

Zero Tolerance Is Effective for Physician Addicts

Monitoring, testing, and consequences for relapse could be extended to abusers in other settings.

BY SHERRY BOSCHERT

FROM THE ANNUAL MEETING OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

SAN FRANCISCO — Zero tolerance for substance abuse and random testing have been the keys to successful rehabilitation of addicted doctors in physicians' health programs—and might help non-physician populations of addicts.

Some of the program elements that have worked well for addicted physicians are beginning to be applied with surprisingly good results in other settings, especially the criminal justice system, Dr. Robert L. DuPont said. "If it's good enough for physicians, why not for everyone else?" he asked.

Intensive monitoring with frequent, random drug and alcohol testing backed by swift and certain consequences for a single relapse appear to keep a large majority of addicts substance free during monitoring periods of up to 5-7 years in recent studies.

That kind of zero-tolerance intensive monitoring differs markedly from competing theories of "harm reduction" and "compassion" for addicts that often amount to "enabling" the addiction, DuPont said.

"If the environment is tolerant of the drug use, then the drug use is more prevalent and it persists. If the environment is intolerant, the use stops, whether it's in physicians or convicted felons," said Dr. DuPont, who was the first director of the National Institute on Drug Abuse 37 years ago and now is head of

the Institute for Behavior and Health, a drug policy nonprofit in Rockville, Md. "If you expect and tolerate relapse, you'll see more of it."

He and his associates studied 904 consecutive admissions to 16 state physicians' health programs and found that 72% of the physicians were still licensed and practicing with no sign of substance abuse in 5-7 years of monitoring. Twelve percent had their license suspended or dropped, 6% were licensed but not practicing, 4% had retired or left practice, 4% had died, and the outcomes of the rest were unknown (J. Subst. Abuse Treat. 2009;36:159-71).

"It's striking how many of them go through successfully," he said.

The physicians' health programs start with a careful initial evaluation followed by referral to intensive, high-quality treatment, which usually lasts for 1-3 months and is mostly in residential facilities. After treatment, the physicians undergo frequent, random drug and alcohol testing for 5 years or longer. Each work day, the physician must call a phone number to find out whether he or she will be tested that day.

The programs are closely tied to community support, mainly the 12-step groups of Alcoholics Anonymous and Narcotics Anonymous.

Participants who leave the program or have a single positive test for drugs or alcohol are removed from practice and sent to more intensive treatment. In addition, they risk losing their medical license after a repeat relapse.

"It's interesting that it's not a treatment program. They don't provide the treatment. It's a care management program," and the treatment is only a few months out of years of monitoring, Dr. DuPont said.

A separate program applied similar intensive monitoring and zero-tolerance elements but without treatment and in nonphysicians. South Dakota's "24/7 Sobriety Project" required people convicted of driving while intoxicated or driving under the influence of alcohol



'If the environment is tolerant of drug use, then the drug use is more prevalent and persists.'

DR. DUPONT

to undergo 4 months of frequent testing. Any positive result or a missed test resulted in an immediate short-term stay in jail, usually for a few days. Testing initially required participants to come to a sheriff's office at 7 a.m. and 7 p.m. for alcohol breath tests, but the program later offered the alternatives of wearing an alcohol-monitoring ankle bracelet, frequent urinalysis, or wearing drug patches that collect sweat samples for drug testing.

From 2005 to 2009, 67% of 11,956 participants who underwent twice-daily breath tests never failed a test, and 17% failed only once, according to an unpublished analysis by Dr. DuPont and his associates. Among 1,383 participants who wore ankle bracelets, 75% had no

violations. The program did 415 tests of patches from 45 participants, and 94% of tests were passes. The 1,261 participants who took 17,730 urine tests passed 98% of the time.

Dr. DuPont said the "quite remarkable" results probably were tied to intensive monitoring plus swift and certain consequences that were serious but not severe. He acknowledged, however, that monitoring was short term and that the program did not cover drugs of abuse.

Another model is being tried in Hawaii's Opportunity Probation with Enforcement (HOPE) program, which enrolls people on probation for the most serious drug problems or crimes (such as murder or rape) regardless of substance abuse.

In that program, participants undergo random drug testing for up to 6 years and are offered a treatment option. Noncompliance will result in immediate, short-term jail stays, usually within 72 hours of the offense, and possible mandatory inpatient or residential treatment.

The techniques used in these three program models in South Dakota, Hawaii, and physicians' health programs might be applicable to other settings where there is leverage to impose swift, meaningful consequences, such as the workplace, employee assistance programs, insurance or health care organizations, or families, Dr. DuPont suggested.

More research is needed, especially on the durability of outcomes after monitoring stops, he said.

Dr. DuPont said he has no pertinent conflicts of interest. ■

Office-Based Opioid Treatment Keeps Ex-Inmates Out of Jail

BY DIANA MAHONEY

FROM THE ANNUAL MEETING OF THE SOCIETY OF GENERAL INTERNAL MEDICINE

MINNEAPOLIS — Opioid-dependent patients with a history of incarceration do well with office-based buprenorphine/naloxone therapy and have fewer interactions over time with the legal and criminal justice systems, according to a data analysis of a previous randomized, controlled trial.

"Our findings should offer some reassurance for community health care providers about initiating buprenorphine/naloxone treatment in the office setting," Dr. David Fiellin reported. The office-based treatment also can be an avenue for addressing other negative health consequences of chronic addiction, including referral for hepatitis C treatment, when indicated, as well as vocational and mental health programs.

Dr. Fiellin, along with lead investigator Dr. Emily Wang and colleagues at Yale University, New Haven, Conn., performed a secondary data analysis of a previous trial of three levels of psychosocial counseling and medication dispensing in conjunction with buprenor-

phine/naloxone maintenance treatment in a primary care clinic (N. Engl. J. Med. 2006;355:365-74). The investigators compared demographics, clinical characteristics, and treatment outcomes for 166 adults receiving primary care-based buprenorphine/naloxone treatment, stratifying by history of incarceration as determined by the legal domain of the Addiction Severity Index.

Of the 166 patients, 52 had previously been incarcerated, Dr. Fiellin reported. Former inmates were more likely than other patients to be older, male, an ethnic minority, and unemployed. Also, they were more likely to have long histories of opioid dependence, have received methadone treatment, and have hepatitis C infection. The mean dose of buprenorphine/naloxone (Suboxone) was 17.9 mg and 18.0 mg for the previously incarcerated and never incarcerated patients, respectively, he said.

Among the previously incarcerated patients, the mean consecutive weeks of opioid abstinence was 6.2 based on opioid-negative urine samples. For other patients, it was 5.9 weeks. Mean treatment duration was 17.9 weeks and 17.6 weeks. The percentage of previ-

ously incarcerated patients completing treatment was 38%; for other patients, it was 46%.

Among patients who remained in treatment, a subsequent longitudinal analysis of self-reported illegal activity and interactions with the legal and criminal justice systems, conducted at 4-week intervals, showed "office-based buprenorphine/naloxone treatment was associated with a statistically significant decrease in participants reporting illegal activity, from 19% to 2%, and in interactions with the legal system, from 16% to 1%," Dr. Fiellin said.

"Approximately 25% of all of those dependent on heroin pass through the criminal justice system each year," Dr. Fiellin said. Correctional facilities provide an obvious opportunity to engage opioid-dependent individuals with treatment. "Unfortunately, less than 0.5% of all opioid-dependent individuals receive treatment while they are incarcerated, and as such they are more likely to connect with services in office-based programs upon release," he said.

Limitations of the study include reliance on self-reported data for assessing incarceration and delinquency, said Dr. Fiellin, though he noted that all of the measures were obtained from previously validated instruments.

In addition, "the initial randomized trial was not designed to detect differences based on history of incarceration," he said. ■

The office setting can also be a way of addressing other effects of chronic addiction in this group, such as referral for hepatitis C therapy or for vocational and mental health programs.