DRUG TESTING FOR
CRIMINAL JUSTICE
INVOLVED INDIVIDUALS
IN MICHIGAN
### DRUG TESTING STANDARDS COMMITTEE

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**Special thanks to Dana O'Neal who was instrumental in planning meetings, taking notes and keeping me organized**

**Special thanks to Paul Cary for his suggestions and edits.**
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From the President’s Desk

Frequent alcohol and drug testing is fundamental to any good drug court program. The Ten Key Components of Drug Courts, as set forth by the National Association of Drug Court Professionals, require that testing policies and procedures utilized by drug courts be based on established and tested guidelines. Accurate alcohol and drug testing therefore can be the most objective and efficient way to establish a framework for accountability and to gauge participant progress.

Those of us who sentence and supervise addicted individuals cannot always stay abreast of drug testing research literature and may not have the time to attend specialized training. Consequently, we run the risk of utilizing insufficient or outmoded testing methods rather than the current best practices. This publication is an effort to fill the gap between our need for high quality alcohol and drug testing information.

In 2010, the Michigan Association of Drug Court Professionals (MADCP) created a drug testing standards task force to address the need and inform our membership regarding the best evidence based practices for alcohol and drug testing. For the last two years, the task force has worked to create a set of standards for drug testing. Barbara Hankey Manager of Oakland County Community Corrections lead a team of experts from government and private industry, which included Alexandra Black of the 52-1 District Court, Amy Adkins from Siemens, Penny West-Palmer from Siemens, Deborah Hendrix of Wayne County, Gloria Kmiec of Macomb County, Russ McPeak of Macomb County, Jenny Grimm of Berrien County, Mary Amend of Saginaw County, Maurice Hills from the Michigan Department of Corrections, Rene Ammonite of Bay County, Grace Kalafut of Kalamazoo County, Roger Canzano from Independent Drug Testing, Mel Hoberman from Independent Drug Testing, and Dana O'Neal of Oakland County.

So, I am very proud to introduce MADCP's inaugural publication, “Drug Testing for the Criminally Involved Individual in Michigan”. The information contain herein is critical to anyone managing or treating an addict and should be read by any judge, probation officer, parole officer, community corrections worker, or professional affiliated with the criminal justice system. Whether you are involved in a drug court or not, I know it will benefit your work, and it will help you save lives.

On behalf of the MADCP, I wish to thank you for taking the time read this important document and congratulate you for your vital work in supporting drug courts.

Judge Brian W. MacKenzie
President Michigan Association of Drug Court Professionals
Executive Summary

Every day drug courts all over the nation refer to the 10 Key Components of Drug Courts to guide their programs. In December 2010 Doug Marlowe J.D, Ph.D. through the National Drug Court Institute, released Research Findings on Adult Drug Courts. This document revealed that the most successful drug courts are those that maintain fidelity to the established drug court model adhering to all 10 key components. Number five of those key components is to monitor abstinence through frequent alcohol and drug testing. The results of participant’s alcohol and drug tests are the basis for a great many sanctions, rewards and frequently define their success. Therefore drug courts must be able to rely on the accuracy of those tests. If drug and alcohol testing is not being performed in accordance with recognized policies and forensically sound practices, than the integrity of the court could be at stake. Furthermore, inaccurately interpreting test results could allow participants who continue to use drugs and alcohol to go undetected, while others may be unfairly sanctioned. In order to operate the most successful drug court programs it is incumbent upon all of us to educate ourselves on the products, research, and policies regarding drug testing.

This manual is intended to act as a guide for Michigan Drug Courts. It is neither all-encompassing nor exhaustive; however it does provide a sound basis for drug testing practices. Nothing within these pages is original; rather it is a compilation of information from nationally recognized experts within the field. I would like to thank each of them for doing this most important and often unappreciated work. A special thanks to Paul Cary who took the time to edit this manual, and offer suggestions towards its betterment.

Barbara M. Hankey, Chair
Drug Testing Standards Committee
Ten Principles of a Good Testing Program

1. Design an effective drug detection program, place the policies and procedures of that program into written form (drug court manual), and communicate the details of the drug detection program to the court staff and clients alike.

2. Develop a client contract that clearly enumerates the responsibilities and expectations associated with the court’s drug detection program.

3. Select a drug-testing specimen and testing methodology that provides results that are scientifically valid, forensically defensible, and therapeutically beneficial.

4. Ensure that the sample collection process that supports effective abstinence monitoring, practices including random, unannounced selection of clients for sample collection and use of witnessed/direct observation sample collection procedures.

5. Confirm all positives screening results using alternative testing methods unless participant acknowledges use.

6. Determine the creatinine concentrations of all urine samples and sanction for creatinine levels that indicate tampering.

7. Eliminate the use of urine levels for the interpretation of client drug use behavior.

8. Establish drug-testing result interpretation guidelines that have a sound scientific foundation and that meet a strong evidentiary standard.

9. In response to drug-testing results, develop therapeutic intervention strategies that promote behavioral change and support recovery.

10. Understand that drug detection represents only a single supervision strategy in an overall abstinence monitoring program.

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DEFINITIONS

**Adulterated Specimen** – A urine specimen containing a substance that is not a normal constituent or containing an endogenous substance at a concentration that is not a normal physiological concentration.

**Adulteration Test** – An initial test, generally performed before any assay test, that is used to determine if a urine specimen is adulterated, dilute, or substituted.

**Calibrator** – A solution of known concentration used to calibrate a measurement procedure or to compare the response obtained with the response of the test specimen/sample.

**Chain of Custody** – Refers to the process used to document the handling and storage of a specimen.

**Confirmatory Drug Test** – A second analytical procedure to identify the presence of a specific drug or metabolite which is independent of the initial test and which uses a different technique and chemical principal from that of the original test in order to ensure reliability and accuracy.

**Control** – A sample used to monitor the status of an analysis to maintain its performance within desired limits.

**Dilute Specimen** – According to SAMHSA a urine specimen with a creatinine value of less than 20 mg/dL.

**Handheld Device or Point of Contact Test** – A device(s) that require manual sampling and observation to produce a qualitative result (either positive or negative)

**Qualitative Test** - The purpose of the test is to determine the presence or the absence of a drug in a urine sample being tested. It cannot determine how much of a specific drug was used. Most immunoassay tests are qualitative.

**Screening Drug Test** – An immunoassay test to eliminate “negative” urine specimens from further consideration and to identify presumptive positive specimens that require confirmation or further testing.

DRUG TESTING METHODOLOGIES

A drug test is a technical analysis of a biological specimen such as urine, hair, blood, sweat, oral fluid/saliva, to determine the presence or absence of specified parent drugs or their metabolites. Some of the most common drug testing methodologies are discussed below.

**Oral Fluid/Saliva**

Oral Fluid testing has become popular mainly due to the ease of collection and lack of gender issues for collection. It is readily available and non-intrusive. However, there have been some concerns with low specimen volume and detecting low levels. Also, the detection window for THC is minimal, typically just within a few hours of use. Currently to use oral fluid technology, testing programs must send their samples

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to a reference laboratory to use ELISA methods to detect drugs and drug metabolites in saliva samples. This method may be useful in some settings for on the spot testing or home visits, however it is not appropriate as the primary method in a drug or sobriety court setting in which timely responses to substance use is necessary.

**Sweat Patch**

Sweat Patch testing has some benefits over urine testing or other types since it is relatively non-invasive and is worn for an extended period of time. The patches are typically designed to be tamper resistant, with adhesives that can only be removed with special solvents. However, there have been documented cases where clients have been able to heat dissolve adhesion to place barriers between the patch and skin. The patches are then reattached to the skin to create the illusion of wearing the patch. When it is known the patch will be removed for analysis, the client may again dissolve the glue to remove the barrier and re-apply the patch. There have also been some possible issues and concerns with external contamination (for instance, if cocaine is on the surface of the patch prior to being applied to skin).

Once the patch is removed it is sent to a laboratory for testing. Although no immediate results are available, the patch is able to capture what the client may have been using over an extended period of time.

**Hair Testing**

Hair testing has some benefits similar to the sweat patch, since it can detect use over a long period of time. If the drug was recently used, it does take some time for it to show up in the hair follicle. Hair testing is advantageous if one is looking to detect any drug use over a period of history, however the results of this test can be misleading for clients who have used in the past but are not currently using.

Similar to the sweat patch, hair is collected then sent to an external laboratory for further testing. If someone does not have head hair, hair has to be removed from other parts of the body. In addition, there have been some concerns with some hair colors (darker hair) retaining the drug differently or longer than lighter hair.

**Urine Testing**

*Immunoassay Drug Screening*

Immunoassays urine drug screening is the most common screening currently used for drugs of abuse testing. Immunoassays use antibodies to detect the presence of drugs or other substances in urine. The antibodies in each assay are designed to react only with the drug being tested (for example, cocaine, PCP, etc.) The various handheld tests or point of contact devices for urine are all immunoassay, as are most of the automated analyzers being employed outside a certified lab. If the drug or drug metabolite is present above a specified amount, it will react with the antibodies on the test device. This causes a chemical reaction which is
read as a positive test result. If the drug or drug metabolite is not present or is not present above the specified amount, no chemical reaction will occur which is read as a negative test result.

All urine testing technologies utilize these specified drug amounts also known as “cutoff levels”. A negative urine assay result does not necessarily prove that the subject did not consume the drug. A negative result only suggests that there may not have been enough of the drug in the donor’s system to exceed the cutoff level.

Detection of drugs in the urine is affected by urine dilution; therefore creatinine and specific gravity values should be taken into consideration on all urine tests (see Adulteration Testing).

*Point of Contact (Instant) Testing Devices*

Point of contact devices vary in design and number of drugs for which they test, usually called panels. Multi-panel devices are designed to test for multiple drugs or drug metabolites at the same time. Each of these panels is a separate drug test and needs to be read independently of one another. Regardless of what design is chosen, it is very important that programs follow the manufacturer’s instructions (package insert) for using the device. These devices usually involve submerging a dipstick into the urine sample, using a pipette to draw out a small amount of urine to be placed on a test cassette or having the test built into the specimen container. Once the urine comes into contact with the testing device the collector must allow the manufacturer’s recommended amount time to pass before “reading” the device for a result. This information can be found on the instrument’s package insert.

Generally these devices will have colored bands next to each drug being tested indicating whether a drug is present or absent in the sample see Figure 1 next page. Most of these devices will also have a "control" band ("C") designed to ensure the testing device is performing according to the manufacturer's specifications. A test should be considered invalid if no colored band (line) appears in the control region (C) of the device. The drug or "test" bands (“T”) indicate whether the testing device has detected a specific drug. The design of the point of contact devices varies; with some devices testing for a single drug, while others contain multiple channels testing for many drugs. Each drug will have its own separate color band. When a colored band/line appears in the drug or test region (regardless of the intensity of the color), the test is considered negative. The absence of a colored band/line next to a drug or test region indicates a "presumptive" positive result.

It should be noted that Point of Contact devices have expiration dates and handling instructions. Test kits that are ripped, torn, or past their expiration date should not be used. All kits should remain unopened until ready for use.
Automated Testing

During automated testing with an analyzer for immunoassay, a chemical reaction occurs that changes the light-absorbing properties of the test mixture. Special instruments called spectrophotometers measure the changes in the amount of light the sample absorbs, which is related to the amount of drug or drug metabolite the sample contains. The more drug or metabolite present in the person’s urine, the greater the response produced. If there is little or no drug present in the sample, the response is lower.

The sample’s response is compared to the response of a calibrator, which contains a known quantity of the drug in question. This known quantity of drug in the calibrator is the cutoff. If the sample’s response is higher than or equal to the calibrator’s the sample is considered positive for the drug. If the sample’s response is less than that of the calibrator, the sample is considered negative.

Programs using automated testing devices must analyze the controls according to the manufacturer’s specifications and time table. All personnel responsible for running samples on an automated instrument should be required to complete training by the manufacturer and follow all recommended maintenance and operational instructions.
URINE DRUG TESTING PROCEDURES

Collection Site
The collection site should be an area which is easily controlled and has only one entrance/exit. This area is designated for specimen collection only and is not open to the general public. The preferable design is a single stall urinal with no accessible running water. A bluing agent should be added to the water in all toilets. This mitigates the chance of a donor substituting or adulterating a sample. If no bluing agent is available, the collector shall instruct the donor not to flush the toilet until a valid sample has been collected.

A sink may be located outside of the urinal area for hand washing. If this is not possible a moist towelette may be provided to the donor for this purpose.

A work surface directly outside of the urinal area is necessary for the collector to be able to perform the test, annotate chain of custody, etc. A desktop or table would suffice for this purpose. The work area should also contain a secure storage option in which extra testing supplies may be stowed. Having the supplies stored in close proximity alleviates the need for the collector to leave the area and possibly leave a donor unattended.

All supplies needed to collect a sample should be gathered by the collector prior to starting the collection process.

Specimen Collection
Before and after the collection process the collector should check the urinal/stall area for any suspicious objects. This observation is to include the toilet or urinal itself, and any other areas in which an adulterant may be stored.

Prior to entering the restroom or urinal with the donor, the collector is to instruct and observe the donor empty their pockets into a designated storage container. In order to ensure the donor isn’t attempting to hide anything, he/she should be asked to remove any excess shirts, coats, jackets and hats. The donor is to be instructed to lift their pant legs one at a time, lift their shirt and run their thumbs around the waistband of their pants. In addition to the above collection procedure, any donor with long or extended fingernails will have their fingernails checked prior to washing their hands for chemical compounds placed underneath them (a common means to bring in adulterants).

Finally, donors are to be instructed to wash his/her hands thoroughly with soap and water and dry completely. All of the above actions are to thwart the possibility of an attempt at concealing adulterated specimens and/or contaminants that may be added to their specimen. If an abnormal substance, container, or contraption is observed the donor will be instructed to remove it from his/her person and present it to the
collector. Collection sites need to establish a policy as to how situations of this type will be handled and inform the referring agency of same. Here are two options:

1. The donor is advised that his/her test for the day is concluded and that the incident will be reported to the referring agent. No sample collected.

2. The donor is allowed to provide a sample and the referring agent is notified of the confiscated items.

Monitoring
Except in the circumstance of an extreme emergency, donors are always monitored by same-sex collectors. This is in accordance with Michigan Department of Corrections policy directive 03.03.115 which states “The person taking the sample shall be of the same sex as the offender providing the sample, unless an emergency condition requires otherwise.” In addition this limits the agencies susceptibility to staff indiscretions or legal action by the donor. Monitoring requires direct observation of the sample leaving the donor to ensure that the sample is from the identified donor and has not been tampered with or adulterated. Collectors should not attempt to collect samples from more than one donor at time. Such a practice could lead to confusion or inadvertent switching of samples. The collection cup should be shown to the donor to satisfy him / her that it has not been tampered with, and is intact. For chain of custody reasons the collection cup is to be kept in full view of the donor and the collector at all times. All specimen cups must be clearly labeled with the donor’s name and / or a unique identifier. Collectors must complete chain of custody forms (samples can be seen at Appendix A) as soon as the sample has been collected. All samples should be refrigerated until ready for transport and / or testing.

A donor who is allowed to, or needs to provide a new sample for any reason, should not be allowed to leave the testing area. Leaving the testing facility or returning at a later time / date presents the possibility that adulterants may be reintroduced into the testing process.

Staffing
All collectors must be trained on proper use of testing equipment. It is imperative that manufacturer’s instructions are followed in order to ensure the accuracy of test results. It is preferable that any staff collecting urine samples or performing urine tests be trained

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3 Agencies who are unable to comply with this directive should consider testing methodologies which do not involve the collection of urine.
directly by the manufacturer and have a certificate acknowledging their competence.

In addition to training provided by the manufacturers, programs must provide comprehensive training to staff in the areas of program policy and procedures. Staff should receive copies of the program policies and procedures and acknowledge their receipt of same through signature. Staff must have knowledge in the areas of testing technology and testing protocol in the event they are called to testify.

Collections sites and / or programs that are contracted for services through the State of Michigan or receive State funding must perform background investigations on staff prior to employment. The program will be responsible for running a records check, at a minimum, through ICHAT and OTIS. Employees must not have outstanding warrants, active personal protection orders for domestic violence, or have any pending criminal prosecution. They may not be on probation, parole or otherwise under the jurisdiction of any federal, state, county or local criminal justice agency without prior written approval from the State. Ex-offenders may not be considered for employment until they have been discharged from all sentences including parole and probation for a minimum period of five years.4

Programs must ensure that an adequate number of staff is available at all times so that same sex monitoring criteria is employed. See the section entitled “Monitoring” above.

**Donor Participation**

The first time a donor reports to an agency for testing he / she will be required to review and sign a Donor Participation Contract (see Appendix B for samples). At this time the rules and regulations will be provided to the donor, if they have not been already. The agency will have the donor acknowledge the receipt of the rules through a signature or other by means. At a minimum, agency rules should contain the following items:

- Donor responsibility for presenting valid identification each time they report for testing.
- The cost of each test, including costs for confirmation or other fees not covered under the per test cost.
- Acceptable methods of payment if applicable.
- Policies regarding leaving the testing area and / or building prior to the completion of a test.
- Time limits on donor’s ability to provide a sample.
- Donor requirements regarding smoking, eating, or drinking prior to reporting for an alcohol/PBT test.
- Days and hours of operation.

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4 Standard language in State of Michigan Department of Corrections contracts
Drug Testing for Criminal Justice Involved Individuals in Michigan

- Random selection procedure and contact information
- Policy / sanctions for adulteration testing, too dilute samples, missed tests, and failure to provide an adequate sample

Any other rules specific to the agency’s operation should also be listed. Paul Cary of the Toxicology Laboratory at University of Missouri further suggests that donor participation forms should be as specific as possible and hold the client accountable. He suggests statements begin with “I understand”, “I have been informed” or “It is my responsibility” when applicable.

**Donor Identification**

Each time a donor reports for a drug or alcohol test, his/her identity must be confirmed. Regardless of how familiar a collector becomes with a donor, the ID should be checked each and every time a donor reports. This may be done through a valid photo ID of the person. Any of the following may constitute a valid photo ID:

- Driver’s license
- Program ID
- Student ID
- Employers ID
- State issued ID card
- Valid Passport
- Jail booking photo with name

Collectors must confirm that the person in the photo is indeed the person taking the test. If there is any question as to the identification of the person, a second supporting form of ID may be requested. These might include *but are not limited to*:

- Social Security Card
- Voter’s registration card
- Medical Insurance Card
- Car Registration / Insurance
- School ID
- Credit Card (s)

If a donor is unable to produce or does not possess a picture ID then three pieces of non-picture ID (from the list) above may be accepted. The donor’s signature should also be checked to ensure a match. To match a
signature, the donor may be asked to sign a piece of paper for comparison. Under no circumstances should a donor be identified on the word of another donor.

**Providing the Urine Sample**
The donor is given a specimen collection container with temperature strip and asked to provide at least a 30ml sample. When the donor is done voiding he/she places the sample on a work surface in view of the collector. From this point forward the sample should not leave the sight of the collector or the donor until either:

1. the test has been completed and sample discarded OR
2. the sample has been sealed with a tamper resistant seal.

The Collector must check the sample for:

- **Adequate sample volume – at least 30ml**

If the sample volume is not adequate, this should be noted on the Chain of Custody form. The donor must be informed that he/she must test again when they are able. When the donor is ready to try again, he/she will be given a new specimen collection container. The new sample cannot be added to the previous sample in order to obtain 30ml or more.

If a donor is not able to provide an adequate sample volume after three attempts or chooses not to provide a second or third sample, the test should be considered as incomplete and the referring agency notified as such.

- **Temperature of the sample**

All specimens must register between 90 -100 degrees Fahrenheit on the temperature strip to be considered a valid sample. Federal standards mandate that the temperature be read within 4 minutes of the donation. If the temperature fails to register in the prescribed range it may have been substituted or adulterated. This should be noted on the Chain of Custody form and the donor should be requested to produce another sample. Due to the serious implications of a sample failing to register a temperature, the donor should be questioned about the anomalies, and the answers noted on the Chain of Custody form.

- **Appropriate physical characteristics**

Samples that appear unusual in color, have an odor of bleach, or appear to be bubbly or fizzy are all indications that adulteration may have occurred. There are several readily accessible over the counter substances that attempt to “mask” illegal drug use. The substances usually result in one of the above mentioned anomalies.
There are several products available through the internet or by other means that promise a negative test result. These products such as Clean n Clear, Gold Seal, Urine Luck, and test-free work, all operate on the premise of waterloading.”. Adulteration tests will assist in detecting donors who are using these products.

Test results of donors who flush the toilet while voiding or directly after completion of their void should be considered suspicious. Donors have flushed adulteration tools, strips, bags, etc., down the toilet. Collectors should inspect the toilet after a donor’s void to safeguard against such events.

**Split Sample**

Once the donor has completed their void in the provided container, the container should be placed on the collector’s work surface. If the program is using a *point of contact (instant) device*:

✧ The collector, in full view of the donor, should pour a small amount of the sample into a second container. The sample in the second container is tested for adulterants (see below) once the results of the adulteration test have been registered the screening test may proceed. The point of contact testing device is dipped into the second container, or a pipette is used to draw a small amount of urine to place onto the cassette. If the initial test has a positive result, the sample in the original container is sealed and prepared to be sent for confirmation. If the initial test has a negative result the remaining urine sample may be discarded. Point of Caution: A sample should only be discarded after the adulteration test and the initial assay test result are negative (see Adulteration Testing for further detail).

If the program is using an *automated testing system*:

✧ The sample is split into a second container as described above. The split sample is tested for adulterants and the outcome recorded. The original container is immediately sealed with a tamper resistant seal and stored for either transport or testing.

**Adulteration Testing**

All samples should be checked for adulterants prior to the drug test being conducted or prior to the sample being poured and sealed. There are a variety of products on the market that assess urine samples for adulterants. At a minimum the adulteration test should check for: creatinine, Nitrite, pH, bleach, and specific gravity. These tests are easy to administer and are designed to determine if a urine sample has been adulterated or tampered with in some fashion by the donor. These tests are usually strips which are dipped into the sample causing a chemical reaction which turns the strip a color that is then compared to a chart for “normal” ranges. See Figure 2. Adulteration tests may also be “built into” the sample cup. Many donors looking to “beat” the testing system will purposefully dilute their urine by drinking excessive water. The practice, also referred to as “waterloading”, “flushing” or “hydrating” may produce a negative test result
even though drugs may be present within the donors’ system. This is why adulteration testing of all samples is vital. An applied adulteration test will indicate that a waterloaded sample has a creatinine and / specific gravity that is abnormal. These samples should be considered dilute and suspect by the program. Programs have a few options if an adulteration test indicates the sample is abnormal.

Figure 2

1. The donor is requested to provide subsequent samples until a normal reading is achieved

2. The test is noted as too dilute and reported to the referring agency for action

3. Complete the immunoassay test and send the sample for GC/MS confirmation regardless of the initial test result

It should be noted that abnormal creatinine levels are generally only achieved through deliberate excessive hydration to mask the detection of drug use. A study conducted in 2005 by Barr, D.B., et al. concluded that less than 1% of the general population has creatinine levels below 20 mg/dL. There are some medical conditions that can cause low creatinine levels however, those conditions including; muscle wasting disease and some kidney ailments are extremely rare.

**Chain of Custody**

5 This may not be feasible as research shows that it may take 10-12 hours for creatinine levels to return to normal.
6 Each drug or sobriety court should develop a policy as to how “too dilute” samples will be handled. See Policy Considerations section.
7 This could become costly for the program or referring agency.
Once the urine sample has been collected a Chain of Custody form must be completed. This form ensures the identity and integrity of the sample through transport, testing and reporting of results. The form contains the donor’s unique identifier which pairs it with the sample. It is on this form that both the donor and the collector sign indicating that the sample has not left either of their sight since the void. The form should also have an area where the collector may note any comments or other observations. The chain of custody form will accompany the sample to its final destination.

**Confirmation Tests: Who Pays?**  
Some courts require the donor to pay for all costs associated with their drug testing activities, including confirmation testing. Some testing programs have adopted a policy whereby the donor pays for the confirmation only if the confirmatory result upholds the initial positive immunoassay test.

If a court requires that all positives be sent for confirmation, the testing program should establish a policy regarding who will be responsible for the cost.

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**RECORDING TEST RESULTS**

**Negative Results**
If the screening test is negative (and the sample has not been adulterated) the donor is advised to dispose of the remaining sample in the urinal/toilet and to dispose of the collection container in the proper receptacle. The negative test result is record and he / she is then free to leave.

**Positive Results**
If the test is positive this is recorded on the Chain of Custody Form. Upon being informed of the positive test result, the donor is to be questioned about time of last use and their response recorded. A policy regarding the handling of positive test results for confirmation testing should be developed in cooperation with the referring agency and / or court.

One or more of the following options could be employed regarding positive immunoassay tests for confirmation testing:

- All positives are sent for confirmation testing.
- The donor admits to recent drug use and therefore a confirmatory test is not necessary. The court accepts the donor’s statement as confirmation. The donor should initial or sign indicating acknowledgement of their recent drug usage.

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9 Kadehjian, L., Dr. (June 2010). Urine Drug Testing in Drug Court Programs. *Michigan Association of Drug Court Professionals Newsletter,*
- The donor is given the option of having the sample sent for confirmation. If he/she refuses to have the sample sent for confirmation the positive immunoassay test result will stand. The donor should initial or sign indicating that he/she was offered the opportunity for confirmation.

- The donor has provided a valid prescription for which a known cross reaction may occur. A confirmation in this instance may not be necessary each time the donor is tested. However random confirmations on these positive tests will ensure that no other substances are being used.

Another possible result on some point of contact devices is called a faint-line. This occurs when the test band is barely visible, is broken, or is faint. In these instances the collector/program should follow the packet insert or directions exactly as written. Most manufacturers will advise that if the test band is visible at all, regardless if it is faint, broken or otherwise, that it is a negative test. Referral agencies and courts should ensure that drug testing programs are reporting test results in accordance with the manufacturer’s instructions.

### CUTOFF LEVELS

Most programs currently utilize the SAMHSA/DOT established standards for initial screening and confirmation cut off levels. These cutoff levels are contained within the chart below and reflect the most current changes to initial screening levels effective October 1, 2010. This chart is part of 49 CFR 40 subpart F §40.87.

<table>
<thead>
<tr>
<th>Initial test analyte</th>
<th>Initial test cutoff concentration</th>
<th>Confirmatory test analyte</th>
<th>Confirmatory test cutoff concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana metabolites</td>
<td>50 ng/mL</td>
<td>THCA&lt;sup&gt;1&lt;/sup&gt;</td>
<td>15 ng/mL</td>
</tr>
<tr>
<td>Cocaine metabolites</td>
<td>150 ng/mL</td>
<td>Benzoylecgonine</td>
<td>100 ng/mL</td>
</tr>
<tr>
<td><strong>OPIATE METABOLITES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine/Morphine&lt;sup&gt;2&lt;/sup&gt;</td>
<td>300 ng/mL ***</td>
<td>Codeine</td>
<td>150 ng/mL ***</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Morphone</td>
<td>150 ng/mL ***</td>
</tr>
<tr>
<td>6–Acetylmorphine&lt;sup&gt;5&lt;/sup&gt; (Heroin metabolite)</td>
<td>10 ng/mL</td>
<td>6–Acetylmorphine</td>
<td>10 ng/mL</td>
</tr>
<tr>
<td>Phencyclidine</td>
<td>25 ng/mL</td>
<td>Phencyclidine</td>
<td>25 ng/mL</td>
</tr>
</tbody>
</table>

**AMPHETAMINES<sup>3</sup>**
Drug Testing for Criminal Justice Involved Individuals in Michigan

<table>
<thead>
<tr>
<th>AMP/MAMP⁴</th>
<th>500 ng/mL</th>
<th>Amphetamine</th>
<th>250 ng/mL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Methamphetamine⁵</td>
<td>250 ng/mL</td>
</tr>
<tr>
<td>MDMA⁶</td>
<td>500 ng/mL</td>
<td>MDMA</td>
<td>250 ng/mL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MDA⁷</td>
<td>250 ng/mL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MDEA⁸</td>
<td>250 ng/mL</td>
</tr>
</tbody>
</table>

¹Delta-9-tetrahydrocannabinol-9-carboxylic acid (THCA).
²Morphine is the target analyte for codeine/morphine testing.
³Either a single initial test kit or multiple initial test kits may be used provided the single test kit detects each target analyte independently at the specified cutoff.
⁴Methamphetamine is the target analyte for amphetamine/methamphetamine testing.
⁵To be reported positive for methamphetamine, a specimen must also contain amphetamine at a concentration equal to or greater than 100 ng/mL.
⁶Methylenedioxymethamphetamine (MDMA).
⁷Methylenedioxyamphetamine (MDA).
⁸Methylenedioxyethylamphetamine (MDEA).

***These are the recommended cutoff levels for criminal justice clients for this drug class. The SAMSHA / DOT established cutoffs are actually 2000 ng/mL for initial screening and 2000 ng/mL for confirmation.

If a specimen is found to contain a drug or drug metabolite in an amount above the established cut off level, the corresponding result will be positive. If the specimen contains a drug or drug metabolite in an amount below the established cut off level, the corresponding result will be negative. It is important to understand that a negative result does not necessarily mean that no drugs were detected. It simply means that the specimen yielded a drug concentration that was below the cut off level.

These cutoff levels have been developed by professionals to ensure that the detection accuracy can be scientifically supported (avoids issues such as passive inhalation) and ensures that legal protections regarding evidentiary admissibility are met.

Courts should be aware of the cutoff levels being employed by the various programs to which they refer. In order to ensure integrity and fairness throughout the system all programs should to whom a court refers should be using the same cutoff levels for screening and confirmation. Screening cut off levels for point of contact devices can be found on the manufacturer’s insert.
There are some programs (drug courts in particular) that may wish to employ lower initial screening cut off levels. Using a lower screening cutoff level can lengthen the amount of time during which a drug may be detected within a person’s system. Lower cutoff levels may also more readily detect individuals who continue to use very low amounts of illegal substances.

Regardless of which cutoff levels are utilized, under no circumstances should programs sanction for concentrations that are below the program’s established cutoff level. Programs that partake in a “zero tolerance” policy and therefore interpret any quantitative amount as a positive test (even when the test is reported as negative) and sanction accordingly may be placing themselves at risk for legal challenges and sacrificing the integrity of the court through “false positives”. A January 2004 (Vol.IV, No.1) Drug Court Practitioner Fact Sheet written by Paul Cary states:

“Not only is the evaluation of urine drug levels in a negative sample the antithesis of the intent of drug testing, but it also violates standards of evidence admissibility. In short, this practice is unethical. A negative test result cannot be interpreted in any other manner than negative.”

However there is some value in using quantitative amounts below the cut off as a means to adjust therapeutic interventions and prevent full blown relapse. This approach should be used cautiously for the reasons stated above.

CONFIRMATION TESTING
Unlike federal workplace testing or other federally mandated testing, criminal justice and treatment testing is not mandated to be confirmed. Each program must develop, in conjunction with their referring agencies, a policy determining when urine samples will need to be confirmed. These policies should take into consideration many factors including sanctions, admissions of use, etc. Any positive screening test result that is called into question by the donor or may result in a loss of freedom (incarceration) for the donor should be confirmed.

Regardless of which screening method is used, it is very important that any samples sent to a reference lab for further confirmation, are being confirmed using GC/MS or LC/MS/MS only. A simple rescreen using an immunoassay test of the initial sample is not sufficient to meet confirmation testing standards.

Some forensic labs do not employ confirmation cutoff levels. These labs are often used for a variety of applications, including determining if even trace amounts of a substance are present for criminal prosecution, rendering cutoffs levels inapplicable. These labs may report the quantitative result of the test (actual
nanograms of the substance), without a positive or negative notation. These confirmation reports may list the analyte of the drug along with the drug itself. For instance a confirmation report for cocaine may list Benzoylecgonine 150, Cocaine 0. Benzoylecgonine is the analyte tested for in a cocaine confirmation test. This would not be a negative confirmation, but rather a positive confirmation for cocaine. This style of reporting can be confusing and could lead to a misinterpretation of the results without proper guidance / training. Using a confirmatory lab that is willing to report confirmation results in a qualitative manner (positive or negative) according to SAMSHA cutoff guidelines removes any guess work on the part of staff.

**Gas Chromatography-Mass Spectrometry (GC/MS and GC/MS/MS)**

Gas chromatography-mass spectrometry is a method that combines the features of gas-liquid chromatography and mass spectrometry to identify different substances within a test sample.

GC/MS has been widely noted as a “gold standard” for forensic substance identification because it is used to perform a specific test for the substance in question. A specific test positively identifies the actual presence of a particular substance in a sample. For example, screening tests will identify the more than 30+ benzodiazepine drugs, but only a more specific confirmation test such as GC/MS can distinguish within the benzodiazepine family of drug if the urine contains Xanax or Valium, etc.,

GC/MS testing is typically done in a reference laboratory setting and it is critical when sending samples for further testing the exact same sample is sent that was initially screened.

**Liquid chromatography-mass spectrometry (LC/MS and LC/MS/MS)**

Liquid chromatography is a technique that combines the physical separation capabilities of liquid chromatography with the mass analysis capabilities of mass spectrometry. LC/MS is a powerful technique used for many applications which has very high sensitivity and selectivity. Generally its application is oriented towards the specific detection of illegal substances even in the presence of interfering substances like adulterants.

**Reference Labs Certification**

Every program conducting drug tests for criminal justice clients should have a reference lab. A reference lab is used to confirm “positive” initial screening or immunoassay tests. A reference lab should be certified through SAMHSA, CAP, CAP/FDT or at a minimum CLIA. A list of SAMHSA reference labs can be found in Appendix C.

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

Laboratories certified by SAMHSA must meet strict guidelines in order to conduct drug and validity testing on urine samples for the federal government. These labs must undergo three rounds of performance testing
plus an on-site inspection to be certified. In order to remain certified they must undergo 2 on-site inspections and 4 rounds of proficiency testing yearly.

*College of American Pathologists (CAP)*

The CAP Laboratory Accreditation Program is an internationally recognized program based on the CAP Laboratory Accreditation Standards. It is designed to go well beyond regulatory compliance, as the program provides a solid foundation for quality practices and helps laboratories achieve the highest standards of excellence to positively impact patient care. Laboratories that are CAP certified are inspected and are required to participate in various proficiency testing programs.

*College of American Pathologists (CAP) - Forensic Drug Testing (FDT) Certification*

This certification is a specialty accreditation available through CAP for laboratories that perform confirmatory drug testing on urine, oral fluid, and hair for non-medical purposes (i.e., workplace drug testing). The program also accepts laboratories that perform urine screen-only testing by non-waived methods. The confirmation testing must be performed by a CAP FDT accredited or SAMSHA certified laboratory.

*Clinical Laboratory Improvement Amendment (CLIA)*

The Center for Medicaid and State Operations has the responsibility for implementing the CLIA Program. This certification is not drug testing specific and most medical labs have this certification. The regulations cover laboratory certification requirements and fees, personnel qualifications and responsibilities, quality systems, proficiency testing, and other provisions. Oversight of the application of CLIA regulations to clinical laboratories is carried out by CMS (Centers for Medicare and Medicaid Services) and its designated state agencies.

All reference labs should be able to provide your program with expert witness testimony as well as access to the certifying scientist in the event of questions regarding the test results.

**ALCOHOL TESTING**

**Breathalyzer (PBT)**

The breathalyzer is a device which produces an estimate of blood alcohol content (BAC) based upon the chemical analysis of an expired breath sample. These devices generally have an LCD where the BAC is displayed. Readings must be manually recorded as there is usually no print capability. These instruments are easy to use, portable and relatively low cost. These devices must be calibrated monthly by a certified technician to ensure accurate readings.
**Ethyl Glucuronide (EtG) and Ethylsulfate (EtS)**

This is a urine test which measures the amount of ethyl glucuronide, a metabolite of ethanol. EtG in urine may be detected from 1 hour after consumption up to 80 hours depending on the dose and cutoff.\(^\text{10}\) An article written by Jason Tizedes (2011) *Understanding the Expectations and Limitations of Two Different Alcohol Testing Methods* indicates that a subject would have to drink an excessively large amount of alcohol for an EtG test to detect it up to 80 hours after consumption. EtG has a half-life in the body of 2-3 hours, meaning that every 3 hours, the amount of EtG present decreases by 50%.\(^\text{11}\) As an example, if a subject drank three six ounce glasses of wine, the likelihood of detecting that episode using an EtG test after 36 hours would be very slim.\(^\text{12}\) There have been courts that have begun to use EtG tests as a “confirmation” technique for positive alcohol events. EtG was not designed to be a confirmation methodology and therefore it is advised not to be used in this fashion. Doing so could leave courts with seemingly contradictory results.\(^\text{13}\)

Ethylsulfate (EtS) is another minor metabolite of alcohol and may be a superior marker for alcohol to EtG, in that it is more sensitive and specific.\(^\text{14}\) EtS is more stable than EtG, it is not degraded or created in urine due to bacterial presence and it cannot be masked by illness. Whenever possible testing should include both EtG and EtS markers to ensure the most accurate and reliable results.

There is currently no established cutoff level for EtG or EtS. However it is suggested by Dr. Leo Kadehjian for EtG that “Using a urine cutoff of 500 or 1,000 ng/mL should minimize the possibility of such incidental exposure leading to positive test results and still allow for reasonable sensitivity.”\(^\text{15}\) It is suggested by Dr. Gregory Skipper that a cutoff for EtS be set at 100ng/mL.\(^\text{16}\) Due to concerns regarding incidental, environmental or accidental exposure, any donor who is subject to EtG or EtS testing should be given a comprehensive list of products that should be avoided (see Appendix D for an example). EtG and EtS levels in urine are affected by urine dilution; therefore creatinine should be taken into consideration and normalized to values of 100mg/dl in the determination of qualitative results for both EtG and EtS. Some labs will make

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\(^\text{10}\) L. Kadehjian, Dr,. Ethyl Glucuronide and Its Utility in the Detection of Recent Alcohol Consumption. Siemens, (2010).


\(^\text{15}\) L. Kadehjian, Dr,. Ethyl Glucuronide and Its Utility in the Detection of Recent Alcohol Consumption. Siemens, (2010).

this adjustment for you, or they can be requested to do so. If the lab will not do so, it can be done with the following equation:

\[
\text{Normalized } U_{100} \text{EtG or } U_{100} \text{EtS} = \frac{100}{\text{urine creatinine}} \times \text{urine EtG or EtS}
\]

Example: if the urine creatinine is 200mg/dl and the urine EtG is 2,000 and the EtS is 500 then the normalized values would be \((100/200) \times 2,000 = 1,000 \text{ng/ml } U_{100} \text{EtG}\) and \((100/200) \times 500 = 250 \text{ng/ml } U_{100} \text{EtS}\).\(^{17}\)

EtG / EtS tests are urine tests and therefore all procedures noted in the Drug Testing section should be observed for these tests as well.

**PBT Testing Procedures**

Donors who are submitting to a PBT test should be void of any objects in their mouth for a period of 15 minutes prior to the test. The donor should not drink, eat, smoke or chew gum prior to the test or while waiting for the test to be performed.

Each donor is supplied with a new, individually wrapped “straw” at the beginning of the test. Under no circumstances should straws be “reused”, even by the same donor. Donors performing a PBT are advised to take a deep breath and blow into the straw. Donors need to maintain a constant stream of air for 3-5 seconds; the collector should be able to hear the air whistling in the straw. Results of the PBT test are displayed in a three-digit sequence; however, per the Michigan State Police Preliminary Breath Testing Training Manual (1998) results should be truncated to two decimal places. The third decimal place is not admissible in court and should therefore not be recorded. Under no circumstances should the third digit be used to “round up” the result. Donors whose test result is .01 or above are to be given a follow up PBT. This test is to be conducted after a subsequent 15 minute waiting period and will assist in determining if the donor’s breath alcohol content is rising or if it is on the decrease.

The result of the PBT is to be recorded on the donor’s PBT log (see Appendix E for a sample log), the collector must also fill in the date of the test, the time of the test and sign their name. Completing all the fields helps the referring agent to contact the appropriate person should there be any question regarding the test. This also assists the referring agencies to detect and or investigate suspected fraudulent PBT entries.

**Reporting of PBT Results**

\(^{17}\) Ibid
Programs need to work with their referring agencies on the way in which PBT results will be reported. Ideally positive alcohol tests should be reported within one business day. Courts and referring agencies may also wish to receive weekly or monthly reports detailing the client’s testing activities.

**POLICY CONSIDERATION FOR PROGRAMS THAT PROVIDE PBT**

**Liability Issues**

Programs must develop policies for those donors who blow “numbers” while at their facility. Below are some options that a program may choose to adopt or use as a guide in developing their own policies:

- Donor’s initial test is under .07 and the retest shows the alcohol content to be decreasing, .06 or below. The donor does not meet the .08 requirement for being intoxicated in Michigan and therefore should be free to go. However, if the donor is visibly impaired he / she should be treated as if their result were .08 or above.

- Donor’s initial test is .07 and the retest shows the alcohol content to be increasing, .08 or above. The donor should be required to call for a ride if they drove or walked to the site. If the donor drove him or herself to the facility, they should be asked to relinquish their keys. The program should observe the donor until his / her ride arrives. If they refuse to turn over their keys, the donor may be informed that the police will be called if they attempt to drive from the parking lot. Programs need to individually assess their authority as to their ability to physically detain a donor.

- Programs may wish to consult with legal counsel to determine any level of liability and if the prescribed policies mitigate that liability.

- If the donor is under the age of 21 Michigan has a zero tolerance law (.02 is zero tolerance) for minors. Minors who test at .02 or higher, should be handled in the same manner as adults who test .08 or higher. See above.

**POLICY CONSIDERATIONS FOR COURTS AND TESTING PROGRAMS**

**Frequency of Testing**

The frequency with which a donor should be tested will vary based on the goals of the program and available resources. Many drug / sobriety courts have standard testing protocols in place which require participants to test a set number of times per week based on the phase (e.g., twice a week during phase 1, once a week in phase 2). To be the most effective in monitoring abstinence, the frequency with which donors test should be
tied to the retention / detection time of the drug in a person’s system. Table 1 provides approximate detection times in urine.

Table 1:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Approximate Detection Time in Urine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamine</td>
<td>1-4 days</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>1-7 days</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>1-7 days</td>
</tr>
<tr>
<td>Cannabinoids</td>
<td>At 50 mg/mL cutoff:</td>
</tr>
<tr>
<td></td>
<td>● Up to 3 days for single event/occasional use</td>
</tr>
<tr>
<td></td>
<td>● Up to 10 days for heavy chronic use</td>
</tr>
<tr>
<td></td>
<td>At 20ng/mL</td>
</tr>
<tr>
<td></td>
<td>● Up to 7 days for single event/occasional use</td>
</tr>
<tr>
<td></td>
<td>● Up to 21 days for heavy chronic use</td>
</tr>
<tr>
<td>Cocaine Metabolite</td>
<td>1-3 days</td>
</tr>
<tr>
<td>Opiates</td>
<td>1-4 days</td>
</tr>
<tr>
<td>Phencyclidine (PCP)</td>
<td>1-6 days</td>
</tr>
<tr>
<td>Alcohol (as ethyl alcohol)</td>
<td>Variable, usually measured in hours</td>
</tr>
<tr>
<td>As alcohol metabolites EtG/EtS</td>
<td>At the 500/100ng/mL cutoff: 24-48 hours</td>
</tr>
</tbody>
</table>

**Random Testing**

Frequent drug testing is best to monitor abstinence and clients should be chosen on a random basis. Most random systems involve assigning the donor with a color and / or letter. Each color and / or letter has a frequency attached to it which only the program should know (e.g. blue may have a frequency of once per week). Each day the donor is required to check with the program to determine if their color and / or letter is required to test that day. This may be done via a phone, website, email or some programs are taking advantage of social media and “tweeting” the color and / or letter of the day. In order for a random system to be effective, the donor should not know the frequency or scheduling of the tests. If a client is aware that they are being tested once per month and their color is called on the second day of the month, he or she may be tempted to use knowing that they would not be tested again for a full month. Therefore programs may wish
to keep donors guessing by occasionally scheduling colors and / or letters more often than their “assigned” frequency.

It is important to note that no matter how “random” a program tries to make its system, it really isn’t random. If an individual has the wherewithal to track the color and / or letter being called each day, the frequency code could be cracked. Therefore programs may want to assign several colors to the same frequency, use “dummy” colors, and /or rotate colors often to foil attempts at breaking the code. It is equally important that programs do not widely distribute the testing calendar or schedule. This should only be given to individuals on a “need to know” basis. The information contained on a scheduling calendar, if available to donors, could place the integrity of a program at risk and worse allow a participant to continue to use drugs while in a drug / sobriety court without detection.

Dilute Tests
The average creatinine level for a human is approximately 100 mg/dL. For men the average is slightly higher at 120 mg/dL and for women slightly lower at 80 mg/dL. Therefore SAMHSA has determined that normal human urine should have a creatinine level greater than 20 mg/dL. Samples in which creatinine levels register below 20 mg/dL should be reported as dilute (see section on adulteration).

The referring agency and / or court must develop a policy for dealing with specimens that have been reported by the program as dilute. Referring agencies could adopt any of the following actions or develop their own:

1. Consider the test a “Positive” and sanction according to policy
2. Consider the test a “Dilute” with unique sanctions
3. Consider the test a “Tamper” with more severe sanctions than a positive
4. Allow for one “Dilute” sample per phase / quarter, etc.

Missed Tests
Under no circumstances should missed tests be tolerated in a drug / sobriety court setting. Missed tests should be treated as “positives” and sanctioned accordingly. Make-up tests should only be granted by the referring agency, and should only be done in rare, well documented situations. The testing program should never allow anyone to test on a day other than their assigned day (other than in situations of prior approval from the referring agency). Donors who miss tests but report the following day, may be doing so in order to give themselves more time to eliminate the substance from their systems therefore increasing their chances of testing negative.
Elimination Benchmark for Marihuana
In order to differentiate between new marijuana use and continued residual excretion from past use, all courts / agencies should set an elimination benchmark. An elimination benchmark is a period of time after which an offender / participant / client would be expected to test negative regardless of past usage. This benchmark then becomes the baseline for abstinence; any positive test beyond this baseline indicates new drug use.

Programs should consider giving donors no more than 30 days from their enrollment / acceptance date to test negative. For example if a person enters drug testing on July 1, he / she would be expected to be testing negative by July 31. This 30 day window is generous and studies show that even among heavy chronic THC users, if testing at established cutoff levels, this is a sufficient amount of time for THC to pass through the system. By the end of the 30 days the donor should be testing negative. Any positive test after the 30 day timeframe should be interpreted as new use.

New Use v. Continued Residual Excretion
There are two different approaches a program can employ during the 30 day elimination period to determine if positive test results are from new use or continued residual excretion.

1. Non-normalized approach

2. Creatinine-normalized approach

The non-normalized approach is easy to use, does not require the use of a mathematic formula, and relies solely on the qualitative (positive or negative) test result. Once a donor has two consecutive negative tests, at least a couple of days apart, he / she may be deemed drug free. Any positive tests after two consecutive negative tests (during this elimination benchmark period) can be considered new use.

The creatinine-normalized method is more complex, requires the use of a mathematical formula and has several factors that must be taken into consideration. The creatinine–normalized approach:

1. is to be used with cannabinoids only

2. can only compare identical testing methods (instrumented)

3. must compare consecutive tests

4. is to be used in conjunction with elimination bench marks

5. cannot be used on samples considered to be dilute

If the creatinine is expressed in mg/dL the formula is as follows:
Urine Cannabinoid (ng/mL) / Creatinine (mg/dL) x100 = “normalized” THC - Creatinine ratio

If the creatinine is expressed in mg/mL the formula is as follows:

Urine Cannabinoid (ng/mL) / Creatinine (mg/mL) = “normalized” THC - Creatinine ratio

Once the THC - Creatinine ratio has been determined it is used to calculate the specimen ratio between two consecutive positive tests. The following formula would be applied:

“normalized” THC - Creatinine ratio / THC -Creatinine ratio of an earlier positive sample = the specimen ratio

In drug court proceedings, an increase in the specimen ratio of 1.5 or more for two consecutive positive urine samples is indicative of new marijuana intake. When using this 1.5 specimen ratio standard, research indicates that new marijuana usage will be accurately predicted approximately 75% of the time, with a false positive rate of less than one percent.¹⁸ (see full article for a more detailed explanation).

Medications

Invariably each program will encounter individuals who are taking prescribed medication that will cause a positive test result. Drug testing programs need to work with the courts and referring agencies to determine how medication issues will be handled. Either the drug testing program or the referring agency will need to track the medications a client has been prescribed. Documentation of medications is necessary for instances of cross reactivity. All prescriptions must be verified to ensure the prescription is in the donor’s name, what is being prescribed, and the dosage. This may be accomplished by having the client provide a copy of the pharmacy information printout which will include the pharmacology of the medication. Positive tests as a result of medication should not be reported as a negative test. Instead, the actual result of the test should be reported with an explanation that the medication may have caused the cross reactivity. All staff involved with individuals who drug test should have a basic knowledge of what prescription drugs may cause a positive test result (for instance Klonopin may cause a positive for Benzodiazepines). If there is any question about the possibility of cross reactivity, programs should consult the manufacturer’s insert, website or contact the manufacturer directly.

Medical Review Officer (MRO)

MROs are required in most work place testing programs. The purpose of a MRO is to determine if a positive drug test result could be caused by anything other than illicit drug use (e.g. a prescription). The MRO will

¹⁸ Cary, Paul, L. M.S. The Use of Creatinine-Normalized Cannabinoid Results to Determine Continued Abstinence or to Differentiate between New Marijuana Use and Continuing Drug Excretion from Previous Exposure. Drug Court Review, Vol. IV,1 (2002). National Drug Court Institute.
contact the donor to discuss medications and provide an answer to the employer about the possibility of cross reactively. However, a MRO will not be able to determine if a person is abusing a prescribed medication or taking it as directed. While some courts have chosen to use MROs, a basic knowledge of cross reactivity on the part of staff can achieve the same result without the additional expense.

**Retention of Urine Samples**

Every donor should have the right to challenge an initial positive result through confirmation testing. Unfortunately donors may not know they have tested positive for up to a month after their test, depending on the type and level of supervision. If a donor is facing a show cause or violation hearing he / she may choose to have the sample sent for confirmation. Therefore collection programs should have adequate freezer and storage facilities to accommodate positive urine samples for a period of no less than 90 days. Urine samples that are being retained for up to 90 days should be frozen.

**Confidentiality**

If a court orders a defendant / offender to drug testing without that testing being used to perform a diagnosis of chemical dependency, referral to treatment, or actual treatment, the test results are not covered by the confidentiality laws because the court is not considered a “program” under applicable Federal statutes. However, when a Drug / Sobriety Court that meets the statutory definition of “program” requires that a participant drug test, the results are subject to confidentiality laws.\(^{(19)}\) Therefore Drug / Sobriety Court programs need to ensure that a proper release of information has been signed by the participant and includes all members of the “team”. While not necessary, it would be prudent for referral agencies and programs alike to treat all drug testing results as if they were subject to confidentiality laws (see Appendix F for a sample release of information).

**Record Retention**

According to the Michigan Trial Courts Record Retention and Disposal Schedule 16.083, probation files must be kept for 3 years after the date of discharge. Probation files may contain drug testing results. Currently there are no industry specifications on how long a drug testing agency is required to keep records. It is suggested that agencies keep drug testing results for a minimum of 12 months from the date of the test.

In 2004 the National Drug Court Institute issued a Drug Court Practitioner Fact Sheet entitled *Urine Drug Concentrations: The Scientific Rationale for Eliminating the Use of Drug Test Levels in Drug Court Proceedings*. Over 7 years later many courts (not just drug courts) continue to use drug test “levels” in court proceedings. The following is a condensed version of the article. The article may be viewed in its entirety at www.ndci.org/publications/publication-resources/fact-sheets.

While urine drug testing remains the primary strategy for the abstinence monitoring of drug court participants, interpretation of test results continues to be problematic for many courts. Absolute drug concentrations are often “interpreted” without adjustments for differences in urine water content. Increases in absolute drug concentrations resulting from changes in urinary output are often mistakenly interpreted as new drug use rather than carryover from previous drug exposure. Many drug courts utilize urine drug levels in an effort to define substance abuse behavior and dispense appropriately measured justice.

“WHILE WELL INTENTIONED AND SEEMINGLY LOGICAL, THE UTILIZATION OF URINE DRUG TEST LEVELS GENERALLY PRODUCES INTERPRETATIONS THAT ARE INAPPROPRIATE, FACTUALLY UNSUPPORTABLE, AND WITHOUT SCIENTIFIC FOUNDATION”.

The fact that urine drug concentrations are of little interpretive value will unfortunately come as a surprise to too many drug court professionals. Court programs have been adjudicating cases based on urine drug levels for years. That fact does not make the practice any more legitimate. If the use of urine drug levels cannot be supported scientifically, then the validity of decisions based upon these levels is questionable.

When asked about the practice of reporting urine drug concentrations, most laboratories admit that these values are not useful for interpretation purposes; however, numerical results continue to be reported because of customer demand. Put another way, laboratories report drug levels because court professionals request those values. Drug testing laboratories yield to the obvious economic forces and drug courts relying on urine drug levels for the dispensation of sanctions and rewards are not inclined to change or find the practice difficult to eliminate. The purpose of the (drug) test is to determine the presence or the absence of a drug in a urine sample being tested – period. Either a drug test is positive or negative.

Drug concentrations in the urine are present in proportion to the total amount of liquid. If
the urine is diluted, the concentration of the drug is reduced and when the urine is more concentrated the drug concentration is increased. The variability of drug concentrations due to changes in urine volume is significant. Drug levels may vary widely within a day or between days even with no additional drug exposure as a result of fluid intake alone. Without some form of normalization technique (some drug courts use creatinine concentrations to correct for the variations that occur in urine volume) the interpretation of urine drug levels is fraught with inaccuracy. Numeric results do not accurately discriminate between whether a participant’s overall drug level is increasing or decreasing even if compared to previous urine drug concentrations from the same client, for the same drug. It is noteworthy that in the federal workplace drug testing programs (DOT, DOE, DOD, etc.), the routine reporting of urine drug levels is never permitted. Federally certified laboratories are never allowed to report the numerical values generated from initial screening procedures.

Eliminating drug levels will not make urine drug testing results any less reliable or useful. However, the continued use of urine drug levels by drug courts in an attempt to interpret drug test results will likely result in both inappropriate and unfair rewards and sanctions for participants.

ARE YOU ASKING THESE QUESTIONS?

Has the urine drug level increased or decreased since the last test? How positive is he/she? Does this level indicate relapse? The level continues dropping so that indicates continued elimination, correct?

If any of these questions are being asked within your drug court setting, it is almost certain that urine drug levels are being used inappropriately in the court’s decision-making processes.
APPENDIX A

COUNTY OF OAKLAND
OFFICE OF THE SHERIFF
Michael J. Bouchard

Forensic Science Laboratory
1200 N. Telegraph Road - Bldg. 36 East
Poniac, Michigan 48341
(586) 856-5016

CONTRACT FOR URINE TESTING

TERMS and CONDITIONS
As part of the RESULTS Program the OAKLAND Forensic Science Laboratory provides urine drug screening for referring agencies. The laboratory will test urine samples as required by referring agencies and will perform tests methods according to SAMHSA laboratory guidelines and requirements as specified by ISO 17025:2005 and NASCL/CLSI international accreditation. Significant deviations from customer requests will be reported. Test results will be posted in the OTStar Program and referring agencies will be mailed a definitive laboratory report for all positive test results. The significance of the laboratory test results will be determined by the referring agent.

DONOR OBLIGATION: Positive samples will be held for four weeks and the laboratory will forward samples to a secondary laboratory for confirmation at donor request but will not be responsible for the results generated or testing fees.

REPORT TO:
Name: ________________________________
Address: ____________________________________________
Phone/Fax: ________________________________
Docket #: ________________________________

COLLECTION INFORMATION [PLEASE PRINT CLEARLY]
Collected/Sealed By: ________________________________
Date Collected: ________________________________
Site: ___________ Oakland Police ___________ Troy

Donor Certification and Consent: I certify that the specimen accompanying this form is my own and that I have provided it to the collector. Further, I certify that the specimen container was sealed with a tamper-proof seal in my presence and that the information provided on this form and on the label is correct. Also, I consent to the sample analysis and release of test results to the party listed above.

Donor Signature: ________________________________ Date: ________________________________

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<tbody>
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<td>Item #1</td>
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<tr>
<td>Cocaine</td>
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<tr>
<td>Methamphetan</td>
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<td>Amphetam</td>
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<td>Creatinine</td>
<td>Normal Dilute</td>
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Date(s) Tested/Completed: ________________________________

Contract for Urine Testing OM 5.0-c version 01 Approved by: K. Gardner 10/15/10 Page 1 of 1
**Drug Testing for Criminal Justice Involved Individuals in Michigan**

---

**WinTOX Demo Site**
Integrated Management Solutions
4900 Bradford Dr.
Huntsville, AL 35805
www.ims-dynetics.com

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### Specimen Handling

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User Defined Certification Text Line 2
User Defined Certification Text Line 3
User Defined Certification Text Line 4
User Defined Certification Text Line 5
User Defined Certification Text Line 6
User Defined Certification Text Line 7
User Defined Certification Text Line 8
User Defined Certification Text Line 9
User Defined Certification Text Line 10
User Defined Certification Text Line 11
User Defined Certification Text Line 12
User Defined Certification Text Line 13
User Defined Certification Text Line 14
User Defined Certification Text Line 15

**Defendant's/Offender's Signature:**

**Date:** | **Time:**

**Positive Specimen Frozen By:**

**Date:** | **Time:**

---

**Receipt / Next Test Date**

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<td>Name:</td>
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<tr>
<td></td>
<td>Tuesday 8am - 5pm</td>
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<td>Thursday 8am - 5pm</td>
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<tr>
<td></td>
<td>Friday 8am - 5pm</td>
</tr>
<tr>
<td></td>
<td>Saturday CLOSED</td>
</tr>
</tbody>
</table>

**NEXT TEST DATE:**

User Defined Footer
OFFICE OF COMMUNITY CORRECTIONS
DRUG TESTING AGREEMENT

Name: ______________________________ Case # ___________________ DOB ___________________

1. I have been referred to the Kalamazoo County Office of Community Corrections (OCC) to provide urine specimens for drug testing purposes. I understand that my participation in Drug Testing is required by the referring agency. The results of these tests will be forwarded to the referring agency and may be used by the Court.

2. Each time I appear for drug testing, I must bring in any medications taken within the previous 2 weeks. I will present the medication to OCC staff in the original package with all pills in the containers.

3. Gender appropriate OCC staff will observe the collection of urine specimens. Protocol will be followed to ensure I have not concealed urine on my person.

4. Hours for urinalysis collection are: Monday through Friday 8 a.m. – 5 p.m.
   Saturday 9 a.m. – 2 p.m.

5. I am required to provide urine screens as follows:
   _______ As Ordered by the Probation Agent, Court, DHS or Referring Agency
   _______ Random Notification (call line) My Color is: _______________________
   I am responsible for calling the drop line 269-387-7237 after 6:30 a.m. MONDAY-SATURDAY to ensure that I do not miss a screen.
   I must begin calling the drop line on _____________________________

6. If I fail to complete a urine screen, or to complete screens when instructed, it may be considered a "positive screen" by the referring agency.

7. I am responsible for the ______ $10 In-County Drug Test Fee ______ $20 Out-of-County Drug Test Fee

8. I understand that I am not allowed to conceal urine for the purpose of beating the drug test. Such attempts are considered program violations and will be reported to the referring agency. I understand I will be required to remain at OCC until I provide a valid specimen. The creatinine level of the urine is tested by the laboratory. Any urine specimen with a creatinine level less than 20mg/dl, will be flagged as a possible tampered urine specimen and is considered a program violation.

9. Should I dispute the results of the screen, I have the right to pay for GC/MS confirmation testing.

10. I understand that bringing children is not appropriate nor allowed at OCC.
RESULTS Program

DONOR AGREEMENT

GENERAL PROGRAM REQUIREMENTS

- You must provide photo identification to register in the Program and payment must be made prior to sample collection – cash only – no coins.

- You will be assigned a color and/or letter code for random sample collection. You must contact the RESULTS Program Hotline each day at 248-975-9662, after 5:30 a.m., and if your color and/or letter code is announced, you must report to a collection site that day.

- You are expected to report to your assigned collection site. However, if you need to travel out of the area you may fax your breath alcohol (PBT) test results to your assigned collection site the day of the test.

- You cannot reschedule. Only a court and/or referring agent may do so.

- You cannot leave the RESULTS building until a test sample has been collected and only persons scheduled for sample collection are allowed in the RESULTS lobby or your test results will be reported as incomplete.

- If your behavior is inappropriate your test results will be reported as incomplete.

- It is your responsibility to provide a list of medications to your referring agent.

DRUG TESTING REQUIREMENTS

- You must provide an adequate urine sample within three attempts or your test results will be reported as incomplete.

- Diluted or adulterated samples will be reported as incomplete.

- Your urine sample will be protected from loss, cross contamination and deterioration and a portion will only be available for thirty days for the purpose of appeals, after which time, the sample will be destroyed.

- You must remove all items from your person, other than clothing, prior to providing a urine sample or your test results will be reported as incomplete.

ALCOHOL TESTING REQUIREMENTS / PBT’s

- You cannot smoke, eat or drink anything 15 minutes prior to sample collection.

- If you test positive, you will be required to submit to a second and/or subsequent sample(s) collection every 15 minutes.

NOTICE: Test results are reported to referring agents.

Federal Regulation 42 CFR part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records. Provides for the confidentiality of records without written consent unless otherwise provided for in the regulations. Consent may be revoked at any time, except to the extent that action has been taken in reliance on prior consent, and in any event, said consent will expire from one year of this date.

<table>
<thead>
<tr>
<th>Donor’s Signature (or parent/legal guardian) of Binding Agreement</th>
<th>Date</th>
<th>Witness Signature</th>
</tr>
</thead>
</table>

Print Name Clearly

White Copy – RESULTS Pink Copy – Donor
APPENDIX C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration

Current List of Laboratories and Instrumented Initial Testing Facilities Which Meet Minimum Standards
To Engage in Urine Drug Testing for Federal Agencies

(Formerly: Bayshore Clinical Laboratory.)


Aegis Analytical Laboratories, 345 Hill Ave., Nashville, TN 37210. 615–255–2400. (Formerly: Aegis Sciences Corporation, Aegis Analytical Laboratories, Inc.)

(Formerly: Kroll Laboratory Specialists, Inc., Laboratory Specialists, Inc.)

Alere Toxicology Services, 450 Southlake Blvd., Richmond, VA 23236. 804–378–9130. (Formerly:
Kroll Laboratory Specialists, Inc., Scientific Testing Laboratories, Inc.; Kroll Scientific Testing Laboratories, Inc.)

Baptist Medical Center-Toxicology Laboratory, 11401 I–30, Little Rock, AR 72209–7056. 501–202–2783. (Formerly: Forensic Toxicology Laboratory Baptist Medical Center.)


Doctors Laboratory, Inc., 2906 Julia Drive, Valdosta, GA 31602. 229–671–2281.

DrugScan, Inc., P.O. Box 2969, 1119 Mearns Road, Warminster, PA 18974. 215–674–9310.

DynaLIFE Dx,* 10150–102 St., Suite 200, Edmonton, Alberta, Canada T5J 5E2. 780–451–3702/800–661–9876. (Formerly: Dynacare Kasper Medical Laboratories.)


Gamma-Dynacare Medical Laboratories,* A Division of the Gamma-Dynacare Laboratory Partnership,

Laboratory Corporation of America Holdings, 7207 N. Gessner Road, Houston, TX 77040. 713–856–8288/800–800–2387.
Laboratory Corporation of America Holdings, 69 First Ave., Raritan, NJ 08869. 908–526–2400/800–437–4986. (Formerly: Roche Biomedical Laboratories, Inc.)


Laboratory Corporation of America Holdings, 1120 Main Street, Southaven, MS 38671. 866–827–8042/800–233–6339. (Formerly: LabCorp Occupational Testing Services, Inc.; MedExpress/National Laboratory Center.)

LabOne, Inc. d/b/a Quest Diagnostics, 10101 Renner Blvd., Lenexa, KS 66219. 913–888–3927/800–873–8845. (Formerly: Quest Diagnostics Incorporated; LabOne, Inc.; Center for Laboratory Services, a Division of LabOne, Inc.)

Maxxam Analytics,* 6740 Campobello Road, Mississauga, ON, Canada L5N 2L8. 905–817–5700. (Formerly: Maxxam Analytics Inc., NOVAMANN (Ontario), Inc.)


MetroLab-Legacy Laboratory Services, 1225 NE 2nd Ave., Portland, OR 97232. 503–413–5295/800–950–5295.

Minneapolis Veterans Affairs Medical Center, Forensic Toxicology Laboratory, 1 Veterans Drive, Minneapolis, MN 55417. 612–725–2088.


One Source Toxicology Laboratory, Inc., 1213 Genoa-Red Bluff, Pasadena, TX 77504. 888–747–3774. (Formerly: University of Texas Medical Branch, Clinical Chemistry Division; UTMB Pathology-Toxicology Laboratory.)

Pacific Toxicology Laboratories, 9348 DeSoto Ave., Chatsworth, CA 91311. 800–328–6942. (Formerly: Centinela Hospital Airport Toxicology Laboratory.)


Phamatech, Inc., 10151 Barnes Canyon Road, San Diego, CA 92121. 858–643–5555.

Quest Diagnostics Incorporated, 1777 Montreal Circle, Tucker, GA 30084. 800–729–6432. (Formerly: SmithKline Beecham Clinical Laboratories; SmithKline Bio-Science Laboratories.)

Quest Diagnostics Incorporated, 400 Egypt Road, Norristown, PA 19403. 610–631–4600/877–642–2216. (Formerly: SmithKline Beecham Clinical Laboratories; SmithKline Bio-Science Laboratories.)
Drug Testing for Criminal Justice Involved Individuals in Michigan

Quest Diagnostics Incorporated, 8401 Fallbrook Ave., West Hills, CA 91304. 800–877–2520. (Formerly: SmithKline Beecham Clinical Laboratories.)


South Bend Medical Foundation, Inc., 530 N. Lafayette Blvd., South Bend, IN 46601. 574–234–4176 x1276.


St. Anthony Hospital Toxicology Laboratory, 1000 N. Lee St., Oklahoma City, OK 73101. 405–272–7052.


Toxicology & Drug Monitoring Laboratory, University of Missouri Hospital & Clinics, 301 Business Loop 70 West, Suite 208, Columbia, MO 65203. 573–882–1273.


U.S. Army Forensic Toxicology Drug Testing Laboratory, 2490 Wilson St., Fort George G. Meade, MD 20755–5235. 301–677–7085.
Example EtG/EtS Drug Court Client Contract

The following document is an example client contract for use with drug court participants undergoing alcohol abstinence monitoring that employs the laboratory test for ethyl glucuronide (EtG). As with any client contract, the primary purpose is to outline the behavioral requirements and compliance standards necessary for continued participation in drug court. In addition, this client contract serves to educate, alert and advise drug court participants to the potential (incidental) sources of alcohol that could produce a positive urine EtG test result. This contract is designed to inform drug court clients of the numerous commercial products that contain ethyl alcohol and to provide them with a list of substances to avoid while in a drug court program. Courts utilizing EtG testing should consider this contract as a tool for advising participants on inadvertent sources of alcohol. This contract may also be useful in the sanctioning of drug court clients when used in combination with a positive EtG test result. Programs should revise this example contract as needed to conform to specific program goals and objectives.

URINE ABSTINENCE TESTING AND INCIDENTAL ALCOHOL EXPOSURE CONTRACT

Recent advances in the science of alcohol detection in urine have greatly increased the ability to detect even trace amounts of alcohol consumption. In addition, these tests are capable of detecting alcohol ingestion for significantly longer periods of time after a drinking episode. Because these tests are sensitive, in rare circumstances, exposure to non-beverage alcohol sources can result in detectible levels of alcohol (or its breakdown products). In order to preserve the integrity of the Drug Court testing program, it has become necessary for us to restrict and/or advise Drug Court participants regarding the use of certain alcohol-containing products.

It is YOUR responsibility to limit your exposure to the products and substances detailed below that contain ethyl alcohol. It is YOUR responsibility to read product labels, to know what is contained in the products you use and consume and to stop and inspect these products BEFORE you use them. Use of the products detailed below in violation of this contract will NOT be allowed as an excuse for a positive test result. When in doubt, don’t use, consume or apply.

Cough syrups and other liquid medications: Drug Court participants have always been prohibited from using alcohol-containing cough/cold syrups, such as Nyquil®. Other cough syrup brands and numerous other liquid medications, rely upon ethyl alcohol as a solvent. Drug Court participants are required to read product labels carefully to determine if they contain ethyl alcohol (ethanol). All prescription and over-the-counter medications should be reviewed with your case manager before use. Information on the composition of prescription medications should be available upon request from your pharmacist. Non-alcohol containing cough and cold remedies are readily available at most pharmacies and major retail stores.

Non-Alcoholic Beer and Wine: Although legally considered non-alcoholic, NA beers (e.g. O’Douls®, Sharps®) do contain a residual amount of alcohol that may result in a positive test result for alcohol, if consumed. Drug Court participants are not permitted to ingest NA beer or NA wine.

Food and Other Ingestible Products: There are numerous other consumable products that contain ethyl alcohol that could result in a positive test for alcohol. Flavoring extracts, such as vanilla or almond extract, and liquid herbal extracts (such as Ginko Biloba), could result in a positive screen for alcohol or its breakdown products. Communion wine, food cooked with wine, and flambé dishes (alcohol poured over a food and ignited such as cherries jubilee, baked Alaska) must be avoided. Read carefully the labels on any liquid herbal or homeopathic remedy and do not ingest without approval from your case manager.

Mouthwash and Breath Strips: Most mouthwashes (Listermint®, Cepacol®, etc.) and other breath cleansing products contain ethyl alcohol. The use of mouthwashes containing ethyl alcohol can produce a positive test result. Drug Court participants are required to read product labels and educate themselves as to whether a mouthwash product contains ethyl alcohol. Use of ethyl alcohol-containing mouthwashes and breath strips by
Drug Court participants is not permitted. Non-alcohol mouthwashes are readily available and are an acceptable alternative. If you have questions about a particular product, bring it in to discuss with your case manager.

**Hand sanitizers:** Hand sanitizers (e.g. Purell®, Germex®, etc.) and other antiseptic gels and foams used to disinfect hands contain up to 70% ethyl alcohol. Excessive, unnecessary or repeated use of these products could result in a positive urine test. Hand washing with soap and water are just as effective for killing germs.

**Hygiene Products:** Aftershaves and colognes, hair sprays and mousse, astringents, insecticides (bug sprays such as Off®) and some body washes contain ethyl alcohol. While it is unlikely that limited use of these products would result in a positive test for alcohol (or its breakdown products) excessive, unnecessary or repeated use of these products could affect test results. Participants must use such products sparingly to avoid reaching detection levels. Just as the court requires Drug Court participants to regulate their fluid intake to avoid dilute urine samples, it is likewise incumbent upon each participant to limit their use of topically applied (on the skin) products containing ethyl alcohol.

**Solvents and Lacquers.** Many solvents, lacquers and surface preparation products used in industry, construction, and the home, contain ethyl alcohol. Both excessive inhalation of vapors, and topical exposure to such products, can potentially cause a positive test result for alcohol. As with the products noted above, Drug Court participants must educate themselves as to the ingredients in the products they are using. There are alternatives to nearly any item containing ethyl alcohol. Frequency of use and duration of exposure to such products should be kept to a minimum. A positive test result will not be excused by reference to use of an alcohol-based solvent. If you are in employment where contact with such products cannot be avoided, you need to discuss this with your Case Manager. Do not wait for a positive test result to do so.

**Remember! When in doubt, don’t use, consume or apply.**

I HAVE READ AND UNDERSTAND MY RESPONSIBILITIES:

___________________________  _________________________
PARTICIPANT                  DATE

Paul Cary would like to thank Michael Hollenbeck and Ron Michaelson of the Dearborn, MI Drug Court program for the concept of this contract and the original draft used to produce this example.
## APPENDIX E

### OFFICE OF THE SHERIFF
Michael J. Bouchard
Forensic Science Laboratory

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## RESULTS
Drug & Alcohol Testing Program

### PBT Log

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All PBTs are to be administered at the RESULTS Program. If a PBT is done elsewhere, you are responsible for faxing each PBT result on the day the PBT is required to the RESULTS Program during our business hours.

---

OAKLAND PONTE OFFICE
250 ELMORE DRIVE, SUITE 100
PONTE VIKING, MI 48341
OFFICE: 248.351.1234
RESULTS FAX: 248.351.1235

SOUTH OAKLAND OFFICE
1951 CHICKASHA ROAD
TROY, MI 48084
OFFICE: 248.554.1239
FAX: 248.554.1238
APPENDIX F

COMMUNITY CORRECTIONS (OCC)
CLIENT INFORMATION RELEASE/EXCHANGE AUTHORIZATION

I, ____________________________, DOB ________________________, Case # _______________, understand that my participation in Community Corrections programming is required by the referring agency, as a condition of my probation, bond, DHS investigation or the disposition of any criminal proceedings against me. I hereby request and authorize the Office of Community Corrections to exchange information about my treatment and participation in this program to these individuals or organizations and only under the conditions listed below:

1. Name of person(s), organization(s) to whom exchange is to be made: OCC and appropriate County Staff, Jim Gilmore Jr. Treatment Center, Circuit Court, District Court, My Probation Officer, Department of Corrections, Michigan Rehabilitation Services, Kalamazoo Psychology, University Substance Abuse Services (USAC), Turning Point, Clearview, Project Rehab, Harbor House, Maternal Support Services, FIA/DHS, KEP, Federal, State and Local Law Enforcement Agencies, My Employer, Prosecuting Attorney, My Attorney, Electronic Monitoring Vendor, Drug Testing Laboratories, Community Mental Health, Access Center, My Family Physician, Family & Children’s Services, Bethany Christian Services, Interact, Catholic Family Services, Lutheran Social Services, Psychological Consultants, Community Healing Center, Family Health Center, Bronson Hospital, Borgess Hospital and: ___________________________________.

2. Specific information to be exchanged: my identity, assessment findings, diagnosis, urine screen results, criminal history, progress in the program, and any resulting recommendations. Disclosure may be made in writing or orally, including testimony before any court having jurisdiction over me.

3. The purpose or need for such exchange: To provide information so that the referring agency, Court, probation officer, or law enforcement agency can determine if I have met the conditions which have been imposed by the referring agency, my release from confinement, the disposition or status or any criminal proceedings against me, or my probation.

4. Duration of consent: The consent should expire: (a) sixty days from the date that participation in Community Corrections programming ends, or (b) when there is a final disposition of the matter requiring my participation. The Office of Community Corrections may continue to provide information hereunder until it has been notified in writing by the court, prosecuting attorney, probation or parole officer, or any other person who made my participation a condition for my probation, parole, release from confinement or disposition of criminal proceedings or that there has been a final disposition of the matter on which my participation in treatment was conditioned.

I also understand that any disclosures made are bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may redisclose it only in connection with their official duties.

5. Revocation of Consent: I agree that I may not revoke the consent given herein until there has been a final disposition of the matter requiring my participation in treatment and Community Corrections programming.

(Client Signature) ___________________________ (Staff Signature) ___________________________

Date ___________________________ Date ___________________________
CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG INFORMATION: 16th CIRCUIT FELONY ADULT DRUG COURT REFERRAL

I, ________________________, authorize
(Name of Consumer)

Community Assessment, Referral and Education (CARE),

and

16th Circuit Felony Adult Drug Court

and

Clinton Counseling Center/Eastwood Clinic/Pioneer Counseling Center/
Sacred Heart/Turning Point/Community Programs, Inc./Macomb Family Services/
 Choices Counseling, Rainbow Treatment Services or ______________________
(Treatment Agency)

to communicate with and disclose to one another the following information:

My name and other personal identifying information; my status as a consumer at any of the agencies listed above; initial and subsequent evaluations of my service needs; alcohol/drug and mental health recommendations and rational for referral(s); summary of treatment progress, cooperation and compliance; appointments scheduled and attendance; discharge plan and discharge status; alcohol/drug testing results; information to support authorization of treatment services; other: ____________________________

The purpose of the disclosures authorized in this consent is, per my request, to provide the Drug Court with the information they need to:

1. determine my eligibility or continued eligibility for Drug Court;
2. determine my treatment needs and authorization for treatment services
3. determine my progress and status in treatment

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment.

I also understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C. F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45CFR Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may redisclose it only in connection with their official duties.

I understand that generally the treatment programs listed above and CARE may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Dated: ________________________

Signature of Consumer

Signature of guardian or authorized representative when required
MACOMB COUNTY ADULT FELONY DRUG COURT

REQUEST/AUTHORIZATION
FOR RELEASE OF CLIENT INFORMATION
CRIMINAL JUSTICE SYSTEM

1. I, ________________________, hereby authorize the communication, re-disclosure, and release of information as indicated below between the Adult Felony Drug Court Team, Community Corrections staff and all of the Macomb County Jail Correctional Programs, including CMS and Mental Health, Clinton Counseling Center, L'Anse Creuse Educational Services, District and Circuit Court, District and Circuit Court Probation, M.D.O.C. Parole Officer, Defense Attorney, the Prosecutor's Representative, Salvation Army Harbor Light, House Arrest Services, Inc., Michigan Works!, C.M.H.-Jail Diversion Project, the State Office of Community Corrections personnel, CARE, and any Community Service Work site supervisor or designee or the following family member(s) or friend(s):

2. Specific type of information to be disclosed shall include, but not be limited to: Treatment Summary, Family History, Drug/Alcohol History, Criminal History/Arrest Record, School Records and Treatment Recommendations.

3. Specific substance abuse information to be disclosed shall include, but not be limited to: History and Diagnosis, Attendance at Treatment Session, Cooperation with Treatment Program and Prognosis.

4. The purpose of and need for the disclosure is to inform the criminal justice agency (ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and any other information pertinent to case.

5. I understand that this consent will remain in effect and cannot be revoked by me until:

   ___ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or the Day Reporting Center, or Urinalysis Program, or Community Service Program, or other Community Corrections Program.

   (Other time when consent can be revoked)

   (Other expiration of consent)

I also understand that any disclosures made are bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties.

Witnessed by ____________________________________________________________

Client's Signature ____________________________ Date Signed 7/13/2008

Client's Case # ____________________________ Date Witnessed ___________________