

Addiction and Treatment *in a Professional Population*

By Dr. Jay A. Weiss

Drug and alcohol problems are common within our society, but we are not the first society to have them. The great physicians Hippocrates and Galen in Greek and Roman societies wrote of the symptoms and damage caused by substances. Indian and Chinese physicians were describing similar problems long before Greece and Rome emerged as civilizations. Our own history records a significant morphine problem after the American Civil War in the mid-1860s. By the early 1900s, we had even more significant problems with over-the-counter heroin and cocaine. We were sufficiently concerned as a society to pass the Harrison Act in 1916. This act placed a physician with prescribing authority in between the consumer and the provider of addictive and dangerous substances. We also were sufficiently concerned with a nationwide alcohol problem to pass the 18th Amendment to our Constitution (prohibition) in 1918. We then repealed it in 1933 after we discovered a number of unintended consequences and decided to live with the damage caused by alcohol as opposed to damage caused by the consequences.

Addiction problems are widespread. They know no social boundaries, and they include a high cost to society and high mortality rates. There is no quick recovery from an addiction problem. Such problems follow a chronic disease model requiring lifelong management and monitoring.

This article addresses the high rate of addiction among professionals and outlines

successful treatment for licensed professionals. Source documents include the American Society of Addiction Medicine (ASAM) Principles of Addiction Medicine Textbook and the American Society of Addiction Medicine overview article published in April 2011.

All addictive substances affect and stimulate a very primitive part of the brain called the limbic system. This area lies just above the spinal cord and controls survival mechanisms such as thirst, hunger and fear. Adjacent areas control the fight-or-flight mechanism and reward mechanisms. This area of the brain is present in all animals and necessary for survival. Addictive substances convince this area of the brain that it must have more of the drug in question as a matter of survival. Addictive substances also simultaneously shut down the higher areas of the brain that control judgment, executive function, and a sense of right and wrong. The main neurotransmitter involved in all addictive substances is dopamine, and this is also the main neurotransmitter involved in schizophrenia. All addictive substances increase the secretion of dopamine in the brain, and an excess of dopamine is well known as an important factor in schizophrenia. All antipsychotics decrease the level of dopamine available to the brain. It should, therefore, come as no surprise that addictive behavior can look a lot like schizophrenia with attendant poor judgment, paranoia and impaired reality testing. It also should come as no surprise that addictive substances can cause some very intelligent people to do

some very stupid and dangerous things.

We as professionals are not immune from medical illnesses, including addictions. We have a higher than average rate of addiction due to the higher levels of stress to which we are subjected. Our addiction rates must be seen within the context of significant long-term drug problems within our society including an accelerating rate of prescription drug addiction. Fortunately, we also have a high rate of success in treatment of addictions and availability of professional health programs like the Louisiana Lawyers Assistance Program, Inc. (LAP). A professional health program has dual roles of enhancing public safety and assisting with rehabilitation and practice reentry of licensed professionals with potentially impairing medical conditions including addiction. LAP in Louisiana provides a confidential opportunity for its professionals to access comprehensive and well-supervised evaluation, treatment, aftercare and monitoring. LAP provides an alternative to severe licensing and disciplinary action with emphasis on rehabilitation and accountability carefully facilitated and documented over time.

Professional populations including attorneys, judges, physicians, nurses, pharmacists, dentists, accountants, engineers and others all share a number of important characteristics. These include lengthy professional training, a body of knowledge unique to the profession, service to the public, a fiduciary responsibility to the public, and licensing boards which moni-

tor professional performance throughout the professional's career. Professionals are held to a higher standard of education and behavior than the average citizen and live under much greater scrutiny than the average citizen. Professionals must master a large database of information which must then be applied in a high-pressure environment requiring superior powers of observation, judgment, and executive function in a dynamic setting where the price for a mistake is very high.

A universal policy among professional licensing organizations is prohibition of alcohol or controlled medications from legal or illegal sources while practicing the profession due to the potential for significant impairment and subsequent erosion of performance. Side effects are variable and unpredictable, but the danger to the public greatly outweighs any possible benefit to the individual professional from consumption of impairing substances while practicing the profession. Important side effects often seen with controlled substances or alcohol include dizziness, drowsiness, insomnia, vomiting, anxiety, blurred vision, confusion, decreased attention, mood swings, impaired executive function, impaired judgment, slurred speech and delirium. Any of these are incompatible with a safe practice of a profession.

Professional licensing organizations in the 1950s would typically suspend or permanently revoke the professional license of a professional identified with a drug or alcohol problem. These problems were considered moral, ethical and legal problems at the time. This punitive policy had the unintended consequence of sweeping a huge problem under the rug and out of sight. Professionals were understandably reluctant to self-report, and fellow professionals were reluctant to report a colleague despite clear knowledge of a problem. Professional health programs were developed over the subsequent 20 years to provide an alternative pathway involving identification, evaluation, treatment and aftercare, with monitoring and random drug screens. The American Medical Association approved this policy for physicians in 1974; almost every state now has a Physicians' Health Program in place, very similar to the Louisiana LAP in organization and mission. Licensing organizations such as Supreme Courts, Medical Boards, Nursing Boards and Pharmacy Boards now offer evaluation,

treatment and monitoring as an alternative to licensing action and expulsion from the profession.

A key to this change is the identification of addiction as a chronic disease rather than moral or ethical problem. The chronic disease model of addiction holds that addiction must be managed over a lifetime, not cured in a short period of time. Like asthma, hypertension or diabetes, addiction tends to recur without proper treatment and long-term management. Proper treatment for this long-term problem involves identification, intervention, detoxification, treatment, and a strong post-treatment monitoring program to include accountability and supervision. LAP endorses all of these well-established and research-validated criteria for an effective treatment program. An attorney who volunteers for LAP and complies with LAP instruction has a very good chance of obtaining successful treatment for his/her addiction, and that in turn may help facilitate a return to the safe practice of law with the full blessing of the Supreme Court, provided that the attorney has not caused substantial harm to the public or the profession.

Two generations of experience with similar professional health programs support a high probability of success in a professional population. LAP, in particular, works closely with the affected attorney to identify and evaluate the problem, intervene early, detoxify if necessary, treat with appropriate inpatient or outpatient programs, and engage in aftercare including close monitoring and accountability to ensure sobriety and prevent relapse. A similar program for physicians in Washington State, with 90 days of inpatient treatment at a good facility followed by professional health program monitoring, resulted in 80-95 percent sobriety at one year, 85 percent continuous sobriety with five years of monitoring, and 85 percent continuous sobriety with 10 years of monitoring. By contrast, a 30-day inpatient treatment with no follow-up yielded an 80 percent relapse rate at one year in this population.

The effectiveness of a 90-day inpatient program should sound familiar to all with professional or military training because we learn best in 90-day increments. It takes about 90 days to internalize a new body of knowledge and a new set of behaviors. Military basic training across cultures and

across time takes about 90 days to turn a young civilian into a soldier. A standard semester in high school, college or professional training takes a minimum of about three months. One does not master constitutional law or gross anatomy by reading a textbook in one evening and taking a test the next day. Virtually all studies of rehabilitation have shown that the patient who stays in treatment longer and attends the most treatment sessions obtains the best post-treatment outcomes. Length of stay is a robust positive predictor of treatment outcome, as are intensity of treatment, supervision, length of monitoring and accountability after treatment.

The Federal Aviation Administration (FAA), another licensing organization with stringent policies regarding drug and alcohol impairment in professional pilots, has a program remarkably similar to LAP designed to treat impaired pilots and return them to flying. The FAA program also involves identification, evaluation, treatment and after-treatment monitoring. The program involves testing, monitoring, accountability and consequences if a pilot identified with a prior substance problem returns to the use of substances. The program also involves return to flying duties with the blessing of the FAA if the pilot complies with a monitoring program, obtains treatment and remains sober.

In conclusion, the overwhelming body of evidence we have today indicates that a professional population benefits from programs like LAP to identify and treat addicted professionals and return them to practice as quickly and safely as possible.

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