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Drug Testing in Adult Mental Health Settings Operating Procedure

Introduction

Assessment of an individual's mental state is ongoing and often repeated formally and informally within mental health settings. Throughout the individual's agreed care pathway, varying methods, approaches and assessment tools are used to formulate an accurate and reliable assessment.

Many individuals who use mental health services may have also used unidentifiable psychoactive substances. These substances will have varying degrees of effect upon an individual's overall level of mental functioning. It is important for the assessing team to be able to quickly identify any ingested substance that may impact upon the mental health of an individual at any one time.

A clear understanding of what might be most likely to be causing or contributing to mental disturbances within an individual will allow the most effective and safe treatment to be considered.

A comprehensive face to face assessment will almost always be sufficient to clearly identify whether psychoactive substances may be a factor in influencing the mental health of an individual. However, this is purely based on the responses of the individual.

Where doubt exists and the assessing team considers there is reasonable evidence to question the validity of the verbalised responses from an individual, drug testing may be considered. Whether or not to utilise drug testing procedure within an assessment will depend upon the clinical setting and the current guidelines and practices that exist within that setting. Occasionally, some medical conditions will mimic acute intoxication- clinicians will need to be aware of this possibility (**See appendix 1**).

Aim

This purpose of this document is to describe the procedure for the safe administration of drug testing within adult mental health settings. Drug testing can be undertaken by analysis of hair, blood, breath, saliva and urine. These guidelines can be applied and followed for all methods of drug testing. The processes detailed here will specifically focus on urine testing with single use disposable drug testing kits.

Objectives

This document will identify the procedural guidance for single use urine drug testing kits within adult mental health settings.

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Scope

This procedure applies to all of our staff in all locations including those with honorary contracts

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has not been completed
Documents to read alongside this Procedure	Chaperone policy: http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/185304 Mental Health clinical risk assessment and management policy: http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/193611 Infection Control Standard precautions procedure: http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/201844 Management of patients /visitors in possession of alcohol / unprescribed or illegal substances policy and procedure : http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/210821 Making Every Contact Count: http://www.cardiffandvaleuhb.wales.nhs.uk/making-every-contact-count
Approved by	Mental Health Clinical Board Policy Group Mental Health Clinical Board Quality & Safety Group

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Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	14/06/2017	18/01/2018	New document

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Procedural guidance for the safe administration of drug testing

Prior to carrying out any drug testing, the assessing team should be clear about the rationale for testing and the perceived therapeutic benefits for the individual being tested. This should be fully discussed and agreed with the individual. The likely implications to the care pathway for the individual of a positive or negative result should be discussed at this early stage prior to undertaking the test. The type of test required, whether urine, saliva or hair should be determined by each clinical area.

The most commonly used method is to test a sample of urine. Saliva or blood tests detect drugs that have been taken over the last 24 hours. Blood tests are more expensive and invasive, so are rarely done. A urine test shows a history for most drug groups of between 1 to 4 days. To test if someone is 'under the influence' then a urine or saliva test is appropriate. Traces of most drug groups disappear quickly in blood, saliva and urine, yet remain trapped in hair as a permanent record. Hair analysis typically provides a profile of drug use for between one week and up to 3 months or more. Hair testing shows drug use history.

Consent should not be implied (i.e. "they willingly gave a sample"), but should be explicit ("they fully understood the rationale behind this"). Consent agreeing or not to the procedure should be clearly documented on the patient's record

All clinicians carrying out drug testing procedures should have appropriate knowledge about drugs and alcohol (effects, risks, impact upon mental and physical health).

All clinicians should be appropriately familiar with the equipment they are using and feel confident in its safe use. All drug testing kits will come with user instructions. Kits should not be used if the clinician does not feel competent in applying it correctly. Drug testing kits should only be used if within expiry date.

(See training requirements below)

All clinicians carrying out drug testing should be familiar with infection control procedures and adhere to these at all times.

If recent substance use is acknowledged, consideration should be given to the value of continuing with testing at this point. Therapeutic discussions around the circumstances of use may be of more benefit than procedures to confirm what is already known. However, a service user can never be 100% sure of what substance they have taken and testing may be a helpful way to clarify this, particularly if they have experienced sudden or unexpected changes in their mental state.

Drug testing should not be used in a punitive way. It is much more helpful if it is presented to the individual as a positive way of helping them to monitor patterns of drug and alcohol use in relation to their mood, behaviours and symptoms.

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If urine is being tested, to reduce the risk of possible contamination or dilution of the sample, the individual may need to be visually observed supplying the sample. The dignity and respect of the individual should be maintained at all times. A chaperone may be required on a case by case basis.

Clinicians should be aware that drug testing equipment is not infallible and there are risks of false positive or false negative results. **(See appendix 2).**

If a result is contested by an individual, consideration should be given to carrying out further testing or sending a sample for laboratory testing for confirmation. Decisions about care and treatment should not be based solely on the results of single, individual tests –unless part of previously agreed care plan.

All clinicians carrying out drug testing should be aware of the average length of time substances of abuse are still detectable in toxicological tests. **(See appendix 3 for drug detection times in urine)**

It may be possible that past acknowledged use is still detectable, even if an individual is claiming abstinence.

The results of a test should not be viewed in isolation. It is important to also assess the clinical presentation, so that the role of substances in any deterioration or improvement in mental state may be fully considered.

All clinicians should have knowledge of local statutory and non statutory substance misuse services, be familiar with referral procedures and be aware of when it is important to discuss seeking specialist support. This should be used as an opportunity to embrace the UHB’s “Making Every Contact Count” strategy.

NB: If the service user has drunk / used drugs in the last couple of hours their level of intoxication may rise before it falls.

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Audit /Governance

Team managers and ward managers should monitor budgets in relation to their expenditure on drug testing equipment. All drug testing kits should be ordered through Pharmacy initially but it should then be the responsibility of the lead CMHN at the CMHT or, if inpatient area, ward manager to order more when required. Minimum and maximum stock levels should be adhered to and the process managed appropriately by the senior nurse within each area. If other testing kits are required, these will have to be ordered in the same way.

There should be a ready supply of drug testing kits in areas where it is deemed more likely they will be used. All kits should be in date and due diligence should be exercised to consider expiry dates when ordering supplies. Pharmacy may wish to conduct routine audits of unused /expired kits and /or over estimated ordering.

Training Requirements

It is the individual clinician's responsibility to ensure they are competent to carry out duties requested or required of them. Any training needs should be raised with their line manager during supervision/ appraisal and incorporated into their Personal Development Plan.

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Appendix 1:

Medical conditions may mimic intoxication secondary to substance use. (Source - NE London NHS Foundation Trust -Managing Substance Misuse in Psychiatric Inpatient Wards Policy).

- Diabetic hypoglycaemia, or hyperosmolar hyperglycaemic non ketotic comacoma
- Subdural haematoma secondary to recent head trauma.
- Delirium tremens and Wernicke's encephalopathy are the commonest substance misuse emergencies that present to psychiatric settings.
- Neuroleptic Malignant syndrome, Serotonin syndrome, atropine psychosis and other organic psychoses may mimic, be triggered by, or be masked by substance misuse.

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Appendix 2:

Agents with potential to cause false positives (Source -Advances in psychiatric treatment (2010), vol. 16, 369–379)

Amphetamine:

Amantadine, amphetamine analogues, benzathine penicillin, bupropion, chlorpromazine, deprenyl, desipramine, ephedrine, labetalol, mebeverine, methylphenidate, perazine, phenothiazines, phenylephrine, phenylpropanolamine, promethazine pseudoephedrine, ranitidine, ritodrine, selegiline thioridazine, trazodone, trimipramine

Benzodiazepines:

Oxaprozin, sertraline

Cannabis:

Non-steroidal anti-inflammatory drugs, efavirenz, proton pump inhibitors, hemp- containing food items

Cocaine:

Derivatives of coca plant, topical anaesthetics

Opioids:

Codeine, poppy seeds, quinolones, rifampicin, verapamil

Phencyclidine:

Diphenhydramine, ibuprofen, ketamine, thioridazine, tramadol, venlafaxine

Methadone:

Phenothiazines, clomipramine, verapamil, doxylamine, diphenhydramine

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Appendix 3:

Drug detection times in urine (Source: Department of Health 2007.)

Alcohol 12 – 24 h

Amphetamines and analogues 2 days

Benzodiazepines

Ultra short acting (e.g. midazolam) 12 hours

Short acting (e.g. triazolam) 24 hours

Intermediate acting (e.g. temazepam, chlordiazepoxide) 2-5 days

Long acting (e.g. diazepam, nitrazepam) 7 days or more

Buprenorphine and metabolites 8 days

Cannabinoids

Single use 3-4 days

Moderate use (three times a week) 5-6 days

Heavy use (daily) 20 days

Chronic heavy use (more than three times daily) -up to 45 days

Cocaine metabolite 2–3 days

Codeine, dihydrocodeine, morphine, propoxyphene 2 days

Methadone (maintenance dosing) 7–9 days