request for services form and entered into RAIN's database:
 - a. Name
 - b. Address
 - c. Telephone number(s)
 - d. Nursing license number(s)
 - e. Referral source (employer, self, ASBN, treatment, legal, etc.)
 - f. Details of why services are being requested (who, what, when, where, and why)

- g. Education
- h. Employment History

DRAFT

Admission Criteria

POLICY: Participation in the RAIN program is limited to those individuals who are healthcare providers licensed or are seeking licensure by the Arkansas State Board of Nursing (ASBN).

PROCEDURE:

1. Eligibility
 - a. Individual shall hold a current, active license issued by the ASBN; or
 - b. Be an applicant for initial licensure or for reinstatement by the ASBN; and
 - c. If applicable, shall voluntarily place license(s) on inactive status until approved for reactivation by RAIN staff.
2. Enrollment

The individual shall request services in writing by submitting all appropriate forms including release of information and providing a copy of all requested legal documents.
3. Referral to the RAIN program requires one or more of the following:
 - a. A finding by an ASBN board approved addiction evaluator or treatment facility that an individual has a substance use disorder and can benefit from monitoring during the early stage of recovery;
 - b. A finding or belief that the ability to practice as a licensee or an applicant for licensure is impaired or potentially impaired due to the use of alcohol or other drugs;
 - c. The individual has requested to participate in the RAIN program;
 - d. The individual is requested to participate in the RAIN program by their employer; or
 - e. The individual has successfully completed treatment for substance use disorder and a reasonable expectation exists that the impairment or potential impairment shall be alleviated.
4. Enrollment in the RAIN program is voluntary regardless of the referral source. The decision to accept or decline services is the individual's, and may affect their licensure status with the ASBN.
5. Enrollment or participation in the RAIN program may be denied if the individual:
 - a. Is unwilling or unable to abstain from potentially addicting drugs (legal or illegal), including alcohol;
 - b. Is unable to abstain from abuse potential medications unless approval for the medication is recommended and documented by a Board-approved addiction evaluator.
 - c. Is unable or unwilling to adhere to the evaluation recommendation, or
 - d. The disciplinary process has begun.
6. Enrollment or participation in the RAIN program shall be denied if the individual:
 - a. Has prior discipline by any board of nursing for substance abuse or diversion;
 - b. Demonstrated unsuccessful participation resulting in termination from the RAIN program or similar program offered in another jurisdiction;
 - c. Is not eligible for licensure in the state of Arkansas.
 - d. Diverted controlled substances for reasons other than self-administration;
 - e. Engaged in conduct resulting in patient harm; or
 - f. Does not have a condition identified for which treatment is available and can reasonably expect to alleviate or significantly reduce the practice issues for which the individual was referred or seeking services.

Referral for Participation

POLICY: Referrals shall be accepted from any external source, the ASBN or by the individual requesting participation.

PROCEDURE:

1. Referral Source
 - a. Self-referrals may result from:
 - i. A licensee experiencing issues related to substance use disorder (e.g. a positive drug screen, workplace issues, diversion for self-administration, transferring from a similar program in another state, etc.).
 - ii. A licensee who has been charged or convicted of a drug-related crime and that crime is not a bar to licensure in Arkansas.
 - b. External referrals may come from any source such as:
 - i. Employer;
 - ii. Co-worker;
 - iii. Family member;
 - iv. Anonymous source; or
 - v. Local, state or national agency, etc.
 - c. ASBN referrals may come from:
 - i. The review of a complaint filed against the licensee if the complaint appears to be related to substance abuse or use;
 - ii. Determination that it is appropriate for the individual to undergo the RAIN program evaluation prior to issuance of an initial license or the reinstatement of an expired license based on the individual's substance abuse or use history; or
 - iii. An ASBN investigator.
2. The referring source shall provide, at a minimum:
 - a. Name of referring source, company or agency if applicable, address and telephone number.
 - b. Demographic information for the individual being referred (name, address and telephone number, profession and license number).
 - c. Detailed reason for referral and date incident(s) occurred or observed, name and contact information for others who may be aware or observed the behavior/incident.
3. Referral reasons may include, but are not limited to:
 - a. Criminal misdemeanor or felony conviction other than minor traffic offense;
 - b. Diversion of narcotics or suspicion of diversion from the workplace for self-use. Note: If a determination is made that an individual is diverting medications for the sole purpose of selling the medications or to provide to someone else, the individual is not eligible for the RAIN program;
 - c. Fitness-for-practice concern;
 - d. Prescription forgery, over-prescribing or "doctor shopping";
 - e. Workplace behavioral changes;
 - f. Toxicology result other than "negative";
 - g. Documentation issues; or
 - h. Diagnosis of substance use disorder.
4. RAIN staff shall not release the information regarding the referring source except to the ASBN.
5. Upon receipt of a referral, a RAIN staff member shall contact the individual by sending a referral notification letter via the USPS certified and regular mail.

6. An individual who is referred to the RAIN program and declines services, does not respond to a RAIN staff's letter of notification, fails to complete an addiction evaluation by the deadline date, or fails to adhere to RAIN staff recommendations shall be reported to the ASBN.

DRAFT

Monitoring Components

POLICY: The RAIN program is a non-disciplinary monitoring program for participants with conduct **concerns** related to substance abuse or use.

PROCEDURE:

1. RAIN staff shall document in writing contacts that are made with a participant, family member, employer, ASBN, or other professionals regarding an individual seeking RAIN program services or who is enrolled in the program.
2. At a minimum, each note shall include, date of contact, purpose of contact, the name of the RAIN staff member, and issues discussed (who, what, when, why). When available full names, titles, and contact information of individuals referred to within the note shall be documented.
3. RAIN staff shall document all attempts to contact an individual, including, but not limited to, messages left on answering machines, voice mail, unanswered calls, and nonworking numbers.
4. RAIN staff shall ensure appropriate release of information forms have been obtained for each participant assigned to their caseload.
5. RAIN staff shall ensure the information maintained in the database is current and correct.
6. RAIN staff shall monitor the participant's contract and ensure all reports required by the monitoring contract are received. This includes, but is not limited to:
 - a. Progress Evaluation by treatment provider - quarterly
 - b. Employer Performance Evaluation - quarterly
 - c. Self-reports - monthly
 - d. Meeting Attendance Record - monthly
 - e. Verification of Prescription Medication – with all new prescriptions
 - f. Drug Screen results - monthly
7. RAIN staff shall meet, at a minimum, quarterly with each participant in their caseload. Monthly meetings may be necessary with participants early in their recovery or who may be noncompliant with the monitoring agreement. Meetings shall be face-to-face and participants understand that virtual meetings are considered a face-to-face encounter under the RAIN contract.
8. RAIN staff shall submit a quarterly report to the ASBN.
9. A safe-to-practice evaluation may be necessary whenever a participant is consistently noncompliant, receives a negative performance evaluation from an employer, or is not progressing satisfactorily in the recovery process.

Compliance Requirements

POLICY: Participants shall follow all requirements as specified in the evaluation recommendations, treatment plan, and the program contract. Failure to comply may result in termination from the RAIN program.

PROCEDURE:

1. Participants shall be responsible for following the addiction evaluation recommendations, treatment plan, if any, and the contract stipulations.
2. Participants shall abstain at all times from the use of controlled or abuse potential substances, whether prescribed or over-the-counter products. Participants shall abstain from alcohol and products that contain alcohol, and shall not consume hemp, poppy seeds, or all products or by-products containing the same. If there is a need for the use of controlled or abuse potential medication, participants must consult with RAIN staff prior to ingesting these medications, or within twenty-four (24) hours of an emergent situation.
3. Participants shall notify RAIN staff of any change, even a temporary one, of name, address, phone numbers, or employment within twenty-four (24) hours of this change occurring. Participants who fail to communicate these changes may be discharged from the program and the ASBN notified.
4. Participants shall respond to callback requests from RAIN staff within one (1) business day.
5. Participants shall assure the financial obligations of their evaluation and treatment are fulfilled.
6. Participants shall refrain from nursing practice until authorized for reinstatement by RAIN staff.
7. Any time RAIN staff believes the participant poses a threat to public safety the ASBN shall be notified the next business day.
8. RAIN staff shall explain to each participant seeking enrollment or enrolled in the program their rights, responsibilities, and the rules and make a written copy available.
9. The participant shall sign the participant form acknowledging they have been informed of their rights.

Employment Conditions and Parameters

POLICY: RAIN staff approval is required prior to return to nursing practice. Specific conditions and parameters for employment shall be outlined in the participant's contract.

PROCEDURE:

1. Participants may request return to nursing practice when the following conditions are met:
 - a. Have an evaluation by a Board-approved addiction evaluator within thirty (30) days of submission of a request for licensure reinstatement. The addiction evaluator shall specifically advise RAIN staff if participant is or is not presently able to engage in safe practice or recommend the conditions, if any, under which safe practice could occur; and
 - b. If diagnosed with substance use disorder, ninety (90) days of 100% compliance with drug screening requirements, and completion of a minimum of ninety (90) days of treatment recommendations.
2. General requirements for seeking employment while participating in the RAIN program:
 - a. Participants shall submit a reinstatement of licensure and return to nursing practice request to RAIN staff with all required documents.
 - b. Upon receipt of a reinstatement of licensure and return to nursing practice request, RAIN staff shall review the request and documents and make a recommendation for return to nursing practice.
 - c. Upon licensure reinstatement, participants may seek employment only within the state of Arkansas.
 - d. Participant shall inform the prospective employer of RAIN program participation. A job description shall be submitted to RAIN staff.
 - e. Participants shall submit to RAIN staff, in writing, the name, address, phone number, and email address for the employer and immediate supervisor.
 - f. Participants shall notify RAIN staff of any change in supervision, even temporary, within twenty-four (24) hours. Participants shall submit an updated signed supervisor acknowledgment form.
 - g. RAIN staff shall conduct a joint conference call with the employer, supervisor, and participant to discuss the participant's RAIN contract work requirements and restrictions prior to beginning employment.
 - h. Participant shall provide employer with a copy of their RAIN contract.
 - i. Approved positions shall include general supervision. Supervisors shall be aware of RAIN participation and meet all supervisory requirements.
3. Supervision Requirements:
 - a. All RAIN participants shall be supervised by another licensed healthcare professional working on the same shift, who shall see the participant periodically throughout the shift and shall be aware of the participant's enrollment in the RAIN program.
 - b. Supervisors shall hold the same level of licensure or greater. Supervisors may be a physician.
 - i. Supervisors shall be on premises and immediately available.
 - ii. Supervisors shall have an active unencumbered license.
 - iii. Approval of supervisors with past discipline shall be considered on a case-by-case basis.

4. The following employment restrictions shall apply for nursing practice:
 - a. Shall not be self-employed, contract for services, or work concurrently for multiple employers in the healthcare field.
 - b. If diagnosed with SUD, shall not have access to narcotics the first twelve (12) months of employment. This includes:
 - i. Access to narcotic keys or controlled substances, including any potentially addicting medications
 - ii. Prepare or administer controlled substances
 - iii. Carry the narcotic keys or access code to the narcotics container or room where controlled substances are stored or located
 - iv. Participate in the count or inventory of controlled substances
 - v. Dispose of or witness the disposal of controlled substances
 - vi. Receive the delivery of controlled substances to the facility or unit
 - vii. Telephone or order controlled substance prescriptions as an authorized prescriber or on behalf of an authorized provider
 - viii. Pick up, deliver, distribute, or return controlled substances
 - ix. Have access to prescription blanks/pads paper or electronic
 - c. Shall not work more than forty (40) hours per week or more than 84 hours biweekly if working 12-hour shifts.
 - d. Shall not work more than twelve (12) hours in a twenty-four (24) hour period or between midnight through six (6) a.m.
 - e. Shall not float to areas not supervised by the participant's approved supervisor.
 - f. While enrolled in the RAIN program, shall not accept any position where (s)he may be required to supervise another participant of the RAIN program..
 - g. Shall not be employed in the following settings:
 - i. substance abuse treatment;
 - ii. home health;
 - iii. hospice;
 - iv. staffing agency; or
 - v. areas of limited ability for supervision such as Critical Care, Emergency Department, Labor & Delivery, postoperative anesthesia, operating room, interventional radiology, cath lab or similar labs.
5. Employment restrictions may be modified after one (1) year of successful nursing practice and documented compliance with the RAIN program.
6. Participants diagnosed with SUDs may be released from the five (5) year contract after thirty-six (36) months of continuous employment which meet the following criteria:
 - a. Provide direct patient care in a clinical healthcare setting; and
 - b. Work for a minimum of sixty-four (64) hours per month for four (4) quarterly periods [one (1) year] of employment. This requirement shall be satisfied until four (4) quarterly periods of employment as a nurse have elapsed. Any quarterly period without continuous employment with the same employer for all three (3) months shall count towards completion of the requirement. Periods of unemployment or of employment that do not require the use of a nursing license shall not apply to this period, and shall count towards completion of this requirement.

Toxicology Testing

Policy: Participants in the RAIN program shall submit to random, and on-demand toxicology testing. Drug screens shall include, but are not limited to urine, hair, nails, and blood. Participants who are required to submit to toxicology testing shall be referred to a Board-approved drug-screen monitoring program, laboratory, and collection site.

Procedure:

1. Accuracy and consistency are provided through a properly completed chain of custody at the collection site¹. Both the collector and the participant who is providing the specimen for testing shall complete the chain of custody document.
2. All drug screens shall be directly observed by the collector.
3. Confirmation of results shall be provided through the process of confirmation cutoffs as outlined in the medical professional panel² (GC/MS – Gas Chromatography/Mass Spectrometry and LC/MS - Liquid Chromatography/Mass Spectrometry) by a Board-approved drug-screen monitoring program³.
4. Results of the drug screens and verification of compliance with screening are available with online access by the Board-approved drug-screen monitoring program. The RAIN staff shall be notified of any positive screen by the Board-approved drug-screen monitoring program. Chain of custody shall be provided for the positive drug screen and shall be sent to the RAIN staff by the Board-approved drug-screen monitoring program.
5. Participant shall check in with a Board-approved drug-screen monitoring program daily to determine if they have been selected for a drug-screen. Participant shall present for a drug-screen the same day of the notification and shall have two (2) hours to have the specimen collected. Participant shall not submit dilute specimens.
6. RAIN staff shall have the right to require additional testing at any time during program participation.
7. Dilute and abnormal urines:
 - a. The participant shall be provided the dilute and abnormal specimen policy.
 - b. Dilute and abnormal urine results shall follow the Progressive Action Policy.
8. Travel guidelines
 - a. Participant shall submit documentation of travel plans and a recovery maintenance plan prior to travel.
 - b. Participant shall notify RAIN staff two (2) weeks prior to traveling within the continental United States. The participant shall be advised of alternate approved collection sites.
 - c. Travel outside the continental United States requires approval at least thirty (30) days prior to traveling.
9. Participant with a positive drug screen agree to place all licensure immediately on inactive status.

¹ Chain of custody criteria

² Confirmation Cutoffs

³ Laboratory Criteria

APRN Specific Requirements

POLICY: APRNs shall be in a practice with a supervisor (APRN or physician) that can meet the stipulation of the Employment Conditions and Parameters Policy. If employed as an RN and not performing as an APRN, supervisor may be another RN.

PROCEDURE:

- I. APRNs are required to participate in a 5-year monitoring. Any change to the 5-year monitoring plan requires approval by the ASBN.
- II. Readiness to return to practice must be thoroughly assessed by RAIN staff, the treatment team and the CRNA prior to re-entry. CRNA's must have a minimum of 1-year of documented recovery prior to re-entering the practice of anesthesia and this may be in a RN role but not as a CRNA. Changes to this requirement are only considered based on the specific treatment recommendations from the RAIN approved treatment program and the final authorization of the RAIN executive director in discussion with the RAIN team.
 - a. CRNAs may be evaluated by RAIN approved evaluators or treatment providers for Naltrexone or Vivitrol therapy prior to return to CRNA Practice.
 - b. CRNAs who receive less intensive treatment either in-patient or out-patient, may be required to refrain from anesthesia practice for a minimum of 18 months and with documented recovery, required meeting attendance and negative screenings. Alterations to the time limitation will be determined for the individual considering the type of treatment completed, severity of illness and treatment team recommendations. The time prior to re-entry to practice may be reduced (in rare circumstances) or extended.
 - i. A fitness for duty evaluation will be required prior to return to work.
 - ii. The CRNA will submit a CRNA Re-entry Contract when satisfactory progress has been made in monitoring and all treatment team recommendation have been met.
 - iii. A CRNA Re-entry Contract must be approved by RAIN and all conditions must be adhered to by the practicing CRNA.
- III. RAIN requires the submission and approval of a new CRNA Re-entry Contract completed by the CRNA and the new employer prior to any change in employment and/or supervisor.

Termination from Program

Policy: Participation in the RAIN program may be terminated and reported to the ASBN when a participant fails to comply with the treatment, monitoring, or contract requirements.

Procedure:

1. Termination may occur for the following reasons:
 - a. Non-compliance with the RAIN contract;
 - b. Practicing or attempting to nursing practice without written approval by RAIN staff;
 - c. Relocation, even temporarily, outside the State of Arkansas without prior approval by RAIN staff;
 - d. Participant requests termination;
 - e. Any circumstance that presents an imminent danger to the public;
 - f. Participant is unable or unwilling to abstain from controlled or abuse potential substances, including alcohol;
 - g. Participant insists RAIN communication, either written or verbal, be filtered through a third party;
 - h. Suspension of drug screening without reactivation;
 - i. Failure to register for drug screening within seventy-two (72) hours of signing the RAIN contract;
 - j. Failure to check-in for screening for more than three (3) consecutive days;
 - k. Falsification of patient records;
 - l. Providing any false records or reports required by the RAIN contract;
 - m. Prescription seeking behaviors to obtain controlled or abuse potential substances;
 - n. Unreported prescriptions for controlled or abuse potential substances;
 - o. Refusal to drug screen at the request of an employer;
 - p. Taking controlled or abuse potential substances not prescribed for participant;
 - q. Submission of a substituted or adulterated specimen;
 - r. Failure to report a misdemeanor or felony charge, plea, or conviction;
 - s. Failure to respond to requests from RAIN staff; or
 - t. Level 2 violation.
2. The participant, employer, treatment providers, and support group (when applicable) shall be notified of the termination by verbal or written communication. Notification shall be documented in the participant's file.
3. Participants may be suspended from the program for financial reasons and may be re-evaluated for re-entry. If after a reasonable amount of time, participants are unable to pay for participation in the RAIN program, the participant's contract shall be terminated and reported to the ASBN.

Program Completion

POLICY: The RAIN program is a non-disciplinary monitoring program for participants with conduct related to substance abuse or use. Successful completion requires meeting all stipulations outlined in the participant contract.

PROCEDURE:

1. Participant shall complete the monitoring contract within the timeframe in the contract.
2. Participant shall demonstrate consistent compliance with the stipulations within the contract.
3. All criteria shall be successfully met to complete the program.
4. Noncompliance with any requirement of the contract may result in a delay in the timeframe for completion of the RAIN program.
5. Criteria:
 - a. No Level 1 warnings within the final six (6) months of the contract.
 - b. If in nursing practice, work place monitoring reports (employer evaluations) shall reflect competent and safe practice.
 - c. Evaluator or treatment provider(s) reports are favorable.
6. Any participant who has not successfully completed the above criteria by the end date of the monitoring period shall be required to continue monitoring.

Short-Term Use of Controlled or Abuse Potential Medications

POLICY: Participants shall not engage in the practice of nursing while taking controlled or abuse potential medications.

PROCEDURE:

1. RAIN staff recognizes that participants may require the use of controlled or abuse potential medications for a short-term timeframe based on medical procedures, surgeries, or other medical conditions. When this is necessary the following guidelines shall apply:
 - a. Participants shall not be authorized to engage in the practice of nursing while taking controlled or abuse potential medications.
 - b. For a planned medical or dental procedure requiring controlled or abuse potential medications, a RAIN prescription medication report shall be completed by the treating practitioner and submitted to the RAIN staff no later than twenty-four (24) hours prior to the date of the procedure. In the event of an emergency procedure, participants or their designee shall notify RAIN staff within twenty-four (24) hours of the emergency.
 - c. Participants shall discuss their recovery and participation in the RAIN program with healthcare providers who prescribe controlled or abuse potential medications. Participants and providers should discuss the least amount of anticipated medication needed for planned procedures.
 - d. A negative drug screen and documentation of the prescription disposal shall be required prior to engaging in the practice of nursing.
 - e. Any exception to this policy shall require approval by RAIN staff.
 - f. Recurrent use of controlled or abuse potential medications by participants may require a full review of the case by RAIN staff and possibly an addiction evaluator.
2. The RAIN contract may be extended because of the use of any controlled or abuse potential medication.

Long Term Use of Controlled or Abuse Potential Medications

POLICY: Participants shall notify RAIN staff of the need for controlled or abuse potential medications and complete all associated forms. Participants shall not engage in nursing practice until approval has been obtained from RAIN staff.

PROCEDURE:

1. A participant who has medical conditions treated with controlled or abuse potential medications on a long-term basis may request consideration for enrollment or continuation in the RAIN program. Long-term basis is defined as greater than three (3) weeks.
2. The goal of the RAIN program is abstinence or to reduce medication as required for the medical conditions to ensure the participant can practice with reasonable skill and safety with no harm to the public.
3. The following are required for consideration:
 - a. The treating healthcare provider shall submit to RAIN staff all medical evaluations, testing, and clinical documentation for prescribing the medication.
 - b. The participant shall be evaluated by a Board-approved addiction evaluator for the appropriateness of the treatment plan and medication to be prescribed.
 - c. The participant may be required to undergo neuropsychological testing to determine a baseline of cognitive function while on the medication.
 - d. After all requested information is obtained, RAIN staff shall review the information and make a recommendation to the ASBN for conditions of participation in the RAIN program.
 - e. The ASBN shall review all documentation and determine if the participant can enroll or continue in the RAIN program.
 - f. If approved, quarterly updates from the treating healthcare provider documenting ongoing care and assessment of the medical condition shall be sent to RAIN staff.
 - g. The participant shall notify RAIN staff within twenty-four (24) hours of receiving a prescription for a controlled or abuse potential medications not previously approved by RAIN staff.
 - h. A medication report form shall be sent by the healthcare provider to RAIN staff within ten (10) days of prescribing any controlled or abuse potential medication.
 - i. RAIN staff may request any of the following:
 - i. Additional information from the treating healthcare provider;
 - ii. An additional evaluation from a Board approved addiction specialist;
 - iii. Additional psychological and/or neuropsychological testing; or
 - iv. Any other type of information or testing that will help determine the participant's ability to practice with reasonable skill and safety while taking the medication.
 - j. The RAIN monitoring contract may be extended because of the use of any controlled or abuse potential medication.
 - k. If RAIN staff determines the participant cannot practice with reasonable skill and safety while taking the medications(s), the participant will be suspended from nursing practice until it is determined the participant is safe to practice. The participant may remain in monitoring until final disposition is determined.
 - l. Approved prescribers for long-term medication use of more than three (3) weeks include:

- i. ASBN approved addiction evaluator;
- ii. American Board of Addiction Medicine (ABAM) certified physician
- iii. A psychiatrist with a Certificate of Added Qualifications in Addiction Medicine and an active American Society of Addiction Medicine (ASAM) member

How does pain management MD fit in here?

Does a ASAM member have to be certified?

DRAFT

Progressive Action Policy

Policy: Noncompliance with the terms of the RAIN contract shall be handled according to the Progressive Action Policy. Progressive action shall be applied when a participant violates the terms of the contract, which may include termination from the program. Termination from the RAIN program shall be reported to the ASBN.

Procedure:

1. A sequence of documented written warnings shall be initiated which identify problems and steps required to correct the problem(s).
 - a. Level 1 violation = written warning letter
 - b. Level 2 violation = termination from the program
2. Depending on the severity of the violation/problem, Level 1 may be skipped.
3. The following items are grouped into two categories (not intended to be all inclusive) of violations of the terms set forth in the participant's contract with the RAIN program. Violations shall result in corrective action up to and including termination.
 - a. Level 1 violation shall be implemented for the following:
 - i. Pattern of failure to check-in for drug screens (>7 in 12 months);
 - ii. Dilute specimen (> 1 in 12 months);
 - iii. Pattern of failure to submit documentation (e.g. personal reports, AA/NA, or other Board approved treatment program reports, counseling reports,, etc.) as required;
 - iv. Pattern of failure to attend required aftercare treatment and/or program meetings;
 - v. Marking the wrong option for screening (>2 in 12 months);
 - vi. Failure to follow the recommendations of the treatment facility;
 - vii. Failure to disclose pertinent information (e.g. hospitalizations, employment status changes, etc.);
 - viii. Two (2) consecutive missed screening check-ins;
 - ix. Failure to drug screen when selected;
 - x. Submission of a drug screen when not requested; and
 - xi. Failure to disclose participation in RAIN program to employer or educational program in which enrolled.
 - b. Level 2 violation (termination from the program) shall be implemented for the following:
 - i. Impairment in the workplace;
 - ii. Beginning employment prior to approval by RAIN staff;
 - iii. Failure to reactivate a suspended account for drug screening;
 - iv. Failure to register for drug screening within seventy-two (72) hours of signing the RAIN contract;
 - v. Failure to check-in for screening for greater than three (3) consecutive days;
 - vi. Falsification of documentation in patient records;
 - vii. Falsification of records or reports submitted to RAIN staff (e.g. reference letters, sponsor letters, employer performance reports, support group meeting reports, prescription ID forms, etc.);
 - viii. Failure to report within specified timeframe any prescription obtained for controlled or abuse potential medications;
 - ix. Refusal to drug screen at the request of an employer;

- x. Consuming controlled or abuse potential substances, including alcohol, not prescribed for the participant and approved by RAIN staff;
 - xi. Evidence of prescription seeking behavior to obtain controlled or abuse potential medications;
 - xii. Submission of a specimen deemed to have been substituted, abnormal, or adulterated;
 - xiii. Failure to report misdemeanor or felony charges, pleas, or convictions that occur while in the program;
 - xiv. Any information or event deemed by RAIN staff to endanger the public;
 - xv. Failure to respond to requests from RAIN staff;
 - xvi. Failure to comply with other conditions of the contract; or
 - xvii. More than three (3) warning letters occurring within twelve (12) months.
4. Violations are “active” for twelve (12) rolling months. For example a participant receives a written warning for a violation June 4, 2017. Any subsequent violation between the written warning and June 4, 2018 shall be considered “active” and progressive action shall be applied. If a subsequent violation occurs after June 4, 2018, the process re-sets.

Criteria for Evaluators and Treatment Providers

POLICY: All evaluation and treatment providers shall be approved by the Arkansas State Board of Nursing.

1. An evaluator shall:
 - a. Be a physician, psychiatrist, psychologist, or mental health certified Advanced Practice Registered Nurse who is engaged in the assessment and treatment of substance abuse or use, including alcohol;
 - b. Demonstrate the ability to perform an examination to include a detailed history with the appropriate testing i.e. drug screens and other psychological testing as indicated;
 - c. Identify, diagnose, and outline a treatment plan ,if indicated;
 - d. Agree to state whether the individual is safe to practice and under what conditions the practice must be restricted ,if any;
 - e. Cooperate and communicate with RAIN staff; and
 - f. Submit evaluation reports according to Board approved criteria.
2. A treatment provider shall:
 - a. Provide outpatient, inpatient treatment, or other support services;
 - b. Cooperate and communicate with RAIN staff;
 - c. Submit an individualized written plan of care to include, but not limited to, assessment, diagnosis, treatment goals, discharge criteria, and recommendations for continuing recovery; and
 - d. Meet all regulatory requirements in their respective state.

PROCEDURE: The following criteria will be used to determine approval of evaluators and treatment providers.

1. All evaluators and treatment providers shall submit documentation requested by the RAIN staff for review and approval by the ASBN.
2. Approved evaluators and treatment providers will be re-reviewed on an annual basis to determine continuation as a Board approved evaluator or treatment provider.
3. ASBN may withdraw approval at any time it is determined the evaluator or treatment provider does not meet the required guidelines for approval.

Advisory Committee

POLICY: The Advisory Committee shall serve to provide guidance and oversight with the operations of the RAIN program.

Composition:

1. The Advisory Committee shall be composed of three (3) ASBN Board members appointed by the Board President. Board members will be appointed for a term of one (1) year and may be reappointed.
2. Support staff to the advisory committee shall consist of:
 - a. ASBN Executive Director
 - b. Director of the RAIN program
 - c. ASBN attorney
 - d. ASBN Assistant Director of Enforcement

DRAFT



ARKANSAS STATE BOARD OF NURSING

1123 S. University Avenue, Suite 800, University Tower Building, Little Rock, AR 72204
Phone: (501) 686-2700 Fax: (501) 686-2714 www.arsbn.org

DATE: May 9, 2018
TO: Board of Nursing
FR: Sue A. Tedford, MNSc, APRN
Executive Director
RE: PEER Support Groups

Board Action Requested: None – general discussion

Background: One of the barriers in past attempts to create an alternative to discipline program in Arkansas was the lack of PEER Support Groups. PEER Support Groups for professionals can sometimes be found in the larger metropolitan areas but are lacking to non-existent in rural Arkansas.

PEER Support Groups are used in addition to AA/NA meetings. According to the Substance Use Disorder in Nursing Resource Manual (2011) the role of the professional support group leader during monitoring includes:

- Sharing experiences and providing strength, hope and support in addressing issues related to the process of recovery from SUD
- Providing support for professional issues including re-entry into the workplace
- Being a resource for additional supportive services
- Reporting weekly attendance to the alternative program
- Providing input and recommendations relative to the needs of alternative program participants

Arkansas moved forward with creating an ATD program with this still identified as a deficit. Over the past ten years the emergence of on-line support groups has occurred. According to the Substance Use Disorder in Nursing Resource Manual (2011) "internet support groups may be best suited for participants with a long-term stable recovery. They must only be used as a supplement or as an adjunct to regular face-to-face support group meetings."

The American Association of Nurse Anesthetists (AANA) suggests all CRNAs with a substance use disorder join the online support group Anesthetists in Recovery (AIR). See following information.

Birchwood Solutions is a company based in Tennessee which provides PEER support groups (face-to-face and virtual) to individuals enrolled in the Tennessee ATD program, TnPAP. See following information.

A search of the web revealed limited professional support groups available. See following information.



Anesthetists in Recovery (AIR)

Anesthetists in Recovery (AIR) is a national network of nurse anesthetists who are in recovery from substance use disorder (SUD). AIR is an organization involved with both education and networking for reasons of peer assistance. It is absolutely confidential and anonymous and has no affiliation with any other organization, including the AANA. AIR has no reporting function with any certifying or licensure body.

The AIR moderated virtual community consists of CRNAs and student nurse anesthetists who are in recovery or need of recovery from SUD. The primary purpose is to help one another achieve and maintain sobriety/clean time and reach out to the student nurse anesthetist/CRNA that still suffers. Members can post at whatever level of sharing they are comfortable with.

- [AIR - for info and to join](#) or call Larry 435-901-1197 or Bridget 203-996-1322

The AIR link is to external sites, which are provided as a convenience and do not imply endorsement. AANA Health and Wellness/Peer Assistance is not responsible for any content on the AIR site but hopes that the resource can help support your sobriety and well-being.

Articles and video about AIR:

- [AIR, Chemical Dependency in the Profession](#) by Carlos Ratliff, CRNA
- [Saving Lives: AIR/PAIR](#) by Anita Bertrand, CRNA, MS
- Video from the Wearing Masks video series: [Support: Anesthetists in Recovery \(AIR\)](#)

At each Annual meeting, AIR moderators hold a Touched by Addiction (open AIR) meeting on site and welcome all the attend. The purpose is to provide support to all who have been "touched by addiction" and introduce participants to the power of 12 Step Recovery. Touched by Addiction meetings are also encouraged for every state nurse anesthesia association meeting.

Members of AIR agree

Members of AIR agree with the American Medical Association (AMA) definition that chemical dependency is a primary, psychosocial, and biogenetic disease. The symptoms of the disease are cunning and baffling as is the disease itself.

Although there is no cure for addiction, there can be lifelong remission contingent on:

- Prompt detection
- Intervention
- Treatment
- Adherence to aftercare program involving 12-step groups, peer support groups, and carefully timed re-entry into the anesthesia profession.
- Re-entry must be structured with tools such as back-to-work contracts.

There are recovering anesthetists working as disciplined professionals all over the country today, who are grateful to be in recovery.

Advertisement

Health & Wellness Contacts

- Peer Assistance Helpline
800-654-5167

[Home](#)[Services](#)[Support Group Services](#)[Consulting](#)[Education](#)[Program Participants](#)[State Program Solutions](#)[Support Group Calendar](#)[Products and Resources](#)[Contact Us](#)[News](#)[Resource Guide for Facilitators](#)[Financial Policy](#)[Privacy Policy](#)[FAQs](#)

STATE PROGRAM SOLUTIONS

The Problems

Running the daily operations of a state alternative program for professionals can be an uphill battle. With the need for assistance programs increasing, the demand for effective services can be daunting. As a result:

- Board Members need accurate and quality program reports
- Program directors are challenged with the accountability of the case managers and program participants
- Case managers are overwhelmed with necessary administrative tasks that reduce their ability to provide adequate oversight
- Facilitators are not monitored for quality, training, and accountability
- Participants become overwhelmed and stressed by undefined processes

Our Solutions

Our solutions provide a multitude of opportunities and resources for an assistance or alternative program, its facilitators, and participants. Birchwood Solutions practices quality assurance and quality improvement principles with objective criteria and research outcomes for both participant recovery and support group systems. Our solutions will:

- Reduce your program overhead, allowing for budget increases in other areas
- Provide quality reporting and data
- Provide participant and facilitator accountability resulting in increased compliance and success rates

Facilitator Accountability and Management

- Birchwood will employ qualified facilitators
- Qualitative analysis and performance evaluations for facilitator efficacy on a quarterly basis based on facilitator evaluations by participant and data compilation
- Ongoing continuing education, training, and implementation of professional development evaluations for facilitators
- Facilitator resource bank for professional growth and support group modules, tracts, and resources

SITE SEARCH

RECENT POSTS

- [Yes You Can: Substance Abuse in the Workplace](#)
- [Intrusive Thoughts: How to Deal](#)
- [Lobby to Make a Difference](#)
- [You Too Can Be A Lobbyist](#)
- [Recovery in Support Groups: Learning from Those Beside You](#)

- And more...

Participant Accountability and Flexibility

- A wide variety of support group options
- Group resources and communications for increase awareness
- Participant attendance compliance audits and reporting
- Online groups offer reduction in travel expenses, care giver expenses, and in missed work time
- Flexible financial payment plans



Data Reporting

- Tailored reporting for participant attendance
- Tailored reporting for participant group participation on, affect, and more...
- Overall program statistics and progress reports scheduled for end of year detailed report
- Customizable program notifications to case managers, facilitators, participants, and program directors with invaluable information to run an effective program
- Able to work with most existing reporting systems to streamline reporting

Financial Assistance Program for participants

- Birchwood Solutions can create a financial assistance program for its participants with varying levels of assistance based on criteria of need.

Participant Job Advocacy

- Birchwood Solutions can conduct community relations and criteria to advocate for jobs for program participants.

To discuss a complete list of program features, please contact us.



About US

MISSION Birchwood Solutions is committed to helping transform lives by offering exceptional programs and services that will empower our clients and professionals to take root. **VISION** It is our Vision...

[Read More](#)



Support Group Services

Connect Program – Connect, Empower Persevere Birchwood Solutions' Connect Program – is an educational network of supportive program professionals dedicated to provide enhanced support group management, aftercare, and continuing education to impaired...

[Read More](#)



State Program Solutions

The Problems Running the daily operations of a state alternative program for professionals can be an uphill battle. With the need for assistance programs increasing, the demand for effective services can...

[Read More](#)



Program Participants

Who? Me? Program Participants are individuals who are receiving monitoring services through their state alternative program. We currently provide online and local support group services to several state alternative programs....

[Read More](#)



FAQs

How do I enroll with Birchwood's CONNECT Program? Request an enrollment packet in the chat feature of our website, email us, or call us. The enrollment packet contains several sections for you...

[Read More](#)

Addiction Treatment Resources for Healthcare Workers

Following are resources for healthcare practitioners who struggle with addiction. Please check your state peer assistance program for additional services/support.

Nurse Anesthetists in Recovery

ANESTHETISTS IN RECOVERY (AIR)

A national network of nurse anesthetists who are in recovery from drug and alcohol addiction. AIR is under the umbrella of the American Association of Nurse Anesthetists (AANA). AIR also sponsors two e-groups: the AIR for Sobriety Support Group, a moderated forum of CRNAs/student nurse anesthetists who are in recovery; and Partners in Recovery (PAIR), which offers support for their loved ones.

PEER ASSISTANCE FOR IMPAIRED NURSE ANESTHETISTS

This is a member service of the American Association of Nurse Anesthetists (AANA) and is not connected to any Boards of Nursing. The AANA website includes state-specific peer support resources, tips on how to recognize an impaired colleague and links to treatment centers for healthcare professionals.

Nurses in Recovery

PEER ADVOCACY FOR IMPAIRED NURSES

Recovery mentoring and relapse prevention services for individual nurses; provides impaired nurses with consults on job-related issues, and referrals to treatment, support groups and legal resources. Conducts education and development services for nursing schools and other entities.

IMPAIRED NURSE RESOURCE CENTER, AMERICAN NURSES ASSOCIATION (ANA)

Provides resources for peer assistance, specialty practice areas in nursing and links to national organizations on drug and alcohol abuse.

NURSES IN RECOVERY Forum

Online forum restricted to healthcare professionals in recovery from addiction. To join, send an e-mail to: aanurses@ontosystems.com and type the word SUBSCRIBE (no quotes) in the message line.

NURSENRECOVERY

Information, advice and inspiration for nurses battling addiction. Includes a daily blog, addiction Q&As, online discussion forums and more.

UNBECOMING A NURSE

Wealth of information on addiction in the nursing profession. Includes a nurse self-survey for chemical dependency risk, an addiction recovery blog, online support resources for impaired professionals and articles about substance abuse in nursing.

This is the website for noted chemical dependency expert Paula Davies Scimeca, RN, MS, author of "Unbecoming a Nurse: Bypassing the Hidden Chemical Dependency Trap" and "From Unbecoming a Nurse to Overcoming Addiction," featuring the personal stories of 29 nurses in recovery (representing 20 states).



ARKANSAS STATE BOARD OF NURSING

1123 S. University Avenue, Suite 800, University Tower Building, Little Rock, AR 72204
Phone: (501) 686-2700 Fax: (501) 686-2714 www.arsbn.org

DATE: May 9, 2018
TO: Board of Nursing
FR: Sue A. Tedford, MNSc, APRN
Executive Director
RE: Naltrexone

Board Action Requested: Discuss the use of Naltrexone by participants in the ATD program.

Background: Naltrexone is approved by the FDA to treat opioid use disorder and alcohol use disorder by binding and blocking the opioid receptors. Some ATD programs permit the use Naltrexone when recommended by the treating professional. There is no current data on how many programs permit its use.

Naltrexone | SAMHSA - Substance Abuse and Mental Health Services Administration

[X samhsa.gov/medication-assisted-treatment/treatment/naltrexone](https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone)

What Is Naltrexone?

Naltrexone is a medication approved by the Food and Drug Administration (FDA) to treat opioid use disorders and alcohol use disorders. It comes in a pill form or as an injectable. The pill form of naltrexone (ReVia, Depade) can be taken at 50 mg once per day. The injectable extended-release form of the drug (Vivitrol) is administered at 380 mg intramuscular once a month. Naltrexone can be prescribed by any health care provider who is licensed to prescribe medications. To reduce the risk of precipitated withdrawal, patients are warned to abstain from illegal opioids and opioid medication for a minimum of 7-10 days before starting naltrexone. If switching from methadone to naltrexone, the patient has to be completely withdrawn from the opioids.

How Naltrexone Works

Naltrexone blocks the euphoric and sedative effects of drugs such as heroin, morphine, and codeine. It works differently in the body than buprenorphine and methadone, which activate opioid receptors in the body that suppress cravings. Naltrexone binds and blocks opioid receptors, and is reported to reduce opioid cravings. There is no abuse and diversion potential with naltrexone.

If a person relapses and uses the problem drug, naltrexone prevents the feeling of getting high. People using naltrexone should not use any other opioids or illicit drugs; drink alcohol; or take sedatives, tranquilizers, or other drugs.

Patients on naltrexone may have reduced tolerance to opioids and may be unaware of their potential sensitivity to the same, or lower, doses of opioids that they used to take. If patients who are treated with naltrexone relapse after a period of abstinence, it is possible that the dosage of opioid that was previously used may have life-threatening consequences, including respiratory arrest and circulatory collapse.

As with all medications used in medication-assisted treatment (MAT), naltrexone is to be prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs.

Naltrexone for Opioid Use Disorders

Extended-release injectable naltrexone is approved for treatment of people with opioid use disorder. It can be prescribed by any healthcare provider who is licensed to prescribe

medications, special training is not required. It is important that medical managed withdrawal (detoxification) from opioids be completed at least 7 to 10 days before extended-release injectable naltrexone is initiated or resumed. Research has shown that naltrexone decreases reactivity to drug-conditioned cues and decreases craving. Patients who have been treated with extended-release injectable naltrexone may have reduced tolerance to opioids and may be unaware of their potential sensitivity to the same, or lower, doses of opioids that they used to take. Extended-release naltrexone should be part of a comprehensive management program that includes psychosocial support.

Naltrexone for Alcohol Dependence

When used as a treatment for alcohol dependency, naltrexone blocks the euphoric effects and feelings of intoxication. This allows people with alcohol addiction to reduce their drinking behaviors enough to remain motivated to stay in treatment and avoid relapses. Naltrexone is not addictive nor does it react adversely with alcohol.

Long-term naltrexone therapy extending beyond three months is considered most effective by researchers, and therapy may also be used indefinitely. Learn more about [alcohol use disorders](#).

Side Effects of Naltrexone

People taking naltrexone may experience side effects, but they should not stop taking the medication. Instead, they should consult their health care provider or substance misuse treatment practitioner to adjust the dose or change the medication. Some side effects include:

- Upset stomach or vomiting
- Diarrhea
- Headache
- Nervousness
- Sleep problems/tiredness
- Joint or muscle pain

Seek a health care provider right away for:

- Liver injury: Naltrexone may cause liver injury. Seek evaluation if have symptoms and or signs of liver disease.
- Injection site reactions: This may occur from the injectable naltrexone. Seek evaluation for worsening skin reactions.
- Allergic pneumonia: It may cause an allergic pneumonia. Seek evaluation for signs and symptoms of pneumonia.

Resources and Publications

Training on Providing Naltrexone

MAT services professionals must acquire and maintain certification to legally dispense and prescribe medications for opioid and alcohol dependency. SAMHSA's Division of Pharmacologic Therapies (DPT) provides opioid prescribing courses for physicians; webinars, workshops, and summits; and publications and research.



ARKANSAS STATE BOARD OF NURSING

1123 S. University Avenue, Suite 800, University Tower Building, Little Rock, AR 72204
Phone: (501) 686-2700 Fax: (501) 686-2714 www.arsbn.org

DATE: May 9, 2018
TO: Board of Nursing
FR: Sue A. Tedford, MNSc, APRN
Executive Director
RE: CRNA Guidelines for return to practice

Board Action Requested: Review and discuss the attached materials. Make recommendations for the guidelines for a CRNA with a SUD diagnosis to return to practice.

Background: Most ATD programs across the United States handle a CRNA returning to practice differently from other licensed nurses. Most programs require the CRNA to be out of practice for at least one year. Some states such as North Carolina and West Virginia require the CRNA to initially return to practice as an RN. The American Association of Nurse Anesthetists (AANA) has developed a Position Statement on SUD and CRNAs. See following information. For the purpose of this discussion, focus on Treatment Recommendations (pages 11-12) and Reentry to Clinical Practice (pages 12-13). Appendix B contains two articles specific to CRNAs.

Following this discussion the ATD Ad Hoc Committee will develop a policy and guidelines specific for CRNAs. This will be brought back to the Board for further discussion.



Addressing Substance Use Disorder for Anesthesia Professionals

Position Statement and Policy Considerations

Table of Contents	
Position	1
Purpose	2
AANA Peer Assistance Advisors Committee	2
Definitions of Common Terms	2
Background	2
Considerations for Creating a Substance Use and Drug Diversion Policy	3
Fitness for Duty and Maintaining Health and Wellness	4
Identify Those at Risk	4
Signs and Behaviors of Impairment and Drug Diversion	5
Harmful Consequences of Drug Diversion and Substance Use Disorder in the Workplace	6
Drug Diversion Prevention	7
Drug Testing	8
Reporting a Colleague to Supervisor or Appropriate Chain of Command	9
Conducting a Safe Intervention	9
Legal Reporting	11
Treatment Recommendations for Anesthesia Professionals	11
Reentry to Clinical Practice	12
Conclusion	14
References	15

Position

The American Association of Nurse Anesthetists (AANA) recommends that facilities address an important element of patient and provider safety through a comprehensive program and non-discriminatory policy that includes education to identify signs and behaviors and strategies to minimize drug diversion and substance use disorder. Substance use disorder should not be ignored, for patient and provider safety. The policy applies and is communicated to employed staff, contracted providers and students training at clinical sites.

If you are reading this document before a policy is in place to address a current situation, call the AANA Peer Assistance Helpline (800-654-5167) and if there is concern due to risk of imminent harm, call 911 immediately.

Purpose

The purpose of this document is to provide a resource for healthcare facilities, nurse anesthesia education programs, and healthcare professionals, including anesthesia professionals, to develop evidence-based policy regarding substance use disorder before a situation occurs.

AANA Peer Assistance Advisors Committee

Since 1983, the AANA Peer Assistance Advisors Committee (PAAC) has provided proactive support for issues related to substance use disorder. The PAAC is committed to educational endeavors and prevention of substance use disorder through informational support and resources. The AANA Peer Assistance Helpline (800-654-5167) responds to nurse anesthetists and students seeking help for substance use disorder, as well as a supervisor, colleague, or family member with concerns, by offering resources and support to help individuals be evaluated for appropriate, life-saving treatment.

To get help for yourself or a colleague, visit www.aana.com/gettinghelp

To view all PAAC resources, visit www.AANAPeerAssistance.com

Definitions of Common Terms

Substance-Use Disorder: Substance use disorder is a disease of the brain characterized by the recurrent use of substances (e.g., alcohol, drugs) that cause clinical and functional impairment such as health problems, disability, and failure to meet major responsibilities at work, school, or home as defined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).^{1,2} The disease involves a circuit of reward, withdrawal, memory and motivation and can be classified as mild, moderate or severe depending on the level of impairment.

Addiction: The most severe, chronic stage of substance use disorder, in which there is a substantial loss of self-control, as indicated by compulsive substance use despite the desire to stop using.^{1,3} Addiction recruits memory systems and motivational systems, weakens inhibitory systems and continues to stimulate use of substances. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Drug diversion: The transfer of any substance from the purpose for which it is intended for any illicit use (e.g., personal use, sale).^{4,5}

Impairment: The inability or impending inability to engage safely in professional and daily life activities as a result of a physical, mental or behavioral disorder (e.g., substance use, abuse, or addiction).^{3,6}

Background

In the United States approximately eight to ten percent of people ages 12 or older are addicted to alcohol or other drugs.¹ Substance use disorder, addiction, drug diversion and related impairment present threats to health and safety of the individuals misusing alcohol and drugs that may result in harm. An increasing concern is the deaths from overdose in the general population, which have more than quadrupled over the past 15 years.⁷ Overdose causes are complex, but most often include the over prescription of pain medications, which can lead to using medications in higher quantities or for another purpose than prescribed, using medications prescribed for someone else, or turning to the less expensive and readily available illicit drugs such as heroin and some containing highly toxic fentanyl.⁷⁻¹⁰

Substance use disorder is an occupational hazard of disproportionately greater risk among the anesthesia profession than in other practice specialties due in part to stresses of working in a demanding profession,

increased availability of highly addictive medications, and possible environmental sensitization to the effects of such medications.^{4,11-14} An estimated 10 to 15 percent of all clinicians, including anesthesia professionals, will misuse drugs or alcohol at some time during their career.^{13,15} The full scope of the problem is likely underestimated due to the many factors that discourage disclosure such as stigma, potential for licensure restriction or loss, potential for legal action, and implications for patient care.^{13,11}

Substances such as opioids (e.g., morphine and fentanyl), inhalational anesthetics and volatile agents (e.g., sevoflurane, nitrous oxide), and intravenous (IV) anesthetic agents (e.g., propofol, which is not classified as a controlled substance) are readily available to anesthesia professionals to provide anesthesia services. Even with medication dispensing and audit controls in place, drugs may be diverted for misuse. Drug diversion may occur through procurement of medications directly from pharmacies, automated dispensing units, retrieval from sharps waste containers of medications remaining in syringes, diversion directly from patient medications, or indirectly through dilution of a medication to appear that nothing is missing from the original container.

Regardless of the substance abused (e.g., alcohol, opioids), impairment on the job can adversely impact patient and provider safety.¹⁶ Facility policy and education that address symptom awareness, prevention, reporting, safe intervention, and reentry to the workplace, when appropriate, may minimize the risk of substance diversion and minimize adverse outcomes. Policies that advocate for fair and uniform management of providers with suspected or diagnosed substance use disorder supports a safe environment for prompt reporting, appropriate treatment, and the possible reentry of the anesthesia professional into clinical practice.

Substance Use Disorder is a Disease not a Choice

Research has provided strong evidence that substance use disorder is a disease of the brain, for which there is no cure and that achieving short term and lifetime recovery is possible and the goal.^{1,16-18} Building and enhancing knowledge of risk factors and preventative coping mechanisms, as well as recognizing the signs and behaviors of impairment and drug diversion can help prevent patient and provider harm.¹

Considerations for Creating a Substance Use and Drug Diversion Policy

A policy that includes the following elements may discourage diversion and substance use, identify possible substance use to intervene to prevent death, and promote the well-being of employees and patients.

- Promotes healthy behaviors to support professional responsibility to be fit for duty.
- Builds awareness of individual risk factors.
- Identifies behaviors and symptoms of substance use disorder and drug diversion.
- Acknowledges harmful consequences of substance use disorder, drug diversion and impairment in the workplace.
- Utilizes drug diversion prevention strategies.
- Optimizes drug testing modalities (e.g., pre-employment, random, for-cause) to include testing for anesthesia drugs.
- Outlines safe reporting processes of impaired individuals through the appropriate chain of command.
- Facilitates a safe intervention for appropriate treatment evaluation.
- Addresses specific treatment considerations for anesthesia professionals.
- Clarifies reporting obligations to authorities and/or licensing boards.
- Requires specific criteria before consideration for reentry into practice.
- Assists with safe transition back to anesthesia practice that includes a return to work contract and monitoring plan.

- Maintains a safe, stigma-free workplace environment.

Visit AANA www.aana.com/SUDWorkPlaceResources for additional resources.

Fitness for Duty and Maintaining Health and Wellness

Overall well-being is the foundation of practice for nurse anesthesia professionals. Professional self-care to maintain fitness for duty is an essential underpinning to best practice to deliver high-quality, safe anesthesia care. Recognizing vulnerabilities and managing stress that puts individuals at risk for developing substance use disorders can help deter the use of harmful substances.¹⁰ Acknowledging personal vulnerabilities, taking precautions to reduce stress, and seeking help can mitigate the risk of developing unhealthy behaviors and destructive choices that can trigger substance use disorder and addiction.¹³

The nurse anesthetist is responsible and accountable for his or her actions, including self-awareness and assessment of fitness for duty.¹⁹ Healthy lifestyle choices can help maintain work/life balance and wellbeing to support coping mechanisms for effective resilience. The AANA Health & Wellness Committee provides education and resources that recognize personal and professional risk factors (such as substance use disorder, workplace and personal stress, physical and mental disorders) and promotes a balanced and fulfilling personal and professional life. For more information and resources, visit www.AANAWellness.com.

The following are some examples of healthy mind, body, and spirit lifestyle choices and coping mechanisms that can help anesthesia professionals maintain fitness for duty:

- **Physical:** manage health through regular, nutritious meals, physical recreation, and healthy sleep; take appropriate time off after injury or illness; avoid tobacco and drug use, limit alcohol consumption; protect yourself from disease and injury, and manage pain appropriately.
- **Emotional:** take vacation time when needed and enjoy life, practice stress reduction, mindful meditation, and positive reframing of the situation,¹⁶ be realistic, adjust expectations to prepare for changes,¹⁶ vent in moderation without ruminating on the issue,¹⁶ build resiliency, recognize and seek help for depression and suicidal ideation, manage finances.
- **Social/Spiritual:** build and cultivate relationships and support from friends, family, colleagues,¹⁶ connect to a spiritual community, practice volunteerism and altruism.
- **Workplace:** cope with critical incidents, disruptive behavior/bullying, ergonomics, career transitions, financial stress, safety, remain positive and make suggestions for improvements.

Identify Those at Risk

Access to highly addictive drugs is a significant risk factor for substance use disorder among anesthesia professionals and all healthcare professionals who have access to addictive medications. The anesthesia professional's risk is increased as he or she may have several of the general risk factors along with anesthesia-specific risk factors described below in Table 1.

Table 1. Risk factors for developing substance use disorder

General Risk Factors ^{13,17,20}	Workplace-Specific Risk Factors ^{4,11-13,20}
Psychological <ul style="list-style-type: none"> • Depression/anxiety • Low self-esteem • Low stress tolerance • Feelings of resentment • Addictive personality • Underlying psychological disease 	<ul style="list-style-type: none"> • Heightened stress of working in high-intensity environment (e.g., operating room) • Production pressure • Fatigue and burnout • Irregular work hours • Role strain • Inadequate work-life balance

General Risk Factors ^{13,17,20}	Workplace-Specific Risk Factors ^{4,11-13,20}
<p>Behavioral and Social</p> <ul style="list-style-type: none"> • Personal history of alcohol or medication misuse • Risk-seeking behavior • Maladaptive coping strategies • Trauma, isolation, abuse, lack of support system • Stressful work, home, community environment • Victim of bullying (e.g., work place, school) • Family history of substance use disorder and addiction • Family dysfunction • Unnecessary prescriptions of addictive medications, including opioids <p>Physical</p> <ul style="list-style-type: none"> • Acute or chronic pain <p>Genetic</p> <ul style="list-style-type: none"> • Inherited predisposition • Deficits in natural neurotransmitters • Absence of adverse reactions 	<ul style="list-style-type: none"> • Lack of education or resources about substance use disorder and curbing addiction <p>Anesthesia-specific</p> <ul style="list-style-type: none"> • Possible sensitization to the effects of opioids and anesthetic agents • Access and availability of opioids, benzodiazepines, IV and inhalational anesthetics in workplace • Unregulated, readily available propofol

Signs and Behaviors of Impairment and Drug Diversion

Early identification of substance-using anesthetists reduces the risk of harm to themselves, colleagues, and patients (see harmful consequences described in Table 3).¹³ Colleagues may be the first individuals to notice changes in behaviors, but may not be equipped to recognize the signs and behaviors that may be associated with substance use or impairment.^{16,21} Healthcare providers are often successful at disguising their issues or their signs are ignored because they are popular, respected, and intelligent.²¹ Suspicious or significant changes in behavior in the workplace may have many causes, and if subtle signs and behaviors of substance use disorder and drug diversion are left unrecognized, the provider may be placed in danger, patient safety may be compromised, and the organization may be placed at risk for liability. Signs and behaviors of impairment and drug diversion are described below in Table 2.

Table 2. Behaviors and signs associated with substance use disorder and drug diversion

Impairment ^{3,17,22,23}	Drug Diversion ^{*4,16,23,24}
<p>Behaviors</p> <ul style="list-style-type: none"> • Severe mood swings, personality changes • Frequent or unexplained tardiness, work absences, illness or physical complaints • Elaborate excuses • Underperformance • Difficulty with authority • Poorly explained errors, accidents or injuries • Wearing long sleeves when inappropriate • Confusion, memory loss, and difficulty concentrating or recalling details and instructions 	<p>Behaviors</p> <ul style="list-style-type: none"> • Consistently uses more drugs for cases than colleagues • Frequent volunteering to administer narcotics, relieve colleagues of casework, especially on cases where opioids are administered • Consistently arrives early, stays late, or frequently volunteers for overtime • Frequent breaks or trips to bathroom • Heavy wastage of drugs • Drugs and syringes in pockets

Impairment ^{3,17,22,23}	Drug Diversion ^{4,16,23,24}
<ul style="list-style-type: none"> • Visibly intoxicated • Refuses drug testing • Ordinary tasks require greater effort and consume more time • Unreliability in keeping appointments and meeting deadlines • Relationship discord (e.g., professional, familial, marital, platonic) <p>Signs</p> <ul style="list-style-type: none"> • Physical indications (e.g., track marks, bloodshot eyes) • Signs indicative of drug diversion* (<i>see right column</i>) • Deterioration in personal appearance • Significant weight loss or gain • Discovered comatose or dead 	<p>Signs</p> <ul style="list-style-type: none"> • Anesthesia record does not reconcile with drug dispensed and administered to patient • Patient has unusually significant or uncontrolled pain after anesthesia • Higher pain score as compared to other anesthesia providers • Times of cases do not correlate when provider dispenses drug from automated dispenser • Inappropriate drug choices and doses for patients • Missing medications or prescription pads • Drugs, syringes, needles improperly stored • Signs of medication tampering, including broken vials returned to pharmacy

Harmful Consequences of Drug Diversion and Substance Use Disorder in the Workplace

Healthcare professionals are responsible for the safety of patients, which includes the duty to deliver care without impairment.^{6,12} Impairment and drug diversion in the workplace can create an environment of disorganization, demoralization, and promote feelings of betrayal among staff, which can adversely impact patient safety and quality of care.²⁵ There are significant harmful consequences when substance use and drug diversion occurs in the workplace for patients, professionals, colleagues, family, friends, communities, and the facility. The consequences directly related to the workplace are described below in Table 3.

Table 3. Harmful consequences of drug diversion and substance use disorder in the workplace

Consequences ^{4,23,26}	
Patient	<ul style="list-style-type: none"> • Undue pain, anxiety, and side effects from improper dosing • Allergic reaction to wrongly substituted drug • Communicable infection from contaminated drug or needle • Victim of medical errors (e.g., medication, procedural) • Loss of trust in the healthcare system
Impaired Professional	<ul style="list-style-type: none"> • Adverse health effects (e.g., respiratory depression, organ failure, death) • Chronic health effects (e.g., liver impairment, heart disease) • Communicable infections from unsterile drugs, needles, injection techniques • Accidents resulting in physical harm • Familial and financial difficulties • Loss of social status • Decline in work performance and professional instability • Felony prosecution, incarceration and civil malpractice • Actions against professional license • Billing or insurance fraud
Colleagues	<ul style="list-style-type: none"> • Injury or infection from blood borne pathogens due to improperly stored equipment (e.g., needle sticks) • At risk for medico-legal liability secondary to shared patient-care responsibilities with an impaired professional, resulting in adverse patient outcomes

Consequences^{4,23,26}	
	<ul style="list-style-type: none"> • Stress due to an increased workload from impaired professional absence • Disciplinary action for false witness of leftover drugs disposal or failure to report impaired professional
Facility	<ul style="list-style-type: none"> • Costly investigations • Loss of revenue from diverted drugs or reimbursement from adverse events due to impaired provider • Poor work quality or absenteeism of the impaired healthcare worker and paying overtime to cover the worker's shifts • Civil liability for failure to prevent, recognize, or address signs of drug diversion or of an impaired provider • Civil liability for patient harm • Damaged reputation due to public knowledge of mandatory reporting or highly publicized drug diversion instances, especially those that led to patient harm • Increased worker's compensation costs

Drug Diversion Prevention

Vulnerability to drug diversion exists when a provider is free to engage in drug procurement from central stores, drug preparation, drug administration to patients, and disposal of drug waste.^{5,27} System-wide initiatives that prevent and identify diversion of controlled substances allow healthcare facilities to promptly intervene when diversion is occurring. These systems require close cooperation between multiple stakeholders, such as departments of pharmacy, safety and security, anesthesiology, nursing, legal counsel, administration, and human resources.

In an effort to discourage drug diversion, inform all employees, contractors and students practicing at clinical sites that protocols are in place to detect and prevent drug diversion, with the primary objective of preventing patient harm. Policies that advocate for fair and uniform management of providers with substance use disorder help create a safe environment for prompt reporting, appropriate treatment, and the potential for the reentry of the anesthesia professional into clinical practice. Practices that may be implemented to help prevent diversion in the workplace are described below in Table 4.

Table 4. Considerations for drug diversion prevention strategies

<ul style="list-style-type: none"> • Institute random drug testing • Install automated drug dispensers to control excess amounts of drugs from being administered^{4,23} • Return all unused medications to a centralized location⁴ • Secure return bins so that unused portions of drugs could be submitted for subsequent random quantitative drug assays before destruction⁴ • Audit anesthesia records to identify outliers using excessive drugs, particularly opioids • Witness disposal of excess waste from medications dispensed and randomly assay waste • Collaborate with other departments (e.g., pharmacy, supply chain management) to create systems to reconcile waste volumes with the dispensing records and patient anesthesia records⁴ • Investigate medication discrepancies (e.g., automated information management)^{4,23} • Withdraw substances for only one patient at a time and administer immediately to patient²³ • Implement policies and procedures for investigations and for managing the many possible outcomes of a confirmed diversion⁴ • Create a safe environment for prompt reporting, including self-reporting, which may result in less punitive outcomes, can discourage continued drug diversion

Drug Testing

Facilities that implement random, for-cause and pre-employment drug testing, within the limits of applicable federal (e.g., Americans with Disabilities Act), state, and local law, as the basis of an effective policy may prevent, deter and detect misuse of substances and drug diversion.^{12,21,28-31} A description of various drug testing modalities is provided below in Table 5. Please consult legal counsel for legal review of drug testing policies and processes.

Table 5. Description of pre-employment, random and for-cause drug tests

<i>Pre-Employment</i>	<ul style="list-style-type: none"> • Predictably scheduled, typically as a condition of employment. • Misses drug use that begins after employment.³² • May deter individuals from using substances, however the predictable, scheduled time makes it easier for impaired individuals to deploy strategies to subvert the test.^{21,33}
<i>Random</i>	<ul style="list-style-type: none"> • Unpredictably scheduled • Administered in a non-discriminatory manner to individuals regardless of whether there is reason to suspect substance use disorder.³² • Compared with pre-employment and for-cause testing, the value of drug testing is improved because individuals do not know when they will be tested, which may deter misuse of substances and drug diversion, especially first-time use, for fear of being caught.^{34,35}
<i>For-Cause</i>	<ul style="list-style-type: none"> • Administered when there is reason to suspect substance use disorder. • While the test may confirm suspicion of substance use, it is not effective in preventing use of harmful substances and impaired individuals may deploy strategies to subvert the test.³³

Facility policies can optimize the validity of testing processes with the following practices:

- Provide pre-employment notification with individual’s signed acknowledgement of facility drug testing policy.
- Select individuals for random testing without human interference.
- Notify individuals of an immediate testing time with escort to an observed testing site for specimen collection.³⁶
- Request disclosure of any legal prescribed drugs or substances they are using that may impact test results.
- Consider privacy in all drug testing settings.³⁶
- Use testing protocols and an extended panel, especially for anesthesia providers that identify anesthesia drugs not commonly detected on standards tests (e.g., fentanyl, propofol).³⁷
- Collaborate closely between the laboratory and medical review officer to help ensure that the best test is being ordered and the results will be interpreted appropriately.³⁷
- Ensure proper chain of custody and prevent tampering of sample.
- Implement protocols for handling false positive and true positive results, including processes to challenge results.
- Provide opportunity for appropriate intervention and treatment arrangements.³³
- Refer impaired individuals for evaluation for substance use disorder by a properly trained addiction professional, without jeopardizing employment, in the event of a positive result.

Facility policies detailing drug testing should be in compliance with practices outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines and all applicable laws, and use a lab that is certified by the U.S. Department of Health and Human Services or an equivalent state

agency.³⁸ Practices outlined by these organizations can help alleviate concerns of a false-positive test damaging careers.²¹ Seeking legal consultation in the development of drug testing policies will help ensure compliance with legal and regulatory requirements and mitigate common concerns with drug testing, which are described below in more detail.³⁹

- Variable detection windows depending on dose, sensitivity of the test method, route of administration, duration of substance use, and variability between individuals.¹²
 - May miss infrequent substance use
 - Standard drug tests do not test for anesthetic substances such as propofol and fentanyl, which are often drugs of choice due to availability⁴⁰
 - Substances such as propofol have short half-lives and require testing via blood draw promptly after use⁴⁰
- Time consuming, expensive and a personnel-intensive procedure
- Potential for issues with regards to the chain of custody of samples by the laboratory
- Time lag between sample collection and test results, making it difficult for a timely intervention.

Reporting a Colleague to Supervisor or Appropriate Chain of Command

Ideally, the anesthesia professional will acknowledge his or her condition, seek help voluntarily, and not require intervention. However, this is often not the case due to denial of condition, stigma, fear of job loss, and other ramifications. Therefore, colleagues play an important role in helping the impaired provider get into treatment.^{22,41} Colleagues are often reluctant to report a suspected colleague for a variety of reasons, such as believing someone else is addressing the issue, it is not their responsibility, the individual will be punished excessively; fear of retribution and being responsible for their colleague's loss of job or license; or lacking knowledge of how to properly report or intervene.³² The AANA Peer Assistance Helpline (800-654-5167) is available for administrator or colleague concerns and questions related to the safe handling an individual struggling with substance use disorder.

Communication forums where individuals can safely and confidentially voice their concerns can empower them to report an individual suspected of substance use disorder and potentially save a life by preventing death from overdose. Maintaining regular departmental operations and promoting confidence among affected staff after a colleague has been removed from practice and placed into treatment can facilitate the provision of optimal and safe patient care.¹⁶

Colleagues may have certain legal responsibilities in identifying and reporting providers to their supervisor or appropriate chain of command.^{6,16} States may have reporting laws which hold colleagues responsible for harm to patients if they fail to report a coworker in whom substance use disorder is suspected. Outline proper steps in facility policies to help guide informants on how to report an impaired colleague, ensure confidentiality of the informant, and offer guidance for investigating and evaluating the credibility of the allegation.⁴² More information on reporting is described in the section below, *Legal Reporting*.

Conducting a Safe Intervention

Critical components involved in an effective intervention need to be in place prior to confronting the individual, which means coordinating a large number of variables. If an individual is suspected of impairment or drug diversion, the facility should follow all appropriate laws and conduct a thorough, objective investigation and plan an intervention to facilitate transition into a treatment program for proper evaluation for treatment. Ideally the intervention will be planned, although some situations may warrant conducting a crisis intervention, (e.g., impaired during patient care, threats to harm themselves). Details on how to proceed with a planned or crisis intervention are described in Table 6. Simulating interventions

(e.g., during grand round presentations) may help to train staff to be better prepared to intervene, whether in a planned or crisis situation.²¹

Assistance for safely handling an individual struggling with substance use disorder is available by contacting the AANA Peer Assistance Helpline (800-654-5167).

Gathering Evidence

Suspicious or significant changes in behavior in the workplace may have many causes; therefore, it is important to have proper evidence that supports the notion of substance use disorder or drug diversion.²⁹ Ensure evidence is documented and convincing, sequential and substantiated, including specific dates and occurrences and accounts from multiple witnesses, if available.

A thorough, nondiscriminatory investigation of the individual suspected is accomplished by:

- Reviewing work behaviors and performance evaluations
- Analyzing utilization of controlled substances
- Documenting changes in appearance and suspicious behaviors, including dates and times
- Collaborating with various departments (e.g., surgery, nursing, pharmacy) to gather evidence

When evidence supports a case of substance use disorder or drug diversion, arrange an intervention and remove the individual from clinical practice.^{43,44}

Assembling an Intervention Team

Assemble an intervention team with a common goal of supporting the individual using people who care about the individual's well-being.⁴⁵ Best practice is to involve a trained interventionist during all points of the intervention; however, during a crisis intervention where there is little time to act, this may not be possible. If possible, contacting an interventionist to coordinate the process should be the first course of action. Sensitivity to the needs of the individual being confronted (e.g., gender, age, ranking) and involving individuals who will make them feel the most comfortable is important to creating a supportive environment.²⁹ Recommendations of individuals to be present during the intervention include:

- Trained interventionist
- Colleagues in recovery (if available)
- Supportive family, friends, and colleagues
- Clinical supervisor
- Administrative supervisor
- Representative from human resources and/or employee assistance program
- Member of security department may be available if there is a particular safety concern

Facilities may have a designated individual or group (e.g., employee assistance programs) with sufficient expertise to assist in interventions.²⁹ Confirm the scope of these services before utilizing them for interventions.

During the Intervention

The intervention is an opportunity to present organized and irrefutable evidence in an atmosphere of care and concern for the individual, where the individual can be empowered to admit their problem, accept help and transition into treatment. These situations are extremely sensitive and must be handled with caution and without coercion to avoid further harm.²⁹ Handle all interventions in a

professional, uniform, nondiscriminatory manner. It is important to confront the individual who is suspected appropriately and in a safe environment to facilitate an effective intervention.

Individuals may become suicidal once the gravity of the situation becomes apparent. Avoid cornering the individual and questioning him or her about suspicious behaviors, and refrain from removing the individual from practice without any plan for treatment evaluation. Never leave the individual alone until evaluation for treatment, and do not allow leaving the intervention unaccompanied.²⁹ Facilitate transfer to a facility for proper treatment evaluation. Table 6 provides an overview of how to facilitate a safe intervention, whether it is planned or conducted in a crisis.

Table 6. Overview of facilitating a safe intervention²⁹

Planned Intervention	Crisis Intervention
1. Assemble an intervention team, including a trained interventionist.	1. Do not let the person out of your sight! Do not let them drive!
2. Gather all the evidence.	2. Get a properly collected drug test.
3. Invite the individual into an intervention meeting. Do not let the person out of your sight! Do not let them drive!	3. Include a trained interventionist, family, spouse, and colleagues.
4. Get a properly collected drug test, if necessary.	4. Bring all evidence.
5. Have a bed in a treatment facility ready.	5. Have a bed in a treatment facility ready.
6. Do not let the impaired individual decide treatment. Remember, they are sick.	6. Do not let the impaired individual decide treatment. Remember, they are sick.
7. Only when all else fails, threaten to call the police. Often, this will cause the individual to admit that he/she has a serious problem.	7. Only when all else fails, threaten to call the police. Often, this will cause the individual to admit that he/she has a serious problem.

Legal Reporting

Since the priority is to get the impaired individual evaluated and into treatment safely, reporting to the proper state medical or nursing board can usually wait until after the individual is safely in treatment. Most states have programs that promote treatment and rehabilitation of impaired providers as an alternative to disciplinary action.^{22,46} Programs vary by state; some programs are housed within the board of nursing, while others are not. Although it is important that facilities are aware of their state's reporting process, the priority is to get the impaired individual safely into treatment.^{16,22}

- Not every state requires reporting unless patient harm has occurred. Therefore it is important to review state law to determine responsibilities in reporting an individual, versus the impaired individual self-report to the state's alternative program and/or state board of nursing.^{20,29,45}
- State requirements should not preclude filing a complaint if it is believed the impaired individual presents danger to themselves or others.²⁹
- Confidentiality must be exercised with disclosure only to appropriate authorities.^{29,45}

Treatment Recommendations for Anesthesia Professionals

Due to their direct access to potent drugs and knowledge of pharmacology, anesthesiologists present unique challenges for treatment and recovery compared to other practice specialties.⁴⁰ They also face potential loss of profession, professional guilt and shame, and a tendency to intellectualize the treatment process.^{20,40,46}

The most desirable inpatient rehabilitation treatment program has experience treating healthcare professionals, specifically anesthesia professionals.²⁹ Completion of a minimum of 28 days inpatient

treatment with at least 90 days of treatment total (inpatient or outpatient) offers the highest success rate.²⁰ An ideal treatment center for anesthesia professionals includes:

- Approval by the state board of nursing⁴⁰
- A comprehensive evaluation and treatment recommendations by an American Society of Addiction Medicine (ASAM) member certified by the American Board of Addiction Medicine (ABAM) who is committed to evaluating and treating anesthesia professionals in abstinence based recovery models in accordance with other safety sensitive occupations such as aviation, department of defense and department of transportation^{13,20,29,43}
- Evaluation by an American Academy of Addiction Psychiatry (AAP) board-certified addiction psychiatrist where appropriate^{20,43}
- Appropriate neuropsychiatric and or psychometric testing²⁰
- Medically supervised detoxification, when clinically indicated²⁰
- Treatment for mental health comorbidities^{20,29,47,48}
- Emphasis on a long-term 12-step model of abstinence-based recovery^{13,49,50}
- Evaluation of suitability for, and timing, of the return to anesthesia practice²⁰

Reentry to Clinical Practice

Intensive inpatient treatment and subsequent follow-up care increases possibility of recovery for healthcare professionals with substance use disorder.³ Upon completion of a rehabilitation program, a safe return to work in anesthesia can be facilitated on an individual basis. Not all practitioners will be able to return to practice. Reentry challenges an anesthesia professional may encounter include stigmatization, shame, working with choice substances, and unresolved pain, all contributing to the threat of relapse.^{13,51,52} Furthermore, the Americans with Disabilities Act (ADA) provides limited protection from employer discrimination against individuals in recovery, further compounding the issue.³⁰

Readiness for reentry is a collaborative decision of the monitoring program, a certified drug and alcohol counselor, and the employer.⁴⁸ A minimum of one year in recovery before returning to the clinical anesthesia arena is recommended.^{13,48,49} The following criteria should be met prior to considering re-entering practice:

- Evaluation by a licensed provider with experience treating substance abuse and dependency^{13,47,48,53}
- Successful completion of a rehabilitation program^{13,48}
- Acceptance of the chronic nature of substance use disorder
- Evidence of a supportive spouse, significant other, or other supportive individuals⁵⁴
- Willingness to take Naltrexone, if appropriate, under direction and supervision of medical professional^{29,46,47}
- Having no untreated psychological comorbidities^{48,50}
- Participation in a monitoring program with random drug testing.^{49,51}
 - Recovery is improved when random drug testing occurs because of the consequences of a positive test.¹²
 - Five-year duration of monitoring with the potential of monitoring for the duration of clinical practice^{29,49}
- Having supportive colleagues, especially administrators and supervisors, at worksite familiar with history and needs^{20,52}
- Grounding in a recovery community, such as *Anesthetists In Recovery*^{46,48}
- Participating in a 12-step program³⁴

Because anesthesia professionals are engaged in safety-sensitive work with considerable consequences when errors occur, abstinence-based recovery and refraining from substitute treatments such as buprenorphine are recommended.³⁵

Disclosure and Return to Work Contracts

Disclosing recovery status to an employer or potential employer is important to gain support and obtain protection from legal repercussions.⁴⁸ Open disclosure may remove the stigma of shame and gives colleagues the opportunity to extend the same care and compassion to a recovering colleague as they do their patients.⁵⁴ Recovering anesthesia professionals may have a difficult time gaining employment after disclosure of their history and managers may not be willing to monitor them in practice.⁴⁰ Various state laws may impact the anesthesia professional's ability to return to full scope of practice in their state.

A return-to-work agreement is highly predictive and supportive of successful reentry into the clinical workplace.²⁰ Include the following stipulations in contracts defining terms of practice reentry:

- Length of the contract
- Phases of the clinical reentry plan, which outline practice restrictions and milestones
- Consequences of failure to comply with contract stipulations
- Plan for treatment (if the contract is signed at the time the anesthesia professional's substance use disorder is first detected) and aftercare⁴⁹
- Practice restrictions, such as no overtime or extra call and limiting administration of narcotics for a period of time^{13,40}
- Supervision requirements⁴⁸
- Random drug testing requirements⁴⁷
- Mandatory attendance at support group meetings
- Job performance standards
- Provision for periodic evaluation meetings with direct supervisor
- Steps to be taken in the event of relapse
- Regular reports from supervisors or work-site monitors
- Monitoring with state board of nursing

Relapse Prevention

Job dissatisfaction and overall stress may be an indicator of potential relapse, especially for the anesthesia professional who is working with substances they formerly abused. Managing stress, and maintaining healthy lifestyle habits (e.g., fitness, nutrition), and support of peers can help prevent relapse.⁵² Additionally, managing triggers to substance use can also help mitigate incidents of relapse.^{52,56} A scale to measure job satisfaction can give the employer and practitioner a score for job satisfaction and alert employers and practitioners of potential relapse due to the level of stress or burnout.⁵¹

Conclusion

Substance use disorder and impairment in the workplace can result in harm to the impaired individual, their colleagues or patients. Education, random drug testing, and drug diversion prevention can help deter substance use disorder and get individuals safely into appropriate treatment. Not all practitioners will be able to return to clinical practice. Those who do return to practice may encounter stigmatization, shame, and work with their choice substances, all contributing to the threat of relapse. Developing facility policies that address awareness, prevention, reporting, and safe intervention and management of impairment in the workplace is a key step in the prevention of adverse outcomes. Policies that advocate for fair and uniform management of providers with substance use disorder help create a safe environment for prompt reporting, appropriate treatment, and the potential for reentry of the anesthesia professional into clinical practice.

References

1. Volkow ND, Koob GF, McLellan AT. Neurobiologic Advances from the Brain Disease Model of Addiction. *N Engl J Med.* Jan 28 2016;374(4):363-371.
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed. Washington, D.C.2013.
3. Baldisseri MR. Impaired healthcare professional. *Crit Care Med.* Feb 2007;35(2 Suppl):S106-116.
4. Berge KH, Dillon KR, Sikkink KM, Taylor TK, Lanier WL. Diversion of drugs within health care facilities, a multiple-victim crime: patterns of diversion, scope, consequences, detection, and prevention. *Mayo Clin Proc.* Jul 2012;87(7):674-682.
5. Centers for Disease Control and Prevention. Risks of Healthcare-associated Infections from Drug Diversion. <http://www.cdc.gov/injectionsafety/drugdiversion/index.html>. Accessed February 15, 2016.
6. American Medical Association. Opinion 9.031 - Reporting Impaired, Incompetent, or Unethical Colleagues. <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9031.page?> Accessed February 24, 2016.
7. National Institute on Drug Abuse. DrugFacts: Prescription and Over-the-Counter Medications. <https://www.drugabuse.gov/publications/drugfacts/prescription-over-counter-medications>. Accessed July 6, 2016.
8. National Institute on Drug Abuse. Prescription Opioids and Heroin. <https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-abuse-heroin-use/heroin-use-driven-by-its-low-cost-high-availability>. Accessed July 6, 2016.
9. United States Drug Enforcement Administration. DEA Issues Nationwide Alert on Fentanyl as Threat to Health and Public Safety <https://www.dea.gov/divisions/hq/2015/hq031815.shtml>. Accessed July 6, 2016.
10. United States Drug Enforcement Administration. National Heroin Threat Assessment Summary - Updated. https://www.dea.gov/divisions/hq/2016/hq062716_attach.pdf. Accessed July 6, 2016.
11. Sharer KB. Controlled-substance returns in the operating suite. *AORN J.* Aug 2008;88(2):249-252.
12. Fitzsimons MG, Baker KH, Lowenstein E, Zapol WM. Random drug testing to reduce the incidence of addiction in anesthesia residents: preliminary results from one program. *Anesth Analg.* Aug 2008;107(2):630-635.
13. Wright EL, McGuinness T, Moneyham LD, Schumacher JE, Zwerling A, Stullenbarger NE. Opioid abuse among nurse anesthetists and anesthesiologists. *AANA J.* Apr 2012;80(2):120-128.
14. Chipas A, McKenna D. Stress and burnout in nurse anesthesia. *AANA J.* Apr 2011;79(2):122-128.
15. Lord M, Magro M, Zwerling A. Substance Abuse and Anesthesia: Why It Is Your Problem and What Student Nurse Anesthetists Are Doing About It. 2010. http://www.aana.com/resources2/health-wellness/Documents/nb_pan_1110.pdf. Accessed February 15, 2016.
16. Tanga HY. Nurse drug diversion and nursing leader's responsibilities: legal, regulatory, ethical, humanistic, and practical considerations. *JONAS Healthc Law Ethics Regul.* Jan-Mar 2011;13(1):13-16.
17. Bettinardi-Angres K, Angres DH. Understanding the Disease of Addiction. *J Nurs Regul.* 2011;1(2):31-37.
18. National Institute on Drug Abuse. The Science of Drug Abuse and Addiction: The Basics. <https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics>. Accessed April 12, 2016.
19. Code of Ethics for the Certified Registered Nurse Anesthetist. Park Ridge, IL: American Association of Nurse Anesthetists; 2005.
20. National Council of State Boards of Nursing. Substance Use Disorder in Nursing. 2011. https://www.ncsbn.org/SUDN_11.pdf Accessed February 17, 2016.

21. Tetzlaff J, Collins GB, Brown DL, Leak BC, Pollock G, Popa D. A strategy to prevent substance abuse in an academic anesthesiology department. *J Clin Anesth.* Mar 2010;22(2):143-150.
22. Bettinardi-Angres K, Bologeorges S. Addressing Chemically Dependent Colleagues. *J Nurs Regul.* 2011;2(2):10-17.
23. New K. Preventing, Detecting, and Investigating Drug Diversion in Healthcare Facilities. *Journal of Nursing Regulation.* 2014;5(1):18-25.
24. Epstein RH, Gratch DM, McNulty S, Grunwald Z. Validation of a system to detect scheduled drug diversion by anesthesia care providers. *Anesth Analg.* Jul 2011;113(1):160-164.
25. Ramer LM. Using servant leadership to facilitate healing after a drug diversion experience. *AORN J.* Aug 2008;88(2):253-258.
26. National Safety Council. How prescription opioids may be affecting your workers compensation program. <http://www.nsc.org/RxDrugOverdoseDocuments/RxKit/EMP-How-Prescription-Opioids-May-Be-Affecting-Workers-Compensation-Program.pdf>. Accessed July 6, 2016.
27. Cummings SM, Merlo L, Cottler L. Mechanisms of prescription drug diversion among impaired physicians. *J Addict Dis.* Jul-Sep 2011;30(3):195-202.
28. Bryson EO, Silverstein JH. Addiction and substance abuse in anesthesiology. *Anesthesiology.* Nov 2008;109(5):905-917.
29. Bryson EO, Hamza H. The drug seeking anesthesia care provider. *Int Anesthesiol Clin.* Winter 2011;49(1):157-171.
30. 42 U.S.C. §§ 12111–12117 (1994).
31. The National Bureau of Economic Research. Employee Drug Testing is Effective. <http://www.nber.org/digest/mar00/w7383.html>. Accessed July 6, 2016.
32. DesRoches CM, Rao SR, Fromson JA, et al. Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. *JAMA.* Jul 14 2010;304(2):187-193.
33. American Society of Addiction Medicine. Drug Testing: A White Paper of the American Society of Addiction Medicine (ASAM). 2013. [http://www.asam.org/docs/default-source/public-policy-statements/drug-testing-a-white-paper-by-asam.pdf?sfvrsn=4#search="drugscreening"](http://www.asam.org/docs/default-source/public-policy-statements/drug-testing-a-white-paper-by-asam.pdf?sfvrsn=4#search=). Accessed February 19, 2016.
34. Marlowe DB, Festinger DS, Foltz C, Lee PA, Patapis NS. Perceived deterrence and outcomes in drug court. *Behav Sci Law.* 2005;23(2):183-198.
35. DuPont RL, Voth EA. Drug legalization, harm reduction, and drug policy. *Ann Intern Med.* Sep 15 1995;123(6):461-465.
36. American Society of Addiction Medicine. Terminology Related to the Spectrum of Unhealthy Substance Use. 2013. <http://www.asam.org/docs/default-source/public-policy-statements/1-terminology-spectrum-sud-7-13.pdf?sfvrsn=2>. Accessed February 12, 2016.
37. Jones JT. Advances in Drug Testing for Substance Abuse Alternative Programs. *Journal of Nursing Regulation.* 2016;6(4):62-67.
38. National Safety Council. Steps to update a drug free workplace program to address prescription drugs. <http://www.nsc.org/RxDrugOverdoseDocuments/RxKit/EMP-Steps-To-Update-Drug-Free-Workplace-Program.pdf>. Accessed July 6, 2016.
39. National Safety Council. The proactive role employers can take: Opioids in the workplace. <http://www.nsc.org/RxDrugOverdoseDocuments/proactive-role-employers-can-take-opioids-in-the-workplace.pdf>.
40. Bettinardi-Angres K, Garcia R. A Consistent Approach to Treatment and Reentry for CRNAs with Substance Use Disorder. *J Nurs Regul.* 2015;6(2):47-51.
41. Kelly JF, Saitz R, Wakeman S. Language, Substance Use Disorders, and Policy: The Need to Reach Consensus on an "Addiction-ary". *Alcohol Treat Q.* 2016;34(1):116-123.
42. *Comprehensive Accreditation Manual for Hospitals 2015.* Chicago, Ill: Joint Commission on Accreditation of Healthcare Organizations.

43. Bertrand, A. Substance Use Disorder (SUD) in the Workplace. *AANA Newsbulletin*. May 2015; 69(3):28-31.
44. Federation of State Medical Boards. Policy on Physician Impairment. 2011. https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/grpol_policy-on-physician-impairment.pdf. Accessed April 7, 2016.
45. Zwerling A, Hamza H, Rampleman G, Stone L. Almost Everything You Want to Know about the AANA's Peer Assistance Advisors Committee. *AANA NewsBulletin*. 2011. http://www.aana.com/resources2/health-wellness/Documents/nb_pan_0311.pdf. Accessed February 16, 2016.
46. Wilson H. Reentry of the Addicted Certified Registered Nurse Anesthetist: A Review of the Literature. *Journal of Addictions Nursing*. 2009;20(4):177-184.
47. Hamza H, Monroe T. Reentry and Recidivism for Certified Registered Nurse Anesthetists. *Journal of Nursing Regulation*. 2011;2(1):17-22.
48. Monroe T, Vandoren M, Smith L, Cole J, Kenaga H. Nurses recovering from substance use disorders: a review of policies and position statements. *J Nurs Adm*. Oct 2011;41(10):415-421.
49. Monroe T, Hamza H, Stocks G, Scimeca PD, Cowan R. The misuse and abuse of propofol. *Subst Use Misuse*. 2011;46(9):1199-1205.
50. Angres DH, Bettinardi-Angres K. The disease of addiction: origins, treatment, and recovery. *Dis Mon*. Oct 2008;54(10):696-721.
51. Valdes JA. The concept of reentry in the addicted anesthesia provider. *AANA J*. Apr 2014;82(2):95-100.
52. Wright EL, McGuinness T, Schumacher JE, Zwerling A, Moneyham LD. Protective factors against relapse for practicing nurse anesthetists in recovery from anesthetic opiate dependency. *J Addict Nurs*. Apr-Jun 2014;25(2):66-73.
53. Monroe TB, Kenaga H, Dietrich MS, Carter MA, Cowan RL. The prevalence of employed nurses identified or enrolled in substance use monitoring programs. *Nurs Res*. Jan-Feb 2013;62(1):10-15.
54. Higgins Roche B. *Substance Abuse Policies for Anesthesia*. Winston-Salem, NC: : All Anesthesia; 2007.
55. Hamza H, Bryson EO. Buprenorphine maintenance therapy in opioid-addicted health care professionals returning to clinical practice: a hidden controversy. *Mayo Clin Proc*. Mar 2012;87(3):260-267.
56. Hamza H, Bryson EO. Exposure of anesthesia providers in recovery from substance abuse to potential triggering agents. *J Clin Anesth*. Nov 2011;23(7):552-557.

The *Substance Abuse and Chemical Dependency* position statement was adopted by the AANA Board of Directors in 1984 and revised in 1998, 2007, and November 2011. In July 2016, the AANA Board of Directors archived the position statement and adopted *Addressing Substance Use Disorder for Anesthesia Professionals*.
 © Copyright 2016

ARKANSAS STATE BOARD OF NURSING

Guideline Number: DG-1

Department/Service Area: Discipline

Subject: Guidelines for Consent Agreements

Reference: Board Approval

GUIDELINES FOR CONSENT AGREEMENTS

1. Staff may propose a Consent Agreement with a Respondent:
 - a. Who has a new disciplinary action;
 - b. With past discipline on licensure if the discipline was:
 - i. a letter of reprimand; or
 - ii. probation that was successfully completed; or
 - iii. suspension but licensure was reinstated by the Board.
 - c. Who is noncompliant with a previous Board Order.
 - d. Who has voluntarily surrendered licensure.
 - e. Who is an applicant for licensure with a history of criminal convictions that would indicate monitoring would be appropriate during the initial period of licensure.
2. If the Respondent self-reports, Board staff may waive the Respondent's civil penalty but assess to the Respondent any investigative costs.
3. If the Respondent has been charged with a crime, Board staff may await disposition of the criminal charge before offering a Consent Agreement to determine if the Respondent should be charged with violation of ACA § 17-87-309(a)(2). However, if additional infractions of the *Nurse Practice Act* need to be addressed immediately, staff may proceed with offering a Consent Agreement regarding the underlying unprofessional conduct issue(s). Any pending criminal case will be addressed once it is adjudicated.
4. If Respondent is charged with a practice issue that does not involve allegations of drug abuse or misconduct involving drugs, the Board staff may not require the Respondent to:
 - a. attend AA/NA, or other recognized treatment program;
 - b. do drug testing; or
 - c. avoid controlled substances, abuse potential substances, and alcohol.
5. If the charge is drug or alcohol related, Board staff may require the Respondent to obtain an evaluation by a practitioner who specializes in substance use disorders before offering the Consent Agreement.
 - a. If Respondent has already completed an evaluation by an evaluator who meets the Board's requirements, then board staff may accept that evaluation and not require a new one.
 - b. Board staff may have the Respondent attend AA/NA meetings or Board approved counseling sessions throughout the term of the Consent Agreement order.
 - c. If the Respondent has successfully completed a drug related recovery program then generally board staff may charge the Respondent with violation of (a)(4) and other applicable violations of §17-87-309.
 - d.
6. Professional Behaviors Course. Board staff may include in the Consent Agreement the requirement for a Professional Behaviors course when the Respondent has forged, stolen, or

Guideline Number: DG-1
GUIDELINES FOR CONSENT AGREEMENTS

misappropriated someone's name, prescription pad, DEA #, assigned medication access number, or in Consent Agreement level cases in which a document was falsified by the Respondent.

7. In the Findings of Fact, board staff must either specifically list or state the following if known:
 - a. The name of the facility, city and state in which the wrongdoing occurred;
 - b. State the wrongdoing. i.e.: tested positive for marijuana, methamphetamines; diverted hydrocodone; stole a prescription pad; inadequate charting; improper wastage of controlled substances; forged assigned medication access number and so forth;
 - c. List all the specific drugs or alcohol reportedly in question;
 - d. If convicted of a crime:
 - i. include all specific crimes;
 - ii. identifying each crime as a felony or misdemeanor and by class if known;
 - iii. name of the Court and jurisdiction, i.e., Circuit Court of Jefferson County; Municipal Court of Little Rock; Traffic Court of Redbud, Arkansas;
 - iv. the ruling for each crime charged; and
 - v. charge the individual with ACA § 17-87-309(a)(2) if the Respondent has a conviction or has entered a plea of guilty or *nolo contendere*.
8. Probation Consent Agreements shall include a statement informing the Respondent,
 - a. Pursuant to Ark. Code Ann. §17-87-309, failure to comply with this Order may result in additional disciplinary action on the Respondent's licensure and/or privilege, including but not limited to, additional probation, suspension, or revocation of licensure and/or privilege to practice nursing in this state.
 - b. Respondent shall not submit dilute specimens.
 - c. Respondent shall not serve as a preceptor during probation.
 - d. Respondent may have personal prescriptions monitored through the Prescription Drug Monitoring Program every three (3) months while under Board order.
9. Format:
 - a. Board staff shall list all of the Respondent's licensure (active, inactive, expired, lapsed, etc.) on the Consent Agreement. If the Respondent is a licensure applicant or endorsement, then PN/RN APPLICANT will be listed in lieu of licensure. Board staff shall not list the Respondent's DEA Registration Certificate number or Social Security number on the Consent Agreement.
 - b. Board staff shall make sure the Consent Agreement is in order, properly initialed, signed, and dated by the Respondent.
 - c. Board staff shall list all of the Respondent's names that appear in the licensure database on the Consent Agreement.
 - d. Any material changes to the original Consent Agreement must be typed and not hand written on the document.
 - e. The heading of:
"In The Matter of: _____ PN/RN APPLICANT or LPN/RN/LPTN/APRN License
No. _____" must be at the top of each page in the Consent Agreement.
10. Other. Board staff may include in the Consent Agreement any other information as allowed under the *Administrative Procedure Act, Nurse Practice Act and Rules*.

Approved: September 11, 2008

Revised: May 12, 2010, September 13, 2012, January 7, 2016, January 8, 2015, January 11, 2018

Reviewed January 8, 2014

ARKANSAS STATE BOARD OF NURSING GUIDELINES

Guideline Number: DG-5

Department/Service Area: Discipline

Subject: Drug Testing while Licensure is Voluntarily Surrendered

Reference:

Voluntary surrender with drug screening Guidelines

1. Licensee who has voluntarily surrendered licensure and is eligible for reinstatement may be requested to provide three (3) consecutive months of drug screens that are negative for controlled substances or abuse potential substances, through a Board approved lab monitoring company directly prior to reinstatement of licensure through probation Consent Agreement or Hearing.
2. Licensee who has been prescribed/taking methadone or buprenorphine may voluntarily surrender licensure until the licensee provides three (3) consecutive months of drug screens that are negative for controlled substances or abuse potential substances through a Board approved lab monitoring company.

ARKANSAS STATE BOARD OF NURSING GUIDELINES

Guideline Number: DG-7

Department/Service Area: Discipline

Subject: Board Order with drug testing and allowable medications.

Reference: Board Approved September 14, 2017

GUIDELINES FOR TREATMENT OF ATTENTION DEFICIT DISORDER, ATTENTION DEFICIT HYPERACTIVE DISORDER, POST TRAUMATIC-STRESS DISORDER, OR ANXIETY/PANIC ATTACKS WHILE UNDER BOARD ORDERED MONITORING FOR CONTROLLED SUBSTANCES AND DRUGS OF ABUSE

1. Board staff will require detailed documentation from a psychiatrist of the diagnosis and treatment guidelines for Respondent who wants to use amphetamine salts or anxiolytics.
2. Board staff will monitor the Prescription Drug Monitoring Report (PDMP) for the Respondent's new and refill activity of controlled substances.
3. Board staff will require a statement from the provider and mental health provider that Respondent is his/her patient and is being treated for the chronic condition.
4. Board staff will require quarterly compliance statements sent from the providers.
5. There will be a stipulation in the Order or Consent Agreement that Respondent may only use one primary care provider or one primary care provider and one mental health provider and one pharmacy while under Order or Consent Agreement.
6. There will be documented coordination of care between the primary care provider and mental health provider of the Respondent if applicable.

Approved September 14, 2017

Reentry and Recidivism for Certified Registered Nurse Anesthetists

Heather Hamza, CRNA, MS, and Todd Monroe, PhD, RN-BC

The self-reported prevalence of drug diversion (diverting hospital medications for self-administration) among certified registered nurse anesthetists (CRNAs) is 9.8%. However, much of the addiction literature fails to focus specifically on CRNAs' reentry into practice. This article discusses reentry and recidivism in CRNAs and includes successful strategies, such as medication therapy.

In 1992, Jason Smith entered his first treatment center after turning himself in for fentanyl addiction at the community hospital where he was working. After 28 days in the treatment center, he was assigned to an aftercare program and told to go to Alcoholics Anonymous (AA). He was not enrolled in a monitoring program and attended AA meetings sporadically. Having lost his job, he worked as a traveling certified registered nurse anesthetist (CRNA) and promptly relapsed. A year later, after some clean time, Jason took a full-time position in a neighboring community hospital, which knew about his history of fentanyl addiction. The hospital issued a last-chance contract, did random urine drug screens, and limited his work hours. In 6 months, he was using again. After a positive result on a urine drug screen, the hospital sent him to a 3-week intensive outpatient program but did not fire him. About 6 months later, he used again and was fired. At that point, his wife asked him to leave their house.

At the time, an alternative-to-discipline program was being developed under a mandate of the state legislature. A pharmacist friend who had just completed long-term treatment asked Jason to accompany him to a Caduceus meeting. Jason was able to share his story with 30 recovering health professionals, and when he was done, the medical director stood up and said, "You never received treatment. I want you here tomorrow morning to be admitted for long-term treatment." The next day, Jason was admitted to an inpatient program.

This article explores issues surrounding reentry into practice and recidivism of recovering CRNAs and includes strategies for success, such as the use of medications.

Prevalence of the Problem and Scarcity of CRNA-Specific Studies

The self-reported prevalence of drug diversion for self-administration among CRNAs is 9.8% (Bell, 2006; Bell, McDonough, Ellison, & Fitzhugh, 1999). Thus, of the more than 40,000 CRNAs in the United States, there would be approximately 4,000 who would self-report as diverting drugs. Though cases of trafficking or diverting to others exist, they are rare, and

Bell's data specifically examine the far more common scenario of self-medication.

An extensive review of the literature reveals that much of the focus on drug diversion has involved physicians and nurses. Nursing publications that examine nurses who divert drugs by specialty fail to include CRNAs. The sparse literature that exists on CRNAs focuses on the incidence and demographic characteristics of those who divert drugs based on self-report (Bell, 2006; Bell et al., 1999).

About one-third of critical-care nurses report easy access to controlled substances, and the combination of having easy access and working in a critical-care specialty has been associated with the greatest likelihood of illicit drug use (Trinkoff & Storr, 1994). These high-risk factors certainly apply to CRNAs, who work in a critical-care specialty and have easy access to controlled drugs.

Components of Safe Reentry into Practice

Several recommendations have been made for reentry programs for CRNAs, but none has been empirically tested. Generally, these recommendations call for detoxification, treatment, and then gradual reentry into practice when it is deemed safe. Whether or not a recovering CRNA (or anesthesiologist) can safely return to anesthesia practice without relapsing, despite follow-up care and monitoring, remains controversial (Berge, Seppala, & Lanier, 2008; Collins, McAllister, Jensen, & Gooden, 2005). One major risk associated with returning to the practice environment is the presence of cues previously paired with drug use, such as handling anesthetic drugs and paralytic agents (Reinze, Wolfing, & Grusser, 2007).

Reentry of recovering health-care professionals (HCPs) into the workplace is an important issue for administrators, leaders, and the public. The American Association of Nurse Anesthetists (AANA) has traditionally advocated for public safety through the removal and safe return of CRNAs suffering from addiction, yet

the AANA recognizes the precarious nature of this undertaking and maintains high standards for reentry.

Two classic textbooks cover the standard components of a safe, reasonable reentry of the anesthesia practitioner (Angres, Talbott, & Bertinardi-Angres, 1998; Higgins Roche, 2007). These components, which appear frequently in the pro-reentry literature (Monroe, 2009), include, but are not restricted to, the following:

- a solid foundation in a 12-step program
- participation in the state's monitoring program (if applicable)
- attendance at Caduceus (HCP support group) meetings
- a work-site monitor
- random drug screens
- a back-to-work contract
- naltrexone use
- no overtime.

Bryson & Silverstein (2008) recommend 1 year away from anesthesia practice before reentry. They believe the recovering addict must focus on recovery and sobriety versus career. Reentry contracts commonly forbid overtime, so the recovering addict has time for 12-step meetings, aftercare, and Caduceus meetings and can maintain a balanced, healthy life (Angres et al., 1998; Bryson & Silverstein, 2008; Higgins Roche, 2007).

The literature on reentry for HCPs does not support opioid replacement therapy such as the mu agonists buprenorphine and methadone, which are commonly used in other opiate-abusing populations. Instead, the literature advocates the mu antagonist naltrexone (Bryson & Silverstein, 2008; Higgins Roche, 2007; Oreskovich & Caldeiro, 2009).

The alternative-to-discipline programs of many state boards of nursing (BONs) and state medical boards require participation in 12-step programs, such as AA or Narcotics Anonymous (Baldisseri, 2007; DuPont, McLellan, Carr, Gendel, & Skipper, 2009; Hughes, Smith, & Howard, 1998). Attending 12-step meetings is a common stipulation in reentry or back-to-work contracts (Angres et al., 1998; Bryson & Silverstein, 2008; Higgins Roche, 2007).

Despite the common recommendation regarding 12-step programs, research on their effectiveness is limited. Galanter, Talbott, Gallegos, & Rubenstone (1990) surveyed 100 physicians in the Georgia Impaired Physicians Program. The 160-question, multiple-choice or numerical-response survey asked the degree to which certain recommendations contributed to recovery. Respondents indicated that AA was the most potent component in their recovery and their group cohesiveness reflected the camaraderie felt by these physician AA members with other members of AA (Galanter, Talbott, Gallegos, & Rubenstone, 1990).

Although only limited data support the standard recommendations, they appear consistently (Wilson & Compton, 2009). Investigators recognize that retrospective analyses are needed to scrutinize the efficacy of each component, including the correlation of relapse rate with the type of treatment or

administration of naltrexone (Oreskovich & Caldeiro, 2009). Berge, Seppala, and Lanier (2008) concur, advocating for data supporting the traditional 3- to 5-year monitoring period set forth by most monitoring programs for nurses and physicians.

Alternative-to-Discipline Programs

An alternative-to-discipline, or diversion, program is a monitoring program for impaired nurses, often run through the state BON (Monroe, Pearson, & Kenaga, 2009). A 2002 seminal study showed that when compared with disciplinary programs, alternative-to-discipline programs had more nurses with active licenses, fewer with criminal convictions, and more employed in nursing (Haack & Yocum, 2002). Clark and Farnsworth (2006) found that nurses who were monitored longer had higher success rates, leading them to recommend increasing the monitoring contract from 3 years to 5 years.

Monroe, Pearson, and Kenaga (2008) note that the information regarding alternative programs is limited, and much of it is dated. Also, some types of monitoring programs may be reluctant to share data, unless the facts cast them in a positive light. See "Model Guidelines for Alternative Programs and Discipline Monitoring Programs" (published here for the first time by the National Council of State Boards of Nursing), on page 42 of this issue.

Physicians also have alternative-to-discipline programs, usually run by the respective state board of medicine and called physician health programs. DuPont, McLellan, Carr, Gendel, & Skipper (2009) retrospectively analyzed 780 nonresident physicians enrolled in physician health programs. The program medical directors were surveyed to analyze their treatment, support, and monitoring regimens. The findings were hopeful: only 22% of physicians tested positive during their 5-year monitoring period, and at 5 years, 71% were still licensed and employed (DuPont et al., 2009).

Measuring Success

Reentry of the CRNA has been considered rarely in nursing publications (Saver, 2008a, 2008b) and even less in physician anesthesiology publications (Berge et al., 2008). The concept of successful reentry into practice has been inferred in this literature—primarily from rates of relapse and recovery from alternative-to-discipline programs.

Monroe and colleagues (2008) found that alternative-to-discipline and disciplinary programs reported success rates for reentry into practice between 68% and 90%. Thus, both types of programs have consistently helped a majority of nurses recovering from addictive disorders to reenter the workforce. However, alternative-to-discipline programs remove impaired clinicians from practice in days to weeks compared with months or years

with disciplinary programs. Thus, the public is protected sooner, and the nurse receives treatment faster.

The success of a program may also be measured in terms of recovery or retention (Monroe et al., 2008). The authors found recovery rates of 47% to 95% and retention rates for nurses in the profession of 61% to 85%. The authors found little empirical evidence in the literature about reentry and monitoring programs. They further caution that success rates may tell us very little about the progress made nationwide in addressing substance use disorders among HCPs (Monroe et al., 2008).

Reentry of Nurses

Data supporting successful reentry of nurses to practice are encouraging. Hughes, Smith, & Howard (1998) evaluated Florida's Intervention Project for Nurses, the first alternative-to-discipline program in the United States, and found that over 80% of impaired nurses reentered nursing, with less than 25% having relapsed (Hughes et al., 1998).

Yocum and Haack (1996) found that alternative-to-discipline programs removed impaired nurses from the workplace faster and had a recovery rate nearly double that of the punitive programs. Baldisseri (2007) reported that up to 75% of HCPs remain sober for more than 10 years after treatment, with 15% to 20% relapsing within 1 to 2 years of initial treatment.

Reentry of CRNAs

Only one study specifically addresses the reentry needs of the CRNA. A retrospective study by Sibert and Demenes (1996) reported results of a four-question survey completed by 60 recovering CRNAs and evaluated important factors for maintaining sobriety to facilitate reentry. Respondents identified these factors as participating in a 12-step program (64.4%), attending support groups (61%), having random drug screening (39%), having sponsorship in support groups (27.1%), and serving as a mentor or sponsor for another addicted CRNA (27.1%). The four most difficult issues related to successful reentry were receiving disciplinary actions from the state BON (69.8%), finding employment (56.6%), working with managers uninformed about chemical dependency (39.6%), and having employers unwilling to monitor the employee adequately (28.3%).

Redirection to Another Specialty

A few studies evaluate reentry programs for anesthesiologists that strongly advocate redirection into another specialty after treatment (Collins et al., 2005). These studies, which are retrospective surveys of academic anesthesiology departments assessing substance abuse and reentry among anesthesia residents, found that when advocating redirection into a different specialty, a program must be aware of the other high-risk settings. In other words, redirecting an addict to another specialty does not automatically remove the risk of relapse. According to Hughes et al. (1998), the highest incidence of chemical dependency is in emergency and

psychiatry units. Monroe and colleagues (2008) also suggest that for nurses unable or unwilling to maintain sobriety, redirection out of the profession may be the only option.

Pharmacotherapeutics in Reentry

Two overall classes of drugs can be used to help treat those recovering from addiction: mu opioid antagonists such as naltrexone and partial mu opioid agonists such as buprenorphine. The literature does not support the use of the latter for recovering HCPs, which will be subsequently discussed.

Naltrexone

Naltrexone has been recommended in addictions literature for several decades. The use of naltrexone, a full mu opioid antagonist, has long been known to reduce alcohol cravings in alcoholics (O'Malley, Krishnan-Sarin, Farren, Sinha, & Kreek, 2002). Judson, Carney, & Goldstein (1981) describe its original purpose in 1963, which was for opioid addiction. The premise for its use was Abraham Wikler's 1948 theory of conditioning, in which the addict could return to his or her previous environment and use opioid antagonism to extinguish the urge to use. Today, the issues of drug-related cues, conditioned responses, and reentry still require proper research (Wilson, 2009).

Judson et al. (1981) studied the effects of naltrexone in recovering heroin addicts ($n = 119$). The authors wanted to know if any difference in safety and efficacy existed between 60-mg and 120-mg naltrexone treatment. The authors found no differences in initial treatment dropout. However, among persons who stayed in treatment more than 3 months, those taking 120 mg of naltrexone stayed longer. Thus, the authors found that so long as abstinence was maintained, naltrexone reduced craving and that reduced craving increased over time with repeated dosing (Judson, Carney, & Goldstein, 1981).

Roth, Hogan, & Farren (1997) retrospectively analyzed success rates of 20 addicted HCPs over a 5-year period. Seventeen were nurses, one was a pharmacist, and two were CRNAs. The authors concluded that the use of naltrexone in addicted HCPs yielded a higher success rate than in the general population because of the motivation to return to work and maintain professional licensure. Several reports specifically recommend naltrexone for addicted anesthesiologists and CRNAs who are returning to work (Bryson & Silverstein, 2008; Higgins Roche, 2007; Oreskovich & Caldeiro, 2009).

Buprenorphine

At least 10 BONs have approved opioid replacement therapy for HCPs returning to work, though no evidence supports the safety of this approach. Buprenorphine is a semisynthetic partial mu opioid agonist and kappa-receptor antagonist (Messinis et al., 2009) used for analgesia and for opioid dependence.

TABLE 1

Summary of Pharmacotherapeutics

Generic Drug Name	Trade Drug Name	Drug Class	Common Dosing Frequency and Administration Route	Diversion and Abuse Potential	DEA Schedule	Potential for Neurocognitive and Psychomotor Impairment	Recommended by AANA for Reentry
naloxone	Narcan	Opiate antagonist	Not applicable (used for overdose)	No	None	No	No (too short-acting)
naltrexone	Revia	Opiate antagonist	Once a day by mouth	No	None	No	Yes
naltrexone	Vivitrol	Opiate antagonist	Once a month intramuscularly	No	None	No	Yes
naltrexone	Addax	Opiate antagonist	Once every 3 to 4 months, subcutaneous pellet	No	None	No	Yes
buprenorphine	Subutex	Partial opiate agonist	Every other day or three times a week; sublingual tablet or film	Yes	Class III	Yes	No
buprenorphine with naloxone	Suboxone	Partial opiate agonist and opiate antagonist	Every other day or three times a week; sublingual tablet or film	Yes	Class III	Yes	No
methadone	Dolophine	Opiate agonist	Every day by mouth	Yes	Class II	Yes	No

DEA = Drug Enforcement Administration
AANA = American Association of Nurse Anesthetists

Compared with full mu agonists, buprenorphine may have a safer pharmacodynamic profile because it slowly dissociates from mu receptors and produces less respiratory depression (Rapeli et al., 2007). This slow dissociation allows for less frequent dosing but can make detoxification difficult. Though it is a partial mu agonist, buprenorphine causes the same physiologic responses as full mu agonists, including cognitive and psychomotor impairment, memory deficits, miosis, respiratory depression, decreased gastrointestinal motility, urine retention, nausea, drug liking, euphoriant effects, drug dependence, and subsequent withdrawal (Messinis et al., 2009; Mintzer, Correia, & Strain, 2004; Rapeli et al., 2007).

Several publications address the abuse and diversion potential of buprenorphine (Higgins Roche, 2007; Mintzer et al., 2004). The indications for buprenorphine are similar to those for methadone, and thus comparisons are common. As a partial mu agonist, buprenorphine is not considered completely free of abuse potential; it just may have less than a full mu agonist such as methadone (Higgins Roche, 2007; Mintzer et al., 2004).

After a series of patients crushing buprenorphine pills and administering them parenterally, the oral tablets were manufactured in a 4:1 ratio of buprenorphine:naloxone. The naloxone is bioavailable only in the intravenous preparation, not in the oral preparation; thus, the active naloxone precipitates opiate withdrawal only if taken parenterally (Mintzer et al., 2004; Rapeli et al., 2007). See Table 1 for a summary of pharmacotherapeutics.

Outcome of Case Study

Following treatment, Jason Smith took a job as a registered nurse in a ventilator-dependent unit. He was under contract, met with his AA sponsor regularly, had quarterly reports sent by therapists, had daily urine drug screens, attended at least five meetings a week, and stayed in contact with his caseworker. When he was considered ready to handle narcotics, he worked in the intensive care unit and then the anesthesia department again. Once he had access to narcotics, he was put on naltrexone. He took the pill every day with his work-site monitor watching, and he was on contract for more than 5 years.

Recently, Jason celebrated 12 years of continuous sobriety, and he has been overwhelmed by remarks about his contributions to other people's recoveries.

Discussion

Reentry of the recovering HCP remains a controversial and a precarious undertaking. The standard recommendations appear consistently in the literature; however, most of them are based on collective expert opinion, not empirical data. The reported successes of the alternative-to-discipline programs do not clearly explain their significant contributions. Studies are largely retrospective analyses and self-reporting, which raises questions. How would one undertake a genuine evidence-based study to assess reentry? Would subjecting participants to reentry methods not yet discussed in the peer-reviewed literature be ethical?

The use of pharmacotherapeutics in HCPs, including CRNAs, needs to be further investigated. Cognitive and psychomotor function has been tested in other drug-abusing populations while taking these maintenance drugs, yet no studies have been done in recovering HCPs. Assessing the effects of these drugs in critical situations that require split-second decision making and precise hand-eye coordination could be done in an operating-room simulator.

The AANA is careful about its reentry recommendations and understands that not every CRNA is an appropriate candidate. Even when people follow guidelines, some relapse, and frequently the least suspected person is diverting medications.

The role of appropriate inpatient and intensive outpatient treatment, aftercare, follow-up treatment, back-to-work contracts, random drug testing, and a solid support system cannot be overemphasized. Addiction must be treated as any other life-threatening illness, and reentry into the workplace must be done with every safeguard available.

The eventual success story reported in this article addresses the relapse potential of a poorly planned reentry-to-work contract. Each relapse makes subsequent reentry attempts more difficult. We must strive for evidence-based, safe, effective standards for reentry that will protect the HCP, the profession and, most importantly, our patients.

References

Angres, D. H., Talbott, G. D., & Bertinardi-Angres, K. (1998). *Healing the Healer: The Addicted Physician*. Madison, CT: Psychosocial Press. Medicine, 35(2), S106-S116.

Baldisseri, M. R. (2007). Impaired healthcare professional. *Critical Care Medicine*, 35(2), S106-S116.

Bell, D. M. (2006). The current state of drug misuse by CRNAs: Prevalence, attitudes & controversies. Unpublished data (used with permission).

Bell, D. M., McDonough, J. P., Ellison, J. S., & Fitzhugh, E. C. (1999). Controlled drug misuse by certified registered nurse anesthetists. *AANA Journal*, 67(2), 133-140.

Berge, K. H., Seppala, M. D., & Lanier, W. L. (2008). An anesthesiology community's approach to opioid- and anesthetic-abusing personnel. *Anesthesiology*, 109(5), 762-764.

Bryson, E. O., & Silverstein, J. H. (2008). Addiction and substance abuse in anesthesiology. *Anesthesiology*, 109(5), 905-917.

Clark, C. & Farnsworth, J. (2006). Program for recovering nurses: An evaluation. *MEDSURG Nursing*, 16(4), 223-230.

Collins, G. B., McAllister, M. S., Jensen, M., & Gooden, T. A. (2005). Chemical dependency treatment outcomes of residents in anesthesiology: Results of a survey. *Anesthesia & Analgesia*, 101, 1457-1462.

Dupont, R. L., McLellan, A. T., Carr, G., Gendel, M., & Skipper, G. E. (2009). How are addicted physicians treated? A national survey of physician health programs. *Journal of Substance Abuse Treatment*, 37, 1-7.

Galanter, M., Talbott, D., Gallegos, K., & Rubenstone, E. (1990). Combined Alcoholics Anonymous and professional care for addicted physicians. *American Journal of Psychiatry*, 147(1), 64-68.

Haack, M. R., & Yocum, C. J. (2002). State policies and nurses with substance abuse disorders. *Journal of Nursing Scholarship*, 31(4), 89-91.

Heinze, M., Wolfing, K., & Grusser, S. M. (2007). Cue-induced auditory evoked potentials in alcoholism. *Clinical Neurophysiology*, 118, 856-862.

Higgins Roche, B. T. (2007). *Substance abuse policies for anesthesia: Time to re-evaluate your policies and curriculum*. Winston-Salem, NC: All Anesthesia.

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

Judson, B. A., Carney, T. M., & Goldstein, A. (1981). Naltrexone treatment of heroin addiction: Efficacy and safety in a double-blind dosage comparison. *Drug and Alcohol Dependence*, 7(4), 325-346.

Messinis, L., Epameinondas, L., Andrian, V., Katsakioti, P., Panagis, G., Georgiou, V., et al. (2009). Neuropsychological functioning in buprenorphine maintained patients versus abstinent heroin abusers on naltrexone hydrochloride therapy. *Human Psychopharmacology: Clinical & Experimental*, 24(7), 524-531. doi:10.1002/hup.1050

Mintzer, M. Z., Correia, C. J., & Strain, E. C. (2004). A dose-effect study of repeated administration of buprenorphine/naloxone on performance in opioid-dependent volunteers. *Drug and Alcohol Dependence*, 74, 205-209.

Monroe, T. (2009). Addressing substance abuse among nursing students: Development of a prototype alternative-to-dismissal policy. *Journal of Nursing Education*, 45(5), 272-278.

Monroe, T., Pearson, F., & Kenaga, H. (2008). Procedures for handling cases of substance abuse among nurses: A comparison of disciplinary and alternative programs. *Journal of Addictions Nursing*, 19, 156-161.

Monroe, T., Pearson, F., & Kenaga, H. (2009). Treating nurses and student nurses with chemical dependency: Revising policy for the 21st century. *International Journal of Mental Health and Addiction*, 7(4), 530-540.

O'Malley, S. S., Krishnan-Sarin, S., Farren, C., Sinha, R., & Kreek, M. J. (2002). Naltrexone decreases craving and alcohol self-administration in alcohol-dependent subjects and activates the hypothalamopituitary-adrenocortical axis. *Psychopharmacology*, 160, 19-29.

Oreskovich, M. R., & Caldeiro, R. M. (2009). Anesthesiologists recovering from chemical dependency: Can they safely return to the operating room? *Mayo Clinic Proceedings*, 84(7), 576-580.

Rapeli, P., Fabritius, C., Alho, H., Salaspuro, M., Wahlbeck, K., & Kalska, H. (2007). Methadone vs. buprenorphine/naloxone during early opioid substitution treatment: A naturalistic comparison of cognitive performance relative to healthy controls. *BMC Clinical Pharmacology*, 7(5), 1-10.

Ruth, A., Hagan, I., & Farren, C. (1997). Naltrexone plus group therapy for the treatment of opiate-abusing health care professionals. *Journal of Substance Abuse Treatment*, 14(1), 19-22.

Saver, C. (2008a). Substance abuse in the OR: Saving lives through treatment, prevention. *OR Manager*, 24(6), 1, 12-13.

Saver, C. (2008b). Substance abuse in the OR: Why managers should not ignore it. *OR Manager*, 24(3), 1, 11-12.

Sibert, R. R., & Demenes, M. (1996). Criteria for successful re-entry as a CRNA provider post-addiction treatment. *AANA Journal*, 64(5), 454. Abstract 51.

Trinkoff, A. M., & Storr, C. L. (1994). Relationship of specialty and access to substance use among registered nurses: An exploratory analysis. *Drug and Alcohol Dependence*, 36, 215-219.

- Wilson, H. (2009). Environmental cues and relapse: An old idea that is new for reentry of recovering anesthesia care professionals [editorial]. *Mayo Clinic Proceedings*, 84(11), 1040-1041.
- Wilson, H., & Compton, M. (2009). Reentry of the addicted certified registered nurse anesthetist. A review of the literature. *Journal of Addictions Nursing*, 20(4), 177-184.
- Yocum, C., & Haack, M. (1996). Interim report: a comparison of two regulatory approaches to the management of the chemically dependent nurse. Washington, DC: US government printing office.

Heather Hamza, CRNA, MS, is a faculty anesthetist and Clinical Instructor at Los Angeles County Medical Center at the University of Southern California; a PhD student at UCLA School of Nursing; and a Peer Advisor with the American Association of Nurse Anesthetists. Todd Monroe, PhD, RN-BC, is a research associate postdoctoral fellow at Vanderbilt University School of Nursing in Nashville, Tennessee.

A Consistent Approach to Treatment and Reentry for CRNAs With Substance Use Disorder

Kathy Bettinardi-Angres, APN-BC, MS, RN, CADC, and Rodrigo Garcia, MSN, CRNA, MBA, ACIT

Certified registered nurse anesthetists (CRNAs) have a high risk of substance use disorder (SUD) as well as high risks of death and patient harm because of their direct access to potent drugs and their expert knowledge of pharmacology. Yet often, CRNAs with SUD are not approached as a distinct population among nurses with SUD, despite their special circumstances. This article presents the unique situation of CRNAs with SUD, the challenges they face in treatment and return to practice, and guidelines and recommendations to create a consistent approach for treatment and reentry for CRNAs.

Boards of nursing (BONs) across the United States successfully collaborate with alternative-to-discipline (ATD) programs to help nurses with substance use disorder (SUD). However, certified registered nurse anesthetists (CRNAs) with SUD are not treated as a distinct group of advanced practice nurses, despite their direct access to potent drugs and specialized knowledge of pharmacology. Recognizing the uniqueness of CRNAs in relation to SUD, this article presents recommendations and American Association of Nurse Anesthetists (AANA) guidelines for use in creating a consistent approach to the treatment and reentry of addicted CRNAs.

Literature Review

The literature on CRNAs with SUD is minimal. Data on anesthesiologists are more widely available and can be used for comparative purposes given the obvious similarities of their practice settings. Research findings indicate that anesthesiologists experience SUD at 2.5 times the rate of the other physicians (Talbot, Gallegos, Wilson, & Porter, 1987) and are 2.79 times more likely to die of drug-related causes than an internist (Alexander, Checkoway, Nagahama, & Domino, 2000). CRNAs likely mimic these ratios among nurses because they have the same risk factors. Most CRNAs with SUD are male (Bell, McDonough, Ellison, & Fitzhugh, 1999). Typically, they have 5 to 10 years in practice (Bell, 2006; Talbot et al., 1987; Wright et al., 2012).

Among CRNAs, the prevalence of diverting drugs for self-administration is 9.8% (Bell, 2006; Bell et al., 1999). The drugs most commonly diverted are fentanyl and propofol. Statistics on opioids such as fentanyl are more plentiful than statistics on propofol because the scope and significance of propofol abuse have been underreported (Welliver, Bertrand, Garza, & Baker, 2012). Propofol is not regulated as a controlled substance with abuse and

dependence potential. Therefore, access to propofol is easier than to a controlled substance such as fentanyl.

Anecdotally, treatment programs report a recent substantial increase in propofol addiction, especially among anesthesia providers. The effects of propofol are described as euphoric, anxiolytic, and calming, and over a third of reported cases of abuse end in death (Welliver et al., 2012). Propofol detection is not part of a standard urine drug screen panel and would require a blood draw during or soon after use because of the drug's short half-life.

Treatment and Reentry

For the most part, treatment for CRNAs with addiction is similar to other nurses or physicians with the same impairment. However, because of their access to more potent and life-threatening drugs, CRNAs with SUD must be immediately removed from their practice setting. For CRNAs suspected of or identified as being impaired, an appropriate action is for the nurse to remain employed by the organization but in a different setting away from access to drugs. By retaining their employment, CRNAs with SUD will be able to access insurance for treatment, and thereby be more likely to seek help.

The treatment program should be approved by the BON. Treatment programs that are designed specifically for health care professionals continue to be the ideal option (Bettinardi-Angres & Bologeorges, 2011). The length of time in a treatment program for professionals typically varies from 6 to 12 weeks. Because of this variance, it is imperative that the choice of a treatment program is endorsed and approved by the BON and has a successful history of treating professionals.

For CRNAs, attention to reentry is critical. Recovering anesthesia providers have the distinct challenge of returning to a practice in which they are continually exposed to their drugs

of choice (Wright, McGuinness, Schumacher, Zweling, & Moneyham, 2014). Moreover, when a major opioid such as fentanyl is the drug of choice, the risk of relapse almost doubles (Domino et al, 2005; Menk, Baumgarten, Kingsley, Culling, & Middaugh, 1990). In those who return to anesthesia practice compared with those who do not, the risk of relapse is increased by 2.5% (Talbot et al., 1987).

Special consideration needs to be given to CRNAs with a history of propofol use and other nonopioid substances, since there are no medication-assisted therapies to improve success in recovery and return to work. In these cases, the CRNA may require longer time away from the operating room and extended supervision and monitoring when he or she returns.

Risk of relapse in CRNAs has not been studied in depth, but the success rates for long-term sobriety and compliance are greater when health care professionals are treated in programs specifically targeted at health care professionals and are subsequently monitored and supported by ATD programs (Angres, Bologeorges, & Chou, 2013; Angres, Talbot, & Bettinardi-Angres, 1998).

Some of the most difficult obstacles for the CRNA in recovery are finding employment and working with managers who are unwilling to adequately monitor a recovering CRNA (Hamza & Monroe, 2011). In light of these obstacles, CRNAs with SUD should have the opportunity to take a medical leave of absence, with an option to return to work after successful treatment, rather than be terminated from their position. Administrators and heads of departments in which recovered CRNAs return to practice should be educated about SUD and the distinct challenges faced by CRNAs with SUD. A workplace monitor upon return to work may alleviate some of the obvious anxieties experienced by both the recovering CRNA and the workplace.

Differing Approaches Among States

A review of 14 states revealed that while some ATD programs operated more independently of the BON, about three-quarters of those states with ATD programs worked directly with BONs. (See Table 1.) For example, when a nurse is reported or self-reports to the BON, the recommendation is to enter the state ATD program. Professional discipline may be mitigated if full compliance is maintained. Failure to adhere to the requirements of the ATD program will likely result in licensure consequences for the nurse with SUD.

However, in other states, when nurses self-report to ATD programs, the BON is not made aware of their enrollment. If those nurses remain compliant with the ATD program's terms, the BON is never notified and there is no public record of those events. The majority of BONs do not publish nurses' names in the public record, and the few that do remove them when treatment is finished.

Not only does reporting vary among states but so does the approach to addressing SUD in nurses. Some states use an independent contractor to monitor nurses and treatment is not required. In fact, approximately half of the states reviewed did not require treatment for SUD at all. Many of these states only require a diagnosis of SUD and those nurses are then enrolled into a monitoring program, not to be confused with treatment. Treatment is a period of time spent in a drug and alcohol rehabilitation program, preferably one specifically designed for health care professionals, followed by monitoring in an ATD program. Basic monitoring consists of self-reported attendance at Alcoholics Anonymous meetings and random drug screens. The majority of information obtained from monitoring is subjective and dependent on the honor of the addicted/recovering health care professional. Treatment and monitoring are separate but linked in the optimal treatment course for an addicted CRNA.

In the review of 14 states, the average contract length for treatment in an ATD program is 3 years, even though the average contract length for physicians and pharmacists is 5 years. The diagnosis and treatment plan most often is determined by the treatment center or a provider chosen by the nurse. Half of the states handle CRNAs differently. For example, if a CRNA in North Carolina is reported to the BON, he or she will automatically be removed from work as a CRNA for 2 years. In Texas, the recovering CRNA must work as an RN for 1 year before he or she can resume practice as a CRNA. In Kentucky, the CRNA must take 1 year off practice from the role of CRNAs.

For reentry, abstinence from all mood-altering addictive substances other than those prescribed for a medical condition (measured by clean urine drug screens), evaluation by an addictionologist, 12-Step participation, weekly aftercare for 1 to 2 years at a Caduceus or similar group, and participation in an ATD program were almost always required by BONs for reentry for all nurses recovering from SUD. A variable among states was the amount of time the returning nurse was barred from administering opioids in the workplace, which typically varied from 3 months to 2 years and was solely dependent on the recommendation of the treatment provider.

According to the review, the average time between when a CRNA is reported to the BON and when the CRNA is investigated is 6 to 12 months. During that time, the addicted CRNA can continue to practice and pose a potential danger to self and the public. Some states immediately place an alert on the license of the CRNA suspected of having SUD. This safeguard not only protects the privacy of the CRNA but also safeguards the public.

AANA Guidelines

The current AANA (2015) guidelines for reentry include successful completion of treatment, a comprehensive evaluation by an American Society of Addiction Medicine board-certified addictionologist, and compliance with all recommendations for

TABLE 1

Differences Among Selected State ATD Programs

This table shows the variation of requirements among alternative-to-discipline (ATD) programs in 14 states.

State	Is there an ATD program?	Are RNs and CRNAs handled differently?	Is BON aware of the nurse's participation in the ATD program?	Is employer notified of participation in the ATD program?	Is the nurse's name published in the public record?	Years of ATD program participation required?	Who determines the terms of the ATD program contract?	Is addiction treatment required by BON?
Alabama	Yes	Yes. RNs may complete program in less time.	BON knows specialty of participants, not names.	Yes	No	5	VDAP coordinator	Yes
California	Yes	No	Yes	No	No	2 to 4	Diversion evaluation committee from BON	No
Georgia	Yes	No	Yes	Yes	Yes	5	BON	Yes
Indiana	Yes	No	No	Yes	No	1 to 3	ISNAP	No
Kentucky	Yes	Yes	Yes	Yes	Yes. Removed at completion of program.	5	BON	Yes
Nevada	Yes	No	Yes	Yes	No	3	BON compliance coordinator	Yes
New York	No	No	Yes	Yes	Yes	2	PAP	No
North Carolina	Yes	Yes	Yes	Yes	Yes. Removed at completion of program.	3	BON compliance coordinator	Yes
Tennessee	Yes	Yes	No	Yes	No	3 to 5	TnPAP	No
Texas	Yes	Yes	Yes	Yes	Yes, unless SUD was self-reported or third-party reported.	5	TPAPN or BON	Yes
Utah	Yes	No	No	Yes	No	5	BON and investigative committee	No
Virginia	Yes	Yes	Yes	Yes	No	3 to 5	HPMP	Yes
West Virginia	Yes	Yes	Yes	Yes	No	5	IPN	No
Wyoming	Yes	No	Yes	Yes	Yes	3	BON	No

Note. VDAP = Voluntary Disciplinary Alternative Program; ISNAP = Indiana State Nurse Assistance Program; PAP = Professional Assistance Program; TnPAP = Tennessee Professional Assistance Program; SUD = substance use disorder; TPAPN = Texas Peer Assistance Program for Nurses; HPMP = Health Practitioners' Monitoring Program; IPN = Intervention Project for Nurses.

continuing care after discharge. The guidelines also recommend "...a minimum of one year out of clinical anesthesia practice for individuals with an IV drug addiction or major opioid addiction" (AANA, 2015).

Within the AANA guidelines, successful reentry also depends on supportive loved ones, treatment of comorbidities, 12-Step meetings with a sponsor, participation in an ATD program, and a workplace mentor, which is a peer who is aware of

the CRNA's recovery, and supports and monitors him or her at the workplace. Lastly, the AANA takes a definitive stand against the use of opioid replacement therapy (i.e., buprenorphine) but supports the use of naltrexone (AANA, 2015).

Recommendations for a Consistent Approach

Promoting a culture of safety is recommended when addressing CRNAs with SUD. To facilitate this culture, all states must agree on mandatory requirements for addicted CRNAs. These requirements must consider finances, which is a prohibitive factor for most who do not comply. Recommendations for a consistent approach toward CRNAs diagnosed with SUD are as follows:

- State BONs should recognize and agree that CRNAs with SUD are a unique group of nurses who require distinct treatment.
- Comprehensive assessment and treatment at a program specifically designed for health care professionals, including CRNAs, should be the entry point for a suspected SUD, with immediate removal from practice.
- ATD programs for CRNAs and monitoring for a minimum of 5 years should be mandated. Nurses in ATD programs have recovery success rates of 47% to 95% (Monroe, Pearson, & Kenaga, 2008). The reasons for the vast differences in success rates have not yet been studied.
- Treatment should be offered as an option for all nurses, including CRNAs, before termination so they have insurance to access treatment (Wright et al., 2014).
- The addiction treatment specialist should determine a mandatory period of time away from the practice of anesthesia. Time away from contact with anesthesia drugs was cited as a tool in maintaining sobriety (Wright et al., 2014). The AANA recommends 1 year away based on the literature (Bryson & Silverstein, 2008). Ninety-eight percent of relapses occur in the first 2 years of recovery, and the first 2 months are the most critical (Hudson, 1998).
- Medication aids for opioid addiction, preferably injectable naltrexone, should be required for no less than first year of the return to anesthesia practice (Angres, 2001; Berry et al., 2003; Farley & Arnold, 1991; Higgins Roche, 2007).
- Upon reentry, the recovering CRNA should secure a work-site monitor, typically a colleague in the same area of nursing. This task tends to be the most difficult directive for the returning CRNA. Optimally, the worksite monitor would have appropriate education in SUD and the ability to support the recovering CRNA. This individual would also act as a liaison between the recovering CRNA and administration, if necessary.
- Organizations should educate personnel in workplaces that employ anesthesia providers. This is essential and is typically the responsibility of administration. Unfortunately, barriers to a successful reentry include prejudice and lack of knowledge in nursing administration (Taylor, Smith, & Howard, 1998; Taylor, 2003).
- Ideally, the recovering CRNA should not work overtime for the first year of reentry (Angres et al., 1998).
- Recovering CRNAs should be required to attend 2 years of weekly aftercare, such as Caduceus or other peer-group meetings, unless location prohibits attendance. In that case, par-

ticipation in an online support group must be considered (e.g., *Anesthetists in Recovery*).

- The recovering CRNA must commit to maintaining his or her well-being, ideally to include using exercise, meditation, nutrition, leisure time, and an increased social network (Scherbaum & Speck, 2008).
- Regular attendance at 12-Step meetings with a sponsor must be mandatory (Wright et al., 2014).
- CRNAs must actively attend to comorbid conditions, including psychiatric and medical conditions and chronic pain states, while in recovery (Angres et al., 1998).
- The use of buprenorphine should be contraindicated because cognitive and psychomotor impairment, dependence, and withdrawal are associated with the drug (Messinis et al., 2009; Higgins Roche, 2007).

Conclusion

Until more evidence-based research is available, the recommendations and guidelines presented in this article offer the optimal course of action for CRNAs in recovery from SUD. With a consistent, national approach to the treatment and reentry of CRNAs with SUD, BONs can enhance collaboration with ATD programs, professional organizations, and employers, and increase the likelihood of successful treatment and return to practice for recovering CRNAs.

References

- Alexander, B. H., Checkoway, H., Nagahama, S. J., & Domino, K. B. (2000). Cause specific mortality risks of anesthesiologists. *Anesthesiology*, 93(4), 922-930.
- American Association of Nurse Anesthetists (2015). *Peer assistance advisors' treatment recommendations*. Retrieved from www.aana.com/resources2/health-wellness/Pages/Peer-Assistance-Advisors%27-Treatment-Recommendations.aspx
- Angres, D. (2001). Chemical dependency in anesthesiologists. *ASA Newsletter*, 65(5), 6-8, 31.
- Angres, D., Bologeorges, S., & Chou, J. (2013). A two-year longitudinal outcome study of addicted health care professionals: An investigation of the role of personality variables. *Substance Abuse Research and Treatment*, 7, 49-60.
- Angres, D. H., Talbot, G. D., & Bettinardi-Angres, K. (1998). *Healing the healer: The addicted physician*. Amazon Press
- Bell, D. M. (2006). *The current state of drug misuse by CRNAs: Prevalence, attitudes & controversies*. Unpublished data
- Bell, D. M., McDonough, J. P., Ellison, J. S., & Fitzhugh, E. C. (1999). Controlled drug misuse by certified registered nurse anesthetists. *AANA Journal*, 67(7), 133-140.
- Berry, A. J., Arnold, W. P. III, Bogard, T. D., Harter, R. L., Hanlon, P. R., Kutz, J. D., . . . Ward, C. E. (2003). *Model curriculum on drug abuse and addiction for residents in anesthesiology*. Retrieved from <http://uthscsa.edu/jme/documents/ModelCurriculumonDrugAbuseandAddictionforResidentsinAnesthesiology.pdf>
- Bettinardi-Angres, K., & Bologeorges, S. (2011). Addressing chemically dependent colleagues. *Journal of Nursing Regulation*, 12(2), 17.

- Bryson, E. O., & Silverstein, J. H. (2008). Addiction and substance abuse in anesthesiology. *Anesthesiology*, 109, 905-917.
- Domino, K. B., Hornbein, T. F., Polissar, N. L., Renner, G., Johnson, J., Alberti, S., & Hanks, L. (2005). Risk factors for relapse in health care professionals with substance use disorders. *JAMA*, 293(12), 1453-1460.
- Farley, W. J., & Arnold III, W. P. (1991). *Unmasking addiction. Chemical dependency in anesthesiology*. Piscataway, NJ: Janssen Pharmaceutica.
- Hamza, H., & Monroe, T. (2011). Reentry and recidivism for certified registered nurse anesthetists. *Journal of Nursing Regulation*, 2(1), 12-22.
- Higgins-Reiche, R. T. (2007). *Substance abuse policies for anesthetists: Time to reevaluate your policies and curriculum*. Winston-Salem, NC: All Anesthesia.
- Hudson, S. (1998). Reentry using naltrexone: One anesthesia department's experience. *AANA Journal*, 66, 360-364.
- Hughes, T., Smith, L., & Howard, M. (1998). Florida's intervention project for nurses: A description of recovering nurse's reentry to practice. *Journal of Addictions Nursing*, 10, 63-69.
- Menk, E. J., Baumgarten, R. K., Kingsley, C. P., Culling, R. D., & Midgagh, R. (1990). Success of reentry into anesthesiology training programs by residents with a history of substance abuse. *Journal of the American Medical Association*, 263(22), 3060-3062.
- Messinis, L., Lyros, E., Andrian, V., Katsakiori, P., Panagis, G., Georgiou, V., & Papatheanasopoulos, P. (2009). Neuropsychological functioning in buprenorphine maintained patients versus abstinent heroin abusers on naltrexone hydrochloride therapy. *Human Psychopharmacology*, 24(7), 524-532.
- Monroe, T., Pearson, F., & Kenaga, H. (2008). Procedures for handling cases of substance abuse among nurses: A comparison of disciplinary and alternative programs. *Journal of Addictions Nursing*, 19(3), 156-161.
- Scherbaum, N., & Specka, M. (2008). Factors influencing the course of opiate addiction. *International Journal of Methods in Psychiatric Research*, 17(S1), S39-S44.
- Talbott, G. D., Gallegos, K. V., Wilson, P. D., & Porter, T. L. (1987). The medical associates of Georgia's impaired physicians program review of the first 1,000 physicians: Analysis of specialty. *Journal of the American Medical Association*, 257, 2927-2930.
- Taylor, A. (2003). Support for nurses with addictions often lacking among colleagues. *The American Nurse*, 35(5), 10-11.
- Welliver, M. D., Bertrand, A., Garza, J., & Baker, K. (2012). Two new case reports of propofol abuse and a pattern analysis of the literature. *International Journal of Advanced Nursing Studies*, 1(1), 22-42.
- Wright, E. L., McGuinness, T., Moneyham, L. D., Schumacher, J. E., Zwerling, A., & Stullenbarger, N. E. N. (2012). Opioid abuse among nurse anesthetists and anesthesiologists. *AANA Journal*, 80(2), 120-128.
- Wright, L. E., McGuinness, T., Schumacher, J. E., Zwerling, A., & Moneyham, L. D. (2014). Protective factors against relapse for practicing nurse anesthetists in recovery from anesthetic opiate dependency. *Journal of Addictions Nursing*, 25(2), 66-73.

Kathy Bettinardi-Angres, APN-BC, MS, RN, CADC, is Professional Assessment Coordinator, Positive Sobriety Institute; Adjunct Faculty, Rush University Department of Nursing, Chicago, Illinois. Rodrigo Garcia, MSN, CRNA, MBA, ACIT, is Executive Director, Parkdale Center, Chesterton, Indiana; Chief Certified Registered Nurse Anesthetist, Great Lakes Anesthesia, Elkhart, Indiana.

Naltrexone (Vivitrol®)

Should We or Shouldn't We?

Dr. Kaci Bohn, Ph.D.

Naltrexone Drug Facts

- Opioid Antagonist
 - Onset of action 15-30 minutes
 - Half life
 - Oral (4 hrs)
 - IM (5-10 days)
 - Duration of action
 - Oral (24 hrs)
 - IM (4 weeks)
 - Dosing
 - Oral 25 mg first day, then 50 mg Q day
 - IM 380 mg Q 4 weeks

Naltrexone

- Vivitrol®
 - Suspension
 - 380mg/vial
- Revia®
 - (Naltrexone HCl)
 - 50mg tablet
 - Discontinued
- Generic
 - 50mg tablet

Naltrexone Drug Facts

- Reversible competitive antagonist
- Patient must be drug free at least 7-10 days prior (confirm with urinalysis and/or naloxone challenge)
- Reduces sensitivity to opioids and cause overdose and/or death in presence of opioids
- No euphoria or high and is therefore not addictive

Combination Drugs

- Contrave® (Bupropion HCl & Naltrexone HCl)
- Embeda® (Morphine Sulfate & Naltrexone HCl)
- Troxyca ER® (Oxycodone HCl & Naltrexone HCl) Dsc

Patient Monitoring

- Injection site
- Suicide ideations
- Liver function tests
- Opioid withdrawal symptoms
- Pregnancy class C
 - Should be discontinued if relapse risk is low
 - Excreted in breast milk

Naltrexone and Naloxone Differences

- Both used in medical treatment of alcohol and drug dependency
- **Naloxone (Narcan®)** is a quick acting drug that brings patient out of an opiate overdose by stripping the opiate from the receptor
- **Naltrexone (Vivitrol®)** is a slower acting drug used to block the effects of drugs and alcohol

Of the 6 states that mention Naltrexone . . .

- State #1 mentions clinical evidence that relapse is lower with Naltrexone administration
 - Participants with higher relapse risk are required to have 1-2 years of monitored therapy
 - Daily log of ingestion, witnessed 2x per week
 - Self-administration is not allowed (Vivitrol IM) and must be signed off on and submitted quarterly
 - If CRNA, therapy must be initiated prior to returning to practice

Naltrexone VS Naloxone Uses

- **Naloxone** is primarily used as an opioid overdose antidote
 - Injection or intranasal
 - Works rapidly to remove effect of drug
 - Now offered as a take home kit
- **Naltrexone** is Primarily used for recovery treatment
 - Used for more than 30 years
 - Injected and slowly released into the body
 - Highly effective in preventing relapse during drug and alcohol recovery

Of the 6 states that mention Naltrexone . . .

- State #2 mentions same clinical evidence
 - Vivitrol can be used in lieu of “narcotic restriction”
 - Monthly reporting done by person administering injections
 - Quarterly progress reports
 - If either form is missing, participant is removed from practice

NCSBN Alternative Program Naltrexone Summary

- Currently unable to determine success rate of participants using MAT (Medication Assisted Therapy) compared to those that do not
- 27 total programs surveyed but data is limited
- 6 of 27 programs mention Naltrexone
- 6 of 27 mention Buprenorphine
- 5 programs mention both
- All programs place responsibility of prescribing MAT on the licensed physician with expertise in addictionology

Of the 6 states that mention Naltrexone . . .

- State #3 mentions lower relapse rate
 - More vague in discussion
 - If considered appropriate for participant, therapy will generally be required 1-2 years

Of the 6 states that mention Naltrexone . . .

- State #4 mentions same efficacy
 - Participants at “high risk for relapse and/or potential overdose” are required to take monitored Naltrexone or Vivitrol for a period of 1-2 years
 - Evaluation must be completed after termination of therapy prior to return to work

ASAM

- American Society of Addiction Medicine 2015
 - “Oral Naltrexone has poor medication adherence. Use is reserved for patients who can comply with techniques to increase adherence such as observed dosing. Extended release injectable Naltrexone reduces but does not eliminate issues with medication adherence.”
 - Efficacy of Naltrexone in combination with psychosocial treatment is established but not without psychosocial treatment
 - Duration of treatment depends on clinical judgment and patient circumstance, therapy can be stopped abruptly

Of the 6 states that mention Naltrexone . . .

- State #5 is vague
 - “Willingness to take medications similar to naltrexone as adjunctive therapy will be considered when determining the participant’s fitness to practice.”

Literature Search

- Gastfriend et. al 2017
 - 49 opioid dependent nurse or CNAs
 - Better retention rates in program, increased opioid negative urine drug screens
 - Increased mental health function and quality of life

Of the 6 states that mention Naltrexone . . .

- State #6 is also vague
 - The program may require a determination of whether a participant will be required to be treated with Naltrexone
 - Participant may seek an independent opinion
 - Monitored use of the medications may be required if more than one expert in the field suggests the need for such pharmaceutical assistance.

