Dec93(Updated Jun 94)

DRUG USE DETERRENCE

RANDOM URINALYSIS

HISTORY

In Jun 71 President Nixon directed establishment of a drug urinalysis program to identify service members returning from Vietnam for rehabilitation. The program had little drug use deterrence. In Dec 81 DSD Carlucci signed a policy statement allowing urinalysis results to be used as evidence. Subsequently, drug testing results were successfully challenged in military courts and in Oct 83 the Deputy Surgeon General of the Army tasked a panel, headed by MG David Einsel, to review operating procedures in each Army/Air Force drug testing laboratory. A report was issued in Dec 83 stating that the system was broken and recommending a number of corrective actions. Concurrently, US Army records were reviewed and over 50,000 soldiers separated from the service based on positive urinalysis results were offered reparations because their drug testing results were legally unsupportable. In Dec 84, DoD Directive 1010.1 formally defined the current drug program. One relevant action in this directive was that drug testing was made the responsibility of Health Affairs. In 1991 this responsibility was shifted to the Coordinator for Drug Enforcement Policy & Support. Prevalence of drug use which was 18.2% in 1982 dropped to 4.3% in 1992 (sociodemographically adjusted figures, use in the last 30 days, DoD Surveys). Workplace drug use testing was formally implemented in the civilian federal sector in APR 88. The effect of the drug deterrence program was best summarized by Bray, et al., who observed that drug use decreased in both the military and civilian sectors between 1980 & 1988, a period of time when there was limited civilian testing, but the "rapidity of the (military) decreases, however, indicates the effectiveness of military efforts to reduce drug use among military personnel" (ref 1988 DoD Worldwid Survey, Summary Conclusions, pg 83).

CURRENT STATUS

Missions & Resources

Currently, all branches of the Armed Forces have a random urinalysis program for military and civilian personnel. Screening for seven drug classes is authorized for military and five for civilian personnel. The number of samples randomly collected for testing per year is 0.5 to 3 (mean = 1) for each employee, depending on the Service and duty of the individual. The urinalysis portion of the program currently costs $44M (military salaries excluded), has 10 drug testing laboratories, requires 531 full time personnel involved in laboratory operations and an estimated ... FTE personnel for collections and rehabilitation. In each of the Services laboratory testing is a medical department responsibility.

Effectiveness

The program is one of the most successful in DoD. Frequent drug use prevalence is less than 4% primarily due to the drug deterrence program (Bray et al., DoD 1992 survey, pg 42). 51.9% of DoD drug users surveyed in 1992 reported that the urinalysis program reduced the likelihood of their using drugs on occasions when they had an opportunity. Drug use has decreased in the face of constant or increasing availability of cannabis, cocaine and heroin (National Drug Control Strategy, Feb 94, Appendix B). At the May 1994 briefings to the Office of the DoD Coordinator for Drug Enforcement Policy & Support, each of the Services stated that drug testing was their top priority in the Demand Reduction Program.

Quality

< 1% of samples received by labs have problems which keep them from being tested. Mean laboratory turnaround times for results are <5 days for negatives and < 20 days for positives. During 1991-3, labs had zero false positive results on AFIP blind proficiencies and submitting units had 48 out of 53,000 challenges. Of 173 Air Force court cases in 1992 for which servicemen were charged with violation of Article 112a, UCMJ, based on urinalysis results, 151 went to trial, 16 resulted in acquittals and 2 of the acquittals were related to problems with the urine testing (BE vs EME & ephedrine vs methamp).

Problems

The choice of problems to cite is subjective but the following would be on most knowledgeable individual's lists:

1. No definitive data/studies exist which show that the current level of drug testing is required to deter drug use.

2. Uncertainty in future personnel structure, resources, missions etc impedes planning & increases costs.
    a. DoD consolidation plan is stalled.
    b. New DoD Directive 1010.1 is stalled.
    c. DoD screening equipment & reagent contract, target completion date of 1989, has no real completion date.
    d. DoD CIM computerization has no completion date.
    e. Each service is short of toxicologists & lab personnel.

3. Coordination between Personnel & Medical Commands is poor (note. Same problem in 1983 for USArmy, see Appendix K, Einsel Report).

4. Urine collection is still the weakest link in the forensic chain (Impallaria, Army Lawyer May 88; personal communication H Martin Jayne, USAF judge, 1993).

FUTURE NEEDS

1. The next DoD Survey/Study needs to be prospective. Observe different testing regimens, frequency of testing, etc. and compare. Estimate that this would be a three year study. Anecdotal and opinion information is not helpful in our current environment of scarce resources, low prevalence of use and the continued availability of drugs.

2. Army needs to facilitate DoD efforts. We need to move! We need a senior military person in charge of the program as in the Navy & Air Force. We need faster turnaround times for results (1 day for accession testing, PRP testing, testing for commands without field screening). We need economy of resources (by FY96 reduce DoD urinalysis expenses by $20 million, lab personnel by 260 & and number of labs from 11 to 5). We need smarter not more collections. We need to replace wornout equipment (some screening equipment is over 10 years old and the current screening method is expensive). We need to facilitate Navy lab computerization. We need to stay one step ahead of courtroom defenses (US Army expert witness demand increased 50% from CY91 to 92 despite increased confidence in urinalysis tests by soldiers in general; 41.2% were confident in 1988 survey vs 50.7% in 1992 survey). We need to train junior officers in forensic toxicology so that the program will have informed military influence 5-10 years from now.

3. Personnel Commands need to focus on collection processes & administrative processing of drug positive personnel. Medical Commands need to focus on labs and rehab. Share summarized information, not functions.

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FACTS

****Interdiction, Survey, Drug Lab Statistics**

*Drug Interdiction Stats: Availability of drugs has not been reduced significantly by interdiction efforts. Available consumption of cocaine in US was 278-445 metric tons in 1989 and 274-442 in 1992. In 1989, cocaine, heroin & cannabis federal-wide seizures were 99.2 metric tons, 1095 kg, approx. 500k pounds, respectively. In 1993, they were 108, 1517 and 769k, respecitively. (from National Drug Control Strategy, Feb94, The White House, Appendix B: Drug-Related Statisitics, pp 105-7). DoD interdiction costs are $750M/year.

*Worldwide military/national civilian surveys:

	Percent of population using illicit drug in last 30 days			
High risk group\ \Year	1982	1985	1988	1992
DoD 18-25yo(male/female)	30-32 %	13.7%(14.1,10.3)	6-7%	6.2%(6.9,2.7)
Civ 18-25 y.o. (male/female)	30.4%	29.0%(30,19.9)	18%	13.0%(16.7,9.5)
Students 1-4yrs beyond H. S.	31.3%	26.1%	18.5%	16.1%

Sources: RM Bray, et al., Worldwide Surveys 1985, 88, 92; RM Bray, et al., Am J Public Health 81: 865-9, 1991; NIDA, National household survey on drug abuse: 1985. Rockville, MD; NIDA, Drug use among American high school students, college students, and other young adults. 1985, Rockville, MD.

*DoD Drug Lab Results

				%				
Year	83	84	85	88	90	91	92	93
%Positive/any drug								
E4 and below								
Army								
Navy							1.1	0.9
AF								
DoD								
All personnel/test cat.'s								
Army	10	5	4.7	1.6		1.4	1.2	1.5
Navy								
AF								
DoD								

****Other stats**

*General Art112a Litigation, US Air Force:

*Blind proficiency samples from the AFIP examine operating procedures at collection sites and in the laboratories. In 1992 5.7% of blind proficiency samples, 1574 samples, were not sent by collection sites to laboratories IAW relevant SOPs. Estimated DoD cost of these unforwarded samples was $ 35,422.

*The table below shows results for negative blind proficiency samples:

YR	NO. NEG CHALLENGES PROPERLY SUBMITTED			NO. FALSE POSITIVE RESULTS**		
	Navy	Army	AF	Navy	Army	AF
91				5	4	0
92	ca8840	ca7072	ca1768	6	8	0
93	8215	6177	1691	13	12	0

**All false positives were due to mixups/misidentification at the collection/submitting units.

*The first overall recommendation of the Dec 1983 Independent Blue Ribbon Panel (Einsel Commission) report was that the USArmy "OTSG needs full-time staff element, headed by a senior officer" as is true for the Navy & Air Force.

*In Feb-Apr 1984 a US Army Urinalysis Review Team found that over 50,000 drug test results produced after implementation of forensic testing were either scientifically or legally unsupportable. All of the involved servicemen formerly separated from the service for drug use were formally notified and offered the opportunity to return to active duty with back pay and reinstatement of rank. Following this occurrence, several officers associated with the urinalysis program were diciplined; one MC general officer was retired, one MSC officer was removed from the O6 promotion list, 2 MSC officers received substandard OER's and one USAF O6 was reassigned.

*Total USArmy urinalysis/rehab/collections program cost, MEDCOM + USADAOA functions, will be $33 M/yr for FY94 (counternarctics money only).