Nurses' Perceptions On Factors That Relate To Their Choices to Refer For Assistance

by

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B.A., University of Victoria, 1988

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

ACCEPTED
FACULTY OF GRADUATE STUDIES
DEAN
DATE 1991-05-13

MASTER OF ARTS

In the Department of Psychological Foundations in Education

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ABSTRACT

The factors associated with the choices to self-refer or to refer colleagues to assistance programs for chemically dependent nurses are examined. A random sample of 300 Registered Nurses working in British Columbia was mailed a questionnaire along with a cover letter explaining the study. A total of 159 nurses responded (54%). The questionnaire requested information on demographic variables, program awareness, perceived incidence of impaired practice, resources for help-seeking, attributes of initial contact persons, and program elements that might enhance the referral environment. The majority of the nurses indicated that they were unaware of programs in their areas to assist impaired nurses; the majority of nurses would either approach an impaired colleague directly, or speak to someone about their concerns; family and friends would be the first choices when seeking help for personal problems resulting from chemical dependency; persons who maintained confidentiality, and were non-judgmental and supportive were more likely to be sought out for help; the referral environment should be one in which reprisal is guarded against, treated nurses are followed up, health insurance coverage is applied to treatment periods, educational efforts are expanded, peer networks are used to identify and assist impaired nurses, accessibility is 24-hours a day,

and availability is province-wide. Recommendations for future study include improved methodology, study of successful referral strategies, and longitudinal follow-up of recovering chemically dependent nurses.

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DEDICATION

This work is dedicated to
AIMEE LYNN BIRD (1975 - 1990),
whose indomitable spirit
I can only hope to approximate.

CHAPTER I

INTRODUCTION

Background

The last decade has seen an increased interest paid by professionals to those within their ranks who become impaired during the course of their careers. Estimates of impaired practice range from 10 to 20 percent within the health care profession (Kelley, 1982). Chemical dependency is the most frequent form of impairment, and six to eight percent of American nurses are said to be addicted to alcohol and/or drugs (Stammer, 1988). The Registered Nurses' Association of British Columbia (R.N.A.B.C.) states that chemical dependency is at the root of most complaints about professional conduct ("Why Nurses...", 1986).

Early identification and referral of impaired employees is closely related to successful treatment outcomes (McCrady, 1989; Steele, 1988). Still a large portion of impaired health care professionals do not receive the benefits of treatment at an early stage of their dependency experience. Recovering nurses report a three to five year time span from the beginning of their dependency to the time they were confronted by someone, usually for questionable job performance (Bissell & Haberman, 1984; Kaab, 1988; Shaffer, 1988). The most common reaction to the discovery of alcohol or drug induced impairment has been to get rid of the problem by terminating the employee (Green, 1989). This may or may

not involve revocation of the licence to practice. This strategy has been referred to as the 'throw away nurse syndrome' (Sullivan, Bissell & Williams, 1988). Such an approach results in either continued impaired practice elsewhere, lowered professional standards and patient jeopardy, or a great expense to the profession for losing a highly trained, experienced individual. Since the nursing profession is facing an acute shortage of nurses, it is advantageous for the profession to conserve its human resources (Green, 1989).

The variety of strategies employed to deal with impaired practice in nursing has ranged from adversarial-like discipline to a rehabilitative management concept (Meyers, 1984) . Recently attempts have been made by industry, business and institutions to address the personal and work related problems of employees by offering resources at the work site. Among the most frequently employed resources for nurses are Employee Assistance Programs (EAPs) and Peer Assistance Programs (PAPs).

Employee Assistance Programs (EAPs)

The history of EAPs can be traced to the early efforts of employers to deal with the work-related problems associated with alcoholism. The past quarter century has seen EAPs evolve into expanded resources that address many situations in the employee's personal and work environments.

Although EAPs contain some fundamental 'core technologies', the individual philosophical, structural and operational components of each organization dictate the particular EAP it will adopt (Sonnenstuhl, 1989). Effectiveness of EAPs is measured by the degree to which the program meets the needs of the employee population(s) it was implemented to serve. While industry has begun to adopt EAPs and find a place for them within their organizational structures, there is much to be done to define the roles of EAPs in institutions such as hospitals (Bissell & Haberman, 1984). Hospitals have been slower than industry to implement EAPs (Creighton, 1988), while at the same time nursing administrators and researchers have advocated EAPs with counselling services to address early recognition and intervention, treatment, and reintegration of the impaired nurse (Crosby & Offer, 1988; Robbins, 1987; Shaffer, 1988). EAPs in hospital settings, however, may be perceived by employees as lacking confidentiality, inviting reprisal, or may be more of a philosophical than a practical program (Sullivan, Bissell & Williams, 1988; Green, 1989).

Peer Assistance Programs (PAPs)

Canada's first PAP was begun in late 1984 in Toronto, Ontario (Penny, 1986). The first PAP to be sponsored by a provincial nursing association began in 1985 in Manitoba (Kotyl, McKnight & Wortzman, 1988). PAPs perform an early

identification and intervention role, which aims to keep nurses from appearing before their disciplinary committees where they face loss of licence to practice. Considerable variation exists among peer-based programs. Staffed primarily by volunteers, peer assistance and peer counselling programs have dealt effectively with troubled individuals in such varied settings as colleges, hospitals, long-term care facilities, mining, and the professions (France, 1989; Hills, Johnson, Michalenko, Docherty & Bucklee, 1989; Mazze, Schneider & Drucker, 1981; McCrady 1989; Molloy, 1989). Peer counselling is a natural resource that enhances and broadens professional services (Carr, Yanischewski & de Rosenroll, 1989). Peers possess a unique understanding of their social system and their use as a strategy to deal with impaired nurses has been advocated in the identification, intervention, and recovery/reintegration processes (Hutchinson, 1987; Stammer, 1988; Williams, 1989).

The nursing profession has recognized the problem of chemical dependency and resultant impaired practice, and has mobilized to develop programs to deal with impairment issues. EAPs within institutions like hospitals are beginning to learn about their roles and how they might fit within the organizational structure, but the degree of their effectiveness is yet uncertain. PAPs vary considerably in approach, personnel, and funding and their particular effectiveness may reflect these variables. A major problem

within the issue of chemical dependency among nurses is the lack of standardized methods by which impaired nurses are ushered into treatment (Shaffer, 1988).

Purpose of the study

Early referrals of impaired nurses, whether by themselves or by colleagues, have happened far too infrequently. Some impaired nurses have gone through an entire career without having been confronted by anyone (Bissell & Haberman, 1984). Supervisors and co-workers are reluctant to refer colleagues for reasons that range from the lack of training in early recognition, to the 'ethical limbo' of labeling someone an alcohol or drug abuser (Crosby & Offer, 1988; Shain & Groeneveld, 1981; Trice & Roman, 1979). Self referrals, although often the most successful of referrals, account for a minority of referrals to assistance programs (Newman, 1983; Sonnenstuhl, Staudenmeir & Trice, 1988). This suggests a need for a clearer understanding of what nurses perceive as a favorable environment in which to seek assistance.

Therefore, the purpose of this study is to learn more about how nurses account for their choices to refer themselves or a colleague to an assistance program for impairment due to alcohol or drug abuse. That is, what do nurses know about programs in their area that may assist impaired nurses; who are they most likely to seek out for

help; what attributes would an initial contact person possess; and what elements would nurses choose to compose an environment that would enhance referral ?

Significance of the study

The information gained from this study could help the nursing profession in British Columbia to gain a more realistic picture of its members' perceptions on how to establish more effective referral mechanisms for impaired nurses. For nursing leaders to implement effective referral programs that address the needs of the profession, first hand information from the members is needed. For those counsellors involved in either EAPs or PAPs, such knowledge could better prepare them for more appropriate and timely intervention and assistance.

Should more accurate perceptions on effective referral mechanisms and environments arise from the information gained by this study, then it would seem possible that more nurses could be retained, the integrity of the profession maintained, and the public safety protected.

CHAPTER II

REVIEW OF LITERATURE

Impaired practice due to chemical dependency is a notable problem in the health care professions. Although precise numbers are unknown, it is recognized that chemical dependency occurs in nursing as it does in other professions. Little research has been done on chemical dependency among nurses, and many questions remain. There is no satisfactory explanation for the cause of chemical dependency, nor has it been determined what factors influence help-seeking in nurses, or what constitutes the best means of assistance (Sullivan, Bissell & Williams, 1988).

Etiology

While there are numerous theories and hypotheses about the nature of chemical dependency, the predominant model in current nursing literature is a unitary 'disease' model. It posits that chemical dependency is a primary, progressive disease that will not subside unless the individual accepts treatment (Crosby & Offer, 1988). This 'medicalization' of troubled employee behavior has important implications for the role of supervisors and for the nature of the assistance that employers recommend for troubled employees (Roman, 1981).

Research on chemical dependency among nurses is rare.

Most research appears as descriptive studies or anecdotal reports about certain personal characteristics of impaired nurses, and certain risk factors present in the nursing environment; yet, a definitive cause of chemical dependency has not been documented (Sullivan, Bissell & Williams, 1988). Throughout the literature, certain factors have emerged that are associated with chemical dependency among nurses. Dispersed within the work environment, the professional culture, and the personal characteristics of those who choose nursing as an occupation, the following factors have attracted the majority of the attention from researchers: stress, familial alcoholism, access to drugs, and cultural attributes of the profession (Adey, 1987; Bissell & Haberman, 1984; Gaskin, 1986; Hutchinson, 1987; Kelley, 1985; Roth, 1987; Solari-Twadel, 1988; Stammer, 1988; Sullivan, 1987).

Stress: Although the evidence is inconclusive that stress itself leads to drinking and other drug abuse, it remains a natural area of inquiry. Adey (1987) reported that 77% of a sample of nurses employed in an acute care hospital suffered stress symptoms at least some of the time, and 16% suffered stress symptoms most of the time. Kelley (1984) surveyed 25 chemically dependent nurses disciplined by their regulatory boards and found that 72% reported stress--marital, physical pain, or job-related--as the reason for taking drugs. Hutchinson (1987) conducted in-depth interviews with 20 chemically dependent nurses. She

concluded that the rapidity with which the nurses became addicted was affected by the degree of pain--psychological to physical--they suffered. Work stress contributed to their experiences of pain. Those who described themselves as 'in crisis' and requiring relief of pain developed their obsession with drugs rapidly. Those who used chemicals merely to 'feel better' at times of stress reported a slower progression toward addiction. However, stress is not a unique feature of nursing, and its reliability as a predictor of chemical dependency should be considered cautiously.

Professional Culture: Nurses are members of a professional culture. The influence of this culture shapes nurses' decisions and behaviors and thus exerts control over individual practitioners by binding them to common sets of ideals. These ideals further manifest in common sets of behavioral and attitudinal attributes (Solari-Twadel, 1988). Some of these cultural attributes interact with the personal attributes of those entering nursing as an occupation, and can predispose some nurses to higher vulnerability to chemical dependency.

Pharmacological perspective: The emphasis placed on drugs as valuable, useful adjuncts to decrease pain, reduce anxiety, and control behavior is unique to the health care professions. Health care professionals are taught to understand and appreciate drugs. Such a 'pharmacological perspective' quickly teaches nurses that taking drugs solves

problems. As professionals, nurses believe themselves to be so well informed that they are immune from the dangers of addiction, and self-diagnosing and self-medicating are commonplace (Green, 1989; Solari-Twadel, 1988; Sullivan, Bissell & Williams, 1988). The access to dangerous narcotics and other addicting drugs places added pressure upon susceptible nurses who may divert drugs from hospital supplies.

Professional enabling/co-dependency: Frequently, the role of colleagues is mentioned in discussions about the work experiences of chemically dependent employees. An attitude of ambivalence appears to exist. Whereas colleagues seem to know for some time that something is seriously wrong with a co-worker, they are reluctant to voice their concerns because they don't want to be the one responsible for jeopardizing a career by labelling a colleague as addicted (Trice & Roman, 1972). Reactions of denial and animosity are feared, and the thought that they may be wrong about their suspicions prevents many colleagues from speaking out. Such behavior on the part of supervisors and co-workers has been referred to as 'co-dependency' or 'professional enabling', and is said to be rampant within the medical profession (Bissell & Haberman, 1984; McCrady, 1989; Sullivan, Bissell & Williams, 1988). Although not strictly a factor considered as causing chemical dependency, enabling is seen as fostering its continuation and progression (Crosby & Offer, 1988;

Shaffer, 1988; Kotyl, McKnight & Wortzman, 1988).

Caregiver mentality and familial alcoholism: A family model called the Adult Child of an Alcoholic Family is characterized by disrupted communication patterns and role strain, particularly for the children (Black, 1981). Female children from such a family system frequently internalize an exaggerated sense of their role as caregiver. Often one parent is chemically dependent and unable to assume a functional parental role, forcing the child to step in and take on the role. It has been reported that greater than one-half of all alcoholics come from a family where one or both parents were alcoholics, and that the caregiver child is not only more at risk to choose a chemically dependent mate, but also to choose a helping role as a professional (Roth, 1987).

Using a qualitative research design, Stammer (1988) interviewed 34 recovering alcoholic nurses for a total of six hours each. Among her findings were that 85% of the nurses reported a strong caregiver attitude, and 75% had a history of alcoholism in the first two generations of their family. Bissell and Haberman (1984) reported on 407 recovering alcoholic professionals, 60% of whom worked in health care. Within the group of 100 nurses, 46% reported alcoholic parents. In the largest population of recovering chemically dependent nurses yet to be studied, Sullivan (1987) surveyed a 'dependent' sample of 139 nurses and a 'nondependent'

comparison group of 522 nurses. In this study 48% of the dependent sample, compared to 22% of the control group, reported that because of dysfunctional family systems, they were forced to assume a parental role during childhood. An alcoholic family member was identified by 62% of the dependent sample, but only 28% of the comparison group reported familial alcoholism.

Incidence

Few data exist that estimate the incidence of impaired practice among professionals, or the types of problems that may lead to impairment. Conservatively, it could be estimated that the rates of incidence should be similar to the general population. Therefore, approximately 7% of practicing professionals would have alcohol problems, and 3% to 5% would have drug abuse problems. Thus, a conservative estimate would have approximately 15% of professionals at risk of dependency (McCrady, 1989). The proportion of them who become impaired is unknown.

Accurate statistics on the incidence of chemical dependency among nurses are unavailable. The data that do exist are based on those nurses who come to the attention of disciplinary bodies or treatment facilities. Other estimates are arrived at by correlating the incidence of various secondary medical diagnoses, such as cirrhosis of the liver or hepatitis, with the incidence of chemical dependency.

Although no studies have been done in Canada to

determine the incidence of chemical dependency among nurses (Kotyl, McKnight & Wortzman, 1988), the American Nurses' Association (1984) has established that 68% of all actions brought upon nurses by state regulatory boards were due to substance abuse. Furthermore, estimates are that 6% to 8% of nurses may have serious alcohol or drug problems. Bissell and Haberman (1984) reported that the average subject within their sample of professionals, 100 of whom were nurses, knew of at least four colleagues whom they had reason to believe were practicing while impaired.

Nurses who are disciplined are those who are caught stealing or using drugs. Consequently, disciplined nurses represent only a portion of those nurses abusing drugs, and usually doesn't include those abusing alcohol (Sullivan, 1987). Bissell and Haberman (1984) found that 75% of the recovering nurses in their sample faced no formal sanctions whatsoever, and only 3% actually lost licences. Those who lost licences were more likely to have been addicted to narcotics as well as alcohol.

Factors that influence help-seeking

Help-seeking in a general context: The phenomenon of help-seeking has many manifestations beyond the simple dichotomy of whether or not to seek help. The level at which one abandons the notion of self-sufficiency varies from person to person. Both intrapersonal and interpersonal

factors influence the decision to seek help from others. Culturally acquired norms regarding physical, psychological and social 'normality', and what the deviation from these norms mean, also impinge on the potential help-seeker's decisions.

Models of help-seeking: Gross and McMullen (1983) have proposed a simplified help-seeking model that involves three stages: (1) perception of a problem that is amenable to help; (2) decision to either accept the problem, help self, or seek help; and (3) strategies to seek out and effectively utilize the help. However, they caution that it is unlikely that such a linear process approximates the tortuous route that characterizes many help-seeking experiences. In fact, although analytically distinct, these stages often are experientially interactive, and at any decision point along the way, each stage may have anticipatory effects on another.

At some distance away on the continuum of models for help-seeking lies a process model presented by Wills (1983). He relates the type of help-seeking behavior to the person's level of subjective distress. Different types of help-seeking vary systematically in the functions they serve, the coping mechanisms they involve, and the types of helpers that are approached. In other words, help-seeking can be seen as a complicated set of behaviors that are specific to the situation. Throughout the literature on models of help-seeking, however, there runs common threads of agreement.

Two stages, or perceptions, are necessary to stimulate a help-seeking response: (1) to define the situation as problematic and to realize that one's own resources are inadequate for resolution; and (2) to make the decision to seek and utilize help.

The cost of help-seeking: Many people in need decide not to seek help at all, and when they do, it is often in an indirect manner. DePaulo (1983) briefly reviews literature on indirect help-seeking and points out that aid-eliciting cues, story-telling, and experience-swapping are strategies that are often used instead of a direct request for help. In their seminal study of help-seeking for mental health problems that spanned twenty years (1957-1976), Veroff, Kulka and Douvan (1981) reported that although 'self-help' answers had declined during that time, it remained remarkable that fully one-third of adults could not conceive of any situation so overwhelming that they would seek help from a professional helper.

It seems, then, that when people face problems, they either choose not to ask for help at all, conceal their efforts as something other than a direct request, or prefer the kind of help they can administer to themselves. The implication from this is that as well as the benefits that may await the help-seeker, there also may be important costs.

Many psychological factors actually inhibit help-seeking. Shapiro (1983) argues that fear of embarrassment is

a major reason why people may not seek help. If seeking help is public, if it is defined in the situation as violating expected and suitable behavior, or when the help-seeker is evaluated negatively by observers, then embarrassment will be increased. The level of perceived inadequacy is a factor that influences help-seeking (Rosen, 1983). A perception of personal inadequacy may influence behaviors like procrastination, refusal of help, or attempted self-help. In addition, an array of cognitive alternatives such as denial, misattribution, or reliance on faith may be the result. The personal characteristics of the individual also influence the decision of whether or not to seek help (Nadler, 1983). Included within a person's characteristics are personality dispositions as well as relevant demographic and sociocultural variables (i.e., gender and gender-related norms). Maintaining personal or public self-esteem, and appropriate sociocultural normative behavior are elements that influence the cost-benefit analysis of help-seeking. The assumption is that the costs of help-seeking will increase to the degree that seeking help is inconsistent with deeply instilled personal norms.

Ambivalence and help-seeking: One implication of this analysis is that ambivalence is inherent in the help-seeking process. Ambivalence is experienced as either psychological or sociological ambivalence (Merton, Merton & Barber, 1983). Psychological ambivalence is the intrapersonal experiences of

various psychological mechanisms that are employed to cope with conflicting emotions, impulses and thoughts involved in the help-seeking process. Sociological ambivalence, on the other hand, focuses on the internal conflict brought about by the built-in structure of social statuses and roles. The normative structure of the helping relationship creates conflict within the help-seeker. Whereas culturally reinforced behaviors of competence, autonomy and responsibility are desired by most adults, the help-seeker is asked to accept the role requirements of dependency, incompetence and inadequacy. Moreover, within professional helping relationships the very structure of the professional culture may accentuate this conflict. Widely accepted professional behaviors such as the uncertainty of outcome, invasion of client privacy, and exercise of professional authority, combine with the contrasts in social statuses to increase the help-seeker's ambivalence. Furthermore, it is more difficult to challenge or reject advice given by a paid professional than that offered by family or friends.

Gender and help-seeking: It is important to note that the attributes and behaviors of self-sufficiency have been considered as masculine values in North American society. Even though every member of this culture has been exposed to these ideals, it is primarily males who are expected, even pressured, to emulate standards of self-reliance (McMullen & Gross, 1983) Thus, the pressures that these culturally

reinforced roles exert are likely to be differentiated within sex roles and gender differences in the help-seeking process.

Horwitz (1977) studied 120 outpatients and short-term inpatients at a community health center to test the processes leading people to enter psychiatric treatment. He found that women had access to larger informal networks and were more likely to discuss their concerns, thereby becoming more apt to diagnose their problem in psychiatric terms, gain more information regarding professional help, and accept professional resolutions to their problems. Men had significantly smaller informal networks and were less likely to discuss problems with network members, less likely to seek professional assistance, and were more likely to be coerced into professional psychiatric treatment. He concluded that both cultural and social control processes influenced the help-seeking and labeling patterns that differentially accounted for entrance into treatment for men and women.

Veroff and his colleagues (1981) found in their longitudinal study of the general population that women define their problems in mental health terms more often than men, and women showed a greater readiness to seek professional help than men. D'Arcy and Schmitz (1981) studied sex differences in the utilization of health services in Saskatchewan. Their results were consistent with others in that women showed a higher utilization rate of all health services, and mental health services in particular. They

concluded that gender was the best predictor of utilization.

<u>Help seeking and the work place-Employee Assistance Programs(EAPs)</u>: There are factors in addition to those that affect help-seeking in general that operate in the context of the work place.

Work constitutes an important major role for most North American adult males, and to an increasing extent adult females. Work strongly defines individual identity and largely influences social status and quality of life. Increasingly, workers are seeking meaningful employment that offers personal fulfillment from accomplishing the work itself rather than from the satisfaction away from work that the income or status may provide (Gould & Smith, 1988; Roman & Trice, 1972; Steele, 1988). Therefore, employers are offering resources at the work place to enhance the work environment by developing strategies that assist employees to deal with personal problems that may affect job performance. While the trend in contemporary assistance programs is to address a diverse array of personal problems, evidence continues to show that alcohol remains a predominant source of emotional problems in most working populations (Kaab, 1984; Trice & Sonnenstuhl, 1989). It is due to this major impact that alcohol has on worker's problems that a great deal of the literature on help-seeking in the work place deals with alcoholism or chemical dependency.

EAP is a generic term that applies to various models of

programming aimed at the humane treatment for employees suffering from personal problems that affect job performance (Shain & Groeneveld, 1980). Fundamental to the 'core technologies' of EAPs is supervisory training in identification, confrontation and referral of troubled employees. However, based on management and labor relations practices, employers may not discipline workers merely because they disapprove of their behavior.

Constructive confrontation is a progressive process where supervisors monitor employees job performance, confront them with evidence of unacceptable performance, coach them on ways to improve their performance, urge them to seek the services of the EAP for personal problems, and emphasize the consequences of continued poor performance. The constructive elements emphasize that the employees are valued and that change is possible. The confrontive elements underscore the stakes in not changing (Sonnenstuhl & Trice, 1987). Therefore, the strategy of constructive confrontation uses a pragmatic definition of chemical dependency based on job performance, thereby absolving the supervisor of the responsibility of diagnosing and labelling someone with a medical problem (Sonnenstuhl, Staudenmeier & Trice, 1988; Trice & Roman, 1972).

Some of the factors that operate on the help-seeking process in the work place arise from fundamental assumptions about the roles of the employee and the employer. To be

employed means that the employer and the employee are engaged in a contract. For acceptable levels of job performance, attendance and interpersonal behavior, the employer offers certain wages, benefits, and a facilitative environment in which to adequately perform the role as worker. Employees are expected to work on a reasonably continuous basis so that the employer can predict and sustain certain levels of productivity. Furthermore, the supervisor can be viewed as the immediate representative of the employer's goals, and the immediate monitor of the contract between the employer and the employee (Roman, 1981). Supervisors, then, are an extension of the employer's philosophy and management style as they come into direct contact with the employees.

EAPs rely heavily upon supervisor participation to identify and confront troubled employees. However, when supervisors convey the perception of a punitive reaction management style to employees, behaviors that are incompatible with help-seeking may arise. Steele and Hubbard (1985) interviewed 760 employees and 83 EAP personnel from seven different corporations. Among their findings was an association between a management style of punitive reaction and behaviors related to worker alienation, tension reduction and escapism (i.e., alcohol and drug use). While this doesn't rule out extra-organizational influences, it suggests that conditions within the work place may reflect on the nature of drug problems in an organization and the readiness

of employees to choose behaviors other than help-seeking to deal with their problems.

Steele (1988) discusses EAP operations in the context of a labor process model which holds that a structurally defined conflict exists between labor and management. Within the social dynamics of the work place, both employers and employees attempt to maximize their respective control over the labor process. Whereas employers attempt to increase efficiency and productivity, employees attempt to ensure they are not manipulated or put at undue risk. This contention impacts on EAPs that are primarily in hierarchical, or top-down models (Molloy, 1989; Sonnenstuhl & Trice, 1987). Moreover, it may add to the perception by employees that management-based EAPs are an arm of management and that they lack confidentiality and may result in reprisals.

Harris and Fennell (1988) studied the attitudes and perceptions of employees about EAPs as a source of help, and their willingness to use them. Their findings illustrate that although men an women are equally as willing to use EAPs, they differ as to their perceptions and attitudes toward them. Women's willingness to use EAPs was related to familiarity with the program, and men's willingness was related to perceptions of program effectiveness, attention to clients, and control issues. In addition, they suggest that the program's philosophy about the cause of alcoholism affected employees' views on help-seeking.

Help-seeking and health care professionals: Historically impaired health care professionals were dealt with poorly. Colleagues usually viewed their problems as signs of moral weakness or failure, and usually didn't consider treatment options. Fear of reaction from the impaired colleague, recognition that confrontation may be perceived as a personal attack, and the realization that continued collaboration might become unduly strained, were factors that precipitated inaction (McCrady, 1989). Only when the impaired professional faced debilitating health, grossly deteriorating professional practice, or came to the attention of legal authorities did the professional licensing board intervene. This usually resulted in loss of licence, income, and status. Such a set of circumstances effectively inhibited help-seeking among health care professionals.

The last fifteen years has seen more humane attention paid to impaired professionals. However, the lack of direct supervisory observation among professionals fosters haphazard identification and confrontation of poor job performance. The potential referral network comprised of patients, colleagues, family and friends is generally unknowledgeable about the process of identifying and confronting impaired professionals. Unless the professional's ability to practice becomes grossly compromised, coercion as an incentive to seek help is greatly reduced (McCrady, 1989).

Research on the help-seeking behaviors of health care

professionals is rare, and information gained thus far generally has emerged inductively. In one of few empirical studies, Bissell and Haberman (1984) interviewed 407 self-admitted alcoholic professionals, 60% of whom were health care professionals (i.e., 97 physicians, 49 dentists, 100 nurses). While every subject eventually turned to Alcoholics Anonymous (A.A.), many reported experiencing some sort of crisis resulting from their alcoholism that prompted their approach to A.A.. The threat of the loss of one's job, family problems, debilitating physical symptoms, and scrapes with the law were the kinds of events that induced their help-seeking. Even then, initial attempts at seeking help began with friends and family. Following the use of these informal sources of help, 35% of the medical professionals sought out the clergy for assistance. More than two-fifths of all subjects contacted psychiatrists. However, only 13% contacted professionals other that the clergy or physicians. The researchers concluded that the general lack of any systematic means for identifying impaired professionals, virtually non-existent assistance programs, and the reluctance of colleagues to approach the impaired professional led to over three-quarters of the nurses, two-fifths of the physicians, and approximately two-thirds of the other professionals not ever having been criticized by anyone about problems associated with their chemical dependency.

Help-seeking and alternatives to EAPs for health care

professionals: The job performance model that underlies most EAPs has been challenged by those who argue that deteriorating job performance is an ineffective means of identifying impaired professionals early in their dependency experience (Bissell & Haberman, 1984; Kaab, 1984; Mazze, Schneider & Drucker, 1981).

One of the hallmarks of chemical dependency is denial. The chemically dependent person employs the defense mechanisms of rationalization, projection and intellectualization to maintain a system of delusion that distances them from reality (Green, 1989). Denial is also present among colleagues and supervisors. Colleagues will cover-up poor work performance, or even 'pick up the slack' for an impaired nurse. Supervisors will transfer an employee out of their department, or terminate them for reasons other than chemical dependency (Sullivan, Bissell & Williams, 1988). While this 'conspiracy of silence' helps colleagues and supervisors avoid the unpleasant task of confronting the impaired nurse, it does nothing but ensure the continuation and progression of the impaired colleague's dependency.

Shaffer (1988) found in her study of recovering nurses that the duration of dependency prior to treatment for her sample ranged between 1-3 yrs (14%), 4-8 yrs (21%), 9-12 yrs (21%), and over 13 yrs (43%). Bissell and Haberman (1984) report that over 75% of their sample of nurses went through an entire career without anyone confronting them about their

drinking. These nurses were advanced cases of alcoholism and should have been relatively easy to identify.

Outcome studies of impaired health care professionals indicate that successful return to practice is possible for a majority of those who find their way into treatment. Furthermore, the earlier one undertakes treatment, the greater the chance of successful rehabilitation and reintegration into the work place (Hutchinson, 1987; Mazze, Schneider & Drucker, 1981; McCrady, 1989; Trice & Roman, 1972).

Within the last ten years alternative strategies to the job performance model have emerged in the professions. Program goals are to identify impaired professionals earlier, and to present less punitive, more supportive environments in which to seek help. Although considerable variation exists among these programs, they share one common element. Fundamental to all programs is peer involvement in the identification and confrontation of impaired colleagues.

The distinct characteristics of Peer Assistance Programs (PAPs) reflect the unique characteristics of the employee populations they serve. However, PAPs emphasize peer relationships rather than hierarchical relationships, and they operate within a philosophy which proposes that to assist troubled colleagues to become well-adjusted human beings should be an end in itself, rather than a means to increase efficiency and production, or to decrease

absenteeism (Sonnenstuhl & Trice, 1987; Sonnenstuhl, Staudenmeier & Trice, 1988). PAPs are generally cautious about management-based programs that possess the potential to 'medicalize' employee problems as a means of social control in the workplace (Roman, 1981).

Within industrial occupations, PAPs are frequently affiliated with union organizations. Some of the longest standing and most successful industrial alcoholism programs in North America have been peer counselling models affiliated with unions (Molloy, 1989; Sonnenstuhl & Trice, 1987). Within the health care professions, however, PAPs either maintain some degree of affiliation with a professional regulating body, or they are completely independent entities (McCrady, 1989; Sullivan, Bissell & Williams, 1988). The more concrete the affiliation is with regulating organizations, the more apt the PAP is to employ coercion as a strategy to enhance compliance. Some PAPs, for example, may report nurses who refuse assessment or treatment to the disciplinary body of their licensing organization. Independent programs, however, usually begin and remain autonomous.

Independent programs are frequently developed by recovering professionals who are concerned about assisting their colleagues. Members usually have in common the personal experience of recovery from a major problem (usually alcohol or drug dependency), and they are members of the same

profession. Most of these groups are independent of licensing bodies, and most utilize support, persuasion and example, rather than mandatory care. These groups are usually organized after learning that formal disciplinary procedures are enacted only after impairment is well advanced, and even then they move slowly, reach only a small portion of those needing help, and are used quite reluctantly by colleagues (Bissell & Haberman, 1984). The group takes calls from members of the profession who have concerns about themselves or a colleague. A third party is contacted to corroborate information, and the possibly impaired professional is approached to discuss the concerns. Strict confidentiality is maintained during all contacts. Those who are approached are not coerced into treatment, not reported to regulating bodies if treatment is refused, and are not treated by program organizers. A minimum of records are kept, and they are usually destroyed after the professional enters into treatment (McCrady, 1989).

Another alternative is programs developed under the auspices of professional associations. In the United States the majority of the state nursing associations have some kind of PAP (Green, 1989; Sullivan, Bissell & Williams, 1988). Staffed mainly by volunteers, many of these programs operate in a manner similar to independent programs. However, some programs include additional elements that address reintegration and follow-up of recovering nurses. In

addition, some programs may report non-compliance to regulating bodies.

While Canada has been somewhat slower than the United States to establish wide-spread assistance programs for nurses, in late 1984 Project Turnabout was established at the Addiction Research Foundation in Toronto, Ontario (Gaskin, 1986). Established as an assessment and referral service, the program service expanded from 52 clients in the first year to over 100 clients within an 18-month period. One common reaction received from nurses who took advantage of the program was relief at finding a program established specifically for their problem. The first provincial nursing association in Canada to sponsor a PAP was in Manitoba (Kotyl, McKnight & Wortzman, 1988). The goals of the program were early identification and intervention with impaired nurses. The first two years of operation saw 52 referrals to the program. In the province of British Columbia, the Registered Nurses' Association of British Columbia (R.N.A.B.C.) instituted a 24-hour telephone assistance and referral program to assist nurses with emotional or chemical dependency problems that might have affected their work performance (Cutshall, 1988). Recently, the R.N.A.B.C. ("Progress...", 1991) stated that although the program could not be maintained as originally established, it does continue to refer troubled nurses, and to assist nurses on ways to approach colleagues who are impaired due to chemical

dependency or other emotionl problems.

PAP strategies differ from the EAP themes of documentation of impaired job performance and progressive discipline. Whereas EAPs reflect top-down designs based on traditional notions of how work organizations operate, PAPs are more horizontal than vertical, more participatory than supervisory and more bottom-up than top-down (Molloy, 1980). These factors create different contexts within which job performance takes on slightly different meanings (Sonnenstuhl, 1989). In management based EAPs, job performance is a cue for supervisory intervention, and a lever for motivating employees to change their behavior. In PAPs peer counsellors and colleagues are not constrained by the same rules as supervisors. Peers are free to confront colleagues on the basis of gossip and off-the-job behaviors. The gossip usually includes talk about family or physical problems. Peers can use such evidence to demonstrate to the impaired colleague how their chemical dependency is destroying their lives. Job performance, then, is only one of many features used by peers to motivate impaired colleagues to seek help.

The advantage of programs that employee a peer assistance model is the possibility of identification and intervention earlier in the dependency experience. Colleagues may be more likely to become involved if they believe that the impaired nurse will be helped rather than

punished (Green, 1989).

Summary of literature review

Although there are divergent views on what causes chemical dependency and how it should be described, the predominant view in current nursing literature is a unitary disease model. This model has implications for treatment options and definitions of success. The incidence of chemical dependency among nurses is only an estimate because of reporting procedures and the lack of valid and reliable research. Studies have focused on identifying characteristics of impaired nurses and issues within the work environment that point to risk factors that appear in the lives of chemically dependent nurses.

Research on help-seeking among nurses is rare. The information that is available is primarily inductive in nature and has been gleaned from what is known about help-seeking in general. The process of seeking help for personal problems is not a simplified affair. Besides the benefits that may accrue from seeking help, there also seems to be many costs. Intrapersonal and interpersonal factors affect the decision of whether or not to seek help. There are structural factors in the normative sociocultural environment that affect the help-seeking process. Most people choose informal help sources rather than professional helpers. Those who do choose professional helpers face certain

structural elements of the helping relationship that may accentuate dependency, incompetence and failure.

The work place is a fundamentally contentious environment where both labor and management attempt to enhance their respective goals. Programs implemented by management are therefore viewed suspiciously by employees. Management style can be related to why employees choose other behaviors to deal with personal problems instead of seeking help. Furthermore, because supervisors either lack the skills or the motivation to confront troubled employees, many impaired employees continue their chemical dependency experience without the opportunity for early assistance.

Programs available to impaired nurses are usually employer-based EAPs or peer-based PAPs. Intervention by EAPs is constructive confrontation that relies on documenting deteriorating job performance. By the time job performance has deteriorated, however, dependency is well advanced. Therefore, EAP strategies are not prompting the desired amount of early referrals. Intervention by PAPs is based more often on personal observations and interactions with the suspected colleague. The quality of the colleague's life, both on and off the job, are evaluated. Coercion may or may not be part of intervention. The social network of peer-based programs appears more conducive to the early recognition of those signs of chemical dependency that affect the interpersonal relationships with significant others.

CHAPTER III

RATIONALE, RESEARCH QUESTIONS AND DEFINITIONS

Rationale

The preceding review of literature has illuminated certain key points regarding impairment from chemical dependency and factors that influence help-seeking in the nursing profession: (a) a substantial problem exists; (b) the profession has begun to deal with the problem; (c) help-seeking is a complicated behavior influenced by factors both inside and outside the nurse; (d) the earlier one is referred for assistance, the greater the chance of a successful outcome; (e) Employee Assistance Programs (EAPs) and Peer Assistance Programs (PAPs) have emerged as two major strategies to address the problem; (f) EAPs have not generated the expected referrals; (g) the structural and operational characteristics of PAPs seem to enhance their ability to recognize and deal with chemical dependency at an earlier stage of development.

Research questions

This study addresses what factors relate to nurses' choices to self-refer or refer a colleague to an assistance program. To deal with this issue certain research questions need to be explored--specifically:

(a) What is the nurses' level of awareness regarding

existing programs to assist nurses for impaired practice ?

(b) If a nurse believed that chemical dependency was causing problems at home or at work, who would be the first person the nurse would contact ?

(c) If a nurse chose to contact someone to deal with a chemical dependency problem, what attributes and characteristics would an initial contact person possess ?

(d) What program characteristics (e.g., affiliation, accessibility, personnel, policies) are perceived by nurses as most important to establish an environment that would enhance early referral for assistance ?

Definitions of terms

Chemical dependency is a condition wherein the reliance upon mood-altering substances has attained such a degree as to cause disruption with work performance, family and interpersonal relationships, financial and social functioning, and physical and/or mental health (Green, 1989).

Impairment refers to any employees who are "...unable to comply with their professional code of ethics and/or standards of practice due to cognitive, interpersonal, or psychomotor dysfunction" (Solari-Twadell, 1988, p. 103).

Intervention is defined as "...a structured method of penetrating the delusional systems of chemically dependent

persons to help them become aware of reality and to become willing to accept help" (Green, 1989, p. 86).

Constructive confrontation means that supervisors confront employees with the evidence of their unsatisfactory job performance, advise them on ways to correct unsatisfactory performance and improve their work, urge the employee to use the services of an assistance program if they have personal problems, and at the same time emphasize to them the consequences (progressive discipline) of continued poor performance (Sonnenstuhl, 1989).

Peer counsellor refers to "...someone who cares about others and who talks to them about their thoughts and feelings. Rather than being an 'advice-giver' or a 'problem-solver', a peer counsellor is a sensitive listener who uses communication skills to facilitate self-exploration and decision-making. The peer counsellor is not a therapist or a professional counsellor. Peer counsellors are [nurses] who have been trained to help other [nurses] think through and reflect on problems they might be experiencing. A major purpose of peer counselling is to increase the number of people in [an organization] who are skilled in helping others, thereby enabling informal and spontaneous assistance to be available" (Carr, 1981, p. 4).

CHAPTER IV

METHODOLOGY

Population and sample

The target population was all registered nurses living and employed in British Columbia, which is estimated to be about 23,000 members (Rollcall, 1989). To access this large population, the researcher enlisted the assistance of the Registered Nurses' Association of British Columbia (R.N.A.B.C.) who provided a random sample of 300 registered nurses.

Instrumentation

Given the specific nature of this study, and the relative lack of attention to the subject in the nursing literature, no standardized instruments were applicable. Thus, a questionnaire was designed by the researcher which requested information concerning demographics, preferred sources of help, awareness of existing resources, attributes of an initial contact person, and components of an optimal referral environment. Open ended questions were included to gain subjective data on helping, requesting help, and referral environment (Appendix B). This information was suggested by characteristics associated with help-seeking and chemical dependency in both the general population and in nurses (Bissell & Haberman, 1984; Merton, Merton & Barber, 1983; Sullivan, 1987; Veroff, Kulka & Douvan, 1981).

Derived from a review of texts on Employee Assistance Programs and Social Work in the work place, a list of items was chosen as representative of components believed to be necessary to establish an effective assistance program (Gould & Smith, 1988; Myers, 1984; Shain & Groeneveld, 1980; Thomlison, 1983; Trice & Roman, 1972). Adapted here to address specific concerns in the nursing profession, the list of key elements was synthesized from models of EAP delivery developed by the National Council on Alcoholism (NCA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and endorsed by the Addiction Research Foundation (ARF) of Ontario (Shain & Groeneveld, 1980).

A five-point Likert-type scale (Strongly Agree to Strongly Disagree) was used to assess the nurses' perceptions on those attributes and characteristics that influenced their choices to take advantage of an assistance program, or to refer a colleague to one.

Procedure

A pilot study of the questionnaire was conducted. The clarity and meaning of the questions, and the format and instructions of the questionnaire were evaluated by 13 volunteer nurses (Appendix A). Their observations and suggestions were applied to the final draft of the questionnaire to decrease ambiguity and misunderstanding about the concepts contained in the questions.

The instrument was delivered to the participants by

mail. A cover letter accompanied the questionnaire which explained the study and stated that return of the survey would be accepted as consent to use the data in the study. A follow-up letter was mailed 10 days later to help increase the percent of return (Appendix C). All responses were anonymous; the questionnaires and follow-up letters were mailed by the R.N.A.B.C. from Vancouver, therefore the R.N.A.B.C. had no knowledge of which subjects responded. The completed questionnaires were mailed to the researcher in Victoria, therefore there was no access to the names of the subjects who had received a questionnaire. This procedure ensured anonymity and confidentiality for all participants.

Three hundred questionnaires were mailed to the nurses, and four were returned because of no forwarding addresses. Of the remaining 296 questionnaires, 159 responses were received, for a response rate of 54 percent. The variables under study were evaluated using descriptive measures.

CHAPTER V

RESULTS AND DISCUSSION

Results

Demographic profile: The sample consisted of 159 registered nurses living and working in British Columbia (B.C.). The majority of the respondents were married females, between 31 and 50 years old, employed full-time in hospitals as general duty nurses, and had 10 or more years of nursing experience. Table 1 illustrates comparative percentages of the selected demographic variables of age, sex, marital status, and education.

Table 1
Demographic Profile of the Sample and the Population

	Sample (N = 159)		Population* (N = 28,014)	
	N	%	N	%
Age				
1. 30 or less	22	13.8	4,027	14.4
2. 31 - 40	62	39.0	9,672	34.6
3. 41 - 50	43	27.0	8,443	30.2
4. 51 and over	32	20.1	5,883	20.8
Sex				
1. Male	11	6.9	631	2.3
2. Female	148	93.1	27,383	97.7
Marital Status				
1. Single	26	16.4	5,906	21.1
2. Married	117	73.6	18,949	67.6
3. Other	16	10.1	3,159	11.3
Education				
1. Diploma	94	59.0	13,262	47.3
2. Post-basic Diploma/ Certificate	29	18.0	10,450	37.3
3. Baccalaureate	33	21.0	3,982	14.2
4. Masters or higher	3	2.0	320	1.1

* Statistics Canada - R.N.A.B.C. News, July - August, 1989.

Notable differences between this sample and the Statistics Canada population (R.N.A.B.C., 1989) appear in the categories of sex and education. This sample contains three times the percentage of males that the population would suggest, however the actual number of males in the sample is small (n = 11). The sample also differs to some degree from the population in the category of education. It contains almost twice as many Masters-or-higher nurses, but again, the actual number is very small (n = 3). There are approximately 50% more Baccalaureate nurses, almost 25% more Diploma nurses, but less than half as many nurses with post-basic certificates. The data on Employment appear in Table 2. The population figures in Table 2 were calculated from the Rollcall Series, published by the University of

Table 2
Employment Data of the Sample and the Population

	Sample (N = 159)		Population* (N = 23,760)	
	N	%	N	%
Employer				
1. Hospital	110	69.2	17,927	75.4
2. Public Health/HomeCare/ Community	26	16.4	2,663	11.2
3. Long Term Care	11	6.9	1,565	6.6
4. Other	12	7.5	1,605	6.8
Position				
1. Clinical	111	69.8	17,183	72.3
2. Supervisor	11	6.9	1,981	8.3
3. Administration	15	9.4	534	2.2
4. Education	11	6.9	636	2.7
5. Other	11	6.9	3,426	14.4

* Compiled from Rollcall Series, University of British Columbia, June 1989.

British Columbia (1989).

Public Health/Homecare/Community nurses are more frequent in this sample than in the general population of nurses working in B.C.. The more notable differences appear within the category of Employment Position. Nursing administrators and educators are over-represented and supervisors are under-represented in this sample.

Program awareness: In an attempt to establish the level of awareness of programs for impaired nurses, the subjects were asked to indicate their knowledge of whether or not such a program existed in their area. Of those who responded to this question (n = 158), 58% said they knew of no programs in their area to assist nurses impaired with chemical dependency. The remaining 42% said that they knew of at least some kind of program within their area that could assist impaired nurses.

Perceived incidence among colleagues: The nurses were asked to indicate their perceptions regarding how many of their colleagues, if any, they had reason to believe were practicing while impaired. Eighty-two percent of the nurses suspected none of their colleagues of impaired practice, whereas 18% indicated that they were reasonably sure that one or two of their colleagues were guilty of impaired practice. No one suspected more than two colleagues. Only two respondents admitted to having had problems with alcohol or drugs that might have affected their work; both of these were

in the past and had since been resolved.

When asked what their reaction would be to a colleague suspected of impaired practice, 73% replied that they would approach the suspected colleague directly. The most common reasons given by those who chose not to confront a suspected colleague were fear of being wrong, or that it wasn't their responsibility. However, 95% of the nurses said that at least they would speak to "someone" about their concerns, (i.e., supervisors, counsellors, or friends and family).

Initial source of help: The nurses were asked to rank order a list of possible sources of help if they believed that drugs or alcohol were causing them problems. Table 3

Table 3
Sources of Help and Percentages of Nurses Who Ranked the Source as First or Second Choice*

Source	First Choice %	Second Choice %	N**
1. Close friend	29.3	24.7	(150)
2. Family member	29.3	20.7	(150)
3. Nurse experienced in these issues	15.3	16.0	(150)
4. Alcoholics/Narcotics Anonymous	7.5	16.3	(147)
5. Psychologist/ Psychiatrist	10.0	10.0	(150)
6. Community agency	4.8	5.4	(147)
7. No one	8.4	.6	(119)
8. Supervisor	2.0	1.4	(147)
9. Other	3.8	4.4	(24)

* These percentages represent only those nurses who offered this information. Some nurses did not respond to each source, and/or gave the same rank to different sources, therefore the percentages do not total 100%.
** Total number of respondents for each source.

shows the potential sources of help and the percentages of nurses who chose the source either as the initial contact, or as a second choice.

The majority of the respondents chose friends and family members as initial resources for help. The first resource beyond family or friends was a nurse experienced in helping with these issues (i.e., peer counsellor). Professional help was ranked further down the list, and supervisors were last to be approached for help. Although only 75% of the nurses responded to the category of 'no one', it ranked above supervisors as a choice. The 'other' category was chosen by only a few nurses; clergy and family physicians were the most frequently mentioned sources of help in this category.

The nurses were asked to rank order selected attributes and characteristics of their first choice of a helper. Eight characteristics were ranked according to their importance to the nurse seeking help, where 1 = Most Important, and 8 = Least Important. In order of importance, the nurses selected (1) confidential, (2) nonjudgmental, (3) supportive, (4) private, (5) empathic, (6) professional, (7) problem solver, and (8) mutuality. In response to a request to list additional attributes of an initial contact person, 65% (n =104) of the nurses offered some 40 more characteristics that they perceived to be important. The most frequently mentioned characteristics were: someone who had specific knowledge about chemical dependency, or who had "been there"

(n = 33); someone who had good listening and communication skills (n = 23); and someone who was available and easily accessible to the troubled nurse (n = 21).

Referral environment data: The nurses were asked to give their opinions on a number of elements that might comprise a favorable environment that would enhance referral. A Likert-style scale (Strongly Agree to Strongly Disagree) was used to gain the nurses' perceptions on each item. Additionally, the nurses were given extra blank space on the questionnaire where they could offer their own opinions on elements that were not mentioned in the questionnaire.

Twenty items were organized into five overall categories including Policy, Personnel, Confidentiality, Affiliation, and Accessibility. The items were categorized this way for clarity in presentation of the results, and were not so categorized in the mail-out questionnaire. The category of Policy referred to employer and employee duties and obligations, staff education, health insurance issues, reporting procedures and employee protection. The Personnel category dealt with issues about who would be involved as contact persons and helpers. The Confidentiality category referred to keeping matters confidential, and the location of counsellors' offices. The category of Affiliation included items that focused on what organizational entities (i.e., management, union, employees) would be involved in program planning and operation. Finally, the Accessibility category

contained items that involved the availability of programs for impaired nurses. Table 4 illustrates the level of agreement or disagreement expressed by nurses for each item.

Table 4
Referral Environment Data: Percentages of Agreement and Disagreement

Elements	SA %	A %	U %	D %	SD* %
Policy					
policy statement	45.4	36.2	7.9	6.6	3.9
chemical dependency focus	19.6	43.8	20.3	12.4	3.9
health insurance	54.8	38.1	6.5	.6	0
staff education	54.5	32.3	2.6	.6	0
job performance criterion	3.9	13.0	7.1	47.4	28.6
follow-up	53.8	43.6	1.3	.6	.6
report refusals	36.4	39.0	15.6	7.1	1.9
no reprisal	60.8	34.0	2.6	2.0	.7
Personnel					
peer counsellors	22.3	55.6	8.5	10.5	3.3
peer network	31.0	49.7	11.6	6.5	1.3
Confidentiality					
off-the-work-site	65.2	29.0	3.9	1.9	0
absolute confidentiality	87.7	8.4	2.6	1.3	0
on-the-work-site	8.4	23.4	20.1	31.2	16.9
Accessibility					
24-hr/day	58.7	27.7	7.7	5.8	0
province-wide	48.1	44.2	3.2	3.9	.6
24-hr 'hot line'	64.5	26.5	4.5	4.5	0
Affiliation					
management only	8.2	10.1	17.6	32.2	27.7
union only	5.2	15.0	29.4	28.1	22.2
union-management co-op	14.8	23.2	25.8	23.2	12.9
employee-management co-op	16.9	32.5	28.6	13.6	8.4

* SA = Strongly Agree; A = Agree; U = Undecided; D = Disagree; SD = Strongly Disagree [See questionnaire, section 4, (Appendix B)].

Within the Policy category, nurses responded that they agreed, or strongly agreed that impaired employees should be

protected from reprisal, that those who are referred for assessment/treatment should be followed up, and that health insurance benefits should be applied to their period of absence for treatment. The nurses also indicated strong agreement that education regarding the issues surrounding impairment due to chemical dependency was an important issue to be considered. However, even though the majority of the nurses agreed that focusing programs on chemical dependency was important, a sizable minority was undecided on this issue. Furthermore, the majority of the nurses indicated disagreement or strong disagreement that deteriorating job performance should be the the primary criterion for referral.

The Personnel category showed that most nurses agreed or strongly agreed that peers were important in identifying and assisting impaired nurses. It was strongly agreed that confidentiality was to be absolute, and the nurses also indicated strong agreement that counselling facilities should be off the work site. Some ambivalence was expressed regarding a counsellor on the work site. Approximately one-half of the nurses disagreed or strongly disagreed that the counsellor should be on the work site, however a sizeable minority agreed or strongly agreed, and just over one-fifth of the nurses were undecided. The majority of nurses indicated strong agreement that programs should be available on a 24-hour basis, and they agreed or strongly agreed that programs should be available province wide.

The greatest uncertainty was expressed in the category of Affiliation. The majority of the nurses disagreed or strongly disagreed with management-only programs. Slightly one-half of the nurses disagreed or strongly disagreed on union-only programs, however, a large minority were undecided. The most notable uncertainty emerged within co-operative programs. The union-management co-operative was equally split between agreement and disagreement, and fully one-fourth of the nurses were undecided. Almost one-half of the nurses indicated that they agreed or strongly agreed on an employee-management co-operative, however, once again, the number of undecided responses was considerable.

The nurses were asked to add any other options that they believed would enhance the referral environment. There were 88 nurses (55%) who chose to list additional elements. Inservice education and publicity to enhance awareness of programs received the most attention (n = 43). A non-threatening environment that included administrative support was the next most common issue (n = 28). The nurses also responded that any program must have a broad scope and include family members, not just employees (n = 15).

Discussion

Summary of results: Before summarizing the results of this exploratory survey of nurses' perceptions on referral for assistance, some caveats are presented. The central themes of this study are presented within hypothetical

contexts, and explored within subjective dimensions. Intellectual reports of willingness to approach a colleague suspected of impairment, or to seek help for one's own impairment, are not synonymous with actual help-seeking behaviors. Although, research indicates that people who mention the use of professional help for a hypothetical problem are more likely to admit that they have actually sought such help (Veroff, Kulka & Douvan, 1981). Furthermore, the issues in this survey are emotionally laden, and reported data may reflect personal experiences with chemical dependency that may have influenced the willingness to participate. The nature of these experiences, and the degree to which they may have influenced participation is unknown, and conclusions should be made with caution.

Although some numbers are too small to warrant unqualified conclusions, this sample is more likely to be male, to be better educated, and to work in the community. This sample contains more administrators and educators, and fewer supervisors than the general population of nurses would suggest. Administrative and educator positions generally require higher levels of education. Furthermore, these nurses are more likely to be involved in dealing with chemical dependency as either interventionists or resource persons. Moreover, nurses who actively continue their education, and strive to advance their status in the

organizational hierarchy can be seen as demonstrating a meaningful commitment to their careers. Perhaps those nurses who are more committed to the career of nursing and come into greater contact with chemical dependency are more likely to respond to a request to participate in a study of this nature.

The under-representation of supervisors in response to this survey is difficult to explain. One explanation may be that the nurses defined their position as more administrative than supervisory. This may have been reflected in the over-representation of administrators in this sample. Research indicates that there is a general reluctance on the part of supervisors to confront the issue of chemical dependency among their supervisees (Bissell & Haberman, 1984; Shaffer, 1988), and perhaps this reluctance is what was reflected in the lower supervisor response. Additionally, to occupy the role of supervisor usually requires a measurable degree of tenure that ensures familiarity with organizational policies and procedures. The issues of chemical dependency and impaired practice among nurses, and how they should be approached, however, have become prominent in Canada only within the last few years (Kotyl, McKnight & Wortzman, 1988; Gaskin, 1986). Although this is speculative, perhaps a number of nurses who currently occupy supervisory positions have not been acquainted with the knowledge and awareness of chemical dependency and how to deal with it. Lack of

awareness and education are said to be associated with "professional denial" on the part of supervisors and colleagues (Crosby & Offer, 1988; Stammer, 1988). Consequently, this sample may reflect supervisors who represent a 'pre-rehabilitation' perspective, and therefore may have been less inclined to respond to a survey that implies a rehabilitative, help-seeking model. Further research on this issue would give the nursing profession in B.C. more concrete information on how supervisors view chemical dependency, and what they know about dealing with it.

Familiarity with an assistance program is significantly related to one's willingness to use it (Harris & Fennel, 1988; Steele & Hubbard, 1985). The majority of the nurses in this study were unfamiliar with any program in their area that could deal with nurses impaired by chemical dependency. Whether the unfamiliarity was due to a lack of public outreach on the part of those who conduct such programs, or to the nonexistence of programs is unknown. In a brief to the B.C. minister of labor and consumer services, the R.N.A.B.C. ("Brief...", 1991) stated that chemical dependency is a problem that requires major expansion of treatment facilities in the province. Currently, B.C. has only nine hospitals with EAPs, and efforts to increase the expansion of EAPs has met with limited success. Health care professionals are among the various special needs groups that the

R.N.A.B.C. has documented as needing treatment resources. Included among their recommendations to the ministry were province-wide availability of chemical dependency resources, and education and manpower expansion to address the problem.

Few nurses in this study had reason to believe that any of their colleagues were practicing while impaired. However, the majority of the nurses said that if they did believe a colleague was having problems with chemical dependency, they would be proactive. That is, they would either approach the nurse directly, or contact someone else about their concerns. These findings differ from studies that indicate the general reluctance of colleagues and supervisors to confront chemically dependent nurses (Bissell & Haberman, 1984; Shaffer, 1988). These results may indicate a more widespread understanding of chemical dependency and an acceptance of the rehabilitative approach to dealing with impaired nurses. This is encouraging, especially with respect to peer-based assistance and the emphasis it places on early identification and referral of troubled employees.

The nurses chose family members and friends as their initial sources when seeking help. Those who chose professionals as their initial source of help amounted to a small minority. These findings are consistent with research on help-seeking (Horwitz, 1977; Newman, 1983; Veroff, Kulka & Douvan, 1981). Besides family and friends, the nurses next chose to seek out another nurse who had special knowledge of

chemical dependency. This finding meshes well with results of other research on peer-based programs that point out the effectiveness with which these kinds of programs get troubled employees into a rehabilitation network (Molloy, 1989; Sonnenstuhl & Trice, 1987). A disturbing finding was that the nurses would rather not talk to anyone than to approach their supervisor for help. The nurses were not asked to explain their choices of whom they chose as a help source, and what it was about supervisors that placed them last on the list of sources for help cannot be learned from the data in this study. However, these results lend some credence to statements made elsewhere that to approach the organizational hierarchy for assistance with personal problems may indicate weakness, invite reprisals, or compromise confidentiality (Sullivan, Bissell & Williams, 1988; Merton, Merton & Barber, 1983).

Among the most important attributes and characteristics of an initial contact person were confidentiality, being nonjudgmental and being supportive. In addition, the nurses said that the contact person should be one who had "been there", or had special knowledge about chemical dependency. Furthermore, that person must be available and accessible, and possess good listening and communication skills. The profile of an initial contact person described by the nurses in this study closely resembles the profile of a peer counsellor (Carr, 1981).

The referral environment described by the nurses would ensure that impaired employees would be protected from reprisal, followed up after treatment, and be given health insurance benefits during their absence from work. In addition, more education on chemical dependency would be given to staff and management, and job performance would not be the major criterion for referral. The nurses responded in favor of a peer-based network for early identification and assistance of impaired colleagues. The program would be province-wide, easily accessible, and include family members as clients. While uncertain about how such a program would be affiliated, most nurses agreed that employees should have a strong voice, and that a non-threatening environment with strong employer support was important.

CHAPTER VI

CONCLUSIONS

This research has been guided by the theory that the earlier an individual who is suffering from chemical dependency is referred for treatment, then the greater the chances that rehabilitation will be successful. The survey asked nurses in B.C. about program awareness, help-seeking, and program elements that would enhance the referral environment. The aim of this study was to better understand what nurses perceive as the most effective environment in which to refer themselves or their colleagues for assistance.

The majority of the nurses who responded to this survey were mature, well educated, and experienced. The nurses described an environment that would be supportive, absolutely confidential, non-punitive, peer-based, accessible, and available province-wide.

Implications

The findings of this survey have several practical implications. One is that there is a notable proactive sentiment among the nurses regarding impaired colleagues and how they could be dealt with. That is, the nurses responded that they would become actively involved with their chemically dependent colleagues rather than ignore or cover up impaired practice. In addition, there is a perception among the nurses that a peer-based approach is a viable

option to strict union or management approaches. This means that within B.C. there is a large natural resource of nurses willing to become involved in addressing the problem of chemical dependency in the health care professions. Furthermore, the need for a wide-spread educational effort to increase awareness about chemical dependency, impaired practice, and available programs for assistance cannot be ignored.

Several limitations in methodology indicate that the results of this survey should be considered cautiously. Although the sample was chosen at random, the actual numbers of respondents in some categories are too small for meaningful comparisons. Therefore, the degree to which the results are representative is unknown. Variables associated with willingness to respond to the questionnaire also are unknown. Similarly, the lack of a standardized instrument could have introduced unknown variables. For instance, some of the questions lacked a sufficient amount of categories to allow for an unbiased response, and at least one question's responses could have inadvertently been included within the responses of a subsequent question. More rigorous attention to validity and reliability of the instrument would ensure its greater usefulness in future studies of this nature.

Although methodological weakness requires caution in generalizing the findings, the study represents an initial exploratory contribution to the limited research on factors

that influence help-seeking and referral for impairment among chemically dependent nurses. Improved methodology in subsequent research would produce more reliable results. Little is known about what kinds of programs enhance referral, or what kinds of programs result in the most successful outcomes. This study was cross-sectional; the nursing profession would gain substantial benefit from following populations of nurses over time to assess the impact of programs for impaired nurses.

The problem of chemical dependency impacts on the individual nurse, the nurse's family, the employer, and the society. In addition to ensuring patient safety, the nursing profession is faced with helping nurses to recover from chemical dependency. One way to assist this endeavor is to establish a favorable environment in which nurses will be more willing to refer themselves or colleagues for assistance.

"...Perhaps if nurses had a safe place to go for help
they would seek it on their own,
rather than fear censure."
(Sullivan, Bissell & Williams, 1988)

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Appendix A

Pilot Study Questions

PILOT STUDY QUESTIONS

Please give your observations and feelings on the following issues regarding the questionnaire:

1. Approximate time for completion:

2. Clarity of instructions:

3. Clarity of questions (wording):

4. Arrangement of questions (format):

5. Clarity of constructs (ideas) in questions:

6. Amount of questions:

7. Additional comments:

Appendix B

Referral Environment Survey (Questionnaire)

REFERRAL ENVIRONMENT SURVEY

IMPORTANT: Select your answer from the choices given, then indicate your choice [x] at right.

The following information is required to determine the degree to which this sample of nurses is representative of all British Columbia nurses.

SECTION 1--PERSONAL DATA

Question	Answer
1. Your age is: A. Less than 30 yrs B. 31-40 yrs C. 41-50 yrs D. 51-60 yrs E. 60+ yrs	1 A B C D E [] [] [] [] []
2. Sex: A. Male B. Female	2 A B [] []
3. Marital status: A. Married B. Single C. Other: Specify_________	3 A B C [] [] []
4. Identify your educational preparation for nursing: A. Diploma B. Baccalaureate Degree C. Masters Degree D. Other certificates: Specify_________	4 A B C D [] [] [] []
5. Identify the length of your total nursing experience: A. Less than 1 yr B. 1-2 yrs C. 3-5 yrs D. 6-10 yrs E. 10+ yrs	5 A B C D E [] [] [] [] []

SECTION 2--PRESENT EMPLOYMENT DATA

Question	Answer
1. Your present employer is: A. Hospital B. Public Health C. Nursing Home D. Other: Specify_________	1 A B C D [] [] [] []
2. Identify your major work emphasis (one only): A. Clinical B. Supervisory C. Administration D. Education E. Other: Specify_________	2 A B C D E [] [] [] [] []
3. Your current employment status is: A. Permanent B. Casual	3 A B [] []
4. You are employed: A. Full time B. Part time	4 A B [] []

IMPORTANT: Select your answer from the choices given, then indicate your answer [x] at right, except where other choices are indicated.

SECTION 3--GENERAL QUESTIONS

1. You know of a program in your area that assists nurses with problems relating to impaired practice due to chemical dependency:

   A. Yes, I do B. No, I don't

   1 — A B [ ] [ ]

2. You are reasonably certain that other nurses known to you have a serious problem with alcohol or drugs:

   A. No, I suspect none B. Yes, I suspect 1 or 2 C. Yes, I suspect 3 or 4 D. Yes, more than 4

   2 — A B C D [ ] [ ] [ ] [ ]

3. Imagine that you suspected a colleague of impaired practice due to chemical dependency: (Circle the response that most accurately describes what you would do) 3

   (a) You would approach that person with your concerns.
   A. Yes, I would B. No, I wouldn't
   If No, what would stop you ? ____________________

   (b) You would speak to someone about your concerns.
   A. Yes, I would B. No, I wouldn't
   If Yes, whom ? ____________________
   If No, why not ? ____________________

   (c) What other options might you consider ? ____________________

4. You now have, or have had, problems with alcohol or drugs that may have affected your work:

   A. No, never B. Yes, in the past C. Yes, currently
   If A, Proceed to question # 5.
   If B, Did you receive assistance ?
   A. Yes, I did B. No, I didn't
   How were you referred ?
   A. Self B. Family doctor C. Employer D. I wasn't E. Other: explain________
   If C, Would you refer yourself for assessment if an assistance program was available ?
   A. Yes, I would B. No, I wouldn"t
   If No, What would keep you from self referral ? ____________________
   What would compel you to seek assistance ? ____________________

SECTION 3--GENERAL QUESTIONS (CONTINUED)

5. Imagine that you knew alcohol or drugs were contributing to your impaired practice and personal problems. Rank order from Most Likely (1) to Least Likely (8), the following persons you would turn to first for help. Read through the list before you choose: 5

_____Family member
_____Nurse experienced in helping with these issues
_____Alcoholics/Narcotics Anonymous
_____Close friend
_____Psychologist/Psychiatrist
_____Supervisor
_____Community Agency
_____No one
_____Other: specify_____________

. . . .

6. Consider your 'Most Likely' answer to question #5 above: Rank order from Most Important (1) to Least Important (8), the following characteristics of that person. Read through the list before you choose: 6

_____Nonjudgemental
_____Professional
_____Problem solver
_____Confidential
_____Private
_____Empathic
_____Supportive
_____Mutuality (shares common sentiments)

. . . .

7. Identify other characteristics of that person you consider to be important: 7

(a)

(b)

(c)

(d)

(e)

. . . .

IMPORTANT: Select your answer from the choices given, then circle your choice at right.

SECTION 4--REFERRAL ENVIRONMENT DATA

Please respond to each of the following statements with one of the following choices:

SA	A	U	D	SD
Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree

Imagine that you were designing a program to enhance referral of nurses for impaired practice. Your program would:

Statement	Response	No.
1...include an explicit policy statement outlining employee and employer obligations and duties.	SA A U D SD	1
2...be established, organized and operated by management.	SA A U D SD	2
3...be available to all nurses 24 hours a day.	SA A U D SD	3
4...be instituted province-wide in major regional areas.	SA A U D SD	4
5...include an off-the-work-site location for the counsellor.	SA A U D SD	5
6...be established, organized and operated by the union.	SA A U D SD	6
7...be absolutely confidential (except where danger to clients, patients, or others is involved).	SA A U D SD	7
8...maintain a 24 hour 'hot line' (telephone).	SA A U D SD	8
9...make impairment due to chemical dependency a major emphasis.	SA A U D SD	9
10..include health care benefits for a referred employee who accepts a treatment option.	SA A U D SD	10
11..include education for staff, supervisors and management on early recognition and confrontation of impaired employees.	SA A U D SD	11
12..refer employees only if job performance shows signs of deterioration.	SA A U D SD	12
13..include an on-the-work-site location for the counsellor.	SA A U D SD	13

IMPORTANT: Select your answer from the choices given, then circle your choice at right.

SECTION 4-REFERRAL ENVIRONMENT DATA (CONTINUED)

Imagine that you were designing a program to enhance referral of nurses for impaired practice. Your program would:	
14..be established, organized and operated by a union-management co-operative.	14 SA A U D SD
15..employ colleagues trained in counselling (peer counsellors) as initial contact persons.	15 SA A U D SD
16..encourage follow-up of all employees who have been referred to the program.	16 SA A U D SD
17..report impaired employees to disciplinary bodies if they refuse professional assessment and/or treatment.	17 SA A U D SD
18..ensure that if assessment and treatment are chosen by the impaired employee, the employee would be protected from reprisal by the employer.	18 SA A U D SD
19..be established, organized and operated by an employee-management co-operative.	19 SA A U D SD
20..develop a peer network to assist in the early recognition and referral of impaired employees.	20 SA A U D SD
21. List three other factors that you believe would help to establish an environment that may enhance referral to an assistance program: (i) (ii) (iii)	

Thank you very much for your time and help in completing this survey.

Please feel free to use the back of this page for any additional comments that will help me to understand more fully your concerns.

Please return your completed response in the enclosed envelope.

Appendix C

Cover letter and follow-up letter

Dear Colleague:

This questionnaire is part of a Masters Thesis I am undertaking at the University of Victoria. The purpose of this survey is to gain insight into your perceptions about nursing and impaired practice. As you may know, impaired practice due to chemical dependency is a notable issue in nursing today, and early referral for assessment is essential for successful treatment outcomes.

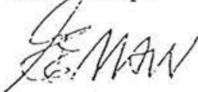
Your input as an employed nurse in British Columbia is necessary to help establish a realistic picture of the factors that affect self-referral or referral of colleagues to assistance programs. Information from this survey can provide valuable input for program planning and implementation, colleague retention, and patient safety.

You are one of only three-hundred nurses who have been randomly selected to receive this questionnaire. The R.N.A.B.C. has generated this random selection of names from their current member list. The R.N.A.B.C. will mail the questionnaires and follow-up letters from Vancouver. I have reimbursed R.N.A.B.C. for these services. I will receive the completed responses in Victoria. The R.N.A.B.C. will have no knowledge of who has responded to a questionnaire, and I will have no knowledge of who has received one. All data will be presented in aggregate form, and in no way used to identify individual participants. Therefore, you will have complete confidentiality and absolute anonymity. Participation is strictly voluntary, and the return of a completed questionnaire will be accepted as consent to use the data in the study.

The questionnaire will take approximately 20 minutes to complete, and responses are requested to be returned by November 30, 1990. A realistic picture of your perceptions can be gained only if a substantial number of nurses participate, therefore I urge your assistance.

I shall take this opportunity to thank you for your time, your concern, and your honesty in support of this study. Please feel free to direct any questions or concerns regarding this study to me.

Sincerely,



Gary E. Maw
2710 Lakehurst Drive
Victoria, B.C. V9B 5E2

Dear Colleague:

Approximately two weeks ago you were mailed a questionnaire. It is part of a study to gain your opinions on the most favorable environment in which to refer yourself, or a colleague to an assistance program for impaired practice.

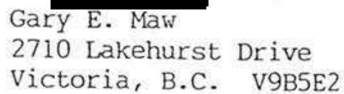
The purpose of this letter is two-fold: first, if you have completed and returned your questionnaire, I thank you for your interest in support of the study; second, if you have yet to complete your questionnaire, I ask that you consider the value of your input and the opportunity to have your voice heard on one of nursing's most pressing issues.

To complete this study within the necessary time frame, your response is required by November 30, 1990. All responses returned on or before that date will be included in the study.

For this project to be truly representative of the views of nurses who are employed in British Columbia, maximum participation is necessary. Therefore, I urge you to take approximately 20 minutes of your time to complete and mail in your questionnaire as soon as possible.

Once again, I extend to you my appreciation for your honesty and concern in support of this study. Should you wish any further information regarding this study, please contact me.

Si



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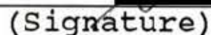
Author 
(Signature)

GARY EDWARD MAW
(Name in Block Letters)

April 29, 1991
(Date)