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▶ Setting the standard for recovery: physicians' health programs.

DuPont R.L., McLellan A.T., White W.L. et al. Request reprint

Journal of Substance Abuse Treatment: 2009, 36, p. 159–171.

US physician health programmes demonstrate that long-term intensive monitoring of substance use allied with swift and certain sanctions and abstinence-based mutual aid and treatment can enable seriously dependent individuals to stop using psychoactive substances.

Original abstract Physician health programmes offer drug- and alcohol-using physicians the opportunity, motivation, and support to achieve long-term recovery, using monitoring through drug and alcohol testing, treatment, and 12-step programmes. In return, physicians sign contracts, typically for five years, to adhere to the programme, including completing treatment and submitting to frequent random drug testing to ensure abstinence. Each working day physicians phone or log-in to find out if they must report for testing. Substance use or any other evidence of non-compliance typically results in immediate removal from medical practice to arrange extended treatment followed by more intensive monitoring.

A sample of 904 physicians consecutively admitted to 16 state physician health programmes was studied for five years or longer to characterise the outcomes of this episode of care and to explore elements of these programmes which could improve the care of other addicted populations. The study consisted of two phases: the first characterised the programmes and their systems of care management, while the second described the outcomes of the study sample as revealed in programme records.

Remarkably, 78% of participants had no positive test for either alcohol or drugs over the five-year period of intensive monitoring. Overall, the positive drug testing rate was 0.54%, meaning that an average of about 1 in 200 samples was positive, even with the extended screens and the random testing used for this monitoring. At post-treatment follow-up, 72% of the physicians were continuing to practice medicine. Of the 904, 19% had a relapse episode and were reported to their licensing boards. However, only 22% of

these had any evidence of a second relapse, indicating that intensified treatment and monitoring had generally reinstated remission.

Implications for addiction treatment generally

This success rate directly contradicts the common misperception that relapse is inevitable and common among substance use patients. Rather than being a defining characteristic of addiction, 'inevitable relapse' may be a defining characteristic of the acute care model of biopsychosocial stabilisation, which offers an opportunity for recovery initiation but lacks the ingredients needed to achieve recovery maintenance. If the key ingredients of physician health programmes – particularly ongoing monitoring for this chronic illness linked to meaningful consequences – were universally available, we might find that relapse was far from inevitable and that addiction careers could be significantly shortened and stable recovery careers extended.

Six key elements of the programmes are worthy of consideration for wider dissemination in substance abuse treatment.
1. *The contingency management aspects* For enrolled physicians there are both significant positive (continued ability to practice medicine; reduction of pending charges against them) and significant negative consequences (loss of license, professional disgrace) from compliance or non-compliance with programme treatment and monitoring requirements.
2. *Frequent random drug testing* Drug testing is seldom used in substance abuse follow-up for the general population and when used, the results are seldom linked to meaningful consequences. Drug testing is never used for such long periods or with the intensity that typifies physician health programmes. Recovering physicians frequently report that testing is a powerful motivator, and it may be the programmes' most effective component.
3. *Tight linkage with 12-step programmes and with the abstinence standard espoused by these fellowships* Physician health programmes require abstinence from alcohol and all non-medical use of mood-altering drugs. Research has repeatedly demonstrated the efficacy of the 12-step approach for physicians with substance use disorders.
4. *Active management of relapses by intensified treatment and monitoring* Relapses do not typically lead to discharge from the programme. Instead, they routinely lead to intensive re-evaluation of treatment plans and implementation of additional care.
5. *A continuing care approach* Treatment, support, and monitoring in traditional addiction programmes lasts 30 to 90 days. There are many novel and effective ways to extend formal care, including telephone- or internet-based monitoring and support and regular home visits. Physician health programmes have formalised this element of sustained continuity of care and focused much of their professional resources on sustaining therapeutic contact over five years or longer.
6. *Focus on lifelong recovery* Physician health programmes rarely see achieving abstinence from the use of alcohol and drugs of abuse as sufficient care. Rather, physicians are supported and encouraged to significantly improve the quality of their lifestyles, both in their personal lives and in their practice of medicine.

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