OPERATIONAL ELEMENT

TASC Critical Element Number 12:

“Policies, procedures and protocols for monitoring TASC clients’ alcohol and drug use through chemical testing.”
DRUG TESTING

Drug testing is key component in the treatment of substance abuse.

Unfortunately, many treatment agency drug testing programs and policies are formulated around the fact that drug testing is a financial burden on the organization.

PROPAGATING THE PROBLEM

Too often, well-meaning treatment agencies try to formulate a drug testing policies based on what they find in interagency contracts, bids and grants, what’s read on the Internet, heard from colleagues, sales pitches from testing kit companies, aggressively marketed laboratories, or simply from “what has been passed down through the ages”.

TEST SMARTER!

Many agencies adopt methods and techniques in their testing program that are not based on EBP, incurring an expense that could be better utilized with an increased effectiveness.

DISCUSSION OUTLINE

• Methodologies
• Laboratory Qualifications
• Prescriptions
• Zero Tolerance
• Interpreting Levels
• Marijuana Testing
METHODOLOGIES
Consider your options

PICK THE RIGHT MEDIA

• Hair Follicle Testing
  ▪ Good baseline, but expensive
  ▪ Not practical for monitoring sobriety

• Oral Fluid Testing
  ▪ Handy for field collections or lack of same gender urine collector
  ▪ Shorter detection than urine, ineffectual for THC

• Urine Testing
  ▪ Overall, best media for drug testing, but…
  ▪ Only as good at the sample collection!
VISUALLY OBSERVED COLLECTIONS

- A Monitored Collection and Direct Visual Observation may mean different things to the collector/clinic.
  - MUST see urine being voided into the collection container
  - Standing behind in a bathroom stall is not sufficient

- Commercial or homemade devices
  - Can deliver urine within 90-100 °F
  - Can fool a collector whose “heart isn’t in it”

Not using visually observed collections? Don’t bother!

INSTANT / POINT OF CARE KITS

- Wide variety of devices available
- Relatively inexpensive
- Qualitative results in minutes
- Varying degrees of accuracy
- May lack specificity of lab-based drug screens
- Only a tool
A WORD OF CAUTION RE: POC KITS

- Follow the instructions carefully
  - Timing may mean the difference from POS and NEG results
- POC test interpretation is subjective
  - Don’t read too much into the interpretation
  - Don’t fall for the “almost positive” bait
  - Automated readers are helpful
- Watch for expired kits
- Carefully review the package inserts
  - Consult with your confirmation laboratory for expectations

BEWARE OF CROSS-REACTIVITY

No screening test is perfect – some are just better than others

In general, there is no way to determine what specific drug is causing the positive drug screen without a confirmation test.
WHAT’S THE FREQUENCY?

Frequency of testing should rely primarily on the clients risk assessment

- Low-Medium Risk
  - 1-3x/month, random days
- Medium-High/High Risk
  - 5-6x/month, random days
  - 3x/month, random days if budget is a problem
  - Best case: 2x/week, random days

KEEP IT RANDOM

Random testing is ideal and an EBP

Avoid telling clients they will test “X” times/month. As soon as they reach that milestone, they have a time frame to cheat.

Throw the client a few curveballs to keep them honest – add an additional test day to their regimen on occasion.
MAKE THE CALL

Consider a random drug testing service that has a client call-in component to encourage sobriety daily

- Interactive Voice Response (IVR)
  - Record of user compliance
- Colors/Animals Program
  - Pre-determined schedule
- Alphabetical
  - Pre-determined schedule by last name

TODAY’S MY DAY

Avoid Day-of-Week testing programs

Specific days of the week allows the client to curtail their substance abuse around the schedule. An exception would be scheduled testing 3x/week (e.g. MWF) with very little time between tests.

Remember:
Your clients probably know more than you about drug testing than you!
DO YOUR RESEARCH

• Demonstrated experience in the field
• Verify Accreditation/Certification
  ▪ SAHMSA
  ▪ CAP-FDT / ASCLD-LAB
  ▪ CLIA
• Accreditation is not the same as participating in a Proficiency Testing program

GET IT IN WRITING

• When negotiating your Lab Contract, be sure to include:
  ▪ Clearly defined performance standards
  ▪ Use industry established cutoff levels
  ▪ Immediate notification in the event of loss or suspension of accreditation
  ▪ Provisions for training and education opportunities to your staff
  ▪ Requirements for Monthly/Quarterly/Annual Statistics
  ▪ Ability to tour the laboratory facility and process
  ▪ Assure availability of trained staff to provide expert testimony
PRESCRIPTION DRUGS OF ABUSE

- Opioids
  - Morphine/Codeine/Oxycodone/Hydrocodone
- CNS Depressants
  - Benzodiazepines (Valium/Xanax/Halcion/ProSom)
  - Non-Benzos (Ambien/Sonata/Lunesta)
  - Barbiturates (Luminal/Nembutal/Mebaral)
- Stimulants
  - Adderall/Dexedrine
  - Methylphenidate (Ritalin/Concerta)
KNOW YOUR OPIATE SCREENING TESTS

- Opiate Class
  - Morphine/Codeine/Hydrocodone/Hydromorphone

- Oxycodone Specific
  - Oxycodone

- Heroin Specific
  - 6-MAM (Heroin)
  - Morphine

CONSULT YOUR LABORATORY

While non-Benzo CNS depressants (Ambien, Lunesta) act on many of the same receptors as benzodiazepines, they do not test positive under a Benzodiazepine screen.

Likewise, Methylphenidate (Ritalin) does not test positive under an Amphetamine screen

Consult your laboratory as to how to test for prescription drugs
WHAT YOU MAY BE MISSING

- Is the client hiding other drug usage?
  - Adderall vs. Methamphetamine
  - Decongestants vs. Amphetamines
  - Prescription Opiates vs. Heroin

- Client has changed his drug of choice altogether?

- Is the client doctor shopping/augmenting treatment?

TRUST BUT VERIFY

- Do NOT ignore positive tests even when the client has a Rx

- Confirm for identification whenever possible
  - Best case: Confirm all positives
  - Otherwise: Order a GCMS or LCMS confirm at least once per month
ZERO TOLERANCE

Well, not exactly…

THERE IS NO ZERO

- No such thing as Zero Tolerance drug testing
  - Cannot test for drugs at a “0” concentration
  - All tests have a Limit of Detection (LOD)
  - Negative means not present at or above the cutoff *only*
- Testing at levels below established cutoffs (to LOD) is discouraged
  - Doesn’t gain you much more effectiveness
  - May challenge well-established legal precedent
  - Hard for lab to defend in court
THERE IS NO ZERO

- Don’t second-guess negative tests, and...
- Don’t withhold positive reinforcement!

INTERPRETING LEVELS

Don’t go there!
WHY ARE YOU ASKING?

Are you looking at levels because you are asking yourself:

- *Is he in dosage compliance for the medication?*
- *Approximately what day did he use?*
- *Is it a little cocaine or a lot?*
- *Is this a relapse?*
- *Are his levels going down?*

RESIST THE TEMPTATION!

You should consider test results to be one of two outcomes:

*Positive or Negative  (Present or Absent)*

Interpretations beyond a Qualitative “yes or no” is unnecessary and have an increased potential for error.
SCREENING LIMITATIONS

Screening test levels are of little use for monitoring levels:

- Different drugs/metabolites are not equally reactive within the assay
- Multiple metabolites are typically present in urine and drug metabolism may differ from client to client
- The screen will only have a limited concentration range that can be determined to be accurate
- Assay reactivity and drug concentration is not a linear relationship

IN SUMMARY

Drug and drug metabolite levels in urine can vary significantly from one person to the next depending on the client’s, age, gender, ethnicity, metabolism, diet, hydration/dehydration, overall health, medications, etc...

In many variables above, the same holds true for the same client from one day to the next.

In short, there is no cookie-cutter answer, magic formula or calculation to give you the answer you desire.
THC MONITORING

Monitoring “THC Levels” should be discouraged whenever possible.

- Could be delaying therapeutic intervention
- Hindering timely sanctions

Too much variability of the disposition of drugs in urine to consider it an exact or reproducible science.
THC CLEARANCE

THC Clearance Data

- Chronic User
- Casual User
- EIA Cutoff
- GCMS Cutoff

Days Since Abstention

THC Concentration (ng/mL)

THC CLEARANCE

THC Clearance - Uncontrolled Population

Number of Clients

Days until Clean

D. Kramer; TASC (2009)
IF YOU MUST... DO IT RIGHT

• THC: Creatinine Ratios required - CONFIRMED samples only

• Normal Clearance:
  ▪ Decrease of 50% every 1-10 days (3.0 ± 2.3 day mean) \(^{(1)}\)

• Abnormal Clearance:
  ▪ Increase of 50% over 24 hours apart (5.6% pos error) \(^{(2)}\)

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TO SUMMARIZE

• Should test clean by 21 days (worst case)

• Look for two consecutive negative samples

• Option to provide a cleanup period if usage self reported

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