

Testimony of the Montana Professional Assistance Program, Inc. regarding SB-401 before the Montana House of Representatives Committee on Human Services given on March 25, 2009:

Members of the Committee:

If adopted, this bill would require us to permit local treatment of referred physicians and dentists. MPAP policy has been to recommend primary treatment by facilities that are staffed and experienced in evaluating and treating health care providers. There also must be provision for extended treatment. I have distributed a copy of pertinent MPAP policies for your information as well.

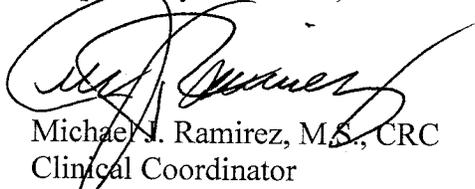
Currently, 49 of 53 active participants have an assigned therapist or aftercare counselor, utilizing a total of 32 providers; while 23 of 49 participants have a second assigned treating professional, usually a psychiatrist or addiction medicine physician for medication management, utilizing a total of 19 providers. All tolled, current active participant caseload utilizes a total of 51 local treatment providers for aftercare counseling and therapeutic support.

The bill, if passed, would impact our effectiveness by decreasing successful outcomes, decreasing our standard of care, and increasing the incidence of relapse due to insufficient primary treatment of affected practitioners.

The issue has never been in-state versus out-of-state. The issue always has been availability of qualified providers. This is a perennial issue that is usually revisited every few years following aftercare non-compliance by a recalcitrant participant or referral.

I respectfully recommend a vote of DO NOT PASS on SB-401.

Respectfully Submitted,



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## **MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.**

The Montana Professional Assistance Program, Inc. is a private, non-profit 501(c)(3) corporation created to serve the rehabilitation needs of licensed physicians throughout the State of Montana. Its mission is to provide advocacy, monitoring and support services to health care professionals with conditions of impairment under separate contracts with the Montana Board of Medical Examiners and the Board of Dentistry. Services include community education and outreach, intervention, appropriate referral, reintegration, and aftercare for program participants and referrals.

The MPAP is structured to provide for early diagnosis and intervention, appropriate evaluation and treatment referrals, and meaningful structured rehabilitation for impaired practitioners before they become incompetent, develop serious or fatal physical disorders, and/or endanger the health and welfare of their patients. The philosophy of the program is that illness or impairment is not always synonymous with incompetence.

MPAP has provided professional advocacy and aftercare monitoring services to licensed physicians in Montana since 1986. Over the years, we have been involved in 469 cases of suspected impairment involving medical professionals. This figure includes 368 physicians referred for consultation and/or evaluation, and 166 physicians who subsequently received treatment and were monitored. For Dentistry, 42 dental professionals have been referred; while 25 dentists have been monitored. Presently, the program has a total of 53 active participants, which includes 42 physicians and ten dentists. Rate of successful rehabilitation for all participants since program inception is 88.5%.

It is important to note that physicians must feel free to seek help for mental health problems before they shall do so willingly. A number of factors contribute to a physician's likelihood to seek help. These factors include training and education regarding conditions which may affect their ability to practice, assurance of confidentiality of patient records, dissemination of information regarding pertinent statutes and rules of conduct, and fostering a physician health system which encourages self-referral free from punitive measures. A rehabilitative posture is paramount to assuring an environment in which physicians are free to seek help for personal problems which may impact their ability to practice with reasonable skill and safety.

MPAP supports the position that early identification and intervention is sound public policy with respect to physician health problems.

Currently, physician colleagues and hospital administration represent the largest referral source at 41%, followed by the Medical Board at 27%, while self-referrals have been reported in 21% of total MPAP referrals. Over time, an increase in the frequency of self-referrals and collegial-referrals, with concurrent reduction in frequency of board referrals indicates a positive trend toward a rehabilitative posture. Additionally, ratio of physician referrals and participants who are known to the board vis a vis those who are unknown to the board is yet another indicator of a healthy professional assistance program. Currently, the Board of Medical Examiners officially knows the identity of 57% of all referrals and 36% of all active participants under their auspices. It is our hope that more and more, program participants will voluntarily enter the MPAP, whether by means of self-referral, or at the urging of professional colleagues, family or friends.

Confidentiality is stressed as one of the cornerstones of the program. The MPAP feels that practitioners, colleagues, family and friends are more likely to be successful in convincing an impaired practitioner to seek help voluntarily when there are no harsh punitive overtones, threats of public embarrassment, or threat to the practitioner's ability to continue his or her professional practice.

Notwithstanding the desire of the MPAP to extend confidential help and assistance to impaired practitioners, the program is bound by state statute to report to the professional licensing board a practitioner who is (a) medically incompetent; (b) mentally or physically unable to safely engage in the practice of medicine; and (c) guilty of unprofessional conduct.

In addition, the MPAP reserves the right to report to the licensing board those individuals who (a) have a clearly definable problem and refuse to seek treatment; or (b) those individuals who have received treatment but fail to adhere to the requirements of their aftercare monitoring contract. Administrative rules governing reporting requirements of the Professional Assistance Program recently were adopted in 2006 (*cf ARM 24.156.401 ff*). Peer review privilege protections were extended to MPAP records for physicians during the 2007 Legislature (*cf 37-3-208, MCA*).

**AMERICAN SOCIETY OF ADDICTION MEDICINE, INC.**

**Public Policy Statement  
on  
The Impaired Health Professional**

**Whereas,** alcoholism and other chemical dependence are chronic progressive and often fatal diseases if untreated;

**Whereas,** effective treatment is available for these diseases;

**Whereas,** if effectively treated, impaired health professionals are able to return to and resume functioning as valuable members of the health care community, ASAM supports the following:

1. Recognition of their impairment caused by these diseases;
2. Early referral into appropriate treatment;
3. Effective monitoring long term;
4. Sharing among health disciplines of effective intervention, rehabilitation and monitoring approaches.

Adopted: 4/12/84

**MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.**

**POLICY FOR DETERMINING THE NEED FOR EXTENDED TREATMENT  
FOR CHEMICAL DEPENDENCY**

It is the philosophy of MPAP, that with rare exception, Montana Health Professionals will benefit from Extended Chemical Dependency Treatment; that is, treatment that extends beyond the usual twenty-eight (28) day community inpatient or outpatient stay for chemical dependency. Following are some of the criteria which are useful in determining the need for extended treatment:

- I. Use of highly rewarding drugs:  
Intravenous use of opiates, cocaine, amphetamines or any other euphoria producing drugs.
- II. Lack of strong support base:  
Uncooperative family or deterioration of other significant relationships.
- III. Inability to remain abstinent, despite apparently adequate initial treatment.
  1. History of multiple relapses coupled with inadequate motivation for sobriety.
  2. Lack of sober support system.
- IV. Advanced physical disease, secondary to chemical dependence.
  1. Cognitive deficits as a result of chemical dependency.
  2. Physical disease such as chronic pancreatitis, cirrhosis of the liver, etc.
- V. Co-existing psychiatric illness affecting recovery; such as:
  1. Character style reflecting severe personality disorder.
  2. Affective disorder.
  3. Chronic psychotic disorders.
  4. Organic brain disorder (other than alcohol).
  5. High risk of potentially successful suicide.
- VI. Monitoring/follow up issues:
  1. Geographic isolation
  2. History of poor follow up or compliance.

3. Severe legal problems

VII. Lack of progress in Phase I or stabilization treatment phase:

In general, the need for extended treatment will be determined by the Medical Director of MPAP in consultation with the Medical Director or Attending Physician of the Chemical Dependency Treatment Facility, ideally around the third week of Phase I or stabilization treatment.

**MONTANA PROFESSIONAL ASSISTANCE PROGRAM, INC.**

**MPAP POLICY ON TREATMENT CENTERS FOR MONTANA  
HEALTH PROFESSIONALS WITH CHEMICAL DEPENDENCY**

Because of some special factors associated with Health Professionals with chemical dependency, it is recognized that there are some special considerations when it comes to selecting appropriate treatment centers for Chemical Dependency Treatment and Rehabilitation. Massive Denial and late-stage disease by the time of detection by others are some of the more important recognized factors in considering appropriate treatment referral sources for Montana Health Professionals.

With rare exception, it will be MPAP policy that Health Professionals be referred to facilities which have staff that are skilled and experienced in dealing with chemically dependent health professionals. In addition, we feel that it is important that the facilities have a high percentage of Peer Health Professionals participation in the treatment process at any given time. Lastly, it is very important that the facility have the ability to provide extended treatment.

MPAP requires that appropriate treatment facilities demonstrate the ability to provide three phases of treatment:

Phase 1: Stabilization

Phase 2: Substance Abuse-Free Existence

Phase 3: Mirror Imaging

During Phase I, or stabilization, we recommend a minimum of four weeks of Residential Treatment or eight weeks of Intensive Outpatient Treatment.

During Phase 2, or substance abuse-free existence, the facility will provide "Feelings Group" experience and individual counseling. Strong Second Step-Spirituality is very important at this point. Also, the facility needs to provide an appropriate therapeutic residence where the Health Professional can gain Group Living Skills, work on the Family Dynamic Issues and achieve integration into the local community AA 12-Step Program. This phase will last for four (4) to eight (8) weeks.

During Phase 3, or the mirror imaging phase, it is important that the facility allow the Health Professional to interface with incoming addicts and alcoholics to enable him to become more aware of the denial associated with chemical dependency. It is important at this stage that the facility continue working with Spirituality Issues, in particular fourth (4th) and fifth (5th) Step Issues. Appropriate Therapeutic Residence continues to be very important whereby the Health Professional gains further Group Living Skills, works on Family Dynamic Issues and integrates more solidly into the AA Community. It is extremely important that the facility provide a Family Program and Family Education about addictive disease.

Any request for departure from policy regarding approved treatment facilities will be considered by the Medical Director of MPAP and/or the Board of Directors of MPAP in consultation with the Regional Coordinator or Chairman of the local hospital committee on Professional Health and Well Being.