

Components of Nurse Substance Use Disorder Monitoring Programs

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Introduction: Nurses with substance use disorder (SUD) present challenges to the nursing profession and patients. With increased recognition of SUD as a disease, alternative-to-discipline (ATD) programs have emerged as a more contemporary, nondisciplinary approach to managing SUD in health professionals and have been implemented by many state boards of nursing (BONs). **Aim:** The aim of this analysis was to explore the components and requirements of state nurse monitoring programs to determine the similarities and differences across programs. **Methods:** A document analysis was performed on U.S. monitoring program materials in August 2017. Participation was requested from all U.S. BONs with ATD programs, and 27 programs (69%) provided materials. **Results:** Twenty-one program components and requirements emerged from the review. Many program components and requirements were found in at least 50% of the program documents, including (a) an alcohol/drug abstinence requirement (85%), (b) use of mood-altering medications for psychiatric/medical conditions while participating in a program (70%), (c) use of Alcoholics Anonymous/Narcotic Anonymous/12-Step program as an acceptable group meeting (62%), and (d) restricted hours and shifts (59%). **Conclusions:** Wide variation exists in the components of nurse SUD monitoring programs. There is a lack of consistency and uniformity among nurse monitoring programs, and additional investigation is needed to determine the essential components and requirements that would lead to positive outcomes for nurses with SUD.

Keywords: Alternative-to-discipline programs, monitoring programs, substance use disorder

Nurses with substance use disorder (SUD) pose a unique challenge to the nursing profession. The behavior resulting from this disease has far-reaching and negative effects, not only for the nurses themselves, but also for the patients who depend on the nurse for safe, competent care. Early recognition, reporting, intervention, treatment, and monitoring are fundamental for keeping patients safe from harm and helping nurses recover.

Boards of nursing (BONs) have traditionally used disciplinary methods to address SUD among nurses reported to them. This process often involves an investigation and a board decision as to whether the nurse should be removed from practice. If the nurse's license is disciplined (which could include suspension, removing the nurse from practice, or probation), that action is recorded permanently in the state nursing board database and with the National Practitioner Data Bank.

With increased recognition of SUD as a disease, a more contemporary, nondisciplinary approach to addressing SUD in nurses has been implemented by many BONs. This method, known as an alternative or nondisciplinary program, is a confidential program that requires ongoing monitoring of the nurse. Alternative-to-discipline (ATD) programs can be administered by the BON or contracted to an outside program. These programs are separate and distinct from treatment programs, but they often require the nurse

to complete treatment. Once the nurse has completed treatment, a thorough assessment that includes a statement about the nurse's safety to practice is completed. If the assessment recommends return to work, then a monitoring plan and a return-to-work plan are developed. Returning to work also provides a method for payment for treatment and monitoring.

Because disciplinary monitoring programs and ATD programs both monitor the nurse, for the remainder of the article, they will be referred to collectively as "monitoring programs."

Background

Substance Use Disorder Definition

Most ATD programs use the definition of SUD from the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5), which defines it as a "cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (American Psychiatric Association, 2013, p. 483). The DSM-5 also delineates the severity of the SUD as mild, moderate, or severe.

Relevant Literature

The study closest to our analysis of nurse monitoring program components is that of DuPont et al. (2009), who studied physi-

cian health programs (PHPs) that detect, intervene, refer to treatment, and continuously monitor recovering physicians with SUD. However, PHPs do not provide addiction treatment but serve as long-term case managers and monitors for participants (DuPont et al., 2009).

DuPont et al. (2009) surveyed 39 medical directors of PHP programs and found that PHPs are fundamentally uniform in their goal of early detection of SUD, assessment and evaluation of cases, referral to abstinence-based treatment, long-term monitoring, and reporting to credentialing agencies. All programs had written agreements with their state licensing boards, and 59% had independent legal authority based on state laws. Costs associated with treatment and drug testing were paid for by physicians. Program contracts are typically for 5 years and detail the care, support, and monitoring activities with which the physician must comply. Failure to comply results in further evaluation and/or treatment, reporting to the state licensing board, or more serious consequences as determined by the board.

PHPs require complete abstinence from alcohol and nonprescribed medications. Throughout the PHP program, physicians are drug tested on random weekdays. According to DuPont et al. (2009), in the first year, participants are typically tested four times per month, whereas in Year 5, frequency of testing decreases to approximately 20 per year. PHPs used urine (95%), hair (50%), and breath (21%) as biomarkers for testing. Other monitoring approaches included appointments with the PHP for ongoing clinical care and evaluation and unannounced visits to worksites.

Required participation in Alcoholics Anonymous (AA), Narcotic Anonymous (NA), and other self-help groups were noted in 95% of programs, and another 70% required worksite monitors. The authors found PHPs to be uniform in their management of relapses based on the severity of the lapse. A Level I relapse consisted of missing therapy sessions, dishonesty, and other behavioral issues. Level II entailed the reuse of substances outside medical practice, and Level III relapse was defined as use of a substance within the context of practice. The consequences for relapse range from increased intensity of monitoring to discontinuation of work to undergo a reevaluation.

In this document analysis, which is Part 1 of a two-part investigation, we explore the components and requirements of state nurse monitoring programs in the United States to determine the similarities and differences across programs. No research has been completed on the effectiveness of the nurse monitoring programs; therefore, there are no data describing the essential program components that would ensure a successful outcome. Identifying the components of a monitoring program is the first step in understanding what program components lead to successful outcomes. In Part 2 of this investigation, Smiley examines the effectiveness of various monitoring program components and requirements (Smiley, 2020).

Methods

Study Design

A document analysis was performed on U.S. nurse monitoring program materials in August 2017. Participation in this review was requested from all U.S. BONs with ATD programs. Of the 39 possible ATD programs, 27 (69%) provided program materials (Alabama, Arizona, California RN, Colorado, District of Columbia, Florida, Idaho, Illinois, Iowa, Maine, Minnesota, Mississippi, Montana, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia RN, and Wisconsin). All programs were de-identified for the program components reporting. Once the BON or contracted program agreed to participate, they were asked to provide the following: (a) program policy and procedures; (b) a blank contract; (c) a blank consent to release information contract (or related form that participants must sign authorizing the release of information to third parties); and (d) a copy of any participant manual/handbook.

The nurse monitoring program materials were reviewed in their entirety and the data were logged into a spreadsheet according to categories and individual components. None of the program materials included information on every single characteristic. Only program components and requirements that were identified in at least 50% of the programs were included in the analysis.

Program Components

The review of nurse monitoring program materials revealed 10 general categories of program components with more than 100 specific subcategories. The general categories included (1) types of programs, (2) entry to program (eligibility and evaluation), (3) program details and definitions, (4) toxicology screening, (5) travel restrictions, (6) monitoring program violations, (7) transitioning to/out of monitoring, (8) restrictions (workplace and self-medication), (9) disciplinary actions on license, and (10) participant termination and completion requirements.

Two types of program components emerged in this review: static and dynamic. Static program components are typically consistent for all participants in a monitoring program. Examples of static components include definitions of noncompliance, relapse, and medication-assisted therapy. Dynamic components are those that may differ among participants and appear to be individualized to the participant on a case-by-case basis. Common dynamic components include required treatment program, length of time in program, type and number of peer support and/or case manager meetings, required therapy, toxicology testing frequency, and workplace restrictions. Regardless of the static or dynamic components, the specifics of each participant's program are detailed in the participant's contract. Contracts reviewed for this analysis often identified the static components and had blank spaces to individualize the dynamic requirements.

TABLE 1

21 Program Components and Requirements Included in Analysis of Nurse Monitoring Program Materials

- Intake evaluation
- Responsibility for payment of program fees and toxicology testing costs
- Minimum monitoring contract length
- Abstinence from drugs/alcohol requirement
- Use of mood-altering medications for psychiatric/medical conditions while in a program
- Medication-assisted treatment
- Toxicology test check-in frequency
- Toxicology test frequency
- Approval of group meetings
- Type of group meetings
- Frequency of group meeting attendance
- Frequency of reports of group meetings
- Sponsor requirement
- Self-report frequency
- Workplace restrictions
- Regular work performance evaluator
- Frequency of reports from evaluator
- Relapse definition
- Relapse response
- Monitoring program noncompliance definition
- Program response to program noncompliance

TABLE 2

Minimum Monitoring Contract Length as Outlined in Nurse Monitoring Program Materials ($N = 27$)^a

Minimum Contract Length	<i>n</i>
6 mo	3
1 y	2
2 y	3
3 y	7
4 y	1
≥ 5 y	4

^a Some program materials did not include this information and are thus omitted from this table.

Results

Demographics

Monitoring programs are either operated by the BON or contracted to an outside entity. Of the 27 programs that participated in this review, 14 were overseen by the BON and 13 were contracted to an outside body. The geographic distribution was wide and representative with nine programs in the West, six in the Midwest, seven in the South, and five in the East.

Analysis of Program Components and Requirements

The 10 general categories found in the review of program materials were narrowed to five general categories for this analysis, as there were not sufficient data available for all 10 categories. Only those categories in which at least 50% of the programs provided data are included. The five general categories included entry to program, program details and definitions, toxicology testing, restrictions (practice and self-medication), and violations were found in the review. Within these categories, 21 program components and requirements were included in the analysis (Table 1).

Intake Evaluation

An intake evaluation is a series of clinical assessments completed by an approved clinical assessor, also known as an evaluator, who has been provided with all necessary collateral information. The clinical assessor must be an appropriately licensed practitioner authorized by his or her scope of practice. The intake evaluation also includes a psychiatric history and can include a specific battery of tests, neuropsychological tests, and a mental status examination (National Council of State Boards of Nursing [NCSBN], 2011).

All sets of program materials mention intake evaluations. Most programs ($n = 15$) use an outside evaluator. Others ($n = 4$) identify an internal program evaluator or a multidisciplinary team, or they identify an evaluator on a case-by-case basis.

Responsibility for Payment of Program Fees and Toxicology Testing Costs

Almost 70% of program materials indicate the responsibility of cost of toxicology testing and/or fees for the program. Most ($n = 12$) indicate that the participant is responsible for all costs. Four indicate the participant pays only testing fees, and 2 determine responsibility for payment on a case-by-case basis.

Minimum Monitoring Contract Length

Each participant enrolled in the program must sign a contract. The contract delineates the length and other components of the programs. The minimum length of the contract varies from 6 months to more than 5 years, with the most frequent minimum contract length being 3 years ($n = 7$) (Table 2). The program materials that indicate less than 3 years as a minimum also have monitoring contracts that vary in length (i.e., 1 year, 2 years, and greater than 5 years on a case-by-case determination).

Abstinence From Drugs/Alcohol Requirement

Abstinence is defined as no use of drugs and alcohol (NCSBN, 2011). Abstinence as a requirement for the program is mentioned directly in 23 sets of program materials. A few sets of program materials ($n = 4$) do not specifically mention abstinence; however, abstinence is implied in those program materials.

Use of Mood-Altering Medications for Psychiatric/Medical Conditions While in a Program

Eighteen sets of program materials allow the use of mood-altering medication for psychiatric or medical conditions while participating in a monitoring program. Documents from one program indicate that some medications require consultation with an addictionologist before approval to use the medication is granted. One other set of program materials indicates the participant cannot work while using mood-altering medications.

Medication-Assisted Therapy

The pharmacological treatment of addiction is often referred to as medication-assisted therapy (MAT). Certain medications are approved by the U.S. Food and Drug Administration for the treatment of alcohol dependence or opioid dependence. These medications are often used during the treatment phase; however, inconsistencies arise when some MAT medications are used when entering the stable recovery phase (NCSBN, 2011).

References to the use of buprenorphine, methadone, naltrexone, or more general MAT were found in several sets of the program materials reviewed. Seven programs include information regarding naltrexone and 10 programs include information regarding buprenorphine (Table 3). The programs vary on whether MAT is allowed if the nurse is practicing and others note specifically which types of medications are allowed. Programs that allow use of any MAT often require specific approval, as well as additional monitoring and other requirements. Two programs require use of naltrexone if the participant is determined to be at high risk for relapse.

Toxicology Test Check-in Frequency

The process of “checking in” can be done via telephone or computer. Checking in also serves as a reminder of the need to remain compliant and abstinent (Intervention Project for Nurses, 2016).

The frequency of check-in for toxicology testing varies among programs, with one third of program materials indicating a daily check-in ($n = 9$), while approximately 20% indicate weekday-only check-in ($n = 6$). Materials for two programs indicate weekday plus Saturday check-ins. Most have some allowance to skip a check-in on a major holiday. One set of program materials specify that if a participant lives more than 25 miles from a collection site, the everyday check-in requirement is adjusted (Table 4).

Toxicology Test Frequency

Several programs ($n = 5$) note a case-by-case determination of the frequency of toxicology testing while others do not indicate the frequency in the program materials. Many programs indicate that the toxicology testing frequency may decrease after the first year depending on program compliance.

TABLE 3

Allowance of Medication-Assisted Therapy (MAT) as Outlined in Nurse Monitoring Program Materials ($N = 27$)^a

MAT Use Rules	<i>n</i>
Use of buprenorphine, methadone, naltrexone, or MAT allowed with additional program requirements	5
General mention allowing use of buprenorphine or methadone with program approval	3
High-risk program participants are required to take naltrexone with additional program requirements	2
Only rare cases will meet program determination for allowing use of methadone, buprenorphine	1
Case-by-case determination for use of naltrexone or disulfiram; will cause a practice limitation	1
No nursing practice allowed if using buprenorphine	1
No nursing practice allowed if using MAT	1

^a Some program materials did not include this information and are thus omitted from this table.

Approval, Type, Frequency, and Reports of Group Meetings

Group meetings are an integral part of monitoring program requirements. Various types of group meetings are used among the programs, including AA, NA, abstinence programs, and other 12-step, self-support, and peer or facilitated nurse support group meetings (NCSBN, 2011).

Group meetings are a component of each monitoring program; however, the approval process for an acceptable group meeting is not often delineated in program materials. Those that do mention the approval process can vary from approval by monitoring program employee ($n = 5$) to a treatment provider ($n = 1$) or to the BON ($n = 1$).

The program materials often indicate that a monitoring program will allow or require attendance at more than one type of group meeting. The most frequently specified type of program is a 12-step program ($n = 17$) such as AA, NA, or abstinence program. An approved peer group program (non-AA or NA) is the second most frequent type of approved program ($n = 10$).

Almost 40% of monitoring programs use a case-by-case determination of frequency of group meetings ($n = 10$). Other sets of program materials ($n = 8$) indicate group meetings are required three times per week but differ in the type of meetings required. Some include AA/NA and peer group, and others indicate all AA/NA-type meetings. Some program materials set group meeting attendance at two meetings per week ($n = 4$) or one meeting per week ($n = 1$).

The frequency of required group meeting reports varies from monthly ($n = 5$), bimonthly ($n = 1$), quarterly ($n = 7$), to a case-by-case determination ($n = 3$).

TABLE 4

Toxicology Check-in and Test Frequency Outlined in Nurse Monitoring Program Materials ($N = 27$)^a

Toxicology Test Guidelines	<i>n</i>
<i>Frequency of Check-in</i>	
Everyday	9
Weekdays	6
Weekdays + Saturdays	2
Every day, unless participant lives > 25 miles from collection site	1
Case by case	5
<i>Minimum Tests per Month</i>	
1	3
2	2
3	1
4	4
^a Some program materials did not include this information and are thus omitted from this table.	

Sponsor Requirement

A sponsor is defined by AA as an individual with alcohol use disorder who has made good progress in the recovery program. Sponsorship is the process of the sponsor “sharing that experience on a continuous, individual basis with another alcoholic who is attempting to attain or maintain sobriety through AA” (AA World Services, Inc., 2019). Sponsorship can be a long-term relationship. The definitions of sponsors vary with other addiction self-help groups. For example, the Addiction and Recovery Information for Individuals, Families and Professionals (2020) defines a sponsor as:

{S}omeone who you would like as a coach to guide you through recovery. They don't necessarily have to be someone who you would like to hang out with as a friend. By choosing a sponsor you're also implicitly saying that you like the form of their recovery and their serenity.

Just over 50% of the program materials ($n = 14$) indicate that a sponsor is required as part of the program. The requirement of a sponsor is made on a case-by-case determination in four programs.

Self-report Frequency

Self-reports are required by many monitoring programs. The self-report form is specific to the monitoring program and generally includes questions about current employment, number of self-help and support group meetings, any recent medical interventions, current stressors, and current support environment.

Self-reports are required in varying frequency in the program materials. Some program materials note weekly, monthly,

bimonthly, or quarterly reports, and some indicate case-by-case determination. Monthly is the most common self-report frequency ($n = 9$).

Workplace Restrictions

When a nurse returns to work during the monitoring program, various practice restrictions are part of the return-to-work agreement. Ninety-three percent of program materials require several workplace restrictions for a program participant. The most common workplace restrictions noted by almost 50% of programs included: (a) prohibition from working at a staffing or registry agency ($n = 14$), (b) prohibition from working in a home or community-based setting ($n = 14$), (c) floating away from regular unit ($n = 13$), (d) limiting work hours/days/shifts ($n = 16$), and (e) limiting access to controlled substances ($n = 16$).

Other less common workplace restrictions included in 10% to 20% of program materials were prohibitions on travel nursing, self-employment, multiple employers, hospice, private duty, and work in emergency departments, intensive care units, operating rooms, recovery rooms, or delivery rooms. Four monitoring programs approve the work setting prior to the nurse returning to work. Twenty percent of program materials indicate the workplace restrictions are determined on a case-by-case basis ($n = 6$). Often, program materials mentioned that workplace restrictions may change either after 1 year of successful completion of a program or on a case-by-case basis.

Regular Work Performance Evaluator and Report Frequency

A work performance report is completed by the work evaluator as designated in the return-to-work agreement. This report often includes information about the position, shift, unit, hours, attendance, punctuality, appearance, decision-making skills, performance, behavior with peers and patients, and any workplace toxicology screen completed.

Twelve programs (45%) require work performance evaluations. The individual who performs the evaluation is typically a workplace supervisor ($n = 5$) or worksite monitor ($n = 5$), but others use the case manager or employer to perform the workplace evaluation. Work performance evaluation reports vary from quarterly ($n = 7$) to monthly report ($n = 2$), bimonthly report ($n = 1$), or on a case-by-case determination ($n = 3$).

Relapse Definition and Response

The majority of programs define relapse in their materials ($n = 17$). At least seven relapse definitions are indicated across the programs and range from “determined by evaluation” to “positive screen for any unauthorized use” (Table 5).

Programs' responses to a relapse varies widely, with many programs having more than one response. In response to a relapse, most monitoring programs require an evaluation or request that the individual cease practice. Other responses include reporting the participant to the BON ($n = 6$), increasing toxicology testing fre-

quency ($n = 5$), or increasing contract length ($n = 5$). Less frequent responses were to notify the employer, increase support group meetings, impose access restrictions, establish a recovery plan and enter treatment. Just over 40% of program materials ($n = 12$) indicate a case-by-case determination of the response to relapse.

Monitoring Program Noncompliance Definition

Noncompliance with a monitoring program is defined by various violations of the program contract or policies. Almost 40% of program materials indicate that a toxicology test violation is evidence of program noncompliance ($n = 10$). This type of violation can be further defined in program materials as a failure to submit/missed test ($n = 10$), positive test ($n = 7$), or substituted/dilute/alterd test ($n = 7$).

Other drug violations may be considered as noncompliance, but these are only noted in a few sets of program materials ($n < 5$). These drug violations may include ingestion/failed abstinence, diversion, possession, failure to obey access restrictions, prescription forgery, drug/alcohol arrest, or failure to take prescribed medications.

Certain participant conduct is also defined as noncompliance ($n = 9$). This conduct can include refusal or failure to respond, a pattern of behavior, unable to practice safely, accepting a position without approval, late/missing/poor reporting, failure to pay fees, lapse of license, and failure to notify. No consistency is revealed across program materials related to the participant conduct as evidence of noncompliance.

Violations of attendance ($n = 5$) or violations of law or contract ($n = 8$) were also mentioned as evidence of noncompliance, but there is broad interpretation among programs with no commonalities across programs; therefore, comparison is difficult. Noncompliance can also be implied by program materials when there are references to the consequences a participant may face for noncompliance, yet no definition of noncompliance is noted.

Program Response to Program Noncompliance

The monitoring programs respond in different ways to program noncompliance. There are at least 16 different types of responses indicated in the program materials, and individual programs may use multiple types of responses for an instance of noncompliance. At least 40% of program materials indicate the response to noncompliance is for the participant to cease practice ($n = 12$), be discharged or terminated from the program ($n = 12$), or be reported to the BON ($n = 14$).

Less than 20% of program materials indicate a response to noncompliance to include message/written notice of noncompliance ($n = 6$), revision/increase length of contract ($n = 5$), return to treatment ($n = 4$), review by medical director ($n = 4$), or review for termination of contract ($n = 4$). Even more infrequent responses to noncompliance are a report to worksite monitor, imposition/change in access restrictions, increase in frequency of meetings, education program, or establishment of a recovery plan ($n < 4$ for each).

TABLE 5

Relapse Definitions as Provided in Nurse Monitoring Program Materials ($N = 27$)^a

Relapse Definition	<i>n</i>
Positive screen for any unauthorized substance	5
Use of unauthorized substance	6
Return to drug/alcohol use after abstinence	3
Admitted use after abstinence	1
Return to use of substances that impede safe practice	1
Return of signs and symptoms after apparent recovery	6
Failure to submit fluid under suspicion	1
Relapse determined by evaluation	2
Relapse mentioned but not specifically defined in program materials	10

^a Seventeen programs defined relapse in their program materials, and several programs had multiple definitions. Ten programs did not include this information and are thus omitted from this table.

Program Information Included in Program Materials

Nurse monitoring program materials vary widely with respect to the type of program information included in the materials (Table 6). The most consistently included information are response to program noncompliance ($n = 25$), workplace restrictions ($n = 23$), and requirement of abstinence ($n = 23$). A majority of program materials included (a) a definition of relapse ($n = 16$), (b) a definition of program noncompliance ($n = 15$), (c) whether use of mood-altering medications for psychiatric/medical conditions while participating in a program is allowed ($n=20$), (d) responsibility for cost ($n = 18$), and (e) a requirement of a sponsor ($n = 18$). These components are static and vital for the participant to understand.

The type of intake evaluator or individual responsible for approval of group meetings are also static components that could easily be included in program materials but are only included 70% ($n = 19$) and 33% ($n = 9$) of the time, respectively.

Other important program components such as toxicology testing check-in ($n = 18$) and toxicology testing frequency ($n = 15$) are also included in program materials. Perhaps the reason some programs omit the frequency of toxicology testing check-in and toxicology testing in the materials is because these are dynamic components often individualized to the participant and the participant's level of SUD. The participant contracts often included fill-in-the-blank portions for toxicology testing check-in and toxicology testing frequency.

The response to a relapse is included in 70% ($n = 19$) of program materials, which again is a dynamic characteristic that depends on the circumstances of the relapse.

TABLE 6

Inclusion of Components in Nurse Monitoring Program Materials (N = 27)

Characteristic	n (%)
Intake evaluators identified	19 (70)
Responsibility for payment	18 (67)
Minimum contract length	20 (74)
Requirement of abstinence	23 (85)
Use of mood-altering medications for psychiatric/medical conditions while participating in a program	20 (74)
Medication-assisted therapy	14 (52)
Responsibility for approval of group meetings	9 (33)
Frequency of check-in for toxicology testing	18 (67)
Toxicology testing frequency	15 (56)
Types of acceptable peer groups	21 (77)
Frequency of group attendance	20 (74)
Frequency of reports of group attendance	16 (59)
Sponsor as a requirement	18 (66)
Self-report frequency	18 (66)
Workplace restrictions	23 (85)
Regular work performance evaluator	13 (48)
Frequency of reports from evaluator	13 (48)
Relapse definition	16 (59)
Response to relapse	19 (70)
Program noncompliance	15 (56)
Response to program noncompliance	25 (92)

Discussion

SUD encompasses a pattern of behavior ranging from misuse to dependency or addiction, whether it is alcohol, legal drugs, or illegal drugs. Nurses who have a SUD create a safety issue for their patients. A nurse's ability to continue to practice depends on whether the nurse can function safely and effectively.

Only four program components/requirements were found in at least 75% of the program documents:

- Requirement of abstinence from drugs/alcohol ($n=23$)
- Types of acceptable peer groups ($n=21$)
- Workplace restrictions ($n=23$)
- Response to program noncompliance ($n=25$).

All other program components show less than 75% consistency among the program documents.

Some of the program documents revealed that many of the components across monitoring programs are individualized to the participant on a case-by-case basis according to the severity of diagnosed SUD. The variability of program components may depend on the levels of mild, moderate, or severe SUD as designated by the DSM-5.

This review revealed that 16 components (intake evaluators, responsibility for payment, use of mood-altering medications, MAT, approval of group meetings, sponsor as a requirement, work performance evaluator, relapse definition, response to relapse, program noncompliance, frequency of check-in for toxicology testing, toxicology testing, group attendance, group attendance report, self-reports, work performance reports) are not included in the program materials on a routine basis. Omitting information about monitoring program components, definitions, and processes may inhibit the participant's understanding of the clear course of action for the participant. Additionally, clearly written definitions, processes, and guidelines are important for monitoring program staff.

This review found three monitoring programs demonstrated an exceptional ability to include and define program components and requirements in the program documents (mean = 88%). It also found that four monitoring programs included less than 50% of the program components and requirements in the program materials. The remaining programs varied regarding the number of program components and requirements included in the materials (mean = 63%).

Limitations

The major limitations of this analysis are that not all jurisdictions agreed to participate and not all jurisdictions that participated provided all the requested materials. Specific types of monitoring program materials were requested of each program; however, varying types of materials were submitted by the programs. Additionally, the submitted monitoring program materials may be outdated and/or may not mirror actual practice at the program. Furthermore, content only published online may be more comprehensive but was outside the scope of the current analysis. Nonetheless, the diversity of the monitoring program types that participated and the volume of shared materials lend important, albeit preliminary, insight into this important topic.

Conclusion

This analysis revealed wide variation in the components of nurse SUD monitoring programs. Overall, there is a lack of consistency and uniformity among nurse monitoring programs as noted in their program materials. More investigation is needed to determine the essential components and the combination of components and requirements that would lead to the most favorable outcomes for nurses with SUD.

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