Treating Addicted Healthcare Professionals

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Disclosures

• Conflicts or potential conflicts of interest: None
• Off-label use of pharmacological agents: Use of topiramate as an anti-craving agent is discussed
Epidemiology

• Alcohol abuse and dependence
  • No difference in incidence or prevalence from general population
  • Most common SUD in physicians
  • Usually has later onset, less antisocial behavior
• Illicit drug abuse and dependence
  • Lower than in general population
  • Marijuana is most common drug of choice
• Prescription drug abuse and dependence
  • Higher than in general population
  • Oral opioids are most common drug of choice
  • Opioid dependence is most common addiction in nurses and pharmacists
Outcomes and Prognosis

- Factors indicating high relapse risk
  - Presence of co-occurring psychiatric illness
  - Injection opioids as drug of choice
- Factors associated with low risk of relapse
  - Longer period of professional treatment (whether residential or outpatient)
  - Longer period of monitoring
  - Active involvement in 12-Step programs
- Factors not shown to influence relapse risk
  - Specialty
  - Precipitating event for entering program
Outcomes and Prognosis (cont.)

• Incidence of relapse in physicians
  • 25% experience one or more episodes of return to use of drug of choice or other chemical(s)
  • 50% + of these receive additional intensive treatment
  • 90% return to practice
  • Approximately 10% of total are unable to complete monitoring due to relapse and/or death

• Incidence of long-term outcomes in physicians
  • A relapse is the best indicator of more relapses
  • Timing of relapse provides valuable indicators of need for further treatment and type of treatment
  • Continued monitoring improves long-term prognosis
  • Addressing return to work issues is critical
Outcomes for Other Professionals

- No large-scale studies
- Dentists’ outcomes appear to be similar to physicians’ outcomes
- Nurses have poorer outcomes
  - Higher relapse rates
  - Higher incidence of license suspension/revocation
  - Lower rates of successful re-entry
  - Probably related to fewer resources for treatment
Initial Treatment of Addictive Disorders

• Reduction of denial and acceptance of diagnosis and need for treatment
• Understanding of chronicity of disease, need for ongoing treatment and monitoring
• Training in relapse prevention
• Identification and treatment planning for complicating co-morbidities
  • Psychiatric
  • Medical
Why Are Professionals Different?

• May be detected and referred for treatment at an earlier stage of disease
  • Increases strength of denial
  • Ultimately improves prognosis if professional is able to accept diagnosis

• Patient safety and regulatory issues
  • Demand for assurance of adequate treatment
  • Ongoing monitoring required to insure compliance and continued abstinence

• Personality traits and enabling systems protect disease and support denial
Risk Factors for Physicians

- Old familiar stress themes
  - Long hours, lack of privacy
  - Responsible for life and death decisions
  - Disrupted family life
- New challenges that cause increased stress
  - Managed care, less autonomy
  - Litigation stress, increasing malpractice rates
- Access to controlled drugs
- Internal issues (personality traits)
  - Perfectionism, compulsivity
  - Difficulties with intimacy, detached from feelings
Risk Factors for Nurses

- Genetics- high incidence of alcohol/drug dependence in family
- Co-dependent, caretaking traits
- Access
- Attitude
  - “Knowledge is power”- knowing how drugs work and what they are prescribed for will somehow lower my risk
  - “Waste not want not”- taking home left over or discarded medication because I might find a use for it later
Assessment and Treatment Planning

• When addiction is suspected, medical professional requires careful evaluation.
  • Is substance dependence a primary diagnosis?
  • Are other psychiatric disorders present which also require immediate treatment?
  • Are there medical conditions which will complicate the treatment and recovery?
• Once diagnosis is established, treatment planning is the next step.
  • What type of treatment is needed?
  • What level of care is indicated for initial treatment?
Essentials Elements of Treatment for Addicted Healthcare Professionals

• Effective confrontation of denial, intellectualization
• Acceptance of chronic nature of disease and need for ongoing treatment
• Relapse prevention which addresses issues specific to the physician’s practice or student’s circumstances
  • Re-entry stresses
  • Access to drugs
  • Need for workplace monitoring
  • Dealing with Board issues, legal issues
Other Important Elements

• Identifying psychiatric co-morbidity
• Addressing complex family dynamics
• Planning for treatment of symptoms which initiated self-prescribing
  • Chronic pain
  • Insomnia
• Exploring career issues
• Developing individualized continuing care and relapse prevention plan
Experience and Training of Treatment Providers

- Familiarity with special needs of professionals
- Familiarity with system with which professional is involved and ability to provide effective care while remaining responsive to system
- Ability to deal with sophisticated defenses
  - Intellectualization
  - Defocusing and redirecting
  - Caretaking
  - Devaluing
- Ability to recognize, explore and utilize transference and countertransference
- **BOUNDARIES**
Boundaries in Treating Professionals

• Maintaining clear therapist-patient relationship with persons with whom one identifies and who may be colleagues
• Keeping focus on the disease, not the system
• If therapist is recovering, coping with interacting with patient in meetings
• If therapist is not recovering, coping with devaluation of lack of personal experience
Level of Care

• Outpatient
  • Individual therapy in early stages of recovery is generally not effective in reducing denial, increasing honesty.
  • Group therapy is more effective, but may also fail due to physician’s tendency to dominate group., nurse’s caretaking behavior, etc.
  • Specialized intensive outpatient programs knowledgeable about needs of professionals are hard to find.

• Residential or Partial Hospital
  • Standard short-term rehabilitation program
  • Specialized short-term rehabilitation program
  • Specialized extended care program (90 days or more)

• Inpatient- reserved for brief stabilization of medical and psychiatric concerns
Medication-Assisted Recovery

- **Disulfuram (Antabuse®)** - widely accepted and utilized for alcohol dependence by peer-assistance and monitoring programs
- **Anti-craving drugs (acamprosate, naltrexone, topiramate*)** for alcohol dependence - accepted
- **Antagonist (naltrexone) therapy for opioid dependence** - accepted and encouraged
- **Agonist therapy for opioid dependence** - controversial

*off-label
Agonist Therapy for Opioid Dependence

- Methadone
  - Majority of physician monitoring programs do not permit doctors to practice on methadone
  - Monitoring programs for nurses more diverse
  - A few programs have no restrictions
  - Increasingly, programs are considering case by case requests and requiring cognitive screening
- Buprenorphine
  - Increasing number of programs are permitting physicians and other professionals to practice on buprenorphine if individual is in stable recovery
  - Some programs require cognitive testing
- Other Issues
  - Malpractice insurance
  - Employer/group practice/managed care concerns
Monitoring

• **Advantages**
  • Improves outcomes
  • Documents abstinence for needed advocacy
  • Addresses demand for protection of patients
  • Rebuilds trust in professional relationships

• **Elements of a monitoring contract**
  • Documentation of treatment compliance and continuing progress
  • Urine drug screens and other testing
    • Compliance with prescribed medications
    • Hair and nail testing if indicated
  • Communication with treatment providers, employers, licensure boards, etc. as indicated
Re-entry Issues

• **Returning to practice**
  - When is the professional ready to re-enter?
  - What preparations and/or restrictions are needed prior to re-entry?

• **Modifications of practice needed**
  - Changing circumstances in work setting
    - Access to drugs
    - Availability of support at work
    - Work site monitoring
  - Changing to different work setting
  - Changing focus of practice
  - Re-training in a new specialty or profession
Central Role of Twelve-Step Program Participation for Recovering Professionals

• Specialized treatment programs for physicians and physician monitoring programs document that non-attendance at AA/ NA is single most common factor in relapse.

• Research data available to support this finding.

• Progression toward relapse often begins with decrease, then cessation in Twelve-Step meeting attendance.
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