Doctors living with addiction have the Physician Health Program. Dentists have a resource network. Nurses do not have a dedicated program to help address their unique needs when overcoming substance-use issues. But that may soon change.

BY MELISSA DI COSTANZO

Kathy spent Christmas 2009 thousands of kilometres away from her two teenage children.

It was a devastating turn of events for the then-49-year-old, who had celebrated more than a dozen holidays with her husband and daughters (then 16- and 17-years-old).

It wasn’t her first Christmas without them. That’s because three years earlier, the couple divorced, and the girls blamed their mother for splitting up the family. “They were so angry at me, they didn’t want to speak to me,” Kathy recalls. Hoping to start a new life, she moved from London, Ont. to British Columbia in 2009. There, “everything just fell apart on me.” In an effort to extend an olive branch, Kathy invited her kids to her new home.

They refused. And for Kathy, it was the last straw.

Crushed by her children’s estrangement, and freshly isolated from her support network, Kathy, a registered nurse of more than 30 years, turned to morphine after wrestling with a substance-use disorder for almost two decades. “When you have the disease of addiction, there’s no off switch,” Kathy says, reflecting on the time. “You don’t take the drug. The drug takes you.”

Kathy’s story is far from unique. Addiction is a very real hazard in high-stress nursing environments, where drugs can be obtained through fraudulent paperwork or by diverting patient medications. And substance use, in many cases, goes hand-in-hand with mental-health issues. According to Toronto’s Centre for Addiction and Mental Health (CAMH), in any given year, one in five Canadians experiences a mental health or addiction problem. Nurses – as well as other health professionals – are no exception. Addiction is a disease that does not discriminate.

* Pseudonyms have been used to protect privacy
When it comes to the prevalence of substance use among nurses, Canadian figures are elusive. The College of Nurses of Ontario’s (CNO) system for tracking complaints and reports of substance misuse does not get that specific. Statistics from the U.S. suggest frequency parallels that of the general population: approximately 300,000 U.S. RNs, or 10 per cent of the workforce. The College of Registered Nurses of British Columbia cites the same ratio.

Kathy’s story can be traced back to 1970, when she was 10 years old. She was diagnosed with excruciating abdominal pain, caused by sporadic – and often unpredictable – spasms in her pancreas’ sphincter. After one trip to the ER, she was given Demerol – her first taste of relief. “I believe I had a strong genetic predisposition to addiction,” she says, acknowledging that although she was young, she recognized the connection between the drug and that sense of relief.

A few years later, at 15, Kathy began binge drinking socially. She says this is when that predisposition really began to take shape. “I always overdid (it) with alcohol; no question,” she says, adding that as she left puberty and became an adult, one of her personal mantras became “work hard, play hard.” She drank and used sleeping pills to help her feel “better, normal, (like) you can cope in the world.”

“I’ve always struggled with alcohol abuse,” she adds. “I was born an alcoholic and an addict.”

The demands of nursing in ERs and ICUs – where Kathy spent most of her nursing career – only added to the turmoil. Due to understaffing, she would often be forced to take on two patients instead of the customary one. Kathy admits she often felt stretched thin. “I enjoy work very much, but it’s a certain kind of stress,” she says.

She continued using drugs and alcohol into her 30s and 40s, admitting her substance use worsened when she separated from her husband. On her own in B.C., she knew what would take that pain away. “I felt extremely helpless. There was nothing left to live for,” she says.

At the height of her illness, Kathy was working at a hospital in Victoria, B.C. She would double patients’ dosages, administering half to the patient, and taking the rest home. She also signed out meds for non-existent patients.

After six months of using morphine to numb the emotional pain, she was called in to a meeting with her manager and a union representative. “I knew,” says Kathy. “At that point, I was actually very glad. I had tried to control it myself and I was in such a living hell, I just wanted it stopped.” After acknowledging she needed help, Kathy moved back to Ontario to seek treatment, and began her long road to recovery.

Today, Kathy is almost five years sober. She has her Ontario nursing license back – with conditions set out by CNO that will be monitored and eventually lifted unless she relapses. She must submit two witnessed urine tests each week, see a physician every three months, and attend a support group for health-care professionals. “I had a lot of hope when my license was first reinstated,” she says. “(But) I’ve been met with such negativity and judgment (that I have) little hope now ofever getting a nursing job.”

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W hen she was in B.C., Kathy admits to reacting with aggravation when she helped care for a patient in the ICU who had overdosed for the 15th time in a month. “It’s easy to get into black-and-white thinking (that) they’re just bad people,” she says. Kathy acknowledges that kind of reaction is not an uncommon one among health-care providers. Now, she sees things differently, and can reflect on moments like this with personal experience. “The best way to understand addiction is not as a moral weakness, but as a disease,” she says. “These people need support and help.”

Harry Vedelago is a physician who once experienced a substance-use disorder himself. He used to lead therapy sessions in Hamilton with Caduceus Group, a nation-wide support network that assists health-care professionals with substance-use disorders. Now chief of addiction medicine at Guelph’s Homewood Health Centre, he echoes Kathy’s comments. “Addiction is a chronic disease. It’s not a lifestyle choice, self-will or self-mediating. It’s a disease state,” he says.

In fact, treatment and outcomes of substance use are similar to those of other chronic illnesses, such as diabetes and cardiovascular disease. If treated, the outcome can be good. If left untreated, the prognosis is much grimmer: long-term complications or even death. Vedelago has found that when health-care professionals are able to access recovery programs with proper monitoring procedures, the results are impressive. “You’re hitting sustained recovery rates of 80 to 90 per cent,” he says. “That’s amazing.”

Caduceus Group offers a no-fee recovery program, which includes treatment, after-care and 12-step meetings. Health-care providers are usually encouraged to attend through their licensing body, professional association, employers, or health-care providers. Attendees are also referred by their physicians. Vedelago says the number of nurses who attend always outweighs
Nurse Practitioner Rosie Yoon

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(RpNA) and cNO are involved in the project.

The four organizations have been working together to draft a

program, and work is underway to proactively address “high-risk incapacity matters” in the “least intrusive manner,

while protecting the public,” according to CNO’s December council

meeting notes. The goal is to employ a recovery management model,

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The Ontario Medical Association started the Physician Health Program in 1995 to help its members with, among other things, substance-use issues. Physicians are offered assessment services, advice and treatment. The Royal College of Dental Surgeons of Ontario has partnered with three drug and alcohol treatment and recovery centres to support Ontario dentists. And, in 2012, the Canadian Dental Regulatory Authorities Federation and the Canadian Dental Association sponsored and organized a two-day conference called On the Road to Wellness: Dealing with Addiction Disease in Dentistry. Nurses still have no equivalent, but news of the funding through CNO is encouraging.

Nurse practitioner Rosie Yoon is an advanced practice NP who works at Toronto’s Jean Tweed Centre providing care to women recovering from substance use and living with mental-health concerns. She says stronger supports need to be in place for nurses experiencing a substance-use disorder. “It saddens me because we’re trained…to be empathetic, compassionate, recovery-oriented, and all of those things are very poorly reflected in the system of services and resources we have for our colleagues,” says the RN of 10 years, who has worked at CAMH and St. Michael’s Hospital’s acute inpatient psychiatry unit.

Yoon cares for nurses overcoming substance-use disorders in her current role, and says supportive workplaces – starting with occupational health and safety and human resources departments – can make all the difference. Policies that clearly outline process when it comes to responding to a nurse’s substance use are imperative, she says.

Awareness campaigns normalizing substance use as a health issue and teaching nurses about vicarious trauma/compassion fatigue (the negative impact of caring for others), stress and mental-health issues will go a long way towards creating a culture of compassion, Yoon adds. “Substance use in general in our society carries a heavy stigma and misunderstanding.”

CNO also has a critical role to play, she says. “The risk of (nurses) losing (their) license is huge,” Yoon explains. “That’s the biggest fear…and the biggest barrier to people asking for help.”

“The college needs to be transparent (and say) ‘we’re here to support you, and to support clients,’” she adds.

Karen McGovern, CNO’s director of professional conduct, acknowledges the legal – and often lengthy – process to determine a nurse’s capacity to practise after disclosure of a substance-use disorder can be

Managers and supervisors are legally required to report a substance-use disorder to the College of Nurses of Ontario (CNO) within 30 days. They can also report if they have information that indicates a nurse’s judgment is compromised, such as tardiness or discrepancies in narcotic administration.

CNO assesses the complaint/report for potential risk to the public. Information about the nurse’s health is reviewed by CNO’s executive director, who must start an inquiry if the information leads to a reasonable belief that the nurse has a condition and it is having an impact on safe practice.

The nurse is notified, and has the opportunity to provide health information (there is, however, no obligation). That information is then forwarded to the Inquiries, Complaints and Reports Committee, a five-member panel that decides if the RN should be considered “incapacitated” and in need of licence limitations.

The committee can request an independent medical assessment, conducted by a physician not involved in the nurse’s treatment. The doctor provides a report that is disclosed to all parties. A nurse can be suspended from practice if the inquiries committee asks for a medical assessment, and that requirement is met.

The individual who is being investigated has another opportunity to respond and could, at this point, be referred to the Fitness to Practise Committee. This referral is posted to Find a Nurse, a website that provides the public with information about nurses in Ontario and any practice restrictions. A referral to the fitness to practise committee may lead the inquiries committee to suspend or restrict a nurse’s licence (if there are urgent safety concerns) until the adjudication has wrapped up.

Between 75 and 90 per cent of matters referred to the committee are resolved without adjudication. CNO negotiates with lawyers, and sometimes with the nurse directly, to reach an agreement that is reviewed by a panel.

Once the nurse has completed the terms of the agreement, CNO sends a letter to the nurse, stating the restrictions have been lifted. If a nurse experiences a full relapse, the entire process starts again.

Since 2010, there have been anywhere between 69 and 101 referrals per year to the fitness to practise committee, most of which concern substance-use disorders and/or other mental-health disorders.
difficult. “The college’s (goal) is to make sure we can identify...risks and do what needs to be done to protect the public,” which also means getting nurses into treatment and returning to practice. “Part of the public interest is access to great nurses,” she says, adding: “Everyone involved in the process here at the college is extremely respectful of the circumstances of these nurses. We’re delighted when someone returns to practise successfully, and completes their conditions.”

McGovern says the college spends “as much time as we need” to explain the legal process to nurses. If the investigation leads to a “fitness to practise” hearing (75-90 per cent of cases are resolved without a hearing), privacy is respected by closing that hearing to the public. And, McGovern adds, the public information that is posted online at Find a Nurse is a high-level summary, and doesn’t contain personal or private health details. Substance-use disorder is not identified as such, but rather grouped under a “health condition.”

For its part, RNAO offers its Legal Assistance program (LAP) to support nurses through CNO proceedings, including incapacity investigations. ONA helps unionized nurses in meetings with their employers, provides members with representation at CNO proceedings, including incapacity identified as such, but rather grouped under a “health condition.”

For its part, RNAO offers its Legal Assistance program (LAP) to support nurses through CNO proceedings, including incapacity investigations. ONA helps unionized nurses in meetings with their employers, provides members with representation at CNO proceedings through its legal expenses assistance fund, and files grievances on behalf of nurses, if necessary.

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**Nurse publishes her story to help others**

An RN of three decades, Idaho-based Karolyn Crowley began swiping samples of Vicodin for almost two years, beginning in 1995, to relieve menstrual cramps. She convinced herself that over-the-counter medications just wouldn’t cut it. At the time, she worked for an ear, nose and throat surgeon who specialized in head and neck cancers. Members of her family struggled with alcoholism, “…but I still never thought (addiction) would happen to me.”

After several attempts to quit the drug, a colleague confronted Crowley, an experience she now considers a blessing.

She started on her road to recovery 17 years ago, and recently decided to share her experience and advice in a book called *Re/entry: A Guide for Nurses Dealing with Substance Use Disorder*. The recently released guide for nurses trying to overcome addiction and resume their practice is also an educational roadmap for supervisors, colleagues and administrators. The content is presented in a conversational way to guide readers through the various stages of addiction while providing tips for those hoping to reenter the job market.

Crowley and her co-author, Carrie Morgan, a recovery coach, couldn’t find any books designed to help nurses transition back into their jobs when they began writing. Crowley says she wishes a book like this existed when she wrestled with her own addiction. “I walked around with this secret for a long time,” she says, adding: “Nurses don’t believe it’s a disease, and if we don’t believe it’s a disease, how can we take care of our patients and ourselves?”

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lison*®* considers herself lucky to have all the ingredients necessary for a successful recovery – including help from friends and family, and a supportive work environment. She used to work as a psych nurse in the emergency department at a northern Ontario hospital. After swapping scrubs for street clothes, she would often go to a local bar with girlfriends to have a few drinks. Some nights, she’d head to a local restaurant with a friend, order the Cajun shrimp and split a bottle of wine. It seemed routine, and Alison thought nothing of it.

Then she began drinking to fall asleep. She worked mostly evenings in the ER and, after returning home most nights around midnight, found it difficult to wind down, likening the end of her shifts to a rock star finishing a set: adrenaline coursing through her body. “I just couldn’t shut myself down.”

The high-drama and intensity of the ER, coupled with the severe illness of some of her patients, sent her mind racing, and Alison needed to apply brakes.

She started by sipping one or two glasses of wine before she tucked in. But as time passed, she needed more and more just to get a decent night’s sleep. Soon she began binge drinking three or four nights a week, blacking out at least once. After three years, Alison realized she needed help. “I did everything I could to keep it hidden... until I just couldn’t keep it hidden anymore.” She told her manager, who was then legally responsible to disclose to the college.

CNO drew up a contract outlining everything from Alison’s hours of work to her treatment plan. The five-year agreement (she is now at the four-year mark) set out that, in year one, Alison could not work more than 37.5 hours per week, or nights and evenings. She had to submit urine drug screens three times a month in the first year (that dropped to bimonthly in year two, and once a month for the final three years). She must meet with her psychiatrist once a month for the entire five years.

Other nurses have similar contracts. Some find them daunting, but Alison, now a manager in one of Ontario’s largest regions, says it has “absolutely worked” for her.

She shares her story with co-workers. Yet she wants to remain anonymous for this story because she wants to protect her organization. She’s afraid clients who discover her past (she’s been clean three years) will think she’s unfit to do her job. “Unfortunately, until we get rid of the stigma, this kind of stuff is going to keep happening,” she says, referring to people’s fear of speaking out.

Kathy agrees that stigma gets in the way of disclosure. She says she would have reached out for help earlier, had she not feared losing the job she loves or judgment from colleagues. “In the health-care field, we’re supposed to be the caretakers; it’s very difficult for us to ask for help,” she says. “We’re supposed to be the strong ones.”

The stigma Kathy experiences from colleagues is hurtful, she says. “It’s so sad that we cannot extend the same Compassions to our own members that we do to (clients),” she adds. “The subject of addiction at the professional level is so often, if not always, swept under the rug. By ignoring the problem, you just drive it underground.”

Kathy is grateful she was given a second chance when she needed it. And she’s appreciative her relationship with her daughters has improved (though they don’t see each other often, they talk regularly over the phone). “Because of what I have gone through,” she says, “I know I’m a kinder, wiser, healthier nurse and human being.”

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