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Six Lessons from State Physician Health Programs to Promote Long-Term Recovery

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Abstract — The success of the nation's state physician health programs (PHPs) provides important new evidence on the potential for dramatically reducing relapse and promoting long-term recovery from substance use disorders. This article summarizes the findings of the first national PHP study and outlines six lessons learned from this model of care management: (1) zero tolerance for any use of alcohol and other drugs; (2) thorough evaluation and patient-focused care; (3) prolonged, frequent random testing for both alcohol and other drugs; (4) effective use of leverage; (5) defining and managing relapses; and (6) the goal of lifelong recovery rooted in the 12-Step fellowships. PHPs are a part of a new paradigm of care management that includes the programs developed for commercial pilots (HIMS) and for attorneys (CoLAP). Elements of this model of care have been used with a dramatically different patient population, and with similar success, in the criminal justice system in HOPE Probation and 24/7 Sobriety. The authors review these programs and discuss implications for extending elements of the new paradigm more widely.

Keywords — addiction, alcohol, drugs, drug test, physicians, recovery

The single most striking characteristic of substance use disorders (SUDs) is not dramatic withdrawal symptoms when drug use abruptly stops; it is relapse to substance use despite repeated serious negative consequences of drug use *after* the patient has become drug-free, even after treatment (DuPont 1997; DuPont & Gold 1995).

The national study of state physician health programs (PHPs) in the US provides important new evidence on the potential for dramatically reducing relapse and promoting long-term recovery (Skipper & DuPont 2011, 2010; DuPont et al. 2009a, b; Skipper, Campbell & DuPont 2009; McLellan et al. 2008). This new evidence also refutes the common view that relapses are to be accepted as part of the biological brain disease of addiction.

This article summarizes the findings of the initial PHP study, outlining six lessons learned from the PHP model of care management. These lessons provide guidance to expand the PHP model to different populations with SUDs, including those within the criminal justice system. Programs reviewed include PHPs, Hawaii's Opportunity Probation with Enforcement (HOPE), South Dakota's 24/7 Sobriety, the Human Intervention Motivation Study (HIMS) program for commercial pilots, and the national Commission on Lawyer Assistance Programs (Co-LAP) for attorneys. Programs similar to the PHPs have been promoted for affluent families and within professional industries. While each is unique, these new initiatives are a part of a new paradigm for long-term recovery (DuPont & Humphreys 2011).

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THE PHP STORY

In the early 1970s the American Medical Association (AMA) supported the development of PHPs to deal with addicted physicians with the twin goals of: (1) protecting patients from impaired physicians; and (2) saving the careers and families of these physicians. PHPs do not deliver treatment services and they do not conduct monitoring or treat coexisting conditions such as physical and mental health problems. Instead, the PHPs select providers and actively manage these services over the course of many years to promote long-term recovery.

Many of the pioneers in the PHP movement were inspired by the then-new employee assistance program (EAP) movement, which initially focused on alcohol but later extended to include other drugs. As in the EAP programs, some of the PHP pioneers were themselves in recovery from addiction, mostly from alcohol dependence.

Under PHP care, physicians are formally evaluated and as indicated, based on this evaluation, they are placed in intensive, high quality substance abuse treatment (mostly residential for one to three months in duration). The physician participants in PHP care management are monitored with frequent random drug and alcohol testing for five years or longer. This long-term intensive monitoring is in accordance with a contract signed by the physician upon entering the program. The PHP contingency contract maintains a standard of zero tolerance for any use of alcohol or drugs with the understanding that successful participation—and successful maintenance of abstinence from all use of alcohol or other drugs—enables the PHP to validate successful participation in the PHPs comprehensive program. Consequences of leaving the PHP or relapse to substance use include risk of the physicians being removed from medical practice and/or the loss of license to practice medicine. PHPs rely on frequent participation in community support groups, including but not limited to 12-Step fellowship programs, for the duration of PHP care management. Substance abuse treatment is intensive at the start of the PHP experience. Additional episodes of treatment are used when needed over the course of care but treatment covers only a small part of the long period of PHP care management. In contrast, frequent random monitoring for any alcohol or drug use and frequent 12-Step participation occur throughout the entire period of PHP care management.

The first national study of the state PHPs tracked 904 physicians from 16 PHP programs over a period of five years or longer (McLellan et al. 2008). Not only is each state PHP different from that of every other state, but every one of the nation's PHPs is continuing to evolve. This article describes the core pattern of care management observed in the national study.

The study, tracking a single episode of PHP care management, was based on a review of PHP records. A total of 88% of physicians met diagnosis criteria for substance dependence, 10% met diagnosis criteria for alcohol or other substance abuse, and 2% of physicians had previously completed a PHP contract and volunteered to sign new contracts for extended monitoring. Of the 802 physicians with known outcomes for five years or longer, at the time of the study 64% had completed their contracts and just over 16% extended their contracts voluntarily to continue monitoring. Only 19% failed to complete their contracts, with more than half of these voluntarily ending their licenses.

Of the physicians who completed or extended their contracts, 81% had not a single positive test for either alcohol or drugs throughout their extended and intensive random monitoring. While a total of 19% had at least one positive test result for either drugs or alcohol only 26% of those with a positive drug or alcohol test had a second positive test. It is no surprise that 99.5% of tests conducted by the PHP programs for all participants were negative for alcohol or any other drug of abuse.

At last contact with the successful physicians, 79% were licensed and practicing medicine, 11% had their license revoked, 3% retired or left the practice of medicine, 4% died, and 3% were unknown. This initial study of PHPs demonstrated the outstanding, long-lasting outcomes of the model of PHP care management.

SIX LESSONS FROM FOUR DECADES OF PHP EXPERIENCE

There are six lessons concerning vital aspects of the PHP care management experience that have the power to create new paths to long-term recovery in significantly different populations and settings.

1. Zero-Tolerance for Any Use of Alcohol and Other Drugs

The most unusual aspect of the PHP experience is the standard on which every aspect of this system of care management is built—the insistence on abstinence from alcohol or other nonmedical drug use (e.g. drug use outside informed medical prescription and monitoring). This approach, like many aspects of this care management system, is not only different from the common patterns of care in substance abuse treatment but is the opposite of much substance abuse treatment. While treatment programs commonly encourage ultimate abstinence from the identified drug of abuse, many programs are lax or agnostic when it comes to the use by their patients of other drugs and alcohol. Even when treatment programs are devoted to the goal of complete abstinence from alcohol and all other nonmedical drug use, they commonly expect and tolerate prolonged use of alcohol and other drugs while in treatment in the guise of "harm reduction" therapy. In this view, continued substance use is tolerated as long as the participants continue to attend treatment. This approach is justified by the

conviction that the patients' substance use in treatment is less than it was when they were at their worst and because the treatment program stands ready for the patients to stop all alcohol and other drug use when the patients are ready to stop.

In sharp contrast to this widely held view of treatment programs, PHPs set a higher standard and expect no use of alcohol or other drugs from the outset of care management and intervene quickly and decisively following any detection of alcohol or drug use (see Lesson 5 for definition and handling of relapses). PHPs have zero tolerance for noncompliance with program rules and requirements, which include attending scheduled treatment sessions and following all recommendations related to the treatment of coexisting conditions, including mental health disorders.

2. Thorough Evaluation and Patient-Focused (Rather than Program-Focused) Care

PHPs surround their participants with a carefully developed and broadly based system that includes substance use treatment and testing for drug or alcohol use. In addition, PHPs deal with other problems that can impact recovery, including mental and physical health problems and family and financial problems. Participants' work environments and families are monitored by the PHP. This wrap-around care management is distinctly different from most treatment as PHP care management is unique in its extended duration.

This is in distinct contrast to the program-focused "black box" approach typical of many treatment programs in the United States. These programs treat all patients the same, for the same period of time, hoping that when they emerge they will be "in recovery." No other system of care in the United States for any other illness approaches treatment with blind adherence to a set program without giving attention to the specific needs of the patients.

3. Prolonged, Frequent Random Testing for Both Alcohol and Other Drugs

PHPs conduct random drug and alcohol tests for five years or more, with participants tested on average twice per month—typically four times or more a month at the start and after prolonged abstinence, typically once a month. Every workday for the entire duration of monitoring, physician participants call a phone number to learn if they have been selected randomly for a test that day. That means that they are at risk of being tested every workday regardless of the frequency of their random testing. Unlike many standard substance use treatment programs, PHPs utilize a large drug test panel which typically includes over 20 substances, with even more expanded drug panels available for use as needed (DuPont et al. 2009a). PHPs typically test not only for alcohol but also for longer lasting metabolites which include ethyl glucuronide (EtG) and ethyl sulfate (EtS) (DuPont, Goldberger & Gold 2009; DuPont, Skipper & White 2007). PHPs have become experts in the drug testing field and are far in advance of other organizations in this regard. In contrast to PHPs, many patients in the United States only receive a single drug test performed upon admission to treatment.

4. Effective Use of Leverage

PHPs, while having no power over the practitioner's license, wield effective leverage in every way possible. PHPs work to maintain credibility with licensing boards, hospitals, medical groups, malpractice insurance companies, health insurers and others thereby increasing their range of leverage. Interventions are conducted nonconfrontationally by letting the participants know that the PHP can assist them if they will submit to a thorough evaluation to determine if there is indeed a problem. If there is no substance abuse problem identified, the PHP can act to assure colleagues that a thorough evaluation was performed and no SUD or other problem that could interfere with the participants' ability to practice medicine was identified. If a problem is identified (as is usually the case), then the PHP offers to advocate for the participants as long as they follow clinical recommendations. Completion of evaluation and treatment are necessary for positive advocacy and reporting to the regulatory board.

5. Defining and Managing Relapses: Swift, Certain and Meaningful Consequences for Any Substance Use and Noncompliance

Under a PHP, relapse is defined as return to any alcohol or other drug use as well as any noncompliance with any PHP requirement including fully compliant treatment participation. For example, missing treatment sessions or failing to submit to a drug test are defined as relapses. Setting this high standard establishes a culture of expectation for total abstinence and treatment compliance. All relapses are met with immediate and serious consequences. Typically, physicians who relapse are removed from medical practice and admitted to residential treatment programs, often for 90 days. Any relapse that may put a PHP participant's medical patients at risk is reported to the Medical Board, thus putting the physician's medical license in jeopardy. Relapses indicate that what has been done thus far is inadequate so the "dose" of care is raised immediately and significantly.

6. The Goal of Lifelong Recovery Rooted in the 12-Step Fellowships

PHPs typically require regular attendance at Caduceus meetings (meetings of physicians in recovery) as well as at other 12-Step fellowship meetings such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) throughout the prolonged period of PHP participation. For the few participants who are unwilling to go to 12-Step meetings, exceptions are made for other intensive

community support activities. This element of PHP care management (in that support meeting attendance is required), like the others described here, is unlike the typical course of substance abuse treatment. These fellowships provide a healthy way of thinking about addiction and recovery and a powerful support system that promotes lifelong abstinence as well as positive lifestyles.

In summary, the nation's PHPs have developed a path to lifelong recovery that is valuable to every substance abuse prevention and treatment program because it sets a new, far higher standard for long-term outcomes. The PHP experience also dramatically changes the understanding of the "disease" of addiction by refuting the view that relapses are all but universal, inevitable and to be expected. It supports the view that expecting—and passively tolerating—relapses makes them more likely to occur and postpones recovery. The PHP experience also shows that the risk of relapse can be dramatically reduced by monitoring and actively controlling the environment in which the decision to use or not to use alcohol and other drugs is made (DuPont 1999).

LOOKING BEYOND PHYSICIANS INTO THE CRIMINAL JUSTICE SYSTEM: A NEW PARADIGM IS ESTABLISHED

PHP results are often criticized because physicians are not a typical or representative substance abuse patient population. The most striking example of the effectiveness of many of the six lessons from the PHP experience occurs in the criminal justice system with convicted felons—about as different a population of people with SUDs from physicians as is imaginable.

Hawaii's Opportunity Probation with Enforcement (HOPE) and South Dakota's 24/7 Sobriety Project are innovative programs that utilize care management techniques similar to those of the PHPs to produce excellent outcomes. Each of these programs works with offenders in the community. Initial studies have shown that they reduce recidivism, reduce alcohol and other drugs use, and reduce incarceration and its high costs compared to standard care in the criminal justice system.

HOPE Probation began in Honolulu under the leadership of Judge Steven S. Alm, who dramatically and creatively changed the standard probation protocol for participants in this new program. HOPE participants are high-risk serious felony offenders who have been identified as likely to violate their conditions of community supervision. They are not "the cream" of the probation population; they are the most high-risk probationers with the most serious charges, including but not limited to violent crimes. Upon entering the program, participants are informed by a judge of the rules of the program, which include submitting to intensive random drug and alcohol testing. Detected violations of probation, including any drug use, missed tests, and missed appointments are met with swift and certain but short-term incarceration. Hearings with a judge generally take place within 48 to 72 hours of incarcerations.

In 2012, HOPE included over 1,800 participants with the most serious drug and crime problems. An independent randomized control study of HOPE in 2009 compared offenders in HOPE to those on standard probation (Hawken & Kleiman 2009). In a one-year period, HOPE participants were 55% less likely to be arrested for a new crime, 72% less likely to use drugs, 61% less likely to miss appointments, and 53% less likely to have their probation revoked. HOPE participants were sentenced to 48% fewer days of incarceration than offenders in standard probation.

All HOPE participants are offered substance abuse treatment at the outset when it is explained to them that any drug use will lead to immediate incarceration. Few participants exercise that option. Treatment is only mandated for HOPE participants who are unable to abstain from drug and alcohol use with monitoring and immediate incarceration for violations including any drug use. In the randomized control study (Hawken & Kleiman 2009), 85% of HOPE participants successfully completed the program, which can last for up to six years without substance abuse treatment.

Another innovative and exemplary criminal justice program using techniques similar to the PHP model of care management is South Dakota's 24/7 Sobriety, which began as a response to unusually high rates of driving under the influence (DUI) offenses in that state. While the 24/7 Sobriety Program initially only included DUI offenders, it now includes offenders released into the community under supervision for whom substance use was a contributing factor to their illegal behavior (Loudenburg, Drube & Leonardson 2011). 24/7 Sobriety utilizes a range of testing devices and protocols due to the short period of time it takes for alcohol to be metabolized after consumption. Twice-daily alcohol breath tests are conducted at local sheriffs' offices for most participants. Participants who live a greater distance from testing sites wear alcohol monitoring ankle bracelets. Participants may also be required to provide random urine samples for drug testing or wear drug test patches. Any positive test for drugs or alcohol or missed meeting results in an immediate short-term stay in jail. Participants spent an average of 111 days in the 24/7 Sobriety program.

A recent evaluation of the 24/7 Sobriety program examined test results of 4,009 participants (Loudenburg, Drube & Leonardson 2011). Of over 800,000 test records for twice-daily alcohol tests, 99.4% passed; only 0.6% of tests were failed or unexcused. A total of 54.5% of all participants passed all alcohol breath tests while in the program. Of the 45.5% of participants who failed, 19.1% failed only once, 12.3% failed twice, 5.4% failed three times, and 8.8% failed four or more times.

TABLE 1
Comparison of Traditional and New Paradigms in the Criminal Justice System

Traditional Paradigm	New Paradigm
Rules are complex, covert and unpredictable	Rules are simple and responses for compliance/violations are automatic
Assumes long-term orientation of offender	Assumes short-term orientation of offender
Expects and tolerates failure, including positive alcohol and drug tests	Expects and rewards compliance and immediately sanctions noncompliance
Testing is infrequent and at scheduled appointments	Testing is random, frequent, and not related to other scheduled appointments
Mandates treatment for all substance abusers	Preserves expensive resources by providing treatment only for those who want it or who fail at monitoring alone (behavioral triage)
Meets violations after long delay, unpredictably and often with long incarceration	Meets rule violations immediately with brief incarceration every time a violation—including any alcohol or other drug use—occurs

This study showed that offenders who participated in 24/7 Sobriety's twice-daily breath tests had lower rates of DUI recidivism when compared to controls not in the program. Minimal days of participation in the program positively impacted recidivism rates for repeat offenders. Participants who were in the program for at least 30 days demonstrated a greater reduction in recidivism (Loudenburg, Drube & Leonardson 2011).

Unlike PHP care management, HOPE Probation and 24/7 Sobriety do not mandate treatment for all participants. A relatively small fraction of HOPE participants are required to participate in treatment, identified through "behavioral triage" (Hawken 2010). Participants who continue to use drugs or alcohol despite incarceration for any violations enter intensive long-term residential treatment. This strategy reserves substance abuse treatment for those substance-abusing offenders whose behavior demonstrates their need for it. Neither of these two criminal justice program requires participation in 12-Step or similar community support programs, though participation in these fellowships is routinely encouraged in both.

The strategies used in HOPE and 24/7 Sobriety have extended a new paradigm into the criminal justice system that is drastically different from traditional approaches to drug-using offenders (see Table 1). Like the PHP care management experience, one important characteristic of the new paradigm is zero tolerance for any use of alcohol or other drugs, a standard that is strictly enforced by frequent random testing. Violations of the no-use contract or other program rules and requirements are met with swift, certain, though moderate, consequences. In both of these programs, that means immediate and brief incarceration and facing a judge. Because of the intensity of testing, any return to alcohol or drug use cannot be hidden for long as can be in most substance abuse treatment settings and routine community corrections programs.

The near-immediate, completely predictable, and meaningful response to any substance use in all three programs described is dramatically different from most treatment settings and virtually all criminal justice programs. While 24/7 Sobriety monitors its participants for a relatively short period of time, monitoring in both HOPE and PHPs lasts for years—five years or more. This duration of intensive monitoring dramatically contrasts with the experiences of most substance abusers in other programs.

For all three of these programs one critically important question remains unanswered: what is the stability of recovery after the period of monitoring with immediate consequences has ended? It may be that treatment and continued participation in the 12-Step programs, as mandated by the PHPs (and not by the criminal justice programs where attendance is common but not required) are especially usefully in sustaining the powerful positive effects of intensive random monitoring after that monitoring ends. How much value is added by these substance abuse treatment and 12-Step participation in these programs remains to be established by future studies, but as a result of our experiences, both authors believe that these two elements add value, especially in the long-run.

IMPLICATIONS FOR EXTENDING THE NEW PARADIGM MODEL OF CARE MANAGEMENT

PHPs and employee assistance programs (EAPs) are based in the workplace. They use the leverage of a job to encourage identification of substance use, as well as intervention, treatment and long-term monitoring. In the criminal justice system the leverage is not a job but a brief time in jail. One key to success in the new paradigm of care management is intensive random monitoring with swift and certain, but moderate, consequences for any violation of the no-use standard.

Elements of the new paradigm model of care management have been successfully applied to commercial pilots through the Human Intervention Motivation Study

(HIMS), an alcohol and drug assistance program analogous to the PHPs that coordinates the identification, assessment, treatment and medical recertification of commercial pilots (ALPA 2009). The HIMS program charter works with pilots, their management, as well as the Federal Aviation Administration (FAA) to help substance-using pilots complete treatment, aftercare, and monitoring so they can return to work (HIMS 2011). Like the PHPs, HIMS does not provide treatment, but rather, manages the care and coordinates the industry-wide efforts to help pilots suffering SUDs. HIMS has been successfully operating since the early 1980s with a long-term recovery rate of 90% (ALPA 2009). As of July 2008, over 4,200 pilots had been successfully treated and had returned to work under monitoring.

In HIMS, intervention typically is followed by an evaluation and diagnosis by a healthcare professional; pilots who are diagnosed with SUDs are removed from flight status to enter treatment (Steenblik 2007). Though different treatment options are available, pilots commonly attend intensive inpatient treatment for 28 days, after which HIMS provides comprehensive continuing care management, which includes intensive participation in 12-Step meetings. The FAA requires pilots to attend monitoring meetings with a sponsoring aeromedical examiner (AME) and separately with a peer every 30 days for a minimum of two years. The AME evaluates the progress and makes recommendations to the FAA regarding the pilots' medical certificate. The pilot is required to remain free from alcohol and other drugs. Although the FAA always requires monitoring of the pilots for three years, it may require monitoring for the duration of a pilot's career.

HIMS is professional program that like PHPs fits the new paradigm. This paradigm can be applied widely for other professions and in other workplace settings where the job is valued by the employee and where the employer is prepared to insist on a zero tolerance standard that is enforced over a long period of time by frequent random monitoring for employees who have been diagnosed with a SUD.

The Commission on Lawyer Assistance Programs (CoLAP) of the American Bar Association (ABA 2010) lists programs in 51 state and Washington DC. These programs are similar to PHPs in addressing the complex needs of attorneys and judges (Krauss, Stek & Dressel 2009). Similar programs now exist for other healthcare professionals including: nurses, pharmacists, and veterinarians, among others.

This new paradigm of care management for SUDs can also be used by families, which have abundant leverage but need guidance in when and how to use it. The recovery coach model is an example of a contemporary care management system with the potential to use many of these principles to improve treatment compliance and long-term success. Recovery coaches can be employed by families to have professional relationships with individuals suffering from SUDs and to address co-occurring problems that interfere with recovery in order to help participants become and remain free of alcohol and other drugs (White 2006). Roles of the recovery coach include motivator, mentor, problem-solver, advocate, and community organizer among others. Recovery coaches offer peer-based support throughout different stages of addiction and recovery. They typically use the best available treatment and encourage lifelong participation in the 12-Step fellowships (White 2006).

All employers can use recovery coaches and other professional providers to support and monitor their most valued employees over long periods of time and through complex treatment and monitoring experiences. Continued compliance with the program of recovery should be a requirement of continued employment. This pattern of long-term care management including intensive random monitoring with swift, certain and meaningful consequences for noncompliance is spreading in the American workplace.

CONCLUSIONS

As the HOPE Probation and 24/7 Sobriety programs show, one of the most promising new applications of the PHP vision of care management lies within the criminal justice system. The new paradigm that has emerged promises better outcomes for the five million Americans now under supervision in the community on probation (4.2 million) and parole (800,000). The new paradigm for long-term recovery is built upon the success of the PHP model, whose lessons can be widely used.

One important frontier for this new paradigm of care management for SUDs is in public and private sector substance abuse treatment programs. The need is to reach more of the 1.5 million Americans who annually enter substance abuse treatment, which now is all too often a revolving door because relapses are exceedingly common—often shortly after leaving even the best treatment. To make this vision a reality will require the determination to do it using meaningful leverage—swift, certain and meaningful consequences—for any violation of the no use standard. This standard must be reinforced by frequent random drug and alcohol testing.

This model of care management for substance use disorders has been pioneered by a small and innovative group of the nation's physicians in their determination to help other physicians save their careers and families while also protecting their patients from the harmful consequences of continued substance abuse. In fulfilling the professional admonition "physician: first heal thyself," these physicians have created a model with wide applicability and great promise.

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