THE CARLAT REPORT
ADDICTION TREATMENT

A CE/CME Publication

CURRENT COVERAGE OF TOPICS IN ADDICTION MEDICINE

Benjamin Oldfield, MD, MHS
Editor-in-Chief

Volume 8, Issue 2
March/April 2020
www.carlataddictiontreatment.com

IN THIS ISSUE

Focus of the Month:
Substance Use in Health Professionals

Learning Objectives
After reading these articles, you should be able to:

1. Evaluate the effectiveness of using appropriate terminology to reduce the stigma associated with substance use disorders.
2. Describe the benefits of using physician health programs to address substance use in clinicians.
3. Summarize some of the findings in the literature regarding addiction treatment.

Reducing the Stigma of Addiction Through Language and Terminology

The words we use in discussing addiction shape the way our patients, fellow clinicians, and communities think about substance use disorders. Addiction has long been viewed as a moral failing, and the terminology of addiction has reinforced this belief. Here, we review the evidence that documents how terminology can perpetuate—or reduce—the stigma associated with substance use disorders and highlight specific recommendations that may promote better engagement in care.

In the US, for each person meeting the criteria for a substance use disorder, only 1 in 10 is in treatment each year (Kelly JF et al, *Am J Med* 2015;128(1):8–9), and stigma heavily drives this gap in care. In the 2018 National Survey on Drug Use and Health, 16% of people who needed or perceived a need for addiction treatment did not seek it because of concerns that doing so would have a negative effect on their job, and 15% did not seek treatment because they felt that neighbors or community members would develop a negative opinion of them (Substance Abuse

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Highlights From This Issue

Clinicians can use specific, person-centered language that has been shown to reduce stigma and may promote engagement in addiction treatment.

Physician health programs boast favorable treatment success rates, and some strategies they employ—including long-term monitoring and regular use of substance use biomarkers—may be applicable to the general population.

Encounter-related "touchpoints"—such as release from incarceration and opioid detoxification—have been shown to present opportunities to intervene, reduce harm, and engage patients in substance use treatment.

Q&A With the Expert

Personal Privacy Versus Public Safety: Addiction Among Health Professionals

Paul H. Earley, MD, DFASAM

Medical director of the Georgia Professionals Health Program, Inc. Distinguished Fellow of ASAM. President of the Federation of State Physician Health Programs.

Dr. Earley has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CATR: Tell us how your interest in addiction came about.
Dr. Earley: When I started working in the world of addiction treatment 35 years ago, there wasn't much specific training. I was trained as a neurologist and always had an interest in patients with substance use disorders. Ultimately, I decided to shift my specialty and wound up cobbling together my own training over years of supervision with psychiatrists, mostly at larger not-for-profit psychiatric institutions, then running addiction programs that had a heavy interface with psychiatry. I stayed active with the American Society of Addiction Medicine (ASAM) so that I could keep up with the evidence base that was evolving at the time.

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Reducing the Stigma of Addiction Through Language and Terminology

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and Mental Health Services Administration, 2019; www.tinyurl.com/t5qkbc7).

The language we use can fuel this stigma. Using words like "junkie," "dirty," "abuse," or even "drug habit" implies a higher degree of choice than what we know to be true about addiction. The public, as well as clinicians, respond very differently when they believe an illness is driven by bad behavior or a moral failing vs a genetic predisposition (Richter L and Foster SE, *J Public Health Policy* 2014;35(1):60–64).

We as clinicians are not immune to the effects of language on our decision making. In a randomized controlled trial, mental health professionals attending two conferences were asked to read a vignette about an individual, both versions of which were identical except that one used the term "substance abuser" (more stigmatizing) and the other used the term "having a substance use disorder" (less stigmatizing). The professionals were then asked to complete various Likert rating scales about the vignette. Those who read the "substance abuser" vignette were more likely to rate the individual worse on the perpetrator-punishment scale, meaning that they believed the patient was more personally responsible for the actions taken in the vignette. In fact, these clinicians were more likely to recommend punitive action (Kelly JF and Westerhoff CM, *Int J Drug Policy* 2010;21(3):202–207). It's easy to see how that perception could lead to different actions taken in treatment planning or drug court settings.

Various organizations have taken up the call to change the language surrounding addiction. The DSM-5 has changed the diagnoses we use from "abuse" or "dependence" to "substance use disorder," as the term "abuse" is associated with negative judgments and punishment. The International Society of Addiction Journal Editors put forth a statement in 2016 calling for a shift in terminology, emphasizing an end to stigmatizing language and promoting more clinical, recovery-oriented terms (Saitz R, *J Addict Med* 2016;10:1–2). The White House Office of National Drug Control Policy issued a statement in 2017 calling for all federal agencies to change from the old language of personal failure to new language recognizing addiction as a brain disorder (www.whitehouse.gov; full website is www.tinyurl.com/y78bnpyg). Even the general public is seeing a shift in language. The 2017 edition of the Associated Press Stylebook advocated for less pejorative and more person-first language when writing about addiction. Recommendations included avoiding words like "abuse" or "problem" and instead using "use" with an appropriate modifier such as "risky," "unhealthy," "excessive," or "heavy." Another recommendation was to avoid terms like "alcoholic," "addict," "user," and "abuser" in favor of "a person with a substance use disorder" (Associated Press. *The Associated Press Stylebook 2017 and Briefing on Media Law.* New York, NY: Basic Books; 2017).

The table above highlights some specific terminology recommendations consistent with DSM-5, the AP Stylebook, and the recommendations of addiction journal editors. As we work to expand access to addiction treatment—such as by increasing the pool of addiction providers and promoting novel care delivery programs, including telehealth—the terminology we use with patients, colleagues, and society at large can help reduce the shame and fear that keep patients from seeking treatment.

Examples of Language for Stigma Reduction

Avoid these terms	Use these instead
Addict, user, drug user or abuser, junkie	Person with opioid use disorder, person with opioid addiction, or patient
Addicted baby	Baby born with neonatal abstinence syndrome
Opioid abuse or opioid dependence	Opioid use disorder
Problem	Disease or chronic illness
Habit	Drug addiction
Clean or dirty urine test	Negative or positive urine drug test
Opioid substitution or replacement therapy	Opioid agonist treatment or medication for opioid use disorder
Relapse	Return to use
Treatment failure	Treatment attempt
Being clean	Being in remission
Moral failure	Brain disorder

CATR VERDICT: Language can influence perceptions of addiction and drive patients away from care. National organizations have issued guidelines advocating for more person-centered terminology. We should try to use precise clinical language in our role as addiction treatment providers. Doing so can reduce stigma and may lead to better patient outcomes.

EDITORIAL INFORMATION

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Learning From the Successes of Physician Health Programs

The rate of substance use disorders among physicians is around the same if not slightly higher than in the general population. Impaired physicians, however, are a public health threat, and in most states there is mandated reporting of impaired physicians (Mossman D, *Current Psychiatry* 2011; 10(9):67–71). So what is to be done for an addicted or impaired physician? Physician health programs (PHPs) can help. Here, we review the successes of PHPs and identify features of these successes that can be applied in the addiction clinic for the general population.

What is a PHP?

PHPs are state-sponsored programs that operate under the authority of a medical licensing board. Currently, all but three states (California, Nebraska, Wisconsin) have PHPs, and California recently announced that its PHP will be reinstated (www.tinyurl.com/urrfekp). These programs evolved in the 1970s as a reaction to increasing disciplinary action against doctors, providing an avenue for impaired physicians to instead seek treatment, maintain their licenses, and rehabilitate their lives and careers. 55% of doctors enrolled in a PHP are mandated to enroll by a licensing board, hospital, or other agency, but the other 45% are self-referred or referred by friends, family, or colleagues (www.physicianhealthprogram.com). After referral, PHP staff conduct an evaluation and issue treatment recommendations, which may involve temporary discontinuation of practice, residential detoxification and rehabilitation, and long-term monitoring. Although PHPs have no direct authority over licensure, following their recommendations may result in avoiding punitive measures. While PHPs often work with medical licensing boards at an organizational level, the medical licensing board is often not notified that individual patients are receiving treatment from the PHP. For more details about PHPs, please see the "Key Elements of PHPs" table below.

Success rates

PHPs boast impressive success rates for addiction treatment. Over 95% of enrollees cooperate with treatment, and 75%–85% return to work (www.physicianhealth.com). In a study of 16 PHPs, results were a little less stellar, but still impressive: 72% of enrollees were licensed and practicing medicine after 5 years, and 78% of participants were completely abstinent (DuPont RL et al, *JSAT* 2009;36(2):159–171). The two most common presenting substance use disorders are alcohol use disorder (AUD) and opioid use disorder (OUD). Success rates are consistent across all presenting substance use disorders and superior to the general population in terms of abstinence, treatment retention, and other various components of recovery. So what is different about these programs?

Typical components of PHPs

Although there are slight state-by-state variations, PHPs share many common features. After the initial referring report is investigated for legitimacy, the physician-patient is asked to complete an evaluation that results in recommendations for treatment; the medical licensing board is generally not notified. This guarantee of protection can help alleviate some of the denial and delay in seeking treatment. The program requirements are, however, intensive and of long duration. Treatment starts with detoxification and inpatient rehab, usually for at least 90 days. A North Carolina study comparing the health programs for addicted physicians and physician assistants (PAs) found that 91% of physicians had a "good outcome" compared to only 59% of PAs; the large disparity in outcomes was deemed partially attributable to physicians undergoing longer and more intensive initial treatment than the PAs (Ganley OH et al, *J Add Dis* 2005;24(1):1–12).

After completing initial rehabilitation, physicians generally undergo a 5-year contract, including intensive monitoring in the context of a consent agreement. Urine testing is frequent and random, and screens encompass a panel of over 20 substances, including ETG (a sensitive biomarker of alcohol consumption; see *CATR* Jan/Feb 2020). For the entire duration of the PHP contract, physicians must call a phone number each work day to learn if they've been selected for random testing, which occurs on average once a week at the start of the contract and once a month after prolonged abstinence. Other stipulations of the contract may include regular 12-step attendance (multiple times per week).

PHPs wield considerable leverage by serving as the primary protection against discipline by licensing boards, hospitals, and insurance companies. This leverage is utilized to ensure compliance with all PHP recommendations. Missing any treatment session or drug test is considered a return to use, and consequences are immediately rendered. Treatment is abstinence-based. An emphasis is placed

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Key Elements of PHPs

Feature	Notes
Frequent, random, robust, and prolonged urine testing	Physicians are urine tested frequently and randomly for 5 years as a part of the PHP contract. The battery of substances screened is more robust than typical, including screening for ETG, an alcohol metabolite.
Intense relapse management	PHPs recognize the commonality of relapse and its threat to recovery. Any deviation from the treatment plan is considered an opportunity for further evaluation and individualization of the recovery plan.
Recovery focus	PHPs focus beyond abstinence and substance use treatment. There is a large emphasis on peer-to-peer eduction, 12-step participation and a wide spectrum of other services, including psychiatry, individual therapy, and family therapy.
Assertive and individualized contingency management	Contingency management works best when the punishments and rewards are consequential and delivered swiftly. PHPs utilize their relationships with medical boards as powerful leverage to incentivize physicians to comply with treatment.
Thorough evaluation and rehabilitation	PHPs set the bar high for the initial steps of treatment. Referred physicians are evaluated across biological, psychological, and social domains and typically have longer residential admissions (90+ days).

Learning From the Successes of Physician Health Programs

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on relapse management, and the typical recommendation after return to use is a 90-day residential program.

Application of PHP principles

The success of PHPs has inspired other professional groups. Lawyers and commercial pilots have adopted comparable programs. Several drug courts, as well as programs such as Hawaii Opportunity Probation and Enforcement (HOPE) and South Dakota's 24/7 Sobriety, have found success within the criminal justice population through implementation of similarly robust contingency management—noncompliance with treatment or urine testing can result in immediate brief jail stays. General addiction providers could implement similar structure by requiring more frequent random drug testing and rigidly enforcing consequences such as additional follow-up or limiting take-home doses as a response to skipped urine screens, missed appointments, or abnormal drug test results. However, PHP principles may not be universally applicable, particularly in cases where harm-reduction approaches may be more suitable than abstinence-only approaches.

Criticism

Corporatization

Not everyone views PHPs as the holy grail of addiction treatment. There have been important questions raised about growing corporatization and profiteering within the system (Boyd JW; www.tinyurl.com/wydv3a4), which in turn lead to concerns about conflicts of interest regarding the initial evaluations as well as reporting of results. Additionally, PHP services are generally paid for by the impaired physician, and costs over the course of treatment and monitoring can be exorbitant. Although criticisms of this nature have been mostly speculative and anecdotal, the monopolistic nature of a singular state-run program and the lack of a transparent appeals process can be interpreted as coercive.

Treating OUD with opioid agonists

An additional critique is how PHPs treat OUD. While nationally PHPs do not have a blanket ban against the use of opioid agonists (methadone and buprenorphine) for the treatment of OUD, many individual PHPs do not allow them. Although some studies point out that those agonist treatments can impair cognitive functioning, it is unclear if there is real-world significance or if the impairment is any worse than what is seen with antidepressants or antihypertensives (Hamza H and Bryson EO, *Mayo Clin Proc* 2012;87(3):260–267). These PHPs' stances against agonist treatment could be deterring some physicians from self-referring and sending a contradictory public health message (Beltsky JD et al, *NEJM* 2019;381(9):796–798).

CATR VERDICT: Physician health programs are highly successful and are the gold standard for abstinence-based treatment. Lessons can be gleaned from their structure and applied to other models, including the importance of a contingency management framework and long-term monitoring.

Expert Interview

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CATR: What drew you to your current role and to working with physicians in particular?

Dr. Earley: In my work, I saw that things were a little different in helping physicians get better. As a physician, I was drawn to their treatment and to the mission of returning our colleagues back to practice. I wound up working in centers that specialized in the treatment of health care professionals. This work, plus the work I did with the Federation of State Physician Health Programs (FSPHP), sparked my motivation for further development in the nuances of this safety-sensitive profession. Later, when Georgia started a physician health program (PHP), I left treatment work and moved to help start the Georgia PHP over 7-1/2 years ago. We built the program with knowledge base accrued from other programs across the US, fostered by our membership and meetings with the FSPHP. Most of the work we do at the Georgia PHP is with substance use, but we also support the assessment, treatment, and monitoring of physicians with bipolar and unipolar mood disorders and some physicians who have other conditions, such as burnout or difficulty in their personality structure.

CATR: What makes health professionals a unique population when it comes to addiction treatment?

Dr. Earley: I think the most important piece to understand is that health care professionals are on the one hand a vulnerable group, and on the other hand in safety-sensitive professions where their impairment could impact public safety. It's important that the care be geared to not only maximizing the health of the physician, but also ensuring the public's safety. And involved in that is a system. Health care professionals, especially physicians, are subject to oversight, whether through a credentialing process, a medical or specialty board, or insurance panels. Specific rules and regulations vary from state to state regarding safety to practice. This is one of the many reasons PHPs are critical. Understanding what PHPs do to help physicians with health problems is important to all addiction practitioners. You are going to run into physicians with addiction issues—in addition to physician assistants (PAs) or nurses with similar struggles. If you do not understand the context of safety requirements, you will be doing certain disservice to your patient or client.

CATR: Society doesn't often think of physicians as, like you said, vulnerable.

Dr. Earley: One of the vulnerabilities comes from the fact that physicians have ready and sometimes constant access to substances with a high potential for causing addiction. Over the years, we've found all sorts of entry portals into addiction because physicians are used to dealing with medications. And at the same time, they may feel like their knowledge protects them from having problems. They tend to have less concern about the use of medications, so experimentation can occur—and that can lead them down a difficult path.

CATR: Do they approach treatment differently, too?

Dr. Earley: Their roles as physicians can impact their willingness to engage in treatment. Physicians feel an enormous amount of shame about how they obtain the substances that they use, and that shame can be a barrier to seeking or sticking

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with treatment. At the same time, for this population, we know that long-term relapse prevention strategies and monitoring ensure the best possible prognosis and maintain public safety (Domino K et al, *JAMA* 2005;293(12):1453–1460).

CATR: Let's say we're concerned about a colleague's substance use. How does one learn about what is locally available?

Dr. Earley: The quickest way to learn more is to go to the FSPHP website at www.fsphp.org and look up your respective state's program. Then call or email that program and say, "Hey, I need to know a little bit about what services you provide." All PHPs are interested in teaching and helping people learn about what they do. So any practitioner—be it a family therapist, a primary care provider, or a colleague of someone whom they're worried about—if they don't know about their PHP in their state, they should search the FSPHP. We get calls all the time from people who say, "Tell me what you do," and we're happy to have that conversation.

CATR: Break down for us what services PHPs provide and to whom.

Dr. Earley: Most PHPs provide a confidential resource for the vast majority of their participants. PHPs work with physicians, but often they cover other health care professionals as well, working with those who have addiction or substance misuse issues, or psychiatric, medical, and behavioral problems (DuPont RL et al, *JSAT* 2009;37(1):1–7). PHPs help with detection. They help steer people to proper evaluation. Physicians are bright, and that intelligence can make it more difficult for an evaluator to make the correct diagnosis. In general, PHPs don't perform evaluations or provide treatment; instead they coordinate and provide oversight.

"PHPs are set up in most states to allow for anonymity of the physician from licensure boards, balancing not only public safety and the right to privacy, but also the opportunity to get care in a way that doesn't threaten the future of a person's medical career."

Paul H. Earley, MD, DFASAM

CATR: Interesting. How does the care coordination occur?

Dr. Earley: PHPs are really chronic disease management systems, much like a nurse in a health care system who works with a patient with diabetes to decrease complications and ensure the best outcome. So that's a way of thinking about us: We coordinate care. We also help deal with the hospital medical staff, the physician's professional liability carrier, and the medical board, if necessary. In doing so, we make sure the individual gets quality care and ensure that, when the time comes for the physician to reenter practice, the public is safe and the physician is ready to return. We are more like care managers, if you will. PHPs make sure that the I's are dotted and the T's are crossed, helping physicians get care with the least possible impact on their license and livelihood. Treatment is followed by long-term disease monitoring, which is critical for chronic mental health conditions like substance use disorders (DuPont RL et al, *JSAT* 2015;58:1–5).

CATR: Could you walk us through an example?

Dr. Earley: Sure. A hospital system someplace in Georgia may call me up and say, "I have a physician I'm worried about. What should I do next?" I would learn a little bit about that case, and if the level of concern is significant enough, I might say, "Maybe you should have this individual call us and we can talk over their options." If an evaluation is needed, we help guide the physician to a facility that specializes in such evaluations. If treatment is indicated, we refer to facilities that have a specialty in caring for health care professionals. As we've discussed, physicians have different needs in terms of workplace access to substances, in terms of licensure issues, and in terms of dealing with the shame associated with their drug or alcohol use.

CATR: How does a PHP navigate the tension between public safety and patient privacy?

Dr. Earley: PHPs are set up in most states to allow for anonymity of the physician from licensure boards. Physicians have a right to privacy, but they also have a desire to ensure that they can practice and have gainful employment. We're balancing not only public safety and the right to privacy, but also the opportunity to get care in a way that doesn't threaten the future of a person's medical career. So in most states, the PHP functions as an alternative to discipline. This is a vast improvement from the era before PHPs where, unfortunately, physicians who became ill were publicly sanctioned.

CATR: What would you say to someone who is concerned about a colleague but who is also concerned that that colleague may be disciplined if treatment is sought?

Dr. Earley: That question is at the crux of how this process works. For example, here in Georgia, if we have a physician who has a substance use disorder, in 95% of the cases, the medical board never knows. The other important point is, if you take a look at the outcomes of our work, they are very impressive for people who stay with us for a sufficient period of time (McLellan AT et al, *BMJ* 2008;337:a2038). When I have a physician who calls me up anonymously, I'll say, "I will help with your anonymity from the medical board if possible, but let's also talk about disease outcome. We provide wonderful opportunities for sustained long-term disease remission." And in that case, the people whom we work with usually say, "Well, I'm a little anxious about you knowing about me, but the fact that you don't have to tell the medical board is good, and the fact that I'm going to have a better prognosis makes me happy to work with you."

CATR: Some PHPs have been criticized recently for not supporting the use of medications in addiction treatment, particularly opioid agonists in the treatment of opioid use disorder.

Dr. Earley: Actually, PHPs are among the earliest supporters of using medications to assist with addiction and looking at the full spectrum of a physician's issues—whether it's an anxiety disorder, depression, or a pain disorder,

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as well as recovery and prevention of relapse. PHPs have no categorical ban on the proper use of any FDA-approved medication for addiction treatment, but it's an evolving issue for some programs.

CATR: Do we know much about addiction or substance use among health professionals who are not physicians?

Dr. Earley: We don't know enough, actually. There is limited research about other health care professionals. One of the main reasons there is more research about physicians is because physicians tend to study themselves. The information on nurse practitioners and PAs is also smaller just because up until the last 10 years or so, they represented a smaller portion of health care providers, but their numbers are now growing rapidly. Among nurses who are not nurse practitioners, there are several fine research studies—but no meta-analysis is yet available. The consensus from health programs for nurses is that they do as well as physicians if they stay in a nurse program, but again that information doesn't pass the muster of hard research, unfortunately. We hope to have research about other health care providers someday soon.

CATR: Do non-physician providers have their own programs?

Dr. Earley: Some states' PHPs do have programs for nurses and/or other health professionals. Our state PHP covers PAs and respiratory therapists, for example. And among our PAs—this is retrospective analysis—our tracking system reports a recovery rate that's very similar to what we see among physicians: maybe just a couple of percentage points lower. This is data from our tracking system, by the way; it is not published research. We think the similar recovery rate with different professions is related to the PHP model of chronic disease management—of looking at the illness as something to be followed over time and addressing a relapse with careful, measured responses rather than "hair on fire" kind of responses. We think it helps participants to know that they don't have to be perfect and that if they have a return to use, we will manage it; we will work with them and we will make sure we can keep them healthy and in practice.

CATR: Can we reach out to PHPs for consultation or general advice?

Dr. Earley: While we are not self-promoters, we are happy to talk to anyone who has questions. I spend a lot of my day talking to partners in medical practices, chief medical officers, and members of medical and nursing boards. The FSPHP, as an organization, likes to teach. So don't be shy—call your local PHP, ask questions, read about it. A good place to start is my chapter in the ASAM textbook on this topic (Earley P. Physicians health programs and addiction among physicians. In: Miller SC, Fiellin DA, Rosenthal RN, Saitz R, eds. *The ASAM Principles of Addiction Medicine.* 6th ed. Philadelphia: Wolters Kluwer; 2019:671–692).

CATR: It seems that the success of PHPs speaks to the need to consider addiction a chronic disease.

Dr. Earley: We have been and remain at the forefront of managing substance use disorders as a chronic illness. We manage people over years with tapering attention, with measured responses to loss of remission. And by doing so, we've learned a ton about the natural history of people who have addictive diseases and how to manage those diseases, so I think we have a lot to teach the field as well. It's a wonderful population to treat. Most of my physicians are deeply grateful for the work I do. It's extremely satisfying.

CATR: Thank you for your time, Dr. Earley.

Research Updates

SMOKING

Stigmatizing Smoking: An Effective Deterrent?

REVIEW OF: Cortland CI et al, *Addiction* 2019;114:1842–1848

Tobacco use is the single most preventable cause of death, disease, and disability in the United States. Among the $50 million the American government spends each year on tobacco cessation efforts, part of that money is spent on public service campaigns that work to shame or stigmatize smoking as an undesirable behavior. This study investigates how the social stereotype threat—creating concern about being judged unfavorably by others—may impact one's ability to resist the next cigarette.

In this randomized controlled trial, 77 non-treatment-seeking, otherwise healthy adult smokers were recruited from the community and randomized to receive a stereotype threat or a control message after 12 hours of abstinence. Specifically, the stereotype threat group was told that the investigators were interested in "whether non-smokers are superior across all positive traits or only certain types [such as] willpower, laziness, weakness, and responsibility," bringing to participants' minds the negative stereotypes of people who smoke. Both the intervention and control groups were given a lighter, an ashtray, some of their favorite cigarettes, and a small monetary reward for delaying smoking during hour-long observation periods.

The investigators did not find any significant difference in time-to-smoke data between the intervention and control groups. However, when the investigators controlled for baseline latency-to-smoke, they discovered that the stereotype threat was associated with lesser latency-to-smoke (hazard ratio 0.50, confidence interval 0.30–0.85). The researchers concluded that the stereotype threat actually functioned as a "smoking-promoting message."

Major limitations of the study include the short length of the observation period and the simplicity of the stereotype threat, which may not well approximate the complex and multifaceted nature of stereotypes in specific communities and in society at large. Another major limitation is that the control group did not receive a non-threat, smoking-related cue.

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CE/CME Post-Test

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These questions are intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Learning objectives are listed on page 1.

1. In 2017, the White House Office of National Drug Control Policy directed all federal agencies to use new language that recognizes addiction as _____ versus the previous language that labeled addiction as a personal failure. (LO #1)
   [ ] a. A treatable problem
   [ ] b. A biologically based mental illness
   [ ] c. A brain disorder
   [ ] d. A dependence

2. According to Dr. Earley, what is the role of physician health programs (PHPs) in assisting clinicians with substance use disorders? (LO #2)
   [ ] a. PHPs perform all physical evaluations necessary for insurance coverage
   [ ] b. PHPs initiate detox protocols
   [ ] c. PHPs provide outpatient counseling rather than inpatient treatment
   [ ] d. PHPs coordinate and oversee substance use–related care

3. According to a 2019 study, two critical encounter–related touchpoints (or risk factors) associated with an increased risk of opioid overdose include: (LO #3)
   [ ] a. Opioid detoxification and release from incarceration
   [ ] b. Benzodiazepine coprescribing and chiropractor use
   [ ] c. Education below high school diploma and use of multiple prescribers
   [ ] d. Use of multiple pharmacies and family dysfunction

4. According to a 2019 study, clinicians who were exposed to stigmatizing language about patients with substance use issues were more likely to feel patients were more personally responsible for their actions as well as to recommend punitive action. (LO #1)
   [ ] a. True
   [ ] b. False

5. Approximately _____ of PHP enrollees who cooperate with treatment are licensed and practicing medicine after 5 years. (LO #2)
   [ ] a. 45%
   [ ] b. 55%
   [ ] c. 70%
   [ ] d. 95%

6. In a 2019 study examining the effect of stereotype threat on smoking adults, which of the following was cited as a study limitation? (LO #3)
   [ ] a. The stereotype threat was overly detailed and lengthy
   [ ] b. The control group was given a larger monetary reward for delaying smoking
   [ ] c. The control group did not receive a non-threat, smoking-related cue
   [ ] d. The observation period lasted for a full 36 hours after threat

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CATR'S TAKE

While it doesn't readily approximate the complex nature of stereotype or stigma, this study suggests that shaming people may increase their likelihood of lighting up. Although public health messaging that focuses on the harms of smoking can be effective, addiction treatment providers should work to minimize shame and stigma in their patients and in society.

—Benjamin Oldfield, MD. Dr. Oldfield has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

OPIOIDS

Predicting and Preventing Fatal Opioid Overdoses

REVIEW OF: Larochelle MR et al, *Drug and Alcohol Depend* 2019;204:107537

The epidemic of opioid-related deaths has been declared a public health emergency. Research has already described risk factors—or "touchpoints"—associated with an increased risk of opioid overdose: for example, certain clinical scenarios or incarceration. What's less clear is the relative risk of overdose death and the potential for averting these deaths at each of the touchpoints.

This retrospective cohort study included over 6 million person-years among Massachusetts residents ages 11 years and older as of January 2014. They were followed for one year or until their month of death. The outcome was fatal opioid overdose. Past 12-month exposure to eight touchpoints was identified. Touchpoints were either related to opioid

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THE CARLAT REPORT
ADDICTION TREATMENT
P.O. Box 626
Newburyport, MA 01950

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prescription (high dose, benzodiazepine coprescribing, multiple providers, or multiple pharmacies) or related to a critical encounter (opioid detoxification, nonfatal opioid overdose, injection-related infection, or release from incarceration).

Of 1,315 Massachusetts residents who died from opioid overdose in 2014, 52% had exposure to one of eight touchpoints within the healthcare, criminal justice, or public health system. Specifically, 20.5% of those who had a fatal overdose had an opioid-prescription touchpoint, and 37.3% had a critical-encounter touchpoint. An overdose death was 12.6 times and 68.4 times more likely among individuals who had an opioid-prescription or a critical-encounter touchpoint, respectively, compared to those without any touchpoint.

The researchers concluded that the eight touchpoints were associated with increased risk of fatal opioid overdose and collectively accounted for more than half of the overdose deaths.

CATR'S TAKE

We should identify and act upon specific risk factors for opioid overdose, especially a history of opioid detoxification, nonfatal overdose, injection-related infection, or release from incarceration. Patients with these risk factors are especially good candidates for outreach efforts and harm reduction strategies, such as overdose education and naloxone distribution.

—Kristen Gardner, PharmD. Dr. Gardner has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.