Drug Testing and the Future of American Drug Policy

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Thank you, David Martin for your distinguished leadership of DATIA and for inviting me to speak today. Dr. Martin tirelessly promotes DATIA as a global leader in drug abuse prevention. He is an international pioneer using drug testing technology to conduct groundbreaking research in Afghanistan, China and South America. Recently he provided international leadership by representing DATIA in China and in the Sweden-based World Federation Against Drugs (WFAD). In my role as the President of the Institute for Behavior and Health, Inc., David Martin has provided frequent and always insightful advice and support.

The world today faces a menacing threat of a rapidly evolving drug abuse epidemic. It cannot be surprising that drug abuse is at the center of the global agenda and that there are powerful competing visions of what the drug problem is and what to do about it. The current levels of illegal drug use are but pale hints of the deadly potential levels of tomorrow's drug problems, as drug using behavior spreads, as the supply of drugs becomes increasingly globalized and sophisticated, and as attitudes toward drug use change. Even the definition of a drug is changing rapidly with the emergence of designer drugs and prescription drugs as the defining drug problems of the 21st Century. The world needs a better drug policy to deal with this menace. Today I offer my proposals for that better drug policy.

Make no mistake about it, the future of drug policy, in the US and around the world, is in real demand reduction. That means the principal goal of a better drug policy is located in powerful ideas that can significantly reduce the number of people using illegal drugs. It is not only supporters of substance abuse prevention and treatment who take this view. Every law enforcement official I have spoken with agrees that the major goal of drug policy is demand reduction. Our national leaders have supported this heightened emphasis on demand reduction. Secretary of State Hillary Rodham Clinton recently announced that U.S. demand reduction is the key to reducing drug-related violence in Mexico and elsewhere around the world, including in Central and South America**.**

Drug testing is the foundation for the nation's demand reduction efforts. Drug testing objectively identifies recent drug use -- that identification is the heart of prevention, intervention and treatment.

Drug testing, despite its immense promise, remains controversial. As a result, today drug testing is tragically underused everywhere, including not only in treatment, but also the workplace, schools, health care and the criminal justice system.

The future of drug policy is not in a defense of the *status quo*. The more effective drug policy of the future will be built on the solid bipartisan balanced and restrictive drug policy that has guided this country, and the global community, for the past four decades. To those who say that this policy has failed, I suggest looking at just three numbers: the percent of Americans age 12 and older who currently use alcohol, tobacco and all illegal drugs combined. Here are those numbers: alcohol 51.8%; tobacco 27.4%; illegal drugs 8.9%. Globally, an estimated 40% of the world's population aged 15 and older drinks alcohol while an estimated 30% of the world's adult population smokes tobacco. In comparison, about 5% of the world's population (about 200 million) age 15 to 64 use any of the thousands of illegal drugs.

How can anyone suggest that any of the illegal drugs, including marijuana and the opiates, are less biologically attractive to drug users than alcohol or tobacco? How can anyone look at these numbers and conclude that legalizing all or even some of the currently illegal drugs, and in particular marijuana, would be in the interest of public health? Many seductive calls for drug policy "reform" propose treating the currently illegal drugs the way we treat alcohol and tobacco, a strategy that is commonly labeled "tax and regulate." The basic numbers make clear the dangerous folly of proposals for drug legalization.

In this presentation today I focus not on current policies but on innovations that hold the promise of significant reductions in drug use in this country. I feature three areas all of which are based on the power of drug testing, the keystone technology of substance abuse prevention. Drug testing is continuing to evolve ever more rapidly to fulfill its unique roles in drug abuse prevention and treatment.

These three innovations are: 1) a new paradigm for drug treatment; 2) reducing drugged driving; and 3) adding student and family drug testing to current drug prevention efforts.

To start we need to understand why drug testing is underused. That requires an understanding of the current drug policy "war," an ideological battle that is being waged globally. The poles of drug policy can be seen as abstinence or zero tolerance vs. harm reduction. In the harm reduction paradigm of drug policy, nonmedical, illegal drug use is seen to be inevitable and all but universal. The goals of harm reduction are to limit some of the negative consequences of drug use without stopping drug use itself. By contrast, a drug policy of zero tolerance means just that: the policy goal is no, zero, nonmedical use of drugs. Reducing illegal drug use is the best way to reduce the negative consequences of drug use.

In the harm reduction model of treatment, abstinence is only one of several acceptable outcomes of treatment. In this model of treatment it is not a failure if a "patient" continues using drugs and alcohol while in treatment or after leaving treatment. A negative or "clean" drug test is not required for the treatment to be considered successful. The same is true of prevention. The aim of harm reduction is not to prevent drug use from starting, or to end drug use if it has begun. The harm reduction goal is to promote "more responsible" or "safer" drug use. The decision to stop drug use entirely is left to the drug user. In the harm reduction paradigm of drug policy most of the "harms" are defined as the actions of the criminal justice system, including arrest and incarceration. Examples of harm reduction policies include "medical marijuana," decriminalizing and legalizing nonmedical drug use, publically funded intravenous injection rooms for drug addicts, needle giveaways, providing addicts with clean syringes to reduce the spread of infectious diseases including HIV/AIDS, and giving intravenous drug users syringes loaded with an antidote in the event of an opiate overdose.

Most proponents of harm reduction oppose drug testing because "punitive" actions might be taken based on a positive test. The claim is that such interventions, especially those involving the criminal justice system, causes "harm" to the drug user as in the following examples: offenders under the supervision of the criminal justice system who test positive can be

incarcerated; employees in safety-sensitive positions who test positive might lose their jobs; individuals seeking unemployment or welfare benefits who test positive for recent drug use may not receive direct aid; students who test positive on a suspicion-based drug test can be expelled from school; and patients in health care who test positive for nonmedical drug use may be "stigmatized.". In my view harm reduction policies ignore and even encourage the fundamental problem of drug abuse -- drug use itself.

Take a minute to consider a simple thought experiment. It dramatizes the differences between the policies of harm reduction and zero tolerance, the central choice for the drug policy of the future. If a family member of yours were using drugs intravenously, would you give your family member clean needles? Would you give your family member with a drug problem a syringe with an antidote for an opiate overdose? Would you want your drug abusing family member to go to a government-run injection room so he or she could inject drugs more safely? That is the harm reduction recipe for drug policy. This approach accepts continued drug use while seeking to mitigate some of the negative consequences of that drug use.

Or, in stark contrast, would you insist that your drug using drug using family member enter a substance abuse treatment program and participate in the fellowships of Alcoholics Anonymous and Narcotics Anonymous? While in treatment and after treatment would you insist that your family member become and stay drug-free? How would you use drug and alcohol testing to ensure that your family member stays drug- and alcohol-free?

For me, the answers to these questions are clear. I know that drug addiction is chemical slavery. I know that the only path to emancipation from this slavery is to be drug-free. I know that addicts' thinking is hijacked by their drug use. I know that the decision to stop drug use is always the result of events and people who forcefully, not just with words but with actions, convince the drug user that continued alcohol and drug use is impossible. The addicted person eventually must want to become and stay drug-free. But that "wanting" is usually initiated by sustained interventions, and it usually comes only after the drug user has become clean and sober, not while the user is actively using drugs. I know that abstinence is best achieved and sustained by long-term testing for drugs and alcohol to reduce relapse and to promote recovery. I

know that if alcohol and drug use resumes then close monitoring with frequent random drug tests permits rapid intervention to reinstate abstinence.

An example of harm reduction drug policy in action is found in the history of Sweden's drug problem. In the mid-1960s, Sweden adopted a harm reduction policy in which illegal drugs, especially amphetamine and opiates, were prescribed for drug addicts by physicians. Early in this drug abuse epidemic the Swedes "medicalized" nonmedical drug use. Under this plan addicts obtained prescriptions for the drugs they wanted to use. The two goals of this Swedish harm reduction policy were first, to separate the addicts from the illegal drug market and second, to gradually wean them off the drugs. Unfortunately, though not unexpectedly, given a continuing "medical" supply of drugs of abuse, the Swedish drug users did not stop using drugs. Worse yet, they spread their drug use to others by giving away and selling the drugs prescribed to them.

After this failed experiment in harm reduction, Sweden shifted its drug policy 180 degrees to one that has zero tolerance for the use of illegal drugs. In the current Swedish model there are big investments in law enforcement plus a strong commitment to both prevention and treatment. Sweden now has the one of the lowest rates of drug use in the developed world. It is "Un-Swedish" to use illegal drugs, including marijuana. Based on this defining drug policy history, today Sweden provides international leadership on drug policy through the World Federation Against Drugs (WFAD) of which I am a Board Member and serve as Chair of the Americas Section. The United States -- and the world as a whole -- has much to learn from Sweden as we work to improve our own drug policy. This point was recently made by President Obama's marvelous White House Drug Chief Gil Kerlikowske.

Critics of the U.S. balanced restrictive drug policy, which includes both supply reduction and demand reduction, describe the drug policy choice facing our country today as "the choice between prison and treatment." They argue that law enforcement creates high costs without significant benefits. Sweden's history with harm reduction and its subsequent drug policy focused on demand reduction brings treatment and law enforcement efforts together to lower drug demand. Lowering nonmedical drug use is the best way to reduce the negative consequences of drug use. This integrative vision, using law enforcement and treatment to

achieve real demand reduction, holds the promise of more effectively reducing illegal drug use than either treatment or law enforcement can achieve alone.

Another simple fact belies the claim of harm reduction supporters that the choice in drug policy is either treatment or prison: 38% of all of the people in substance abuse treatment in the US today are there *because* of the criminal justice system (49% for adolescents in treatment). Keeping drugs including marijuana, cocaine, methamphetamine and heroin illegal is a significant and positive public health strategy. The future of drug policy is not to be satisfied with the *status quo*; it is to improve on current programs and policies not by legalizing nonmedical drug use but by making the linkages of the systems of treatment and criminal justice work better together.

Here are three ways to significantly improve drug policy in the United States. They are all built on the successful use of drug testing.

The New Paradigm of Treatment

Based on abundant evidence, a "new paradigm" for substance abuse treatment has evolved that is the exact opposite of harm reduction. This paradigm enforces a standard of zero tolerance for alcohol and drug use that is enforced by monitoring with frequent random drug and alcohol tests. Detection of any drug or alcohol use is met with swift, certain, but not draconian, consequences.

Using this paradigm, the four decades-old state physician health programs, or PHPs, have set the standard for effective use of drug testing. These pioneering state programs provide services to health care professionals with substance use disorders. The programs are run by physicians, some of whom in recovery themselves. PHPs feature relatively brief but highly focused treatment followed by active lifelong participation in the 12-step fellowships of Alcoholics Anonymous and Narcotics Anonymous. The key to the success of the PHP system of care management is the enforcement of the standard of zero tolerance for any alcohol or other drug use by intensive long-term random testing for both alcohol and drugs with swift and certain consequences for even a single use of alcohol or any other drugs of abuse. PHPs use drug panels

of 20 or more drugs. The PHPs commonly use EtG and EtS tests to detect recent alcohol use. Similar comprehensive programs have been developed for commercial pilots and attorneys. These innovative programs of care management produce unprecedented long-term, outcomes.

Take a moment to contemplate these numbers. The first national study evaluating the outcomes of PHP care found that 78% of the tested physicians had not a single positive test for either alcohol or other drugs during five years or more of intensive random testing. Of the remaining 22% for whom at least one positive test was reported, two-thirds (or 14% of the total group) did not have another positive test for either alcohol or other drugs. Do you know of any other care system for people suffering from substance use disorders that results in anything approaching that outcome over such a long time, as verified by such extensive random drug testing? I don't. This evidence is why I believe that the PHP care management system provides a new and far higher standard for treatment outcomes for the biological disease of addiction.

While the new paradigm was first seen with physicians and other professional groups including commercial pilots and attorneys, its power also can be seen in programs within the criminal justice system. This population of drug abusers is as different demographically from physicians as it is possible to be. The pioneering programs of Hawaii's HOPE Probation and South Dakota's 24/7 Sobriety Project fundamentally change the way in which criminal offenders in the community are supervised. The US criminal justice system includes many of the nation's heaviest drug users. These drug users create the some of the highest costs to society. They also have among the poorest prognoses for recovery. These new programs, like the state PHPs, use zero tolerance for any alcohol or drug use enforced by intensive random drug tests.

HOPE Probation manages the most high-risk offenders on probation including repeat offenders who committed violent crimes. Smoked methamphetamine, notoriously difficult to treat, is the most common drug used by offenders in Hawaii. In HOPE Probation, participants are put on notice from the beginning that any drug use, or any other noncompliance such as missed appointments, will be met with an immediate, short-term jail stay. HOPE participants are subject to random testing every day. Treatment is reserved for those who want it and for those offenders

who demonstrate a need for treatment by continuing drug use in the face of these swift and certain consequences.

In a randomized control study of HOPE Probation, participants were compared to a control group assigned to standard probation. HOPE participants were 55% less likely to be arrested for new crimes, 72% less likely to use drugs, 61% less likely to miss appointments with probation officers, and 53% less likely to have their probation revoked. HOPE probationers also spent or were sentenced to an average 48% fewer days of incarceration. Remarkably, over the course of one year, 61% of all HOPE participants never had a single positive drug test; 20% had only one, 9% had two, and the remaining 10% had three or more positives. Have you seen data from a recidivist offender population in the community that was closely monitored with frequent random drug tests with such outstanding results? I have not. The HOPE Probation model is scalable to the entire five million Americans now on probation and parole.

The 24/7 Sobriety Project in South Dakota extends this new paradigm of care management to those drivers in South Dakota who are found guilty of repeat Driving Under the Influence (DUI) offenses. This program is applicable to the more than one million Americans arrested each year for DUI. 24/7 Sobriety enforces a policy of zero tolerance with intensive alcohol and drug testing linked to immediate brief incarceration for any violation or for any missed test. An evaluation of 24/7 Sobriety demonstrated that the program is notably successful in achieving abstinence from alcohol and drug use among these high-risk offenders. Of all participants, 55% never failed a single drug or alcohol test; 17% failed only once, 12% failed only twice and 16% failed three or more times. Offenders who participated in twice-daily breath tests had significantly lower rates of DUI recidivism when compared to individuals who did not participate in the program. Even minimal days of participation in 24/7 Sobriety reduced recidivism rates. Offenders with at least 30 days or program participation demonstrated greater reductions in DUI recidivism.

Both the HOPE Probation program and the 24/7 Sobriety program are now spreading throughout the country. They are being considered in other countries. These two programs are

greatly improving the performance of the criminal justice system. They reduce drug and alcohol use, reduce criminal recidivism, and reduce incarceration.

These three programs, the state PHPs, HOPE Probation, and 24/7 Sobriety, demonstrate the importance of zero tolerance and the vital role of intensive random drug tests to enforce that standard. This new paradigm of care management for people suffering from substance use disorders cost-effectively emancipates many of them from chemical slavery. It is built on the foundation of drug testing with a new twist -- random drug testing linked to swift, certain and serious consequences. The potential application of the new paradigm extends beyond its current uses to many other settings including substance abuse treatment programs, the workplace, schools, and in health care.

Reduce Drugged Driving

Drugged driving is a highway safety threat of the same magnitude as drunk driving. Significantly reducing drugged driving now is a national priority thanks to the sustained leadership of Gil Kerlikowske, Director of the Office of National Drug Control Policy (ONDCP). There are three primary goals of the initiative to reduce drugged driving: 1) to improve highway safety, 2) to provide a major new path to long-term recovery (as drunk driving now does for alcohol), and, 3) to reduce illegal drug use. Drug testing is at the heart of ONDCP's ambitious efforts to reduce drugged driving.

In 2010, the Institute for Behavior and Health (IBH) was asked by the National Institute on Drug Abuse (NIDA) to develop a White Paper on drugged driving research which would create a research agenda to lead national efforts to reduce drugged driving. The White Paper, recently published on the NIDA and ONDCP websites, reviewed the extensive and growing body of research that identifies recent drug use by drivers through testing of blood, urine and oral fluids. The National Roadside Survey showed that over 16% of weekend nighttime drivers were positive for drugs other than alcohol. A study conducted by the National Highway Traffic and Safety Administration (NHTSA) showed that one-third of all fatally injured drivers who had confirmed drug test results were positive for drugs (28% were positive for marijuana). While the

number of drivers killed in motor vehicle crashes has declined over the past five years, the number of fatally injured drivers positive for drugs has increased 18%.

Widespread alcohol testing has been a critical part of the impressive reductions in drunk driving that has occurred over the past 30 years. The development and use of the breathalyzer combined with the use of the now universally adopted .08 BAC *per se* law fundamentally changed and improved DUI enforcement. The development and extensive use of improved tests for drugs as well as implementation of drug *per se* laws, in which the presence of an illegal drug in a driver constitutes an offense, will do the same for drugged driving.

Add Student and Family Drug Testing to Drug Prevention

Alcohol and drug use commonly begin in childhood. My third new idea improves drug prevention for the nation's youth. The best new idea in prevention is to promote widespread student and family drug testing. Family drug testing is a tool parents can use to prevent their children from using drugs. The expectation that a teen will be drug tested acts as a strong deterrent to drug use. Drug testing makes meaningful parental insistence that their children must not use alcohol or drugs. Family drug and alcohol testing can be done through the use of at-home drug testing kits.

Additionally, many schools across the country and abroad have successfully implemented random student drug testing, or RSDT, programs as integral parts of their overall drug prevention programs. Drug testing in public schools was supported by the Supreme Court in two cases (Vernonia School District 47J v. Acton, 1995; Board of Education of Independent School District No. 92 of Pottawatomie County, et al, Petitioners v. Lindsay Earls et al, 2002). Together they held that it is constitutional to drug test public school students involved in athletics and extracurricular activities. While the constitutionality of drug testing all students in public schools has not been considered by the US Supreme Court, all students with approval from their parents may elect to participate voluntarily in RSDT programs in the public schools. RSDT programs, both mandatory and voluntary, have become increasingly popular. Private schools may require testing for all students. The testing of students in private schools is not limited by the same legal

constraints that are imposed on public school testing. Some schools include teachers and other school personnel in these testing pools as well, though this has been a point of contention, particularly among unionized teachers.

In RSDT programs, eligible students are randomly selected for a drug test. They are typically brought to a designated place in the school such as the nurse's office where they provide a sample to be tested. Third Party Administrators (TPAs) are used for collection and analysis. TPAs provide drug testing services to schools. Many of you may be serving in this capacity. The goals of RSDT are 1) to deter drug use, 2) to identify students who need help becoming and staying drug-free, and 3) to reinforce all other prevention efforts. RSDT programs are intended to be non-punitive; they do not interfere with academics. RSDT does not include either suspension from school or official school records. Records of positive drug tests are typically destroyed when students leave the school. Drug test results are strictly confidential and shared only on a need-to-know basis. Students who test positive for drugs are commonly referred to counseling and assessed for their treatment needs. RSDT programs provide students with a compelling reason not to use drugs. They also provide schools with the tools to constructively intervene with students who are using drugs. They telegraph the standard of zero tolerance to the school community. Random student drug testing does not result in students being out of school but drug use definitely does.

Concluding Remarks

My career started with drug testing. In August of 1969 I conducted drug tests on every person being brought into the Washington, DC jail. Those results identified for the first time the close link between the heroin and crime epidemics. The results were published in the *New England Journal of Medicine*. That study, and our subsequent massive treatment effort that reached 15,000 heroin addicts over three years, led to the modern drug policy that balanced the traditional law enforcement approach with a new emphasis on prevention, treatment and research.

A decade later in the late 1980s I was in the center of the controversy over the introduction of workplace drug tests. At that time Abby Hoffman in his book Steal This Urine Test labeled me as one of "the gang of four" that was bringing drug tests to the American workplace. Then in the first decade of the 21st century I led the pioneering movement to make drug testing a major part of comprehensive drug and alcohol prevention in schools. Each major step of my career was built on drug testing.

Drug testing is not standing still. Because drugs of abuse are found in all tissues, drug testing is evolving rapidly from the urine cup to include testing of oral fluids, hair, sweat and most recently, breath. Today new drug testing technology is being used in innovative ways to make prevention, treatment and intervention more effective. Drug testing has been at the heart of the evolution of modern drug policy

The three initiates I have described today will accomplish major reductions in illegal drug use. They reflect a national commitment to reject illegal drug use and to move our nation toward the time when the majority of Americans view drug use as "Un-American."

DATIA is leading the way in promoting the next generation of drug testing technologies. You are the leaders who will make the breakthroughs, formulate the policies and work with governments and private organizations to launch new drug testing technologies.

I salute you, the leaders of the drug testing industry, for your profoundly important contributions to the nation's public health and public safety.

Thank you for the opportunity to be with you today.

For more information about the Institute for Behavior and Health, Inc., visit the IBH websites:

www.ibhinc.org – This website is devoted to drug abuse policy and outlines its five priorities: 1) improve treatment; 2) improve prevention, 3) reduce drugged driving; 4) reduce prescription drug abuse; and, 5) engage in and improve international drug policy. All of these priorities relate to the use of drug testing.

www.StopDruggedDriving.org – This website is considered to be the leading resource now available on this national threat to the safety of the public. It combines news, a large database devoted to research findings, and information about the development and use of improved drug testing technologies to identify drug use on the nation's roads.

www.PreventionNotPunishment.org – This website devoted to random student drug testing (RSDT) encourages school administrators, communities, parents, and teens to develop school-based RSDT programs as part of a larger drug prevention initiative. IBH provides recommendations, model policies and legal guidelines. The site explains drug testing procedures and the roles of the Third Party Administrator (TPA) and Medical Review Office (MRO). It includes information from school administrators describing the experience with establishing and running RSDT programs.

www.PreventTeenDrugUse.org – This website has been developed for parents. It provides research on the negative effects of drugs by children, teens and young adults, with particular attention paid to early marijuana use. Marijuana is the most widely used drug in the United States and the world. This website includes a listserv that broadcasts articles, research, news, and policy information relevant to the need to reduce nonmedical drug use by youth. The use of home drug tests by parents as a preventative is suggested.

Visit the World Federation Against Drugs website: www.wfad.se – WFAD is a multilateral community of non-governmental organizations and individuals. Founded in 2009, the aim of WFAD is to work for a drug-free world.

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