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Oral Testimony of
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before the
DEPARTMENT OF CONSUMER AFFAIRS
SUBSTANCE ABUSE COORDINATION COMMITTEE
SB 796 (2017) Review of Uniform Standard #4
April 23, 2018

Good morning. My name is Julie D'Angelo Fellmeth, and for 32 years I have worked as an attorney at the Center for Public Interest Law (CPIL) at the University of San Diego School of Law. For those of you who are not familiar with CPIL, we monitor California agencies that regulate business, professions, and trades. We have extensive experience tracking health care boards with diversion programs and health care boards without diversion programs — because of the obvious public interest in protecting patients from substance-abusing licensees of health care boards.

I appreciate Ms. Matthews' recounting of the history of the Uniform Standards. While I do not disagree with her, I'd like to bring you a slightly different perspective.

The Uniform Standards required by Senate Bill 1441 (2008), which enacted Business and Professions Code section 315, did not come out of nowhere. They resulted from the failure of the first and oldest diversion program in the Department: the Medical Board of California's (MBC) physician diversion program, which was created in 1981. That program was audited three times by what used to be called the Office of the Auditor General in the 1980s; it failed all three performance audits. From 2003–2005, I served as the Medical Board Enforcement Monitor, a legislatively created position to which I was appointed by the DCA Director after a competitive bidding process. One of my tasks was to audit the Medical Board's diversion program for substance-abusing physicians. My audit — issued in November 2004 — became the fourth performance audit that program failed. In 2007, the Bureau of State Audits performed another audit that confirmed many of my findings, noted that many of those problems continued to exist, and resulted in the Medical Board's unanimous vote in July 2007 to abolish that program. And it was abolished as of June 30, 2008.

In March 2008, Senator Mark Ridley-Thomas, then Chair of the Senate Committee on Business, Professions and Economic Development, held a public hearing on DCA's health care boards and the way they deal with substance-abusing licensees. He required representatives of boards with diversion programs and boards without diversion programs to appear and to answer questions about the way they handle substance-abusing licensees. He

asked boards, for example, how many times per month their licensees who are in diversion programs or on probation for substance abuse issues are drug-tested — he got wildly inconsistent answers. He quickly realized that no board had ever sought legislation or adopted regulations to set enforceable standards for these programs — even though diversion programs had existed at some boards (*e.g.*, the Medical Board, the Dental Board, the Board of Registered Nursing) for decades.

Thus, he authored SB 1441, which required DCA to create a "Substance Abuse Coordination Committee" (SACC) to develop "uniform and consistent standards" which all the DCA health care boards "shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program…." Business and Professions Code section 315 sets for 16 separate areas in which the SACC was directed to adopt "uniform and consistent" standards. These 16 areas are in the exact critically important areas in which MBC's (and other boards') programs lacked any enforceable standards. The SACC met on numerous occasions during 2009–2011; I attended most of its meetings and provided input into what became known as the "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees," which were finalized in April 2011.

During 2017, the legislature enacted SB 796, which requires DCA to reconvene the SACC and to review Uniform Standard #4, which concerns all aspects of drug testing," in order to determine whether that standard should be "updated to reflect recent developments in testing research and technology." That is why we are here today.

Ms. Matthews identified several requirements in Uniform Standard #4 which have proven to be inconvenient or impractical to implement since 2011. She may be correct, but I would like to tell you where those requirements came from and why they are important.

For example, she discussed the requirement that participants in diversion programs or probationers must call in daily (including weekends and holidays) to determine whether they must submit a urine sample that day. This requirement did not come from nowhere. In my 2004 audit of MBC's diversion program, we found that the program would send a list of collection dates for each participant to local urine collection businesses. Those businesses would frequently and unilaterally move collections OFF weekend days and holidays and move them disproportionately to Tuesdays and Thursdays. If you are a doctor, you are going to figure that out in about 20 minutes. You will know when you are least likely to be tested and when you are most likely to be tested, and you will adjust your behavior accordingly. In this way, that program was very easy to "game." That is why Uniform Standard #4 includes a requirement that participants/probationers be tested on the date that has been randomly generated by a computer.

Ms. Matthews also mentioned Uniform Standard #4's requirement that urine collections be observed by the collector. Of course, they must be observed. If you allow them to be unobserved, what you will get is someone else's urine substituted for the urine of the participant/probationer, or you will get urine purchased on the Internet. At MBC, we saw

that one participant substituted his DOG's urine for his. That is what you will get when you permit unobserved collections.

Yes, it may be inconvenient for a participant/probationer to be tested on a Sunday, and yes, it may not always be possible for collections to be observed, but your job as state regulatory boards is public protection. Each of the enabling statutes creating each of the health care boards contains mandatory language stating that "protection of the public" is each board's highest priority, and that when public protection is inconsistent with some other interest sought to be promoted (such as licensee convenience), "public protection is paramount."
I want to assure you that the original Uniform Standards finalized in 2011 were the subject of multiple public hearings and clinical input from substance abuse experts. Dr. Elinor McCance-Katz, a psychiatrist and an addiction medicine specialist from UC San Francisco, was a member of this Committee in 2011; she had constant input. Additionally, experts from rehabilitation programs across the state — including Dr. Tom Horvath, who runs Practical Recovery in La Jolla — attended hearings of this Committee and provided both oral input and written testimony. Finally, this Committee heard from other experts in addiction medicine, including the California Society of Addiction Medicine, the California Psychiatric Association, and the California Medical Association. They all contributed to the development of these Uniform Standards.

I do not believe you should be tinkering with these Uniform Standards in any significant way in the absence of both science and data. With all due respect, you have little or no data, because not one health care board has complied with the data collection requirements in both Uniform Standard #4 and Uniform Standard #16. In particular, Uniform Standard #16 has required each health care board — since 2011 — to compile considerable data on substance-abusing licensees and submit an annual report containing that data to both the Department and to the legislature. As the Uniform Standards were finalized in 2011, each board should have submitted five or six of those annual reports by now — but no board has submitted any annual report containing that information.

And I do not agree with an earlier comment that you get to wait until the legislature "requests" this information. Business and Professions Code section 315(c)(16) requires this Committee to develop "measurable criteria and standards to determine whether each board's method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term," and this Committee — back in 2011 — agreed that this could best be done by way of an annual report containing detailed information concerning the performance of diversion program participants or probations in complying with the relevant requirements. Uniform Standard #16 requires each board to annually compile that annual report and submit it to both the Department and the Legislature. No "request" is required.

Let's recall who you are. You are the State of California. You have granted a privilege to an individual — a privilege which can and should be revoked or restricted if a licensee is not capable of safe and competent practice. The agencies you staff are charged with protecting

the public as their highest priority. When public protection is inconsistent with some other interest sought to be promoted, public protection is "paramount." The law could not be more clear.

And let's recall who you are dealing with. Sometimes this discussion become sterile because we refer to them as "participants," and we forget who we are talking about. Health care board licensees who participate in a diversion program or who are on probation due to serious substance abuse are not "social drinkers" or "recreational users." They are confirmed substance-abusers whose addiction is "dangerous or injurious to the licensee, or to any other person or to the public."[1] They have either admitted to or been found to have seriously abused drugs and/or alcohol.

Dr. Lubin has used a very important word on several occasions today: "abstinence." You have required these individuals, and they have agreed (or been ordered), to abstain completely from all use of alcohol and unapproved drugs, and they have agreed to have their behavior monitored for relapse or pre-relapse behavior. The only way for you to responsibly measure compliance with such an agreement or order is to require intrusively frequent drug testing — particularly for licensees who are permitted to work. From the perspective of the State of California and its occupational licensing agencies, the primary issue should be use or non-use — and that can only be measured via frequent drug testing. Non-use will be confirmed; use can be proven. Dr. Lubin just told you that hair and/or nail testing never proves abstinence; urine testing is the gold standard. In other words, your chosen drug testing frequency should test the licensee for <u>abstinence</u> — because that is what you have required, and that is what the participant/probationer has agreed to.

Licensees who are in their first year or two of recovery and who are permitted to practice <u>must</u> be tested for abstinence. According to Dr. Lubin, frequent drug testing deters noncompliance and encourages recovery – which is what we all want. Random drug testing once or twice per month does not test for abstinence; it hopes (unreliably) to detect relapse. There is a difference. Random drug testing once or twice a month will <u>not</u> detect any and all banned uses, and it will not measure compliance with the contract — which is the *raison d'etre* of a diversion program.

CPIL is not unsympathetic to the cost issue. It may be that the cost of drug testing can be lessened by measures such as the one suggested by Dr. Lubin: After considerable experience with a particular participant or probationer, perhaps every drug testing panel need not test for every conceivable drug. We are aware that the costs of participating in a diversion program (which may include the costs of drug testing, group meeting attendance, required psychotherapy, and treatment) may become substantial. However, from the State's perspective,

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[1] *See, e.g.*, Business and Professions Code sections 2239 (physicians), 1681 (dentists), 4301 (pharmacists), 2762 (registered nurses), 3110 (optometrists). *See also* Watson v. Superior Court, 176 Cal. App 4th 1407 (Aug. 25, 2009), review denied Dec. 2, 2009.

the crucial issue is use vs. non-use, and the only cost relevant to that crucial issue is testing that is frequent enough to ensure abstinence.

Uniform Standard #4 is flexible and has stood the test of time. I would note that the Standard already authorizes the use of testing methods other than urine testing: "A board may use other testing methods in place of, or to supplement biological fluid testing, if the alternate testing method is appropriate" (from page 10 of the Uniform Standards). Indeed, the Medical Board has already authorized the use of "Soberlink" technology in some cases — because this is permitted under the Uniform Standards.

I do not think you should alter this standard in the absence of science or data — and so long as those annual reports are outstanding, you have no data.

Thank you for your consideration of these comments.