Urine Testing for Drugs of Abuse

A Survey of Suburban Parent-Adolescent Dyads

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Background: The American Academy of Pediatrics is opposed to involuntary diagnostic testing for drugs of abuse.

Objective: To gather data about attitudes of parents and their teenagers about involuntary drug testing on parental request.

Design: Adolescents and their accompanying parents separately answered a printed survey in the offices of their private pediatrician. The survey posed 2 hypothetical questions about urine testing: (1) Do parents have the right to ask a teenager’s physician to order a urine test for drugs of abuse without the teenager’s knowledge—if the teenager has falling school grades, an uncooperative attitude, and major untruthfulness? (2) In such a case, should the teenager’s physician obtain a urine test for drugs on parental request only, without the teenager’s consent?

Results: A total of 393 paired evaluable surveys were collected: 77.6% from Virginia and 22.4% from Ohio. There were no significant differences in answers between the 2 study sites. Of the students, 85.8% had either an A or a B grade point average. Current marijuana use was unusually low in our teenaged respondents. Of the parents surveyed, 81.7% would want a physician to be able to perform a urine test for drugs of abuse for a problematic teenager without the young person’s consent. The answers to the 2 questions about urine drug tests had poor \( \kappa \) coefficients of agreement between teenagers and parents (0.04 and 0.09, respectively). Reanalysis, using the variables of age, grade point average, and frequency of marijuana smoking, showed little difference in agreement scores.

Conclusions: In the 2 suburban pediatric practices surveyed, parental opinions and expectations were at variance with the American Academy of Pediatrics policy statement on nonsensical urine drug testing in the presence of clinical problems. Pediatricians need to be conscious of this clinical-ethical dilemma, become familiar with the American Academy of Pediatrics policy on drug testing, and develop their own position and expertise in this area. The dyad method (parent-teenager survey) is novel and improved the methodology of our study. We surveyed middle-class suburban adolescents while previous studies of adolescents surveyed inner-city populations.

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THE AMERICAN Academy of Pediatrics (AAP) recommends that adolescents be asked about their use of tobacco, alcohol, marijuana, and other drugs during a routine sports or annual health assessment or even during illness-related office visits.\(^2\) With few exceptions, the information provided by the adolescent is expected to remain confidential. Such confidentiality is believed to protect the special relationship between competent teenaged patients and their physicians. Pediatricians are encouraged to maintain this confidentiality unless there are severe extenuating circumstances.\(^2\)\(^3\) The 1996 AAP policy statement, “Testing for Drugs of Abuse in Children and Adolescents,” states that, “Involuntary diagnostic testing is not deemed appropriate in adolescents with decisional capacity—even with parental consent—and should be performed only if there are strong medical or legal reasons to do so.”\(^4\)\(^5\)\(^6\)\(^7\) The AAP statement further states that, “Consent from the older adolescent may be waived when there is reason to doubt competency or in those circumstances in which information gained by history or physical examination strongly suggests that the young person is at high risk of substance abuse.”\(^5\)\(^6\)\(^7\)\(^8\) The ethical principles of confidentiality and informed consent must still apply in most cases.

The AAP statement points out the limitations of broad-brush urine screening without specific reasons. It distinguishes between screening athletic teams or all students attending a specific high school (not recommended) and testing a specific patient based on behaviors or signs/symptoms suggestive of drug abuse, as previously noted. The policy statement clarifies the requirements necessary before the pediatrician may obtain urine drug tests.
without the adolescent’s consent. A similar statement was published earlier by the AAP Committee on Bioethics.³

In some situations, a parent requests a urine drug test for his or her teenager without the adolescent’s voluntary knowledge or consent.⁴⁺ during the study design and the survey instruments and had no ethical or technical objections, and the study was approved without a formal presentation. The revised version of the survey was distributed to 6 consenting adolescents for a pilot study, the purpose of which was to evaluate the understandability of the questions and the average time required to complete the survey.

The subjects were patients of 1 of 2 suburban group pediatric practices located in either Fairfax County, Virginia, or Mason, Ohio (suburban Cincinnati). Consecutive teenagers who had scheduled appointments with one of us (R.H.S.) and an accompanying parent were asked to participate at the Virginia location. A convenience sample (not consecutively enrolled) of consenting teenagers and their parents were solicited from the Ohio office. The teenagers came to their pediatrician’s office in the late spring, summer, and early fall of 1999 for their annual health assessment or an illness-related visit. Parents and teenagers were told that their physician was conducting a survey about drug testing. Verbal permission to participate in the survey was obtained from all parents and their teenagers. Confidentiality was promised in writing. A receptionist monitored the waiting room to ensure noninterference from parents or friends. The accompanying parent was given the parent form and requested by the office receptionist to be seated apart from his or her child. When a teenager came to the office without a parent, the parent version of the survey was given to the teenager in an unmarked envelope for the parent to complete at home and mail back to the office. The completed survey was folded, as instructed by the office receptionist, and inserted into a “ballot box.” For their cooperation, participating teenagers earned a $2 bill. Approximately 7% of consecutive teenagers and/or parents from the Virginia site refused to participate. Surveys from Ohio were sent by United Parcel Service to Vienna, Va. Teenager-parent completed surveys were paired by matching the last 4 digits of the household telephone number. All responses from completed surveys were entered into a spreadsheet, reviewed for accuracy, and analyzed using SAS statistical software, version 6.12 (SAS Institute Inc, Cary, NC).

STATISTICAL ANALYSES

All survey responses were categorical. Differences in proportions were calculated using the x² statistic. To measure agreement, a specific form of association between parents and their teenagers, simple κ coefficients, and 95% confidence intervals were calculated according to the method of Cohen. For this study, κ values of 0.00 to 0.39 indicated no to slight agreement; 0.40 to 0.79, moderate agreement; and 0.80 and greater, excellent agreement. To assess for any trend in responses of teenagers according to age, the Cochran-Armitage test result was calculated. If the count in any cell of a contingency table decreased below 5, exact measures were calculated. A type I level error of α = .05 was considered statistically significant.

Completed surveys were collected from 393 adolescent-parent pairs, 305 (77.6%) from the Virginia site and 88 (22.4%) from the Ohio site. A question-by-question comparison of answers to demographic and drug-related questions revealed only minor differences in responses from the 2 study sites. Therefore, data from the 2 sites were combined. Of the 393 teenagers, 203 (51.7%) were male and 190 (48.3%) were female. Also, 244 (62.1%) were aged 13 to 15 years, 116 (29.5%) were aged 16 to 17 years, and 33 (8.4%) were aged 18 to 19 years. Of the teenagers, 329...
(83.7%) lived with both parents, 32 (8.1%) lived with one parent, and 32 (8.1%) described their living situation as other (percentages do not total 100 because of rounding). Also, 150 (38.2%) of the subjects had a GPA of A, 187 (47.6%) had a GPA of B, 46 (11.7%) had a GPA of C, and 10 (2.5%) had a GPA of D. The respondents were predominantly middle-class college-bound teenagers and their parents. From previous surveys, we knew that most of the parents in the Virginia practice were college graduates who were employed as professionals, administrators, computer experts, supervisors, or government employees. Of the 393 teenagers, 41 (10.4%) admitted to having smoked marijuana at least once while 23 (5.9%) admitted to having done so in the previous month (“current marijuana use”). Of the 393 parent responders, 105 (26.7%) reported smoking marijuana at least 10 times during their teenage years, but none admitted current marijuana use. We did not inquire about use of other illicit drugs.

Of the 393 parents-teenagers, 321 (81.7%) of all parents vs 211 (53.7%) of all teenagers believed that a parent had the right to ask the physician to order a nonconsensual urine test for drugs of abuse for a problematic teenager without the teenager’s knowledge or consent. Forty-two (10.7%) of the parents vs 121 (30.8%) of the teenagers said the parent had no such right. The remainder of both groups (30 [7.6%] of the parents and 61 [15.5%] of the teenagers) were undecided. When a more specific form of association (κ coefficient) was used to examine the agreement in responses between parents and their teenage children, poor agreement was found (κ, 0.04; 95% confidence interval, −0.02 to 0.11). Fifty-nine (35.5%) of 166 teenagers aged 13 to 15 years, 35 (43.2%) of 81 teenagers aged 16 to 17 years, and 9 (34.6%) of 26 teenagers aged 18 to 19 years answered no to this scenario when their parents answered yes. While we expected the percentage of teenagers answering no when their parents answered yes might increase with increasing age, no discernible trend was found (P = .67).

Of the 393 parents-teenagers, 315 (80.2%) of all parents vs 224 (57.0%) of all teenagers agreed that a physician had the right to order a nonconsensual urine test for a teenager with interpersonal, behavioral, and academic problems. Significantly more parents than teenagers (57.0% vs 28.0%; χ² = 67.7, P < .001) believed that a physician had the right to order such a nonconsensual urine test. When a more specific form of association (κ coefficient) was used to examine the agreement in responses between parents and their teenage children, poor agreement was found (κ, 0.09; 95% confidence interval, 0.03-0.15). The trend for increasing teenager disagreement with increasing teenager age was not significant (P = .16). For both scenarios, controlling for GPA and affirmative answers to questions about current or lifetime teenage use of marijuana had no significant effect on agreement scores.

### COMMENT

Screening for substance use certainly raises ethical issues for the practicing pediatrician. Ethical concerns relating to screening involve issues of informed consent, confidentiality, and civil rights. The AAP has a long history of contribution to this area. Throughout its history, the AAP consistently asserts that parental permission is insufficient for involuntary screening of the competent adolescent. However, it also concedes that consent may be waived when there is reason to doubt competency, when the medical assessment suggests a high risk of serious damage due to substance use, or when there are legal reasons. In reflecting on the AAP position, it is of interest to review the ideas of other contributions to this issue. The American Academy of Child and Adolescent Psychiatry agrees that an adolescent patient should be given the right of informed consent to alcohol and other drug treatment, but qualifies it by adding: “It may be appropriate, however, to obtain informed consent for testing from the parents alone, when the minor patient exhibits poor judgement, cannot make a positive treatment alliance, is dangerous to himself or herself or to others, does not show concern for his or her condition, and/or refuses help.” DuPont extends this indication by claiming: “The standard against which all counselor’s actions should be judged is the teenager’s best long-term interests.”

Neveloff Dubler and Quinn also support a balanced approach, stating clearly that a physician is never forbidden by law or by the application of ethical principles from sharing information with the parent under circumstances in which the patient is in danger to himself or herself. Finally, completing the spectrum of views, King and Cross consider screening for drugs to be unethical except when the patient accepts it freely or there are strong clinical reasons for the request. The AAP guidelines, and the different thoughts expressed, need to be considered by each practicing physician according to the teenager’s age and level of maturity.

Our study asked 2 variations on one question. Is it acceptable for parents or physicians to request a drug test on urine obtained without consent from a teenager exhibiting symptoms consistent with drug use? As a result of our experience with this survey and the finding of divergent perspectives between parents and their adolescent children, we propose that it is important to discuss the ethics issues involved in urine screening and search for common ground. The following considerations may provide a starting point.

1. Screening for drugs of abuse during adolescence must be scientifically sound.
2. There should be a clinical basis for requesting it.
3. Physicians need to respectfully share the rationale for or against screening with patients and parents and help them through the process. The AAP guidelines may serve as a background.
The AAP is opposed to involuntary testing of adolescents for drug use, regardless of parental consent for such testing. Such testing is viewed as violating the confidentiality of the adolescent. This survey of middle-class suburban teenagers and their parents found that 82% of parents would want a physician to be able to perform a urine test for drugs without the adolescent’s consent if the parents were concerned about drug use. There was little agreement between teenagers and parents on attitudes toward testing.

4. Screening should be part of a comprehensive therapeutic plan.

The findings of this report are subject to several limitations. The adolescents studied were from middle- to upper-middle-class high-achieving families. Their academic standing was well above average. Lifetime and current marijuana use reported by teenaged respondents were less than one percent. Test results from long-term daily marijuana users may be positive for several weeks after last use, but remain positive for only a few days after infrequent use. A positive test result for amphetamines or opiates is more difficult to interpret because several over-the-counter decongestant medicines can produce a positive test result for amphetamines and the ingestion of poppy seed–containing breads or pastries can produce a positive test result for opiates. Experienced drug users often have lots of tricks to avoid a positive urine test result for amphetamines or opiates. Those drugs can usually be detected for 2 to 3 days after use. Because of the long half-life of marijuana metabolites, test results from long-term daily marijuana users may be positive for several weeks after last use, but remain positive only for a few days after infrequent use. A positive test result for amphetamines or opiates is more difficult to interpret because several over-the-counter decongestant medicines can produce a positive test result for amphetamines and the ingestion of poppy seed–containing breads or pastries can produce a positive test result for opiates.

Despite these limitations, our survey has potentially important implications. Our results show a poor correlation between the opinions of parents and their teenagers on the issue of how a physician should respond to a parental request for nonconsensual urine tests for drugs of abuse when a teenager is having serious problems. This subject should make for interesting parent-teenager discussions about alcohol and other drug use, optimally before substance use occurs.

In the population surveyed, more than 4 of 5 of the parent respondents believed that they had the right to request involuntary nonconsensual urine drug tests if a hypothetical teenager had deteriorating school grades, a noncooperative attitude, and major untruthfulness. There was a significant disparity between the expectations of middle-class parents, their teenaged children, and the AAP policy statements on urine drug testing. The gap between the AAP statement and the expectations of many middle-class parents needs to be recognized. At least, pediatricians should be knowledgeable of the AAP policy statement on urine drug testing and should be prepared for a brief discussion of their beliefs and practice with parents and adolescents, particularly for those parents who are concerned about their teenager’s deteriorating habits, behaviors, and school performance.

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REFERENCES

10. American Academy of Child and Adolescent Psychiatry position statement on urine drug testing and should be prepared for a brief discussion of their beliefs and practice with parents and adolescents, particularly for those parents who are concerned about their teenager’s deteriorating habits, behaviors, and school performance.