BSAS

PRACTICE GUIDANCE: DRUG SCREENING AS A TREATMENT TOOL

Prevent • Treat • Recover • For Life

I. RATIONALE:

BSAS' intention[1] in issuing Practice Guidance is to disseminate information about emerging best practices, and to stimulate examination of existing practices, in order to improve prevention and treatment of substance use disorders and promote life long recovery. This Practice Guidance explores use of drug screening in substance abuse treatment, with particular attention to evidence of effectiveness and to tailoring care to the needs of the individual. These two principles inform the decision to use drug screening: first, the decision is guided by treatment effectiveness. Second, the decision is guided by individual's treatment need based on history, current condition, medications, and observed behavior. These factors are clearly demonstrated in acute care (detoxification) where drug screens provide information essential to document substance use and guide safe treatment. Similarly, in medication assisted treatment drug screens are essential for treatment planning, monitoring dosage and interactions, and for diversion control.

This Practice Guidance focuses primarily on beliefs and practices related to drug screening in other levels of care, such as outpatient counseling and residential rehabilitation, where screens are often used to determine whether the individual in treatment has used alcohol or drugs. This practice is largely based on the belief that individuals will under-report their substance use, a belief derived from the findings of survey and epidemiological research. In fact, in general population studies, individuals do tend to under-report use.[2] However, research strongly suggests that under-reporting is substantially less prevalent in treatment settings, where there is a high correlation between self-report and drug screen results[3]. Further, the accuracy of drug screens can be undermined in several ways. For example, some drugs, such as cannabis and benzodiazepines, excrete over long periods of time, potentially producing positive results when there has been no drug use.[i] When drug screens are used to monitor abstinence compliance, positive findings often trigger negative consequences. In those circumstances motivation to adulterate or dilute specimens is great; and no one method of preventing adulteration – including observation – is a guarantee of specimen purity.[ii] Nor is it possible to reliably synchronize drug screens with an individual's actual drug use and no protocol that is limited by agency schedules can be truly random.[iii] These findings undermine assumptions about the necessity and effectiveness of drug screening as a treatment tool.

Some may also believe that the implied risk of discovery through drug screens may prevent relapse, especially when consequences of a positive screen are severe. However, we already know that more than half of individuals in treatment are likely to use substances

[1] Strategic Plan: Principles of Care and Practice Guidance.

[2] National Institute on Drug Abuse Research Monograph, no. 167. The validity of self-reported drug use: improving the accuracy of survey estimates. R.J. Williams and N. Nowatzki. (2005) Validity of adolescent self-report of substance use. *Substance Use & Misuse, 40:299-311*

[3] Ibid. and TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, Rockville (MD): Substance Abuse and Mental Health Services Administration (US), 2005. http://www.ncbi.nlm.nih.gov/books/NBK64164/

while in treatment or shortly thereafter,[4] and that most people need at least three months in treatment to achieve abstinence.[5] Drug screens do not add to our knowledge or understanding. And given what we know about the course of recovery, a positive drug screen result alone cannot justify adverse consequences, including discharge. BSAS has issued a Practice Guidance on Responding to Relapse that describes effective responses to relapse.

When individuals are engaged in treatment relationships, trust and shared goals promote disclosure. In contrast, individualized treatment and treatment relationships are undermined when drug screens are conducted on the basis of program policy. This is especially true if positive screen results are the sole, or primary, basis for a treatment re-assessment or decision. A re-assessment of treatment, in addition to occurring at regular intervals, should be triggered by observed changes – or lack of changes -- in the individual.[6] Staff need to be particularly alert in observing individuals who are taking prescribed medications that may affect well-being, mood or behavior. These observations are based on knowledge of the individual arising from engagement in a relationship that supports treatment and recovery. The relationship is the primary tool and a conversation with the individual should precede consideration of drug screening. If a solid treatment relationship is in place, drug screen results would simply confirm what the individual and the treatment provider have already acknowledged in their conversations.

If a drug screen is indicated, for example as part of a contingency management plan, a conversation among the individual, the treatment provider and the individual's healthcare provider can establish whether the screen is medically necessary, and ensure proper authorization for the test. Most insurers require authorization by a healthcare provider who is treating the individual.[7]

Given the evidence and the importance of individual need as the guide for treatment, drug screening is rarely warranted outside of acute care and medication assisted treatment.

II. GUIDANCE:

A. Organization:

Policy:

- Agency policy, including Client Policy Manual:
  - Describes purpose of drug screening as adjunct to individualized assessment and treatment planning.

---

[4] National Institute on Drug Abuse, (Website updated 2010) *Drugs, Brain, Behavior: The Science of Addiction*
[5] National Institute on Drug Abuse, *Seeking Drug Abuse Treatment: Know What to Ask*. NIH publication 12-7764.
[6] TAP 32: Clinical Drug Testing in Primary Care, Rockville (MD): Substance Abuse and Mental Health Services Administration (US) 2012
http://store.samhsa.gov/product/TAP-32-Clinical-Drug-Testing-in-Primary-Care/SMA12-4668
[7] See Division of Medical Assistance regulations regarding Independent Clinical Laboratories, 130 CMR 401.000, as an example.

- Requires that drug screening be used only for purposes described in individual treatment plans.
- Prohibits categorical use of drug screens, for example, for all non-acute or non-medication assisted treatment admissions, following all overnight or weekend passes.
- States that a positive drug screen may not be the sole basis for any treatment decision, but must be considered in the context of the individual's strengths and needs in relation to treatment, abstinence and recovery.
- Describes application of 42 CFR Part 2 and HIPAA to drug screen process and results, i.e. individual's consent specifies both collection and analysis of specimens and reporting of results to the treatment provider.
- Requires that when an outside entity (e.g. licensed laboratory) carries out specimen collection, as well as analysis and reporting, the entity is required to comply with agency policy regarding collection, reporting and third-party payment, as specified in a Qualified Service Organization Agreement.
- Prohibits use of over-the-counter or web-ordered screen kits by staff.

Operations:

- Agency ensures that analysis of specimens is carried out by licensed facilities that comply with all applicable federal and state licensure and certification requirements.
- Procedures for drug screening specify:
    - Circumstances that might prompt consideration of a drug screen, such as individual's history, current medications, status in treatment and/or behavioral indicators or concerns regarding medication dosage or interactions. Observed behavior changes may include changes in:
        - hygiene and appearance,
        - daily functioning,
        - interactions,
        - consistency in treatment participation and other obligations, and
        - mood.
    - Required discussion with the individual about whether a drug screen is the most effective way to address concerns, or whether other approaches would better support the individual's treatment needs.
    - Required communication with the program medical director or with individual's healthcare provider so that the healthcare provider can determine whether the screen is medically indicated and can be properly ordered.
    - Required supervisory approval of drug screen, in programs without medical staff.
    - Methods for collection of specimens in ways that reduce possibilities for adulteration or dilution, and eliminate need for observation, for example:
        - temperature strips,

        - minimum specimen volume, and
        - turning off running water.
    - Methods for collection of specimens in ways that preserve dignity of individuals, including accommodations in specimen collection, e.g. for persons with disabilities, or collecting in ways that are sensitive to trauma.
    - Process for discussing results with individuals.
    - Prohibit use of 'dirty' or similar terms to describe screen results.
    - Prohibit the treatment provider from requiring individuals to pay for drug screening, with the exception of those enrolled in First Offender Driving Under the Influence Programs.
- Coordination with other entities, such as state agencies, courts or correctional facilities, includes:
    - Clarifying specific 42 CFR Part 2 consent requirements, regarding collection, analysis and release of drug screen results;
    - Educating these partners about the limitations of drug screens in substance abuse treatment;
    - Establishing mechanism to promote collaboration with other entities in supporting recovery goals (for example, child safety or completion of parole); and
    - Clarifying provisions for proper authorization of and payment for drug screens.
- Procedures for responding to positive drug screens include:
    - Review of results with individual,
    - Review of treatment plan, with emphasis on developing treatment options that avoid termination,
    - Team discussion to assess efficacy of treatment.
- Agency periodically seeks feedback from individuals in treatment about their experiences related to drug screening.

Supervision, Training and Staff Development:

- Staff training sessions periodically review:
    - Uses and limits of urine drug screening
    - Appropriate methods of collection, including alternative modes of screening, e.g. for individuals with for whom providing a urine sample would be difficult
    - Appropriate responses to results.

B. Service Delivery and Treatment:

Admission:

- Drug screening policy and procedures are described to applicants at admission.

Treatment Planning:

- Treatment planning includes discussion of ways drug screening might be used to support the individual's treatment, for example when screening might be used as part of a contingency management plan at the individual's request.

Coordination of Care:

- When urine drug screening is a component of the individual's service plan with another entity (e.g. a state agency, court or criminal justice facility), coordination includes:
  - Clarifying distinctions between that entity's service plan and the individuals substance abuse treatment plan; and that the substance abuse treatment provider is not responsible for obtaining drug screens on behalf of criminal justice agencies;
  - A plan for coordination and collaboration with other entities, including responsibilities for specific services, referrals or actions, and plan for team meetings;
  - Defining responsibility for obtaining proper authorization for the drug screen;
  - Defining responsibility for and method of payment for the drug screen; and
  - Defining the method and scope of disclosures of results, with specific reference to requirements of 42 CFR Part 2 consent requirements.

Response to Positive Drug Screen:

- A positive drug screen is discussed with individual.
- A drug screen that is positive for alcohol or illicit drugs triggers assessment of treatment plan and efficacy of treatment.

III. MEASURES:

- Staff and consumer surveys and focus groups.
- Tracking number of requests for urine drug screening.

IV. RESOURCES:

BSAS Resources:

BSAS Principles of Care and Practice Guidance
Responding to Relapse
Partnerships with DCF
Available at:

http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html

TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, Rockville (MD): Substance Abuse and Mental Health Services Administration (US), 2005. http://www.ncbi.nlm.nih.gov/books/NBK64164/. See Chapter 9 for a thorough review of various drug screens, and their applications and limitations; and for guidance on proper procedures for collecting specimens.

Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs In-Service Training
http://buprenorphine.samhsa.gov/tip43_curriculum.pdf

Principles of Drug Addiction Treatment: A Research-Based Guide (Second Edition)
http://www.drugabuse.gov/publications/principles-drug-addiction-treatment

TAP 32: Clinical Drug Testing in Primary Care, Rockville (MD): Substance Abuse and Mental Health Services Administration (US) 2012. This TAP contains detailed discussion and guidance on proper uses of drug test. Available at:
http://store.samhsa.gov/product/TAP-32-Clinical-Drug-Testing-in-Primary-Care/SMA12-4668.

Olaf H. Drummer, Drug Testing in Oral Fluid, Clin Biochem Rev. 2006 August; 27(3): 147–159.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1579288/

Resources related to consents:

Legal Action Committee: Sample Forms: Contains sample consent forms regarding child welfare and criminal justice among others, including reference to both 42 CFR and HIPAA. Also includes a sample Notice Prohibiting Redisclosure.

BSAS welcomes comments and suggestions. Contact: BSAS.Feedback@state.ma.us

---

[i] National Institute on Drug Abuse Research Monograph 73, *Urine drug testing for drugs of abuse.*

[ii] Jafee, W.B., et al (2007) Is this urine really negative? A systematic review of tampering methods in urine drug screening and testing. *Journal of Substance Abuse Treatment*, 33:33-42.

Moran, J., et al. (1995) Program monitoring for clinical practice: specimen positivity across urine collection methods. *Journal of Substance Abuse Treatment.* 12(3): 223-22.

Center for Substance Abuse Treatment (2005) TIP 43: Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[iii] Parinno, M.W. (2003) A commentary on 'Urine testing in methadone maintenance treatment: applications and limitations'. And DuPont, R.L. (2003) A commentary on 'Urine testing in methadone maintenance treatment: applications and limitations' Thinking outside the cup. Both in *Journal of Substance Abuse Treatment*. 25:67 – 68 and 71-73.