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THE NEED FOR, AND THE LEGAL IMPACT ON, EMPLOYEE DRUG TESTING IN MONTANA'S ACUTE CARE HOSPITALS

By

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CHAPTER ONE

INTRODUCTION

Thesis Overview

Employee drug testing is here to stay. Its recent, rapid expansion, coupled with an associated increase in litigation to define the rights of both employers and employees, mandates the attention of Montana's hospital employers. Little has been written specifically regarding the need for employee drug testing in the acute care hospital setting; however, the ever increasing employment demands placed on the health care professions due to increased technology warrant an in-depth analysis. This thesis provides that analysis. Specifically, this thesis addresses whether or not there is a need for employee drug testing in Montana's acute care hospitals; and if, so, what is the legal impact on hospitals which decide to test. Throughout this analysis, drug abuse and drug testing includes alcohol, along with all other drugs common in society today.

Research Methods

A review of pertinent articles and publications on employee drug impairment and drug testing provides one with a wealth of information. It is difficult, however, to find any information developed directly from the employee population, and no published studies exist which deal specifically with job impairment of health care employees caused by drugs. If there is such a problem, could an employee drug testing program help solve it, and what are the legal implications of developing an effective employee drug testing program?

In order to develop background information, national articles and publications were reviewed. Federal and state legislation were reviewed to determine how our elected officials are responding to the problem. Federal and state court cases were reviewed to determine how these statutes and regulations are being interpreted. Because this research did not reveal any specific information concerning drug-induced job impairment among health care workers in Montana, a questionnaire was sent to the administrators of all licensed hospitals in Montana. This direct research method was designed to determine whether or not the administrators believed there was a drug problem in their employee population, whether or not the problems produce noticeable job impairment, and what methods were being used to solve the problem if it existed.

It was felt that a survey directed at employees would not produce reliable information. Employees would probably not answer truthfully about drug use and job impairment for fear of job loss or identification, even though confidentiality was promised.

To supplement the administrators' survey, personal interviews were conducted with four health care workers who are presently recovering from drug addiction.

These direct and indirect research methods are the cornerstone of this study.

Limitations of the Study

This study has been limited by the inability to gain reliable statistical data from a sample of all of Montana's health care employees. The survey conducted, gathered data based on perception and belief. The personal interviews were not statistically relevant because they were limited in scope, and included the views of those who had admitted their abuse and job impairment. It may be somewhat naive to believe a sample of all health care workers would produce a statistically accurate response to questions such as, "Do you presently work while impaired by the use of drugs?" Most employees would probably not answer correctly if they believed they worked impaired; and many, in a stage of denial, would answer negatively because they honestly don't believe they are working impaired.

Scope

The scope of this thesis encompasses a discussion of the employee drug problem (job impairment), which has attracted the attention of many employers and legislators, a discussion of the legal impact of developing employee drug testing programs in Montana's acute care hospitals, and a discussion of whether or not there is a need to implement employee drug testing programs in Montana's acute-care hospitals.

The problem of employee impairment is more thoroughly identified in Chapter Two. Also, specific tests and testing methods are discussed. Chapter Three breaks down the impact federal legislation, regulations and court cases have had on employee drug testing. Specific Montana legislation and judicial interpretation of employee rights are also discussed to provide the necessary backdrop for a proper analysis of the need for employee drug testing in Montana's acute-care hospitals. Chapter Four discusses the statistical results of the survey and personal interviews, and the conclusions and recommendations drawn from the research are presented in Chapter Five.

General Employer Concerns

It is self-evident employers desire to fill each job vacancy with the best qualified applicant. In service industries like hospitals, the quality of their employees is considered to be at the heart of their competitive

position, even their very existence. Employers must, therefore, look beyond the information voluntarily supplied by the applicant. Even the best applicants tend to highlight their good points and downplay the bad. In this day and age when diplomas can be bought and crime and drug abuse are everyday occurrences, it would be foolhardy to assume all job applicants are completely honest about their backgrounds and qualifications.[1] Three areas of vital importance for screening applicants, especially health care job applicants, are competence, character and health.

Determining a job applicant's competence is fundamental to making a good hiring decision. Employers want employees who can do the job. Sometimes competence testing is easily accomplished, as with a typing test for a typist position. Other positions do not lend themselves so easily to such objective criteria. Nurses must be licensed, have an ability to get along with others, and additionally have patience, compassion and a degree of assertiveness. Licenses can be easily confirmed, but the more intangible qualities are more difficult to determine. Employers can check with the applicant's former associates and employers and hope responses are accurate. A probationary or provisional employment period can also be utilized.

Character assessment is equally important. It does not serve the employer well to hire the most competent applicant only to find the new worker gone in a week, along with a company typewriter or a co-worker's tool box. The applicant

may be well qualified, but have character traits that lead to poor job performance, e.g., wasting time or abusing sick leave. "Time theft" by competent employees can be a major financial problem. A lab technologist may falsify data to cover up a mistake, or a nurse may falsify a medication dosage in order to convert the medication to his own use. Frequent job changes can lead to a conclusion that the applicant is a "job switcher," and a waste of training time and money. Other personal qualities can bear upon quality of work and productivity. Conscientiousness, thoroughness, laziness, carelessness and self-motivation can affect the quantity and quality of an employee's work output. Drug abuse is a severe character flaw which can seriously affect job ability and performance.

Mental and physical health go hand in hand with productivity. Poor health can lead to absenteeism, high insurance costs, work place safety problems or even loss of the employee due to disability or death. In the health care setting, poor employee health can have an even more severe outcome when it affects not only the employee, but the patient as well. Many health care jobs require physical exertion, (lifting and moving patients), and great mental stress (emergency situations which require fast, accurate life and death decision-making). Health screening of applicants is a common practice; however, excluding applicants with health problems may run into handicap and

age discrimination laws.[2] The test itself may contravene federal or Montana legal privacy protections.[3]

Chapter Endnotes

[1]David J. Cherrington, Personnel Management, William C. Brown, Co., 1983. Also a phone conference with June Schafer, Equifax (a pre-employement investigating firm), revealed that in August, 1988, they conducted an internal survey of 200 job applications which found: 4% had inaccurate former job titles listed; 29% had false previous employement dates; 3% had false degrees or diploma dates; 11% had false reasons for leaving their last job; and, 3% had false companies listed as former employers.

[2]School Board of Nassau County v. Arline, 107 S.Ct. 1123 (1987). (This case was codified on March 22, 1988, when both houses of Congress overrode President Reagan's veto of the Civil Rights Restoration Act, Pub. L. 100-259.

[3]The Constitution of the State of Montana, Article II, Section 10, (1972). "The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest."

CHAPTER TWO

PROBLEM ANALYSIS

Job Applicant Drug Testing

Job applicant screening is undoubtedly as old as the history of employment, but drug testing is of recent vintage and growing rapidly. Surveys indicate the percentage of Fortune 500 companies who test job applicants for drug use rose from 3 percent to 30 percent between 1982 and 1985.[1] An October, 1986, survey of Fortune 100 companies found that forty-five test job applicants for drug use.[2]

Until a few decades ago, job applicants had few, if any, legal rights to address discriminatory practices by employers. However, major labor and civil rights legislation in the 1960s, and emerging constitutional and common law principals receiving attention in the courts, have broadened and given wide protection to job applicants and employees.[3] On the other side of the coin, and expanding just as rapidly, was the increasing use by employers of various new technologies to assist in employee selection. In the thirty years between 1940 and 1970, the use of aptitude, intelligence and psychological tests took hold and expanded. This may have been an attempt to replace direct

racial discrimination through the use of what appeared to be a business-purpose related test, but the United States Supreme Court[4] dealt this form of testing a severe blow by ruling it violated the race discrimination prohibitions of Title VII of the Civil Rights Act of 1964.[5]

In the 1970s many employers stopped testing because the Equal Employment Opportunity Commission (EEOC) required employers to validate their tests by showing a correlation to job performance if the test had a disparate impact on a protected minority group.[6] This federal attempt to limit discrimination ironically caused employers to stop one of the few objective means they had to determine qualifications in the hiring process, and returned employers to a more subjective, and, therefore, suspect approach.

Advances in toxicology in the 1960s made urine drug testing a possibility, and such testing became firmly established by 1966 as a legitimate tool of the government in drunk driving cases.[7] Since that time drug testing of job applicants has increasingly expanded until the 1980s when employers, scrambling to institute such tests, came under extensive legal attack by unions, employees and civil rights groups.[8] In March, 1986, the President's Commission on Organized Crime recommended all employers screen applicants for drugs.[9] When prestigious groups issue such recommendations, intelligent employers at least begin to stop, look and listen.

Employee Drug Testing

The debilitative effects of drug abuse on worker productivity were well documented by a Research Triangle Institute survey which revealed that in 1983 drug abuse in the workplace cost the American economy $25.8 billion, and estimates of $100 billion are not uncommon today.[10] The federal government has strongly signaled its involvement in the fight against drugs in the workplace. Affirmative action by President Reagan was taken in 1986 when he required all federal agencies to adopt testing programs for all employees in sensitive positions,[11] and authorized the testing of those in non-sensitive positions:

(a) upon reasonable suspicion of drug use;

(b) in investigations of accidents or unsafe conditions; or

(c) as part of a follow-up to a drug rehabilitation program.[12]

Federal legislation which involved private employers occurred in October, 1988, when Congress passed the Omnibus Drug Bill. This legislation required private employers, contracting with the government for property or services valued at $25,000 or more, to certify they would provide a drug-free workplace.[13]

It is not difficult to understand why so many people in such lofty positions are becoming directly involved with the problem of drug abuse in the workplace when the problem's magnitude and associated costs and risks are fully

appreciated. One 1986 survey suggests between 10 and 23 percent of American workers regularly abuse drugs in the workplace.[14] Such a statistic is disquieting when applied generally to the health care industry, and specifically to the acute care hospital setting. Access to medication, financial resources of employees provided by relatively high paying jobs, and high stress levels of employees produced by constant and close association with life and death decision-making should direct the attention of health care employers to the potential risks inherent in their labor force.

The legal and business danger to the employer is twofold. There is the danger of ignoring the issue of substance abuse in the workplace. There is also the danger of over-reacting. The legal issues associated with employers' reactions to such abuse are still evolving. The technical issues of who to test, when to test and what tests to use are complex, and emotions of employers and employees are strong and divided. There are no simple solutions. The "just say no" approach has a certain appeal and effectiveness for children, but cannot be expected to be of much value to the millions of Americans who have already said yes. However, before employers attempt to tackle a problem, good business management should force them to first understand and specifically identify what the problem is.

Substance abuse is a broad term that refers to the voluntary use of drugs (this term includes alcohol) outside the scope of medically authorized and/or socially permitted

patterns. It includes any use of drugs that cause physical, psychological, economic, legal or social harm to the user or to others affected by the user's behavior.[15] It must be understood that the distinction between "use" and "abuse" is an important factor which should be considered when developing management strategies. The adverse impact on employers stems from "abuse," not "use." If an employee uses alcohol on Saturday night, such use will probably not affect the employee's job performance on Monday. But use of alcohol which does affect Monday's job performance can, by definition, be termed "abuse;" and to this employee action the employer's attention must be focused. Business survival depends on identifying individual behavior that is beneficial, and rewarding it, and eliminating behavior that has an adverse impact on the employer. One method used to eliminate adverse behavior produced by drug abuse is drug testing. Adverse impacts are felt in different ways:

(a) threat to public safety;

(b) threat to other employee's safety;

(c) loss of employees (replacement costs);

(d) loss of productivity ("time theft");

(e) theft;

(f) harmful effect on public image (especially critical in the health care industry).

Drug testing will assist in identifying the cause of the unwanted behavior, and through other means, e.g., job termination or rehabilitation, the behavior can be

eliminated from the workplace. Drug testing should be viewed as only one part of the elimination process. Management training, employee education, employee assistance and discipline are other necessary parts.[16] The employer should be directly concerned and involved in the demand reduction process. The supply reduction process is a governmental concern and should not be a concern of most business employers; however, in hospital settings, supply reduction needs to be addressed, and access to medications closely monitored.

Employer's interests arise when drug use translates into impaired job performance - "abuse." Most employers would probably agree the only acceptable level of drug-induced work impairment is zero. To accept any greater level, employers must accept such impairment consequences as lost productivity, decreased workplace safety and increased insurance costs.

Productivity, Safety and Costs

Estimates place lost workplace productivity due to drug abuse between $25.8 billion and $100 billion.[17] Some use a conservative estimate of $50 billion.[18] One study indicates productivity suffers because drug users function at 67 percent of their work potential,[19] another places the functional level somewhere between 60 percent and 65 percent.[20] Also, employees involved with drug use are absent sixteen times more often, have nearly three times as

many absences of eight days or more, have nearly four times as many accidents, receive three times the sickness benefits and file five times as many workers compensation claims.[21]

A confidential survey by the National Cocaine Helpline revealed 75 percent of those surveyed used drugs on the job, 44 percent provided drugs to fellow employees and 25 percent reported daily drug use at work.[22] After a drug testing program was implemented by the United States Postal Service in Philadelphia, 230 job applicants were rejected based on the results of their urinalysis tests.[23] Various banks in California had 35 percent to 40 percent of their job applicants fail to return when told all applicants would be tested for drugs.[24] Should an employee be terminated, or voluntarily leave as a result of workplace drug use? The cost of hiring and training a replacement has been estimated in one industry from $4,000 for an hourly worker to $17,000 for a mid-level manager.[25] An employer's business costs can be influenced by identifying and treating drug impaired employees. Drug abusing employees, after treatment, show a reduction of between 26 percent and 69 percent in total medical care utilized.[26]

With these numbers as a highlight, it can be readily understood how financially damaging to an employer drug abusing employees can be, and the numbers are growing. Attempts to control workplace drug impairment by implementing drug testing programs are also likely to be expensive--$10 to $25 per sample for initial screening and

$25 to $100 for confirmatory follow-up.[27] An estimated five million drug tests were performed in 1986 at a cost of $60 million.[28] Spending on such tests is expected to grow to $200 million a year by the early 1990s.[29]

Employer Alternatives

Employers have used a wide variety of techniques in trying to detect and eliminate workplace drug abuse. These methods have included wiretapping, video cameras, searches, questioning employees,[30] drug sniffing dogs, undercover detectives and drug and polygraph testing.[31] Costs for these methods are unknown, and their success has been limited at best. Neurobehavioral testing, which directly measures physical impairment, is gaining recognition as an alternative to urinalysis.[32] Neurobehavioral testing is considered an optimal method for detecting workplace impairment because test results reveal impairment of an employee's thinking and behavioral output derived from any source. A battery of six to eight tests would be administered, taking approximately one hour. It could be administered by a trained layperson, but must be interpreted by a professional. The testing equipment would cost approximately $150 and one hundred scoring sheets another $15.[33]

Another method which may achieve good results is the training of employees to recognize behavioral characteristics of drug abuse.[34] Although this method lacks

the high-tech excitement of some other methods, it has been endorsed by the federal courts in the context of drug abuse by public safety officers.[35] In the case of Taylor v. O'Grady,[36] the court heard testimony from Dr. Sidney Schnoll, M.D., an expert in the research and treatment of drug abuse. Dr. Schnoll testified that:

> "chronic drug use is generally detectable by easily identifiable changes in behavior, i.e., tardiness, decrease in ability to perform tasks, increased absences, and changes in relationships with supervisors and co-workers. These ... signs ... can readily be detected by untrained lay personnel."[37]

Even though this method has met court approval, many employers continue to use drug tests, and more are developing and implementing such drug testing programs.[38] The 1987 survey by Business & Legal Reports sampled over 2,000 organizations with employee populations of under 100 to over 500 throughout the United States which included organizations involved in manufacturing, insurance, finance, communications, retailing, transportation and health care/education. Of those who were not already testing 44 percent were considering or definitely planning to implement drug testing programs, and 57 percent of the larger organizations (over 500 employees) were considering or definitely planning to implement such programs.[39] Of those not testing and not considering such programs, 48 percent cited legal implications, 25 percent cited moral implications and 14 percent cited time and energy required.[40]

Even though employers have concerns over the legal implications, there was a dramatic rise in drug testing in the eighteen month period between April, 1987, and September, 1988--from 9 percent of all employers to 19 percent.[41]

Drug Test of Choice - Urinalysis

There are many drug testing methodologies from which an employer may choose. Drugs can be detected by analyzing a variety of body tissues or fluids, e.g., blood, skin, urine, breath, or hair.[42] Although most employers have chosen urine testing,[43] it is only effective in determining prior drug use and cannot indicate or prove by itself what level of intoxication the employee is then experiencing, or the employee's degree of impairment.[44] It can, however, be used in a broad based program for identifying employees who have exhibited other mental or physical abnormalities which by themselves are less likely to support confrontational action by the employer. These employees, once identified, could be directed to employee assistance programs, rehabilitation, treatment and education. Disciplinary action is also initiated to make certain accurate objective records are kept to indicate the employer's dissatisfaction with the employee's job performance. The degree of job performance impairment generally dictates employers response.

Urinalysis has gained its popularity because:

- the collection of urine is a simple procedure and less intrusive than blood or tissue;
- the concentrating action of the kidneys produces a more concentrated version of a drug and its metabolites than in other body fluids or tissue;
- urine is easier to analyze--it lacks the protein and cellular constituents found in blood and tissue; and,
- urine can be stored longer in a frozen state because of the stability of drugs and their metabolites in frozen urine.

Although there are strong reasons supporting urinalysis as the test of choice, there are drawbacks, e.g., results given as yes/no do not give a quantitative answer. Because there is no quantitative response, it is impossible to rely solely on a true positive result in order to prove job impairment. Because certain drugs last for different periods in the human body, it is impossible to pinpoint the time of ingestion.[45] Although absolute precision of time of ingestion cannot be ascertained, many studies exist which give a general guide for bodylife of the most common drugs:

- Alcohol - rapidly eliminated from the body. Even after consumption of a large amount, it is rarely detected in urine more than 24 hours later. Preferred methods of determination are assays of blood alcohol levels and breath analysis.

- Heroin - metabolized into morphine and then morphine glucuronide. Little true heroin is found in urine, but each metabolite can be detected. A 10 mg. dose can be detected up to 48 hours, and larger doses up to 72 hours. In addition to morphine and morphine glucuronide, the enzyme technique also detects codeine.
- Amphetamine - a dose as low as 20 mg. can be detected for up to 24 hours. Excretion may be hastened by ingestion of urine-acidifying agents such as ammonium chloride, ascorbic acid, cranberry juice or vinegar.
- Barbiturates - therapeutic doses of short-acting barbiturates, e.g., pentobarbital, secobarbital, hexobarbital and thiamylal, can be detected up to 24 hours after ingestion. Intermediate-acting agents, e.g., amobarbital, aprobarbital, butabarbital and butalbital, can be detected up to 72 hours; and long-acting agents, e.g., barbital and phenobarbital for up to seven days.
- Benzodiazepines - short-acting agents are eliminated rapidly, while long-acting agents, e.g., diazepam, can be detected up to three days after use.

- Cocaine - eliminated almost entirely as the metabolites benzoylecognine and ecognine can be detected up to three days after ingestion.
- Phencyclidine - (PCP) can be detected up to two weeks after ingestion. Tests for PCP should also assay the specific gravity and pH of the sample because drug may be masked by alkaline urine.
- Methadone - causes a specific reaction with the enzyme test. Metabolites that may remain for several days after ingestion cause no reaction.
- Marijuana - metabolites of tetrahydro-cannibinol, the active ingredient of marijuana, may be detected for periods ranging from several days to several weeks depending on patterns of use. Small quantities of smoke passively inhaled by a non-smoker are unlikely to cause a positive reaction.[46]

Specific Methods of Urinalysis Testing

There are a number of analytical urine test procedures available; however, studies have shown that among those available, e.g., enzyme multiplied immunoassay technique (EMIT), radioimmunoassay (RIA), thin-layer chromatography (TLC), gas chromatography (GC) and gas chromatography/mass spectrometry (GC/MS), an initial screening procedure of EMIT and a confirmatory procedure of GC/MS provides the most

legally defensible results.[46] Two surveys, one of drug testing experts and one of arbitrators with experience in drug testing cases, produced the following results:

- of single procedure methods applied to the drugs amphetamines, barbituates, benzodiazepines, cannabinoides, cocaine, methaqualone, opiates and phencyclidine, no test rated lower than 1.7 with a high of 4.0 using the following scale:
  - 1 = fully defensible against legal challenge
  - 2 = somewhat defensible
  - 3 = difficult to defend
  - 4 = unacceptable for legal defense
- of multiple-procedure methods, e.g., an initial test with a follow-up confirmatory test, EMIT and GC/MS rated a consistent 1.0 with the experts and 1.7 with the arbitrators. Most other combination procedures ranged from 2.1 to 3.8[48]

Initial Screening Test

In the immunoassay techniques, specially engineered antibodies are added to the urine sample.[49] Physically metabolized by-products of drug use, known as metabolites, are attracted to the antibodies and bind with them, causing a measurable change in the chemical content of the sample.[50] The principal disadvantage of immunoassay tests is the possibility of the antibodies binding with innocent substances in urine, e.g., cold and cough products such as

Benadryl, causing false positive results. The numerical results provided from the test (results which indicate the presence of a screened for drug when none factually exists) are compared with numerical data for calibration standards.[51] These calibrated standards provide a degree of objectivity to this technique.

False negatives (test results which indicate employees who have a drug in their system, but the drug metabolites are not traceable in the samples) are produced generally through employee attempts to weaken or "beat" the test by adding foreign agents to the sample, e.g., water to dilute the sample, rubbing alcohol, laundry bleach or other products.[52] Advertisements have appeared in newspapers offering $50 for "clean" urine specimens; and extreme measures are known to occur, e.g., injecting "clean" urine directly into the bladder by catheter to later produce a "clean" specimen during testing.[53] The potential for employee abuse makes the collection procedure critical.

Confirmatory Test

Because of the possibility of false positives, a confirmatory test is necessary to protect both the employee and the employer. The confirmatory test best able to satisfy both parties' needs is the GC/MS. Experts have indicated confirmation by a second procedure not based on the same chemical principle as the first procedure (screening test), added significantly to the reliability of

the analysis, hence to the defensibility of the data.[54] The chromatography and spectrometry techniques are slow, complicated and expensive, and therefore better suited for confirmatory tests, e.g., GC/MS tests can run from $100 to $200.[55]

In the chromatography technique, the urine sample is treated to extract its chemical constituents. The materials taken from the urine are then mixed with an inert gas, e.g., nitrogen or helium. The mixture is then forced through a thin glass column which contains a fine, sand-like material. The various compounds extracted from the urine can be identified by measuring the time each one takes to pass through the tube and emerge at the other end. It is possible for innocent substances to travel at the same speed as drug compounds, leading to false positives.[56] However, when using the combination test, i.e., GC/MS, as each component emerges from the chromatograph tube, the mass spectrometer breaks up the molecules into fragments, called ions, that can be measured and identified.[57] Each type of molecule has unique properties; thus, drug metabolites cannot be confused with innocent substances thus producing a very high quality result.[58] When coupled with mass spectrometry, the possible false positives are virtually reduced to zero. GC/MS is specifically required in the Federal Drug Testing and Department of Defense programs.[59]

Chain of Custody

Testing, even if accurate, accomplishes nothing if the result cannot be exactly matched to a particular employee. Assuming identification, if the result is a false negative because of employee tampering, the program has failed in its basic goal of reducing its business risk, i.e., decreasing accidents, insurance costs, and increasing productivity. A variety of specific measures have been instituted to control and identify the test specimen from its collection to the final analytical test result. This continuous link from employee to test result is referred to as the "chain of custody." Many procedures are used to insure a proper chain of custody. Whatever procedure is used, it must insure no possibility of tampering or misidentification. Procedures which offer a high level of confidence generally include some form of the following:

- Accurate applicant/employee identification, e.g., driver's license or social security number.
- Accurate and complete medication history including usage of over-the-counter drugs, especially allergy and cold medications, sleeping pills and muscle relaxants.
- Laboratory requisition filled out in applicant's/employee's presence, indicating the drugs to be assayed; employee should check the accuracy of identifying information.

- Witness to the sample collection. Precaution should be taken to insure a minimum of embarrassment without sacrificing reliability. Requiring a patient gown to be worn prior to entering the collection site will help prevent the addition of foreign substances. Other methods include eliminating hot water--sample will be at body temperature, and coloring toilet water blue will prevent an attempt to dilute sample with water. If personal witnessing is not possible, the temperature, specific gravity and pH should be checked immediately to negate tampering.
- Seal specimen in laboratory-provided container. The witness and applicant/employee must initial and date the seal. Explain that the initialing by the employee is an acknowledgment of ownership of the sample.
- Send specimen promptly to the laboratory for analysis or store in a refrigerator until pick-up. At pick-up, the courier and witness must sign off in a log book attesting to the unbroken seal. After reaching the laboratory, the courier and laboratory technician must sign the log book attesting to the unbroken seal.
- Use of disposable test tubes by the laboratory should prevent contamination by foreign material

sometimes found in reusable test tubes. EMIT positives are confirmed by GC/MS.

- Negative results are reported as "normal." Positive results are sent by confidential letter to the person in charge of the drug testing program.
- Company policy determines protocol for follow-up of positive results.

Problem Analysis Summary

Job applicant testing is not new, but the use of a drug test in the applicant screening process is a relatively recent employer innovation. Employers are using drug tests not only for applicant screening, but also to weed out employees who are drug impaired. Drug impaired employees are unproductive and a financial liability to employers.

Most employers, who have implemented drug testing programs, have generally settled on urinalysis testing as the procedure to be used to identify impaired applicants and employees. The results of urinalysis testing can identify an employee who has recently used drugs, but the results cannot specifically identify the degree of impairment. This is the major drawback to urinalysis testing.

Because employers generally take some form of disciplinary action against employees who test positive, testing procedures must be accurately controlled. An initial positive result must be confirmed by another test of

the same urine sample. The confirmatory test should be a test based on a different chemical principle. This will insure all positive results are accurate. The entire testing procedure must also follow strict guidelines. These guidelines are designed to insure the urine sample given by the employee is not tainted, and is positively matched to the employee throughout the initial and confirmatory testing procedure. These guidelines are necessary to protect the employee from false results, and to protect the employer from making decisions about the employee based on false results.

Chapter Endnotes

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[2]Alan M. Koral, Employee - Privacy Rights, Executive Enterprises Publications Co., Inc., 1987, p. 19.

[3]For a discussion see Federal Legislative Issues, beginning on page 34 of this paper.

[4]Griggs v. Duke Power Co., 401 US. 424 (1971).

[5]42 U.S.C., §2000e, (1982).

[6]Uniform Guidelines on Employee Selection Procedures, 29 Code of Federal Regulation (C.F.R.), §1607.

[7]Schmerber v. California, 384 U.S. 757 (1966).

[8]For a discussion see Chapter Three, Legal Issues, beginning on page 27.

[9]Koral, p. 19.

[10]Ibid.

[11]Executive Order 12546, 3 C.F.R. 224, September 15, 1986, (set out in full in Appendix I).

[12]Ibid., §3(c)(1)-(3).

[13]James S. Ray and Barbara Berish Brown, "Federal Legislation Update: January-October 1988," The Labor Lawyer, Winter 1989, pp. 135-150, at 142.

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[18]William F. Alden, "The Scope of the Drug Problem," a speech delivered to the American Society of Industrial Security on 24 June 1986, Vital Speeches, October 1, 1986, p. 754.

[19]Ibid., p. 754. (Also see Chapter Four of this paper, Personnel Interviews, beginning on p. 60).

[20]Glenice Sheehan, A Resource for the Development of an Employee Assistance Program, Cambridge College, July 1987, p. 84.

[21]Ibid.

[22]Michael S. Cecere and Philip B. Rosen, "Legal Implications of Substance Abuse Testing in the Workplace," Notre Dame Law Review, Winter 1987, p. 859.

[23]Ibid.

[24]Ibid.

[25]Sheehan, p. 84

[26]Ibid., p. 85

[27]Julius A. Gylys, "Drug Testing at the Workplace," The Professional Medical Assistant, November/December 1987, pp 17-18.

[28]William C. Collins, "Drug Abuse Testing in the Workplace: Avoiding Pitfalls and Problems," MLO, February 1987, p. 31.

[29]Ibid.

[30]Peter A. Susser, "Legal Issues Raised by Drugs in the Workplace," 36 Lab. Law Journal, January 1985, p. 47.

[31]Janice Castro, "Battling the Enemy Within," Time, March 17, 1986, pp. 52-61.

[32]Taylor v. O'Grady, 669 F. Supp. 1422 (N.D. Ill. 1987), p. 1433.

[33]Castro, p. 59.

[34]See Appendix 2.

[35]Lovvorn v. City of Chattanooga, 647 F. Supp. 875, 883 (Ed. Tenn., 1987).

[36]669 F. Supp. 1422 (N.D. Ill., 1987).

[37]Ibid., p. 1432.

[38]"1987 Survey of Drug Testing in the Workplace," Business & Legal Reports, 1987, p.?

[39]Business & Legal Reports, 1987, p. 8.

[40]Ibid., p. 13.

[41]"Survey Documents Dramatic Rise in Drug Testing," Personnel Managers Legal Reporter, February 1989, p. 7.

[42]Gylys, p. 18.

[43]Council on Scientific Affairs, "Scientific Issues in Drug Testing," Journal of the American Medical Association, June 12, 1987, p. 3110.

[44]Gylys, p. 17

[45]Journal of the American Medical Association, June 12, 1987, p. 3112.

[46]Robert Swatek, "Urine Testing for Drug Abuse," Physician Assistant, February 1988, pp. 113-114.

[47]David W. Hoyt, Robert E. Finnigan, Thomas Nee, Theodore F. Shults, and Thorne J. Butler, "Drug Testing in the Workplace - Are Methods Legally Defensible?" Journal of the American Medical Association, July 24, 1987, p. 505.

[48]Ibid., p. 506.

[49]Kurt M. Dubowski, "Drug-Use Testing: Scientific Perspectives," Nova Law Review, 1987, p. 417.

[50]Ibid., p.461.

[51]Hoyt, Finnigan, Nee, Shults and Butler, p. 505.

[52]Farrish Sharon and William E. Wilkinson, "Drug Screening in the Workplace - Scientific and Legal Issues," Nurse Practitioner, February 1988, p. 41.

[53]Ibid., p. 45.

[54]Hoyt, Finnigan, nee, Shults and Butler, p. 507, also see Michael A. Peat, "Analytical and Technical Aspects of Testing for Drug Abuse: Confirmatory Procedures," Clinical Chemistry, March 1988, p. 471.

[55]Sharon and Wilkinson, p. 41.

[56]Dubowski, pp. 737-738.

[57]Ibid., pp. 479-484.

[58]Ibid.

[59]Peat, p. 472.

[60]Sharon and Wilkinson, p. 44.

CHAPTER THREE

LEGAL ANALYSIS

There exists a wealth of federal and state constitutional, legislative, administrative and judicial language which attempts to prescribe and regulate employers' actions toward their employees. Some of the constitutional and legislative language was not specifically drafted to cover employer drug testing requirements. Employees who feel their rights have been violated have found little difficulty in forming legal arguments against employers incorporating such language against drug testing requirements.

Federal Administrative Issues

On September 15, 1986, President Ronald Reagan issued Executive Order 12564[1], requiring most Executive Branch agencies to develop plans to achieve a drug-free workplace.[2] The Order stated that each plan developed by an agency must provide for drug testing and an Employee Assistance Program (EAP) to aid employees who seek assistance. The EAPs to be established were to offer assessment, short-term counseling, and referral services for alcohol, drugs and mental health

problems affecting job performance.[3] The EAPs were also to monitor the employee's progress while in treatment.[4]

Drug testing was mandated for federal employees in sensitive positions, and authorized for other employees when a reasonable individualized suspicion existed the employee uses illegal drugs, was involved in an accident or unsafe practice, or as part of, or follow-up to, treatment through an EAP.[5]

On November 28, 1986, the United States Office of Personnel Management issued a memorandum outlining procedures for the implementation of Executive Order 12564,[6] and the Department of Health and Human Services published its standards for drug testing procedures and laboratory certification on April 11, 1988.[7]

The drug testing requirements of Executive Order 12564 must be viewed against the backdrop of other federal statutes, regulations and the protective guarantees of the United States Constitution. Because Executive Order 12564 only imposes duties on federal agencies/employers, only federal employees were affected.

Federal Constitutional Issues

Federal employees and others affected by these federal regulations, have raised a number of legal challenges to governmental drug testing mandates. Employees have argued drug testing violates the First[8], Fourth[9], Fifth[10], and Fourteenth[11] Amendments to the United States Constitution.

The First Amendment challenges have generally centered on the freedom of religion provision and its free exercise clause. This clause "guarantees" citizens the government will take no action that proscribes an individual's free exercise of religious beliefs. But this freedom, like all others, is not absolute, e.g., freedom of speech does not allow an individual to yell "fire" in a crowded theatre. When government action, taken for legitimate purposes, restricts this freedom, the governmental purpose must outweigh the restriction in order for the action to be successful against legal challenge. In Rushton v. Nebraska Public Power Dist.,[12] the plaintiffs alleged that mandatory participation in a rehabilitation program for alcohol-addicted employees violated their free exercise of religion because they believed that alcoholism was a sin, not a disease. Because it was a sin, they should be able to seek help from their religious leaders, rather than a mandated program. The court found the program was the least restrictive means to achieve workplace safety, and workplace safety was a compelling governmental purpose; therefore, the employee's challenge failed.

Fourth Amendment challenges to drug testing have been numerous. The critical Fourth Amendment clause provides for the protection of the people against unreasonable searches and seizures; and if a search or seizure is to take place, that "probable cause" must first be present. Generally thought of in a criminal context, these Fourth Amendment protections

also apply to administrative searches;[13] and, in the employment relationship, government employer searches of their employees' property.[14] It has been firmly established that requiring a blood test constitutes a search, and therefore comes under the protection of the Fourth Amendment.[15] A compulsory urinalysis test has likewise been found to come within the purview of Fourth Amendment protection.[16] When an involuntary search is conducted, some measure of an individual's privacy is violated.

Physiological information obtained from a urinalysis test can be considered private; and therefore, there is some interference with privacy in the mere process of urine sample collection.[17] However, a close reading of the Fourth Amendment reveals this right of privacy, i.e., protection against unreasonable searches, is based on "reasonableness." The "reasonableness" of a search requires weighing the intrusiveness of the search against its promotion of a legitimate governmental interest.[18] Considering the interests of the parties in the employment relationship, the United States Supreme Court held the "probable cause" standard (more often related to criminal cases and which generally defines "reasonableness") as unworkable, assuming the search is conducted for a work-related reason.[19] The Court held that:

> "...in the case of searches conducted by a public employer, we must balance the invasion of the employee's legitimate expectation of privacy against the government's need for supervision, control and the efficient operation of the workplace."[20]

The standard used to weigh the competing interests then became one of "reasonableness under all the circumstances."[21] The Court inferred the reasonableness of an employee's expectation of privacy can be affected by the nature of the employment. One could reasonably conclude that in jobs where employees have historically faced a high level of scrutiny, the employee's expectations of privacy would be much lower than in other, not so regulated, jobs. The Supreme Court has further held that while "some quantum of individualized suspicion is usually a prerequisite to a constitutional search or seizure...the Fourth Amendment imposes no irreducible requirement of such suspicion."[22] However, when searches are permitted without individualized suspicion, e.g., random drug testing, the government must employ safeguards to insure that the employee's reasonable expectation of privacy is not "...subject to the discretion of the official in the field."[23]

The Fourth Amendment does place certain limitations on public employers who subject their employees to drug tests. However, drug testing programs have generally been found reasonable as long as there is some reasonable basis for requiring an employee to submit to the test, e.g., employees' jobs have a serious impact on public safety,[24] documented workplace drug problems[25] or a drug-free work force is essential because of the nature of the job,[26] and there are safeguards to insure the invasion of privacy is no greater than absolutely required. It is therefore safe to

say that drug testing programs which are activated by individualized suspicion are much more likely to pass constitutional muster under the Fourth Amendment than programs which test employees randomly or require all employees to be tested.[27]

Employees, who use the Fifth Amendment to support their position that drug testing programs are unconstitutional, have argued such tests violate their right against self-incrimination.[28] The issue here is one which defines the basic right. If demanding drug tests in some way violated the Fifth Amendment sanction, public employers could not use drug testing as a tool to provide a drug-free workplace. The United States Supreme Court has held the constitutional privilege against self-incrimination is a bar against compelling "communications" or "testimony" and does not apply when compelling the "accused" to provide real or physical evidence.[29] Urine testing involves obtaining information from physical evidence, and therefore, does not invoke this Fifth Amendment protection.

Employees have also used the Fifth Amendment to challenge testing programs as violative of its "due process" clause.[30] Due process guarantees, both procedural and substantive, are also applicable to state government employers under the Fourteenth Amendment.[31] Procedural due process requires that the decision-making process in which the government takes an individual's "life, liberty, or property," e.g., his job, have procedural fairness or "due

process." Substantive due process requires the rule, e.g., testing requirement, itself be fair and reasonable. Procedural challenges to testing programs concentrate on whether or not the procedure employed in administering the test is fair, e.g., does the employer have a written policy outlining the test and does the policy provide for a proper chain of custody to insure accuracy. Substantive challenges focus on the initial decision to have a testing program, and whether that decision was arbitrary and capricious, e.g., does the reliability of the drug test results bear a reasonable relationship to a legitimate governmental purpose. The Fifth Circuit Court of Appeals addressed that issue and found the confirmatory test made the results sufficiently reliable to defeat any due process challenge.[32]

The Fourteenth Amendment's equal protection clause[33] makes the federal constitutional guarantees applicable to the states. Although no specific equal protection guarantees proscribe federal employer's actions, the Supreme Court has held its protections are encompassed in the "due process" clause of the Fifth Amendment.[34] Under our discussion, this protection basically holds that any drug testing program applied to one employee must be equally applied in the same manner to all other similarly-situated employees. Exceptions to this rule allow categories or classifications of employees to be treated differently if the employer can justify a legitimate purpose for the

separate classifications, i.e., has not acted arbitrarily and capriciously in forming the classifications.[35]

Federal Legislative Issues

In addition to the administrative and constitutional issues applicable to public employers, other federal legislation may have a tremendous impact on how a public employer approaches the implementation of its drug testing program.

Civil Rights Act of 1964

Title VII of the Civil Rights Act of 1964[36] prohibits discrimination based on race, sex, religion or national origin. An employer whose drug testing program does not discriminate against any protected group in its application, or in action taken as a consequence of test results, should have no concern about Title VII. However, one employee claimed religious protection for his use of peyote in services of the Native American Church. Not only was his use found to be legally protected, but the Court found his employer could reasonably accommodate his four time a year practice.[37]

Vocational Rehabilitation Act of 1973

The Vocational Rehabilitation Act of 1973[38] prohibits federally funded employers from discriminating against the handicapped. This Act applies not only to federal agency employers,[39] but to federal grant recipients[40] and many

federal contractors.[41] Most hospitals have signed federal Medicare participation agreements; however the federal Office of Management and Budget, responding to inquiries about the application of the Drug-Free Workplace Act of 1988,[42] has indicated such third party reimbursements are not made by way of a procurement contract or grant.[43] Although alcoholism and drug dependence are defined as handicaps in federal regulations,[44] and treated as such by federal courts,[45] employees with "current" drug abuse problems are not considered handicapped if their impairment interferes with their ability to work or poses a danger to persons or property.[46] Reasonable accommodation must be provided to a handicapped applicant, if such accommodation will assist an otherwise qualified applicant in performing the job. The accommodation need only be reasonable, e.g., supplying special equipment or a slight adjustment of job duties. It need not work an undue hardship on the employer. An example of a reasonable accommodation might include allowing the recovering alcoholic employee the use of sick or vacation time to attend counseling. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970[47] is applicable to federal employees only, and requires federal agencies to have alcoholism treatment programs.

Labor Management Relations Act of 1973

The Labor Management Relations Act[48] requires employers of unionized workers to negotiate major changes in working conditions with workers' representatives. The implementation of drug testing has been considered a substantial change in working conditions and held to be a mandatory subject of bargaining.[49] Unionized government employees fall under the Federal Service Labor-Management Relations Act,[50] which requires bargaining in good faith as to working conditions. A federal agency has the right, however, to set is own internal security practices--including drug testing, without recourse to the union to negotiate.

The duty to bargain does not mean the agreement of the union must be secured prior to implementation of the drug testing program, unless there is a current contract provision prohibiting testing. If the employer and the union have bargained in good faith and have reached a "bona fide" impasse, the employer is free to implement the policy.[51] Once implemented under the "impasse" conditions, the union may bring an unfair labor practice claim. If it does, most unfair labor practice claims involving drug abuse policies have been deferred to arbitration. Most arbitrators in these situations attempt to determine the reasonableness of the policy. The following criteria play an important role in establishing the reasonableness of a drug testing program:

- Does the program call for random v. incident-related testing? (Incident-related testing will provide a stronger argument for reasonableness.)
- Does the program apply to all employees, non-union, e.g., management, as well as union? (Application to all employees will provide a stronger argument for reasonableness.)
- Does the program provide procedures to insure accuracy, e.g., chain of custody and qualified laboratory? (A well written program containing employee protections will contribute to a finding of reasonableness.)[52]

Occupational Safety and Health Act of 1985

The Occupational Safety and Health Act (OSHA),[53] simply stated, requires employers to furnish to their employees a recognized hazard-free workplace, i.e., hazards which are likely to cause death or serious physical harm.[54] It is not inconceivable that this statutory requirement could form the basis of a claim against an employer for failing to screen or identify employees for drug abuse if a drug-impaired employee caused injury to a co-worker. This legislation may serve to support drug testing programs.

Montana Issues

Constitutional Issues

The Montana Constitution states:

> "The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest."[55]

This provision appears to constitutionalize and broaden the Griswold holding,[56] which defined "zones of privacy" protection emanating from the Fourth Amendment, even though no specific federal constitutional right of privacy exists.[57]

Statutory Issues

In 1987 the Montana Legislature amended its anti-polygraph statute,[58] by adding language which addressed employee drug testing, after the amendments were debated at length in Committee.[59] The amendments added language which heavily restricted employer's drug testing procedures.[60] Comments received during committee hearings referred to the unreliability of drug testing (single test programs), and the unjust imposition of discipline by some Montana employers for single test results.[61]

An employer may still test, but only under two circumstances:

1. Job applicants can be tested if the position's primary duties involve security, public safety or fiduciary responsibility, or the job is performed in a hazardous work environment;[62] and,
2. Employees may be tested as a condition of continued employment if the employer has reason to believe the employee is impaired on the job due to the use of alcohol or illegal drugs.[63]

Whether or not certain hospital jobs are involved with "security," "public safety" or are "hazardous work environments," as these terms are used in the statute, has not yet been judicially determined. It may well be a violation of the statute to require certain job applicants to submit to a drug test. Procedural protections, found in the statute, provide for a written testing policy to be made available to the employee prior to the test, specimens collected in a manner that minimizes invasion of personal privacy while insuring the integrity of the collection process, and adequate anti-tampering and chain of custody procedures. Test results may not be released without the employee's authorization or as required by law.[64]

Additionally, a confirmatory test, using a different method than that used in the initial test, is mandated.[65] The employee must receive a copy of the test results, as well as an opportunity to obtain an additional retest at a laboratory of the employee's choice at the employee's expense. The employee must be given an opportunity to explain or rebut the test results,[66] and no adverse personnel action can be taken if the employee presents a reasonable explanation or medical opinion indicating the results were not caused by alcohol or illegal drug use.[67] Violation by the employer is grounds for prosecution (misdemeanor),[68] but does not provide for a private civil action (one of the few state statutes which does not).

Human Rights Act

The Montana Human Rights Act[69] prohibits employment discrimination against the handicapped except on the basis of the reasonable demands of the job,[70] but reasonable attempts to accommodate are required.[71] The statute does not define alcoholism or drug addiction as a handicap, but in its rulings on discrimination, the Human Rights Commission has so held.[72]

Veterans and Handicapped Persons Employment Preference Act

The Veterans and Handicapped Persons Employment Preference Act[73] provides for preferential hiring of veterans and handicapped persons by government employers. This statute specifically defines "mental" impairment (considered a handicap), as excluding alcoholism or drug addiction.[74] There is no parallel reference to the handicap of "physical" impairment.

Common Law Issues

Although there is no constitutional or statutory basis for a claim of negligent hiring,[75] the United States District Court for the District of Montana did hold such an action could be maintained.[76] This may lead employers into considering drug testing job applicants; however, with the serious restrictions placed on employer drug testing by the 1987 legislative amendments,[77] it is highly unlikely an action would receive serious judicial consideration.

A successful defamation claim in the context of employment relations generally requires the employer to have knowingly made a false statement, or with reckless disregard for its veracity. The Ninth Circuit Court of Appeals (Montana's circuit), has held that allegations of defamation were sufficient to submit the case to a jury upon facts indicating the plaintiff's employer had circulated a letter from another employee accusing the plaintiff of drug dealing.[78]

A Montana employer who mismanages a drug testing program may also be subject to a claim of "intentional infliction of emotional distress."[79] As an example of the seriousness of this tort theory, a jury awarded an employee (an oil rig worker), $1 in damages for invasion of privacy, and $125,000 for intentional infliction of emotional distress after the plaintiff was required to submit to the collection of a urine sample in front of several of his co-workers. The plaintiff was discharged on the basis of a positive test result.[80]

Wrongful discharge as a valid tort theory in Montana exploded on the heels of the Gates cases,[81] and the Nye v. Department of Livestock case,[82] which specifically established the tort of wrongful discharge when the discharge violates a public policy. Subsequent to this line of cases, the Montana Supreme Court recognized the theory of wrongful discharge claims based on a public policy violation.[83] Prior to these cases, Montana had held firm to

its employment-at-will statutory wording which stated employees could be terminated, with few exceptions, at the discretion of the employer.[84]

Shortly after the theory of wrongful discharge took hold, Montana employees successfully argued wrongful discharge theories in tort actions, as well as theories in contract actions based on an implied covenant of good faith and fair dealing.[85, 86]

In response to the expanding case law, the Wrongful Discharge from Employment Act[87] was adopted by the Montana Legislature in 1987. The Act establishes a discharge as wrongful only if:

- it was in retaliation for an employee's refusal to violate public policy or for whistle-blowing, i.e., reporting violations; or
- it was not for good cause and the probationary period, if any, was completed; or
- the employer violated the express provisions of its own written personnel policy.[88]

It would appear the new Act will severely limit employees' claims in the future; however, the Act must first withstand constitutional scrutiny before the Montana Supreme Court.

Hospital employers instituting a drug testing policy in Montana should do so with the common law theories as a back drop. Although these theories require special attention, if hospital employers focus strongly on the business objectives to be accomplished, they should have little difficulty

defending their programs. Certain definitional ambiguities found in the drug testing statutes will undoubtedly be judicially resolved in the near future.

Legal Analysis Summary

Drug testing programs are not developed and implemented in a vacuum. Employers must understand the legal impact on such programs. Employees are using present federal constitutional, legislative and administrative language to challenge the legality of drug testing programs in court. Most courts are finding that drug testing programs are legally defensible in theory, but mandate employers to implement programs which treat employees fairly from a procedural standpoint. How the testing program is applied to the employee is critical to its judicial success.

Montana has specifically legislated employee drug testing requirements. Employers must meet pre-testing criteria, and even then, drug testing programs must contain explicit procedures for conducting the test. If Montana employers implement drug testing programs which do not meet these statutory requirements, employers subject themselves to litigation by employees harmed by these programs, e.g., privacy right violations, defamation, and intentional infliction of emotional distress.

Chapter Endnotes

[1]3 Code of Federal Regulations (C.F.R.) 224 (included as Appendix 1).

[2]The Armed Forces were excluded along with employing units of the Judicial and Legislative branches and the U.S. Postal Service. See Appendix 1, §3(f)(b).

[3]Executive Order 12564, §3 7(f), see Appendix 1.

[4]Ibid.

[5]Ibid., §3(c)(1-3).

[6]Federal Personnel Manual (FPM) Letter 792-16, November 28, 1986, as amended (to be incorporated into FPM supplement 792-2).

[7]Department of Health and Human Services/Alcohol, Drug Abuse, and Mental Health Administration: Mandatory Guidelines for Federal Workplace Drug Testing Programs, 53 C.F.R. 11, 970 et seq. (1988).

[8]United States Constitution, Amendment I (see excerpts in Appendix 3).

[9]United States Constitution, Amendment IV (see excerpts in Appendix 3).

[10]United States Constitution, Amendment V (see excerpts in Appendix 3).

[11]United States Constitution, Amendment XIV (see excerpts in Appendix 3).

[12]653 F. Supp. 1510 (D. Neb. 1987) aff'd 844 F.2d 562 (8th Cir. 1988) (nuclear power plant employees).

[13]Camara v. Municipal Court, 387 U.S. 523, 87 S. Ct. 1727 (1967); Marshall v. Barlow's Inc., 436 U.S. 307, 98 S. Ct. 1816, (1978).

[14]O'Connor v. Ortega, 107 S. Ct. 1492 (1987).

[15]Schmerber v. California, 384 U.S. 757, 86 S. Ct. 1826 (1966).

[16]National Treasury Employees Union v. Von Raab, 816 Fed 170 (5th Cir. 1987), cert. granted, 108 S. Ct. 1072 (1988), U.S. Supreme Court, No. 86-1879, 3/21/89.

[17]McDonell v. Hunter, 809 F.2d 1302 (8th Cir. 1987); Shoemaker v. Handel 795 F.2d 1136 (3rd Cir. 1986).

[18]There is no Constitutional right of privacy; however, the Supreme Court in Griswold v. Connecticut, 381 U.S. 479 (1965), indicated there were "zones of privacy" that are constitutionally protected. The zones of privacy discussed in the Griswold line of cases have generally centered on family, marriage and procreation, and it seems doubtful such zones will be found in the employment relationship.

[19]O'Connor v. Ortega, 107 S. Ct. 1492 (1987), p. 1502.

[20]Ibid., p. 1499.

[21]Ibid.

[22]United States v. Martinez-Fuerte, 428 U.S. 543, 560-561 (1976).

[23]National Treasury Employees Union v. Von Raab, 816 F.2d 170, quoting Delaware v. Prouse, 440 U.S. 648, 654-655 (1979).

[24]Rushton v. Nebraska Public Power District, 653 F. Supp. 1510 (D. Neb. 1987) aff'd 844 F.2d 562 (8th Cir. 1988) (nuclear power plant employees).

[25]Jones v. McKenzie, 1 I.E.R. Cases 1121 (D.C. Cir. 1987).

[26]National Treasury Employees Union v. Von Raab, U.S. Supreme Court, No. 86-1879, 3/21/89, 816 F.2d 170 (5th Cir. 1987), 108 S. Ct. 1072 (1988), (Customs Service occupations involving drug interdiction).

[27]National Treasury Employees Union v. Von Raab, U.S. Supreme Court, No. 86-1879, 3/21/89, (which upheld mandated testing of U.S. Customs Service employees seeking transfers or promotions into sensitive jobs); and Skinner v. RLEA, U.S. Supreme Court, No. 87-1555, 3/21/89, (which upheld post-accident testing of entire railroad crews without individualized suspicion).

[28]United States Constitution, Amendment V, (see excerpt in Appendix 3).

[29]Schmerber v. California, 384 U.S. 757, 86 S. Ct. 1826, (1966).

[30]See excerpts in Appendix 3.

[31]United States Constitution, Amendment XIV, sec. 1, (see excerpts in Appendix 3).

[32]National Treasury Employees Union v. Von Raab, U.S. Supreme Court, No. 86-1879, 3/21/89, and Skinner v. RLEA, U.S. Supreme Court, No. 87-1555, 3/21/89.

[33]United States Constitution, Amendment XIV, sec. 1, (see Appendix 3).

[34]Bolling v. Sharpe, 347 U.S. 497 (1954).

[35]Shoemaker v. Handel, 795 F.2d 1136 (3d Cir.) cert. denied, 107 S. Ct. 577 (1986), (drug test of jockeys but not other race track personnel was a justifiable classification scheme).

[36]42 U.S.C., §2000e, (1982).

[37]Toledo v. Nobel-Sysco, Inc., 41 Fair Employment Practice Cases 282, (BNA), (D.N.M. 1986).

[38]29 U.S. C., §701 et seq. (1982).

[39]29 U.S.C., §791.

[40]29 U.S.C., §794.

[41]29 U.S.C., §793, (the Act covers federal contracts of $2,500 or more).

[42]Public Law 100-690, Title V, Subtitle D.

[43]The law firm of McDermott, Will & Emery, "Regulations Implementing the Drug-Free Workplace Act of 1988," Health Law Update, March 6, 1989, p. 1.

[44] 29 C.F.R. 323 (1987).

[45]Davis v. Bucher, 451 F. Supp. 791 (E.D. Pa. 1978).

[46] 29 U.S.C.A., §706 (8)(13), (Supp. 1987).

[47]42 U.S.C., §290 dd-1(c)(1), (1970).

[48]29 U.S.C.A., §141 et seq. (1973 and Supp. 1987).

[49]National Labor Relations Board General Counsel Memorandum No. GC 87-5, (Sept 8, 1987).

[50]5 U.S.C.A., §7101 et seq., (1980 & Supp. 1987).

[51]Taft Broadcasting Co., 163 NLRB 475, (1967).

[52]The Law of Substance Abuse for Healthcare Providers, A Substance Abuse Task Force of the AHA Ad Hoc Labor Relations Advisory Committee Report, American Hospital Association, September 1987.

[53]29 U.S.C.A., §651 et seq., (West 1985 and Supp. 1987).

[54]29 U.S.C.A., §657, (1985).

[55]The Constitution of the State of Montana, Article II, Section 10, (1972).

[56]Griswold v. Connecticut, 381 U.S. 479, (1965).

[57]See Endnote 18.

[58]Montana Code Annotated (Mont. Code Ann.), §39-2-304 et seq., (1987).

[59]Montana Legislative Committee Notes, (1987), (State Law Library).

[60]Mont. Code Ann., §39-2-304 et seq., (1987).

[61]Montana Legislative Committee Notes, (1987), (State Law Library).

[62]Mont. Code Ann., §39-2-304(1)(b).

[63]Mont. Code Ann., §39-2-304(1)(c).

[64]Mont. Code Ann., §39-2-304(2).

[65]Ibid.

[66]Mont. Code Ann., §39-2-304(3).

[67]Mont. Code Ann., §39-2-304(4).

[68]Mont. Code Ann., §39-2-304(5).

[69]Mont. Code Ann., §49-1-101 et. seq., (1987).

[70]Mont. Code Ann., §49-2-303.

[71]Administrative Rules of Montana, (A.R.M.), § 24.9.1404-1405.

[72]Fullerton v. Flathead County Commissioners, Case No. SMsHpE 82-1683, (1983).

[73]Mont. Code Ann., §39-30-101 et. seq., (1987).

[74]Mont. Code Ann., §39-30-103(6)(b).

[75]Negligent hiring alleges the employer is liable for acts of an employee if the employer knew, or had reason to know, the employee would commit the acts complained of.

[76]Vollmer v. Bramlette, 594 F. Supp. 243 (D. Mont. 1984).

[77]Mont. Code Ann., §39-2-304 et seq., (1987).

[78]Tellez v. Pacific Gas & Elec. Co., 817 F.2d 546 (9th Cir. 1987).

[79]Ibid.

[80]Kelley v. Schlumberger Technology Corp., (heard in the District Court for Massachusetts), No. 85-4794-7, (Sept. 9, 1987).

[81]Gates v. Life of Montana Insurance Co. (Gates I), 196 Mont. 178, 638 P.2d 1063 (1982); and reviewed August, 1983 at _____, Mont._____, 668 P.2d 213 (1983), (Gates II).

[82]196 Mont. 222, 639 P.2d 498, (1982).

[83]Keneally v. Orgain, 186 Mont. 1, 606 P.2d 127, (1980).

[84]Mont. Code Ann., §39-2-503.

[85]Crenshaw v. Bozeman Deaconess Hospital, _____ Mont. _____, 693 P.2d 487 (1984), (Crenshaw was a probationary employee who alleged her termination resulted from the bad faith and unfair dealing of her employer based on its negligent handling of the investigation of her alleged misconduct.).

[86]For a full discussion of the history of wrongful discharge in Montana, see Shelley A. Hopkins, and Donald C. Robinson, "Employment At-Will, Wrongful Discharge, and The Covenant of Good Faith and Fair Dealing in Montana, Past, Present, and Future," 46 Montana Law Review 1, Winter 1985, pp. 1-24.

[87]Mont. Code Ann., §39-2-901 et. seq. (1987).

[88]Mont. Code Ann., §39-2-904.

CHAPTER FOUR

SURVEY ANALYSIS

In order to gain insight into the drug problem in Montana's acute-care hospitals, as perceived by hospital administrators, a survey[1] was conducted with questionnaires mailed to the administrators of the sixty licensed hospitals in Montana.[2] Because the results are based on the administrators' perceptions and beliefs, additional direct information was obtained through personal interviews with four health care employees who are presently recovering from an addiction to alcohol or barbiturates. Although not statistically relevant, their responses give a more personal perspective to the question posed by this paper. It is interesting how similar their responses and comments were to each other, although the interviews were conducted separately, without discussions among the four. Interesting also, were their perceptions/ observations of the drug problem among fellow employees. Their involvement gave a perspective which was much different from the administrators.

Montana Hospitals

Of the sixty licensed hospitals surveyed, twenty-seven (45 percent) responded. Of the twenty-seven responding, 93 percent were private and 8 percent government-owned. In only 11 percent were employees unionized, and then ranging from 2 percent of employees to 90 percent. The differences in responses by government versus non-government and unionized versus non-unionized were not statistically significant enough to group the hospitals by those categories. The size of the employee population in each hospital did, however, appear to make a significant difference in responses, and the hospitals have therefore been broken down into three categories by employee size, e.g., hospitals with employee populations from 1 to 100 (small hospitals - seventeen responding); from 101 to 500 (medium hospitals - eight responding); and, over 500 (large hospitals - two responding).

Survey Results

A detailed discussion of the survey results follow.[3] Note should be taken that the results may not add to 100 percent for each question because some did not respond to all questions, and some questions elicited multiple responses from the same hospital.

Perceptions Of The Drug Problem

Overall, only 23 percent perceived the problem more serious in their own organizations now than seven years ago;

while 6 percent of small hospitals, 38 percent of medium hospitals, and 100 percent of large hospitals found the problem had grown more serious in the last seven years. Fifty percent of all hospitals surveyed saw the problem as the same. Fifty percent found the problem more serious now than seven years ago in other organizations, more than twice as many as those who viewed the problem more serious in their own organizations. Only 8 percent overall presently perceived the drug problem a serious one in their hospitals. While no small hospital viewed it as a serious problem, 50 percent of the large hospitals saw the problem as serious. Sixty-nine percent of small hospitals indicated drugs were not a problem.

The drugs causing the biggest problems overall were:

First	alcohol	77 percent
Second	marijuana	23 percent
Third	cocaine	12 percent

In small hospitals barbiturates/amphetamines tied with marijuana for second at 13 percent.

Administrators based their perceptions of the problem on their own observations (88 percent), reports from colleagues (69 percent), and their hospital disciplinary records (42 percent).

Testing Job Applicants For Drugs

None of the hospitals test job applicants for drugs.

Testing Employees For Drugs

Less than 4 percent of the hospitals responding presently test employees for drugs. Urine, blood and breath tests were used, with no differentiation of tests used among levels of employees, e.g., managerial, supervisory, clerical and line workers were all tested the same. Confirmatory retests were blood or urine tests. Tests were only conducted after employees showed aberrant behavior or were involved in an "accident," i.e., reasonable cause was present. All tests were conducted internally. There was insufficient historical data for the testing hospitals to indicate percentages of positive results after first tests or confirmatory tests; but those who employed a confirmatory test used the same test as the first. This practice now violates Montana law.[4] If test results were positive, normal disciplinary measures were used. Other disciplinary procedures were implemented if employees refused to be tested.

Of the remaining 96 percent of hospitals which do not presently test, only 12 percent are considering testing, and those considering are evenly split among small, medium and large hospitals. The reasons given for not testing include:

Legal implications	35%
No need to test	27%
Cost of testing	23%

Moral implications (employee embarrassment)	19%
Time and energy required	19%

Search Policies

Only 8 percent search employees' lockers or personal effects when there is a reasonable suspicion of employees' drug involvement.

Other Drug Control Measures

Half of the hospitals surveyed take other measures to control their perceived drug problem. Education (35 percent) was the measure most used, followed closely by printed material (27 percent), and treatment (25 percent). Sixty-three percent of small hospitals use no other measures, while 63 percent of medium hospitals and 100 percent of large hospitals did.

Management Decisions

Hospitals were initially asked to indicate what disciplinary actions they would take if confronted with an incident in which a significant loss occurred involving time or money, because an employee was impaired on the job due to one of several drugs. The second question asked involved employee job impairment due to drug use, but no loss had been sustained.

For a first offense, after suffering a significant loss, only 35 percent of those hospitals surveyed would terminate for heroin or cocaine, and 19 percent for

marijuana and alcohol. For a second such offense, 73 percent would terminate for barbiturates/amphetamines, heroin and cocaine; while 69 percent would terminate for alcohol and 65 percent for marijuana.

Hospitals were much more lenient when no loss was involved, with 19 percent terminating on a first offense for barbiturates/amphetamines, heroin and cocaine. Alcohol and marijuana caused termination for first offenders in only 15 percent of the hospitals surveyed. This figure rose dramatically to 65 percent for second offenders for all drugs, except marijuana, which was slightly lower at 62 percent.

Less than 4 percent would ignore the incident for a first offense, with no loss, if the drug involved was marijuana. This was the only time hospitals indicated they would ignore the problem.

Small hospitals generally followed the statistics of all hospitals for termination after a first offense involving a significant loss, and were slightly more lenient after a second offense. Large hospitals were generally more lenient for first offenses with 50 percent terminating on first offense if a significant loss was involved, only if heroin or cocaine were involved. No first offense terminations would be imposed for the other drugs. If there was not a loss, large hospitals did not terminate for first offenses no matter what drug was involved. Second offenses

prompted 100 percent termination response from large hospitals, whether or not a loss was involved.

Drug Testing Policy

Less than 4 percent of the hospitals surveyed had a written drug testing policy.

Personal Interviews

Four individuals, all presently working in acute care hospitals, volunteered to be interviewed. Two were female (referred to hereafter as Mary A. and Mary B.), and two were male (referred to hereafter as John A. and John B.). Two presently hold mid-management positions, and two are involved with direct patient care. All have been in health care for an extended period of time, ranging from seven years to twenty-three years, and only one developed addiction after entering the health care field. Three abused alcohol and the fourth abused barbiturates.

Mary A.

Mary A. has been involved in direct patient care for more than fifteen years, and had been abusing drugs for more than twenty. She indicated she has worked while impaired, but her impairment never affected her clinical care. She believes she worked at a 50 percent level during a using period and 95 percent when not directly using, which was about 60 percent of the time. This translates into lost time as follows: 40 hours per week at 40 percent; 40

percent at 40 hours equals 16 hours per week; 16 hours at 50 percent capacity equals 8 hours impaired per week or one day unproductive. Her attitude toward her peers suffered when she was using because she was overly demanding and inflexible. She overcompensated for her impairment by demanding near perfection from herself and those with whom she worked. She felt her way was the only way, and this attitude caused problems for her with her supervisor. This perfectionist attitude was a common thread among those interviewed.

Mary A. indicated her rate of pay made no difference in her drug use, nor did raises she received tend to increase her use.

Mary A. does not believe any untoward event involving a patient occurred while she was working impaired. Her supervisor mentioned her "bad attitude" to her twice, implying she might have a "problem," but did not directly confront her, or follow-up in any way. Her supervisor's comments did add to Mary A.'s desire to seek help. Her job was all important, and she could not financially jeopardize losing her job by "getting caught." As a result, when Mary A. discovered her insurance would pay for treatment, she contacted her employer's employee assistance coordinator and went into treatment. Her supervisor was told after she had left for treatment, and her supervisor was very supportive. A month later Mary A. was back at work and has not abused drugs since. She is now more supportive of her fellow

workers and less demanding of herself. She believes a drug testing program would be beneficial for her present employer because she believes approximately 30 percent of her peers are working impaired -- either directly as a result of their own addiction, or indirectly as a result of a spouse's addiction. Mary A. believes about 95 percent of health care professionals have some drug dependency in their background, i.e., extended family.

Mary B.

Mary B. has also been involved in direct patient care for a number of years and abusing drugs for much longer. She believes she works at 80 percent capacity now that she no longer works impaired, but worked only at a 30 percent level during periods of withdrawal. Mary B. experienced withdrawal symptoms about twice a week, which means: two days per week (16 hours) at 30 percent capacity equals 11.2 hours lost per week (almost 1.5 days per week). She believes she worked impaired 100 percent of the time prior to treatment. Mary B. asked her peers for assistance if she was required to give direct patient care that she felt she could not handle while in withdrawal. Mary B.'s peers were always willing to help, and never questioned the reasons Mary B. gave for requesting their assistance, e.g., if required to start an I.V. (intravenous injection) while suffering withdrawal, she would tell a peer she just

could not find the vein, rather than attempt the procedure with shaky hands.

Mary B. came to the conclusion she needed help and sought help on her own. Her employer was very understanding after she entered treatment and supported her efforts. Mary B. was forced to begin work immediately after treatment, which she believes was directly responsible for her first relapse. The explanation given to her by her employer was, "If you fall off your horse, you need to get right back on again to overcome any doubts you have." Stress and professional access to her drug of choice caused Mary B.'s relapse, which occurred two weeks after her return. Her relapse caused her to resign. After six months of inactivity, she applied at another hospital. She explained her past addiction during her application process and was hired on a trial basis. She agreed to allow her new employer to test her for drug use on a random basis. After five months, Mary B. relapsed again, sought additional treatment and has remained off drugs ever since. She believes the encouragement of her present employer has helped her.

Mary B.'s thoughts on employer drug testing agree with Mary A.'s -- a drug testing program would prove beneficial for employers, as well as impaired employees. The program should not be one of retribution, but it would be more successful if geared toward identification, confrontation and treatment. Mary B. believes 30 to 40 percent of health

care workers involved in direct patient care are impaired to some degree by the use of drugs or drug use by close family members.

John A.

John A. developed his addiction after working in the health care field for seven years. That was almost sixteen years ago. John A. believed strongly in his need to be perfect when dealing with patients. He medicated the tension created by this attitude. John A. received praise for his clinical skills, even though he worked impaired, and was eventually promoted to a mid-management position. His desire to be the best "boss" in the facility continued the stress and tension John A. imposed on himself; and, as a result, his self-medication grew. His attitude toward his subordinates became more and more strained as he accepted no excuses for mistakes. His immediate superior challenged his "dictatorial behavior," but did not directly confront him about his possible drug use. Not until John A.'s drug problem had increased to the point he was avoiding making necessary management decisions, did his boss call him in and force him to seek treatment. His "medication" had failed to cure the problem. While working impaired, John A. believes he was working at a 50 percent capacity level. Two and one-half days per week were wasted.. He only did what was observable.

John A. reluctantly sought treatment, and was gone for thirty days. Upon John A.'s return, his employer granted him special accommodations to leave work to attend support meetings. John A. abused this accommodation. He was gone so much John A. felt his performance dropped to a 40 percent level. John A. was again called in and confronted; not because he was working impaired, but because John A. was so involved with his recovery that his work was suffering more than before. John A. now feels he is working at 80 percent capacity, and he attends support meetings during off hours.

John A. believes 40 percent of his colleagues are working impaired, and has been working with several to get them into treatment. He indicated a person will not seek treatment until they realize they have a problem, and many are not yet to that stage. Although those impaired do not show observable impairment on the job, John A. has a more watchful eye on his subordinates. He feels he would not be supported by his employer if he confronted an impaired employee because there is no corporate policy indicating appropriate procedures.

John B.

John B.'s addiction started shortly before entering the health care field. During those early years, John B.'s addiction never seemed to get "out of hand." His addiction, however, slowly did get out of hand over a period of fifteen years. Over that time span, John B. worked for several employers, none of which observed his problem directly. His

job and his license to practice were his main priority, and John B. made sure he hid his addiction well. Even though John B. came to work impaired about 40 percent of the time, and worked at less than 40 percent capacity (two days per week lost), he always maintained a controlled appearance. John B. was promoted to a mid-management position which required additional paperwork. He found it more and more difficult to get his reports in on time, and began to use his vacation and sick leave to escape deadlines. His increased absence brought him to the attention of his superior, who confronted John B. about his absences, and formally disciplined him. He promised to do better, but found he could not. He came to work more often, but was working more impaired. His desire to maintain his license, and an incident unrelated to his work, made John B. seek treatment. His employer was "very understanding," but told John B. if he did not finish treatment he did not have a job. John B. finished treatment and resumed his position upon his return. His work capabilities have increased to more than 80 percent, and his absenteeism is no longer a problem.

John B. feels an employer drug testing program would only be beneficial if used as a tool to help employees, not terminate them. Such an attitude from an employer aids rehabilitation. Employees are more likely to seek assistance if they know their efforts will be supported by their employer.

John B. believes 20 to 30 percent of all health care workers are working impaired. John B. bases this belief on personal observation and discussions with other recovering health care professionals.

Personal Interview Results

All four individuals appeared honest and forthright in their responses. It was evident they all felt the drug problem among health care workers in hospitals is more serious than the administrators surveyed. Three of the four felt the personality traits which draw individuals to seek a health care career, e.g., empathetic, eager to please, also make them more susceptible to overlook the drug problem of a colleague. They tend to "enable" their colleagues to get by undetected, or at least without being confronted. They all believed an employer drug testing program would be beneficial only if used as a tool to aid and assist employees to see their problem and seek treatment.

Survey Analysis Summary

The survey revealed a significant difference between small and large Montana hospitals, both in the recognition of an employee impairment problem caused by drug abuse, and in the desire to address the problem by testing. Small hospitals generally do not recognize they have a drug problem among their employees, and therefore, see no reason to implement an employee drug testing program.

Formerly impaired employees, presently working in Montana hospitals, believe the problem is much more serious than employers admit. They recommend the implementation of drug testing programs to identify and help impaired employees, not to punish them. Most employers have indicated their first reaction would be to help impaired employees; therefore, it appears there is agreement on this critical issue, i.e., most employers would develop programs with a rehabilitation format rather than a disciplinary format.

Chapter Endnotes

[1]A sample Survey is included as Appendix 4.

[2]A list of the sixty Montana licensed hospitals was provided by the Montana Hospital Association and included as Appendix 5.

[3]Matrixed results of pertinent parts can be found in Appendix 6.

[4]Mont. Code Ann. §39-2-304 (2).

CHAPTER FIVE

CONCLUSION

Analysis

Federal and state laws and regulations, and their judicial interpretation, have clearly begun to define employee drug testing. These definitions will guide Montana's acute-care hospitals, should they decide to formulate and implement drug testing programs. At present, the majority of hospitals surveyed clearly do not see the need to address the drug problem with drug testing programs. Legal implications, program development/implementation costs weigh heavily in their decisions not to test. Many still feel there is no problem. In our litigious society, it may well be that the risk of not having a program is far outweighed by the risk of an ill-conceived or mismanaged program. Certainly all hospitals should apply a cost/benefit analysis to their ultimate decision. It is of some note that 27 percent of all hospitals surveyed do not feel there is a need. Their feeling is based on their belief they either do not have a problem, or they can address the problem by other means. Forty-six percent feel

there is not a drug problem in their organizations, and only 50 percent use other means to combat a perceived problem.

This belief appears to fly in the face of national statistics, which suggest between 10 and 23 percent of American workers regularly abuse drugs in the workplace. Are Montana's hospitals and health care workers immune from these national statistics?

Conclusions

Blending the apparent need to test applicants and employees of Montana's acute-care hospitals with federal and state mandated testing requirements will be a difficult task at best. However, such blending needs to be pursued by some, if not all, of Montana's hospitals.

At first blush, the cost/benefit analysis may weigh against a drug testing program for Montana's small and medium sized hospitals; however, if any of Montana's hospitals begin to test, those who do not may find a greater number of their applicants to be drug abusers. Drug abusers will begin to shy away from applying at hospitals which test applicants and employees, and gravitate toward non-testing hospitals. Non-testing hospitals will therefore have an increasing percentage of their applicants made up of already impaired workers.

National surveys indicate the problem is growing, and Montana's hospitals cannot afford to wait for the problem to

force the issue. It would be better for Montana's health care industry to take a proactive stance.

Those hospitals which decide to test must approach their programs cautiously. The legal impact on drug testing programs in Montana is considerable. The state legislature has placed many restrictions in the path of employers in order to safeguard the rights of employees. These restrictions must be specifically addressed as drug testing procedures are implemented.

Although there may be other drug testing methods used to identify drug impaired employees, these methods do not appear to be able to stop the steady rise in drug use in the American workplace. These methods may still work in Montana's hospitals, but for how long? If the problem is growing, should not hospitals take a leading and proactive role in developing drug testing policies that could serve as examples for other employers who are less "health" oriented?

Recommendations

Montana's hospitals would be wise to enlist the aid of its state association, the Montana Hospital Association to provide leadership in the area of employee drug testing. The Association should develop a set of legally sufficient guidelines and proposed drug testing procedures which could be adopted, with some modifications for unique needs, by all Montana's hospitals. Again, a proactive posture should be assumed. The Montana Hospital Association has the unique

ability to cross over competitive lines, and bring the needed expertise together to show the Montana health care consumer, and health care employee, a united effort. A united effort to strongly position Montana hospitals so they can deal with an employee problem sure to be found in every hospital. This problem will not disappear by Montana's hospital employers burying their collective heads in the sand.

Montana's hospitals should also recognize an employee drug testing program is not a panacea to the employee drug problem. It is merely a tool. When combined with other tools, e.g., better hiring techniques and well-designed employee assistance programs, drug testing programs will enable Montana's hospitals to more adequately identify the drug impaired employees in their work force. Identification should only be the first step in providing needed assistance to drug impaired employees, and a better, safer environment for Montana's health care consumer.

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National Treasury Employees Union v. Von Raab, 816 Fed 170 (5th Cir. 1987), cert. granted, 108 S. Ct. 1072 (1988), U.S. Supreme Court, No. 86-1879, 3/21/89.

Nye v. Dept. of Livestock, 196 Mont. 222, 639 P.2d 498, (1982).

O'Connor v. Ortega, 107 S. Ct. 1492 (1987).

Rushton v. Nebraska Public Power District, 653 F. Supp. 1510 (D. Neb. 1987) aff'd 844 F.2d 562 (8th Cir. 1988).

Schmerber v. California, 384 U.S. 757, 86 S. Ct. 1826 (1966).

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Skinner v. RLEA, U.S. Supreme Court, No. 87-1555, 3/21/89.

Taft Broadcasting Co., 163 NLRB 475, (1967).

Taylor v. O'Grady, 669 F. Supp. 1422 (N.D. Ill. 1987).

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Toledo v. Nobel-Sysco, Inc., 41 Fair Employment Practice Cases 282, (BNA), (D.N.M. 1986).

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APPENDIX 1

EXECUTIVE ORDER 12564:

DRUG-FREE FEDERAL WORKPLACE

THE WHITE HOUSE,

September 12, 1986.

Labor Organizations

ARASA Division; Brotherhood of Railway, Airline and Steamship Clerks
Brotherhood of Locomotive Engineers
Brotherhood of Railway, Airline and Steamship Clerks, Freight Handlers, Express and Station Employees
Brotherhood of Railway Carmen of the United States and Canada
Brotherhood of Railroad Signalmen
International Association of Machinists and Aerospace Workers, AFL-CIO
International Brotherhood of Boilermakers and Blacksmiths
International Brotherhood of Electrical Workers
International Brotherhood of Firemen and Oilers
National Transportation Supervisors Association
Police Benevolent Association
Sheet Metal Workers' International Association
United Transportation Union
United Transportation Union—Railroad Yardmasters of America Division

Editorial note: For White House announcements on the establishment and the appointment of the membership of Presidential Emergency Board No. 212, dated Sept. 12 and 23, 1986, respectively, see the *Weekly Compilation of Presidential Documents* (vol. 22, pp. 1181 and 1249).

Executive Order 12564 of September 15, 1986

Drug-Free Federal Workplace

I, RONALD REAGAN, President of the United States of America, find that:

Drug use is having serious adverse effects upon a significant proportion of the national work force and results in billions of dollars of lost productivity each year;

The Federal government, as an employer, is concerned with the well-being of its employees, the successful accomplishment of agency missions, and the need to maintain employee productivity;

The Federal government, as the largest employer in the Nation, can and should show the way towards achieving drug-free workplaces through a program designed to offer drug users a helping hand and, at the same time, demonstrating to drug users and potential drug users that drugs will not be tolerated in the Federal workplace;

The profits from illegal drugs provide the single greatest source of income for organized crime, fuel violent street crime, and otherwise contribute to the breakdown of our society;

The use of illegal drugs, on or off duty, by Federal employees is inconsistent not only with the law-abiding behavior expected of all citizens, but also with the special trust placed in such employees as servants of the public;

Federal employees who use illegal drugs, on or off duty, tend to be less productive, less reliable, and prone to greater absenteeism than their fellow employees who do not use illegal drugs;

The use of illegal drugs, on or off duty, by Federal employees impairs the efficiency of Federal departments and agencies, undermines public confidence in them, and makes it more difficult for other employees who do not use illegal drugs to perform their jobs effectively. The use of illegal drugs, on or off duty, by Federal employees also can pose a serious health and safety threat to members of the public and to other Federal employees;

The use of illegal drugs, on or off duty, by Federal employees in certain positions evidences less than the complete reliability, stability, and good judgment that is consistent with access to sensitive information and creates the possibility of coercion, influence, and irresponsible action under pressure that may pose a serious risk to national security, the public safety, and the effective enforcement of the law; and

Federal employees who use illegal drugs must themselves be primarily responsible for changing their behavior and, if necessary, begin the process of rehabilitating themselves.

By the authority vested in me as President by the Constitution and laws of the United States of America, including section 3301(2) of Title 5 of the United States Code, section 7301 of Title 5 of the United States Code, section 290ee–1 of Title 42 of the United States Code, deeming such action in the best interests of national security, public health and safety, law enforcement and the efficiency of the Federal service, and in order to establish standards and procedures to ensure fairness in achieving a drug-free Federal workplace and to protect the privacy of Federal employees, it is hereby ordered as follows:

Section 1. *Drug-Free Workplace.*

(a) Federal employees are required to refrain from the use of illegal drugs.

(b) The use of illegal drugs by Federal employees, whether on duty or off duty, is contrary to the efficiency of the service.

(c) Persons who use illegal drugs are not suitable for Federal employment.

Sec. 2. *Agency Responsibilities.*

(a) The head of each Executive agency shall develop a plan for achieving the objective of a drug-free workplace with due consideration of the rights of the government, the employee, and the general public.

(b) Each agency plan shall include:

(1) A statement of policy setting forth the agency's expectations regarding drug use and the action to be anticipated in response to identified drug use;

(2) Employee Assistance Programs emphasizing high level direction, education, counseling, referral to rehabilitation, and coordination with available community resources;

(3) Supervisory training to assist in identifying and addressing illegal drug use by agency employees;

(4) Provision for self-referrals as well as supervisory referrals to treatment with maximum respect for individual confidentiality consistent with safety and security issues; and

(5) Provision for identifying illegal drug users, including testing on a controlled and carefully monitored basis in accordance with this Order.

Sec. 3. *Drug Testing Programs.*

(a) The head of each Executive agency shall establish a program to test for the use of illegal drugs by employees in sensitive positions. The extent to which such employees are tested and the criteria for such testing shall be determined by the head of each agency, based upon the nature of the agency's mission and its employees' duties, the efficient use of agency resources, and the danger to the public health and safety or national security that could result from the failure of an employee adequately to discharge his or her position.

(b) The head of each Executive agency shall establish a program for voluntary employee drug testing.

(c) In addition to the testing authorized in subsections (a) and (b) of this section, the head of each Executive agency is authorized to test an employee for illegal drug use under the following circumstances:

(1) When there is a reasonable suspicion that any employee uses illegal drugs;

(2) In an examination authorized by the agency regarding an accident or unsafe practice; or

(3) As part of or as a follow-up to counseling or rehabilitation for illegal drug use through an Employee Assistance Program.

(d) The head of each Executive agency is authorized to test any applicant for illegal drug use.

Sec. 4. *Drug Testing Procedures.*

(a) Sixty days prior to the implementation of a drug testing program pursuant to this Order, agencies shall notify employees that testing for use of illegal drugs is to be conducted and that they may seek counseling and rehabilitation and inform them of the procedures for obtaining such assistance through the agency's Employee Assistance Program. Agency drug testing programs already ongoing are exempted from the 60-day notice requirement. Agencies may take action under section 3(c) of this Order without reference to the 60-day notice period.

(b) Before conducting a drug test, the agency shall inform the employee to be tested of the opportunity to submit medical documentation that may support a legitimate use for a specific drug.

(c) Drug testing programs shall contain procedures for timely submission of requests for retention of records and specimens; procedures for retesting; and procedures, consistent with applicable law, to protect the confidentiality of test results and related medical and rehabilitation records. Procedures for providing urine specimens must allow individual privacy, unless

the agency has reason to believe that a particular individual may alter or substitute the specimen to be provided.

(d) The Secretary of Health and Human Services is authorized to promulgate scientific and technical guidelines for drug testing programs, and agencies shall conduct their drug testing programs in accordance with these guidelines once promulgated.

Sec. 5. *Personnel Actions.*

(a) Agencies shall, in addition to any appropriate personnel actions, refer any employee who is found to use illegal drugs to an Employee Assistance Program for assessment, counseling, and referral for treatment or rehabilitation as appropriate.

(b) Agencies shall initiate action to discipline any employee who is found to use illegal drugs, *provided that* such action is not required for an employee who:

(1) Voluntarily identifies himself as a user of illegal drugs or who volunteers for drug testing pursuant to section 3(b) of this Order, prior to being identified through other means;

(2) Obtains counseling or rehabilitation through an Employee Assistance Program; and

(3) Thereafter refrains from using illegal drugs.

(c) Agencies shall not allow any employee to remain on duty in a sensitive position who is found to use illegal drugs, prior to successful completion of rehabilitation through an Employee Assistance Program. However, as part of a rehabilitation or counseling program, the head of an Executive agency may, in his or her discretion, allow an employee to return to duty in a sensitive position if it is determined that this action would not pose a danger to public health or safety or the national security.

(d) Agencies shall initiate action to remove from the service any employee who is found to use illegal drugs and:

(1) Refuses to obtain counseling or rehabilitation through an Employee Assistance Program; or

(2) Does not thereafter refrain from using illegal drugs.

(e) The results of a drug test and information developed by the agency in the course of the drug testing of the employee may be considered in processing any adverse action against the employee or for other administrative purposes. Preliminary test results may not be used in an administrative proceeding unless they are confirmed by a second analysis of the same sample or unless the employee confirms the accuracy of the initial test by admitting the use of illegal drugs.

(f) The determination of an agency that an employee uses illegal drugs can be made on the basis of any appropriate evidence, including direct observation, a criminal conviction, administrative inquiry, or the results of an authorized testing program. Positive drug test results may be rebutted by other evidence that an employee has not used illegal drugs.

(g) Any action to discipline an employee who is using illegal drugs (including removal from the service, if appropriate) shall be taken in compliance

with otherwise applicable procedures, including the Civil Service Reform Act.

(h) Drug testing shall not be conducted pursuant to this Order for the purpose of gathering evidence for use in criminal proceedings. Agencies are not required to report to the Attorney General for investigation or prosecution any information, allegation, or evidence relating to violations of Title 21 of the United States Code received as a result of the operation of drug testing programs established pursuant to this Order.

Sec. 6. *Coordination of Agency Programs.*

(a) The Director of the Office of Personnel Management shall:

(1) Issue government-wide guidance to agencies on the implementation of the terms of this Order;

(2) Ensure that appropriate coverage for drug abuse is maintained for employees and their families under the Federal Employees Health Benefits Program;

(3) Develop a model Employee Assistance Program for Federal agencies and assist the agencies in putting programs in place;

(4) In consultation with the Secretary of Health and Human Services, develop and improve training programs for Federal supervisors and managers on illegal drug use; and

(5) In cooperation with the Secretary of Health and Human Services and heads of Executive agencies, mount an intensive drug awareness campaign throughout the Federal work force.

(b) The Attorney General shall render legal advice regarding the implementation of this Order and shall be consulted with regard to all guidelines, regulations, and policies proposed to be adopted pursuant to this Order.

(c) Nothing in this Order shall be deemed to limit the authorities of the Director of Central Intelligence under the National Security Act of 1947, as amended, or the statutory authorities of the National Security Agency or the Defense Intelligence Agency. Implementation of this Order within the Intelligence Community, as defined in Executive Order No. 12333, shall be subject to the approval of the head of the affected agency.

Sec. 7. *Definitions.*

(a) This Order applies to all agencies of the Executive Branch.

(b) For purposes of this Order, the term "agency" means an Executive agency, as defined in 5 U.S.C. 105; the Uniformed Services, as defined in 5 U.S.C. 2101(3) (but excluding the armed forces as defined by 5 U.S.C. 2101(2)); or any other employing unit or authority of the Federal government, except the United States Postal Service, the Postal Rate Commission, and employing units or authorities in the Judicial and Legislative Branches.

(c) For purposes of this Order, the term "illegal drugs" means a controlled substance included in Schedule I or II, as defined by section 802(6) of Title 21 of the United States Code, the possession of which is unlawful under chapter 13 of that Title. The term "illegal drugs" does not mean the use of a controlled substance pursuant to a valid prescription or other uses authorized by law.

(d) For purposes of this Order, the term "employee in a sensitive position" refers to:

(1) An employee in a position that an agency head designates Special Sensitive, Critical-Sensitive, or Noncritical-Sensitive under Chapter 731 of the Federal Personnel Manual or an employee in a position that an agency head designates as sensitive in accordance with Executive Order No. 10450, as amended;

(2) An employee who has been granted access to classified information or may be granted access to classified information pursuant to a determination of trustworthiness by an agency head under Section 4 of Executive Order No. 12356;

(3) Individuals serving under Presidential appointments;

(4) Law enforcement officers as defined in 5 U.S.C. 8331(20); and

(5) Other positions that the agency head determines involve law enforcement, national security, the protection of life and property, public health or safety, or other functions requiring a high degree of trust and confidence.

(e) For purposes of this Order, the term "employee" means all persons appointed in the Civil Service as described in 5 U.S.C. 2105 (but excluding persons appointed in the armed services as defined in 5 U.S.C. 2102(2)).

(f) For purposes of this Order, the term "Employee Assistance Program" means agency-based counseling programs that offer assessment, short-term counseling, and referral services to employees for a wide range of drug, alcohol, and mental health programs that affect employee job performance. Employee Assistance Programs are responsible for referring drug-using employees for rehabilitation and for monitoring employees' progress while in treatment.

Sec. 8. *Effective Date.* This Order is effective immediately.

RONALD REAGAN

(Pub.464)

APPENDIX 2

INDICATORS OF DRUG ABUSE

(Compiled by Theodore F. Shults)*

Work Performance Indicators

Poor attendance, particularly a pattern of absenteeism on Mondays and Fridays.

Frequent and extended job breaks.

Poor performance, low output and poor quality.

Increased operating errors.

Wasted materials or damaged equipment.

Extensive overtime with no increase in workload.

Failure to meet deadlines, procrastination.

Faulty decision-making.

Argumentative and defensive behavior.

Frequent job-related accidents.

Time lost due to frequent off-site accidents.

Progressive decline in work performance.

Interpersonal Indicators

Sudden emotional swings.

Emotional overreaction - laughter, crying.

Overreaction to criticism.

Mood changes from morning to afternoon.

Blaming co-workers, supervisors or managers for performance problems.

Complaints from co-workers and others about behavior.

Denial that there is a problem.

Increased isolation, new associations.

Impaired communication.

Irrational or inappropriate statements.

Rambling conversation.

Physical Indicators

Deterioration of physical appearance.

Odor of alcohol.

Discovery of drug paraphernalia.

Gross intoxication.

Bizarre behavior.

Slurred speech.

Staggered gait.

Involuntary eye movements.

Glazed or red eyes.

*Lex K. Larson and Theodore F. Shults, Employment Screening, Mathew Bender, 1988, p. EG 1-25.

APPENDIX 3

UNITED STATES CONSTITUTION

(Excerpts)

Amendment I (1791)

Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

Amendment IV (1791)

The right of the people to secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

Amendment V (1791)

No person shall be held to answer for a capital, or otherwise infamous crime, unless on presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

AMENDMENT XIV (1868) (Section 1 only)

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities or citizens of the United States; nor shall any State deprive any person of life, liberty or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

APPENDIX 4

SURVEY OF DRUG TESTING

April 18, 1989

_____
Administrator
_____
_____

Dear _____:

I am gathering information to complete my Master's Thesis entitled IS THERE A NEED FOR AN EMPLOYER DRUG TESTING PROGRAM IN MONTANA'S ACUTE CARE HOSPITALS?, in partial completion of an M.B.A. degree from the University of Montana (Malmstrom A.F.B. Program). I am surveying all Administrators/CEOs of Montana's licensed acute care hospitals.

Your responses will greatly enhance my ability to conclude my Thesis, and should help provide valuable information to Montana's health care industry in the future. The Montana Hospital Association has reviewed the survey enclosed and encourages your response.

If you will assist me by completing the survey enclosed and returning it to me no later than Wednesday, April 26, 1989, I will provide you a free copy of my Thesis upon its publication. A self-addressed, stamped envelope is provided for your convenience.

Thank you for the time you have taken.

Sincerely,

Michael L. McPherson

IS THERE A NEED FOR AN EMPLOYER DRUG TESTING PROGRAM IN MONTANA'S ACUTE CARE HOSPITALS?

SURVEY OF DRUG TESTING

1. Demographics

Organization Size. What is the total number of employees in your entire organization?

____ 1-100
____ 101-500
____ over 500

Are you: ____ Government Employer
____ Private Employer

Union Status. Is your organization unionized? ____ Yes ____ No
If yes, what percentage of workers belong to the union? ____%

2. The Drug Problem

Since 1981-1982, what is your perception of the "alcohol and drug" problem today?

In your organization:
____ Less of a problem than in 1981-1982
____ The same
____ More serious

In other organizations:
____ Less of a problem than in 1981-1982
____ The same
____ More serious

Please check the statement that best describes the drug problem in your organization:
____ The most serious problem we face
____ A serious problem
____ A problem
____ Not a problem

What drugs cause the biggest problems in your organization? (Please rank the top three, 1,2,3, with 1 for the biggest problem.)
____ Alcohol
____ Marijuana
____ Barbiturates/Amphetamines
____ Heroin
____ Cocaine
____ Other drug (Please specify) _____

On what do you base your beliefs about the drug/alcohol problems in your organization? (Please check all that are appropriate.)
____ Your own observations
____ Reports of your colleagues
____ EAP referrals
____ Disciplinary records
____ Briefings from your management
____ Sources outside the organization
____ Accident rates
____ Other (Please specify) _____

3. Testing of Applicants for Drugs

Please note: the questions in this section concern **applicants** for employment, not current employees.

Are you testing **applicants** for employment in your organization? ____ Yes ____ No

If NO, please go to the next question (Question 4).

If YES, who is subject to testing? Please check below to indicate how many applicants in each group are tested.

	Extent of Testing		
Managerial applicants	____ All tested	____ Some tested	____ None tested
Supervisory applicants	____ All tested	____ Some tested	____ None tested
Clerical applicants	____ All tested	____ Some tested	____ None tested
Line worker applicants	____ All tested	____ Some tested	____ None tested

If a prospective employee has passed all basic job selection criteria, and fails a drug test, your action would be:

____ Reject candidate and tell why
____ Reject candidate without telling why
____ Refer for treatment
____ Retest before making a decision
____ Treatment varies
____ Other action (Please specify) _____

What percent of applicants test positively on the first round of tests:

Applicants Testing Positively (first test)

Managerial Applicants	Supervisory Applicants	Clerical Applicants	Line Worker Applicants
____ 0-10%	____ 0-10%	____ 0-10%	____ 0-10%
____ 11-20%	____ 11-20%	____ 11-20%	____ 11-20%
____ 21-30%	____ 21-30%	____ 21-30%	____ 21-30%
____ 31-40%	____ 31-40%	____ 31-40%	____ 31-40%
____ 41-50%	____ 41-50%	____ 41-50%	____ 41-50%
____ Over 50%	____ Over 50%	____ Over 50%	____ Over 50%
____ Unknown	____ Unknown	____ Unknown	____ Unknown

If you retest those who test positively, what percent test positively the second time?

Applicants Retesting Positively (second test)

Managerial Applicants	Supervisory Applicants	Clerical Applicants	Line Worker Applicants
____ below 50%	____ below 50%	____ below 50%	____ below 50%
____ 51-75%	____ 51-75%	____ 51-75%	____ 51-75%
____ 76-85%	____ 76-85%	____ 76-85%	____ 76-85%
____ 86-90%	____ 86-90%	____ 86-90%	____ 86-90%
____ 91-95%	____ 91-95%	____ 91-95%	____ 91-95%
____ 96-100%	____ 96-100%	____ 96-100%	____ 96-100%
____ Unknown	____ Unknown	____ Unknown	____ Unknown

What kinds of tests do you use for first tests?

	Managerial Applicants	Supervisory Applicants	Clerical Applicants	Line Worker Applicants
Urine	____	____	____	____
Blood	____	____	____	____
Saliva	____	____	____	____
Breath	____	____	____	____
Hair	____	____	____	____
Brain Waves	____	____	____	____

Other (Please Specify) _____

What kinds of tests do you use for retests (if used)?

	Managerial Applicants	Supervisory Applicants	Clerical Applicants	Line Worker Applicants
Urine	____	____	____	____
Blood	____	____	____	____
Saliva	____	____	____	____
Breath	____	____	____	____
Hair	____	____	____	____
Brain Waves	____	____	____	____

Other (Please Specify) _____

What is the cost of the tests?

First test: $_____ per test Retest: $_____ per test

4. Employee Testing

Does your organization currently test any employees for drugs? ____ Yes ____ No

If NO, please answer the two questions below, and then go to question 10.

Why have you chosen not to test?

(Please check all that are appropriate.)

____ Bad experiences with testing in the past
____ Problems with union contract
____ Legal implications of testing (privacy, etc.)
____ Morale implications (embarrassment, etc.)
____ Cost of testing
____ Time and energy required to test
____ Other (Please specify) _____

Are you considering testing in the future?

____ No
____ Considering but no decision as of yet
____ Will implement within one year
____ Other (Please specify) _____

If YES, who is subject to testing? Please check below to indicate how many employees in each group are tested.

	Extent of Testing		
Managerial employees	____ All tested	____ Some tested	____ None tested
Supervisory employees	____ All tested	____ Some tested	____ None tested
Clerical employees	____ All tested	____ Some tested	____ None tested
Line worker employees	____ All tested	____ Some tested	____ None tested

What percent of the employees tested are members of a union?

Managerial Employees	Supervisory Employees	Clerical Employees	Line Worker Employees
____ 0-25%	____ 0-25%	____ 0-25%	____ 0-25%
____ 26-50%	____ 26-50%	____ 26-50%	____ 26-50%
____ 51-75%	____ 51-75%	____ 51-75%	____ 51-75%
____ 76-100%	____ 76-100%	____ 76-100%	____ 76-100%

If tested employees are union members, is testing part of the bargaining agreement? ____ Yes ____ No

5. Tests Used on Employees

What kinds of tests do you use for first tests?

	Managerial Employees	Supervisory Employees	Clerical Employees	Line Worker Employees
Urine	____	____	____	____
Blood	____	____	____	____
Saliva	____	____	____	____
Breath	____	____	____	____
Hair	____	____	____	____
Brain Waves	____	____	____	____

Other (Please Specify) _____

What kinds of tests do you use for retests?

	Managerial Employees	Supervisory Employees	Clerical Employees	Line Worker Employees
Urine	____	____	____	____
Blood	____	____	____	____
Saliva	____	____	____	____
Breath	____	____	____	____
Hair	____	____	____	____
Brain Waves	____	____	____	____

Other (Please Specify) _____

What is the cost of the tests:

First test: $_____ per test Retest: $_____ per test

6. Testing Procedures for Employees

Under what circumstances is testing conducted?
(Check as many as appropriate)

____ Individual employee under suspicion
____ Random unannounced
____ Announced
____ Other circumstance (Please specify) _____

Where is the test administered?
(Check as many as appropriate)

____ At your worksite
____ At outside facility
____ At both locations
____ Other location (Please specify) _____

By whom is the test administered?
(Check as many as appropriate)

____ Your staff
____ Outside organization's staff
____ By both
____ Other party (Please specify) _____

How often are the tests administered?

____ At least once a month
____ At least once a quarter
____ At least once a year
____ Other time (Please specify) _____

What percent of employees test positively on the first round?

Employees Testing Positively (first test)

Managerial Employees	Supervisory Employees	Clerical Employees	Line Worker Employees
____ 0-10%	____ 0-10%	____ 0-10%	____ 0-10%
____ 11-20%	____ 11-20%	____ 11-20%	____ 11-20%
____ 21-30%	____ 21-30%	____ 21-30%	____ 21-30%
____ 31-40%	____ 31-40%	____ 31-40%	____ 31-40%
____ 41-50%	____ 41-50%	____ 41-50%	____ 41-50%
____ Over 50%	____ Over 50%	____ Over 50%	____ Over 50%
____ Unknown	____ Unknown	____ Unknown	____ Unknown

7. Retesting of Employees

If an employee tests positively, do you do a retest? ____ Yes ____ No

If YES, do you?

____ Retest with same test?

____ Administer other confirming test?

If you retest with either kind of test, what percent test positively?

Employees Retesting Positively (second test)

Managerial Employees	Supervisory Employees	Clerical Employees	Line Worker Employees
____ below 50%	____ below 50%	____ below 50%	____ below 50%
____ 51-75%	____ 51-75%	____ 51-75%	____ 51-75%
____ 76-85%	____ 76-85%	____ 76-85%	____ 76-85%
____ 86-90%	____ 86-90%	____ 86-90%	____ 86-90%
____ 91-95%	____ 91-95%	____ 91-95%	____ 91-95%
____ 96-100%	____ 96-100%	____ 96-100%	____ 96-100%
____ Unknown	____ Unknown	____ Unknown	____ Unknown

8. Action after Testing of Employees

What action do you take when test (and retest if used) is positive:

____ Follow normal discipline system

____ Terminate

____ Issue warning

____ Refer to help program or EAP (Employee Assistance Program)

____ No standard policy

____ Other action (Please specify) _____

What action do you take if employee refuses to take test?

____ Discipline for insubordination

____ Other discipline procedure

____ No action

____ Treat as if test results were positive

____ Other action (Please specify) _____

What documents are signed by person taking test?

____ Memo of understanding of test uses

____ Release of test information

____ Other document (Please specify) _____

What is the reaction of employees who are tested?

____ Very positive

____ Somewhat positive

____ Very negative

____ Neutral

____ Somewhat negative

9. Special Problems

Have you encountered problems in any of the areas listed? ___ Yes ___ No

If YES, please specify:

___ Morale problems caused by testing policy
___ Legal problems resulting from testing
___ Procedural problems
___ Test reliability problems
___ Other problems (Please specify) _____

10. Search Policies

Have you ever searched lockers or personal effects? ___ Yes ___ No

If YES, under what circumstances?

___ Unannounced random inspections
___ Announced inspections
___ Upon suspicion of an individual
___ Other circumstances (Please specify) _____

If YES, are these conducted

___ On an ongoing basis
___ Rarely

11. Other Drug Control Measures

Are you taking any other measures? ___ Yes ___ No

If YES, please indicate:

___ Education
___ Treatment
___ Printed materials
___ Meetings
___ Support groups
___ Other actions (Please specify) _____

12. Management Incidents (Please answer even if you do not test)

(Please answer the questions below whether or not you test)

Incident Number 1. You have just been informed that a significant loss (of money, time, etc.) has occurred because of an employee's inability to perform his or her job. The inability was caused by the employee being under the influence of (see list). What would your reaction be?

	Ignore	Warn	Refer to Help Program	Terminate	Inform Police	Other (Please specify)
First Offense						
Marijuana	___	___	___	___	___	_____
Barbiturates/ Amphetamines	___	___	___	___	___	_____
Heroin	___	___	___	___	___	_____
Alcohol	___	___	___	___	___	_____
Cocaine	___	___	___	___	___	_____
Second Offense						
Marijuana	___	___	___	___	___	_____
Barbiturates/ Amphetamines	___	___	___	___	___	_____
Heroin	___	___	___	___	___	_____
Alcohol	___	___	___	___	___	_____
Cocaine	___	___	___	___	___	_____

Incident Number 2. You have just been notified that an employee is under the influence of some drug; however, no direct loss has been suffered. What would your reaction be?

	Ignore	Warn	Refer to Help Program	Terminate	Inform Police	Other (Please specify)
First Offense						
Marijuana	___	___	___	___	___	_____
Barbiturates/ Amphetamines	___	___	___	___	___	_____
Heroin	___	___	___	___	___	_____
Alcohol	___	___	___	___	___	_____
Cocaine	___	___	___	___	___	_____
Second Offense						
Marijuana	___	___	___	___	___	_____
Barbiturates/ Amphetamines	___	___	___	___	___	_____
Heroin	___	___	___	___	___	_____
Alcohol	___	___	___	___	___	_____
Cocaine	___	___	___	___	___	_____

Note: These management incidents are taken with permission from a survey by Business and Legal Reports of Madison, Connecticut

13. Written Policies

Do you have a written policy on drug testing? ___ Yes ___ No

If YES, please send a copy along with the questionnaire and please sign the release below so that we can share you policies with your colleagues.

Permission is hereby given for Michael L. McPherson to reproduce the materials I have enclosed.

___ Publish as is

___ Please keep anonymous by eradicating references to my organization

Signed _____ Date _____

Title _____

14. Comments

We would appreciate any comments you have that will clarify any answers or that will help us and readers to understand your perception of the drug problem. Please write your suggestions, warnings, experience, or anything else you want to share on a separate sheet and attach to this survey.

Thank you

Thank you very much for your participation. Please return the survey to **Michael L. McPherson, 808 5th Avenue North, Great Falls, MT** 59401, as soon as you can. Thanks again.

MHA MONTANA HOSPITAL ASSOCIATION 1720 NINTH AVENUE • P.O. BOX 5119 HELENA, MT 59604 • (406) 442-1911

February 1989

LICENSED HOSPITALS

*Accredited - Joint Commission on Accreditation of Hospitals

Hospitals	No. of Beds
Community Hospital of Anaconda 401 W. Pennsylvania Avenue Anaconda, Montana 59711 Tel: 563-5261 Adm: Roger Mayers D of N: Robert Stewart, R.N.	40
Fallon County Medical Complex - Hospital 320 West Hospital Drive Box 820 Baker, Montana 59313 Tel: 778-3331 Adm: Sandra Kinsey D of N: Walter Sallani, R.N.	12
Big Sandy Medical Center P. O. Box 530 Big Sandy, Montana 59520 Tel: 378-2188 Adm: Harry Bold D of N: Amber Beaudette, R.N.	9
Sweet Grass Community Hospital West Fifth Street Big Timber, Montana 59011 Tel: 932-5917 Adm: Karen Herman D of N: Millie Bigelow, R.N.	15
*Deaconess Medical Center of Billings, Inc. 2813 Ninth Avenue North P. O. Box 2547 Billings, Montana 59103 Tel: 657-4000 Adm: Lane Basso D of N: Elaine Watkins, R.N.	253
*Rivendell of Billings, Inc. (Adolescent Psychiatric) 2620 - 7th Avenue South Billings, Montana 59101 Tel: 259-3900 Adm: Dr. Robert Duncan D of N: Janet Hawley, R.N.	60

Hospitals	No. of Beds
*Saint Vincent Hospital & Health Center 1233 North 30th Street P. O. Box 35200 Billings, Montana 59107-5200 Tel: 657-7000 Adm: James T. Paquette D of N: Sister Therese, R.N.	280
Bozeman Deaconess Hospital 915 Highland Blvd. Bozeman, Montana 59715 Tel: 858-5000 Adm: Gary Kenner D of N: Gloria Larson, R.N.	86
Rivendell of Montana, Inc. (Children's Psychiatric) 55 Basin Creek Road Butte, Montana 59701 Adm: Steve Heinz, Psy. D. D of N: Richard Sorenson, R.N.	48
*St. James Community Hospital 400 South Clark Street 2500 Continental Drive P. O. Box 3300 Butte, Montana 59701 Tel: 782-8361 Adm: Sister Loretto Marie Colwell D of N: Larry McGee, R.N.	180 90
Liberty County Hospital Chester, Montana 59522 Adm: Richard O. Brown D of N: Jere Schaub, R.N.	11
Teton Medical Center 915 4th Street N.W. Box 820 Choteau, Montana 59422 Tel: 466-5763 Adm: Rosalyn Bushman D of N: Pat Thorn, R.N.	14
McCone County Hospital Box 47 Circle, Montana 59215 Tel: 485-2063 Adm: Nancy Berry D of N: Patricia Wittkopp, R.N.	20

Hospitals	No. of Beds
Stillwater Community Hospital 44 West Fourth Avenue North P. O. Box 959 Columbus, Montana 59019 Tel: 322-5316 Adm: Tim Russell D of N: Rose Blenkner, R.N.	27
*Pondera Medical Center 805 Sunset Blvd. Conrad, Montana 59425 Tel: 278-3211 Adm: L. Carl Hanson D of N: Lorraine Stilwell, R.N.	34
Roosevelt Memorial Hospital P. O. Box Drawer 419 Culbertson, Montana 59218 Tel: 787-6621 Adm: Paul Hanson D of N: Mel Snow, R.N.	14
Glacier County Medical Center 802 Second St. S.E. Cut Bank, Montana 59427 Tel: 873-2251 D of N: Gelene Berkram, R.N. Admin. Intern Vivicna Rieser	20
Montana State Hospital - (Galen Campus) Mailing Address: (Montana State Hospital - Galen Campus) (Warm Springs, Montana 59756) R.F.D. No. 1 - Galen Deer Lodge, Montana 59722 Tel: 693-7000 Supt: Jane Edwards D of N: Lucille Siegle, R.N.	33
*Powell County Memorial Hospital 1101 Texas Avenue Deer Lodge, Montana 59722 Tel: 846-2212 Adm: Jonathon E. Frantsvog D of N: Barbara Simonson, R.N.	23
Barrett Memorial Hospital 1260 South Atlantic Dillon, Montana 59725 Tel: 683-2324 Adm: Ray Worthington (Acting) D of N: Jeanie Schemm, R.N.	31

Hospitals	No. of Beds
Madison Valley Hospital P. O. Box 397 Ennis, Montana 59729-0397 Tel: 682-4222 Adm: Mr. J. Page Puckett D of N: Mrs. Lois Olsen, R.N.	11
Rosebud Health Care Center (Hospital) 383 North 17th Avenue Forsyth, Montana 59327 Tel: 356-2161 Adm: Joyce Asay D of N: Marilyn Kanta, R.N.	20
Chouteau County District Hospital at Fort Benton 1501 St. Charles Street P. O. Box 249 Fort Benton, Montana 59442 Tel: 622-3331 Adm: Robert E. Smith D of N: Mrs Maxine McDede, R.N.	17
*Frances Mahon Deaconess Hospital 621 Third Street South Glasgow, Montana 59230 Tel: 228-4351 Adm: Kyle Hopstad D of N: Pat Nessland, R.N.	72
*Glendive Medical Center 202 Prospect Drive Glendive, Montana 59330-1999 Tel: 365-3306 Adm: John H. Solheim D of N: Mrs. Maxine Voorhees, R.N.	46
*Columbus Hospital 500 - 15th Avenue South P. O. Box 5013 Great Falls, Montana 59403 Tel: 272-3333 Adm: William J. Downer, Jr. D of N: Mrs. Mary Valacich, R.N.	198
*Montana Deaconess Medical Center 1101 - 26th Street South Great Falls, Montana 59405 Tel: 761-1200 Adm: Kirk G. Wilson D of N: Gretchen Hofland, R.N.	288

Hospitals	No. of Beds
Marcus Daly Memorial Hospital 1200 Westwood Drive Hamilton, Montana 59840 Tel: 363-2211 Adm: John Bartos D of N: Jean Clary, R.N.	48
Big Horn County Memorial Hospital 17 North Miles Hardin, Montana 59034 Tel: 665-2310 Adm: Michael N. Sinclair D of N: Rhonda Harris, R.N.	16
Wheatland Memorial Hospital 530 Third Street N.W. Harlowton, Montana 59036 Tel: 632-4351 Adm: John Johnson D of N: Kelley Johnston Joiner, R.N.	23
*Northern Montana Hospital P. O. Box 1231 Havre, Montana 59501 Tel: 265-2211 Adm: Gerald W. Bibo D of N: Constance Adams, R.N.	100
*St. Peter's Community Hospital 2475 Braodway Street East Helena, Montana 59601-4999 Tel: 442-2480 Adm: John A. Guy D of N: Connie Sorrels, R.N.	96
Shodair Children's Hospital (Psychiatric) 840 Helena Avenue P. O. Box 5539 Helena, Montana 59604 Tel: 444-7500 Adm: Jack Casey D of N: Pam Savage, R.N.	20
Glacier View Hospital (10 Psych.) 200 Heritage Way (30 Chem. Depend.) Kalispell, Montana 59901 Tel: 752-5422 Adm: Tom Dunlap D of N: Steve Bryson, R.N./M.C.	40

Hospitals	No. of Beds
*Kalispell Regional Hospital 310 Sunnyview Lane Kalispell, Montana 59901 Tel: 752-5111 Adm: George Clark D of N: Camille Scott, R.N.	93
Central Montana Hospital 408 Wendell P. O. Box 580 Lewistown, Montana 59457 Tel: 538-7711 Adm: Robert G. Conrad D of N: Jean Beel, R.N.	47
St. John's Lutheran Hospital 350 Louisiana Avenue Libby, Montana 59923 Tel: 293-7761 Adm: Raymond Bergroos D of N: Kathy Pearson, R.N.	26
Livingston Memorial Hospital 504 South 13th Street Livingston, Montana 59047 Tel: 222-3541 Adm: Richard V. Brown D of N: Connie Lehnertz, R.N.	45
Phillips County Hospital Association 417 South Fourth East Malta, Montana 59538 Tel: 654-1100 Adm: Leslie Urvand D of N: Merle Williams, R.N.	21
*Holy Rosary Hospital 2101 Clark Street Miles City, Montana 59301 Tel: 232-2540 Exec. Dir: James A. Rotert (Interim) D of N: Mary Jo Stein (Acting)	99
*Community Medical Center, Inc. 2827 Fort Missoula Road Missoula, Montana 59801 Tel: 728-4100 Adm: Grant Winn D of N: Tana Casper, R.N.	115

Hospitals		No. of Beds
*St. Patrick Hospital		169
500 West Broadway		
Providence Center	(Mental Health)	26
900 Orange Street	(Chem. Dependency)	18
Missoula, Montana 59806		
Tel: 543-7271		
Adm: Larry White		
D of N: Sister Rogene Fox, R.N.		
Granite County Memorial Hospital		10
P. O. Box 729		
Philipsburg, Montana 59858		
Tel: 859-3271		
Adm: Mike Kahoe		
D of N: Margery Metesh, R.N.		
Clark Fork Valley Hospital		16
P. O. Box 768		
Plains, Montana 59859		
Tel: 826-3601		
Adm: Michael D. Billing		
D of N: Geri Larson, R.N.		
Sheridan Memorial Hospital		19
440 West Laurel Avenue		
Plentywood, Montana 59254		
Tel: 765-1420		
Adm: Jerry Beaudette		
D of N: Mrs. Fauna Allen, R.N.		
*St. Joseph Hospital		40
Skyline Drive		
P. O. Box 1010		
Polson, Montana 59860		
Tel: 883-5377		
Adm: Fred Summary		
D of N: Helen Henman, R.N.		
Poplar Community Hospital		22
P. O. Box 38		
Poplar, Montana 59255		
Tel: 768-3452		
Adm: Margaret B. Sage		
D of N: Juanita Martin, R.N.		
Carbon County Memorial Hospital		22
600 West 21st Street		
P. O. Box 590		
Red Lodge, Montana 59068		
Tel: 446-2345		
Adm: Mark Teckmeyer		
D of N: Mary R. Orler, R.N.		

Hospitals	No. of Beds
St. Luke Community Hospital 107 Sixth Avenue S.W. Ronan, Montana 59864 Tel: 676-4441 Adm: Shane Roberts D of N: Rosemary Miller, R.N.	22
Roundup Memorial Hospital 1202 Third Street West Roundup, Montana 59072 Tel: 323-2302 Adm: Fern Mikkelson D of N: Dorothy Harper, R.N.	17
Daniels Memorial Hospital P. O. Box 400 Scobey, Montana 59263 Tel: 487-2296 Adm: John Walker D of N: Naomi Stentoft, R.N.	8
Toole County Hospital 640 Park Drive P. O. Box P Shelby, Montana 59474 Tel: 434-5536 Adm: Warner Bartleson D of N: Edith Clark, R.N.	20
Ruby Valley Hospital 220 E. Crofoot Street P. O. Box 336 Sheridan, Montana 59749 Tel: 842-5778 Adm: Randall G. Holom D of N: Pat Kremer, R.N.	20
Community Memorial Hospital P. O. Box 1690 Sidney, Montana 59270 Tel: 482-2120 Adm: Don Rush (Acting) D of N: Diane Theil, R.N.	49
Mineral County Hospital Brooklyn & Roosevelt P. O. Box 66 Superior, Montana 59872 Tel: 822-4841 Adm: Madelyn Faller D of N: Zona Harris, R.N.	10

Hospitals	No. of Beds
Prairie Community Hospital P. O. Box 156 Terry, Montana 59349 Tel: 637-5511 Adm: James Mantz D of N: Carleen Gaub, R.N.	5
Broadwater Health Center 110 Oak Street P. O. Box 519 Townsend, Montana 59644 Tel: 266-3186 Adm: Barbara Kysar D of N: Dennis Lindholm, R.N.	10
North Valley Hospital 6575 Highway 93 South Whitefish, Montana 59937 Tel: 862-2501 Adm: Dale Jessup D of N: Mara Fields, R.N.	44
Mountainview Memorial Hospital Box Q White Sulphur Springs, Montana 59645 Tel: 547-3321 Adm: James Tavary D of N: Tina Hedin, R.N.	6
Trinity Hospital 315 K Street Wolf Point, Montana 59201 Tel: 653-2100 Adm: Jerry E. Jurena D of N: Bonnie Wemmer, R.N.	42

APPENDIX 6

Partial Survey Results

(Specific results may not equal 100 percent as a result of no responses to some questions and multiple responses to other questions.

The Drug Problem

Since 1981-1982, what is your perception of the "alcohol and drug" problem today:

	All Employers	Small Hospitals	Medium Hospitals	Large Hospitals
In my organization				
Less of a problem	15%	25%	0%	0%
The same	50%	56%	50%	0%
More serious	23%	6%	38%	100%
In other organizations				
Less of a problem	15%	0%	0%	0%
The same	38%	44%	38%	0%
More serious	50%	50%	38%	100%

Please check the statement that best describes the drug problem in your organization:

	All Employers	Small Hospitals	Medium Hospitals	Large Hospitals
The most serious we face	0%	0%	0%	0%
A serious problem	8%	0%	13%	0%
A problem	35%	25%	50%	50%
Not a problem	46%	69%	13%	50%

Drugs Causing the Biggest Problem

What drugs cause the biggest problems in your organization? (Please rank the top three, with 1 being the biggest problem.)

	All Employers	Small Hospitals	Medium Hospitals	Large Hospitals
Alcohol				
First	77%	75%	75%	100%
Second	4%	6%	0%	0%
Third	4%	0%	13%	0%
Marijuana				
First	4%	0%	13%	0%
Second	23%	13%	38%	50%
Third	8%	13%	0%	0%
Barbiturates/Amphetamines				
First	4%	6%	0%	0%
Second	15%	13%	25%	0%
Third	8%	0%	25%	0%
Heroin				
First	0%	0%	0%	0%
Second	0%	0%	0%	0%
Third	0%	0%	0%	0%
Cocaine				
First	0%	0%	0%	0%
Second	0%	0%	0%	0%
Third	12%	6%	13%	50%

Reasons for Not Testing

Why have you chosen not to test?

	All Employers	Small Hospitals	Medium Hospitals	Large Hospitals
Bad experience in past	0%	0%	0%	0%
Problems with union contract	0%	0%	0%	0%
Legal implications of testing	35%	31%	50%	0%
Morale implications (embarrassment)	19%	31%	0%	0%
Cost of testing	23%	31%	13%	0%
Time and energy required to test)	19%	31%	0%	0%
Other (No demonstrated need)	31%	38%	25%	0%

Other Drug Control Measures

Are you taking any other measures? If so, what are they?

	All Employers	Small Hospitals	Medium Hospitals	Large Hospitals
Education	35%	25%	38%	100%
Treatment	25%	13%	50%	50%
Printed Material	27%	25%	25%	50%
Meetings	4%	0%	13%	0%
Support Groups	8%	6%	13%	0%
Other Actions (Empl. Assist. Prog.)	12%	6%	0%	50%

Management Incidents

Incident #1: Employee's impairment caused significant loss. Impairment was caused by one of the drugs listed, and employer took the following action:

Total

	Ignore (%)	Warn (%)	Refer to Help Program (%)	Terminate (%)	Inform Police (%)
First Offense					
Marijuana	0	62	62	19	12
Barbiturates/ Amphetamines	0	54	62	27	12
Heroin	0	46	58	35	19
Alcohol	0	58	73	19	4
Cocaine	0	42	62	35	19
Second Offense					
Marijuana	0	4	27	65	
Barbiturates/ Amphetamines	0	4	19	73	
Heroin	0	4	19	73	
Alcohol	0	8	23	69	
Cocaine	0	4	19	73	

Small Hospitals

	Ignore (%)	Warn (%)	Refer to Help Program (%)	Terminate (%)	Inform Police (%)
First Offense					
Marijuana	0	63	63	19	13
Barbiturates/ Amphetamines	0	50	63	31	13
Heroin	0	44	63	38	19
Alcohol	0	50	75	19	6
Cocaine	0	38	69	38	19
Second Offense					
Marijuana	0	6	38	56	25
Barbiturates/ Amphetamines	0	6	25	69	25
Heroin	0	6	25	69	31
Alcohol	0	6	25	69	25
Cocaine	0	6	25	69	31

Medium Hospitals

	Ignore (%)	Warn (%)	Refer to Help Program (%)	Terminate (%)	Inform Police (%)
First Offense					
Marijuana	0	38	38	25	13
Barbiturates/ Amphetamines	0	38	38	25	13
Heroin	0	38	38	25	13
Alcohol	0	50	38	25	0
Cocaine	0	38	38	25	13
Second Offense					
Marijuana	0	0	25	50	13
Barbiturates/ Amphetamines	0	0	25	50	13
Heroin	0	0	25	50	13
Alcohol	0	3	38	50	0
Cocaine	0	0	25	50	13

Large Hospitals

	Ignore (%)	Warn (%)	Refer to Help Program (%)	Terminate (%)	Inform Police (%)
First Offense					
Marijuana	0	100	100	4	0
Barbiturates/ Amphetamines	0	100	100	0	0
Heroin	0	50	50	50	50
Alcohol	0	100	100	0	0
Cocaine	0	50	50	50	50
Second Offense					
Marijuana	0	0	0	100	0
Barbiturates/ Amphetamines	0	0	0	100	0
Heroin	0	0	0	100	50
Alcohol	0	0	0	100	0
Cocaine	0	0	0	100	50

Incident #2. Employee's impairment has not caused any loss. Impairment was due to one of the drugs listed, and employer took the following action:

Total

	Ignore (%)	Warn (%)	Refer to Help Program (%)	Terminate (%)	Inform Police (%)
First Offense					
Marijuana	4	54	54	15	8
Barbiturates/ Amphetamines	0	54	54	19	8
Heroin	0	42	58	19	15
Alcohol	0	54	58	15	0
Cocaine	0	42	58	19	15
Second Offense					
Marijuana	0	8	23	62	15
Barbiturates/ Amphetamines	0	4	23	65	15
Heroin	0	0	23	65	23
Alcohol	0	8	27	65	12
Cocaine	0	0	23	65	23

Small Hospitals

	Ignore (%)	Warn (%)	Refer to Help Program (%)	Terminate (%)	Inform Police (%)
First Offense					
Marijuana	0	56	56	13	6
Barbiturates/ Amphetamines	0	56	56	19	6
Heroin	0	38	63	19	19
Alcohol	0	50	63	13	0
Cocaine	0	38	63	19	19
Second Offense					
Marijuana	0	13	25	63	19
Barbiturates/ Amphetamines	0	6	25	69	19
Heroin	0	0	25	69	31
Alcohol	0	6	25	69	13
Cocaine	0	0	25	69	31

Medium Hospitals

	Ignore (%)	Warn (%)	Refer to Help Program (%)	Terminate (%)	Inform Police (%)
First Offense					
Marijuana	0	50	50	25	13
Barbiturates/ Amphetamines	0	50	50	25	13
Heroin	0	50	50	25	13
Alcohol	0	63	63	25	0
Cocaine	0	50	50	25	13
Second Offense					
Marijuana	0	0	13	75	13
Barbiturates/ Amphetamines	0	0	13	75	0
Heroin	0	0	13	75	0
Alcohol	0	13	25	63	0
Cocaine	0	0	13	75	0

Large Hospitals

	Ignore (%)	Warn (%)	Refer to Help Program (%)	Terminate (%)	Inform Police (%)
First Offense					
Marijuana	0	100	100	0	0
Barbiturates/ Amphetamines	0	100	100	0	0
Heroin	0	100	100	0	0
Alcohol	0	100	100	0	0
Cocaine	0	100	100	0	0
Second Offense					
Marijuana	0	0	0	100	0
Barbiturates/ Amphetamines	0	0	0	100	0
Heroin	0	0	0	100	0
Alcohol	0	0	0	100	0
Cocaine	0	0	0	100	0