Comments on: SB 1441 Substance Abuse Coordination Committee Meeting - Roundtable Discussion on DRAFT Uniform Standards #1 - #6

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#1.

Why use both “substance abuse” and “chemical dependency?” Chemical dependency is a less accepted term, and not used in the diagnostic manual (DSM-IV-TR). I suggest consistency by using substance abuse. I suggest explicitly referencing the DSM-IV-TR, with a diagnosis required (if present) from one of its substance disorder categories.

For psychologists, the qualification should be holding the Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders from the American Psychological Association's College of Professional Psychology. Other professions may have similar qualifications. Requiring only three years experience without any outside validation of the quality of the experience seems risky. I recommend against allowing that criterion.

The evaluation proposed here is a tall order. The “acceptable professional standards” are not well established. Determining threat may require someone with the same license as the person being evaluated. “Threat” as used here is an all-or-none term, but in reality it is not all-or-none. No guidance is offered about how much risk is acceptable. If no risk at all, is anyone fit to practice?

The first aspect of an evaluation is determining the history, which points to the diagnosis. The professional may not be forthcoming or accurate about history. Determining the diagnosis under these conditions is difficult. The evaluator is not a private investigator, but might need to be to get the information needed.

The second aspect of an evaluation, making a prognosis, is equally problematic in substance abuse, because substance abusing individuals can change dramatically, with or without treatment, if sufficiently motivated. Treatment facilities don’t emphasize this point because it is bad for business. However, the DSM-IV-TR

mentions specifically (page 221) that 20% or more of individuals with alcohol dependence achieve long-term sobriety without treatment. In fact I believe they have underestimated this percentage.

Recommendations for treatment are very problematic, because there are so many options for treatment. Evaluating professionals may only be familiar with some forms of treatment. Forcing professionals into treatment that is not well suited for them can be harmful to the professional, and ultimately to the public. As I will argue shortly, requiring clean tests would be a much more sensible approach, vs. requiring treatment.

Evaluations of professionals have often been done by a multi-disciplinary team, and often take several days. However, the facilities that conduct these evaluations have almost always recommended 90 days of residential treatment in their own facility. Such a recommendation if often ridiculous and purely self-serving. In the DOT regulations evaluators (SAPs, Substance Abuse Professionals) may not treat those they evaluate. A similar safeguard would be essential here.

Can a professional who disagrees with the results of the evaluation get a 2nd opinion? There needs to be a way to contest the evaluation. I have seen many poorly argued evaluations. The standards need to protect the public from substance abusing professionals, as well as professionals from false accusations. There are both false negatives and false positives in any testing situation.

#2.

These standards place too much faith in expert opinion and not enough faith in evidence. When professionals have substance abuse problems, and pose a risk to the public, they should be immediately suspended from practice until they test clean for a sufficient period of time. The “sufficient period of time” could be suggested by expert opinion, and would vary according to the severity of the problem. Continuation in practice would be dependent on continued clean tests. A second serious offense would suggest license termination.

I am recommending that temporary removal from practice be the first response, along with immediate and continuous drug testing. Frequency of drug testing should be based on the substance involved, and the evolving technologies available for drug testing. The evaluation should make recommendations about how long the testing should occur, and treatments the impaired professional, at his or her discretion, might consider (i.e., the treatment is recommended, but not required). What the state needs to ascertain is clean tests, not treatment compliance. Otherwise you are forcing impaired professionals into treatment, which is often not very helpful, and at worst promotes the illusion you are doing something when you may not be. The something you need to be doing is assuring non-use, which can only be accomplished by drug testing.

I own and operate a treatment facility. We will lose business if treatment is not required of impaired professionals. But I take pride in being a good citizen above a self-interested businessman. Public safety is promoted by

continuous drug testing, not by treatment.

#3.

I recommend that a professional's involvement with the licensing board or diversion program be quite public. The fact that a professional has fallen under suspicion of substance problems, and is now undergoing testing, should at least be known to employers. If the professional tests clean, the allegations should be easy enough to get beyond. We live in a country that asserts that someone is innocent until proven guilty. If the professional does not test clean, then further actions will be taken, and it will be clear to all that substance problems are dealt with quickly and effectively.

#4.

Many of these details about the mechanics of testing are fine. But the serious flaw here is random testing. Testing needs to be continuous. Two examples: If alcohol is being tested for: an EtG test covers 80 hours. There are 168 hours in a week. Monday/Friday testing can cover 160 hours, M-W-F covers the entire week with overlap. EtG testing needs to take into account that very low scores/results may not be alcohol consumption, but incidental contact.
If stimulants are being tested for, they are usually testable for 2-3 days. M-W-F is appropriate.

Scheduled testing is actually easier than random testing on the individual being tested. It is a known event, and can be planned for. Random testing requires much oversight by a diversion program and drug testing facility, and is cumbersome for participants. It introduces much noise into a system that needs to be simple.

After a long period of continuous testing, there should be some method for applying for reduced testing frequency. When this application should be allowed (months, years?) would be a good question for expert opinion. Random testing may have a use at that time.

#5.

These groups, like treatment, should be optional. Facilitators should be licensed professionals.

#6.

If a professional is testing clean, why should treatment be required? The ultimate outcome of treatment, as far as a licensing board should be concerned, is testing clean. Someone might be declared a "dry drunk" but if the professional functions well professionally that issue is not the board's business.

If the licensee can provide this outcome without treatment, why require treatment? If the threat of loss of license is not going to get someone clean, how much more help will attending treatment add?