REVIEW

State programs assisting pharmacy professionals with substance use disorders

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ABSTRACT

Objectives: To identify which states currently have substance use disorder (SUD) programs to facilitate the return of pharmacy professionals (including technicians, interns, and student pharmacists) to active practice, to identify the operational structures used by the states in providing these services and compare them with those reported previously, and to compile the most current and accurate contact information for each state SUD program.

Methods: Information specific to each state program was identified from Internet resources including state pharmacy associations, licensing boards, and professional associations. Each state's site was evaluated for currency within 2016-2017. Direct contact by e-mail or telephone using the program information, or association, or licensing board contacts was pursued to identify the current program status.

Results: Five states with no program in 1990 have since developed programs, and 2 states with programs in 1990 have closed their programs. Overall, 4 states do not currently have a program, 2 of which have never had one. One of the 2 states has recent authorization from their legislature to develop a program. Three other programs are currently in transition from 1 model to another, resulting in website inaccuracies. The operational models have undergone significant shifts with a decrease in the association (± [with or without] Foundation) model toward a group health care association or organization model including other health- or all state-licensed professionals.

Conclusion: Currently, 46 states have programs for assisting pharmacy professionals. Information presented in this article provides the most current contact information and model structure used by states with programs. Frequent updating of program information is critical for those who might decide to seek assistance. Expansion to include a central database that enables rigorous evaluation of outcomes and specific features is viewed as desirable.

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The DSM-5 provides the current criteria for diagnosis of alcohol use disorder (AUD), substance use disorder, and or drug use disorder (DUD).[1] National epidemiologic information from a population of adults in the United States age 18 years and older reported that 12-month prevalence of AUD was 13.9%, whereas lifetime prevalence was 29.1%.[2] Likewise, national epidemiologic analysis from a similar population identified the 12-month prevalence of DUD as 3.9% and the lifetime prevalence as 9.9%.[3]

Of particular importance are the prevalence estimates for subgroups, especially pharmacists and physicians. Such estimates are challenging to obtain to the precision of the above estimates. Baldisseri[4] provides estimates that 6%-8% of physicians have SUD and up to 14% of them have AUD. Others report prevalence estimates for physicians similar to the general population (10%-15%).[5-7]

Extensive studies of large populations of pharmacists have not been conducted; however, several smaller studies have reported estimates ranging from 7% to 15%,[8-10] 18% to 21%,[11] and 14% to 25%, specifically for opioids and anxiolytic agents.[12] Overall, the suggestion of an occupational risk for pharmacists has been advanced.[9] Among student pharmacists, the picture is less clear but equally concerning. A recent review

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Key Points

Background:

- Pharmacy professionals experience an increased risk for substance use disorders and most states have developed programs for assisting their pharmacy professionals.

Findings:

- Due to the risk of substance use disorders, information and contact details for each state's program to assist pharmacy professionals must be constantly updated and readily available to individuals needing assistance.

Table 1
Timeline of program development during the 1980s

Year	Development
1982	APhA House of Delegates adopts policy statements regarding impaired pharmacists.[20]
1983	APhA begins sponsorship of a Pharmacy Section of the University of Utah School on Alcoholism and other Drug Dependencies.
1983	The American Society of Health-System Pharmacists (ASHP) House of Delegates endorses the APhA position and activities.
1985	A survey study indicates that 12 states have operational programs and 24 states have begun program development.[21]
1985	APhA publishes a handbook for helping states plan, develop, and implement a program for impaired pharmacists.[22]
1987	Thirty-eight state programs are operational. The Impaired Pharmacy Program Network (IPPN) of representatives from each state is announced.[23]
1988	The Texas Impaired Pharmacists Program publishes a detailed description of their experiences.[24]
1990	A survey study reports that 40 states have an impaired pharmacist program.[25]
1990	The Impaired Pharmacy Program Network is recast as the Pharmacists Recovery Network (PRN) for 47 state programs.[26]
1994	APhA Academy of Students of Pharmacy becomes cosponsor of the pharmacy section of the University of Utah School on Alcoholism and other Drug Dependencies.
1996	"*Points of Light*: A Guide for Assisting Chemically Dependent Health Professional Students" is published by APhA.[27]

Abbreviations used: APhA, American Pharmacists Association.

estimates that 25%-30% of student pharmacists engaged in hazardous or binge drinking (5 or more drinks in 1 occasion) during the past 2 weeks.[13] In addition, this report estimates that the current marijuana use among student pharmacists is 6%-21%, past year use of stimulants is 5%-19%, and current opioid use is 1%-6%, with lifetime prevalence estimates of opioid use ranging from 8% to 15%.[13] These estimates among student pharmacists might not be substantially different from the estimates of 21% for current marijuana use and 7% for illicit drug use other than marijuana among college-age students.[14] However, the authors support the concern regarding an occupational risk for SUDs within the pharmacy profession.[8,11,15-17]

Given this information, programs should be developed to educate and provide mechanisms for early identification, treatment, and sustained recovery of pharmacists with SUDs. The sustainability of these programs are vital to maximize the resilience of the pharmacy profession. Absent of these programs, pharmacists will continue to experience the career-ending consequences of overdose death, disability, or felony controlled substances violations.

In 1982, a student pharmacist published a viewpoint regarding the failure of the pharmacy profession to develop policy positions related to pharmacist impairment.[18] Unlike the pharmacy profession, the medical profession had already formulated policies for impaired members, and many state medical associations had established programs of assistance.[16] The American Pharmacists Association (APhA) House of Delegates adopted policy statements directed toward pharmacists later that year.[19]

Throughout the 1980s, many states developed and implemented programs for pharmacists who needed assistance (Table 1). Most of these programs were primarily supported by state pharmacy associations and targeted the identification, intervention, referral for evaluation, needed treatment, care and follow-up after treatment discharge, and the return of the pharmacist to the practice. In some cases, the state board of pharmacy took the lead role or cooperated with the association-based programs.

A quarter of a century has passed since the last published report on the status of state programs for pharmacists.[25] Therefore, we sought to identify the current operational status of state programs for pharmacists and the models in use (e.g., association-based, board-based) and to provide an updated resource of contact information for the various state programs.

The need for such an updating is not solely to ensure accurate contact information. The changes in the provision of mental health care and the ongoing financial constraints on licensing boards and professional associations presage the consolidation of pharmacy-specific programs with identical programs for other licensed professions. Increased public accountability and protection also derive from the increased national attention in regard to SUDs, as evidenced by the recent report from the U.S. Surgeon General.[28] Throughout the remainder of this article, SUDs will be referenced to include those arising from alcohol, cannabis, opioid, stimulants, and other mood- or mind-altering substances.

Currently, there are no published reports providing empirical evidence of outcomes for pharmacists with any of these programs. Indeed, only 1 such study has provided outcomes from similar programs for physicians.[29] This report on a population of 904 physicians across 16 state physician health programs (PHPs) over at least 5 years reported that 78% demonstrated abstinence by drug testing. This finding is consistent with the anecdotal reports regarding pharmacy programs claiming an 80%-85% success rate, without specific definition.[30,31]

Clearly, an important aspect of building resilience in the profession begins when student pharmacists enter the

profession. Guidelines and examples have been developed for the educational curriculum, yet most pharmacy programs do not include significant coverage of SUDs—a finding attributed to the absence of this topic from the licensure examination.[30,32]

Objectives

The objectives of this study are to identify which states currently have SUD programs to facilitate the return of pharmacy professionals (including technicians, interns, and student pharmacists) to active practice, to identify the operational structures used by the states in providing these services and compare them with those reported previously,[25] and to compile the most current and accurate contact information for each state SUD program.

Methods

Information specific to each state SUD program was sought from Internet-based resources beginning with the United States America Pharmacists Recovery Network (USAPRN) website.[33] This site, developed and maintained privately by an individual pharmacist from Ohio, is currently the only known resource that includes all state information. The USAPRN website was checked for each state program. If the provided links to specific state information did not work, that state's pharmacy association and licensing board websites were checked. When more information was needed, the authors conducted a general Internet search using the Google search engine and the following terms: "pharmacist impairment," "impaired pharmacist," "pharmacist substance abuse," "PRN," and "pharmacy recovery network." The websites supported and maintained by national professional pharmacy organizations (APhA, American Society of Health-System Pharmacists, National Community Pharmacists Association, and National Association of Boards of Pharmacy) were also searched for relevant information. Finally, state associations and licensing board personnel were contacted directly when current contact information was not found for a state.

When the provided links to specific state information proved operational, we conducted extensive review of the websites, including visiting the various submenu links explaining various aspects of the program to gain a clear understanding and evidence of information currency. Information currency was evidenced by dated forms, pages, or events in the range of 2016-2017. For state websites not demonstrating currency, direct contact using the listed telephone or helpline numbers was attempted. When those attempts were unsuccessful, direct contact with the state association or licensing entity was pursued.

Results

By 1990, 7 states had not developed SUD programs for pharmacists (Table 2).[17] Currently, 4 states do not have a program. Since 1990, program changes have been bidirectional, with 5 states developing programs (Delaware, Colorado, Maine, Nevada, and West Virginia), 1 state (Rhode Island) modifying its program, and 2 states (Alaska and Vermont) closing programs (Table 2). Finally, 2 states (Hawaii and

Table 2
Changes in state program status, 1990 compared to current period

State	1990	Currently
Alaska	Yes	No
Colorado	No	Yes
Delaware	No	Yes
Hawaii	No	No
Maine	No	Yes
Missouri	No	No
Nevada	No	Yes
Rhode Island	Yes	Yes[a]
Vermont	Yes	No
West Virginia	No	Yes

[a] Limited to employees of corporate sponsors. yes, program present; no, no program.

Missouri) without programs in 1990 continue without programs. However, the Missouri legislature recently passed statutory language allowing the Board of Pharmacy to develop a program.[34]

Table 3 provides details of the 46 current state programs. A review of state-by-state program information revealed several that were outdated. In a few cases, entire program structures changed without evidence from website review alone. The majority of the information was found to be accurate and current. Those programs not demonstrating currency within the 2016-2017 criteria were contacted directly for information updating. Ongoing or recent program reconfiguration was identified for 3 states (Iowa, Massachusetts, and Maryland). The Iowa program was reconfigured, and it is now operated by a committee confirmed by the Board of Pharmacy. The program in Maryland remains active, with updated information provided; however, the state association is considering modifications that could be implemented later this year. No initial website was identified for the Massachusetts program, and an e-mail message did not reveal further information. Nevertheless, our search produced evidence of legislative activity in 2016.[35] Direct telephone contact with the state licensing board identified that the program was under redevelopment from an umbrella program to a board-based program, and the contact information of the board was indicated as currently the best.

The Nevada Board of Pharmacy website link to their program was outdated; however, the corrected e-mail address was provided, and another website providing accurate information regarding the Licensees Assistance Program was identified. Finally, for 3 states (Minnesota, Oregon, and Virginia), the primary program configurations are umbrella programs available to all health professionals. Nevertheless, the pharmacy-focused progenitor programs continue activity by providing support meetings for pharmacists.

It appears that all programs include some form of recovery monitoring with support and advocacy for the pharmacist returning to practice. Specific details can vary considerably, especially related to the duration of monitoring. An important aspect of future work is the identification of these details and the evaluation of their effects on outcomes.

Perhaps the most valuable finding relates to the changes in program structure over the intervening 26 years. In 1990, 25 programs were operated by the state pharmacy associations; 5 were operated by the state board of pharmacy, 6 were operated

Table 3
Active state programs for pharmacists

State	Program name	Website	Contact	Eligible	Model	Currency
Alabama	AL-BOP Wellness	albop.com/BOP_WellnessProgra.aspx	(251) 866-5585	P, I, T	BoP → Comm.	2017
Arkansas	AR Pharmacy Support Group (ARPSG)	www.arpsg.org	(870) 636-0923	P, I, T	BoP → Comm.	2017
Arizona	Pharmacists Assisting Pharmacists of AZ (PAPA)	www.azpharmacy.org/papa	(480) 207-7869	P, S, T	BoP→Comm. Assoc., Fdn.	2017
California	Pharmacists Recovery Pgm.	www.pharmacy.ca.gov/licensees/personal/pharmacist_recovery.shtml	(800) 522-9198	P, I	HCA BoP contract	2016
Colorado	Pharmacy Peer Assist. Pgm.	peerassistanceservices.org/programs/peer-health-assistance-programs/	(303) 369-0039 (866) 369-0039	P, others	HCA BoP contract	2017
Connecticut	Pharmacists Concerned for Pharmacists	www.ctpharmacists.org/i4a/pages/index.cfm?pageid=3811	(860) 674-7984	P, S	Assoc., Fdn., SHSP	2017
Delaware	DE Prof.s' Health Monitoring Pgm.	www.delawaremonitoring.com/	(855) 575-9350	P, others	HCO, Div Prof Reg.	2017
Florida	Prof.s Resource Network (FL-PRN)	www.flprn.org	(800) 888-8776 (904) 277-8004	P, T, others	HCO, DoH	2017
Georgia	PharmAssist	www.gpha.org/foundation/	(404) 419-8130 (404) 558-1983	P, S, T	Assoc., Fdn.	2017
Idaho	Pharmacists Recovery Network	southworthassociates.net/monitoring/pharmacists-recovery-Program	(800) 386-1695 (208) 334-2356	P	HCA BoP contract	2017
Illinois	IL Prof.s Health Pgm. (IPHP)	www.advocatehealth.com/illinoisProfessionalshealthProgram	(800) 215-4357	All	HCO	2017
Indiana	PRN IN	www.prnindiana.com	(317) 634-4968	P, S, T	BoP → funded Comm., Prof. Lices. Agcy.	2017
Iowa[a]	IA Pharmacy Recovery Network (IPRN)	www.iowarecovery.org/	(515) 725-2253	P, S, T	BoP → Committee	2017
Kansas	Kansas PRN (KsPRN)	www.ksrx.org/Kansas-Pharmacists-Recovery-Network	(785) 217-7091	P, S	Assoc. → Committee, BoP	2016
Kentucky	KY Prof. Recovery Network	www.kyprn.com/	(502) 749-8385	P, S, T	HCA BoP contract	2018
Louisiana	LA BoP Impairment Recovery Pgm.	www.pharmacy.la.gov	(225) 925-6496	P, T	BoP	2017
Maine	Medical Prof. Health Pgm.	www.mainemphp.org	(207) 623-9266	P, S, others	HCA BoP	2017
Maryland[a]	Pharmacists' Education & Advocacy Council MD (PEAC MD)	www.peacmaryland.org	(410) 983-0302 (410) 808-0748	P, S, T	501(c3), BoP, Assoc., SHSP	
Massachusetts[a]	MA Substance Abuse Recovery Pgm.	www.mass.gov/dph/Boards/pharmacy	(800) 414-0168	P,	BoP, pending redevelopment	2016
Michigan	Health Prof. Recovery Pgm. (HPRP)	www.hprp.org	(800) 453-3784	P, S, T	HCA, Bureau Hlth. Care Serv.	2016
Minnesota	Health Prof. Services Pgm. (HPSP) None	mn.gov/boards/hpsp	(651) 642-0487	All	HCO	2017
Minnesota (2)	PRN/MN—support	None	(612) 825-5533	P, S	Vol. Comm	2017
Mississippi	MS Assoc. Recovering Pharmacists (MARP)	www.mymarp.com	(800) 582-1454	P, T	BoP → Comm.	2017
Montana	MT Impaired Pharmacists Pgm. (MIPP)	mtassist.org/pharmacy/	(406) 251-4210 (888) 630-4210	P, S, T, others	HCA BoP	2017
North Carolina[b]	NC Physicians Health Pgm. (NCPHP)	www.ncphp.org/	(800) 783-6792	P, others	PHP	2017
North Dakota	ND Pharmacist Assist. Pgm. (Pharm-Assist)	nodakpharmacy.net/wordpress1//?s=pharm-assist	(701) 258-4968	P, I, S, T	Vol. Comm., Assoc.	2017
Nebraska	NE Licensee Assist. Pgm. (NE LAP)	www.lapne.org/	(402) 354-8055 (800) 851-2336	All	HCO, DoH	2016
Nevada[2]	PRN-PRN	medboard.nv.gov/licensees/assistance-programs	(702) 251-1377 or lespadero@strategicbh.com	P, S, T	HCA	2016
New Hampshire[2]	NH Prof. Health Pgm.	www.nhphp.org/index.shtml	(603) 491-5036	P, I, T others	PHP-501(c3)	2016

Table 3 (*continued*)

State	Program name	Website	Contact	Eligible	Model	Currency
New Jersey	Prof. Assist. Pgm. of NJ (PAPNJ)	www.papnj.org/	(609) 919-1660	All	HCO	2017
New Mexico[2]	NM Monitored Treat. Pgm.	www.monitoredTreatment.com/	(505) 271-0800	P, S, T	HCO	2016
New York	Prof. Assist. Pgm. (PAP)	www.op.nysed.gov/prof/pap.htm	(518) 474-3817 x480	P, I, T & others	HCO	2016
Ohio	Pharmacist Rehabilitation Org. OH (PRO OH)	www.ohiopro.org	(614) 506-5690	P, S, T	501(c3), BoP, Assoc, SHSP	2016
Oklahoma	OK Pharmacists Helping Pharmacists (OPHP)	www.opha.com	(800) 260-7574 x5773 (405)557-5773	P, S,	Assoc. → Comm.	2017
Oregon	Health Prof. Services Program (HPSP)	www.oregon.gov/pharmacy/pages/hpsp.aspx	(888) 802-2843	All	HCO	2017
Oregon (2)	ORPRN	www.prnoforegon.org	(971) 563-3893	P, S,	501c3	2017
Pennsylvania	*Secundum Artem* Reaching Pharmacists with Help (S.A.R.P.H)	www.sarph.org	(800) 892-4484	P, S	501(c3), BoP, State	2017
Rhode Island[d]	Coastline EAP	www.coastlineeap.com	(800) 445-1195 (800) 833-0453	P	EAP	2017
South Carolina	SC Recovering Prof. Pgm. (SCRPP)	scrpp.org/for-the-health-care-Professional/	(877) 349-2094	All	HCO	2017
South Dakota[c]	SD Health Prof. Assist. Pgm. (SD HPAP)	www.mwhms.com/ [2]	(605) 275-4711	P, others	HCA	2017
Tennessee	TN Pharmacists Recovery Network (TPRN)	www.tnpharm.org/member-center/tn-pharmacists-recovery-network/	(615) 256-3023	P, I, S, T	Assoc. → Comm.	2017
Texas	TX Prof. Recovery Network	www.txprn.com	(800) 727-5152	P, S, others	Assoc. → HCA, BoP	2017
Utah	UT Recovery Assist. Pgm. (URAP)	www.dopl.utah.gov/programs/urap/	(801) 530-6106	All	HCO	2017
Virginia	Hlth. Practitioners' Monitoring Pgm. (HPMP)	www.dhp.virginia.gov/	866-206-4747	All	HCO	2017
Virginia (2)	Pharmacists Aiding Pharmacists Pgm. (VaPAPP)	www.virginiapharmacists.org/?page=VaPAPP	(800) 527-8742 (x303)	P, I, S, T	Assoc.	2017
Washington	WA Recovery Assist. Pgm. for Pharmacy (WRAPP)	www.wsparx.org/?page=WRAPP	(800) 446-7220	P, E, I	Assoc., SHSP, BoP	2017
West Virginia	WV Pharmacy Recovery Network	www.wvprn.com/default.asp	(304) 533-6844	P, I, S, T	BoP → 501(c3).	2017
Wisconsin	WI Pharmacy Recovery Network (WPRN)	www.pswi.org/Resources/WPRN/Overview	(608) 827-9200	P, I, S, T	Assoc.	2017
Wyoming	WY Prof. Assist. Pgm.	www.wpapro.org/	(307) 472-1222 (307) 441-4463	P, others	HCO	2017

Abbreviations used: Agcy, agency; Assoc., association (state pharmacy); BoP, Board of Pharmacy; Comm., committee; Div., division; DoH, Department of Health; EAP, employee assistance program; Fdn., foundation; HCA, health care association (private or non-profit); HCO, health care organization (government entity); Hlth., health; I, pharmacy interns; Lices., licensing; P, pharmacists; PHP, physicians health program; Prof., professional; Reg., regulation; S, student pharmacists; Serv., services; SHSP, Society of Health System Pharmacists; T, pharmacy technicians; Vol., voluntary; 501(c3), non-profit entity.

[a] Program under redevelopment.
[b] Website does not indicate recent inclusion of pharmacists.
[c] Website pending updates.
[d] Available only to corporate sponsors.

by independent committees, 3 were operated by volunteer pharmacists, and 6 listed their operational model as "other." This last category included collective health care groups, departments of professional regulation, hospital pharmacy associations, nursing programs, and nonprofit corporations.[25] In addition, the 1990 data included notation that 5 programs were administered by more than 1 entity. Unfortunately, the 1990 data were reported in aggregate; thus, the identification of which states moved from 1 model to another is not possible.[25]

Not surprisingly, there have been several modifications of the state programs for pharmacists, especially within a theme of consolidation across health professions or in some cases across state-licensed professions. Table 4 shows a marked decrease in the predominant structure of 1990 as state association−based programs declined from 25 to 8.

A shift toward programs structured as health care groups, departments of professional regulation, or related entities has occurred in 26 states (Table 4). Among these, 10 are structured as health care associations (private treatment group under contract with the licensing authority), 13 as health care organizations (or umbrella approach) funded through state government, and 3 involving an employee assistance program (Rhode Island) or transfer of pharmacists into the state PHP (North Carolina, New Hampshire). We discovered the consolidation of the program for pharmacists in the state of New Hampshire with the program for physicians only through the publication of legislative

Table 4
Models of state pharmacy programs and distribution across states

Model structure	No. states currently	No. states in 1990[a]
State association or foundation	8	25
BoP	9	5
Independent committee, 501(c3)	3	9
Health care group, department professional regulation, hospital pharmacists council or association, nonprofit corporation	26	6
PHP, EAP	3	—
HCA	10	—
HCO (umbrella organizations)	13	—

BoP, Board of Pharmacy; PHP, physician health program; EAP, employee assistance program; HCA, health care association; HCO, health care organization.

[a] Five programs administered by more than 1 group in 1990.

authorization.[36] The website for the New Hampshire PHP program does not yet indicate the inclusion of pharmacists.

Discussion

At the time of the previous report, the identification of program availability was obtainable only by contact with each state association, licensing entity, or word of mouth among pharmacists. The development of the Internet has revolutionized societal communications, and it provides avenues for improved information currency. The efforts of a single pharmacist to develop and sustain a website for state programs have been instrumental in preventing the loss of a central resource; however, the task is more than a single individual acting privately can sustain.[33]

The strength of this report is its insight into how program models have changed over time. As presented in Table 4, a major shift in program structure since 1990 has been the move away from the association (± Foundation)–based model (25 → 8) toward the more consolidated health care group model (6 → 26). We hypothesize the underlying motivation as primarily economic; however, no objective data were pursued as part of the present study. Further study is needed, including a focus on whether 1 model is preferred in terms of outcomes, costs, or effect on the magnitude of the problem.

Limitations of this report attain to the reality of the constant state of flux regarding program details, contacts, models, and the composition of specific features. From a broader perspective, the absence of a readily available and constantly updated resource providing each state's program contact information presents significant challenges. Ideally, the existence of a coordinated database structure allowing deidentified data of individual participants as they progress through structured monitoring would return significant benefits in terms of identifying outcomes, the number of participants over time, successful returns to practice, relapse rates, and rates of continued sobriety over the entire career of those involved.

An intriguing hypothesis that could be evaluated is the impact of an active pharmacist support network to improve recovery outcomes given equal monitoring conditions. This and other specific program features can be identified to mitigate the increased risk inherent in the profession.

Our country seems to experience periodic waves or epidemics of substance-focused problems, such as the cocaine epidemic of the 1980s, the methamphetamine epidemic of the 1990s into the early 2000s, and the present epidemic of opioid use disorders involving both prescription and illicit entities of greater potency (heroin, fentanyl analogs). Perhaps it is time for the second most respected profession[37] to take seriously its inherent occupational risks by directing significant efforts toward mitigating that risk and to better the public it serves.

Acknowledgment

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