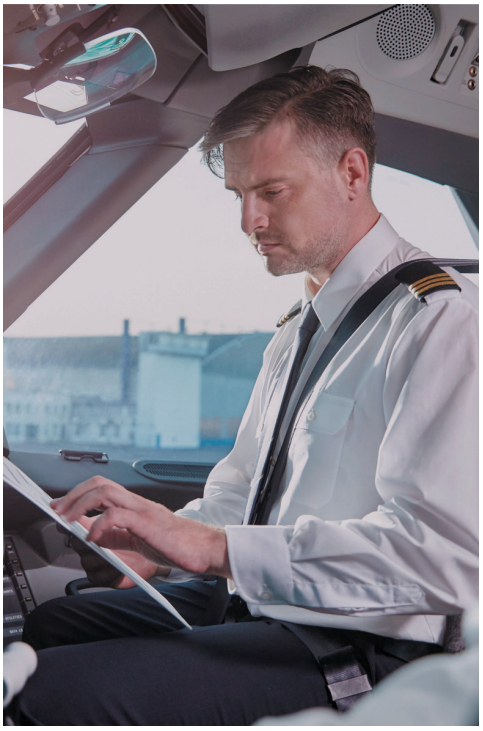
ADDRESSING MENTAL HEALTH AND ADDICTION PROBLEMS FOR EXECUTIVES AND PROFESSIONALS

Why these leaders remain untreated for so long and why specialized treatment programs are the most appropriate treatment option for them.



SILVER HILL HOSPITAL

Introduction

Mental illness and addiction destroy lives, dreams, and families across all socioeconomic levels.[1] And yet, when it comes to addressing these problems, executives and high-status professionals face a unique set of challenges securing timely and appropriate treatment.

Although executives and professionals are afflicted as often and severely as other occupational groups, the very nature of their achieved status often contributes to significant denial (within affected individual, his/her family and workplace) and significant barriers that often delay the process of identifying problems and receiving suitable help through a quality treatment program. While high-achieving individuals have ready access to many more life opportunities, experiences, and services than others, one major exception is that they often do not have access to high-quality, effective, and discreet inpatient or residential treatment for their mental health and addiction problems.

There is much at stake in better understanding these high-achievers and ensuring a more direct pipeline to specialized treatment programs. Their careers involve significant responsibility for the welfare, livelihood and success of their organization, employees or public served. Any behavioral health problems they experience can cause major disruptions and threats to their health and performance, success or safety in their workplace, and the well-being of their family.

> **THERE IS MUCH AT STAKE IN BETTER UNDERSTANDING THESE HIGH-ACHIEVERS AND ENSURING A MORE DIRECT PIPELINE TO SPECIALIZED TREATMENT PROGRAMS.**

This paper examines the nature of mental health and addiction problems of executives and professionals, why these problems remain undetected and untreated for such long periods of time, the barriers to effective treatment, and the need to address their distinctive problems through specialized treatment programs.

Defining the Executive and High-Status Professional

Executives are current or former senior leaders (e.g., C-suite, EVPs, SVPs, VPs) of business, healthcare, education, law, government, transportation, financial, sports, entertainment, and other industries.

Professionals are typically individuals with significant, specialized education and training to perform their job and often have significant organizational responsibility for patient, client, employee, or consumer care or service. Examples of professionals are physicians, other healthcare professionals, attorneys, pilots, brokers, bankers, and educators. The term "Pedestal Professionals" conveys society's view of these people as high-status role models entrusted with the care of others as evidenced by their being carefully selected, trained, and often licensed/monitored by regulatory boards or agencies to protect the well-being, safety and lives of others.[2]

What traits/qualities do these individuals share?

Executives and professionals possess traits or qualities common to high achievers.[1,3] They have been variously described as: independent, self-determined, intelligent, driven, demanding, powerful, resourceful, perfectionistic, overachieving, multitasking, reward seeking, image conscious, superb in crises, energetic, workaholic, resilient, never sick, materialistic, highly competitive, compartmentalizing, overconfident, rescuing, and controlling. Their highly developed interpersonal, organizational, and problem-solving skills serve them very well in the workplace. Most successful executives and professionals manage multiple organizational constituencies and priorities. Many define their career identity as their personal identity. Some define themselves based on what they produce and possess, epitomizing society's focus on outer-directed goals of money, power, influence, reputation, and prestige. Many have unrelenting standards for achievement and perfectionism, and they may need to be perceived as infallible and managing life very successfully.[1-3]

Why are these individuals at-risk? What is the impact of unaddressed impairment?

Unaddressed impairment in executive or professional leaders can harm the individual and their family and be devastating to the vitality of an organization, regardless of its size or mission.[4] Unfortunately, many executives and professionals remain at the helm for long periods of time while battling alcoholism, drug addiction, depression, or other psychiatric disorders. While these individuals excel at successfully managing multiple organizational constituencies and priorities, the responsibilities, expectations, activities and stress of their role can take a heavy toll over time.

Too often, the time and energy required for managing the workplace performance goals and the needs of others takes priority over the leader's effective management of their own health and the well-being of their family. As a result, their problems may not be recognized until a time of crisis, including suicidality, or when other destructive behaviors place their family, clients, or employees at significant risk. Without prompt diagnosis and assertive treatment, impairment in the workplace and at home can lead to devastating consequences for the sufferer and his or her family, friends, partners, employees, and organization.

UNADDRESSED IMPAIRMENT IN EXECUTIVE OR PROFESSIONAL LEADERS CAN HARM THE INDIVIDUAL AND THEIR FAMILY AND BE DEVASTATING TO THE VITALITY OF AN ORGANIZATION, REGARDLESS OF ITS SIZE OR MISSION.

Understanding the Problem

Executives and high status professionals suffer greatly from mental health and addiction problems. One important difference between them and the general population is the types of barriers that prevent them from gaining access to appropriate treatment. Stigma, discrimination and adverse consequences keep these common problems hidden and poorly misunderstood.

To reinforce the reality that executives and high status professionals are plagued as often and severely as other occupational groups, a sample of research on executives and selected professional groups is summarized below and on the following pages. Following these highlights is caveat information about the insufficient research on executives and high-status professional groups other than physicians.

Executives

The rates of alcoholism among executives appear to be at least as high as in the general population (15% of men, 10% of women)[8]. Washton and colleagues[9] found that threatened job termination was the major motivator for treatment among 1/2 of a clinical sample of opioid dependent executives treated with Naltrexone. Over 2/3 completed their recommended treatment, achieved temporary abstinence, and returned to work. In addition to the internal barriers to receiving treatment that are common among other professionals, executives often experience occupational enabling in the form of administrative assistants and colleagues engaging in significant cover-up of a substance use disorder[4].

Attorneys

There is some evidence that alcohol problems may be higher in lawyers (18-30%) than physicians, whereas depression may be higher in physicians[10]. Attorneys in treatment for addiction may have higher rates of co-occurring psychiatric disorders and leave treatment earlier in comparison to other professionals[11]. In a large survey of 12,825 attorneys across 15 state bar associations, Krill and colleagues[7] found that 1 in 5 screened positive for problem drinking and reported similar rates of depression, anxiety, and stress symptoms[12-14]. Lawyers preferred treatment programs specifically for their profession and, like physicians, experienced significant barriers to treatment related to their privacy and confidentiality concerns.

Airline Pilots

The Federal Aviation Administration, National Transportation Safety Board, and airline industry maintain data on airline pilot impairment based on fitness for duty exams, disability claims, and accident and incident analyses. Other than accident and incident analyses, information on the overall rates of substance use and mental health disorders among pilots is generally not available to the public or published in scientific journals. One exception is the independent, anonymous survey of depression in 1,837 pilots conducted by Wu and colleagues[15] that estimated about 13% had clinical depression and 4% reported recent suicidal thoughts. The effectiveness of specialized treatment for pilots has been reported as comparable to the high success rates found for programs for impaired physicians, likely due to the license/regulatory pressures, intensive treatment, and long-term continuing care and testing for alcohol and drug use.

Physicians

As mentioned, in comparison to the scant research literature on other occupational groups, there have been many studies on the mental health and addiction problems of physicians, mostly in connection to their involvement in Physician Health Programs (PHPs). Representative national surveys of broader groups of physicians are more limited. A national survey of US physicians estimated that 13% of male physicians and 21% of female physicians met diagnostic criteria for an alcohol use disorder[16]. Higher severity drinking problems were associated with younger age, hours worked, burnout, depression, suicidal ideation, lower quality of life, lower career satisfaction, and recent medical errors. When compared to the general population, physicians have similar rates of alcohol use, higher rates of prescription drug use, and lower rates of illegal drug use[16-24].

Although research findings are inconsistent, the rates of depression and anxiety are at least as high among physicians as in the general population[19-20,23,25-27]. Substance use often co-occurs with these and other psychiatric disorders, and this is very much true for physicians hospitalized for impairment. Among those admitted to a psychiatric hospital for treatment of depression, nearly 1/4 also had a substance use disorder and 2/3 had a personality disorder. Among physicians admitted to a hospital for addiction treatment, nearly all suffered from a mood disorder and over 1/2 from a personality disorder[28]. Particularly alarming is the finding that nearly 3/4 of physicians in treatment for addiction report suicidal thoughts, and 1/3 have made an attempt[29].

Compared to the general population, physicians more often die from three conditions (suicide, cirrhosis, and accidents) which are highly related to substance use disorders and depression[30-31]. Anesthesiologists have the highest addiction-related mortality rate of all

Physicians (continued)

physician groups[32]. This may relate to their much greater access and use of high potency anesthetics and narcotics with significant overdose potential[33].

While physicians experience substance use, mood, and personality disorders at least as often as the general population, they differ from this group in having an increased number of barriers to their recognizing problems and taking action. Physicians may be reluctant to seek help due to a personality and professional culture of perfectionism (not acknowledging perceived weaknesses or mistakes), denial of emotional needs, professional or legal implications, loss of status, and sense of medical invincibility[8,27,34]. The barriers to receiving treatment experienced by physicians frequently extend to other healthcare providers. More than 2/3 of nurses in treatment felt their problems could have been recognized earlier, and that fear, embarrassment, and concerns about loss of license were prominent barriers to seeking help[35].

A survey of UK physicians found that many held highly stigmatized views of depression regardless of whether they ever suffered from the disorder. Although depression is highly treatable, most depressed physicians have not sought help, citing concerns about privacy, career disruption, and fear of disappointing colleagues or patients[36]. Delays in detection and intervention mean that most physicians subject themselves and their patients, colleagues, and family members to significant risk for many years and only seek treatment when their disorder becomes severe, and there is some threat of job loss[37].

The Need for More Research

Other than extensive research on the problems and outcomes of physicians[5-6], the scientific literature is extraordinarily limited for other professionals and executives. The disproportionate attention to physicians is likely a reflection of two interrelated factors. First, the public and the healthcare industry are significantly concerned about the harm that can occur when society's most esteemed healers are impaired. Physicians are placed on a pedestal of impossible expectations of being immune from and ultimately responsible for the health concerns of others. Thus, their impairment is deemed most deserving of attention and study. Second, this attention has resulted in the development of a specialized treatment approach to support their recovery and return to practice. State-sponsored PHPs serve a large cohort who have been willing to have their outcomes evaluated. With a couple of exceptions, most notably a recent large survey of attorneys described previously, no other professional group has been the focus of much research.

> **PHYSICIANS ARE PLACED ON A PEDESTAL OF IMPOSSIBLE EXPECTATIONS OF BEING IMMUNE FROM AND ULTIMATELY RESPONSIBLE FOR THE HEALTH CONCERNS OF OTHERS.**

There have been relatively few national surveys of mental health and substance use disorders that specifically included a focus on high-achieving individuals.

Some of the same barriers that impede seeking treatment (described later) also result in an unwillingness to participate in research. Professionals and executives rarely attend addiction or psychiatric treatment programs at research universities that enroll patients into diagnostic and treatment studies. The existing data on non-physician professionals and executives is mostly limited to small, isolated studies of programs that treat high-achieving patients. Thus, what we know about professionals and executives comes from highly selective programs treating severely impaired patients or the clinical wisdom of the psychiatrists or psychologists who treat and write about them. Almost nothing is known about the much larger group of executives or professionals who need but never seek treatment and never volunteer for research studies. And very little is known about the presumably large number of physicians who seek treatment that is not under the coordination of their state's PHP because their problems have not reached a level of impairment requiring mandated reporting by a colleague or employer.

STIGMA, DISCRIMINATION, AND ADVERSE CONSEQUENCES KEEP THESE COMMON PROBLEMS HIDDEN AND POORLY UNDERSTOOD.

Comment on Personality Disorders

Although there is very little diagnostic research on this issue, it is widely believed that many high-achieving executives and professionals have narcissistic personality disorder. Indeed, many high-status individuals are very focused on impression management and have achieved success through their interpersonal charm, dominance, or manipulation. Some may have high levels of entitlement and low levels of empathy, shame, guilt, or remorse. For these personality traits to be considered narcissistic personality disorder, a psychiatrist or psychologist would need to interview and diagnose the person as experiencing dysfunction or causing significant distress to self or others. Most executives or professionals are not diagnosed with this condition other than in the context of being treated for a mood, anxiety, or substance use disorder. There are valid, brief self-report measures for alcohol, drug, mood, and anxiety disorders, allowing for estimates based on surveys or treatment studies. However, an accurate personality disorder diagnosis requires a detailed clinical interview to determine the persistence, pervasiveness, and maladaptivity of personality traits. Executives and professionals often have extreme personality traits, but those may or may not be indicative of a personality disorder.

Signs of Impairment

Signs of existing or emerging behavioral health impairment may include increases in unpredictable, inappropriate, aggressive, or erratic behavior; signs of being overwhelmed or losing perspective; poor judgment and loss of interpersonal skills; excessive emotionality, over-reactivity, or irritability; forgetfulness, confusion, inattention, indecisiveness; increased suspiciousness, distrust, pessimism, or withdrawal from others; defensiveness when concerns are raised or support offered, and notable changes in work performance (e.g., absenteeism, lateness, missed deadlines, poor presentations, sloppy reports, impacted productivity)[3-4,38-39]. Burnout is an unfortunately common phenomenon among healthcare providers and other client- or consumer-facing professions. Although this phenomenon is different from clinical depression, a burned-out leader may be at risk for depression, substance misuse, and stress-exacerbated medical problems – which are serious conditions that increase risk for suicide as well as harmful acting out behaviors in the workplace and at home.

Physical signs and symptoms more specific to a substance problem include the smell of alcohol, shaking, poor hygiene, changes in skin and weight, falls and other injuries, slurred speech, stumbling or loss of balance, poor sleep, fatigue, hangover or withdrawal symptoms, changes in appearance of eyes (blood shot, watery, dilated or constricted pupils), daytime sleepiness or sedation, unexplained hyperactivity or agitation, and increased perspiration. Legal issues may suddenly emerge such as arrests for DWI, disorderly conduct, domestic disturbance, or fights[38-39].

The barriers to receiving effective treatment are so numerous and complex that the mental health and addiction problems of executives and professionals typically escalate to a state of crisis before problems are recognized and addressed.

This crisis point is most commonly reached when one of three scenarios occurs. First, a serious workplace performance issue results in an intervention and referral for evaluation and treatment. Second, problems at work may remain unobserved or ignored, but significant family problems push the person into treatment. And third, a problem continues or worsens after the leader is terminated or retires and a concerned healthcare provider, family member, or friend urges treatment.

In his seminal book, *Executives in Crisis*, Speller (1989)[39] highlights the many reasons why addiction or mental health impairment remain undetected for so long.

1. **Most executives and high-status professionals have a high level of independence and autonomy with regard to their schedule. They may not be under anyone's day-to-day supervision of where they are or what they are doing. They often have off-site meetings and come and go from their work area as necessary.**

2. **Effective executives and high-status professionals usually have built a strong and supportive team surrounding them whose livelihood depends on the continued success of their boss. These loyal staff may cover up problems related to work reliability, availability, quality, follow-through, and inexplicable or inappropriate behavior. They unrealistically believe or hope the problem is temporary and will stop because the leader knows how to deal with all kinds of problems.**

3. The most senior executive to whom the impaired person reports (e.g., board chair, president, senior partner, general counsel, academic chair or dean) may lack sufficient awareness, courage, compassion, kindness, or willingness to effectively confront a problem that may require treatment, a leave of absence, and painstaking follow-through with human resources.

4. The executive or professional may unrealistically believe they are tougher, stronger, healthier, more stress-tested and resilient than the average employee. Unfortunately, an executive or professional in crisis has symptoms that usually exceed what can be controlled by force of will or "pulling oneself up by the bootstraps."

5. In the case of addictive behaviors like substance use, problem gambling, or compulsive sex, the high compensation of their position means they can continue their self-destructive behaviors for a much longer period before encountering the serious financial consequences that cause them or family members' distress. And in the case of alcoholism (and sometimes drugs), substance use may be an integral part of the work landscape or a sanctioned form of stress relief. This normalizing contributes to the denial of having a disease that requires intensive ongoing treatment as opposed to modest life style changes or periodic attempts to cut back.

6. Executives, high status professionals, and other public figures have very legitimate concerns about the privacy and confidentiality of their seeking help. The stigma and discrimination associated with these conditions is particularly intense for these individuals because of their pedestal status. Any knowledge of limitations in the workplace can create significant risks with regard to career progression, vulnerabilities to rivals inside or outside organization, as well as reprisals or estrangement from associates and accounts.

High-functioning, high-achieving individuals are entrusted with making critical decisions at work often related to ensuring the health, success, or welfare of others.

As occupational leaders and role models at the top of their profession, it can be very difficult for them, their families, and their workers to accept that they are mentally ill or addicted. They are perceived to be on a pedestal – in control of their lives and careers, and more immune to the common human problems of the people they serve or lead. Executives and professionals view themselves and have reputations for being strong problem solvers, gifted performers, highly resilient, more stress-tested, and better equipped to deal with their problems than the average person. They have a lot to lose and thus feel greater motivation to deny their problems and rationalize any addictive or dangerous behaviors[1-4,38-39].

The barrier maintained by the executive's or professional's supervisor – referenced earlier in #3 of Speller's[38] highlights about barriers – is worth elaboration. Without adequate knowledge of the most effective treatments for serious behavioral health problems, even well-intentioned supervisors trying to act compassionately may make mistakes in trying to help. They may not appreciate, for example, how off-hours heavy drinking at business dinners or meetings could be impacting on-the-job performance. They may believe that the executive's problems can be solved by giving him/her time off to reduce the heavy stress levels and burdens of leadership, or that temporarily reassigning duties to reduce level of responsibility or exposure is a solution. The supervisor may even try to assume a concerned friend or counselor role and make matters worse by keeping the problem 'between the two of us,' or may trust that confronting their key employee in a caring, directive manner to cut back on drinking or get more rest will spur them to respond with positive, self-directed and health promoting behaviors. When a problem has progressed to the point of being noticed in the workplace, it is usually beyond the point where it can be eliminated through a colleague's advice, compassion, or limit setting. It usually means some level of professional consultation and treatment is needed to restore the executive or professional to healthy and productive functioning.

Continuum of Services Available

As is the case with other members of the workforce, identifying the right treatment program for impaired executives and professionals depends on an assessment of the duration and severity of their mental health and addiction problem.

As described earlier, the problems of a higher status individual often must reach a crisis point before they are recognized and addressed by others and before the person can feel willing to get help, even if only to address the complaints and concerns of a spouse or employer.

Although Employee Assistance Programs (EAPs) may be helpful in preventing or intervening in the behavioral health problems for many employees, higher level executives and professionals rarely consider EAP or their human resources director as an appropriate gateway to solutions. Many senior leaders even have concerns about making use of their company-sponsored insurance for mental health and addiction treatment. The perceived stigma and discrimination associated with these conditions is particularly severe for these individuals because of their organizational leadership roles. For the most senior leaders – their board of directors, general counsel, or chair are the ones making recommendations and requirements for treatment. This may involve the senior human resources director only in cases when short-term disability is being claimed or other employee complaints have surfaced about the impaired leader. A high level of organizational discretion is often necessary to protect the confidentiality of the leader as well as the public image of the company.

The recognition of a mental health or addiction problem in an executive or professional represents a critical decision point for the individual, family, and workplace which few are prepared to manage. With this in mind, the following descriptions are intended to provide guidance around the treatment options available.

Outpatient Treatment

If detected early enough with appropriate professional evaluation and intervention, an attempt can be made to treat the mental health and addiction problems of executives and professionals on an outpatient basis. Short-term detoxification or psychiatric hospitalization may be the initial first step in cases with severe symptoms, however, this medical stabilization should be followed by at least weekly appointments with a psychiatrist, psychologist, social worker, or marriage and family therapist. Intensive outpatient programs (IOP) or partial hospitalization programs, in which patients live at home and attend several hours of therapy meetings each week for 4 or more weeks, can be very effective especially when followed by ongoing weekly outpatient appointments and medical monitoring.

Two factors interfere with the executive or professional accessing outpatient programs. First, IOPs and partial hospital programs that specialize in executives and professionals are virtually non-existent in most parts of the country. Many geographic regions have none available and sometimes even have limited availability of individual providers experienced working with executives and professionals. Second, many business leaders, public figures, or "pedestal professionals" are reluctant to join programs treating heterogeneous patients from their local community. Their shame may have them worried about how the people or community they serve may judge them for their problems. They may have very legitimate concerns about confidentiality and the impact of this on their reputation and career. For this reason, executive and professional patients with mood, anxiety, or personality disorders may seek initial treatment with a doctor (primary care physician, psychiatrist, or psychologist) in their community with a reputation for discreet and effective treatment for high-status patients. Executives and professionals with addiction problems may also seek the well-guarded anonymity and daily accessibility of 12 step meetings, particularly early morning meetings attended by stably employed people who are highly motivated to maintain sobriety.

The insufficient research on executives and professionals prevents clear conclusions on the benefit of outpatient vs. IOP/partial hospitalization vs. inpatient/residential treatment. Due to the scarcity of specialized IOP or partial hospitalization programs, the executive or professional (or their concerned family or employer) is often left with a choice between once weekly professional treatment while the patient continues to work at their job or a 1-2 month leave of absence to attend a specialized inpatient or residential program. If the problem is detected and treated early enough, weekly outpatient treatment (and 12 step meetings in the case of addiction) may be sufficient. However, due to some of the factors mentioned above, executives and professionals are often delayed in their asking for help or being forced to get help and thus may be too severely ill to be safely managed in weekly outpatient and/or self-help meetings, and specialty hospital treatment is urgently needed. Outpatient or IOP treatment is also essential after completing these more intensive inpatient or residential treatment programs.

Specialized Tracks within Hospital-Based Treatment

When outpatient treatment is insufficient or unsafe, a time away from major sources of stress or symptoms may be required for everyone's (patient, family, co-workers) well-being and to enable an intensive period of professional treatment in a highly confidential setting specifically designed to address the needs of the executive or professional. Residential or inpatient treatment provides intensive daily exposure to a range of professionally-delivered, evidence-based treatments, wellness activities, and self-help meetings. A mixture of individual, group, and family therapy is generally considered best practice. Careful treatment and discharge planning ensure ongoing outpatient treatment and family, work, and community supports for the person to sustain the gains achieved in the hospital. The failure to follow a rigorous post-discharge recovery plan (which usually involves medication, psychotherapy, self-help meetings and/or other peer recovery support) almost guarantees relapse of symptoms within 3 months of hospitalization.

The advantages of a specialized inpatient or residential treatment track for executives and professionals in comparison to weekly outpatient therapy is the ability to provide an intensive level of treatment with a cohort of similar patients. Executives and professionals can be challenging and complex patients who need specialized treatment that addresses their common traits, qualities, and work-life experiences[3-6]. Most people with embarrassing or stigmatizing problems prefer to work on their problems with a group of highly similar peers, and this may be especially salient for business leaders, public figures, or pedestal professionals. Executives and professionals will be more open to seeking and accepting help if they can do this in the company of peers who have walked in their shoes and share the particular form of shame they feel for how unmanageable their life has become and the effect of this on people they love, serve, or support. Empathy and understanding are more likely to come from others familiar with their high accomplishments, stressful work life, time demands, and standard of living. They may feel more comfortable sharing and working through their problems with peers who appreciate the unique occupational challenges, stressors, and emotional burdens of being responsible for the health and well-being of a large group of people.

> **EXECUTIVES AND PROFESSIONALS CAN BE CHALLENGING AND COMPLEX PATIENTS WHO NEED SPECIALIZED TREATMENT THAT ADDRESSES THEIR COMMON TRAITS, QUALITIES, AND WORK-LIFE EXPERIENCES[3-6].**

There are two other reasons why inpatient or residential treatment may be chosen initially over outpatient, IOP, or partial hospitalization programs. One relates to ensuring safety and the other relates to the containment sometimes needed in the wake of events which precipitate the urgent need for

treatment. With regard to safety – addiction and mood disorders can be a lethal combination that can lead to suicide, overdose, or unintended accidents. Executives or professionals whose sense of life meaning has been shattered by a recently lost job or threatened career identity and whose marriage is heading toward dissolution are among the highest risk for suicide or other forms of harmful behavior. In these cases, outpatient treatment, while living at home, may not provide sufficient safety from destructive outcomes. Often, the patient initiates outpatient therapy, and this provider determines that a higher level of care is needed. An inpatient or residential treatment environment with 24-hour staff supervision and a highly trained and licensed professional treatment team may be life-saving.

A second reason is somewhat distinct from the acute safety and symptom management needs of the individual patient. Sometimes, it is the family or employer that needs the patient to leave home or work for some period of time. The impairment has often caused significant harm, fear, liability risk, and loss of trust that family and work can no longer allow to impact its members. These groups have their own legitimate need for protection or containment from a loved one's or colleague's crisis. They may need time or distance from the impaired person to reduce their own stress, resume functioning, and evaluate whether and how the patient can resume family and/or career role functions. The separation may need to be short or long-term so that all parties can begin healing. Common reasons include: marital infidelity or intimate partner violence; harassment in the work place; fraud allegations; unethical or illegal activities resulting in investigation or arrest; employment termination for cause; and highly public failures or falls from grace. In these situations, entering an inpatient or residential treatment program may indicate both the patient's genuine acknowledgment of their need for intensive treatment as well as their need for compliance with the demands of significant people in their life.

> **THE SEPARATION MAY NEED TO BE SHORT OR LONG-TERM SO THAT ALL PARTIES CAN BEGIN HEALING.**

They may feel pressured to enter a hospital program in order to demonstrate to others that they are taking matters seriously enough to avoid losing their family or job. Inpatient or residential treatment may be demanded by a victimized spouse, required as a condition of employment or license retention/restitution, or advised by an attorney for strategic purposes in pending legal cases.

Summary: Treatment Options

- Outpatient treatment
- Intensive outpatient program
- Partial hospitalization program
- Residential or in-patient treatment

Outcome Studies

Because there are no well-designed, controlled comparison outcome studies of programs for executives and professionals, it is challenging to speak about 'gold standard' treatments specific to this group of high-achieving individuals.

In lieu of this, providers, families, and employers responsible for directing executives and professionals to an appropriate treatment program, should be aware of several issues related to best practices: 1) outcomes research on physicians; 2) evidence-based treatments for addiction and psychiatric disorders; 3) differentiating effective treatment from effective marketing (discussed in the next section).

Physicians are the only professional group whose outcomes have been studied in any consistent way. It is important to note that these findings are limited to physicians treated for a substance use disorder in the context of monitoring by their state's PHP. The results are impressive and far exceed the positive outcomes seen in addiction treatment studies in the general population. Success rates for impaired physician treatment are in the range of 60-90% over a 2-5 year period, defined variously as program completion, recovery, or return to work[23,40]. A 5-year longitudinal study of 16 US physician health programs found that about 80% completed treatment and resumed practice under supervision and monitoring[23]. These excellent outcomes are likely due to a combination of factors. Physicians whose treatment is overseen by a PHP are typically highly-motivated and trying to avoid the serious consequence of losing a high-status professional license and identity they have spent years achieving. Physicians may be more willing to submit to long-term professional treatment, mandated substance use monitoring and reporting, and consistent self-help meeting attendance[23] – a form of chronic disease management that most addiction experts agree is state-of-the-art.

There are few if any differences in the rates of successful PHP outcome as a function of medical specialty[41-43]. One possible exception may be anesthesiologists who abuse inhalational anesthetics[44]. Anesthesiologists who abuse opiates have significantly worse outcomes (recovery, return to work) than other physician groups[45-46] and likely require the use of antagonist medications to resume the practice of medicine[47].

Effective treatment components of most PHP-mandated services for physicians typically include:

- Comprehensive evaluation
- An initial, intensive phase of treatment – inpatient, residential, or partial hospital depending on the duration and severity of the problem – followed by weekly outpatient appointments
- Several years of professional monitoring (including breath alcohol and urine drug testing)
- Required 12-step or other recovery support meetings as part of larger treatment program
- Compliance reporting to licensing/regulating bodies

A similarly intensive model has been adopted for airline pilots suffering from alcoholism. Developed as the Human Intervention Motivation Study (HIMS) and run out of the FAA-supported Air Line Pilots Association (ALPA), HIMS has coordinated services for over 5,000 pilots who have been successfully treated for alcoholism and returned to flying. Although a 90% success rate has been reported, this program has not been subjected to independent or rigorous evaluation of outcomes published in peer review journals to the same extent as PHPs for physicians. It also should be emphasized that drug addiction and other psychiatric disorders are typically not treated in the same way as HIMS is for alcoholism.

Similar to pilots, little if any rigorous research has been done evaluating outcomes for attorneys, other healthcare professionals, or executives. An essential component to the success of the PHP and HIMS programs appears to be the strong involvement of licensing, regulatory, or professional associations. This level of professional oversight is either not in place, in the case of business executives, or resisted, in the case of attorneys. For these and other groups of executives or professionals, it is usually a family member who is the major source of pressure for the individual seeking treatment.

Treatment programs for executives and professionals should aspire to the same level of intensive treatment, continuous care management, medical monitoring, and (in the case of addictions) 12 step meetings that have been found to be effective for physicians and pilots. However, this is more challenging to implement with success without a licensing or professional organization enforcing these treatment recommendations. Regardless of whether there is a strong compliance enforcement component, the treatment of all executives and professionals should emphasize what research has proven works for many people with addiction and other psychiatric disorders from all walks of life.

TREATMENT PROGRAMS FOR EXECUTIVES AND PROFESSIONALS SHOULD ASPIRE TO THE SAME LEVEL OF INTENSIVE TREATMENT, CONTINUOUS CARE MANAGEMENT, MEDICAL MONITORING, AND PEER SUPPORT THAT HAVE BEEN FOUND TO BE EFFECTIVE FOR PHYSICIANS AND PILOTS.

An extensive research literature strongly supports the following recommendations with regard to effective treatment and should constitute best practices for professionals and executives.

- Many people with mental health and addiction problems benefit most from a combination of medication to treat symptoms, psychotherapy to increase insight and coping skills, and mutual self-help or family/social support to strengthen recovery and reduce relapse risk. Most experts consider this "3-legged stool" of medication, psychotherapy, and mutual support to offer the best chances for long-term recovery. This does not mean that all patients need all three components all the time. Some people enter long-term recovery from alcoholism by attending AA meetings and never seek professional treatment. Some people are treated successfully for bipolar disorder by a psychopharmacologist who does not provide psychotherapy. And some people with anxiety disorders are best treated by time-limited cognitive-behavioral or behavioral therapies without medication or peer support. However, some blend of the three approaches (medication, psychotherapy, self-help) typically becomes necessary when repeated relapses occur and disorders become severe and chronic.

- There are highly effective medications for treating symptoms of alcoholism, opioid addiction, major depression, bipolar disorder, psychotic disorders, and attention-deficit hyperactivity disorder. And medications can be useful additions to the treatment of some sleep and anxiety disorders. There are no consistently effective medications for the treatment of personality, eating, somatic, trauma, or dissociative disorders, or for addictions to drugs other than alcohol and opioids. Interventional psychiatry approaches (electroconvulsive therapy, transcranial magnetic stimulation, and ketamine) can be very effective for cases of severe depression.

- Based on decades of research, Behavioral or Cognitive-Behavioral Therapies (CBT) are considered the psychotherapeutic models of choice for eating disorders, borderline personality disorder (especially Dialectical Behavior Therapy) and some other personality disorders, as well as many of the anxiety, obsessive-compulsive, and trauma-related disorders. CBT can be as effective as medications in the treatment of depression, more effective than medication in the treatment of anxiety and personality disorders, and broadly effective across most substance and behavioral addictions.

- Research indicates that people who regularly attend self-help meetings improve upon the positive outcomes of professional treatment. In fact, it appears that some people (including executives and professionals) have achieved recovery from alcoholism and drug addiction through an intensive commitment to 12-step meetings with minimal involvement in professional treatment. Peer led or other mutual support groups for other psychiatric disorders are less available than they are for the addictions, but they are important for providing social support to individuals and families. High quality treatment programs place significant emphasis on helping their patients get exposed to and participate fully in self-help mutual support groups.

Summary: Treatment Components

- Comprehensive evaluation
- Initial, intensive treatment followed by weekly outpatient appointments
- Several years of professional monitoring
- Compliance reporting to licensing/regulating bodies
- Behavioral or Cognitive-Behavioral Therapies
- Use of the “3-legged stool” approach combining medication, psychotherapy, and mutual support
- Use of medications or interventional psychiatry approaches in cases of severe depression
- Regular attendance of self-help meetings, 12-step programs, peer led or other mutual support groups

Finding Effective Treatment for Executives and Professionals: Doing Your Own Research

Experts consider addiction and other severe psychiatric disorders to be chronic health conditions (diseases) that require an extended period of continuing treatment, close professional monitoring, and peer-based recovery support services.

Short-term inpatient or residential services are ineffective when delivered as stand-alone programs disconnected from the continuum of care necessary after discharge.

Because inpatient or residential programs for executives and professionals may be more available than occupation-specific IOPs or partial hospitalization programs, several important factors should be considered by patients, employers, and family members researching treatment options at a time of crisis or urgency: 1) location of the treatment facility; 2) level of professional services offered; 3) connection to ongoing outpatient services.

More specifically, it is important to consider the following to increase the chances of an effective course of treatment.

- Carefully consider the location of the program. Family involvement and a smooth transition back to an outpatient provider near home and work are often important for executives and professionals. If getting to the program involves air travel, then the spouse, parent, or an adult child should be prepared to travel there one or more times to visit and participate in treatment. Referring outpatient providers also should have an option of visiting the patient or being able to have phone or video calls with the patient if that is important for continuity and consultation with the treatment team around treatment and discharge planning.

- High price does not always equate to a high level of professional services or high-quality expert care. Patients and families should not accept quick promises that insurance will cover all the treatment costs, and they should be prepared for sometimes substantial, out-of-pocket expenses. It is important to ask for an estimate of the total cost of treatment and what approximate percent of this goes toward evidence-based treatments (individual, group, family therapy) vs. ancillary wellness activities (meditation, yoga, massage) vs. luxury amenities (private room, house accommodations, transportation services, chef, on-site or off-site recreation activities, special outings).

- Be wary of programs that have only one physician on staff or that primarily make use of consulting physicians from the community to oversee medical and psychiatric care. A general rule of thumb is for each patient to have a minimum of 1 hour of contact each week with a physician with appropriate training in general psychiatry, addiction psychiatry or medicine.

- Programs that promise expertise in treating substance use disorders co-occurring with other psychiatric disorders should have proportionately more psychiatrists, psychologists, and social workers on staff than professional counselors, recovery coaches, or other non-licensed service providers.

- Programs should be regarded with skepticism if their websites: feature persistent pop-up ads or intrusive 'chat now' or 'call now' boxes; provide far greater emphasis on the luxury amenities or 12-step recovery and de-emphasize evidence-based, professionally-delivered therapies; claim that many patients completing inpatient or residential treatment do not require ongoing outpatient treatment; or boast 1-year abstinence rates greater than 50% (unless these programs are closely connected to intensive case management and monitoring programs for physicians and pilots).

- Be wary of phone calls with intake staff who insufficiently assess the nature of the patient's problems, make guarantees of being able to help, quote high success rates, or fail to discuss whether other lower intensity treatment options have been tried first. An early offer to facilitate air or car transportation to a treatment facility is a red flag and questionable business practice in the absence of a full assessment of the problem. Caution is needed for programs that over-emphasize up-front the importance of ongoing residential living (sober, recovery, or half-way houses) in that geographic region following inpatient treatment or that devalue the benefits of outpatient treatment and continuing care monitoring.

- It is important to ensure that the inpatient or residential program is willing to closely collaborate with and maintain communication with a referring provider, employment representative, licensing or professional organization, and that also emphasizes the importance of family involvement during treatment.

- It is important to note that, when it comes to effective treatments for serious mental health and addiction problems, research has ***not*** proven the effectiveness of equine or pet therapy, swimming, massage, acupuncture, horticulture, karaoke, yoga, recreational outings, creative expression, or wilderness/nature activities. These activities can be very important components of an intensive treatment program because they provide time for rest, reflection, rejuvenation, social interaction, personal growth, stress management, fun, and meditation within a busy schedule of treatment and self-help meetings. However, these ancillary activities should not dominate the program schedule. If a program website or description seems more like a spa or vacation resort than a treatment program, the patient and family should consider seeking a highly professional treatment first. A spa or vacation are wonderful activities to do once a period of recovery has been established.

Summary: Doing Your Own Research

Considerations for Finding Effective Treatment for Executives and Professionals

- Number of full-time physicians on staff
- Number of licensed service providers on staff to treat co-occurring disorders
- Be wary of websites with persistent pop-up ads, heavy emphasis on luxury amenities, 1-year abstinence rates greater than 50%
- Be wary of calls with intake staff who fail to assess nature of problem
- Importance of collaboration with referring provider, employer, family, etc.
- Ancillary activities should not dominate treatment program schedule

Conclusion

People in positions of leadership, influence, power, and organizational stewardship can be among the hardest to identify and help for mental health and addiction problems. An earlier detection of impairment can protect lives and save careers and families. To make progress in this area, attitudes within the family and workplace cultures need to shift through greater education and de-stigmatizing of the problem and increased awareness about the options for getting help. It is not acceptable or helpful to the individual, much less good for business or the family, to delay intervention until the executive or professional completely decompensates and wreaks havoc on loved ones and colleagues. Delayed treatment means that many people are at risk of harm. Employees suffer alongside their impaired boss, business performance and profits can be adversely affected, and spouses and children are devastated by the lost connection and reliance on a loved one. In many ways, taking the time to identify the problem, intervene, and support treatment of the struggling executive or high-level professional is not only the most compassionate approach to addressing impairment, but also the more cost-effective and forward-thinking. The most common psychiatric disorders (mood, anxiety and substance use) are highly treatable. Firing an executive or professional also can be very costly in terms of severance pay and settlements, disability claims, lawsuits, and recruitment and training to replace the leader. Assisting the high-achieving employee in obtaining effective treatment can help return a high-performing employee with an increased sense of loyalty to a company that has cared enough about them, their career, and their family to support getting help[39].

IN MANY WAYS, TAKING THE TIME TO IDENTIFY THE PROBLEM, INTERVENE, AND SUPPORT TREATMENT OF THE STRUGGLING EXECUTIVE OR HIGH-LEVEL PROFESSIONAL IS NOT ONLY THE MOST COMPASSIONATE APPROACH TO ADDRESSING IMPAIRMENT, BUT ALSO THE MORE COST-EFFECTIVE AND FORWARD-THINKING.

In order to move the needle on earlier detection and appropriate treatment of the impaired executive or professional, the medical, mental health, and research communities must address the dire need for increased research on high-status occupational groups and effective treatments. Specialized treatment programs for executives and professionals should consider what has been learned from the effective programs in place for physicians and pilots and evidence-based therapies in general.

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