

SHUNT SELF-SURVEY FOR NURSES: PILOT TEST STUDY RESULTS OF NURSES BETWEEN 44-58 YEARS OF AGE AND LICENSED OVER 15 YEARS

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ABSTRACT:

Self-screening tools currently in use to identify substance use disorders (SUDs) do not provide advanced warning indicative of risk for individuals with no prior history, nor do they provide a measure by which to gauge the quality of recovery from such disorders. As nurses with SUDs pose a threat to themselves and patients in their care, a self-survey specifically designed to identify early indicators of risk for SUDs in nurses was developed. The purpose of this study was to compare the score of nurses in recovery from SUDs to the score of nurses who reported no issue with substance use, and to compare the current score of nurses in recovery to their score on the same items based on their recall of circumstances in the three months prior to sobriety. This pilot test demonstrated similar current scores for all nurses sampled while great disparities existed in the current score of nurses in recovery versus their score on the same items based on recall of their circumstances in three months prior to sobriety. Further studies are needed to construct validity, reliability and to test internal consistency but given the potential benefits, self-survey by all nurses, particularly those with a genetic predisposition or past history of substance abuse, seems warranted.

INTRODUCTION

Most studies have cited the incidence of substance use disorders (SUDs) in nursing professionals to be between 10% and 20% (Griffith, 1999). The potential consequences to substance abusing nurses are quite steep, including deterioration of physical and emotional health, professional and criminal prosecution, and surrender of professional license, accompanied by the loss of income, health benefit coverage, reputation and self-esteem. Substance abuse in nurses also poses a risk of fatality to the nurse and a threat to patient safety (Smith, 1998).

Self-screening tools to identify SUDs in the general population have been in use for some time, including the Michigan Alcohol Screening Test (MAST), Drug Abuse Screening Test (DAST), Alcohol Use Disorders Identification Test (AUDIT), CAGE and CAGE-AID (Adapted to Include Drugs). As positive findings on these tests correspond to characteristics which already meet criteria for SUDs, these screenings do not offer advanced warning to alert at-risk individuals regarding an escalating trend in risky behaviors and/or circumstances.

Since it is likely that a nurse may not score positive for SUDs on any of the existing self-screening tests prior to potentially jeopardizing the public, themselves or their career, it seems that an easy-to-use, self-administered survey which assesses risk markers for SUDs specific to nursing professionals may be of value. If such a self-survey tool were available, ongoing self-appraisal by all nurses may offer warning of an escalating trend towards increased risk, providing some nurses

with opportunities to modify their behavior and/or circumstances and seek formal evaluation and treatment.

Self-appraisal of the earliest tendency towards elevated risk for SUDs may be particularly advantageous for nurses with a strong family history or their own past history of consequences due to substance use or abuse. Likewise, nurses in recovery from SUDs may benefit from having a yardstick by which to measure their exposure to behaviors and/or circumstances which may threaten or weaken their recovery.

In an effort to develop a self-survey of risk factors for SUDs specific to nurses, which could capture earlier indicators of risk, ten separate characteristics were identified. These traits were extracted from general research studies regarding SUDs, studies specific to nurses with such disorders and direct observation of nurses who voluntarily surrendered their license to practice nursing due to SUDs.

SHUNT SELF-SURVEY OF 10 RISK FACTORS FOR SUDs

Social withdrawal or self-isolative behavior. Both CAGE and CAGE-AID note annoyance at receiving criticism from others regarding substance use is an indicator of risk for SUDs. Concern and worry expressed by others is also noted on MAST, DAST and AUDIT screening tests. In response to such remarks, substance users often shy away from interacting with those who verbalize concern regarding their substance use.

Lack of meaningful relationships has been observed in those with SUDs (Smith-DiJulio, 2006). Evidence suggests that loneliness is a risk factor in the development of SUDs and that the prevention of loneliness may be helpful in the prevention and treatment of SUDs (Page 1990; Page, 1991; Nerviano, 1976). Nurses confronted in the workplace due to SUDs often face stigma and harsh judgment from co-workers (Taylor, 2003). Other groups rejected by their peers have been found to have intensified feelings of loneliness (Brennan, 1982). Nurses may not be entirely immune to increased loneliness in response to rejection from their peers. For these reasons, social withdrawal or self-isolative behavior was identified as a risk factor on the self-survey for nurses.

Self-care behaviors beneath societal, professional or nurse's own standards. Self-care behaviors have been noted to be deficient in many individuals with SUDs (Moore, 2001). One of the most striking observations of those with advanced progression of SUDs is a disheveled appearance. Common psychodynamic factors such as low self-esteem and lack of self-regard have been observed in those with SUDs (Smith-DiJulio, 2006). Lack of self-regard may negatively impact an individual's attention to self-care practices. As the hallmark of addiction is an uncontrollable urge to use substances, it is likely that self-care would be deferred in favor of satisfying overwhelming cravings which substances relieve. Self-care behaviors beneath societal, professional or the nurse's own standards was included on the self-survey.

History of chemical dependency in the nurse's own family. A family history of SUDs is a risk factor as research has demonstrated a strong correlation between genetics and the occurrence of SUDs (Kreek, 2004). Because history of SUDs in the immediate family is highly predictive of a genetic predisposition to SUDs, history of chemical dependency in the nurse's immediate family was added to the self-assessment tool for nurses.

History of negative consequences related to the nurse's substance use. SUDs have long been described as chronic and progressive conditions. Earlier initiation of substance use has been identified as a risk factor which increases the likelihood of more serious problems with ongoing substance use, abuse and addiction (NIDA, 2007). As one of the best indicators of a future problem with SUDs is a past negative consequence related to alcohol, drug or prescription medication use, a history of negative consequences related to the nurse's substance use was included as a risk factor.

Untreated or unremitting emotional or physical pain. Co-morbidity of mood and other psychiatric disorders in clients with SUDs has been well documented (NIDA, 1999). Major depressive disorder and bipolar disorder have been noted as the most significant indicators for relapse in nurses in recovery from SUDs (Fogger, 2009). Chronic physical pain is frequently present in nurses with SUDs (Dunn, 2005; Maher-Bryson, 2007). For these reasons, untreated or unremitting emotional or physical pain was noted as a risk factor measured on the self-survey.

Using medication for a reason it was not intended or in a manner not recommended. Nurses have been noted to be at significantly higher risk of addiction to mood-altering prescription substances compared to the non-nurse population (Trinkoff, 2000). As using medication for a reason it was not intended or in a manner not recommended are both examples of medication misuse and such misuse is a risk for SUDs, this item was included on the self-assessment for nurses.

Nursing practice routinely in excess of 55 hours per week. Overwork has been noted as a frequent occurrence in nurses with SUDs, particularly those who obtain their substance(s) from the workplace. Nurses who routinely work far beyond the equivalent of full-time hours required for their position naturally have less time available to recuperate from stressors related to work. Maintenance of optimal health practices such as relaxation, exercise and other endeavors which support and fortify emotional and physical health are often negatively impacted by excessive work (Dunn, 2005). Overtime is strictly curtailed by most monitoring programs when nurses initially return to practice after restoration of their license related to SUDs in order to minimize the risk of relapse. To identify the risk inherent in overwork, nursing practice routinely in excess of 55 hours per week was noted on the self-survey.

Nursing duties include frequent access to controlled substances. Frequent access to mood-altering substances has been noted as a risk factor in the development of SUDs in nurses (Dunn, 2005; Trinkoff, 2000). While access does not pose a problem for the vast majority of nurses, it

has been demonstrated to be a factor in the development and/or exacerbation of SUDs in some nurses and merits inclusion in any self-appraisal instrument specific to nursing professionals' risk for SUDs.

Transitional period requiring major adjustment within the past year. Navigation through major transitional stages has been found to be extremely difficult for those with SUDs (Sinha, 2001). As transitional stages are universal life experiences and present special challenges to those susceptible to SUDs, a transitional period requiring major adjustment in the past year was included in the self-survey.

Turmoil or tragedy with unresolved conflict. Clients with SUDs often possess less than adequate coping skills and tend to respond to stress by using or abusing substances (Gelfand, 1990; Naegle, 1988). A history of past trauma has been noted in some research regarding nurses with SUDs (Ponech, 2000). Use of substances as a coping strategy to deal with emotional discomfort often precipitates ongoing difficulties in family life and the workplace (Coleman, 1997). Continued substance use does not resolve such issues and may lead to increased turmoil and conflict. For these reasons, turmoil or tragedy with unresolved conflict was identified as the tenth risk factor on the self-survey for nurses.

Each of the letters in the word SHUNT corresponds to the first letter of the first word in two of the ten items on the survey. The word SHUNT seemed fitting not just as an acronym but because the aim of this self-survey is to shunt nurses away from behaviors and circumstances which increase their risk of SUDs.

The purpose of this study was to (a) determine the self-survey score range of nurses in recovery; (b) compare the self-survey score range of nurses who report that they do not have a problem with substance use with the score range of nurses in recovery from SUDs; (c) compare the current score range of nurses in recovery with the score range based on their recall of circumstances in the three months immediately prior to sobriety.

METHODS

A small convenience sample of currently licensed and employed nurses was invited to complete an anonymous questionnaire. The nurses were not representative of any particular clinical specialty, nor were they gathered for a purpose in any way related to SUD treatment or recovery. No incentive was provided to nurses for completing the survey nor was there any coercion to participate. All nurses were provided an envelope in which to place the completed questionnaire which was addressed to a PO Box, but was not stamped for mailing. All respondents were afforded the opportunity to hand in the envelope with the completed questionnaire, or, if they felt more confident that their anonymity would be secured, mail the completed form to the PO Box.

All respondents were asked to assess themselves on the ten items on the SHUNT Self-Survey for Nurses described in “Unbecoming A Nurse” (Scimeca, 2008) by answering “yes” or “no” regarding the current presence or absence of certain behaviors or circumstances in their life.

All nurses who reported that they were in recovery from SUDs were asked to assess themselves again on the same ten items based upon their recall of circumstances during the three months immediately prior to the sobriety date they noted earlier on the questionnaire.

To test the perception nurses in recovery held regarding their ability to recall their behavior and circumstances immediately prior to sobriety, they were asked at the beginning of the questionnaire to rate their recall of events immediately prior to sobriety as excellent, very good, good, fair, poor or unsure. One (20%) nurse in recovery reported excellent recall, 3 (60%) reported very good recall and 1 (20%) reported good recall.

After nurses in recovery self-assessed their current score on the ten items and self-assessed themselves again on the same ten items based on their recall of circumstances during the three months immediately prior to sobriety, they were asked to rate their level of overall confidence in the accuracy of answers provided regarding the three months prior to sobriety. Four (80%) nurses in recovery reported being very confident in the overall accuracy of the answers they provided based on recall and one (20%) reported being fairly confident.

RESULTS

Respondents who completed and returned the survey numbered 23 out of 37, or 62%, of those invited to participate. Twenty completed surveys were collected on the date they were distributed and 3 were received by mail within seven days of the distribution date. No attempt was made to determine the reason some nurses chose not to participate and no assumptions were made in this regard.

Without providing any definition of recovery from alcohol and/or drugs, including prescription medication(s) on the questionnaire, all respondents were asked if they considered themselves to be in recovery from alcohol and/or other drugs, including prescription medications. Of the 23 respondents, 5 (22%) reported they were in recovery. Nurses in recovery had a mean age of 49.6 years and a median age of 49 years. One recovering nurse (20%) was male.

Recall of Circumstances Three Months Prior to Sobriety by Nurses in Recovery

Nurse respondents who identified themselves as in recovery were provided with the following definition of sobriety date: “the day after your last use of alcohol and/or any other mood-altering substance, excluding any medications which were taken exactly as prescribed by a treatment provider.” Nurses in recovery were asked to provide their sobriety date based on the above definition, and reported sobriety dates of between 10 and 26 years duration, with a mean length of sobriety of 18.4 years and a median length of 18 years.

The recovering nurses' age at the time of their reported sobriety date ranged between 26 and 43 years. The mean age at the time of their reported sobriety date was 30.8 years, with a median age of 28 years. The number of years nurses in recovery were licensed as nurses at the time of their reported sobriety date was between 3 and 22 years, with a mean of 8.6 years of licensure and a median length of 7 years licensure.

The score based on recall of behavior and events during the three months prior to sobriety ranged from 4-9 with a median score of 8. All nurses in recovery reported a family history of SUD and all reported history of a negative consequence related to their substance use. Four nurses in recovery (80%) recalled themselves as socially withdrawn or self-isolative in the three months prior to sobriety; 4 (80%) recalled self-care deficits during that period; 4 (80%) recalled untreated or unremitting pain at the time; and two (40%) recalled misuse of medication in the three months prior to sobriety.

One nurse in recovery recalled working over 55 hours per week routinely in the three months immediately prior to sobriety, however this was not the same nurse in recovery who reported currently working in excess of 55 hours per week. Four nurses in recovery (80%) recalled frequent access to controlled substances in the three months prior to sobriety.

All nurses in recovery recalled having a transitional period requiring major adjustment in the year prior to sobriety. Four nurses in recovery (80%) recalled turmoil or tragedy with unresolved conflict in the three months prior to their sobriety date.

Current Self-Assessment of Nurses in Recovery

The median score of nurses in recovery post-sobriety was 3, which is 5 points less than their score prior to sobriety indicating they have greatly reduced their risk for SUDs. Whereas 80% of the nurses in recovery reported social withdrawal or self isolative behavior and self-care behaviors below societal, professional or nurse's own standards and untreated or unremitting emotional or physical pain prior to sobriety, none currently reported these behaviors. Similarly, whereas 40% of nurses in recovery used medication for a reason not intended or a manner not recommended prior to sobriety, none did so after achieving sobriety.

One of the nurses in recovery (20%) reported routinely working over 55 hours per week prior to sobriety but no longer continues to work those long hours. However this was not the same nurse in recovery who reported currently working in excess of 55 hours per week. The number of nurses who reported frequent access to controlled substances in their current workplace was reduced by half after sobriety, down from 80% to 40%. Nurses in recovery who reported they had a transitional event requiring major adjustment within the past year decreased by 40% pre-sobriety to post-sobriety, as did the number of recovering nurses who reported turmoil or tragedy with unresolved conflict.

Nurses Who Reported They Were Not in Recovery

Current scores of all nurses regardless of recovery status were similar. The median score of nurses who did not identify themselves as in recovery was 2, versus the median score of 3 for nurses currently in recovery while the median score for nurses in recovery prior to sobriety was 8. The slightly higher median score of 3 for nurses in recovery was predominantly due to the historical traits of a family history of SUDs as only two-fifths of those not in recovery reported a history of chemical dependency in their family and none reported negative consequences related to their substance use. Scores of nurses not in recovery were identical to post-sobriety nurses as none currently reported no social withdrawal or self-isolative behaviors, no self-care behaviors below standards, or use of medication for a reason not intended or a manner not recommended.

Over half of the nurses not in recovery reported their duties include frequent access to controlled substances. Nurses not identified as in recovery were much more likely to currently report untreated or unremitting emotional or physical pain (16.5%) than nurses in recovery (0%). Far fewer nurses not identified as in recovery reported the traits of practicing more than 55 hours a week (5.5%), turmoil or tragedy with unresolved conflict (22%), or a major adjustment during a transitional period in the last year (33%).

DISCUSSION

In this small sample, the incidence of respondents reporting that they are in recovery from SUDs is 22%, slightly higher than the anticipated prevalence most studies have cited specific to nurses. All nurses in recovery reported a history of SUDs in their immediate family, supporting prior research which indicates the risk for SUDs is greater in individuals who have a family history of SUDs. All nurses in recovery also noted a history of negative consequences related to substance use while none of the nurses not identified as in recovery reported this trait.

On average, five additional risk indicators were identified by nurses in recovery in the three months prior to sobriety. The median score of nurses in recovery based on recall of circumstances in the three months immediately prior to sobriety was 8, compared to their current median score of 3 in recovery.

That no nurses currently reported self-isolative behavior or self-care deficits, while 80% of nurses in recovery recalled the presence of both of these traits in the three months prior to sobriety seems to indicate that the presence of these traits increases risk for SUDs. As relapse into substance use after a period of sobriety is not at all uncommon and the nurses in recovery in this sample reported uninterrupted sobriety of 10-26 years, the absence of social withdrawal and self-care deficits appears to be associated with a reduced likelihood of relapse into substance use.

Although a predominant presence of SHUNT traits immediately prior to sobriety would not be unexpected based on prior studies of the general population with SUDs and research specific to nurses with SUDs, there were some noteworthy findings in this pilot that indicate avenues of future exploration.

One such area is that as nurses advance in age, an increased incidence of pain symptoms would not be unexpected. It therefore seems significant that while 16.5% of nurses not in recovery reported currently having untreated or unremitting pain symptoms, the nurses in recovery, 80% of whom recalled such symptoms prior to sobriety, currently report no such issues. Since recovery from SUDs cannot directly account for any reduction or elimination of physical or emotional pain experienced by nurses in recovery, especially those who recall such symptoms at a much younger age, and recovery from SUDs does not offer any protection against developing additional physical or emotional pain in the future, the total absence of untreated or unremitting pain symptoms in all recovering nurses appears worthy of note.

This finding may reflect that nurses in recovery are more attentive to situations which might provoke pain or that they may be more highly motivated than nurses not in recovery to avoid such circumstances. The drastic reduction in pain in these recovering nurses may indicate that they seek out professional evaluation and/or care for pain as soon as it occurs, or that they are more vigilant in maintaining preventive health practices, such as following exercise and dietary guidelines. It is also possible that these recovering nurses do not report untreated or unremitting pain due to surgical intervention after their sobriety date and/or due to ongoing care by treatment providers that has alleviated their prior symptoms.

Possibly a combination of these and other factors is the reason for the total absence of unremitting or untreated physical and emotional pain in nurses in recovery in this pilot. Given that pain is a risk factor for SUD development and relapse and the nurses in recovery in this pilot report successful management of both pain and SUDs, this may be an important area for future study.

In this pilot study, all respondents, including nurses in recovery from SUDs, denied current misuse of medications. Additionally, the majority of nurses in recovery (60%) reported no misuse of medications in the three months prior to sobriety. As the past decade has given rise to a social climate in which over 15% of youth report the use prescription medications to get high by the time they reach 12th grade (Johnston, 2008) and more aggressive treatment of pain has prompted more frequent prescription of opiate medications, even for the acute pain relief of children post tonsillectomy, the prevalence of medication misuse among nurses under the age of thirty may be significantly higher than the incidence found in this pilot.

Frequent access to controlled substances in the workplace was reported by 80% of nurses in recovery prior to sobriety. Only one nurse with frequent access prior to sobriety also reported medication misuse pre-sobriety. Of the two nurses in recovery who currently have frequent access to controlled substances in recovery, one of them was among the nurses in recovery who reported using medication for a reason not intended or manner not recommended prior to sobriety.

That there is a reduction in frequent access to controlled substances in nurses in recovery and that, as a group, the current percentage of nurses in recovery who do not have frequent access is higher than the nurses who report they are not in recovery is not surprising. This may indicate that some

of the nurses in recovery purposely avoided nursing positions after sobriety which included access. It is also possible that the SUDs in some nurses in recovery did not involve medications obtained from the workplace. That one of the two nurses who reported frequent access and misuse of medications prior to sobriety continues to maintain sobriety while holding a position involving frequent access to controlled substances indicates successful re-entry into unrestricted nursing practice with the ability to maintain sobriety even when access is present. However, this pilot did not measure the length of time, if any, which the nurse was restricted from access either by a self-determined choice or due to the dictates of an alternative program.

Transitional periods requiring major adjustment within the past year was reported in all nurses in recovery in the three months before sobriety. While the presence of this trait was decreased to 60% in the nurses in recovery, only 33% of nurses not in recovery reported such events. It does not seem likely that the presence of this trait is directly related to the aftermath of SUDs as the length of sobriety in nurses in recovery was over 10 years in this pilot sample. A larger sample of respondents may provide a better indication as to whether there is an ongoing increase in the incidence of transitional events, even for nurses in long-term recovery, compared with nurses who identify no past or current indication of SUDs.

The presence of turmoil and tragedy in nurses in recovery was reduced by half from pre to post sobriety levels. Although report of this risk factor remained higher for nurses in recovery (40%) than the nurses not identified as in recovery (22%), half of the nurses not in recovery reporting this trait also reported having an immediate family member with a history of SUDs. As SUDs have a genetic component and the disorder itself as well as the earliest recovery phase tends to be accompanied by ongoing conflict in the immediate family, it is possible that some of the elevated incidence of turmoil or tragedy with unresolved conflict, may be related to the SUD of another member of the family unit not yet in recovery or in an early or unstable phase of recovery.

Although initial exposure to one or more addictive substances may be identifiable in individuals with SUDs, addiction is not usually considered a distinct event. The progression of SUDs is often insidious, with evidence of increasing loss of volition and inability to refrain from use over time. Likewise, recovery from SUDs is viewed as a process rather than a discreet event. As such, recovery from SUDs must be managed and maintained with vigilant attention on a daily basis similar to health practices used to successfully manage other chronic diseases like diabetes and heart disease.

As SUDs are processes rather than distinct events which simmer beneath the level of customary detection for some time, there are multiple opportunities for assessment and intervention along the continuum of these disorders which may prevent their actual occurrence or the development of worst case scenarios. Similarly, as recovery from SUDs is an ongoing, lifelong process, opportunities to assess the strength or vulnerability of an individual's recovery may identify the need for additional support or more attention to recovery efforts to prevent relapse.

Early identification of all chronic disorders, including SUDs, is important. SUDs, however, are unique from other chronic disorders in that despite a constellation of factors that moderate one's susceptibility to developing SUDs, the key precipitant, without which there is never the development of a SUD, is direct exposure to one or more addictive, mood-altering substances.

Given that SUDs are serious and potentially lethal conditions which occur in 1-2 out of every 10 nurses, vigorous measures to identify nurses at risk is a necessary step towards prevention of harm to nurses as well as the public.

This pilot sample demonstrates a preponderance of SHUNT risk factors present in nurses in recovery three months prior to sobriety and a corresponding, highly significant reduction in these same traits in these nurses in long-term recovery. The absence of these traits in nurses not identified as in recovery or with any history of SUDs was also clearly evident in this pilot study.

These findings support the earliest introduction of the SHUNT self-survey to the student nurse population as more than half of nurses who develop SUDs identify that problematic substance use was evident during or prior to nursing school. SHUNT self-screening by all nurses already in practice seems advisable in order to offer the earliest possible warning of behaviors and situations associated with an increased risk of SUDs. The practice of regular ongoing self-assessment seems particularly advantageous for those with a family history of first degree relatives with SUDs. Additionally, the use of this instrument by all nurses in recovery seems indicated as a proactive measure by which to identify any trend towards a weakening in recovery strength prior to actual relapse.

LIMITATIONS

The pilot test sample of nurses was too small to draw absolute conclusions from but points out several areas for future study using a larger sample that is dispersed geographically throughout the U.S. Though the percentage of nurses who already experienced an issue with an alcohol or drug problem was within 2% of the widely accepted range for lifetime incidence in the nursing profession established by most previous studies, it is undetermined whether some of the nurses who had not identified a problem with substances were in denial and would actually meet SUD criteria if evaluated professionally. Self-selection was a limitation as no attempt was made to determine the reason nurses chose to participate or not to participate.

No nurse under the age of 44 participated in the pilot test study, nor were there any respondents who were licensed for less than 15 years. The age of respondents may have skewed the results of this small sample in several ways. Given the statistically significant rate of recreational prescription drug use documented among teens over the past decade and the extremely addictive qualities of these substances, which the 44 to 58 year old respondents in this sample were not exposed to in their youth, it may be that a future study including younger nurses may demonstrate

a greater reported frequency of misuse of medications. If that is the case, it is possible that other items on the self-survey may also be impacted.

The nurses in recovery in this pilot test possessed what could only be categorized as long-term recovery from SUDs. The inclusion of nurses reporting shorter lengths of sobriety may elicit different results. While some research suggests that such self-reports based on recall may not be as unreliable as once thought (Davidson, 1986; Hesselbrock, 1983; Sobell, 1979), the recall of nurses in recovery may be limited or unreliable. Recall of events which never occurred, omission of events which did occur, and/or temporal displacement in which the perceived timing of events may be erroneous makes nurses in recovery's report of the three months prior to recovery suspect.

Future study may be able to minimize any erroneous reports in the recall of nurses in recovery regarding the three months prior to sobriety by asking for concurrent appraisal of the same risk factors by the nurses' treatment providers in addition to the nurse's self-assessment. As alternative programs often require initial evaluation and ongoing reports from various objective sources regarding nurse participants, retrospective analysis of nurses with SUDs may be a possible avenue for future study to confirm the range of scores based on nurses recall of events immediately prior to sobriety.

In spite of possible errors or omissions in nurses' self-reports of their current and/or past situations, their perception of their own behavior and circumstances may have some significance regarding their vulnerability of developing SUDs and/or relapsing into SUDs after beginning the recovery process. A nurse's self-assessment may allow some to use such findings as a yardstick against which to measure initial and/or ongoing risk for SUDs. Particularly for nurses in recovery, the ability to gauge any escalating score upon self-survey may help to decrease their risk of relapse.

SUMMARY

Screening tools for self-administration by individuals to identify possible or probable SUDs such as MAST, DAST, AUDIT, CAGE and CAGE-AID have been in use for some time. While these and similar tools have a place in identifying individuals with SUDs, they do not offer early detection of risk factors for SUDs and do not include indicators specific to nurses. Given that there is a significant incidence of SUDs in nurses, that SUDs are chronic and progressive in nature, and that SUDs may pose a threat to the safety of patients as well as the nurse, earliest detection of risk indicators has many advantages.

SHUNT takes a different approach than these other screening tools. SHUNT evaluates potential risk factors for nurses rather than existing behaviors and conditions. For example, SHUNT asks if you have a family history of SUD. Just because you have a family history of SUD doesn't mean you currently have a substance use disorder. But if you do, you are potentially at greater risk for developing such a disorder.

The most frequently reported items present in the three months prior to sobriety were self-isolation, self-care deficits, unremitting or untreated pain, frequent access to controlled substances, turmoil with unresolved conflict and recent transitional events.

This pilot study suggests that higher levels of SHUNT self-assessment scores are associated with SUDs in that nurses in recovery from such disorders reported the presence of most of the risk factors prior to sobriety. Conversely, SHUNT scores were greatly decreased in nurses in long-term recovery and were consistently very low in nurses who reported they had no issue with SUDs.

Therefore, the SHUNT Self-Survey For Nurses seems to be able to identify risk factors in nurses who are either progressing towards, or actually meeting criteria for SUDs. Additionally, nurses in recovery may use this instrument as an ongoing gauge by which to highlight increased risk of relapse, thus providing them with a visible means by which to recognize risk and make modification in behaviors throughout the continuum of sobriety to enhance the likelihood of uninterrupted recovery and decrease the risk of relapse.

Given the elevated risk for prescription medication abuse that youth are exposed to in the current social environment and the greater chance that they have also been exposed to the legitimate use of opiates by caregivers which may have primed the brain of those at greatest risk for SUDs due to genetic and other factors, it seems that all student nurses should be provided with not only the knowledge but the incentive to self-assess and monitor their risk for the development of SUDs as part of their education, training and acculturation into the profession.

While further studies are needed to construct validity, reliability and to test internal consistency of this tool, given the significant and persistent physical, emotional, legal, financial and professional consequences SUDs pose to nurses, the minimal investment of time, low cost of administering this self-assessment, and the potential benefits of recognizing a SUD prior to the development of the most dire sequelae, a self-survey by all nurses and students nurses, particularly those with a genetic predisposition and/or past negative consequence related to their own substance use, seems warranted.

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