



Healthcare Professionals in Treatment

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Prevalence

- › Most reports estimate that 10-15% of HCPs have substance abuse problems in the US, which is similar to the general population, with alcohol being the most commonly abused and prescription drugs, particularly opioids, being the second (tends to be higher than the general population).
- › According to a report published in 2007, over 100,000 health professionals nationwide have a substance abuse disorder.
- › **According to Monroe and Kenaga (2011), between 14% and 20% of nurses in the United States may have a problem with dependence or abuse of drugs and/or alcohol, which likely addresses the suspected prevalence of unreported substance dependence cases.**



Impaired Professionals: Definition

- › The inability of a HCP to perform the essential functions of his/her practice with reasonable skill or safety because of chemical dependency on drugs or alcohol or mental illness.
- › **Negligence**- occurs when a patient's life is harmed due to failure on the HCP's part to exercise reasonable and prudent behavior.



Clinical Manifestations

› Physical:


- Flu-like symptoms
- Appearance of over-sedation
- Bloodshot or watery eyes
- Runny nose
- Changes in sleep or eating patterns
- Complaints of frequent back problems, migraines
- Sleeping on the job
- Lack of coordination; hand tremors; stumbling
- Deterioration in appearance, hygiene



Clinical Manifestations

› Job-related:

- Decreased productivity
- Negligence in patient care i.e. inattention, rudeness
- Tardiness, absenteeism, excessive use of sick time, last minute call-off requests
- Unexplained disappearances i.e. frequent or long breaks
- Memory lapses, forgetfulness
- Medication and charting errors
- Asking physicians for prescriptions
- Patient and colleague complaints
- Inappropriate or emotional responses
- Increased conflicts with staff, patients, peers



Clinical Manifestations


› Diversion:

- Missing/broken vials
- Failure to document wastage
- Paying extra attention to patients receiving opioids
- Volunteering to count narcotics or to give narcotics to patients
- Signs out more narcotics than co-workers
- Asking peers to prescribe for them
- Obtaining prescriptions for family members
- Forging prescriptions
- Substituting water or saline for patient's medication




Clinical Manifestations

- › Emotional:
 - Changes in mood/affect
 - Pessimism, hopelessness
 - Irritability, mood swings
 - Over-emotional; appearing overwhelmed
 - Panic attacks
 - Overly suspicious, paranoid
- › Social:
 - Decreased social life and interactions outside of work
 - Financial, marital and family problems




Comorbidities

- › More than 2/3 of HCPs with a SUD reported a comorbid psychiatric disorder with major depression accounting for approximately 40% of these cases and 58% reporting the use of psychiatric medications (Rojas, Brand, Fareed & Koos (2012).




Challenges in Treating HCPs

- › May struggle with a greater sense of guilt and shame due to their role as caregivers.
- › Are constantly listening and giving to others.
- › May experience a sense of incompetence or failure when confronted by problems in their lives.




Challenges in Treating HCPs

- › Can become so defined by their professional roles that they lose a sense of who they are outside of this role.
- › Are reluctant to seek help as there is an assumption that they can handle things by themselves, including their substance use.
- › Struggle in taking on the role of the patient.




Increased Vulnerability for HCPs

- › Occupational stress including increased workloads, decreased staffing, double shifts, mandatory overtime, rotating shifts, and floating to unfamiliar shifts
- › Difficulties with coping with stress leading to physical and emotional/mental health problems
- › Greater access to prescription drugs
- › Using to self-medicate
- › Elaborate justification and minimization



Predisposing Characteristics


- › Family histories that include:
 - › Substance Abuse
 - › Mental health issues
 - › Physical or sexual abuse
 - › Physical or emotional neglect
 - › Misattunement on the part of caregivers
 - › Being placed in the role of the caretaker at an early age



Predisposing Characteristics

› As a result of dysfunctional family histories the HCP could experience:

- Tendency to deny personal problems
- Low self-esteem
- Strong drive for achievement (perfectionism)
- Sense of over-responsibility
- Tendency to be self-reliant and self-sufficient
- Tendency to place others' needs above their own
- Struggle in communicating needs and coping with stress
- DISSOCIATION




Stigmatization of Addicted HCPs

› In spite of the fact that addiction has been recognized as a disease among the general population, there is still a stigma associated with the addicted or impaired HCP.

› This increases the level of shame on the part of the HCP which can negatively impact the recognition that there is a problem.


› HCPs are perceived to be highly educated, responsible people who have earned a position of trust with patients and patients' family members.



Stigmatization of Addicted HCPs


› Unfortunately, some healthcare systems deny that substance abuse is a significant problem in their organization.

› Rather than deal with the problem, some organizations dismiss or terminate employees with substance abuse issues without reporting them or providing treatment.




**Why Do HCPs Keep Secrets?:
Perpetuating the Code of Silence**

- A distorted sense of loyalty
- Fear of being a hypocrite, particularly if they had drank after work with co-workers
- Guilt or fear of jeopardizing a co-worker's license to practice or to have legal charges brought against them
- Don't want to put their relationships with co-workers at risk
- The need to protect others, particularly co-workers




**Why Do HCPs Keep Secrets?:
Perpetuating the Code of Silence**

- > Justify certain behaviors by telling themselves that patients had not been harmed.
- > May tend to bend rules or view certain behaviors as normal i.e. "Everyone does that."
- > May not report co-workers for fear of being perceived as whistleblowers.
- > May be concerned about retribution for reporting, such as having their own work scrutinized or criticized.




**Why Do HCPs Keep Secrets?:
Perpetuating the Code of Silence**

- > Confronting a co-worker who becomes angry, denies the problem, or pleads for another chance can be extremely difficult.
- > Most HCPs are not educated about how to recognize or intervene with a co-worker who is abusing substances; this can lead to a sense of second guessing on the part of the concerned HCP.




De-stigmatization of Addicted HCPs

- › If addicted HCPs are not helped, they are in danger of harming patients, the hospital or clinic, the profession, and themselves.
- › It is essential that institutions create a culture that allows for reporting and tracking substance abuse incidents.
- › According to professional organizations, the HCP is responsible for responding when a co-worker or colleague is exhibiting suspicious behaviors.
- › Finally, it is important to provide education on addiction and to provide support for those in need of help.




Referral Process

- › The **Pennsylvania Justice Network (JNET)**, a bureau within the Pennsylvania Office of Administration's Office for Information Technology, provides a secure online environment for authorized users to access public safety and criminal justice information from various contributing municipal, county, state and federal agencies.
- › Information received via JNET is forwarded to the appropriate state licensing board. Following information that is received, a letter will be sent to the licensee from the **Professional Health Monitoring Program (PHMP)** advising them to contact an provided substance use evaluator.




Referral Process

- › Depending upon the type of license, the HCP will also be referred to a monitoring and advocacy program i.e. **PNAP** (nurses), **PHP** (physicians, physician assistants, medical students and residents, hygienists, or dental assistants) or **SARPH** (pharmacists) for support and advocacy.
- › The HCP will then contact the approved evaluator in order to arrange for a substance use evaluation.
- › Contact will be made on the part of the evaluator with PHMP and the monitoring program to confirm the scheduling of the evaluation.



Assessment


› In addition to being adept at assessing SUDS and other comorbid conditions i.e. psychiatric issues, there needs to be awareness on the part of the assessor in regards to medical practices, licensure issues and work environments.



Assessment

› The assessment should consist of:

- Acute intoxication/withdrawal i.e. need for detoxification
- Co-occurring medical problems
- Co-occurring mental disorders and complications
- Suicidality
- Readiness to change
- Relapse potential
- Recovery environment



Assessment


› Comprehensive drug testing

› Collateral contacts

› Pharmacy reports (PDMP)


› Workplace Issues:

- Risk to patients
- Ability to manage occupational triggers
- Work environment factors e.g. access to drugs
- Adequacy of work supervision
- Adequacy of support network




Assessment

- › Prior to the actual evaluation, a determination will be made if the HCP would be best served having this done on an inpatient or an outpatient basis.
- › Based on the outcome of the evaluation, a determination will be made as to the most appropriate level of care i.e. detox, inpatient/residential, IOP, or Outpatient.




Ineffective Responses Towards the HCP

- › Being insincere or lacking genuineness
- › Being preoccupied i.e. not being present
- › Accusing or blaming
- › Making judgments or generalizations
- › Getting into power struggles or debates
- › Being inconsistent i.e. *double standards*
- › Offering vague and general concerns
- › Making promises that cannot be fulfilled
- › Providing immediate responses to dilemmas of the HCP
- › Over-stepping boundaries




Treatment

- › From the onset of treatment, it is important to set clear boundaries because HCPs have a natural instinct to push limits or to engage in *triangulation*.
- › Following stabilization in a more intensive level of care, participation in a weekly HCP group for at least 6 months.
- › Involvement with other HCPs can reduce shame and promote self-disclosure.




Treatment

- › HCPs may feel more confident of confidentiality in a group of peers.
- › HCPs may be less likely to adopt a professional role in the treatment setting.
- › Other HCPs can provide encouragement, hope and model certain behaviors and attitudes.
- › Can address similar work-related scenarios that could increase increased vulnerability for relapse i.e. work-related stress, high rates of burnout and being in the caregiver role.




The Therapeutic Relationship

- › In order to develop a strong therapeutic relationship it is important for the HCP to develop a sense of trust and safety with the counselor.
- › This starts with the counselor's acknowledgement and validation of the difficulties that lead the HCP into treatment, as well as other difficulties that were experienced throughout their life.
- › The counselor may need to abandon traditional approaches towards treatment and recovery in order to have a successful therapeutic outcome.




The Therapeutic Relationship

- › Engage the HCP into the treatment planning process setting reasonable and realistic goals that are within the context of their monitoring contract
- › Identify the HCP's responsibilities for following through with expectations of the treatment process




The Therapeutic Relationship

- > Reframe Personality Disorder diagnoses as these can be pejorative and not reflect underlying developmental traumas or attachment wounds.
- > It is essential for the counselor to explore issues of counter-transference within supervision or group consultation.
- > The therapeutic relationship can be reparative given the HCP's previous difficulties in relationships with others.




Effective Therapeutic Approaches in Dealing with HCPs

- > Utilization of Motivational Interviewing (Miller & Rollnick) which is based on Stages of Change Model (Prochaska, DiClemente & Norcross)
- > Utilization of Solution-Oriented treatment approach that focuses on positive characteristics, abilities and strengths of the HCP
- > Utilization of CBT/DBT in response to maladaptive behavioral responses




Effective Therapeutic Approaches in Dealing with HCPs

- > Utilization of stress management techniques i.e. self-hypnosis i.e. grounding, guided visualization/imagery, etc.
- > Utilization of Family Systems Model which involves not only family education but involvement of the family in the treatment process
- > Utilization of Attachment/Ego-State therapies when providing longer-term psychotherapy



Factors Contributing to Relapse (Baldessari, 2007)


- › Failure to understand and accept the illness
- › Continued denial
- › Presence of co-morbid mental health disorder
- › Poor mechanisms to cope with stress
- › Poor relationship skills
- › Inability to accept feedback
- › Setting unrealistic goals
- › Social and professional isolation
- › Complacency
- › Overconfidence
- › Self-pity, shame, blame, guilt
- › Dysfunctional family dynamics
- › Not attending support group meetings



Return to Work

Determination of readiness to return to work is based on:


- Acceptance and understanding of addiction as a chronic disease
- Understanding of relapse triggers and plans to sufficiently address these
- Documentation of sustained abstinence
- Intact support system
- Acceptance as to the need for ongoing monitoring as part of PHP contract



Return to Work


› There are various stressors associated with the HCP's return to work which include:

- Dealing with co-workers- *"Do I tell...and if so, how much?"*
- Access to drugs
- Need for workplace monitoring
- Dealing with the board, legal issues




Return to Work

- › For certain HCPs, particularly nurses, the ability to work could be more stressful:
 - The difficulty in finding gainful employment due to the inability to dispense controlled substances for 6 months
 - Due to the inability to find gainful employment as the result of termination there are struggles related to:
 - Lack of financial income
 - Lack of insurance
 - Increased stigma




Components of a Return to Work Contract

- › Abstinence from all mood-altering substances, including OTC medications that could cause stimulation/sedation
- › Random drug screening
- › Participation in weekly HCP group
- › 12 step involvement
- › Caduceus or other professional support group




Resources

- › Baldisseri, M.R. (2007). Impaired healthcare professional. *Critical Care Medicine*, Vol. 35, No. 2.
- › Dunn, D. (2005). Substance abuse among nurses- Defining the issue. *AORN Journal*, Vol. 82 (4) 573-596.
- › Kenna G.A. and Lewis D.C. (2008). Risk factors for alcohol and other drug use by healthcare professionals. *Substance Abuse Treatment Prevention Policy*; 3:3.



Resources

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- › Monroe, T. and Kenaga, H. (2011). Don't ask don't tell: Substance abuse and addiction among nurses. *Journal of Clinical Nursing* (20) 504-509.



Resources

- › Roja, J. I., Brand, M., Fareed, S., & Koos, E. (2012). Psychiatric comorbidity in health care professionals with substance use disorders. *Addictive Disorders & Their Treatment*.
- › Ziegler, P.P. Treating addicted healthcare professionals (PowerPoint presentation) Providers Clinical Support System @ www.pcss-o.org.
