CUTTING EDGE ISSUES IN DRUG TESTING AND DRUG TREATMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, INTERNATIONAL AFFAIRS, AND CRIMINAL JUSTICE

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

HOUSE OF REPRESENTATIVES

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CUTTING EDGE ISSUES IN DRUG TESTING AND DRUG TREATMENT

FRIDAY, JUNE 5, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY,
INTERNATIONAL AFFAIRS, AND CRIMINAL JUSTICE,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 11:05 a.m., in room 2154 Rayburn House Office Building, Hon. J. Dennis Hastert (chairman of the subcommittee) presiding.

Present: Representatives Barr, Mica, Souder, Barrett, and Cummings.

Staff present: Robert B. Charles, staff director and chief counsel; Dale Anderson, investigative counsel; Amy Davenport, clerk; and Michael Raphael, minority counsel.

Mr. HASTERT. The hearing of the Subcommittee on National Security, International Affairs, and Criminal Justice will come to order.

Good morning, everyone, and thanks for being here. Today and again next Wednesday, we will address the treatment component of our war against drugs.

Today's hearing will be devoted to various methods of drug treatment, drug testing in the workplace and how we determine what really works and what doesn't work. Next Wednesday's hearing will be devoted to testing and to treatment in the criminal justice system. We hope to learn from today's witnesses, who include a Congressman, corporate experts, scientists, and those involved in both drug treatment programs and drug testing: First, what successful treatment strategies have been developed by the business community; and second, whether these successful treatment strategies might be adopted in other environments such as within government employment, and where the drug testing should be an integral part of every drug treatment dollar spent.

Before I introduce our witnesses and begin the testimony, let me reaffirm that we may see many fronts in our Nation's drug war; that we want the administration to seek to end the stalemate in all these areas and to join us so that we can win on each and every front. As we launch into our first treatment hearing, let me conclude with these points.

First, good treatment methods will help us win, just as bad treatment methods will cause us to lose the war while wasting the taxpayers money. Second, we have 12 million drug users in the workplace. Two million of them work for the Government. If we can as-

sure every employee that drug use will be detected and will not be tolerated, our society will be a lot better off. Finally and rhetorically, I ask, how do we identify and treat those employees without drug testing?

I'd like now to turn to my good friend, Congressman Barrett, for his opening statement.

Mr. BARRETT. Thank you, Chairman Hastert. I'm pleased to be here this morning. I'm pleased that we have two panels of distinguished witnesses from government, academia, the private sector, and the scientific community. I welcome you all here this morning to examine drug testing approaches and technologies that may have applications in the private sector workplace. Just as important, I look forward to exploring the important role of drug treatment in creating drug-free workplaces across the country.

In the private sector, employers have had a relatively free hand to include drug testing as a condition of employment. Since 1987, the number of U.S. corporations that use drug testing has risen 277 percent. Ninety percent of Fortune 500 companies use drug tests to screen potential employees, including on-the-job screening. That means as many as 30 million employees in our country are subject to drug testing annually. The question of whether that explosion in drug testing has made a difference in the past decade or promises results in the future is something our witnesses will help us answer today.

During our consideration of this subject, I hope we can be guided by a few fundamental principles. Drug testing must be accurate, particularly in the workplace, where employment decisions can have enormous impact on people's lives. Drug testing standards must be applied fairly and consistently, and the method used to detect drugs must not yield disparate results based on race or ethnicity. Finally, drug testing policy methods—and methods—must take into account the personal privacy interest of those being tested and test results must be kept confidential. Perhaps most important of all, drug testing must go beyond simply punishing drug users. If drug testing is to become part of an effective drug strategy, workplace testing programs must be accompanied by an array of treatment and counseling actions. The point is to keep our work force healthy, drug-free, and, if at all possible, gainfully employed. I look forward to hearing the testimony this morning.

Mr. HASTERT. I thank the gentleman from Wisconsin. I, too, join with him. I think there needs to be good, credible standards. I also believe that those people who are employed and test positive need to be helped to move forward so they are gainfully employed. I look forward to working with you.

Does anybody else have an opening statement? Mr. Barr.

Mr. BARR. Thank you, Mr. Chairman. I would like to commend the Chair for pulling together this hearing today. We all know, at least most of us know, and all of us certainly on this subcommittee know, the dangers of mind-altering drugs, particularly the dangers posed in the workplace. We know that the vast majority of persons who use illegal drugs are employed. We know that a large percentage of those—some one-sixth of the entire population—employed population works for the Government. I think, therefore, it's very important that we explore the reasons why there is hesitancy or

those that argue that Federal employees somehow are in a special category. Even though they work for the public—are employed by the public and in many instances perform very sensitive, unique tasks—that somehow their employment by the public, rather than hold them to a higher standard, entitles them to a lower standard, that they have a right to use drugs and not be tested as those in the private sector are.

The logic of that escapes me, although I'm sure some of the witnesses today will explain to us why that is logical. But I do think that we need to look at the reasons why we are running into this problem and look for ways to get around it. Certainly the courts—the Supreme Court—has not addressed this issue head-on and hopefully it will. Hopefully, it will recognize that it certainly is in the public interest to have its public employees subject to drug tests the same way as persons in the private sector; that rather than hold or entitle public employees to a lower standard and basically give them a free ride and hold private sector employees to a higher standard that does provide a safer environment for the public—that the court will agree with that.

I think that there are some parallels that can be drawn with regard to other sectors where testing is appropriate, even though it does involve the Government. Rather than allow those who argue on behalf of drug users and against drug testing by public employees to sway the day up here, I think that we ought to be creative and work in the public interest, not especially on behalf of special interests. For example, those who have interest to perform certain type of tests and those tests may be considered more intrusive and, therefore, they don't—they're not favored. I think that we ought to be proactivists in this area and support the public interest in having the public employees subject to random drug testing.

I think that this is an important step in that direction to air these issues and I think develop a public record and, if necessary, legislation to ensure that the public is protected. At least insofar as the very minor intrusion, if one even considers it an intrusion, the public employees should be subject to random drug testing to determine whether or not they are violating the law. That we can, through this hearing, develop the appropriate legislation if that is necessary—although I don't believe that it is. We ought to move forward, Mr. Chairman. I appreciate these hearings and your continued work on its behalf.

Mr. HASTERT. I thank the gentleman for his statement. Any comments from Mr. Mica?

Mr. MICA. Thank you, Mr. Chairman. I do want to commend you on calling this hearing today and for, again, your leadership on this entire issue of devastating effects of illegal drugs and narcotics in our society, and particularly in our workplace. The statistics I've read is that 70 percent of those who use illegal drugs are in fact employed—some in the private sector and some in the public sector. It's very important, I think, that we as Members of Congress look at both the activity in the private sector and the public sector, and what methods of drug testing are both cost effective and also efficient for the taxpayers, but also can give us the best results and a handle on this situation.

The cost of drug abuse treatment in our Nation now exceeds $3 billion a year. The question of drug testing and drug testing itself has turned into a small cottage industry with big numbers. It's important that we get, again, an accurate reading on the tests that are being done in the private sector and in the public sector, and that we look for effective methods of incorporating those tests in our criminal justice system, in our society at large, and make them available again at every level. I think we have that important responsibility.

With that, Mr. Chairman, I thank you for your leadership. I look forward to hearing the witnesses and their testimony today and next week, and what we can do again in a cost-effective manner and effective analysis of what's going on in our workplace. Thank you.

Mr. HASTERT. I thank the gentleman from Florida.

Now, it's a great honor to introduce our first witness. This gentleman certainly needs no introduction here, but certainly a good friend and colleague and chairman of the Rules Committee, Jerry Solomon from New York. Jerry, thank you for being with us today and welcome.

STATEMENT OF HON. JERRY SOLOMON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. SOLOMON. Thank you, Mr. Chairman. I'm just a little out of breath here. We were trying to rush over to the floor to be timely. I know how it is when committees and subcommittees like yours are holding meetings. As chairman of the Rules Committee, if people are late I usually don't take it kindly. So, I appreciate you bearing with me.

Mr. HASTERT. We're probably not quite as tough as the chairman of the Rules Committee. [Laughter.]

Mr. SOLOMON. Mr. Chairman and members, I just want to commend your subcommittee on holding these hearings and on your overall effort dealing with one of the most devastating problems that this country has. I have five children and raised those five children during a period of time when drug use among us, especially among youngsters, was just beginning. Now I have six grandchildren. Some of the stories that one of my grandchildren tells me about drug use in a university that she's attending, and others in high school, and even in the lower grades—it is just heartbreaking. That is why I'm just so proud of your committee that you would undertake to try to deal with this terrible thing that's happening to a whole new generation.

As the chairman knows, I just was in Europe with him and diverted from part of that NATO meetings to go to the Netherlands. I saw in the city of Amsterdam terrible situations where they have just had a philosophy of tolerance toward illegal drugs. To see what's happening to those people in their twenties and thirties, and even into their forties, is just terrible. We just cannot let that happen to American society.

That is one of the reasons I would just ask unanimous consent, if you would, to have my entire statement appear in the record and I won't bother going into all of that. I hope that you would all take the time to look at it.

Mr. HASTERT. Without objection.

Mr. SOLOMON. Thank you, thank you very much. But you know it all goes back to—and the reason that myself and Joe Barton and you, Mr. Chairman, have just yesterday sponsored legislation that we applied for—in other words, early in this Congress and made provisions for in the rules of the House; that was to establish a system of random drug testing in the Congress and that means for Members of Congress and for all of our employees. Now does that mean that you and I think that there is a serious problem of drug use among congressional employees or even Members of Congress? The answer is no. But when you look at the very cogent fact that throughout all of America, 75 percent of drug use, illegal drug use, in America today, does not come from where you would expect it, from the inner core cities, problems that we have right here in Washington, DC—75 percent of all the illegal drug use in America today comes from constituencies perhaps like yours and mine. It comes from the middle class, upper-middle class, suburban weekend recreational drug users.

That is terrible. But that creates demand. Because if you took away that 75 percent of the demand, what would that do to the price of these drugs? You know, no longer would these drugs be coming in across the Mexican border, Colombia, or up in Canada where I come from. They'd be making bathtubs, or whatever they used to make, before they got into the drug business. So the whole idea is for this Congress to do all that it can to help set the example. That's what we want to do here.

If you recall, back in the very early 1980's, Ronald Reagan, who was my hero, implemented—at my urging and others—a system of random drug testing in our military. Why did he do that? Because at that time, there was an admitted 25 percent illegal drug use by our military in all branches of service. Four years after he implemented that program, it dropped from 25 percent down to 4 percent. Now that's an 80 percent drop. Now, if we could do that in the Congress; if we could do it in the U.S. Government; if we could do it in States and counties and towns and villages and cities in the public sector, we could drop the use 80 percent. Then if the Fortune 500 companies—which incidently are making great progress—because companies like GE and others have implemented random drug testing. But if you could drop the use 80 percent across this Nation, that would just about be a great huge step in solving our problems.

So I just wanted to report to you the bill that we introduced. It has six categories because you have to be worried about it and everybody—I'm almost a libertarian myself and I worry about the invasion of privacy. But there are perhaps constitutional amendments with some kind of drug testing. So, therefore, in our bill that we introduced, we, first of all, in the first category included all Members of Congress. Now that could or could not be constitutional, but there's a severability clause that, if it were, it would still leave the other five categories.

The second category would be all Members of Congress as a condition of employment. In other words, it's my contention that when Jerry Solomon hires someone on his staff or on the committee staff that, when they are hired, that one of the conditions of employment

is that they submit to a random drug test—random drug test, not mandatory. That may or may not be constitutional.

But the third category would be all new hires as a condition of employment, taking into consideration that perhaps, if they were originally hired and it was a condition of employment, maybe that would be an excuse for the Supreme Court to say it was unconstitutional. So therefore, the third category would be new hires as a condition of employment. I think, especially under some of the decisions that have now come out of the big courts and the Supreme Court, I think that would even be constitutional.

The fourth category would be, in other words, a request by the supervisor for testing for drugs if there was a suspicion—you know, probable cause.

Then fifth would be random drug testing of all security and safety. We know that's already been upheld by the court, so that certainly would be upheld under this bill.

Finally, any employee who has access to the floor of Congress—and you know that over in the old Administrative Office Building, where members of the administration have access to that building and to the White House, that's already been found to be constitutional. So we say any employee who has access to the floor of the House. Now who is that? I have here Representative Ken Bentsen, who just happens to appear on the list, but it would be 80 percent of all of his employees, maybe even more, who would have access to the floor of the Congress. If you flip over and you go to the Committee on Government Reform and Oversight, Mr. Chairman, it's almost everybody—in other words, at one time or another—the majority whip's office, and all of the other minority and majority offices. So in that sixth category, you would be talking about just about all.

If we were to do this, we would certainly set the example. I know some Members are going to argue and with all sincerity that Members of Congress shouldn't be because they are elected by the people and they are different. I think the Georgia court, you know, there was a problem there in their decision. But the truth is, we can't include our employees and then not include ourselves. I mean, let's include ourselves, and then if it's challenged and if it goes to the court, let's let the court rule on all of these. Once we get that ruling on these six categories, we'll know where we stand, but we will have at least told the American people that we really want to try to contribute and do something.

Because it doesn't matter about all the interdiction you have; it doesn't matter about all the treatment; it doesn't matter about all the education—those things are terribly important. But society itself has to say no and we need to go after those weekend recreational drug users. How best to do it than we and our employees who come from that type of society?

Having said that and taken too much of your time, I really appreciate your letting me testify today, and I'd be glad to try to answer any questions before I go back to a Rules meeting.

[The prepared statement of Hon. Jerry Solomon follows:]

Mr. Chairman,

Thank you for allowing me the opportunity to testify before you today about drug testing in the workplace. I also appreciate the work you put into the bill we introduced yesterday requiring drug testing of Members of Congress and staff.

Those who ridiculed the idea of drug testing Members and staff should take a close look at the Stigile decision by the U.S Court of Appeals for the District of Columbia. This upheld the decision to require employees with access to the Old Executive Building to submit to random drug tests, **regardless of the nature of their work**. In other words, it is virtually certain that the courts will uphold the provision in our bill requiring testing of all legislative staff in the personal offices, leadership staff and most committee staff. Yet, we are also very serious about testing Members of Congress. How can we justify testing our legislative staff and not subject ourselves to the same requirement?

I know there are Constitutional concerns and that this may end up before the Supreme Court and I do not believe we have a serious drug problem in the Congress. What I do believe is that we have the responsibility and the duty to set an example for the rest of the federal government - which is the largest employer in the United States - and the rest the country.

Illegal drug use is the single most serious problem we face as a nation. It is the common denominator in the problems facing America! Illegal drugs are the biggest problem facing our **education system**... with drug use on the rise by eighth graders and heroin use on the rise by college students. Illegal drugs drive our **health care** costs through the roof...with emergency rooms packed with the victims of drug related shootings and drug overdoses. In addition, thousands of babies are born each year addicted to illegal drugs!!!

Illegal drug use is also the reason behind most of the **crime and violence** in this country. Over 50% of all men arrested for murder test positive for illicit drugs at the time of arrest. Drugs are a factor in half of all family violence, and most of this violence is directed against women and children!

Illegal drugs hurt our educational and health systems and create most of the violence in this country...but what about its impact on our **economy and the workplace?** We all know that illegal drug use causes countless billions of dollars of lost productivity to our economy each year but let me be more specific by noting the results of a study conducted by the U.S.Postal Service. The study concluded that persons who test positive for drug use were 70% more likely to be involuntarily terminated over a three year period. The study also found that people testing positive for drugs were absent from their jobs 12% of the time while negative testers were absent 6% of the time.

The typical drug abusing worker:
-is late for work 300% more often than the non-abusing worker

-requests time off 200% more often than his non-abusing co-worker and
-is 500% more likely to file a workman's compensation claim

Mr. Chairman, the results are in...drug testing in the workplace more than pays for itself. For several years I introduced legislation to make it easier for businesses, large and small, to test their workers for drug use. Thanks to you Mr. Chairman and the Speaker this measure will finally be enacted.

Mr. Chairman, you and I know that interdiction and law enforcement are important weapons in the war against drugs. But the war will never be won without dramatically reducing the demand for illegal drugs in our country. As a result of a 1992 Solomon Amendment over half of the states in this country suspend the drivers licenses of drug users. And this year's Higher Education Act contains a Solomon Amendment suspending student assistance (grants and loans) to drug users. **A third Solomon Amendment, included in the appropriations process, will deny DEA registration to prescribe schedule two through five drugs to doctors who prescribe or recommend schedule one drugs**. As you know, Schedule One drugs include so called medical marijuana. These are all efforts to reduce the demand for illegal drugs by restricting governmental benefits.

Yet, drug testing is also an effective way to reduce the demand for illegal drugs. It is the one deterrent we know works for sure. When drug testing was implemented by the Pentagon in 1982, illegal drug use in the military dropped from 27% to 4% --- a 82% reduction.

We all know that the drug problem has worsened in recent years. According to a study by the Rand corporation 75% of the drug use in this country is by so called recreational drug users. The truth be told, it is these recreational or **casual drug users** who increase the demand for drugs and who **are the driving force behind the murders** and drive-by shootings --- where innocent young children are killed --- in the inner city!

The courts examine everything we do with an eye to protecting the fourth amendment and I don't disagree with them. But in their deliberations they must also consider the national interest. Illegal drugs jeopardize the American way of life Illegal drugs are not discriminating. Rich or poor, African American or white. there is not a mother or father in America who does not worry about their child becoming involved with illegal drugs. The well being of every child in this country is threatened by illegal drugs.

Reducing the demand for these dangerous killers is and has to be the focal point in the war against drugs. Drug testing is the single most effective weapon in this war. Thank you Mr. Chairman.

Mr. HASTERT. I want to thank the chairman. I know the requirements of your time and I know any questions will certainly be brief. I just want to say I appreciate you being here. We know of your continued commitment to make this a better place, to make sure that Congress is someplace that people can look up to and be set for standards of behavior and work throughout this country. I certainly understand that your efforts are sincere and we appreciate what you do.

I open up to any questions that you might have. The gentleman from Wisconsin, Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman. Just very briefly, and I appreciate your taking the time to be here as well, are you aware of how many offices currently test?

Mr. SOLOMON. Random drug testing?

Mr. BARRETT. Yes.

Mr. SOLOMON. There are a few that I know of—mine, Joe Barton's, and a number of others that do it—not systematically, but do it from time to time.

Mr. BARRETT. So, obviously, there's no prohibition for Members who want to do it now?

Mr. SOLOMON. Well, the trouble is we can't use congressional funds to do it; it comes out of our pockets.

Mr. BARRETT. Thank you. Thank you very much and we'll let you keep up the good work.

Mr. SOLOMON. Thank you very much.

Mr. HASTERT. At this time, I'd like to introduce our second panel of witnesses. They certainly are nationally known within the treatment and workplace communities.

First of all, we have Dr. Robert DuPont. Dr. DuPont was the first Director of the National Institute on Drug Abuse and served under Presidents Nixon, Ford, and Carter. Dr. DuPont was also the second Director of the White House Drug Abuse Prevention Office, now known as the drug czar of the ONDCP. He is presently a practicing psychiatrist and specializes in problems in the workplace.

Also, we have Dr. Ian Macdonald. Dr. Macdonald served in many capacities under President Reagan. He was the drug czar as the Alcohol, Drug Abuse, and Mental Health Administrator, and the Assistant Surgeon General.

We also have Dr. Murray Lappe. Dr. Lappe is president of the National Medical Review Offices.

We also have Mark deBernardo, who is an attorney specializing in work drug issues. Mr. deBernardo is the director of the Institute of Drug-Free Workplace.

I thank all of you for being here today. It's a rule of our committee that we swear-in all of our witnesses. I ask you to please stand and raise your right hands.

[Witnesses sworn.]

Mr. HASTERT. Dr. DuPont, please proceed with a brief summary of your written testimony. All testimony will be included in the record.

STATEMENTS OF ROBERT L. DUPONT, PRESIDENT, INSTITUTE FOR BEHAVIOR AND HEALTH; MURRAY LAPPE, MRO PRESIDENT, NATIONAL MEDICAL REVIEW OFFICES, INC.; IAN MACDONALD, M.D., CHAIRMAN, EMPLOYEE HEALTH PROGRAMS; AND MARK DEBERNARDO, ATTORNEY AND EXECUTIVE DIRECTOR, INSTITUTE FOR A DRUG-FREE WORKPLACE

Dr. DUPONT. Thank you very much, Mr. Chairman. I'm delighted to be able to submit formal testimony with some detail to it and this opportunity to summarize three points.

The first—and most fundamental—is a redefinition of the concept of demand reduction with a focus on socially imposed consequences for drug users with the goal of discouraging drug use and maintaining a drug-free standard in this society. The single greatest failure of our national drug policy has been our difficulty focusing on the user and imposing consequences. These consequences need not be draconian, but they need to be stiff and serious and escalated for repeated offenses. This redefinition is not in any way contrary to the goals of treatment or prevention, but is a necessary precondition for treatment and prevention to work. Dr. Macdonald is going to develop this concept in more detail. I want to echo and support everything he says. He is a great leader in this field. His vision is unique and tremendously valuable.

I want to underline the point that demand reduction is not simply conventional prevention and treatment. Demand reduction is socially imposed consequences, drug testing in the workplace being an outstanding example. Another outstanding example is the DWI program that is having a profound beneficial effect on highway safety in this country. So that's the first point.

The second point I want to make is that it's very important that hair testing be added to urine testing and, for that matter, sweat testing be added as well, to increase the effectiveness of drug testing. Hair has a tape recording of recent drug use. Hair is created on the head about half an inch a month. So an 1½ inch piece of hair has a 90-day record of drug use. It is extremely important, particularly in preemployment testing in the workplace, that hair testing be used.

Not only is the 90-day surveillance window important, but also the resistance to deception. With urine testing, deception is a very serious problem, particularly among the most serious drug users. Also, the poppy seed problem in urine testing has made it virtually ineffective at detecting heroin use. The new concern about hemp oil and hemp products also threatens the use of urine testing for marijuana positives as well. Those problems don't exist for hair testing which also is less intrusive than urine testing.

I call your attention to two charts that are put up down here that show that hair testing identifies far more positives than urine testing in two settings. First, is the criminal justice system—the chart on the right which shows that in juvenile arrestees, 8 percent were urine positive and 57 percent were positive by hair tests. Second, the left, is data from the private sector that shows that, there again, there's very substantial increase in positive tests with hair testing. These increases in positive tests mean that the drug test is not only identifying more drug use, but that the deterrence effect of testing is very substantially increased. So it is very important

that hair testing be added to the drug testing techniques in everyday use.

Mr. HASTERT. Would the gentleman yield? I hate to interrupt here, but is that a time function or is that a quality function?

Dr. DUPONT. It's a time function. Basically, a urine test has a surveillance window of 1 to 3 days while a hair test has a surveillance window of 90 days.

Now the final point I want to make—and I've still got a green light here which is a wonderful relief—is that almost unspoken in discussions of what's happening in our national war on drugs is what I describe as the secret weapon in the war on drugs. That secret weapon is the 12-step programs: Alcoholics Anonymous, Narcotics Anonymous, and Al-Anon. Most discussions fail to recognize that the way real people get well from drug problems is by participating in these fellowships of recovery. The disease of addiction is a disease that has a profound spiritual dimension. Recovery also has a very profound spiritual dimension.

I invite the members of the committee and anyone else who is interested in seeing the devastation of drugs and alcohol on people's lives and also in seeing the wonder of recovery, the miracle of recovery, to go yourself to an AA or an NA meeting. I say this in little exaggeration: in the United States you are never more than 2 hours and 2 blocks from the 12-step program meeting. Look around you, find a meeting, and go to it. You will see there evidence of how serious this disorder is on the one hand and how it can be overcome on the other hand. This evidence is right in your face and it will be very, very dramatic. You won't need any fancy studies to prove it.

The 12 steps are absolutely ubiquitous in this country. It is not drug treatment. It is something that helps people keep well and reorient their lives in positive ways. AA is one of the great gifts of America to the world in terms of dealing with the drug and alcohol problem. It started in Akron, OH, in 1935. It is a modern miracle and is the secret weapon in the war on drugs. Thank you, Mr. Chairman.

[The prepared statement of Dr. DuPont follows:]

Thank you, Mr. Chairman and members of the Subcommittee, for this opportunity to address the Government Reform and Oversight's Subcommittee on National Security, International Affairs, and Criminal Justice. I speak as a psychiatrist -- a medical doctor -- having spent the majority of my professional life in the field of addiction medicine. In 1968 I went to work in the District of Columbia Government under Mayor Walter E. Washington creating a model heroin addiction treatment program in the D.C. Department of Corrections. It was expanded in 1970 to become a comprehensive city-wide heroin addiction treatment program (the Narcotics Treatment Administration [NTA]). I became the second White House Drug Czar in June of 1973 and the first Director of the National Institute on Drug Abuse (NIDA) in September of that year.

I have remained active in the addiction field since I left government service in 1978, contributing extensively to the literature on drug abuse prevention, treatment, and policy. My most recent book, *The Selfish Brain: Learning From Addiction*, published by the American Psychiatric Press in 1997, summarizes my views on addiction on a global basis. I am especially proud of the generous Foreword by Betty Ford, a great leader in this field.

My fundamental thesis is that demand reduction is an important, and inadequately developed, element in a more effective drug control policy. Demand reduction, however, should not be equated with conventional prevention and treatment efforts since these, like supply reduction, are relatively helpless in the face of the biology of addiction. What is needed for real demand reduction are powerful initiatives throughout society based on a

drug-free standard. Real demand reduction is first and foremost drug testing linked to serious consequences. This approach increasingly characterizes both private and public sector employment in the United States. Real demand reduction is the growing use of drug testing linked to consequences in the criminal justice system. Real demand reduction is zero tolerance for illegal drug use so that illegal drug users, and would-be users of illegal drugs, know that they will be caught quickly and that the consequences of their illegal drug use will be painful. For repeated violations of the drug-free standard, the personal consequences must be progressively more severe. In the workplace the ultimate penalty is termination of employment, in the criminal justice system it is prison.

This is a new way to look at demand reduction. For prevention and treatment to work, real demand reduction has to be in place. Absent real demand reduction -- detection of illegal drug use linked to tough consequences -- then prevention and treatment will not work for most addicted people.

Having said that real demand reduction needs to be a top priority of an effective national drug control strategy, however, let me add that supply reduction does work when it is in concert with effective demand reduction. Once demand for illegal drugs is curbed -- by tough anti-drug use initiatives -- then curbing drug supply works much better. Supply reduction adds greatly to the effectiveness of demand reduction by reducing the exposure to drugs, thus reducing the appeal of drugs in the society. Effective

supply reduction reduces the purity and raises the price of illegal drugs. It makes it harder and riskier to sell and to use illegal drugs.

Today I will focus on seven points, each of which is developed in *The Selfish Brain: Learning From Addiction* and in my other writings, so I will state them here in summary form to encourage vigorous and full discussion with the Subcommittee. These seven points are part of a single, comprehensive view of the problem of addiction as a uniquely modern, uniquely human, and terribly serious problem.

1. Addiction is a lifelong brain disease which is contracted from repeated use of addicting substances. It is characterized by two principal features, continued use despite the manifest problems generated by that use, and by dishonesty. Addiction to illegal drugs is a biopsychosocial disorder with deep roots in all three areas: biology, psychology, and the social environment.

The disease of addiction comes from the use of addicting substances as these chemicals interact with the users' brains. No use and addiction does not start. That is the central point of prevention of addiction -- prevent use of addicting substances and you prevent addiction. Drug use is a personal choice that has important legal and moral dimensions.

I recognize that some people who may be attracted to my tough approach to demand reduction will be disturbed by my use of the word "disease" to describe addiction to illegal drugs. One reason the disease concept is unpopular is that it implies that addicts

are "innocent victims" of their brain biology. Worse yet, calling addiction a disease for many people implies that the addict is helpless in terms of getting well. I do not believe that addicts are "innocent" or "helpless." Let me explain why.

Addiction is a disease in the sense that the brains of addicted people are changed as a result of their repeated drug use. This change is permanent in that even years of abstinence from drug use will not return once-addicted brains to their premorbid state. Addiction is a disease in the sense that there is a predictable pattern to the illness with predictable behavioral and physiological manifestations. In accordance with the views of the 12-step fellowships, based on and including Alcoholics Anonymous (AA), the disease of addiction is unitary so that people who suffer from this disease must stop all illegal drug use and alcohol use to hope to regain control of their lives. The return to even occasional use of any addicting drug threatens relapse to full-blown addiction. Thus, abstinence from alcohol and illegal drug use is the foundation of recovery from addiction. I have learned that there is a profound spiritual dimension to the disease of addiction and that selfishness and self-centeredness are at the core of this disease.

What I definitely do not mean by calling addiction a disease is that the addicted person is not responsible for the use of drugs and the consequences of that use. In fact, it is only by accepting direct, personal responsibility for drug use that the addicted person has a realistic hope for getting well. I do not accept that

relapses are inevitable or that addicted "patients" should be absolved of responsibility for relapses. Again, it is only when the best is expected and only when addicted people carry the heavy burden of personal responsibility for all of their behaviors that getting well from addiction is possible.

My view on drug control policy is diametrically opposed to "harm reduction," a new name for the old idea that the most appropriate social policy toward addictive substance use is to accept that the use of illegal addictive substances is normal and inevitable. The goal of harm reduction is to find clever ways to reduce some of the painful consequences of illegal drug use without stopping illegal drug use itself. In this harm reduction view, socially imposed consequences for illegal drug use create the "harm" which is most of our "drug problem." Harm reductionists conclude that socially imposed consequences for illegal drug use are wrong.

In contrast to this seductive and dangerous view, I believe that socially imposed consequences offer the best hope for both the prevention and the treatment of addiction. Society does not create the major harm from drug use. The use of illegal drugs is what creates the vast majority of the harm created by illegal drugs. I believe effective harm reduction should aim to reduce illegal drug use. That is not a popular idea with contemporary harm reductionists who turn a blind, if not a sympathetic, eye toward illegal drug use. Their views are easily seen in their support for needle exchanges and medical marijuana.

2. Clearly separate legal from illegal drugs. They are different biologically and historically. Social policy toward them needs to be separated. Legal drugs for adults (alcohol and tobacco) are not subject to an absolute drug-free standard, while other drugs (such as marijuana, cocaine, and heroin) are. Alcohol use and tobacco use by minors are illegal and subject to the strict drug-free standard.

Critics of the current drug policy not only in the United States but throughout the world are now eagerly blurring the line between legal and illegal drugs. Removing the bright line between legal and illegal drugs has bad effects on public policy toward both legal and illegal drugs. There are good reasons that the currently illegal drugs are illegal. It is important to the nation's public health to keep them illegal. Whatever new policies are adopted toward the adult use of alcohol and tobacco, these policies need to be separated from how the nation treats illegal drugs.

Today most young people do not recognize that alcohol and tobacco are illegal for them because the laws against youthful use of alcohol and tobacco are so seldom enforced. I strongly support far more aggressive and consistent enforcement of the laws now on the books related to young people using drugs, as well as laws against young people using alcohol and tobacco.

3. Respect the illegal drug user as a person, but take all reasonable actions to discourage illegal drug use. Recognize that addiction is often chronic and relapsing, but expect addicted

people to take responsibility for their lives, including their decisions to pick up or not pick up illegal drugs.

Related to this attitude of respect for the addicted person, retain hope for recovery for all addicted people no matter how long they have been addicted and no matter how many times they have relapsed. Recovery from addiction is a great gift that can only be earned by addicted people themselves, one person at a time. Others, including family members, therapists, employers, criminal justice personnel, and friends, can facilitate recovery but they cannot do it for addicted people. They should not enable continued illegal drug use by misguided efforts to protect addicted people from the often painful consequences of their addictive substance use. Pain as a result of addiction is the principal stimulus for beginning to work to get well. Removing the pain that flows from the addicts' own choices to use addicting substances, even though it is often well-meaning, is crippling to addicted people. Enabling prolongs and deepens addiction.

4. A reasonable level of addiction treatment should be offered to all addicted people who are motivated to get well. The costs of addiction treatment are important to consider and they need to be fit within the context of other health care costs. As a general statement, addiction treatment is one of the best buys in all of health care today, returning more in personal and social benefits than most other health care expenditures. This is true for both inpatient and outpatient care in both the public and the private sectors.

It is reasonable to expect that addicted people return something for the treatment that they receive, including paying for at least part of their own care and contributing community service and documented periods of freedom from alcohol and other drug use after treatment.

In the past two decades addiction treatment has become one of the leading paths by which addicted people find their ways into lifelong membership in the 12-step fellowships. Treatment is not only a point of introduction to these fellowships, but it is also a way for addicts and their families to understand and to begin to use these fellowships.

Treatment needs active drug testing to work. Treatment cannot work without a systematic incentive to get well and to stay well. I invite the Subcommittee to look into the way Impaired Physicians programs work in every state in the union. They all rely on a compassionate and tough use of drug testing and 12-step fellowships with addiction treatment often being part of the mix. These programs set the standard in terms of low recidivism.

5. Tripwires need to be built into all aspects of modern life to identify illegal drug use and to ensure that interventions are conducted to bring it to a stop. Modern drug testing technology provides a powerful basis for illegal drug use identification. The experience of the U.S. military with drug testing linked to tough consequences is an excellent model, as is the increasing use of drug testing and Employee Assistance Programs (EAPs) in private sector workplaces over the past decade. Other social institutions

need to build these real demand reduction strategies into their everyday functioning. The most promising new area today is the criminal justice system (CJS) where the strict drug-free standard needs to be established and enforced: If you are under any form of CJS supervision (in jail or prison, on parole or probation) you will be drug tested. If you test positive, indicating recent illegal drug use, you will lose privileges and be subject to more intensive supervision and more frequent drug testing. Repeated violations of the drug-free standard while under CJS supervision will lead to escalating penalties to ensure that no one under supervision continues to use illegal drugs.

There are many other places where illegal drug use tripwires need to be put in modern American society, including public and private schools and on our highways. They need to be extended in the workplace and developed in other institutions, especially in health care and in disability and welfare programs.

The initial consequences for violation of drug-free tripwires need not be draconian. To work to deter drug use, the consequences for initial detection of illegal drug use need only to be swift and certain. They need to lead illegal drug users into tighter supervision to actively detect any continued illegal drug use over prolonged periods of time. Repeated violations of the drug-free standard should be met with escalating punishments. Drug users need to be educated about the disease concept of addiction.

6. Add hair testing to urine testing for more effective drug detection in many settings, especially preemployment drug testing

and long-term drug testing on parole and probation. The current reliance on urine testing needs to be expanded to include hair, sweat, and saliva testing. In particular, the hostility to wider use of hair testing needs to be resolved since the benefits of hair testing for illegal drugs -- the resistance to deception, the ease of collection, and the 90-day window of detection -- are of tremendous value to the nation's efforts to discourage illegal drug use.

Hair testing has many advantages when compared to urine testing. It uses the same immunoassay screening test followed by a mass spectrometry confirmation. In disputed cases it is possible to take a second hair sample, something that cannot be done with urine testing because of the limited window of detection for urine testing.

The criticisms of hair testing have been studied extensively and sound answers exist for each of them, including the concerns over racial bias and passive exposure which have been shown not to be issues of practical importance. Because some people who resist drug testing, and others who have professional and financial interests in urine testing, have joined forces to oppose wider use of hair testing, I encourage the Subcommittee to explore the science behind hair testing and the unwarranted opposition to wider application of hair testing. The simple and fundamental standard needs to be the public interest. When that standard is applied, hair testing joins urine testing as two important components of an effective drug abuse prevention strategy.

7. The single best way to get well -- and to stay well -- from addiction is to participate in the 12-step fellowships including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Al-Anon. These programs are truly the secret weapons in the war on drugs. It is clearly in the national interest for all people working to prevent and treat addiction to support these lifesaving programs which are available in all parts of the nation today, at no cost to taxpayers.

The standard I use in my practice of addiction medicine, whether with my richest or my poorest addicted patients, is to encourage them to go to 90 12-step meetings in 90 days, to get a sponsor, and to diligently implement the 12-steps in their everyday lives. When addiction treatment works over the long haul, it usually works with the support of a 12-step fellowship. The 12-step programs are not addiction treatment. They complement addiction treatment, they do not compete with it. The 12-step programs are not run by doctors, psychologists, or social workers. They do not use health care funds and they do not require government licenses. They are run by addicted people in recovery for their own benefit. They are tailored to all economic, ethnic, and social groups in the society. They are ubiquitous and they are free. The 12-step programs are a modern miracle, one that Americans can be especially proud of having contributed to since the founding of AA in Akron, Ohio by two alcoholics, one an unemployed salesman and the other a troubled doctor, on June 11,

1935. That is one of the most important dates in the history of addiction.

The 12-step programs use the wisdom gained from six decades of saving lives from addiction to alcohol and other drugs. These are not religious programs, but they have an important spiritual basis. The bedrock of the values of the 12-step programs is honesty, the potent antidote for addictive thinking.

Among the most powerful anti-addiction efforts in America today are the Driving While Intoxicated (DWI) programs which intervene in no-nonsense ways in the lives of about one and a half million Americas a year. DWI programs contribute greatly to the safety of our highways and to the recovery of hundreds of thousands of alcoholics. These low-cost state and local law enforcement efforts are systematically linked to the 12-step programs, as are most contemporary drug courts. These are two good models for how to use the 12-step programs in real demand reduction.

In conclusion, I call your attention to my many published papers and two books which review most of these issues in greater detail than I can pursue today. In addition to *The Selfish Brain: Learning From Addiction* mentioned earlier, I wrote *A Bridge to Recovery--An Introduction to 12-Step Programs* with John P. McGovern, M.D., a widely honored physician and a great leader in our nation's efforts to prevent and treat addiction. I have written extensively about drug testing in general and about hair testing in particular, including a paper for Medical Review

Officers (MROs) on the appropriate interpretation of hair test results.

Thank you Mr. Chairman and members of the Subcommittee. I welcome your comments and questions. I salute you for your important efforts to chart a new course for our national drug policy with a focus on the cutting edge issues in drug testing and drug treatment.

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Mr. HASTERT. Thank you very much, Dr. DuPont.

Now, I'd like to introduce Dr. Macdonald.

Dr. MACDONALD. Thank you, Mr. Chairman. I appreciate the opportunity to be here. In my brief remarks, I'm going to go beyond the context of the workplace and talk about the national drug problem. I'm going to frame my remarks around the quotes of Nils Bejerot that are in my prepared statement.

The first quote that Dr. Bejerot made that shaped my philosophy was—and Dr. Bejerot is a Swedish psychiatrist and historian scholar—his quote was that the only way history shows us that drug wars and drug epidemics have ever been halted is when the focus is on the user. The only way. Dr. Bejerot would look at our supply side dollars and all the money we were spending and say that's fine, but it's not going to work, and give examples from history, and some of those are in my paper.

Well, if we're going to focus on the user, how do we do that? I'm not here to talk about prevention—for when you're talking about prevention, you're talking about people that don't use. You're also talking about an investment in the future and that's important. Where prevention programs, in my mind, have their biggest lack in our strategy is there is no consequence to users. It's wonderful to tell them that they're going to get lung cancer when they're 47 years old, but they still smoke cigarettes. There needs to be—and testing fits into that model—a reasonable response from the community to people who step over the line. I'll come back to treatment later.

Treatment is not where most of our drug users are. Those that are in it tend to be the dependent and they're further along. There are loads of people that should be in treatment that are not. I'll come back later to say that treatment without drug testing doesn't make a whole lot of sense either. But the great majority of users come to the workplaces, which we are discussing today as you, Mr. Chairman, pointed out. The workplace is where most drug users are. Focusing on the issues of accidents and healthcare costs, and lost productivity are clearly a part of workplace problems that fit with what I call fitness for duty testing. But let's talk instead about deterrence testing and using testing as a method of convincing the non-user or the casual user to quit. Testing also gives us a tool to take those in the penal and treatment systems and enforce what we want to do.

Mr. Solomon's comments I support absolutely. I think it is about time that Congress follow the model that the White House adopted in an Executive order in 1986—testing the President and the Vice President and members of the executive branch—not because we felt that the President and the people in the White House were drug users, but because we wanted to send an example and show our concern. That message carried well. It was part of the Drug-Free Workplace Act. He, the President, saw the importance of the message.

A couple of trends that are very important are related to what we're discussing here: Perhaps the most important thing that is affecting the use of workplace testing now is the high employment rate. We hear from a number of employers that they're really worried about drug testing because it's going to discourage the people

that they need to hire. If they can't hire workers by reason of drug testing, they may decide to quit testing. I think that's a bad decision. The other disturbing trend is the reemergence of the high school drug user—the person who is going to fill the jobs that industry is asking to fill. With their high use rates, this is a real issue.

My view of what should happen is that employers should say not that they won't test, because we can show them why drug use is dangerous to their interest as well as national interest, but that they should have some way of identifying drug-using employees and seeing that they get to help and return as useful employees. When you talk about treatment, the phrase "treatment on demand" has always offended me a little because I think that the phrase means that the user, the addict, would control the treatment system.

The second quote from Dr. Bejerot that's affected my thinking is a quote that says "a voluntary treatment system is as effective as a voluntary penal system." What he says, and Dr. DuPont and I both believe, is that people don't go to treatment because they want to get better. They go to treatment because they want to avoid the consequences of their use. They want to continue use without consequences.

What we see in a workplace program in California, that I'm aware of and others, is that we're finding workers, through drug testing who are detected earlier in their illness and are easier to treat, and easier to get back on the job. We have a wonderful tool in this regard. Drug testing gives us a tool to change behavior. That's what we're trying to do.

If we want to stop this drug epidemic, we've got to change the behavior—not of the people in Colombia and Peru and those countries; we've got to change the behavior of the people who use drugs here. I thank you for the opportunity to make these comments.

[The prepared statement of Dr. Macdonald follows:]

TESTIMONY
before the Congress of the United States
House of Representatives
Committee on Government Reform and Oversight

by
Donald Ian Macdonald, M.D.

I appreciate the opportunity to speak with the committee about the important subject of drugs in the workplace. My remarks today will be based on my experience as a provider of drug-free workplace services and as an advisor on national drug control policy. The issues of drugs in the workplace will be my focus and I will try to frame my remarks in the broader context of a national drug control policy that, in my view, gives them insufficient attention.

Our company, Employee Health Programs (EHP) of Bethesda, Maryland provides drug-free workplace services to more than three thousand client employers including large and small corporations, government entities, a congressional office, a professional sports league, and even a country. Many of our clients are in federally mandated testing programs but the majority of the drug tests that we conduct are not mandated. Our physician staff answers our 800 line 24 hours a day, 365 days a year, responding each day to calls from hundreds of individuals who call to discuss their positive drug tests. These trained physicians, certified as medical review officers (MROs), discuss test results with workers seeking to find legitimate medical explanations for their laboratory confirmed positive tests. Our MROs speak with laboratories, pharmacies, physicians, and others as required by the circumstances of each case and keep copious notes of all that they do. Additional testing is ordered as required and donors are informed of their rights to have a portion of their specimen re-analyzed at another laboratory.

All of our employees including myself are subjected to random testing, a procedure that we believe sends a strong signal to our employees and clients that we intend to be a drug free workplace. Ours is not unlike the motivation to provide a good example to the country that led to the signing of an Executive Order in 1986 calling for a drug-free federal workforce and testing of federal non-military workers. We believe that the Congress has the opportunity to set a similar example and send a strong anti-drug message by initiating the member and staff testing program that has been proposed.

Many see drug testing as a great way to reduce accidents, raise productivity, and lower health care costs in industry and experience is showing this to be the case[1] [2]. This is an important concept but not, in my mind, as important as the effect such programs will have on dealing with

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[1] Normand, J., Salyards, S.D., & Mahoney, J.J. (1990). An Evaluation of preemployment drug testing. Journal of Applied Psychology, 75, 629-639.

[2] Delancey MM; Does drug testing work; 2nd Ed: Institute for a Drug Free Workplace, Washington, DC 1994.

this country's drug epidemic. Drug testing programs not only send an important message of disapproval to drug users but they also confront drug using workers with a choice that has important consequences if poorly made.

Random testing programs are, for the most part, deterrence programs using the possibility of being called to test at any time as a deterrent to use. From a national drug control policy standpoint, deterrence testing, is, by far, the most important form of testing. The principal goal of these programs should not be to catch drug users, although that may be beneficial to the identified users, but to provide a strong incentive for others in the pool to refrain from starting.

Two key societal changes are already affecting the way employers see their drug-free workplace programs. The first, stimulating increased interest in pre-employment drug testing, is the rise in the use of drugs by those adolescents who are about to begin their work careers[3]. The second that may cause some employers to seriously and foolishly consider decreased testing, is the high rate of employment that is making it hard for employers to find workers. This ostrich approach may fill their ranks but it will fill them with workers who are going to cause them problems.

The other approach to the shortage of workers, and the one that we prefer, is to welcome testing as a way to spot drug users and to provide them with assessment and jobs depending on their willingness to accept the recommendations of a qualified substance abuse professional and to consent to a program of regular unannounced testing. Creative payment solutions can be worked out that assign responsibility for these cost to the worker with the stipulation that the employer will make restitution of at least some of the expense if the employee remains drug free and continues their good performance.

Much of my philosophy of how best to respond to a national drug epidemic was taught to me by Nils Bejerot, the Swedish psychiatrist and drug historian. Dr. Bejerot taught and I believe that, "The **only** way drug epidemics have ever been halted is when the focus has been on the user." If he were alive today, he would tell us that there is not enough in the American anti-drug strategy that addresses his key point and that unless there is a substantial change in our focus, we run the risk of eventually forgetting the casualties of drug use and turning our attention to the casualties of the "Drug War." If this happens as an increasing number have suggested it should, we will toss in the towel. Dr. Bejerot might trace for us the history of those campaigns that have been successful and those that have not, making us aware that the core element of those efforts that have been worked has been a focus on the drug user and that those efforts that have ended in failure have not adequately addressed the user, if they have addressed him at all.

Bejerot might remind us of the cessation of alcohol use in Muslims that occurred only after Mohammed told believers the religious consequences of their use. Or he might recount the successful conclusion to the Japanese amphetamine epidemic in the 1950s brought about by some user-focus. Or he might remind us that American prohibition failed and tell us that it failed because the strategic focus was on the bootlegger and largely ignored the user. An examination

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[3] Johnston LD, O'Malley PM, Bachman JG; national Survey results on drug use from monitoring the future survey: NIDA/HHS, Rockville, MD 1996.

of our present national strategy shows that many still believe that Elliot Ness can get the job done.

We have a demand strategy that appropriately includes prevention and treatment efforts but barely addresses the great majority of American users who have passed the prevention stage and either do not need treatment, do not yet require treatment, or are in need of treatment but not receiving it. We do have programs for testing those in the criminal justice system and in the military but the civilian workforce, where most adult Americans spend their day, is pretty much ignored by the federal strategy. Exceptions are in the programs mandated by the Department of Transportation and the Nuclear Regulatory Commission but neither of these covers anywhere near a majority of American workers.

I would be the last one to downplay the importance of prevention but we must see prevention programs as investments in the future and not a solution to today's problems. They are not the user-based programs that Bejerot would have us adopt as the centerpiece of our national strategy.

Treatment programs are user-focused but they reach only the dependent user and ignore the much larger group of users who are not in treatment. Although the value of treatment is well documented,[4] not all treatment is as good as it might be. So-called "treatment on demand" programs that put the responsibility for successful treatment on the government or the provider of treatment and not on the user have led to a revolving door system in which there is little consequence to a user who comes in for a brief period of "treatment" and then decides to go back on the street and resume his drug use. Bejerot's comment was, "A voluntary treatment system is as effective as a voluntary penal system." An old maxim says that if the user has not "hit bottom" he will be a poor candidate for treatment success. We believe this to be true but we also believe that in a user-focused strategy, a stick can be provided that can raise the bottom. For treatment tied to workplace drug testing, the consequences of continued employment can be strong incentives to abstain and to avoid relapse.

Workers, in trouble with alcohol and other drugs, who are performing satisfactorily on the job are often in the earlier and more easily treatable stages of chemical dependency. Random testing programs that identify these workers before they "hit bottom" can be very successful. David Smith, M.D., a recognized expert in the field of addiction medicine and the supervisor of a large corporate testing and rehabilitation program, is convinced of the value that workplace testing brings to workers as well as employers[5]. The carrot of continued employment based on measurable abstinence has effectively raised the bottom for many.

Aside from a number of creative, promising, and abandoned user-focused programs, such as the DEA's seizure of cars in the Bronx or the program dubbed the "Miami Sting" by columnist George Will, this country's principal user-focused programs have been drug testing programs. Testing programs in the military, in the penal system, and in the workplace have all been successful at lowering drug use among the populations being tested. The SmithKline Index

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[4] Analyzing of findings from the National Household survey on drug abuse: population estimates: SAMSHA/HHS, Rockville, MD 1994.

[5] Smith DE: Personal communication.

released annually[6] has shown an annual decrease in the positivity rates among all work groups tested. The rates of positivity in testing in the military have fallen from more than 20 percent at the time the program was started to current positive rates of less than 3 percent.

The findings of these reports are significant but they raise some issues. Principal among them is whether these programs are really effective in reducing drug use or do they just drive it from employers who test to employers who do not? Probably, some of each. Data from the National Household survey confirm a wealth of anecdotal reports suggesting that self-admitted drug users are less likely to apply for jobs with employers who test[7]. But as more and more quality jobs are with employers who test, the incentive to quit has grown.

EHP, provides education and training to companies and provides assessment and counseling services for troubled employees and for employees who have failed their drug and alcohol tests. An increasing number of our clients allow employees who have failed a drug test to return to work after being evaluated by one of our substance abuse professionals (SAPs) and cleared for work. It is our belief that the factors behind this increase are the awareness of the value of keeping employees who are trained and experienced, especially in a time of high employment. Another factor may be the increasing awareness of the effectiveness of drug treatment especially when there is a process in place to monitor compliance with SAP recommendations and to randomly test for drugs and alcohol.

In conclusion, it is my view that drug testing is an underutilized tool of value not just to employers seeking to reduce the consequences and costs of worker drug use but an underutilized tool of a national strategy focused too little on the real cause of our drug problem, the user.

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[6] Drug testing index: SmithKline Beecham Clinical Laboratories, Collegeville, PA 1997.

[7] An evaluation of drug use and workplace policies and programs. The 1997 Substance Abuse and Mental Health Services Administration (SAMSHA) National Household Survey, Washington, DC.

Mr. HASTERT. Thank you very much, Dr. Macdonald. Appreciate your testimony and we'll have some questions for you in a little bit.

Dr. Lappe—is that right?

Dr. LAPPE. Lappe, that's correct.

Mr. HASTERT. Thank you for being with us today. Please proceed with your testimony.

Dr. LAPPE. Good morning, Chairman Hastert and members of the subcommittee. My name is Murray Lappe, and I'm the medical director of National Medical Review Offices in Los Angeles, a drug-testing company.

I'd like to say that drugs, being a very, very powerful substance, have not found countermeasures in our society at-large nor in the family. But the workplace has found countermeasures to counteract, through drug testing, the use of drugs in the workplace. Drug testing is a powerful tool. It has been successful in the private sector to detect drug use accurately and to deter drug use through the penalties of company policies for the use of drugs while employed.

There are three essential components of a drug testing program: First, a sample must be properly collected, legally defensible; second, the sample must be analyzed properly; third, the employee, subject to testing, must have an opportunity in privacy and confidentiality to discuss a positive result with a neutral third-party prior to that information being released back to their employer. That private, or that neutral third-party, is called a medical review officer in workplace jargon. That model was created by the Federal programs, and in particular, the Department of Transportation mandate for drug testing in the transportation workplace.

So that every time a laboratory detects the presence of drugs in a sample, that that information would be transmitted to a neutral party who is skilled and qualified as a physician in the area of substance abuse and drug testing. The individual has an opportunity to discuss in private their medical history, the legal therapeutic drugs that they're taking, possibly foods or over-the-counter substances that might have interfered with the test. The physician has the authority to overturn the laboratory positive result and return a passing remark, or negative result, to the workplace to protect that individual's right to privacy. So no adverse employment action would ever be taken in the face of an existing medical condition, protecting the individual's rights to privacy under the Americans With Disabilities Act and also protecting the employer from liability.

The National Medical Review applauds this subcommittee in its effort to identify and support the most accurate and technically superior drug-free workplace programs and commends to the committee's attention the model legislation by the Institute for a Drug-Free Workplace.

I'd like to add that in the private sector, 40 million drug tests were done last year. We know that there is a migratory effect, that is, workers who use drugs seek employment in workplaces that don't test for drugs. The positive rate is substantially higher in the smaller employers who fear the complexity of the laws and the legal liability in doing drug testing. This model legislation, which is voluntary, would encourage employers with drug-free workplace programs to utilize state-of-the-art testing methods that would pro-

tect employee rights and maintain the highest standards of testing quality and accuracy, since the laws, in the best interest of the American public, would help ensure that drug testing is conducted in a manner which eliminates potential harm and technical errors, while effectively detecting and deterring employee drug use. Thank you very much.

[The prepared statement of Dr. Lappe follows:]

I. Introduction

Good morning, Chairman Hastert and Members of the Subcommittee. My name is Murray Lappe, and I am President and Medical Director of National Medical Review Offices, Inc., (NMRO) in Los Angeles, California. It is a pleasure to be here today to share with you our experience, and to discuss the procedures and policies that produce a successful drug-free workplace program.

Previously, I was in the private practice of occupational medicine, and directed one of the nation's first workplace drug-testing programs in 1983. I enjoyed my medical career, but felt that in order to effectively promote substance abuse-prevention, I had to dedicate myself to a Medical Review Officer (MRO) practice exclusively. Ten years ago, I founded NMRO in order to pursue a career as a full-time MRO.

NMRO is now the largest MRO provider in the world, and a leader in its field. We have more than 130 employees, a computer network with direct links to more than 50 drug-testing laboratories certified by the Department of Health and Human Services (DHHS), and review nearly 5 million workplace drug tests each year. We have unparalleled resources to provide oversight and medical review services to workplace substance-abuse prevention programs nationwide. National Medical Review Offices has contributed to,

and is familiar with, thousands of successful workplace substance-abuse prevention programs in every state in the country.

It is also my pleasure to serve on the Board of Directors of the Institute for a Drug-Free Workplace, an organization which contributes enormously to the very worthwhile cause of employee drug-abuse prevention – a cause to which I am sure every one of us in this room is committed.

II. Summary of Position

The most effective workplace drug-testing policies include the use of a neutral third party – the Medical Review Officer – to ensure that employee drug tests are accurate and reliable, and to protect employees' privacy regarding their medical conditions and their personal use of legally prescribed therapeutic drugs.

A Medical Review Officer is a medical doctor with a specialty in substance-abuse issues. Responsible workplace drug-abuse prevention programs utilize the services of an MRO to review all laboratory positive drug tests – *before* they are reported to the employer. An MRO can determine whether a laboratory positive drug test could have been caused by: (1) the legitimate use of a prescription drug; (2) the normal use of over-the-counter medication; or even (3) normal food consumption.

An MRO also reviews laboratory reports to ensure that all chain-of-custody and laboratory testing procedures have been followed. If not, the MRO has the authority to

cancel or overturn the laboratory results to ensure that no employee will be erroneously reported as positive for drug use. In short, the use of an MRO greatly strengthens the integrity of the entire drug-testing process.

It is also essential to the integrity of the analytical laboratory process to confirm *all* positive drug tests using a more *specific* testing process than that used merely to rapidly screen samples.

Thus, the most responsible drug-testing programs: (1) ensure that the sample collection is performed using a strict forensic chain-of-custody procedure; (2) confirm all initial drug screen positives, with a second highly specific analytical method; and (3) utilize the services of a qualified MRO. These programs clearly are superior in ensuring the accuracy and integrity of every test result.

Employers and employees alike benefit from these procedures. NMRO encourages its clients to use MRO services whether or not required by federal or state law,[1] and works only with DHHS-certified drug-testing laboratories to ensure that these necessary safeguards, including chain-of-custody procedures and confirmatory tests for samples that screen positive, are utilized consistently and without exception.

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[1] The "Mandatory Guidelines" for drug testing of federal employees, promulgated by DHHS, *require* MRO review of positive drug screens (*Mandatory Guidelines for Federal Workplace Drug Testing Programs*, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Federal Register Notice, June 9, 1994, at 29922); as does the U.S. Department of Transportation's (DOT) drug-testing rule covering 7.4 million workers in the private sector in transportation-related, safety-sensitive jobs (49 C.F.R. Part 40); and as do several states, including Hawaii, Iowa, Louisiana, Montana, Oklahoma, and Oregon (although most states do not address this issue).

NMRO applauds this Subcommittee in its efforts to identify and support the most accurate and technically superior drug-free workplace programs, and commends to the Committee's attention the model legislation advanced by the Institute for a Drug-Free Workplace.

This legislation, which is voluntary, would encourage employers with workplace drug-testing programs to utilize state-of-the-art drug-testing methods that would protect individual employee rights and maintain the highest standards of testing quality and accuracy.

Such a law is in the best interests of the American public and would help ensure that drug testing is conducted in a manner which *eliminates* potential human and technical errors, while effectively *detecting and deterring* employee drug use.

III. National Medical Review Offices' Practices, Procedures, and Philosophy

As the members of this Subcommittee may be aware, substance abuse in the workplace costs American businesses many billions of dollars a year. While there is some disagreement as to exactly *how* much substance abuse costs employers, there is virtually no disagreement that this cost is enormous.

Why is substance abuse so costly to employers? Substance abuse has a direct correlation to workplace accidents. In addition to the human costs associated with these accidents, employers with substance-abusing employees experience increased workers'

compensation and health care costs. Moreover, substance abuse in the workplace has a demonstrated and substantial adverse impact on employee productivity and morale.

The American workplace has responded with substance-abuse prevention programs. Numerous studies and individual corporate experiences alike confirm that efforts to reduce substance abuse in the workplace can be extraordinarily effective. The prevalence of drug testing throughout the employer community alone demonstrates that companies recognize that their programs work. Last year, more than 40 million drug tests were performed in the American workplace – a 1000% increase in the past 10 years. There is, additionally, a "migratory effect"[2] which has forced drug users seeking employment into the workplace of smaller employers who do not perform drug testing due to the fear of legal liability, and to the complexity of some state and local laws.[2]

National Medical Review provides guidance and medical consultation to our clients to assist them in developing and maintaining their drug-free workplace programs. We stay up-to-date on all federal, state, and local laws, and assist our clients in staying informed as well. When necessary, we provide expert testimony for our clients.

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[2] A recent SAMHSA (Substance Abuse and Mental Health Services Administration) survey found that workers in small businesses of 1-to-24 employees have the highest rate of current illicit drug use at 11 percent. By contrast, workers in businesses of 25-to-499 employees and 500 or more employees report a much lower current illicit drug use rate of 5.4% each. The survey affirmed the correlation between employee drug use and workplace substance-abuse prevention programs that include drug testing. Only 22.5% of workers employed in small-sized businesses are subject to drug testing, while 52.2% of workers in medium-sized businesses and 68% at large-sized businesses are subject to drug testing. *From the Institute for a Drug-Free Workplace's Legislative Update, May 29, 1998.*

All of our clients' drug tests are sent exclusively to laboratories certified by DHHS.[3] These laboratories ensure the highest quality analytical service, and provide NMRO and its clients with the most legally defensible test results. While employers in the private sector who are not regulated by the federal DOT are *not* required to use DHHS-certified laboratories, we insist that *all* of our clients do so to provide the American worker with the highest standard of care available today.

NMRO has created a unique nationwide laboratory-information network. We are on-line with more than 50 DHHS-certified drug-testing laboratories, so that when a laboratory completes the testing process, our MROs access the information on-line and begin the review process immediately.

NMRO delivers final results to its customers in a variety of ways, according to their needs. Information about employee drug-test results is available to our clients 24 hours a day via an on-line computer service, *or* via a 24-hour automated telephone system, in addition to the more traditional methods, like fax and secure e-mail. The confidentiality of the employee is always placed foremost.

Our efforts are geared toward providing our clients with the information they need – in a secure format – as soon as it is available. In fact, since drug testing is in fact an information science, information solutions are employed, so that hiring decisions are

[3] Previously known as "NIDA-certified laboratories," although the laboratory certification function has been shifted by DHHS from NIDA to the Substance Abuse and Mental Health Services Administration (SAMHSA).

expedited, and safety concerns (that is, *not* having drug-abusing employees on the job) are addressed on a more timely basis.

Moreover, these digital reporting methods eliminate burdensome and voluminous paperwork and increase the confidentiality with which test results are reported. These services reflect our strong belief that the science of reporting drug-test results can be as important as the results themselves.

In sum, NMRO provides substance-abuse program management services, drug-test data management, and medical analysis of workplace drug tests. This combination of medical science with information technology has defined NMRO as the leading provider of medical review services anywhere in the world.

IV. The Role of the Medical Review Officer

Because drug tests detect only the presence or absence of drugs (or their metabolites) in a urine specimen, a positive drug test alone is not evidence that an individual has used an illicit drug. These tests also detect the presence of drugs from the legitimate use of prescription medications, as well as over-the-counter medications and certain types of food.

The skilled MRO speaks personally with each laboratory-positive employee, in confidence, to investigate each and every legitimate reason which could account for a

false-positive test result. If a legitimate medical explanation is found and verified, the MRO simply reports to the employer that the individual has passed the test.

The MRO also reviews each sample's chain-of-custody to ensure that the sample has been handled properly from collection through to the final laboratory confirmation test.

By acting as a neutral third party, the MRO protects *employees* from being wrongly accused of illegal or illicit drug use, while protecting *employers* from potential liability associated with drug testing, and helps them comply with the Americans with Disabilities Act (ADA), by eliminating their need to discuss sensitive medical issues directly with employees, *and* by helping avoid adverse employment action based upon an employee's legitimate medical treatment for a condition covered by the ADA.

Employers who utilize an MRO's services therefore can take employment action with the highest level of confidence that a positive test result is truly positive due to the illegal use of one or more controlled substances. Moreover, employees who test positive are treated with dignity and respect while the cause of the positive test is being investigated.

The use of MROs was first required federally by the Department of Health and Human Services for federal workplace drug-testing programs, and subsequently by the U.S. Department of Transportation as a necessary legal requirement for transportation-related drug-testing programs. Currently, a number of states also have adopted laws that require employers to utilize MROs for drug-testing programs. Unfortunately, however, many states neither require an MRO, nor regulate workplace drug testing.

V. Elements of Responsible Workplace Substance-Abuse Testing Programs

Most responsible workplace substance-abuse prevention programs include drug testing. Drug-testing requirements can range in breadth and application quite widely. Most employers who perform drug testing require pre-employment drug tests. Some employers have implemented universal random testing – for every employee from the company president to the newest clerical hire. Other companies may implement more limited employee drug testing. For example, many employers require employees to submit to drug tests only "for-cause", when an employee is exhibiting symptoms that may indicate a substance-abuse problem. In this case the employee is usually tested for both drugs and alcohol use in violation of company policy.

Companies may require follow-up testing for individuals who have recently participated in rehabilitation efforts, or post-accident testing for employees involved in accidents, or random testing, i.e., testing without notice – especially for those employees in safety-sensitive positions.

No matter what size the employer, nor the extent of the testing program, responsible employers should implement safeguards that maximize the accuracy and minimize the intrusiveness of workplace drug testing.

Responsible workplace drug-testing programs maintain chain-of-custody procedures, including documentation that tracks the specimen from the time of collection until sample testing is completed at the laboratory. Chain-of-custody procedures give the employee

being tested, and the employer requiring the test, the assurance that each specimen tested is the sample that the tested individual has provided.

Once a specimen has been collected and transported to the testing facility, it is screened for the presence of illicit drugs. This type of screening procedure can be conducted using a range of different scientific procedures and products, and actually may be performed in a laboratory, at a collection site, or even at the employer's workplace. Whether on-site test kits or laboratory tests are utilized, the initial screen is just that – an accurate initial test which may register the presence of a drug of abuse.

A screening test is *not*, however, a valid basis for concluding that an individual has engaged in illicit drug use. DOT and DHHS require all samples which test positive on the initial screen to be subject to a different confirmatory test, using a more sophisticated and extraordinarily accurate scientific process.

However, many employers are *not* testing pursuant to federal law, *not* regulated by state law, and *not* required to perform confirmatory tests. Some employers choose to act based on the results of the screening test alone. NMRO believes this practice benefits no one – not the employer, not the employee, and places the reputation of all workplace drug-testing and substance-abuse prevention programs at risk.

The state-of-the-art confirmatory test is known as GC/MS, or more fully, gas chromatography/mass spectrometry. This test actually reads the molecular fingerprint of each drug to confirm without error the presence of the exact drug identified. If a test has

been confirmed positive using GC/MS, an employer and employee can be sure that the sample tested actually contains the identified substance, and no other similar substances. The only question unanswered at this point in the process is whether the detected substance came to be in the sample through the legal and appropriate use of a therapeutic medication or legitimate product, or through illicit use of an illegal drug.

At this point, the MRO steps in – *if* the employer has chosen to use an MRO's services. The MRO reviews the chain-of-custody and drug-test results, and works, as necessary, with the laboratory and the tested individual to ensure that the sample has been correctly reported as positive. The MRO also explores the reasons – legitimate or otherwise – that the sample has tested positive.

As discussed earlier, the MRO has specialized medical knowledge about drug use and drug abuse, and acts as an expert neutral third party to evaluate and double-check a confirmed positive laboratory test result. If the MRO determines that the test is accurate, but positive for a reason other than the use of an illicit drug or drugs, the test is reported to the employer as negative, or as a "pass." If the MRO determines that the test is accurate, and that there is no legitimate medical explanation for the positive result, the test is reported as positive, or a "fail."

Of course, not all employers use MRO services. These employers must seek to determine whether the positive test reflects the legitimate use of a drug or food, through a direct, potentially embarrassing, and legally problematic interview with the employee.

Alternatively, the employer can choose to assume the test reflects the use of an illicit drug – and risk legal action if an employee successfully proves that conclusion wrong.

Chain-of-custody, GC/MS confirmatory tests, and the use of an MRO are all elements of a responsible drug-free workplace program which protects the employer from legal liability, protects the employee from erroneous test results, prevents inappropriate adverse employment action, and protects the integrity and effectiveness of the drug-testing process.

VI. Responsible Programs Can Be Encouraged with Appropriate Legislation

Remarkably, most states do *not* require employers to utilize chain-of-custody procedures, to ensure that initial positive tests are confirmed using GC/MS, or to utilize an MRO as part of the confirmation process.

Moreover, for employers not testing pursuant to DOT or other federal requirements, there is no federal law either encouraging or requiring employers to follow these safeguards. As a result, employers may choose *not* to utilize *any* of these highly appropriate safeguards in their drug-testing programs.

A number of states have, however, adopted legislation either encouraging or requiring employers to maintain appropriate chain-of-custody procedures, to confirm all initial positive tests by GC/MS, and to use MROs. These state laws, while appropriate, often

vary significantly state-to-state, making compliance for multi-state employers a significant challenge.

NMRO supports the Institute for a Drug-Free Workplace's model legislation, which does not limit an employer's flexibility to choose an appropriate drug-testing program, but rather encourages employers using drug testing to include these responsible safeguards in whatever drug-free workplace program they choose to implement.

Earlier in the Clinton Administration, the Institute for a Drug-Free Workplace's model legislation was endorsed by the President's Commission on Model State Drug Laws, the only legislation addressing workplace drug testing endorsed by this bipartisan organization.

Moreover, the Institute's model bill has been used as the basis for legislation introduced and enacted – at least in significant part – in Alaska, Arizona, Idaho, Iowa, Mississippi, and Oklahoma, and is itself modeled on portions of the voluntary law enacted a decade ago in Utah which several Institute principals helped draft.

NMRO believes that this legislation is in the best interests of both employers and employees, and of the American public at large. We encourage members of this Subcommittee to support this legislation at the federal level, with the goal of influencing employers nationwide to include these very appropriate procedural safeguards in their own drug-abuse prevention programs – *in exchange for the assurance that their employment actions based on drug-test positives will enjoy a presumption of validity if*

legally challenged. Such an exchange is appropriate and sound public policy, and we commend the Committee for its attention to these worthwhile goals.

VII. Conclusion

Thank you, Chairman Hastert and members of this Subcommittee, for inviting NMRO to share its experiences with, and recommendations for, the very best and most appropriate practices in workplace substance-abuse prevention. If you have any questions for me, I would be happy to answer them.

Mr. HASTERT. Thank you, Dr. Lappe.

Mr. deBernardo, thanks for being with us today. Please offer your testimony.

Mr. DEBERNARDO. Thank you, Mr. Chairman. Thank you, Ranking Minority Member Barrett, and also Mr. Barr. I appreciate this opportunity to testify on what I think everyone in this room considers to be a critically important issue on that of drug abuse in our society—a problem which I think is growing and which affects employers in very, very significant ways.

According to the U.S. Government, more than 73 percent of Americans who engage in illicit drug use are employed. Where are they? They're in our workplaces. The employer community has addressed this issue, is addressing this issue. Increasingly, it's addressing this issue, and addressing it very effectively.

We are very active in this regard. The institute is almost 10 years old. I should give a little bit of background on the institute, and that is that we are a nonprofit coalition of major businesses and business organizations dedicated to preserving the interest of employees and employers in substance abuse prevention programs. We include in our membership more than 100 major employers and employer organizations, including many of the largest companies in the United States and a wide range of chambers of commerce, trade associations, and community coalitions representing businesses from all sides. It's my privilege to serve as executive director.

Over the last 10 years, we've seen very dynamic changes in terms of drug-testing laws. The institute publishes an annual publication. Our seventh edition is coming this summer. It's more than 600 pages and it covers the laws at the State and Federal level. Essentially, the raison d'etre for the institute was the fact that there was a threat at the State level to employer rights to effectively address drug testing in the workplace. This threat was manifested in 1987 when six anti-drug testing laws were enacted at the State level, and that's essentially why it was a response by the employer community to address this issue. I'm happy and proud to report that this issue has turned around at the State level; that, since 1989, there's not been a single anti-drug testing law enacted at the State level in any jurisdiction in the United States. In fact, the majority of the bills being considered at the State level are pro-drug testing, create incentives—much like Representative Portman's bill at the Federal level—for businesses to address substance abuse in the workplace and to do drug testing.

In fact, the institute has drafted model legislation at the State level which has been enacted by four States in the last 2 years and by six States overall. It was enacted in Iowa earlier this year, which is very significant, because Iowa was one of the States that enacted highly restrictive drug-testing laws back in 1987. So, from our standpoint—the employer community standpoint, and frankly from the standpoint from those who believe that employers should have the flexibility to address substance abuse and use the appropriate tools to maintain drug-free workplaces, this was a "two-fer." We struck from the books in Iowa one of the most restrictive State laws and we had enacted a slightly modified version of the institute's model legislation.

What's included, Mr. Chairman and members of the subcommittee, in our testimony is a draft of that legislation, the model legislation which the institute has endorsed. But I think that it's significant to note that it's also been endorsed by the President's Commission on Model State Drug Laws. Earlier in the Clinton administration, unanimously adopted, the only workplace drug-testing bill endorsed by the President's Commission on Model State Drug Laws was the institute's drafted bill. We are the only business witnessed before that organization. A majority of the members of the President's Commission were Democrats. It was a very bipartisan effort. This legislation again is gaining momentum at the State level, and it's something that we feel should be considered at the Federal level and we certainly commend to your attention.

That is included in my testimony as the Drug-Free Workplace Act. The basic premise of this is it's a voluntary bill and there's a quid pro quo. For employers who choose to follow the safeguards, the checks and balances, that are included to make sure that employers do drug testing in the most responsible fashion and most accurate and credible fashion, there's a benefit. That benefit is the employer cannot be sued for acting in good faith under drug test results. There's a shield to liability if you follow these safeguards. These safeguards, frankly, they're in everybody's interest, and as a practicing attorney, what I recommend to our clients, certainly the institute recommends to its members, and I think our members uniformly adopt these consensus guidelines for what is the most responsible way to do drug testing. I think it's very positive.

There's a second bill I also want to bring to your attention which is included—the text is included in testifying before this subcommittee before. It's one that members of the committee expressed interest in. I think it's very important. That's the Public and Employee Safety Assurance Act. This is a bill which would address the problem of the fact that right now in America some employers are being compelled to put back to work in highly safety-sensitive positions employees, individuals, who have a history of substance abuse, individuals who have tested positive for that very employer. What we're talking about is a very small number of jobs, clearly much less than 1 percent. We feel, the institute feels, the employer community as a whole feels, that there are certain jobs that are so highly safety-sensitive in nature, that there is so much of a risk of tragedy if you have an impaired individual on that job, and it's appropriate that that very small number of jobs that employers be permitted to refrain from hiring or remove from those jobs—or remove from consideration for those jobs—those with a history of substance abuse.

I appreciate this opportunity to testify and would be glad to answer any questions you may have.

[The prepared statement of Dr. deBernardo follows:]

I. Statement of Interest

Good morning Chairman Hastert, Ranking Minority Member Barrett, and Members of the House Subcommittee on National Security, International Affairs and Criminal Justice. My name is Mark A. de Bernardo, and I have the privilege of serving as the Executive Director of the Institute for a Drug-Free Workplace (the "Institute").

The Institute is a coalition of major employers and employer organizations that has been actively involved in national and state policy-making on workplace drug-testing and drug-abuse prevention issues for nearly a decade.

I also am an attorney and serve as the Managing Partner of the Washington office of Littler Mendelson, the largest – by a *wide* margin – employment and labor law firm in the country with 31 offices and more than 360 lawyers, all of whom exclusively represent management on employment and labor issues, including counseling on workplace drug-abuse prevention policies and programs.

In addition, I serve as employment counsel to the U.S. House of Representatives on drug-testing issues, and currently represent on this and related issues more than 30 of the "Fortune 200" corporations. My clients also include five Federal executive branch agencies; the States of

California, Kansas, and Louisiana; the governments of the Bahamas, Japan, and Spain; and nearly 20 national trade associations.

I appreciate this opportunity to: (1) testify in support of responsible workplace drug-testing and drug-abuse prevention programs; (2) submit to this Subcommittee two legislative proposals which we believe to be both pro-employer and pro-employee, and which – more importantly – are pro-employee-safety; and (3) testify in support of H.R. 3853, the Drug-Free Workplace Act of 1998.

II. Background on the Institute

The Institute for a Drug-Free Workplace is a non-profit coalition of major businesses and business organizations dedicated to preserving the interests of employers and employees in effective and responsible drug- and alcohol-abuse prevention programs. The Institute includes in its membership more than 100 major employers and employer organizations, including many of the largest companies in the United States, and a wide range of chambers of commerce, trade associations, and community coalitions representing businesses of all sizes.

The Institute was the *only* business witness before the President's Commission on Model State Drug Laws; the *only* business witness in the 103rd Congress on H.R. 33, the Dingell-Bliley drug-testing bill; one of the business witnesses before this Subcommittee on workplace drug-testing issues in the 104th Congress; and the sole or primary business witness at legislative and regulatory hearings more than 30 times at the state level.

Among the more than 30 Institute publications is the *Guide to State and Federal Drug-Testing Laws*, a comprehensive (nearly 600 pages) overview and analysis of all state and federal case and statutory law relevant to private-sector workplace drug-testing and drug-abuse prevention programs.

Among other functions, the Institute disseminates information on substance-abuse prevention and treatment programs with the goal of having a constructive influence on government and corporate consideration of these issues. The Institute is uniquely situated to provide relevant and helpful information on the nature and dangers of employee drug and alcohol abuse, the effectiveness of workplace drug-testing and drug-abuse prevention programs, and the public policy and legislation that best serves the interests of employers and employees alike in promoting drug-free workplaces and a meaningful and effective response to the widespread and too often devastating effects of substance abuse.

III. Background on State Action on Drug Testing, and Summary of the Institute's Position

The Institute was created in March 1989 in large part because of the proliferation of proposed state legislation and regulation that unduly restricted, or would have unduly restricted, employee drug testing and employers' ability to address drug abuse effectively.

Fortunately, that trend has been reversed. The majority of bills now being considered at the state level are favorable on drug testing, not unduly restrictive, and not one anti-drug-testing bill – federal, state, or local – has been enacted since 1989.

In fact, numerous states – Alabama, Alaska, Arizona, Florida, Georgia, Idaho, Iowa, Louisiana, and Mississippi in particular – have enacted legislation which effectively fosters an appropriate balance between employer and employee rights and responsibilities, and encourages responsible drug-free workplace programs.[1]

This approach has been refined and improved, and was incorporated in the Model Drug-Free Private-Sector Workplace Act of the President's Commission on Model State Drug Laws.[2] It is this approach which the Institute believes is *most* appropriate for *state* action, and for which the Institute and its members are *most* supportive. We now come before this Subcommittee to seek *federal* legislation consistent with this worthwhile approach to one of the nation's most critical problems, the national plague of drug and alcohol abuse.

In addition to state legislative action, state regulatory action in the '90s has either been supported by the employer community or considered neutral by the employer community — that is, consistent with the substance and philosophy of state legislative action, state regulatory agencies have *not* implemented regulations which have been unduly or inappropriately restrictive of workplace drug testing.

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[1] *See* 1997-1998 *Guide to State and Federal Drug-Testing Laws*. Institute for a Drug-Free Workplace. Washington, DC. 1997. A copy of this publication has been submitted to the Subcommittee on National Security, International Affairs and Criminal Justice for inclusion in its resources and records.

[2] Drug-Free Families, Schools, and Workplaces. The President's Commission on Model State Drug Laws. The White House. December 1993. p. M-199. The President's Commission on Model State Drug Laws was comprised of 24 Commissioners, a majority of whom were Democrats. The Commissioners included state attorneys general, state legislators, police chiefs, treatment service providers, an urban mayor, a housing specialist, district attorneys, a state judge, and drug-abuse prevention specialists.

Nonetheless, there *are* six states (Connecticut, Maine, Minnesota, Montana, Rhode Island, and Vermont) and Puerto Rico which have enacted unduly restrictive drug-testing laws.[3] We seek preemption of those laws and a better, more consistent, less partisan, and more effective legislative response to the tragedy of drug abuse as it affects our American workers. That approach is embodied in the Private-Sector Drug-Free Workplace Act, draft legislation which I will discuss today, and have included in section X of this statement.

IV. Nature of the Drug-Abuse Problem

The Institute for a Drug-Free Workplace recognizes the human tragedies and economic costs associated with drug and alcohol abuse,[4] the necessary and legitimate role of employers in the "war on drugs," and the need for fair and effective utilization of all available tools to deter, detect, and treat the employee drug-abuse problems which are so prevalent in our workplaces,[5] endanger

[3] One state – Iowa – which had enacted a particularly restrictive anti-drug-testing law in 1987, repealed that law earlier this year, and replaced it with a law consistent with the Institute's model bill.

[4] The U.S. Government estimates that the total economic cost of alcohol and drug abuse was $276.3 billion in 1995. National Institute on Drug Abuse & National Institute on Alcohol Abuse and Alcoholism. Rockville, Maryland. May 1998.

[5] *See* discussion of the magnitude of the drug problem as identified by employees regarding their own workplaces, Gallup National and 17 State Surveys of Employee Attitudes on Workplace Drug Abuse and Drug Testing, conducted for the Institute for a Drug-Free Workplace, by the Gallup Organization, Princeton, New Jersey (1989-1995).

our workers,[6] and plague our society.[7] These problems pose an enormous risk to public health and safety, and have substantial social and economic costs and consequences in every community and for virtually every person across the country (for example, higher taxes, higher crime rates, higher health-care costs, and higher insurance rates).[8]

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[6] Drug-using employees are 3.6 times more likely to be involved in a workplace accident and are five times more likely to file a workers' compensation claim. Backer, Thomas E. *Strategic Planning for Workplace Drug Abuse Programs*. National Institute on Drug Abuse. 1987. p. 4.

Drug using employees are more likely to have had three or more employers in the past year than those who do not use drugs (32.1 percent vs. 17.9 percent); to have taken an unexcused absence from work in the past month (12.1 percent vs. 6.1 percent); to have voluntarily quit work in the past year (25.8 percent vs. 13.6 percent); and/or to have been fired from work in the past year (4.6 percent vs. 1.4 percent). "An Analysis of Worker Drug Use and Workplace Policies and Programs." Substance Abuse and Mental Health Services Administration. Office of Applied Studies. Rockville, Maryland. July 1997.

Between 1975 and 1986, more than 50 train accidents were directly attributable to drug or alcohol abuse. The results of the accidents: 37 fatalities, 80 injuries, and more than $34 million in property damage. "Battling the Enemy Within." *Time*. March 17, 1986. p. 52.

[7] A strong correlation also has been demonstrated between violent acts and the abuse of drugs and alcohol. For example, the Center for Substance Abuse Prevention at the United States Department of Health and Human Services reported that alcohol and other drugs are associated with 68 percent of manslaughter charges, 52 percent of rapes, and 50 percent of spousal abuse cases. Although separate statistics are not maintained for drug-related occupational violence, it is reasonable to infer that a substantial percentage of violent conduct by drug-abusing employees is attributable to their substance abuse. The overall cost of family violence to employers has been estimated at between $3 billion and $5 billion annually. "When Employees Make Good on Bad Intentions." *EAP Association Exchange*. September 1993. p. 15.

[8] More than one-half of all people arrested for major crimes – including homicide, theft, and assault – were using illicit drugs at the time of their arrest. U.S. Department of Justice. National Institute of Justice. 1991 Drug Use Forecasting Annual Report. Washington, DC: NCJ-136045. 1993. p. 21.

One out of every 144 American adults is behind bars for a crime in which drugs or alcohol was involved, including: violating drug or alcohol laws, being intoxicated at the time the crimes were committed, stealing property to support a drug- or alcohol-abuse addiction, or having a history of drug- or alcohol-abuse addiction. "Behind Bars: Substance Abuse and America's Prison Population." National Center on Addiction and Substance Abuse. Columbia University. New York. January, 1998.

Drug-related hospital emergency-room visits increased 21 percent between 1989 and 1995, to a total of 487,600. Estimates from the Drug Abuse Warning Network. U.S. Department of Health and Human Services. November 1997.

In particular, the Institute recognizes the threat that drug abuse – cognizant that alcohol is a major drug of abuse – poses for employers and employees alike. Among other consequences, drug abuse decreases productivity and increases accidents, absenteeism, product defects, medical and insurance costs, and employee theft.[9] Clearly, employers and employees have a large stake and a legitimate role to play in the "war on drugs."

V. Employer and Employee Rights

For employees, the consequences of drug abuse can be tragic not only for abusers and their families, but also for co-workers and customers who are put in jeopardy by others' illicit use of drugs. Moreover, beyond the physical dangers, employees' jobs may be jeopardized if a company's profitability is undermined by the poor performance, mistakes, and accidents of drug abusers.

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[9] The U.S. Government recently reported that the estimated losses in productivity in 1992 caused by drug and alcohol abuse were $81.9 billion. "The Economic Costs of Alcohol and Drug Abuse in the United States, 1992." National Institute on Drug Abuse & National Institute on Alcohol Abuse and Alcoholism. Rockville, Maryland. May 1998.

In 1991, the reported cost of drug abuse to the business community was $75 billion annually, or approximately $640 per employed person based on 117 million U.S. workers. Tasco, Frank T., Chairman, Marsh & McLennan Companies, and Chairman, The President's Drug Advisory Council. Address delivered to President Bush and the President's Drug Advisory Council. Nov. 15, 1991.

The U.S. Postal Service would have saved $52 million by 1989 had it screened out all drug-"positive" postal service applicants in 1987. Employees testing "positive" on their pre-employment drug tests were 77 percent more likely to be fired in their first three years of employment, and were absent from work 66 percent more often than those who tested "negative." Normand, Jacques, Stephen Salyard, and John J. Maloney. "An Evaluation of Pre-employment Drug Testing." Journal of Applied Psychology. Vol. 75, No. 6. 1990. pp. 629-639.

Employees testing "positive" on pre-employment drug tests at Utah Power & Light were five times more likely to be involved in a workplace accident than those who tested "negative." Crouch, Dennis J., Douglas O. Webb, Paul F. Buller, and Douglas E. Rollins. "A Critical Evaluation of the Utah Power and Light Company's Substance Abuse Management Program: Absenteeism, Accidents, and Costs." *Drugs in the Workplace: Research and Evaluation Data.* NIDA. 1989. pp. 169-193.

For employers, the consequences of drug abuse also can be highly detrimental. If American companies are to remain competitive in a global economy, they must strive to maintain a work force that is free from drug abuse.

In so doing, company drug-abuse prevention programs should be implemented in a fair, consistent, and equitable manner with due consideration of the rights, responsibilities, and privacy interests of all concerned parties.

Concerning employee rights, companies must maintain a commitment to all their employees, including the vast majority who are not – and will not – become drug abusers. Business's responsibility to protect its employees and their rights goes far beyond protecting the rights of those who choose to engage in illicit drug use. Employers not only have a right to expect a workplace free from drug abuse, they may well have a duty to ensure it.

VI. Drug Testing

The Institute recognizes that drug testing is not for all employers and all employment situations; that drug testing is not, in and of itself, a drug-abuse prevention program; and that – as mentioned earlier – drug testing should be done "right," or not at all.

"Right," in regards to drug testing, embodies a series of safeguards and procedures widely embraced by the scientific and medical communities – and formally endorsed by the Institute in its

Policy Statement – as necessary and appropriate. These safeguards and procedures – and others – are specifically articulated in the "Private-Sector Drug-Free Workplace Act" (which the President's Commission endorsed and we commend to your attention today), and include: (1) acting in accordance with a written corporate policy; (2) performing confirmatory tests using a different chemical process to help ensure accuracy before acting upon a "positive" drug screen; (3) ensuring chain-of-custody and proper documentation for test samples; (4) maintaining the confidentiality of test results as reasonably and appropriately as feasible; (5) using certified laboratories with scientifically and medically accepted laboratory protocols and procedures to assure accuracy and fairness; and (6) using Medical Review Officers to verify all confirmed "positive" drug-test results.

While recognizing the necessity of procedural and policy safeguards to drug testing, and the limitations of drug testing (*vis-à-vis* an overall, comprehensive drug-abuse prevention program), the Institute also fully recognizes that drug testing, *if done properly*: (1) can be a vital component of an effective drug-abuse prevention program; (2) is fair and accurate; (3) can act as a strong deterrent to drug abuse; (4) is a legitimate and appropriate prerogative of employers; and (5) is ultimately in the best interests of *both* employees and employers.

VII. Magnitude of the Drug Abuse in the Workplace Problem

SmithKline Beecham announced on April 7, 1998 the results of its annual "index" of drug-testing results.[10] It found a "positive" rate of 5 percent on nearly 5 million drug tests of U.S. employees and job applicants. One-in-twenty Americans, *knowing* they were subject to testing, *still*

[10] SmithKline Beecham Press Release: "Workplace Drug Test Positives Decline By Nearly 14%." Collegeville, Pennsylvania. April 7, 1998.

failed their drug tests. What does this say about the magnitude of the drug problem and the attitude of drug abusers in our country?

Roger Smith, the former Chairman of the Board of General Motors, said that drug abuse cost GM $1 billion a year.[11]

One of the "baby Bells," a Fortune 50 telecommunications giant, reported that 40 percent of its health-care costs were attributable – directly or indirectly – to substance abuse.[12]

American Airlines lost $19 million because one employee, high on marijuana, failed to properly load a tape into its central reservations computer, causing eight hours of computer down time (*no one* could get a reservation on American Airlines nationwide) and significant erasures.[13]

As these examples demonstrate, drug abuse is a major threat to the workplace, a threat which has enormous human and economic costs.

These examples – and many others like them – have gotten the attention of the employer community. Employers know drug abuse costs lives and money in the workplace. They are aware

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[11] *Drug Abuse in the Workplace: An Employer's Guide for Prevention.* Second Edition. U.S. Chamber of Commerce. Washington, DC. 1990. p. 1.

[12] *What Every Employee Should Know About Drug Abuse.* Institute for a Drug-Free Workplace. Washington, DC. 1998. pp. 5-6.

[13] *See* fn. 11, *supra.*

of the potential legal liabilities. They know they cannot afford to ignore the problem, and they want as much flexibility as appropriate to best address these problems effectively *and* cost -effectively.

These concerns are all responsibly and appropriately addressed by the Private-Sector Drug-Free Workplace Act which the Institute seeks to advance – legislation which embraces the language endorsed by the President's Commission on Model State Drug Laws, the *only* private-sector drug-testing bill endorsed by the Clinton Administration's Final Report of the Commission, a Commission of which a majority of the members were Democrats.[14]

In addition, the Institute strongly supports and seeks to advance the Public and Employee Safety Assurance Act, legislation which is necessary to ensure the protection of worker safety and the environment. This bill would permit employers to remove, from consideration for the most highly safety-sensitive positions, those individuals who test "positive" for, or have a history of, substance abuse.

Once again, on behalf of the Institute for a Drug-Free Workplace, I appreciate this opportunity to testify today, commend Chairman Hastert for his outstanding leadership on this issue, and respectfully urge your favorable consideration of our suggested legislation on workplace drug testing.

[14] *See* fn. 2, *supra.*

VIII. Support for the Drug-Free Workplace Act of 1998

The Institute also wishes to express its support for H.R. 3853, the "Drug-Free Workplace Act of 1998," which was recently introduced by Representative Rob Portman. That bill, currently pending before the Subcommittee on Empowerment of the House Committee on Small Business, would particularly benefit small companies by encouraging them to develop and implement drug-free workplace programs.

Figures recently released by the Substance Abuse and Mental Health Services Administration found that workers in small businesses (defined as those that employ fewer than 25 employees), employ a disproportionately high number of self-admitted drug abusers. In fact, 59 percent of current drug abusers work for a small business, despite the fact that small businesses account for only 39 percent of the jobs in this country.[15]

Eleven percent of small business employees told the SAMHSA researchers that they currently abuse drugs; in contrast, 5.4 percent of those working for larger companies report recent illegal drug use.[16]

The survey affirms what many employers have long known – employees at workplaces with substance-abuse prevention programs that include drug testing are less likely to use drugs. Moreover, employees who use illegal drugs often seek out employers that do not have drug-

[15] "An Analysis of Worker Drug Use and Workplaces and Programs," Substance Abuse and Mental Health Services Administration. Office of Applied Studies. Rockville, Maryland. July 1997.

[16] *Id.* at 23.

testing programs. In fact, only 22.5 percent of employees at small businesses are covered by a workplace drug-testing policy. In contrast, 52.2 percent of employees at mid-sized employers (employing between 25 and 499 individuals), and 68 percent of employees at the largest employers (500 or more), are subject to drug testing.[17]

The Drug-Free Workplace Act of 1998 would encourage small businesses to address the problem of drug abuse in their workplaces, by creating a demonstration program to: (1) educate small businesses on the advantages of drug-free workplace programs; (2) provide financial incentives and technical assistance to small businesses that do develop such programs; and (3) assist businesses to educate their employees – and their children – about the dangers of drug abuse.

To qualify for the benefits that H.R. 3853 would create, an employer would be required to adopt a written policy prohibiting illegal drug abuse; adopt an employee drug-testing policy; provide basic training on substance abuse to employees and supervisors; make available additional education for parents; and provide access to an employee assistance program.

Representative Portman's goal is to help smaller businesses realize that it is more cost-effective to address workplace drug abuse than to ignore the problem – a premise the Institute supports wholeheartedly. H.R. 3853 recognizes that the employer community overall has been highly successful in addressing the problems of substance abuse, and the Institute commends Representative Portman for his efforts to extend workplace drug-abuse prevention programs to employers of all sizes.

[17] *Id.* at 39.

IX. Advantages of the Private-Sector Drug-Free Workplace Act

The Institute strongly believes that the goals of achieving drug-free workplaces *and* ensuring accuracy and fairness in workplace drug-testing programs would both be effectively served by enactment of legislation embracing the concepts of the legislation endorsed by the President's Commission on Model State Drug Laws and the Institute, and enacted into law in Alaska, Arizona, Idaho, Iowa, and Utah.

This approach has major advantages. The Private-Sector Drug-Free Workplace Act would expressly permit private-sector employers to drug and alcohol test *any* of their employees and prospective employees, *provided* specific accuracy and fairness standards are met.

These standards would require, among other things: (1) a written policy that is distributed to employees; (2) employer payment for the tests and, for employees, wages for the time in which the test is administered; (3) a second (or "confirmatory") test (using a different chemical process than the first test) prior to any employer action; (4) use of certified laboratories for confirmation tests; (5) maintenance of confidentiality to preserve employees' privacy; (6) safeguards in the collection, labeling, storage, and transportation of samples; and (7) the use of Medical Review Officers to confirm all drug-test "positives" before any adverse employment action is taken, including denial of employment.

The bottom line on this legislation is: employers who follow drug-testing safeguards and exemplary procedures in their substance-abuse prevention programs would be immune from legal challenges for acting in "good faith" on the results of employee drug tests.

Seven Major Advantages of the Private-Sector Drug-Free Workplace Act

- It is voluntary. Employers could not argue that this legislation is a regulatory imposition, because they could simply choose not to use the accuracy and fairness safeguards articulated in this bill. Of course, they would not qualify for the benefit of this bill – a "shield" from legal claims based on their acting in "good faith" on the test results.

- It is pro-employee Employees would benefit from increased employer responsibility in testing because testing inaccuracies would be far less likely to occur. Respect for employee rights in the process would be put at a premium. (Of course, by promoting workplace safety and health, this bill would achieve an even more significant employee benefit.)

- It is revenue-neutral. This bill would not cost taxpayers a dollar. Rather, it would create a private-sector incentive for action that is in both employers' and employees' interests. There is no need for government regulation and enforcement since the process is self-policing: an employer who does not comply simply would be subject to potential legal liability.

- It would reduce litigation. By limiting the causes of action and encouraging model programs with a proper balance of employer and employee interests, this bill would reduce litigation, legal fees, the backlog in the courts, and the unproductiveness of an increasingly litigious society. It therefore matches up *very* comfortably to the legislative interests of tort reform.

- It represents the "carrot" approach for employers, not the "stick" approach, by giving employers the incentive – if they are going to do drug or alcohol testing – to do it the *right* way.

- It would encourage a business focus on drug-abuse prevention. Of the "Fortune 200" corporations, 98 percent do drug testing of one or more classes of employees or job applicants.[18] This bill would send a credible message to employers that their commitment to drug-free workplaces is necessary and appropriate.

[18] Corporate Membership Surveys. The Business Roundtable. New York, N.Y. December 1991.

- It would promote safety and health. By encouraging responsible programs, the bill would result in safer workplaces, fewer product defects, and less of a substance-abuse impact on motorists. Safety and health are the primary reasons why employers are addressing substance abuse, and this bill would help deter, detect, and treat substance-abuse problems, thereby helping to protect the safety and health of the public at large.

X. Suggested Workplace Drug-Testing Bill

The language on drug testing which the Institute respectfully urges you and your colleagues in Congress to support is, as discussed, identical in concept and purpose and largely identical in substance to the language endorsed by the President's Commission on Model State Drug Laws.

In addition, this bill, again with only minor alterations (and again identical in concept and purpose), and with the strong support of the Institute, has been enacted into law in four states in the last two years, and six states overall.

It is, without question, the *best* drug-testing law in America from the Institute's and the employer community's points of view.

The language of the President's Commission's bill – slightly modified, updated, and expanded (to fit a federal context, for example), is incorporated into the "Private-Sector Drug-Free Workplace Act," which follows.

PRIVATE-SECTOR
DRUG-FREE WORKPLACE ACT

Section A. Title — This Title shall be known and cited as the **"Private-Sector Drug-Free Workplace Act."**

Section 2. Finding — Whereas drug and alcohol abuse by employees has been demonstrated to seriously compromise workplace safety and health, and to endanger the public at large and the environment, be it enacted that this Title shall become law.

Section 3. Definitions — As used in this Title:

(A) "Alcohol" means ethanol, isopropanol, or methanol.

(B) "Drugs" means any substance considered unlawful under the Controlled Substances Act (21 U.S.C. § 812 *et seq.*).

(C) "Employer" means any person, firm, company, corporation, labor organization, employment agency or joint labor-management committee, including any public utility or transit district, which has one or more full-time employee(s) employed in the same business, or in or about the same establishment, under any contract of hire, express or implied, oral or written. "Employer" does not include, for purposes of this Act, the United States, the states, or other public-sector incorporated municipalities, counties, or districts, or any Native American tribe.

(D) "Employee" means any person in the service of an employer, as defined in Subsection (C) of this Section.

(E) "Good faith" means reasonable reliance on facts – or that which is held out to be factual – without the intent to deceive or be deceived and without reckless, malicious, or negligent disregard for the truth.

(F) "Prospective employee" means any person who has made application to an employer, whether written or oral, to become an employee.

(G) "Sample" means any sample of the human body capable of revealing the presence of alcohol or other drugs or their metabolites.

Section 4. Applicable conditions for a legal policy — It is lawful for an employer to test employees or prospective employees for the presence of drugs or alcohol, in accordance with the provisions of this Title, as a condition of continued employment or hiring. However, in order to qualify for a bar from being subjected to legal claims for acting in good faith on the results of a drug or alcohol test, employers must adhere to the accuracy and fairness safeguards included in subsequent Sections of this Title.

Section 5. Collection of samples — In order to test reliably for the presence of drugs or alcohol, an employer may require samples from its employees and prospective employees, and may require presentation of reliable individual identification from the person being tested to the person collecting the samples. Collection of the sample shall be in conformance with the requirements of this Title. The employer may designate the type of sample to be used for this testing.

Section 6. Scheduling of tests — Regarding the timing and costs of drug and/or alcohol tests, and in order for an employer to qualify for the benefits of this Title:

(A) Any drug or alcohol testing by an employer of employees normally shall occur during, or immediately before or after, a regular work period. Such testing by an employer shall be deemed work time for the purposes of compensation and benefits for current employees.

(B) An employer shall pay all actual costs for drug and/or alcohol testing required by the employer of employees and prospective employees.

(C) In addition, an employer is required to provide transportation or to pay reasonable transportation costs to current employees if their required tests are conducted at a location other than the employee's normal work site(s).

Section 7. Testing procedures — All sample collection and testing of drugs and alcohol under this Title shall be performed in accordance with the following conditions:

(A) The collection of samples shall be performed under reasonable and sanitary conditions.

(B) Sample collections shall be documented, and these documentation procedures shall include:

(1) Labeling of samples so as to reasonably preclude the possibility of misidentification of the person tested in relation to the test result provided and handling of samples in accordance with reasonable chain-of-custody and confidentiality procedures; and

(2) An opportunity for the employee or prospective employee to provide notification of any information which may be considered as relevant to the test, including identification of currently or recently used prescriptions or non-prescription drugs, or other relevant medical information. This may be accomplished by providing procedures for review by a qualified medical professional to verify a laboratory sample which tests "positive" in a confirmatory test.

(C) Sample collection, storage, and transportation to the place of testing shall be performed so as reasonably to preclude the possibility of sample contamination, adulteration, or misidentification.

(D) Confirmatory drug testing shall be conducted at a laboratory: (1) certified by the U.S. Department of Health and Human Services's Substance Abuse and Mental Health Services Administration; (2) approved by the U.S. Department of Health and Human Services under

the Clinical Laboratory Improvements Act; or (3) approved by the College of American Pathologists.

(E) Drug and alcohol testing shall include confirmation of any "positive" test results. For drug testing, confirmation will be by use of a different chemical process than was used by the employer in the initial drug screen. The second – or confirmatory – drug test shall be a chromatographic technique such as gas chromatography/mass spectrometry, or another comparably reliable analytical method. An employer may take adverse employment action – including job denial to a prospective employee – based only on a confirmed "positive" drug or alcohol test.

(F) Whenever an individual's drug-test screen and confirmation are "positive," whether an employee or a job applicant, the drug-test result shall be reviewed by a Medical Review Officer, who is a licensed physician with knowledge of substance-abuse disorders, prior to an employer taking any adverse employment action, including denial of employment to job applicants.

Section 8. Testing policy requirements

(A) Testing or re-testing for the presence of drugs or alcohol by an employer shall be carried out within the terms of a written policy which has been distributed to every employee subject to testing, and is available for review by prospective employees.

(B) In order to comply with the provisions of this Title, and to qualify for the legal benefits, employers must provide employees, when requested and/or as appropriate, with information as to the existence and availability of counseling, employee assistance, rehabilitation and/or other drug-abuse treatment programs of which the employer is aware.

(C) Within the terms of the written policy, an employer may require the collection and testing of samples for, among other legitimate drug abuse prevention and/or treatment purposes, the following:

(1) Deterrence and/or detection of possible illicit drug use, possession, sale, conveyance, distribution, or manufacture of illegal drugs, intoxicants, or controlled substances in any amount or in any manner, on- or off-the-job, *or* the abuse of alcohol or prescription drugs;

(2) Investigation of possible individual employee impairment;

(3) Investigation of accidents in the workplace or incidents of workplace theft or other employee misconduct;

(4) Maintenance of safety for employees, customers, clients, or the public at large; or

(5) Maintenance of productivity, quality of products or services, or security of property or information.

(D) The collection and testing of samples shall be conducted in accordance with this Act and need not be limited to circumstances where there are indications of individual, job-related impairment of an employee or prospective employee.

(E) The employer's use and disposition of all drug or alcohol test results are subject to the limitations of this Title if the employer is to qualify for the legal benefits and protections available under this Title.

(F) Nothing in this article shall be construed to encourage, discourage, restrict, limit, prohibit, or require on-site drug or alcohol testing.

Section 9. Disciplinary procedures — Upon receipt of a confirmed "positive" drug or alcohol test result which indicates a violation of the employer's written policy, or upon the refusal of an employee or prospective employee to provide a testing sample, or upon an employee's or prospective employee's failure to cooperate in good faith in his or her employer's drug-testing program (including any attempt to adulterate, substitute for, or tamper with a sample), an employer may use that test result, test refusal, or lack of good-faith cooperation as a valid basis for disciplinary and/or rehabilitative actions, which may include, among other actions, the following:

(1) A requirement that the employee enroll in an employer-provided or -approved rehabilitation, treatment, and/or counseling program, which may include additional drug and/or alcohol testing, participation in which may be a condition of continued employment, and the costs of which may or may not be covered by the employer's health plan or policies;

(2) Suspension of the employee, with or without pay, for a designated period of time;

(3) Termination of employment;

(4) Refusal to hire a prospective employee; and/or

(5) Other adverse employment action in conformity with the employer's written policy and procedures, including any relevant collective bargaining agreement provisions.

Section 10. Sensitive Employees' Job Removal — If the confirmatory drug- or alcohol-test of an employee is "positive," and the employee is in a sensitive position wherein an accident could cause loss of human life, serious bodily injury, or significant property or environmental damage, the employer may permanently remove the employee from the sensitive position and transfer or reassign the employee to an available non-sensitive position with comparable pay and benefits, or may take other action, including termination or other adverse employment action, consistent with the employer's policy for drug- or alcohol-test "positives" for employees in sensitive positions, provided there are not applicable contractual provisions that expressly prohibit such action.

This Title shall preempt any Federal or state law, rule, regulation, order, or standard that applies to the continued employment or reemployment in a sensitive position of a drug addict,

recovering drug addict, drug abuser, alcoholic, recovering alcoholic, or alcohol abuser, or to the reinstatement or rehiring of any employee in a sensitive position for whom an employer has administered a drug or alcohol test consistent with this Act that has produced a confirmed "positive" drug- or alcohol-test result.

Section 11. Employer protection from litigation — No cause of action is or shall be established for any person against an employer who has established a policy and initiated a testing program in accordance with this Title, for any of the following:

(A) Actions in good faith based on the results of a "positive" drug or alcohol test, or the refusal of an employee or job applicant to submit to a drug test;

(B) Failure to test for drugs or alcohol, or failure to test for a specific drug or other controlled substance;

(C) Failure to test for, or if tested for, failure to detect, any specific drug or other substance, any medical condition, or any mental, emotional, or psychological disorder or condition; or

(D) Termination or suspension of any substance-abuse prevention or testing program or policy.

Section 12. Causes of action based on test results

(A) No cause of action is or shall be established for any person against an employer who has established a program of drug or alcohol testing in accordance with this Act, unless the employee's action was based on a "false positive" test result, and the employer knew or clearly should have known that the result was in error, and ignored the true test result because of reckless, malicious, or negligent disregard for the truth and/or the willful intent to deceive or be deceived.

(B) In any claim, including a claim under this Title, where it is alleged that an employer's action was based on a "false positive" test result:

(1) There is a rebuttable presumption that the test result was valid if the employer complied with the provisions of this Title; and

(2) The employer is not liable for monetary damages if its reliance on a "false positive" test result was reasonable and in good faith.

(C) There is no employer liability for any action taken related to a "false negative" drug or alcohol test.

Section 13. Limits to defamation causes of action — No cause of action for defamation of character, libel, slander, or damage to reputation is or shall be established for any person against an employer who has established a program of drug or alcohol testing in accordance with this Title, unless:

(A) The results of that test were disclosed to a person other than the employer, an authorized employee, agent, or representative of the employer, the tested employee, or the tested prospective employee, or the authorized agent or representative of the employee; *and*

(B) The information disclosed was a "false positive" test result; *and*

(C) The "false positive" test result was disclosed negligently; *and*

(D) All elements of an action for defamation of character, libel, slander, or damage to reputation as established by the relevant state's statute or common law, are satisfied.

Section 14. No employer requirement to implement a policy or testing — No cause of action arises in favor of any person against an employer based upon the failure of the employer to establish a program or policy on substance-abuse prevention, or to implement drug or alcohol testing.

Section 15. Confidentiality of results — All communications received by an employer, relevant to employee or prospective employee drug- or alcohol-test results, and received through the employer's drug-testing program are confidential communications and may not be used or received in evidence, obtained in discovery, or disclosed in any public or private proceeding, except in a proceeding related to an action taken by an employer under this Title.

XI. The Need to Permit Employers to Remove Substance-Abusing Employees from Safety-Sensitive Positions

Section 10 of the Private-Sector Drug-Free Workplace Act[19] addresses a current concern which is critically important. The Public and Employee Safety Assurance Act, which follows, addresses the same concern – and in a more effective manner.

These provisions would permit employers to permanently remove from the most highly safety-sensitive positions those employees (or deny employment to those job applicants) who test "positive" for drugs or alcohol, provided it is consistent with the employer's established policy and not contrary to contractual obligations (such as collective bargaining agreement provisions).

[19] *See* Section 10 of Section IX, at 20, *supra*.

In addition, the Public and Employee Safety Assurance Act permits employers to remove, from consideration for the most highly safety-sensitive jobs, those individuals with a history of substance abuse.

Individual assessments of fitness – as required under current law[20] – should not be required to disqualify a recovering alcoholic or drug addict from employment or continued employment in designated safety-sensitive positions. Alcoholism and drug addiction are not distinguishable from other disabilities – such as diabetes and epilepsy – that have been viewed as disqualifying (even in the absence of individual assessments) in such very limited, specific, and highly safety-sensitive types of employment.

In the interests of enhanced employee safety and health, employers should be able to lawfully bar recovering alcoholics and drug addicts from certain positions *all* of the time. Some positions pose such inherent dangers that the risk of catastrophic accident and potential harm to life and property demands elimination of any known danger, even risks that cannot be quantified precisely.

Even if employers cannot terminate recovering alcoholics and drug addicts who occupy designated safety-sensitive positions, it is *not* discriminatory to offer such employees alternative positions with the same pay, seniority status, and benefits in order to minimize the risks to the employee, his or her co-workers, the public, the environment, and the company's interests at large.

[20] Americans with Disabilities Act, 42 U.S.C. § 1212(d).

Corporate policies against placing recovering alcoholics and drug addicts in safety-sensitive positions are consistent with business necessity and the safe performance requirements of the job.

Both the courts and regulatory agencies historically have accepted the proposition that certain medical conditions are inherently disqualifying for positions with a high safety component because these conditions can have a severe impact on an individual's conduct and job performance without prior warning.[21] The reasons for this disqualification are obvious: some positions involve such a high element of safety responsibility that lives literally hang in the balance. Individuals with a history of serious medical conditions that may – without warning – impair performance and pose an unacceptable risk to life and property when such individuals occupy certain positions. While the timing of such a threatening recurrence typically cannot be predicted, the seriousness of the potential harm justifies the exclusion of these individuals from appropriately designated employment positions.

Historically, the courts have accepted this treatment for medical conditions such as diabetes and epilepsy, which long have been viewed as posing unacceptable risks for highly safety-sensitive positions. Categorical exclusions of individuals with these conditions have been utilized by various Federal, state, and local agencies in both their employment of government workers (such as FBI agents), and in their regulation of fields of commerce (*e.g.*, those engaged in public or commercial transportation).

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[21] *See, e.g., Chandler v. City of Dallas*, 2 F.3d 1385 (5th Cir. 1993), cert. denied, 511 U.S. 1011, 114 S. Ct. 1386 (1994) (finding that drivers with insulin-dependent diabetes or vision impairment that fail to meet safety standards are not otherwise qualified as a matter of law); *Ward v. Skinner*, 943 F.2d 157 (1st Cir. 1991), cert. denied, 503 U.S. 959 (1992) (Department of Transportation blanket exclusion of medication-dependent epileptics from driver positions was reasonable safety rule).

Recovering alcoholics and drug addicts pose dangers similar to those posed by persons with diabetes or epilepsy whose conditions do not appear to be currently active. Those who have previously experienced problems of alcoholism and drug abuse pose an unacceptable risk of relapse or recurrence – with potentially catastrophic consequences – that many corporations do not desire to assume and many others simply are not *capable* of assuming. Any dictate to the contrary – through the interpretation of disability discrimination laws – would unnecessarily and inappropriately impose substantial safety and health risks on employees and the public at large, and would pose equally unnecessary and inappropriate dangers to property and the environment.

It is clear that rehabilitation programs – even the most responsible programs – are *not* universally successful or permanent in altering addictive and abusive behaviors. It would be wonderful to conclude that individuals who enter – and complete in good faith – treatment programs can be presumed "cured," now and forever. However, that is obviously *not* the case. The likelihood of a recovering alcoholic's relapse is significant.[22] There are many other well-documented, substantial studies of relapse among alcoholics and drug addicts who seek to end their damaging and destructive behavior, but are unable to maintain their sobriety. For example, one study of alcohol recidivism reported that approximately 90 percent of alcoholics are likely to experience at

[22] In 1988, six operating administrations of the DoT adopted sweeping regulations on substance-abuse prevention in commercial transportation operations, including mandatory drug-testing requirements. *See, e.g.*, Federal Highway Administration policy statement accompanying original drug-testing rules, 53 Fed. Reg. 47,135 (1988) The strong public policy behind these DoT regulations was definitely underscored by the U.S. Congress in its enactment by wide vote margins in both the Senate and the House of Representatives of the Omnibus Transportation Employee Testing Act of 1991, 49 U.S.C. app. § 2717, which mandated random and other types of drug *and alcohol* testing for employees in safety-sensitive, transportation-related jobs regulated by DoT's operating administrations. These legislative mandates have become new requirements for regulated transportation carriers and industry workers. *See* 59 Fed. Reg. 7302 (1994) (final agency rules limiting alcohol use by transportation workers and mandating alcohol testing).

least one relapse over the four-year period following treatment.[23] Another study reported that approximately 55 percent of people with chemical dependency will relapse at some time during their recovery.[24]

In addition to the sizeable percentages of recovering alcoholics and drug addicts who experience relapses, there are no clear indicators that universally signal an oncoming relapse. While constant, comprehensive assessments of an individual's mental and physical state – if they were feasible – might produce some information regarding an individual's difficulties in "remaining clean," such mechanisms do not exist. The suggestion that even close observation and monitoring ensure that individuals with addiction histories and proclivities will relapse is not borne out by real-world experience.

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[23] J.M. Polich, *et al.*, *Stability and Change in Drinking Patterns*, The Course of Alcoholism: Four Years After Treatment, 159-200 (1981).

[24] M. Dusoe, *supra*. *See also*, D. Ellis & J. McClure, *In-patient Treatment of Alcohol Problems – Predicting and Preventing Relapse*, Alcohol & Alcoholism J., 449 (1992) (34 percent of males and 55 percent of females had relapsed six months after completing alcohol treatment program; after one year, rates were 47 percent and 61 percent, respectively); P.J. Frawley & J.W. Smith, *One-year Follow-up after Multimodal Inpatient Treatment for Cocaine and Methamphetamine Dependencies*, J. Substance Abuse Treatment 271 (1992) (47 percent relapse rate one year after treatment for cocaine dependence); J.W. Smith & P.J. Frawley, *Treatment Outcome of 600 Chemically Dependent Patients Treated in a Multimodal Inpatient Program Including Aversion Therapy and Pentothal Interviews*, J. Substance Abuse Treatment 359 (1993) (35 percent relapse rate in 12 months after treatment of chemically-dependent patients, 40 percent relapse rate after 14 months, and only 13 percent relapse rate of airline pilots completing treatment program); K.M. Carroll & B. J. Rounsaville, *A Comparative Trial of Psychotherapies for Ambulatory Cocaine Abusers: Relapse Prevention and Interpersonal Psychotherapy*," Am. J. of Drug & Alcohol Abuse 29 (1991) (compared results of one cocaine recovery program with a 67 percent success rate and another program with a 38 percent success rate); Milton R. Ayala, *Mean-Work Hours of Substance Abusing Employees*, 10 Alcoholism Treatment Q. 203 (1993) (analyzed the record of union employees after completing rehabilitation program and showed that 55 percent relapsed within one month and 79 percent relapsed within one year). The Institute's membership survey in 1992 offers equally damaging percentages – even following company rehabilitation programs. Despite the fact that these programs were carefully designed to provide the optimal rehabilitation techniques available for employees, were well-funded, and were conducted by those companies who are among the most committed in the country on this issue, the relapse rates were as high as 80 percent for some members and virtually never lower than 30 percent. Institute for a Drug-Free Workplace, *Institute Member Surveys* (1992).

These studies also reveal that there is no fixed time period which signals a total "cure" and obviates the need for future concern of relapse. Any combination of pressures, stress, or problems – many of which likely will be entirely unknown to the employer – can lead to a relapse that terminates an extended period of sobriety. Simply presuming that an individual who goes six months, one year, two years, or five years is forever cured of addiction problems is arbitrary. Such periods of abstinence are not reliable indicators that employees with past addiction problems are "risk free" in terms of recurrence.

In addition, supposed "warning signs" of a relapse provide inadequate protection to employers, co-workers, and the public with respect to individuals who perform highly hazardous activities. The Institute is a strong proponent of the key role of supervisory training in the implementation of a substance-abuse prevention program. Supervisors should be familiar with corporate policies, acquainted with treatment and assistance alternatives, and prepared to respond to situations in which employees appear to be "under the influence" of drugs or alcohol at work – or in violation of the company's drug- or alcohol-prevention policy in some other regard At the same time, it is quite clear that such training efforts do not create medical or treatment and assessment "experts." Reliance on the perceptions and assessment capabilities of lay supervisors provides an inadequate means of assurance for a vast quantity of high-risk positions.

Furthermore, such oversight "options" are entirely meaningless for positions that are not supervised, or where "rank-and-file" tasks are performed in transit or at remote work locations. Apart from the potential loss of life and human suffering that might be avoided, corporations have

millions – or, in some cases, billions – of dollars potentially at risk in a single catastrophic incident or error.

For all these reasons, Congress should not permit government agencies to compel employer reliance on the limited oversight effect of supervision, observation, random testing, or some other combination of these procedures where a high-risk job is involved *because no procedure or combination of procedures would be fail-proof.*

Scientists may not be able to precisely quantify the likelihood that an individual with a prior alcoholism or drug addiction problem will suffer a relapse. That fact does not mean that these risks and concerns are not valid or substantial. To the contrary, the fact that the precise means to identify, quantify, and limit risk *do not* exist make the need for the application of company policies that call for permanent removal – in limited circumstances – compelling, appropriate, and necessary. This need would be appropriately addressed by the Public and Employee Safety Assurance Act.

The Institute strongly believes that *both* of its proposals that would permit "sensitive-employees' job removal" – the Public and Employee Safety Assurance Act *and* Section 10 of the Private-Sector Drug-Free Workplace Act – are appropriate, would promote workplace safety and health (consistent with the overall goals of virtually *all* employer drug-abuse prevention programs), are both pro-employer and – ultimately – pro-employee, and are highly appropriate for enactment as part of our more comprehensive bill *or* as stand-alone legislation. Moreover, the Institute considers such legislation necessary.

XII. Suggested Safety-Sensitive Position Worker Protection Bill

The following legislation, if enacted, would allow employers to protect their employees, their property, the environment, and the public at large by permitting those individuals who test "positive" – or who have a history of substance abuse – to be removed from consideration from the most highly safety-sensitive positions.

PUBLIC AND EMPLOYEE SAFETY ASSURANCE ACT

Section 1. Title – This Act shall be known and cited as the **"Public and Employee Safety Assurance Act."**

Section 2. Finding – Whereas drug and alcohol abuse by employees has been demonstrated to seriously compromise workplace safety and health, and to endanger the public at large, property, and the environment, and whereas some employment positions are so highly safety-sensitive in nature that no individual who has failed a drug or alcohol test, or who has a history of substance abuse, should be eligible for employment or reemployment in those positions in order to ensure public and employee safety and health, and the protection of property and the environment, be it enacted that this Act shall become law.

Section 3. Definitions – As used in this Act:

(A) "Alcohol" means ethanol, isopropanol, or methanol.

(B) "Drugs" means any substance considered unlawful under the Controlled Substances Act (21 U.S.C. § 812 *et seq.*).

(C) "Employer" means any person, firm, company, corporation, labor organization, employment agency or joint labor-management committee, including any public utility or transit district, which has one or more full-time employee(s) employed in the same business, or in or about the same establishment, under any contract of hire, express or implied, oral or written. "Employer" does not include, for purposes of this Act, the United States, the states, or other public-sector incorporated municipalities, counties, or districts, or any Native American tribe.

(D) "Employee" means any person in the service of an employer, as defined in Subsection (C) of this Section, and for the purposes of this Act includes the employees of an employer's contractors, subcontractors, and vendors who are working for the employer and subject to its drug- and alcohol-testing policies and programs, as well as any independent contractors subject to such policies and programs.

(E) "Safety-sensitive position" means any job wherein an employee, if impaired by drug or alcohol use, could cause or significantly contribute to an accident which results in loss of human life, serious bodily injury, or significant property or environmental damage, or those managerial or supervisory positions to which such individuals report.

(F) "Confirmatory drug test" means any follow-up test for the presence of illicit drug use which is conducted after a "positive" drug-screening test, and is conducted at a laboratory: (1) certified by the U.S. Department of Health and Human Service's Substance Abuse and Mental Health Services Administration; (2) approved by the U.S. Department of Health and Human Services under the Clinical Laboratory Improvement Act; or (3) approved by the College of American Pathologists.

(G) "A history of substance abuse" means any past substance-abuse problem of an individual, including, but not limited to, having ever been treated or participated in a rehabilitation or employee assistance program for drug or alcohol dependency, or having been clinically diagnosed as having drug or alcohol dependency problems, or having had a criminal conviction for a drug- or alcohol-related offense.

(H) "Job applicant" means any person who has made application to an employer, whether written or oral, to become an employee.

(I) "Sample" means any sample of the human body capable of revealing the presence of alcohol or other drugs or their metabolites.

Section 4. Sensitive Employees' Job Removal – If the confirmatory drug or alcohol test of an employee is "positive," or that employee has a history of substance abuse, and that employee is in a safety-sensitive position, his or her employer may permanently remove that employee from that safety-sensitive position, and any other safety-sensitive position, and transfer or reassign the employee to an available non-safety-sensitive position with comparable pay and benefits, or may take other action, including termination or other adverse employment action, consistent with the employer's policy for drug- or alcohol-test "positives" for employees in safety-sensitive positions, provided there are not applicable contractual provisions that expressly prohibit such action.

Section 5. Denial of Employment to Job Applicants – If the confirmatory drug or alcohol test of a job applicant is "positive," or that job applicant has a history of substance abuse, and that job applicant, if hired or rehired, would be in a safety-sensitive position, his or her employer may permanently deny employment to that job applicant from that safety-sensitive position, or any other safety-sensitive position, provided there are not applicable contractual provisions that expressly prohibit such action.

Section 6. Preemption – This Act shall preempt any Federal or state law, rule, regulation, order, or standard that applies to the hiring, employment, continued employment, or reemployment in a safety-sensitive position of a drug addict, recovering drug addict, drug abuser, alcoholic, recovering alcoholic, or alcohol abuser, or to the reinstatement or rehiring of any employee in a safety-sensitive position for whom an employer has administered a drug or alcohol test consistent with this Act that has produced a confirmed "positive" result.

XIII. Conclusion

The Institute for a Drug-Free Workplace respectfully urges the Subcommittee on National Security, International Affairs and Criminal Justice to favorably consider H.R. 3853, the Private-Sector Drug-Free Workplace Act, *and* the Public and Employee Safety Assurance Act, as advanced in this testimony, endorsed by the Institute, supported by the employer community, and – in the case of the Private-Sector Drug-Free Workplace Act – largely embraced in concept, purpose, and substance by the President's Commission on Model State Drug Laws.

On behalf of the Institute for a Drug-Free Workplace, I sincerely thank and commend Chairman Hastert, Representative Barrett, and the Members of this Subcommittee for this opportunity to testify in support of responsible workplace drug-testing programs and to advance what we – and many, many others – consider to be model legislation in the workplace drug-abuse prevention area.

I would be pleased to answer any questions which you may have now or in the future in this regard.

Mr. HASTERT. Just a quick point. Is that because of the Americans With Disabilities Act?

Mr. DEBERNARDO. This—yes. The bill that we have drafted and discussed and submitted to this committee would, in fact, include pre-emption, and preemption of the ADA in that regard.

Mr. HASTERT. I thank the whole panel and Mr. deBernardo and others for giving your testimony today. Let me open up with some questions.

Dr. DuPont and Dr. Macdonald, when you look at the whole issue of workplace testing—and we've heard testimony that the whole issue of people don't want to necessarily be tested and people don't necessarily want to go into treatment, but treatment is a way out from punishment. It's a way not to get into the legal system and actually keep a normal life.

Also, Dr. DuPont, you talked about the faith-based groups and how they work and there actually has to be an act of will of individuals to prove their lot in life through that process. Basically, you see two incentives here—people want to improve themselves and people want to avoid a type of punishment or incentives to get into treatment. But testing is the threshold to both rules. What has the success been in faith-based as opposed to people just wanting to avoid the consequences? Dr. DuPont.

Dr. DUPONT. Well, it's important that you use the term "faith-based," because the 12-step program is spiritual, as opposed to religious. It is an important point because these programs—Alcoholics Anonymous and Narcotics Anonymous and Al-Anon—are generally nonreligious, but they are spiritually based.

Mr. HASTERT. I stand corrected.

Dr. DUPONT. Well, it sounds legalistic, but it's important because it has to do with the universality of the message. That's important to these programs.

I can summarize it very, very quickly with two points that have to do with the 12-step programs. You mentioned that there are these two things—the sort of carrot and the stick, a kind of punishment concept and then some kind of reward. What happens basically is that people come into treatment to avoid punishment, to avoid painful consequences from the employer, from the criminal justice system, from the family. They enter out of fear because of the consequences of their use.

Once there, they go through a transformation and become interested in having a life that matters, having relationships that have value. The key to doing that is twofold. One is the concept of a higher power that is something that is more important than the self because it's selfishness and self-centeredness that is the core of addiction. So, the higher power is something that's bigger than one's self, and for many people that's God, but the essential point is that it's not you; it's something bigger and more important than you.

Then the second point is honesty. You can't be a drug addict without being dishonest or without being a liar. You get well by becoming an honest person. When you go to 12-step meetings, you'll hear this word honesty over and over and over again. The people in recovery feel that they are now living an honest life and that is a tremendous relief. So that is a very big part of this process of get-

ting well. For many people, that includes being involved with religion. But whether it does or doesn't, it's going to involve these two points—first, something more important than oneself and second, living in an honest life.

Dr. MACDONALD. There was an older statement that used to sort of pervade our belief, and that was that you could not get treatment successfully until you've hit bottom, whatever that bottom was. What we began to investigate was the idea of what would happen if we raised the bottom. What about if we make sure that people are in treatment before they've lost their lives and their families and all of these other things? What was found was that indeed treatment with imposed consequences was equally effective as the natural consequences of allowing this disease to continue.

Workplace testing really gives us that opportunity. In many companies we are now demonstrating that—return people to work, not so much with a punishment upfront, but with the carrot. If you want to continue this job, this is the condition that you have to follow.

Mr. HASTERT. I've read some research and been told of some actions and actually where schools are doing testing. They can do it in some situations—athletes or somebody that's going out in a special situation or representation at school. Is there the same type of movement in the treatment because of disciplinary action? What's the success rate in what you've been able to observe in that area?

Dr. MACDONALD. Well, I don't know the legal ramifications of testing high school kids, but I'm all in favor of it. One of the controversial parts of the law is akin to the minimum sentencing guidelines. It's almost as if, if we were to do this, we ought to maximize sentencing guidelines for kids and treatment. That's sort of where we lost it all in the 1970's with this draconian punishment for kids that got caught with drugs. But rather than modify the consequences, we dropped them altogether. My view is that we should take young people, and when they have a drug offense, there should be an action and something that they can expunge from their record. What I don't want to do is—well, let me give you an example of what one stockbroker company did.

Their view of treatment was, when somebody failed the drug test, they called them in. The personnel manager said, You know, you can't continue to work with people's money and represent this company and use this drug. We're not going to give you any more than a second chance. The only reason we're giving you a second chance is that we've got a lot of investment in you. Then the individual would say, what about treatment? The company would say, No, you're missing the point. We're not talking about treatment; we're talking about you being drug-free in our tests. But you should know that we do have an insurance policy to cover treatment. We also have an employee assistance program. But what we're going to judge you on is being drug-free.

I wouldn't sentence people to treatment. I would sentence people to a monitored drug-free program with escalating consequences and would advise them, if they've got any sense and they can't give it up, they better get help. Then, the help could be available.

Mr. HASTERT. So the consequences are there facing the individual constantly and it's up to the individual—he has the aspects

here, the way, the means to get treatment. It's up to him to seek that treatment. Is that what you're saying?

Dr. MACDONALD. It's more important, in my mind, than what happens to that individual. That individual whose raking the yards at the school on Saturday because he had some drug problem—what I want to have happen is I want all of those kids in the school to see him out there doing that and understand that he's now on a different track and deter them from drug use. In my mind the strongest urge to prevention is: I don't want the consequences of getting caught.

Dr. DUPONT. Mr. Chairman, I was the expert on the case that went to the Supreme Court, the *Vernonia* case, that established the constitutionality of drug testing in the public schools. That was a landmark decision. To stop the increase that has come about since 1992 in teenage drug use in this country is to focus on the user. We need to have socially imposed consequences on teenagers who use drugs. It needs to be the kind of thing that Dr. Macdonald was talking about. The U.S. Supreme Court essentially said that drug testing is part of an adult stewardship responsibility for children and does not violate the Constitution, and I would encourage that direction.

Mr. HASTERT. Dr. Lappe.

Dr. MACDONALD. If I could, Mr. Chairman, I just want to make one other comment, if I may, about that. In my background, the part that they didn't mention is that I love children. I was a pediatrician for 25 years before I got into this business and I don't want anybody to interpret that my concern about kids has anything to do with wanting to see their lives ruined or punished.

Mr. HASTERT. Thank you. Dr. Lappe, you talked about the Federal drug-testing program, such as the Department of Transportation. Two questions: First of all, is it effective in your opinion?

Dr. LAPPE. It has been effective in that we have a dramatic reduction in the test positive rates since 1989. We have a very strong random drug-testing program in Transportation which we don't see in the private sector and nonsafety-sensitive workplaces. We know that the more frequently we random test, the lower the positive rate.

Mr. HASTERT. And the other part of this is the other side of the equation is that you talk about fair procedures for a person that's being tested. First of all, is the appeal process working well in protecting the rights of individuals? Are there fair procedures that the private sector is doing that we could learn from?

Dr. LAPPE. Absolutely. The appeal procedure is—I wouldn't even describe it as an appeal procedure because it fills a glitch in the analytical process. Laboratory tests cannot determine whether drug use is legal or illegal. It can only detect the presence of drugs. So the medical review process—the post-analytical review—is more than an appeal. It finishes off the analytical process to focus on individuals whose samples have drugs in them and without being accusatory in that the individual is immediately considered to be an illicit drug user. But rather give them the opportunity to present their medical history, and only in the absence of any significant history that would have produced a positive result from legal use would we then focus on the illegal or illicit source of drug. Drug-

testing programs must have this or else individuals will be falsely accused and their private medical conditions will be exposed before the workplace. That is absolutely not appropriate.

Mr. HASTERT. Thank you, Doctor.

At this time, I recognize the gentleman from Wisconsin, Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman.

Dr. DuPont in both your written testimony and your oral comments, you talked a lot about hair testing—a test that I didn't know existed until I started doing a little preparation for this hearing. So, it was news to me that that was even in existence. One of the issues that you raised is that the people who are opposed to it are opposed if they have a financial interest in urine testing or skin testing. Just for the record, I assume you have no financial interest in any of this. Is that accurate?

Dr. DUPONT. No. I am a consultant to the Psychemedics Corp. and I do own stock in that company also. So it's a major manufacturer and I do have a financial interest in that company.

Mr. BARRETT. OK, just for the record, I think it's important for us to know that.

Dr. DUPONT. Sure.

Mr. BARRETT. One of the issues, again, that was raised to me by my staff—and I think the panelists on the next panel will raise this issue, too—is the whole issue of false positives for minorities.

Dr. DUPONT. Right.

Mr. BARRETT. In your written testimony, you said that that can be easily explained.

Dr. DUPONT. Right.

Mr. BARRETT. If you would be so kind.

Dr. DUPONT. Yes. The criticism has to do with hair color and not with race. The argument is that people who have dark hair have to use less drugs to get a positive hair test than people who have light-colored hair. There is some laboratory basis for that. When that question is put into the real world hair testing is found not to be racially biased. The question was raised, about whether there is a disparate positive rate by race on hair tests compared to urine tests. In a large study the answer was no, that there was no increase in the positive rate for hair compared to either urine or self-report based on race. This was repeated in the Chicago police department, where there were 2,000 urine and hair tests done. There was no racial basis. So any concern for racial basis has been answered by real world data. Whatever concerns there are are entirely based, to my knowledge, on laboratory considerations on hair color and not on race.

Mr. HASTERT. OK. I just wanted to hear your explanation. The gentleman behind you is shaking his head, so we'll ask him the same question on the next panel, but I wanted to make sure we had both sides of that story.

Dr. Macdonald, you talked about the difficulties that occur when there's a shortage of labor and you have a situation where companies may not want to test. Is it your experience or your belief that what happens there is that you lose workers who are more likely to test positive for drugs which would be—and you made reference to the ostrich problem. Or do you believe that you have, then, peo-

ple who might have privacy concerns and conclude that, well, some employer, some potential employer, is asking these questions in this area right now? What will he or she be delving into in the future? What do you think is going there?

Dr. MACDONALD. Well, I think some of all of that exists. One of the things we've learned in polling data that really hasn't changed a lot over the last 15 years is that about 80 percent of the workers and people in the Congress here approve of testing if it has the proper guidelines and the proper way of being put together. Some of those people are concerned about their rights and government and employer infringement of those rights. But more often people that object are users. We had somebody who applied for work with us recently and we routinely do preemployment and random testing. He never showed up for the drug test—never came back, gone. We've had that happen a couple of times. So that if, indeed, just having the test will cause people to go somewhere else—I don't know if I'm answering your question.

Mr. BARRETT. Again, you think it's—if you were going to put a percentage on each, how many of those people are going because they may be——

Dr. MACDONALD. A great majority are drug users.

Mr. BARRETT. The second comment: You do have an interesting background for this area as a former pediatrician. One of the things that we have heard time and time again on this committee over the last year and one-half is that there's been an increase in drug use among teenagers. From your perspective, what's going on here?

Dr. MACDONALD. Well, I think that there are a lot of things going on. The drug czar is now coming out with advertisements to give the good side of staying off of drugs. I think more important would be looking at the encouragements to use drugs that are beginning to show up again in the media and the music of our young people and that really disappeared to large extent in the early 1980's. I think that the example of a national leadership, Nancy Reagan and President Reagan, saying kids should not use drugs, enabling parents to do what parents needed to do—in my view, as a pediatrician, parents do have the key role in this, but we've sort of cut them off at the pass if we don't provide them the national support and encouragement that they need and the programs. More research on what works would be very, very helpful. I think it's a lot of factors.

Mr. BARRETT. Mr. deBernardo, I have the letter that you wrote to Mr. Thomas where you did a very good job in talking about the concerns that you had with drug testing. I believe this is your letter, is that correct?

Mr. DEBERNARDO. Correct.

Mr. BARRETT. If you could just, with the Member issue, sort of elucidate what your concerns are—of the constitutionality of a testing of Members of Congress?

Mr. DEBERNARDO. While the Supreme Court has addressed this issue and addressed it in *Miller* v. *Zeller* last year and the Supreme Court came—that was the only case that's been before the Supreme Court in which drug testing was not upheld. I think it has very direct ramifications in terms of suspicionless testing of Members of

Congress. Sir, as I articulated in the memo, yes, I think there are legal concerns with progressing in that direction. I am a very strong supporter of drug testing and I would like to see drug testing here on Capitol Hill. I think there are a number of scenarios by which drug testing is appropriate and would be legally defensible. But I don't believe that suspicionless testing of Members of Congress would withstand legal challenge.

Mr. BARRETT. Do you draw the—and I understand where you would be a strong supporter of testing here on Capitol Hill and that there are ways that it could be done. Are there ways it could be done for Members?

Mr. DEBERNARDO. You know——

Mr. BARRETT. When you say there are ways it can be done, are you referring to employees——

Mr. DEBERNARDO. Yes. Staff versus Members. In terms of Members, I would think that the conditions upon which drug testing would be able to withstand legal challenge would be if there was suspicion-based testing. So if there was a for-cause or a reasonable basis, or if there was an identified drug problem among Members of Congress, so there was a justification. That was one thing that the Supreme Court made clear that in the *Miller* v. *Zoeller* case: There was no basis to assume that candidates for a political office—there was no identified problem. This was not addressing a known problem so, therefore, it really was a baseless basis to have testing. If, in fact, we identified that Members of Congress had a significant ratio of drug problems—rate of drug problems—or if there were other interests; if there were security threats; or some Members of Congress were carrying firearms onto the floor; or there were threats of active violence by a Member of Congress, him or herself, that would be a different situation, but, obviously, there's none of that.

Mr. BARRETT. And you believe that—if I may, Mr. Chairman, just one quick comment—you believe that the national security exception that was created in the D.C. circuit case, you think that would be adequate to cover the staff, or where do you see the constitutionality of the staff issue come in?

Mr. DEBERNARDO. Sure, I think there's a strong basis to test elements of the staff on Capitol Hill. Certainly security guards who carry firearms—that's a no-brainer; that's going to be very clear. People who are in safety-sensitive positions who are operating—there's a limited number of people operating vehicles; certainly that would be justifiable. I think staffers who have positions that affect national security or criminal justice law enforcement, those involved in finances and certain offices here, security people here—arguably as Representative Solomon said—I have worked closely with Representative Solomon in the past and have nothing but praise for his efforts in this regard. But as he pointed out, those with access to the House floor, that would be an example. In the case that he referred to I think is a basis, and certainly that's discussed in our memo. Those who have access to the House floor would be analogous to those who have access to the President and the executive branch and have passes for the Old Executive Office Building.

Mr. BARRETT. OK, thank you.

Mr. HASTERT. I thank the gentleman. The gentleman from Georgia, Mr. Barr.

Mr. BARR. Thank you, Mr. Chairman. I don't quite understand, Mr. deBernardo, this access to the House floor. I mean, either—it seems to me either drug testing is appropriate for congressional employees and Members or it isn't. What is the distinction? What additional danger—if there is a danger—as opposed to if you walk on the House floor, as opposed to walking into a Member's office, passing a Member in the hallway, the whole range of both issues, people with which every—virtually every staffer and Member up here comes in contact with?

Mr. DEBERNARDO. Sir, the idea, I think, is that there are certain areas on Capitol Hill where the risk is magnified. So, the fact that the——

Mr. BARR. Wouldn't it be magnified in a Member's office more so than on the floor?

Mr. DEBERNARDO. Well, on the floor, you know, you could have 400 Members of Congress together at once.

Mr. BARR. Not likely, but—[laughter.] It's just I'm concerned——

Mr. DEBERNARDO. Certainly you can have——

Mr. BARR [continuing]. To me, it's sort of rather arbitrary, to say the least. I'd like to explore, though, for a moment the broader issue of drug testing—of random drug testing of Federal employees and congressional employees. I know that sort of theory behind those who argue against it is that it's a fourth amendment intrusion because inherently it's the Government that's doing the testing as the employer. Are there not, though—what would be your view on looking at this, as I know you have, more on a contractual basis or on an implied consent basis? People don't have a right to a Government job. Therefore, as a condition of that similar to people who don't have a right to be licensed to drive when that is a privilege similar to employment. Why not look at this—if our goal is to help reduce, do something to reduce the use of mind-altering drugs in this country, something which I consider the administration has basically abrogated it at this point, but if we in the Congress are trying to do something about that, would not random drug testing of Federal employees be an important part of that? We tried that, I guess, back in the 1980's and it seemed to have some impact.

That being the case, would your advice to the Congress be for us to be aggressive and proactive and imaginative, draft some legislation, and you know, if those that think that Federal employees have a right to use drugs, let them challenge it in the courts. But let's tee this up and move it forward. Would you see any reason not to do that?

Mr. DEBERNARDO. I do see a reason not to do that. I'm managing partner of the Washington office for Littler Mendelson—it's the largest employment law firm in the country. We advise many, many employers on employment issues, more than anybody in the country, and many on the drug prevention issue. So if Mobil or Georgia Pacific or IBM come to me, they want to know what they can do and what is the most legally defensible way of doing it.

The downside risk is, if there were implemented on Capitol Hill a drug-testing program, there undoubtedly will be a legal challenge to that. I have no questions that there are Members of Congress,

among the 435, there are opponents of drug testing. You will have civil disobedience if you subject it to Members or to Members' staff. You will have Members or Members' staff who are going to refuse to comply and the question is, what are the consequences when you have somebody who has a refusal to test or refusal to implement or refusal to enforce? They're not going to discharge a staff member who has testified.

So that has the potential to give a black eye to drug testing and to the cause of drug testing and to the cause of drug abuse prevention in the country. What I say to Mobil and Georgia Pacific, and what I said at the U.S. House of Representatives, is let's design as bulletproof a policy as possible—one that can be implemented; one that's going to withstand legal challenge. Inevitably, we feel that there is going to be legal challenge if Congress moves ahead on this. There are downsides to this. I think the media would love this. I think that you would have Members of Congress who would love to take this issue on.

Mr. BARR. Do we simply then say that Federal employees and congressional employees and Members of Congress have a free ride?

Mr. DEBERNARDO. No, not at all. I think——

Mr. BARR. Well, all I'm saying, is there not some merit in drafting legislation that, whether one looks at it as basically an implied consent or a matter of contract law, drafting that and moving forward with it, rather than just sitting back and saying, gee, it's going to be challenged; therefore, we shouldn't do anything.

Mr. DEBERNARDO. Mr. Barr, I don't think anybody's saying let's sit back and not do—what I say is let's do what's doable. Let's do—let's implement a program that makes sense, that's legally defensible. Speaking as Mark deBernardo, someone who's a very strong supporter of drug testing and a very strong supporter of drug-free workplaces, I'm all for it. I wish everybody in the Capitol could be tested. But speaking as a managing partner of a law firm that is very active on this issue, you know, again I'm giving advice to the client on what is doable. Perhaps it's a two-step process. Perhaps what we can do is do what's doable now, establish a record, withstand the legal——

Mr. BARR. Maybe I don't understand. What can we do now?

Mr. DEBERNARDO. Well, I have laid out—Mr. Barrett has made reference to a memo that we submitted, a lengthy memo, and subsequently, I have drafted two House resolutions on this: one which I think is absolutely defensible and the other which I think is very doable. There's a whole series of different types of drug testing, such as drug testing of those staff members with access to the House floor, drug testing of those staff members——

Mr. BARR. Do you really think that drawing those sorts of distinctions would successfully withstand an equal protection challenge—I mean if a staffer has access to the lobby outside of the House floor but can't get onto the House floor because their Member is managing a bill——

Mr. DEBERNARDO. That creates a——

Mr. BARR [continuing]. I think you'd have an awful hard time——

Mr. DEBERNARDO. That creates an incentive for Members to implement the drug-testing program because if they want their staffers to come—to have access to their staffers to come to the House floor, then they have to be in the random drug-testing pool. I think that creates a——

Mr. BARR. I'm not sure that would provide much incentive. I think it would be subject to a very serious challenge.

Mr. Chairman, could I just make one comment to Mr. Macdonald very briefly?

Mr. Macdonald, I appreciate a couple of things that you mentioned, most importantly, the Just Say No Program and role of parents in this program. We had before this committee, I think last Congress, a lady who was being threatened with criminal prosecution by the FDA for simply trying to make home drug test sample kits available to parents. I think that because of the publicity that was brought to bear on that and the pressure on FDA, they backed down classifying this home test collection kit as a class II medical device, subject to all of the rules and regulations and sanctions of a pacemaker literally. But I do think that it is very important that we remember that perhaps the front line in all of this, with regard to at least their teenagers and even younger kids, unfortunately, is our parents. I appreciate you highlighting that because I think it is the overlooked part of this equation.

Mr. HASTERT. I thank the gentleman from Florida. Now I take great privilege in introducing and asking the gentleman from Baltimore, who has been very much involved in drugs and drug testing—it's your time.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

I'm just curious as to—first of all, who is your typical drug user profile, Dr. DuPont? Who's a typical drug user? Employed? Is it woman, male, white, black? Who are they?

Dr. DUPONT. About 80 percent of illegal drug users are white. About 75 percent are not from inner-city communities, as you've heard. About 73 percent are employed. There's a strong age dimension to this, so many are between 20 and 40, with the highest rate between 18 and 25. Males predominate about 2 to 1 to females. That's the profile of American illegal drug users. It could be anyone, but there are higher rates among some groups than others.

Mr. CUMMINGS. The 12-step program which I'm quite familiar with, I understand pretty much how it works. I think it was Dr. Macdonald who said that there was at one time this theory that you had to reach rockbottom and then you had to raise the bottom. I'm just wondering do people—I mean, the people that I talk to in my neighborhood, a lot of them just get tired of going out there chasing death.

Dr. DUPONT. Yes. "Sick and tired of being sick and tired" is the phrase used in 12-step programs.

Mr. CUMMINGS. Yes, they come to a point where they're just tired.

Dr. DUPONT. Exactly.

Mr. CUMMINGS. I don't know whether that's considered a negative consequence. I mean, one of you all mentioned negative—they're trying to avoid the negative consequences.

Dr. DUPONT. I think that what makes the people sick and tired is all the consequences that have piled up over the years of use, one of them being the financial consequences, but also criminal justice consequences, consequences in their family, consequences with employment. When you talk about people who have come and said, I'm sick and tired of being sick and tired, if you look back on what's happened to that person, you will usually see quite a long list of consequences that have been endured in the pursuit of what I call the love affair with the drug.

Mr. CUMMINGS. Now when you look at these workplace programs, do you—I don't know whether you can answer this or not, but do you find that more people get to the point of the consequences—they come forward voluntarily or do more—are more noticed when somebody says, Johnny over there is coming in a little tipsy? I mean, which is the most? In other words, how is it brought to the attention——

Dr. DUPONT. Most of them have some kind of consequences. It may be the family. Sometimes it's the spouse who says, go into the EAP program. But oftentimes, it's a positive drug test that gets the person into the net of the employee assistance program and then into the 12-step programs. Again, as Dr. Macdonald pointed out, the idea of drug testing them afterward, so that the condition of continued employment is the drug test being negative, is a very important part of success. But consequences are many-fold, including physical illness, the doctor who refers people because they have a physical problem as a result of the drug use, for example. But the most important one, particularly for this hearing, is the positive drug test. That is a very powerful tool to help people reach bottom. As Dr. Macdonald said, drug tests raise the bottom.

Mr. CUMMINGS. What happens when—if somebody comes to you and says, Let me go to you, Doc?

Mr. DEBERNARDO. deBernardo.

Mr. CUMMINGS. Somebody in your law firm, a senior partner comes and says, We know Johnny over here, one of your main players in the law firm, has got a drug problem. I think that one of the problems is that the person feels that, even if there's a drug policy established, you've got somebody like in a law firm that may come forward. It's like, you know, will I suffer no matter what? I mean, what would happen, do you think, in your law firm? You follow what I'm saying?

Mr. DEBERNARDO. If I was——

Mr. CUMMINGS. They're already kind of prejudiced. They feel like they're going to be—and I think it's a reasonable assumption that there may be some problems, even if they say, OK, I'm going to get treatment, or whatever, that their tenure at your law firm may not be very long.

Mr. DEBERNARDO. Yes; I think that if I knew that I had a colleague who had a significant substance abuse problem, knowing what I do on these issues, I would advocate intervention no matter what. Because, absent intervention, a person who has a serious substance abuse problem—narcotic, drug problem, alcohol abuse problem—is likely to die a premature death.

Mr. CUMMINGS. But what about his job?

Mr. DEBERNARDO. The average alcoholics die 12 years—well, I think health and life is more important than the job. Now, frankly, one of the very good things about corporate America and its programs is employee assistance programs. The lowest recidivism rate for patients in treatment is in company-referred patients in EAPs and treatment. So you have the best shot of straightening out your life if your company's referred you. Typically, it includes the promise of continued employment, of continued salary while you're on the treatment program. There's confidentiality. You're supported by coworkers who have similar problems and there's family counseling, as well. What corporate America does in this regard I think is very responsible.

Dr. LAPPE. Can I also add that the Americans With Disabilities Act protects rehabilitated drug users from discrimination. We have that.

Mr. CUMMINGS. All right. Thank you very much.

Mr. DEBERNARDO. You know, Mr. Cummings, if I could just make one additional comment. There is what's called the tough love policy. At some point, you have to enforce your policy. People can't have free rides.

Mr. CUMMINGS. Oh, I agree.

Mr. DEBERNARDO. So in that regard, loss of a job for somebody who's got a chronic drug abuse problem and refuses treatment or refuses to cooperate in treatment or straighten themselves out—I mean, that's the appropriate course.

Mr. CUMMINGS. Mr. Chairman, just one comment. You know, when I was in the Maryland legislature, I was in charge of workmen's compensation; I was the top person in the House. One of the things that I was trying to put forth was something that you all said about the escalating consequences. People didn't seem to get it then. They seem to be getting it now since I left. But because that just made sense to me. You don't just kick a guy out—or a woman out—from the very beginning. You try to figure out ways that if they do, you give them an incentive for treatment. Hopefully, they'll do it and there won't be any negative consequences; there'll be positive consequences. I think that goes along with what you were just saying to some degree.

Thank you all.

Mr. DEBERNARDO. Agreed.

Mr. BARR [presiding]. The gentleman from Florida, Mr. Mica.

Mr. MICA. Thank you, Mr. Chairman. Mr. Chairman, since we don't have too much time, I'm going to yield some of my time to my colleague. I heard the talk today about the need to go more to mandatory, rather than voluntary testing. Is that correct? I see, do you support that, Dr. DuPont?

Dr. DUPONT. Yes, we do.

Mr. MICA. Dr. Macdonald? I think you spoke to that——

Dr. MACDONALD. I'm not sure exactly what you mean by mandatory, but random testing——

Mr. MICA. Well, in my mind, it is a condition of——

Dr. MACDONALD. Pre-employment testing in many people's minds is an intelligence test. If you can't stay off the drugs for 2 or 3 days, you're either awfully stupid or awfully hooked.

Mr. MICA. Then we get into the question of 2 or 3 days, which it appears the urine test seems to substantiate, versus the hair test which can give us information over a broader timeframe. Which would you favor, Dr. Macdonald?

Dr. MACDONALD. Well, let me just say about the urine testing, even with this minimum window, the national percentage of pre-employment tests that are positive are about 5 percent. There are a lot of people that come in and test before the other. The issue of hair testing that Dr. DuPont and others stress does give you a much longer, broader look at people.

Mr. MICA. But which do you favor?

Dr. MACDONALD. Well, I still am in this undecided camp. All of the questions about hair testing have not been satisfactorily answered, at least in my opinion. Dr. DuPont, who is my good friend and trusted coauthor, doesn't exactly come down in the same place. If I could honestly get from enough members of the scientific community to endorse workplace hair testing, we can do a toxicology on hair and I would also endorse it. So that's really sort of where I am.

Mr. MICA. So you don't think, at this point, hair testing has the validity of the urine testing? Is that what you're saying?

Dr. MACDONALD. I think that I'm not expert enough to decide that, but that the experts that I've turned to, the great majority, have said they have serious reservations.

Mr. MICA. Dr. DuPont, what's your opinion?

Dr. DUPONT. I've been in the drug abuse field for 30 years. I was here when urine testing came in and these same folks had the same concerns about the fact that we hadn't dotted all "i's" and crossed all the "t's" with urine tests. We did battle on that and urine drug tests have become just accepted now. The same thing is happening with hair testing. We're on the same path. I think this controversy will have exactly the same outcome. The science is there, but there are many people for many reasons who are reluctant to bless it, so now it's a battle. I feel confident that hair testing is the way of the future for most drug tests for the reasons that we're talking about today. And even the opponents agree with that. It's just a matter of when is the time.

From my point of view, the time to adopt hair testing was 10 years ago. From their point of view, it's 5 years from now. It's not a question of whether you do it, it's when. I think the time is well past because the science is there.

Mr. MICA. Well, I have many additional questions. I'm going to submit them in writing. But I will yield to my colleague at this point.

Mr. SOUDER. Welcome, you all. I have a series of questions here that I'll give you in writing and, hopefully, rapidly. My subcommittee moved that Portman bill up to Talent at the full committee level in the Small Business and he was just asking me some questions on the floor. And I've got one in particular I wanted to flag here for Dr. Lappe. Is that correct?

Dr. LAPPE. Yes, that's correct.

Mr. SOUDER. In your testimony, you refer to a study, actually Dr. deBernardo's group, and he also refers to it in his testimony, about the migratory effect of small businesses because they aren't doing

as much drug testing. But in yours you say you do not perform drug testing due to the fear of legal liability. What do you mean by that?

Dr. LAPPE. That the larger employers in this country have the legal resources and financial resources to defend a claim by an employee that the drug test was improperly performed.

Mr. SOUDER. Are you suggesting—and Mr. deBernardo, you obviously refer to the Portman bill that we're moving—do you think that we would be wise to have a fund or something in here to help provide legal assistance? Or do you agree that that's one of the things that's kept businesses out?

Mr. DEBERNARDO. I absolutely agree that's one of the things that keeps small businesses from addressing this. There's a perception that drug testing is a minefield, so you have these businesses say, gee, yes, there's a lot of court cases, gee, do I really want to go forward with this? And that creates a disincentive.

Really, the two reasons why an employer wouldn't do drug testing is ignorance—they don't know about it; they're too busy doing other things. They're making widgets and selling widgets. Or, two, because of this fear of being sued. Frankly, I think the most appropriate approach is the one that's embodied in the Drug-Free Workplace Act, which creates that incentive for employers. You follow the safeguards. You do drug testing in the most responsible way. You cannot be sued for taking the adverse employment action, acting in good faith.

That would create a terrific incentive for small businesses and others to address it and removes one of the potential reasons not to do it.

Mr. SOUDER. But, as a small businessman, I'm not sure that would convince me I'm not going to be sued because you can still get harassment suits that you may not be able to handle. But I agree with you that the best protection to winning the suit——

Mr. DEBERNARDO. But you cannot be sued for taking adverse employment action against somebody, including denial of employment to a job applicant, based on a positive drug test. If you know that you can give a drug test and, as long as you follow the safeguards, you're not going to be sued for discharging somebody or denying employment to somebody, I think that——

Mr. SOUDER. OK. I would like to followup a little bit more because the other thing, particularly with Dr. DuPont and Dr. Macdonald, is that—have you seen the Ramstad bill on treatment? And, if not, could you try to get a copy of that and look how we might work—it's, basically, to get some parity for alcohol and drug abuse treatment. We're trying to limit it so it doesn't bust the costs, possibly how testing might be worked into that? Because it's one that may or not move here in the immediate future.

And I also wanted to say to Dr. Macdonald, several points back in our résumés, when I was public and staff director at the Children, Youth, and Family Committee, and Congressman Hastert was on that, you worked with us on several hearings, and I appreciate your leadership over a long period of time on these subjects.

Mr. MACDONALD. Thank you, Mr. Souder.

Mr. BARR. Thank you. I'd like, on behalf of the chairman and the entire subcommittee, to thank this panel of witnesses. We appre-

ciate your testimony and the answer to the questions and we would appreciate it if any followup questions which are sent to you would be responded to as quickly as possible. We thank you and we will stand in recess for about 15 minutes while we go vote and then we will be honored to hear the second panel.

[Recess.]

Mr. BARR. The subcommittee will reconvene.

And if we could ask our panelists to take the seats with the appropriate name card. On behalf of Chairman Hastert, I'd like to welcome you all and thank you for appearing before us today. I'd like to briefly introduce the panelists and then we will have them sworn in. We'll proceed.

I think you all probably know the rules fairly well. We have 5 minutes. You certainly do not need to take the entire 5 minutes. Your full written statements and any attachments thereto will be entered into the record and there may be a number of followup questions which you could answer both today and there may be followup questions in writing. We would appreciate you all responding in writing as quickly as possible to those questions.

Starting from my left, we have Dr. Tom Mieczkowski who's a professor at the University of South Florida. We have Mr. Harold Green, president of the Chamberlain Contracting Co. We have Mr. Neil Fortner, vice president of Laboratory Operations for PharmChem Laboratories. We have Ms. Roxanne Kibben, president of the National Association of Alcoholism and Drug Abuse Counselors. And we have Dr. David Kidwell who's a chemist with the Naval Research Laboratory. Welcome and I appreciate you all being here today.

It is a rule of the committee that all witnesses who appear before us be sworn.

[Witnesses sworn.]

Mr. BARR. We could now start with Dr. Mieczkowski. If you would, please, you have 5 minutes to read into the record or make such statement as you might like. And, again, your full statement will be entered into the record.

STATEMENTS OF TOM MIECZKOWSKI, PH.D., PROFESSOR, UNIVERSITY OF SOUTH FLORIDA; HAROLD GREEN, PRESIDENT, CHAMBERLAIN CONTRACTORS; NEIL FORTNER, VICE PRESIDENT, LABORATORY OPERATIONS, PHARMCHEM LABORATORIES; ROXANNE KIBBEN, PRESIDENT, NATIONAL ASSOCIATION OF ALCOHOLISM AND DRUG ABUSE COUNSELORS; AND DAVID KIDWELL, PH.D., NAVAL RESEARCH LABORATORY

Mr. MIECZKOWSKI. Thank you for the opportunity to express my views on the important issue of drug policy. I shall confine my opening remarks to the specific areas of interest that I have explored in my research.

I have, since the early 1980's, been an active researcher in the area of drug abuse.

Mr. BARR. Doctor, could you pull the mic just a little bit closer, please. It makes it a lot easier both for us and for the audience to hear, as well as for the court reporter.

Mr. MIECZKOWSKI. I have, since the early 1980's, been an active researcher in areas of drug abuse, drug-related criminal behavior, and in the measurement of drug use prevalence and incidence, especially by the use of various drug identification technologies. Specifically, I've been involved in urinalysis testing, including being a site manager and a consultant to the National Institute of Justice's Drug Use Forecast Program. Furthermore, since 1989, I have conducted several large projects assessing the utility of hair analysis in various criminal justice contexts, including jails, correctional settings, and diversion programs.

Additionally, in the last 2 years, I have been assessing the applications of a new technology, ion mobility spectrometry to the detection of drug exposure in certain criminal justice populations. These projects have included males and females, youth and adult offenders, and members of all racial and ethnic groups. The number of subjects in total for all these projects numbers in the thousands.

In general, our research has consistently revealed several fundamental and I believe important findings. Among the most important is that, for the purposes of estimating drug prevalence and incidence, methods which do not use a biologically based assay system to assess the accuracy of personal self-reports are inevitably going to underestimate the true degree of drug use, and probably underestimate it by a very significant amount. Almost universally, our research and that of many others shows that survey-based procedures inevitably result in underreporting of drug use. This is true regardless of the type of bioassay procedure used.

For the last 8 years, I have also assessed the utility of hair analysis for five categories of illegal drugs—marijuana, cocaine, heroin, PCP, and amphetamines—primarily in criminal justice populations. I have been interested in hair analysis primarily because it can provide a larger window of detection than urine or plasma-based testing techniques. This is especially important for rapidly excreted drugs like cocaine and heroin, which have a very short detection life in urine or plasma.

We have found hair analysis, when correctly done, to be an excellent technique for this purpose. We have assessed approximately 5,000 cases in various field settings and had generally excellent results. These assessment projects include testing of juvenile offenders, testing adult arrestees, testing probationers over a long timeframe, and testing persons in adult diversion programs who were followed over a long timeframe. In all these projects, we used both hair and urine-based tests as well as interviewing and questioning subjects about their drug use.

Additionally, I have conducted evaluations of several issues of controversy regarding hair analysis. This includes evaluation of the potential hazards of passive contamination of hair by environmental contact with drugs and the putative relationship between hair analysis and racial bias. Our research fails to show that either of these effects are significant and do not appear to have a meaningful impact on the accuracy and utility of hair-based drug analysis.

We have also examined the degree to which the quantified values of drugs uncovered in hair may be used to assess the degree or intensity of drug use in individuals. In general, we have found that

hair analysis presents sufficient information to make a rank-order assessment of drug use, that is, drugs as something like high, medium, or low. However, hair analysis cannot be used to back-calculate a specific dose of drug taken by a person.

We have also examined the degree to which hair analysis may be used to infer a pattern of past use by segmental analysis of hair strands. Generally, we have found it useful for assessment purposes. For example, we clearly and consistently see diminution of drugs and drug metabolites in the hair of persons in treatment programs who have stopped using drugs.

However, like dosage, hair analysis cannot pinpoint an exact moment in time when a person used a drug. It does, however, allow some inference over a several-week period. For example, we conventionally treat a hair sample of approximately 1½ inches as allowing us to examine approximately a 3-month timeframe and to estimate whether the consumption patterns changed over that 3-month period. The ability to do this historical assessment is contingent on the subject, of course, having hair of sufficient length.

In sum, my work has shown that hair analysis is a credible and useful tool for the purposes of drug monitoring. It is my view that, in many circumstances, the use of drug testing is a critical element for many kinds of programs. Hair analysis, especially when coupled with other testing procedures, such as urine testing and IMS testing, represents in total an extremely effective tool to detect drug use and also forms a potent deterrent for those undergoing treatment or otherwise involved in programs which require drug abstinence. Thank you.

[The prepared statement of Mr. Mieczkowski follows:]

Summary Statement
Dr. Tom Mieczkowski
Professor, Department of Criminology
University of South Florida

Thank you for the opportunity to express my views on the important issue of drug policy. I shall confine my remarks to the specific areas of interest that I have explored in my research.

I have since the early 1980's been an active researcher in areas of drug abuse, drug-related criminal behavior, and in the measurement of drug use prevalence and incidence, especially by the use of various drug identification technologies. Specifically, I have been involved in urinalysis testing, including being a site manager and consultant to the National Institute of Justice's Drug Use Forecast Program. Furthermore since 1989 I have conducted several large projects assessing the utility of hair analysis in various criminal justice contexts including jails, correctional settings, and diversion programs. Additionally, in the last two years we have been assessing the applications of a new technology, ion mobility spectrometry, to the detection of drug exposure in certain criminal justice populations. These projects have included males and females, youth and adult offenders, and members of all racial and ethnic groups. The number of subjects in total for all these projects numbers in the thousands.

In general our research has consistently revealed several fundamental and, I believe, important findings. Among the most important is that for the purposes of estimating drug prevalence and incidence methods which do not use a biologically based assay to assess the accuracy of personal self-reports are inevitably going to underestimate the true degree of drug use, and probably underestimate it by a very significant amount. Almost universally, our research (and that of many others) shows that survey-based procedures inevitably result in under-reporting of drug use. This is true regardless of the type of bioassay procedure.

For the last eight years I have also assessed the utility of hair analysis for five categories of illegal drugs (marijuana, cocaine, heroin, PCP, and amphetamine) in criminal justice populations. I have been interested in hair analysis primarily because it can provide a larger "window of detection" than urine or plasma-based testing techniques. This is especially important for rapidly excreted drug like cocaine and heroin, which have a very short detection life in urine or plasma. We have found hair analysis, when correctly done, to be an excellent technique for this purpose. We have assessed approximately five thousand cases in various field settings and had excellent results. These assessment projects include testing of juvenile offenders, testing adult arrestees, testing probationers over a long time frame, and testing persons in adult diversion who were also followed over a long time frame. In all these projects we used both hair and urine-based tests as well as interviewing and questioning subjects about their drug use.

Additionally, I have conducted evaluations of several issues of controversy regarding hair analysis. This includes evaluation of the potential hazards of "passive contamination" of the hair by environmental contact with drugs and the putative relationship between hair analysis and "racial bias". Our research fails to show that either of these effects are significant and do not appear to have a meaningful impact on the accuracy and utility of hair-based drug analysis.

We have also examined the degree to which the quantified values of drugs uncovered in the hair may be used to assess the degree or intensity of drug use in individuals. In general, we have found that hair analysis presents sufficient information to make a rank-order assessment of drug use (e.g., drug use as "high", "medium", or "low"). However, hair analysis cannot be used to "back-calculate" a specific dose taken by a person.

We have also examined the degree to which hair analysis may be used to infer a pattern of past use by segmental analysis of hair strands. Generally, we have found it useful for assessment purposes. For example, we clearly and consistently see diminution of drugs and drug metabolites in the hair of persons in treatment programs who have stopped using drugs. However, like dosage, hair analysis cannot pinpoint an exact moment in time when a person used a drug. It does, however, allow some inference over a several week period. For example, a sample of hair approximately 1.5 inches long would allow us to examine a three month period of time and estimate whether the consumption patterns changed over that three month interval. The ability to do this historical assessment is contingent on the subject having hair of sufficient length, of course.

In sum, my work has shown that hair analysis is a credible and useful tool for the purposes of drug monitoring. It is my view that in many circumstances the use of drug testing is a critical element. Hair analysis, especially coupled with other testing procedures such as urine and IMS testing, represents an extremely effective tool to detect drug use and also forms a potent deterrent for those undergoing treatment or otherwise involved in programs which require drug abstinence.

Probation Monitoring by Hair and Urine Testing
Pinellas County, Florida

Examining Cocaine Values by Race and Hair Color in a Group of Probationers

Probation Study
Pinellas County

- 152 probationers recruited, 90 completed [illegible] complete 6 month project and 101 persons provided 5 samples. Only 3 were African American
- 699 hair and urine tests were performed
- For probationers testing (+) for cocaine, African Americans had a lower mean concentration of cocaine in hair
- The difference was insignificant by ANOVA if equal variances are assumed

[illegible]

Comparing Mean Hair Assay Values for Cocaine

Probation Study
Assay Outcomes by Race

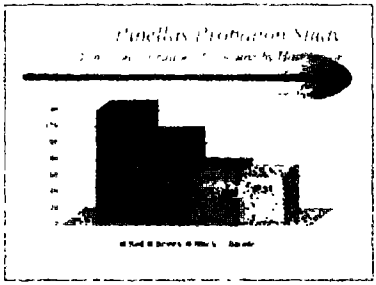
- 10 hair tests for African Americans and [illegible] tests for Caucasians were cocaine (+)
- Only 14 urinalyses were cocaine (+) out of 590 tests
- 2 of 18 urinalyses (11%) were cocaine (+) for African Americans and 12 of 460 (2%) were cocaine (+) for Caucasians

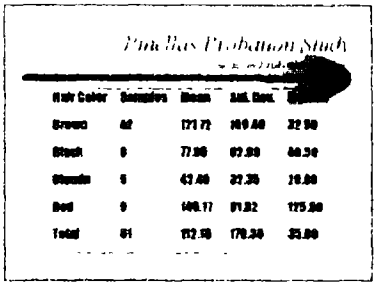
Pinellas Probation Study
Hair Color

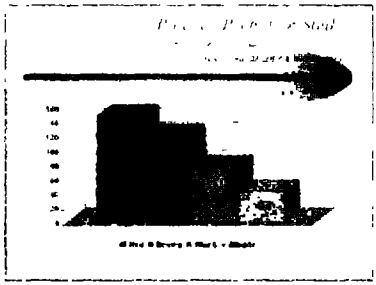
- Four hair color types were observed in the [illegible] group: [illegible] black, blonde and [illegible]
- [illegible] were [illegible] cocaine (+) samples of these [illegible] type
- Red hair had the highest mean value and blonde the lowest
- ANOVA was not significant for color

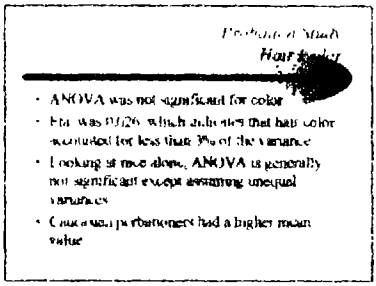
Probation Study
Cocaine Concentration by Hair Color

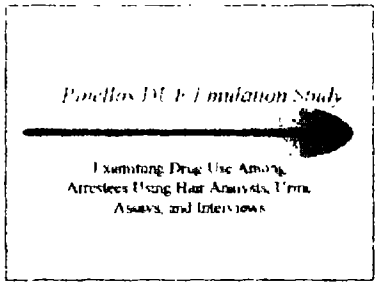
Hair Color	Samples	Mean	Std. Dev.	[illegible]
Brown	61	102.83	100.86	30.0
Black	26	98.85	87.01	48.70
Blonde	9	67.11	40.70	31.0
Red	6	136.63	40.57	114.56
Total	99	93.84	130.14	43.0

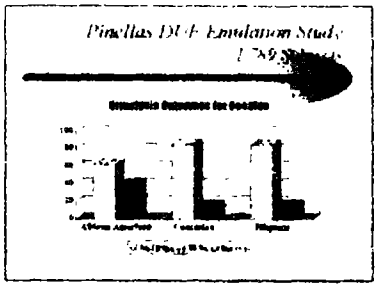

Pinellas Probation Study

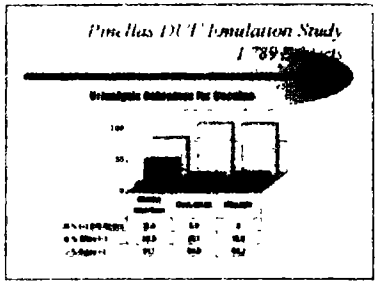

Pinellas Probation Study
Hair Color
Brown
Black
Blonde
Red
Total

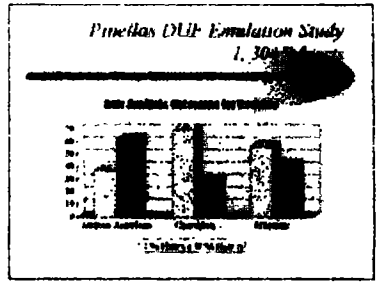

Pinellas Probation Study

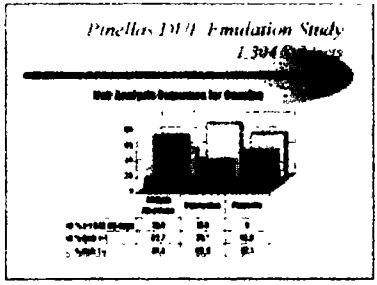

Probation Study
Hair Color
ANOVA was not significant for color
Eta was 0.026, which indicates that hair color accounted for less than 3% of the variance
Looking at race alone, ANOVA is generally not significant except assuming unequal variances
Caucasian probationers had a higher mean value

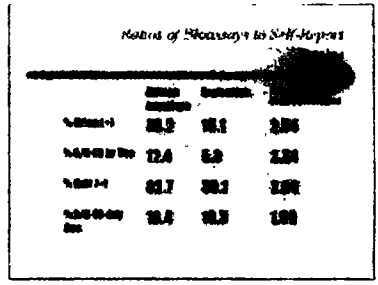

Pinellas DUF Emulation Study
Examining Drug Use Among Arrestees Using Hair Analysis, Urine Assays, and Interviews

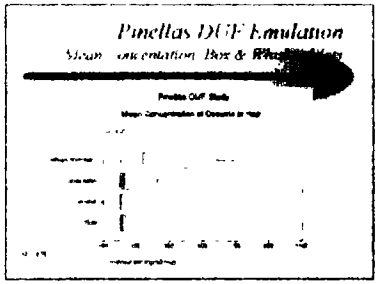

Pinellas DUF Emulation Study

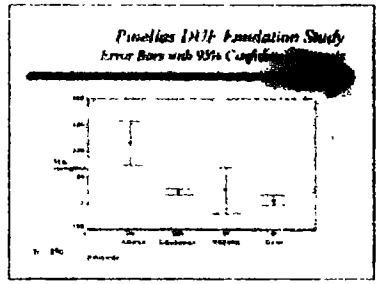

Pinellas DUF Emulation Study


Pinellas DUF Emulation Study


Pinellas DUF Emulation Study


Ratios of Bioassays to Self-Reports


Pinellas DUF Emulation


Pinellas DUF Emulation Study

The Needs Assessment Project
Analysis by Hair and Urine Testing
Pinellas County, Florida

Comparison of Urine and Hair Assay
Outcomes by Race
Pinellas County, Florida

CSAT Needs Assessment Study
Analysis by Hair and Urine Testing

- 291 urinalyses and 30 hair tests [illegible] subset of 436 arrestees
- Only categorical [illegible] results reported
- Only 2 African Americans were [illegible]
- 29 Caucasian were [illegible]

African American tested [illegible] [illegible] of [illegible] the [illegible] Caucasian

CSAT Needs Assessment Study

Lucaine	% Urine (+)	% Hair (+)
African American	51.8	[illegible]
Caucasian	25.9	48.4

[illegible]

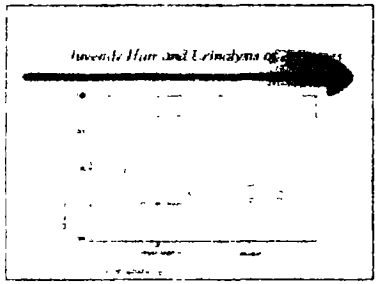
[illegible] Hair Assays and [illegible]

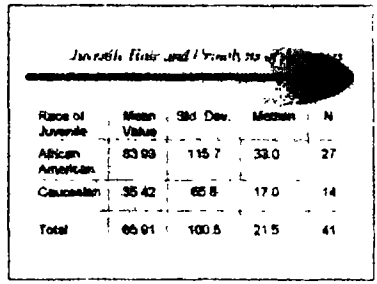
Comparison of Urine and Hair
Assays for Juvenile Arrestees in
Pinellas County and Cleveland

[illegible]

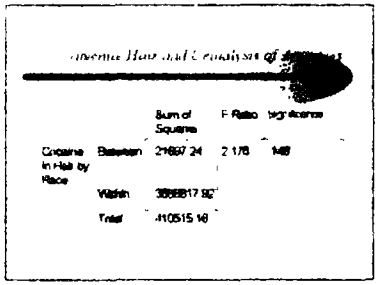
	% African American	% Caucasian	Ratio
Urine (+)	21.3	2.6	8.2
Hair (+)	54.5	5	8.5

[illegible]

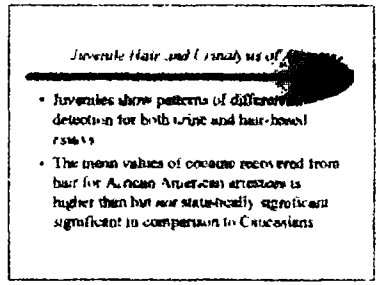




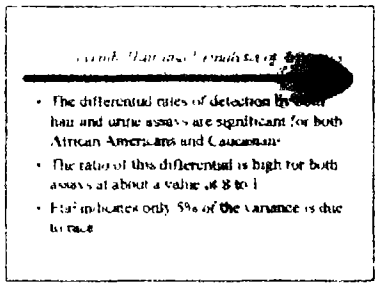
Race of Juvenile	Mean Value	Std. Dev.	Median	N
African American	83.99	115.7	33.0	27
Caucasian	35.42	65.8	17.0	14
Total	66.91	100.5	21.5	41



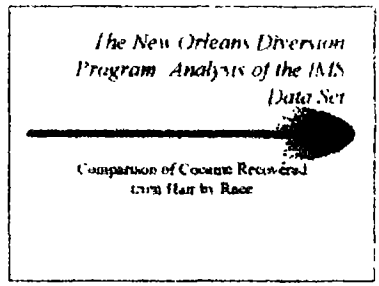
		Sum of Squares	F Ratio	Significance
Cocaine in Hair by Race	Between	21697.24	2.178	.148
	Within	3956817.92		
	Total	4110515.16		



- Juveniles show patterns of differential detection for both urine and hair-based assays
- The mean values of cocaine recovered from hair for African American arrestees is higher than but *not* statistically significant significant in comparison to Caucasians



- The differential rates of detection in hair and urine assays are significant for both African Americans and Caucasians
- The ratio of this differential is high for both assays at about a value of 8 to 1
- Hair indicates only 5% of the variance is due to race



The New Orleans Diversion Program Analysis of the IMS Data Set

Comparison of Cocaine Recovered from Hair by Race

The New Orleans Diversion Program

- This analysis is based on 189 persons who constituted the study group of a recently completed 2 year project
- These persons were subjected to cocaine use and hair assays [illegible] the addition of the use of an IMS for purposes of identifying exposure to illicit drugs

The New Orleans Diversion Program

- 124 African Americans, 63 Caucasians, [illegible] Hispanic, and 1 Asian comprise this group
- There were 7 Caucasians and 20 African Americans who had positive hair assays
- Caucasians had a higher mean value for cocaine in hair
- Caucasians: 207.57 ng/10 mg; African Americans: 90.20 ng/10 mg

The New Orleans Diversion Program

The New Orleans Diversion Program

The New Orleans Diversion Program

Recovering Ecstacy From Hair

The Glasgow Study

National Household Survey on Drug Abuse
Race Ethnicity, SES and Drug Abuse

"The term 'race/ethnicity' represents the categorical distinctions between states of non-Hispanic origin, Black or non-Hispanic origin, those with Hispanic ethnic origin (any race), and those of other races. Not all individuals fall neatly into a single category, and there is enormous ethnic diversity within categories concerns over the accuracy, and for some individuals the appropriateness of this racial/ethnic classification cannot be disregarded."

SARBIN, 1995

The National Institute on Drug Abuse
Drug Use Among Racial/Ethnic Minorities

"The definition of 'race' varies from survey to survey. According to Statistical Policy Directive No. 15 the basic racial categories are American Indian/Alaskan Native, Asian/Pacific Islander, African American, and White. The directive identifies Hispanic origin as an ethnicity. Persons of Hispanic origin can be of any race."

The Statistical Policy Directive
Abuse, 1997

[illegible]
[illegible]
Definition of Race

[illegible]

The National Institute on Drug Abuse
[illegible]
Definition of Race

"The concept of 'race' as used by the Census Bureau reflects self-identification; it does not denote any clear-cut scientific definition or biological stock. Therefore, the data for race represent self-classification by people according to the race with which they most closely identify."

National Institute on Drug Abuse
Multiple Survey Data

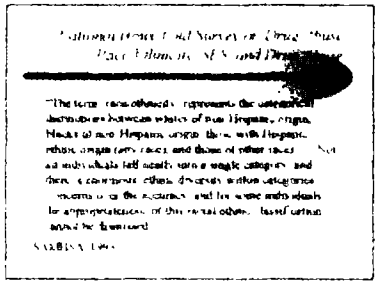
Use Cocaine in the Last 30 Days*

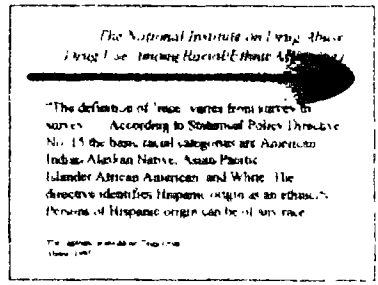
	18-25	26-34	35+
White	1.6%	0.9%	0.2%
Black	1.3%	1.8%	1.4%
Hispanic	2.1%	1.1%	0.7%

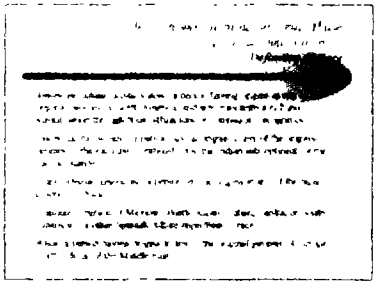
National Household Survey on Drug Abuse
[illegible]

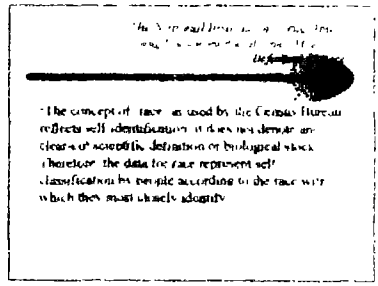
Use Cocaine at Least Monthly in the Past Year*

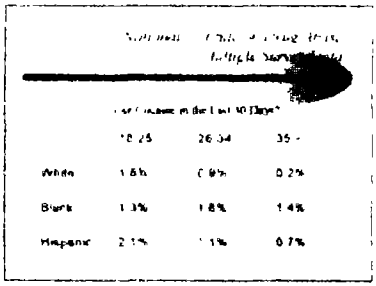
White	0.6%
Black	2.3%
Hispanic	1.6%

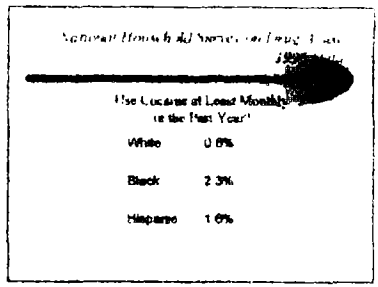


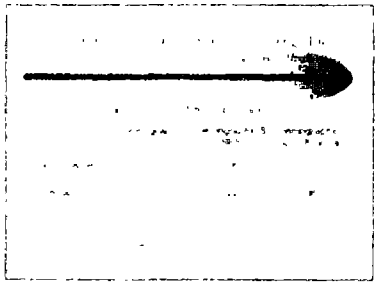


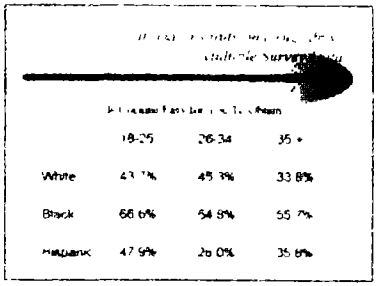




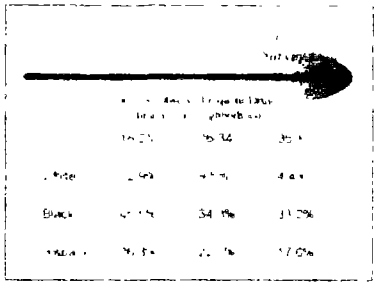








	18-25	26-34	35 +
White	43.7%	45.3%	33.8%
Black	66.6%	54.9%	55.7%
Hispanic	47.9%	26.0%	35.6%



Mr. BARR. Thank you, Dr. Mieczkowski.

Mr. Green, if you would please. You might summarize your statement and your full statement will be introduced for the record.

Mr. GREEN. Thank you. I'd like to share with you a perspective of the small business employer who has been doing drug testing for 12 years and has been involved in this area for approximately 16 years. We came to the issue in 1982 because of increased frequency of workers' compensation premiums and vehicle accidents. As a result of those increasing frequencies, we, in 1985 and 1986, developed a comprehensive drug and alcohol policy and combined that with an employee assistance program and commenced drug testing, conditional employment drug screens, random drug screens, at-fault drug screens on January 1, 1987.

I want to give you reasons why small business owners believe that it is beneficial to have such a program and they are as follows: First, there is a profit incentive. Most small business owners are focused on the bottom line. When we started this program in 1986, we were paying in excess of $252,000 annually for insurance premiums, workers' compensation, and auto liability. By 1991, we were paying $120,000 and, in 1998, we are paying $119,000 for our insurance premiums. The benefit to my company is in excess of $130,000 alone just in insurance premium savings. So one of the points I want to make is that there is a bottom line need and if you can communicate to small business owners, they can save money by doing drug testing, they will embrace it.

Second point, most small business owners are enablers. They enable the negative behaviors that we see and we have been talking about this morning to occur. And that is because most small businesses are focused on the short-term. Production and sales this week, this month, and this quarter, and they do not have a long-term perspective to put in place a drug and alcohol testing program and wait the 2 to 3, 4-year period to fully see the benefit in terms of reduced insurance premiums, higher productivity, and, as a result, the bottom line increased profitability to their companies.

Last point that I would make is that, by coming to put in place a drug-testing program and an employee-assistance program, fully one-third of all my employees that are currently with me have been through my program and I would rather have dealt with those people who are good, honest, hard-working people who unfortunately may be in an environment where they are subject to negative behaviors to give them the appropriate mechanism to get treatment, to get turned around in their life, and be subsequently effective employees for me. It's a benefit to me because it's cheaper for me to deal with their problem and to give them the appropriate counseling than it is to terminate them and then have to go out and to hire new people.

I just wanted to give you a small business owner's perspective. Thank you.

[The prepared statement of Mr. Green follows:]

"Parking Lot Specialists"

I come here this morning in support of an effort to implement a comprehensive drug and alcohol testing program. Such a plan could be a win/win solution for both the employee and employer (in this instance the U. S. Government.)

Having implemented a program at my firm more than 12 years ago, I can testify in detail that just such a system can significantly alter, for the good, the relationship between employer and employee.

Committing to, implementing and maintaining a comprehensive drug and alcohol testing program, linked to an employee assistance program, helps those persons who are afflicted by substance abuse, alcoholism and/or other social problems. Such a program is essential for the health, well-being and profitability of both a business organization and the individual--no matter if the company is a small business, a large Fortune 500 company or the U. S. Government. Both parties benefit from having an established, meaningful, effective program to prevent improper behaviors from occurring, while providing help for those people who, unfortunately, have problems.

At Chamberlain Contractors, Inc., we put a comprehensive drug and alcohol testing program in place in 1986. For us, the increased frequency of Worker's Comp.

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claims, vehicular accidents, lost productivity, high absenteeism and tardiness were all factors that were impacting the quality of the work that we were doing and the profitability that could be made on each job.

After educating our employees as to the benefits of installing a drug and alcohol program, we started to see substantial improvements in productivity, absenteeism and the quality of the work being executed. Soon thereafter, the profitability of the firm increased. Additionally, we were able to reduce our insurance premiums from a base of $252,000 in 1987 to just $120,000 by 1991. In fact, in the 1998/1999 calendar year, Chamberlain's insurance premiums are only $119,000--essentially flat for over eight years.

How the government benefits by putting a drug and alcohol testing program in place, is to be a more concerned employer who takes a more pro-active approach to their employees. Instead of waiting for an employee to fall and stumble after immersing him or herself in drugs or alcohol, by testing, you help prevent that negative behavior from overwhelming the individual, provide appropriate treatment, set standards of job performance, and eliminate drug and alcohol usage from an individual's life.

In small businesses, the reason why drug and alcohol use is prolific, is that most small business owners are entrepreneurs who focus their efforts on sales and

production issues. Their attention is to details associated with payroll, collections and production--today, this week, this month and this quarter. They do not plan for the long term success of their business or the health and welfare of their employees. They enable and reinforce negative behaviors. The end result is that the employees are there to work for a paycheck, which they subsequently use to fund their inappropriate behaviors.

By having the government take a stand, putting in place a comprehensive drug and alcohol testing program, coupled with an employee assistance program, to help address those negative behaviors and rehabilitate individuals, you will reduce your health care costs, you will reduce your insurance costs, you will increase your productivity and you will have a more loyal work force. It works the same, whether it be in private business or government.

My challenge to the Congress today is that you consider doing what most Fortune 500 companies and a small percentage of small businesses are already doing. Employees of the government should be tested like private business. Employees of the government have the same afflictions, are subjected to the same temptations and have the same problems, whether they be troubled adolescents, conflicts with a spouse or financial difficulties; all which can manifest themselves over time in drug and alcohol addiction problems.

At Chamberlain Contractors, we test on many levels: conditional employment drug screen with physical, random drug screen for 10% of the entire employee population monthly, at-fault accidents for both vehicular and Worker's Comp. claims, and for those individuals who are in safety sensitive positions. We also now use a retinal eye scan to test the responsiveness of the pupil to light and motion.

If government is interested in developing a drug and alcohol testing program, they can overcome the concerns relating to confidentiality.

It's time for the government to become a leader instead of a follower in the implementation of drug testing.

Small business owners/entrepreneurs are historically great enablers, enabling negative behaviors to be reinforced by the persons they employ. At Chamberlain Contractors, we oftentimes would get, "Do you have a minute?" or a given afternoon, which would turn into a $1,000 loan to prevent the individual's belongings being turned out on the street because he couldn't pay for in arrears rent. Of course, you always want to help your fellow man. Unfortunately, by doing so, you provide the fuel for the continuation of the negative behavior to occur. The following morning, the individual would not show up to work. He would have paid his drug dealer or purchased additional substances. He would, of course, have his belongings put out on the street. He would be back again borrowing money to get a new apartment. His

financial situation would be even more chaotic.

Don't let government be an enabler. Take a stand. Get involved.

i.e., Reference Kiplinger Newsletter - 6/1
Reference Nation's Business - June issue

other\talkondrugsandalcoholandcap

Mr. BARR. If I could, with unanimous consent, Mr. Green, just ask you one quick question.

Mr. GREEN. Yes, sir.

Mr. BARR. I was just reviewing your testimony here. You mention retinal eye scans.

Mr. GREEN. Yes, sir.

Mr. BARR. What are those used for?

Mr. GREEN. Basically, employees in safety sensitive positions, including tandem dump truck drivers that are driving around the beltway or heavy equipment operators that are operating heavy equipment in close proximity to employees. Those individuals, on a daily basis, do a 30 second test which is a performance measurement of the retinal eye. And what they do is we collect a data base of approximately 30 or 40 incidences of their daily eye performance and then subsequently it's in the computer and every morning, somebody comes in, they put in their Social Security number, it's a 15 or a 30 second test. It measures movement of the eye, responsiveness to it, and also responsiveness to light. And then that person is either given a fitness for duty, a card that says, green, go to work, or a referral to go see your supervisor to determine if there is a sleep deprivation issue, if there is a drug or alcohol abuse issue. It does not communicate what the problem is, it just makes the referral to the appropriate supervisor.

Mr. BARR. Interesting. Thank you.

Mr. Fortner, if you would like to summarize your statement and it will be submitted in full into the record.

Mr. FORTNER. Yes, sir. Good afternoon, Mr. Chairman, members of the subcommittee. In addition to my written testimony, which you have received, I'd like to point out that PharmChem is here today to review some of the tools that are available to the drug testing arena. PharmChem is the largest independent drug testing agency in the United States serving the U.S. Federal court system, in addition to supporting corporate America on its war on drugs.

I serve on the board of directors for the Institute for a Drug-Free Workplace and the American Probation and Parole Association and, certainly, in those roles, PharmChem supports any legislation that this subcommittee would develop that furthers the war on drug issue. I have taken the liberty to provide the members of the subcommittee with an information packet. Contained within that packet are some products that, back in 1996, I had the opportunity to testify again before this same subcommittee.

One of those products, and both of these are being used in corporate America, is commonly referred to as PharmChek or the sweat patch. This is a device that, at this point in time, as it was back in 1996, remains the only other alternative matrix testing process that has been reviewed and cleared by the Food and Drug Administration. Corporate America is using these, in addition to urine testing, because it provides a much longer window of detection for the presence of drugs. Typically it's an additional 1- to 2-week period, as that's the typical time period that the patch is worn.

It has some very unique properties in that it's tamper evident, it cannot be removed, but also can detect the presence of parent drugs which, as earlier alluded to, addresses one of the large issues

current in drug testing with respect to the analysis of urine samples for the presence of heroin use. It can detect parent heroin use as well the parent drugs of all the other matrices.

The other product that we developed and is an FDA-cleared process, pursuant to corporate America's request, is also contained in your packet and it's a rapid onsite testing device. It can test for anywhere from one to five different commonly abused classes of drugs. It goes by the trade name PharmScreen and is currently being used by many employers in the corporate workplace as a rapid onsite test.

Certainly those are testing procedures that are outside the auspices of the federally mandated testing, as that program, at this point in time, does not permit onsite testing. Positives are sent to a centralized lab for confirmation testing and it gives certain employers the ability to grant immediate access to workplace situations where a very rapid turnaround time is required.

Certainly PharmChem supports the Institute's model drug testing bill and PharmChem Laboratories would certainly make available any information and assistance that it can to assist this subcommittee as its efforts proceed forward on the war on drugs. Thank you, Mr. Chairman.

[The prepared statement of Mr. Fortner follows:]

STATEMENT ON

NEW TECHNOLOGIES FOR DRUG-ABUSE PREVENTION

before the

SUBCOMMITTEE ON NATIONAL SECURITY,
INTERNATIONAL AFFAIRS AND CRIMINAL JUSTICE
of the
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,

UNITED STATES HOUSE OF REPRESENTATIVES

PHARMCHEM LABORATORIES, INC.

Introduction and Overview of Position

Good morning, Mr. Chairman, and members of the Subcommittee. My name is Neil Fortner, and I am Vice President of Laboratory Operations for PharmChem Laboratories, Inc., which is headquartered in Menlo Park, California. I also serve as Scientific Director and oversee the laboratory operations of PharmChem's U.S.-based laboratories. I hold a B.S. and an M.S. in Biochemistry and am presently completing my Ph.D. in Neurochemistry.

I have published numerous scientific papers in the area of forensic toxicology and have provided expert testimony in more than 350 cases involving drug testing in all types of courts.

I am also a member of several scientific associations, including the American Academy of Forensic Sciences, the Society of Forensic Toxicologists, the American Board of Forensic Examiners, and the American Association of Clinical Chemists. I

am certified as an inspector for the National Laboratory Certification Program directed by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, as well as the College of American Pathologists' Forensic Urine Drug Testing Program. I also serve on the Board of Directors for the American Probation and Parole Association and the Institute for a Drug-Free Workplace, through which PharmChem supports corporate substance-abuse prevention efforts.

In that regard, I would like to express PharmChem's strong support for any legislative effort which you and this Subcommittee may undertake that would endorse and encourage responsible business efforts to eliminate substance abuse. I also commend to your attention the Institute for a Drug-Free Workplace's model drug-free workplace act, a bill which permits employers to utilize all appropriate technologies and procedures to detect drug abuse while also requiring a clear statement of the employee's anti-drug policy, drug-abuse education, and procedural safeguards to ensure the integrity and extensive testing safeguards to ensure the accuracy and fairness of the testing process.

Today, I would like to discuss an exciting development in the area of substance-abuse testing which has great potential for application in the workplace. PharmChem has developed, in conjunction with Sudormed, Inc., a product called the PharmChek™ sweat patch which is used to detect drugs of abuse excreted in sweat. Studies have shown that this product is not only highly effective at detecting drug abuse, but it also can be used in a manner which is significantly less invasive than

the more commonly used urine testing. The PharmChek™ sweat patch can be applied to a person's upper arm for a period of days during which time it collects drugs that are excreted along with the body's natural loss of moisture from the skin. The sweat patch is approved by the Food and Drug Administration of the U.S. Department of Agriculture and is capable of detecting five drugs of abuse.

The PharmChek™ sweat patch has performed well in several studies and as part of the federal probation and parole program. We are optimistic that it will prove to be a popular and effective tool for workplace substance-abuse detection and deterrence as well.

In addition, in response to the increased demand for on-site drug testing, PharmChem now offers the PharmScreen™ rapid test. The PharmScreen™ testing device has been incorporated into our full-service product line, further increasing the options available to drug-free workplace programs.

Thank you for providing PharmChem Laboratories this opportunity to present testimony to the Subcommittee. Mr. Chairman, I commend you for taking such an active role in the area of drug-abuse prevention, and I am pleased to have the opportunity to describe PharmChem's efforts in this area.

About PharmChem Laboratories, Inc.

PharmChem Laboratories, Inc., was founded in 1971 specifically because of a need for a facility that could detect and deter the use of illegal drugs and alcohol. Since that time, PharmChem has analyzed more than 20 million urine samples for drugs of abuse – 3.2 million in the last year alone – and urine testing continues to comprise the vast majority of the tests we perform. Today, PharmChem Laboratories has more than 300 employees and operates three fully licensed and certified laboratories: one in Menlo Park, California; one in Fort Worth, Texas; and one, operating under the name MedScreen, in London. We serve more than 1500 customers in all 50 states and several foreign countries. Among our customers are the federal Departments of the Interior, State, and Energy, as well as more than 40 other federal government departments or bureaus. PharmChem performs tests for most drugs of abuse, including cocaine, marijuana, methamphetamines, opiates, PCP, and alcohol.

In addition, PharmChem prides itself on its customized, integrated customer services which are designed to support customers in developing and maintaining cost-effective drug-testing programs. In that regard, we offer a range of drug-testing products and services, including urinalysis laboratory testing, a sweat patch drug test, and a new on-site urine drug screen.

PharmChem has pioneered many of the most important innovations in forensic drug testing.

In the 1970s, PharmChem was the first laboratory to apply strict chain-of-custody procedures to criminal justice and drug-treatment testing.

In the 1980s, PharmChem applied those procedures to workplace drug testing and developed the detailed testing procedures that were validated by the U.S. Supreme Court in its landmark decision National Treasury Employees Union v. Von Raab, 489 U.S. 656, 109 S. Ct. 1384, 103 L. Ed. 2d 685 (1989). In 1988, those procedures were incorporated into the regulations adopted by the U.S. Department of Health and Human Services for all federal workplace drug testing.

In the 1990s, PharmChem has developed the PharmChek™ sweat patch drug-detection system. The PharmChek™ sweat patch allows drugs and alcohol to be detected for a more substantial period than is available using urine testing, is much less invasive of employee privacy than urine testing, and is more cost-effective. In addition, PharmChem has recently added the PharmScreen™ on-site rapid drug test, which provides almost instant results to employers in time-sensitive industries.

Design and Operation of the PharmChek™ Sweat patch

Researchers discovered some time ago that drugs a person ingests are later excreted in that person's sweat. By capturing sweat over a period of time, therefore, scientists can learn whether an individual recently has ingested an illicit drug or alcohol. PharmChem, in conjunction with Sudormed, Inc., a medical device company, developed a practical way to capture sweat for testing. Known as the PharmChek™

sweat patch, this device works by collecting non-volatile components of sweat, which includes drugs of abuse.

The patch looks like a two-inch by three-inch bandage, and consists of an adhesive plastic film that holds an absorbent pad in place against the skin. The patch is manufactured by 3M and uses technology and adhesives similar to their widely used wound dressings.

The adhesive portion of the patch is a semi-permeable barrier that allows oxygen, carbon dioxide, and water vapor to pass through so that the skin underneath can breathe normally. Larger molecules (such as drugs) are trapped in the absorbent pad portion of the patch. The patch is carefully designed so that contaminants from the environment cannot penetrate the adhesive barrier from the outside, and therefore the patch can be worn during most normal activities (bathing and swimming, for example) without affecting the integrity of the test.

The patch collects two distinct types of sweat. "Sensible perspiration" is the active, controlled loss of sweat from specific glands in the skin, which typically occurs when a person is physically active. "Insensible perspiration" is the passive, uncontrolled loss of sweat which occurs regardless of whether a person is physically active. Because people typically produce 300 - 700 milliliters of insensible sweat each day, from all over the body, the absorbent pad in the patch can be expected to trap the analytes from at least 2 milliliters of sweat per week. Sensible perspiration only adds to the amount of sweat collected.

The patch is typically worn on the upper outer arm, or on the lower midriff. It should be worn for a minimum of 24 hours to ensure that a adequate amount of sweat is collected, but may be worn for a period of up to two weeks. The skin where the patch is to be worn is cleaned with an alcohol wipe prior to application. Studies of the patch in use indicate that the adhesive used in PharmChek™ is very well-tolerated; it is very uncommon for individuals to have any skin sensitivity to the patch.

The patch is tamper-evident, and each patch is imprinted with a unique number to aid in chain-of-custody and identification. After the patch is removed, the absorbent pad is removed from the patch and sent to PharmChem Laboratories to be tested for drugs of abuse. Clinical studies have shown that drugs and drug metabolites on the pad are stable for days at room temperature and months in the freezer, obviating the need for highly specialized and expensive packaging or shipping.

Once the pad is received at PharmChem, any drugs present are washed from it into a liquid extraction solvent. The liquid is then tested using immunoassays similar to those used in testing urine samples. The liquid is tested for five specific drugs: cocaine, opiates, amphetamines, PCP, and marijuana. Positive immunoassay results are confirmed by gas chromatography/mass spectrometry (GC/MS)

Improvement Over Urine Testing for Drugs of Abuse

The PharmChek™ sweat patch provides several distinct advantages over urine testing:

1. Less Intrusive.

The sweat collection process generally is perceived to be less invasive than collection of urine samples. For example, in studies of sweat patches used on individuals' upper arms, no effort was made to ensure that same-sex laboratory personnel applied or removed the patch. Nevertheless, no participant objected to having members of the opposite sex perform these procedures.

2. Longer Detection Period

Urine testing typically can detect only that drug use which has occurred within the 12-to-72 hours previous to specimen collection. In contrast, a sweat patch worn for up to a week is capable of detecting drugs of abuse used just before and during that entire time period. Therefore, the window of detection can be considerably longer for the sweat patch than is the window for urine testing.

This extended period improves detection. In a study of the patch conducted in a prison setting (the Michigan Department of Corrections study, which I discuss in greater detail later in this testimony), the patch was 39% more effective at detecting drug use than was urine testing, even though the urine testing was conducted roughly three times as often as was sweat-patch testing.

3. More Precise Test Results.

The molecules of the actual "parent" drug, as well as the drug's metabolites, can be collected and identified in sweat. Urine tests, by contrast, typically detect only a drug's metabolites. The detection of the parent drug is particularly useful in

distinguishing between the use of heroin and the use of other products containing opiates which may be legally prescribed.

In urine, heroin typically is detected by the presence of morphine, a metabolite. Also present in urine, for a very few hours, is a chemical known as 6-AM, or 6-acetylmorphine, which is unique to heroin. It is very difficult to "trap" 6-AM in a urine test so as to be absolutely sure that the drug consumed was heroin, rather than another, possibly legal, opiate derivative. When the PharmChek™ patch is used, heroin molecules themselves are trapped, as well as 6-AM, eliminating the possibility that codeine, poppy seeds, or other opiate molecules are responsible for the positive test. Therefore, the PharmChek™ sweat patch is likely to be considerably more accurate and economical in identifying heroin abusers than is urine testing. This is particularly significant because heroin use has, unfortunately, increased in recent years, and is projected to continue to increase in the near future.

4. More Difficult to Adulterate.

While individuals can attempt to beat urine testing by consuming large amounts of fluid in an attempt to "flush" their systems, sweat is not susceptible to such adulteration efforts and therefore may be more accurate in that there will be fewer "false negative" tests.

5. Added Value As A Deterrent.

Last, the sweat patch is particularly useful in a rehabilitation setting, as it may act as a deterrent to drug use during the period in which it is worn. While it is possible that so-called "casual" drug users will be able to discontinue the use of illicit

drugs during the time the patch is being worn, such a deterrent effect is to be desired, and is one of the primary benefits of corporate substance-abuse testing programs at any rate.

Pilot Program: Michigan Department of Corrections

In December 1994 PharmChem conducted an extensive study of the efficacy of the PharmChek™ sweat patch in conjunction with the Michigan Department of Corrections' criminal justice program. The project sought to compare the positive rates of sweat patches and urine specimens, determine the durability of the patch in use, determine the ease of patch application and removal, and determine the acceptance of the patch by both prisoners and corrections staff. The results of the study were extremely positive.

The PharmChek™ patches were applied to the study participants for either seven or 14 days. After removal, the pads inside the patches were shipped to PharmChem for analysis. Once the pad had been flushed with fluid and screened for the presence of drugs, initial positive results were confirmed using gas chromatography/mass spectrometry (GC/MS).

Intensive urine testing was conducted concurrent with the sweat-patch testing with each individual submitting a sample approximately once every three days. The cutoff levels used to determine positive results using urine samples were those approved by the Substance Abuse and Mental Health Services Administration for federal workplace programs. Cutoff levels for drugs found in sweat are considerably

lower because of the limited amount of fluid available for testing. Urine samples collected two days before the application of the sweat patch, during patch wear, and two days after the patch was removed were correlated to the patch's results for analysis.

The results of the study were instructive: the sweat patch detected 39 percent more drug users than did urine testing, even when the data was *not* adjusted for the fact that almost *three times* the number of urine specimens were collected. In total, 140 patches from 95 subjects were screened and confirmed positive for drug use, representing a 9 percent positive rate. By contrast, only 104 urine specimens from 69 subjects were confirmed positive, representing a 6.5 percent positive rate.

The patch detected more than four times as many cocaine users than were detected through urine testing. A total of 5.8 percent of the subjects tested with the patch were positive for cocaine, while 1.4 percent of the subjects' urine specimens were positive for cocaine. While the patch detected about the same number of opiate users as urine testing, the patch test provided confirmation of heroin use by more than 60 percent of the positive subjects. Two patches were positive for amphetamines; no urine specimens were positive for amphetamines.

Finally, while patch testing was three times less effective in detecting marijuana use in the program, the test technology for THC (the psychoactive ingredient in marijuana) detection has since been significantly modified to compensate based on analysis of the data.

The study also demonstrated that the patches may be worn effectively. In 85 percent of the cases in which wear data was reported on the chain-of-custody form, the patch was worn without discomfort or problems with detachment. However, in some high-security facilities prisoners were more likely to refuse to wear the patches, and those prisoners had a greater incidence of the patch "falling off" than those prisoners who were participating in a work-release program.

Additional Studies and Supporting Research

As noted earlier, the Food and Drug Administration of the United States Department of Agriculture has approved the sweat patch for purposes of testing for cocaine, opiates (including heroin), amphetamines (including methamphetamines), PCP (phencyclidine), and THC (marijuana).

The PharmChek™ sweat patch drug test also has been studied in a number of different clinical settings. For example, comparative studies of urine testing versus sweat patch testing were initiated at the United States Probation Office and the United States Pretrial Service Office for the Central District of California, and at the California State Department of Corrections, Parole, and Community Services Division.

In addition, a number of researchers have performed their own experiments using the sweat patch. For example, Dr. Edward J. Cone, Chief of the Chemistry and Drug Metabolism Section at the Addiction Research Center of the National Institute on Drug Abuse, and his colleagues have performed extensive research on the ability of

the sweat patch to detect heroin and cocaine and their metabolites. They demonstrated that concentrations of cocaine in sweat rise in apparent relation to the size of the administered dose. They also confirmed that heroin is excreted in sweat, as is 6-acetylmorphine, the metabolite specific to heroin. Dr. Cone concluded that testing individuals for illicit drugs with sweat patches worn continually for a week could provide effective coverage for detection of any abuse of illicit drugs.

Dr. Marilyn Huestis, Division of Intramural Research, NIDA/NIH is currently involved in a study on the cognitive effects of chronic long-term marijuana use, which utilizes the PharmChek™ sweat patch.

In addition, scholarly articles on the PharmChek™ sweat patch have been published by researchers Marcelline Burns of the Southern California Research Institute and Randall C. Baselt of the Chemical Toxicology Institute regarding the effectiveness of sweat patch testing for detecting cocaine use; by Vina Speihler of Speihler & Associates and John Fay of STC Diagnostics, and their colleagues, regarding the use of immunoassay procedures to detect drugs of abuse in sweat; and by Pascal Kintz, Antoine Tracqui, Carole Jamey, and Patrice Mangin of the Institute de Medecine Legal in Strasbourg, France, who have published the results of a study finding that codeine and phenobarbital (a barbiturate) use can be detected accurately using the PharmChek™ sweat patch.

Court Challenges

Of course, individuals who test positive for illicit drugs using the PharmChek™ sweat patch often seek to defend themselves by challenging the validity of the test itself. Since its introduction, the sweat patch has been challenged – unsuccessfully – in 14 separate proceedings. Six of those cases were brought in U.S. District Courts as part of probation proceedings; the other proceedings were brought in state court in a variety of circumstances, including family court proceedings.

Of particular note are several cases challenging the admissibility of sweat patch test results as evidence, on the ground that the methodology was too new or too unreliable to be considered in a court of law. In *every* such case the courts have recognized that the PharmChek™ sweat patch has been accepted by the scientific community, and upheld the validity of the tests.

The sweat patch is an exciting technology, and its use and application is only just beginning to be understood. PharmChem envisions that the sweat patch will emerge as a highly desirable method of detecting illicit drug abuse in the workplace.

Ongoing Research

A number of other drug-detection programs are using PharmChek™ technology in their environment. A notable example is the Federal Corrections and Supervision Division of the United States Courts. This agency is responsible for pre- and post-trial supervision of arrests in the federal justice system, and has conducted pilot studies in eleven different judicial districts across the country. Based upon its demonstrated utility, the technique has been made available to all 94 districts for use in their drug-testing programs.

PharmChem's Newest Product: PharmScreen™

In response to customer needs for on-site testing devices capable of rapidly determining whether an individual has used illegal drugs, PharmChem has introduced PharmScreen.™ The PharmScreen™ on-site testing device is capable of detecting five classes of drugs – amphetamines, cocaine, morphine, marijuana, and phencyclidine – in urine.

PharmScreen™ tests can be performed at the collection site with results available in as little as three minutes after the time the test is exposed to the sample. The test requires no mixing, no addition of external reagents, and no refrigeration. Moreover, each PharmScreen™ test has its own built-in control. The control test is visible as a colored line indicating that the specimen was properly applied to the testing device.

PharmScreen™ tests also are easy to read and interpret. If the specimen is negative for drugs, a distinct line will appear in the test area. If the sample is positive for drugs, no line will appear. The results are so distinct they can be photocopied for a permanent record. Any positive test result is then sent to PharmChem's laboratory for confirmation using GC/MS.

PharmChem is the only SAMHSA-certified laboratory that has its own FDA-cleared on-site testing device. The PharmScreen™ test has a chain-of-custody document unique to it, and PharmScreen™ has been incorporated into PharmChem's centralized laboratory testing services. PharmChem is proud to support employers and others in their efforts to detect and deter illegal drug use with its full-service state-of-the-art testing services and is commited to on-going development and technical advances in this arena.

Conclusion

PharmChem appreciates this opportunity to testify before the Subcommittee on National Security, International Affairs and Criminal Justice regarding its efforts to assist in the detection and deterrence of illicit drug use, and in particular regarding its scientific and technical success, the PharmChek™ sweat patch. We are confident that the sweat patch will prove to be a useful tool, particularly for employers who seek to eliminate substance abuse through detection, deterrence, and rehabilitation.

We commend you, Mr. Chairman, for your attention to this critical issue and support your efforts to ensure that the employer community continues its

commendable efforts to create incentives for employees to get and stay off drugs. In this regard, PharmChem would be happy to assist the Subcommittee in any appropriate manner in its consideration of legislation affecting workplace substance abuse prevention programs, emerging technologies for detection of substance abuse, and employers' legitimate and necessary role in addressing drug abuse prevention.

Mr. BARR. Thank you, Mr. Fortner.

Ms. Kibben, if you would summarize your statement and it will be submitted in full for the record, please.

Ms. KIBBEN. I'd like to thank the chairman, the ranking member, and the subcommittee for inviting me on behalf of the National Association of Alcoholism and Drug Abuse Counselors [NAADAC] to provide our insight on these important issues of drug testing and drug treatment. We're very pleased to be given this opportunity.

NAADAC is the largest national organization representing the interests of alcoholism and drug abuse counselors across the United States. NAADAC supports the implementation of workplace policies and procedures for drug testing, assessing, treating, and supervising employees suffering from alcoholism and drug addiction. We believe the purpose of testing should be to identify employees with alcoholism or drug addiction and enter them into treatment for the diagnosed disease. We do not endorse treatment—excuse me, we do not endorse testing used for punitive measures.

More than 70 percent of the people who currently use illicit drugs as well as 75 percent of those who are alcoholics are employed. NAADAC acknowledges that the recovering employee, once appropriate assistance has been offered, must be held responsible and accountable for his or her recovery. Records show that thousands of employees have returned successfully to their jobs after treatment. The airline industry has returned hundreds of pilots to their positions following successful treatment and testing regimes required by the FAA. This model is so successful that United Airlines estimated it receives $16.95 returned for every $1 invested in a drug-free workplace program.

Indeed, scientific research has greatly improved our understanding of the chronic diseases of alcoholism and drug addiction. Addiction, defined by Dr. Allen Leshner, the director of the National Institute on Drug Abuse, is a disorder that alters the brain's metabolic activity, receptor availability, gene expression, and other physiological aspects of a person's brain.

A recently released General Accounting Office [GAO] study offers very strong recent analysis of treatment's effectiveness. We're encouraged by the GAO's review, which notes that even conservative evidence of treatment effectiveness, substantiated by urine tests, show that 71 percent of crack cocaine users and 83 percent of opiate users in a treatment test sample had not used drugs in the month prior to the followup screening. As the study states, "consistent evidence shows drug treatment is beneficial."

Thanks to continued research, we know that addiction treatment is similar to other chronic diseases such as hypertension, diabetes, and asthma. Much like treatments for diabetes and hypertension, addiction treatment requires compliance with a treatment protocol that includes major behavioral and lifestyle changes and, often, medication. The previously mentioned GAO study shows that addiction treatment has compiled a record of effectiveness that compares favorably with treatment for other chronic diseases. Less than 50 percent of people with diabetes and fewer than 30 percent of hypertension or asthma patients complied fully with their treatment regime. Similarly, 40 percent of addiction treatment patients fully comply with their treatment regime. Despite treatments'

strong record, only one in four people who need treatment receive it.

Given the red light, I'm going to skip to the end and say, in conclusion, a drug testing program must include an assessment and treatment component. And we too are very strong proponents for the parity issue that was referenced earlier by Representative Souder. Ramstad's bill will ensure adequate insurance coverage for treatment for employees and improves the health, safety, and welfare of America's work force and their families. NAADAC is eager to work with the subcommittee to develop policies that encourage the provision for appropriate, professional and effective and safe treatment of America's workers.

Once again, thank you for inviting me and NAADAC. We look forward to working with Chairman Hastert, Representative Barrett, and the subcommittee on these important issues.

[The prepared statement of Ms. Kibben follows:]

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Statement for the Record

on behalf of
THE NATIONAL ASSOCIATION OF ALCOHOLISM AND DRUG ABUSE COUNSELORS

on
"Cutting Edge Issues in Drug Testing and Drug Treatment"

House Government Reform and Oversight Committee's Subcommittee on National Security, International Affairs and Criminal Justice

Hearing Held on June 5, 1998

Thank you for inviting the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) to testify. We are very pleased to be given this opportunity. On behalf NAADAC, please accept the following comments regarding current drug testing and drug treatment. NAADAC, with 17,000 members, is the largest national organization representing the interests of alcoholism and drug abuse treatment and prevention professionals across the United States.

NAADAC supports the implementation of workplace policies and procedures for testing, assessing, treating and supervising employees suffering from alcoholism and drug addiction. Appropriate workplace assessment and testing which leads to treatment will combat addiction and save individuals' lives, restore families, and improve communities. These policies can be used as a part of the requirements to meet drug free workplace standards. NAADAC also supports, where appropriate, training in such policies and procedures for appropriate personnel as well as fitness for duty exams.

One of the most important aspects of a drug screening policy is its intent. We do not endorse testing used for punitive measures. The purpose of testing should be to identify employees with alcoholism or drug addiction and enter them into treatment and help them return to full productivity in their job. Positive screens should be accompanied by a thorough assessment by a qualified practitioner. We further endorse the referral of the identified employee to a certified/licensed drug abuse counselor when treatment is deemed appropriate. Also, we believe there should be adequate insurance coverage for an employee to receive the appropriate level of treatment.

NAADAC contends that identification, referral to appropriate treatment and follow-up of employees to be a joint responsibility shared by the employee, employer and professional treatment resources for a period of no less than two years. In addition, NAADAC acknowledges that the recovering employees, once appropriate assistance has been offered, must be held responsible and accountable for his/her recovery and all behaviors before and after treatment.

NAADAC makes the following endorsements regarding the use of drug testing in the workplace:

A clear written policy should be in place and communicated to all employees prior to the implementation of drug screens. It should include but not be limited to the reason for the policy, chain of custody measures, method of obtaining a urine, hair, or blood sample, confidentiality, confirmation, due process and consequences. It is recommended all employees (labor, management, et.al.) be subject to the policy and drug screens.

The most recent study on drug abuse in the workplace showed that alcohol abuse accounted for more than 67.7 billion in lost productivity in 1992. Clearly employers must address alcohol related problems along with the problems of illegal drugs. An effective drug screen program must include blood tests and/or breathalizer test to detect alcohol, as alcohol remains the number one drug of abuse. Any screening process should have the capability of identifying all drugs of potential abuse. Note that hair tests, despite their ability to test for illicit drugs, are unable to identify individuals who are abusing alcohol or are alcoholic.

To reiterate, an employer's drug testing policy MUST include assessment and treatment components. Without them, the policy is simply costly and ineffectual in rehabilitating and restoring a company's most valuable assets, its people, to full productivity.

Records show that thousands of employees have been returned successfully to often critical jobs following, screening, assessment, and treatment. Among these efforts is the highly respected airline industry's alcohol-rehabilitation program run by the Federal Aviation Administration. In effect since 1973, the airline industry has returned hundreds of pilots to full function recovering members of the aviation community. Similar success has been accomplished by the military with pilots, and ship captains and with nuclear industry personnel, and others in sensitive positions. Also, studies by medical organizations report similar outcomes. These outcomes are due to important achievements on the part of the scientific and treatment communities.

First, scientific research of alcoholism and drug addiction has greatly improved our understanding of these disorders. Addiction, defined by Dr. Alan Leshner, Director of the National Institute on Drug Abuse, is a chronic brain disorder, that alters persons brain cells' physiology. In his words, "The addicted brain is distinctly different from the nonaddicted brain, as manifested by changes in brain metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues... addiction is tied to changes in brain structure and function...fundamentally, [it is] a brain disease."

Prolonged use of drugs brings about the symptoms of persistent drug and alcohol seeking and use, even if that search and use causes other detrimental health and social consequences in the addict's life. As a chronic recurring disease, addiction's symptoms and treatment can be most properly compared to similar diseases, such as hypertension, diabetes and asthma. Much like treatments for diabetes and hypertension, addiction treatment requires compliance with a treatment protocol that includes major behavioral and lifestyle changes, and often, medication.

What follows from our enhanced understanding of the diseases of alcoholism and drug addiction is the development of a body of knowledge and consistent clinical improvements in the provision

of effective alcoholism and drug addiction treatment. In the past thirty years, the effectiveness of treatment, when provided by certified/licensed professional counselors, has been proven by scientific research and clinical studies.

The recently released General Accounting Office (GAO) study concerning treatment's effectiveness offers very strong, recent analysis of treatment's effectiveness. The GAO's review cites that even conservative estimates of treatment effectiveness, substantiated by urine tests, prove that 71.3% of cocaine/crack users and 83.3% of opiate users in a treatment test sample had not used drugs in the month prior to the follow-up screening. As the study states, "consistent evidence shows drug treatment is beneficial."

NIDA's recently released, Drug Abuse Treatment Outcome Study (DATOS) corroborates earlier findings that treatment is effective. Methadone treatment was found to reduce heroin use by 70% by the conclusion of the three-year study. Treatment also resulted in 50% reductions in weekly or more frequent cocaine use at a one-year follow up interview.

Last year's National Treatment Improvement Evaluation Study (NTIES) found that treatment clients' use of their primary drug declined by 48.2%. More specifically, NTIES also found that treatment reduced crack use by 50.8% and cocaine use by 54.9%. In addition, treatment reduced marijuana use by 42%-57% depending upon the other drug(s) of abuse for which the patient was also being treated.

Parkside Medical Services Corporation's 1991 study of treatment patients found abstinence rates of 57% and 62% recovery rates (abstinence with a single episode of use) two years following treatment.

NIDA's 1988 study, The Effectiveness of Drug Abuse Treatment, found that, 5 years after beginning methadone treatment, the number of former opiate abusers who were no longer using had grown to 92% of the original test group. The study also found that the number of daily opiate users in therapeutic community treatment was reduced from 52% to 29% after 90 days in treatment.

Of 10,000 treatment admissions in the Treatment Outcome Prospective Study (TOPS), in 10 cities in 1979, 1980, and 1981, abstinence rates for drugs other than marijuana ranged from 40%-50%. With regard to alcoholism, the TOPS study concluded that:

- During treatment, the proportion of clients reporting alcohol problems decreased by 46%, particularly among residential clients.
- Over 50% of the clients showed substantial reductions in alcohol use during treatment as compared to use prior to treatment.

NIH's Drug Abuse Reporting Program (DARP), conducted from 1968-1989, included 44,000 clients entering 50 treatment programs in the United States. Subsets of the original test group were studied 6, and again 12 years after their initial interviews. Within the test group, the study found that:

- Daily drug and alcohol use dropped 63% in the first year of treatment, and continued to decline throughout the rest of the testing years. (Testing years included yrs. 1,2,3,6, and

12)

- The treatment needed for substance relapse dropped as low as 31% by the 12th year interviews.
- Treatment reduced the importance of "Sensation-seeking", one of the main reasons for drug use, from 87% to 20%.

These statistics are promising in light of the treatment success rates the scientific and medical community documents for other chronic diseases such as diabetes, hypertension, and asthma.

- Fewer than 50% of sufferers from insulin dependent diabetes are compliant with their medication regimen
- Only 30% are compliant with diet and foot care.
- 30% or fewer of people with medication dependent hypertension or adult asthma are compliant with their treatment protocols.

(see McLellan, A. Thomas, *Is Drug Dependence A Medical Illness?*, March 1998)

Treatment has not only been proven to greatly reduce levels of substance use, it also causes positive trends in many other aspects of the lives of the patients as well as the community-at-large. Both DARP and TOPS concluded that treatment reduced the chances of relapse, reduced criminal activity, and (according to TOPS) improved productivity.

The NTIES study found treatment brought about:

- a decrease in the crime rate (from 64% to 14%)
- a decrease in workers sick days,
- a 50% reduction in risky sexual behaviors,
- a 53% reduction in physical and mental health hospital visits.

Treatment is also cost effective, reducing other medical care utilization and health costs as well as federal government expenditures on the public health/entitlement system. One study, *Socioeconomic Evaluations of Addictions Treatment*, conducted by Rutgers University found that:

- On the average, untreated alcoholics incur general health care costs at least 100% higher than those of non-alcoholics.
- After addiction treatment, days lost to illness, sickness claims and hospitalization droppec by 50%.

Another study carried out by the California Department of Alcohol and Drug Programs, *The California Drug and Alcohol Treatment Assessment* (CALDATA) reported that treatment brought about:

- a 17% increase in health status and significant decreases in health care utilization after treatment.
- drug overdose hospitalization reductions of 58%,
- mental health hospitalization reductions of 44%,
- emergency room visit reductions of 38%.

Despite treatment's strong record, only one in four people who need treatment, receive it. Almost all employee insurance plans do not cover alcoholism and drug addiction services to the

same extent as other medical services. The need for improved access to treatment among America's workers is undeniable.

Every year, as many as 20 million Americans, more than 11% of the population, experience difficulties resulting from alcohol or drug addiction. The vast majority of people who experience alcoholism or drug addiction problems are employed at a full time job. More than 70% of people who currently use illicit drugs, as well as 75% of individuals who are alcoholics, are employed.

For these reasons, NAADAC makes its strongest recommendation for the inclusion of parity in a drug testing policy. A parity law will greatly improve employer provided insurance policies to ensure that alcoholism and drug addiction are covered to the same extent as other similar chronic diseases such as diabetes and hypertension. Parity will maximize fair access for America's working families to treatment - our most effective weapon in the battle against addiction - without placing a mandate upon employers. Under parity, employer health plans set the same aggregate limits on lifetime and annual dollar caps on alcohol and drug addiction coverage as they set for medical and surgical services. Parity applies to deductibles, co-payments and treatment limits on visits.

Most employer provided insurance policies today discriminate against alcoholism or drug addiction. According to the Bureau of Labor Statistics, in 1995, roughly 80% of employees working for medium and large employers have health plans that cover some level of detoxification/treatment for these diseases. However, fewer than 7% of these employer provided health plans covered alcoholism and drug addiction treatment to the same extent as other medical conditions. Employees' plans that do cover treatment, requiring greater patient burden for cost sharing, copayment, and deductibles, while offering less coverage for number of visits or days of coverage and annual/lifetime dollar expenditure limits for treatment. For example, a typical insurance plan might cap lifetime medical benefits at $1,000,000. The same plan might cap substance abuse treatment lifetime benefits at only $25,000 or $5,000.

NAADAC is aware of concerns that health care costs under such a plan may rise. However, The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, conducted by Mathematica Policy Research, Inc. and released in March, 1998, projected 0.2% cost increases based upon data from states which have enacted parity for mental health and substance abuse treatment. Another study, conducted by the actuarial firm of Milliman and Robertson, found that composite cost increases for employer provided plans would amount to only 0.5%. Given the seriousness of the diseases of alcoholism and drug addiction, and the minimal costs of implementation, parity is affordable.

In its analysis of employers in states with parity laws, the Mathematica study found that employers, when permitted to do so, did not eliminate their coverage to avoid parity requirements. In addition, the study found that, "Employers have not attempted to avoid parity laws by becoming self-insured." In fact, the study investigators found little evidence of any attempts to avoid parity. Study informants cited the low costs of parity as a reason for not changing their employee health insurance package. Companies continue to provide alcoholism and drug addiction treatment coverage because treatment helps employees return to full productivity and it is affordable. In addition, the study found that employers do not pass on the

minimal cost increases resulting from parity to employees. The low costs of adopting parity allows employers to keep employee healthcare contributions at the same level they were before parity."

Parity can also include business safeguards. One current parity proposal exempts health plans if the cost of a group health plan will increase by 1% or more due to this provision. In addition, small employers (employers of 50 people or less) would be exempt from the parity requirements. It should be noted that in state parity laws which had small employer exemptions, small employers usually selected benefit packages subject to parity because costs increases were nominal and parity benefits better served their employees. Also, with parity, their health plans were more competitive with other employers.

The current system of discriminatory and limited coverage for alcoholism and drug addiction is a tremendous drain on national and employers' resources. A new study released by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) found that the total costs of alcohol and drug abuse was $246 billion in 1992. By comparison, diabetes cost $137.1 billion, or 17% less than alcoholism, in 1992. Heart disease cost $125.8 billion, or 24% less than alcoholism, in 1991 and cancer cost $96.1, or 42% less than alcoholism, in 1990. Clearly, addiction to alcohol and drugs is the nation's most expensive health problem when untreated. Alcoholism and drug addiction treatment with trained, certified professionals is a proven, effective tool in reducing the costs of alcohol and drug use.

In conclusion, a drug testing program must include an assessment and treatment component. Ensuring adequate coverage of treatment for employees improves the health, safety and welfare of America's workforce and their families. It enhances a sense of security for all employees and makes for better relations with management. In addition, it improves morale between employees and employers.

NAADAC is eager to work with the subcommittee to develop policies that encourage the provision of appropriate, professional, effective and safe treatment to America's workers. If you have any questions regarding the work of our association or our position on the issues of drug testing and treatment effectiveness, please call Linda Kaplan, Executive Director, or Bill McColl, Associate Executive Director of Policy and Government Relations at 703/741-7686.

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Mr. BARR. Thank you, Ms. Kibben.

Dr. Kidwell, if you would please summarize your statement and it will be submitted into the record in full.

Dr. KIDWELL. Thank you, Mr. Chairman. It's a privilege to speak with you and the committee today.

For the past 13 years, the Naval Research Laboratory has been evaluating hair analysis as an adjunct to a replacement for urine analysis, detecting and deterring illicit drug use. This presentation summarizes some of the research findings that we and others have made in this area.

Early on in our research effort, we uncovered a number of concerns about hair testing that called into question some proposed scientific hypotheses. These concerns focused on three broad areas: low-use detection, that is, detection of a single use of a drug or a drug taken in minute dosages, such as LSD; passive exposure, that is, being falsely accused of drug use for merely working or living around drugs; and racial bias, that is that not all hair absorbs and retains drugs equally well, which can raise issues on fairness in testing.

I would like to delve into each of these three areas in more detail. The first area of concern is false accusation of drug use due to passive exposure. We devoted considerable effort in the late 1980's to establish the mechanism of drug incorporation into hair. We proposed that some or all of the drugs in hair originated from sweat. The proportion of drugs coming from sweat has great importance because drugs may be in sweat for two reasons: one, a drug user may ingest drugs and the drugs appear in sweat or, two, a non-drug-using individual may come in contact with sufficient quantities of drugs to contaminate his or her sweat. The contaminated sweat then leads to being falsely accused of being a drug user by a hair test some days after the contamination event.

We conducted many hundreds of laboratory experiments that show that drugs are absorbed into hair from dilute solutions of drugs in as little as 5 minutes and, once present, will not completely wash out. These experiments were so successful that many laboratories now prepare hair standards by similar procedures, hair standards that, for all intents and purposes, are indistinguishable from the hair of real drug users. An analogy for hair may be a concrete block wall, solid-looking, but permeable to the outside as anyone with a leaking basement may attest.

In two separate studies, we illustrated that passive exposure can occur under realistic conditions by examining the hair of children living with cocaine-using mothers. Our first study produced such unexpected results that we repeated it with a second group of subjects. In both studies, the children had similar cocaine levels in their hair as did the drug-using mothers. Furthermore, no cutoff level could be proposed to differentiate the non-using children from the drug-using mothers. An independent study by Louis, et al., found similar results. The children in an exposed environment show positive hair tests. Anecdotal evidence indicates that passive exposure can occur in employment situations as well, especially where drug exposure and sweating occur together.

The second area of concern that I want to amplify on is racial bias or matrix bias. Through our laboratory experiments we quick-

ly demonstrated that different hair types absorb and retain drugs in widely varying amounts, up to 27 times more in one hair type over another. African-American hair tends to retain and absorb drugs more readily than Caucasian or Asian hair and the differences do not appear to be related only to the melanin content. These invitro differences in drug absorption and retention by hair types have been replicated in a number of independent laboratories.

Differences among hair types have been seen in a number of animal studies in Japan and at the University of Utah. They've also been encountered in controlled administrations of cocaine to humans in studies at both UC Davis and the NIDA Addiction Research Center. In the controlled human studies, concentration variations up to fivefold have been measured for the same cocaine dosages. Because larger concentrations of drugs are easier to detect, African-Americans may be more readily identified as drug users compared to other groups. This is especially true and important at the lower-use rate that occurs in the employed and recreational drug users.

Finally, the third area of concern is low-use detection. One application of hair analysis is as an adjunct to urinalysis, to assess if a urine positive was accidental or a one-time use. Alternatively, hair analysis could be used to refute a urinalysis positive. Unfortunately, in both scenarios, hair analysis would need to have the same sensitivity as urinalysis for the detection of single or low drug use.

For our research, we have monitored the hair of individuals in drug rehabilitation and failed to detect cocaine in 58 percent of the individuals at the positive cutoff levels where commercial laboratories make their decisions. Likewise, in an early Navy study conducted by a commercial laboratory, only 23 percent of the patients in drug rehabilitation for cocaine were detected as positive by hair testing.

These studies are not alone. Henderson, Harkey, and Jones have administered single doses of labeled cocaine to addicts. In only 4 out of 26 cases, were the levels above commercial positive cutoff levels, even though the doses administered were 2 to 3 times typical street doses. These four positives just happened to be non-Caucasians. Baumgartner has estimated that one would need to ingest at least 264 milligrams of cocaine per month to be positive by hair analysis. Thus, recreational drug use of a few times per month would likely be undetectable by hair analysis, especially for certain hair types.

In summary, hair analysis for drugs of use have several areas that need further research regarding low-use detection, passive exposure, and racial bias before the promises of hair testing can be more fully realized. Thank you for your time.

[The prepared statement of Dr. Kidwell follows:]

Unresolved Issues in Hair Analysis for Drugs of Abuse
Summary of Research

For the past 13 years the Naval Research Laboratory has been evaluating hair analysis as an adjunct to or replacement for urinalysis in detecting and deterring illicit drug use. This presentation summarizes some of the research findings that we and others have made in this area. For more extensive discussions on our findings, I have attached leading references to the written record to document the summaries that I am presenting today.

Early on in our research effort we uncovered a number of concerns about hair testing that called into question some proposed scientific hypothesis. These concerns focused on three broad areas: (1) Low use detection. Detection of a single use of a drug or a drug taken in minute dosages, such as LSD. (2) Passive exposure. Being falsely accused of drug use for merely working or living around drugs. (3) Racial bias. Not all hair absorbs and retains drugs equally well which can raise fairness issues in testing.

I would like to delve into each of these three areas in more detail.

Low use detection:

One use of hair analysis is as an adjunct to urinalysis to assess if a urine positive was accidental use or a one-time use. Alternatively, hair analysis could be used to refute a urinalysis positive. Unfortunately, in both scenarios hair analysis would need to have the same sensitivity as urinalysis in detection of single or low drug use. For our research, we have monitored the hair of individuals in drug rehabilitation and have failed to detect cocaine in 58% of the individuals at the positive levels where the commercial hair analysis laboratories make

their cut-off. Likewise, in an early Navy study conducted by a commercial laboratory, only 23% of the Navy individuals in drug rehabilitation were detected as positive by hair testing for cocaine. These studies are not alone. Henderson, Harkey, and Jones have administered single doses of labeled cocaine to addicts. In only 4 out of 26 cases the levels were above commercial positive cut-off levels. These 4 positives were non-Caucasians. Baumgartner has estimated that one would need to ingest at least 264 mg/month of cocaine to be positive by hair analysis. Thus, recreational drug use of a few times per week or per month will likely be undetectable, especially for certain hair types.

False accusation of drug use due to passive exposure:

We devoted considerable effort in the late 1980s to establish the mechanism of drug incorporation into hair. We proposed that some or all of the drugs in hair originated from sweat. The proportion of drugs coming from sweat has great importance because drugs may be in sweat for two reasons: (1) A drug user may ingest drugs and the drugs appear in sweat, or (2) A non-drug using individual may come in contact with sufficient quantities of drugs and contaminate his/her sweat. The contaminated sweat then leads to being falsely accused of being a drug user by a hair test some days after the contamination event. We conducted many hundreds of laboratory experiments that showed that drugs are absorbed into hair from dilute solutions in as little as five minutes and once present will not completely wash out. These experiments were so successful that many laboratories now prepare hair standards by similar procedures - hair standards that for all intents and purposes are indistinguishable from the hair of real drug users. An analogy for hair may be a concrete block wall - solid looking but permeable to water as any one with a leaking basement may attest.

In two separate studies, we illustrated that passive exposure can occur under realistic conditions by examining the hair of children living with cocaine using mothers. Our first study produced such unexpected results that we repeated it with a second group of subjects. In both studies the children had similar cocaine levels in their hair, as did their drug-using mothers. Furthermore, no cut-off level could be proposed to differentiate the non-using children from the drug-using mothers. An independent study by Lewis *et al.* found similar results, those children in an exposed environment show positive hair tests. Anecdotal evidence indicates that passive exposure can occur in employment situations as well, especially where drug exposure and sweating both occur.

Passive exposure can easily be demonstrated in laboratory settings and apparently can happen in some real-life situations as well.

Racial or Matrix Bias:

In our laboratory experiments, we quickly demonstrated that different hair types absorb and retain drugs in widely varying amounts, up to 27 times more between different hair types. African American hair tends to retain and absorb drugs more readily than Caucasian or Asian hair and the differences do not appear to be related only to the melanin content. These *in vitro* differences in drug absorption and retention by hair types have been replicated in several laboratories.

In vivo differences among hair types have been seen in a number of animal studies in Japan and at the University of Utah. They have also been encountered in controlled administrations of cocaine to humans in studies at both UC-Davis and the NIDA Addiction Research Center. In

the controlled human studies, concentration variations of up to 5 fold have been measured for the same dosage of cocaine. Because larger concentrations of drugs in hair are easier to detect, African Americans may be more readily identified as drug users compared to other groups. This is especially true at the lower use rate that occurs in the employed and recreational drug users.

Conclusions

In summary, hair analysis for drugs of abuse has several areas that need further research regarding low use detection, passive exposure, and racial bias before the promises of hair testing can be more fully realized.

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Mr. BARR. Thank you, Dr. Kidwell. I'd like at this time to recognize for a first round of questions the gentleman from Wisconsin, Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Barr. Dr. Kidwell, I asked this question of Dr. DuPont, so it's only fair to ask of you: Do you have any financial interests or ties to any form of testing——

Dr. KIDWELL. None at all.

Mr. BARRETT. Any contracts with any urine——

Dr. KIDWELL. No. I work only for the Federal Government.

Mr. BARRETT. I just want to make sure—Mr. Mieczkowski, do you have any financial ties?

Mr. MIECZKOWSKI. No.

Mr. BARRETT. OK. Just again, I wanted to, for the record, have that out there.

Doctor, I'd ask you to respond to Dr. Kidwell, please.

Mr. MIECZKOWSKI. Yes. I'm in quite profound disagreement with Dr. Kidwell's interpretation of this data and I think a very detailed response to his critiques may be beyond the scope of today's hearing. I would point out several important things. First of all, we have attempted to replicate these phenomena such as racial bias in the real world. The research that Dr. Kidwell is referring to is primarily based on prolonged soaking of cocaine—of hair in cocaine solutions, which have questionable value in terms of their application in clinical settings.

It's also important that you keep in mind that the conclusions reached in many of the studies that Dr. Kidwell's referred to—and they really primarily come from only two other researchers, the team of Henderson and Harkey at UC Davis and the research of Ed Cone at the NIDA Addiction Research Center in Baltimore, have often failed to produce, by our—the clinical standards we applied, for instance, in our New Orleans program or in Ellis County epidemiology program, to produce a single positive over the entire course of the research project.

For instance, the Henderson and Harkey data, based on 32 subjects producing well in excess of 400 hair segments, not a single segment would ever be considered a positive. That's because the doses which were given to these individuals were very minimal. That's understandable. That's because these experiments are controlled, of course, by human subjects concerns and you don't give massive doses of drugs to individuals for the purposes of research. But the doses which were given to these individuals were on the order of magnitude of one-fiftieth, perhaps one-two hundredth of what we see in typical drug abusers. So it's very difficult to project these findings onto what you see in the real world. And keep in mind that my research base is primarily criminal justice, where I see, you know, persons who are in extraordinary levels of addiction.

I also have very major reservations about the use of the term race in this entire discussion. For a number of years now I have tried to point out to individuals who use this term in their analysis that, if you look at, for instance, the American Academy of Physical Anthropology, you will see there's a consensus that the biological meaning of race is unknown. Clearly it—I'm not going to take a position here which violates our common sense. Race is a powerful socio-cultural concept. But when you start to talk about identifying

race with biological markers such as racial hair types, I have major reservations. I don't think that there's any scientific literature, for instance, that would sustain the fact that you could make racial distinctions looking at hair types, with any kind of reliability based on any kind of chemical testing.

Mr. BARRETT. Let me pause, have you stop there, because I want to get back to Dr. Kidwell on that very point. The concern I have with your statement, Doctor, is, if the tests—if we do have a lot of false tests—false positives with people who are clearly African-American or Asian, that raises some questions and maybe I'd ask Dr. Kidwell at this point to just elaborate a little bit on what you have found there.

Dr. KIDWELL. About false positives?

Mr. BARRETT. Yes; with African-Americans, for example, or maybe just——

Dr. KIDWELL. I'm not saying the hair test generates false positives, I'm saying it's easier to detect it in that hair type than it is in the Caucasian hair types.

Mr. BARRETT. OK.

Dr. KIDWELL. And certainly the best studies are the controlled dosage studies and we're most concerned with low-level use, not the high-level use in the criminal justice system. Certainly if everybody takes whopping amounts of drugs, it doesn't matter that African-Americans tend to have more in their hair than Caucasians. If they're whopping amounts, it's very easy to detect it in all hair types. It's only when the use is very low that you see this difference between hair types.

Mr. BARRETT. You're saying for low-level users, it shows up more often——

Dr. KIDWELL. It would be easier to detect in certain hair types, which just happen to be African-American.

Mr. BARRETT. OK. Let me switch gears. Ms. Kibben, we've heard a lot of criticism here on Capitol Hill about treatment; that treatment's just a bunch of do-gooders and isn't effective. Could you respond from your experience as to where treatment fits in all of this?

Ms. KIBBEN. Yes. I think it's very clear through a number of different sources that I've cited in the testimony about how we have evidence that treatment does work and is effective. Now, it may not, in fact, be that we have—it depends on how we're defining effective. It may not be that we have 100 percent abstinence, but even the NTIES report, the National Treatment Improvement and Evaluation Study done last year, showed just one outpatient visit with some very chronic, severe cases showed an increase in advantageous, you know, like they've reduced their use, they reduce their criminal activity, and they reduce their—they increase their work time. All of that was shown out of just one outpatient visit.

So we do know that treatment effectiveness is directly correlated to the length and appropriateness of treatment placement. So I think in—and relevant to the drug testing is that drug testing can be a very helpful tool in extending the treatment plan and having a mechanism to intervene later on, let alone early on.

Mr. BARRETT. And, Mr. Green, if I—say I were working for you and I tested positive for a drug, what would happen?

Mr. GREEN. And you're currently employed in my firm, sir?

Mr. BARRETT. Yes.

Mr. GREEN. Basically, once you had met with the medical review officer and you would have met with Stosch, our EAP provider, he would come back and make a recommendation to us in terms of an appropriate program, whether you would require an outpatient, inpatient program, if he felt that it was a, you know, aberration and it would never happen again. And so we basically rely upon the experts, which would be the employee assistance program specialist to make a recommendation. We then sit down with the individual, we outline various steps that the EAP provider would communicate to us, and then we would have that person sign an agreement. We would also increase the frequency, then, of followup drug screens for a period of time and that, again, is dependent on what Stosch, the EAP provider, would communicate.

So the point is that we, as owners of the business, remove ourselves from the process of passing judgment and attempting to provide appropriate sentence or treatment and really refer to the professionals and all we're there to do is to provide a certain standard and to be a help for the employee to return to full service.

Mr. BARRETT. If there was a second occurrence, would you be helped then or does it——

Mr. GREEN. Again, there's a specific set of rules——

Mr. BARRETT. OK.

Mr. GREEN [continuing]. And policies that govern it, but, usually at that time, and I can give you an instance when that did occur and the individual then had a difficult choice to whether to continue employment or to go into an inpatient program and he elected to go into an inpatient program and we paid for that cost and continued his pay during that treatment program for 20 days.

Mr. BARRETT. Do you think you're unusual in that regard?

Mr. GREEN. Yes, sir.

Mr. BARRETT. OK. It sounds like you are. Thank you very much.

Mr. BARR. Thank you. The gentleman from Indiana, Mr. Souder, is recognized for 5 minutes.

Mr. SOUDER. I wanted to followup with Dr. Mieczkowski and Dr. Kidwell. You had a fascinating discussion going there. Let me see if I understood. I think you said that there were two studies and you were referring to the Harkey study that said 42 subjects, they were not abusers, there were minimal controlled levels in that survey. Does that roughly——

Mr. MIECZKOWSKI. No, this is a controlled-dose study that was done between 1990–1993 under the sponsorship of NIJ in which 32 recruited subjects were given doses of cocaine either ranging at something like six-tenths of a milligram per kilogram of body weight or 1.2 milligrams per kilogram. Some of the subjects were given dosages by nasal insufflation. They were sprayed up their nose with a Dristan-type of device or, in a few cases, the subjects were injected with the cocaine.

Mr. SOUDER. And you said there was a second—you said that the data that's in dispute based on two——

Mr. MIECZKOWSKI. Well, there is also a second—a followup to that which was recently published in which the control group was derived from this 1990 study and then a mixed-race group of indi-

viduals was—nine individuals—were also given controlled doses and then these two groups were compared. In this case, the control groups were Caucasians, ostensibly Caucasians, selected from the 1990 to 1993 data set.

Mr. SOUDER. So that, if indeed, and I want to ask you this follow-up on the race question, if indeed it were true that in this study there were racial differences, it's based on nine cases?

Mr. MIECZKOWSKI. Yes. And let me—I feel compelled that I need to clarify this further. Keep in mind that in these studies, first of all, you have a racial division which is, in some cases, considered as nothing more than Caucasian-non-Caucasian. So everyone who's not Caucasian becomes non-Caucasian. This often includes Hispanics, for instance. If you look at the U.S. Census Bureau, you find that the definition of being Hispanic is an ethnic definition which specifically states in Federal guidelines, "can be of any racial group."

Sc from a statistics point of view, from an analysis point of view, to be folding these categories together and then making allegations that these individuals stand for racial groups is just not appropriate data analysis. In fact, in the 1998 Henderson and Harkey article, which ostensibly supports the notion there's a racial distinction between the Caucasians and non-Caucasians, if you take out the two Hispanic subjects, which leaves behind, I believe, three African-Americans and two African-Caucasians—they have a somewhat more elaborate scheme—the significance disappears.

So all of the variance is due to two cases and it's difficult for me, as an epidemiologist, because epidemiologists like big data sets. I mean, we think there's lots of variability in the world and the way you get around problems of variability is you look at lots of cases. And so for people to promulgate what I think of as, you know, a rather outrageous use of the term race on the basis of this kind of data is troubling to me.

For instance, the characterization of hair types, even in Dr. Kidwell's work. You look at the work he's presented or published. He talks about Korean hair and Italian hair and Romanian hair. Now what scientific basis is there for these kinds of distinctions? There's no laboratory in the world that can say, I can identify Italian hair. Yet these things appear in graphs that are used to purport to show racial bias.

It seems to me that if you're serious about looking at the issues of bias and hair, if you look at the issue of hair color, first of all, which is divorced from race entirely. Second, if you want to look at hair color, you develop a precise scientific method for measuring hair color. Color can be measured in terms of wavelengths of light. But even if you look at hair color ratient assessments in these studies that purport to do racial basis, you say, well, how did you categorize the hair? Well, we looked at it and some was brown and some was black. And, in fact, in the Cone article, what's interesting is every African-American has black hair. None of these studies ever found an African-American who has brown hair or red hair.

So, you know, on what basis are these distinctions being made? I find this to be very troubling. And, especially given that race is such a sensitive issue in our society, that it, you know, it's some-

thing that you ignite and then it becomes a truism. And, unfortunately, from my point of view, this is exactly what has happened.

We have shown with our data on a very large data set that from a patterning point of view, we simply cannot find differential detection rates between hair in humans. In fact, in most of our assessments on cases which number anywhere from 1,000 to 2,000, we find that there's actually worse differential detection by urinalysis. That, if you want to simply say that, given a large population of persons that, if you detect more by system A than B, that's an indicator of bias, then, in fact, what we find in our populations is that African-Americans are more likely to be urine-positive at a greater rate compared to their self-report than hair-positive.

Mr. SOUDER. Dr. Kidwell, obviously, you've raised a subject that is so inflammatory here, partly because of the differences we had in punishments on types of cocaine, a general feeling that none of us want to inadvertently lock up people of one background and not another when the abuse level is the same, because you've clearly said it's not a matter that they aren't abusing it; the question is, in your opinion, would we detect it at lower levels among African-Americans which could result in more lock-ups, more job loss for a particular group of people?

We've heard his extended explanation, then, that, in fact, it may be down to a couple cases here. Are there other studies? Do you disagree with the analysis there, and would you comment?

Dr. KIDWELL. There are a few other studies, but you're correct, the controlled studies, which are the best studies we can possibly do scientifically, are by their very nature on a few people. It just so happens that in the Henderson-Harkey's the non-Caucasian individuals, and they just happened to be Hispanic and Asian in that particular group that I'm familiar with, were the ones that were positive above the commercial cutoff level.

Now this issue of racial bias is a very contentious one and to try to establish guidelines or to try to understand it better, I am cochairing, with Dr. Baumgartner, a workshop on racial bias. And in that workshop—it'll be in October at a Society of Forensic Toxicology meeting—we're trying to first explore is racial bias real? And, second, if it's real, is there a way to solve it?

I believe there's a way to solve it. I don't have any scientific evidence that I can solve the problem or that the problem can be normalized, but I believe that there is potentially procedures out there that could remove the problem with racial bias in hair testing.

Mr. SOUDER. Mr. Chairman, could I ask one followup? I got really confused for a second. Did I understand you——

Mr. BARR. The gentleman is recognized for 1 additional minute to remove any confusion.

Mr. SOUDER. Did you say that if you took the Hispanic and Asians out——

Dr. KIDWELL. No, no. In the study that I'm familiar with Henderson-Harkey, the Hispanic and Asians were the only ones that were caught. They were the highest level.

Mr. SOUDER. Then how did you make the statement that African-Americans were testing that way?

Dr. KIDWELL. This is a further study by Ed Cone at the NIDA Addiction Research Center which has not been published. So it's more like a private communication.

Mr. SOUDER. At some point I'd like Dr. Mieczkowski's comments on that, if you're familiar. Thanks.

Mr. BARR. I thank the gentleman from Indiana. The gentleman from Florida, Mr. Mica's recognized for 5 minutes.

Mr. MICA. Thank you, Mr. Chairman. A couple of questions, if I may. Ms. Kibben. I guess in your testimony or you have also devocated by your association, you want—you would like alcohol included in any kind of testing program?

Ms. KIBBEN. Well, we do believe that alcohol is the most widely used drug problem in America with the condition of addiction that we're considering. And we know that alcohol is a hard one to test for.

Mr. MICA. It's also a legal substance. What would be your position if we, as a Congress, said that anyone who receives Federal compensation or a Federal employee must first submit to a drug test and would not be eligible for employment or compensation if they tested positive?

Ms. KIBBEN. And we're talking, now, testing positive for illegal, illicit——

Mr. MICA. Yes; right.

Ms. KIBBEN. OK. You know, I believe that that is a deterrent and I think that's a step in the right direction. I don't have anything against, for pre-employment or post-employment condition of employment, the use of drug testing. I think drug testing can be a very effective tool to intervene. My only point of—well, perhaps not my only point—my strongest point of contention with it is when it's independent of any treatment services, or independent from anything other than a way of using it in the whole scope of providing services.

As, I think it was Dr. Macdonald, earlier said that it can be an effective way to raise the bottom, it also can be up to the employee about whether they apply for the job or whether they seek treatment, whatever it is. But the absolute concrete evidence about whether addiction—I mean, whether an illicit substance has been used can be a very helpful tool.

Mr. MICA. The other position I guess you've taken is that—or your association has taken—that if you're employed and you are subject to either mandatory or random testing, that it not be used in a punitive fashion that there be some treatment. Is that correct?

Ms. KIBBEN. Yes; that's correct.

Mr. MICA. Do you think that's the obligation of public and private employers?

Ms. KIBBEN. Well, I can tell you that what I've seen, that works with the clients I've worked with—and I'm thinking particularly of physicians and nurses that have a random drug testing as a part of their ongoing continuing care plan—it is by far one of the best measures to get them back into recovery, if they're, you know, heading toward relapse.

I also find that most of them, also, do not knock on my door and say, oh, gee, it's a nice day to get sober. I think I'll get help today. And when they have a positive drug test that they have to answer

to, most of the times, they will come in and they will have their excuses. But when we get down to it and get through the dishonesty, that test can often be the measure of the door—actually the door opening, for them to have a turnaround in their life.

Mr. MICA. Dr. Mieczkowski, I think I read in your testimony—correct me if I've got it confused with another one. I've been reading through testimony rather than hearing it—that you said that cocaine and heroin are better detected—and they're pretty tough drugs, heroin and cocaine—that you said, I think, that they're better detected because of the nature of the chemicals or whatever with the hair analysis? Was that you or——

Mr. MIECZKOWSKI. Yes. I—certainly that's contained in my statement. It may be contained in the statement of others, Mr. Mica. And that's a time function, as came up in the first panel. That is not a quality function of testing. It's just that these drugs in urine and plasma relatively rapidly disappear or fall below detectable levels and, consequently, their persistence in hair means that hair affords the opportunity to detect these drugs for a longer time period.

Mr. MICA. There seems to be some reluctance, however, I guess. It appears to me some of this is vendor-driven and we've got another individual here—is it Fortner—who's got a different—this sweat patch. Maybe you could comment, is there legitimate reason why we shouldn't be going more to hair testing or some other alternatives? Is some of the opposition vendor-driven? What is your opinion of what's going on in the marketplace? And, then, the Federal Government's paying a lot of money for testing, and others are. What's happening?

Mr. MIECZKOWSKI. Well, I'm a university professor, so I'm not necessarily very savvy in the business world. I know that, my personal view, is that we ought not to restrict the capability of people who need and want to test and have a legitimate reason to test for drugs. That any particular tool, all of these tools, it seems to me, have appropriate and useful applications. So I don't think we need to think of them as pitted against one another or preferring one over the other. If I could make a primitive analogy, it's sort of on the golf course. You know, you use a pitching wedge to do one kind of shot, you use a driver to do another. These tests ought to be thought of as different kinds of tools.

I think the most impressive program in the country, if you really want to examine this in action, is to take a look at the New Orleans adult diversion program run by Mr. Harry Connick where we do not only urine and hair analysis, we now do ion mobility spectrometry analysis on individuals looking for particulate matter on them. So if they're selling drugs, they become drug-contaminated. And what we do is we provide to the clinicians in that program who have to sit across the table from this person and deal with them, this capability of now bringing together many different kinds of instruments.

So, in my view, I think we ought not, you know, we certainly are justified in moving forward, again, provided that, of course, as we would expect with any kind of drug testing with any matrix, that it be done responsibly, that it be done competently. And I would, you know, my urging, if I were to have an editorial moment, is that

we need the help of the Federal Government to cut through the morass of arguing, to set some reasonable and credible standards for us, help us in this process of finding a useful and responsible way to apply this so that we preclude charlatans and other people who may enter the field because it's unregulated and, you know, help us in this endeavor and I think that that helps in some small way to further the Government's aim of reducing drug use, of enhancing treatment. And I can speak from the treatment side, in terms of clinical staff, greatly enhance the morale of staff people who have these tools available to them and doing a very difficult job of counseling and trying to help people with drug abuse problems.

Mr. BARR. Thank you, doctor.

Mr. MICA. Mr. Chairman, I'm not confused but I'd like to be enlightened. Would it be possible to have Mr. Fortner, who I——

Mr. BARR. Why don't—if the gentleman would suspend, we can have a quick second round.

Mr. MICA. OK. Thank you.

Mr. BARR. Mr. Green is sort of the representative from private industry here sort of on the receiving end where the rubber hits the road, so to speak, of this problem. Is it your concern whether you have somebody who is a low-level drug user, a mid-level drug user, or a high-level drug user, or is your concern that you don't have drug users of whatever level working in your company and endangering people?

Mr. GREEN. Zero tolerance, sir. Basically, at my firm, the entire program now is actually managed by our employees and they themselves ask for a zero-base tolerance in terms of drug usage or alcohol abuse. And so I think any drug use, whether it be even recreational on the weekend is still not a behavior that we would allow to occur and many of these guys are working 50, 60, 70 hours a week and so, just because you may be smoking pot or doing cocaine on Saturday evening, you still are possibly under the influence of those residual drugs Monday morning at 6:30 and if you are operating a piece of equipment, you can injure individuals. And I've had many instances, unfortunately, where my employees have been injured by another employee because of drug use, even though they were not doing drugs at the time.

Mr. BARR. And would it be fair to say that, as an employer, the drug identification program and the treatment programs that you have are not in any way racially biased or targeted? Your interest, whether it's an employee with dark hair or light hair or light skin or dark skin or a lot of hair like yourself or a little bit like myself or Dr. Mieczkowski here, that—[laughter.]

And, regardless of whether or not one type of analysis may detect higher or lower levels would not really be your concern as long as it is a uniform program that does not discriminate in its application to anybody?

Mr. GREEN. That is correct and we do have African-Americans, Latinos, you know, Caucasians, men, women, you know, in a company of 65 people and they are all subject to the same rules of employment and I've never had one employee in the 12 years that we've had our program in place file any sort of discrimination ac-

tion or complaint about what we are doing. They themselves actually run the entire program now.

Mr. BARR. I think that's—with all due respect to everybody else—probably the most important perspective that we can have on this. And I appreciate it.

I'd asked you earlier about the retinal eye exam which, from the standpoint of the intrusiveness of the different types of detection procedures that we're talking about here, anything from a blood sample to a urine sample to a hair sample to a retinal eye exam, the retinal eye exam would be the least intrusive, it would seem. Given that, if I could turn to the two doctors anchoring the ends of our panel here, beginning with you, Dr. Mieczkowski, are you familiar with the retinal eye exam that Mr. Green talked briefly about and whether it has some applicability as a very, very unobtrusive testing mechanism?

Mr. MIECZKOWSKI. No, I'm not, Mr.—I mean, I'm aware it exists and I've heard of it, but I really have no expertise or knowledge I could show that you wanted.

Mr. BARR. Thank you. Dr. Kidwell, are you familiar with it? Is it something that is really being looked at in terms of drug testing?

Dr. KIDWELL. No, again, I'm aware it exists, but that's all.

Mr. BARR. OK. Hopefully we'll see more on that.

Mr. GREEN. Mr. Chairman, if I could just add one point is that, you know, the retinal eye scan is being used at the Federal level. I believe at the FAA and it also is being used in the military and through your rail system, from the people that I am associating with.

Mr. BARR. Is it that it would not—would it indicate directly drug usage or the symptoms of possible drug——

Mr. GREEN. All it is, it would provide a symptom, whether it be drugs or alcohol, as was communicated here. Or it could be an issue of sleep deprivation. What it is measuring is job performance and if you are not up to performing a given task, whether it be working around a piece of heavy equipment or driving a tandem dump truck around the Washington Beltway, you should not be in that position. And so it does not communicate whether you are doing drugs, alcohol, or sleep deprived. It just says you are not fit for duty.

Mr. BARR. Do the results depend on whether you have blue eyes or green eyes or brown eyes?

Mr. GREEN. No, sir. There is no racial bias associated with it.

Mr. BARR. Maybe something that really has a great deal more hope if we can sort of get something that is objective like that and nonintrusive.

Mr. GREEN. I've used it now for 4½, almost 5 years and it is a good screening mechanism. And I offer you to go on out to my office and see it in use.

Mr. BARR. Well, we might do that and if you have some material on that, it would be very helpful for us to look at if you could submit that.

Mr. GREEN. I will be glad to get that information for you, sir.

[The information referred to follows:]

FIT®

The Employee Safety Screener

It's wise man who stays home when he's drunk.
Euripides, *The Cyclops* (c. 425 B.C.)

The strongest have their moments of fatigue.
Nietzsche, *The Will to Power* (1888)

66% of Aviation Accidents
95% of Highway Accidents
50% - 95% of Industrial Accidents
Accidents due to Human Error,
Government Statistics (1994)

Introduction

On a daily basis, impaired workers injure themselves, damage equipment and products, contribute to low productivity, poor quality and morale. This is costing companies billions of dollars.

Since the early 1900's companies have spent 100's of millions of dollars improving safety and productivity. The primary focus has been on training, tools/equipment and procedures/processes.

However, government statistics demonstrate that certain risk factors are associated with accidents and errors. Drugs, such as marijuana, cocaine, opiates, amphetamines, as well as fatigue (sleepiness), are similarly cited as increasing the risk of accidents and errors. Hence, individuals under the influence of one or more of these factors are potentially people of "high risk". Not just high risk of catastrophic accidents, but high risk of causing equipment damage, lost time and poor work quality.

Government regulators, industry and labor have endeavored to reduce the incidents of impaired workers. Strict hours-of-service and other work rules attempt to decrease worker fatigue. Random testing for alcohol and other drugs identifies some abusers. In spite of these efforts, many workplace accidents and performance errors continue to occur. Performance impairment, regardless of its cause, is a significant contributor to unsafe behavior and reduced quality in the workplace.

These concerns have led to a growing interest in "fitness-for-duty" testing. Such testing, usually done at the beginning of a shift, screens for workers that are at "high risk". This has created a need for a reliable and economical way to identify on a real-time basis, in a non-invasive manner, employees of "high risk".

The FIT® System

FIT is the first system specifically designed for the workplace as a practical tool that reduces the risk of accidents and errors by screening for the "current" presence of factors that can cause an employee to be "high risk".

The FIT is a self-administered, user friendly product. The subject simply looks into a view port and follows a lighted target for approximately 30 seconds. The non-invasive test is completely safe and causes no discomfort. The result, given as a simple *low risk* or *high risk,* is available immediately. The FIT can be used as part of a daily screening program, as part of a high frequency random screening program or as a"for cause" screener to actively manage the risk of impaired workers.

How Does the FIT Work?

Using a thirty second **self administered** test, the FIT employee screener compares **involuntary** eye reactions to an employee's own baseline. This brief eye test identifies changes in the central nervous system that result from the active influence of factors that can impair a person's **decision making, concentration,** and **motor skills.**

Baselines are a key part of the FIT operation. A baseline is established for each individual during the first week of testing. This baseline contains all the information necessary to compare a current reading to the expected range of responses for that individual.

The FIT measures a set of eye parameters and compares these to a set of baseline parameters for that individual. Based on this comparison, the FIT produces a *low risk* or *high risk* output. The FIT reliably produces a *low risk* output for people under normal conditions and a *high risk* output for people who are under the influence of specific risk factors such as alcohol, drugs or extreme sleepiness.

Validation

This new technology is the culmination of decades of pioneering work by cognitive, neurophysiological and pharmodynamics research. Scientific literature shows that a variety of factors are known to change the oculo-motor parameters measured by the FIT. These include alcohol, psychoactive drugs (either illegal or prescription) and extreme sleepiness. A *high risk* test can therefore be the result of any one of these factors or a combination of two or more.

Controlled dose studies to determine the sensitivity of the FIT to alcohol, marijuana and cocaine have been carried out at several leading research institutions. These drugs were chosen to demonstrate the range of capabilities of the FIT, they also represent the most commonly abused drugs in the workplace. The sensivity of the FIT to sleep deprivation and fatigue were also investigated in several studies. Some of the studies determined the sensitivity of the FIT to prolonged sleep deprivation while others determined the sensitivity of the FIT to a single extended work day with a mentally demanding task.

All of the testing for drugs and alcohol were performed using randomized, double blind, placebo controlled, repeated measures studies of human volunteers. In such testing, neither the subject nor the researcher knows which of several doses (including zero, or placebo dose) of the test drug is being given while the data are being collected. Repeated testing of the same subject is carried out on separate days at different doses. FIT tests were taken before and at intervals after administration of each dose.

The data from these laboratory studies demonstrate that the FIT is sensitive to a broad range of factors that can increase the risk of an employee causing an accident. The sensitivity occurs only while the factors continue to have an impact on the central nervous system. As a result, the FIT is directly relevant to employers interested in high quality, exacting, detailed work, as well as general safety and quality without violating the privacy rights of the employee.

The following institutions have participated in this validation effort:

- The Addiction Research Center (National Institute of Health)
  Johns Hopkins University, Baltimore, Maryland
- The Vermont Alcohol Research Center, Burlington, Vermont
- The National Highway Traffic Safety Administration, Washington, DC
- The Federal Rail Administration, Washington, DC
- The University of Iowa Department of Ophthalmology, Iowa City, Iowa
- Walter Reed Army Medical Center, Washington, DC
- Institute for Circadian Physiology, Boston, Massachusetts
- Naval Aerospace Medical Research Lab, Pensacola, Florida

Results from the Workplace

What happens when the FIT is used in a real industrial setting? The recent experience of one Fortune 500 company illustrates the impact.

The plant employs approximately 2500 and includes union and non union workers. More than 150 workers were screened daily over a four month period. Workers who were identified as *high risk* were evaluated to help determine a possible reason for the result. The evaluation, conducted by the medical staff at a nearby hospital included a brief history, urine drug screen and a blood alcohol determination.

There were 169 total participants screened over 20,000 times and six people (.03% of tests) were identified by the FIT as *high risk*. Of these six people, three were found to have blood alcohol concentrations, one had taken a large dose of antihistamine and one had the flu and had not slept well. This experience successfully demonstrates that the FIT can make a significant impact on workplace safety, quality and productivity.

Summary

Everyone experiences daily changes in their alertness, decision making abilities and motor skills. These changes may occur as a result of inadequate sleep, illness, the use of medications, alcohol, or other durgs. Such changes can put an employee at "high risk" of causing errors and having accidents.

The FIT is a scientifically validated and field tested tool that can assist employers in reducing the very real risk of the impaired worker by screening for the current presence of factors that can cause an employee to be "high risk". Reducing this risk will help companies achieve an elevated level of safety, quality and productivity be ensuring that the workforce is "fit-for-duty".

Mr. BARR. Thank you. Mr. Fortner, in view of the discussion on the last panel concerning the, again going back to the intrusiveness of the urine and hair analysis, and considering the bill, the legislation that we have pending, do you think it would be useful or advisable to add sweat testing to the legislation that we're considering?

Mr. FORTNER. Well, I certainly think that that would be a minimal approach. The Department of Health and Human Services, under the Drug Testing Advisory Board for federally mandated employees has already looked at that through two hearings last year. We are in the process of assisting them to write the specimen collection procedures to incorporate sweat testing under the Federal programs. It certainly is a less invasive procedure and it's comparable to applying a Band-Aid to an individual. Takes all of a few minutes. And then can allow that individual to continue normal activities for up to 2 weeks.

Mr. BARR. And it, well, just for the record, where will this normally be worn? It would be worn in a place where it would not telegraph to everybody around you that you have a problem? It would be under clothing?

Mr. FORTNER. Typically, it's worn on the upper arm. It can be worn on the rib cage or on the lower back.

Mr. BARR. OK, so it could be something that would protect the immediate privacy of the wearer?

Mr. FORTNER. Yes, sir.

Mr. BARR. OK, thank you. Mr. Barrett, did you have any follow-up questions? OK. I think Mr. Souder, you just had a couple of very brief questions and then Mr. Mica had, again, a couple of very brief questions. If we could limit it just to 2 minutes. Mr. Souder, please.

Mr. SOUDER. I have some other questions I may submit just for written testimony, but I have two in particular. There was a reference to—and it sounds first off in the earlier discussion on the racial question—that there is minimal data out there. There are other studies out there, I know, that, Ms. Kibben, you were referring to a number of studies on treatment, but a lot of those were people who were self-coming forth as opposed to being necessarily monitored in a typical scientific way.

The question I have is: Is there sufficient research on treatment and different treatment questions that is professionally done enough, whether it be through the criminal justice system or in other areas, or is that a need in the mix here, because we are spending a lot of dollars on treatment? For example, Congressman Greenwood has a bill that would take 1 percent of our treatment dollars and put it toward directed research, because many of us are frustrated about the conflicting information that we're getting. Could I get some reaction?

Ms. KIBBEN. I think I understand what your asking. Is there information that actually is scientifically gathered that shows that treatment's effective? Yes. And is there also a need for additional scientific data that shows that treatment is effective and how can it become more effective? Yes. So yes to both those questions.

In the full length of the testimony, you will see about five or six different cites of very scientifically researched data that is not voluntary. An Oregon study that showed, I think, for every $1 in-

vested in treatment within the first year, $5.46 was returned and that was not a study done of people that voluntarily——

Mr. SOUDER. I mean, I've seen all those type of studies——

Ms. KIBBEN. OK.

Mr. SOUDER [continuing]. But what I'm looking for are studies of which kind of treatment works better, which kind of drug testing, which works better, that are scientifically sound and I want to, because my time's going out.

[The information referred to follows:]

Ms Kibben

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MEMORANDUM

TO: House Government Reform and Oversight Committee's Subcommittee on National Security, International Affairs, and Criminal Justice

FROM: The National Association of Alcoholism and Drug Abuse Counselors (NAADAC)

RE: Follow-up information answering questions from Subcommittee hearing on Drug Testing and Drug Treatment (June 5, 1998).

SUBJECT: Studies supporting validity of treatment effectiveness analysis using self reported data

DATE: June 16, 1998

Psychology of Addictive Behavior's report on the Drug Abuse Treatment Outcome Study (DATOS) states that, "A significant body of research on self-reported data suggests that most data so obtained are reasonably reliable and valid." The following citations substantiate the validity of treatment effectiveness studies utilizing self-report data.

1) Amsel, Z., Mandell, W., Matthias, L., Mason, C., & Hocherman, I. (1976). Reliability and Validity of Self-Reported Activities and Drug Use Collected from Narcotic Addicts. *International Journal of the Addictions*, 11, 325-326.

2) Bonito, A., Nurco, D. N., & Shaffer, J. W. (1976). The Verdicality of Addicts' Self-Reports in Social Research. *International Journal of Addictions*, 11, 719-724.

3) Hser, Y., Anglin, M. D., & Chou, C. (1992). Reliability of Retrospective Self-Report by Narcotics Addicts. *Psychological Assessments*, 4, 207-213.

4) Maisto, S. A., McKay, J. R., & Connors, G. J. (1990). Self-Report Issues in Substance Abuse: State of the Art and Future Directions. *Behavioral Assessment*, 12, 117-134.

5) McElrath, K., Chitwood, D. D., Griffin, D. K., & Comerford, M. (1994). The Consistency of Self-Reported HIV Risk Behavior Among Injection Drug Users. *American Journal of Public Health*, 84, 1965-1970.

6) Weatherby, N. L., Needle, R., Cesari, H., Booth, R., McCoy, C. B., Watters, J. K., Williams, M., & Chitwood, D. D. (1994). Validity of Self-Reported Drug Use Among Injection Drug Users and Crack Cocaine Users Recruited Through Street Outreach. *Evaluation an Program Planning*, 17, 347-355.

CSAT by Fax

June 10, 1998
Vol. 3, Issue 11

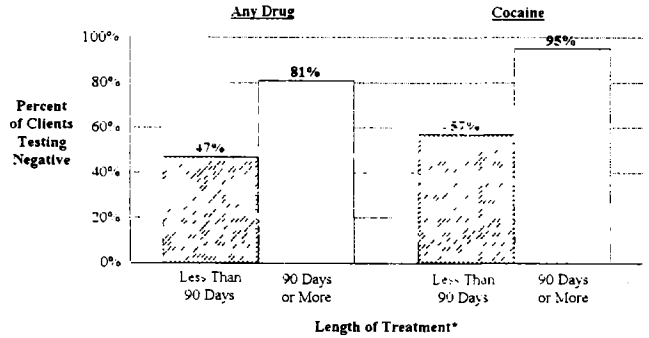
A Special Edition of CESAR FAX

A Collaborative Effort of the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Research (CESAR)/University of Maryland

Clients Who Remain in Treatment at Least 90 Days Nearly Twice As Likely to Be Drug-Free One Year After Treatment

Data from the national Drug Abuse Treatment Outcome Study (DATOS) show that longer stays in treatment are associated with more favorable outcomes. According to the researchers, "clients remaining in LTR [long-term residential] programs (including therapeutic communities) for 3 months or longer had significantly better outcomes in all key areas of behavioral functioning than did earlier program dropouts" (p. 304). Clients staying in LTR programs for 3 months or longer were nearly twice as likely to have urinalysis results negative for any drug or for cocaine (see figure below). A similar relationship was found for clients of outpatient methadone treatment programs--those who stayed a year or longer had greater reductions in drug use during the follow-up period.

Percentage of Long-Term Residential Treatment Program Clients Testing Negative by Urinalysis One Year After Treatment, by Length of Treatment



*Less Than 90 Days, n=30; 90 Days or More, n=37.

SOURCE: Adapted by CESAR from data from D. Dwayne Simpson, George Joe, and Barry Brown, "Treatment Retention and Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS)," *Psychology of Addictive Behaviors* 11(4):294-307, 1997. For more information, contact D. Dwayne Simpson at 817-921-7226.

DATOS Findings Now Available on the World Wide Web

The Drug Abuse Treatment Outcome Study (DATOS) now has its own internet web site (**www.datos.org**) summarizing key findings from this national evaluation of treatment effectiveness.

CSAT by Fax is supported by funding from CSAT, Substance Abuse and Mental Health Services Administration, and may be copied without permission with appropriate citation. For mailing list modifications contact CESAR at •• 301-403-8329 (voice) •• 301-403-8342 (fax) •• CESAR@cesar.umd.edu •• www.cesar.umd.edu ••

SELECTED REFERENCES ON LEGAL COERCION AND DRUG TREATMENT

Prepared by

Douglas Young, Vera Institute of Justice

Steven Belenko, The National Center on Addiction and Substance Abuse

April 1998

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OBSERVATIONAL STUDY OF COURTROOM DYNAMICS IN SELECTED DRUG COURTS

By Sally L. Satel, MD[iv]

In this ground breaking article, Dr. Sally Satel (93) reviews the literature in the field, interviews drug court judges and program participants and observes 15 courtroom settings in an attempt to describe and analyze the role of the drug court judge. This far ranging article of first impression looks at what makes a good drug court judge, the psychological implication of the drug court judicial model and how the drug court environment can effect program outcomes.

Dr. Satel is a practicing psychiatrist as well as a lecturer at Yale University School of Medicine. She has written extensively on drug abuse and cocaine addiction. Her clinical and research expertise is in addiction medicine. She has worked in the Washington, DC Drug Court as a Staff Psychiatrist and consultant.

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JUDICIAL PERCEPTIONS OF TREATMENT:

A 1990 study by the New York City Criminal Justice Agency examined factors and perceptions affecting judges' decisions regarding the adjudication of crack and powdered cocaine offenders.[10] Eighty two percent of the 71 judges interviewed agreed that diversion of selected crack cocaine, related defendants would be a reasonable option "if effective treatment existed." Among judges who identified a preferred type of treatment referral, 77% named residential programs. They felt that those most likely to benefit were defendants who showed "motivation" to receive treatment. Interestingly, data does not support this all-too intuitive belief. Indeed, numerous studies have shown that patients coerced into treatment do as well or better than those who volunteer for it.[11] Furthermore, judges had expressed disappointment with treatment, citing its failure to follow up with the court, verify patient participation and administer urine drug screens. It is no coincidence, then, that integration of information and collaboration between criminal justice and treatment services are substantial departures for the judiciary and the very hallmark of drug court programs.

PSYCHOLOGICAL IMPLICATIONS FOR THE JUDGE:

[14] Judges' attitudes toward participants can be complicated. The Freudian concept of transference refers to the patient's "transferring" tightly held attitudes (beliefs) and emotional dispositions forged in childhood onto new individuals in their lives. Since parent-child relationships are the first attachment that a child develops, they almost always influence all later relationships, including formal helping relationships in adulthood. The therapist's interpretation of the transference allows the patient to better distinguish between remnants of past relationships and the real association between himself or herself and the therapist.

conscious) desire to be punished or controlled or to elicit concern through censure.

These kinds of psychodynamic scenarios are more likely to get played out in a drug court, with its somewhat relaxed structure, than in a standard court where proceedings, expectations and personnel roles are clear, traditional and fairly predictable. The expression of the participant's psychological conflicts and needs naturally find outlet in a setting where a potent figure (the judge) actively probes for personal details and takes a visible interest in their lives. While it would be a grave mistake for the judge to fashion himself or herself as a therapist – better to be seen as a moral authority with the flexibility to be practical and compassionate while demanding accountability – the judge should be aware that the unconventional nature of his or her relationship with participants can engender complex reactions in himself or herself.

PARTICIPANT'S ASSESSMENTS OF THEIR RELATIONSHIPS WITH THE JUDGE:

[15] As important as the drug court judge is to the court process, dynamics and outcome, there remains a variable that plays an equally paramount role in drug court – the participants. Focus groups, surveys and exit interviews allow us to learn about the participant's impressions of the drug court experience. Urban Institute researchers conducted focus groups with participants of the Washington, DC Drug Court.[12] The researchers found, not surprisingly, that the certainty of consequences was psychologically powerful and important to the participants. "The reason the sanctions track people did so well is because they knew what the judge would do. And he did it," said senior researcher Adele Harrell who conducted focus groups with study participants. She also

cares", these participants have made the all too common mistake of confusing the failure to demand accountability with compassion. Yet another interpretation of "caring" is simply that the drug court judge is more involved in their personal situation than a traditional judge who sentences them and/or sends them to jail.

It is clear in the American University 1997 Drug Court Survey Report that drug court participants identify the purpose and importance of sanctions. It queried 256 participants from 53 drug courts and found that the highest percentage (82%) responded that "the possibility of sanctions (being) imposed if you didn't comply with the program" was "very important." Seventy-five percent said it was "very important" that "a judge monitors my progress." Unfortunately, there was no elicitation of spontaneous comments; the participants were limited to five responses, none of which referred to their interaction with the judge.[6] However, as mentioned earlier, 80% said that they would not have remained in the drug court program if they were not required to appear before a judge as part of the process.

THE MIND OF THE ADDICT:

[16] Insight into the mental life of the addict is helpful to the drug court judge and other criminal justice personnel whose aim is to reduce subsequent crime through changing offenders' behaviors. Partly, this change will be effected through behavior modification (sanctions, consequences and rewards), but it will also be influenced, to some degree, by the relationship with the judge. Nevertheless, there are aspects of the addicts' attitudes and actions that can make it difficult for the judge to form a relationship. It is not uncommon, for example, for a participant to choose drug court simply because he or she wants to avoid jail and to imagine that he or she will simply go through the motions ("get over and get

nipulated and tested in drug court settings by future investigators. Researchers could employ focus groups to assess the impression of the judge's actions on participants and, ultimately, correlate this with outcome. The ideal set-up for comparison evaluations would be a stable drug court treatment program with an explicit sanction algorithm overseen either by judges who rotate or by more than one judge simultaneously presiding over status and sanctions hearing. Though the "drug court model" does create concerns that some judges may attempt to act as therapists, the seemingly extraordinary potential of this model, warrants its continued development and study.

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Mr. SOUDER. The second type of question that I'm also interested in—and you can respond in writing, since I don't have much time here—but we are—it's fast and we're pending some of these bills that are coming through. I was very concerned when Dr. Kidwell mentioned—we talked about the race, question about the kids question. I wonder if Dr. Mieczkowski you were off, talking about the race question—but when he said that the kids of mothers with cocaine or do we have similar research, information lacking there, that we need to know?

Mr. MIECZKOWSKI. Well, I would refer you, Mr. Souder, to materials I submitted to the committee earlier. There's an article I published in FSI which describes in detail the critique of Dr. Kidwell's study of children and, also, there's an article I submitted in which we evaluated approximately 50 undercover police officers involved in cocaine operations to see if there was an issue of passive contamination related to their exposure to cocaine, in some cases over many years. I can tell you that, basically, our results are negative. That, while exposure certainly and contamination does occur, it is not of sufficient magnitude to negate the value of the testing.

Mr. SOUDER. Dr. Kidwell, do you believe there is more research needed in these areas or what's your——

Dr. KIDWELL. I think more research does—is needed. I would like to comment just briefly on the police officer study. One officer was positive out of the 44 in your table and another person had cocaine present that was below the positive cutoff levels. In that article it was explained that perhaps the officer was ingesting small quantities of drugs. However, if there's any validity to the amount that you ingest versus the amount that shows up in hair, I don't think that argument is tenable.

Mr. SOUDER. I thank you both. It's been very interesting and a good learning experience.

Mr. BARR. Thank you. Did the gentleman from Florida have additional questions and, if so, he's recognized for 2 minutes.

Mr. MICA. Yes. Mr. Chairman I wish to be enlightened. Thank you. And my question goes back to Mr. Fortner. Well, you're sort of a newer product getting on the market, patch or whatever you want to call it. Tell me what you're seeing. I just heard what the professor heard about his side of this story. Is this—a lot of this vendor-driven? It looks like, in the past, everybody's resorted to urine analysis to do the testing and now there's some new products or approaches that are on the board and I read that one vendor's sort of trashing the other is the approach. What do you see?

Mr. FORTNER. Well, sir, unfortunately you always see that kind of information out there, one vendor trashing another vendor, whether there's any validity to those challenges or not.

Mr. MICA. Scientifically, you're——

Mr. FORTNER. Scientifically——

Mr. MICA [continuing]. Your patch works.

Mr. FORTNER. Yes, sir.

Mr. MICA. The hair thing works.

Mr. FORTNER. Well, I think, if you look at how the patch was developed. It was developed with full review and submission to the Food and Drug Administration through the Scientific Advisory Board, which required demonstration to that board that, if you give

drugs to individuals, you can detect them in the patch. That if you have large clinical populations, such as detained parolees in a large Statewide program, determine its effectiveness. And it can detect three times as many positives as urine.

Mr. MICA. Is the government using it?

Mr. FORTNER. Yes, sir. It is cleared under the administrative office of the U.S. courts, all 94 districts have access and are using it.

Mr. MICA. Are they using it?

Mr. FORTNER. Yes, sir, they are. I have testified in eight cases across the country, Federal probation parole pretrial in which those were the results used to take action against those detainees. Now, certainly, as evident from what the subcommittee has heard today, hair testing, while it offers some very promising opportunities, still has a number of questions that, because it hasn't gone through the same scrutiny and FDA review, scientific advisory board-type approach, leads it to interpretation from various individuals. And I would certainly suggest that that would indicate additional research and studies going forward.

Mr. MICA. See you're—now you're getting into it, too. Dr. Kidwell.

Mr. FORTNER. Well, but, commercially, I don't know that it's an issue. With the sweat patch, PharmChem has marketing and distribution rights, but there are many labs across the country that can do that analysis.

Mr. MICA. Dr. Kidwell, what's the Navy using, primarily?

Dr. KIDWELL. Only urine.

Mr. MICA. And you haven't used either of the others?

Dr. KIDWELL. We've looked at them scientifically.

Mr. MICA. Are they as effective?

Dr. KIDWELL. Effective is defined as how? The trouble——

Mr. MICA. Can hair give me a 3-month versus a 3-day? Or is that——

Dr. KIDWELL. It has been alleged to do that, yes.

Mr. MICA. And his patch, have you not had any experience with it?

Dr. KIDWELL. I have looked at it, but I haven't had extensive——

Mr. MICA. Do you put this out for bid? I mean, some—the drug testing?

Dr. KIDWELL. You mean, how is urine testing?

Mr. MICA. Urine—yes, how—the urine analysis, you're doing it internally?

Dr. KIDWELL. Oh, I'm not the one who's doing it. The Navy——

Mr. MICA. No, I mean the Navy. I'm talking about the Navy.

Dr. KIDWELL. Oh. The Navy has three drug testing laboratories doing urine. One in Great Lakes, near Chicago; one in San Diego; and one in Jacksonville, FL.

Mr. MICA. Internal or commercial?

Dr. KIDWELL. Internal but I believe there is one commercial laboratory also testing for the Navy.

Mr. MICA. Well, my time's expired, but I'd like to know more about the effectiveness of these tests. We've got more hearings to come up and then the cost and implementation effect and what re-

sults we're getting and see what's the most effective. And I thank you, Mr. Chairman.

Mr. BARR. I thank the gentleman from Florida. There will be additional hearings and one would hope, Dr. Kidwell, that, as sort of a representative of the Government here, not as a Government employee, but working for the Government, that we would urge you and your colleagues to look at maybe some of these alternatives. Private industry may be a little bit ahead of us here.

One of the issues that we haven't talked about with this panel but, as you all heard from the earlier panel, is the issue of Government testing. And I know, Mr. Green, you discussed that at least in your written statement. Aside from whatever problems there might be with legal challenges to the testing of Government employees, do any of the panelists here think that Government employees ought to be treated more specially than employees generally in terms of drug testing and drug usage? Everybody would agree that they ought to be treated, theoretically, the same as everybody else. And I certainly agree.

And, there being no further questions, again, I'd like to thank the panelists and we will leave the record open for 2 weeks if you all would, if you have any additional material that you would like to submit and, certainly, any material in direct response to questions that have been posed today or that might be posed—I think the gentleman from Indiana indicated that he would be submitting some questions in writing—we would appreciate those within 2 weeks.

We thank you and I thank the members of the subcommittee and we're now adjourned.

[Whereupon, at 2:06 p.m., the subcommittee adjourned subject to the call of the Chair.]

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