TabA

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STRATEGIC PLAN

DRUG DEMAND REDUCTION PROGRAM

MISSION:

To assist commanders in keeping a ready fighting force by deterring service members and selected civilians within their commands from using illegal drugs.
To assist the families of service members by helping them live healthy drug-free lifestyles.

VISION:

Continue to be the best demand reduction program in the United States by optimizing urine drug testing to be truly random with the highest quality forensic test results.
Continue to be the best demand reduction program by focusing adult education and using performance measures to direct it.
Continue to have the most effective youth anti-drug programs in the United States.

GOALS:

Achieve and maintain a fighting force in which drug testing positive rates for each Service are 10% less than rates the previous year (high risk group & all ages included separately in the statistic) and 30 day use rates by survey are 25% less than three years previous for the high-risk group (18-25 year old enlisted males). These objective goals are for each Service with active, NG, reserves, & civilians accounted separately.

Begin a program to assist recruitment of drug free servicemen and servicewomen.

Have one outreach program in each state as effective as the New York Corps of Cadets program.

Begin family counter-drug programs in each Service that has objective performance measures.

OBJECTIVES & ACTIONS:

New Policies:

•Promulgate a minimum DoD standard for consequences of drug use

•Ensure that each service member receives & understands prior to entry on active duty that drug use is incompatible with military service and illegal drug use will result in discharge under other than honorable circumstances or worse

•Test each service member at the recruit training center and discharge the positive personnel

•Implement testing for 2-oxo-3-hydroxyLSD using liquid chromatography/mass spectrometry or liquid chromatography/tandem mass spectrometry to detect LSD use.

•All collectors will be DoD certified to perform their duties

•Have each laboratory capable of testing samples from any Service. The testing laboratory will be selected to conserve money and improve forensic efficacy, not to ensure that the service for the donor and the laboratory are the same.

•Establish cells within each DoD laboratory for more efficient development of methods to detect emerging drugs

•Focus adult education by emphasizing a top down policy on drug use and ensuring each member knows the policy.

•Evaluate NG supported outreach programs by state.

•Expand DEFY.

•Add NG, USAR and DoD civilians to the Worldwide Survey of Health Related Behaviors

•Initiate a recurring annual status report of drug use in the military for the DepSecDef

•Fund part of the expense for sending selected service members returning from combat to their hometown to present an anti-drug message to local youth groups or schools

•Determine if the high-risk group is tested at twice the frequency of the low-risk group and implement changes to accomplish this if not

Current policies continued:

•Continue to emphasize urine drug testing as the most effective component of the DDRP

•Continue the current random testing program but enhance it by ensuring that each organization uses the DTP or similar random selection computer-based program

•Ensure that selection for testing in the random testing program is truly random with no ability of the donor to know or predict a testing time

•Establish a DoD panel composed of the Service managers that will select and implement throughout the DoD the best practices from each Service.

•Test each service member at least once every two years and ensure that the minimum mean testing rate within each Service is once per year

•Collect all samples under direct observation & in a forensically acceptable manner

•Implement bar code labeling of collected samples and needed laboratory automation to enhance specimen integrity and processing efficiency

•Make available web-based reporting of test results

MEASURES OF EFFECTIVENESS:

♣Drug testing positive rate
♣Past 30 day drug use by the high-risk group (males only for more valid comparisons between services) based on a well controlled survey
♣Cost per endstrength
♣Goal 1 programs by analogy, personal assessments of directors and unbiased personnel, independent survey of selected programs

PERFORMANCE STANDARDS

•Fraction of positive results from drug testing will be 10% less than those for the previous year for the high risk group and all members. Each category; active duty, reserve, NG and civilians accounted separately.
•Past 30 day drug use by the high-risk group (males only for more valid comparisons between services) based on a well controlled survey will be 25% less than the statistic on the last triennial survey for each Service
•Cost per endstrength less than $35 for each Service
•Outreach programs by analogy, personal assessments of directors and unbiased personnel, and independent survey of selected programs must be at least as effective as the Corps of Cadets Program in NY.

HISTORY & PAST PERFORMANCE:

The current drug testing program became forensic in 1982 when Deputy Secretary of Defense Carlucci removed a restriction to prosecuting members with a positive urine drug test. The program philosophy was simple. Identifying users by random urine drug testing and punishing them would be an effective drug use deterrence program. The impetus for this action was the high drug use rate by members, the failure of treatment-based drug testing to prevent new use and occurrence of several drug-related incidents, most notably the drug related aircraft accident aboard the USS Nimitz. In that accident 14 sailors were killed, 48 other personnel injured and damage was estimated at $150M. One year before the incident, a DoD Worldwide Survey of Health Related Behaviors had indicated that over 27% of active duty personnel had used an illegal drug in the previous 30 days. Use in the past 30 days became a measure of routine drug use and in 1998, the latest triennial DoD survey, this figure had dropped to 2.7%. Many attributed the largest portion of this reduction to the drug testing program, including Bachman[1] who published survey results over two decades, 1976 to 1995, comparing high school seniors who enlisted in a military service with those going to college or entering the civilian workforce. He concluded, "Recent military drug policies appear to deter illicit drug use among enlistees." The current program maintains the rate of illegal drug use at about one fourth that for age- and sex-matched civilians[2].

The DoD program became the model for civilian programs, the federal program established in 1988 and later private industry programs. DoD remains the model for innovation and vision for several reasons. Reason 1: Drug use by military members is a violation of law while civilian drug use is usually contrary to a personnel policy. The harsher consequences for military personnel elevates the requirements for scientific and chain of custody procedures that are used as evidence. Reason 2: DoD is also a leader as a result of having personnel around the world who live in a variety of drug cultures. DoD tracks and acts on intelligence about these regions and remains the leader in preventing the use of emerging drugs. For example, DoD tracked the use of the club drug Ecstasy beginning in the late 1980's and continued through the 1990's because it was available to our personnel in Europe. Based on this intelligence DoD implemented testing for Ecstasy in 1997, just before its escalated prevalence of use in the United States in 1998. Reason 3: DoD's program is lean and targeted making it easier to make needed changes to policy. One example, three months after a Biochemical Testing Advisory Board recommendation to lower the cutoff concentration for marijuana use in order to detect more users, DoD implemented the policy. Department of Health and Human Services took three years to implement the same change for civilian testing.

Drug education has been a part of the demand reduction program from its beginning. It was the primary means of deterrence prior to drug testing and did not work. History taught us that it needs to be a companion program to drug testing, it needs to be targeted toward selected drugs and behaviors, and needs to incorporate a message from top leadership that is clear and outlines specific punitive consequences of drug use.

In 1990, Congress introduced DoD's contribution to programs to keep America's kids off drugs with a requirement for DoD to direct funds to youth anti-drug programs. In 1996 Congress curtailed funding without comment. DoD maintained some of the programs that were most effective and benefited DoD, such as those sponsored by the National Guard and the Young Marines, a Marine Corps affiliate.

[1]JG Bachman, et al., University of Michigan, *Am J Public Health* 1999, May; 89:672-7
[2]Worldwide Survey of Substance Abuse and Health Related Behaviors among Military Personnel, Research Triangle Institute, Research Triangle Park, 1998

CHALLENGES (In Q&A format):

US Attitude: Q1: The drug use rates are now so low, why don't we declare victory in the war on drugs and stop drug testing? A1: This rationale sounds clever but does not make sense. If the war were won, then drugs would not be available to potential drug users. Drugs are still available and drug use is currently low due to deterrence programs like drug testing. If the deterrence programs are stopped, drug use will increase. The fight to control drug use should not be compared to a war since they are not analogous efforts and have different endpoints. If analogies for drug use are necessary to present a concept then immunizations would be a better analogy. Drugs like tetanus organisms remain in the environment and drug testing like immunization prevents people from using the drugs and suffering from a disease. Even though the incidence of tetanus infections is extremely low, most rational people would not consider eliminating immunizations when organisms are still in the environment.
Q2: Why hasn't DoD justified their level of testing by well-controlled studies showing the resources that should be expended to get the level of deterrence they require? A2: DoD has attempted to design such studies. The problem is that many elements of the program are subjective, for example, the acceptable level of drug use in the force. Some really bright people contracted to look at this problem in the early 1990's concluded that it was no better to design and complete studies with subjective endpoints than to subjectively establish the level of testing, type of testing and consequences.

Legal: Q1: Drug testing is a violation of privacy and was originally justified based on overriding safety and security concerns resulting from prevalent use. With the low prevalence of use, is it still justified? A1: All indicators are that if we stop testing, drug use will increase. On this basis it is still justified.
Q2: Members in different services routinely suffer differing consequences based solely on their Service, not the safety and security concerns of their duties. Should the military courts consider this issue before sentencing those court-martialed for drug use? A: Justice Sullivan considered this argument in the Court of Appeals of the Armed Forces decision regarding US v Green and commented that unequal treatment by the judicial process was a concern. He did not comment on unequal treatment by non-judicial processes. In the final analysis, Green's conviction was upheld and Sullivan concurred. Even though we have no court precedent pressing the issue of fairness between commands, DoD is addressing the issue and is trying to force more consistency in punishments across the Services.

Commercial Lobbies: Q1: Since drug testing is not a mainstream mission of the military, why don't we save resources by contracting the program? A1: Reason 1: Commercial drug lab testing is more expensive. (See OMB A76 decision, 1998). Collections are much more expensive, $10.5/collection for military worldwide vs $43/collection for

CONUS civilians. Also, most civilian collection agencies are unwilling to submit bids for collecting in all overseas areas. Reason 2: Customers, i.e. commanders and JAG officers, prefer interacting with military personnel who understand their system and present military bearing in judicial proceedings. Reason 3: Commanders can more easily control and direct an in-house program.
Q2: Why don't we save money by field screening with commercial non-instrumented devices and sending only the positive samples to the laboratories? A2: It does not save money. The Army used to do business this way. In one of their 1989 studies they showed that advocates of field screening overlooked the costs of training operators, maintaining a QA system, independent inspections of multiple sites to ensure compliance to standards, and required management of forensic records. The study also showed that the system was subject to abuse by local commanders. On site testing had more false positive and false negative reports primarily due to operator error. Commanders were frustrated by added complications from field testing when taking action against soldiers with positive test results. Turnaround times were longer with field screening in place and cases were lost in court when screening personnel were successfully challenged by defense attorneys who attacked their credentials and knowledge of proper procedures for maintaining chain of custody.
Q3: Direct observation of urine collections is humiliating for the donor. Why doesn't DoD follow civilian practices of private collections? A3: Experience within DoD and the civilian sector showed that donors who are drug users will attempt to substitute or adulterate their urine specimens if not observed during collection. A study by Quest Diagnostics Drug Testing Laboratories showed that 3.5 % of positive urine specimens collected without observation from across the United States were diluted or had evidence of adulteration compared to <0.2 % of negative specimens. The Department of Health & Human Services is currently designing standards for specimen validity testing, i.e. conducting a battery of tests on each sample to determine if it was diluted or adulterated. They are proposing lengthy guidelines that mandate this testing be implemented because of the high incidence of adulterated and substituted specimens from unobserved collections in the federal civilian program. Specimen validity testing seems to be necessary in programs using unobserved collections but is fraught with problems. There have been successful and expensive law suits challenging specimen validity testing within the civilian program. Specimen validity testing adds extra expense due to additional testing costs. There is no current battery of tests for determining a valid specimen that meets the same forensic standards as drug testing.

Alternative Specimen Lobbies: Q1: Why doesn't the military use hair testing? Detection times are longer, collection problems with urine could be avoided, and hair could be collected less often saving training time. A1: Currently, hair testing does not meet DoD's forensic standards. Reason 1: Hair testing is subject to hair color bias, e.g. dark hair cocaine users concentrate much more drug in their hair than blond hair users. This bias is unacceptable in a random, no-probable-cause testing system. Reason 2: Hair can be contaminated with drugs, e.g. individuals who did not use cocaine and conducted normal activities in a room where cocaine was previously used had positive hair tests. Reason 3: The most difficult drug to detect in hair is marijuana, the most prevalent drug of abuse by service members. (Marijuana currently accounts for 70% of all drug positive results).

DoD's Biochemical Testing Advisory Board, a scientific panel reporting to the DASD CN, continuously reviews alternative specimens and methods for detecting drug abuse. They recommend changes when the new methods meet forensic standards and are helpful. Many who might argue that this Board is resistant to change and is overlooking the advantages of hair testing do not know that original investigations to see if hair testing was a viable alternative to urine testing were initiated by this Board in the 1980's and paid for by the Navy.
Q2: What about saliva or blood testing? A2: The detection times are too short, hours vs days for urine.

Out of the Mainstream: Q1. Is it true that top Defense leaders have inadvertently implemented changes deleterious to the DDRP because it is not in the mainstream of defense missions? A1. Yes. One example was the transfer of DDRP from OASD Health Affairs to OASD SOLIC/Drug Enforcement Policy and Support, initially without a transfer of money and no clear directives for the new organization because the DDRP was invisible in an overall reorganization process. A second example was a consideration in the Defense Reform Initiative of 1996 to contract all military drug testing. Drug testing was included in a list of DoD activities to be outsourced without serious input from program staff officers despite the existing program's well-known success. A memo to outsource was being prepared and was reversed following an impromptu 20-minute briefing to DepSecDef. (The original effort to outsource drug testing attracted commercial interest. When the original plan was reversed, commercial lobbies forced DoD to conduct an OMB A76 study that took two years. The study, completed in 1998 after an OMB arbitration decision and federal court decision, came to the conclusion that in house testing was much less expensive. On this basis alone, all testing was brought into the military laboratories to include that conducted in commercial laboratories at the time.) Had the outsourcing decision been promulgated by DepSecDef as originally planned, the DDRP would have been contracted without review. Once contracted, by law, the program would have been constrained to remain commercial unless DoD could prove a 10% cost savings, including expensive startup costs, by bringing the program back in house. Mission requirements would no longer be an acceptable justification. Q2. How can the program continue to be lean and mean but avoid being forgotten in future planning? A2. Marketing the continued effectiveness of the program to top leaders must itself be part of the routine program. In addition to keeping the program visible, routinely presenting information about drug use by military and civilian personnel to senior leaders will keep them informed of the readiness of the fighting force.

PROBLEM LIST (order of priority):

1. *Consequences*--Users are not discharged expeditiously and early in their careers to save training costs. Consequences are not uniform across the Services and are not clearly understood by service members. Army is expected to fight implementation of recruit testing and may fight mandatory discharge policy. Air Force may feel that a mandatory discharge policy encourages administrative discharge in lieu of courts-martial.

2. *Randomness*--Testing is not random in many units. A random testing system is in place but it needs to be pushed and improved.

3. *LSD testing*—The current confirmation test for LSD is the weakest of the 7 drug panel. It is difficult to maintain, has only a one-day detection time and measures the parent drug, which is acceptable but not preferred. The new test, developed by the Navy, overcomes these weaknesses. Its weakness is that it is new using a newly discovered metabolite (discovered by Navy scientists) and a technology that has been in practice for over ten years but not used in drug testing court cases. Air Force JAG stated that they would concur with the policy if someone got a consensus of nationally reputed scientists to say it is forensically acceptable and if DoD contracted an independent civilian lab that could conduct tests for defendants if requested.

4. *Certified collectors*--Collection of urine is the weakest link in the forensic chain. Collectors are in general the least trained and least controlled of individuals in the forensic process. Most instances of dropped charges or acquittals are due to problems with collection. The Services may fight a DoD standard claiming interference but may support it as a mechanism to improve their own standards for collectors. Note. DOT already has a central certification requirement for collectors of DOT civilian employees' samples and HHS is considering extending this to all government civilian employee collections.

5. *Army priorities*--Chief of Staff of the Army has not placed his position on drug use in the list of top command priorities. This will probably be an easy fix. We believe that DCSPER Army would fully support getting drug use in the top priorities after FY01 statistics are released showing that only Army had an increase from FY00 to FY01 in drug positive personnel.

6. *Measures for effective education*--There are no standard measures of effectiveness for adult anti-drug education. Need some creative ideas from the Service representatives. May be a good topic for the DoD panel that promotes best practices.

7. *Recruitment*—The Counternarcotics Office has usually interacted with Military Personnel Policy (recruitment) by being on the opposite side of issues. Supporting recruitment of drug-free applicants may be a good same side issue.

8. *Tri-service laboratories*—Currently, nearly all samples tested by Service laboratories are from their own Service. Air Force position is that Navy & possibly Army laboratory standards are not good enough for their litigious system. Service managers are negotiating a tri-service laboratory SOP. When finalized and signed by the Surgeon's General of each Service, there will be no reason that the laboratories cannot test regional samples from any Service. One immediate consequence will be that the Air Force laboratory can receive more samples thus reducing their cost per test. A long-term consequence may be that DoD can consolidate testing into fewer laboratories and save money.

STAKEHOLDERS

Every service member and DoD civilian is a stakeholder in this program. This program requires that they not use prohibited drugs. It requires them to donate urine specimens for testing without probable cause. If it is not effective, the dangerous nature of their duties put them at risk of being killed or injured by a co-worker who is impaired by drug use.
The following functional list highlights the top stakeholders.

Commanders—drug demand reduction is a commander's program
Counternarcotics personnel—they are tasked to accomplish the counter-drug mission
Attorneys—drug use is against the law and users may be prosecuted
The American people—failures of the US fighting force jeopardize their freedom
Civilian drug testing industry—DoD has led the way to civilian programs
Commercial drug testing industry—DoD procures products that add to their growth
Government Counter-drug Organizations (ONDCP, NIDA, DEA, etc.)—DoD has been a leader in drug testing R&D and in implementing effective programs. These organizations ask us to continue this leadership.
Forensic community—DoD's quality assurance principles in drug testing established the basis for forensic requirements in other forensic laboratory testing in federal, then state courts. The forensic community continues to look to DoD for new requirements and are not always pleased when new, higher standards are established in our courts.