Addictive Disorders: Management Principles & the MPHP Approach

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Disclosures

I have no disclosure of conflicts of interest
Objectives

- Discuss epidemiology of addiction
- Describe the brain disease model of addiction.
- Describe Physician Health Program (PHP) management of addictive disorders as potential template for management of patients with addictive disorders in the general population

Addiction Facts

- Lifetime prevalence: 10-12%
- 31 million Americans and <12% receive treatment.  
  (SAMHSA, 2013 NSDUH)
- 40-60% of people relapse after drug and alcohol treatment.  (NIDA)

- 80% relapse rate with opioid dependence.  
  (NIDA)
Addiction Facts, contd.

- Causes 20% of all deaths per year
- Costs in excess of $600 Billion per year
- 1/3 of all hospital in-patient costs are addiction related (SAMHSA, 2013 NSDUH; Ries, et al., 2014)
- 25% of primary care patient visits (Jones et al., Am. Fam. Physician, 2003)

WHEN SHOULD YOU START TREATMENT???
WHEN SHOULD YOU START TREATMENT???

Melanoma

WHEN SHOULD YOU START TREATMENT???
WHEN SHOULD YOU START TREATMENT???
WHEN SHOULD YOU START TREATMENT???

Diabetic Foot
WHEN SHOULD YOU START TREATMENT???

HOMELESS
No Family or Support
Health Problems
Could use Some Compassion
Really Need The Help.

Rats
Self-administer Heroin
Rats Self-administer Cocaine

Sagittal Plane View of Brain:

Human

Rat

Virtually Identical Reward Circuit
“Lizard Brain”

Brain Reward Pathway

prefrontal cortex

nucleus accumbens

VTA
EXCELLENT ARTICLE: BRAIN DISEASE MODEL

STAGES OF ADDICTION

- Binge & Intoxication
- Preoccupation & Anticipation
- Withdrawal & Negative Affect

Refers to potential that the brain has to reorganize by creating new neural pathways to adapt.

Behaviors during the three stages of addiction change as person transitions from experimentation to addiction.

(Volkow et al, 2016)
NEUROPLASTICITY

- Progressive behavior change during process of becoming addicted represents compromised neurocircuitry
  - i.e., disruption of the dopamine and glutamate systems and the stress-control systems of the brain
  - affected by corticotropin-releasing factor and dynorphin.

(Volkow et al, 2016)

REGIONAL NEUROPLASTICITY

- Neuroplastic changes triggered by drugs have been uncovered in various regions of the brain:
  - Nucleus accumbens (brain-reward)
  - Dorsal striatum (encoding of habits and routines)
  - Amygdala (emotions, stress, and desires)
  - Hippocampus (memory)
  - Prefrontal cortex (self-regulation and salience attribution[the assignment of relative value]).

(Volkow et al, 2016)
“The alcoholic at certain times has no effective mental defense against the first drink.”

*Alcoholics Anonymous, 4th Ed*

47,055 Deaths (All O.D. Deaths)

CDC, Web-based Injury Statistics Query and Reporting System (2014)
Adverse Selection

- Patients with mental health and substance abuse co-morbidities are more likely to receive chronic opioid therapy than patients who lack these risk factors.
  
  (Edlund MJ, et al., 2010)
CDC Guideline for Prescribing Opioids for Chronic Pain

- No evidence shows a long-term benefit of opioids in pain and function versus no opioids for chronic pain with outcomes examined at least 1 year later (with most placebocontrolled randomized trials ≤6 weeks in duration)

- http://www.cdc.gov/drugoverdose/prescribing/resources.html

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CDC Guideline for Prescribing Opioids for Chronic Pain

- Extensive evidence shows the possible harms of opioids (including opioid use disorder, overdose, and motor vehicle injury)

- http://www.cdc.gov/drugoverdose/prescribing/resources.html
CDC Guideline for Prescribing Opioids for Chronic Pain

- Extensive evidence suggests some benefits of nonpharmacologic and nonopioid pharmacologic treatments compared with long-term opioid therapy, with less harm
- [http://www.cdc.gov/drugoverdose/prescribing/resources.html](http://www.cdc.gov/drugoverdose/prescribing/resources.html)

12 Recommendations:
Three Areas

- Determining when to initiate or continue opioids for chronic pain.
- Opioid selection, dosage, duration, follow-up, and discontinuation.
- Assessing risk and addressing harms of opioid use.
- [http://www.cdc.gov/drugoverdose/prescribing/resources.html](http://www.cdc.gov/drugoverdose/prescribing/resources.html)
What is a “Distressed Physician”???
Challenges of Practicing Medicine

- Reimbursement hassles
- Electronic medical records
- Prior authorization
- Maintenance of certification
- Scope of practice
- The prescription drug crisis!!!

Culture of Medicine

- “Suck it up and get it done!”
- Resilience is not taught, it is expected
- Asking for help is stigmatized and not praised
- Psychiatric issues are not considered “real” illnesses
Characteristics of Medical Work

- Long hours
- Intense involvement
- Emotionally charged interactions
- Requirement for complex decision making
- Ambiguous and frustrating solutions/outcomes
- Requirement for constant “giving” (e.g., time, knowledge, empathy)
- Breeding ground for distress

Distressed Physician: Outcomes

- Healthy coping skills: resolution of problem
- Unhealthy coping skills: potential harm to patients
  1. Substance abuse/addiction
  2. Anxiety, depression, burnout
  3. Suicide
  4. Professional boundary violations/misconduct
  5. Disruptive behavior
  6. Impairment
Burnout: Syndrome Triad

1. Emotional Exhaustion (feelings of emotional overextension and fatigue)
2. Depersonalization (negative, cynical attitudes and feelings about patients; dehumanized perception of others)
3. Reduced Sense of Personal Accomplishment

Emotional Exhaustion

- I feel emotionally drained from my work.
- I feel fatigued when I get up in the morning.
- Working with people all day is really a strain for me.

Higher rating associated with burnout
**Depersonalization**

- I feel I treat some patients as if they were impersonal objects
- I've become more callous towards people since I took this job
- I don't really care what happens to some patients

*Higher* rating associated with burnout

**Personal Accomplishment**

- I deal very effectively with the problems of my patients
- I feel I'm positively influencing other people's lives through my work
- I feel exhilarated after working closely with my patients

*Lower* rating associated with burnout
Burnout Triad:
Reported by Physicians

- 46-80% report moderate levels of emotional exhaustion
- Up to 93% report moderate to high levels of depersonalization
- Up to 79% report low to moderate levels of personal achievement
  (S. Chopra et al, JAMA, 2004)

Effects of Burnout

- Highly statistically significant association between burnout and alcohol abuse or dependence.
- Highly statistically significant association between burnout and suicidal ideation.
- We know that burnout and depression often go hand in hand.
- We know that alcohol abuse has a strong association with medical errors.
  (Shanafelt, et al., 2014)
Physician Addiction

- ≈ 12% (8%-13%) lifetime prevalence
- Physician illicit drug use < general population
- Physician alcohol abuse > general population (14-15%)
- Physician benzodiazepines & opiates use > general population
  (Ries, et al., 2014; Oreskovich et al., 2012)

What is MPHP?

- 501 (c) 3 non-profit, charitable organization incorporated in 1978
- Subsidiary of the Mississippi State Medical Association
- Empowered by a Memorandum of Understanding with the Mississippi State Board of Medical Licensure
What is the Purpose of MPHP?

To provide a confidential, non-punitive alternative to disciplinary sanctions for licensees who may be suffering from potentially impairing conditions or illnesses.

Purpose, cont’d

- Early detection, intervention, and long term, intensive management of physicians with potentially impairing conditions
- Primary focus on potential impairment from substance use disorders
- End result: facilitation of a return to healthy, safe and productive medical practices
History of PHPs

- MPHP originally created by Ellis and Nina Moffitt and MSMA in 1978 and incorporated as a 501(c)3 charitable organization
- By 1980 all but 3 Medical Societies had authorized or implemented impaired physician programs
- FSPHP created in 1990

MPHP Monitoring

- MPHC evaluation
- Blood/urine drug screens
- Work place monitoring
- Recovery support group attendance
- MPHP Case Manager: check-ins/ visits
- Medication monitor
- QR to MSBML
- Level II and III relapse reported within 24 hours
### Contingency Management: The “Stick”

- **MSBML**
  - Executive Director
  - Full Medical Board:
    - Hearing/action/order/public record
- Practicing medicine is much more difficult with Medical Board orders/restrictions
  - Loss of Specialty Board certification
  - Malpractice coverage

### Contingency Management: The “Carrot”

- **MPHP Confidentiality/anonymity:**
  - PHPs referrals: exponentially increase when confidentiality is respected by Medical Boards
  - Decreases stigma of treatable conditions (addiction)
    - Promotes early intervention (days-to-weeks)
    - Promotes physician health
  - Contingent on full cooperation/compliance
  - Avoids costly legal battles
  - Protects the public
Without Confidentiality...

- Licensees more likely to “fight” the process
- Intervention is delayed: months-to-years instead of days-to-weeks
- Addiction is stigmatized: treatment is discouraged
- Addiction is enabled
- Increased risk of public harm

Limits to Confidentiality

- Defined in the *Memorandum of Understanding* (MOU) with the MSBML
- Anonymous cases are reported to the MSBML as a number, and not by name
- All relapses are reported to the MSBML
- The MSBML is the final authority and is not bound by any recommendations by the MPHP
### California Diversion Program

- Discontinuation in 2008 by the California Medical Board
- Firestorm of negative publicity led by charges of hiding “physicians on drugs” by a Citizen Advocacy Group

### Unequivocal Success of PHPs

- 5-year abstinence rates: 78%-84%
- Return to work rates: 96%
- Virtually no risk of harm to patients treated by participating physicians
- 45 States and District of Columbia have PHPs

(Domino et al. 2005; McLellan et al. 2008)
Patient Safety?

- Project Blueprint: One (1) Report of Patient Harm (Overprescribing)
  (McLellan, AT et al. 2008)
- Consistent with another study of 259 physicians monitored over 11 years that failed to document even one case of patient harm.
  (Domino, 2005)

Addictive Disorders: Management Principles

- Longitudinal contingency management is best
- Residential, abstinence based treatment is best
- Encourage 12 step fellowship participation
- Expect denial, minimization and cognitive distortion
- Maximize leverage, encourage family involvement
Addictive Disorders:
Management Principles

- Minimum quantities + short duration
- Avoid controlled substances for chronic, non-terminal conditions
- Do not prescribe controlled substances to patients with addictive disorders, unless unavoidable

Thank You!
REFERENCES


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Substance Abuse and Mental Health Services(SAMHSA), 2013 National Survey on Drug Use and Health(NSDUH).


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