# *2018 NCSBN Scientific Symposium* - Regulation: A Comparison of SUD Monitoring Programs Across the U.S. Video Transcript

So, what can we learn from this? So first, I do want to say that there was some methodology background to this which was reviewing the Substance Use Disorder and Nursing Appendix that NCSBN put out.

And we also collected program materials and this was just a solicitation to each of the state programs about, please offer up any policy or procedure documents, especially participant handbooks or manuals that they receive once they sign their contract or right before their contract, and then blank contracts because sometimes if a policy doesn't actually list, say, the testing frequency, sometimes the blank contracts will lay bare that there are options for those, so we can find if there's a case-by-case basis for an attribute or if it's actually mandated through all these documents.

And then finally, once we received all these documents, the goal was to just read all of them, which is very time-consuming. Only a few things could actually be word-searched through just a simple digital search process because every state uses different language and they're in different sections and sometimes it usually is implied only.

So it really does necessitate an entire reading of these documents. So for this presentation, I'll be presenting on 18 programs out of the 27 that we have information for, and here is the list of the ones we have. If you do not see your jurisdiction on this list, don't worry. We probably have your documents, but if not, feel free to contact me.

So... when we started, I got on the phone with some people from the IPN in Florida and walked through a bunch of attributes that I'd seen from different samples of procedural documents and policy manuals.

And ultimately, it narrowed down to about 9 broad categories and 160 attributes. This is a long list of things that can involve family involvement in peer support groups and if they do educational outreach, but it can also be more foundational elements such as the eligibility for a program, your intake evaluation.

And these are the nine categories that we consolidated all of these attributes into and they are... Of most important, it's entry to program, drug screening, violations, which we're going to cover a lot of, and restrictions, actions on licensure. So those are generally your non-compliance or relapse and then the consequences thereof.

So, the results of this analysis so far are that most of these programs have case-by-case stipulations, which on its face makes sense, you want to give your case managers, your practicing physicians, as much leeway to exercise their expertise, understanding, and then adapt a contract that is most efficacious for a given participant, not to say that that's the best way, it is the most common way.

So, some of the program policy and procedures do indicate variability in the requirement of a treatment program, and what kind of treatment program, the length of time in the program is very variable and we're going to see more of that later, and then the type of peer support groups, and so on. And some of the more interesting ones that we hope to put forward in this paper are workplace restrictions and how that may result in a better outcome for a participant.

documents on-hand. And so, further surveys and discussions with these programs will elucidate what actually is happening on the ground.

And then, the next most common attribute to be discussed about in these documents are about how it is required for high-risk participants. High-risk is determined case-by-case, and in that case, it is required for one to two years. And then, the other most common attribute is that it is actually...

Can be used as a substitute for key restrictions or narcotic restrictions. One of those documents only said Vivitrol even though they had previously said naltrexone. So I'd want to ask them more about that. And then, if appropriate, will be required again for one to two years, and then case-by-case. Buprenorphine actually has fewer mentions.

Usually, they're j

Whether that causes a problem for the program or participants is unclear, again, further surveys and discussions will reveal that. So other violations that are considered noncompliance is a much longer list and this is actually an exhaustive list. There's nothing left out from this. So, you have failure to notify at the bottom, license lapsed...

But then, one thing I do want to point out is where the last column was largely two programs that explicitly lay out noncompliant drug violations. With this list, you have a lot more variability among the programs. So, whether there is an institutional history where they felt that it was important to put, say, failure to pay fees as noncompliance in their documents, is an interesting thing to follow up with.

I would like to know more about that. So, late report... The most common one though is refusal or failure to respond. And that's among the four programs. So, program noncompliance, the two most common violations are very broad and those are attendance and violation of contract or law, and these are necessarily broad for a program so that they could say that, "Listen, you signed this contract and you are out of the terms of this contract, so you are in noncompliance."

So that gives them a much bigger catchall. That may mean that they would then belong to all the other violations of, if you are arrested, if you are violating your access restrictions. And then, attendance is another broad category and that applies to meetings with case managers, peer reports or peer meetings, and then even work and work site meetings.

And then, some programs don't explicitly list noncompliance but they do indicate the consequences for noncompliance. Even though they lack a definition. So, a little bit of a breakdown about what may be considered as noncompliance and then some programs where a certain thing is the only consideration for noncompliance.

So, you see a lot of variability with the programs that will consider failed drug test as noncompliance, but those same programs... So e programs tol-13 ce0 g0 G[(-)20(2)21(-)13(w)-64(2)21(us)-s21(-)7(7)( )]TETQq0.00000912 0 6

You may think that they want to have more leeway about what they're going to respond with, and then other ones felt the need to have clear mandated options such as increased drug frequency, increased contract length. Some of these will just go to a reevaluation for SUD which would, in that case, re-trigger an increase in contract length or a new contract.

And so, for the consequences... Sorry, the response to noncompliance, it goes on... This previous list was, these may be required or considered, and then this is the list of what is absolutely required response to noncompliance. And again, this is a much smaller list.

This is program D, has a referral to discipline as required, and then increase contract length for program E is absolutely required for noncompliance. A lot of programs vaguely mention written warnings where they have scales for noncompliance. So if you are a Level 1 noncompliance, then you would get a written warning. But if you rose to Level 2 noncompliance, you would get further actions.

But again, none of those were required. They all used "may" language instead of "shall" or "will" or "is required." So that's noncompliance, very quick overview. I do want to cover in the remaining few minutes the definition of relapse across these programs.

The most... So unlike the other ones which were ordered according to the number of programs in a descending order, this one is in a descending order or increasing order of more stipulations for what relapse is. So it'll start with just a positive screen.

And so, this is, for lack of a better word, the most simple definition, and then the one with more stipulations are something like return to drug and alcohol prescription, or admitted use after a period of abstinence. So there you have three new definitions for relapse. The majority of programs have return to signs and symptoms after apparent recovery.

Again, this is a very broad definition of relapse. And then, you have six don't define relapse. Again, this is for the 13 programs. This is not for the full 27. No program has multiple definitions across these for what relapse is. So there's no confliction or conflicting accounts across the documents. So the response to relapse is varied across programs.

Down here, when it says case-by-case, that's a program that leaves details up to case managers, again, and it doesn't use "shall" or "will" language. And these are similar to the noncompliance, you would cease practice, evaluation for SUD, increase contract length, but the other unique ones are impose access restrictions, and support meetings.

The programs that do not define their responses to relapse, one of them has a definition of relapse but doesn't list responses to relapse. So it's an uncommon thing to have a program define relapse and then

And then noncompliance definitions vary across the programs. Relapse definitions are generally defined as a return to substance use in seven programs and it is determined by an evaluation in one program, and then not defined at all for five. And so, further study, as I said, Richard Smiley and I are going to