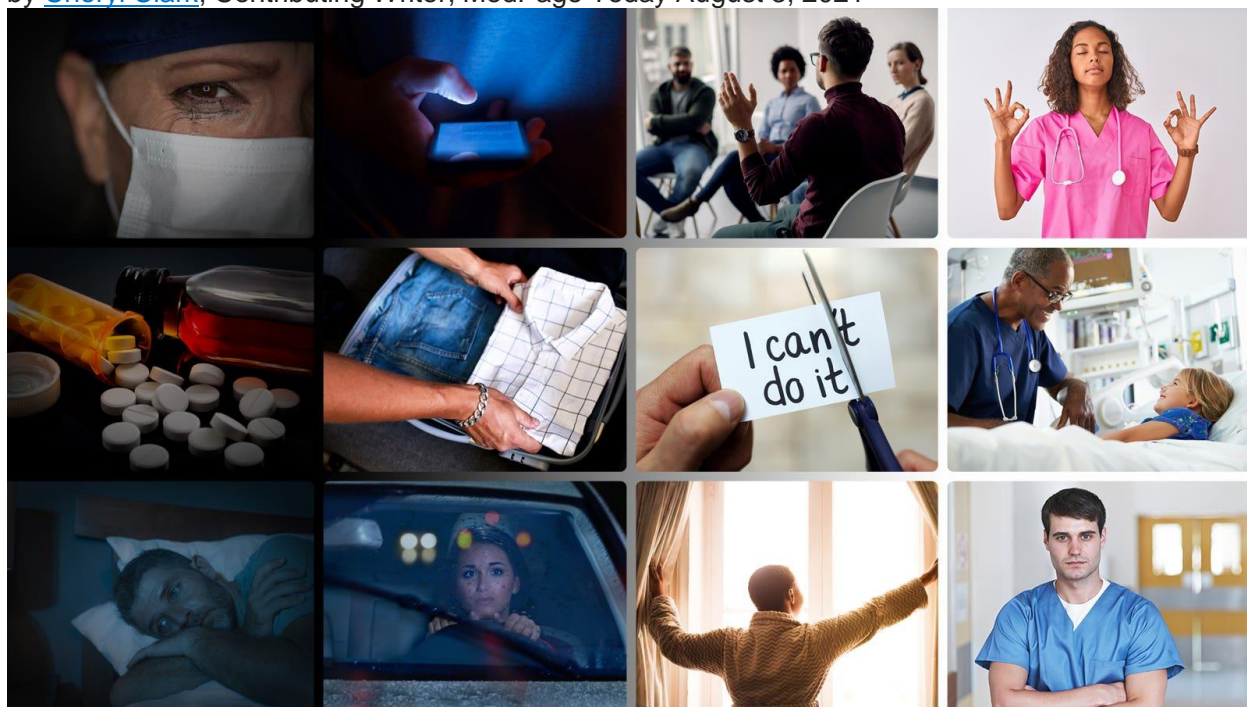


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Nurse Rehabilitation Programs: Why Is Enrollment So Low?

— Some big states' annual new enrollment in confidential rehab dips to single digits

by [Cheryl Clark](#), Contributing Writer, MedPage Today August 3, 2021



This story is part of a MedPage Today series on alternative-to-discipline nurse rehabilitation programs.

A 3-month investigation by *MedPage Today* has revealed that enrollment among alternative-to-discipline (ATD) rehabilitation programs for nurses -- believed to be the best option to help them overcome substance use disorder without discipline -- is "tragically small," in the words of one nursing expert.

Thus, many nurses who could benefit don't get the care they need earlier, before their addictions have disrupted their lives and careers.

With the current prevalence of substance use disorder conservatively estimated at 1% to 3% of the nation's 4.2 million nurse licensees, the path to sobriety can be a complicated, difficult, and shamefully public one if caught.

But a concept that emerged in the 1970s and now adopted by all but a handful of state nurse licensing agencies is the ATD program, in which nurses can escape harm to their reputation and public disciplinary action in exchange for their participation in a state-authorized protocol that can include workplace monitoring.

Research has shown that when these alternatives are offered and the nurse stays sober with successful completion, her earlier problems can disappear, with no public marks on her record.

The programs are designed to view the nurse's issue as a disease, not a crime or a character flaw, particularly since nurses with vulnerabilities are exposed in the workplace to temptation, perhaps more than for workers not in healthcare. After all, that opportunity "comes with the territory, and it's almost always an environmental or occupational risk," said Marvin Seppala, MD, an addiction specialist who himself battled a drug and alcohol problem while in high school. Seppala is now chief medical officer of the Hazelden Betty Ford Foundation, which operates recovery programs in eight states, including several focused on nurses.

Stephen Strobbe, PhD, RN, clinical professor at the University of Michigan School of Nursing, was lead author of a widely endorsed 2017 [position statement](#) from the Emergency Nurses Association as well as the International Nurses Society on Addictions that advocates for the ATD option for nurses. These programs are effective in helping nurses overcome substance use disorder and return to valued careers in the healthcare workforce, and should be considered "the standard for recovery," the statement said.

Run properly, they "provide a path that saves nurses' careers, promote long-term recovery, and are an attractive option for nurses with alcohol and other drug problems," said Robert DuPont, MD, author of numerous papers on the benefits of such programs for health professionals and the first director of the National Institute on Drug Abuse.

"The public and the nursing profession are well served by maximizing this as the go-to choice," said DuPont.

Single-Digit Enrollment

The *MedPage Today* investigation found that among the states with the largest numbers of nurses -- representing 66% of the nation's licensees -- annual enrollment is astonishingly low, sometimes in the single digits or in the teens.

ALTERNATIVE TO-DISCIPLINE PROGRAM FOR NURSES: NEW ENROLLMENT

STATE	LICENSEES	2020	2019	2018	2017	2016
CALIFORNIA	457,604	112	115	109	159	
TEXAS	359,636	26	99	107	147	136
FLORIDA	333,951	196	212	213	255	308
PENNSYLVANIA	232,300	103	146	162	225	180
OHIO	230,608	16	11	11	10	8
ILLINOIS	212,299	9	25	33	4	
MICHIGAN	189,241	159	168	184	191	184
NORTH CAROLINA	147,292	36	44	55	48	53
NEW JERSEY	134,819	468	524	556	539	575
MINNESOTA	118,394	117	112	113	120	
VIRGINIA	111,224		82	91	103	106
TENNESSEE	109,267	68		61		
ALABAMA	91,272			66	69	71
COLORADO	82,391	131	116	107	100	
	TOTAL 2,810,579					

NOTES

The number of actively practicing nurses could be lower than the number of active licenses by up to 20%.

The number of licensees (except for Michigan) were taken from the National Council of State Boards of Nursing website July 28.

Michigan does not participate in the NCSBN and provided its own licensee data.

Texas 2020 data is first quarter only.

Florida and Colorado numbers include disciplinary and non-disciplinary enrollees.

New Jersey reported all participants each year, potentially duplicating any nurse enrolled for multiple years.

Tennessee new enrollment available only for 2020 and 2018.

Alabama data after 2018 have not been approved by the board.

Some states reported data by fiscal year and some by calendar year.

Even in states that conflated their ATD enrollment with those who were ordered by the board as part of a disciplinary process to enroll in a peer support program, numbers fell far short of 1% of that state's licensees.

"Regardless of the denominators, we're still seeing what would cause concern in terms of relatively low levels of enrollment and engagement in any of these programs," said Strobbe.

Examples of low participation rates in some of the biggest states that offer ATD programs include:

- **Ohio**, which has some 230,608 active nurse licenses, reported that its Alternative Program for Chemical Dependency enrolled between eight and 16 new enrollees each year from 2016 to 2020, according to its compliance manager, attorney Lisa Ferguson-Ramos, RN, JD.
- **Illinois**, with 212,000 active nurse licenses, administrator of the Recovering Professionals Program Kimyada Wellington reported only 87 new enrollees in the Recovering Professionals Program during fiscal years 2017 through 2021, with just four new enrollees in 2017 and nine in 2020 alone.
- **California**, which has by far the largest number of nurses in the nation with some 457,604 licensees, reported 159, 109, 115, and 112 new enrollees, respectively, from fiscal years 2017 to 2020 in its Board of Registered Nursing Intervention Program, operated by a subcontractor Maximus.
- **Texas**, with the third highest numbers of nurses in the country at 359,636, reported a somewhat higher number of nurses annually enrolled in its Texas Peer Assistance Program for Nurses: 136, 147, 107, and 99 from fiscal years 2016 to 2019.
- **Virginia**, which has 111,224 licensed nurses, has enrolled 82 to 106 nurses into its Health Practitioner Monitoring Program in fiscal years 2016 to 2019.
- **Tennessee**, with 109,267 licensed nurses, reported 61 and 68 new enrollees in fiscal years 2018 and 2020.

Enrollment was far lower than 1% even when taking into consideration that not all of a state's licensed nurses are working. (Extrapolating data from states that collect employment status on re-licensure applications, an estimated 20% of nurse licensees have retired or are taking extended time out but paid their dues to keep their licenses active.)

Data on annual new ATD enrollment was difficult to obtain from many states, and officials from most states declined to discuss their programs in detail.

After weeks of emails and calls, an official for one state, Massachusetts, said that any response would have to come through a formal public records request, which was not fulfilled by publication time.

Some states with seemingly larger annual new enrollment numbers clarified, after follow-up e-mails, that their data conflated nurses in the ATD program with those who were ordered as part of a disciplinary process. Some states also counted the same nurse multiple times in a multi-year treatment program, which could lead one to believe the number of individuals enrolled was many times as large as it actually was.

Why So Low?

When *MedPage Today* followed up to ask states why their ATD enrollment was so low, most did not respond.

Researchers who have studied addiction treatment programs for nurses did weigh in. In general, their reasons spanned the gamut.

Seppala, a psychiatrist with decades of experience treating addiction, said co-workers and employers, such as hospitals, just aren't looking very hard to find nurses who would benefit.

"Most healthcare organizations have little in place to prevent medication diversion or to identify substance use disorders of staff members," he said. "Among doctors and nurses there can also be an undiscussed silence about substance misuse even to the point of 'protecting' those who may have a problem, rather than pursuing the help they need. Addiction is a stigmatized, confounding illness as well and people don't feel comfortable getting involved."

All experts interviewed acknowledged that eliminating stigma attached to a nurse who self-reports or is caught with a substance use disorder is not easy, even if more attention were spent on educating professionals about underlying medical causes.

Financial resources are also at play. Unlike physicians with addiction who are more likely to have the means to enroll in such programs, nurses are paid far less. If their state or employer requires that they stop working during treatment, they may lose any health coverage as well. A few states subsidize some monitoring costs with license fees, but the nurse must come up with the lion's share.

"It's the cost," said Nancy Brent, RN, JD, a Wilmette-based attorney who represents nurses who get in trouble with their employers or the Illinois nurse

licensing agency. "Can they take a family medical leave with paid-time off? All of this is at the nurse's expense."

In California, healthcare organizations must report to the licensing agency any disciplinary action taken against physicians for a period longer than 14 days, the so-called "[805](#)" section of the California Business and Professions code. But nurses are not covered under that statute. Robert Fellmeth, an attorney and founder of the Center for Public Interest Law, said the California Nurses Association has fought patient advocates' attempts to change this practice.

Absent that requirement, an organization can suspend or terminate a nurse quietly, without the messy process of filing an official complaint. Thus, some nurses with substance use issues don't come to a licensing agency's attention, at least until the problem has grown much more severe. They just move on to another healthcare setting.

Ohio's Enrollment Challenges

In Ohio, program compliance manager Ferguson-Ramos acknowledged low ATD enrollment and the difficulty in getting nurses to enroll. "We find that when offered the Alternative Program, frequently licensees respond that they do not believe they have an addiction, and they say they do not need monitoring and assistance." Others agree to sign up, but then fail to complete the application, she said.

Additionally, large employers like health systems utilize their internal employee assistance programs in lieu of regulatory board programs. "Despite the mandatory reporting [statute](#), nurses with substance use disorders are not reported to the Board if they are able to take administrative leave and successfully complete treatment, without government involvement," she said.

Two years ago, the board succeeded in getting a rule change that expanded eligibility from those with "chemical dependency" to "substance use disorder," anticipating some nurses would enter the program "earlier in their disease process, and participation would increase." It also changed rules to allow nurses prescribed Suboxone to participate, because previously they were ineligible.

Ferguson-Ramos noted that Ohio's numbers may not be comparable to other states' because in Ohio, the program is only open to nurses with no prior discipline, requires temporary license suspension, and is unavailable to new applicants.

Other Reasons: Poor Messaging, Punitive Approaches

Seppala put some of the blame on the educational system, which he said fails to educate students about their future risks of addiction in the workplace, an emphasis that could help them better recognize their vulnerability.

"They budget on average 8 hours in medical school, and mostly that's about liver pathology from alcoholic liver disease, nothing about addiction itself. And in nursing school, it's even worse. So, we've got a healthcare workforce that doesn't even understand addiction in the first place. Culturally, we don't understand it. And yet we expect people to do something about it and identify it in their peers and among themselves. It's just not going to happen."

Strobbe pointed out a failure in messaging, a lack of positive stories about nurses who recovered from a substance use disorder. An estimated 25 to 40 million individuals in the U.S. are in remission or recovery, he said. "Success rates of treatment for healthcare providers -- nurses and physicians -- are absolutely the highest. ... The roadmaps are there."

He added, "In some states, there's a mandatory punitive approach, meaning that nurse may never work again. As a result, people are reluctant to self-report, or share concerns or suspicions about a peer or colleague if they believe it might lead to loss of employment, professional license, and healthcare benefits."

"It's only under circumstances in which a nurse is actively retained and her healthcare benefits not stripped away that increase the likelihood she will participate in what is often a rigorous and expensive pursuit to establish and maintain adherence," said Strobbe.

Some officials and addiction researchers said in background conversations that they saw reluctance to enroll nurses in their sanctioned ATD programs, or discuss their programs with *MedPage Today*, because of a "low tolerance" political climate in their states, such as California, especially in the last decade as opioid prescriptions and deaths climbed and healthcare worker [drug diversion](#) cases -- some of which jeopardized [patient safety](#) -- were increasingly [publicized](#).

Because California provided notably low enrollment data considering its size, the state Board of Registered Nursing's executive officer, Loretta Melby, RN, was asked for an interview. She declined and prohibited a reporter from speaking with the director of its treatment contractor, Maximus.

In response to why California enrollment was so low, agency spokesperson Michelle Cave replied that nurses must volunteer for the program, agree to undergo medical and/or psychiatric evaluations, and cannot have been

previously disciplined by the board for a substance abuse or mental illness issue. The nurse also may not have been previously terminated from an intervention program because of non-compliance.

"The issues that affect a person's choice to seek assistance in their recovery from substance abuse or mental illness vary and are complicated," Cave wrote.

Creative Ways to Divert

Keith Berge, MD, a retired anesthesiologist at the Mayo Clinic, chaired its Drug Diversion Prevention Committee during a time when the clinic grappled with a flurry of drug diversion cases, most of them among nurses, and was forced to design elaborate safeguards to monitor for patient protection.

"It seems clear that many nurses who should be engaged with their state program are falling through the cracks," he said.

Berge, who also was a consultant with the Veteran's Administration system's drug diversion prevention program, suggested the low numbers of enrollees in ATD programs could be blamed on the "inability of treatment providers to compel reporting" that a nurse had enrolled in a treatment program.

He strongly advocates that boards of nursing require they be informed when a nurse who diverts drugs from the workplace is enrolled, citing a highly publicized case 10 years ago in which a nurse anesthetist with a fentanyl addiction repeatedly cycled through an alternative treatment program, returning to work only to get repeatedly caught without the board knowing about it.

Berge recalled a variety of surprisingly creative schemes in which addicted health professionals diverted drugs from the workplace.

Yes, some nurses may consider ATD rules for participation too strict and perhaps abusive, taking over a nurse's life for months to years and restricting her ability to work, he said, but the mission of these programs "is to protect the public from potentially impaired caregivers, and not to satisfy those caregivers' desires."

Solutions from Alabama

One state whose officials wanted to tout their program's outreach was Alabama, which has 91,272 licensed nurses and a bigger challenge relative to opioid addiction, with the [highest opioid prescribing rate](#) in the nation in 2018, acknowledged state Board of Nursing spokesman Honor Ingels.

In a [paper](#) he co-authored in the *Journal of Nursing Regulation* last October, Ingels noted that 8,000 Alabama nurses currently working -- that's 6% to 8% -- "may have a substance-related impairment." To recruit more nurses into its program, the board modified entry criteria and expanded an aggressive public outreach campaign to educate families and the public about various diversion schemes.

Before that paper's publication, Alabama's Voluntary Disciplinary Alternative Program (VDAP) annually enrolled between 57 and 72 nurses from fiscal years 2013 to 2018, said Abby Migliore, the nursing board's administrative director for discipline/compliance monitoring.

Subsequently, VDAP reported that enrollment increased 65% to 130% annually and peer reports went up by more than 110%. Migliore was not able to release enrollment numbers for 2019 or 2020.

Best Practice?

If there is one consistency throughout the national landscape of ATD programs, it's that no two are alike, giving rise to the expression many interviewed for this story repeated: You've seen one ATD program, you've seen *one* ATD program.

In a [paper](#) in the *Journal of Nursing Regulation* last year, the National Council of State Boards of Nursing's associate director of regulation Kathleen Russell, RN, JD, noted "wide variation" and "lack of consistency and uniformity."

Some of that variation was extensive, including their contract length (6 months to more than 5 years), whether the state shares any costs, whether they allow mood-altering medications, frequency of toxicology testing and check-ins, whether the nurse is required to attend group meetings, and whether the nurse must have a sponsor (50% don't require it). There's wide variation in the definition of relapse, with seven distinct definitions, and non-compliance, and in how the program responds and in the extent of workplace restrictions.

"Each state has kind of developed its own program, usually out of necessity and often because they had enough nurses with an SUD [substance use disorder] that they just had to do something," said Seppala. "And they don't necessarily seek any kind of standard. ... Some of the older programs are just doing the same things they've done for a long period of time and no one has looked at the apparent best practice."

Strobbe, who is also a co-founder and clinical director of the University of Michigan's Addiction Treatment Services, which includes a special program for health professionals, said enrollment in ATD programs is "tragically small."

"Addiction inherently strives to remain hidden, covert, secretive, and out of view," Strobbe said. It's correctly viewed as a disease, he emphasized, "and when we treat it ostensibly as a criminal offense instead of an illness, little wonder we continue to stumble in the dark."

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