MONTANA STATE SENATE
JUDICIARY COMMITTEE
MINUTES OF THE MEETING

February 17, 1987

The thirtieth meeting of the Senate Judiciary Committee was called to order at 10:00 a.m. on February 17, 1987 by Chairman Joe Mazurek, in Room 325 of the state Capitol.

ROLL CALL: All committee members were present.

CONSIDERATION OF SENATE BILL 338: Senator Paul Boylan, Senate District 39, introduced SB 338, which is an act to regulate the testing of blood and urine of employees and prospective employees. He told a story about his own dairy farm and how the milk inspectors tested the milk for a virus, and found it. They shut him down without a second opinion. Senator Boylan said when he got a second opinion, the milk tested negative to the virus. He felt a drug test of humans or animals should get a second chance in the testing process.

PROPONENTS: Steve Ungar, Bozeman attorney, felt the bill should be fair to both, the employee and employer because currently, the drug testing is not fair to both sides. He said there are no set guidelines in the law now to follow. He felt this bill would give a second chance to both, employee and employer. He believed the guidelines set up in the bill will prevent employers from lawsuits. He gave the committee some information on drug testing. (Exhibits 1 and 2)

Lynn Hetland, representing herself, favored the bill because drug testing is critical for many of today's jobs. She said as far as drug testing goes, a person has to watch the employee give the specimen, to know it wasn't tampered with. She said there should be guidelines for the cleanliness of a container, and proper labeling of the urine sample is very important. She said an employer should keep track of who handled the sample also.

Jim Murry, AFL-CIO, supported the bill. (Exhibit 3)

Dan Edwards, Oil, Chemical and Atomic Workers International Union, Billings, Montana, supported the bill. (Exhibit 4)

Eileen C. Robbins, R. N., representing The Montana Nurses' Association, favored the bill. (Exhibit 5)

Francis Marceau, U.T.U. Local 978, gave the committee a fact sheet for SB 338, in favor of the bill. (Exhibit 6)

Susan Gregory, a drug tested employee of Burlington Northern, said the drug test she submitted to, without just cause, was humiliating and was not performed fairly. She explained how the test was administered, and that it showed positive. She explained they wouldn't give her a second test to make sure they were correct in their findings. She lost her job at Burlington Northern because of the one test.

George Lucker, BN employee, explained his story on a drug testing incident that happened over two years ago. He said he was cleaning up a derailment of a train, which he had no part in as far as the derailment, when his (chief) boss asked him to take a drug test. He said the drug test was embarrasing because a woman watched him give the specimen from approximately 10 inches distance. He said they told him nine days later that it tested positive. He admitted that 5 years previous to the drug test, he had smoked pot, but had not done it since that time. He was not given a second testing. He said he was asked to sign a form saying, "I was on a drug at the time of the accident." He refused and he lost his job. He explained that he has seen people drunk on the job and the boss covers up for them. He supported the bill because of his situation.

Bill Leary, Montana Hospital Association, supported the bill because it is fair to both parties involved.

Glen Kincaid, representing himself, said he tested positive for drugs at Burlington Northern; however, he said he went through arbitration and the court system and won his case and got his job back. He said he had never used illegal drugs in his life. He supported the bill.

Jeff Renz, ACLU of Montana, stated that "probably cause" for drug testing must be found and verified before a person can be subjected to a test. He said most statistics show one of eleven people who tested positive to drug test actually used illegal drugs. He explained how studies

have shown people who had poppy seeds on food have tested positive for heroin. He said the testing is not a sound system yet because of all the different types of chemical reactions people can have to different legal drugs, like hay fever medicine testing as marijuana, or just to food like the poppy seed bread. He supported the bill.

Bill Leaphart, representing himself, favored the bill because drug testing is done for safety purposes and the test should be done properly. He said the test should be fair, but should be done for the safety of others.

OPPONENTS: John Fitzpatrick, Pegasus Gold Corp., opposed the bill because the drug testing procedure should not have two specimen samples, but one, and that one would be used for the two tests. He explained how dangerous it is for his company to have a person on drugs working at the gold company. He explained how he just caught someone today smoking a marijuana joint on the job. He gave the committee amendments for SB 388, which he felt were appropriate. (Exhibit 7)

DISCUSSION ON SENATE BILL 338: Senator Pinsoneault asked why the testing person has to be so close to the person giving the specimen. Mr. Renz said it is amazing how people will tamper with a specimen while giving it. He gave an example of how people will put salt on their fingers and get it into the urine so it will destory any chemicals in the sample. Mr. Fitzpatrick echoed the same reasoning for getting so close; it will be a cleaner test.

Senator Blaylock asked Mr. Fitzpatrick how many tested positive for "coke" at the Pegasus Corp. Mr. Fitzpatrick said two. Senator Mazurek asked if the two who tested positive petitioned against the test. Mr. Fitzpatrick said they did not.

Senator Boylan closed the hearing on Senate Bill 338.

CONSIDERATION OF SENATE BILL 226: Senator Halligan, Missoula, introduced the bill and said it was by the request of the Juvenile Justice Commission and amends the laws relating to the Youth Court.

Dorothy McCarter of the Attorney General's office explained the bill. Senator Halligan presented a statement of intent. (Exhibit 7A)

PROPONENTS: Dorothy McCarter gave details of every section amended. (Exhibit 8)

Steve Nelson, Board of Crime Control, said the bill will give a youth a "probable cause" hearing to see if they should leave him in jail or take him to a youth detention center. He said 18 out of 20 districts do these hearings at the present time. He said Curt Chisholm, Department of Institutions, supports the bill also, but he didn't agree with section 5 of the bill. He gave no comments on why he did not agree.

Ted Lechner, Thirteenth Judicial District, supported the bill because there is no definite law on the books in Montana for this situation. He said no one likes to be in charge of this kind of thing. He said the bill states who is to enforce the decision on a delinquent youth and the guidelines to follow with a youth.

Mike Schaffer, representing himself, felt youths should not be held in adult jails because of the youth's age and immaturity.

Jeff Langan, Montana Youth Justice Council, supported SB 226 because it brings to the attention of the public what a problem this really is.

OPPONENTS: There were none.

DISCUSSION ON SENATE BILL 226: Senator Pinsoneault asked about page 12, line 14 and how they intend to handle a youth who has committed a serious crime by putting him in a detention facility. Mr. Langan said there are different levels of detention and there are protection standards written for each facility.

Senator Mazurek asked if the bill doesn't pass, what happens with the federal agency that is involved. Mr. Langan said one of the main issues here is the state is complying to a federal program that is already set up.

Senator Beck said it will take rural areas a little more time than 24 hours to get a youth court judge there because of the distance and remoteness. Mr. Langan said there has not been a problem with that so far.

Senator Halligan closed the hearing on SB 226.

ADJOURNMENT. The meeting adjourned at 12:00 p.m.

SENATOR JOE MAZUREK, Chairman

mh

DATE 2/17/89

COMMITTEE ON JUDICIARY

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
Jeff Renz	ACLU of MT	338	X	
Colleen Reilly	Montana Newspaper Assn	338	X	
Jim Mular	Bro Rwy & Airlines Clerks	338	X	
William Leaphart	Self	338	X	
Ed Mawson	U.P.U. local 978	" "	X	
Bill Leaphart	Montana Hospital Assn	338	X	
Dan C Edwards	Mt Chemical Assn Mont.	338	X	
Eleanor Eisenzimer	self	338		
Peggy Lynch	self	338	X	
[illegible]	Mt. Youth Justice Council	338	X	
Robert Robinson	ACLU	338	X	
John Kappenman	Pegasus Gold Corp	338		X
Susan Gregory	self		X	
Lynn B. Hetland	self	338	X	
Dorothy McCarter	Atty Gen	338	X	
Steve Nelson	Bd Crime Control	338	X	
Ted M. LeVasseur	13 Judicial Dist	338	X	
Jim Murry	Mont. State AFL-CIO	338	X	

(Please leave prepared statement with Secretary)

(This sheet to be used by those testifying on a bill.)

NAME: JEFFREY M. LANGAN DATE: 2/17/87

ADDRESS: 414 W. BROADWAY, MISSOULA MT. 59802

PHONE: (406) 721-3582

REPRESENTING WHOM? MONTANA YOUTH JUSTICE COUNCIL

APPEARING ON WHICH PROPOSAL: SB 226

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: Eileen Robbins DATE: 3/17/87

ADDRESS: 331 Spencer - Helena

PHONE: 442-6710

REPRESENTING WHOM? Montana Nurses' Assoc

APPEARING ON WHICH PROPOSAL: HB 338

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT:

Testimony attached.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: _____ DATE: _____

ADDRESS: _____

PHONE: _____

REPRESENTING WHOM? _____

APPEARING ON WHICH PROPOSAL: _____

DO YOU: SUPPORT? _____ AMEND? _____ OPPOSE? _____

COMMENT: _____

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: Lynn B. Hetland DATE: 2/17/87

ADDRESS: 443 Lewis Ave., Billings, MT 59101

PHONE: (406) 245-2923

REPRESENTING WHOM? Self

APPEARING ON WHICH PROPOSAL: SB 338

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: Francis Marceau DATE: 2-16-07

ADDRESS: 1317 Khanabad Mola

PHONE: 549-9068

REPRESENTING WHOM? UTU Local 978

APPEARING ON WHICH PROPOSAL: B. 11 338

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT: _____

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: W. William Leaphart DATE: 2/17/87

ADDRESS: 1 No. Last Chance

PHONE: 442-4930

REPRESENTING WHOM? Self

APPEARING ON WHICH PROPOSAL: Urine & Drug testing of Employees

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: Don C. Edwards DATE: 2-17-89

ADDRESS: Box 21635, Billings, MT 59104

PHONE: 406-669-3253

REPRESENTING WHOM? Oil, Chemical & Atomic Workers Int'l Union

APPEARING ON WHICH PROPOSAL: SB 338

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT: See attached testimony

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

JOURNAL OF AMERICAN MEDICAL ASSOCIATION

Mandatory Unindicated Urine Drug Screening: Still Chemical McCarthyism

In the late 1960s as the psychoactive drug abuse epidemic spread throughout this country, the advance of toxicologic technology prompted many troubled and well-intentioned persons to propose a new solution to this old plague: urine drug screening.

Society was looking hard for solutions. Probation department officials perceived the need to monitor parolees, leaders of methadone maintenance treatment programs for heroin addiction sought to convert previously hopeless addicts into functioning citizens, and the US military was being harmed seriously by widespread, demoralizing psychoactive drug use among its personnel. Urine drug screening was established as one approach to deal with these complicated problems. At that time, I was actively involved in medical aspects of drug abuse and toxicology in one of the focal points of this problem—southern California—that was being called "the largest open-air insane asylum in the world."

Concerned about hypocrisy, injustice, and infringements of civil liberties and aware that there were serious analytical problems in the theory and practice of toxicology, I wrote the following letter, which Franz Ingelfinger published in the *New England Journal of Medicine* in 1972.[1] Upon rereading these reflections, I note that "the more things change, the more they remain the same."

Urine Drug Screening: Chemical McCarthyism

Big Brother devises new ways of watching you as 1984 draws nearer. An era of chemical McCarthyism is at hand and guilty until proven innocent is the new slogan.

It is becoming recognized that urine drug screening in our society is now a commonplace event with far-reaching consequences. United States military personnel, amateur and professional athletes, race horses, probation parolees, methadone-program patients, and hospitalized overdose patients are being joined by business employees and applicants as subjects for these screenings. An addict's freedom, a boxer's world title, an employee's job, and a soldier's future employability may rest on these results.

Numerous laboratories of variable quality and morality, generally not subject to licensure, control, or proficiency testing, have sprung into this lucrative business. The performance of even the "best" toxicology laboratories on urine drug screens is *grossly defective* with frequent false-positives, false-negatives, and misidentifications.[2] Error rates on unknown samples commonly run as high as 20% to 70%.[3-6]

The sources of error arise from the frequent unexplained "spots" found on thin-layer chromatographic plates of urine, failure of confirmation by a second technique, variances regarding sensitivity, other legally available drugs taken by the subject, prolonged excretion of some of these legal drugs and their metabolites, specimen mix-ups, manual transcription errors, and phony specimens. In fact, the use of black-market drug-free urine voided through artificial micturition devices has prompted the creation of new job categories of "micturition observers," who watch the urine from urethra to container—the police state par excellence.

It is important for the medical community to (1) recognize that the state of the art of urine drug screening is faulty and attempt to improve these techniques, (2) publicize the fact that these techniques are imperfect to prevent the general public from being duped into accepting them as laboratory truths, with resulting potential injustices, and (3) bring pressure to require that standards are set, regulations developed and followed, and quality control and proficiency testing applied and monitored for intrastate and interstate toxicology laboratories—by law, if necessary.

There is serious question as to whether urine drug screens should be done at *all* under current circumstances. Frequently incorrect laboratory data are worse than no laboratory data. The waste of money and the potential harm to individuals may exceed any benefits gained by these programs, except for the clinically ill person. Of course, hypocrisy flourishes here as it does in most other drug areas—i.e., the U.S. Army screens often exempt officers, and most screening programs ignore the principal drug of abuse—ethyl alcohol.

If we actually want to be serious about screening for psychoactive drugs that might alter behavior that matters (rather than playing public relations games), we should start by screening the highest officials in government, industry, labor, academia, etc., rather than the enlisted man at Fort Ord or some filing clerk somewhere.

GEORGE D. LUNDBERG, M.D.
Department of Pathology
University of Southern California
School of Medicine
Los Angeles

1. Fujimoto JM, Wang RIH: A method of identifying narcotic analgesics in human urine after therapeutic doses. *Toxicol Appl Pharmacol* 16:186-193, 1970.
2. Sine HE, Murray MH: Role of state health departments in testing proficiency of drug abuse toxicology for intrastate clinical laboratories. *Clin Chem* 18:592, 1972.
3. Unpublished quality control data, California Association of Toxicologists, May 1972.
4. Unpublished data, Laboratory Standards Committee, Department of Hospitals, County of Los Angeles, June 1972.
5. Unpublished data, Contra Costa County Probation Department, March 1972.
6. Unpublished data, State of California, Department of Corrections, 1971.

Now, 14 years later, how have things changed and how have they remained the same?

1. The drug abuse epidemic continues to be a major phenomenon of our time. The number of abusers waxes and wanes and the drugs change but the problems remain, seemingly recalcitrant to whatever efforts we put forth. Psychoactive drugs continue to be widely available at relatively low cost and are widely used. People continue to die every day of both legal and illegal drugs, but much more of legal than illegal.

2. Urine drug screening technology has improved immensely. It is now possible for the vast majority of legal and illegal psychoactive drugs of abuse to be sought, found,

that the most commonly lethal drugs (ethyl alcohol and tobacco) continue not to be part of urine drug screening in most settings.

11. When people know their behavior is being observed they often change. There is no question but that the realization that observation in the form of urine drug screening may occur will prevent many healthy people from using illegal drugs. Thus, urine drug screening can have a salutary deterrent effect on the use of drugs. This is a strong argument in favor of unannounced screening. Incidentally, this preventive effect is operative whether or not the analyses are actually done. Some have suggested that one should simply collect the specimens and throw them away (a classic sink test) since as long as the specimen donors do not realize what is going on, the beneficial effect would be the same and the process would be much less expensive and hazardous.

12. Whether or not civil liberties are violated in urine drug screening has not been adequately addressed. The question of whether any individual who is apparently functioning normally with no demonstrated impairment can be subjected to a form of intimate body search remains a serious problem to be worked out in the courts. If a prospective employee is fully informed that urine drug screening is part of the normal preemployment procedure, the applicant must accept such testing as a condition of employment. However, to initiate a policy of random, unannounced, unindicated (no probable cause) urine drug screening during one's employment tenure is an entirely different question. Certainly, in a purely practical sense (leaving ethical questions aside) it wouldn't make any difference to a person who is drug free to be tested periodically—*if* there were not the specter of specimen mix-ups, erroneous false-positives, and direct observation, which will be thought of as odious and demeaning by many. These risks are very real.

13. How much will it cost? It is estimated that the direct and indirect costs of specimen procurement, transportation, analysis, and reporting is costing the military about $90 to $100 per specimen, not including time lost from work. If one theorized that a similar approach with only one specimen per employee per year would be utilized for our entire US work force, one comes up with a cost to society around $8 to $10 billion per year. This is terrific for the laboratory industry and all the attorneys who will argue these cases in court, but should we spend that kind of money on this process? In fact, we have not found one proper cost-benefit analysis of this process in any peer review journal.

Those of us in the drug-industrial complex are, of course, elated by the symbolic importance of the new billion dollar investment in the "war against drugs." However, the probability of serious and lasting benefit for any large group in society other than the politicians and bureaucrats produced by such ill-conceived spending is very low.

Interestingly, recent data indicate that deaths and serious impairment resulting from the use of psychoactive drugs in this country have been decreasing of late. Thus, it is a particularly opportune time for politicians to rail against psychoactive drug abuse and increase spending to counteract it since it is on a downslope anyway. They can gain credit for the decline whether or not they had anything whatsoever to do with the changes.

The delicate questions of personal liberty vs societal needs and the doctor-patient relationship remain difficult to deal with. A sensible person must conclude that they should be individualized with judgment and restraint on a case-by-case basis, especially when dealing with persons in very sensitive positions like commercial pilots, air-traffic controllers, and surgeons.

There is, of course, no way to get rid of harmful psychoactive drugs in a free society. They are too easy to make, too easy to transport, and too easy to buy. Moreover, humans are unstable animals and show no serious indications of becoming more stable.

What should be done? We have technology. We have law. What we don't have but need are cost-benefit analyses under specific circumstances.

It is wonderful that the tide of popular opinion seems to be rolling against the abuse of psychoactive drugs. We should keep it rolling. However, the adverse effects of excessive zeal on individuals, organizations, and society can be enormous. We should not perform actions that are as likely to cause harm as good. Salient points that must not be ignored include:

- If the technology is to be applied, it must be with excellent accuracy and reliability.
- Due process for individuals must be ensured.
- Hypocrisy must be minimized.
- Any actions taken must be with the recognition that the parties involved may end up in court; this is often the case.
- For persons in jobs that involve assumption of great responsibility for other individuals, or for society as a whole, the application of mandatory unannounced random urine drug screening is more justifiable than for a person in a position without such responsibilities.
- For highly visible individuals and professions, whose private lives are unlikely to cause great social harm, direct screening may be beneficial from a public relations or exemplary standpoint. Television actors and rock stars, along with professional athletes, might bear this in mind.
- For employees or others who show evidence of impairment, the employee assistance program approach should be fully used.

In summary, psychoactive drug abuse is a phenomenon of our time as it has been throughout recorded time. No degree of law enforcement or punitive activities are likely to have much effect in a free society. Peer pressure remains the principal force at all ages. If our society feels that the problems of drug use are so great as to justify the loss of individual freedoms, mandatory random urine drug screening can be done. However, if this is to be the case, it should come from a group societal decision by the vote process of an informed electorate, probably through state-by-state referenda. Such a national application would probably necessitate an amendment to the US Constitution. The issue is that important.

The times remain interesting. Fortunately, the rule of innocent until proven guilty still obtains in our society.

George D Lundberg, MD

1. Lundberg GD. Urine drug screening: Chemical McCarthyism. *N Engl J Med* 1972;287:723-724.
2. Hansen HJ, Caudill SD, Boone J. Crisis in drug testing. *JAMA* 1985;253:2382-2387.
3. Ziporyn T. Designer drugs. *JAMA* 1986;256:3061-3063.

Drugs Detectable by Drug Screen

This test specifically screens for the presence of each of the drugs listed below (by both generic and trade name). Results are quantitative in serum and qualitative in urine and gastric fluid.

Serum (and Gastric)

Barbiturates:
Allobarbital (Dialog®)
Amobarbital (Amytal®)
Aprobarbital (Alurate®)
Alurate® (Aprobarbital)
Amytal® (Amobarbital)
Barbital
Butabarbital (Butisol®, etc.)
Butalbital (Fiorinal®)
Butisol® (Butabarbital)
Dialog® (Allobarbital)
Fiorinal® (Butalbital)
Mebaral® (Mephobarbital)
Mephobarbital (Mebaral®)
Mysoline® (Primidone)
Nembutal® (Pentobarbital)
Pentobarbital (Nembutal®)
Pentothal® (Thiopental)
Primidone (Mysoline®)
Phenobarbital
Secobarbital (Seconal®)
Seconal® (Secobarbital)
Thiopental (Pentothal®)

Minor Tranquilizers:
Dalmane® (Flurazepam)*
Diazepam (Valium®)*
Chlordiazepoxide (Librium®)
Flurazepam (Dalmane®)*
Librium® (Chlordiazepoxide)
Oxazepam (Serax®)*
*Nordiazepam (Tranxene®)**
Serax® (Oxazepam)*
Tranxene® (Nordiazepam)*
Valium® (Diazepam)*

Hypoglycemics:
Acetohexamide (Dymelor®)
Chlorpropamide (Diabinase®)
Diabinase® (Chlorpropamide)
Dymelor® (Acetohexamide)
Orinase® (Tolbutamide)
Tolazamide (Tolinase®)
Tolbutamide (Orinase®)
Tolinase® (Tolazamide)

Anticonvulsants:
Carbamazepine (Tegretol®)
Celontin® (Methsuximide)
Depakene® (Valproic Acid)
Dilantin® (Phenytoin)
Ethosuximide (Zarontin®)
Methsuximide (Celontin®)
Phenytoin (Dilantin®)
Tegretol® (Carbamazepine)
Valproic Acid (Depakene®)
Zarontin® (Ethosuximide)

Sedatives:
Doriden® (Glutethimide)
Ethchlorvynol (Placidyl®)
Meprobamate (Miltown®, etc.)
Methyprylon (Noludar®)
Methaqualone (Quaalude®)*
Miltown® (Meprobamate)
Noludar® (Methyprylon)
Placidyl® (Ethchlorvynol)
Quaalude® (Methaqualone)*
Glutethimide (Doriden®)

Major Tranquilizers:
Chlorpromazine (Thorazine®)*
Mellaril® (Thioridazine)*
Thioridazine (Mellaril®)*
Thorazine® (Chlorpromazine)*

Antidepressants:
Amitriptyline (Elavil®)*
Aventyl® (Nortriptyline)*
Desipramine (Norpramine®)*
Doxepin (Sinequan®)*
Elavil® (Amitriptyline)*
Imipramine (Tofranil®)*
Ludiomil® (Maprotiline)*
Maprotiline (Ludiomil®)*
Norpramine® (Desipramine)*
Nortriptyline (Aventyl®)*
Sinequan® (Doxepin)*
Surmontil® (Trimipramine)*
Tofranil® (Imipramine)*
Trimipramine (Surmontil®)*

Analgesics:
Acetaminophen (Tylenol®)*
Acetylsalicylate (Aspirin®)
Aspirin® (Acetylsalicylate)
Advil® (Ibuprofen)
Butazolidin® (Phenylbutazone)
Darvon® (Propoxyphene)
Ibuprofen (Motrin®, Advil® Nuprin®)
Motrin® (Ibuprofen)
Naprosyn® (Naproxen)
Naproxen (Naprosyn®)
Nuprin® (Ibuprofen)
Phenylbutazone (Butazolidin®)
Propoxyphene (Darvon®)
Salicylate
Tylenol® (Acetaminophen)

Sympathomimetics:
None

Stimulants:
Caffeine°
Nicotine*
Strychnine*
Theobromine° (cacao bean products)
Theophylline (aminophylline, etc.)

Urine

All drugs detectable in serum are also detectable in urine, except glutethimide. Because the minor tranquilizers are extensively metabolized, they are not likely to be detected in urine unless an overdose is taken. The following are detected in urine but not in serum:

Sedatives:
Doxylamine (Unisom®, etc.)
Pyrilamine (Sominex®, etc.)
Sominex® (Pyrilamine)
Unisom® (Doxylamine)

Sympathomimetics:
Anahist® (Thonzylamine)
Benadryl® (Diphenhydramine)
Chlorpheniramine
Diphenhydramine (Benadryl®)
d,l-ephedrine (Sudafed®, etc.)
Sudafed® (d,l-ephedrine)
Thonzylamine (Anahist®, etc.)

Analgesics:
Demerol® (Meperidine)
Dolophine® (Methadone)
Meperidine (Demerol®)
Methadone (Dolophine®)
Opiates (by class)
Pentazocine (Talwin®)
Talwin® (Pentazocine)

Major Tranquilizers:
Chlorpromazine (Thorazine®)
Compazine® (Prochlorperazine)
Mellaril® (Thioridazine)
Prochlorperazine (Compazine®)
Stelazine® (Trifluoperazine)*
Thioridazine (Mellaril®)
Thorazine® (Chlorpromazine)
Trifluoperazine (Stelazine)*

Stimulants:
Amphetamine (Benzedrine®)
Angel Dust (Phencyclidine)
Benzedrine® (Amphetamine)
Cocaine
Desoxyn® (Methamphetamine)
Dexatrim® (Phenylpropanolamine)
Metamphetamine (Desoxyn®)
Methylphenidate (Ritalin®)
Phencyclidine (Angel Dust)

Phenylpropanolamine (Dexatrim®, etc.)

Ritalin® (Methylphenidate)

*Drug detectable only at supratherapeutic levels.
°Results reported only if >15 µg/mL.
'Only detectable in serum at grossly elevated concentrations—rely on urine for screening.

SENATE JUDICIARY
EXHIBIT NO. 3
DATE Feb. 17, 1987
BILL NO. SB 338

MONTANA STATE AFL-CIO
APRIL 29 1956

Box 1176, Helena, Montana

JAMES W. MURRY
EXECUTIVE SECRETARY

ZIP CODE 59624
406/442-1708

TESTIMONY OF JIM MURRY ON SENATE BILL 338 BEFORE THE SENATE JUDICIARY COMMITTEE, FEBRUARY 17, 1987

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, FOR THE RECORD MY NAME IS JIM MURRY AND I'M HERE TODAY ON BEHALF OF THE MONTANA STATE AFL-CIO TO TESTIFY IN SUPPORT OF SENATE BILL 338.

WE BELIEVE THAT THE WORKPLACE SHOULD REMAIN DRUG AND ALCOHOL FREE. ALCOHOLISM AND DRUG ABUSE CAN SERIOUSLY IMPAIR A PERSON'S PHYSICAL AND MENTAL PERFORMANCE WHEN USED ON-THE-JOB. AND THE SERIOUS SIDE-EFFECTS CAUSED BY DRUG AND ALCOHOL ADDICTIONS ARE HARMFUL NOT ONLY TO THE PERSON INVOLVED, BUT ALSO TO FAMILY, FRIENDS AND CO-WORKERS.

IT'S IMPORTANT TO UNDERSTAND THAT ALCOHOL AND DRUG ABUSE ARE ILLNESSES AND THAT PEOPLE SUFFERING FROM THESE ADDICTIONS NEED TREATMENT AND MEDICAL HELP; NOT PUNISHMENT.

UNFORTUNATELY, IT HAS BECOME INCREASINGLY COMMON FOR EMPLOYERS BOTH IN THE PUBLIC AND PRIVATE SECTORS, TO USE RANDOM DRUG TESTING AS A METHOD TO SCREEN ALL JOB APPLICANTS OR AS A CONDITION OF EMPLOYMENT.

WE STRONGLY OPPOSE THE USE OF RANDOM DRUG TESTS BECAUSE THEY ARE INVASIONS OF PRIVACY AND VIOLATE PROTECTIONS AGAINST UNREASONABLE SEARCH AND SEIZURE. PROVISIONS ENACTED IN ANY DRUG TESTING PROPOSAL MUST PROTECT A WORKER'S CONSTITUTIONAL RIGHTS, WHILE AT THE SAME TIME PREVENTING AN ALCOHOL OR DRUG IMPAIRED INDIVIDUAL FROM CONTRIBUTING TO AN UNSAFE WORKPLACE.

WE BELIEVE THAT THIS BILL HAS SAFEGUARDS TO PROHIBIT RANDOM AND INDISCRIMINATE DRUG TESTING AND PROTECTS THE CIVIL RIGHTS OF WORKERS.

BESIDES THE PRIVACY ISSUES INVOLVED IN RANDOM DRUG TESTING, WE ALSO CONTEND THAT DRUG TESTING PROCEDURES THEMSELVES ARE OFTEN FLAWED. FALSE POSITIVE TESTS CAN OCCUR AT LEAST 25 PERCENT OF THE TIME. THEY CAN BE TRIGGERED BY SUCH COMMON SUBSTANCES AS COLD MEDICATIONS, COUGH SYRUPS, CAFFEINE AND ASTHMA MEDICINES. WITH THIS HIGH DEGREE OF INACCURACY, WE ARE CONCERNED THAT EMPLOYEES WILL BE INACCURATELY LABELED AS SUBSTANCE ABUSERS AND DISCHARGED WITHOUT CAUSE.

HOWEVER, THIS BILL APPEARS TO ALLEVIATE MOST OF OUR CONCERNS OVER INACCURATE TEST RESULTS. EMPLOYEES HAVE THE OPPORTUNITY, AT THE EMPLOYER'S EXPENSE, TO CHALLENGE ANY TEST RESULT BY OBTAINING INDEPENDENT TESTS AT A LAB OF THEIR OWN CHOICE. ALSO, BY GIVING EMPLOYEES THE OPPORTUNITY TO REFUTE OR EXPLAIN POSITIVE TEST RESULTS, YOU BUILD SAFEGUARDS AGAINST FALSE ACCUSATIONS BY EMPLOYERS.

THE MONTANA STATE AFL-CIO BELIEVES THAT BOTH WORKERS AND EMPLOYERS SHOULD CONTINUE WORKING TOGETHER TO DEVELOP CONSTRUCTIVE SOLUTIONS TO DRUG AND ALCOHOL ABUSE. WE DO NOT BELIEVE THAT EMPLOYERS, WHO ARE INCREASINGLY CAUGHT IN THE HYSTERIA SURROUNDING DRUG USE, SHOULD USE IMPROPER OR PUNITIVE DRUG TESTING PROCEDURES. WE DEPLORE ANY DRUG TESTING MEASURES WHICH ARE ARBITRARY OR WHICH EXCESSIVELY INFRINGE ON THE RIGHTS OF EMPLOYEES.

BECAUSE THIS BILL SUFFICIENTLY PROTECTS WORKERS' RIGHTS AND ATTEMPTS TO REMEDY SUBSTANCE ABUSE PROBLEMS, WE URGE YOU TO SUPPORT SENATE BILL 338.

SENATE JUDICIARY
EXHIBIT NO. 3
DATE 2-17-87

SENATE JUDICIARY
EXHIBIT NO. 4
DATE Feb. 17 1987
BILL NO. SB 338

SB-338
(Proposing to Amend 39-2-304)

STATEMENT OF DAN C. EDWARDS
International Representative
Oil, Chemical and Atomic Workers International Union
P.O. Box 21635
Billings, MT 59104
669-3253

Before the SENATE JUDICIARY COMMITTEE, 10:00 am, February 17, 1987, Helena, Montana

Good Morning:

My name is Dan Edwards. I am an International Representative with the Oil, Chemical and Atomic Workers International Union. I live in Billings, but my area of assignment includes the entire State of Montana. I am also speaking on behalf of the Montana State AFL-CIO on this Bill.

The Oil, Chemical and Atomic Workers International Union (OCAW) represents approximately 110,000 workers in the oil, chemical and related industries. As are all of you, OCAW is vitally concerned about the abuse of alcohol and drugs in our society. However, we are also vitally concerned that any policy or program that deals with the testing of workers for alcohol or drugs be based upon a sound "probable cause" basis.

Perhaps before I go any further, I should briefly tell of my background in this field. Prior to my transfer to Billings in the latter part of 1986, I was the Director of Health and Safety for the International Union, located in Denver, Colorado. In that capacity, one of my areas of responsibility was to assist our Legal Department in the development of a just and reasonable position regarding testing of employees for alcohol and drugs by employers. For a period of nearly 18 months I spent about 80% of my time doing research in this area and assisting OCAW Local Unions across the Country in fighting unreasonable, unfair testing programs. This experience makes me qualified to address this most important Bill.

There is a wave of hysteria sweeping the United States today surrounding this matter--and small wonder with the President and First Lady being the Head Cheerleaders. We hear so much about the evils of drugs--and they are evil--that very little is being said about the many problems that are found regarding the adoption of workplace drug testing programs. Problems that deal with the accuracy of the testing, of the accurate reporting of the results of drug testing, of persons exposed to marijuana smoke, but not smoking it themselves, testing positive, of the absolute necessity for reasonable "sensitivity" or "cut off" levels for determining that an employee has tested positive for drugs, and of the stigma that can attach itself to a worker when that worker is required to "pee in the bottle".

First, I want to make it very clear that OCAW does not support or condone in any way whatsoever, the use of drugs or alcohol on-the-job, or coming to work under the influence of any substance. However, unless it can be demonstrated by clear, objective evidence that a worker is impaired on the job, or that a worker's job performance is effected, we believe that workers have the same rights as any other American against unwarranted employer intrusion into an employee's private life away from the workplace. IT IS NOT THE ROLE OF THE EMPLOYER TO BE SOCIETY'S POLICEMAN. That's what this Bill SB-338 is all about.

The abuse of alcohol and drugs is not new. In fact, figures I have seen seem to indicate that in some areas the use (and abuse) of alcohol and drugs is actually declining as people become better informed about the hazards of their use. What is new, is the technology to cheaply detect the metabolites of certain drugs in a persons body fluids. In my sincere opinion, one of the major driving forces behind the rash of drug testing programs are the many company--most of them brand new companies that didn't even exist a few years ago--which see BIG BUCKS to be made by selling industry drug testing programs. Drug testing kits for the initial drug screen can be found for under $5.00 each. Now any reputable drug testing company is going to require that a second test, using a different methodology be done to confirm the results since the tests used for the initial screening can have a high rate of

false-positives. But, there are no laws that I'm aware of in any State in the Nation to require confirmation testing to be done. I don't think it takes a real genious to see that many companies, especially smaller companies, are not going to bother to have the confirmation testing done--especially since the confirmation testing is much more expensive ($75-100.00). They are simply going to fire the worker if they can.

I used the word "false-positive" just a minute ago. This term means that a test comes back as "positive" when in fact the drug or substance being tested for is not present in the sample. There are many reasons this can happen. Rather than take your valuable time here today I have attached a copy of a study done by the Center for Disease Control (CDC) which shows false-positive error rates as high as 66% in drugs commonly tested for. This scientific study was published in the Journal of the American Medical Association in April of 1985. If you take the time to read this study you will see why caution is necessary.

A second thing about drug testing that most people aren't aware of is that the drug tests we have been talking about do not detect the psychoactive ingredients in a person's urine--they detect the metabolites of the drugs. In some cases, most notably marijuana, the drug metabolites can remain stored in a persons body fat for many weeks. The metabolites do not cause impaired performance. In fact, all manufacturers of drug testing kits are very careful to point out in their literature that a positive test does not prove impairment, or under the influence.

It is for the above reasons, that even when drug testing is done in "for cause" situations reasonable "sensitivity" or "cut off" levels must be established. The CCAW has spent a great deal of time and effort to determine what constitutes reasonable sensitivity levels for the drugs commonly tested for. Our Legal Department and Health and Safety Department collaborated with David Johnson, M.D., Professor of Internal Medicine and Pharmacology and Chief of the Endocrinology Section at the University Medical Center, University of Arizona College of Medicine, to arrive at reasonable sensitivity levels--these are attached as Appendix A.

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There are many other pieces that were we here today to talk about the development of reasonable drug testing policies between management and the Union, I would go into. Since, however, my purpose here today is to urge this Committee to pass this modest piece of legislation, I will end my prepared remarks at this point.

I would be pleased to answer any questions that members of the Committee might have.

Thank you.

Respectfully submitted,

Dan C. Edwards

Dan C. Edwards

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APPENDIX A :

The following levels of toxicity are reasonable and shall be utilized as minimum guidelines:

Amphetamines (dextro-amphetamines, methamphetamine and phentermine);
Between 3 and 10 micrograms per mil

Barbituates (secobarbital, amobarbital, butabarbital, pentobarbital, phenobarbital):
Between 20 and 60 micrograms per mil

Benzodiazepines (diazepam, desmethyldiazepam, chlordiazepoxide, oxazepam):
Between 10 to 30 micrograms per mil

Benzoylecogonine:
Between 6 and 60 micrograms per mil

Cannabinoids:
Between 100 and 150 nanograms per mil

Methadone:
3 to 10 micrograms per mil

Methaqualone:
50 micrograms per mil

Opiates:
Morphine: 3 micrograms per mil
Codeine: 10 micrograms per mil
Phencyclidine: between 0.6 and 6 micrograms per mil

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Crisis in Drug Testing

Results of CDC Blind Study

Hugh J. Hansen, PhD; Samuel P. Caudill, PhD; D. Joe Boone, PhD

• **In response to questions about the reliability of the results of screening urine for drugs, we evaluated the performance of 13 laboratories, which serve a total of 262 methadone treatment facilities, by submitting prereferenced samples through the treatment facilities as patient samples (blind testing). Error rates for the 13 laboratories on samples containing barbiturates, amphetamines, methadone, cocaine, codeine, and morphine ranged from 11% to 94%, 19% to 100%, 0% to 33%, 0% to 100%, 0% to 100%, and 5% to 100%, respectively. Similarly, error rates on samples not containing these drugs (false-positives) ranged from 0% to 6%, 0% to 37%, 0% to 66%, 0% to 6%, 0% to 7%, and 0% to 10%, respectively. These blind tests indicate that (1) greater care is taken with known evaluation samples than with routine samples, (2) laboratories are often unable to detect drugs at concentrations called for by their contracts, and (3) the observed underreporting of drugs may threaten the treatment process. Drug treatment facilities should monitor the performance of their contract laboratories with quality-control samples, preferably through blind testing.**

(*JAMA* 1985;253:2382-2387)

FROM 1972 through 1981, the Centers for Disease Control (CDC), in conjunction with the National Institute on Drug Abuse, conducted a proficiency testing (PT) program for drugs-of-abuse screening laboratories.[1] In this program, ten drug-spiked urine samples were mailed quarterly to each participating laboratory (each laboratory received 40 "mailed PT" samples per year). The participants in the program tested the samples for the requested drugs and submitted a report for grading on each quarterly survey by the cutoff date. If at least 80% of the responses were correct, the laboratory was classified as "satisfactory"; otherwise, the laboratory was classified as "unsatisfactory."

Early in the program, allegations were made that some laboratories were not subjecting mailed PT samples to the same testing procedures as their routine patient samples. These claims prompted two CDC studies in which data were collected through an alternative mode of PT—the blind test. This mode of testing requires the use of a dedicated surrogate office to introduce the test samples into the laboratory without the laboratory's knowledge (for example, a physician's office or a drug treatment facility). In these studies (one in 1973, with 24 laboratories, and another in 1975, with nine laboratories), results of mailed PT were compared with blind PT laboratory performance.[2] Although the percentage of drugs detected by laboratories in the two studies ranged from 76% to 100% (average, 98%) on mailed PT samples, the percentage on blind PT samples for the same laboratories testing identical samples ranged from 11% to 100% (average, 69%). Additional CDC blind studies (an initial study in 1978 conducted with the assistance of the Federal Bureau of Prisons and another in 1980 with the assistance of two treatment centers) provided results similar to those from the earlier CDC blind studies.[3] The percentage of drugs detected by the six laboratories ranged from 37% to 74% (average, 61%).

Supportive of the CDC blind studies, other investigators have reported on blind studies that showed error rates of a magnitude comparable with those found by the CDC. In one such study, in 1976, Gottheil et al[4] reported blind testing results for a drug-screening laboratory that detected only 65% of the drugs in the samples.

From the Clinical Chemistry and Toxicology Section, Performance Evaluation Branch, Division of Technology Evaluation and Assistance (Drs Hansen and Boone), and Management Development and Consultation Division (Dr Caudill), Laboratory Program Office, Centers for Disease Control, Atlanta. Dr Hansen is now with the National Institute for Occupational Safety and Health, Centers for Disease Control, Atlanta.

Reprint requests to Centers for Disease Control, Bldg 6, Room 316, 1600 Clifton Rd NE, Atlanta, GA 30333 (Dr Boone).

purposes of this report, the acceptance sampling plans used were designed to classify laboratories as acceptable or unacceptable based only on their FNRs. This decision was made because false-negatives tended to occur much more frequently than false-positives and because the results when presented in this form are more amenable to comparison with results in previous studies.

The acceptance sampling plans for each drug or drug class are presented in Table 2, where n represents the number of positive challenges and r represents the maximum number of false-negatives a laboratory could have and still be classified as acceptable. Also presented in Table 2 are the probabilities with which laboratories with the associated FNR would be expected to be classified as acceptable based on the corresponding sampling plan. These probabilities give an indication of how well the various sampling plans should perform in discriminating between laboratories with various FNRs. Inspection of Table 2 will show that these plans can be expected to classify (with $P>.90$) laboratories with an FNR of 0.05 or less as acceptable and to classify (with $P\leq 0.10$) laboratories with an FNR of 0.20 or greater as acceptable. For example, a laboratory with an FNR of 0.05 for barbiturates would have a probability of about .96 of receiving an acceptable classification (ie, four or fewer false-negatives in a set of 38 samples containing barbiturates), whereas a laboratory with an FNR of 0.20 for barbiturates would have a probability of only .10 of receiving an acceptable classification.

In the evaluation process, barbiturates and amphetamines were each treated as a class. The metabolites of methadone and cocaine were added to mimic a patient sample and were not treated separately. Morphine and codeine were treated separately. At the treatment facilities, the blind samples were intermixed among patient samples and thereafter treated exactly as patient samples. The number of blind samples entering the laboratory from any given treatment facility was not greater than 10% of the total number of samples submitted.

Table 3.—Laboratories With Acceptable Performance*

Drug or Drug Class	Total No. of Laboratories†	No. (%) of Laboratories With Acceptable Performance
Barbiturates	11	1 (9)
Amphetamines	12	0 (0)
Methadone	12	6 (50)
Cocaine	11	1 (9)
Codeine	13	2 (15)
Morphine	13	1 (8)

*Laboratories were considered acceptable for a particular drug based on the statistical design of the 1981 blind study.

†To ensure (with $P\geq.95$) that laboratories with a false-negative rate of 0.25 or more would be classified as unacceptable and to ensure (with $P\geq.90$) that laboratories with a false-negative rate of 0.05 or less would be classified as acceptable, only laboratories subjected to at least 29 positive challenges for a given drug or drug class were included.

Comparison of blind studies, 1973 through 1981, shown as the percentage of correct responses on positive challenges by drug: 1973, Centers for Disease Control (CDC), 24 laboratories; 1975, CDC, nine laboratories; 1976, Jefferson Medical College, one laboratory (see reference 4); 1978, CDC, four laboratories; 1980, CDC, two laboratories; 1981, CDC, 13 laboratories. (Supporting data for this figure contained in Table 4.)

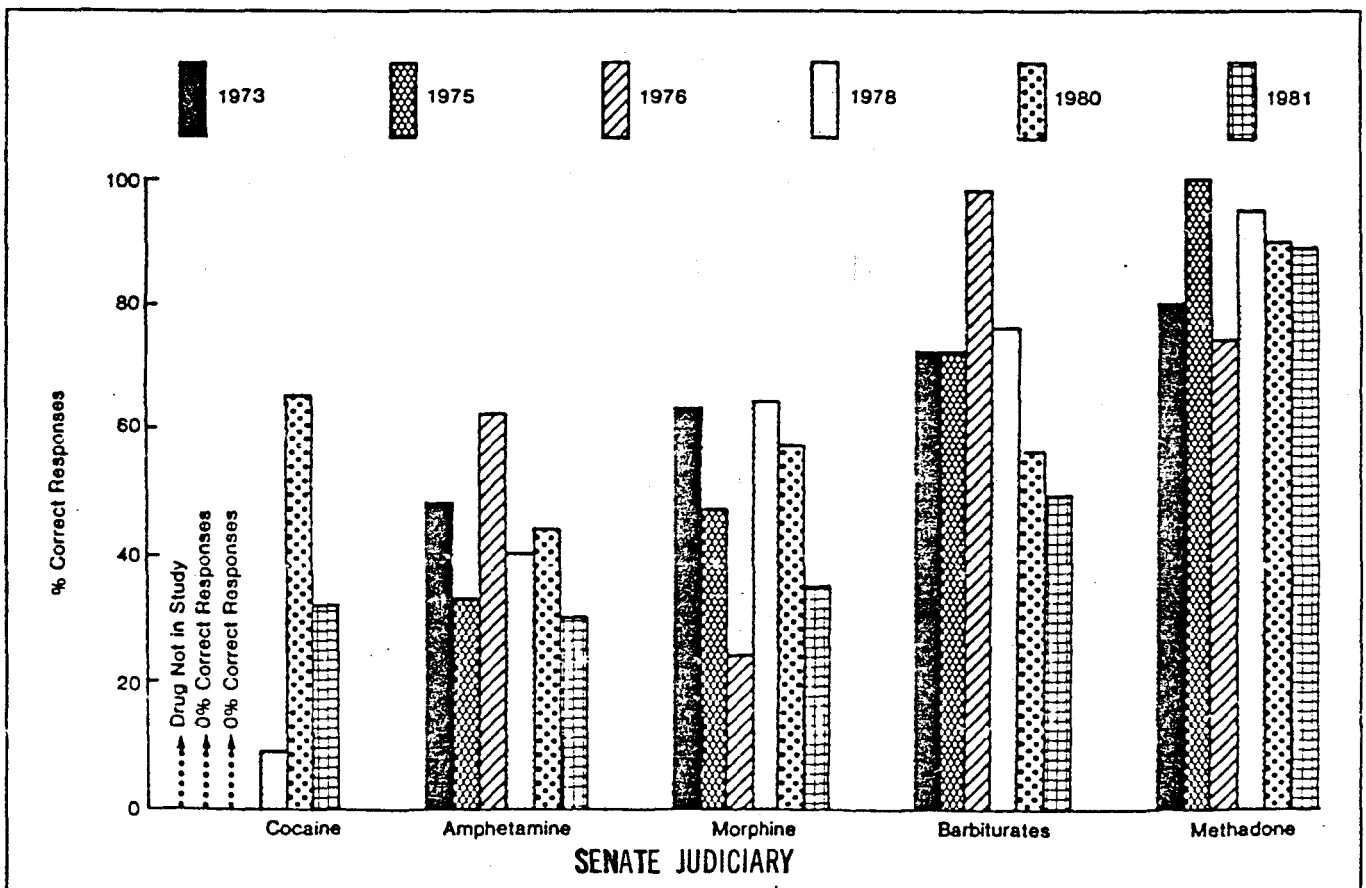

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Table 1.—Summary of Data on Drug or Drug Class Included in the 1981 Blind Study*

Drug or Drug Class	Centers for Disease Control's (CDC) MRLs, μg/mL	Concentration† Range, μg/mL	No. of Challenges: Drug	No. of Challenges: Total
Barbiturates				
Phenobarbital	1.0	1.0-2.0	26	
Pentobarbital	1.0	1.2-3.0	5	38
Secobarbital	1.0	1.0-2.0	7	
Amphetamines				
d-amphetamine	1.0	1.0-2.0	32	56
Methamphetamine	1.0	1.0-3.0	24	
Methadone				
Methadone (parent)	1.0	1.0-2.0	44	88
Methadone (metabolite)‡	1.0	1.0-2.0	44	
Cocaine				
Cocaine (parent)	2.0	2.0-4.0	23	57
Cocaine (metabolite)§	4.0	4.0-5.0	34	
Opiates				
Codeine	0.5	0.8-2.0	40	
Morphine (parent)‖		0.1-0.8	39	118
Morphine (metabolite)¶		0.9-1.8	39	
Others#				
Phencyclidine hydrochloride (PCP)	1.0	0.3-4.3	24	
Methaqualone (Quaalude)		1.0-2.0	27	
Pentazocine (Talwin)		1.0-2.0	11	67
Propoxyphene hydrochloride (Darvon)		3.0	3	
Cannabinoid (Δ^9-metabolite)		0.2	2	

*The minimum reporting levels (MRLs), concentration range, and the number of samples containing a particular drug.

†Concentrations below the CDC's MRLs were not used in the evaluation.

‡2-Ethyl-1,5-dimethyl-3,3-diphenylpyrrolium perchlorate.

§Benzoylecgonine.

‖The MRL for total morphine was 0.5 μg/mL. No sample had less than 1.0 μg/mL.

¶Morphine glucuronide.

#Not considered in evaluation.

Table 2.—Sampling Plans and Associated Probabilities for the Centers for Disease Control Blind Study (Positive Challenges Only)

Drug or Drug Class	Sampling Plan* n	Sampling Plan* r	P of Acceptable Classification† FNR=0.05	FNR=0.10	FNR=0.20	FNR=0.25
Barbiturates	38	4	.96	.67	.10	.02
Amphetamines	48	4	.91	.47	.02	.003
Methadone	45	4	.93	.53	.04	.01
Cocaine	34	3	.91	.55	.07	.02
Codeine	42	4	.94	.59	.06	.01
Morphine	40	4	.95	.63	.08	.02

*n indicates the intended number of positive challenges; r, the maximum number of false-negatives allowable for acceptable classification.

†FNR indicates false-negative rate (ie, the relative frequency in routine testing with which a laboratory concludes that a positive [drug present] sample is negative [drug absent]).

The laboratory also reported 152 false-positive results occurring in 106 (66.5%) of the 160 samples.

With the background of previous studies that suggested a number of laboratories may have high error rates on routine patient samples, a blind study was undertaken with two primary objectives in mind: (1) to determine error rates that would reflect the laboratory error rates on routine patient samples and (2) to classify the laboratory's performance as acceptable or unacceptable on the basis of predefined drug-screening error rates.

METHODS

Selection of Laboratories

The primary factor in selecting the laboratories included in this study was the number of methadone centers they served and not their previous performance on mailed PT or reports of poor performance from treatment programs. The number of methadone centers served by the selected laboratories ranged from four to 83 and spanned 26 states. The 13 laboratories selected served a total of 262 methadone centers. Although all laboratories in the mailed PT program were informed that selected laboratories would be surveyed in blind studies, the specific laboratories selected were not notified of their selection.

Sample Preparation

Each laboratory in the study received 100 urine samples. Each sample was selected from stock samples previously analyzed in the CDC's mailed PT program by 450 toxicology laboratories, including 40 reference laboratories. Each sample was prepared from human urine that had been screened by thin-layer chromatography and found to be free of the drugs being tested for in this study. The urine pool was prefiltered through a 0.22-μm membrane. Drugs or their metabolites in their salt form were added quantitatively to provide the concentrations shown in Table 1. Each pool was sterilized by filtration and dispensed asceptically into 60-mL vials. The samples were then stored at +4 °C until they were shipped to the treatment facilities. The samples were reanalyzed at the end of the study, and the initial concentrations were confirmed.

Minimum Reporting Levels

The CDC Mailed Proficiency Testing Program provides minimum reporting levels with each PT survey. All drug concentrations above the minimum reporting levels are to be reported positive; those below, negative. The CDC's minimum reporting levels (Table 1) were decided on by a peer review committee established by the National Institute on Drug Abuse, which consisted of consultants selected from the ranks of nationally known toxicologists. All laboratories included in this survey were able to detect drugs at the minimum reporting levels listed in the quarterly mailed surveys, as evidenced by satisfactory performance in the mailed surveys.

Study Design and Analysis

The CDC blind study was designed to classify (with $P \geq .90$) laboratories with a false-negative rate (FNR) and a false-positive rate (FPR) of 0.05 or less as acceptable and to classify (with $P \leq .05$) laboratories with FNR or FPR of 0.25 or greater as unacceptable. This objective was accomplished using "attribute acceptance sampling plans"[] to specify the number of positive (drug present) and negative (drug absent) samples to be tested by each laboratory for each drug and a rule for deciding whether a given laboratory has an acceptable FNR and FPR. For the

Table 4.—Supporting Data for the Figure: Number of Positive Drug Challenges and Percentage of Correct Responses by Drug by Year*

Drug or Drug Class	1973, 24 Laboratories; No. (%)	1975, 9 Laboratories; No. (%)	1976, 1 Laboratory; No. (%)	1978, 4 Laboratories; No. (%)	1980, 2 Laboratories; No. (%)	1981, 13 Laboratories; No. (%)
Cocaine	Not included	7† (0)	66 (0)	90 (9)	85‡(65)	412 (32)
Amphetamines	82 (43)	9 (33)	66 (62)	106 (40)	169 (44)	566 (30)
Morphine	111 (63)	45 (47)	66 (24)	120 (64)	164 (57)	470 (35)
Barbiturates	110 (72)	36 (72)	66 (36)	165 (76)	160 (56)	456 (49)
Methadone	100 (80)	54 (100)	66 (74)	105 (95)	134 (90)	538 (89)

*Percentages were obtained by dividing the total number of correct responses by the total number of positive drug challenges.
†Only seven of the nine laboratories in the study offered a service for testing for cocaine.
‡Data were available from only one laboratory for cocaine testing.

Table 5.—Summary of Results on Positive Samples by Drug or Drug Class From Blind Study*

Laboratory	Drug or Drug Class																	
	Barbiturates			Amphetamines			Methadone			Cocaine			Codeine			Morphine		
	No.	CRR, %	CI, %	No.	CRR, %	CI, %	No.	CRR, %	CI, %	No.	CRR, %	CI, %	No.	CRR, %	CI, %	No.	CRR, %	CI, %
A	38	16	6-31	47	0	0-8	44	73	57-85	34	0	0-10	40	8	2-20	39	44	28-60
B	38	50	33-67	47	74	60-86	44	89	75-96	34	76	59-89	40	33	19-49	39	49	32-65
C	38	89	75-97	47	81	67-91	44	100	92-100	34	0	0-10	40	100	91-100	39	95	83-99
D	38	26	13-43	47	43	28-58	44	91	78-97	34	9	2-24	40	53	36-68	39	3	0-11
E	18	6	0-24	20	20	6-44	28	86	67-96	20	90	68-99	16	19	4-46	18	17	4-41
F	38	16	6-31	47	0	0-8	44	98	90-100	34	0	0-10	40	0	0-9	39	0	0-9
G	19	16	3-40	31	65	45-81	24	67	45-84	18	0	0-19	19	0	0-18	19	53	29-76
H	37	46	29-63	44	11	4-25	45	78	63-89	32	19	7-36	44	59	43-74	42	40	26-57
I	38	21	10-37	47	0	0-8	44	100	92-100	34	0	0-10	40	25	13-41	39	5	1-17
J	40	43	29-59	48	13	5-25	45	93	82-99	36	61	43-77	42	38	24-54	40	13	4-27
K	38	63	46-78	47	40	26-56	44	100	92-100	34	100	90-100	40	93	80-98	39	31	17-48
L	38	61	43-76	47	6	1-18	44	89	75-96	34	32	17-51	40	33	19-49	39	23	11-39
M	38	84	69-94	47	47	32-62	44	86	73-95	34	38	22-56	40	53	36-68	39	85	69-94

*The number of samples, the correct response rate (CRR), and the 95% confidence interval (CI), on the CRR for the 13 laboratories in the Centers for Disease Control blind study. Confidence intervals were computed based on the binomial probability distribution.

Table 6.—Summary of Results on Positive Samples by Drug or Drug Class From Mailed Proficiency Testing Surveys 1979 II through 1981 I*

Laboratory	Drug or Drug Class																	
	Barbiturates			Amphetamines			Methadone			Cocaine			Codeine			Morphine		
	No.	CRR, %	CI, %	No.	CRR, %	CI, %	No.	CRR, %	CI, %	No.	CRR, %	CI, %	No.	CRR, %	CI, %	No.	CRR, %	CI, %
A	35	100	98-100	32	97	86-100	30	100	88-100	29	100	88-100	28	68	48-84	29	100	88-100
B	19	100	82-100	19	95	77-100	18	100	82-100	17	100	81-100	19	74	49-91	18	100	82-100
C	39	100	91-100	36	97	88-100	34	100	90-100	31	100	89-100	32	100	89-100	32	100	89-100
D	39	100	91-100	36	100	90-100	34	100	90-100	32	84	69-100	32	84	67-95	32	88	71-96
E	39	95	83-99	36	100	90-100	34	97	87-100	32	97	86-100	32	97	86-100	32	100	89-100
F	39	97	89-100	36	92	78-98	34	100	90-100	31	97	86-100	...†			...†		
G	34	100	90-100	32	100	89-100	29	100	88-100	25	100	86-100	27	100	87-100	27	100	87-100
H	39	95	83-99	36	83	67-94	34	100	90-100	31	100	89-100	32	100	89-100	32	97	86-100
I	39	97	89-100	36	100	90-100	31	100	89-100	31	100	89-100	32	100	89-100	32	100	89-100
J	34	97	87-100	31	94	79-99	29	100	88-100	25	96	82-100	26	92	82-100	26	69	48-86
K	39	92	79-98	36	97	88-100	34	100	90-100	31	97	86-100	32	97	86-100	32	97	86-100
L	39	100	91-100	36	94	81-99	34	100	90-100	31	100	89-100	32	84	67-95	32	100	89-100
M	39	97	89-100	36	94	81-99	34	100	90-100	31	87	70-96	32	100	89-100	32	100	89-100

*The number of samples, the correct response rate (CRR%), and 95% confidence interval (CI) on the CRR for each of the 13 laboratories in the Centers for Disease Control 1981 blind study. Confidence intervals were computed based on the binomial probability distribution. Quarterly surveys are designated by the numbers I through IV.

†Service not offered for these drugs.

RESULTS

The number and percentage of laboratories whose performance was found acceptable on a particular drug according to the acceptance sampling plan described in Table 2 are shown in Table 3. A graphic comparison by drug or drug class of the overall correct response rates of the 13 laboratories in the 1981 CDC blind study with those obtained in the aforementioned five previous studies is presented in the Figure, with supporting data summarized in Table 4.

A summary of results on positive samples by drug for each laboratory in the blind study is provided in Table 5. Similarly, a summary of results on positive samples used in mailed PT surveys 1979 II through 1981 I are listed by drug for each laboratory in Table 6 (quarterly surveys are designated by a number I through IV). Although not listed, there were at least 36 non-drug-containing (negative) samples for each of the drugs per laboratory in both blind and composite mailed PT surveys (except for laboratories B and F in the mailed surveys). A summary of correct response rates on both positive and negative samples is listed in Tables 7 and 8 for the blind study and for the composite of mailed surveys. All laboratories in the study had satisfactory scores in the mailed PT survey before the blind test was performed.

For the drugs used in the evaluation, an increase in correct response rate on positive samples with increased drug concentration was suggested by a χ^2 goodness-of-fit test for the drugs—barbiturates ($P<.002$), morphine ($P<.008$), and codeine ($P<.009$)—test results were not significant for D-amphetamine and methadone; methamphetamine and cocaine did not have a range of concentrations amenable to analysis.

Table 7.—Comparison of Laboratory Performance on Positive Samples From Blind Study and Mailed Surveys.*

Drug or Drug Class	Blind Study: Average No. of Challenges per Laboratory	Blind Study: Average CRR, %	Blind Study: CRR Range, %	Mailed PT: Average No. of Challenges per Laboratory	Mailed PT: Average CRR, %	Mailed PT: CRR Range, %
Barbiturates	35	41	6-89	36	98	92-100
Amphetamines	44	31	0-81	34	96	92-100
Methadone	41	88	67-100	32	100	97-100
Cocaine	32	36	0-100	28	98	87-100
Codeine†	37	45	0-100	30	91	68-100
Morphine†	36	38	0-96	30	89	69-100

*Correct response rates (CRRs) for 13 laboratories in the Centers for Disease Control test data: 1981 blind study and mailed proficiency testing (PT) surveys 1979 II through 1981 I (quarterly surveys are designated by the numbers I through IV). Laboratory A did not participate in mailed PT survey for 1981 I.
†Service for these drugs was not offered by laboratory F.

Table 8.—Comparison of Laboratory Performance on Negative Samples From Blind Study and Mailed Surveys*

Drug or Drug Class	Blind Study: Average No. of Challenges per Laboratory	Blind Study: Average CRR, %	Blind Study: CRR Range, %	Mailed PT: Average No. of Challenges per Laboratory	Mailed PT: Average CRR, %	Mailed PT: CRR Range, %
Barbiturates	53	100	94-100	38	100	98-100
Amphetamines	49	97	63-100	41	99	97-100
Methadone	51	88	34-100	43	100	98-100
Cocaine	61	99	94-100	46	100	98-100
Codeine†	55	99	93-100	44	99	95-100
Morphine†	56	98	90-100	44	98	92-100

*Correct response rates (CRRs) for 13 laboratories in the Centers for Disease Control test data: 1981 blind study and mailed proficiency testing surveys 1979 II through 1981 I (quarterly surveys are designated by numbers I through IV). Laboratory A did not participate in mailed proficiency testing survey 1981 I.
†Service for these drugs was not offered by laboratory F.

COMMENT

The results presented in this article show that the laboratories in the study missed a substantial number of the drug challenges. While the results reflect serious shortcomings in the laboratories, the laboratories are only a part of a complex picture involving also the treatment centers, the clients, and the local, state, and federal governments. As early as 1972, Finkle* mentioned the lack of common standards or operational guides among treatment facilities and the absence of "regulations" for analytical practice in the laboratories. Our observations confirm that little has changed even a decade later; contracts between treatment facilities and laboratories lack uniformity in minimum reporting levels, minimum quality-control requirements, and reporting procedures for results. Some treatment facility directors were knowledgeable about the content of their laboratory contracts, but others appeared to have only superficial knowledge of the contract or had no written contract at all.

A possible factor in laboratory behavior resulting in the high level of false-negative errors reported herein may be laboratory perceptions of the kind of results that substantiate progress in the treatment setting. Specifically, negative results are an indicator of successful treatment and the compliance of the patient as well. In addition, they justify the public expenditures for such types of treatment, decrease laboratory costs, and reduce the likelihood that legal means will need to be pursued.

The laboratory behavior leading to low correct response rates on blind samples and generally higher correct response rates on mailed samples does not appear to be the avoidance of testing ("sink testing") in the blind studies; rather, the data suggest less sensitive testing. For example, methadone has the highest correct response rate for both blind and mailed surveys, whereas amphetamines have the lowest for both surveys. This agreement in both testing modes suggests that the minimum reporting levels are higher (less sensitive) in routine testing than in mailed PT. Less sensitive testing may be the primary factor responsible for the high FNRs and comparatively lower FPRs. Less sensitive testing (which means that more drugs will be missed) may result from methodological design, personnel problems, or the reimbursement process. Because contracts are generally awarded to

the lowest bidder, with no prior assessment of testing quality, inadequate reimbursement for services may induce the need for a higher throughput of patient samples. If realistic fee schedules were established for drug tests, perhaps more reliable procedures would be established and better-trained personnel would be hired, leading to higher-quality testing.

A large portion of treatment program budgets is spent on urine testing.[1] In 1976, Gottheil et al[4] projected that 30 million urine samples would be tested. Based on this figure and the error rate range that we have observed in blind studies (37% to 69%), the losses resulting from erroneous results alone would range from $37.2 million to $75.6 million. For urine testing to continue as a major instrument in drug treatment facilities, responsible clinicians and treatment directors should move to curb the waste of private and governmental expenditures. Our experience shows that remarkable improvements may be obtained through effective contracting with laboratories followed by monitoring of the quality of services received.

In recent years, the CDC has demonstrated that high-quality urine testing can be obtained from drug-screening laboratories when they are monitored by blind testing. The use of blind testing as a monitoring instrument for large screening laboratories produced substantial improvements in laboratory performance. Blind testing is highly regarded as a means of obtaining estimates of laboratory error rates.[2-10]

These studies demonstrate the effectiveness of blind testing as an objective monitoring tool. In this assessment 91% of the laboratories had unacceptable FNRs for barbiturates; 100% for amphetamines; 50% for methadone; 91% for cocaine; 15% for codeine; and 92% for morphine. With automation and computerization such evaluations obtained by monitoring could be reduced to routine activity. Blind testing should be implemented by all those responsible for drug treatment to periodically assess the quality of service being provided.

This study was supported by an interagency agreement with the National Institute on Drug Abuse.

We gratefully acknowledge the assistance of the staff of the Clinical Chemistry and Toxicology Section who prepared the samples used in these studies and the staff of the treatment facilities who provided their time and resources to make this study possible.

References

1. Boone DJ, Guerrant GO, Knouse RW: Proficiency testing in clinical toxicology: Program sponsored by the Centers for Disease Control. *J Anal Toxicol* 1977;1:137.

2. LaMotte LC, Guerrant GO, Lewis DS, et al: Comparison of laboratory performance with blind and mail-distributed proficiency testing samples. *Public Health Rep* 1977;92:554-560.

3. Boone DJ, Hansen JH, Hearn TL, et al: Laboratory evaluation and assistance efforts: Mailed, on-site, and blind proficiency testing surveys conducted by the Centers for Disease Control. *Am J Public Health* 1982;72:1364-1368.

4. Gottheil E, Caddy GR, Austin DL: Fallibility of urine drug screens in monitoring methadone programs. *JAMA* 1976;236:1035-1038.

5. Duncan AJ: *Quality Control and Industrial Statistics*, ed 4. Homewood, Ill, Richard D Irwin Inc, 1974, pp 155-178.

6. Finkle BS: Forensic toxicology of drug abuse: A status report. *Anal Chem* 1972;44:18A.

7. Goldstein A, Horns WH, Hansteen RW: Is on-site urine testing of therapeutic value in methadone treatment program? *Int J Addict* 1977;12:717-728.

8. Jain NC, Sneath TC, Budd RD: Blind proficiency testing in urine drug screening: The need for an effective quality control program. *J Anal Toxicol* 1977;1:142-146.

9. Mason MF: Some realities and results of proficiency testing of laboratories performing toxicological analyses. *J Anal Toxicol* 1981;5:201-208.

10. Shoemaker MJ, Klein M, Sideman L: Drug abuse proficiency testing in Pennsylvania 1972-1976. *J Anal Toxicol* 1977;1:130-138.

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SENATE JUDICIARY
EXHIBIT NO. 5
DATE Feb. 16, 1987
BILL NO. SB 338

Montana Nurses' Association

2001 ELEVENTH AVENUE (406) 442-6710

P.O. BOX 5718 • HELENA, MONTANA 59604

SB 338

The Montana Nurses' Association supports SB 338 which, if passed, would regulate the testing of blood and urine of both employees and prospective employees.

Job performance should be the deciding factor in the retention of employees. If an employee cannot perform a given job due to being high, stoned, drunk, or otherwise impaired on the job, the employer has every right and responsibility to insist on appropriate discipline. But testing should only be used after there is evidence through unsatisfactory job performance that an employee may be impaired.

Blood and urine tests are not accurate unless there is evidence of impairment, because urine may test positive for a drug like marijuana days after smoking one joint. It is not the employer's business to hold in judgment an employees' actions during non work time, unless the employee's work performance suffers.

The Montana Nurses' Association supports SB 338 because it is both unfair and unreasonable to force workers who are not even suspected of using drugs, and whose job performance is satisfactory, to submit to degrading and intrusive urine tests. Innocent workers should not be treated as "guilty". MNA also strongly opposes subjecting an applicant to a pre-employment blood or urine test as a condition of employment, because the tests are not an accurate measurement of an individuals ability to perform a given job if hired.

This bill is good for employees and employers because wrongful discharge lawsuits and grievances are increasing in number for alleged unfair or inaccurate drug tests; without guidelines, employers are exposed to great liability, and employees are susceptible to a humiliating and degrading experience. With the passage of SB 338, an employer will reduce liability risks, have a good defense to actions related to drug testing, and will have objective criteria available for use in dealing with workers who have work performance problems linked to use of drugs.

The bottom line is that employees who do not use drugs, although having nothing to hide, have the right to be left alone!

I urge you give this bill a DO PASS recommendation.

Respectfully submitted,
Eileen C. Robbins, R.N.
February 17, 1987

SENATE JUDICIARY
EXHIBIT NO. 6
DATE Feb. 17, 1987
BILL NO. SB 338

Legislative Fact Sheet

SENATE BILL 338

"F A I R N E S S I N D R U G T E S T I N G"

SB. 338 amends existing law on the use of lie detector testing (polygraphs) to include guidelines for the use of blood or urine tests as a condition of employment (Section 39-2-304 M.C.A.).

The new section states that in order to require a blood or urine test, an employer must have reason to believe, and demonstrable evidence, that the employee was impaired on the job due to illegal drug use, and that his/her impairment presented a safety risk.

If this threshold is satisfied, and the employee tests positive for drugs, he/she must be allowed a "confirmatory" test and the opportunity to explain the results.

Drug testing guidelines are needed in Montana, by employees and employers alike, for the following reasons:

A. VIOLATION OF CONSTITUTIONAL STANDARDS

-blood and urine tests are considered "bodily searches" under the Fourth Amendment's prohibition against unreasonable searches and seizures.

-tests should be limited to workers who are reasonably suspected of illegal drug use on the job.

-indiscriminate testing is un-American: it is unfair to treat the innocent and guilty alike.

-Although the U.S. Constitution does not apply to private employers, the Montana Constitution guarantees a much broader protection of personal privacy and should protect our citizens against the abuses of unrestricted drug testing.

-numerous drug testing programs of public employees (firefighters, customs agents, school teachers, prison guards) have been invalidated as unconstitutional.

B. UNRELIABILITY

-the most commonly used urine test (EMIT) results in a "false positive" as much as 30% of the time.

-urine tests commonly confuse cold medications, headache remedies and even some foods for illegal drugs.

-dirty specimen bottles, poor lab techniques, and mix-ups in the "chain of custody" can all result in faulty tests.

-follow-up "confirmatory" tests are rarely done, despite the fact that the employee's job is on the line.

C. UNFAIR TO EMPLOYEES

-giving a urine sample can be a humiliating and degrading experience -- the employee must urinate while being closely observed by another person -- and yet failure to take the urine test results in dismissal.

-long-time employees with good work records are being fired on the basis of a single and often inaccurate test.

-dismissals due to a "false positive" result can plague an employee for the test of his/her working life.

-even if the result is negative, suspicion itself can cause the employee irreparable harm.

D. EMPLOYERS NEED GUIDELINES

-wrongful discharge and bad faith lawsuits are assaulting employers in increasing numbers; a growing number of these suits are filed by employees fired for what they contend were unfair or inaccurate drug tests.

-without guidelines, the employer is exposed to great liability.

-the proposed amendment will provide guidelines and reduce this risk: an employer who has followed the proposed procedures will have a good defense to these actions.

E. ISSUE OF PRIVACY

-urine tests don't measure current impairment -- job performance should be the bottom line.

-urinalysis cannot determine when a drug was ingested -- what happens on Saturday night is not the employer's business.

-people who don't use drugs may have "nothing to hide," but under our system of government they have the right to be left alone.

SENATE JUDICIARY
EXHIBIT NO. 7
DATE Feb. 17, 1987
BILL NO. SB 338

Proposed Amendments
to SB 338

submitted by:

John S. Fitzpatrick
Manager of Administration
~~Montana~~ Tunnels Mining Inc.
Jefferson City, Mt 59638

1. Page 1 Strike lines 17-25 in their entirety

2 Page 2. Strike lines 1-5 in their entirety

3 Page 2. Insert in lieu of the matter above the following:

New Section. Employer Rights: All employers have the right to inquire into current ~~use of~~ ~~illegal~~ usage of mood altering drugs by current or prospective employees including the administration of drug tests and to discipline or refuse to hire persons

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~~employee~~ whose pattern of drug usage deviates from standards established by the employer

New Section. Drug Testing Procedure. Employer administering drug tests shall adhere to the following procedural steps:

1. Specimens of body fluids shall be provided by the person as directed by the employer in a quantity sufficient to allow at least six tests to determine the presence of mood altering drugs.

2. Specimens shall be divided into collected two equal parts, ~~one~~ sealed in tamper proof containers, and signed by the individual providing the specimen. One half of the specimen shall be forwarded to a licensed diagnostic laboratory for testing. The second half shall be held in safe keeping by the employer or his designated representative and shall be available to confirm test results obtained from the initial ~~one~~ tests.

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3 A test for the presence of mood altering drugs shall not be considered positive until confirmed by two or more tests have been conducted using different testing procedures

4. The result of any drug test conducted by any employer shall be available to the person tested the person may challenge the validity of the test results in which case, the second half of the specimen held in safekeeping shall be tested in the presence of witnesses at a licensed diagnostic laboratory. The results of the confirmatory test shall be considered conclusive.

5. Any action taken by a person to substitute or adulterate specimens of body fluids collected under this section is prohibited and violation thereof is sufficient cause for the termination of all employment rights

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6. The results of drug tests are confidential and may not be released by the employer unless authorized in writing by the person or as required by a court of law. This provision is waived in the event of any public disclosure of the test results by the person.

7. A copy of this procedure shall be provided to each employee and job applicant prior to the administration of any drug test.

SENATE JUDICIARY
EXHIBIT NO. 7A
DATE Feb. 17, 1987
BILL NO. SB 226

50th Legislature LC 418

STATEMENT OF INTENT
SB Bill No. 226

A statement of intent is required for this bill because section 5 allows the department of institutions to adopt rules for the licensing of detention facilities.

Currently, Montana statutes make no provision for the licensing of juvenile detention facilities. There are presently two counties in the process of establishing detention facilities who need assurance that their facilities will meet minimum established standards on program operations and environmental conditions.

It is anticipated that the rules developed under this act will establish minimum standards for juvenile detention facilities. These standards should govern such matters as the capacity of the facility, its location, design, construction, equipment and operation, fire and safety precautions, medical services, qualifications and number of personnel, and the quality of services provided to the juveniles.

The rules should contain a procedure for notifying the appropriate officials of compliance or deficiencies. If the facility is found deficient, a procedure for remedying those deficiencies should be included with specific time limitations.

It is anticipated the state will conduct annual inspections of each facility, and may require written reports containing such information as the agency may need to set and enforce its standards.

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SENATE JUDICIARY
EXHIBIT NO. 8
DATE Feb. 17, 1987
BILL NO. SB 226

SUMMARY OF SB226 (HALLIGAN)
(Prepared by Senate Judiciary Committee staff)

SB226 is by request of the Juvenile Justice Commission and amends the laws relating to the Youth Court. This bill establishes a requirement that there be a "probable cause" hearing before a youth can be detained. The hearing must be held within 24 hours after a youth is taken into custody, excluding weekends and holidays. Under current law, there is no hearing requirement; a youth can be held in jail until a probation officer files a petition in court, which must be done within a certain amount of time.

The sections of the bill are summarized as follows:

- Section 1. NEW. Requires probable cause hearing. A parent, guardian, or legal custodian may be held in contempt of court for failing to be present at a probable cause hearing unless he cannot be located or is excused by the court. If probable cause exists to believe that a youth is delinquent or in need of supervision and meets other detention criteria (41-5-305), the court may order the youth to be placed in a shelter care facility or detention facility (see summary of section 9).

- Section 2. NEW. Allows detention of a youth in a jail or other adult facility after being taken into custody and before probable cause hearing, under certain conditions.

- Section 3. NEW. Allows a youth who is placed in a detention or shelter care facility to be released on bail.

- Section 4. NEW. Allows counties and cities to create regional detention facilities. County of youth's residence is responsible for costs of detention.

- Section 5. NEW. Authorizes Department of Institutions to make rules governing licensing procedures for regional and county detention facilities. (Note: requires Statement of Intent)

- Section 6. Amends 41-5-103. Defines "Detention facility" as "a physically restricting facility designed to prevent a youth from departing at will".

- Section 7. Amends 41-5-303. Clarifies language regarding detention. Requires immediate notification to parent, guardian, or legal custodian [or close relative or friend if others cannot be found].

- Section 8. Amends 41-5-305. Clarifies language relating to probable cause hearing and detention. Adds the following criteria to list of criteria that permit detention:

Page 10, line 6 -- the youth's detention is required to protect persons or property; and

Page 10, line 8 -- there is good reason to believe the youth will not appear for court proceeding as ordered.

- Section 9. Amends 41-5-306. Clarifies language relating to changes regarding probable cause hearing and detention. Deletes provisions relating to detention in a jail or other adult facility. Youth alleged to be in need of supervision can be place in a foster home, child welfare agency facility, or

youth group home. Youth alleged to be delinquent can be placed in above facilities or in a detention facility.

- Section 10. Amends 41-5-502. Page 13, line 16, inserts the word "legal" before "custody".

- Section 11. Amends 41-5-802. Provides that county commissioners instead of youth court judge shall hire and fix salary of personnel to staff county youth detention facility and provides that county commissioners must arrange inspection every 3 months. Requires youth court judge to inspect county youth detention facility once a year.

- Section 12. Amends 7-32-2221. Changes language relating to county jails to conform to this act.

- Section 13. Amends 53-30-229. Changes statute relating to taking into custody and detention of youth alleged to have a violated an aftercare agreement to conform to this act.

- Section 14. Codification instruction. To be codified in various parts of Youth Court Act.

- Section 15. Coordination instruction. If bill creating new Department of Family Services passes, rulemaking authority given to Dept. of Institutions by this bill is transferrred to new Department.

COMMENTS: **As drafted,** the bill would prohibit detention in a jail or other adult facility. The significance of this is that counties would be required to have access to juvenile detention facilities [either establish and maintain one or pay another county to keep youth in the other county's youth detention facility]. Section 41-5-802 authorizes counties to acquire and maintain youth detention facilities. The Board of Crime Control will propose an amendment that would make this prohibition not effective until July 1, 1989; that is, until that time, a youth can be placed in a jail or other adult facility, but after that time, counties will have to make other arrangements for detention of these youths. The fiscal note doesn't seem to take into account the acquisition or maintenance of such facilities or payments to other counties to keep youth in another county's facility.

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