THE CARLAT REPORT ADDICTION TREATMENT

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David A. Frenz, MD
Editor-in-Chief
Volume 2, Number 2
March 2014
www.carlataddictiontreatment.com

IN THIS ISSUE

Focus of the Month:
Coping with Bad Outcomes

Learning objectives for this issue: **1.** Describe some of the ways that healthcare providers can help bereaved families after a death due to addiction. **2.** Summarize some of the legal considerations for providers when a bad outcome occurs. **3.** Explain some of the ways to provide support for clinical caregivers faced with a bad outcome or adverse event. **4.** Evaluate some current research regarding addiction.

A Personal Tale of Loss: How Providers Can Help with Grief

Gloria Englund, MA
Recovery Coach, Author, National Speaker

Ms. Englund has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Summary

- Losing a family member to addiction carries with it a different kind of grief that can often be wrapped up in stigma, guilt, and shame
- Healthcare providers can help bereaved family members after a death due to addiction by meeting with them to offer support and following up with a letter of acknowledgment on the one-year anniversary
- Providers can suggest that survivors get involved in addiction support groups, such as Al-Anon family groups

My oldest son Aaron died of a heroin overdose in May 2007 at age 33. He had battled addiction for more than 20 years.

The death of a child is an unfathomable loss. Losing a child to addiction carries with it a different kind of grief, often wrapped up in stigma, guilt, and shame. The reaction of others, including the healthcare providers who tried to treat the addiction, can help or hurt in healing from that grief. Let me tell you Aaron's story.

Aaron's first exposure to drugs happened shortly after he was 11 years old, when he experienced an accidental "high" after inhaling gasoline fumes while filling the lawn mower. Around this age

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Q & A With the Expert

Saying "I'm Sorry" and Other Legal Dimensions of Bad Outcomes

Mark R. Whitmore, Esq.

Shareholder and Chief Operating Officer
Bassford Remele
Minneapolis, MN

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

CATR: Mr. Whitmore, please explain the difference between what would be considered a bad outcome and malpractice in medicine?

Mr. Whitmore: You can think of a bad outcome as something unfortunate that happens that is a known consequence of a particular intervention or plan of care. It's just a risk inherent to the treatment that occurs every so often, even if all of the appropriate care is provided. Malpractice, on the other hand, is negligence. And the question in assessing negligence is whether the provider failed to comply with the standard of care. In other words, was the care provided reasonable under the circumstances?

CATR: Who decides what's malpractice and what's an appropriate practice decision?

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we discovered he was sneaking alcohol from our liquor cabinet. Experimentation with substances continued, and by the age of 12 he was smoking marijuana. In his mid-teens he was using LSD, other hallucinogens, and amphetamines. By his late teens, he had moved on to heroin.

A Struggle to Get Sober

Aaron's troubles went beyond substance use. When he was 14 years old I admitted him to an adolescent treatment center to undergo a mental health and chemical dependency evaluation. The psychiatrist there gave him a preliminary diagnosis of attention deficit disorder, along with oppositional defiant disorder and conduct disorder. His chemical dependency evaluation was never completed because Aaron was dismissed early after he bit an orderly who was trying to take away his cigarettes.

About a year later, I sought further evaluation from a psychiatrist who specialized in childhood behavioral disorders and addiction. He confirmed the previous mental health diagnosis and also diagnosed Aaron with substance abuse.

Aaron was soon skipping school and staying away from home. As he delved deeper into a world of drugs, it became necessary for him to deal drugs to support himself and his habit. By the time he died, he had made many attempts at recovery ranging from traditional 12-step programs to those that followed a health realization model, which focuses on "innate health" and the role of mind, thought, and consciousness in creating a person's experience of life (Sedgeman JA, *Med Sci Monit* 2005;11(12):HY42–52). Many of these programs involved the use of methadone to prevent opioid withdrawal and cravings, with the ongoing use of this medication following initial stabilization.

Aaron's last attempt at sobriety began with a rapid opioid detoxification in Chicago, a procedure that is risky, expensive, and proved to be ineffective (O'Connor PG, *JAMA* 2005;294(8):961–963). This was followed by hospitalization in Minneapolis to try to quell lingering withdrawal symptoms.

Ten days in the hospital did not relieve his withdrawal symptoms and the doctor's only recourse was to put Aaron back on a small dose of methadone. At a treatment program following this hospitalization, continuing withdrawal symptoms kept him from completing the program.

Desperate, Aaron found hope in a treatment program at HealthEast Care System in St. Paul, Minnesota. [Editor's note: Dr. David Frenz, editor-in-chief of *The Carlat Addiction Treatment Report,* is employed by HealthEast.] HealthEast used the blood pressure medication clonidine (Catapres) along with buprenorphine (Suboxone) to ease withdrawal symptoms. The combination proved to be helpful with Aaron's opioid withdrawal.

One of Aaron's treatment goals was to be free of his anti-anxiety and antidepressant medications as well as opioid agonist medications. But as his medications were reduced, Aaron became more emotionally unstable and found it increasingly difficult to remain in the inpatient program. He discharged from the program a week early with the understanding that he would participate in an outpatient program.

Aaron was released on a Tuesday and made it to the first day of his outpatient program on Wednesday. On Thursday morning I spoke to him and he said he had finished his prescriptions of clonidine and Suboxone and was not doing well. He didn't think he would be able to make it to treatment that day. That night, he overdosed on heroin and died.

What Helped Me Cope

Within months of Aaron's death, I began attending a grief support group for parents whose children had died. There were two positive things that I got out of this group. First, my husband, Bob, often joined me at these meetings and, here, we were able to share our grief with each other in a way that we could not always do by ourselves. Second, I developed a bond with a woman whose adult child died from complications of alcoholism. She was the only parent who really understood that addiction is a brain disease and accepted it as an illness. Although other parents attempted to be supportive, they often conveyed the feeling that addiction was a pitiful character defect that eventually caught up with Aaron.

The action that offered me the most support immediately following Aaron's death was receiving an invitation from his attending physician to come to his office and talk. At that meeting, I expressed anger about the ways I thought HealthEast had failed Aaron.

But as I talked and he listened, it became clear that his invitation had not been extended so he could defend any issues I had with Aaron's experience in treatment. It was extended because he genuinely cared and wanted to be a compassionate listener who grieved the loss of my son along with me.

His reaching out made me feel like Aaron wasn't just another addict who didn't survive. I appreciated it when he shared the positive impact that Aaron had on several other patients in the treatment program. Later, I found more support

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EDITORIAL INFORMATION

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Editor-in-Chief: **David A. Frenz, MD,** is medical director of addiction medicine at HealthEast Care System in St. Paul, MN.

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Steve Balt, MD, ABAM, is a psychiatrist in private practice and addiction psychiatry in the San Francisco Bay area. He is also the editor-in-chief of *The Carlat Psychiatry Report.*

Gantt P. Galloway, PharmD, is a senior scientist at the California Pacific Medical Center Research Institute in San Francisco, CA and executive and research director of New Leaf Treatment Center in Lafayette, CA.

Amy R. Krentzman, MSW, PhD, is an assistant professor at the University of Minnesota School of Social Work in St. Paul, MN.

Joshua Sonkiss, MD, is medical director of the behavioral health unit at Fairbanks Memorial Hospital in Fairbanks, AK.

Michael Weaver, MD, FASAM, is a professor and medical director at the Center for Neurobehavioral Research on Addictions at the University of Texas Medical School.

All editorial content is peer reviewed by the editorial board. Dr. Frenz, Dr. Galloway, Dr. Krenztman, Dr. Sonkiss, and Dr. Weaver have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity. Dr. Balt discloses that his spouse is employed as a sales representative for Otsuka America, Inc. This CE/CME activity is intended for psychologists, social workers, psychiatrists, and other mental health professionals with an interest in the diagnosis and treatment of addictive disorders.

A Personal Tale of Loss: How Providers Can Help with Grief

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when he followed up with a letter of acknowledgement on the one-year anniversary of Aaron's death (Bedell SE et al, *N Engl J Med* 2001;344(15):1162–1164).

Daily prayer and meditation were also extremely helpful. Praying for my healing as well as that of other loved ones gave me a sense of power in a completely powerless situation (Frantz TT et al, P*astoral Psychol* 1996;44(3):151–163). It seemed the more I prayed and meditated, the more support I received from the least expected places.

What Hindered the Healing Process

Many of those around me did not provide the kind of support I needed and this had a negative effect on my healing process. The lack of understanding from the other parents in my grief group, while not malicious, was painful.

I was troubled when friends and family would not talk about Aaron—not just his death, but also his life. I believe this was caused by the same stigma that surrounded his life as an addict.

I finally asked a friend just to say his name, "Aaron," every time she saw me. It was comforting to hear someone else speak his name.

How Providers Can Help Families Heal

Healthcare providers can help grieving loved ones (Prigerson HG & Jacobs SC, *JAMA* 2001;286(11):1369–1376). I encourage those who care for a client who dies from addiction to offer their support to survivors soon after their loved one's death.

Set up a time to meet personally and listen compassionately. Share openly what their loss meant to you. Include any personal, positive anecdotes about the client, which assures survivors that you saw them as a person, not just another client under your care. Honor the yearly anniversaries of the client's death with a written acknowledgement to loved ones and offer them your time for another check-in.

As healthcare providers, embrace the idea that death from addiction is a different kind of grief. My experience is that death resulting from addiction holds a secondary loss—the loss of hope for your loved one's possible recovery. Survivors may experience guilt, shame, and the resulting isolating stigma (da Silva EA et al, *J Psychoactive Drugs* 2007;39(3):301–306).

Providers can suggest that survivors get involved in addiction support groups such as Al-Anon family groups. Although these groups generally focus on living with someone who abuses alcohol or other drugs, members can also provide support following death due to addiction.

Finally, providers should offer specialized grief support groups not only to your clients' loved ones but also to the wider community. You may believe that being transparent about client deaths might jeopardize your position in the community, but it does two important things. First, it provides a clear message to the community, clients, and their loved ones: addiction is a serious illness and death can and does occur if the disease is not treated with your help. Second, you will support the often-invisible survivors of clients who do not recover. This honesty and openness helps to reduce the stigma of addiction that follows clients and their loved ones in life as well as death.

Editor's note: Gloria Englund is a recovery coach and offers grief support to others dealing with the loss of a loved one to addiction. Her website is www.recoveringu.com. She offers individual and group grief support.

Expert Interview

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Mr. Whitmore: Ultimately, a jury decides. In a malpractice case, the patient's lawyers argue that certain interventions should have happened, and they blame the bad outcome on the fact that the patient didn't receive appropriate care. Lawyers for the care provider present evidence to the contrary saying this isn't the community standard, this isn't the way we do it here in this state. After both sides have had the opportunity to present their evidence, including expert testimony, and make those arguments, the jury decides what was reasonable under the circumstances.

CATR: As their lawyer, how do you see providers typically reacting to bad outcomes?

Mr. Whitmore: Honestly, providers are generally very compassionate and caring people, and my experience has been that bad outcomes bother them, not just on a professional level, but on a personal level. Providers want what is best for their patients, and it troubles them when things don't go as planned.

CATR: And how should providers deal with that?

Mr. Whitmore: I tell my clients that when a bad outcome or an unexpected event happens, one of the best things they can do is to show their humanity. In other words, talk with people, show them you care, give them your time. That goes a long way in terms of dealing with the bad outcome and helping the family. In some instances, it prevents lawsuits because patients are less inclined to sue just to get answers. But I also think in the mind of the care provider it helps them deal with a difficult situation.

CATR: How does this play into the legal considerations around bad outcomes?

Mr. Whitmore: There's a big difference between saying, "I'm sorry this happened and that your family is dealing with a difficult situation," and saying, "I'm sorry that I caused this to happen. I'm sorry that I made a mistake." So I encourage my clients to talk to and express their compassion to patients and their families, because in the end we are all people and it's completely normal to do that. I also think many would argue that it's not only the right thing to do, but in some ways it's also therapeutic to have that conversation.

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Expert Interview

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CATR: From a legal standpoint, what would be inappropriate or unhelpful to say when talking to families?

Mr. Whitmore: Providers should avoid getting defensive and talking about "what-ifs." Although patients and families might want you to speculate about how things could have been different, we just don't know what would have happened if care had been delivered differently. Also, speculating about possibilities isn't fair to either the practitioner or the family because it creates false assumptions and guesses about the outcome.

I encourage my clients to talk to and express their compassion to patients and their families.

Mark R. Whitmore, Esq.

CATR: So when a family member presents you with a what-if scenario, what's the skillful way to respond?

Mr. Whitmore: I would just be honest and tell them you don't know what might have happened. You need to deal with what *did* happen. You can say, this is what went into my decision as the provider—this is why I did it, based on the literature or certain circumstances. And you can tell them, I'm sorry that it hasn't worked out as we had hoped or expected.

CATR: What's the best way to organize these conversations? Should the provider talk with the patient or family alone? Or should someone from risk management or a lawyer be present?

Mr. Whitmore: I wouldn't want the practitioner to have the conversation alone. It's best to do it on a clinical basis with someone else with you, such as the chair of your department. Bringing lawyers or even risk managers creates a certain level of defensiveness or maybe even anxiety, whereas another doctor who wasn't involved with the patient's care won't do that. I tell providers that they should always assume that the patient or family members are taping them, and, actually, if the family asks to record the conversation, that's usually okay. We don't want to appear as though we are hiding anything, yet we are not going to speculate on possibilities.

CATR: Let's talk about how this is different if there's clearly an error in care and not just an unfortunate outcome.

Mr. Whitmore: Okay, say it's a medication error or something very clear-cut like that. I always encourage practitioners to acknowledge that it happened. However, before you have a meeting with the family you should first communicate with your risk management department. Second, you or risk management should notify your malpractice insurer. You would hate to have a situation where you think you're doing the right thing and then your insurer contends that you made certain admissions unbeknownst to them that somehow put them on the hook for something. That would potentially give the insurer a basis to deny coverage for the claim, which is something the care provider definitely wants to avoid.

CATR: How should we approach medical documentation?

Mr. Whitmore: I would acknowledge in the medical record that a family conference took place—when and where, and who attended. You can write a generic note along the lines of "the patient's outcome was discussed," but this is not the place for a summary of the actual bad outcome or to advocate for your position as to whether you were right or wrong. Keep it factual and clinically-based.

CATR: Can you tell us briefly about "I'm sorry" laws?

Mr. Whitmore: There are a number of states with laws on the books that allow providers to tell patients and family members they are sorry without it being admissible in court (Mossman D, *Curr Psychiatr* 2013;12(12):30–33). I see nothing major wrong with these laws, but I'm not a huge fan because I think that providers sometimes get lulled into a false sense of security. Providers sometimes think those laws protect everything they say from being used against them in a lawsuit, and that isn't the case. The laws generally say that if you tell somebody you're sorry they are dealing with a tough situation, that's not admissible. But if you say, "I'm sorry for my mistake," that is admissible. That is the situation whether the state has an "I'm sorry" law or not. Also, I look at this from a lawyer's perspective. Statements of empathy are appropriate and I kind of like a jury knowing that my physician or other client cared enough to have that conversation. Some of these laws make that inadmissible, so the jury never knows that the doctor cared enough to show emotion and empathy with the family.

CATR: It can be very traumatizing for a provider to experience a bad outcome. Risk managers have historically told us to be careful about who we talk to, which can leave us feeling isolated and take an emotional toll. Do you have any advice for how providers can deal with this?

Mr. Whitmore: I always tell my clients that they have to take care of themselves. It's traumatic to see a good person have something unexpected and terrible happen to them when the provider's goal was to help the patient get better. I always encourage providers to take advantage of what resources are available to them because they need time to heal as well. In most, if not all states, there are privileges that allow them to get help and those conversations are by law confidential and privileged.

CATR: What are some examples of these conversations, outside of the obvious attorney-client privilege?

Mr. Whitmore: A conversation with a faith leader—such as a priest or a rabbi—is always confidential and something that nobody can be compelled by subpoena to disclose. And there are other people that the privilege exists for, too. For example, licensed care providers—psychologists, therapists, psychiatrists—the law protects those conversations as well. Another privilege that exists, but is a little bit different from state to state, is a peer review privilege. So what is said in the course of discussing a patient's care or outcome in those forums is protected. And, finally, in most states there is also a spousal privilege. That one differs a little bit from the privilege with a faith leader or your own care provider. If the spouse chooses to reveal something, they are allowed to do so, but they can't be forced to. Whereas a priest, for example, can't even choose to do that legally.

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Caring for Clinical Caregivers

David A. Frenz, MD
Medical Director, Addiction Medicine
HealthEast Care System
St. Paul, MN

Beth Lown, MD
Medical Director
The Schwartz Center for Compassionate Healthcare
Boston, MA

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

Dr. Lown has disclosed that she is employed by the Schwartz Center for Compassionate Heathcare. The editors have reviewed this article and found no evidence of bias in this educational activity.

In today's fast-paced, technology-focused, and cost-conscious healthcare environment, many clinical caregivers find themselves anxious, frustrated, and under pressure.

For people working in substance abuse treatment, those feelings can be magnified as they work with patients with chronic illnesses who often struggle to change their lives, frequently relapse, and sometimes never fully succeed in their recovery.

Unfortunately, there is often no structured outlet for clinicians to express their own feelings. Who can clinicians talk to about the physical and emotional exhaustion associated with treating high-risk patients who persist in self-damaging behaviors? And what about all the bad outcomes, both small and large, with the attendant grief, shame, and self-doubt?

Caring for Yourself While Caring for Patients

Caring for others starts with caring for yourself. Whether at an institutional level, or personally, we recommend that caregivers:

- Take heed of stress and other negative emotions. Although addiction treatment professionals commonly experience them, they should not be considered normal.
- Recognize the "second victim" phenomenon that often occurs following adverse events, which can lead to trouble coping. Reach out to colleagues if you are involved in a bad outcome. Offer them the same support when adverse events happen to them.
- Take part in regular clinical supervision, ideally on an individual basis. Openly discuss your feelings, emotions, and personal struggles, not just the specifics of various patients on your caseload.
- Introduce system-level initiatives such as Schwartz Center Rounds or peer support teams. Hard-wire caring for caregivers in your organization.

Here are more details on how to incorporate these recommendations into your work.

Caregivers as Second Victims

Bad outcomes can take their toll. Providers involved in adverse events can become second victims. For example, a survey in one healthcare system found that one-third of respondents had experienced negative emotions following an adverse event (Scott SD et al, *Jt Comm J Qual Patient Saf* 2010;36(5):233–240). These included depression and anxiety, as well as concerns about their job performance. Fully 15% had seriously considered leaving their chosen profession.

Second victims can also experience typical symptoms of depression, such as fatigue, sleep disturbance, and problems with concentration (Scott SD et al, *Qual Saf Health Care* 2009;18(5):325–330). Other issues can include flashbacks, intrusive thoughts and memories, and phobic avoidance of the patient care area where the adverse event occurred. Although these symptoms are distressing and disabling, the majority of providers try working through them on their own (Scott SD, 2010, *op.cit*).

One small study of 31 second victims found that recovery proceeded through six stages that sometimes occur simultaneously, starting with the chaos and response surrounding the event and ending with "moving on" (Scott SD, 2009, *op.cit*). The final stage had three possible trajectories. Some providers make a good recovery ("thriving") from the adverse event. Others, however, continue to experience intrusive thoughts and persistent sadness ("surviving") or more serious struggles ("dropping out").

Caregivers and the Status Quo

What kind of support do providers working in substance abuse treatment generally experience? They likely participate in regular staff meetings and meet with a clinical supervisor. The former typically involve group discussions about funding, care progression, and the day-to-day behavior of the patient mix. The focus is squarely on patients. "How should we deal with her behavior?" "Should we expedite discharge for patient X because he is sabotaging the recovery of others?"

Clinical supervision has a long tradition in certain mental health professions such as psychology and psychiatry. Good supervision goes beyond troubleshooting and promotes provider well-being and ongoing professional development (Hawkins P & Shohet R, *Supervision in the Helping Professions.* 4th ed. New York: Open University Press; 2012:98). Unfortunately, time pressures often force this kind of supervision to the periphery or reduce it to a perfunctory exercise dealing with the mechanics of care delivery. This can leave providers feeling isolated, overwhelmed, and increasingly burned out.

Schwartz Center Rounds

When Ken Schwartz, a Boston healthcare attorney, was battling lung cancer, he found that what mattered to him most was the care and compassion he received from his caregivers. Before he died at the age of 40, Schwartz founded the Schwartz Center for Compassionate Healthcare in 1995 to ensure that all patients receive compassionate healthcare and to provide support for clinical caregivers—the people who Schwartz said "made the unbearable bearable" (http://bit.ly/1beDsEy).

Led by a facilitator trained by the Schwartz Center, Schwartz Center Rounds bring clinical caregivers and

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Research Updates

SCREENING

Single Question Screeners for Addiction

Substance use disorders are relatively common in primary care settings. Can busy physicians accurately detect them with just one question?

Researchers at Boston University recruited 303 patients sitting in the waiting room of a primary care clinic. They explored alcohol and drug use in those patients using the Alcohol Use Disorders Identification Test (AUDIT [consumption items only]), Drug Abuse Screening Test (DAST [10-item version]) and Composite International Diagnostic Interview (CIDI). The former two instruments are often used to screen for addiction. CIDI served as the study's gold standard and determined the presence or absence of substance dependence.

Single question screeners were also deployed. For alcohol, patients were asked, "How many times in the past year have you had X or more drinks in a day?" The National Institute on Alcohol Abuse and Alcoholism's binge drinking definitions were used, where X=5 for men and X=4 for women. For other drugs, patients were asked, "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical purposes?"

Nine percent and 12% of patients met criteria for alcohol and drug dependence, respectively. Data for the single question screeners were then analyzed to find the best balance between sensitivity and specificity for detecting addiction. For alcohol, the cutoff was heavy drinking more than seven times in the preceding year. For other drugs, the corresponding cutoff was drug use more than two times in the past year.

Researchers then determined the positive predictive value (PPV) of these cutoff values. (PPV is the percentage of patients with a positive test who actually have the disorder.) For alcohol, patients with a score above cutoff had addiction 35% of the time. For other drugs, a score greater than the cutoff represented addiction in 38% of cases.

On face value, these numbers don't seem very impressive. After all, the majority of positive screens were false positives. But the single question screeners outperformed AUDIT (PPV=23%) and compared favorably with DAST (PPV=46%), which are longer, more time-consuming instruments.

More importantly, the single question screeners had high negative predictive value (NPV) for ruling out addiction. (NPV is the percentage of patients with a negative test who do not have the disorder.) They effectively excluded addiction when scores were below the cutoff values (Saitz R et al, *J Stud Alcohol Drugs* 2014;75(1):153–157).

CATR's Take: Many patients seek primary care for health problems related to addiction. Detecting substance use disorders can be challenging as diagnosis is entirely clinical and largely depends on patient self-report. These single questions screeners, when negative, effectively rule out addiction. Positive findings, while wrong more often than not, are about as accurate or possibly more reliable than standard multi-question inventories.

Caring for Clinical Caregivers

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members of the healthcare team together, usually for one hour once a month, to discuss their experiences, perspectives, and feelings on a range of topics drawn from actual patient cases.

The meetings provide a safe forum so providers can talk about a wide range of topics that may rarely get discussed elsewhere. For instance, they might share stories of hope or despair, or talk about issues such as the impact of patient violence, the potential emotional toll on caregivers when a patient is unable to initiate or sustain behavior change or dies, and what happens when a provider makes a mistake.

Since its pilot at Massachusetts General Hospital in Boston in 1997, more than 350 hospitals and other healthcare institutions across the US have adopted the program, which reaches more than 100,000 caregivers a year. It's not only used in hospitals, but in outpatient settings, nursing homes, and home health and hospice agencies.

A study demonstrated that caregivers who participate in multiple Schwartz Center Rounds say they have an increased readiness to respond to patient and family needs, better appreciate their colleagues, have decreased feelings of stress and isolation, and are more open to receiving and giving support (Lown BA & Manning CF, *Acad Med* 2010;85(6):1073–1081).

Other Options

The University of Missouri has a program known as the Scott Three-Tiered Interventional Model (http://bit.ly/1moIfIq). This program is used for general education about the second victim phenomenon and includes specific interventions for those involved in an adverse event.

Tier one involves immediate emotional first aid delivered by frontline managers and colleagues (http://1.usa.gov/1cR9GAO). Tier two consists of support from trained peers through a "forYOU" team that provides counseling, mentoring, and connecting the second victim with other institutional supports 24 hours per day. Tier three involves professional counseling through chaplains, social workers, clinical psychologists, and the University of Missouri's employee assistance program.

Other healthcare systems have developed similar solutions. For example, Brigham and Women's Hospital has been operating a peer support team since July 2006 (van Pelt F, *Qual Saf Health Care* 2008;17(4):249–252; http://bit.ly/MsQyD0), and Johns Hopkins University has established a Second Victims Work Group to address the problem (Edrees HH et al, *Pol Arch Med Wewn* 2011;121(4):101–108). These programs can help caregivers care for themselves and deal with the emotional impact of bad outcomes.

CE/CME Post-Test

To earn CE or CME credit, you must read the articles and log on to www.CarletAddictionTreatment.com to take the post-test. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by March 31, 2015. As a subscriber to *CATR,* you already have a username and password to log on www.CarlatAddictionTreatment.com. To obtain your username and password or if you cannot take the test online, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CE/CME post-test. This page is intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Note: Learning objectives are listed on page 1.

1. According to Gloria Englund, a letter on the one-year anniversary of a patient's death is a welcome acknowledgement (Learning Objective #1)?
   [ ] a) True [ ] b) False

2. According to attorney Mark R. Whitmore, Esq., in order to determine that a provider was negligent what must a jury find? (LO #2)?
   [ ] a) The provider failed to comply with the community standard of care
   [ ] b) The provider did not seek a second opinion
   [ ] c) The provider did not document the care that they provided
   [ ] d) The provider did not comply with health privacy laws such as HIPAA

3. Healthcare providers involved in adverse events can become what is known as which of the following and may have trouble coping (LO #3)?
   [ ] a) Collateral damage [ ] b) Impaired physicians [ ] c) Unsympathetic victims [ ] d) Second victims

4. A study of 31 providers involved in an adverse event found that recovery from a bad outcome proceeded through how many stages that can sometimes occur simultaneously (LO #3)?
   [ ] a) Four [ ] b) Five [ ] c) Six [ ] d) Seven

5. Researchers at Boston University found which of the following when it comes to the use of single question screeners for addiction (LO #4)?
   [ ] a) When negative, they effectively ruled out addition
   [ ] b) When findings were positive, they accurately established a diagnosis of addiction
   [ ] c) When findings were positive, they were not as effective as standard multi-question inventories
   [ ] d) They were more time consuming than standard inventories

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News of Note

Possible Solution to the "Poppy Seed Defense"

Seinfeld fans may remember the episode where Elaine tested positive for opioids after she ate poppy seed muffins (http://bit.ly/1fzuzRn).

A new study may lead to better drug tests that can distinguish between heroin use and the ingestion of poppy seeds, such as on a bagel or in salad dressing. Research published in the journal *Drug Testing and Analysis* described the identification of a heroin metabolite excreted in urine that could represent an important advance in forensic toxicology (Chen P et al, *Drug Test Anal* 2014;6(3):194–201).

Poppy seeds and heroin come from the same plant, *Papaver somniferum,* which is also known as the opium poppy. As a result, people who consume poppy seeds can test positive for opioids. Although levels are generally quite low, this can be used as a legal defense to beat a heroin charge.

The study's authors believe they have identified such a novel urinary marker, which could be a solution to the so-called "poppy seed defense."

Fentanyl Fueling Heroin Deaths

The Substance Abuse and Mental Health Services Administration (SAMHSA) sent out an alert in February to addiction treatment professionals warning of an increase in deaths since the beginning of the year that are reportedly linked to heroin containing fentanyl.

Fentanyl, a potent opioid analgesic medication, can rapidly cause severe injury and death when mixed with heroin, according to the alert. There have been more than 17 deaths linked to the possible use of fentanyl-laced heroin in the Pittsburg, Pennsylvania, area alone since mid-January. In the first two weeks of January, 22 such deaths were reported in Rhode Island, with other deaths occurring in New Jersey and Vermont. It was not known where the heroin containing fentanyl originated, but the alert said distribution could expand quickly to include larger and more distant areas of the country.

SAMHSA asked treatment providers to alert their patients and others in the community of the increased risk of fatal overdose. An opioid overdose toolkit, released last year by SAMHSA, contains information on recognizing and responding to overdoses (http://1.usa.gov/1d6Mtev).

ASAM Releases Standards of Care for Addiction

The American Society of Addiction Medicine (ASAM) has developed standards of care for physicians who treat

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Expert Interview

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CATR: Do you have any other resources you would recommend?

Mr. Whitmore: I wrote an article titled "Help! I've Been Sued" that I usually give to providers when they have a new case because it gives them a sense of what's going to happen (Whitmore MR, *Minn Med* 2005;88(6):40–41). The same issue of that journal [June 2005] had a number of other articles on malpractice and legal issues.

CATR: Thank you, Mr. Whitmore.

Mark Whitmore can be contacted at mwhitmore@bassford.com

News of Note

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patients with substance use disorders.

ASAM announced the publication of those standards, intended to outline a minimum standard of physician performance, in February. The full document and a related video can be found on ASAM's website (http://bit.ly/PDwwrk).

The standards are meant to apply to any physician assuming responsibility for the care of patients with addiction, even if the physician is not certified in addiction medicine or psychiatry. The standards speak to pharmacotherapies and psychosocial treatments for addiction, including specific language regarding treatment planning and treatment management standards.

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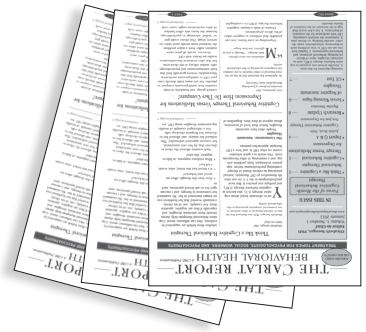

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