



Stephanie Nunez, Chair  
**Respiratory Care Board**

Elinore F. McCance-Katz, MD, PhD  
**CA Dept. of Alcohol & Drug Programs**

Kim Madsen  
**Behavioral Sciences, Board of**

Richard De Cuir  
**Dental Board of California**

Virginia Herold  
**Pharmacy, Board of**

Steve Hartzell  
**Physical Therapy Board**

Louise Bailey  
**Registered Nursing, Board of**

## **Substance Abuse Uniform Standard #4 Subcommittee Meeting**

Wednesday, March 9, 2011  
12:30 p.m. to 4:00 p.m.

First Floor Hearing Room S-102  
1625 North Market Blvd., Sacramento, CA 95834

### **AGENDA**

1. Welcome, Chair Stephanie Nunez
2. Subcommittee Member Introductions
3. Purpose of Meeting, Chair Stephanie Nunez
4. Approval of August 4, 2010 Meeting Minutes
5. Recommendations for Proposed Amendments to Uniform Standard #4 Regarding Drug Testing Requirements
6. Public Comment
7. Adjournment

### **NOTICES**

- The Subcommittee may take action on any item listed on this agenda unless designated as "Informational Only."
- This meeting is accessible to individuals with physical disabilities. Providing a disability-related accommodation request at least five (5) business days before the meeting will help to ensure availability of the requested accommodation. To make a request please contact Jeff Toney at (916) 574-7803 or by sending a written request to the Department of Consumer Affairs, Division of Legislative and Policy Review, 1625 North Market Blvd., Suite S204, Sacramento, CA 95834, Fax: (916) 574-8655, Email: [jeff.toney@dca.ca.gov](mailto:jeff.toney@dca.ca.gov). Requests for further information should be directed to Mr. Toney at the same address and telephone number.
- This meeting is being conducted in accordance with the Bagley-Keene Open Meeting Act. Additional information about the SB 1441 Substance Abuse Coordination Committee and Uniform Standards applicable to healing arts substance-abusing licensees is available online at [http://www.dca.ca.gov/about\\_dca/sacc/index.shtml](http://www.dca.ca.gov/about_dca/sacc/index.shtml).



**DIVISION OF LEGISLATIVE & POLICY REVIEW**

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**DRAFT Uniform Standard #4 Subcommittee DRAFT**

**Substance Abuse Coordination Committee (SACC)**

**Date:** Wednesday, August 4, 2010

**Time:** 9:30 a.m. – 12:30 p.m.

**Location:** First Floor Hearing Room, S-102  
1625 North Market Blvd., Sacramento, CA 95834

**Attendees:**

Subcommittee Members:

Stephanie Nunez, Respiratory Care Board, Committee Chair  
Elinore F. McCance-Katz, M.D., Ph. D. CA Department of Alcohol & Drug Programs  
Kim Madsen, Board of Behavioral Sciences  
Richard De Cuir, Dental Board of California  
Virginia Herold, Board of Pharmacy  
Steve Hartzell, Physical Therapy Board  
Louise Bailey, Board of Registered Nursing

DCA Staff:

Susan Lancara, LPR  
Katherine Demos, LPR  
LaVonne Powell, Legal Counsel  
Erica Eisenlauer, LPR

Guests:

Frederick Ly	Victoria Thornton	Christina Price	Jill Alleock
Francine Farrell	Chuy Ibarra	Catherine Hayes	Mary Hegarty
Jessica Sieferman	Pam Davis	Marilyn Kimble	Millie Lowery
John Horning	Virginia Matthews	Lori Reis	Mona Maggio
Monny Martin	Larry Collins	Kristine Brothers	
Shana Doolin	Margie McGavin	Anne Sodegren	

*Please note that attendees were not required to sign-in and some names may be misspelled.*

**Agenda Item 1. Welcome**

Ms. Stephanie Nunez, welcomed everyone and thanked them for attending the SACC Uniform Standard #4 Subcommittee (Subcommittee) meeting.

**Agenda Item 2. Subcommittee Member Introductions**

Ms. Nunez invited the Subcommittee members to introduce themselves.

**Agenda Item 3. Purpose of Meeting**

Ms. Nunez, said the purpose of the meeting is to discuss the proposed drug frequency testing schedule and the drug testing requirements of Uniform Standard #4 (Standard). Ms. Nunez provided an overview of the meeting attachments including: charts providing

other states' information, an article from the Journal of Addictive Diseases<sup>1</sup>, and letters from Elinore F. McCance-Katz, M.D., Ph.D., Professor at the University of California, San Francisco (sent 8/3/2010) and Julianne D'Angelo Fellmeth, Administrative Director of the Center for Public Interest Law at the University of San Diego (sent 6/28/2010) submitted for the record. Ms. Nunez also discussed the requirements as the Standard currently reads, and the repercussions identified by the Subcommittee if the Standard remains in its current form.

The Subcommittee discussed the number of urine tests that should be required for the first year a substance abusing licensee is in a treatment program. The Subcommittee addressed the letters from both universities submitted for the record. The Subcommittee also addressed the importance of testing licensees prior to and upon their return to work. The Subcommittee acknowledged the difference between the boards that have diversion programs and those that do not, and discussed the level of monitoring the licensees receive.

#### **Agenda Item 4. Discussion and Drafting of Proposed Drug Testing Frequency Schedule**

Ms. Nunez opened the floor for public comment and Subcommittee discussion regarding the sample testing frequency schedules.

Virginia Matthews, Maximus Project Manager, stated that she supports the alternating testing schedule and believes that testing more frequently when individuals return to work is best because of potential patient harm and cost associated with testing. She informed the Subcommittee that the testing schedule varies for each board for which Maximus provides services. The current testing schedule in Uniform Standard #4 (104 times per year) is too frequent, is not supported by literature, and would not increase the probability of detecting a substance abusing licensee. She reported that Maximus always tests more than once a month and if they have an unconfirmed positive drug screen, they automatically add more drug screenings while they continue to investigate the positive screen.

#### **Subcommittee Discussion**

The Subcommittee discussed the difference in substance abusing licensees who are practicing and those who are not. The members discussed the risk for relapse, time frame statistics, how chronic diseases are viewed, and the process for returning a licensee to work.

Francine Farrell, Pacific Assistance Group, stated that most people in monitoring programs enter voluntarily or participate for disciplinary reasons. Ms. Farrell stated that creating a standard approach to fit all participants is not possible. She stated that 90% of people that come out of the 90-day treatment programs will relapse if they do not

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<sup>1</sup> Crosby, Ross D., Carlson, Gregory A., Specker, Sheila M. "Simulation of Drug Use and Urine Screening Patterns" Journal of Addictive Diseases (2003) 22:3,89-98.

receive continued monitoring. When the standards are set too high, the public feels “safe,” but people are caught more often with random testing, versus increased testing. There are other ways of monitoring people, such as face-to-face contact, which is more effective than random urine testing. Ms. Farrell stated that the departments’ mandate is to protect the public, but if we set the standard too high, we will create a huge pool of people who will not seek treatment. Additionally, she discussed the number of times per month that the Medical Board diversion program participants were tested when it was operating. She stated that in every monitoring program there are going to be problems, and that she doesn’t know of any state that tests licensees 104 times per year. She hopes the Subcommittee will create a program that will encourage people to participate.

Diversion Program Participant, stated that there is no way she could have afforded the diversion program with the testing requirement of 104 times per year. She acknowledged that it is true that you need ongoing monitoring after the completion of the program. She believes that the diversion program works, and that testing 18-24 times per year, with the possibility of increased testing, is the best option.

#### Subcommittee Discussion

A member of the Subcommittee suggested that all healthcare practitioners should have access to these kinds of programs.

Francine Farrell, Pacific Assistance Group, stated that she believes these programs work to protect the public and these standards should not make it so difficult that people do not come into these programs. Participants speak out about how they would never have entered the program if they were aware of the changes being made to the programs.

#### Subcommittee Discussion

The Subcommittee discussed the cost of the testing and announced that there is a new department contract in place that will reduce the cost for participants to be tested. The contracted cost for urine screening includes: \$29 for a testing fee; and \$25 (varies slightly between sites) for a collection fee.

Diversion Program Participant, stated she has been in the program for three years and could not afford testing 104 times per year since she has not been working. She discussed the details of the testing and the program. She believes testing 24-36 times for the first year is reasonable, and agrees with weekend testing.

Diversion Program Participant, discussed what it is like to be a participant in the Maximus diversion program for the past two years. She touched on how every participant is handled on a case by case basis. She believes Maximus is more than just urine screening vendors; they offer help and support to licensees.

Subcommittee Discussion

The Subcommittee discussed that the testing is based on direction provided by the board to Maximus, and that additional testing is added if necessary, based on the participant's performance and progress in the program. Maximus suggests that 24 tests per year be the bare minimum of tests for participants in treatment.

The Subcommittee discussed the number of acceptable urine drug screenings. Some members stated that two to four urine screenings in the first month is reasonable and the licensee should not be working during that time.

Ms. Nunez provided the Subcommittee with a handout including five different testing frequency schedules. The Subcommittee was encouraged to evaluate and discuss the samples and select one for presenting to the full SACC Committee in lieu of the present Uniform Standard #4. The samples included the number of minimum testing, based upon the months, quarters, or years.

Steve Hartzell made a motion, seconded by Stephanie Nunez, to adopt Sample #1 testing frequency schedule, which included the following:

- 18 tests for months 0-2 (2x per week)
- 46 tests for months 2-12 (1x per week)
- 24 tests for months 12-24 (2x per month)
- 12 tests for months 24-36 (1x per month)

The Subcommittee discussed the motion and various scenarios as to how they would unfold using this frequency of testing. Some members thought that additional language would need to follow the frequency table for further instruction. A member of the Subcommittee reminded the members that these standards are required to be implemented by Maximus and followed by the participants regardless of whether they are voluntary or self-referred into the program. Another member of the Subcommittee said that they agree with Sample #1, if the first level was removed. It was noted that it would then be more like Sample #4, with the numbers 46, 24, and 12 inserted in the different levels. Mr. Hartzell amended his motion to replace Sample #1 with Sample #4 as shown in the table below, and to have Legal Counsel draft language to state that if there is a voluntary, self-referred participant in the board's contracted diversion program, that board will consider the time of participation.

The motion was unanimously passed to adopt the sample (see table below) for licensees who are working and on probation or in a diversion program.

<b>Level</b>	<b>Segments of Probation/Diversion</b>	<b>Number of Random Tests</b>
I	Year 1	48
II	Year 2	24
III	Year 3+	12

#### **Agenda Item 5. Discussion and Drafting of Amendments to Uniform Standard #4 Regarding Drug Testing Requirements**

The Subcommittee discussed the frequency of testing for participants who are not working. A number of Subcommittee members recommended that testing for licensees, who are not working should not cease, but rather decrease in frequency.

Ms. Nunez invited the public to comment on the amended language to Standard #4.

Mary Haggerty, suggested that the Subcommittee listen to the experts in the field, instead of their own ideas about substance abuse and treatment for these individuals.

Diversion Program Participant, asked if there is anyway that the Subcommittee will revote on the sample schedule. She would like the numbers to be 24 tests per year if you are not working and 26 times per year if you are working for the first year.

#### **Subcommittee Discussion**

The Subcommittee discussed possible exceptions regarding driving under the influence of alcohol violations and the different scenarios they have experienced with substance abusing licensees. The Subcommittee questioned if a solitary driving under the influence violation is considered substance abuse, and if those licensees would be held to the same standard.

Diversion Program Participant, stated that she understands the need for standards, but wants the Subcommittee to acknowledge that these are people with families. She provided a couple of scenarios for the Subcommittee to consider regarding licensees and participation in diversion programs.

#### **Agenda Item 6. Scheduling of Next Meeting**

The Subcommittee announced that they will meet again in September.

#### **Agenda Item 7. Public Comment**

There was no public comment.

#### **Agenda Item 8. Adjournment**

The meeting was adjourned at approximately 11:30 a.m.

## Uniform Standard #4 Subcommittee DRUG TESTING PROPOSED AMENDMENTS - RATIONALE

Uniform Standard #4, adopted by the Uniform Standards Committee in 2009, provides that any person subject to testing shall be tested a minimum of 104 times (an average of 2x/week) the first year and no less than 50 times, every year thereafter. The Uniform Standard #4 Subcommittee was established to revisit this standard to determine if it was the most pragmatic approach, given additional considerations, and provide a recommendation to the full Uniform Standards Committee for consideration.

According to the analysis of SB 1441, the drive to establish standards was to maintain public confidence in different healthcare licensing boards' *"diversion programs."* The author stated the bill was necessary to "ensure that public safety remains the paramount mission of healing arts licensing boards when dealing with licentiates who are suffering from drug or alcohol *abuse* or *dependency* problems." "The impetus for this bill [was] the repeated failures of the MBC's Physician Diversion Program (PDP), and the immediate and grave risks to the public posed by physicians who continue to practice medicine despite their chemical dependency." Some additional noted factors were: failure to respond to potential relapses timely; failure to require a physician to immediately stop practicing medicine, after testing positive; 26% of tests were not done as randomly scheduled, and failure to have a method to formally evaluate its collectors, group facilitators and diversion evaluation committee members to determine whether they are meeting program standards. In addition, the author pointed out that "no audit or review has been conducted on the other health care licensing boards that maintain and operate their own *diversion programs* for licensees that suffer from chemical *dependency* or on the singular program (e.g. Maximus) which administers the diversion programs... ."

One of the most difficult hurdles in establishing Uniform Standards for all health boards, is the fact that there are numerous boards/bureaus, each with their own methodology and approach to discipline and for a handful of boards/bureaus, this includes rehabilitation or diversion programs.

Health care boards with diversion programs find their programs successful in providing immediate intervention for licensees whose substance abuse has not risen to the threshold of actual harm to the public. The diversion programs provide immediate removal from the practice, while the licensee focuses on recovery. Diversion provides a mechanism for immediate evaluation, treatment, monitoring, support, and recovery of the licensee.

For some boards, revocation or surrender of the license is the only option for high risk cases (under the influence while at work, numerous alcohol/drug convictions or acts). These boards establish their role solely as a Consumer Protection agency and do not find that it is their role, nor are they the best qualified, to provide rehabilitative efforts. Some may also believe that a licensee's commitment to recovery and maintaining sobriety will be stronger, if that licensee seeks rehabilitation and establishes a support base on his/her own accord. Following the revocation/surrender of a license, most licensees may return to the board requesting reinstatement after a period of one year. At that time, he/she may provide evidence and

testimony of rehabilitative efforts. Generally, if reinstatement of the license is granted, the licensee will be tested for a set period of time. With that being said, it is possible that an underlying substance abuse problem may exist even for a person who may only have two convictions or acts, that result in probation.

While there is no shortage of compassion for the licensee in regard to his/her struggles with alcohol or drug abuse or addiction and the financial liabilities of testing, boards/bureaus understand that their role, first and foremost, is to ensure patient safety. Alcohol and drug violations or violations where alcohol/drugs were a contributing factor, may be indicative of a more serious substance abuse problem. The only alternative in these high risk cases is revocation or surrender of the license.

The proposed amendments to Uniform Standard #4, were developed based on:

- \* An article published in the Journal of Addictive Diseases in 2003, titled "Simulation of Drug Use and Urine Screening Patterns,"<sup>1</sup>
- \* The Diagnostic and Statistical Manual of Mental Disorders,<sup>2</sup> with consideration given to risk factors associated with health care workers, and
- \* The testing frequency of physicians in 35 other states who reported this data to the Federation of State Physician Health Programs, Inc. (attached).

The article published in the Journal of Addictive Diseases in 2003, titled "Simulation of Drug Use and Urine Screening Patterns" is referenced in numerous documents including the "Physician Health Program Guidelines," developed by the Federation of State Physician Health Programs, Inc., and published in 2005. The abstract for this article provides:

"Urine drug screens are used extensively in substance abuse treatment, especially methadone maintenance treatment programs, as well as criminal-justice and clinical research settings. While positive urinalysis generally indicates drug use, no information is provided about the context or pattern of use. A computer generated model was created to examine the influence of drug use patterns and drug screen schedules upon urine test results. The results indicate that (1) when urine testing is performed at a rate of eight times per year, the probability of testing positive in a given month is little better than 50-50 even for daily use, (2) infrequent drug use is difficult to detect regardless of drug testing frequency, and (3) the benefits of more frequent drug testing are greatest with moderate drug use. The data presented provides a guide for clinicians to match drug screen schedules to frequency or pattern of suspected drug use."

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<sup>1</sup> Crosby, Ross D. , Carlson, Gregory A. and Specker, Sheila M. (2003) 'Simulation of Drug Use and Urine Screening Patterns', Journal of Addictive Diseases, 22: 3, 89 — 98

<sup>2</sup>American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

As published in this article, through a computer-generated model, the *mean average days to a positive urine test* considering the frequency of drug use vs. the frequency of urine testing, was developed. Below are those tables for substances that can be detected within a 1) 24 hour window (e.g. alcohol) and 2) 72 hour window (most other drugs).

	24-Hour Detection Window Urinalysis Frequency					72-Hour Detection Window Urinalysis Frequency				
	2x/wk	1x/wk	2x/mo	1x/mo	8x/yr	2x/wk	1x/wk	2x/mo	1x/mo	8x/yr
Every Day	3	7	15	30	46	3	7	15	30	46
Every Other Day	7	14	31	59	93	4	8	18	35	51
2x/week	12	24	51	110	152	5	11	23	48	71
1x/week	23	46	102	219	323	9	18	40	80	118
2x/month	52	108	305	437	670	19	39	91	160	272
1x/month	107	193	403	781	1625	36	71	150	306	560

In principal, testing a licensee an average of two times per week sounds like a sound practice to detect alcohol/drug use. However, the number of days substance use is detected in the more chronic user (and therefore, in most scenarios, the greater the risk) varies much less, regardless of the frequency of testing. One could make the argument that this is evidence for more frequent testing. However, given consideration to the risk factor of a person who uses once a month or less, the importance of “randomness” in testing, and the need to find a reasonable and pragmatic approach, this solution would appear to be implausible.

When this standard was initially established, there were several issues that had not been considered. This paper will address some of those issues, including random testing, sobriety, disparity of substance use, feasibility, and potential outcomes.

### Random Testing

The current standard of testing 104 times per year and 50 times each year thereafter, diminishes the most key component in testing: randomness. Random is defined as without definite aim, direction, rule or method. It is clearly established that if a person can gauge when they will be tested, they will consider one or more days a “safety period” following the submission of a biological sample for testing. Therefore, it is key that some testing be done back-to-back, as well as, at different intervals. Proposing a specific number of tests, and publicly announcing those figures, provides active users, a much more reliable “safety period” to use, especially for alcohol and any other drugs that stay in the system less than three days. By establishing a minimum standard *range*, and diligently employing “randomness” in testing, the “safety period” is diminished. It is critical with any Testing Frequency Schedule, that testing is done without regular intervals or patterns.

## Sobriety

There are also cases where a person who is an admitted recovered substance abuser or addict, has already participated in a rehabilitation program before entering diversion or being placed on probation. In cases where there is evidence that the person has been randomly tested and has maintained sobriety, some flexibility should be granted to the board in determining the duration of high frequency testing, that is equivalent to the proposed testing schedule.

## Disparity in Substance Use

As suggested in the analysis of SB 1441, consideration should also be given to licensees who the board has reason to believe pose a risk to patients and those where the risk is speculative.

Many, if not all, boards/bureaus pursue disciplinary action for single violations (e.g. single conviction for marijuana use, DUI, discipline in another state for minor violations, etc...) or violations that occur outside of the work place. Failure to acknowledge the great disparity in a single conviction vs. an admitted user and the testing requirement employed thereof, may have negative consequences. Applying the same rigid standard for both low and high risk testers is not equitable, nor was it the intent or driving force for SB 1441. It is possible that a shift may occur over a period of time, where some boards/bureaus find an alternative, lesser form of discipline in these cases, that does not include drug testing. Weighing the intrusive and financially burdensome testing requirements with the cause for action, testing may be found to be far reaching and overzealous.

According to the *Webster's New World Medical Dictionary, Third Edition*, "There is no universally accepted definition of substance abuse." However, a definition of substance abuse that is frequently cited is that in DSM-IV, the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) issued by the American Psychiatric Association. The DSM-IV defines, in summary, "substance abuse" as recurrent or continued substance use despite negative consequences.

While a single occurrence of a person under the influence on the job or driving under the influence, by itself would not classify that licensee with "substance abuse," the fact that our role as a consumer protection agency has a direct correlation to a person being under the influence on the job, creates a greater concern. Whereas a person driving under the influence (outside of work) is considered a lower risk because it indicates a misuse of alcohol *and* does not directly impact the safety of patients in the person's role as a health care provider. In addition, most individuals do not repeat this behavior after a single incident that results in negative consequences.<sup>3</sup>

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<sup>3</sup>DSM-IV sites, "At some time in their lives, as many as 90% of adults in the US have had some experience with alcohol, and a substantial number (60% males and 30% females) have had one or more alcohol-related adverse life events (e.g. driving after consuming too much alcohol, missing school or work due to a hangover). Fortunately, most individuals learn from these experiences to moderate their drinking and do not develop Alcohol Dependence or Abuse."

## Feasibility

Drug testing costs have been another area of concern expressed by many. While costs should not deter a board/bureau from carrying out its highest priority of consumer protection, they must be given some weight of consideration, in the application of testing frequency. Costs are identified in the chart below. Boards/bureaus have the option of passing this cost on to those who directly incur the charges, or they may use fees collected from the general licensee population to cover all or a portion of the costs.

<b>TESTING COSTS</b>	<b>Urine Analysis</b>	<b>Collection Fee</b>	<b>Totals</b>
<b>Current Rate</b>	\$30-\$58 per test	\$20-\$30	\$50-\$88 each
Total Cost for First Year at 104x year	\$3120 - \$6032	\$2080-\$3120	\$5200-\$9152
Total Cost for First Year at 104x year X 20 New Probationers	\$62,400-\$120,640	\$41,600-\$62,400	\$104,000-\$183,040

Testing a probationer 104 times the first year, would currently cost approximately \$7,200 per each probationer. Keep in mind, that many probationers are required to repay discipline costs in the first year of probation that can range greatly. In addition, some boards require probationers to pay a monthly monitoring fee. It is realistic to believe, that all these fees could total \$1000 a month and it is likely, a great deal more for several boards. While the position that probation is a final opportunity to regain clear licensure, and that costs should bear no weight, there are a number of factors that should be considered:

- \* The disparity in income levels of allied health professionals vs. registered nurses and physicians.
- \* Licensees who are unemployed.
- \* Licensees who are tolling.
- \* Administrative Law Judge's and each board's willingness to revoke a licensee based on the sole violation that the license is unable to pay for testing, and the financial repercussions should board's absorb these costs.

The disparity in income levels for many allied health professionals vs. physicians is great. It is estimated that some allied health professionals have annual salaries near \$50,000, and to the extreme other end, physicians may have a salary near or over \$200,000. While this should not necessarily effect frequency in testing, it should be considered by boards in whom pays for testing.

There are also licensees in every profession, whether on probation or in a diversion program, who are unemployed or tolling (residing out-of-state). These people pose no immediate threat to the public or California consumers, and a method of extending the time period for testing should be considered.

For some boards, probationers are required to provide a credit card number to the drug testing contractor, which is billed for every test. Probationers pay the collection fee, at the time they

provide a specimen. If payment is not made, the contractor will no longer test the probationer. Of course, many boards should attempt to test such probationers if they continue to practice, but many lack the resources to maintain a high frequency of testing. [SB 1172, statutes of 2010, also provides a mechanism for boards to suspend a probationer or a person in diversion for failing to test or testing positive, that may be implemented by each board in the near future].

Testing 104x a year, may result in a probationer's non participation in the testing program. Many boards will be forced to send the case to the Office of the Attorney General to pursue revocation for a probationers' failure to adhere to the Biological Fluid Testing term and condition.

For example, let's look at a board who licenses lower salaried allied health personnel, that may have 65 probationers subject to biological fluid testing, at any given time. While existing probationers may not be subject to the first year requirements, up to 20 new probationers established each year, will be subject to new testing requirements.

It is realistic to believe that at least half, if not more, will not be able to afford testing 104x a year, resulting in the pursuit of revocation of the license. Therefore, it is estimated that this board will incur the prosecution and hearing costs associated with revoking ten probationers, for an annual cost of an estimated \$50,000. These costs do not take into account the staff resources needed to process these cases.

Further, it is uncertain, if at hearing, an Administrative Law Judge, or even the board itself, for that matter, would revoke the individual, if cost is the sole basis for revocation. If an extension of probation is ordered, it will only set the probationer up for failure, as he/she will still not be able to afford the testing. Or it could be ordered that the probationer is not responsible for the costs, to which the board would then need to pay these additional costs, after already incurring costs for prosecuting the violation. This would result in additional layers of bureaucracy and costs, not serve the public or the licensee, and be completely inefficient. Further, the inequity, would raise additional issues with other probationers who are paying the costs.

Therefore, the many boards who have passed testing costs on to the licensees, may find it difficult to achieve any form of resolution, if in fact, licensees are being further disciplined, solely because they cannot pay testing costs.

#### Potential Outcomes

Implementing the existing standards of testing 104 x the first year and 50 x each year thereafter, could have irrevocable effects. There is no evidence or even the suggestion of evidence to provide that implementing the existing standard will provide the greatest benefit to consumers.

Immediate implementation of these standards could result in greater substance abuse due to lack of randomness, lesser discipline for minor violations, and greater bureaucracy, that would likely result in fee increases for all boards. None of California's boards come close to testing any probationer 104 x a year and therefore, there is no means to reasonably assert projected reliability or effectiveness.

However, should boards need to increase their fees to sustain a drug testing program in the future, they may consider legislation that specifically raises a fee to fund their drug testing program.

## RECOMMENDATIONS

1. **Recommendation:** Establish minimum testing frequency “ranges” and clear standards to secure the “random” component of a testing program and provide boards flexibility in assessing the level of risk.

Establishing minimum standard “ranges” will diminish a licensee’s ability to anticipate when testing will occur. Clearly, the frequency of testing should be increased for any person the board suspects is currently using or has had a lapse in sobriety for a minimum of a year<sup>4</sup>, and where that board does not pursue immediate suspension or expeditious revocation of the license. In such cases, testing may actually exceed the minimum range. In any case, the proposed standards should include specific instruction to maintain an effective “random” testing program.

2. **Recommendation:** Provide an exception that allows boards flexibility in determining the duration of high frequency testing, equivalent to the proposed testing frequency schedule, in cases where there is evidence that the person has been randomly tested and has maintained sobriety for a length of time. No greater purpose is served by requiring a licensee to undergo the same level of testing when he/she has already participated in a bona fide program. In fact, failure to recognize equivalent testing standards may be punitive and may have negative repercussions.
3. **Recommendation:** Provide an exception from the standard testing frequency schedule, for those isolated incidents that occur outside and unrelated to the workplace and span a great period of time. This will provide some equity in applying standards for low risk candidates and prevent potential repercussions mentioned previously.
4. **Recommendation:** Provide an exception and extension for persons tolling or who are unemployed. These licensees pose no threat to California consumers. Failure to recognize this may appear punitive and result in adverse outcomes.
5. **Recommendation:** Collect useful and reliable data for a three-year period following implementation, to review the outcomes and effectiveness of this standard and determine if amendments are appropriate. There was no evidence, scientific or otherwise, to support the original standards. These proposed standards are based on some research, yet the real outcomes are unknown. Given the numerous unknown outcomes and the potential adverse effects, it is key to responsible government, to measure and review real data and experiences to determine the effectiveness of this standard.

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<sup>4</sup>The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), cites, “Because the first 12 months following Dependence is a time of particularly high risk for relapse, this period is designated “Early Remission” and “During the first 12 months after the onset of remission, the individual is particularly vulnerable to having a relapse.”

In summary, the existing uniform standard #4 is premature, unfounded, rigid, and inequitable on many levels. There is clearly potential for serious consequences. It is clear there are a number of interested parties on both sides of this issue, though all are passionate about consumer protection. The proposed amendments provide a compromise from both ends of the spectrum, with the condition to revisit the issue with real data, three years following implementation to determine if amendments are necessary. The proposed amendments are a responsible and reasonable approach to prevent adding layers of bureaucracy, scapegoats, and misfortunes, while providing greater consumer protection. The proposed amendments are a significant leap, specifically in increasing frequency, for many, if not most boards. If acted upon in good faith, while collecting appropriate data, together, we can achieve the most effective standard to protect consumers.

## Uniform Standard #4 Subcommittee PROPOSED AMENDMENTS

### #4 SENATE BILL 1441 REQUIREMENT

Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomness, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

### #4 Uniform Standard

The following ~~drug testing~~ standards shall apply to each licensee subject to drug testing govern all aspects of testing required to determine abstention from alcohol and drugs for any person whose license is placed on probation or in a diversion program due to substance use:

~~Licensees shall be randomly drug tested at least 104 times per year for the first year and at any time as directed by the board. After the first year, licensees, who are practicing, shall be randomly drug tested at least 50 times per year, and at any time as directed by the board.~~

### TESTING FREQUENCY SCHEDULE

A board may order a licensee to drug test at anytime. Additionally, each licensee shall be tested RANDOMLY in accordance with the schedule below:

<u>Level</u>	<u>Segments of Probation/Diversion</u>	<u>Minimum Range of Number of Random Tests</u>
<u>I</u>	<u>Year 1</u>	<u>52-104 per year</u>
<u>II*</u>	<u>Year 2+</u>	<u>36-104 per year</u>

\*The minimum range of 36-104 tests identified in level II, is for the second year of probation or diversion, and each year thereafter.

Nothing precludes a board from increasing the number of random tests for any reason. Any board who finds or has suspicion that a licensee has committed a violation of a board's testing program or who has committed a Major Violation, as identified in Uniform Standard 10, may reestablish the testing cycle by placing that licensee at the beginning of level I, in addition to of any other disciplinary action that may be pursued.

## **EXCEPTIONS TO TESTING FREQUENCY SCHEDULE**

### **I. PREVIOUS TESTING/SOBRIETY**

In cases where a board has evidence that a licensee has participated in a random testing program meeting equivalent qualifications as those required in this standard, prior to being subject to testing by the board, the board may give consideration to that testing in altering the testing frequency schedule so that it is equivalent to this standard.

### **II. VIOLATION(S) OUTSIDE OF EMPLOYMENT**

An individual whose license is placed on probation for a single conviction or incident or two convictions or incidents, spanning greater than seven years from each other, where those violations did not occur at work or while on the licensee's way to work, where alcohol or drugs were a contributing factor, may bypass level I of the testing frequency schedule.

### **I. NOT EMPLOYED IN HEALTH CARE FIELD**

A board may reduce testing frequency to a minimum of 12 times per year for any person who is not practicing OR working in any health care field. If a reduced testing frequency schedule is established for this reason, a licensee shall notify his/her board, prior to returning to employment in the health care field as required by his/her board. At such time the person returns to employment, if he/she has not previously met the standard, he/she shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

### **II. TOLLING**

A board may postpone all testing for any person whose probation or diversion is placed in a tolling status if the overall length of the probationary period is also tolled. A licensee shall notify the board upon his/her return to California and shall be subject to testing as provided in this standard. If he/she returns to employment in a health care field, and has not previously met the standard, he/she shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

## **OTHER DRUG STANDARDS**

Drug testing may be required on any day, including weekends and holidays.

The scheduling of drug tests shall be done on a random basis, preferably by a computer program, so that a licensee can make no reasonable assumption of when he/she will be tested again. Boards should be prepared to report data to support back-to-back testing as well as, numerous different intervals of testing.

Licensees shall be required to make daily contact to determine if drug testing is required.

Licensees shall be drug tested on the date of notification as directed by the board.

Specimen collectors must either be certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the U.S. Department of Transportation.

Specimen collectors shall adhere to the current U.S. Department of Transportation Specimen Collection Guidelines.

Testing locations shall comply with the Urine Specimen Collection Guidelines published by the U.S. Department of Transportation, regardless of the type of test administered.

Collection of specimens shall be observed.

Prior to vacation or absence, alternative drug testing location(s) must be approved by the board.

Laboratories shall be certified and accredited by the U.S. Department of Health and Human Services.

A collection site must submit a specimen to the laboratory within one (1) business day of receipt. A chain of custody shall be used on all specimens. The laboratory shall process results and provide legally defensible test results within seven (7) days of receipt of the specimen. The appropriate board will be notified of non-negative test results within one (1) business day and will be notified of negative test results within seven (7) business days.

[Additional language here that will allow for other types of biological testing (e.g. blood, hair, etc...) and the use of new technology to monitor for abstention (e.g. electronic bracelet, etc...)].

## **OUTCOMES AND AMENDMENTS**

For purposes of measuring outcomes and effectiveness, each board shall collect and report historical and post implementation data as follows:

### **Historical Data - Two Years Prior to Implementation of Standard**

Each board should collect the following historical data (as available), for a period of two years, prior to implementation of this standard, for each person subject to testing for banned substances, who has 1) tested positive for a banned substance, 2) failed to appear or call in, for testing on more than three occasions, or 3) failed to pay testing costs.

### **Post Implementation Data- Three Years**

Each board should collect the following data annually, for a period of three years, for every probationer and diversion participant subject to testing for banned substances, following the implementation of this standard.

### **Data Collection**

The data to be collected, shall include, but may not be limited to:

Probationer/Diversioneer Name

Probation/Diversion Effective Date

General Range of Testing Frequency by/for Each Probationer/Diversioneer

Dates Testing Requested

Dates Tested

Identify Who Performed Each Test

Dates Tested Positive

Dates of Questionable Tests (e.g. dilute, high levels)

Identify Substances Detected or Questionably Detected

Dates Failed to Appear

Dates Failed to Call In for Testing

Dates Failed to Pay for Testing

Date(s) Removed/Suspended from Practice (identify which)

Final Outcome and Effective Date (if applicable)