Recognition & Management Substance Use Disorders in Physicians

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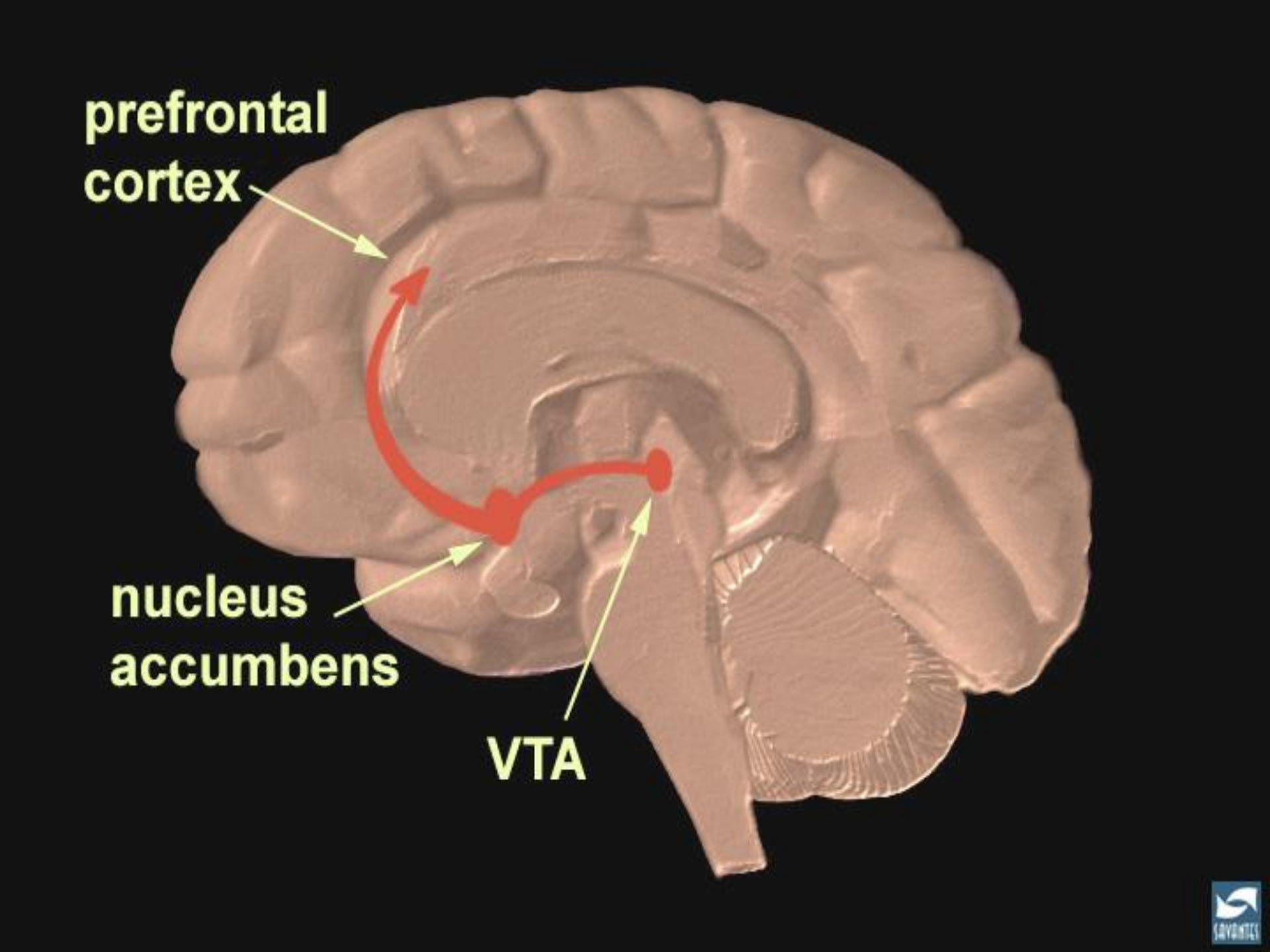
Substance Use Disorders

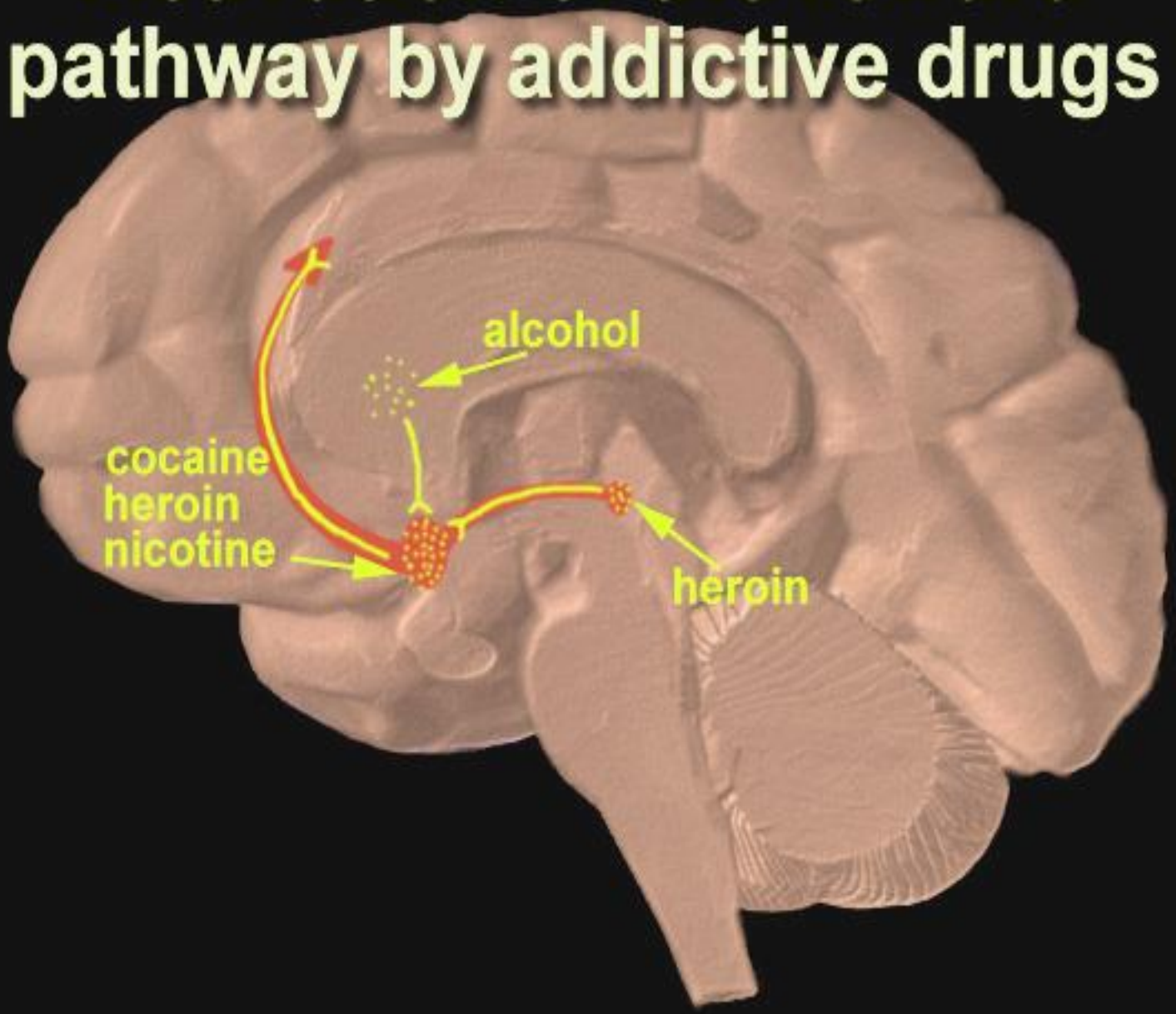
Substance Use Disorder is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: Impaired control over chemical use, preoccupation with the drug, use of chemicals despite adverse consequences, and distortions in thinking, most notably denial.

Substance Use Disorders

1. "Primary" refers to the nature of SUD's as a disease entity in addition to and separate from other disease states which may be associated with it. "Primary" indicates that SUD's, are not a symptom of an underlying disease state.


prefrontal
cortex
nucleus
accumbens
VTA

Activation of the reward pathway by addictive drugs



Substance Use Disorders

2. "Disease" means an involuntary disability. It represents the sum of the abnormal phenomena displayed by a group of individuals. These phenomena are associated with a specified common set of characteristics by which these individuals differ from the norm, and which places them at a disadvantage.

Substance Use Disorders

3. "Often progressive and fatal" means that the disease persists over time and that physical, emotional, and social changes are often cumulative and may progress as drinking or drug use continues. SUD causes premature death through overdose, organic complications involving vital organs, and by contributing to suicides, homicides, motor vehicle crashes and other traumatic events.

Substance Use Disorders

4. "Impaired control" means the inability to limit chemical use or to consistently limit on any using occasion the duration of the episode, the quantity used, and/or the behavioral consequences of using.

Substance Use Disorders

5. "Preoccupation" in association with alcohol or drug use indicates excessive, focused attention given to the drug, its effects, and its use. The relative value thus assigned to the drug by the individual often leads to a diversion of energies away from important life concerns.

Substance Use Disorders

6. "Adverse consequences" are alcohol-related problems or impairments in such areas as: Physical health, psychological functioning, interpersonal functioning, occupational functioning, and legal, financial, or spiritual problems.

Substance Use Disorders

7. "Denial" is used here not only in the psychoanalytic sense or a single psycho-logical defense mechanism disavowing the significance of events, but more broadly to include a range of psychological maneuvers designed to reduce awareness of the fact that chemical use is the cause of an individual's problems rather than a solution to those problems. Denial becomes an integral part of the disease and a major obstacle to recovery.

Substance Use Disorders

Abbreviated Definition

SUD is a disease characterized by continuous or periodic:

Impaired control over chemical use, preoccupation with the drug, use of drugs despite adverse consequences, and distortions in thinking, most notably denial.

Substance Use Disorders

ASAM Defines Addiction:

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019

Substance Use Disorders

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by the following symptoms occurring within a 12-month period:

Substance Use Disorders

1. Substance is often taken in larger amounts and/or over a longer period than the patient intended.

2. Persistent attempts or one or more unsuccessful efforts made to cut down or control substance use.

3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from effects.

Substance Use Disorders

4. Craving or strong desire or urge to use the substance

5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.

6. Continued substance use despite having persistent or recurrent social or interpersonal problem caused or exacerbated by the effects of the substance.

Substance Use Disorders

7. Important social, occupational or recreational activities given up or reduced because of substance use.

8. Recurrent substance use in situations in which it is physically hazardous.

9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Substance Use Disorders

10. Tolerance, as defined by either of the following:

a. Markedly increased amounts of the substance in order to achieve intoxication or desired effect

b. Markedly diminished effect with continued use of the same amount

Substance Use Disorders

11. Withdrawal, as manifested by either of the following:

a. The characteristic withdrawal syndrome for the substance;

b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;

Substance Use Disorders

2-3 Symptoms Present – Mild

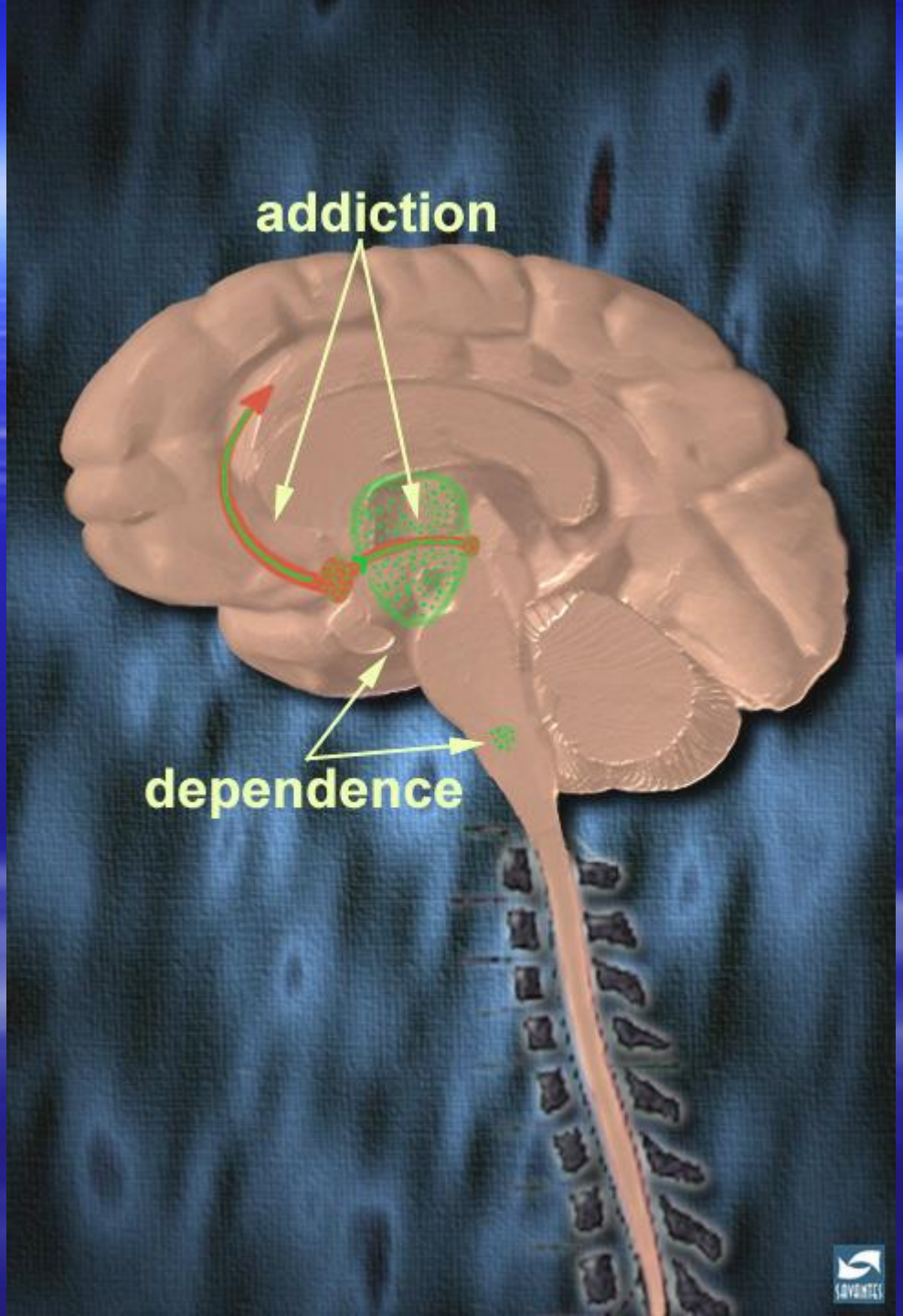
4-5 Symptoms Present – Moderate

6 or more Symptoms Present – Severe

Definition of Terms

- Physiological Dependence

  Physiological dependence is a state of adaptation that is manifested by a drug-class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist


addiction
dependence

Recognition of SUD's

A. Family Indicators

1. The physician withdraws from family activities; there are unexplained absences.

2. The spouse becomes a caretaker.

3. Fights increase in frequency; there is dysfunctional anger; the spouse tries to control the physician's substance use/abuse.

Recognition of SUD's

A. Family Indicators

4. The spouse becomes isolated, angry, and physically and emotionally unable to meet the demands of the addict's illness.

5. There may be child abuse and/or neglect.

6. The children assume responsibility for maintaining normal family functioning.

Recognition of SUD's

A. Family Indicators

7. The children develop abnormal, antisocial behavior (depression, promiscuity, running away from home, substance use/abuse.

8. Sexual problems emerge, including impotence and extramarital affairs.

9. The spouse disengages, abuses drugs and/or alcohol, or enters recovery.

Recognition of SUD's

B. Community Indicators

1. The physician becomes isolated and withdraws from community activities, church, friends, leisure, hobbies, and peers.

2. He or she exhibits embarrassing behavior at clubs or parties.

3. The physician receives DUI citations, experiences legal problems, and exhibits role-discordant behaviors.

Recognition of SUD's

B. Community Indicators

4. The physician's behavior is unreliable and unpredictable in the community and social events.

5. The physician is unpredictable in personal behavior, engaging in excessive spending and risk-taking behavior.

Recognition of SUD's

C. Physical Status Indicators

1. The physician's personal hygiene deteriorates.

2. His or her clothing and dress habits deteriorate.

3. The physician has multiple physical symptoms and complaints.

Recognition of SUD's

C. Physical Status Indicators

4. The physician writes numerous prescriptions for personal use.

5. The physician experiences frequent hospitalizations.

6. The physician has numerous visits to other physicians and dentists.

Recognition of SUD's

C. Physical Status Indicators

7. The physician is involved in multiple episodes of accidents and trauma.

8. There is evidence of a serious emotional crisis.

Recognition of SUD's

D. Office Indicators

1. Patient appointments and schedule become disorganized and progressively later.

2. The physician's behavior toward staff & patients is hostile, withdrawn, or unreasonable.

3. The physician orders excessive office supplies of controlled drugs.

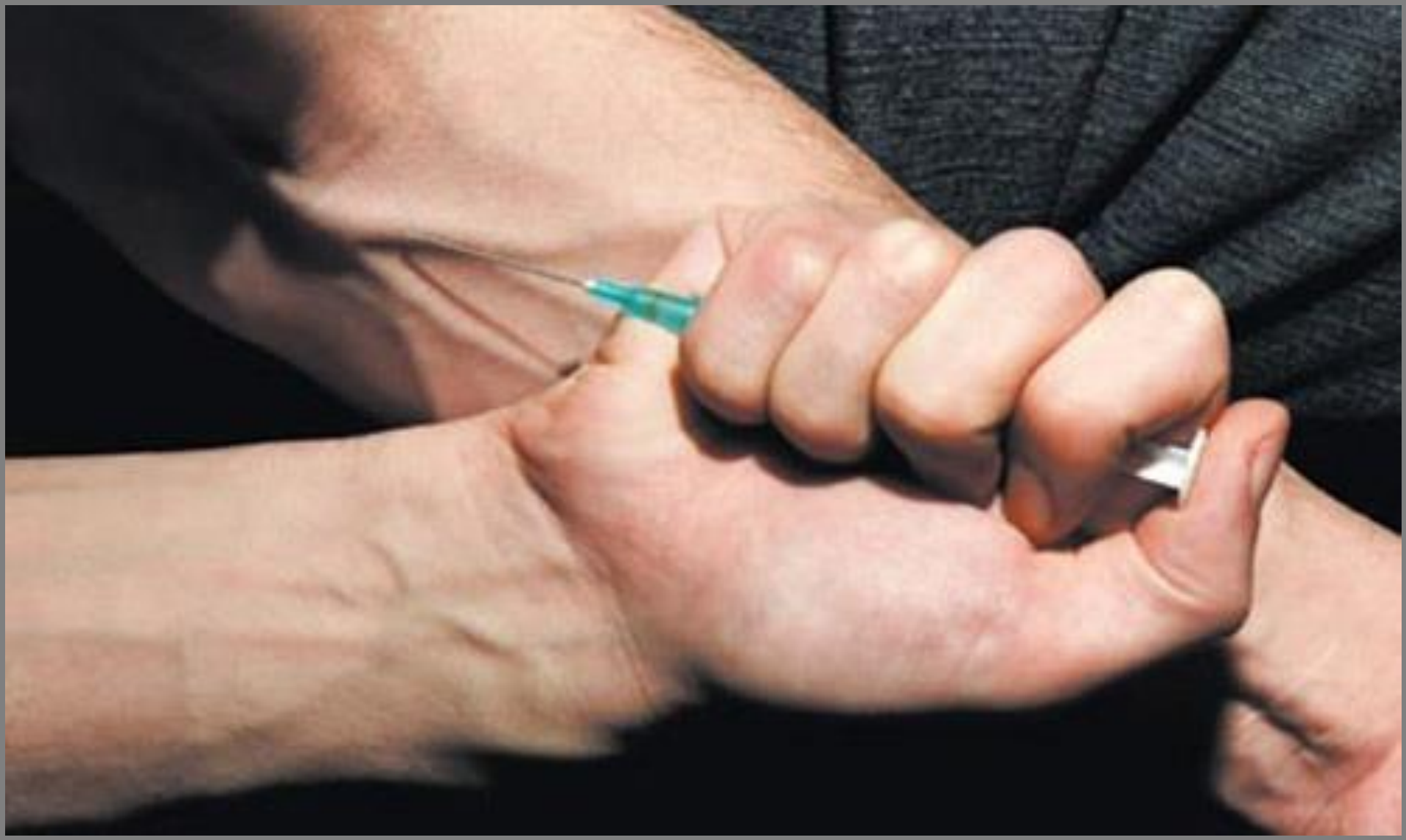
Recognition of SUD's

D. Office Indicators

4. Patients complain to staff about the physician's behavior.

5. The physician is frequently absent from the office or has unexplained or frequent absences.

6. The physician spends time behind 'locked doors'.



Recognition of SUD's

E. Hospital Indicators

1. The physician makes rounds late or exhibits inappropriate or abnormal behavior.

2. There is a decrease in the quality of the physician's performance in staff presentations, writing in charts, etc.

3. The physician enters inappropriate orders for or over-prescribes controlled medications.

Recognition of SUD's

E. Hospital Indicators

4. Nurses, secretaries, orderlies, and other staff report that the physician's behavior has changed.

5. The physician becomes involved in malpractice suits and/or legal sanctions against the physician or hospital.

6. The physician does not respond to pages, or is slow to do so.

Recognition of SUD's

E. Hospital Indicators

7. Emergency department staff report that the physician is unavailable for or responds inappropriately to telephone calls.

8. He or she is reluctant to undergo immediate physical examination or to submit to urine drug screens.

9. The physician engages in heavy drinking at medical staff functions.

Recognition of SUD's

F. Professional History Indicators (CV Clues)

1. The physician has changed jobs numerous times within the preceding five years.

2. The CV documents frequent geographic relocations without clear explanations.

3. There is a history of frequent hospitalizations.

Recognition of SUD's

F. Professional History Indicators (CV Clues)

4. The physician has a complicated and elaborate medical history.

5. The CV shows unexplained time lapses between jobs/practices.

6. The physician submits indefinite or inappropriate medical references and vague letters of reference.

Recognition of SUD's

F. Professional History Indicators (CV Clues)

7. The physician has been employed in one or more positions that are not appropriate to his or her qualifications.

8. There is a decline in the physician's professional productivity.

* If any 3 of the above are present on an application, the index of suspicion should be high.

Recognition of SUD's

G. Family History Risk Ratio

1. No family history = 0.3 - 3% risk of SUD

2. One parent with SUD =
   20% lifetime risk of SUD

3. Two parents with SUD =
   30% lifetime risk of SUD

Recognition of SUD's

H. Addiction in Physicians

Average lifetime rate = 10 - 15%

Highest Risk Fields – Emergency Medicine and Anesthesiology

#1 Cause of physician disability between the ages of 25 – 55

Recognition of SUD's

H. Substance Use Disorders in Physicians

High recovery rate due to factors including:

- Professional interventions
- High quality treatment
- Peer assistance (OPHP)
- Long-term monitoring of compliance (OPHP, State Medical Board of Ohio)

Recognition of Chemical Dependence

Who to Contact

- Ohio Physicians Health Program

  (614) 841-9690 or www.ophp.org

  Craig T Pratt, MD, DFASAM, FAPA – Medical Director

  Nelson H Heise, MS, PCC-S LICDC-CS– Clinical Director

Recognition of Chemical Dependence

Who to Contact

- Shepherd Hill - (800) 223-6410 or (220) 564-4877 or www.ShepherdHill.net

Amanda Betts, RN – Admissions 220-564-4877

Eric Hockenberry, RN, CARN – Admissions 220-564-4898

W. Andrew Highberger, MD, FASAM, DABAM – Medical Director

Primary Treatment Goals

- Education
- Self Diagnosis
- Self Responsibility
- Self Treatment

One-Bite Program

In 2018, the Ohio General Assembly established a program that allows an eligible practitioner who is impaired due to a substance use disorder to avoid formal disciplinary action by the State Medical Board (SMBO) by utilizing established confidential monitoring and treatment conditions as defined in ORC 4731.251 and 4731.252 - this is known as the One-Bite Program.

In 2019, the Ohio Physicians Health Program (OPHP) was approved by the State to serve as the sole monitoring organization responsible for determining whether a practitioner is eligible to participate in the One-Bite Program and for administering the One-Bite Program. Reports of suspected impairment related to a practitioner licensed by the SMBO are required to be made to OPHP. OPHP shall not disclose to the SMBO the name or any records relating to a participant under the One-Bite Program unless certain conditions exist and in accordance with ORC 4731.251(D).

For additional information contact info@ophp.org or call (614) 841-9690.

Levels of Care at Shepherd Hill

- **Detoxification (Withdrawal Management)**

ASAM Level 4

Shepherd Hill Cottage C (or LMH inpatient unit/ICU if medically unstable)

Average LOS 2 – 5 days for detoxification

Transition to appropriate level of treatment following successful detoxification

Levels of Care at Shepherd Hill

- **Detoxification as inpatient advised**
  - Alcohol (> 6 – 12 beers or 1 pint liquor daily)
  - Benzodiazepines and barbiturates (4 mg of alprazolam daily or equivalent)
  - Opiates (IV heroin, oxycodone, Fentanyl)

Levels of Care at Shepherd Hill

Relative Indications for Inpatient Alcohol Detoxification

- History of severe withdrawal symptoms
- History of alcohol withdrawal seizures or DT's
- Multiple past detoxifications
- Concomitant medical or psychiatric illness
- Recent high levels of alcohol consumption
- Lack of reliable support network
- Pregnancy

Levels of Care at Shepherd Hill

- **Detoxification (Withdrawal Management)**

  Safely manages the physical symptoms of drug and/or alcohol withdrawal.

  Only the first stage of addiction treatment.

  Alone, does little to change long-term drug and alcohol use

Levels of Care at Shepherd Hill

- **Residential Treatment**

  Level 2.5 (Partial Hospitalization + Overnight Stay)

  Cottage E

  LOS 28 Days

  Transition to Extended Residential, IOP, or other appropriate level of care upon completion of treatment plan

Levels of Care at Shepherd Hill

- **Partial Hospitalization**

Ohio Medical Practice Act requires treatment at a Medical Board approved facility for Medical Board licensees. Length of stay determined by clinical progress.

Levels of Care at Shepherd Hill

- **Intensive Outpatient Program (IOP)**

ASAM Level 2.1

Shepherd Hill Cottage A

Average LOS 6 – 8 Weeks

Offered mornings and evenings (M – F offered, but sessions usually on M, T, and F)

Transition to Aftercare care upon completion of all treatment goals

Levels of Care at Shepherd Hill

- **Aftercare**

Ohio Medical Practice Act requires a minimum of 6 months of aftercare with length of treatment determined by the treatment team

Weekly Wednesday evening sessions on Shepherd Hill campus, with Caduceus support meeting for healthcare practitioners

Motivation to Enter/Sustain Treatment

- Effective treatment need not be initiated due solely to *internal* motivation.
- Sanctions/enticements, or *external* motivation, (family, employer, licensing boards, etc.) can increase treatment entry/retention.
- Treatment outcomes are similar for those who enter treatment under legal/licensing board pressure vs. due to *internal* motivation.

Duration of Treatment

- Depends on specific patient problems/needs.
- Treatment duration of 90 days or more yields increased rates of sustained remission and recovery.
- Longer duration treatment is frequently indicated.

Medications for Addiction

- Suboxone® (buprenorphine) *
- Methadone *
- Naltrexone – ReVia®
  Vivitrol®
- Campral® (acamprosate)
- Nicotine Replacement
- Chantix® (varenicline)

* Just recently approved by SMBO for Medical Board licensees while practicing medicine in Ohio

Post-Treatment Evaluation

- **Positive response to treatment**
  - Accepts diagnosis and understands the disease of addiction
  - Bonding with AA/NA with active sponsorship
  - Good relapse prevention skills
  - Healthy family relationships
  - Co-occurring psychiatric disorders in remission
  - Balanced lifestyle
  - Committed to 5 year monitoring program (OPHP)
  - Confident to return to practice and not relapse

Post-Treatment Evaluation

- **Incomplete response to treatment**
  - Incomplete acceptance of diagnosis of addiction
  - Some denial/minimizing
  - Incomplete bonding with AA/NA (but improving)
  - Recovery skills incomplete but improving
  - Co-occurring psychiatric disorders improved
  - Some family dysfunction remains
  - Overconfident regarding relapse potential
  - Some resistance to monitoring process/procedures

Post-Treatment Evaluation

- **Poor response to treatment**
  - Lack of acceptance of diagnosis of addiction
  - Prolonged addiction history
  - Poor bonding with AA/NA
  - Recovery skills incomplete but improving
  - Major co-occurring psychiatric psychopathology
  - Significant family dysfunction
  - Significant relapse despite adequate treatment
  - Inability to follow treatment and monitoring process/procedures

Questions?