When young patients want to leave a center too soon — or try to run away

A report from a committee of the National Academies of Sciences, Engineering and Medicine makes a case for screening and brief intervention strategies and DWI courts as part of an effort to eliminate alcohol-impaired driving deaths.

Residents of treatment programs are not locked from the inside. They are not jails, and they are not psychiatric facilities where people are locked in when they are deemed harmful to themselves (suicidal) or others. That said, parents whose minor children — and parents of young adult children — want to know that their child is safe. They don’t want to hear that their child has run away, as happened last month when a young woman left Timberline Knolls, based in Lemont, Illinois, after her father drove her there from Pennsylvania.

We talked to two large programs last week about the best ways to handle young people who want to leave. One, Rosecrance Health Network based in Illinois, treats adolescents ages 13 to 20 years old in its young persons’ program, and takes the view that if young people want to leave, they should be allowed to. The other, Recovery Centers of America (RCA) based in King of Prussia, Pennsylvania, does not have an adolescent-specific program but admits patients starting at age 18, and has a strategy of moves de-

Bottom Line…
How two treatment centers — both unlocked — handle the patient who wants to run away — a not uncommon feeling among young people in treatment for substance use disorders.

A lower blood alcohol limit for driving and a substantial increase in alcohol taxes likely will be the most discussed recommendations in a new report from a panel examining strategies for eliminating alcohol-impaired driving fatalities, but improving treatment opportunities also receives its due attention in the recom-

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Alcoholism & Drug Abuse Weekly DOI: 10.1002/adaw

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signed to encourage these patients to stay. Still, neither is locked.

Evaluating motivation

“In a residential program such as Rosecrance, the kids are asking to come,” said David Gomel, Ph.D., president of the Rockville, Illinois–based program. “There may be some parental coercion,” he said, so the first step is for the center to evaluate the teen’s motivation. When the parents leave, it’s the teen who is left in the program, which is unlocked from the inside. (“Like our homes, we lock it from the outside,” said Gomel.)

If the patient is a young adult who wants to leave, Rosecrance looks for a “more appropriate place,” said Gomel. “We’re not going to take someone who says, ‘I don’t want to be here,’ and make them stay, because that doesn’t work,” he said. “We talk with the families to find something else.”

Sometimes, when these young people see the gears are in motion to find them a different place, they have a change of heart, said Gomel. “Rosecrance happens to be a very nice treatment facility, and the individual thinks, ‘If I have to be someplace, I’ll be here, where there’s art therapy and a nice environment — I’ll try it.’” But the bottom line is: “If a child doesn’t want to be here, we won’t make them stay.”

Taking a walk, sometimes with a dog

But that doesn’t mean patients are allowed to walk out the door unescorted. “My greatest fear of a young person trying to run away is for their own safety,” said Gomel. “By the time we’ve accepted them, we’ve ruled out the propensity of harm towards others or violence, but we’re worried about these kids leaving and potentially hurting themselves,” he said.

It’s virtually impossible for a young person to leave without being noticed, said Gomel. “We have an adult counselor with our kids 24/7,” he said. And there is a protocol that a counselor would walk with the young person who goes out the door. “We are nestled in about 70 acres of woods and cornfields,” he said. “Kids are typically upset, angry, and in and of itself it’s therapeutic to let them take a walk,” he said. But the counselor would be by the patient’s side, verbally de-escalating the situation, he said.

“Sometimes, exercise alone will help,” he said.

Gomel recollected the time when a counselor came to him describing a young patient who was agitated and “hell-bent on not being here.” Gomel went to the patient with the program’s therapy dog.

“I said, ‘Let’s take the dog for a walk.’” He said that he “did very little; the dog and the walk did it all.”

The young patient returned and recovered.

Security is used at night to monitor the parking lot and the front door, but in terms of staff, Rosecrance only uses counselors, not security with young patients.

“When a young person is saying I don’t want to be here anymore,’ you take it seriously,” said Gomel. It’s important to try to find out what is causing the problem, and to deal with it — possibly with an intervention with the family on the telephone, a medication adjustment or talking through it.

‘All hands on deck’ to block AMA discharge

Deni Carise, Ph.D., chief scientific officer for RCA, doesn’t have a specific adolescent program but does treat patients 18 years old and up. Like Rosecrance, treatment is not in a locked unit, but for the safety of the patient, RCA does make sure someone “has to go through a lot if they want to leave, especially if they want to leave on the spur of the moment.”

DOI: 10.1002/adaw
When a patient wants to leave RCA, “it’s all hands on deck to block this AMA [against medical advice] discharge,” said Carise. “The therapist, psychiatrist, nursing staff all reach out. We call their family and say leaving is a bad idea.” But she notes that “we can’t force them to stay.”

The first few days are the most critical for young people, said Carise. “We tell the parents there’s a good chance your kid is going to call you tomorrow or the next day and say ‘I hate this place, I want to go home,’” she said. “We pre-empt this by preparing the family for it.” And RCA has a blackout period in which the patients can’t use the phone for the first five days of treatment. They also can’t use their own cell phones, because (like Rosecrance and most other facilities) cell phones, iPads and laptops are not allowed in treatment. “We take away anything that connects to the internet,” she said. “I didn’t want to do this at first, but the fact was that people were using their phones for all manner of things, including calling out for cigars.”

Staff document where patients are at least once an hour, 24 hours a day, said Carise. There is also a grounds monitor who is usually outside, walking around the campus.

RCA has five facilities — Mays Landing, New Jersey; Earleville, Maryland; Danvers, Massachusetts; Westminister, Massachusetts; and Devon, Pennsylvania. The New Jersey facility is on the bus line, since it is both outpatient and residential. The Maryland facility is in a very secluded rural area, with a two-mile driveway to get to the front door. The other three are in more suburban areas.

The therapeutic power of choice

There is a therapeutic value to being in an unlocked facility. “These kids have to make decisions about their drug use, their peer relations,” said Gomel. Most are only at the Rosecrance residential program for a month. They have to go back to school and make decisions (Rosecrance has tutors so that they don’t fall behind on their schoolwork when in treatment).

Giving someone the power to know that it’s up to them to stay — it’s their decision — can actually make them less likely to want to leave, said Gomel. When a young person is walking into the facility for the first time, and says, “I’m not coming in,” Gomel will then tell the individual that the doors aren’t locked, and ask him or her to go in on their own, and then to see that the doors aren’t locked. “When they go in, and turn around, and realize they are not locked in, it takes away part of the fear because they know it’s a choice,” he said. “I tell them, ‘I promise you, this is your decision.’”

Carise agrees that it’s important for patients — who by definition are impulsive since they are both addict-ed and young — to have a cooling-down period when they want to run away, which can be managed diplomatically (like Gomel’s dog walk).

For example, staff at RCA let the patient know that before they leave, they need to get prescriptions signed by the doctor and that they need to get their belongings (cell phone, money, etc.) that have been locked up. “There’s a whole psychology behind allowing them to make their own choice,” she said. “There are some patients for whom we say, ‘OK, let’s get you started to go’ and then they back down a little bit. We say, ‘It’s time for lunch; just have lunch first while we do your paperwork.’” And then they change their mind.

But there are patients who don’t want their phone or their money back, and don’t even tell RCA they want to leave. They just plan to leave. “I take this seriously,” said Carise. “If we see them leaving, we’ll go after them. We say, ‘We don’t want you to leave in your pajamas; let’s get your clothes.’ And most important, we say, ‘We want to get you a ride.’”

As for the Timberline Knolls incident, owner Acadia Healthcare told Fox32 that “safety is our first priority and all law enforcement and appropriate agencies are notified as warranted.” We reached the secretary of CEO Joey Jacobs and asked for an update on what happened there. By press time, nobody had called back.

More comments from 42 CFR Part 2 listening session

In last week’s issue, we covered the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) listening session on 42 CFR Part 2, which took place on Jan. 31.

The final rule on supplemental provisions was issued last month (see ADW, Jan. 8) and weakened consent provisions, but not to the point of completely aligning the regulation with the Health Insurance Portability and Accountability Act (HIPAA), as many commenters wanted.

Under HIPAA, patients don’t consent to having their information released. It just is released — but it

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has to be under certain terms. Under 42 CFR Part 2, patients must consent to have their information about their drug and alcohol treatment released.

The 42 CFR Part 2 regulation has been in effect for more than three decades, and never caused any problems until the advent of electronic health records, which made the paper-and-pencil consent inconvenient, and in fact, which make any consent inconvenient, according to some.

Kimberly Johnson, Ph.D., who until last week was director of SAMHSA’s Center for Substance Abuse Treatment, seemed to suggest that moving toward a HIPAA standard was a possibility. Some commenters even want opioid treatment programs (OTPs) to put the names and doses of patients into prescription drug monitoring programs (PDMPs), not allowed by SAMHSA and not in the purview of 42 CFR Part 2.

Below are some of the comments made at the listening session that we did not publish last week due to space issues. There is no transcript; we wrote down the comments as we heard them.

“I wrote the law requiring HHS to rewrite Part 2,” said Tim Murphy, Ph.D., former Republican congressman from Pennsylvania. “The PDMP was put into place to allow doctors to track if people were doctor-shopping to get different opioids. Methadone is not included in the PDMP because of Part 2 rules. It doesn’t make sense that a doctor wouldn’t be allowed to know what medications a patient is on, he said.

Eric Bailly, business solutions director for Anthem, wants 42 CFR Part 2 to be aligned with HIPAA. “We believe the changes” fall short, he said. Bailly, who is also an alcohol and drug counselor, wants one regulation, and he wants it to be HIPAA.

“I understand the need for consent,” said Gerard Scheitlin, vice president for security, risk, and assurance with Orion Health. But he cited the work of the ONC (Office of the National Coordinator for Health Information Technology, part of the Department of Health and Human Services) in trying to have consent flow nationwide. “It’s more and more difficult to manage electronically, not because we can’t say yes, this person is not consented, but because it is becoming, programmatically, a major challenge,” he said. “I urge SAMHSA to work with CMS and ONC.”

“Methadone clinics are some of our clients,” said Al Guida, speaking on behalf of Netsmart. Consent2Share, the open-source software developed by the federal government to help health care information technology adapt to 42 CFR Part 2, is not practical to implement, he said. “We would need every hospital system, every primary care practice, every ACO, every health information exchange in the United States to adopt this open-source technology in order to operationalize the rules,” he said. The fact is that Consent2Share, which would allow electronic consent under 42 CFR Part 2, isn’t even being used, he said. “Netsmart is worried about this,” he said. Guida also added that medication interactions between methadone and other medications need to be known by health care providers.

“We can’t treat addiction in isolation,” said Kelly Corredor, director of advocacy for the American Society of Addiction Medicine (ASAM). “The barriers that 42 CFR Part 2 places cause significant harm,” she said. (ASAM came out in favor of gutting 42 CFR Part 2 last year.)

Indeed, methadone patients are the ones most likely to be harmed by any further weakening of consent, which the final rule issued last month already did. Some, like the American Association for the Treatment of Opioid Dependence, the Legal Action Center, and Faces & Voices of Recovery, don’t want the broad rubric of “health care operations” to allow unconsented release of records. Others do. And the main call when it comes to medication interactions seems to be that they want to get into the records of patients in OTPs, because all other prescribed controlled substances can be found in the PDMP. If methadone patients lose control of their privacy, they may not want to come to treatment. People are still losing custody of their children and losing their jobs because they are in treatment with methadone, as H. Westley Clark, M.D., J.D., notes frequently on these pages.

The deadline for comments to SAMHSA is Feb. 28. Send them to PrivacyRegulations@samhsa.hhs.gov. “Any input we may receive subsequent to the meeting may be used as SAMHSA continues to determine how best to implement Part 2,” an agency spokesman told AD4W after the listening session.

by an addiction-trained clinician.

The report of recommendations was commissioned by the National Highway Traffic Safety Administration (NHTSA). Its drafters state that most of the strategies they are recommending for elimination of alcohol-impaired driving deaths are not new ideas, but they stress that a plateauing of reductions in fatality rates in recent years signals that the overall effort needs to be reinvigorated. “Progress has stagnated and even reversed,” states the report, Getting to Zero Alcohol-Impaired Driving Fatalities: A Comprehensive Approach to a Persistent Problem.

Yes, the report uses a framework of eliminating, not simply reducing, the problem of alcohol-impaired traffic accidents that claimed more than 10,000 lives in the United States in 2016 (a 1.7 percent increase from 2015). The NHTSA and other federal agencies in 2016 launched the Road to Zero coalition, articulating an ambitious goal to end all traffic fatalities within 30 years (this is modeled after a Vision Zero approach to traffic safety that Sweden adopted two decades ago).

“Each alcohol-impaired driving crash represents a failure of the system — whether that is excessive alcohol service, poor road design, lack of effective policies or enforcement — and is preventable with a coordinated, systematic approach across multiple sectors,” the committee’s report states.

Lofty proposals?

The highest-profile recommendations in the Health and Medicine Division’s report are those most likely to clash with competing political interests. But Ralph Hingson, Sc.D., who directs the Division of Epidemiology and Prevention Research at the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and was one of the report’s official reviewers, told ADAW that all of the document’s recommendations, including on the legal blood alcohol limit and alcohol taxes, were issued with a solid research basis behind them.

“The report was very well-documented,” Hingson said. “I did feel that they did a very thorough job reviewing the literature.”

Regarding impaired driving, the report recommends that states set a standard of 0.05 percent blood alcohol concentration (BAC), a level Hingson says applies in a majority of other countries around the world. The recommendation adds that the federal government should incentivize this change at the state level, much as it did when it tied eligibility for state highway funding to a reduction of the BAC from 0.10 to 0.08 (as well as when it applied that to other measures, such as the increase in the legal drinking age from 18 to 21).

Utah currently is the only state with enacted plans to lower the standard for impaired driving to .05, with its new law set to take effect in late December of this year.

The report states that laboratory and epidemiological studies indicate that an individual’s ability to operate a motor vehicle diminishes at a BAC well below .05. Hingson, who says he personally recommends no driving after any level of alcohol use, adds that the risk at levels of .05 and below is greater for younger drivers.

The committee also recommends that alcohol taxes be increased significantly, or “enough to have a meaningful impact on price and therefore on reducing alcohol-related crash fatalities,” the report states. “The increases should comprise a meaningful percentage of the net-of-tax price (e.g., 30 percent or more), of alcohol products, and cover the marginal, external (i.e., secondhand) costs incurred by the sale of alcohol.”

The report adds that alcohol taxes arguably have the strongest research base for reducing binge drinking, with evidence suggesting that a doubling of alcohol taxes would generate an 11 percent reduction in traffic fatalities.

Treatment focus

In its treatment-related recommendations, the committee suggests that every state implement DWI courts and that all health insurers and health systems cover and facilitate effective prevention and treatment services, featuring a screening, brief intervention and referral to treatment approach. Treatment strategies should incorporate both medication treatments and cognitive behavioral therapy, the report states.

Tom Deitzler, senior clinical advisor to the executive vice president of treatment at Caron Treatment Centers, believes in the ability of postarrest programs to bring about change among DWI offenders. Prior to his latest stint at Caron, Deitzler was instrumental in molding a DWI program that Caron had originated into the establishment of a tailored program for second and third offenders in Berks County, Pennsylvania, a county-funded initiative that continues to thrive. The program, Continues on next page
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which was created as a 90-day partial hospitalization design with a residential component (allowing participants to maintain their job schedules), has helped to establish a culture of treatment in the county, according to Deitzler.

He told ADAW that a particular challenge treatment providers will face in working with the DWI offender involves “a very high level of denial.” He said, “They rationalize, saying things like, ‘If my left turn signal hadn’t been out, I wouldn’t have gotten stopped.’” This kind of logic might be used even if someone had been driving with a BAC three times the legal limit, Deitzler said.

He says a consequence in the individual’s life is usually what serves as the vehicle for change, but he does not consider higher taxes or lower BACs to be the prime motivator. A lower BAC might intercept more violators, but that’s not what generally stops people from using at harmful levels, Deitzler said. Lasting damage to one’s career or family life poses a more potent threat, he said.

The program in Berks County seeks to define the DWI event as a gift of sorts, in potentially serving as the catalyst for lasting change.

Among the other recommendations in the committee’s report are strengthening laws to block underage and other illegal alcohol sales; offering insurance incentives for use of advanced technology in development to block operation of a motor vehicle when a person’s BAC is above the legal limit; and imposing stricter regulations on alcohol marketing, with the report calling the alcohol industry’s existing voluntary standards “permissive and vague, not consistently followed, and without penalties for violations.” •

‘They rationalize, saying things like, “If my left turn signal hadn’t been out, I wouldn’t have gotten stopped.”’

Tom Deitzler

CADCA tackles e-cigarettes, vaping and nicotine

Community Anti-Drug Coalitions of America (CADCA) takes vaping — also known as e-cigarette use, or ENDS (electronic nicotine delivery systems) — seriously. We talked to Keith A. Vensey, CADCA’s director of the Geographic Health Equity Alliance, last week during the organization’s annual national leadership forum.

The Geographic Health Equity Alliance is CADCA’s national network dedicated to addressing geographical health disparities related to tobacco use and cancer. Funded in part by the federal Centers for Disease Control and Prevention (CDC), Vensey’s group has developed training sessions and breakout sessions that can help health workers dispel some of the myths about ENDS.

One of the arguments made in favor of ENDS is that it’s safer than smoking tobacco cigarettes — a notion CADCA disputes. “We do not espouse the position of harm reduction as of yet, because we do not have enough irrefutable evidence,” Vensey told ADAW. “What we are still trying to figure out is the biological pathways that are activated when ENDS are used. We do know that the consumption of nicotine in adolescence can severely impede brain development.”

In addition, the aerosol route of delivery penetrates more deeply than the combustible, which results in increased absorption of nicotine, he said.

Indeed, nicotine is so addictive that it’s hard to stop, even for cancer patients. At last week’s meeting, Vensey’s department developed several sessions, including one on cancer survivors who continue to smoke, and how to bring about smoking cessation among these patients.

FDA

Some of the ingredients put in the cartridges have been designated GRAS (“generally recognized as safe”) by the Food and Drug Administration (FDA), but not for the respiratory route of administration, said Vensey.

Indeed, the FDA has not been clear on nicotine. “It appears that there’s some equivocation on their stance as it relates to the isolation of nicotine and the consumption of nicotine via ENDS,” he said. “We would like the FDA to clarify its stance on nicotine.”

Tell kids the truth

Prevention with youth should not talk down to them, said Vensey. “The Real Cost” anti-tobacco campaign by the FDA has shown that
“we should abandon the notion that we need to sugarcoat things with youth,” he said.

There are fundamental, across-the-board messaging techniques that work with youth and adults, said Vensey. It comes down to telling the truth. “We should present this to youth as we would to an adult population,” he said. “In this day and age, people, including youth and adolescents, want to be told things the way they are.”

Vaping in schools has become extremely problematic, because there are now vaping devices that look like a regular ink pen, noted Vensey. When the teacher turns his or her back, the student takes a drag.

Industry responsibility

Vensey blames the industry for circumventing existing laws with vaping. It all comes down to language, he said. “I’m not trying to simplify it, but it’s all about the wording,” he said. “The CDC had to redefine their nonsmoking laws.” Local governments and states are also trying to stay on top of the issue.

“The tobacco industry is doing what it does very well, steadfastly attacking claims,” he said. “This is not only a public health coalition fight; it’s a state fight.”

Coalitions are a great avenue for change, but Vensey urges that political representatives “be held to a higher standard in being more expeditors in responding to changes,” he said. “We revere the market, we revere the private sector,” but what about health?

In the meantime, Philip Morris is working on other ways to deliver nicotine, including a device that heats tobacco to a temperature that’s just below combustion but delivers the same amount of nicotine and tobacco as a regular cigarette. This is approved in many countries, but so far, the FDA has not allowed it to come to market in the United States.

“These people don’t sleep,” said Vensey of the industry. “There’s no telling what they will come up with next.”

Youth CADCA leader passionate about using his voice

Curtis Mark is a 16-year-old youth leader from Orange, New Jersey, who frequently uses the word “passion” to describe his work with the Community Anti-Drug Coalitions of America (CADCA). In an interview by phone last week while he was attending CADCA’s annual national leadership meeting, he told ADW that “often youth voices are not taken into consideration.” It’s important to have youth feel “passionate” about drug and alcohol prevention, he said.

“In my town, a major issue is alcohol retailing,” he said. “There are a lot of liquor stores by my school.” Two years ago, one of his friends asked a stranger to go into a store and buy alcohol for the friend, which the stranger did. “That helped me understand that this is important, that the school and the community need to address the problem,” he said.

As a young person, he is able to communicate with other students. “We try to stress that peer pressure is a really big problem,” he said. “Just because your friend is doing something you think is cool, it really isn’t. He may be going through another problem at home, or at school.”

Mark is also concerned about marijuana legalization, which will make use of the drug more open and accessible to young people. “I’m definitely not for it,” he said.

Mark’s friends are impressed by his work with CADCA, which includes travel. But he is also worried about his own neighbors.

“I live in a community where drugs and alcohol are really prevalent, you see people drinking out of a paper bag” on the street, he said. He thinks that when he comes back from training, he can help other youth do the same kind of work he does. “I tell them, ‘Just go to a town hall meeting and express your voice. People will listen.’”

Mark is currently a high school junior, and hopes to go to Rutgers or Johns Hopkins. “I want to do something dealing with substance abuse, or something in the health care field, especially with a nonprofit organization,” he said.
New HHS head directed to focus on opioid crisis, but first to get Rx drug prices down

In administering the oath of office to Alex Azar, confirmed last month as the new secretary of the Department of Health and Human Services (HHS), President Trump urged him to “roll back regulations,” “get those prescription drug prices way down” and “lead our efforts to confront the national emergency of addiction and death due to opioids.” President Trump said that “we’re going to be very tough on the drug companies in that regard and very tough on doctors in that regard.” According to President Trump, patients “go in for a minor operation,” and “they come out, they’re addicted to opioids.” Azar has been with HHS before, as general counsel and as deputy secretary, and was also president of Lilly USA. Ultimately, getting prescription drug prices down will be the top priority, said President Trump. “I know you can do it,” said the president. “You know the system and you can do it.” Azar’s first remarks after taking the oath were to note that he is the grandchild and great-grandchild of immigrants from Lebanon, from the Ukraine, from England and from Switzerland, and that this could happen only in America. Azar is the second HHS secretary during the year-old Trump administration; the first, Tom Price, M.D., was asked to resign, ostensibly because he spent too much money on private airfare, but more likely because he was unable to get the president. “You know the system and you can do it.” Azar’s first remarks after taking the oath were to note that he is the grandchild and great-grandchild of immigrants from Lebanon, from the Ukraine, from England and from Switzerland, and that this could happen only in America. Azar is the second HHS secretary during the year-old Trump administration; the first, Tom Price, M.D., was asked to resign, ostensibly because he spent too much money on private airfare, but more likely because he was unable to get Congress to repeal the Affordable Care Act.

SPLC files class action suit against HHS over Medicaid work requirements

Last month, the Southern Poverty Law Center (SPLC) and two other organizations filed a lawsuit in the U.S. District Court for the District of Columbia on behalf of 15 Kentucky residents who are enrolled in Medicaid. The class action suit challenges the Department of Health and Human Services’ (HHS’s) approval of state plans to require Medicaid enrollees to work. The first such waiver was approved for Kentucky earlier this month (see ADAW, Jan. 22). The waivers violate the authority of HHS under the Social Security Act, because they are not consistent with the objectives of the Medicaid Act, according to the lawsuit. “Through imposition of premiums and cost sharing, ‘lockouts,’ benefits cuts, and a work requirement, the waiver will radically reshape Medicaid in a manner that, by the state’s own admission, will result in substantial reductions in coverage,” the lawsuit states. After HHS announced approval of Kentucky’s waiver, Gov. Matt Bevin signed an executive order that calls for the end of the state’s Medicaid expansion if the approved waiver was found to be illegal. “The governor’s threat — to punish the 400,000 residents who have received Medicaid under the expansion if a court rules against the Kentucky HEALTH project — is shameless,” SPLC Deputy Legal Director Samuel Brooke said, “We will not be intimidated. We will defend the rights of individuals to enroll in Kentucky’s Medicaid program.” The National Health Law Program and the Kentucky Equal Justice Center, along with the SPLC, are representing the plaintiffs.