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## Risk Factors for Release in Nurses with Substance Use Disorder

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RISK FACTORS FOR RELAPSE IN NURSES WITH SUBSTANCE USE DISORDER

BY  
KATHLEEN J. TINKLENBERG

A thesis submitted in partial fulfillment of the requirements for the

Master of Science

Major in Nursing

Specialization in Clinical Nursing Leadership

South Dakota State University

2013

**RISK FACTORS FOR RELAPSE IN NURSES WITH SUBSTANCE USE DISORDER**

This thesis is approved as a credible and independent investigation by a candidate for the Master of Science degree and is acceptable for meeting the thesis requirements for this degree. Acceptance of this thesis does not imply that the conclusions reached by the candidate are necessarily the conclusions of the major department.

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## ABBREVIATIONS

1. AMA – American Medical Association
2. ANA – American Nurses Association
3. CINAHL – Cumulative Index to Nursing and Allied Health Literature
4. DSM-IV – Diagnostics and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition
5. HPAP – Health Professionals Assistance Program
6. HPM – Health Promotion Model
7. NCSBN – National Council of State Boards of Nursing
8. NIDA – National Institute on Drug Abuse
9. SAMSHA – Substance Abuse and Mental Health Services Administration
10. SBN – State Boards of Nursing
11. SUD – Substance Use Disorder

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## ABSTRACT

## RISK FACTORS FOR RELAPSE IN NURSES WITH SUBSTANCE USE DISORDER

KATHLEEN J. TINKLENBERG

2013

Substance Use Disorder (SUD) is defined as the continued use of mood-altering addicting substances despite adverse consequences (Morse & Flavin, 1992). Nurses are not immune from this progressive and fatal disease and if left untreated, a nurse with SUD poses a double jeopardy: risk to the patients and a threat to her or his own health. Many State Boards of Nursing (SBN) have implemented a non-disciplinary alternative to punitive treatment of professionals with SUD; such programs offer monitoring for nurses afflicted with SUD. While studies have found a lower relapse rate for healthcare professionals enrolled in these monitoring programs than that of the general public, data on risk factors for relapse of nurses participating in an alternative monitoring program are lacking. This study seeks to answer the following: 1) What characteristics are common to nurses in a SUD monitoring program who relapse? 2) What characteristics are common to nurses in a SUD monitoring program who do not relapse?

Pender's Health Promotion Model "depicts the multidimensional nature of persons interacting with their interpersonal and physical environments as they pursue health" (Pender, Murdaugh, & Parsons, 2006, p. 50). This retrospective chart review used a descriptive, correlational and comparative design to examine and describe characteristics common to two groups of nurses while enrolled in a SUD monitoring program: those who relapsed and those who did not relapse.

This research identified two risk factors for relapse of nurses: a family history of SUD and self-identified concern regarding emotional well-being. Nurse monitoring programs need to assess for these risk factors among participants and specific interventions developed before more nurses are lost to this disease. A network of resources could be developed and referrals for additional help and support implemented.

## **Chapter One**

Drug or substance abuse is a major national health problem affecting millions of Americans (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). In 2008, an estimated 22.2 million persons (8.9 %) of the population aged 12 or older were classified with substance dependence or abuse in the past year based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (SAMHSA, 2008). Addiction is defined as the continued use of mood-altering addicting substances despite adverse consequences (Morse & Flavin, 1992). The American Medical Association (AMA) first began to describe addiction as a disease in the 1950s. This disease affects persons of every segment of society, including health care professionals. Of nursing professionals, the rate of nurses with addiction ranges from 2% to 20% (Bell, McDonough, Ellison, & Fitzhugh, 1999; Monroe, et al., 2011).

### **Statement of the problem**

Substance use disorder (SUD) among nurses is an important and persistent problem. As substance abuse escalates to substance dependency for a nurse, patients, co-workers and institutions are at risk. West (2002) reported that many impaired nurses are not identified until patient safety is compromised. In their mandated role to protect the public from unsafe nursing practice, State Boards of Nursing (SBNs) address cases of impaired nurses frequently. Substance abuse issues are a primary factor in 67% to 90% of all disciplinary actions taken by SBNs across the country (Smith & Hughes, 1996). In 1982, the American Nurses Association (ANA) addressed the problem of impaired nursing practice, recommending an increased focus on intervention, treatment and rehabilitation of the nurse impaired by drug abuse or addiction.

Over the last two decades, many SBNs have implemented a non-disciplinary alternative to punitive treatment of impaired professionals (Brown, Trinkoff, & Smith, 2003; Darbo, 2005). The focus of these alternative-to-discipline programs is treatment and monitoring of the chemically dependent professional rather than punishment through the traditional disciplinary process. The goal of these programs is to ensure that the nurse is safe to return to the workplace as a practitioner through close, multi-faceted monitoring of the nurse's recovery. Angres, Bettinardi-Angres, and Cross (2010) advocate that continuing care during recovery from substance use disorder is just as essential as initial treatment. They recommend monitoring that may be done in conjunction with a five year monitoring healthcare professional program.

While studies have found a lower relapse rate for healthcare professionals enrolled in these monitoring programs than that of the general public (Baldwin & Smith, 1994; Domino et al., 2005), data on risk factors for relapse of nurses participating in an alternative monitoring program are lacking. One 1994 study by Baldwin and Smith described the prevalence of relapse among licensed nurses while under an SBN order and identified factors or characteristics involved in the relapse of chemically dependent nurses. Factors related to increase incidence of relapse included less than three months of recovery, outpatient treatment for SUD, drug diversion by the nurse from their place of employment, and lack of obtaining a sponsor. Current research is lacking however and studies specific to nurses and relapse need to be completed.

The state of South Dakota (SD) has a monitoring program for nurses with SUD. The mission of this program, the Health Professionals Assistance Program (HPAP), is to enhance public safety and support for regulated health professionals by facilitating early

intervention, treatment, and safe return to practice of health professionals whose functioning is impaired by the use of alcohol and/or other drugs (SD Board of Nursing, 2010). The SD HPAP has a number of participants who are mandated by the SD SBN into the program with no associated disciplinary action.

### **Purpose of the study**

This study focused on a sample of nurses participating in the SD HPAP monitoring program, and examined data from participants' case files while enrolled in the program. Each case was put into one of two groups: those participants who relapsed while in the program and those who have not relapsed while in the program. This study sought to describe characteristics common to each group of nurses and identify any trends or characteristics that occur more frequently in nurses who have relapsed versus those who have not.

### **Research Questions**

This study focused on the following research questions: What characteristics are common to nurses in a SUD monitoring program who relapse? What characteristics are common to nurses in a SUD monitoring program who do not relapse?

### **Significance**

A major consequence of substance abuse is the dysfunction that interferes with exercising judgment (Yocum & Haack, 1996). Untreated, a substance dependent nurse poses a double jeopardy: risk to patients, and a threat to her or his own health of a progressive and fatal disease. For agencies charged with the task of protecting the public from unsafe practitioners, there is the challenge of achieving this charge while promoting

treatment and rehabilitation of the impaired licensee. Returning a knowledgeable, skilled nurse to a productive role in society is imperative as the nursing shortage looms.

### **Definitions**

Substance use disorder or addiction is a physical and psychological habituation to a mood or mind-altering drug, such as alcohol or cocaine (American Heritage Medical Dictionary, 2007). The National Institute on Drug Abuse (NIDA) (2008) defines addiction as a chronic, often relapsing disease of the brain that causes compulsive drug seeking and use even in the face of negative health and social consequences. For this study, data will be collected on the diagnosis of each participant as determined during the chemical dependency evaluation and before enrollment in the SUD monitoring program.

Currently, the healthcare community does not yet have a definitive definition of relapse. Baldwin and Smith (1994) cautioned that relapse can be defined as a discreet event that occurs simultaneously to the resumption of drug use or a process that occurs over time. Relapse has been defined in relation to complete abstinence from mood- or mind-altering substances; the treatment program is then described as successful or a failure based on the relapse (Talbot, 1995). Talbot argued that other healthcare disciplines do not judge treatment of other primary, chronic, relapsing, biological, genetic diseases such as arthritis or diabetes as a failure of treatment when the patient suffers a relapse. Addiction experts have sought to redefine the term “clinical relapse” as a process, characteristic of the disease, and sometimes a critical part of the recovery process (Gorski & Miller, 1986). Talbot (1995) differentiated between what he termed “malignant relapse”, a treatment failure which severely disturbs or aborts the continuum of the recovery process and “slips or recovery relapses”, which occur without any

significant consequences to the recovery process. For this study, resumption of any mood-altering drug after the initial diagnosis and completion of primary treatment will constitute a relapse.

According to the National Council of State Boards of Nursing (NCSBN, 2007), alternative-to-discipline programs are broadly defined as those focused on early detection and treatment of nurses with substance use disorder. The goal of such programs is to protect the public and assist with the rehabilitation of the nursing professional. Monitoring of the compliance of the nurse diagnosed with SUD during treatment and recovery is essential to assure patient/client safety and nurse competency to practice (Sheets, 2001). These programs typically provide active care management for the healthcare provider, as well as monitoring and supervision for persons who have signed formal, binding contracts for participation (DuPont, McLellan, White, Merlo, & Gold, 2009).



## **Chapter Two: Review of Literature and Conceptual Framework**

### **Introduction**

A literature search of studies of relapse risk factors for chemically dependent nurses utilized key words including: risk factors for relapse, nurses, chemical dependency, healthcare professionals, addiction, nursing, and relapse, in varying combinations. Cumulative Index to Nursing and Allied Health Literature (CINAHL), and EBSCO MegaFile databases produced 1,516 articles. Through reading the abstracts and reviewing the studies, these were considerably narrowed to thirteen studies which were identified as pertinent to this study.

Sullivan, Bissell, and Leffler (1990) conducted a qualitative survey study of 300 nurses recovering from substance use disorder from multiple settings. They sought to determine certain characteristics regarding drug use and dependency, including observable effects of drug use at work, influence of gender and choice of drug on subsequent disciplinary actions. This study found that drug use and dependency frequently started at a young age for these nurses. It often began prior to and continued during nursing school. Subjects also reported multiple serious job performance problems.

Brown, Trinkoff, and Smith (2003) evaluated the type of overall burden of life stressors experienced by the chemically dependent nurses prior to and during an alternative-to-discipline program participation. This study was a cross sectional survey of 618 nurses enrolled in an alternative-to-discipline program in April 2000. The authors examined the relationship-of current problems with the nurse's confidence in her ability to resist relapse; they did not specifically evaluate relapse rate. They measured the types

of problems the nurses experienced and their confidence in ability to resist relapse. The authors found that current problems significantly reduced the nurses' confidence in the ability to resist relapse. Additionally their study identified that depression and anxiety were associated with low confidence in ability to resist relapse.

A very recent study by Fogger and McGuinness (2009) did evaluate the effectiveness of Alabama's alternative-to-discipline program for chemically dependent nurses through feedback from 173 nurses on a 46-item survey. In this study, 94% of the nurses reported no relapse since entering the monitoring program, however, the relapse rate of six percent may not be accurate since self-report was used to document relapse. This study also did not evaluate the factors related to relapse.

Haack and Yocum (2002) investigated the effects of two state regulatory policies on nurses with SUD on relapse rates and retention in the nursing workforce. This longitudinal comparative study evaluated 100 nurses with disciplinary actions against their nursing licenses by four United States Boards of Nursing with a cohort of 119 nurses from three states participating in the alternative-to-discipline program. This study collected data at six points in time over six months. The authors found that the alternative-to-discipline sample had more nurses with active licenses, fewer nurses with criminal convictions, and more nurses employed in nursing than nurses with disciplinary action against their licenses. They noted no difference between the two groups in the relapse rate of 15%.

An older, quantitative, descriptive study of a self-selected sample of 130 nurses sought to provide information on characteristics of chemically dependent nurses and to identify variables associated with recovery or relapse from addiction (Sullivan, 1987). In

this study, relapse occurred more frequently among nurses who were threatened with or had actual job loss, used narcotics, had received disciplinary license action, and had more than one treatment course for SUD. Additionally, nurses who were infrequent attendees at Alcoholics Anonymous or Narcotics Anonymous support meetings were more likely to incur a relapse. Those nurses who had relapsed often reported narcotic dependence, had undergone more severe consequences related to their drug use, and reported less participation in a recovery program.

Baldwin and Smith (1994) studied records of 108 nurses in a sample of nurses who were stipulated into the alternative-to-discipline program in Arizona by the Board of Nursing. Baldwin and Smith sought to describe the prevalence of relapse among these nurses and identified characteristics or factors involved in relapse. Results demonstrated a 41% relapse rate, which compares favorably to a general population relapse rate exceeding 75%. These researchers were able to identify a critical time interval for relapse during the first three months of recovery. The relapse rate was lower among nurses who had completed an in-patient treatment program and who had obtained a sponsor; however, the relapse rate was 50% for nurses who diverted drugs from their place of employment, compared to 36% for those nurses who had obtained their drugs through legitimate means, such as by prescription through their primary care provider.

A more current study focuses on risk factors for relapse for general healthcare professionals with substance use disorder (Domino, et al. 2005). Domino et al. identified factors that might predispose a healthcare professional with a substance use disorder to relapse. This study evaluated the records of 292 healthcare professionals enrolled in the Washington Physicians Health Program. The participants were physicians from an array

of medical, surgical, and anesthesiology specialties, as well as pharmacists, dentists, physician assistants, and veterinarians. The researchers found that 25% of participants had at least one relapse. They identified family history of substance use disorder increased the risk of relapse as did use of a major opioid, especially in the presence of a co-existing psychiatric disorder. The authors also concluded that the presence of all three of these identified risk factors markedly increased the risk of relapse.

DuPont, McLellan, White, Merlo, and Gold (2009) found similar relapse rates in a larger research study of physicians participating in Physician Health Programs across several states. Of the 809 physicians, 71% had no relapse or substance abuse during their recovery. Random chemical testing, completed on average twice a month, was utilized to detect relapse.

### **Summary of Literature Review**

In summary, essentially only three research studies over a span of nearly twenty years have examined risk factors for relapse of healthcare professionals with substance use disorder. These three studies, Sullivan (1987), Baldwin and Smith (1994) and Domino, et al. (2005), identified a number of risk factors which portend relapse. Sullivan (1987) found nurses were more likely to suffer a relapse if they experienced a threatened or actual job loss, used narcotics, had received disciplinary license action, and were infrequent attendees at 12 step support meetings. Baldwin and Smith's study revealed that the relapse rate was lower for nurses who had completed an in-patient treatment program and who had obtained a sponsor; a higher risk for relapse was identified for those nurses who diverted drugs from their place of employment. Lastly, research by Domino et al. (2005) found that healthcare professional participants of a monitoring

program who had a family history of SUD and those who used a major opioid were more likely to relapse. This risk was higher in those participants who also had a co-existing psychiatric disorder.

It is evident that research on this topic is sparse. Only one of the studies was conducted in the last ten years. Further research regarding risk factors for relapse is clearly needed.

### **Conceptual framework**

The conceptual framework for this study comes from Pender's Health Promotion Model (HPM) (See Figure 1.1). This model "depicts the multidimensional nature of persons interacting with their interpersonal and physical environments as they pursue health" (Pender, Murdaugh, & Parsons, 2006, p. 44). This model integrates components of the expectancy-value theory and social cognitive theory within a nursing perspective of holistic human functioning. Expectancy-value theory suggests that a person will engage in a given action and will persist in it to the extent that (a) the outcome of taking action is of positive personal value, and (b) based on the available information, taking this course of action is likely to bring about the desired outcome (Pender et al, 2006). Social-cognitive theory emphasizes self-direction, self-regulation, and perceptions of self-efficacy (Pender et al, 2006). Pender outlined six elements of behavior-specific cognitions and affect in her model (Pender, et al. 2006). These include client perceived benefits of action, perceived barriers to action, perceived self-efficacy, and activity-related affect, interpersonal influences, and situational influences.

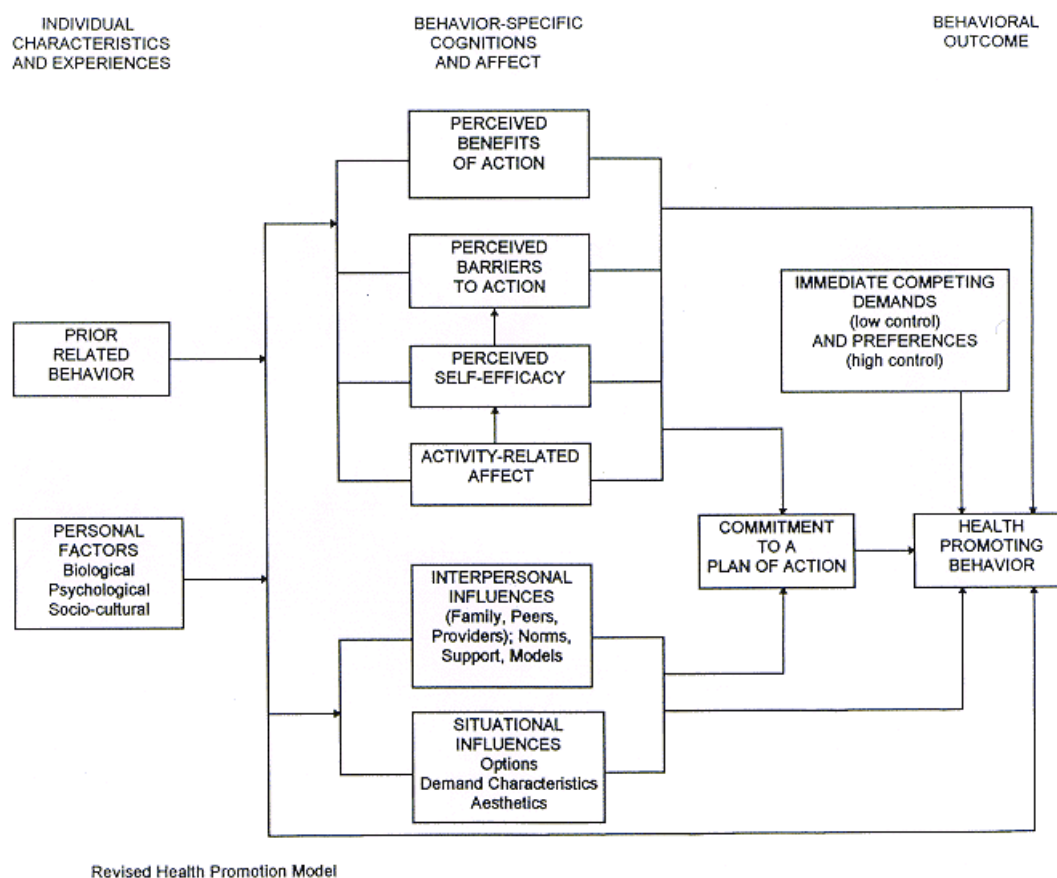


Figure 1.1: Pender's Health Promotion Model. From

<http://www.nursing.umich.edu/faculty/pender/chart.gif>

This conceptual framework guided this study in the following way. By abstracting and evaluating the behaviors, specific cognitions, and affect conditions from the case files of nurses participating in the HPAP monitoring program who have relapsed, this study identified any trends, characteristics, and conditions that occur in greater frequency in nurses who have relapsed versus those who have not. The behavioral outcome evaluated in this study was maintenance of sobriety or relapse. The individual characteristics and experiences in the HPM, which were examined in this analysis included the variables of age at entry, sex, type of nursing license, family history of SUD,

drug of choice, marital status, number of jobs over the last five years, current emotional status, suicidal ideation (past or present), failure to understand and accept SUD as a disease, cross addiction with another substance or addictive behavior, and if the participant has been the victim of maltreatment. In the behavior-specific cognitions and affect area of the HPM, the study examined the variables of the nurses' emotional status, and self-identified concern regarding emotional well-being. Interpersonal influences in the HPM include family, peers and providers. In this study, variables reviewed related to these influences include family background, and familial relationships. The variable of willingness to participate in the monitoring program fit the perceived self-efficacy area of the HPM.

Upon diagnosis of SUD, a primary goal of treatment and recovery for most nurses is to return to their profession of nursing. Relapse may delay this return and indicate more treatment and recovery time is needed before the nurse is well enough to return to the demands of the profession. When research identifies these characteristics or behaviors which are risk factors for relapse, the monitoring programs will be able to assess for these risk factors in new participants. For the nurse who has these risk factors, a network of resources could be developed and referrals for additional help and support implemented.

### **Chapter Three: Method and Procedures**

A retrospective case file review was used to study the sample of nurses enrolled in the SD HPAP. The sample was divided into two groups: one group included aggregate intake assessment data of nurses who have had no relapse while enrolled in the program, and the other group included aggregate intake assessment data of nurses who have had one or more relapses while enrolled in the program. The aggregate assessment data of each group was reviewed, and characteristics common to each group identified.

#### **Research Design**

This retrospective chart review used a descriptive, correlational, and comparative design (Burns & Groves, 2009) to examine and describe trends or characteristics common to each of two groups of nurses while enrolled in HPAP since January 2006: those who did not relapse and those that had one or more relapses while enrolled in HPAP.

#### **Sample and Study Setting**

The sample for this study included aggregate intake assessment data of all nurses who have participated in the SD HPAP since January 2006 (N = 79). This sample excluded case files of any nurses who voluntarily enrolled in the SD HPAP and those who did not successfully complete the enrollment process.

#### **Study Procedure**

To protect the confidentiality of each participant, a HPAP staff member copied the intake assessment form of the participants that met the criteria described above. The name of each participant was removed and the intake assessment form was given a number by a HPAP staff member. The HPAP staff member also recorded on this intake



assessment form the mental health diagnosis for each participant based on the chemical dependency evaluation completed prior to enrollment into HPAP. Data was recorded in aggregate form on worksheets using only the number identifier of the intake assessment. Each intake assessment was destroyed immediately after the transfer of data to the aggregate form.

Similar to the Domino et al. (2005) study, aggregate data from the SD HPAP intake assessment forms included the following: date of program enrollment, age at entry, sex, type of nursing license, family history of SUD, drug of choice, and route of drug administration. Additional data collected from the intake assessment forms included: marital status, number of jobs in the last five years, current emotional status, suicidal ideation (past or present), willingness to participate in HPAP, legal history, current legal charges, family background, familial relationships, and if the participant had been the victim of maltreatment.

Resumption of any mood-altering drug after the initial diagnosis and completion of primary treatment constituted a relapse. The method of detection of the relapse, date of relapse, and the date of return to practice was also recorded. This study sought to abstract additional available data as available. For example, Angres et al (2010) identified the following as causes of relapse, which the proposed study also collected: failure to understand and accept SUD as a disease and cross-addiction with another substance or an addictive behavior.

### **Protection of Human Subjects**

Institutional review board approved this project as exempt human subjects' research. Before the data were given to this investigator, each participant's identity was

locked out on the copy of the forms by the staff at the HPAP office. Based on the principle of respect, anonymity was maintained as this researcher was not able to link the identity of the participant with his or her individual responses (ANA, 1985). The copy of the assessment intake forms and the quarterly reports were then given a code number for identification purposes. The copied forms were stored in a locked cabinet in the researcher's office. Additionally, the door to this office was locked nightly. The only persons with access to this locked cabinet were the researcher and her assistant. Data were then analyzed as group data only so that individuals could not be identified by their responses.

### **Analysis**

The data were analyzed using descriptive, correlational, and comparative statistics. Any significant relationships between characteristics within each group of nurse participants were identified using the Pearson  $r$  statistic for interval level data and the Chi Square statistic for categorical or nominal level data. The significant differences of characteristics or behavior traits between the two groups were assessed using the independent  $t$ -test for interval level data and Chi Square statistic for categorical or nominal data. Additionally, factors associated with relapse were examined.

## Chapter Four: Results

### Description of the Sample

Of the 79 HPAP nurses who met inclusion criteria, four were excluded for incomplete enrollment into the HPAP program. Of the 75 individuals remaining, 88% were female, 70.7% were Registered Nurses (RN), 4.0% were Advanced Practice Nurses (APN), 20.0% were Licensed Practical Nurses (LPN), and 5.3% were either nursing students or licensure applicants. The mean age of the participants was 38.3 years with a range of 23-55 years. The marital status of the participants was 58.6% married, 18.7% divorced and 22.7% single. Sixty percent had a positive family history of SUD.

For this study, the drug of choice was categorized into six groups: fentanyl, other major opioids (includes morphine, meperidine hydrochloride, methadone hydrochloride, heroin, controlled-release oxycodone hydrochloride), minor opioids (butorphanol, codeine, hydrocodone, nalbuphine hydrochloride, oxycodone, pentazocine, propoxyphene, and tramadol hydrochloride), alcohol, cocaine, and other (including benzodiazepines, methamphetamines, marijuana). For nearly half of the participants ( $n = 34$ ), the drug of choice was alcohol; the next commonly cited drug of choice was other ( $n = 16$ ). Only three nurses listed fentanyl as their drug of choice and one listed cocaine. Cross-addiction of the participants was 37% ( $n = 28$ ). There were no cases involving the use of heroin, methadone or time-released oxycodone. Nearly fifty-five percent of the nurses had no legal history, but 45% were facing charges at the time of entry into the HPAP program. Just under one-half (48%) of the participants reported either physical or sexual maltreatment at some time in their lives, and 55% had a dual diagnosis of a psychiatric illness (Table 1).

Table 1  
*Sample Characteristics*

Characteristics	No. (%) of individuals N = 75
Sex	
Female	66 (88%)
Male	9 (12%)
Age year	
< 40	39 (52%)
>40	36 (48%)
Licensure	
RN	53 (71%)
LPN	15 (20%)
APN	3 (4%)
Other	4 (5%)
Drug of Choice	
alcohol	34 (45%)
major opioids	5 (7%)
minor opioids	14 (19%)
other	16 (21%)
Family history of substance use disorder	
yes	45 (60%)
no	30 (40%)
Dual Mental Health Diagnosis	
yes	34 (45%)
no	41 (55%)
History of maltreatment	
yes	36 (48%)
no	39 (52%)

Family background and familial relationships were examined. Sixty-five percent of participants had been raised by both parents, while just fewer than 15% identified they were raised by mother and step-father. Seventy-nine percent stated they were “close to mom” and 61% identified being “close to dad”.

### **Characteristics of the relapse group**

Thirty-eight (51%) of the 75 nurses experienced a relapse during their participation in the HPAP program. Relapse by LPNs was slightly more common than RNs; the lowest relapse rates were among the student or applicant cohort. The range of time in months until relapse was 1.1 to 89.1 with a mean of 16.7 months. Time between relapse and return to practice was a mean of 9.2 months. The drug of choice in the nurses who relapsed was predominantly alcohol (47%, n = 18), with other at 21% (n = 8), followed by major opioids at 13% (n = 5). Most relapses were detected by chemical monitoring, such as urine or blood testing (n = 21); an additional 15% of relapses were detected by workplace monitoring. Twenty-nine percent (n=22) of all HPAP nurse participants eventually left the nursing profession sometime after enrollment into the program; all of these 22 nurses had experienced relapse while participating in HPAP.

The relapse group had a similar frequency of criminal convictions as those who did not relapse, 54% (n = 17) compared to 55% (n = 17); however, this group had a higher rate of mental health diagnoses (61%, n = 23) along with chemical dependency as compared to those who did not relapse (49%, n = 18).

Evaluating the relapse group's responses regarding their family background and familial relationships reflected similar results as the non-relapse group: 62% were raised by both parents, 14% were raised by mother and step-father. Additionally, 78% reported they were close to mother, and 57% were close to father.

The group of nurses who relapsed demonstrated a greater frequency of family history of SUD, however. While the cohort group had a 60% frequency of positive family history for SUD (n = 45), only 51% of the non-relapse nurses did (n = 19) ,

compared to 71% of the nurses who did relapse ( $n = 27$ ). Additionally, those nurses who relapsed reported more frequently of maltreatment in their lives; 55% reported physical or sexual abuse ( $n = 21$ ), compared to 41% of nurses who did not relapse ( $n = 15$ ).

### **Analysis**

Data was analyzed utilizing SPSS 21.0 (IBM, 2012). An initial analysis was completed between the mean age of the nurses enrolled in the program who relapsed (40.45 years) and those nurses enrolled in the program who did not relapse (36.11 years). An independent t-test demonstrated no statistically significant difference between the two groups ( $t = 2.28$ ,  $df = 73$ ,  $p < 0.18$ )

Differences between the two groups were assessed on the categorical variables of type of license held by the participant, history of criminal convictions of the participant, mental health dual diagnosis of the participant, and whether the participant had been a victim of physical or sexual maltreatment, and those who answered affirmatively to the intake assessment question “Are you worried about your emotional well-being?” The chi square test of independence analysis of cross-tabulated data was completed for each of these sets of variables. The results demonstrated no statistically significant difference in frequencies of data between relapse and license type, relapse and history of criminal convictions, relapse and history of maltreatment or relapse and mental health diagnoses (Tables 2-5).

Table 2

*Cross-Tabulation: Variables Licensure Type and Relapse*

		Relapse		
		Yes	No	Total
Licensure	RN	26	27	53
	LPN	9	6	15
Total		35	33	68

<i>Chi-Square Tests</i>		Value	df	Asymp. Sig (2-sided)
Pearson Chi-Square		.561 <sup>a</sup>	1	0.454
Phi coefficient		-0.091		

<sup>a</sup> 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.28.

Table 3

*Cross-Tabulation: Variables Criminal History and Relapse*

		Relapse		
		Yes	No	Total
Criminal History	None	20	21	41
	Positive	18	16	34
Total		38	37	75

<i>Chi-Square Tests</i>		Value	df	Asymp. Sig (2-sided)
Pearson Chi-Square		.129 <sup>a</sup>	1	.720
Phi coefficient		-.041		

<sup>a</sup> 0 cells (.0%) have expected count less than 5. The minimum expected count is 16.77.

Table 4

*Cross-Tabulation: Variables Comorbidity and Relapse*

		Relapse		Total
		Yes	No	
Comorbidity	Yes	21	13	34
	No	17	24	41
Total		38	37	75

<i>Chi-Square Tests</i>	Value	df	Asymp. Sig (2-sided)
Pearson Chi-Square	3.065 <sup>a</sup>	1	0.080
Phi coefficient	.202		

<sup>a</sup> 0 cells (.0%) have expected count less than 5. The minimum expected count is 16.77.

Table 5

*Cross-Tabulation: Variables Victim of Maltreatment and Relapse*

		Relapse		Total
		Yes	No	
Victim of Maltreatment	Yes	21	15	36
	No	17	22	39
Total		38	37	75

<i>Chi-Square Tests</i>	Value	df	Asymp. Sig (2-sided)
Pearson Chi-Square	1.628 <sup>a</sup>	1	.202
Phi coefficient	0.147		

<sup>a</sup> 0 cells (.0%) have expected count less than 5. The minimum expected count is 17.76.



### Characteristics common to nurses who relapse

Between the variables relapse and family history of SUD, however, the chi square test of independence analysis of cross-tabulated data was significant ( $X^2 = 5.440$ ,  $df = 1$ ,  $p < .02$ ) (Table 6).

Table 6

*Cross-Tabulation: Variables Family History of SUD and Relapse*

		Relapse		Total
		Yes	No	
Family History of SUD	Yes	21	10	31
	No	1	5	6
Total		22	15	37

<i>Chi-Square Tests</i>	Value	df	Asymp. Sig (2- sided)
Pearson Chi-Square	5.44 <sup>a</sup>	1	.020
Phi coefficient	0.383		

<sup>a</sup>0 cells (.0%) have expected count less than 5. The minimum expected count is 17.76.

The Phi coefficient ( $\phi$ ) shows the strength of the relationship between the two variables (Burns & Grove, 2009). The phi coefficient value ( $\phi = .383$ ) reflects a moderate degree of relational strength between the variables of relapse and a positive family history of SUD.

The difference in the relationship between relapse and the participants' concern regarding their-emotional well-being was then assessed using the chi square test of independence. Twenty-one percent of the entire group identified that they were concerned about their emotional well-being. Of those who did not relapse, the

percentage was 13%, but of those who relapsed, the percentage was just under 30%. A chi square test of independence analysis of the cross-tabulated data was performed between the two groups, which was statistically significant ( $X^2 = 4.144$ ,  $df = 1$ ,  $p < .042$ ). The Phi coefficient ( $\phi = .378$ ) indicates a moderate degree of relational strength between the variables “worried about emotional health” and relapse (Table 7).

Table 7

*Cross-Tabulation: Variables Worried about Emotional Health and Relapse*

		Relapse		Total
		Yes	No	
Worried about Emotional Health	Yes	11	5	16
	No	4	9	13
Total		15	14	29
<i>Chi-Square Tests</i>		Value	df	Asymp. Sig (2-sided)
Pearson Chi-Square		4.144 <sup>a</sup>	1	0.042
Phi coefficient		0.378		

<sup>a</sup> 0 cells (0.0%) have expected count less than 5. The minimum expected count is 6.28.

### Summary of Analysis

The initial data review identified a predominantly female group, of whom 71% were RNs, with a mean age of 38.3 years. The drug of choice was alcohol for nearly half of the participants. Sixty percent of the nurses identified a family history of SUD, and just over 65% reported either physical or sexual maltreatment sometime in their lives. Over half (55%) of the participants had a dual diagnosis of psychiatric illness.

The relapse rate of this study was 51% with 38 of the nurses experiencing a relapse during their participation in HPAP. The mean time in months until relapse was 16.7 months. Strikingly, of the relapse group, 22 nurses enrolled in the monitoring program, eventually left the nursing profession. An independent t-test between the relapse group and the no relapse group on age found no significant difference. Chi-square analyses between the relapse and no relapse groups on license type, relapse and history of criminal convictions, relapse and history of maltreatment or relapse and mental health diagnoses also identified no significant difference between the two groups.

Significant difference was not found between the relapse and no relapse group and the variables of type of license, criminal history, mental health dual diagnosis and victim of maltreatment. A significant difference, however, was identified between the relapse groups and family history of SUD, and between relapse groups and concern regarding emotional well-being. These differences were found to have a moderate degree of relational strength.

## Chapter Five: Conclusions

This study provided multiple findings. The initial observation was that 51% of 75 nurses relapsed in the HPAP program. While this relapse rate is higher than reported in other studies cited earlier, the duration of the monitoring program in past studies is not clear. For example, Haack and Yocum (2002) report a 15% relapse rate, but the study collected data at six points in time over just six months. In this study, the mean time in months to relapse was 16.7, thus no comparisons can be made between the rates of relapse. Domino et al. (2005) and DuPont et al. (2009) report relapse rates of 25% and 29% respectively, however, their study groups were comprised primarily of physicians and no nurses. Additionally their study groups were predominantly male, 84% and 86% respectively. Baldwin and Smith (1994) identified a 41% relapse rate for their study group of nurses, which is similar to this study's results.

This study found a number of similarities between the relapse group and the no relapse group. For both groups, the drug of choice was alcohol and minor opioids or major opioids were second. LPNs relapsed somewhat more frequently than RNs, which was not statistically significant. Family background (raised by both parents) and family relations (close to mother, close to father) were also very comparable between the two groups. The frequency of nurses having a criminal history is nearly identical between the group of nurses who did relapse and the group of those nurses who did not relapse. There was also no significant difference between the two groups in the number of nurses that were a victim of physical or sexual maltreatment. The nurses who did not relapse reported a 41% positive response rate, and the nurses who did relapse reported a 55% positive response rate, which, upon analysis, was not significantly different.

Several studies have reported similar results of association between maltreatment and SUD. More than half of all individuals who abuse drugs and enter treatment for drug addiction report a history of child abuse or neglect (Min, Farkas, Minnes & Singer, 2007; Pirard, et al, 2005). Likewise, Brady et al. (1994) found 47% of the female sample had reported at least one form of childhood abuse. In a review of 67,853 women in the Nurses' Health Study II, Rich-Edwards et al (2010) identified that 54% of the nurses reported child or teen physical abuse and 34% reported sexual abuse. This study demonstrated similar rates of reported victim of maltreatment (48% of all nurses). However, as cited earlier, the difference between the relapse group and the no relapse group and the variable victim of maltreatment was not statistically significant.

As reported in Harvard Mental Health Letter (2010), the United States National Survey on Drug Use and Health identified a higher rate of substance abuse or dependence problem for males (11.5%) than females (8.4%). This study found a similar rate; 12% of the participants in the program were male. Harvard Mental Health Letter (2010) also cited that females develop the medical or social consequences of addiction faster than men, and are more susceptible to relapse. This study did see a higher proportion of males in the monitoring program relative to the percentage of male nurses in South Dakota: twelve percent males in HPAP compared to eight percent male nurses in SD as of March, 2013 (NCSBN, 2013). This study did not demonstrate a higher susceptibility to relapse for females, as it noted males were slightly more likely to relapse than females (13.5% males relapsed compared to 10.5% who did not). This finding, however, was not statistically significant.

A significant difference was identified between the two groups of nurses and family history of SUD. This finding supports the study findings by Domino, et al. (2005), which cited the presence of a family history of SUD in healthcare professionals with SUD significantly increasing the likelihood of relapse. Family history of SUD as a risk factor has been identified as a risk in the general population as well. Family modeling of drug using behavior and permissive parental attitudes towards children's drug use are family influences related specifically to an increased risk of alcohol and other drug abuse by the children (Hawkins, Catalano, & Miller, 1992).

The significant difference between the two groups of participants and the participants' concern for his/her emotional health, however, has not been previously reported in the literature. In the framework of Pender's Health Promotion Model, this factor correlates with the perceived barriers to action (Figure 2). Pender noted that barriers usually arouse motives of avoidance, and anticipated barriers have been found to affect intentions to engage in a particular behavior (Pender, Murdaugh & Parsons, 2011). Exploring this perceived barrier with nurses who identify this concern on their monitoring program intake assessment may provide early support for the nurse. Additional intervention to address their concern is essential for nurses with this risk factor for relapse.

## PENDER'S HEALTH PROFESSIONAL MODEL *Applied to SUD among Nurses*

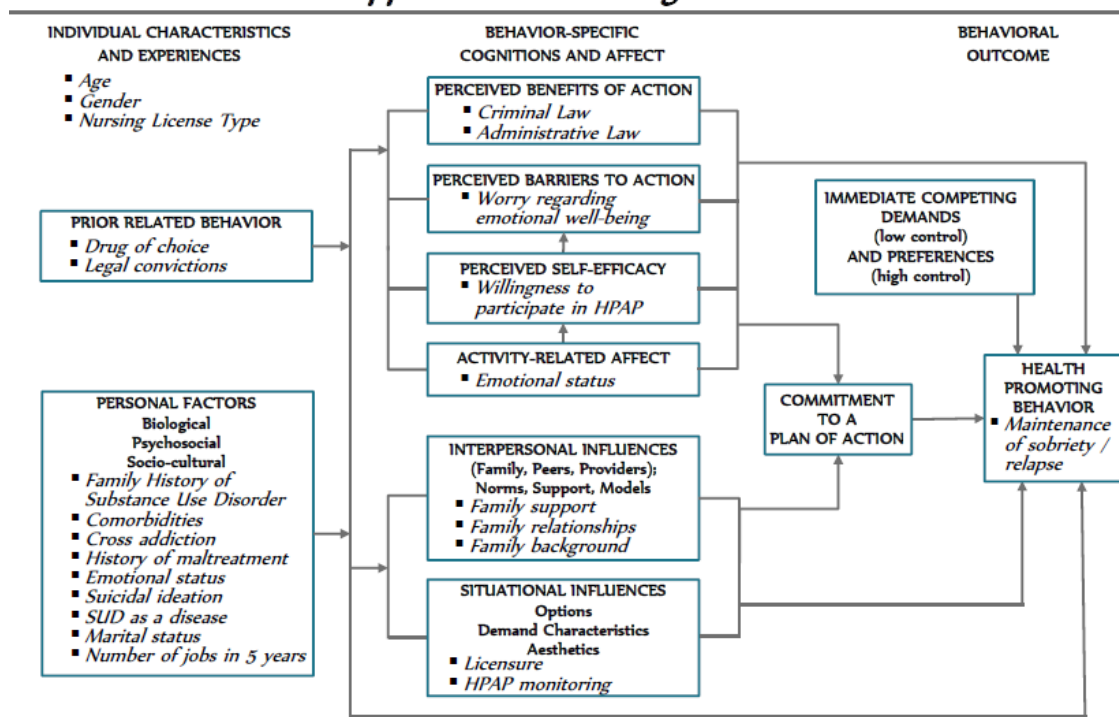


Figure 2: Pender's Health Promotion Model applied to SUD among Nurses

Lastly, a salient finding of this study is that any relapse is significant. Nearly one-third of the nurses (N=22) in this study who subsequently experienced a relapse, eventually quit their career of nursing. This denotes a tragic loss to the nursing profession, and again suggests the importance of identifying risk factors for relapse so that strong prevention modalities for nurses with SUD may be developed.

### Implications

State alternative to discipline programs for nurses need to include an appraisal of the nurse's perception of her emotional well-being, similar to the SD HPAP question:

“Are you worried about your emotional well-being?” Detection and treatment of

affective conditions could be important to maintaining recovery. A network of resources should be developed and referrals for additional help and support initiated for those nurses who respond affirmatively to this inquiry. These programs also need to consider managing nurses who have a family history of SUD with more intensive and more prolonged monitoring.

### **Limitations**

The statistical significance of the relationship between the variables of relapse and positive family history of SUD, and between relapse and participants' concern regarding emotional well-being cannot be inferred as a causal relationship. The data in this study was also derived from a single state monitoring program and of the nursing profession alone; thus, extrapolation to other programs or professions must be carefully considered. The number of individuals in this study was small, and even more so as the data were divided into categories.

### **Recommendations for Further Research**

Avenues for further research on risk factors for nurses with SUD would employ a state to state or multi-state comparison of similarly structured alternative to discipline programs. Qualitative studies on the process of relapse for nurses could also clarify the significant relationship to family history of SUD and to nurses' emotional well-being. The frequency of physical or sexual maltreatment reported by the nurses in this study indicates that further research in this area may be relevant. Additional investigation to examine the relationship between relapse and the subsequent decision of the nurse to eventually leave the nursing profession would be valuable.



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## APPENDIX A: APPROVAL LETTER



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Office of Research/Human Subjects Committee  
SAD Room 124  
Box 2201 SDSU  
Brookings, SD 57007

To: Kathleen J. Tinklenberg, College of Nursing  
Date: May 15, 2012  
Project Title: Risk Factors for Relapse in Nurses with a Substance Use Disorder  
Approval #: IRB-1205007-EXM

Thank you for taking such care in completion of the request and research protocol. This project is approved as exempt human subjects' research. The basis for your exempt status from 45 CFR 46.101 (b) is:

(4) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

If there are any unanticipated problems involving risks to subjects or others, or changes in the procedures during the study, contact the SDSU Research Compliance Coordinator. At the end of the project please inform the committee that your project is complete.

If I can be of any further assistance, don't hesitate to let me know.

Sincerely,

*Norm*

Norman O. Braaten  
SDSU Research Compliance Coordinator

APPENDIX B: HPAP INTAKE ASSESSMENT FORM

State of South Dakota  
**HEALTH PROFESSIONALS ASSISTANCE PROGRAM**

**INTAKE ASSESSMENT**

Please provide the following information as completely as possible:

Date: \_\_\_\_\_ 20 \_\_\_\_\_

NAME: \_\_\_\_\_

**DEMOGRAPHIC DATA:**

D.O.B. \_\_\_\_\_ Male \_\_\_ Single \_\_\_ Children: \_\_\_ Yes \_\_\_ No  
Female \_\_\_ Married \_\_\_ If yes, number of children \_\_\_\_\_  
Divorced \_\_\_

Email Address: \_\_\_\_\_

Residence Address: \_\_\_\_\_  
\_\_\_\_\_

Others in Residence: \_\_\_\_\_

Length of Residence: \_\_\_\_\_

**REASON FOR REFERRAL:**

Please describe the circumstances under which you have been referred to the Health Professionals Assistance Program. If you need more space please use the back of this page or attach additional sheets.

**EMPLOYMENT HISTORY:**

Are you currently employed: \_\_\_ Yes \_\_\_ No \_\_\_ Full Time \_\_\_ Part Time

Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

How many hours per week do you work: \_\_\_\_\_

How long have you worked here: \_\_\_\_\_

What is your present job title: \_\_\_\_\_

Please describe your job duties: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you been disciplined at work and/or is your job in jeopardy: \_\_\_ Yes \_\_\_ No

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does anyone at work know about your alcohol or other drug use: \_\_\_ Yes \_\_\_ No

Who at work is aware of your seeking assistance from the Health Professionals Assistance Program: \_\_\_\_\_

\_\_\_\_\_

Are these individuals supportive: \_\_\_ Yes \_\_\_ No

List the ways in which your present job has been affected by your alcohol or other drug use (e.g. tardiness, absenteeism, accidents, poor performance, conflict with co-workers, supervisors, or patients, etc. ): \_\_\_\_\_

**EMPLOYMENT HISTORY (CONTINUED)**

Have you had any special problems with your job: \_\_\_Yes \_\_\_No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you satisfied with your current job: \_\_\_Yes \_\_\_No If no, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Past employment history (list most current information first):

	<u>NAME OF AGENCY</u>	<u>JOB TITLE</u>	<u>DATES OF EMPLOYMENT</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Which of the above jobs were lost or given up due to alcohol or drug use either directly by termination or otherwise? Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PHYSICAL/EMOTIONAL HISTORY:**

Date of Birth: \_\_\_\_\_ Place of Birth: (City) \_\_\_\_\_ (State) \_\_\_\_\_

List all current physical, medical, or emotional problems (illness, disability, psychiatric involvement) : \_\_\_\_\_

\_\_\_\_\_

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**PHYSICAL/EMOTIONAL HISTORY (CONTINUED):**

Do you have any recurring pain such as headaches, back pain, etc.: \_\_\_\_\_

---

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Are you currently under a physician's care and/or taking prescribed medication?  
\_\_\_ Yes \_\_\_ No If yes, please explain: \_\_\_\_\_

---

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---

List any significant **past** medical or emotional problems: \_\_\_\_\_

---

---

I would presently describe myself as: (Check as many as apply )

- |                                      |                                    |                                    |
|--------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Depressed   | <input type="checkbox"/> Guilty    | <input type="checkbox"/> Panicked  |
| <input type="checkbox"/> Angry       | <input type="checkbox"/> Ashamed   | <input type="checkbox"/> Bored     |
| <input type="checkbox"/> Embarrassed | <input type="checkbox"/> Happy     | <input type="checkbox"/> Lonely    |
| <input type="checkbox"/> Relieved    | <input type="checkbox"/> Hopeful   | <input type="checkbox"/> Deserted  |
| <input type="checkbox"/> Afraid      | <input type="checkbox"/> Apathetic | <input type="checkbox"/> Pressured |
| <input type="checkbox"/> Confused    | <input type="checkbox"/> Disgusted | <input type="checkbox"/> Nervous   |

Are you worried about your emotional well-being: \_\_\_Yes \_\_\_No If yes, please explain: \_\_\_\_\_

Have you ever had thoughts of suicide: \_\_\_Yes \_\_\_No

Have you actually attempted suicide: \_\_\_Yes \_\_\_No If yes, please provide specifics:

---





\_\_\_\_\_ ( ) Yes ( ) No

\_\_\_\_\_ ( ) Yes ( ) No

\_\_\_\_\_ ( ) Yes ( ) No

**ALCOHOL/DRUG USE HISTORY:**

Please answer the following questions in terms of your experiences in the past six months. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, marijuana, cocaine, heroin, or other opiates, stimulants, depressants, hallucinogens, or inhalants)

\_\_\_ Yes \_\_\_ No

Have you felt that you use too much alcohol or other drugs? \_\_\_ Yes \_\_\_ No

Have you tried to cut down or quit drinking or using alcohol or other drugs?

\_\_\_ Yes \_\_\_ No

Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, counselors or a treatment program.)

\_\_\_ Yes \_\_\_ No

Have you had any health problems? For example, have you (check as many as apply):

- \_\_\_ Had blackouts or other periods of memory loss
- \_\_\_ Injured your head after drinking or using drugs
- \_\_\_ Had convulsions, delirium tremens
- \_\_\_ Had hepatitis or other liver problems
- \_\_\_ Felt sick, shaky, or depressed when you stopped
- \_\_\_ Felt "coke bugs" or a crawling feeling under your skin after you stopped using drugs
- \_\_\_ Been injured after drinking or using
- \_\_\_ Used needles to "shoot" drugs

Has drinking or other drug use caused problems between you and your family or friends?

\_\_\_ Yes \_\_\_ No

Has your drinking or other drug use caused problems at school or work?

\_\_\_ Yes \_\_\_ No

Have you been arrested or had other legal problems? ( Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)

\_\_\_ Yes \_\_\_ No

Have you lost your temper or gotten into arguments or fights while drinking or using other drugs? \_\_\_ Yes \_\_\_ No

Do you need to drink or use drugs more and more to get the effect you want?

Yes  No

Do you spend a lot of time thinking about or trying to get alcohol or other drugs?

Yes  No

When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?

Yes  No

Do you feel bad or guilty about your drinking or drug use?

Yes  No

**The next questions are related to lifetime experiences.**

Have you ever had a drinking or other drug problem?

Yes  No

Have any of your family members ever had a drinking or drug problem?

Yes  No

Do you feel that you have a drinking or drug problem now?

Yes  No

Please identify your previous Alcohol/Drug Treatment:

	<u>Dates</u>	<u>Type</u>	<u>Location</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Do you believe Alcoholism/Drug Addiction to be an illness: ( ) Yes ( ) No

Explain: \_\_\_\_\_

\_\_\_\_\_

What do you feel are the factors responsible for your alcohol and /or drug use:

\_\_\_\_\_

\_\_\_\_\_

Do you feel your use of alcohol or drugs is harmful to yourself or others: ( ) Yes ( ) No

List your "drug(s) of choice" in order of preference: \_\_\_\_\_

---

**FAMILY BACKGROUND:**

By whom were you brought up:

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> Mother & Father | <input type="checkbox"/> Stepmother & Father | <input type="checkbox"/> Orphanage |
| <input type="checkbox"/> Mother          | <input type="checkbox"/> Stepfather & Mother | <input type="checkbox"/> Relative  |
| <input type="checkbox"/> Father          | <input type="checkbox"/> Foster Parents      | <input type="checkbox"/> Other     |

Which of the following best describe the relationship you have with your family ( check as many as apply):

- |                                       |                                    |   |
|---------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Warm         | <input type="checkbox"/> Angry     | <input type="checkbox"/> Frequent Arguments |
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Resentful | <input type="checkbox"/> Unpredictable      |
| <input type="checkbox"/> Cold         | <input type="checkbox"/> Stable    | <input type="checkbox"/> Chaotic            |

Did you ever have to live away from your family: \_\_\_ Yes \_\_\_ No If yes, please explain:

---

What was/is your mother's occupation:

---

Level of education: \_\_\_\_\_

How close would you say you are/were to your mother:

- Close       Not too close       Frequently at odds       Not Applicable

Alcohol/Drug Usage:  None  Mild  Moderate  Severe

Please Explain: \_\_\_\_\_

---

What was/is your father's occupation:

---

Level of education: \_\_\_\_\_

How close would you say you are/were to your father:

- Close       Not too close       Frequently at odds       Not Applicable

Alcohol/Drug Usage:  None  Mild  Moderate  Severe

Please Explain: \_\_\_\_\_

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Have you ever been the victim of any form of abuse? ( ) Yes ( ) No If yes, please explain.

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Describe your Adulthood experience:

Happy                       Sad                       Normal                       Abnormal

Please explain: \_\_\_\_\_

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Is there any additional information you believe it would be important the HPAP know:  Yes  
 No

If yes, please explain: \_\_\_\_\_

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