Remaking behavioral healthcare

How five challenges of healthcare reform will shape our future

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New Jersey's HMIS called "a model"

SPECIAL SECTION: DRUG TESTING SOLUTIONS
A two-pronged approach

Effective drug testing strategies deter abuse in the workplace yet support those in recovery

BY ALISON KNOPF

Drug and alcohol testing, commonly used in the workplace as a hiring and firing tool, is used in substance abuse treatment settings for a very different reason: helping patients recover. In substance abuse treatment programs, testing is used for two purposes: to establish a baseline level for any recent substance use by the patient and to monitor patients who are involved in ongoing substance abuse treatment. In neither case is the purpose to "catch" someone abusing drugs or alcohol, because the patient has already asked for help.

There are strict federal regulations for the use of drug testing in the workplace, but no rules—within the narrow exception of methadone and buprenorphine treatment—for the use of substance abuse treatment programs, says Robert Lubran, director of the division of pharmacologic therapies at the Federal Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA). "Programs are pretty much on their own when it comes to deciding what kinds of tests to use, and what to test for," he tells Behavioral Healthcare.

But urine is definitely the kind of specimen that is preferred—in part because of the scientific rigor labs have developed as a result of the federal workplace testing program—considering it passed the muster of the U.S. Supreme Court.

Urine testing update

The "classic five" drugs that are tested for in the workplace via urine testing are heroin, cocaine, PCP, methamphetamine, and cannabinoids (marijuana and hashish), says Robert L. Stephenson II, director of the division of workplace programs at the Center for Substance Abuse Prevention, also part of SAMHSA.

"When we created the workplace program 22 years ago, we made a deliberate decision not to test for prescription medications so that we did not get between a patient and a physician," says Stephenson. "Today, the situation is somewhat different. Given the increasing abuse of prescription medications, drug testing programs cannot be limited to "illegal" drugs. Legal opioids—fentanyl, oxycodone, methadone, codeine, and morphine, for example—are increasingly popular as drugs of abuse, instead of in addition to illegal opioids like heroin. Stephenson points out that if a substance abuse program utilizes labservices, the program must clearly explain that the testing for its testing is a treatment center, not a workplace.

There are two basic kinds of urine tests: the screen (done either on site or in a lab), which are given a "negative or "presumptive positive," and a second more expensive and definitive confirmation test (always done in a lab on that presumptive test).

Instead of an expensive confirmation test, in the treatment setting, the confirmation will usually be the admission of the patient, says Stephenson. "They will say that they relapsed or used," he says. If, however, the patient doesn’t admit to drug use, the treatment provider should send the urine off to an accredited lab for the confirmation testing.

"Point of care" tests, in which the treatment program tests the urine immediately instead of sending it out to a laboratory, can have error rates as high as 30–40 percent, says Stephenson. "In the real world, some programs might discharge patients for positive tests," he says, and strongly recommends against taking any action at all based on a positive point-of-care test that the patient denies.
SAMHSA, together with the FDA and the Health Resources and Services Administration, is developing a physician’s guide for the selection of drug and alcohol testing, says Lubran. He says that the guide will be available later in 2010 and can be expected to help doctors with screening, brief intervention, and referral to treatment (SBIRT) for substance use disorders, a key component of the national drug strategy issued last month by the White House.

Workplace tests tend to have high cutoff levels for a positive, and Stephenson strongly urges that treatment programs use low cutoff levels to detect even the slightest level of drug use.

New saliva test options
The “next agenda” beyond urine testing is oral fluid testing, says CSAT’s Lubran, adding that methadone treatment programs are already using saliva testing.

Intercept, the first oral fluid drug test, was cleared by the FDA for use in 2000 (see figure). Since then, oral testing has seen significant advances, explained Ron Ticho, senior vice president for corporate communication for OraSure Technologies, the Bethlehem, Pennsylvania-based manufacturer of the Intercept drug test. Currently, this test may be used to detect 10 different drugs, and, over the course of the next few months, several more drugs will be added.

One saliva specimen is taken, with various “microplates” used for the testing.

The collection is done on site and the sample is stored in a container provided by OraSure and then sent to the lab. Various labs are set up for doing the testing, with results in 72 hours, says Ticho.

CDT marks heavy drinkers
Researchers are exploring the use of “biomarkers” test for very heavy drinking, based not on the presence of alcohol in the body, but on its effects on the body. Carbohydrate-deficient transferrin (CDT) is one such test, explains Raymond Anton, MD, director of the Clinical Neurobiology Laboratory at Medical University of South Carolina in Charleston.

Anton became interested in CDT testing because in the course of his alcohol research, “it became clear that people don’t accurately report what they drink.” He says that anyone who tests positive on the CDT test is likely to have been drinking “at least five to six drinks a day a few weeks.”

Treatment providers can contract directly with Anton’s lab for CDT testing, which is performed using blood. If the provider doesn’t have the ability to collect blood, Anton can do the testing through a commercial lab, which has collection sites where patients can have blood drawn.

Be mindful of testing’s limits
At Caron Treatment Centers, based in Wernersville, Pennsylvania, all patients are given a comprehensive drug screen and alcohol breath test upon admission. The alcohol test is used to help clinicians determine whether the patient will have withdrawal symptoms, says medical director Kenneth Thompson, MD, noting that even in a treatment program, patients may not want to admit the extent of their drinking. “If their blood alcohol is positive, we know the drinking was recent,” says Thompson. Breath tests correlate with blood tests for alcohol: the results are immediate.

There are limitations to drug tests, says Dr. Thompson. “A drug test does not tell you whether a person is addicted or not,” he says. “It doesn’t tell you whether somebody is impaired. And the level of drugs found in the urine does not necessarily correlate with cognitive functioning.” But tests can be used therapeutically “to confront someone’s denial,” he says. And that, for treatment programs and patients alike, can be the key to a successful outcome. “In a good treatment program where there is a therapeutic alliance, the patient should see that the test is therapeutic for them, as a useful tool to prove that they’re sober.”

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