

**THE EXPERIENCE OF NURSE FACILITATORS OF SUPPORT GROUPS
FOR NURSES WITH CHEMICAL DEPENDENCY IN CALIFORNIA, USA**

by

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This thesis is dedicated to my son

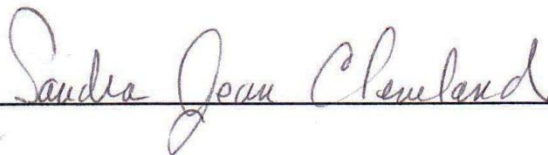
Bart Aspen

with love and gratitude for all his help
and sacrifices that allowed me to have the time to
complete this thesis.

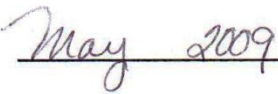
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DECLARATION

I declare that **THE EXPERIENCE OF NURSE FACILITATORS OF SUPPORT GROUPS FOR NURSES WITH CHEMICAL DEPENDENCY IN CALIFORNIA, USA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



Sandra Jean Cleveland



Date

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THE EXPERIENCE OF NURSE FACILITATORS OF SUPPORT GROUPS FOR NURSES WITH CHEMICAL DEPENDENCY IN CALIFORNIA, USA

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ABSTRACT

Chemical dependency in the health profession is a growing concern. With easy access to controlled substances, many nurses divert prescription drugs and even work while under the influence. Nurses who are under the influence and working with patients are an obvious public hazard. Many states in the USA have non-punitive programs to offer recovery to nurses with chemical dependency and return them to work. In California this program is named the Diversion Program. Part of the requirements of successful completion of the Diversion Program is to attend weekly meetings called support groups. These support groups are facilitated by other nurses experienced in the field of chemical dependency. This study explored the experiences of nurse facilitators of support groups for nurses with chemical dependency in the California, USA, Diversion Program. Data were collected through twelve individual interviews selected through purposeful, non-probability convenience sampling. A phenomenological research design was used that was descriptive, explorative, and contextual. The data analysis revealed four major themes: (1) experience of communication within the Diversion Program; (2) experience of the structure of the Diversion Program; (3) experience of their role within the Diversion Program; and (4) experience of facilitation of support groups. The study revealed that even though many of the nurse facilitators' experiences were positive with respect to the support groups they expressed concern about the communication patterns within the Diversion Program. To offer support for the nurse facilitators, guidelines and a conceptual framework were created to enhance their experience and mitigate their feelings of marginalization from the Diversion Program.

KEY CONCEPTS

Nurse facilitators, support groups, chemical dependency, diversion program

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CHAPTER 1

ORIENTATION TO THE RESEARCH PROBLEM

1.1 INTRODUCTION

For millennia, human beings have altered their moods and consciousness by ingesting, inhaling, or injecting psychoactive substances (Naegle & D'Avanzo 2001:2). Once this behaviour exceeds recreational, religious, or cultural use and becomes a dependency it accounts for the disruption of many lives in contemporary society (Naegle & D'Avanzo 2001:5-7). Dependency is defined as the inability to discontinue a compulsive behaviour that is harmful to self and others (Kneisl, Wilson, & Trigoboff 2004:262; Naegle & D'Avanzo 2001: 2; Hawes & Hawes 2001:19; Twerski & Nakken 1997:1-10; Inaba & Cohen 1993:1-2). Chemical dependency is considered to be among the most prevalent of psychiatric disorders in the general United States population, where it is estimated that between 14 to 18 million people are chemically dependent (Hawes & Hawes 2001:xii), with one-in-four deaths being attributed to some form of addiction from a total of 2 million deaths per year in the United States (Hack & Adger 2002 cited in Marcus & Brown 2005:93).

Although chemical dependency is a general public concern, research has shown that nurses have a similar risk factor for becoming chemically dependent (Clark & Farnsworth 2006:223). Registered nurses (RNs) are particularly susceptible to substance abuse problems due to high stress work environments, frustration with lack of support at work and home, extensive work hours with limited staffing, high expectations from self, peers, and public, the opportunity to divert controlled substances at work, and nurses' denial of the dependency (Clark & Farnsworth 2006:223). Without intervention and treatment for nurses with chemical dependency, the safety of those accessing health care is jeopardised. In many states in the USA, help for nurses with chemical dependency is available through specialised programs that offer intervention and the opportunity for recovery. In California, this process is through the California Diversion Program under the auspices of the Board of Registered Nursing (California Board of Registered Nursing 2009a). The Diversion Program was established to help registered nurses over-come chemical dependency and return to

work. One of the requirements of successful completion of the Diversion Program is the attendance at support groups to help in their recovery. These support groups are meetings where the nurses can talk about their issues, and are facilitated by individuals, who are also nurses, to help the flow of communication.

The purpose of this study was to describe and explore the lived experiences of the nurse facilitators of the support groups. Through a pilot study a tentative hypothesis emerged that the facilitators experience many difficulties within the Diversion Program and a need for guidelines for their support was necessary. Therefore, this study sought to formulate guidelines for the support of nurse facilitators of support groups for nurses with chemical dependency in California, USA.

This chapter presents the background of the research inquiry, such as an explanation of the regulatory power of the California Board of Registered Nursing (California Board of Registered Nursing 2009b), as well as a brief description of the California Diversion Program is included. The problem of nurses with chemical dependency is addressed and the significance of the support groups as an important component in their recovery is discussed.

1.2 BACKGROUND

In 1990 the National Center on Addiction and Substance Abuse reported that 4.5 million women in the United States are alcoholics, 3.5 million abuse prescription drugs, and 3.1 million regularly use illicit drugs (Straussner & Attia, 2002:3). Chander and McCaul (2003), and Room (1998; cited in Grupp 2006:5) found that women who abuse substances were at high risk for work-related problems. The American nursing profession, which is predominated by women, is not exempt from the problems of substance abuse and chemical dependency. Dwyer, Holloran, and Walsh (2002:20) report that nurses are equally susceptible to alcoholism as the general public, but are at significantly higher risk for drug addiction. Estimates of rates of chemical dependency among nurses vary among studies, but most of them range between 1 in 7 to as high as 1 in 12 (Clark & Farnsworth 2006: 223; Kinsley 2006:94; Naegle & D'Avanzo 2001:46) These estimates vary because specific information about chemical dependency among nurses is difficult to access due to the sensitive nature of the information (Bugle 1996:41).

Starting in the USA in the 1970s, diversion programs for health professionals were established (Monahan 2003:1880), and in 1982 the American Nurses Association (ANA) recognised addiction as a disease that would result in impaired practice (Heise 2003:118; Mynatt & O'Brien 1993:28). However, it was not until 2001 that the ANA revised its *Code of Ethics with Interpretive Statements* to reflect that all nurses should advocate appropriate assistance for their peers who may be chemically impaired (Fletcher 2004:93).

Trossman (2003:27) has described the image many people in the USA carry in their minds of the nurse as the epitome of perfection dressed in white from the top of her cap to her spotless white shoes, with no significant problems or vices of her own. Many nurses, too, tend to expect nothing less than perfection of themselves. Consequently, Kirkwood (2005:29) has challenged nursing education programs to stop creating "the super nurse syndrome". Kirkwood (2005) argues that when nursing students become RNs they are not being prepared to cope well with making mistakes.

The situations nurses face in their work environment can be challenging. Nurses are expected to provide safe, high quality care to patients whose lives often depend on their skilled assessment and precise split-second decision-making. Reese (2006:5) identifies the difficulties of transitioning from student nurse to RN, as being heavy patient loads, busy shifts, time demands, new people, and new policies. Studies have found these factors, along with easy access to controlled substances, contribute to a high risk for chemical dependency problems in nurses (Kinsley 2006:94; Clark & Farnsworth 2006:223; Mynatt & O'Brien 1993:27).

Chemical dependency in health care is a clear occupational and public hazard (Connecticut Nursing News 2001:21). To protect the public, the California Nursing Practice Act specifies patient safety as the hallmark priority in nursing practice (California Board of Registered Nursing 2009c). Safety is the number one criteria by which the National Council for Licensure Examination-Registered Nurse (NCLEX-RN) tests its prospective licensees as evidenced by the critical thinking ability of the applicant (clinical judgment), i.e., whether the applicant's choice of test answers on the NCLEX-RN indicates that the applicant is safe to practice as an RN (Saxton, Nugent, & Pelikan 2003:2).

Critical thinking as it pertains to patient safety involves the nurse taking charge of issues and situations as they present themselves by being self-directed, self-monitored, self-disciplined, and self-corrective (Paul & Elder 2001:1). Undoubtedly, patient safety will be compromised if the nurse's critical thinking is impaired by the use of chemical substances. Nurses who work in high stress environments with easy accessibility to controlled substances may be tempted to self-medicate to overcome fatigue, stress, depression, and/or anxiety (Kornegay, Bugle, Jackson, & Rives 2004:125). Literature indicates that repeated exposure to a substance or drug increases the chances that a person will use it (Kasl 1992:94). Estimates range from 2% to 18% of American nurses practice nursing while under the influence of chemical substances to the point of endangering their patients. The wide range of these estimates is most likely a reflection of the lengths that nurses go to hide their chemical dependency for fear of loss of employment. To deny that nurses can be affected by chemical dependency is to ignore what is considered to be a major health problem for nurses today (Darbro 2005:169; Naegle & D'Avanzo 2001:45).

Prior to the advent of diversion programs, nurses found to be working under the influence of alcohol or drugs were fired immediately with no recourse for treatment and their licenses were revoked (Kinsley 2006:94; Fletcher 2004:92; Lachman 1986:41). However, offering treatment to nurses affected by chemical dependency should be an important concern for the nursing profession, because it involves medical professionals invested with high quality skills. Furthermore, another incentive for the recovery is to limit the progress of the nursing workforce shortage that poses a serious threat to the delivery of adequate health. It is estimated that by 2020, California will need over 60,000 additional nurses (Coffman, Spetz, Seago, Rosenoff, & O'Neil 2001:1), with an overall total of 800,000 nurses needed in the USA by the same year (Berg 2006:3).

The ubiquitous nursing shortage makes it even more imperative that nurses with chemical dependency be supported in their recovery. A solution for successful rehabilitation and return to work of nurses with chemical dependency in each state in the USA, are quality diversion programs which oversee the recovery process. Currently it is estimated that forty states have some type of program (Clark & Farnsworth 2006:224; Stringer 2005:32-33).

An important component of a diversion program is the use of peer support groups, which have been found to be one of the most effective treatments in the process of recovery

(Wolfert 2004:24). Successful treatment through support groups is largely dependent upon a group leader whose responsibility it is to facilitate a learning environment in a supportive atmosphere (Zabalegui, Sanchez, Sanchez, & Juando 2005:370; Wolfert 2004:21; Rindner 2000:38; Yalom 1995:106; Alley & Foster 1990:1383). Consequently, the researcher wished to explore the experiences of facilitators of support groups for nurses with chemical dependency within the Diversion Program. In line with this background, the next section gives a brief description of the Diversion Program, whereas Chapter 3 includes an in-depth description of the program of the California Board of Registered Nursing.

1.3 BRIEF OVERVIEW OF THE CALIFORNIA DIVERSION PROGRAM

The California Board of Registered Nursing (BRN) is charged with the protection of the safety of the public, as well as overseeing the licensing, regulation, and supervision of registered nurses as defined in the California Nursing Practice Act (California Board of Registered Nursing 2009c). The BRN intercedes and controls all arbitration and outcomes when nurses falter in their professional responsibility in the care of the public, such as instances in which chemical dependency is the issue. In the attempt to curtail the problem of impaired nurses in California, a Diversion Program was established in 1985 as a confidential voluntary rehabilitation program offered as an alternative to an involuntary judicial enforcement program. The goal of the Diversion Program is to protect the public by early detection of RNs who are chemically impaired or have mental illness, as well as to provide supportive supervision throughout the nurses' treatment process (Naegle & D'Avanzo 2001:46).

The Diversion Program (California Board of Registered Nursing 2009a) offers intervention and the opportunity for treatment to nurses with chemical dependency, as well as direction and support during the recovery time period. The program includes confidential consultation, assessment and referral for appropriate detoxification and treatment, development of a rehabilitation plan, monitoring and reassessment of treatment and recovery, random body fluid testing, referral to local nurse support groups, and encouragement and guidance during the lengthy recovery process. Successful completion of the Diversion Program protects the license of the nurse, and allows the nurse to resume unrestricted nursing practice; all records of the original complaint and participation in the Diversion Program are expunged (California Board of Registered Nursing 2009a)..

Once a nurse is accepted into the Diversion Program, his or her nursing license is not suspended but rather the license cannot be used for purposes of employment. Throughout the treatment program the nurse is carefully monitored. Successful completion in the program, results in the return to full nursing practice without prejudice (Naegle & D'Avanzo 2001:47). However, unsuccessful completion may involve BRN referral to the Enforcement Program with the possibility of disciplinary action, or immediate revocation of the nurse's license. Records resulting from participation in the Enforcement Program become permanent public record, with the legal infraction accessible to public inquiry (California Board of Registered Nursing 2009d).

1.4 STATEMENT OF THE PROBLEM

It is estimated that over 10% of the American public will have a problem with alcohol or drugs sometime in their lives. Research has shown that nurses have a similar risk factor for becoming chemically impaired (Clark & Farnsworth 2006:223). Registered nurses are particularly susceptible to substance abuse problems due to the stress of the workplace, frustration with lack of support at work and at home, extensive work hours with limited staffing, high expectations from self, peers, and public, the opportunity to divert controlled substances at work, and the nurse's denial of the dependency (Clark & Farnsworth 2006:223). The wellbeing of the public is jeopardised without intervention and treatment for these nurses. Help is available through the auspices of the California Diversion Program which offers intervention and the opportunity for recovery to nurses who are addicted (California Board of Registered Nursing 2009a).

Nurse facilitators of support groups for nurses with chemical dependency in California, USA, lack supportive guidelines to assist them in the facilitation of their support groups. Facilitators are fundamentally left to their own devices as to the manner in which each group is conducted, with little or no communication or support among themselves, or with the different parts of the Diversion Program.

The researcher became increasingly aware of the need for supportive guidelines for nurse facilitators of support groups after being appointed by the BRN to a Diversion Evaluation Committee (DEC). It became apparent while serving on this committee that monitoring the treatment and recovery of impaired nurses is a complex responsibility for the Diversion

Program manager, the Diversion Evaluation Committees (DEC), the Diversion Program contractor, and the facilitators of nurse support groups because nurses with chemical dependency are an increasing problem within the nursing profession in the USA (Clark & Farnsworth 2006:223; Naegle & D'Avanzo 2001:46). One option for recovery of nurses with chemical dependency is available under the purview of the BRN, wherein it authorises the Diversion Program to administer thirteen Diversion Evaluation Committees located throughout the state of California. However, there appears to be a paucity of communication among the DECs, the nurse support group facilitators, the contractor, and the Diversion Program manager that has resulted in each individual part of the program seemingly operating in near isolation from the other parts, resulting in a lack of cohesiveness within the Diversion Program. The apparent loss of cohesiveness has often resulted in confusion, anger, and despair among the nurses with chemical dependency as expressed in their nurse support groups. Many of the nurse facilitators in the study related that they too felt frustrated and marginalised as to their role in the Diversion Program.

An important component of recovery for nurses with chemical dependency in the Diversion Program is the mandatory attendance at nurse support groups. In a study involving health care professionals it was determined that support and close monitoring in the early stages of recovery were a deterrent to relapse after completion of a recovery program (Domino, Hornbein, Polissar, Renner, Johnson, Alberti, & Hanks 2005:1453-1460). The BRN requires that nurses who are accepted into the Diversion Program are required to attend a nurse support group once each week for all but the last year of their program, when they enter the Transition phase. For one nurse this could amount to attending a nurse support group approximately 144 times for three years if he or she remains in the Diversion Program, and is in the transition phase for the fourth year. This equals approximately 2,304 contact times (face-to-face) that each nurse facilitator has with the nurses in his or her support group. This contact time amounts to a large workload for one person: for each week, to meet, offer support, and work with nurses during their entire treatment process, from beginning emotions of anger and denial, to acceptance, responsibility, and recovery, and all the setbacks in between.

In the California Diversion Program the nurse facilitators are on their own as to how they conduct the support groups, what content or situation they focus on, and how they maintain

group process and how they interpret the role of a facilitator. There is very little opportunity for interaction among the facilitators due to being separated by large geographical distances extending from one end of California to the other, as well as the code of confidentiality they must honour. At the present time there is no regular process in place for the facilitators to identify commonalities of experiences and explore problem-solving solutions together. This problem led to the following research questions.

1.5 RESEARCH QUESTIONS

In order to complete this study, the researcher formulated the following two research questions:

- What is the lived experience of nurse facilitators of support groups for nurses with chemical dependency in California, USA?
- How could the research be used to support nurse facilitators of support groups for nurses with chemical dependency?

1.6 PURPOSE OF THE STUDY

In order to answer the above research questions, the researcher had to state her purpose for this research. In line with this thesis, the main purpose of this study is to formulate and describe guidelines for support of nurse facilitators for nurses with chemical dependency in the state of California, USA.

1.7 RESEARCH OBJECTIVES

The researcher conducted the study by addressing two important research objectives in order to accomplish the main purpose of the study as described above, in the following manner:

- To explore and describe the lived experiences of facilitators of support groups for nurses with chemical dependency in California, USA.
- To formulate and describe guidelines based on the research findings and literature for support of nurse facilitators of support groups for nurses with chemical dependency in California, USA.

1.8 PARADIGMATIC PERSPECTIVE OF RESEARCH

A paradigm or worldview is fundamentally an individual's view of the universe; it is a personal construction or framework by which an individual's life may be guided and understood by self and others. The same is true of the research paradigm which creates the context for a study (Ponterotto 2005:128). The research paradigm establishes the worldview that guides the study in order to make the research process, methods, and conclusions understandable to the researcher and others (Polit & Beck 2008:13). Filstead (1979:34 cited in Ponterotto 2005:127) defines a paradigm as a "set of interrelated assumptions about the social world which provides a philosophical and conceptual framework for the organised study of the world". Creswell (2009:9) argues that a paradigm has an action agenda that has the potential to change peoples' lives by supporting and empowering them. Denzin and Lincoln (2005:22) compare a paradigm to a "...net that contains the researcher's epistemological, ontological, and methodological premises...". In the next paragraph the researcher identifies the paradigm, or "interpretive framework or "basic set of beliefs" that guided the study (Denzin & Lincoln 2005:22).

A postmodern constructivist paradigm guided the current study. Denzin and Lincoln (2005:191 citing Denzin & Lincoln 1994) conclude that "the legitimacy of postmodern paradigms is well established...". The post-positivist constructivist paradigm was chosen as an alternative to the positivist scientific paradigm which relies on empirical evidence resulting from quantifiable information gathering. In the positivist scientific paradigm the researcher maintains an impartial distance from the research participants in order to deduce from observable data if a hypothesis was supported (LoBiondo-Wood & Haber 2005:155). On the other hand, constructivist research focuses on shortening the distance between the researcher and participants (nurse facilitators in the current study) in order to dynamically and holistically describe and explore the multiple interpretations of reality that would be discovered during the interactions (Loiselle, Profetto-McGrath, Polit, & Beck 2007:14-15; Speziale & Carpenter 2007:13).

In Chapter 2 the link between the constructivist paradigm and qualitative phenomenological research design is further explored.

No research is value free (Botes 1995:9), and it is for that reason in the following section the researcher describes the three types of assumptions that guided her research decisions according to the paradigmatic perspective: meta-theoretical, theoretical, and methodological.

1.8.1 Meta-theoretical assumptions

Even though the following meta-theoretical assumptions are not testable, they are discussed because they reflect the researcher's beliefs about human beings and society (Botes 1995:9). The following meta-theoretical assumptions reflect phenomenological perspectives that guided the study (Burns & Grove 2009:40-41; Loiselle et al 2004:216).

- It is possible to capture the unity of meanings of the lived experiences of nurse facilitators through intuition and reflection.
- The nurse facilitator is central with the environment. The nurse facilitator's world is shaped by him or her and he or she is shaped by the world.
- There is an essence and structure that can be narrated from the shared experiences of nurse facilitators, and all problems are related to finding definitions for those essences (Speziale & Carpenter 2007: 76; Marshall & Rossman 1999:112).
- Intentionality or consciousness is present in individuals because they are always intentionally conscious of something. Further, intentionality has a meaning and guides individuals to a direction. The object of intentionality and intentionality are interrelated (Moustakas 1994 28; 58-59).
- The subject-object dichotomy does not exist. Reality of an object can only be perceived within the meaning that the experience has for the individual (Creswell 1998:53).

The meta-theoretical assumptions indicate the researcher's transition from a natural attitude to one of self-consciousness (Polifroni & Welch 1999:371).

1.8.2 Theoretical assumptions

Theoretical assumptions are testable (Botes 1995:10) and indicate knowledge based upon the paradigmatic perspective. The following theoretical assumptions or “basic beliefs” about constructivism, were informed by Denzin and Lincoln (2005:204) and Patton (2002:96-97).

- The realities of the nurse facilitators are multiple, local, and specific.
- Each nurse facilitator constructs his or her own individual worldview, and each nurse facilitator’s worldview is as valid as another’s.
- Nurse facilitators may co-create their truth through narrative and negotiation.
- Information from the nurse facilitators is contextually significant as attention is directed to the reciprocal relationships between the nurse facilitators and their environments.
- Research takes place in naturalistic settings.
- Qualitative methods are used because no valid measures exist for investigating the lived experiences of nurse facilitators of support groups for nurses with chemical dependency.

1.8.3 Methodological assumptions

The methodological assumptions according to Botes (1995:10) should identify the researcher’s perspective about the structure of science relative to the researcher’s discipline and should direct the research design. The predominant methodological assumption in the study is that the research should reveal the essence of the lived experiences of nurse facilitators. Individual interviews were the best way to obtain this information in order for the essence of the lived experiences to be revealed.

1.9 OPERATIONAL DEFINITION OF IMPORTANT TERMS

Nurse. A nurse is a licensed health care professional educated in the care of the ill or potentially ill, with the overall goal of promoting the health of individuals (Roy 1976:4). The

nurse facilitators in the study are educated and experienced in matters of chemical dependency.

Facilitator. A facilitator is a person who makes a process easier; a leader of a group who assists the progress of a person or persons; someone who helps a group adapt and accomplish its goals (Klein 2000:191; Bostrom, Anson, & Clawson 1993:151). Group facilitators understand the group process, intervene, help the group stay in the here-and-now, and keep the group focused on the task at hand. In the study the nurse facilitators of support groups for nurses are knowledgeable and experienced in group process. Even though a nurse facilitator of a support group is not by definition a therapist, yet Yalom's (1995:106) identification of the basic manner in which a therapist should approach a patient as one of "concern, acceptance, genuineness, empathy," applies also to how a facilitator should approach a nurse in a support group (Ackerman 1996:97; Klein 2000:175).

Support group. A support group is a place where peers meet for the specific purpose of supporting, educating, and socializing. According to Fontaine & Fletcher (2003: 244-245) a support group is a place where an individual can feel safe, be honest, and feel accepted without being judged.

Chemical dependency. Chemical dependency is a chronic condition through which a person knowingly persists in behaviour that is harmful to self and others. Chemical dependency is a primary disease that is genetically linked, progressively debilitating, and potentially fatal without treatment (Bryson & Silverstein 2008: 905-907).

Treatment. In the context of this study, treatment entails detoxification, abstinence, and recovery (Inaba & Cohen 1993:74).

Recovery. Recovery comprises treatment and the restructuring of an individual's lifestyle (Brewer 2006:176). Abbott (1987:874) describes four phases of recovery: (1) *pre-motivation* when a denial system is strong; (2) *breakthrough* when denial is no longer strong and the individual develops a commitment to sobriety; (3) *early phase* is the assimilation of a new self-identity without alcohol or drugs; and (4) *extended recovery* when the individual re-evaluates his or her life and makes healthy decisions.

1.10 RESEARCH OVERVIEW

A qualitative phenomenological research design that was descriptive, explorative, and contextual was used to investigate how nurse facilitators of support groups for nurses with chemical dependency experience their role. The research was conducted in two phases. The first phase consisted of a qualitative phenomenological inquiry on the meaning of the experience to the individual experiencing it (Polit & Beck 2008: 64), nurse facilitators with respect to their involvement in the support groups. The second phase involved the development of guidelines for the support and enhancement of the experience of a common phenomenon. In her research design the experiences of the participants are interpreted through the perceptions of the researcher (Burns & Grove 2009: 25). Therefore, epoche, meaning “to refrain from judgment” and to look “inside to become aware of personal bias (Patton 2002:484-485),” was drawn on by the researcher in order to protect the integrity of the nurse facilitators perceptions as they spoke about their experiences.

1.10.1 Pilot study

A pilot study was conducted preceding the commencement of the research study in order to confirm that further research was warranted. The researcher interviewed two nurse facilitators individually. Each interviewee signed an informed consent allowing the researcher to tape record the interview. Each interviewee was given the same instruction: Please tell about your experiences as a nurse facilitator of support groups for nurses with chemical dependency in California. Each interview lasted over an hour. Both interviews were transcribed verbatim. The researcher concluded that further research was warranted after examining an in-depth evaluation of both transcribed interviews in which relevant themes emerged.

1.10.2 PHASE 1: The exploration of the lived experience of nurse facilitators

This phase consisted of the phenomenological exploration of the lived experience of nurse facilitators of support groups of nurses with chemical dependency in California, USA. The researcher conducted in-depth individual interviews with nurse facilitators throughout the thesis. The researcher starts by orientating the reader to the population and the sampling

techniques used to recruit research participants to this study. The researcher briefly orientates readers on data collection and analysis techniques used in the study. This section is closed with a brief overview of ethical rigor.

1.10.2.1 *Recruitment and sample population*

The sample population included all nurse facilitators of support groups for nurses with chemical dependency in California, USA. They were invited to participate in the study. Each facilitator was recruited by telephone from a list published by the BRN.

1.10.2.2 *The interview process*

The researcher either travelled to meet with and interview the nurse facilitator or the interview was conducted by telephone. In both cases the interviews were tape recorded. A written consent form was sent to each nurse facilitator, and the interview was not begun until the consent form was signed. Data gathering occurred over a ten month period. The recorded interviews were later transcribed verbatim. Scripts were then coded and subjected to thematic analysis to capture the essence of the interviews. Observational notes were also made and entailed descriptions of the events that were observed and heard by the researcher. For instance, from the face-to-face interviews the notes were more specific and different from the notes taken from the telephone interviews. In face-to-face interviews the field notes focused on the direct observations of the researcher, such as how the nurse facilitators were seated, how they were dressed, their affect, voice tone, eye contact, body posture, and awareness of space. Whereas the field notes from the interviews conducted by telephone reflect paralanguage, such as voice quality and repetitive phrases such as: “you know?”

1.10.2.3 *Data analysis*

Data analysis was accomplished by using Tesch’s (1990) eight step process according to reoccurring themes. The researcher explains in depth in Chapter 2, Section 2.4.4, and in Table 2.2 the application of Tesch’s process to the data analysis.

1.10.2.4 Ethical considerations

In the study ethical considerations were addressed to protect the rights of the participants' (nurse facilitators) in the following manner: clearance to conduct the study was received from the University of South Africa's Health Studies Research Ethics Committee (HSREC). Approval to conduct the study was granted by the California Diversion Program. A signed informed consent for interviewing and tape recording was granted by each nurse facilitator and each interview was coded in order to protect their identities. The printed results of the research do not contain any identifying references to the nurse facilitators. Chapter 2 contains a detailed description of ethical rigor for this study.

1.10.3 PHASE 2: The formulation and description of supportive guidelines for nurse facilitators

This phase introduces the reader to the strategy that will be used to formulate guidelines and a conceptual framework for support of nurse facilitators of support groups for nurses with chemical dependency. The guidelines in this thesis are a result of the synthesis of research findings and literature used by the researcher to control findings. See chapter 5 for a detailed description of guidelines used to support nurse facilitators of support groups for nurses with chemical dependency. This phase is guided by the survey list posed by Dickoff, James, and Wiedenbach (1968:425-433) that will guide the development of the conceptual framework from which the guidelines are based.

1.11 DEFINITION OF A CONCEPTUAL FRAMEWORK

Concept. A concept is an abstract term that describes and gives a name to an object or phenomenon in order to give it a separate identity or meaning (Burns & Grove 2009:692). In the study, for instance, communication, empathy, and stress are concepts.

Conceptual Framework. When concepts are organised together to indicate an inter-relational pattern, it can be called a conceptual framework (Polit & Beck 2008:749). In the study the conceptual framework will be described in detail as to how it was formulated as a result of the findings and the literature review.

1.12 CONCLUSION

Chapter 1 introduced the problem of chemical dependency in the nursing profession and argued for the importance of recovery programs for nurses with chemical dependency. Furthermore, the importance of the California Diversion Program to the recovery of these nurses was identified, specifically the role played by the facilitators of support groups that are an essential part of the recovery process. In line with the objectives of the research study a qualitative phenomenological research design that was descriptive, explorative, and contextual to investigate the lived experiences of nurse facilitators of support groups for nurses with chemical dependency in California, USA was described.

Chapter 2 discusses the research method to include the research purpose and objectives, research design and method, methods of data collection, data analysis, and measures of trustworthiness. Dickoff and colleagues' (1968:425-433) six survey aspects from their situation-producing theory are discussed as to their relevance to the study.

CHAPTER 3

DESCRIPTION OF THE DIVERSION PROGRAM AND LITERATURE REVIEW

3.1 INTRODUCTION

Chapter 2 discussed the research purpose and objectives, research design, research methodology, and measures of trustworthiness. A phenomenological qualitative research design that was explorative, descriptive, and contextual was developed in order to explore the lived experiences of nurse facilitators of support groups for nurses with chemical dependency in California, USA.

Chapter 3 provides an in-depth examination of the regulatory power of the California Board of Registered Nursing, a history and description of the California Diversion Program, to include identification of the requirements for admission, expectations for successful completion of the program, support groups, and procedural requirements for nurse facilitators of support groups.

Also, included in this chapter is the literature review for purposes of imparting the findings in other studies that are similar to this study, and to connect the present study to an ongoing dialogue with a larger audience. Another purpose for the literature review is to provide a framework from which the importance of the study will be established (Creswell 2009:25).

3.2 CALIFORNIA BOARD OF REGISTERED NURSING

The California Board of Registered Nursing (BRN) is a professional regulatory Board within the California Department of Consumer Affairs. Its primary responsibility is to protect the health and wellbeing of the public; however, it also oversees the licensing and regulation of registered nurses. The BRN's responsibilities are outlined in the Nursing Practice Act (California Board of Registered Nursing 2009c) which provides the BRN the authority to administer a Diversion Program (California Board of Registered Nursing 2009a).

It is the intent of the [California] Legislature that the Board of Registered Nursing seek ways and means to identify and rehabilitate registered nurses whose competency may be impaired due to abuse of alcohol and other drugs, or due to mental illness so that registered nurses so afflicted may be rehabilitated and returned to the practice of nursing in a manner which will not endanger the public health and safety. It is also the intent of the Legislature that the Board of Registered Nursing shall implement this legislation by establishing a diversion program as a voluntary alternative to traditional disciplinary actions.

A major portion of the California BRN's mandate to protect the public involves the monitoring and supervision of the professional conduct of registered nurses. The BRN intercedes and controls all arbitration and outcomes when nurses falter in their responsibility to deliver safe care to the public. In cases where chemical dependency is suspected, nurses may be offered the opportunity for rehabilitation through voluntarily entrance into the Diversion Program, where direction and support is given during the recovery process (California Board of Registered Nursing 2009a).

3.3 EXECUTIVE OFFICER

The Executive Officer is appointed by the BRN and performs and accomplishes the duties as dictated by the BRN. The executive officer must be a registered nurse, and shall not be a member of the BRN (California Board of Registered Nursing 2009e).

3.4 DIVERSION PROGRAM

The Diversion Program was established in California in 1985 as a confidential voluntary rehabilitation program. It is an alternative to judicial enforcement to give nurses a chance to recover from their affliction and return to work. The goal of the Diversion Program is to protect the public by early detection and suspension from nursing practice. The program offers oversight of treatment and recovery services to nurses with chemical dependency.

The Diversion Program is comprised of several sub-groups that work together to provide the services required for nurses with chemical dependency. The relationship between the Diversion Program (and its sub-groups) and the BRN is represented in Figure 3.1 (BRN 1999). The figure identifies the lines of communication as envisioned by the BRN. Beginning with the Board of Registered Nursing, the communication flows to the Executive Officer, to the Diversion Program Manager, and finally it moves horizontally through three

areas: the Diversion Evaluation Committee, the Diversion Program Contractor, and the Nurse Support Group. In the organisational chart, which depicts the envisioned ideal flow of communication, the nurse support groups are identified as an equal part of the Diversion Program.

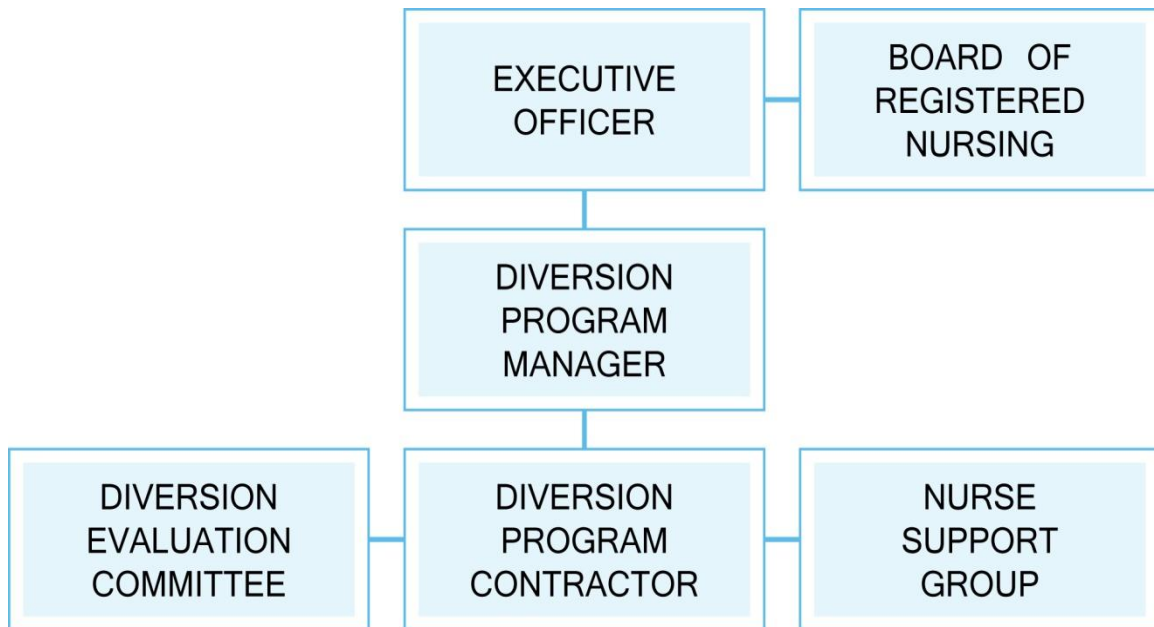


Figure 3.1: Organisational chart as envisioned for the Diversion Program by the California BRN

3.4.1 Entry into Diversion Program

Nurses may enter the Diversion Program in one of two ways. One is by self-referral, signifying recognition of a problem with chemical substances. In this case assistance is sought by directly applying to the program. The other way of entering the program is by BRN referral as a result of a legitimate complaint against a nurse. Once nurses are accepted into the Diversion Program they are suspended from nursing practice until a Diversion Evaluation Committee (DEC) recommends to the BRN reinstatement of the nurse. The length of time in the program varies from three to four years with a maximum of five years if necessary (BRN Diversion/Discipline Committee Minutes 04/08/04).

3.4.2 Warning signs of chemical dependency

Warning signs of chemical dependency in nurses, according to the BRN Diversion Program are absenteeism, excessive requests to work overtime, larger withdrawals of controlled substances compared to other nurses, documentation of excessive wasting of controlled substances, volunteering to medicate other nurses' patients, increased isolation, patients complaints that pain is unrelieved when given medication, incorrect controlled substances count, and numerous corrections on records for controlled substances. Emotional and behavioural signs of chemical dependency may be increased irritability and mood swings, unkempt appearance, impaired motor coordination, slurred speech, smell of alcohol on breath, hand tremors, unsteady gait, excessive use of mouthwash or breath mints, falling asleep on the job, or inappropriate 'cheerfulness' (BRN Diversion Program Pamphlet 1999). It must be kept in mind that not all nurses fit this description because some nurses with chemical dependency are able to project an image of professionalism to mask the above mentioned warning signs. That is why it is important for colleagues of nurses with chemical dependency to know the warning signs of chemical dependency and to document facts, not conclusions.

3.4.3 Eligibility

Eligibility for the Diversion Program requires that the nurse is licensed in, and is a resident of the State of California, and is actively using substances to the extent that nursing practice may be compromised. The nurse must also voluntarily accept the terms of the recovery contract, and agree to medical and/or psychiatric evaluations.

Ineligibility for the Diversion Program is based on previous disciplinary action by the BRN for chemical dependency, termination from any diversion program for non-compliance, selling of drugs, or causing harm or death to patients (California Board of Registered Nursing 2009a).

3.4.3.1 Cost

The BRN requires fiscal responsibility of the nurse admitted to the Diversion Program. A monthly fee is charged by the BRN to defray the costs of supervising the program. Another monthly fee is paid to the Diversion Program's contractor for administration of the program.

Clinical laboratory fees are also charged for random body fluid testing and can range between 45 and 65 dollars. A fee-for-service to the nurse support group facilitator is determined by the facilitator. Any cost related to further treatment, such as inpatient and outpatient treatment facilities, psychotherapy, medical treatment, and expert evaluations will be the responsibility of the nurse. Payment of all fees is part of the contract between the nurse and the Diversion Program. All fees must be paid in full at time of service in order for the nurse to be considered fully compliant and to be allowed to continue the program.

In special circumstances the BRN may choose to waive the required fees when the nurse is unable to pay for services. It is the philosophy of the Diversion Program that no nurse will be turned away because of a lack of funds.

3.4.4 Recovery service

The Diversion Program offers confidential consultation, assessment and referral for detoxification and treatment, development of a rehabilitation plan, monitoring and reassessment of treatment and recovery, random body fluid testing, referrals to nurse support groups, and encouragement and guidance to the nurses during the recovery process. Successful completion of the Diversion Program protects the license of the nurse, allows the nurse to resume unrestricted nursing practice, and all records of the original complaint and participation in the Diversion Program are expunged (BRN Diversion Program Pamphlet 1999).

Unsuccessful completion of the Diversion Program may involve BRN referral to the Probation Program with possible disciplinary action if the applicant is determined to be a threat to the public or to his or her own health and safety (Board of Registered Nursing, Diversion Program Minutes. January 10, 2003:3). Records resulting from participation in the Probation Program become public record, and are never expunged (BRN Probation Program Pamphlet [sa]).

3.4.5 Contract terms

When a nurse accepts the contract as set forth by DEC, full compliance is required for the mandatory stipulations of recovery which begin with abstention from the use of alcohol and

all mind-altering drugs. The stipulations may be all or any combination of the following BRN Recovery Contract Terms (California Board of Registered Nursing 2009a):

Inpatient treatment: The nurse must enrol in an approved inpatient treatment program within 14 days of detoxification treatment. A commitment of 30 days is required, with the treatment facility submitting a weekly progress report and a discharge summary.

Outpatient treatment: After the nurse has completed an inpatient treatment program, the next step is to enrol in an approved intensive outpatient treatment program with attendance confirmed by a facility professional.

Aftercare: Attendance at an aftercare program for twelve months and submission of quarterly reports is required after the nurse has been discharged from an inpatient treatment program.

Residential program: A DEC may recommend that the nurse in recovery live in a residential program for a designated length of time.

Recovery home: A DEC may recommend or mandate that a nurse move to a group home for recovering chemically dependent individuals.

Counselling: A DEC may recommend or mandate that the nurse receive counselling by a licensed psychiatrist, psychologist, licensed clinical social worker (LCSW), marriage and family therapist (MFT), or addiction specialist counsellor.

Psychiatric evaluation/treatment: A DEC may mandate that a nurse must have a psychiatric evaluation and treatment plan completed by a licensed psychiatric professional within a designated time period.

Alcoholics Anonymous or Narcotics Anonymous meetings: A DEC will mandate that a nurse new to the Diversion Program must attend an Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meeting seven days per week for three months (90/90), and only one meeting per day counts towards the 90/90, although a nurse may attend as many meetings per day as he or she wishes.

Other 12-Step programs: A nurse may be required to attend other 12-step meetings such as Co-dependents Anonymous, Pills Anonymous, Emotions Anonymous, or Gamblers Anonymous.

Sponsor: At the beginning of treatment a nurse must choose a sponsor who will function as a role model and mentor. The sponsor must be a recovering alcoholic or addict with a minimum of five years of sobriety and be the same gender. Frequent contact between a sponsor and the nurse must include work on the 12-Steps.

Nurse support group: A nurse in diversion will be mandated to attend a weekly nurse support group, with attendance and assessment to be documented monthly by the support group facilitator.

Random body fluid testing: Random urine testing of nurses in diversion is required. The urine collection must be at an authorised laboratory on a randomly scheduled day.

Family therapy: Family therapy may be recommended by the DEC, but cannot be required of family members.

Suspension from practice: A nurse in diversion is suspended from nursing practice until he or she has successfully completed 24 consecutive months in the Diversion Program with 100% compliance. Once this has been accomplished, the nurse is allowed back into nursing with the following possible restrictions:

- Work area may not be changed except with approval of a DEC consultant and/or a DEC
- May not dispense any controlled medications
- May not carry keys or have access to controlled substances
- May not count controlled substances
- Work shift that is permitted at the beginning of returning to nursing practice are days only with no double shifts, no double backs, and may not float
- May not work more than 40 hours per week
- May not work more than 2 different shifts in a 7-day period
- May not work in charge/supervisory positions

- May not work as only RN on duty in assigned area
- May not work for registries or home health agencies
- Must have an RN as a work site monitor who is aware of the Diversion Program rules, and agrees to submit quarterly reports
- Must complete fifteen classroom continuing education units in chemical dependency before graduation from the Diversion Program
- The next DEC reassessment to be scheduled by the DEC according to the nurse's compliance and progress with his/her recovery

3.4.6 Typical contract when entering the Diversion Program

The typical contract for a nurse when entering the Diversion Program includes the following: Suspension from nursing practice, individualised treatment which includes thirty days of inpatient treatment followed by aftercare treatment. Once aftercare is completed the nurse must attend ninety AA or NA meetings in ninety days, plus a weekly nurse support group. Random urine testing continues throughout the period a nurse is in the Diversion Program. The nurse must attend every appointment scheduled with a DEC.

3.4.7 Typical progression through the Diversion Program

The typical progression of a nurse with chemical dependency through the Diversion Program includes the progression from daily AA or NA meetings to two or three meetings per week, plus a weekly nurse support group meeting. From there, the nurse is allowed to return to non-patient care, then to patient care without access to controlled substances, and finally to patient care with full access to controlled substances. Upon initial return to work the nurse must have the nursing position approved by the DEC, and obtain a work-site monitor, must authorise communication between the work-site monitor, the director of nursing, the Diversion Program contractor, and the DEC.

3.5 DIVERSION EVALUATION COMMITTEE

Thirteen Diversion Evaluation Committees (DEC) are spread throughout the state of California. Each DEC is comprised of four voting members appointed by the BRN (two registered nurses, one physician, and one public member). All committee members are

required to be experts in the areas of chemical dependency and/or mental illness (Board of Registered Nursing Diversion Program Committee Minutes, December 4, 2003:3). The term limits for members may be no longer than two consecutive four-year terms on one particular DEC, or as adjusted by the Diversion Program manager. The DEC member may transfer to another DEC and begin the terms anew.

3.5.1 Responsibilities of a DEC

The responsibilities of the DEC are to interview and evaluate the nurses applying to the Diversion Program and to determine eligibility. The DEC establishes a contract for recovery with each nurse, and determines the range of nursing practices allowed for each nurse in diversion. Additionally, the committee determines whether a nurse has successfully completed the Diversion Program or to terminate a nurse from the program for unsuccessful completion or for being a danger to the public.

3.6 DIVERSION PROGRAM CONTRACTOR

The BRN contracts with a private sector contractor to provide for the management of the Diversion Program. Some of the duties of the contractor are to: provide for chemical dependency intervention services, maintain 24-hour crisis intervention services, conduct initial assessment interviews, prepare evaluation reports for the DEC, monitor each nurse's recovery and compliance with the program contract, provide financial, legal, and child-care counselling, and provide consultation services to employers of nurses with chemical dependency.

3.7 NURSE SUPPORT GROUPS

At the time the research was conducted there were thirty nurse support groups throughout California. The groups are facilitated by registered nurses who have been approved by the BRN. The support groups are designed to assist and support nurses in their treatment and recovery. The groups are not designed to be AA or NA meetings, nor professional therapy groups.

3.7.1 Support group facilitators

Nurse support group facilitators are registered nurses with backgrounds in chemical dependency. The majority of the facilitators are recovering from chemical dependency themselves, each with many years of sobriety. Most hold graduate degrees and some are licensed as therapists. A few have taught in nursing programs, others have held hospital or community nursing positions ranging from staff nurses, specialty nurses, administration nurses, and nurse leaders.

3.7.1.1 Criteria for approval as a facilitator

The BRN stipulates that a nurse facilitator of a support group must be a registered nurse, and must show evidence of expertise in the field of chemical dependency. This may be in the form of either one year of work experience in the area within the last three years, or have at least two semester units, three quarter units, or thirty hours of continuing education units in chemical dependency, or certification or eligibility for certification in the area, or have a minimum of six months experience facilitating group process, or if in recovery, must have a minimum of five years recovery (California Board of Registered Nursing, 2004.DIV-P-11).

3.7.1.2 Procedural requirements

The nurse facilitator is required to maintain the confidentiality of the nurses in the support group. He or she must also record and report weekly attendance to the contractor, respond to calls from the contractor within a timely manner, observe and record any changes in a nurse that might indicate a lapse in recovery, and report relapses to the contractor. The nurse facilitator must be accessible to nurses in the support group 24 hours a day for crisis intervention, and allow a nurse to attend the nurse support group regardless of ability to pay (California Board of Registered Nursing. 2004.DIV-P-10).

3.7.1.3 Role of facilitators

The role of nurse facilitators as identified by the BRN is to facilitate the support group meeting, to keep the group focused on professional issues and recovery, and to apply the principles of group process. He or she must also provide input and recommendations as

related to the expectations of the Diversion Program, and to be supportive of the Diversion Program (California Board of Registered Nursing. 2004.DIV-O-01).

The BRN credits the attendance at a nurse support group to be an especially vital part of the recovery process. The BRN requires that nurse facilitators of nurse support groups embrace the philosophy of alcoholism and addiction as disease processes, and the 12-step recovery program. The role of the nurse facilitator is identified, as well as general parameters for conducting meetings and group process rules, such as being expected to be a role model and provide support in the recovery process (California Board of Registered Nursing.2004.DIV.P.11). At no time is the nurse facilitator an employee of the BRN or the Diversion Program. Once the nurse is approved by the BRN as a facilitator, no specific format exists to explain how the meetings are to be conducted, therefore it is left to the facilitators as to how each support group functions. This open-ended approach could be positive with respect that each facilitator may adapt the group to the needs of its members, or it could be negative when the facilitator is not adept at group process or the problems that accompany chemical dependency. It was important to learn from the nurse facilitators about their thoughts and feelings regarding their lived experiences as facilitators of support groups for nurses with chemical dependency in order to discover information which might be useful in understanding that role.

3.8 LITERATURE REVIEW

In this section a comprehensive exploration of the literature relating to the study is presented. The following three questions guided the literature search: What is the role of nurse facilitators of nurse support groups? Are nurse support groups essential to the success of a diversion program for registered nurses with chemical dependency? Are registered nurses with chemical dependency a danger to the safety of the public?

In addition to the three questions identified in the preceding paragraph, the following sections of this chapter further describe the literature that addresses support groups in general and support groups for health professionals with chemical dependency, the problem of nurses with chemical dependency in the USA, Alcoholics Anonymous Twelve-Step Program, and a brief summary of diversion programs in other USA states. In the following sections the review of literature will speak to the three questions raised herein.

3.8.1 What is the role of nurse facilitators of nurse support groups?

“Of the best leader, when the job is done the people say ‘we did it ourselves’” (Lao Tzu from the Tao-Te Ching, cited in Ruete 2004-2008:2).

The role of nurse facilitators of nurse support groups is explored below, starting with a description of facilitation in general, followed by facilitation as it specifically relates to nurse support groups.

3.8.1.1 Group facilitator

Group facilitation is a concept utilised in many areas of education, counselling, psychotherapy, society, and theology. Facilitation imbues the image of enabling trust, assisting in the arena of learning, collaborating among individuals, and promoting insight and change. Those who act in the capacity of a facilitator invoke the image of genuineness, compassion, and empathy (Wolfelt 2004:23-25). Harms and Benson (2003:49-56) point out that facilitators must have secure boundaries, manage conflict and anxiety levels of group members, create a positive environment, minimise acting-out, and promote honest communication in order for group members to be able to focus on the goals of the group.

A facilitator is critical to a group’s effectiveness by being supportive and by having the skills to lead, provide structure, and deal with disruption. A facilitator’s actions will also influence group process, objectives and outcomes, and relationships among the group members (Gitterman 1989:95-96; Bostrom et al 1993:147, 155-156). Research conducted by Zabalegui et al (2005:370) on the effectiveness of support groups for cancer patients, indicates that an important indicator for the success of support groups is leadership type and how the leader manages the group. Zabalegui and colleagues (2005:370) identify leadership indicators of group success as the ability to coordinate and control the group, sensitiveness to participants’ needs, empathy, flexibility, spontaneity, as well as promotion of group cohesion, offering structured information, providing confidentiality, strengthening honesty, and providing objectivity. Even though there is abundant literature on support groups and their members, there is a paucity of information on the facilitators of such groups. Coward (2003:291-300), in a discussion of a support group for breast cancer survivors, identifies three purposes of the support group: (1) to convey basic information,

(2) to provide emotional support, and (3) to improve coping skills; however, the importance of support group facilitators was not specifically addressed. Unfortunately, this oversight was more the rule than the exception. In a literature review of group facilitators by Clawson and Bostrom (1993:325), the authors found that two facilitative functions identifiable in the literature: structure and support, and self-awareness were identified as central to the role of facilitator. Gitterman (1989:96) describes how support group members will test a facilitator's ("worker's") authority, function, and boundaries in order to understand where that person fits into the interpersonal network being established by the group.

3.8.1.2 Nurse support group facilitator

The first account of a nurse as a professional facilitator came as a result of the Senior Nursing Officer Training Scheme that was organised by the National Staff Committee for Nurses and Midwives in 1983 (Becket & Wall 1985:259). Over the span of twenty-six years from 1983 until the present the role of nurse facilitators has expanded in one specific area as they facilitate support groups for nurses with chemical dependency. In this capacity they function as registered nurses who are educated in the subject of chemical dependency, and who are experienced in the care of individuals with this disease. In their role as nurse facilitators of support groups for nurses they mediate and advocate for them in a group setting in which they all share in a common desire to assist one another to reach a state of self-understanding, wellbeing, and recovery. A nurse facilitator functions in a group as a role model and a resource person, as well as a positive influence and provider of safety for the nurses with chemical dependency (Ghais 2005:; Henderson 1998:28). It is necessary for a facilitator of a nurse support group to be empathetic and compassionate while maintaining clear boundaries; to communicate therapeutically and assertively; to be a role model for healthy living and healthy relationships; and to be an advocate for a clean and sober recovery program. Support groups offer opportunities for nurses with chemical dependency to observe and learn from the group facilitator and other group members.

3.8.2 Are nurse support groups essential to the success of a diversion program for nurses with chemical dependency?

"Using groups to solve problems is as old as human behaviour itself" (Keltner 1989 cited in Clawson & Bostrom 1993:323).

In this section the question of nurse support groups as essential to the success of a diversion program is explored through the literature. Contingent to this, a broad overview of support groups is explored first, followed by a focus on nurse support groups.

3.8.2.1 Support groups

Human beings are born into groups, beginning with the family, and extending to the cultural, religious, social, peer, and work groups (Cara & MacRae 2005:532). Throughout an individual's life he looks to others in his group for safety, support, and validation as both a unique individual and as a group member. It is in groups that individuals learn how to interact and cooperate with others, thereby enhancing their own lives and the lives of others (Yalom 1995:17). Furthermore, it is in groups where goal-setting is first learned and achieved (Kneisel et al 2004:685; Kauffman, Dore, & Nelson-Zlupko 1995:355). Freire (2003:3) confirms that, "[t]o be human is to engage in relationships with others and the world".

The first establishment of support groups may have been when human ancestors gathered around campfires for survival or celebration. A support group of family and tribal members would have been a comforting presence during frightening and confusing times, as well as when times were good and the group felt a need to come together to celebrate. To this day reaching out to others continues to be a comforting action for people. Human beings in every century, race, culture, religion, and language have had affirmations similar to the Native American Sioux proverb: "With all things and in all things, we are relatives" (James 2006:35). It is undeniable that support from others has long been identified as essential for physical and emotional survival (Kneisel et al 2004:685).

A group has been defined as a collection of individuals who share common interests or purposes (Cote-Arsenault & Freije 2004:652). A group functions in several ways to support, teach, socialise, inform, establish norms, complete tasks, govern, and empower (Yalom 1995:79; Townsend 2000:126). In whatever way a group is identified, whether as a therapy group, support group, or self-help group, the purpose is a mutual responsibility for members to offer comfort, support, guidance, and reality to one another (Wolfelt 2004:7-9). Group members hold up a mirror to one another whereby each can see his or her actions from the perspective of others (Kauffman et al 1995:355). Groups offer a safe haven where

members can rehearse healthy ways to interact with others and to learn new ways to cope with the challenges of life. Group members sustain one another in times of hardship; they are advocates for one another and they collaborate and problem solve together, all the while tolerating one another's missteps, drama, and tragedies (Cote-Arsenault & Freije 2004:652).

The function of a support group incorporates all of the characteristics of a group, but is specifically focused on providing communication and reinforcement as it empowers group members with the tools to be successful in their recovery (Fontaine & Fletcher 2003:245). Support groups offer each member the opportunity to learn through actual experience and thereby alter thinking and behaviour in an accepting atmosphere (Gitterman 2005:93). Research has shown that an atmosphere of acceptance is especially necessary for women with chemical dependency because they lose the support of friends more readily than men, and have fewer opportunities for socialisation. Therefore they enter treatment lacking the skills to establish and maintain functional relationships, even though women often identify their relationships with others as crucial to their recovery (Kauffman et al 1995:357).

In the early 1900s in America, different forms of group therapy were initiated, but it was the use of different types of therapy and support groups initiated by the United States Veterans Administration in the 1940s when the practice became common (Cara & MacRae 2005:532). Support groups became a major presence in the discipline of psychotherapy in the United States after World War II when thirteen million veterans of the USA armed forces returned from war too psychologically traumatised to successfully return to the workforce (Albee 1998:189). The sheer numbers of people needing psychotherapy became an impossible task for the small community of psychiatrists, who for the most part, believed that the hallmark of effective treatment was either an analytical Freudian-style psychotherapy or organic therapy such as insulin coma or electric convulsion therapy. Either type of therapy had to be individually conducted, therefore these therapies were time consuming and expensive with no guarantees for recovery, as well as being impractical to use for the millions of war veterans (Cara & MacRae 2005:157; Albee 1998:190). The Veterans Health Administration, the largest health care system in the USA (Oliver 2007:5), initiated a program in its hospitals whereby patients could reap the benefit of therapy in groups. This proved to be a solution that was economically and therapeutically effective,

and continues to this day to be a valuable treatment option in various settings (Albee 1998:193).

Support groups offer comfort, camaraderie, validation, feedback, and information to their members in the spirit of universality (Yalom 1995:302). They offer a place of safety where solutions to problems may be reviewed and rehearsed in an empathetic environment. They serve as mirrors in which individuals may clearly see themselves and their lives. Nurse support groups assist in alleviating the stigma, fear, depression, and isolation that often are a part of the chemical dependency problem. They also educate the members about chemical dependency, treatment, and recovery (Kauffman et al 1995:355).

3.8.2.2 Nurse support groups

Historically the nursing profession has turned a blind eye to nurses with chemical dependency. Often nursing staff covered for the impaired nurse and nursing managers and supervisors looked the other way until the actions of the impaired nurse could no longer be avoided. At that point the nurse's employment was terminated and the infraction was most likely reported to the state's regulatory nursing board. As a result, the employer's problem might have been solved, but the nurse's chemical dependency problem was not (Miller 1997:57). It was not until the 1980s when diversion programs for nurses in a handful of states in the USA appeared, with nurse support groups as a part of the treatment plan. These nurse support groups offered the nurses with chemical dependency a sanctuary where they could find support among their peers

One of the goals of a nurse support group is to educate nurses about addiction, relapse, prevention and recovery. At the beginning of treatment some nurses may be resistant to attending nurse support groups because they are reluctant to expose their chemical dependency to peers, and they do not want to hear stories about nurses relapsing and losing their licenses (Quinlan 2003:149). Another reason nurses may stop attending support groups may be due to a reluctance to admit to themselves and others that they have a chemical dependency problem.

3.8.3 Are nurses with chemical dependency a danger to the safety of the public?

“While I was using my only interest was getting drugs. I don’t think I ever put a patient’s life in danger, but that was only by the grace of God” (Hastings 2007:79).

“All nurses should consider addiction a disease and an occupational hazard” (Quinlan 2003:150).

In this section the concern about the danger to the safety of the public when nurses with chemical dependency are engaged in the care of patients is explored through the literature. Furthermore, chemical dependency as a disease is discussed.

3.8.3.1 Chemical dependency and nurses

To begin answering the question if nurses with chemical dependency are a danger to the safety of the public, first chemical dependency must be defined. Chemical dependency is a chronically progressive primary disease where a compulsion exists to use alcohol or drugs which continues over time despite the escalation of personal, familial, and occupational problems in a person’s life, and if left untreated, ultimately leads to imprisonment, insanity, or death (McCall 2001:50; Abbott 1987:870). Chemical dependency continues on a path, that is sometimes short or sometimes long, but whatever the length of the ill-fated journey, it ends in the wounding and ruination of lives. It can be found throughout history in all races, ages, cultures, and socio-economic levels. It occurs where forbidden or where celebrated. It usurps all reason, knowledge, love, and awareness in a person as it careens down a predictable course of self-destruction, and for more times than not, other-destruction. Risk factors for chemical dependency in the general population have been identified as a family history of addiction (genetic influences), dysfunctional family dynamics, family secrets (incest), abuse, isolation, low self-esteem, stress, and poor coping skills (Lillibridge, Cox, & Cross 2002:220). Brewer (2006:175), who writes specifically about alcoholism, cites 2004 figures from the National Institute of Alcohol Abuse and Alcoholism (NIAAA) wherein it is estimated that 28 million Americans have the disease of alcoholism, and 11 million of those are women where alcoholism is found to be a growing problem. DiClemente (1999:474) points out that chemical dependency creates direct and indirect costs: direct costs are the economic, psychological, and legal

consequences that often lead to serious illness and early death; and indirect costs are the effects felt by health care systems, educational systems, judicial systems, employee assistance programs, and treatment and recovery programs. DiClemente (1999:473) further argues that the “collateral damage to family members, innocent victims of alcohol or drug related accidents and violence, losses in productivity in the workplace, and the crime spawned by illegal activities”.

Chemical dependency not only has severe repercussions in the emotional, psychological, and social realms of an individual, but also in the biological as well, where the “chronic use of addicting substances produces specific effects on the mesocorticolimbic dopaminergic reward centre of the brain,” a pathway that is responsible for rewarding and reinforcing the positive and natural stimuli for survival, such as for food and procreation. Repetitive use of addictive substances releases dopamine, serotonin and endogenous opioids in the brain which produce euphoric feelings in the individual where it becomes a learned behaviour involving the stimulus and response mechanism or Pavlovian conditioning (Berry 2005:13; Littleton 2007:115-116). This reward pathway in the brain of the individual with chemical dependency may have been pre-sensitised for addiction by inheriting a genetic predisposition for the disease because research has shown “that genetic factors play a role in predisposition and susceptibility to chemical dependency” (Berry 2005:15). Considering all the information about the causes and consequences of chemical dependency, it might be thought that most people understand that it is a serious disease that calls for serious treatment, and yet many in the general public continue to think of it as a moral breakdown, and a lack of willpower, not as a disease of the brain. This stigma especially persists when it is a nurse who has the disease of chemical dependency (Trossman 2003:27).

Chemical dependency among health professionals is not new, but has been chiefly disregarded until the 1970s (Smith, Talbott & Morrison 1985:69). Specific risk factors that lead to chemical dependency in nurses are identified by the American Nurses’ Association as attitudes and accessibility (Sharer 2008:249; McCall 2001:51; Abbott 1987:870). The risk of a nurse becoming chemically dependent is substantially higher if he or she has all or several of the risk factors that are prevalent in the general population, such as a family history of chemical abuse and dependency, and interpersonal exploitation and violence

(Sharer 2008:249; Dunn 2005:574-575). If the nurse has the predisposing factors for chemical dependency as seen in the general public, plus the precipitating factors of multiple stresses at home and at the place of employment, combined with an attitude that her education and experience will keep her from becoming chemically dependent, and the availability of controlled substances, her chances for becoming chemically dependent are great. Dittman (2008:324) identifies professional impairment as “the inability to carry out professional responsibilities consistent with the standards established by professional and regulatory agencies”.

Mynatt (1999:17) created a Triad of Risks for Chemical Dependency in Nurses that was based on information from studies about women with chemical dependency. In Mynatt’s conceptual model she identifies three risk factors for a female nurse for becoming chemically dependent: (1) dysfunctional family of origin with chemical dependency and ineffectual parenting; (2) victimisation as a child, including abuse of some form; and (3) low self-esteem as a result of the needs of the child not being met. In contrast, Dittman’s (2008:324-329) later study explored the lived experiences of male nurses recovering from chemical dependency, where the researcher found predisposing factors for the development of chemical dependency to be similar in both sexes, such as a chaotic family of origin and some form of abuse, but male nurses with chemical dependency also had some uniquely different behaviours from those of most female nurses. Dittman’s (2008:324-330) study describes how the male nurses were thrill seekers who were willing to take risks on a grandiose level; how they manipulated (masterminded) everyone from family, friends, and colleagues; how they put their drug seeking needs above the needs of their patients with no sense of shame or guilt; and how they were able to mentally compartmentalise their chemical dependency using a highly inventive denial and rationalisation process.

Both the public and the nursing profession assume that nurses monitor their own colleagues and profession in order to protect the public. This assumed oversight of nurses with chemical dependency by the nursing profession is not substantiated in the literature because there is little research about the numbers of nurses with chemical dependency and their recovery (Sisney 1993:107). In a study by Smith (1992: 295), the negative attitudes about chemical dependency in nurse colleagues are barriers to identification and

intervention. On the other hand, nurse managers who are knowledgeable about chemical dependency as a disease process are more able to support impaired nurses in their recovery. A later study by Bugle, Jackson, Kornegay, and Rives (2003:126) confirmed Smith's findings that the higher the education level of nursing supervisors, the more they believe in the benefits of a non-punitive treatment program for the nurse with chemical dependency, whereas a fellow staff nurse who discovers a nurse diverting drugs from patients is more likely to use a formal reporting system.

Even though nurses are at high risk for developing chemical dependency, at the same time nurses are notoriously ignorant about the disease of chemical dependency. Along with ignorance is the problem of denial has been found to be just as prevalent in the peers of nurses with chemical dependency as in the impaired nurse. Coupled with ignorance and denial is enabling behaviour in other nurses who shield the impaired nurse from the consequences of his or her actions and in this way prevent the impaired nurse from seeking help (Berry 2005:16; Quinlan 2003:149). The actual incidence of substance abuse among nurses is not known because of the secrecy surrounding the problem. Investigating recent history the literature reveals that in 1990, Kelly and Mynatt (1990:35) blew the whistle on chemical dependency by declaring that 10% to 20% of health care workers abused drugs and alcohol, and that the rate of nurses with chemical dependency was 50 times higher than for non-nurses. Hughes (1995:37) wrote that prior to 1995 it was known that there were nurses with chemical dependency, but "only recently has [chemical dependency] begun to receive widespread attention".

Dunn (2005:574) refers to the American Nurses Association who estimated that there were 6% to 8% of nurses with chemical dependency. In 2003, Zwerling, who was at the time a Peer Assistance Committee advisor from the Pennsylvania State Nurses Association, estimated 3% to 6% of nurses practiced while impaired (Trossman 2003:27). In 2006, Shumaker and Hickey (2006:745) referred to the National Council of State Boards of Nursing who estimated that the figure was approximately 15% of nurses who had chemical dependency problems at some point in their professional lives. In 2007, Hempstead (2007:176) estimated the percentage of nurses with chemical dependency to be between 7 and 24 percent. Since there is such a wide range of estimates as to how many nurses in the USA have the disease of chemical dependency, a comprehensive study of the current

percentage of nurses with chemical dependency in the United States is due. The factors that place nurses at risk for chemical dependency, which include stress in the workplace, chemical dependency in the family of origin, social and workplace accessibility to drugs, and inadequate employee assistance programs (Miller 1997:56) will most likely not change for the better in the near future. Perhaps it is time that the nursing profession doubles its efforts and becomes more proactive in its plans to educate nurses (and nursing students) about chemical dependency as a disease, and to instil in them the sense that it is their professional responsibility to identify, intervene, and recommend treatment for colleagues who are suspected of being impaired in order to deflect the problem of increasing numbers of registered nurses with chemical dependency.

It might be thought that nurses with chemical dependency are the worst of the lot, but research findings do not support this view. On the contrary, the majority of nurses with chemical dependency tend to be the high achievers who are success driven. Most of them graduate with high grades, hold advanced degrees, work in highly responsible positions, are intelligent, and extremely competent. The blemish in this seemingly perfect picture is that they are multi-substance abusers, who divert drugs at the workplace to support their habits, are resistant to therapy, and have little to no support in recovery (Hempstead 2007:178; Miller 1997:57). Another deterrent to recovery lies in the nurse's ability to disguise his or her chemical dependency from others, often for years, even though it is usually at the workplace where the nurse procures the drugs, which is an indication that when it is addressed it is late stage chemical dependency (Quinlan 2003:149).

Diversion programs for the treatment of nurses with chemical dependency, as overseen by USA state boards of registered nursing, are discussed in the following section.

3.8.3.2 *Diversion programs*

Chemical dependency has long been recognised as a hazard for health care professionals. However, it was not until the 1980s that the American Nursing Association (ANA) (now the American Nurses Association) recognised the problem in nursing practice (Darbro 2005:169). At that time, nurses with chemical dependency who were diverting drugs were subject to disciplinary actions that most often resulted in the loss of employment. Today, however, most states in the USA have confidential alternative treatment programs that

focus on the recovery of nurses with the goal of rehabilitation and return to nursing practice. The very existence of diversion programs is due to the American Nurses Association, Emergency Nurses Association, and state Boards of Registered Nursing recognition that chemical dependency is a disease that with treatment recovery is possible, ideally in a diversion program where the impaired nurse is among his or her peers (Hempstead 2007:176).

Weiss (2005:65) identified approximately 40 states in the USA that offer confidential diversion programs for treatment and monitoring of nurses with chemical dependency. This indicates that recovery programs for nurses are available in most areas although the article does not distinguish different types of diversion programs. The assumption can be made that most boards of nursing recognise diversion of controlled substances as part of an addiction process, and thus endeavour to avoid punitive consequences for diverters. Quinlan (2003) estimates that diversion programs that are constructed well will have an 80 to 95 percent recovery rate (Trossman 2003:27).

Diversion programs in the USA for nurses come under different banners, depending on the state, and may deal with different issues. The North Carolina Board of Nursing, for example, sports a Chemical Dependency Discipline Program, which deals with nurses using drugs or alcohol (North Carolina Board of Registered Nursing 2009). On the other hand, North Dakota's Board of Nursing's Workplace Impairment Program handles a range of cases including chemical dependency, physical disorders, psychiatric impairments, and practice deficiencies (North Dakota Board of Nursing Department 2009). In 1987 New Mexico established a diversion program for nurses with chemical dependency, and identifies its main objectives as protection of the public and the identification and assistance of impaired nurses (New Mexico Board of Nursing 2009).

It is important for the nursing profession to find a way to salvage nurses with chemical dependency by assisting them in their recovery and welcoming their return to safe nursing practice. A diversion program offers a non-punitive opportunity for recovery for these nurses by supervising their recovery process, while at the same time protecting the safety of the public. Diana Quinlan, chairperson of the AANA's Peer Assistance Committee estimates that 80% to 95% of nurses with chemical dependency will remain clean and sober if they are involved in diversion programs that are well organised and competently

supervised (Trossman 2003:27). According to the latest information from the California BRN (2009) 1200 nurses have successfully completed the Diversion Program (California Board of Registered Nursing 2009a).

In the next section the Alcoholics Anonymous Twelve-Step Model is briefly described because it is an integral part of the California Diversion Program's treatment philosophy.

3.8.3.2.1 Alcoholics Anonymous Twelve-Step Model

Self-help groups have been shown to be an integral component of recovery by providing a caring environment where the group members feel understood, supported, and strengthened by peers and facilitators, as well as receiving information and educational material (*National Association for the Mentally Ill [sa]*). Research in relation to recovering alcoholics found that self-help group involvement after treatment was predictive of lower rates of relapse (Fiorentine & Hillhouse 2000:66).

A popular self-help group for recovering alcoholics is the Alcoholics Anonymous (AA). A self-help group is a group that does not require the presence of a professional, but rather the group members help one another. Alcoholics Anonymous is a non-profit organisation offering services to individuals with alcohol dependency. Since its inception in 1935, membership has increased significantly to an estimated 1 million members in the USA and Canada in 1990 (Alcoholics Anonymous World Survey 1990), and to a global membership of 2 million in 2007 (Alcoholics Anonymous 2007:7). Satellite branches have also been established, such as Narcotics Anonymous (NA), which focuses on chemical dependency on substances other than alcohol (Wells 1987:581). These groups identify themselves as self-help groups and operate free of cost. They are often used in conjunction with professional treatment programs as aftercare activity that is considered by some as essential for long-term abstinence (Fiorentine & Hillhouse 2000:65).

Both AA and NA use a 12-step self-help program to help members recover from their chemical dependence. Research indicates that groups using the 12-step approach are helpful in maintaining abstinence for at least a portion of the attendees (Fiorentine & Hillhouse 2000:66). The program consists of the 12 steps outlined in Table 3.1 and as described in the AA Fact File (Alcoholics Anonymous 2007:13). Although the program

seems spiritually oriented, it has been shown to be effective in both believers and non-believers (Tonigan, Miller & Schermer 2002:536).

Table 3.1: 12-step program of AA and NA

Step	Description
1	We admitted we were powerless over alcohol [addiction (NA)] – that our lives had become unmanageable
2	Came to believe that a Power greater than ourselves could restore us to sanity
3	Made a decision to turn our will and our lives over to the care of God as we understood Him
4	Made a searching and fearless moral inventory of ourselves
5	Admitted to God, to ourselves and to another human being the exact nature of our wrongs
6	Were entirely ready to have God remove all these defects of character
7	Humbly asked Him to remove our shortcomings
8	Made a list of all persons we had harmed, and became willing to make amends to them all
9	Made direct amends to such people wherever possible, except when to do so would injure them or others
10	Continued to take personal inventory and when we were wrong promptly admitted it
11	Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out
12	Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs

Source: Alcoholics Anonymous (2007:13)

3.9 CONCLUSION

In Chapter 3 the Diversion Program of the California BRN was described. A comprehensive exploration and review of the literature related to the study was undertaken. Three questions guided the literature review: (1) What is the role of nurse facilitators of nurse support groups? (2) Are support groups essential for the success of a diversion program for nurses with chemical dependency? (3) Are nurses with chemical dependency a danger to the safety of the public? Literature review indicated that the role of nurse facilitators was multi-faceted, and that nurse facilitators must understand group process, be compassionate and empathetic, educate the group members about chemical dependency,

assist the nurses in their recovery, and provide a safe environment. For the second question, the literature review described support groups and identified their importance in treatment programs. Lastly, the literature supports the conclusion that nurses who are actively chemically dependent are a danger to the safety of the public. This chapter also addressed support groups in general, the disease of chemical dependency, Alcoholics Anonymous Twelve-Step Model, and a brief summary of other diversion programs.

Chapter 4 presents the research findings and literature control, and a description of the sample. Major themes, categories and sub-categories are identified and supported with quotations from the interviews with the nurse facilitators. Evidentiary literature appropriate to the themes and categories is identified.

CHAPTER 4

FINDINGS AND DISCUSSION

4.1 INTRODUCTION

Chapter 3 identified the role of the California Diversion Program in the treatment and recovery of nurses with chemical dependency, including a description of the function of support groups. A literature review addressed sources relevant to the study.

This chapter describes the sample, research findings and literature control. During data analysis four major themes were identified from the interviews with the nurse facilitators: (1) how nurse facilitators experience communication within the Diversion Program; (2) how nurse facilitators experience the structure of the Diversion Program; (3) how nurse facilitators experience their role within the Diversion Program; and (4) how nurse facilitators experience facilitation of support groups in the Diversion Program. These four themes, along with categories and sub-categories, are discussed in detail throughout Chapter 4, along with verbatim quotations from the interviews and relevant literature for control validation.

4.2 DESCRIPTION OF SAMPLE

The nurse facilitators interviewed were licensed Registered Nurses (RN) in the state of California, USA. Coupled with this, most of the nurse facilitators held dual licenses principally in the areas of social work, psychotherapy, or marriage and family therapy. Both male and female nurse facilitators were represented in the study. A total of twelve nurses were interviewed, but since there are only a few male nurse facilitators in California, the exact number for each sex is not presented in order to protect anonymity. The nurse facilitators' ages ranged between 40 to 60 years. The nurse facilitators were educationally and experientially qualified in the subject of chemical dependency and most were recovering from chemical dependency of alcohol or drugs. Two of the nurse facilitators were retired psychiatric nurses and a few of them had taught in nursing programs. The experience of working with support groups ranged between 1 and 20 years.

Table 4.1 presents the four themes identified, with categories and sub-categories, that resulted from the analysis of the interviews.

4.3 THEME 1: EXPERIENCE OF COMMUNICATION WITHIN THE DIVERSION PROGRAM

The data indicated a need to broaden communication within the Diversion Program in order to promote support for nurse facilitators. In section 4.3 those areas in the Diversion Program are identified where communication must be strengthened in order for nurse facilitators to feel supported.

4.3.1 Nurse facilitators experience poor communication within the Diversion Program

Many nurse facilitators related their experiences with poor communication within the Diversion Program and how it restricts their ability to carry out their responsibilities as facilitators of support groups. This poor communication or lack of communication was perceived to be between the nurse facilitators and all other parts of the Diversion Program: Diversion Program manager, Diversion Program contractor, Diversion Program Evaluation Committees, and among the nurse facilitators.

4.3.1.1 Poor communication between nurse facilitator and the Diversion Program manager

Nurse facilitators believed that poor communication between themselves and the Diversion Program manager was a result of the Diversion Program manager's lack of awareness or acknowledgement about the importance of their role within the Diversion Program. They described this oversight by telling how they learned about facilitating a support group by being supportive of one another and by teaching one another, rather than receiving assistance from the Diversion Program manager. This problem has been ongoing for many years in California as concern about the lack of communication is documented as far back

Table 4.1: Themes, categories, and sub-categories of the experiences of nurse facilitators

Themes	Categories	Sub-categories
4.3 Experience of communication within the Diversion Program	4.3.1 Nurse facilitators experience poor communication within the Diversion Program	4.3.1.1 Poor communication between nurse facilitators and the Diversion Program manager
		4.3.1.2 Poor communication between nurse facilitators and Diversion Program contractor
		4.3.1.3 Little communication between the nurse facilitators and Diversion Evaluation Committees (DEC's)
		4.3.1.4 Poor communication among nurse facilitators
4.4 Experience of the structure of the Diversion Program	4.4.1 Nurse facilitators experience frustration with the structure of the Diversion Program	4.4.1.1 Lack of structure
		4.4.1.2 Lack of consistency
		4.4.1.3 Poor supervision
4.5 Experience their role within the Diversion Program	4.5.1 Nurse facilitators experience marginalisation by the Diversion Program	4.5.1.1 Lack of orientation for new nurse facilitators
		4.5.1.2 Lack of mentoring of new nurse facilitators
		4.5.1.3 Poor communication from Diversion Program resulting in marginalisation of the nurse facilitators
4.6 Experience facilitation of support groups in the Diversion Program	4.6.1 Nurse facilitators experience a lack of acknowledgement regarding facilitation of support groups as essential for support of nurses with chemical dependency	4.6.1.1 Lack of supportive guidelines
	4.6.2 Nurse facilitators' experience of support groups	4.6.2.1 A place to build support networks
		4.6.2.2 Group dynamics assist in the recovery process by nurses regaining trust and sharing
		4.6.2.3 Confidentiality is mandated for everyone as part of recovery
		4.6.2.4 Accountability means that each group member answers to himself/herself and to others in the group

Themes	Categories	Sub-categories
4.6 (continued)	4.6.3 Nurse facilitators experience various roles as facilitators of support groups	4.6.3.1 Communicator
		4.6.3.2 Informed resource person knowledgeable in expectations of the Diversion Program
		4.6.3.3 Educator able to teach about chemical dependency as a primary disease process and ways to achieve and maintain a healthy life of sobriety
		4.6.3.4 Role model a holistic approach to living an authentic life
		4.6.3.5 Mentorship of group members by supporting, guiding, providing feedback, advocating, and instilling hope.
		4.6.3.6 Facilitator
		4.6.3.7 Change agent: makes change possible through interactional learning
		<ul style="list-style-type: none"> • Knowledgeable
		<ul style="list-style-type: none"> • Provides feedback
		<ul style="list-style-type: none"> • Instils hope

as 1988 at a meeting of the Northern California Task Force for Nurse Support Group Facilitators (Minutes 1988). Some nurse facilitators related how they had never received a phone call from anyone in management at the Diversion Program. They explained how better communication with the Diversion Program manager could empower them in their work with the nurses in their support groups. This is what one of the nurse facilitators said regarding the lack of communication in the Diversion Program:

Now I get people [nurses with chemical dependency] calling me, and they have been referred to me, and I have absolutely no idea about these people. So there's another piece where we are kind of hanging out there without a lot of information. And the feedback that I've been given is that confidentiality prevents us from giving you any information, so what am I to do?

4.3.2 Poor communication between nurse facilitator and the Diversion Program contractor

The nurse facilitators spoke of being concerned about a lack of feedback from the Diversion Program contractor. As one nurse facilitator put it:

I guess I would like to have more contact, more input, maybe meetings, that kind of thing, to know exactly where they stand because some of the things that come down the line are kind of unusual, and everybody is different.

Another nurse facilitator expressed frustration that he or she was not informed of new nurses with chemical dependencies joining the support groups. This is what he or she said:

From the contractor, I have a really hard time with the fact that I don't get notifications from them when I have a new person coming. I don't get any information until I get a call from somebody saying, "They told me to call you." I have no idea that I'm even supposed to be looking for somebody new. I thought that the contractor should have at least been keeping me updated on who I am supposed to have attending my group.

Another experience of the nurse facilitators was that the nurses with chemical dependency were held to higher standards by the contractor than the contractor expected of him or herself. This is what one nurse facilitator had to say:

If I were to say the thing that sticks in my craw the most is there are conditions of adherence to a contractual relationship that the nurses are held to, that I don't think are equally adhered to by the contractor.

It was suggested by one nurse facilitator that in order to address the issues with the contractor the two parties should have meetings.

The nurse facilitators explained that the Diversion Program contractor did not inform them of any problems the nurses might have that would be important for them to know. They felt that this left them at a disadvantage and caused confusion in the support groups, thereby potentiating the possibility of an unsafe environment developing. They found this lack of information as not only discourteous, but a problem for them as they strived to maintain safety, confidentiality, and consistency in their groups.

I never get any kind of communication if a nurse comes up with a dirty urine [failed drug test], or if the DEC requires more treatment, or something different for the nurse.

4.3.3 Little communication between the nurse facilitators and the Diversion Evaluation Committees (DEC)

The nurse facilitators also expressed their experiences with communication with the DEC, and most nurses complained about the paucity of communication with them. They identified that feedback would be appreciated in order to have a better idea of what was happening with the nurses in their support groups. They also identified that feedback from the DEC would help them correlate their work with the nurses in their groups with the contracts between the DEC and the nurses. Some of them were concerned about not being informed by the DEC when a new nurse was assigned to their support group, and that they are expected to share information with the DEC, but the DEC does not share information with them. One of the nurse facilitators said:

I'm just asking for feedback from the DECs. I know that people do better when there is feedback.

Once again, the issue was about new nurses showing up in support groups unannounced, but this time the complaint was directed at the DEC for not informing the nurse facilitators of a new arrival in their support group. One of the nurses explained:

I got this phone call, "Hello, my name is [blank] and the DEC told me I have to come to your group because I'm going through orientation at my hospital for four weeks," and I went, "Helloooooo." Or I get a call that so-and-so's daughter is having surgery on the night her support group meets, so the DEC tells her to show up at my group that week. The DEC's are saying that. These people show up at my group and I don't have any idea who they are.

The problem of limited communication coming from the DEC to the nurse facilitators was addressed by one nurse facilitator:

We can give the DEC information that we have, but the DEC can't give me information that it has. So there is a little push-pull on this.

Another nurse facilitator offered the solution that the nurse facilitators and the DEC should meet as it became necessary:

If the DEC members met with support group facilitators without the recovering nurses there? What do you think? Do you think that might work?

4.3.4 Poor communication among nurse facilitators

The nurse facilitators experienced feeling isolated due to a lack of contact with other nurse facilitators in California. The poor communication and lack of contact was principally due to the large geographical distances separating them from one another in California, lack of continuity among them regarding facilitation of their support groups, no established networking system, and no guidance from other parts of the Diversion Program.

4.3.4.1 Large geographical distances between them

California is one of the largest states in the USA, and nurse facilitators are scattered from one end to the other--from the south beginning at the border with Mexico, to the west ending at the Pacific Ocean, to the east bordering the Sierra Nevada mountain range, and to the north ending at the border of the state of Oregon. This large distance separating the nurse facilitators were grounds for feeling isolated from one another, leaving them to solve problems by themselves. These are some of the things that were said during the interview regarding contact with other California nurse facilitators:

I haven't been in contact [with other nurse facilitators], no. I have had a call or two. I'm sure they are kind of in the same way. It is pretty isolated.

I don't know what anyone else is doing.

We have no contact with one another. I don't know what anyone else is doing with their groups.

I'm not in contact with other facilitators. Everyone is isolated.

4.3.4.2 Lack of continuity among the nurse facilitators

Poor communication among nurse facilitators was perceived to result in a lack of continuity in facilitation of their support groups. The perception of a lack of continuity resulted from feelings of disconnection among the nurse facilitators where sharing of ideas and experiences was interrupted by their isolation from one another. Two nurse facilitators expressed their ideas about the problem in the following ways:

– not that the groups need to be led the same, but more communication amongst the group facilitators....just the communication that is lacking because of isolation.

4.3.4.3 No networking system

Some of the participants expressed their views on a networking system between nurse facilitators. Many of them suggested that a network of nurse facilitators which would enable them to communicate regularly would be beneficial in supporting them in their role. There is no official networking system in place to reach out to one another. It was suggested that some form of regular communication process needs to be created, such as a newsletter, in order to establish peer support.

Diversion should have some form of communication with the facilitators, perhaps a newsletter.

It would be just great to call one of the other facilitators and be able to say, "How is this new [urine] test working for you? We are having a lot of people coming up positive. What's your feeling on this?" It's just really helpful because sometimes you're really feeling like you're solving problems by yourself.

I would always tell facilitators to call other facilitators to see what they did in their groups and how that worked out, and get some dialogue going.

4.3.4.4 Lack of guidance

Two nurse facilitators identified that their experiences with the lack of guidelines makes them feel isolated, and another nurse felt that the Diversion Program is not consistent in its treatment of people.

I feel a little “out there”. I would like to help, support, guidance. I would love to talk to other facilitators, my fellow people. I feel absolutely out in left field.

There are extreme differences as to how people are treated in Diversion.

One person dispensing information to another with no responsibility for how or if the message was received does not constitute communication. Facilitative communication aims to use communication to build trust and to have an exchange of ideas and feelings (Kneisl et al 2004:153). Communication can be thought of as a circular process whereby the sender has a goal to disperse information, sends the message to the receiver, and asks for feedback. This circular process can continue until the sender is confident that a clear message was sent, and feedback from the receiver indicates the message was received and understood. The sender of the message has the goal of maintaining the continuance of the communication circle until completion is achieved. In such a circular process no one is left out and everyone understands the message and has the opportunity to respond to it (Fontaine & Fletcher 2003:55). The accomplishment of communication in the support groups is the responsibility of the nurse facilitators. It is they who must be able to organise, provide structure, summarise, clarify, harmonise, energise, inform and lead the group members in interpersonal exchanges that encourage a positive atmosphere conducive to support and learning (Bostrom et al. 1963:160; Ackermann 1996:97). In the support groups, the sharing of information is vital to maintain a cohesive environment that provides safety to its members. Feedback can be used to check for clarity of the message in the communication process. Feedback allows for misunderstood messages to be corrected (Kneisl et al 2004:151). Feedback is a reaction from one individual's communication or talk to another's. Feedback can be non-verbal or verbal, negative or positive, but it will be always be responsive and informative (Yalom 1995:42-43; Bens 2005:115-118).

To whom does the nurse facilitator turn when he or she needs someone to talk to? Working with groups of any kind is an emotionally daunting task. Most schools of psychotherapy require their students to spend some time in therapy. Psychotherapists often continue meeting with their own therapist long after they have completed their schooling (Yalom 1995:526), but to whom do nurse facilitators turn for solace and understanding? The findings indicate that nurse facilitators feel isolated from one another due to poor communication among them. This isolation leaves them with no one to talk to about the stress of facilitating support groups for impaired nurses, and thus their need for guidance.

4.4 THEME 2: EXPERIENCE OF THE STRUCTURE OF THE DIVERSION PROGRAM

The findings indicate a need for critical action within the Diversion Program in order for nurse facilitators to feel supported. Critical action means crucial or urgent action. Action that is important and relevant to solving the problem of needed change within the structure of the Diversion Program. The following information in section 4.4 identifies the areas in the Diversion Program where there is need for critical action in order to bring about changes that will facilitate support for the nurse facilitators.

4.4.1 Nurse facilitators' experience frustration with the structure of the Diversion Program

A category that emerged from the analysis of the interviews revealed that the nurse facilitators often experienced frustrations with the structure of the Diversion Program.

4.4.1.1 Lack of structure in the Diversion Program

Aside from the frustration about the lack of structure in the Diversion Program, the nurse facilitators also indicated that they were confused by it. One nurse facilitator reflected on the inconsistency of the program's structure, while another, through such frustrations, had lost respect for the program. Others still, described the hiring process as a lengthy and draining procedure. Many of the participants also reported being unaware of the structure and inner workings of the Diversion Program. They said they did not know where support groups fit into the overall structure of the treatment and recovery program. This was evident in that many of them often talked about "the Board" (or the Board of Registered

Nursing), when in fact they were referring to the Diversion Program. This is what some of the participants had to say about the lack of structure within the Diversion Program:

I just don't understand it and quite honestly I'm not having a lot of respect for the way the [Diversion Program] is working things in a lot of areas.

I've been contemplating not continuing with this [being a facilitator] because there's very tight structure in some ways and then very loose in other ways.

The [hiring] process with the State took, I am going to say close to a year, maybe even two. It was sort of a trial by fire. I thought well, okay, they don't need me, or they don't want me, or they don't like me, or something, and then something would happen, just about the time you throw up your hands, or some of the group members would say they were in my area, and they would call, but that was the first part of it, it was a pretty lengthy, draining kind of process that you never knew what was actually going to occur, and then once we did, it went pretty smoothly.

Structure is important for building a cohesive organisation. Structure must be established in an organisation by being clear about individual roles, rules, and expectations (Klein 2000:44). Kurtz (1997:43) describes structure as a means to maintain an efficient organisation. In addition to their experiences with the lack of structure of the Diversion Program nurse facilitators also talked at length about their perceived inconsistency within the structure of the Diversion Program.

4.4.1.2 Lack of consistency in the Diversion Program

The nurse facilitators commented that the perceived lack of consistency in the Diversion Program created problems for them in their support groups because they had to deal with the aftermath of frustration from the group members, as well as their own frustration. The inconsistencies of the Diversion Program were reported to result in a lack of trust for one nurse facilitator, and caused conflict in his or her group. Another participant commented that his or her biggest challenges were not with the nurses in the support group, but rather were with the Diversion Program. This is what some of them said about the lack of consistency in the Diversion Program:

It's the way people are treated. It just amazes me the extreme differences. One may be told to go to outpatient. Another may be told to extend her time in Diversion. It causes a lack of trust in terms of the process; I'm speaking just of the group I facilitate. It also causes conflict

with everyone talking about it. When I talk to some nurses they feel there is a lack of compassion in the whole process.

I think that probably the bigger challenges I've encountered have not come from within the group setting itself, but has come as the Diversion Program has gone through its many changes.

Others have learned to accept the flaws and inconsistencies of the program, saying that it is the way that it has always been.

I've had complaints with the Diversion Program's operation and inconsistencies and contradictions, and that's just the way it's been.

Contrary to the majority of the participants one nurse facilitator felt that the Diversion Program is the best it has ever been.

I'm not expecting perfection and I have to tell you that the Diversion Program now is probably better than it ever has been.

In a program like the Diversion Program where frustration, anxiety and stress are often an everyday occurrence for the nurses with chemical dependency, consistency is especially necessary for an atmosphere of safety and trust to prevail.

Consistency is at the heart of trust because without it, everything else is thrown off balance. If each one of the synonyms for consistency were applied within the structure of the Diversion Program there would be agreement, conformity, continuity, intelligibility, symmetry, tenacity, and uniformity (Roget 1977:881), and there would be trust and balance.

4.4.1.3 Poor supervision

A perceived lack of supervision by the Diversion program was reported as being frustrating for the nurse facilitators. Comments ranged from describing the lack of oversight as unpredictable, isolating, and angering, to questioning the hiring process. One nurse facilitator believed that:

Sometimes the person calling the shots doesn't really know anything.

Another nurse facilitator expressed his or her concern about receiving no information about conducting meetings:

I received no information from the BRN about how to conduct meetings, the fees, etc.

Three nurse facilitators questioned the hiring practice for nurse facilitators:

Are they interviewing them over the phone, is it in person? What's the background of the person, or is it just that they want to lead, a nurse, wants to start a nurse support group?

It is pretty wide open. They did an interview and said, what do you think? I told them what my background was and where I was anticipating going with the group.

Shame on the BRN [Diversion Program]! Everything was so disorganised. It took over a year for them to get back to me.

One nurse facilitator thought that the Diversion Program did not stay informed about the number of nurses in the support groups, and another brought up a reoccurring concern about no one at the Diversion Program calling nurse facilitators.

Well, I don't think the Board [Diversion Program] actually keeps track of how many is in a group. I mean, there's no, I don't think there's any one overseeing anything once the nurse facilitator gets the go ahead to start a group.

I never received a call or anything from anyone running Diversion. I never received a call from the DEC. And I've never received a call from anyone at the BRN [Diversion Program].

Supervision is an inherent part of leadership, and is a valuable component of training. According to Cara and MacRae (2005:655-656), supervision is acknowledged as a learning situation, and carries with it the responsibility for providing an adequate orientation to the worksite, provides services such as reports and documents, evaluates the skills of the supervisee, and provides guidance to the supervisee. The data from the study indicates that these types of supervisory services from the Diversion Program would be welcomed by the nurse facilitators.

4.5 THEME 3: EXPERIENCE OF THEIR ROLE WITHIN THE DIVERSION PROGRAM

The nurse facilitators expressed feelings of being marginalised by the Diversion Program. The findings indicated that the role of nurse facilitators was marginalised by the Diversion

Program, and that there is a need for role empowerment according to the findings. Areas of disempowerment of nurse facilitators are identified in section 4.5.

4.5.1 Nurse facilitators experience feeling marginalised by the Diversion Program

The nurse facilitators gave every indication of their willingness to fill an active role within the Diversion Program. They expressed a desire to take creative action and to be a part of a change process except for their feelings of being marginalised by the Diversion Program. They identified issues that were thwarting their efforts to be better support group facilitators, such as a lack of meetings for nurse facilitators, a lack of support and guidance from the Diversion Program, no clear chain-of-command identified for them to turn to, and a lack of supportive guidelines for them to utilise.

4.5.1.1 Marginalisation of the nurse facilitators by the Diversion Program due to poor communication

The nurse facilitators expressed feelings of being treated as outsiders, of feeling marginalised and unappreciated, which many of them blamed on a lack of cohesiveness and focus within the Diversion Program. They considered the rules of the Diversion Program, at worst to be non-existent, and at best to be ambivalent, fluctuating between rigidity and unpredictability. This led to the perception that they were being kept on the outside. As a whole, the nurse facilitators' perception of how they were treated by the Diversion Program was arbitrary and negative. They expressed feelings that they were not treated equitably, nor acknowledged as professionals. This is what some of the nurse facilitators said about feeling marginalised:

I would say that my biggest complaint is that the way the program was originally set up was with the three areas: the DEC's [Diversion Evaluation Committees] the [private] contractor, and the nurse support groups. I still feel that the nurse support groups are marginalised.

I do know that right now they have the Diversion Liaison Committee, but generally they pick one group facilitator from Northern California and one from Southern California. That's the only chance for people to get together. I know that it is difficult for people to get away often to attend something like that.

From the [Diversion Program management] I don't have much communication.

Marginalisation sets individuals outside the sphere of influence, and dismisses their opportunity for cooperation. Firstly, communication must take place between all parties in order to correct this problem (Freire 2005:168).

4.5.1.2 Lack of orientation for new facilitators

It appears that the feeling of marginalisation of the nurse facilitators started early in their role. Many of the participants expressed their feeling regarding the minimal orientation that they received as new facilitators. As new facilitators they expected an orientation from the Diversion Program and were disappointed when none was given to them. This is what one of them had to say about this issue:

[The Diversion Program interviewer] said: "That is lovely. We'll wait for you to contact us and tell us when your group is starting." I didn't know about getting a meeting place or how to notify the participants. I felt like an idiot. I knew nothing about probation and diversion. We facilitators need guidance. I was hired on the phone. I would never hire someone on the phone without a face-to-face interview."

Orientation is an act of inclusion which offers direction to individuals, especially when entering new situations. Orientation identifies the expectations and describes the responsibilities of everyone involved, and familiarises the new individual to mutually agreeable goals (Townsend 2000:85-86). Orientation by the Diversion Program for new nurse facilitators would help to overcome established barriers to communication.

4.5.1.3 Lack of mentoring for new nurse facilitators

A concern of the nurse facilitators was that there was a perceived lack of mentoring for new nurse facilitators. Three nurse facilitators related their own experiences of feeling alone and adrift when they were new:

It was another facilitator who really helped me out. She shared everything with me, handouts. I had nothing.

For somebody who is brand new, are they coming up under somebody? So that they have that person to rely on because starting a brand new group you really need mentoring. Especially those people who start a group out in the middle of nowhere. Anyone just starting out really needs mentoring.

Mentoring by the Diversion Program for new nurse facilitators was found to be lacking. Arnold (2005:509) finds that it is not uncommon for more experienced facilitators to mentor newer ones, but that it was not an optimum situation in some cases because the type and extent of mentoring was too unpredictable. Bidwell and Brasler (1989:24) describe mentoring as an active process that may continue for years. Mentors may function as role models, but their responsibility goes beyond that to being professionally active in guiding the neophyte. A mentor may assume several roles in the process of mentoring, such as counsellor, teacher, sponsor, and guide.

4.6 THEME 4: EXPERIENCE OF FACILITATION OF SUPPORT GROUPS IN THE DIVERSION PROGRAM

The fourth theme that emerged from the data revolved around the nurse facilitators' experience of facilitation of support groups within the larger context of the Diversion Program. On one side, participants believed the support groups were important for the recovery of the impaired nurses, and the various roles they assumed as facilitators, such as mentor, role model, and educator also served the nurses well in their recovery. On the other, they experienced a lack of acknowledgement from the Diversion Program related to their role as facilitators and supporters of nurses with chemical dependency.

4.6.1 Nurse facilitators experience a lack of acknowledgement by the Diversion Program

The nurse facilitators interviewed for the study perceived their role in the support groups as an essential part of recovery of the nurses with chemical dependency, yet they did not believe that the other parts of the Diversion Program were of the same opinion. They were concerned that their role was under-appreciated because of misunderstandings, and desired to have a voice in correcting any misconceptions of their roles in the support groups. The following perceptions by nurse facilitators identify their various roles and responsibilities as facilitators of support groups for nurses with chemical dependency.

4.6.1.1 Unclear guidelines for facilitating support groups

The nurse facilitators reported being surprised at the minimalism and superficiality of the guidelines they received from the Diversion Program. Many of them indicated that more in-

depth guidelines that would have provided strategies and direction for group facilitation would have been welcomed. They believed that such guidelines would have helped them form a course of action in planning and processing their support groups. They expressed frustration that without clear guidelines there was no established map for them to follow which meant that each of the thirty support groups might be operating in accordance with their own ad-hoc guidelines.

I would be very willing to start another group if I had some supervision. I don't know what is the right thing to do, or what is the wrong thing.

They are just the contractor and doing paperwork, yet it sounds to me that nurse facilitators are turning to them about decisions about running support groups.

Maybe I am just looking for more guidance. Maybe support groups don't need to be as structured as I thought they were supposed to be.

Guidelines can be as simple as suggestions or as complex as rules or directives. In any case, they are specifically laid out directions for individuals engaged in a collective undertaking to better understand and follow in order for all to arrive at a common goal in an orderly fashion (Patton 2002:330-331).

4.6.2 Nurse facilitators' experience of support groups

Many of the nurse facilitators expressed the intent that their groups should be structured in ways that everyone felt equally supported. Most of the groups were conducted using a democratic leadership style; only a few believed the leadership style of their groups should be more autocratic. All agreed that support groups were necessary in order to raise the self-esteem of nurses with chemical dependency and to facilitate their recovery.

The nurse facilitators spoke of their knowledge and involvement in the recovery process as addressed in their support groups. They confirmed that the experience of receiving support was an integral part of the recovery process for the nurses. They identified the ways they supported each nurse in their groups, and that it was in the support groups where the nurses learned to support one another. Most of the nurse facilitators led their groups strictly as support groups. One nurse facilitator related that if a support group resembled a therapy group it would be an unusual occurrence resulting from a situation that could not be

disregarded or postponed. The following experiences were perceived as vital for the composition of a support group:

Keep [the group] on the support side, rather than the actual therapeutic side. In the course of a year or so, I have done both. It has actually had to be therapeutic at times, but always supportive, so it worked out really good....Anytime you put a room full of people who are addicts and alcoholics, there are issues in there of infidelity, child abuse, of some serious wrongdoings—that need a place to go, you know, some real suicidal ideation occurs occasionally.

“What’s a nurse support group?” I explained to him, just like I’m explaining to you about how it was beneficial for my recovery to be able to talk to other health professionals, and to know that there was recovery because prior to my having my addiction and coming into the [Diversion] program, a nurse with a drug problem, they disappeared. They just left from the hospital and you didn’t know where they had gone. You didn’t know if they had been arrested or what.

This is a very serious program. I need to tell them that I’m supportive. I want them to look forward to coming to group. I want them to feel accepted. I want to feel that they feel good about coming to my group.

When they enter the Diversion Program they cannot use their nursing license in a work situation, so many lose their homes, their cars, their dignity, their self-respect. Many are just scared to death. The irony is that the nurses we are losing are super nurses. It has been a badge of honour to always do more.

Support groups assist members to work on problems in their personal lives. A support group is a place where encouragement and support are provided by other group members and a qualified professional facilitator who can help members cope with their problems. The ultimate goals for support group members are for self-understanding and a changed lifestyle to result from communicating and learning from others in a group setting (Schwarz 2002:20-21). Gitterman (1989:93) identifies small group process as integral to healing. He points out that it is in small groups where group members can experiment with trying out nonchemical coping skills. Support groups are important for the recovery of nurses with chemical dependency because impaired nurses have lost the ability to trust others and to share their problems because of fear of discovery. It is in support groups that nurses can learn to share and to trust again (Rodas-Meeker & Meeker 2005:89). Group dynamics, such as size of the group, leadership style, group cooperation, and group members’ roles

in the group have the power to build trust in group members or destroy it. The findings revealed that confidentiality and accountability were the two dominant dynamics of concern for the nurse facilitators.

4.6.2.1 A place to build support networks

The building of support networks within the support groups was believed to be necessary by the nurse facilitators in order for the nurses with chemical dependency to feel safe and supported. The nurse facilitators were unanimous in their belief that support groups were an important place for the nurses to learn how to develop healthy relationships. The nurse facilitators were aware that for a support group to function well it was necessary for the group members to be like-minded individuals who could establish a collegial relationship around common themes. Bens (2005:7) points out that “facilitation is a way of providing leadership without taking the reins,” so that the group members may assume responsibility for finding solutions to their problems (Bens 2005:7). One nurse facilitator stressed how he or she made sure to communicate to the nurses in the support group that they were supported. For another nurse facilitator it was important for the nurses to know that they were supported in every way, including emotionally and spiritually, because it was apparent that the longer the nurse members were in a group the more they were going to open up and discuss more intense issues and feelings. One of the participants reflected:

Either you are going to run the thing at an incredibly superficial level, “how did your week go?”, or you are going to try actually be a support, you know, meaning emotionally, spiritually, everything that you are going to need to have some group dynamics because the longer these people are together, the more opens up, and the more intense it gets.

Maintaining the group as strictly a support group came up with several of the nurse facilitators, and the issue was resolved when the group members agreed to keep the groups as support groups only.

Seeing as how it was a support group, we decided from the very beginning that the group would set its own limits in terms of how many members.

Building support networks was another concern with many of the nurse facilitators. One way this was done was by assigning a nurse who was new to the support group to a nurse who was doing well in his or her recovery. In another group the nurse facilitator redirected

the nurses to support one another by describing the support group as a laboratory for the real world.

I assign a new nurse in my support group to a nurse who is doing a good solid program of recovery and has at least two years of recovery.

I try to re-direct the nurses to support each other because I see the group as a laboratory for the real world.

Further discussion centred on how facilitating support groups made them realise that nurses were very giving people, and one nurse facilitator remarked that the nursing profession was not supportive of the nurses with chemical dependency due to ignorance about the illness. There was concern for the nurses who were without peer support once they had relapsed and were no longer in the Diversion Program.

Probably mostly what I have learned running a nurse support group is that nurses are the most giving people I've ever met in my life.

I find that in the most part the nursing profession out there is not supportive because of ignorance, just ignorance, and then the fear because we are all supposed to be pure.

With nurses who relapse, I think principally the one thing they miss is that fellowship with their peers.

Brennen (1991:14) advocates that a nurse who is suspected of being impaired should be referred to a peer assistance program. In her work with nurses with chemical dependency in Michigan, Fletcher (2004:92-93) finds that peer support was valuable to their recovery because support groups were found to be exceptional places for the members to learn about various ways to change. She referred to the American Nurses Association *Code of Ethics for Nurses with Interpretive Statements* (2001) where it is stated that all nurses have the responsibility to advocate for colleagues who may show evidence of impaired work performance.

4.6.2.2 Group dynamics assist in the recovery process by nurses trusting and sharing

Group dynamics may include such aspects as the different roles individuals bring to the group, their expectations for learning to trust and share, and how the facilitator explains the

expectations of the group. The results indicated that two aspects were identified by the nurse facilitators as the most important in order to assist the nurses to trust and share; confidentiality and accountability are discussed below.

4.6.2.2.1 Confidentiality is mandated as part of the recovery process

The rules of the support groups include the agreement from each group member that the information disclosed in the groups is not be revealed outside of the groups. Confidentiality in the groups was built on trust and accountability, and the nurse facilitators accepted responsibility for maintaining confidentiality in their support groups because they wanted the nurses to return every week feeling secure that what they disclosed in support group remained confidential. One facilitator explained:

Do we want to keep the confidentiality sufficiently that the person [nurse] can feel that they can come on a week to week basis and just tell us everything that is going on?

According to Patton, (2002:408) confidentiality means “that you know but won’t tell”. Confidentiality conveys a sense of privacy and discretion to individuals who are revealing personal information that exposes them to the scrutiny and possible disparagement by others, and in some cases, actual danger (Creswell 2009:91). It is important that nurse facilitators adhere to the rule of confidentiality in their support groups in order to instil trust and lessen feelings of vulnerability in the nurses attending their groups because group members are concerned about confidentiality when sensitive issues are disclosed (Schwarz 2002: 360-362).

4.6.2.2.2 Accountability is mandated as part of the recovery process

The participants also expressed their experiences with insisting on personal accountability from the nurses in their support groups. Many of the facilitators insist that each nurse must be accountable to himself or herself, as well as to all others in the group, because each member of a support group relies on one another. One nurse facilitator spoke about how holding the nurses accountable reinforced his or her commitment to being accountable:

Because it holds me accountable, and then each one of the nurses as they come through are being held accountable by me. When I see them out in the community and that kind of thing,

it is something that we can... we have something in common that we can look at each other and say, hey, you know we are doing okay. You know, we are making it, that kind of thing.

One of the things that we require in our group is a total commitment to the group. You are going to have to be here every week for the time that you are in the program, or have a good excuse not to be. It makes people accountable for that.

I hold nurses accountable for attending support group and staying clean and sober.

Personal accountability implies that an individual is answerable and responsible for his or her choices and behaviour. Accountability to others is another expectation in a group setting. Responsibility, a synonym for accountability, is defined in *A Manual for Group Facilitators* (2007:2) as an adult person being responsible for his own life and what happens in it is due to the choices he makes. Klein (2000:157-158) explains accountability as something that “forces people to think about their actions and the consequences of their behaviour”.

4.6.3 Nurse facilitators experience various roles as facilitators of support groups

The nurse facilitators perceived their role in various ways. Some saw their role as one of a labour of love. Another nurse facilitator explained how he or she would give support and guidance. This is what he or she said:

Basically it's what's happened to you since the last time we saw you, and what do you have going on between now and the next time we see you, that you want to talk to us about.

Another nurse facilitator thought his or her role should be more confrontive:

We have to be really careful. We are more confrontational; we cover responsibility; help people through their relationships in the group to get more understanding about themselves. We are more than a support group and less than a therapy group.

Some facilitators expressed pride in their role as managers who were punctual with paperwork and meeting times:

I start my group on time. I do not lock the doors to keep out late-comers. I don't report every little infraction, but I do include in my monthly reports any infraction of the group rules by individuals that have become a pattern. Each client [nurse] receives a copy of his or her monthly report.

One nurse facilitator believed that his or her role was not one of being a therapist or counsellor. Most nurse facilitators described their role as fulfilling to them, no matter how it was individually perceived. At times their role seemed frustrating and isolating to them, but it was always considered necessary and important. The overall premise of how they perceived their role was positive and hopeful. They were also proud of their work with the nurses in their support groups. Their altruism, empathy, and compassion became evident in the interviews. This is what some of them said about this:

I don't find it [being a nurse facilitator] hard because I am just there for them to blow it off, so that they can get through it, so we can talk them through it. I let them know that I am available anytime they need to call me. They don't have to wait until a meeting. They can call me anytime if they have concerns or questions....It is just like take it one day at a time, and just look at what you need to do.

Probably the most difficult thing that I have found as a nurse support group facilitator is that I can get very attached to some nurses because they are like little guardian angels in life and they don't have a clue what wonderful human beings they are.

4.6.3.1 Communicator

When acting in the role of communicator, a nurse facilitator explained what is talked about in his or her support group, such as discussing school, work, recreation, and vacations. This nurse facilitator emphasised that communication in the groups was not restricted to only certain topics. This is what she said:

We talk about school. We talk about work. We talk about recreation. We talk about vacations. We talk about all the things that comprise life. And it gives a broader scope to the group. We never lose track of why we're there, and the issues can always raise their ugly heads, at any given moment, but it's not a militant addiction program, you know.

Another nurse facilitator communicated to the nurses by distributing information about the support group, the facilitator, confidentiality, and expectations.

I have a several page, long description of my support group, and how it works, a little bit about myself, about the expectations, especially, confidentiality, and what they can expect of me as a facilitator.

Communication is the essential skill a support group facilitator must have in order to communicate effectively with the group members (Chilberg 2005:151). Underscoring the communication process for the nurse facilitator is the ability to actively listen, actively see, and actively support the communication of the support group nurses (Bens 2005: 151).

4.6.3.2 Informed resource person

The nurse facilitators share a wealth of resources with the nurses in their support groups. The following three nurse facilitators explained the type of information they share with the nurses.

We talk a lot. We talk about how the contractor operates. Where to get urine testing, and I also focus a lot on addiction as a process.

My handout is very basic, but it does with things like confidentiality in the group. It deals with them learning how to support each other, and it has a list of phone numbers, as in "please pick up the phone and call other nurses."

If we get into something too serious, then contacts have been made with a number of psychiatric facilities and people that we can have some place adequate to refer them to, and they have taken advantage of that.

A resource person, sometimes called a case manager, is someone who can link the appropriate organisation and community resources and formulate a plan for the benefit of individuals who do not have such access (Cara & MacRae 2005:638). The resource person may develop a resource book identifying agencies that might be of service to individuals. Several of the nurse facilitators mentioned that they had developed resource information for the benefit of the nurses in their support groups.

4.6.3.3 Educator

The Diversion Program's treatment program for nurses with chemical dependency is based on the Alcoholics Anonymous (AA) Twelve-Step Program. The nurse facilitators perceived their role as one of supporting and educating the nurses about the importance of investing their recovery in AA. The nurse facilitators related how they felt they were changed by facilitating support groups for nurses with chemical dependency and how this brought

about an increased awareness in them. Education was seen as an important way for the nurses to gain an understanding of chemical dependency.

Out of my nurse support group grew to what I saw as a need to educate nurses on what is the Diversion Program, what is addiction, what is the Board of Nursing [sic], and what is their authority.

We encourage the Twelve-Step program involvement, their sponsorship, and all that stuff. We see that as a huge advantage.

In this disease process you don't get a second opinion.

One nurse facilitator summed up the opinions of several nurse facilitators who were concerned about the ignorance of nurse administrators about chemical dependency and the Diversion Program.

Well they [hospitals and nurse administrators] are totally ignorant of diversion, etc. because I have been asked to talk to a group of nurse administrators here in the spring sometimes when they work me into a meeting, just to talk about it because they don't understand diversion, or anything. For the most part, the hospitals, if they know about it [nurse in diversion], they fire him, they don't want him back, at least that's how it is in this area.

Reid and colleagues (1999:310), describe the value of education and learning in their research on improving support for mental health staff as a means for individuals to gain self-knowledge, to change, and to curb burnout. Nordgren and co-workers (2008:1350) believe the acquisition of information and knowledge to be a fundamental requirement in order for individuals to understand and cope with their problems.

4.6.3.3.1 Chemical dependency disease process

The nurse facilitators identified the experience of chemical dependency as politically incorrect and full of social prejudice, particularly if one were a nurse.

There is a lot of social prejudice with this process [of treatment for chemical dependency].

Politically it is not fashionable to be an addict, and definitely not fashionable to be a nurse addict!

One nurse facilitator related how chemical dependency is a disease similar to cancer, but regarded negatively by society, and another described how the nurses' were very ill when first seen.

The analogy that I use is that addiction is like a cancer.

Their chemical dependency and co-dependency is out of control when I first see them.

Chemical dependency as a disease process is still not fully accepted by health professionals, especially when the impaired individual is a health professional (Haack & Hughes 1989:23). Chemical dependency is the repetitive use of any mind-altering substance which impairs the thinking, feelings, actions and behaviours which take over a person's life to the detriment of the person, loved ones, associates, and community. Negative effects of chemical dependency are evidenced by decreased productivity, lack of insight and self-growth, lack of authentic intimacy, isolation, regression, and increasing use of denial (Fontaine & Fletcher 2005:428; DSM-IV 1994:176).

- **Sobriety**

Support groups were identified as a good place for the nurses with chemical dependency to work on their sobriety because it is better to work on it in the company of peers, rather than to try to maintain it alone.

I think the support group is a good place for nurses to concentrate on their sobriety.

I mean, it is really hard to try and get people get through it somehow, and we all have, and I did, too. Because I could concentrate on my sobriety, and I know that that is probably what they are doing, to try to get a good basis of sobriety.

- **Relapse**

When discussing the potential for relapse the nurse facilitators related their concerns about how the partners of nurses with chemical dependency were potentially a serious threat to the nurses' sobriety. Another concern was the lack of a peer support system once the nurse is no longer in the Diversion Program. One nurse facilitator's distressing prediction was that two out of three nurses would relapse. The consensus for staying in recovery

seemed to be that nurses needed to remain in support groups after they graduated from the Diversion Program.

One of the biggest relapse issues for women is their partners.

There is no peer program. There is no peer mediator, kind of like the Betty Ford program where there are peer contact people throughout the state.

I have really developed a great clarity of the reality that two out of three nurses who get into recovery are going to relapse.

And a nurse who is non-compliant with the Diversion Program, chances are they're using. Nine-nine percent chance they're using. And that's what non-compliance is about.

Support groups can encourage nurses who relapse to get back into recovery.

I don't think that we ever graduate from this disease of addiction.

The experience of the nurse facilitators was that it was important to focus on recovery in the nurse support groups because they knew that nurses with chemical dependency were always in imminent danger of relapse, and that maintaining the focus on sobriety was vital to their recovery. Research by Banonis (1989:37) identifies the risk of relapse as high during the early months of recovery when a person runs the risk of returning to familiar patterns of chemical dependency. Chappel and Dupont (1999:427) write about the success of the Alcoholic Anonymous Twelve-Step program due to its belief that every individual must be committed to maintaining a life based on sobriety.

- **Recovery**

Recovery was viewed in different ways by the nurse facilitators. Some focused on their own recovery and used themselves as role models to encourage nurses with chemical dependency who had relapsed to return to the recovery program. Others stressed how important the nurse support groups and the Diversion Program were to recovery. As a whole, the nurse facilitators viewed their own experiences in recovery as an advantage when relating to the nurses with chemical dependency. Nurse facilitators who were not chemically dependent focused on the nurses' individual problems and how those might cause relapse behaviour. However most of the nurse facilitators were eclectic in their approaches as to how and when recovery was discussed in their groups.

Another thing I like to watch, and that's just the journey, I love to watch the changes that take place when people realise that addiction is about self-destruction and recovery is about building yourself to be the best person that you can possibly be.

I have really learned a lot from the nurses because I get to see them very early in their recovery, in their denial, in their anger, in their blaming ...Their co-dependency and their chemical dependency is out of control....and then I get to see them in recovery and slowly become wonderful models of nurses who are now at a healthier place in their life.

It was the belief of the nurse facilitators that the experience of recovery is an on-going, life-long process, yet they were concerned that the Diversion Program may not prepare them for understanding that recovery is for the rest of their lives.

I don't feel this Diversion process as looking at the whole person in terms that this is a lifelong process.

They also emphasised how recovery is a positive, lifelong experience,

Recovery is like watching a birth. It's a miracle.

One of the great gifts to me is to be part of the miracle of recovery.

I think that the nurses that were in the group liked it when the facilitator was in recovery.

The nurse facilitators regarded the experience of support as valuable to the process of recovery by their understanding that support could come from various places: family, friends, fellow nurses, nurse facilitators, and strangers, but at the same time one nurse facilitator pointed out a lack of a networking system for nurses in recovery.

There is no treatment network for these nurses in recovery, and the disease doesn't go away; it's chronic, it's lifelong, it's progressive.

In her research on addiction Banonis (1988:37; 43) describes the researcher's idea of recovery as a process of change where the individual with chemical dependency changed, evolved, and healed. However, she found that her subjects described recovery differently, as going from darkness to light, of making healthy choices, of choosing the comfort of recovery versus the comfort of chemical dependency. Jacobson and Greenley (2001:482-484) identify two different aspects of recovery in their conceptual model of recovery: (1) the

internal aspects of recovery as hope, healing, empowerment, and social connection; and (2) the external aspects of recovery as human rights and recovery-oriented services.

4.6.3.4 Role model

The nurse facilitators were unanimous in their belief that part of their perceived role was to be a role model to the nurses with chemical dependency by showing them how to live a happy and healthy life.

For a nurse in recovery, living a happy, joyous free life in sobriety, and that's the other role model.

I know that the nurse facilitator is the most important part of their contract because the nurse facilitator has hands on, eyes on, these nurses once a week.

I've seen my role as a nurse group facilitator as two things: I share my experience of strength and hope, which is what addicts do, with them because that is what alcoholics and nurses do with each other, and so I am there as a recovering person, but I am also there as a role model.

Two nurse facilitators would like to see nurses who are about to graduate or have graduated from the Diversion Program to occasionally return to the support groups to serve as role models.

Because I think, see especially up until when they get finished with transition, and then they don't have to come anymore [to support group], but I would also like to encourage them to at least stay in touch with us, so the others who are just coming in will get to see somebody finish, you know, finishing the program.

Nurses should be required to attend support group during Transition. It makes no sense that they are left on their own at a time when they need the support of other nurses. Besides they would serve as role models to the nurses.

A nurse facilitator of nurses with chemical dependency acts as a role model who is supportive about the struggles during treatment, and facilitates the learning of new coping skills that will sustain recovery (Jones, Walters, & Akehurst 2001:152).

4.6.3.5 Mentor

The nurse facilitators identified their role as that of a mentor to the nurses in their support groups and they encouraged the nurses to mentor one another. Not only did the nurse facilitators expect to function as mentors, but they also believed that the nurses in the support groups should mentor one another

The purpose of the nurse mentor is, if somebody is coming to my group from Diversion recommendation, I assign them to somebody who has been in the Diversion Program that is really doing a good solid program of recovery, and that may have one-and-a-half to two years of recovery. I want that person to mentor the new nurse. [It] is to give them the notion that nurses can mentor other nurses.

Nurses mentoring other nurses. I love it. And it makes them pick up the phone.

I really think that the nurse community, in recovery, is a good connection.

For me, I find that working with these people first coming in that it's reminding me where I could go again, and it also helps the others who have already gotten through it to say, you know what, I have been there, let me help you.

Bidwell and Brasler (1988:23-24) identify mentoring as an active process that takes place over a long period of time in a close relationship. The mentor serves as counsellor, teacher, advisor, sponsor, and guide. In the Alcoholics Anonymous Twelve-Step Program, the alcoholic must find a sponsor to mentor them throughout the recovery program and after.

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4.6.3.6 Facilitator

The nurse facilitators pointed out how their role entailed providing structure. They were not overly concerned with the amount of paperwork required by their role. They took the

approach that it was part of their job. They saw themselves as change agents, who are knowledgeable, and who instil hope and give feedback.

One of the things I do when a nurse first joins my group is I give them a handout of what they can expect from the facilitator, and what is expected of them.

It's interesting the dynamic between the facilitator and the group. My approach to this is the group is only valuable if I can create a space that enables nurses to talk with each other to make me unnecessary.

I'm not their counsellor. I'm the facilitator for the support group.

The role of support group facilitator is many faceted, as are the skills that are necessary for leading a group. The behavioural skill essential for a group facilitator according to Stokes and Tait (1980:299) is the ability to intervene in a manner that will promote individual growth in group members. In a study evaluating facilitators of a cancer support group (Cella, Sarafian, Snider, Yellen, & Winicour 1993:123) the data revealed that the group members rated caring, involvement, sensitivity, and understanding to be the highest desirable characteristics of a facilitator; whereas, Bostrom et al (1993:146) define the chief characteristic of facilitation as assisting group members to achieve outcomes more easily. Bostrom et al (1993:147) also point out that facilitation is not just leading a group, but involves all the duties and activities before, during, and after a group meeting. Schwarz (2002:41) goes one step further as he describes a group facilitator as someone who helps groups perform more effectively by promoting the leadership skills in the group members.

4.6.3.7 Change agent

Once again, the nurse facilitators perceived their role in a positive manner. This time it was as a change agent where they described that role as a fulfilment of their lifetime of work.

I think of that time someday when I'm going to be dying and I'll think about what I've done with my life, and this is probably one of the best things I've done in my life.

It is a metamorphous, of course. We are all changing.

One of the tasks of a nurse facilitator is to be a change agent whereby he/she encourages individual learning and motivates it to become group action. This type of interaction among

everyone in the nurse support group can have a dynamic influence on everyone, including the nurse facilitator (Marquardt 2000:235).

4.6.3.7.1 Knowledgeable

Knowledge about facilitating groups was important to the nurse facilitators. They defined their role as one that allows the group members to have an active role in the group process. The nurse facilitators were adamant that their role was to be knowledgeable about therapeutics, support group facilitation, psychology, chemical dependency, and nursing.

Facilitators need knowledge of therapeutics. Knowledge of doing groups. Knowledge of support. Certification in some sort of psychology. A lot of things could qualify the person, but at least some professional expertise as a basis for approving the person as a group facilitator.

So my initial experience with nurse support groups was an incredible understanding of alcoholism, from my personal and professional aspect.

The nurse facilitator who is knowledgeable is someone who knows about life, and who understands that people are motivated by hopes and dreams; who know that obstacles are opportunities in disguise; who know that people are fulfilled when they learn to take responsibility for their choices and actions; and who know that teamwork can be fraught with stress and tension, but is necessary for getting the task done. Nurse facilitators are aware that communication and shared goals are necessary to maintain cohesion within a support group, and they know that recovery and sobriety lies within the reach of everyone, but the decision is up to each individual to find hope and joy in themselves rather than in a chemical (Epps 2005:565-567).

4.6.3.7.2 Instils hope

The nurse facilitators saw giving hope to the nurses with chemical dependency as a way of helping them learn to trust in a future that could be a place of safety and happiness, thereby giving them a sense of courage and purpose to change their present conditions. The nurse facilitators believed that a nurse support group was an important place where the nurses could learn about hope in the context of real life. The nurse facilitators were

committed to offering hope to the nurses in order that they might learn to anticipate a better future no matter how hard life was for them at the moment.

That they see somebody that has already been through it and can get back to working full time and, you know, in good standing.

Giving them hope, that is the first thing I heard when I first went to a meeting.

When you see somebody that is getting back on their feet, and working full time, and almost finished with Transition, it is like wow, it is possible.

Lohne (2008:238) identifies hope as central to experiences of suffering and recovery, and refers to Eriksson when identifying hope as multidimensional and holistic containing movement between hope and hopelessness. Lohne (2008) describes hope as an active process involving feeling, thinking, behaving, and relating, where the individual searches for appropriate goals and solutions.

4.6.3.7.3 Provides feedback

The perception from the nurse facilitators was that they used feedback as a tool for gathering, dispersing, and confirming information. They indicated a good understanding of how feedback should work by making sure that the nurses in their support groups received information from them and understood what they heard or read. Feedback was regarded as important in order for learning to take place.

I will share things. I certainly do give substantive feedback if I think it will facilitate the process.

Each client receives a copy of his or her monthly report from me.

I think the most important place for feedback is with the nurse facilitator.

Freire (2005:44) believed that when people are left out of the communication process they feel oppressed and disenfranchised and cannot see their world clearly.

4.7 THE STRUCTURE OF THE DIVERSION PROGRAM AS EXPERIENCED BY THE NURSE FACILITATORS

In Figure 4.1, the organisational chart represents how the nurse facilitators in the study perceived the flow of communication beginning with the BRN and continuing throughout the Diversion Program. The facilitators' perceptions indicated three areas of communication, each isolated from the others: (1) communication among the Board of Registered Nursing, the Executive Officer and the Diversion Program Manager; (2) communication between the Diversion Program Contractor and the Diversion Evaluation Committee; and, (3) communication between the nurse facilitator and support group. The nurse facilitator is acknowledged as part of the Diversion Program, albeit in a marginalised position, isolated from the other strategic parts.

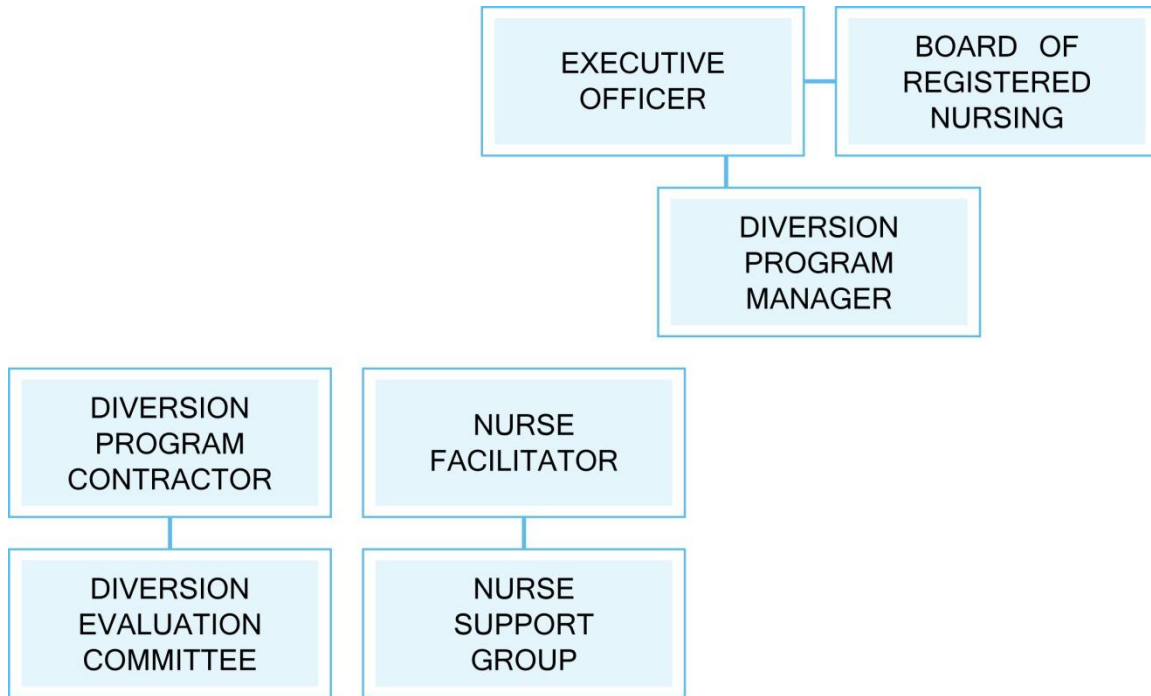


Figure 4.1: Organisational chart of the California Diversion Program as indicated by the findings

4.8 CONCLUSION

This chapter was structured around the four themes that became apparent during the analysis of the data. Verbatim quotations and literature control were included as validation for the research findings.

Chapter 5 explains the justification for the formulation of guidelines and a conceptual framework for support of nurse facilitators. The survey list from Dickoff and colleagues (1968:425-433) is used for the basic structure of the guidelines and the conceptual framework. The nursing process from the Neuman systems model (Stanhope & Lancaster 2004:202-205) is employed to access the structure and function of the Diversion Program.

CHAPTER 5

GUIDELINES AND CONCEPTUAL FRAMEWORK

5.1 INTRODUCTION

Chapter 4 discussed the research findings that resulted from the interviews with nurse facilitators about their experiences facilitating support groups for nurses with chemical dependency. Four themes were identified from the data analysis. Literature control was addressed for validation.

This chapter justifies why guidelines were formulated from the personal phenomenological experiences of the nurse facilitators. The data revealed that the nurse facilitators felt strongly unsupported in their roles, and their experiences provide invaluable information to the Diversion Program to enhance the experiences of the nurse facilitator. The researcher applied the survey list of Dickoff and colleagues (1968:425-433) as a foundation for the guidelines and the conceptual framework. The nursing process according to the Neuman Systems Model was employed to clarify and assess the structure and function of the Diversion Program (Stanhope & Lancaster 2004:202-205).

5.2 RATIONALE FOR GUIDELINES

Guidelines were formulated for support of nurse facilitators of support groups for nurses with chemical dependency in California, USA because no guidelines existed that reflected input about the experiences of the nurse facilitators. The guidelines that were distributed by the Diversion Committee to the nurse facilitators could more accurately be identified as basic rules and which, according to the findings, did not meet the complex needs of the nurse facilitators.

5.3 SUPPORTIVE THEORY

The study was guided by Dickoff and colleagues' (1968:425-433; Reed & Shearer 2009:385) survey list in creating guidelines and a conceptual framework for support of the nurse facilitators.

5.3.1 Survey list

The conceptual framework for the study was structured by using the survey list from Dickoff and colleagues (1968:425-433; Reed & Shearer 2009:521-529; Dickoff & James 1968:197-203; Ohashi 1985:17-20) situation-producing theory as the foundation. Dickoff and co-workers consider their situation-producing theory (prescriptive theory) to be a theory of the highest level because it is “produced to guide action to the production of reality (Reed & Shearer 2009:523)”. The goal of a situation-producing theory is to bring about a desired action or outcome.

The survey list is part of a larger perspective that describes the characteristics of the three ingredients of their fourth level situation-producing theory as: (1) goal content is clearly specified; where situations that are brought into existence are broadly explained; (2) prescriptions are clearly stated directives for the activities that are intended to bring about the goal; and (3) a survey list is aimed at significant aspects of activity and resources that are pertinent to the activity. The six survey list ingredients are agent, recipient, framework, procedure, dynamics, and terminus. The six ingredients from the survey list are described below as they relate to the study (Dickoff et al 1968:425-433).

Agent: The agent is the individual who performs the activity. In the case of this study, the activity would be any nursing activity that contributed to a nursing goal, for instance as identified in the terminus (Dickoff et al 1968: 425). The agent is the Diversion Program manager, who is a clinical nurse specialist in mental health and chemical dependency. This clinical nurse specialist will have knowledge about chemical dependency and mental health problems, accompanied by the necessary managerial skills to maintain a cohesive, high functioning Diversion Program, where individuals in all parts of the organisation feel equally supported. The agent/Diversion Program manager is someone who has the intention of a goal and propels action towards that goal if the goal is to be achieved.

Recipient: According to Dickoff and colleagues (1968:426-428) the recipient is the individual who receives the activity from the agent. The implementation of the formulated guidelines requires that the nurse facilitator of a support group for nurses with chemical dependency be the recipient of the activity, and the activity to be initiated by the agent (i.e. the Diversion Program manager).

Framework: The framework is simply the context in which the activity takes place (Dickoff et al 1968:428). For this study the framework is the California Diversion Program.

Terminus: The terminus is defined as the goal or the outcome of the study. The terminus identifies what the activity has accomplished (Dickoff et al 1968:428-430). The terminus of the implementation of the guidelines as suggested by this study is the perception of nurse facilitators supported by the Diversion Program.

Procedure: The procedure indicates the protocol for the Diversion Program manager, who may involve other parts of the Diversion Program as needed, to bring about support for the nurse facilitator. The procedure entails the formulation of guidelines to provide a course of action for the Diversion Program manager to follow in order to bring about the perception of support for nurse facilitators (Dickoff et al 1968:430-431).

Dynamics: The dynamics of an activity are the power sources for that activity, these being the driving forces behind the procedure (Dickoff 1968:431-433). The dynamics, or motivation, for the activity is the feeling of support by the nurse facilitators which is provided through the Diversion Program.

In Table 5.1 the researcher organised aspects of activity as they relate to the articulation of the conceptual framework by using Dickoff and colleagues' survey list.

Table 5.1: Survey list adapted from Dickoff et al (1968:425-433)

Aspects of activity	Question	Answer
Agent	Who or what performs the activity?	Diversion Program Manager who is a clinical nurse specialist in mental health/chemical dependency.
Recipient	Who or what is the recipient of the activity?	Nurse facilitators of support groups for nurses with chemical dependency
Context (framework)	What is the context where this activity takes place?	California Diversion Program
Terminus	What is the goal or outcome of the activity?	<p>Communication will be increased among the different parts of the Diversion Program.</p> <p>Nurse facilitators will feel supported and regarded as integral to the purpose of the Diversion Program.</p> <p>Structure of the Diversion Program will be improved. *Role of Nurse facilitators will be empowered.</p>
Procedure	What are the relevant realities?	Guidelines are created for support of nurse facilitators by the Diversion Program
Dynamics	What is the energy source for the activity?	The motivating factor is for nurse facilitators to feel supported by the Diversion Program.

5.4 CONCEPTUAL FRAMEWORK

The conceptual framework identifies the foundation, including the rational and definitions of key concepts (Dickoff et al 1968:425-433).

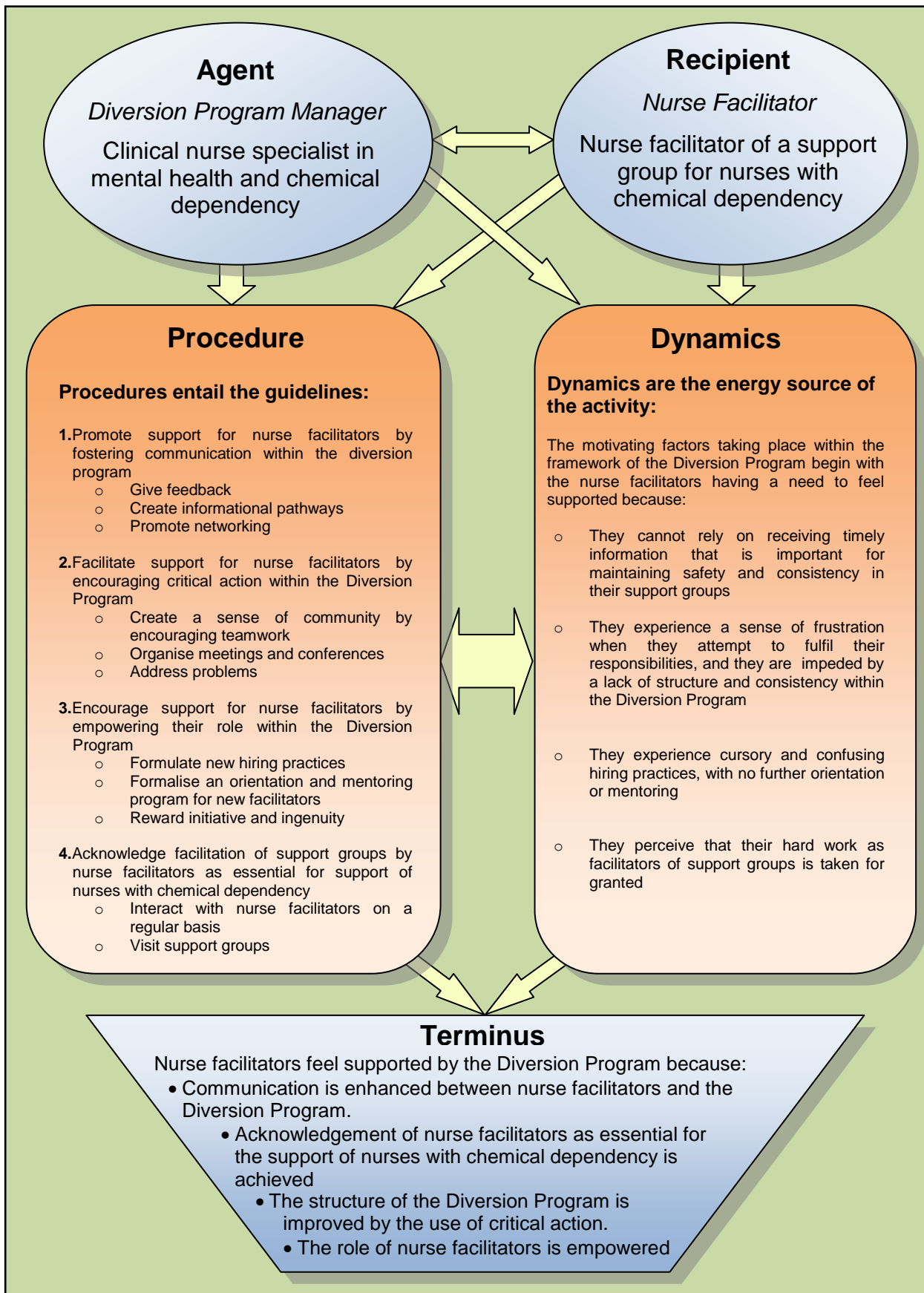


Figure 5.1: Conceptual framework

5.5 PHASE 2: FORMULATION AND DESCRIPTION OF SUPPORTIVE GUIDELINES FOR NURSE FACILITATORS OF SUPPORT GROUPS FOR NURSES WITH CHEMICAL DEPENDENCY

Guidelines provide boundaries and frameworks. They are, as the word indicates: lines that guide. Lines may be drawn in the sand or written in a paragraph, but their very presence alludes to the assumption that they are necessary; that without them there would be only ambiguous destinations. They organise information, identify problem areas, offer solutions, and indicate through purposeful planning how to arrive at those solutions.

Through the analysis of the lived experiences of the nurse facilitators it became increasingly clear that most of them do not feel connected to and supported by the Diversion Program. Therefore the researcher felt it necessary to conceptualise and suggest a framework to the Diversion Program through which the nurse facilitators would feel supported in their roles. A guiding question for this section of the thesis therefore became: how can the Diversion Program provide support to nurse facilitators to enhance their experience?

The researcher offers the following suggestions to the experience and to promote the feeling of support of nurse facilitators. It is believed that the nurse facilitators would feel more supported by increased communication practices, the encouragement of critical action, the empowerment of their roles, and the acknowledgement of their roles as essential to nurses with chemical dependency.

5.5.1 Promote support for nurse facilitators by increasing communication within the Diversion Program

Communication is an ongoing circular process that must move among the different entities of the Diversion Program. In this manner messages will be sent back and forth and feedback will occur. Information will be circulated to everyone involved in an effort to improve the cohesiveness of the program. Communication acts as a unifying agent sustaining the supportive concepts of information. "Language influences thought; thought then influences action; thought and action together evoke feelings in relation to a situation or context (Peplau 1969 cited in Tomey & Alligood 2006:699)." Increasing communication

within the Diversion Program has the potential for promoting support for the nurse facilitators by creating understanding about their role, and thus, influencing the feelings and actions taken on their behalf.

Problem: The results of the analysis of the interviews with the participants indicated that the nurse facilitators felt that there was not enough communication between them and other parts of the Diversion Program. This led the nurse facilitators to feel unsupported and marginalised from the rest of the program. This was evident through their remarks that they did not know when new members would join the group, or updates about current members' statuses in the recovery program, or that it seemed to take "forever" to get anything done through the Diversion Program.

Strategies for improving communication within the Diversion Program:

- Improve communication within the Diversion Program by:
 - Utilizing the latest digital communication devices
 - Creating a monthly electronic newsletter
 - Scheduling regular meetings with the Diversion Program manager with the different parts of the Diversion Program
 - Generating a networking system to improve contact among the nurse facilitators
 - Improving exchange of information between the nurse facilitators and the Diversion Program contractor, and between the nurse facilitators and the DEC's
 - Scheduling a yearly conference with guest speakers who are experts in chemical dependency, with break-out sessions covering issues relevant to the Diversion Program for brainstorming and problem-solving.

5.5.2 Facilitate support for nurse facilitators by encouraging critical action within the Diversion Program

Critical action, often referred to as praxis, is action based on critical reflection, indicating that measures are taken that allow for optimum functioning by encouraging full participation of all involved parties. Critical action serves to bring about transformation by the conscious utilisation of teamwork when everyone involved believes that the proposed action can bring about positive results (Minkler & Cox 1980:311-312).

Problem: The analysis of the data revealed that nurse facilitators were often frustrated with the loose structure within the Diversion Program. The loose structuring was perceived to marginalise them and erode the solidarity of the Diversion Program. They perceived that certain practices were remiss in fostering the premise of the program, such as hiring nurse facilitators over the phone, focusing more on punishment rather than treatment, conflicting directives causing major problems in the groups, and neither an orientation program for new nurse facilitators nor guidelines in support of them. Following are strategies proposed to bring about changes that could correct these problems that are eroding the solidarity of the program.

Strategies for encouraging critical action within the Diversion Program:

- Improve the structure of the Diversion Program by enlisting the assistance of all parts of the program. Investigate other diversion programs for new ideas. Reinforce the awareness that structure is not seen directly, but what is seen is the resulting behaviour that the structure produces (Schwarz 2002:27).
- Establish consistency within the different parts of the Diversion Program with oversight by the Diversion Program manager.
- Develop a plan for supervision from the Diversion Program manager that is acceptable to all parts of the program, i.e., that allows for individual decision-making, but still retains continuity.

5.5.3 Enhance support by empowering the role of nurse facilitator within the Diversion Program

Freire defined empowerment as a consequence of liberatory learning where groups of people identify their problems, formulate a vision of a healthier future, and develop strategies to bring that vision to a reality (Freire 2005:45-47; Wallerstein & Berstein 1988:380). Barker, in his Tidal Model, describes empowerment as lying at the heart of the caring process (Tomey & Alligood 2006:702). Empowerment of the nurse facilitators could be accomplished by applying the two definitions of empowerment by Freire and Barker, wherein the cognitive and emotional needs of the nurse facilitators would be addressed. Their critical thinking and learning skills could be utilised by involving them in the development of strategies to bring about a more cohesive Diversion Program, one that might involve the development of a new paradigm. In this manner they would no longer feel marginalised by the Diversion Program, but rather, appreciated and cared about.

Problem: Marginalisation of nurse facilitators by the Diversion Program. Examples of perceived marginalisation were described in the interviews as receiving no communication from the Diversion Program, no idea whom to contact for guidance, and not an interdisciplinary team approach.

Strategies for empowering the role of nurse facilitator within the Diversion Program:

- Invite the nurse facilitators to strategizing meetings in the Diversion Program.
- Improve qualification standards for nurse facilitators. For example to include, but not limited to, face-to-face interviews of all new applicants in front of a committee composed of the Diversion Program manager, two current nurse facilitators, and one recent graduate of the Diversion Program. At that time the applicant could identify his/her level of expertise in leading support groups, as well as knowledge of chemical dependency and mental illness. It would be important for the committee to investigate the applicant's background and motives for applying for the position of a nurse facilitator of a support group.
- Utilise the suggested guidelines from this study or formulate new guidelines for support of nurse facilitators

- Empower the role of nurse facilitator by developing a basic template for the nurse facilitators to follow in order to establish a sense of continuity among the support groups
- Establish a line of contact for the nurse facilitators to utilise when they need assistance and guidance
- Formulate an orientation program for new nurse facilitators to teach them about basic standardisation of group process, rules, paperwork, fees, and expectations (i.e., nurse support groups should not mimic a therapy or Alcoholics Anonymous group), yet allow freedom for individual group needs and each facilitator's leadership style.
- Establish an evaluation tool by which nurse facilitators would be evaluated by the nurses in the support groups. The evaluation tool could be published Online on the California BRN's home page, after which group members could be invited to evaluate nurse facilitators on certain points once a year. Those points may include, but not limited to: (1) knowledge of the Diversion Program; (2) knowledge about support group process; (3) expertise in the principles of group leadership; (4) knowledge about chemical dependency, relapse, and recovery; (5) skilful use of therapeutic communication and assertiveness; (6) maintenance of confidentiality; (7) functions as a role model; (8) able to keep clear boundaries; (9) gives timely feedback; (10) maintenance of group infrastructure, such as arrangement for meeting place, paperwork, fees, and reports. The completed evaluation forms would be forwarded to the Diversion Program manager, with each nurse facilitator receiving copies completed by his/her support group nurses.
- Create a system for mentoring new nurse facilitators whereby experienced facilitators would mentor newcomers. A nurse facilitator mentor would agree to be available to the new nurse facilitator by phone, email, or in person for six months. A new nurse facilitator would be expected to attend a month's meetings (one meeting per week) led by the mentor. If the mentor so agreed, the new nurse facilitator would be allowed to co-lead some of the groups, with the option to be assisted and critiqued by the mentor.

5.5.4 Promote support for nurse facilitators by acknowledgement from the Diversion Program that facilitation of support groups by nurse facilitators is essential for support of nurses with chemical dependency

Acknowledgement is sought by the nurse facilitators from the Diversion Program so that their role as facilitators of support groups is regarded as essential for the support of nurses with chemical dependency. Clawson and Bostrom (1993:333) in their investigation about the responsibilities of group facilitators identify the following consistently critical themes: “rapport and relationship building, outcome development and emphasis, and the establishment/maintenance of structures and support.” In light of this study, it appears warranted that the nurse facilitators receive their due recognition by the Diversion Program where their role is reviewed and acknowledged as essential to the treatment mission of the program.

Problem: The interviews with the nurse facilitators indicated that they perceived the Diversion Program considered their role in the recovery process of the nurses with chemical dependency as not important. This perception was likely related to the feelings of marginalisation.

Strategies for acknowledging that facilitation of support groups by nurse facilitators are essential for support of nurses with chemical dependency

- Acknowledge the various roles (mentor, educator, role model, facilitator, confidant, resource person, etc.) that nurse facilitators assume for support of nurses in their support groups
- Acknowledge the knowledge base of nurse facilitators by increasing their role in the community as expert resource contacts for increasing the awareness of the problem of chemical dependency among nurses.

5.6 REVIEW OF THE DIVERSION PROGRAM APPLYING THE NEUMAN SYSTEMS MODEL

5.6.1 Input, process, and outcome

During the conduction of the study the researcher became aware that the nurse facilitators did not experience the Diversion Program as an open system with clearly defined roles and responsibilities among its different parts. It became obvious to the researcher that there was no tool for the assessment of the structure and function of the Diversion Program. The nursing process according to the Neuman Systems Model is suggested as a means to continually assess the structure and function of the individual parts of the Diversion Program. In the processes of input and outcome, the client (individual, group, or community) is considered to be an open system. Input and outcome reflect information, matter, and energy that are exchanged between the client and the environment. Process refers to the client-system as it exchanges energy, information, and matter with the environment, all the while using available energy resources to move towards stability and health (Tomey & Alligood 2006:320).

In Table 6.1 the Neuman Systems Model (Tomey & Alligood 2006:320) is employed as an explanation about the Diversion Program as an open system where all of its parts exchange information and energy within its organisational structure. Borrowing from Neuman, the Diversion Program is identified as the client with inter-dependent and interacting parts.

Table 5.2: Input, process, and output

	Input	Process	Output
Nurse facilitator	Communicates, facilitates group, role models, mentors, reference person, provides safety	Mediates, advocates, provides emotional support, sets goals, provides feedback, maintains clear boundaries, empathetic, compassionate, observes & learns from support group, teach about chemical dependency & recovery, maintains & explains healthy group dynamics	Interactional cooperation accomplished, clear boundaries maintained, mutual responsibility accepted, assertive communication, empathetic, compassionate, observe & learn from group, supportive network building
Nurse with chemical dependency	Denial & increased use of defence mechanisms, poor coping skills, ignorance about chemical dependency, secrecy, disguise of normalcy, predisposing & precipitating factors, inadequate treatment programs	Confidentiality, peer mentoring	Self-awareness increased, peer mentoring adopted, confidentiality mandated, accountability & change welcome, understanding about chemical dependency as a primary disease
Nurse support group	RN group members in all stages of chemical dependency & recovery	Group dynamics, confidentiality, universality, instillation of hope	Teamwork accomplished, networking increased, peer support & mentoring adopted, trust in self & others improved, involvement in harmonious social relationships
Diversion Program Manager	Unknown credentials	Managerial responsibilities.	Diversion Program Manager is a clinical nurse specialist in mental health and chemical dependency, who is a role model & spokesperson for the Diversion Program, advocates for nurses with chemical dependency, & communicates & attends meetings on a regular basis with the different parts of the Diversion Program, attends each nurse support group once a year
Diversion Evaluation Committee	DEC is made up of two RN's & two other credentialed specialists in mental health/chemical dependency	DEC meets to evaluate, admit, and supervise the treatment & recovery status of nurses with chemical dependency who are admitted to the Diversion Program	Continuity continued, a sense of community increased, more networking initiated.

Table 5.2 (continued)

	Input	Process	Output
Diversion Program contractor	Contracted to provide for administrative activities of Diversion Program, and monitoring of nurses with chemical dependency	Supervises the infrastructure of the Diversion Program by managing the treatment program of the nurses with chemical dependency	Increased communication with other parts of the Diversion Program, improved managerial & administrative skills equal to the expectations of other parts of the Diversion Program, timely feedback achieved, improved cohesiveness and teamwork, positive changes set in motion, better interactional cooperation, mutual interests, improved

5.1 PROPOSED ORGANISATIONAL CHART FOR THE CALIFORNIA DIVERSION PROGRAM

In the proposed organisational chart suggested by the study (Figure 6.1), the different parts of the Diversion Program have free flowing communication lines. The communication flow is less hierarchical to include all parties and mitigate the feeling of isolation or marginalisation. The role of the Diversion Program Manager is shown in a central position. Communication is a back-and-forth flow from the Board of Registered Nursing to the Executive Officer, to the Diversion Program Manager, where communication continues in a circular format as it joins with the Diversion Evaluation Committee, the Diversion Program Contractor, the Nurse Facilitator and Nurse Support Group. In the centre of the circle, in touch with all parts of the Diversion Program, is the Diversion Program Manager, who is shown as pivotal to the success of the communication process within the Diversion Program.

5.2 CONCLUSION

The researcher believes that by incorporating some or all of the above discussed guidelines in Chapter 5 the experiences of the nurse facilitators will be enhanced and they will be made to feel as integral parts of the Diversion Program. Their role, too, will be empowered once they are acknowledged as critical agents in the recovery process of nurses with chemical dependency. If nurse facilitators feel that they are being included, supported, and empowered by the Diversion Program they will be motivated to participate

more fully in the dynamics of the Diversion Program, as well as to expand into their communities as experts about nurses with chemical dependency. In Chapter 5 the survey list from Dickoff et al (1968:425-433) was utilised to provide guidance in the formulation of guidelines and a conceptual framework for support of nurse facilitators of support groups for nurses with chemical dependency. The nursing process from the Neuman Systems Model utilized to provide the format for assessing the structure and function of the Diversion program.

Chapter 6 concludes with a comprehensive summary of the study, and identification of limitations, and recommendations.

CHAPTER 6

CONCLUSIONS

6.1 SUMMARY

The researcher became aware of the seriousness of the problem of nurses with chemical dependency in California by reason of serving on a California Diversion Evaluation Committee. A problem associated with the issue of nurses with chemical dependency came to light when the nurses who served as facilitators of nurse support groups in the Diversion Program made it known that they felt that their role was misunderstood and under-appreciated. As a result of this early information, the researcher came to believe that an interesting question to investigate might be: What are the lived experiences of nurse facilitators of support groups for nurses with chemical dependency in the Diversion Program in California, USA? First, a pilot study was conducted in order to evaluate the efficacy for further in-depth research. The pilot study involved two nurse facilitators who were interviewed about their lived experiences. From the interviews it was discovered that the participants mainly reflected on their experiences with the Diversion Program operations. These were categorised into five themes: nurse facilitators felt (1) they were an oppressed and marginalised group within the Diversion Program; (2) a lack of communication among nurse facilitator was seen as problematic; (3) there is a lack of awareness in the nursing profession about nurses who have the disease of chemical dependency; (4) their role of nurse facilitator was not acknowledged by the Diversion Program as essential for the support of impaired nurses; and, (5) that some changes needed to be made within the Diversion Program for them to feel included. The pilot study indicated that a fuller, in-depth study could be valuable to the California Diversion Program and to the California Board of Registered Nursing. Therefore a qualitative phenomenological research study that was descriptive, explorative, and contextual was undertaken to explore the lived experiences of nurse facilitators of support groups for nurses with chemical dependency in California, USA.

Four major themes emerged from the interviews with twelve nurse facilitators: (1) how nurse facilitators experience communication within the Diversion Program; (2) how nurse facilitators experience the structure of the Diversion Program; (3) how nurse facilitators

experience their role within the Diversion Program; and (4) how nurse facilitators experience facilitation of support groups in the Diversion Program. The analysis of the data revealed an overwhelming perception by the nurse facilitators that their role was unsupported by the Diversion Program. This information led to the observation that communication patterns within the Diversion Program as perceived by the nurse facilitators were different from the communication flow conceptualised by the program itself. This perception resulted in the nurse facilitators feeling marginalised from the rest of the program. The ultimate goal of the study was to formulate suggestions for the Diversion Program to make the nurse facilitators more included in the operations of the recovery program for the nurses with chemical dependency.

From the information gathered during the study, guidelines and a conceptual framework were formulated for the support of nurse facilitators. Dickoff and colleagues' (1968:425-433) survey list provided the foundation for the guidelines and the conceptual framework. The nursing process from the Neuman Systems Model (Stanhope & Lancaster 2004:202-205) was utilised to provide a format by which to assess and clarify the structure and function of the Diversion Program. A proposed organisational chart for the Diversion Program was offered as a means of enhancing the flow of communication within the Diversion Program.

Limitations of the study concluded that the problem of transferability in qualitative research may be a problem in this study, also. Recommendations for nursing practice, the Diversion Program, and the nurse facilitators were discussed. Further research was recommended in two areas: nurses with chemical dependency who attend the support groups, and nursing students with chemical dependency.

6.2 LIMITATIONS OF THE STUDY

The main limitation of the study is the question of transferability. Qualitative research is contextual both geographically and temporally, meaning that subjective experiences vary with place and time. However, this is an openly acknowledged issue in qualitative research (Polit & Beck 2008:202). Since the experiences described and explored in this study are specific to nurse facilitators of support groups in California, the application of the results to other diversion programs requires caution.

6.3 RECOMMENDATIONS

Recommendations for further research, nursing practice, the Diversion Program, and nurse facilitators are discussed. In 6.3.4, the recommendation is to apply Neuman Systems Model (Tomey & Alligood 2006:320-323) to the Diversion Program to ensure that the structure functions as an open system with inter-acting parts.

6.3.1 Nursing practice

Chemical dependency should be clearly identified as a disease process in order to abolish ignorance and prejudice among nurses, and to establish awareness that treatment and recovery can return a nurse to full nursing practice without shame. Nurses must take ownership for the probability of chemical dependency among their own and not distance it as something that does not happen to a nurse. The literature is unclear about how aware some nurses are of the serious problem of chemical dependency among their colleagues. This is evidenced by the variability in estimates of the number of nurses in the USA with chemical dependency (California Board of Registered Nursing 2009f). Surveys indicate that nurses who suffer with chemical dependency are an unknown number and because of denial the nurse with chemical dependency may be the last one to know. Often, many nurses are in denial about their colleagues' chemical impairment, and only a very small number recognise chemical impairment in a peer (Sullivan, Bissell & Williams 1988:15; Quinlan 2003:149). It is obvious that there is an urgent need for information to be disseminated regarding this hazard. A suggestion for the Diversion Program is to sponsor an on-line continuing education course specifically about chemical dependency in the nursing profession. Nurses should be made aware that nurses with chemical dependency who are practicing in the workforce are an immediate threat to the safety of patients, as well as a liability to the reputation of the nursing profession.

One possible solution for providing information about nurses with chemical dependency could be to increase the role of nurse facilitators in the community as expert resource contacts. Another suggestion is to create an informational presentation to be conducted by nurse speakers who are experts in chemical dependency as a means of reaching nurses and engaging them in dialogue about the disease. An obvious choice for speakers would be nurse facilitators who have the experience and knowledge to answer questions relevant

to issues in the workplace. This would be a way for nurse facilitators to gain visibility, recognition, and respect for their role. Nurse facilitators as speakers and as role models could be the right choice for taking the fear out the prospect of entering into the Diversion Program for nurses with the disease of chemical dependency. For nurses in the audience who do not have the disease, the information could alert them to the signs and symptoms of chemical dependency in their colleagues, as well as to identify their responsibility to report it in order to protect the safety of the public.

6.3.2 Diversion Program

The BRN's organisational vision for the structure of the Diversion Program appears on paper to be sound. However, the perception from an internal subgroup (nurse facilitators) is that the organisation of the program (and its execution) leaves some of its members feeling marginalised. This indicates that the conceptualised organisation of the Diversion Program needs to be executed more cautiously. Therefore, the Diversion Program could benefit from further guidance in order to achieve the level of operation envisioned by the BRN. The individual components of the Diversion Program require more fluid communication and interactive patterns, and should function as an open system composed of interdependent entities. It is necessary for the health of the Diversion Program that all of its entities sustain a constant awareness and interaction with one another in order for the entire system to maintain balance and integrity. By applying the nursing process according to the Neuman Systems Model (Stanhope & Lancaster 2004:202-205) to the Diversion Program, the efficacy of the structure and function could be routinely assessed.

6.3.3 Nurse facilitators

This research offered an outlet for nurse facilitators to express their experiences of facilitating support groups for nurses with chemical dependency. The chief concern of the nurse facilitators was a perceived lack of support from the Diversion Program. Four themes were identified from the interviews (Chapter 4). Consequently, guidelines and a conceptual framework were formulated (Chapter 5), through which the different parts of the Diversion Program could provide support for the nurse facilitators. However, it should not be overlooked that one part of the Diversion Program includes the nurse facilitators. Therefore, the researcher suggests that they, too, share the responsibility for participating

in the solution to the problem of the lack of perceived communication. The abbreviated four themes are presented in question form with suggestions for the nurse facilitators to provide their share of solutions.

6.3.3.1 How can nurse facilitators assist in increasing communication within the Diversion Program?

The nurse facilitators perceived that they were marginalised by the Diversion Program because of a lack of communication. The following suggestions are offered as potential resolutions for this concern:

- Request to meet with the other parts of the Diversion Program
- Develop an informative newsletter that includes non-confidential information about the different parts of the Diversion Program and its functioning both locally and state-wide
- Utilise Online electronic resources

6.3.3.2 How can nurse facilitators assist with making changes within the structure of the Diversion Program?

Nurse facilitators could initiate the following actions in order to encourage changes with the Diversion Program:

- Design a short-term training program for new nurse facilitators
- Request that the program manager schedule meetings to include all parts of the Diversion Program for the purpose of problem-solving and strategizing about possible changes within the Diversion Program
- Utilise the guidelines in this thesis or develop others

6.3.3.3 How can nurse facilitators empower their role?

Nurse facilitators could empower their role by:

- Identifying the experience and education that should be required for new nurse facilitators
- Planning improvements in the hiring practice of nurse facilitators

- Creating a mentoring system for new nurse facilitators
- Networking with nurse facilitators from other states
- Creating their own separate organisation for California nurse facilitators
- Accepting speaking engagements
- Publishing about their role in professional magazines and journals, as well as publications outside of nursing.

6.3.3.4 How can nurse facilitators gain acknowledgement of their role as essential for support of nurses with chemical dependency?

Ways in which nurse facilitators could gain acknowledgement of their role as essential for support of nurses with chemical dependency are:

- Encourage nurse graduates of the Diversion Program to advocate for the support of recovering nurses with chemical dependency
- Offer to address nursing students about the problem of chemical dependency within the nursing profession
- Be visible as a change agent to a larger population other just within the Diversion Program

6.4 PROPOSED ORGANISATIONAL CHART FOR THE CALIFORNIA DIVERSION PROGRAM

In the proposed organisational chart suggested by the study (Figure 6.1), the different parts of the Diversion Program have free flowing communication lines. The communication flow is less hierarchical to include all parties with the aim to mitigate the feeling of isolation or marginalisation. The role of the Diversion Program Manager is shown in a central position. Communication is a back-and-forth flow from the Board of Registered Nursing to the Executive Officer, to the Diversion Program Manager, where communication continues in a circular format as it joins with the Diversion Evaluation Committee, the Diversion Program Contractor, the Nurse Facilitator and Nurse Support Group. In the centre of the circle, in touch with all parts of the Diversion Program, is the Diversion Program Manager, who is shown as pivotal to the success of the communication process within the Diversion Program.

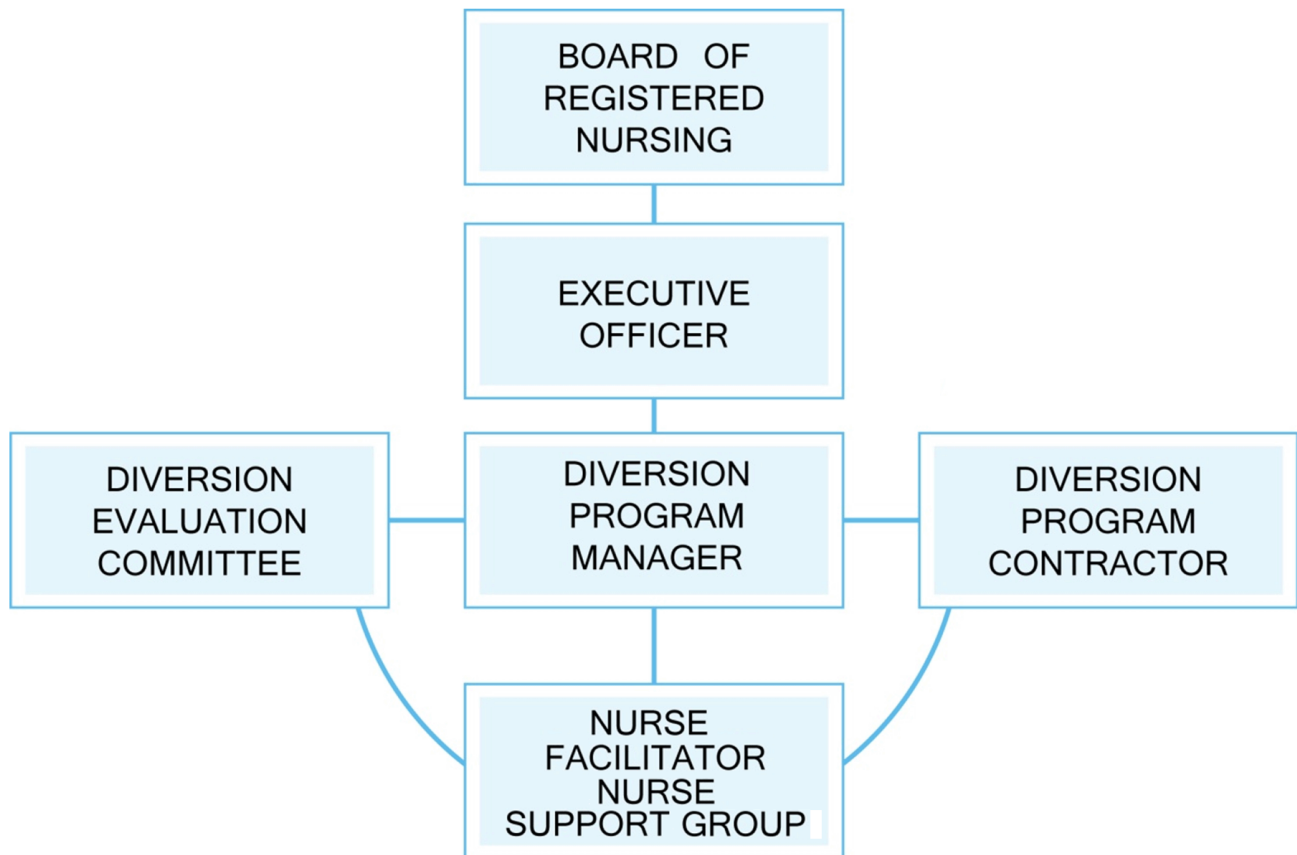


Figure 6.1: Proposed organisation chart for the California Diversion Program

6.5 FURTHER RESEARCH

This study explored the experiences of nurse facilitators of support groups of nurses with chemical dependency in the California Diversion Program. The research has revealed important perceptions regarding the operations of the support groups and the Diversion Program itself. For greater understanding and theory building regarding the perceived operations of the support groups, qualitative investigations of the nurses with chemical dependency who attend the groups is necessary. Similarly, for a greater understanding of the perceived operations of the Diversion Program, phenomenological interviews of the other parties involved (i.e., DEC, program manager, program contractor) are needed. Similarly, studies are required in other states in order to validate the importance of the role of nurse facilitators of support groups for nurses with chemical dependency.

It came to the attention of the researcher when serving on a DEC that perhaps there is a case for researching nursing students with chemical dependency (Ahmadi, et al 2004:60),

since there is speculation that a new generation of nursing students has been abusing alcohol and/or drugs from a very young age, and that pattern of behaviour has continued throughout their years as nursing students, only to come to light once they are nurses. A new research question might be: Are students with chemical dependency enrolled in nursing programs? Florence Nightingale's (Tomey & Alligood 2006:74) family opposed her desire to become a nurse because at that time nursing had the reputation as the only place for female drug addicts and alcoholics to find employment. The nursing profession has a duty to protect itself from a return to such an image. Also, nursing educators have a responsibility to anticipate the problem of chemical dependency among nursing students, and to engage in research to identify the problem and formulate solutions.

6.6 CONCLUSION

Keeping in mind that the focus of the qualitative research study was to arrive at an element of discovery, the research was guided by a holistic approach during the interviews with the nurse facilitators. Feedback from the nurse facilitators who were interviewed indicated that they were eager to be a part of the study about their experiences leading support groups for nurses with chemical dependency. They seemed pleased to learn that the researcher viewed their experiences as significant enough to create a study about them. Even though many of the verbatim comments by the nurse facilitators revealed their frustration, anger, and confusion with the Diversion Program, it was apparent to the researcher that underlying those feelings was hope that the results of the study would lead to positive changes in the Diversion Program, as well as to inform the nursing profession about the problem of chemical dependency within its ranks, and provide solutions for addressing the problem.

Research is necessary to add to the body of knowledge about nursing, and the present research goes a step further and speaks of an issue within the nursing profession that is often overlooked. The problem of chemical dependency in a profession, especially a profession that is dedicated to the safety, health and wellbeing of the public, is always a major concern, but it is not always acknowledged or addressed. The information resulting from the study will help to enlighten the nursing profession in order that it may better understand that nurses with chemical dependency are redeemable and their recovery is possible, especially under the guidance of a diversion program. The significance of this

study is that a group of nurse facilitators of support groups for nurses with chemical dependency in the California Diversion Program were given a voice with which to air their perceptions, concerns and ideas, and whose role as vital to the success of the program was validated.

The researcher trusts that the guidelines and conceptual framework will function as change agents in the California Diversion Program. If other states or countries see a need for a change in their diversion programs, or even the first-time establishment of a diversion program, it is suggested that they consider the information that was discovered from this study for their own use. The result of this study will inform the profession of registered nursing in California and the USA about the vital role of support group facilitators in Diversion Programs. The researcher also anticipates that the study will have a global impact as it informs the international nursing profession about the necessity of diversion programs for nurses with chemical dependency, and especially how necessary nurse facilitators of support groups are to the recovery of these nurses. Nursing is a global profession. Chemical dependency is a global problem. Diversion programs are a global solution. The study revealed that diversion programs, and the nurse facilitators of support groups for nurses with chemical dependency who are integral to them, are poised to participate in this solution.

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ANNEXURE A**SAMPLE INTERVIEW:**

Legend: NF = Nurse Facilitator; SC = Researcher (Sandra Cleveland)

SC: We're meeting to hear from you about your experience as a nurse facilitator for support groups for addicted nurses in California in the United States of America. You may say whatever you want to say about your experience.

NF: OK. I'm trying to think when I started. I started in, oh gosh, let me think. [date deleted], I think, or maybe [date deleted].

And my understanding was that it was literally to be a support group.

I guess we had one meeting in Sacramento, and I was amazed that there were a number of people who were particularly from certain areas and they were charging quite a bit. You know, it was 30 something dollars an hour.

SC: Um-hum.

NF: It was so much an hour, and it was really like it was some sort of therapy and it was pretty structured.

The way I run it was, I don't really talk a lot because we haven't been doing the group that way.

The group has developed its own personality.

It's supportive.

We talk a lot.

We talk about how [Name of Diversion Program contractor] operates and what goes on with the state.

From where to get urine's [tested], and that kind of thing; and also ah, I focus a lot on addiction as the process.

I talk with them a lot about relapse, and recovery behavior.

What's recovery behavior versus what's relapse behavior.

Some of the dilemmas I've had is that I often feel that diversion runs more punitive versus treatment.

I think there needs to be a certain amount of structure with dealing with the addictive disease process, but I don't feel or felt that it is very individualised.

I think there's a lot of old school stuff that goes on.

I've recently done some training with Stephanie Covington and Rollin Williams. The analogy I use is with the nurses is that it's like a cancer, this addiction. You know Stephanie says there's 23 different kinds of breast cancer, and yet I think with the disease of addiction it is still unique within each one of them, and considering their families, the family system, their work system, you know, it's just their whole life.

I often feel that they do too many canned directives with the nurses.

If I was diagnosed with cancer and somebody told me that I had to go to 90 and 90 (Alcoholics Anonymous (AA) , I don't know if I could manage that.

I would have to go to 90 cancer groups in 90 days to get treatment.

I find that just overwhelming, and I just use that as an example.

If there's a relapse, be it accidental or intentional, rather, I find that there's a group that makes a decision.

I just had a woman: "You've got to go to inpatient."

I never receive a call on any input from anyone running Diversion.

I never receive a call from anyone from Diversion Evaluation Committee (DEC).

And I never get a call from anyone on the Board [Diversion Program manager], and I've had a number of my clients say "if you don't go inpatient, you're out of the program."

That's where I get the punitive process going on versus treatment.

There was one person prior that was very much aware of recovery, that I worked with but was with the prior company DP contractor, and we did very well together, but she has since moved on.

I see a lot of canned..., I guess what I'm saying is I think is that they get more of a 12-Step approach to their diversion versus a treatment approach.

I don't see the disease model used much.

From what I'm getting, from my reports, it's either fair, good, or excellent.

That's so subjective in terms of their level of participation.

I don't think we have enough meetings for nurse facilitators.

I've been to one in the seven years that I've been doing this.

SC: This has come up with other nurse facilitators.

NF: Just in terms of a contact person for the Board [DP manager], I'm not even sure who that is at this point; I think it's [name deleted].

I've recently been getting non-compliant letters, but if you look at it, to me it's very 12-Step: dirty urine, signature cards...

That's what you do in 12-Step.

I don't see the treatment.

You know, Stephanie talks a lot about in terms of their issues around their relationships, around their identity, around their sexual orientation, or, you know, their identity as women and men.

Their social life, you know.

I don't see any input at, ahmm, that the state [DP] is really supportive.

I see minimal, they're very, the women are, ah, a lot of major pain issues.

I think that we're very primitive in terms with the chronic pain issue.

[NF spoke of two nurses who were dismissed from the DP because of a question about their chronic pain issues.]

SC: Not benefiting from the program?

NF: They were discharged.

They don't see... I don't feel this Diversion process as looking at the whole person in terms that this is a lifelong process.

Another thing I really don't understand is why, what the rationale is behind with when they get into Transition, they don't have to go to RN support group.

I think that's the time where they need even more of it.

I've worked with a number of even trying to put together another group out in the community that have been called graduates.

I don't think we ever graduate from this disease of addiction.

So even our language is behind the times.

NF & SC: (laughter)

NF: Transition is behind the times.

It's a process of recovery not a Transition away from, and I think that's when we lose some people.

I've lost several people, not necessarily through death, but through relapse, and if their relapses are severe and they are not willing to go to inpatient,they drop out.

SC: Then they've lost the support.

NF: Again, that's that punitive approach, that I feel, that if I had to say: is the state of California treating our professional people? No!

We've what we do is you comply, you know, or you shape up or you ship out.

It's kind of the way I was raised – you pull yourself up by your bootstraps.

There are people to this day who believe that if anyone has an addiction you should put them out on an island and it will all go away.

I think we are way behind the times in terms of this disease, I think that we need to be offered more things.

Even in support groups we need to be....we should have some options there.

Sort of like if you don't agree with the doctor you get a second opinion?

SC: That's what we hear.

NF: In this disease process you don't get no second opinion.

And we're medical people, and we're not even approaching our people who are in trouble.

We're not even using the old traditional model.

NF &SC: Both laugh.

NF: It's still kind of like the 12-Step.

We should offer [another recovery program]; I'm not saying that it is better.

The 12-steps are excellent to live by, but there needs to be other input.

I think the treatment plans to involve the family.

I think we are treating these people in a vacuum.

I don't see...I mean I'd love to have a family support group with people in Diversion.

I love to have the family.

When I get to meet the family is out in the parking lot when they are picking them up.

That's kind of how I've treated adults in most other programs I've worked; there's no family component.

It's similar to adolescents; when the parents are still using and the kid's in treatment, they don't show up.

It brings up a number of these men and women in Diversion, and they're with a partner who's using.

SC: A partner who's using?

NF: Yeah. Even to the point of maybe growing something out in the yard.

And yet there's no....get that family member in here.

That member may call and scream, and now they screen their calls.

It's very hard get through to Diversion people because there's been a lot of irate family members.

SC: I understand what you're saying. It sounds like a good idea. Of course, for the families it would have to be a voluntary commitment, but they would learn so much.

NF: So I would really like to see a family component, and a collateral component because there's different positions involved.

SC: It's almost like we're creating an impossible expectation from the nurses going through the Diversion Program....because they're going back to the same environment that has not understood any of this.

NF: Uh-huh, and it's very typical and not unusual particularly because most...and it sounds sexist...but most of the people in Diversion are women...

SC: Yes, it makes me wonder why. I was going to say maybe that's because most nurses are women, but that may not be an accurate picture.

NF: One of the biggest relapse issues for women is their partner, and going back into the same environment.

SC: Um-hum.

NF: And the partner, I don't necessary always mean, they're using, but they may be very controlling.

For example, one of the people the other day was able to say, "My trigger is my controlling spouse."

But it has taken a year, year and a half, to get to that point.

So it's not always that partner is using.

Again if we don't have the family involvement in Diversion we're really...we're not...we're really not doing a good service; we're not representing....

SC: It's almost like, in a sense, when someone does graduate from the program, they almost need to be away from their family, but that's not realistic. The nurse and family need the tools to understand this problem.

NF: Yes, and a lot of them will say if it wasn't for Diversion they wouldn't be here.

Already I have a couple in Transition, and as soon as they are, we never see them again, or they come for...I can predict that they will come no more than three months after they have been granted Transition.

In that three month period they will come one or two times, and they slowly get tired because they are working ten hour shifts....they're out there and all of a sudden they

are aligned with Diversion people, but they are really not aligned, you know, with a support group.

SC: Right.

NF: So I come from the area of wanting treatment, but Diversion is strictly a kind of police process then....I would hope that we want to do more than, you know, than kind of watch these people.

There are nurses who are discharged from diversion for lack of benefit and have been reported and ironically, they're still working.

And to me that doesn't make a lot of sense when we are licensed to protect the public and yet the Diversion people dismiss somebody and this person is still working.

SC: You're saying they are dismissed from Diversion and still working as nurses?

NF: Yep.

SC: So are they moved over to Enforcement?

NF: Apparently some go into Diversion because they are reported.

SC: Ok, but I heard that it will take the BRN between 2 to 3 years before they start investigating these people.

NF: Uh-huh.

SC So legally, they can work.

NF: And what is more troublesome is that these are the dangerous ones because they refused to comply with diversion. I know of [number deleted] who are working and actively using. So I question the purpose of all of this sometime.

SC: Yeah. Any ideas about how to correct this problem?

NF: You know, see these are things I don't think the Board knows about. Another issue that is major, major is the punitive versus treatment.

The people who have been reported to the Board and they get dismissed by Diversion, and I think it's the poor communication.

If somebody gets dismissed, and nobody lets me know anything from Diversion or the Board.

They just stop coming so I call. I call.

If I want to know anything from Diversion people, I need to call.

I've recently been getting letters of non-compliance, but that's it.

I had one who I didn't see and didn't call, and it turned that this person had been arrested, and they knew about it, and they never....it doesn't go both ways.

SC: So the contractor does not inform you of something like this?

NF: No. Another thing that has been interesting

It's the way people are treated.

It just amazes me, the extreme differences.

One may be told to go to inpatient.

Another may be told to extend her time in Diversion.

And it causes a lack of mistrust in terms of the process; I'm speaking just of the group I facilitate.

It also creates conflict with everyone talking about it: "Boy, she really got the book thrown at her, and yet you're still working and you had an accidental overdose [relapse]."

I just had another one with an accidental overdose and she had to go to inpatient or out of the program.

And I had one several months ago with an accidental overdose and she's still sitting in Diversion and working.

Another cannot work and has to go to inpatient.

Similar relapse issues: one was out of work for over six months, took a wrong medication, and another one, was just dismissed due to lack of benefit and is now back for her third time in Diversion.

So, the inconsistencies. Need to look at some consistency in terms of how they handle relapse accidental or intentional.

Because, see, even though there's a lot of 12-step, like 90 and 90, and those kind of measurable things, even some of what gets prescribed, is not even....you know, I think there needs to be some kind of guidelines so that if this happens, this happens, and this happens, then this happens, and it's sort of like the shock effect.

So a lot of what hampers me is....ahmmm, well take for example, I have no way of knowing if they're telling me the truth, because I work in a vacuum as a facilitator unless I call and find out from them what did they get on the self-reports.

And I had one that I got a call about for some reason, at the time I was signing the [attendance] card, and they sent me a copy of it and I said that isn't even my signature.

So, people, it turns out, can forge I think because of the lack of communication...it breeds dishonesty.

SC: Good point.

NF: They get this mixed message: we're [DP] going to be real tight on you and practically strangle you and you're going to comply, and yet it's open it's loose, loose, loose, in other ways. Do you know what I'm saying?

SC: You're being very clear.

NF: If a client wants to go away on a holiday, it never goes through me if she should go away on a holiday or not; no one contacts me to see if someone should go away on a holiday or not; I'm just told.

So, sometimes, I've been contemplating not continuing doing this.

It reminds me so much like working with the adolescent when the parent isn't going to show up for family meetings; you know, the kid's acting out all over the place because there's very tight structure in some ways, and then very loose in other ways.

SC: How does that make you feel?

NF: Undermined.

They [DP] said it was an accidental overdose and you didn't have to go to inpatient. Then another has the same situation and that nurse is told to go to inpatient."

So even in my small, in my group, I have lots of major conflict from the directives that come down because they have the authority; they have the police power.

SC: It's an eye-opener.

NF: Yes. Get a sponsor. Get your signatures. Do your 90 and 90. Go to your support group. Get your fifteen [continuing education] units .

Those are about five requirements. Pay your bill. Pay your urine bill. You know, make your call.

Those are basic, those nine to ten things, I am aware they have to do; their monthly reports, but where's the treatment?

As long as they show compliance, you know, that's what I really enforce in my group, we talk about, you know, you're in a relapse mode or like I have one that it's not just a drug thing but a gambling deal.

When I was doing continuing ed, I was told: "Well, they really don't know how to handle mental health problems."

They really don't know how to handle that.

For me, it's when someone is spending thousands and thousands of dollars and she turns into a casino, like it's a signal light, it's like she has an eating disorder, and the relapse may be the binging and the purging.

And I don't see us, as a group of professionals, working with professionals and focusing on that.

It's sort of talking the talk versus walking the walk; I don't see the emphasis on the treatment really changing life style.

When I write letters I talk about lifestyle changes that I hear them talk about in the group, but I don't know what Diversion's willing to do in terms of the whole issue around money...oh my gosh, it's just been a major, major deal.

Some have lost their homes; they've lost their furniture; and it causes them to do things that are not necessarily kosher, you know.

SC: I can imagine.

NF: I had one who had, he can't drive because of a suspended license, so he has to go down to the store. So what does he do? He borrows a motorised scooter. And then he ends up running into something. So he's got these bruises and abrasions all over his body, but all we're concerned about is that he doesn't drive and he got tested and it costs him \$62 dollars for his urine to be tested and he doesn't have the money.

So who knows if he is stealing from [relationship deleted] to send the lab people their dollars or....and I know he's doing that.

SC: You've brought up some very enlightening points.

NF: I don't think we do a good job with encouraging the people in Diversion to have a good health screening.

Really, I don't know, but a number are overweight. Others have eating problems along with the alcohol or drugs. I see a lot of caffeine being taken. That's where I say we're behind the times.

A lot of sweets. The thing of candy to group the other day! That goes back to the movie "Twenty-eight Days" with Sandra Bullock when everybody buys sugar and gum.

SC: Right.

NF: We're still in the fifties and sixties. Consuming huge amounts of caffeine and sugar and gaining weight. So we have contributed in switching addictions in Diversion. Food, sugar, gambling, stealing from a family member to pay the bills.

And I wonder if people really understand the disease of addiction.

I mean this is a disease process.

This whole disease process....what's that term that we use for kind of the secondary?...we're lower, we kind of treat them just like how addicts are treated out in the community.

For example, I had a methadone clinic where some of my people would go over to the local ER to get treated and one came back in tears because the doc wouldn't give her antibiotics because he said, "You're an addict and you're going to sell them on the street."

I guess I reached the point where I see that they're still treated as lower class people.

This is what I was talking to them last week about, that what is so powerful with the disease of addiction is that we have to face our fear and our shame.

Yet what they get reminded of constantly is their shame.

And so I say to them how conflicted to face your fear and shame and to admit to accept, using some of the 12-Step terminology, treatment, just like if I have cancer and I need to admit that I need to do whatever it is to take care of myself and I'm so afraid of it, and I don't.

So really what we want the treatment about doesn't happen because of, you know, "you have to go into inpatient because of an accidental overdose or I mean an accidental relapse."

SC: What about the whole profession of nursing? How does the profession threat them?

NF: I think that we can we say that the whole profession has fear and shame about the whole chemically dependent nurse.

SC: So you see that as another big problem?

NF: Absolutely. There's the impetus to get into treatment and to begin facing that, yet we want to keep it covered up, the whole fear and shame thing.

We want to put a blanket over it.

We almost want to suffocate it.

SC: Good point.

NF: The nurses in group, they know nurses that are out there....using and working.

It's really ironic, when you look at health care today, and I've worked for a number of different places, so many years of work as a nurse, so many years of service, and I've had one drug screen and that was in another state, but if I go to work for Walmart or Target, I'm going to get a drug screen, but not in health care.

SC: I brought that up as far as nursing instructors, but was told the union would never allow that.

NF: So what we need to face is what we've got the lid on. And underneath that is that punitive approach, poor communication, minimal contact with all involved in each

case; there's a real void between [the DP contractor] and the DEC consultant; sometimes that person who's calling the shots doesn't really know. And I think that's an awful lot to put on someone's shoulder, to make that one consultant make the decisions about somebody's life.

SC: I agree with you.

NF: It's not an interdisciplinary team approach at all. We don't do that with other diseases; there's no unilateral decision making that I'm aware of.

SC: Well, that would be a throw-back to the medical model.

NF: Yeah. You do what the doctor says, and the nurse agrees, and that's the end of it. And that's what we're doing with our nurses in Diversion.

They're real strict with paperwork from the client, but they are not strict about paperwork from [the DP contractor] in return.

They lose stuff. I'm constantly battling: "keep everything, keep everything," I tell the nurses in my support group.

I've been battling this from when I started; it's like – you get your paperwork in, but they don't have to get there's in. It's like there's no respect. If we lose your paperwork, just send other copies.

They don't figure the cost factor, the time, the copying. It's very expensive when you ask for a signature receipt.

There's a lack of orientation. After we get into trouble then we find out it goes to another building, and that's not equitable.

SC: It doesn't seem to be.

NF: They are the one's who lose. The client loses. It's like what we do with health care today.

There's a lot of rigidity, its unpredictable. They need some kind of structure, some kind of orientation.

When I talk to some nurses, they feel there is a real lack of compassion in the whole process.

It's like a little book I read many years ago, Compassion Versus Self-Hate; it's like we contribute more to the reminding of the terrible things they've done, rather than to offering compassion.

I don't see that. The compassion to really look at the disease and, I tell them, "You have a cancer, and this can kill you. This is serious."

I don't see a serious Axis I diagnosis [from the DSM-IV-R].

There just seems to be a lack of compassion.

It's sort of like I'm walking up the mountain and I get to this point of Transition, and I take the step, and then I fall off.

There is no peer program. There is no peer mediator. Kind of what the Betty Ford [Clinic] designed many years ago. She has it throughout the state that there's contact people.

There's no networking for recovery in this diversion program. And yet when you look at cancer throughout this country, the United States, there's networking.

The only networking these people have is if they go out of town and they go to AA or NA meetings.

There's no treatment network for people in recovery. None, no treatment network.

And the disease doesn't go away; it's chronic; it's lifelong; it's progressive. As we know.

Anywhere you have a medical condition you can find support: "I've got diabetes, I've got MS," and people are there for you.

I've have an addiction, where can I go as a professional, there's nowhere to go.

No networking.

And I know for a fact that there's some networking in some of the facilities in the area because there's some places that will hire, but if you look throughout the state, there are just air pockets.

And in this area the hospitals will not hire anyone in Diversion, at all.

Another thing that happens, too, is there's a major lack of education for the impaired professional because we've lost some sites for employment because somebody relapsed, and no releases of information.

Again there's no network; not just the fact that there's a lack of network, there's not even networking in the process.

SC: It seems like there is still so much to do.

NF: There's nothing with the worksite monitor.

If there are some serious things, I ask the person to sign a release and we were ok, but if I didn't know that this nurse wanted me to give this person some input, ...and how can we expect when they're so sick to be the case manager of their own case?

To coordinate their care, to advocate for themselves, and yet that's the position we put that nurse in.

You've got to answer to here, got to answer to here, got to go to this group and I don't want to be here, and scream and holler, and then the worksite monitor.

At anytime in their life they are, you know, the core, and yet we would never ask a patient on the medical side to coordinate, or case manage, or advocate for themselves.

They're being treated like they're a nurse, but a nurse taking care of themselves as the client, not like they are the client, and I don't see that anyone sees that. It's on an unconscious level.

And we do this, sort of like the dream catcher; there's this dream of the nurse that they are all so sick and we are all these people putting in at different times and sometimes I feel like I'm being strangled.

And that's been my dilemma. Do I stay and do this or do I pull out? Because the more I get into it I have to ask myself, how much do I want to support this pathology?

SC: That sounds like a difficult decision.

NF: Or if you want to use the old term: be codependent to the pathology.

SC: Yeah.

NF: We stay enmeshed with this. So it's a sick process.

SC: Do you think that codependency and enmeshment are not being viewed as a sickness?

NF: Really. And they don't see it.

Because it is the co-addiction that keeps bringing these people down, and they can't answer to that.

They're exposed to that. And they decide that I'll just do what I'm supposed to do and then,

And there's another breakdown: there's no communication when they go into treatment! None! Not with me! I asked them to call me once a week, so again they're managing themselves while they are inpatient to [the DP contractor] sending their little report, or give me a call.

Now if I was in chemotherapy, would I be having to call my doctor to say that I've just put up my own IV. Now how many drips per minute should I make it for?

"I've just gone to ten meetings, and I've just met with my therapist at such-and-such a place and just want to let you know." What's wrong with this picture?

It reminds me of the story "Alice in Wonderland." How am I going to get out of that hole?

So that's been my dilemma: support the ladies and the gentlemen and yet, ...

Another thing that is uppermost in my mind that you need to stress is that somewhere we need to do something because we've done a horrible, horrible job with the mentally ill nurse.

I don't believe that we have done a good job. They need to be separated.

They still have a disease, but it still needs to be respected just like addiction is. I did have one nurse stay and went to meetings, but we do a horrible job with the mentally ill nurse. We're just not dealing with them. I've lost quite a few in this RN support process.

What Diversion has done, is they say you don't have to go to a RN support group.

And there are a number of mentally ill impaired nurses, and no kind of support and that's as serious a disease as addiction.

And there's a number of them that are out there andit's like the nurse with the chronic pain...well, you're not benefiting, so once Diversion is done, you don't have to go to a nurse support group.

So if you have an opiate dependency, for instance, then you can't be on methadone, yet there's a whole lot of professions out there, and I'm not suggesting nurses should be on methadone, I'm just saying there's a dichotomy.

If I'm a nurse I can't have the same treatment as my other colleagues, an attorney, or owns a business, or is a CEO.

There are clinics in this country who open early in the morning for those people so they won't be seen, but yet during regular hours at the clinic all we see are just "those people," and I'm just using this one example.

Yet all we see are "those" people getting methadone.

But there's a whole population out there that's hiding it and we don't see them, and they are just as much a profession as a registered nurse or an MD.

Yet we are not allowed that treatment because of the thinking.

High-end addicts and high-end treatment is for other professions, but not nursing.

They [methadone clinics] have early hours and they make exceptions to their take-homes, and you'd be surprised if you knew who even in this community frequents them.

SC: I'm sure.

NF: I'm just saying that there's a prejudice which goes back to if you're a nurse and you go into treatment, you are looked a lot differently than if you are an attorney, or a pro football player, or whatever.

And I've had them go into county run facilities since I've done support groups, to the levels of Betty Ford, and there's still the prejudice.

It's similar to the woman addict, how she's looked at when she's a woman, and if she's pregnant, and if she has two little ones, she's looked at very differently then.

There's a lot of social prejudice with this process.

And that's why I believe that California doesn't talk about that because they go back to the shake deal,if the public knew about a bill for Diversion, I imagine it could be voted out with the way politics are today, if nurses would be allowed.

This is discriminatory because they know that LVN's and LPT's don't have this right. They could probably file a class-action suit against the state.

So politically, it's a hot ball.

Now with our present governor, who has a smoking tent, this may be the time to address it since he's an addict to cigars!

But politically it's not fashionable to be an addict because the last big Hollywood star ended up in Corcoran [Prison], so, you know, it's a very punitive approach.

So it's a very difficult struggle.

Oh I know, the analogy is; as long as we jump through the right hoops we'll get through. That goes back to what I was saying about Diversion.

And that's pretty much my thing.

NF: I worry and I'm concerned that some of these support groups exploit some of these people that are, that are there because they have to be there. I hear about some leaders, it is almost like they have a beef, it's almost like you have a confronting situation. And I've heard other comments that the charge is so very high. So that concerns me in that process that they have to be there. So that's a dilemma, you know?

SC: Yeah.

NF: And sometimes someone will say, "and you don't do that."

SC: Uh-huh.

ANNEXURE B

**UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee
(HSREC)
College of Human Sciences**

CLEARANCE CERTIFICATE

Date of meeting: **18 May 2005**

Project No: **N/A**

Project Title: **Support for nurses facilitators of support groups for chemically dependent nurses in California, USA**

1st Researcher: **S Cleveland**

2nd Researcher: **Prof TR Mavundla (Promoter)**

3rd Researcher: **Dr B Lester (Joint Promoter)**

Department: **Health Studies**

Degree: N/A

DECISION OF COMMITTEE

Approved


Conditionally Approved

20 May 2005

Date:



**Prof L de Villiers
RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES**



**Prof SM Mogotlane
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE C

Consent Form for Participation in Doctoral Research Study

Title of Dissertation: **“A Model for Support of Nurse Facilitators of Support Groups of Nurse Addicts in California, USA.”**

Researcher: Sandra Cleveland, MSN, RN. (Ph.D. Candidate)
 Department: Graduate Nursing, University of South Africa, Pretoria
 Research Chair: Dr. TR Mavundla, Ph.D,RN, South Africa
 Co-Chair: Dr. Barbara Lester, Ph.D,RN, United States

I, _____, hereby consent to participate

in the research study titled: “A Model for Support of Nurse Facilitators of Support Groups of Nurse Addicts in California, USA.” The researcher, Sandra Cleveland, MSN, RN, has explained the research study to me. I understand that I am free to voice concerns or ask questions. I also understand that if I have additional concerns or questions I may contact

Sandra Cleveland, MSN, RN, at 559-297-1810 or via email at: sjcleve10@yahoo.com

Purpose of the Research Study

The purpose of the research study is to create a model and identify guidelines for support of nurse facilitators of support groups of nurse addicts in California, USA. The information gathered in audio taped interviews will provide facilitators the opportunity to give voice to their lived experiences, and from this information the researcher will create a model and guidelines. The research study will provide information to the California Board of Registered Nursing, as well as to the registered nursing profession, about the experiences and roles of nurse facilitators.

Procedure to be Followed

By consenting to participate in this study, I understand that the interview will be tape recorded either in person or by phone, and the results will be transcribed by the researcher or a professional transcriber. I will be asked to respond to the following:

- “Describe your experiences as a nurse facilitator of support groups of nurse addicts in California, USA.”

I will be encouraged to share my thoughts, feelings, and perceptions about these experiences until I have nothing more to say. I understand that the interview will be transcribed verbatim and the researcher will strive to identify common themes among the interviewees until saturation occurs.

Publication

I understand that at some point the results of the study will be submitted for publication in peer reviewed nursing journals.

Risks or Discomfort

There are no anticipated risks or discomfort to the participants in this study.

Approval for Research

The researcher, Sandra Cleveland, MSN, RN, has received approval from the California Diversion Program manager to conduct the research.

Benefits of the Study

The participant will receive no monetary reimbursement, or in any manner receive any identifying acknowledgment for being a part of the study. The benefits will lie in the creation of a model and guidelines for support of nurse facilitators of support groups of nurse addicts from the information revealed about the lived experiences of the nurse facilitators in California. The results of this investigation will assist the facilitators to gain more in-depth insight into their role and purpose, offer them a model to follow in order to achieve uniformity among the support groups, as well as to alert the Registered Nursing profession about the role the nurse facilitators play in the recovery of nurse addicts.

Confidentiality and Participant's Rights

I understand that my participation is voluntary, and I may choose to withdraw from the study at anytime. My identity will remain confidential and only general demographic information will be utilized in the research summary. No identifying information about the support groups will be disclosed, such as names, locations, meeting dates and times, and descriptions of nurse addicts. I understand that the audiotape of my interview will be coded for transcription purposes only. All data will be stored in a secure place.

If I choose to discontinue my participation in the research study, I may contact Sandra Cleveland and inform her of my decision. I also understand that if I am not satisfied with the manner in which the study is conducted, I may discuss my concerns with Sandra Cleveland.

I have read the consent form and all of my questions have been answered to my satisfaction. My signature on this form indicates that I understand the above information and consent to be interviewed as a participant in this study.

_____ Date _____
Signature of Participant

Printed Name of Participant

Address of Participant: _____

Email of Participant: _____

ANNEXURE D**Re: Research Proposal - Chapter 4 Methodology**

Tuesday, May 31, 2005 11:43 AM

From: "Lisa_Kawano@dca.ca.gov" <Lisa_Kawano@dca.ca.gov>
To: "Sandra Cleveland" <sjcleve10@yahoo.com>
Cc: lisa_kawano@dca.ca.gov
Title of Dissertation for Ph.doc (20KB), CHAPTER 4.doc (63KB)

Hi Sandra,
The questions are fine, approval granted. Good luck with your project - it's quite impressive. We look forward to the results.
Lisa Kawano
Diversion/Probation Program Manager
(916) 324-2986

Sandra Cleveland <sjcleve10@yahoo.com>
05/27/2005 01:53 PM

To: lisa_kawano@dca.ca.gov
cc:
Subject: Research Proposal - Chapter 4 Methodology

Hi Lisa,
I'm attaching the methodology chapter of my research proposal so you can take a look at it, and forward on to your manager to get permission for me to conduct the research.

The research questions are on page 9.

The chapter is formatted using the Harvard (or Cambridge) method, not APA, in case you wondered. The Harvard format is required for me because it is accepted globally, whereas APA format is only acceptable in the US. I find the Harvard method a little easier than APA, but both are very similar; where they differ most is in the footnoting.

Thank you very much for doing this, Lisa. I really appreciate the time you're taking to help me out.

Sandra Cleveland