

CHEMICAL DEPENDENCY
AND
HEALTH CARE PROFESSIONALS
RESOURCE GUIDE



Department of Health and Human Services
Division of Public Health - Licensure Unit
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TABLE OF CONTENTS

Introduction.....	1
Definitions.....	1
Understanding Chemical Dependency	
Etiology.....	2
Incidence.....	3
Physical & Behavioral Indicators of Chemical Dependency.....	4-8
Reasons why Peers, Supervisors, Employers Don't Identify the Chemically Dependent Health Care Professional.....	9
Intervention	
Barriers to Intervention.....	10
Basic Principles to Intervention.....	10
Licensee Assistance Program.....	11
Treatment/Educational Options.....	12
Return to Work	
Guidelines.....	13
Sample Return to Work Agreement.....	14
NE Licensee Assistance Program Monitoring Agreement.....	15- 16
Relapse Prevention Issues.....	17
Mandatory Reporting.....	18
Community Support Contacts and Additional Resources.....	19
References.....	20

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INTRODUCTION:

This resource guide was developed by the Nebraska Department of Health and Human Services, Division of Public Health, Licensure Unit and the Nebraska Licensee Assistance Program (NE LAP) for the purpose of providing information about the disease of chemical dependency and health care professionals. This guide provides information on how to recognize the signs and symptoms of the disease of chemical dependency, intervention, treatment, recovery, relapse prevention and return-to-work considerations.

The information presented in this guide is intended to be an educational tool and is not mandated as regulation by the Department of Health and Human Services, Division of Public Health, Licensure Unit.

DEFINITIONS:

Substance Use: A reasonable ingestion of a mood-altering chemical substance or drug, for a clearly defined beneficial purpose, that is regulated by that purpose

Substance Misuse: Inappropriate use of any substance, such as alcohol, a street drug or misuse of a prescription or over the counter drug

Substance Abuse: Unreasonable ingestion of a mood-altering substance that causes harm or injury to the abuser

Chemical Dependency: A compulsive or chronic need for, or an active addiction to, alcohol or drugs

Enabling: The reactions or behaviors of family members, friends or co-workers that shield the chemically dependent person from the harmful consequences of their alcohol and/or drug use

Intervention: Helping a person, who is in denial as a result of their chemical dependency, recognize their need for help and treatment

Treatment: Education, counseling and specialized groups and programs designed to overcome substance abuse and dependency

Recovery: A voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship

Sobriety: Abstinence from alcohol and all other non-prescribed drugs

Relapse: A recurrence of the symptoms of dependency after a period of improvement

UNDERSTANDING CHEMICAL DEPENDENCY:

Etiology

Research suggests that some of the population is *genetically* predisposed to become chemically dependant. Studies indicate that people identified as being chemically dependent lack adequate production of the brain chemicals dopamine and serotonin. When the person is introduced to alcohol/other drug use, they report feeling normal for the first time. These outside stimulants take the place of brain chemicals that might be depleted or lower than normal.

There are also several factors in the *environment*, which contribute to a person becoming chemically dependent. Availability and accessibility of mood altering chemicals are two strong environmental factors.

The *psychological* factor focuses on a person's psychological needs. The person uses alcohol/other drugs to fill emotional voids, such as sadness, loneliness and depression.

There is no reliable way to predict who will become chemically dependent. There is no typical personality, no set of physical attributes, just as there are no health care professionals that are immune to the disease.

Individuals do not necessarily become addicted to a certain drug. However, they can become addicted to the feeling it produces and will seek out the same or similar drugs to get the same feeling.

Chemical dependency is a *primary disease*. It has specific symptoms and is not to be confused with stress, poor relationships, or unmanageable work demands.

Chemical dependency is *progressive*. If left untreated, the symptoms of the disease worsen.

Chemical dependency is a *chronic* relapsing disease and it cannot be cured. Like many other diseases, the symptoms of chemical dependency can be temporarily stopped, but without significant lifestyle changes and continued maintenance, the symptoms will reoccur.

Chemical dependency can be *fatal*. Many accidental overdoses, deaths and suicides involve an individual who is chemically dependent. Additionally, long-term use of chemicals can affect certain body systems or organs and lead to eventual failure and death.

Incidence

Alcohol and drug abuse/dependence affects a significant number of healthcare professionals. Limited data is available on the rates of incidence because substance abusing health care professionals rarely report substance abuse/dependence for fear of disciplinary action against their license to practice. It is also difficult to gather accurate statistics because employers often fail to recognize signs and symptoms of the disease. Available literature on the subject estimates that between 10% to 15% of health care professionals are afflicted with the disease.

Health care professionals are at particular risk for chemical abuse/dependency for many reasons. Drugs are the tools used by health care professionals to treat and help their patients. They prescribe, administer and dispense medications every day. Exposure and accessibility to mood-altering medications, pharmacological knowledge of the drugs which fosters a false sense of control and a tendency to self-treat or self-medicate are a few contributing factors.

When health care professionals find themselves in need of relief from pain and emotional stress, they may find themselves self-prescribing or taking a medication from a patient or from the stock supply. If health care professionals do not suffer any negative consequences while self-medicating, they may start doing it on a regular basis. When self-medicating, the health care professional convinces himself/herself, "it's only going to happen once."

Many health care professionals do not receive the appropriate intervention and treatment needed due to the lack of proper identification of a dependency problem. Data gathered from reporting state agency disciplinary action reports show that a majority of license revocations are related to alcohol/other drug dependency.

Physical and Behavioral Indicators of Chemical Dependency:

There is no single indicator for a diagnosis of chemical dependency. If an indicator is present, then others are usually present also.

Personal

- Deteriorating personal hygiene
- Multiple physical complaints
- Accidents
- Personality and behavioral changes
- Many prescriptions for self and/or family
- Emotional or mental crises
- Lying

Home and Family

- Behavior excused by family and friends
- Drinking or using activities are a priority
- Emotional outbursts or arguments
- Withdrawal from family and fragmentation of family
- Neglect of children
- Abnormal, illegal, or anti-social actions of children
- Sexual problems
- Extramarital affairs
- Separation or divorce
- Unexplained absences from home

Medical/Physical

- Observable decline in physical health
- Atypical weight changes
- Pupils either dilated or constricted; face flushed or bloated
- Emergency-room treatments: overdose, cellulitis, gastrointestinal problems, systematic infections, unexplained injuries and auto accidents.
- Drug seeking behaviors such as frequent treatment for migraines or other pains or illness.
- Inability to focus and keep track of a conversation
- Shakiness, tremors of hands
- Slurred speech
- Unsteady gait
- Runny nose
- Nausea, vomiting, diarrhea

Friends and Community

- Isolation from normal friends
- Embarrassing social behavior
- Driving while intoxicated or drug impaired
- Alcohol/drug related legal problems
- Neglect of social commitments
- Unpredictable behavior, such as impulsive spending or missing dates with friends

Office/Health Care Practice Setting

- Workaholic behavior
- Disorganized schedule
- Unreasonable workplace behavior
- Inaccessibility to patients and staff
- Frequent trips to the bathroom or other unexplained absences
- Decreased workload or workload intolerance
- Excessive drug prescriptions and supply
- Excessive ordering of drug supplies
- Frequent complaints by patients regarding the professional's behavior such as disputes with patients or clients
- Prolonged lunch breaks
- Frequent absences or illness
- Sporadic punctuality

Office/Health Care Practice Setting (continued)

- Unsatisfactory work/chart performances
- Withdrawal from professional committees or organizations
- Defensive if questioned or confronted
- Less creativity; coasting on reputation from previous work
- Observed poor practice judgment
- Short absences from the work setting followed by inadequate or elaborate explanations
- Alcohol on breath with attempts to cover with mints or mouthwash
- Observed occurrences of intoxication, drowsiness, or hypersensitivity during work hours
- Deadlines barely met or missed altogether
- Illogical or sloppy documentation with regard to accountability of controlled substances
- Increased interest in patient pain control
- Patient complaints of ineffective pain medications
- Discrepancies in treatment orders, progress notes and medication records
- Frequent incorrect medication or narcotics count
- Appearing at the workplace on days off

Other Professional Problems

- Frequent job changes or relocation
- Impatience for state licensure by endorsement prior to verification of credentials
- Unusual medical history
- Vague letters of reference
- Inappropriate or inadequate qualifications
- Deterioration of professional reputation
- Increasing malpractice incidents
- Licensure issues

The most critical component in identification of chemical dependency is to know the personal and practice baseline from which a person has normally functioned. Negative behaviors and practice that clearly move away from the individual's baselines are common indicators of chemical dependency. Health care professionals struggle to maintain their personal, family, and professional standards, and may continue functioning for a long time in spite of their active addictions before they reach a point of deterioration that is impossible to ignore.

Reasons why Peers, Supervisors, or Employers Don't Identify the Chemically Dependent Health Care Professional

- Uncertainty or disbelief about signs and symptoms
- Reluctance or refusal to identify signs and symptoms
- Hoping that “things will get better”
- The possibility that legal sanctions for the professional might occur
- Involvement with a chemically dependent colleague involves its own risks
- Enabling behavior
 - a. Ignoring
 - b. Covering for
 - c. Trying to protect
 - d. Making excuses
 - e. Doing the job for the impaired health care professional

INTERVENTION:

Barriers to Intervention

Many health care professionals do not understand their role in identifying signs and symptoms that indicate a co-worker or peer may have a problem related to alcohol/other drug use. Fear is the number one barrier to identification of signs and symptoms of alcohol/other drug dependence for supervisors and colleagues. Thoughts of “what if?”, “what if I’m wrong?” and “what if he/she denies it?” are common when deciding whether or not to intervene. Supervisors and colleagues often disregard signs and symptoms because of their misconception that they must be able to prove alcohol/other drug dependency prior to an intervention. The goal of intervention is not to diagnose alcohol/other drug dependency, but to make sure a problem is recognized before anyone is harmed.

Basic Principles of Intervention

Report unmistakable signs of chemical impairment immediately to supervisor/administrator

- Document specific observations including date, time and place of observation
- Become familiar with the health care professional’s practice baseline
- Become familiar with the workplace policy on reporting of concerns
- Do not discuss suspicions with colleagues

Nebraska Licensee Assistance Program

Once identification of a potential problem occurs, contact the Nebraska Licensee Assistance (NE LAP) provided by the Best Care Employee Assistance Program for further guidance and assistance with your concerns. The NE LAP will provide assistance in managing the situation and possibly conducting an intervention. The NE LAP is an assessment, treatment, referral, case management, monitoring, and educational service designed to help licensees, certificate holders, and registrants of the State of Nebraska work through substance abuse or addiction problems.

The NE LAP offers health care professionals an opportunity to discuss alcohol or drug abuse issues openly and confidentially with the professionally trained NE LAP Coordinator.

NE LAP office hours are Monday through Thursday, 8:00 a.m. to 8:00 p.m.; Friday 8:00 a.m. to 4:30 p.m.; and Saturday, 8:30 a.m. to 1:00 p.m. A 24-hour answering service is also available. The NE LAP can be contacted by phone at (402) 354-8055 or (800) 851-2336 or visit the website at www.lapne.org.

Treatment/Educational Options

There are four types of treatment available for someone who is chemically dependent.

Inpatient/Residential Treatment: Inpatient treatment usually consists of a minimum inpatient stay of at least 28 days and medical management of detoxification. Residential treatment provides medical supervision of detoxification. The professional receiving inpatient or residential treatment is removed from the availability of alcohol/other drugs and daily outside distractions. This setting gives the individual the needed time to focus on the task of understanding and accepting the disease of chemical dependency and working on their recovery.

Outpatient Treatment: This type of treatment offers more flexibility and provides less disruption to the individual's everyday life than inpatient treatment. Those receiving treatment are able to remain living in their home environment and may also be allowed to continue to work. The individual receives treatment on a short term basis at the treatment provider's facility.

Extended Treatment: This type of treatment usually is recommended at the conclusion of a 28-day inpatient or residential treatment program. This treatment option is very structured and can range in length anywhere from two months to two years. During the period of extended treatment and rehabilitation, the individual moves into a halfway or three quarter way house and obtains employment prior to completion of the program.

Continuing Care/Aftercare: This type of treatment is a vital extension of the primary treatment program and ranges from six months to one year in length. Continuing care usually involves one weekly aftercare group meeting and may also include individual counseling sessions with a treatment professional.

Twelve-Step Meetings: Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.) are self-help recovery groups and are an integral part of maintaining sobriety. Generally, a minimum of at least two meetings per week are required throughout treatment and continuing care.

RETURN TO WORK:

Guidelines

A health care professional that has received treatment or is in a structured treatment program for chemical dependency should be allowed to return to work only under a monitoring plan that includes an agreement or contract. The NE LAP can assist in setting up a work site monitoring plan and coordinate the monitoring of the professional's progress. Monitoring improves the prognosis of recovery and rebuilds trust in professional work relationships.

A monitoring plan should address the following:

1. Treatment requirements, including regular phone or written progress reports;
2. A recovery plan, including requirements for continuing care/aftercare and documented attendance at Twelve-Step meetings and utilization of a sponsor;
3. Random body fluid screens, specifying who will be responsible for the cost of testing;
4. Utilization of a peer assistance program;
5. Regular conferences with the workplace and NE LAP monitoring coordinators;
6. Provision for re-evaluation and revision of the plan.

The monitoring plan needs to be individualized to the professional's practice, work setting and personal and family situations.

SAMPLE RETURN TO WORK AGREEMENT

This agreement is to clarify expectations regarding the return to work of

_____ at _____.
(health care professional) (employer)

This agreement shall be in effect from _____, 20____, to _____, 20____.

The contents of this agreement are mutually agreed upon and may be modified as agreed upon by both parties.

I agree to the following:

1. Abstain from the use of all alcohol/other drugs and mood altering substances. In the event that medications may be needed as a part of my health care, I agree to notify my employer by providing evidence of a prescription from a licensed medical practitioner. Over-the-counter drugs must also be reported.
2. Abide by the monitoring agreement as set forth by the Nebraska Licensee Assistance Program (NE LAP).
3. Random body fluid screening at the discretion of my employer or the NE LAP. Body fluid screens will be paid for by _____ (employee/employer).
4. Work a schedule set by employer, _____ days/hours as agreed to by both parties.
5. Not administer or have access to any controlled substances.

I have read the above agreement and agree to abide by the terms thereof. I understand that if I fail to conduct myself according to this agreement, I will be subject to disciplinary action, up to, and including employment termination, and a report will be made to the State Licensing Board.

(Signature: Employee)

(Date)

(Signature: Employer)

(Date)

(It may be necessary to modify this agreement to fit individual health care professional practice and worksite expectations.)

NEBRASKA LICENSEE ASSISTANCE PROGRAM MONITORING AGREEMENT

I understand participation in the Nebraska Licensee Assistance Program (NE LAP) is voluntary and during my participation, I agree to take personal responsibility for adherence to and completion of the following mutually agreed upon terms and conditions.

I, (Name of Participant), agree to participate in the Nebraska Licensee Assistance Program (NE LAP) monitoring program and to adhere to the rules and regulations set forth in this agreement. I understand that certain criteria must be met in order to successfully complete the NE LAP monitoring program and I agree to complete the following:

1. Abstain from all personal use or possession of controlled substances and all other prescription drugs unless prescribed or administered to me by a licensed practitioner for a diagnosed medical condition. Advise all treating physicians, dentists, and other licensed treating practitioners of my history of substance abuse/dependency, and of all substances I am currently taking at the time of treatment.

Request that the licensed practitioner send the NE LAP a letter reporting the medical reason for the use of any controlled substance and prescription drugs included in any treatment.

Report on a monthly basis to the NE LAP any controlled substance and prescription drugs used by or administered to me. This monthly report must be submitted if you have used a controlled substance or other prescription drugs. Failure to submit a monthly report indicates that you have not taken any controlled substance or prescription drugs during that month.

2. Abstain from the consumption of alcohol.
3. Notify the NE LAP Coordinator if I am hospitalized or must undergo any surgical procedures.
4. Report any changes of employment to the NE LAP Coordinator.
5. Complete aftercare at (Treatment Facility, City/Town/State) and to follow all continuing care recommendations.
6. Attend a minimum of two 12-step meetings each week and maintain a meeting attendance verification record. Submit the meeting verification record on a monthly basis.

7. Obtain a Twelve-Step program sponsor and utilize my sponsor at least weekly for assistance with working a healthy recovery program.
8. Contact the NE LAP Coordinator by telephone at least one time a month or more, if requested to provide progress updates.
9. Submit a quarterly report to the NE LAP Coordinator outlining my recovery and progress.
10. Cease the practice of my profession upon relapse and notify the NE LAP Coordinator immediately.
11. Arrange a timely return for a reassessment with the NE LAP Coordinator or affiliate provider designated by NE LAP if there are relapse or non-compliance issues.
12. Participate in the full duration of the NE LAP program, which is generally a minimum of one year, and understand extended involvement may be recommended.
13. Complete necessary authorizations to exchange information between NE LAP and my employer, treatment providers, and others as requested.
14. Comply with my treatment provider's, employer's or NE LAP's body fluid screen program.
15. Pay for the expenses incurred outside of NE LAP services which are my responsibility.

I have read, understand and agree to the above terms of the NE LAP Monitoring Agreement.

Licensee/Registrant/Certificate Holder

Date

NE LAP Coordinator/Witness

Date

Relapse Prevention Issues

The health care professional returning to work will face many re-entry stressors that may include:

- Practice or licensure restrictions
- Fear of criticism or avoidance by colleagues
- Colleague suspicions and mistrust
- Self-imposed stress caused by trying to make up for past mistakes
- Stress in meeting treatment and/or recovery commitments (continuing care, counseling, and recovery meetings)

The returning health care professional should return to a schedule that is as accommodating for treatment and recovery activities as possible. The treatment provider's recommendations for work schedule should be incorporated into the monitoring plan. Considering the additional demands on the health care professional's time, work schedules (when at all possible) should be restricted to a reasonable work week, generally no more than 40 hours.

MANDATORY REPORTING:

Mandatory reporting requirements were incorporated into the Uniform Credentialing Act (UCA) December 1, 2008. The law applies to all professionals that were regulated by the former Bureau of Examining Boards of the Nebraska Department of Health at the time the legislation was passed. The regulations, 172 NAC 5 – Regulations Governing Mandatory Reporting by Health Care Professionals, Facilities, Peer and Professional Organizations, and Insurers, became effective May 8, 1995.

There are three specific requirements for reporting:

1. Reports must be made within 30 days of the occurrence/action;
2. Reports must be made when a person has first-hand knowledge of an occurrence;
3. Reports are confidential and persons making the reports are immune from criminal or civil liability, except for those who self-report.

All professionals must report persons who are practicing without a license. All professionals must report professionals of the same profession for:

1. Gross incompetence;
2. Patterns of negligent conduct;
3. Unprofessional conduct;
4. Practicing while impaired by alcohol/drugs or physical, mental or emotional disability;
5. Violations of other regulatory provisions of the profession.

All professions are to report professionals of a different profession for:

1. Gross incompetence;
2. Practicing while impaired by alcohol/drugs or physical, mental or emotional disability.

There are also requirements for self-reporting, for reporting by health facilities, peer review organizations, professional associations, insurers and courts.

All mandatory reports filed are reviewed by a screening committee to determine if an investigation will be conducted. All investigation reports are taken to the appropriate board for review and decision regarding disciplinary/non-disciplinary action.

COMMUNITY SUPPORT CONTACTS:

Nebraska Licensee Assistance Program800-851-2336
Center Pointe Professional Plaza
9239 West Center Road
Omaha, NE 68124-1977
www.lapne.org

Alcoholics Anonymous (AA)888-226-3632
www.AA.org (National)
www.Area41.org (Nebraska)

A1-Anon888-553-5033
www.A1-Anon.Alateen.org

Narcotics Anonymous (NA) Nebraska
www.na.org McCook.....308-345-5839
www.nebraskana.org Scottsbluff.....308-632-7603
Lincoln.....402-474-0405
Omaha.....402-978-3105

License Support Group Meetings (LSG)

Health care professional support group meetings are available throughout the state. The meetings are confidential in nature and are based on the 12 steps. For more information regarding meeting locations and times, contact Judi Leibrock by phone at 1-800-851-2336.

ADDITIONAL RESOURCES

Angres, Daniel Bettinardi-Angres, Kathy and Talbott, Douglas, G. (1998). **Healing the Healer, The Addicted Physician.** Psychological Press: Madison, Connecticut.

Corley, Deborah M., Schneider, Jennifer P., and Richard Irons (2003). **Embracing Recovery from Chemical Dependency: A Personal Recovery Plan.** Gentle Path Press: Scottsdale, Arizona.

Coombs, Robert Holman (1997). **Drug Impaired Professionals.** Harvard University Press: Cambridge, Massachusetts and London, England.

Scimeca, Paula Davies (2008). **Unbecoming A Nurse.** Sea Meca, Inc.: Staten Island, New York.

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Crosby, Linda, and Le Clair Bissell (1989). **To Care Enough: Intervention with Chemically Dependent Colleagues**. Johnson Institutes: Minneapolis, Minnesota.

Johnson, V.E. (1973). **I'll Quit Tomorrow**. Harper & Row: New York.

McAuliffe, Robert M., and Mary Boesen McAuliffe (1975). **The Essentials of Chemical Dependency: Alcoholism and Other Drug Dependencies**. The American Chemical Dependency Society: Minneapolis, Minnesota.

Sullivan, Eleanor, Bissell, L., and E. Addison-Wesley Williams (1988). **Chemical Dependency in Nursing: The Deadly Diversion**. Menlo Park, California.

Physician's Recovery Network (Complete reference source not available)