



2016 MEMBERSHIP ASSEMBLY

# Report of the Reference Committee

- ▶ **Dialogue Forum  
Recommendations**
- ▶ **Proposed Revisions to  
the Policy: Criteria for  
Organizational Affiliates**

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June 25, 2016

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Grand Hyatt Washington

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Washington, DC  
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## 2016 Annual Membership Assembly Meeting

### Report of the Reference Committee

Presented by

Mary Tanner, PhD, RN, Chair ANA Reference Committee

Madam Chair and members of the ANA Membership Assembly:

#### **Dialogue Forum #1: Nursing Advocacy for Sexual Minority and Gender Diverse Populations**

The Dialogue Forum Topic, *Nursing Advocacy for Sexual Minority and Gender Diverse Populations*, was submitted by the Individual Member Division and ANA's Center for Ethics and Human Rights. See Appendix A for background document.

#### ***Issue Summary:***

Increasingly, discrimination and stigma are causes of health disparities and differences in access to care that are closely linked with social, economic and environmental disadvantages. In particular, members of the LGBTQ community face many structural barriers including health care professionals who are biased (which may be largely unintended) and have limited knowledge of culture as well as legal barriers.

According to the *ANA Code of Ethics for Nurses with Interpretive Statements*, the need for and right to health care is universal and inclusive of different cultures, values, and preferences of the individual patient, family, group, community, and populations. Registered nurses must be able to provide culturally congruent, competent, safe, and ethical care to all patients across all settings. A fundamental principle that underlies all nursing practice is respect for the inherent dignity, worth, unique attributes, and human rights of all individuals.

Nurses have an ethical duty to respect the beliefs, values, and decisions of all patients as well as an obligation to address disparities and inequalities through solutions that are ethical and

respectful of human rights. Nurses are positioned to identify and address barriers to health care, such as intended and unintended bias and prejudice.

***Dialogue Forum #1 Participant Comments:***

- Multiple comments were made regarding the need to ensure that written and electronic documentation is gender and relationship neutral. This would facilitate data capture that could be used to support nursing research.
- Multiple comments noted the need for additions to nursing curriculum and professional development that speaks to the specific cultural and health concerns within each group of the LGBTQ community.
- Several comments focused on the need to mainstream the care of the members of the LGBTQ community into the health care experience.
- Comments also addressed the need for standardized terminology to enhance nurses' communication with patients and families. There was recognition that any terminology would need to evolve.
- Comments focused on the notion that if a mistake is made, there is a need to apologize and own it. It was also noted that a "safe place" is needed to allow for open and frank dialogue.
- Several comments centered on the need for neutral communication strategies to support nurses as they approach a patient/client/family interaction.
- Several comments acknowledged that conscious and unconscious bias influences care. One suggestion was to consider applying a "universal precautions" approach to all patients.
- Several comments noted the need to monitor and/or update local, state and federal law and organizational policies to ensure non-discriminatory, family-friendly, gender identity policies.
- A limited number of comments cited the need to hear the varied perspectives of different generations (e.g., millennial) of nurses on the nursing care needs of members of the LGBTQ community.
- The President of the National Student Nurses Association (NSNA) noted that NSNA association has several [position statements](#) that speak to care and the LGBTQ community.
- Another comment spoke to the need for patient education materials to be developed that address the unique needs of the LGBTQ community.
- Several commenters noted the need to monitor and/or update local, state and federal law and organizational policies to ensure non-discriminatory, family-friendly, gender identity policies.

***The Reference Committee Recommends that ANA:***

1. Promote applications of *ANA's Code of Ethics for Nurses with Interpretive Statements* to ensure unwavering, culturally sensitive, unbiased and non-discriminatory care of members of the LGBTQ community.
2. Promote strategies to educate nurses about the potential impact of personal bias, whether conscious or unconscious, on patient care particularly as it relates to care of individuals within the LGBTQ community.
3. Identify strategies to raise the competency of nurses in caring for members of the LGBTQ community.
4. Promote standardized gender-neutral terminology and documentation.

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## **Dialogue Forum #2: Dealing with Substance Use Disorder in Nursing**

The Dialogue Forum Topic, *Dealing with Substance Use Disorder in Nursing*, was submitted by the New Jersey State Nurses Association and ANA's Department of Nursing Practice and Work Environment. See Appendix B for the background document.

### ***Issue Summary:***

In an intensely stressful profession with easy access to controlled substances, nurses can be especially susceptible to Substance Use Disorder (SUD). Approximately 10 to 15% of nurses struggle with drug and alcohol abuse, which is similar to that of the general population. If a nurse suspects another nurse has SUD, they are professionally and ethically required to report it.

Currently, there are disciplinary and non-disciplinary programs for nurses with SUD. The disciplinary approach is through the state boards of nursing and may involve loss of nursing license and termination with the disciplinary action made available through public record. Non-disciplinary programs allow nurses that meet pre-determined criteria to remain in nursing if they are treated and monitored for their addiction.

Since the 1980s, ANA has supported non-disciplinary treatment programs. Currently, several state nurses associations offer substance abuse recovery and monitoring programs for nurses and in a few states, the board of nursing administers a substance use monitoring program.

### ***Dialogue Forum #2 Participant Comments:***

Participants identified the following barriers to developing a recovery and monitoring program in their state, territory, or organization:

- Access (treatment programs, funding sources, employer support)
- Stigma
- Lack of coordination (between nursing associations, compact states)
- Unwillingness of peers to report
- Lack of state legislative support (e.g. dept. of health)
- Lengthy monitoring in some programs
- Legal issues
- Challenges finding re-employment opportunities
- Lack of education on SUD

Participants then brainstormed potential resolutions to these barriers:

- Participating in support groups
- Obtaining funding
- Removing stigma

- Helping with transition from recovery to work
- Decreasing stress
- Enforcing workplace processes and policies
- Providing education on stress reduction measures
- Recruiting nurses to serve as peer facilitators and to speak with student nurses
- Treating SUD as a chronic disease
- Applying the provisions of *ANA's Code of Ethics with Interpretive Statements*
- Establishing state and corporate processes for recovery and re-entry
- Maintaining the privacy of a colleague with SUD
- Benchmarking programs in progress that work

Participants recommended that the following resources be developed to further assist nurses with SUD:

- Develop a toolkit for C/SNAs and registered nurses
- Advocate for funding for drug testing and monitoring programs
- Educate nurses on how to identify peers with SUD and how to report it
- Collaborate more closely with APNA on resource development
- Improve schools of nursing recovery programs
- Recognize and address personal biases
- Develop national list of treatment centers
- Increase peer mentoring programs and alternative discipline programs
- Increase volunteers for education and peer mentoring
- Develop strong evidence-based alternative discipline programs
- Increase the consistency of the provisions of Impaired Provider Programs (IPPs)
- Provide guidance on peer assistance and alternative discipline

Participants noted the following substances were of particular concern in their state or specialty: ETOH, cocaine/crack, Ritalin, Periop-Fentanyl, methamphetamines, and opioid use.

With respect to who to partner with to increase or improve SUD resources and programs, participants noted the following:

- Schools of nursing to increase substance abuse education in nursing programs
- Boards of nursing
- Employers – Employee Assistance Programs
- Other state nurses associations and related associations (American Hospital Association, Visiting Nursing Association)

The importance of educating employers about the need for nurses with SUD to receive appropriate support was stressed. Recommendations for integrating this education into the work environment included: educating the entire nursing staff; emphasizing that SUD is a disease; assessing and reflecting on biases and perceptions related to addiction; identifying and implementing evidence-based and recovery-oriented policies; and incorporating ANA's Code of Ethics into messaging.

***The Reference Committee Recommends that ANA:***

1. Engage stakeholders to explore gaps in current research and policy on SUD in the nursing profession.
2. Promote strategies to educate students, nurses, and employers about preventing, identifying, and reporting suspected SUD across care settings.
3. Partner with stakeholders to develop model programs to support employers and nurses before, during, and after treatment for SUD.

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**Proposed Policy Revisions: *Criteria for ANA Organizational, Labor, and Workforce Advocacy Affiliates***

At their September 11, 2015 Executive Business Session, the ANA Board of Directors approved a motion to recommend forwarding to the 2016 ANA Membership Assembly for consideration proposed revisions to the House of Delegates Policy, *Criteria for Organizational Affiliates*. See revised policy in Appendix C.

***Issue Summary:***

These revisions are being proposed to:

- Clarify the purpose of the policy and consolidate the types of affiliations;
- Include additional “minimal criteria” that must be met by an organization seeking to affiliate formally with ANA; and
- Delineate additional considerations that the ANA Board of Directors may take into account when considering an organization’s request to affiliate (e.g., degree of alignment of mission or advocacy positions; membership growth; additional points of collaboration, use of ANA services) when considering an affiliation).

***The Reference Committee Recommends that ANA:***

Approve the proposed revisions to the House of Delegates Policy, *Criteria for ANA Organizational, Labor, and Workforce Advocacy Affiliates*, as provided in Appendix C.

**Appendix A:** Background Document, *Nursing Advocacy for Sexual Minority and Gender Diverse Populations*

Dialogue Forum #1

Nursing Advocacy for Sexual Minority and Gender Diverse Populations

Friday June 24, 2016: 11:00am – 12:15pm

**Topic Submitted by:** Individual Member Division, ANA's Center for Ethics and Human Rights

**Invited Speakers:** Tanya Friese, DNP, RN, CNL, USN (Ret.)

Dave Hanson, MSN, RN, ACNS-BC, NEA-BC, IMD Chairperson

**ANA Staff Contacts:** Sharon Morgan, MSN, RN, NP-C, Senior Policy Advisor, Nursing Practice & Work Environment

Liz Stokes, JD, RN, Senior Policy Advisor, Center for Ethics and Human Rights

**Session Overview:**

The purpose of this Dialogue Forum is to discuss the overall health care disparities and discrimination within health care settings for gender diverse populations and to identify strategies that nursing and organizations can undertake, including but not limited to nursing education that supports sexual minority and gender diverse populations and their families, to address these barriers in order to provide the highest standard of care in a safe non-judgmental environment.

**Session Objectives:**

- Discuss the role of stigma in the development of health care disparities.
- Describe the tools available to nurses to combat bias, intentional and unintentional, and discrimination against LGBTQ communities in their everyday practices.
- Identify how ANA, C/SNA's and OA's can assist with this issue.

**Overview/Background:**

The lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ) community makes up an estimated 5-10 percent of the U.S. population (IOM, 2011). With a projected 65 or older population of 88.5 million by 2050, approximately 1 in every 13 elders will identify as LGBTQ (Lim & Levitt, n.d.). Numerous disparities within the LGBTQ community exist in relation to

disease patterns and behaviors affecting health (Schenck-Gustafsson et al., 2012). For example, LGBTQ youth are two to three times more likely to attempt suicide, and are more likely to be homeless than their heterosexual peers (National LGBT, n.d.). They are also at higher risk for acquiring HIV and other sexually transmitted diseases (STDs), and are more likely to be bullied (National LGBT, n.d.). Gay men and other men who have sex with men (MSM) are at higher risk of contracting HIV and STDs, especially among communities of color (National LGBT, n.d.).

LGBTQ individuals are much more likely to smoke than others are; they also have higher rates of alcohol or other substance use and depression and anxiety (National LGBT, n.d.). Elderly LGBTQ individuals face additional barriers to health care because of isolation, diminished family support and reduced availability of social services (National LGBT, n.d.). Approximately 8 percent of LGBTQ individuals surveyed, nearly 27 percent of transgender and gender-nonconforming individuals, and almost 20 percent of HIV-positive individuals reported being denied necessary health care (National Women's Law Center, 2014). Thus, disparities are not caused by one's sexual identity; rather, sexual orientation-related health discrimination and disadvantages create health disparities (Cochran et al., 2014).

Researchers have increasingly recognized discrimination and stigma as frequent causes of health disparities and health differences in access that are closely linked with social, economic and environmental disadvantages (Office of Disease Prevention, 2016). Structural and institutional discrimination includes intentional and unintentional policies and practices that result in restricted opportunities for people who have been stigmatized (Poteat et al., 2013). Whereas stigma is a social process of "othering, blaming and shaming" that leads to loss of status and discrimination. The LGBTQ community faces many structural barriers including health care professionals with limited knowledge of culture, health care professionals' bias (which may be largely unintended), and legal barriers for partners to have decision-making ability for their loved ones (Schenck-Gustafsson et al., 2012).

According to the *ANA Code of Ethics for Nurses with Interpretive Statements*, the need for and right to health care is universal and inclusive of different cultures, values and preferences of the individual patient, family, group, community and populations (ANA, 2015; ANA, 2015a). The American Academy of Nursing (AAN) opposes any discrimination based upon sexual orientation or gender identity in health care and society as a whole ([AAN, 2012](#)). AAN has [advocated](#) for patients and families in the LGBTQ community to have equal rights for surrogate decision-making and access to their loved ones while hospitalized (AAN, 2015).

Nurses must be able to provide culturally congruent, competent, safe and ethical care to all patients across all settings. Culturally congruent practice is the application of evidence-informed nursing that is in agreement with the preferred cultural values, beliefs, worldview and practices of the health care consumer and other stakeholders (ANA, 2015a). To demonstrate

cultural congruence and safe practice, nurses must advocate for equal treatment, services and resources for all populations that may be adversely affected by bias or prejudice. “A fundamental principle that underlies all nursing practice is respect for the inherent dignity, worth, unique attributes, and human rights of all individuals” (ANA, 2015, p.1). Nurses have an ethical duty to respect the beliefs and values of all patients, as well as to respect their decisions.

Nurses have an obligation to address disparities and inequalities through creative and innovative solutions that are ethical and respectful of human rights. For example:

- Nurses should create an individual inventory of one’s own values, beliefs and cultural heritage (ANA, 2015a).
- Nurses should collaborate with other health professionals and effectuate change through increasing awareness, education and open dialogue (ANA, 2015).
- Nurses should consider the effects and impact of discrimination and oppression on practice within and among vulnerable cultural groups (ANA, 2015a).
- Nurses should use skills and tools that are appropriately vetted for the culture, literacy and language of the population served (ANA, 2015a).
- Nurses should partner with LGBTQ advocacy organizations and groups to champion continuous awareness within the nursing profession as well as within the public.
- Nurses should participate in institutional and legislative efforts to raise awareness of the burdens that inequities and disparities create and should promote the health and safety of all patients (ANA, 2015).

Organizations can facilitate nurse learning by implementing the following recommendations:

- Encourage participation in provider referral programs through LGBTQ organizations (e.g., [www.gлма.org](http://www.gлма.org), or local LGBTQ organizations) or encourage other providers to advertise their practice in LGBTQ media.
- Develop brochures or other educational materials, conduct trainings, and include relevant information for LGBTQ individuals.
- Integrate visuals showing racially and ethnically diverse same-sex couples or transgender people, or link to posters from non-profit LGBTQ or HIV/AIDS organizations.
- Develop and provide community resources that support LGBTQ individuals.
- Acknowledge relevant days of observance in your practice such as, LGBTQ Pride Day, World AIDS Day and National Transgender Day of Remembrance.
- Provide Guidelines for Forms and Patient-Provider Discussions
  - Use the term “relationship status” instead of “marital status,” including options like “partnered.”
  - Adding a “transgender” option to the male/female check boxes on relevant forms.
  - Encourage gender-neutral language throughout such as “partner(s)” or “significant other(s).”

- Encourage the incorporation of LGBTQ issues in continuing education and certification.

Most important, nurses and organizations must exemplify unwavering culturally sensitive, unbiased and nondiscriminatory care. Nurses are positioned to identify and address barriers to health care, such as intended and unintended bias and prejudice. Nurses should be diligent in creating a moral milieu that is sensitive to diverse cultural values and practices.

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**Appendix B:** Background Document, *Dealing with Substance Use Disorder in Nursing*

Dialogue Forum #2

Dealing with Substance Use Disorder in Nursing

Friday June 24: 3:10pm – 4:25pm

**Topic Submitted by:** New Jersey State Nurses Association and ANA Staff

**Invited Speaker:** Suzanne Alunni-Kinkle, RN, BS, CARN, Chief Nursing Director  
Intervention Project for Nurses

Jillian Scott, MSN, RN, Director, Recovery and Monitoring Program  
Institute for Nursing, The Foundation for NJSNA

**ANA Staff Contact:** Holly Carpenter, BSN, RN Policy Associate, Nursing Practice & Work  
Environment

**Session Overview:**

The purpose of this dialogue forum is to explore how the American Nurses Association (ANA), its constituent and state nurses associations (C/SNAs) and its Organizational Affiliates (OAs) can most effectively assist registered nurses and employers with resources in identification of and intervention for registered nurses with Substance Use Disorder (SUD).

**Session Objectives:**

- Describe the two types of recovery and monitoring programs for nurses with SUD currently available (disciplinary and non-disciplinary) and the subtypes within these two types.
- Discuss the challenges and opportunities with different non-disciplinary recovery and monitoring programs.
- Identify how ANA, its C/SNAs, and OAs can assist with identifying and developing relevant resources for registered nurses with SUD and their employers.

**Overview/Background:**

- Substance abuse is a national epidemic to which nurses are not immune. In an intensely stressful profession with easy access to controlled substances, nurses can be especially susceptible. It is estimated that approximately 10 to 15% of nurses struggle with drug and alcohol abuse, similar to that of the general population (Thomas & Ciela, 2011). ANA has a strong history since the 1980's of supporting non-disciplinary treatment programs (Bettinardes-Angres et al, 2012).

- Signs and symptoms of nurses with SUD include behavioral changes, physical symptoms, and unusual nursing actions (Thomas & Ciela, 2011). These unusual nursing actions can occur at any time but can be especially evident during breaks, narcotic administration, narcotic counts, and narcotic wasting (Thomas & Ciela, 2011).
- Nurses with SUD put their patients, their employers, their communities, and especially themselves at risk. Impaired judgement and altered mental status during work put patients in harm's way. Nurses with SUD can affect their employer and patients by suboptimal staffing (e.g., no-shows, call outs, late arrivals), law suits, financial loss, narcotic diversion, and loss of facility reputation. Finally, the nurse with SUD faces monumental personal risks: loss of health, income, relationships, license, career, and possibly even their own life. Additional risks are felony criminal prosecution and malpractice suits (Berge, Dillon, Sikkink, Taylor, & Lanier, 2012).
- If a nurse suspects another nurse has SUD, they are professionally and ethically required to report it (NCSBN, 2014). The suspicion should be reported to the nursing supervisor and may also need to be reported to the state board of nursing depending upon state regulations (NCSBN, 2014).
- Currently there are two types of programs in place for nurses with substance use disorder: disciplinary and non-disciplinary.
  - The disciplinary approach is through the state board of nursing and may involve loss of nursing license and termination with the disciplinary action made available through public record (Bettinardi-Angres et al, 2012). Ultimately, the Final Order of Discipline requires the nurse to enroll in a monitoring program and sign a contract indicating that he or she will follow the terms, conditions, and requirements of this program until completed (NCSBN, 2011).
  - Non-disciplinary or alternative-to-discipline programs allow nurses that meet pre-determined criteria to remain in nursing if they are treated and monitored for their addiction (Bettinardes-Angres et al, 2012). The non-disciplinary approach offers early intervention, monitoring, and treatment through multiple methods including: total abstinence from substance use, a 12-step program, a treatment plan with a yearlong aftercare program, substance use and recovery education, therapy, family involvement, random and for-cause drug screening, mandatory reports of any suspected substance use, and support groups with other nurses, often referred to as peer-assistance programs (Bettinardes-Angres et al, 2012; NCSBN, 2011). In these programs, a nurse with SUD is closely monitored to allow for appropriate public safety (Bettinardes-Angres et al, 2012). Non-disciplinary programs must be approved and may be offered by nurses associations, state boards of nursing, and various other contractors and sub-contractors. (Bettinardes-Angres et al, 2012; NCSBN, 2011).

- At this time several state nurses associations offer substance abuse recovery and monitoring programs for nurses: Georgia Nurses Association, Indiana State Nurses Association, Missouri Nurses Association, New Jersey State Nurses Association, South Carolina Nurses Association, Tennessee Nurses Foundation, Texas Nurses Association, and Wisconsin Nurses Association. In a few states, the board of nursing administers substance use monitoring programs. Peer assistance programs are also operated within some specialty nursing organizations such as the American Association of Nurse Anesthetists.

#### Questions for Dialogue Forum:

- What are the barriers to developing a recovery and monitoring program for your state, territory, or organization? If you already have a program, what challenges have you encountered? Discuss resolutions to these barriers and challenges.
- What programs and resources are currently available for a nurse with SUD in your state or specialty? Is there a specific issue, diagnosis, or drug of particular concern in your state or specialty?
- Who might you partner with to increase or improve SUD resources and programs in your state or specialty? Do you currently work with your state's board of nursing or the National Council of State Boards of Nursing regarding SUD in nursing?
- What resources would you like to see developed for your particular C/SNA, OA, and/or ANA to further assist nurses with SUD?
- How have you/might you engage employers of nurses to better understand and support nurses with SUD?

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**AMERICAN NURSES ASSOCIATION**

*Membership Assembly*

*Policy/Position*

<b>Title:</b>	<b>Criteria for ANA Organizational Affiliates</b>
Source:	ANA Membership Assembly
Date:	June 25, 2016
Replaces:	HOD Policy # 2.59 (2008) Criteria for ANA Organizational Affiliates, Labor and Workforce Advocacy Affiliates
Policy/Position:	The ANA Membership Assembly resolved that:

**Purpose**

According to the ANA Bylaws (2015) Article II, Section 2, “ANA has organizational affiliates that could be labor organizations, workforce advocacy organizations, or specialty nursing associations.” The Bylaws further specify that an Organizational Affiliate of ANA is “1) a national organization that represents the interests of registered nurses that meets criteria established by the Membership Assembly; 2) Does not take action counter to the interests of ANA or any of the C/SNAs or the IMD; and 3) Has been granted organizational affiliate status by the ANA Board of Directors.” The purpose of this policy is to establish the criteria for granting organizational affiliate status and provide guidance to the ANA Board of Directors when considering and approving Organizational Affiliates.

**Policy**

The American Nurses Association welcomes affiliations with national nursing organizations for the purpose of supporting the work of the profession and advancing the interests of nurses and the patients they serve. Organizations that want to affiliate with ANA must meet the following criteria, which will be applied at the sole discretion of the ANA Board of Directors. ANA may accept or reject applications for formal Organizational Affiliate status, or may discontinue an affiliation, as the Board of Directors deems appropriate.

*Minimum Criteria for Affiliation*

An Organizational Affiliate must:

- Have a mission and purpose harmonious with the purposes and functions of ANA;
- Be national in scope with at least 500 members;
- Be incorporated for at least two years, conduct at least a biennial meeting and maintain a national office;
- Be comprised and governed by a majority of registered nurses;

- Agree to pay an annual fee; and
- Not engage in any activity deleterious to the interests of ANA and/or its C/SNA, subsidiaries, or members.

*Additional Considerations*

The Membership Assembly authorizes the ANA Board of Directors to consider additional factors such as the degree to which the mission or advocacy positions of a potential or current Organizational Affiliate align with those of ANA in making a decision to deny or terminate Organizational Affiliate status.

Membership growth for ANA may be considered in connection with the value of the affiliation.

ANA may propose additional points of collaboration or the use of ANA services by the potential or current Organizational Affiliate, and additional agreements may be adopted by the parties.