Need for Urine Drug Testing

We are very concerned to learn about the proposed elimination of all mandatory urine testing, with the exception of the initial drug screening urinalysis. This proposal holds the potential for both counterproduction and retrogression against the worthy goals of addict rehabilitation. The proposal has been made apparently on the following grounds: (*a*) mandated weekly urine testing on all patients is a waste of time, and the money saved could be utilized more effectively by hiring additional counseling staff or meeting other program needs; (*b*) controlled blind proficiency testing has shown that a percentage of reported results are inaccurate, raising questions about the validity of urine testing; (*c*) some clinics make only minimum use of urine test results because of the questionable validity factor; and (*d*) delays between urine collection and the receipt of urinalysis reports are sometimes excessive.

The advantages of mandatory urine testing are many:

1. A continuity of observation is established on a uniform basis.
2. As differentiated from "soft subjective" indicators, urinalysis is a solid, objective measure of the progress of clients.
3. It is an extremely useful tool for client confrontation in clinical management and is vital in penetrating the veil of self-deception developed by addicts.
4. It exposes the real behavior of a client and thus generates an honest basis between the client and the clinician[1,2].
5. It is a valuable psychological aid and deterrent, both in breaking the individual's drug-using habit and in keeping the client away from harmful street drugs of unknown identity.
6. In certain legal situations, it may well prove beneficial to the client's situation.
7. It can provide a sound basis for rational statistical determinations concerning individual treatment plans or the performance of modalities and/or programs.
8. It can be of *sine qua non* value in the therapeutic community or residential setting where weekend passes, peer level changes, responsibility assignment, and job readiness decisions must be made.
9. It has indispensible deterrent value in avoiding methadone diversion.
10. It provides visibility regarding epidemiological potential of illicit drugs of different types "sold on the street."

The relative cost of mandatory urine testing is not excessive. Urinalysis costs have been estimated at about 12 million of the 262 million total (about 5%). The view that a reduction in costs of urinalysis will permit the expenditure of those funds to increase the counseling staff is a defective argument. A counselor prepared with urinalysis data is in a position to be more efficient in his or her approach; conversely, a counselor not so prepared can be expected to be less efficient because of the time-consuming and less reliable techniques he or she must employ to determine what the client is really doing. It would seem paradoxical, at the minimum, to increase staff level and at the same time to take a course of action that would make every counselor less efficient. We believe that the abandonment of mandatory urinalysis for the purpose of increasing social services to the clients will open a pandora's box where performance cannot be rationally measured. A fear that programs will deteriorate to mere amusement centers appears reasonable.

Urinalysis credibility, if that is an issue, can be increased by providing guidance to laboratories in the establishment of effective quality control systems and the semiautomatic revalidation of challenged results. The U.S. Center for Disease Control ought to increase its minimum sensitivity requirements. It is not practical to abandon mandatory urinalysis because certain laboratories do not provide consistent, high quality results. Physicians faced with an analogous diagnostic situation can be expected to request test(s) while recognizing the inherent probability of a controllable level of error. There are so many options open to a well-trained counselor when error is suspected, including even recollection of specimens, that abandonment of the visibility provided by mandatory urinalysis cannot be justified on this ground.

The delay factor between urine collection and the reports of urinalysis is another argument offered by urine testing antagonists. However, an emergency treatment situation, as in the case of a hospitalized patient, is not analogous to the long-term methadone treatment situation. This argument, therefore, is also invalid.

Regarding the argument that the current mandatory urine testing does not give any choice to the clinician and/or the program or medical director according to the needs of their clients, we propose several "sets" of tests of alleged drugs of abuse. The clinician and /or program or medical director can select one set according to the individual needs of clients and also according to the drug abuse pattern of the geographical location of the treatment unit.

The proposed sets are:

A. Morphine, codeine, heroin adulterant optional, drugs used in treatment such as methadone and LAAM, amphetamines including methamphetamine (Desoxyn and Methedrine), phenmetrazine (Preludin), barbiturates, and propoxyphene (Darvon).

B. Morphine, codeine, heroin adulterant optional, and drugs used in treatment such as methadone and LAAM.

C. Amphetamines including methamphetamine (Desoxyn and Methedrine), phenmetrazine (Preludin), barbiturates, and drugs used in treatment such as methadone and LAAM.

D. Cocaine as its metabolite benzoylecgonine.

E. Benzodiazepine-type drugs of high abuse potential such as diazepam (Valium), oxazepam (Serax), and chlordiazepoxide (Librium).

F. Pentazocine (Talwin), antihistaminic-type drugs such as tripelennamine (Pyribenzamine), and phenothiazine-type tranquilizers.

G. Requests for special testing of drugs not listed above having a recognized abuse potential and a feasible qualitative and specific test. These drugs might include sedative–hypnotics like meprobamate (Miltown and Equanil) and ethchlorvynol (Placidyl), opiates such as hydromorphone (Dilaudid) and hydrocodone, hallucinogenic drugs such as phencyclidine (PCP), and antidepressants such as doxepin (Sinequan).

The following mandatory urine testing is viewed as minimally acceptable:

1. Provision for continued weekly analysis for any new or readmitted client and for those clients who have failed to have a clean urinalysis for a consecutive 3 months, with the clinician's choice of one of the above sets of tests according to the individual need of the client.
2. Provision for continued weekly analysis for parolees and other clients subject to the Criminal Justice System.
3. Provision for monthly urinalysis for all clients who were not tested on the weekly schedule.

In conclusion, we believe it is fair to observe that *all* aspects of drug abuse treatment at all levels need improvement. Scrapping of mandatory urinalysis cannot be justified for any of the grounds set forth in the first paragraph. In the lofty name of providing flexibility to the clinician, the proposed regulation sets up a clearly predictable abandonment of minimum urinalysis by insincere programs. Sincere programs surrounded by programs that abandon even minimum urinalysis will experience major difficulties in staff morale and retention because of the predictable attitude that they are being unfairly burdened with an unnecessary task.

The net result of the proposed elimination of mandatory urine testing will be a deterioration in methadone program effectiveness.

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[1] E. C. Senay and P. F. Renault, *J. Psychedelic Drugs*, **3**, 47 (1971).
[2] K. K. Kaistha, *J. Chromatogr.*, **141** (2) (1977); *Chromatogr. Rev.*, **21** (2), 145 (1977).