A Best Practices Review of Drug Detection for Court Professionals

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Best Practices

- frequency of testing
- random testing
- witness collection & specimen integrity
- custody & control
- accurate results & confirmation
- rapid turn-around time

Drug Testing Basics

Reasons for Drug Testing - WHY?

- act as a deterrent to future drug use
- identify participants who are maintaining abstinence
- identify participants who have relapsed
  - rapid intervention
  - efficient utilization of limited resources
- provides incentive, support and accountability for participants
- adjunct to treatment & frames sanction decisions

Why Do We Drug Test?

- addiction is an insidious disease
  - relentless, unforgiving, goal is the death of its host
  - tells the brain to use at all costs
- demonstrated to support recovery
- frames/revises treatment plans
  - "thermometer" analogue
- demonstrated to support refusal skills
- frequency should not decrease with phase progression

Drug Testing Specimens

- **urine - current specimen of choice**
  - **generally readily available - large quantities**
  - **contains high concentrations of drugs**
  - **good analytical specimen**
  - **provides both recent and past usage**
- **alternative specimens**
  - **breath**
  - **hair**
  - **sweat - patch test**
  - **saliva - oral fluids**

When to Test?

- KEEP 'EM GUESSING !
- effective drug testing must be random
  - unexpected, unannounced, unanticipated
  - limit time between notification & testing
- test as often as possible - twice weekly
- consider use of multiple specimens (hair, saliva, sweat)
- testing frequency remains constant throughout phase progression

Drug Testing Reality Check

- When developing and administering your drug testing program assume that the participants you are testing know more about urine drug testing than you do!
- Sources:
  - Internet
  - High Times magazine
  - other court clients

Challenging Urine Collection Strategies

"Witnessed" collection (for urine)

- single most important aspect of effective drug testing program
- urine collections not witnessed are of little or no assessment value
- denial component of substance abuse requires "direct observation" collections of participants

Sample Collection:

- pre-collection preparation
  - site selection
    - minimize access to water sources
    - use an area with a scant floorplan
    - find privacy & security
  - gather supplies beforehand
  - obtain proper collection receptacle
- removal of outer clothing

Sample Collection: (continued)

- wash hands prior to donation
- "witness" collection
  - additional clothing removal
  - body inspection
  - squat and cough
- label sample correctly

Sample Collection: (continued)

- accept sample & inspect
  - temperature (90-100° F)
  - color (no color ➔ diluted ?)
  - odor (bleach, sour apples, aromatics, vinegar, etc.)
  - solids or other unusual particulates
- store sample properly
- forensic sample - custody & control

Developing control strategies to prevent sample tampering is critical.

Once clients understand that they cannot beat the system, they are much more likely to engage in the therapeutic process toward recovery.

Drug Testing Methods

Two-Step Testing Approach

- screening test – designed to separate negative samples from samples that are "presumptively" positive
- confirmation test – follow-up procedure designed to validate positive test results
  - distinctly different analytical technique
  - more specific and more sensitive

Step One – Screening

- often based on immunoassay technology
- more drug – more binding - more "color" produced – more instrument detector response
- numerous commercial manufacturers
- designed for high throughput instrumentation or on-site devices

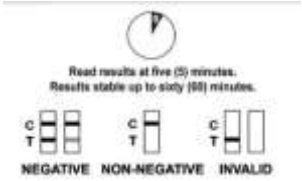
On-site DOA screening

- often based on immunoassay technology
- concept of color "switch"
- "dynamic" versus "static" calibration
- hand-held cassettes or test-cup devices
- one test at a time - no batching
- available in DOA panels or single drugs
- numerous commercial manufacturers
  - differential sensitivity & selectivity

On-site Drug Detection:

Follow package insert guidance exactly!

On-site Drug Detection:



Intensity of band is NOT quantitative!

Step Two - Confirmation

- gas chromatography-mass spectrometry (GC/MS) or LC/MS
  - drug molecules separated by physical characteristics
  - identified based on chemical "finger-print"
  - considered "gold standard"
- other chromatographic techniques

Why confirm ?

- Is it really necessary to confirm drugs that tested positive by initial screening tests?
- Why can't the court adjudicate cases based on the screening test results?
- FALSE POSITIVES

Drug tests & cross reactivity:

- screening tests can and do react to "non-target" compounds
  - amphetamines
  - benzodiazepines
- obtain list of interfering compounds from lab or on-site test vendor
- initial screening ("instant" tests) may only be 60-70% accurate
- confirm positive results

Interpretation of Drug Test Results

Negative or None Detected Results

- indicates that no drugs or breakdown products (metabolites), tested for, were detected in the sample tested
- no such thing as "zero" tolerance or "drug free"
- negative does not mean NO drugs present

Negative/None Detected Interpretation

- client is not using a drug that can be detected by the test

Other possible explanations

- client not using enough drug
- client's drug use is too infrequent
- collection too long after drug use
- urine is tampered
- test being used not sensitive enough
- client using drug not on testing list

Negative/None Detected Interpretation

- no need to second-guess every "negative" result
- not suggesting withholding positive reinforcement & rewards for positive behaviors
- drug testing is a monitoring tool
- assess none detected drug testing results in the context of your client's overall program compliance (or non-compliance) and their life's skills success (or lack thereof)

Positive Test Result Interpretation

- indicates that drug(s) or breakdown products (metabolites), tested for, were detected in the sample tested
- drug presence is above the "cutoff" level
- greatest confidence achieved with confirmation
- ALWAYS confirm positive results in original sample

Typical Cutoff Levels

screening & confirmation

amphetamines *	500 ng/mL	250 ng/mL
benzodiazepines	300 ng/mL	variable
cannabinoids *	20 & 50 ng/mL	15 ng/mL
cocaine (crack)*	150 ng/mL	100 ng/mL
opiates (heroin) *	300/2000 ng/mL	variable
phencyclidine (P□CP) *	25 ng/mL	25 ng/mL
alcohol	20 mg/dL	10 mg/dL

- * SAMHSA (formerly NIDA) drugs

What is a "cutoff" level ?

- cutoffs are not designed to frustrate CJ professionals
- a drug concentration, ***administratively*** established for a drug test that allows the test to distinguish between negative and positive sample - "threshold"
- cutoffs provide important safeguards:
  - scientific purposes (detection accuracy)
  - legal protections (evidentiary admissibility)
- measured in ng/mL = ppb

The Issue of Urine Drug Concentrations

Drug Tests are Qualitative

- screening/monitoring drug tests are designed to determine the presence or absence of drugs - NOT their concentration
- drug tests are NOT quantitative

Drug concentrations or levels associated with urine testing are, for the most part, USELESS !

- cannabinoids 517 ng/mL
- opiates negative
- cocaine metabolite negative
- amphetamines negative

The Twins

A

B

200 mg Wonderbarb
@ 8:00 AM

Collect urine 8:00 PM
12 hours later

The Twins - urine drug test results

A

Wonderbarb = 638 ng/mL

B

Wonderbarb = 3172 ng/mL

The Twins - urine drug test results

A

physiological make up

exact amount drug consumed

exact time of ingestion

exact time between drug exposure and urine collection

AND YET . . . . .

B

The Twins - urine drug test results

Twin B's urine drug level is 5 times higher than Twin A

A

Wonderbarb = 638 ng/mL

B

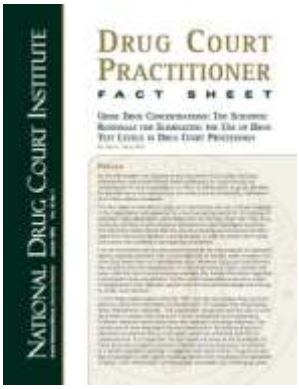
Wonderbarb = 3172 ng/mL

Are any of the following questions being asked in your court?

- How positive is he/she?
- Are his/her levels increasing or decreasing?
- Is that a high level?
- Is he/she almost negative?
- Is this level from new drug use or continued elimination from prior usage?
- What is his/her baseline THC level?
- Does that level indicate relapse?
- Why is his/her level not going down? (or up?)

THE ISSUE

Urine drug concentrations are of little or no interpretative value. The utilization of urine drug test levels by drug courts generally produces interpretations that are inappropriate, factually unsupportable and without a scientific foundation. Worst of all for the court system, these urine drug level interpretations have no forensic merit.



Scientific Rationale

- Technical Issues
  - testing not linear
  - tests measure total drug concentrations
- Physiological
  - variability of urine output
  - differential elimination of drug components

THIS ?

432 indicates he going up, right?

is 22 above the cutoff?

does 219 mean new use?

307 – well she's almost negative, correct?

639 is really high for THC, isn't it?

115 is down from yesterday, probably continued elimination?

I think 1200 is a new record, isn't it?

515 is much higher than last week, right?

don't we need to consider relapse at 57?

OR THIS ?☐

Negative or Positive

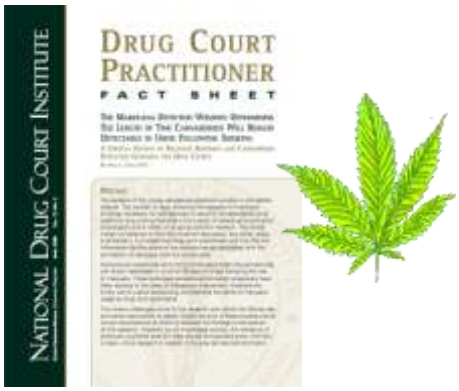
The Drug Detection Window

Drug Detection Times - by Drug
(this is general guidance!)

- amphetamines: up to 4 days
- cocaine: up to 72 hours
- opiates: up to 5 days
- PCP: up to 6 days
- barbiturates: up to a week
- benzodiazepines: up to a week
- . . then there's alcohol & cannabinoids

Cannabinoid Detection in Urine

- Conventional wisdom has led to the common assumption that cannabinoids will remain detectable in urine for 30 days or longer following the use of marijuana.
- RESULT:
  - delay of therapeutic intervention
  - hindered timely use of judicial sanctioning
  - fostered denial of marijuana usage by clients



Cannabinoids - Recent/Relevant Research

- **30+ day detection window often exaggerates duration of detection window**
- **reasonable & pragmatic court guidance**
- **detection time: at 50 ng/mL cutoff**
  - **up to 3 days for single event/occasional use**
  - **up to 10 days for heavy chronic use**
- **detection time: at 20 ng/mL cutoff**
  - **up to 7 days for single event/occasional use**
  - **up to 21 days for heavy chronic use**

Recent Cannabinoid Use versus Non-recent use (double sanction issue):

- How do drug courts discriminate between new drug exposure and continued elimination from previous (chronic) use ?
  - an issue only in first phase of program
  - only drug that poses concern is cannabinoids
  - "two negative test" rule – two back-to-back negative drug tests post clean out

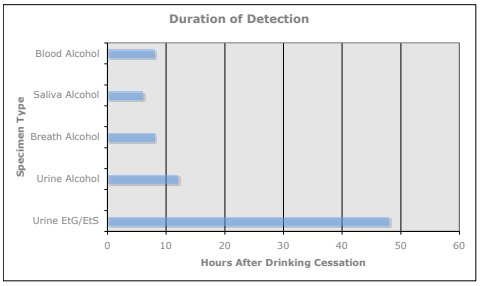
EtG & EtS – Strategy for Monitoring Alcohol Abstinence

Alcohol is the most commonly abused substance by drug court clients and the most difficult substance to detect in abstinence monitoring.

Advantages of Ethyl Glucuronide & Ethyl Sulfate

- unique biological marker of alcohol use (no false positives)
- direct marker indicating recent use
- longer detection window than alcohol
- stable in stored specimens (non-volatile)
- is not formed by fermentation
- is not detected in the urine of abstinent subjects

Extending the detection window



Disadvantages of EtG/EtS

- testing available at relatively few laboratories
- EtG testing more costly than abused drugs
  - expensive LC/MS/MS technology
- introduction of new testing approaches

- most significant concern – casual, inadvertent, environmental alcohol exposure causing positive results

Sources of "Incidental" Alcohol Exposure

- OTC medications (Nyquil, Vicks Formula 44)
- mouthwashes (Listermint & Cepacol)
- herbal/homeopathic medications (i.e., tincture of gingko biloba - memory)
- foods containing alcohol (such as vanilla extract, baked Alaska, cherries jubilee, etc.)
- "non-alcoholic" beers (O' Doul' s, Sharps)
- colognes & body sprays
- insecticides (DEET)
- alcohol-based hand sanitizers (Purell, GermX)

Is a positive urine EtG/EtS test result a definitive indicator of relapse or prohibited drinking?

Is a positive urine EtG/EtS test result sufficient justification for client sanctioning?

Consensus Cutoffs:

- EtG minimum of 500 ng/mL
- EtS minimum of 100 ng/mL

Positive EtG Result (500 ng/mL):

- a result reported as EtG positive in excess of the 500 ng/mL cutoff is consistent with the recent ingestion of alcohol-containing products (1-2 days prior to specimen collection) by a monitored client
- studies examining "incidental" exposure widely conclude that results in excess of the 500 ng/mL cutoff are not associated with inadvertent or environment ethanol sources

Negative EtG Result (500 ng/mL):

- a result reported as EtG negative is indicative of a client who has not ingested beverage alcohol within 1-2 days prior to specimen collection
- a negative result is not proof of abstinence
- advertised "80-hour" window of detection not "real-world" applicable

Best Practices for EtG/EtS Testing:

- provide those being monitored with an alcohol use advisory document - EtG/EtS specific contract - mandatory
- use appropriate cutoffs:
  - EtG - 500 ng/mL
  - EtS - 100 ng/mL
- test for EtS (ethyl sulfate) - biomarker of choice

The Effective Use of Urine Creatinine Measurements in Abstinence Monitoring

The most common form of specimen tampering is sample dilution.

Creatinine testing is a specimen validity issue!

EVERY urine sample collected for drug detection should be tested for creatinine!

You can't intervene to change behavior if you don't know a client has relapsed!

What is creatinine ?

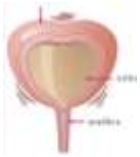
- creatinine is produced as a result of muscle metabolism
- creatinine is produced by the body at a relatively constant rate throughout the day
- creatinine is a compound that is unique to biological material (i.e. urine, other body fluids)
- creatinine measurements can:
  - determine the "strength" or concentration of a urine sample
  - ensure the sample being tested *IS* urine

Two Types of Urine Specimen Dilution

- pre collection dilution
  - consumption of large quantities of fluids *prior* to collection
- post collection dilution
  - adding fluid to specimen *post* collection

Pre-Collection Dilution

- high-volume ingestion of fluids (water loading, flushing, hydrating, etc.)
- may be in conjunction with products designed to "enhance" drug elimination or removal of drugs (Gold Seal, Clean 'n Clear, Test-Free, Naturally Klean, etc.)
- no evidence these products have any additional effect on drug elimination



Client has a bladder full of urine with a drug concentration of greater than the cutoff level of the test - thus producing a positive result.

Urine in the bladder is diluted by the consumption of large amounts of non-drug containing fluid; which results in a drug concentration that is less than the cutoff level of the test - thus producing a negative result.

Water contains no drugs!

- easiest, cheapest, simplest
- urines with a creatinines of less than 20 mg/dL are considered "dilute" and rarely reflect an accurate picture of recent drug use
- dilute samples are more like water than like urine
- incidence of low creatinines in a population undergoing random drug testing is significantly (up to 10 times) greater than a non-drug tested population

The "Normal" Urine Creatinine

- normal urine creatinine: 2005 study "Urinary Creatinine Concentrations in the U.S. Population" determine the mean (based upon 22,245 participants) was 130 mg/dL
- study was not associated with drug testing
- subjects came from a variety of ethnic groups
- samples were collected AM, mid-day, and PM
- less than 1% below 20 mg/dL
- less than 1% greater than 400 mg/dL

Creatinine Facts

- some diseases that produce low urinary creatinines
  - muscle wasting disease - RARE
  - some kidney aliments - RARE
- low creatinines ARE NOT routinely associated with:
  - pregnancy
  - diabetes
  - obesity
  - exercise
  - high-blood pressure
  - being vegetarian

More Creatinine Issues

- **rapid ingestion (90 minutes) of 2-4 quarts of fluid will almost always produce low creatinines & negative urine drug tests within one hour**
- **recovery time of urine creatinine and drug concentrations can take up to 10 hours**

"Dilute" Result Interpretation:

- negative or none detected results should never be interpreted as indicating no drug use (abstinence), because if, in fact, drugs were present, they probably could not be detected by the test
- positive drug test results from a dilute sample however, are considered valid (donor was not able to dilute the sample sufficiently to deceive the test)

Two final thoughts about dilute urine samples . . . . .

- a creatinine of less than 20 mg/dL (associated with a drug test) is nearly always an attempt by the donor to avoid drug use detection - REGARDLESS of how much liquid was consumed in order to achieve this result
- place a dilute sample prohibition in your client contract and sanction for repeat dilute samples

SUMMARY

- TEST FOR CREATININE!
- incorporate creatinine guidance in your SOPs and client contract
- institute a dilute sample prohibition
- understand very low urine creatinine levels are NOT normal occurrences
- dilute samples are nearly always an attempt by the donor to avoid drug use detection
- sanction for repeat dilute tests
- follow urine creatinine patterns

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