



Program Guidelines for Drug Testing in the Treatment of Opioid-Use Disorders

Drug testing, the collecting of biological samples (urine, blood, saliva, sweat, hair, other), is a crucial therapeutic tool in the identification, assessment, recovery, and ongoing treatment of individuals with opioid-use disorders (as well as other substance use disorders). The results of a drug test, as with any medical test, must be evaluated alongside other pertinent clinical, self-report, and historical data.

- An agency's/program's procedures regarding drug testing should be reviewed, and provided verbally and in writing to clients, upon intake.
 - If drug tests are to be used as part of a contingency plan, this must be clear to the client.
 - Example: A certain number of negative consecutive drug screens could equate to an increased amount of take-home medication, or decrease in visit frequency.
 - Example: A specific positive result, such as a non-prescribed benzodiazepine in a client on methadone or buprenorphine, might increase the intensity of services or signal the need for a higher level of care.
 - Staff need to be trained that drug tests are a therapeutic tool to guide assessment, and treatment for clients with opioid-use disorders. They should never be used as a "gotcha." Drug tests simply report whether or not substances are present or absent.
 - Drug tests are confidential. Exceptions to this must be client/program specific and accompanied by necessary releases and permissions.
- Drug-test refusals and discrepancies between self-report and a drug test are clinical matters to be explored.
- If in-office "quick-read" (presumptive/qualitative/Point of Care) tests are used, there should be accompanying guidelines as to when more definitive/quantitative confirmatory tests through a DPH certified laboratory/vendor will be used. Such as:
 - When there is a discrepancy, or dispute, between results and self-report.
 - When additional substances need to be screened, such as fentanyl, or clonazepam.
 - When quantification of drug levels is desired.

- When results are unclear.
- When there are concerns over a possible false-positive or false-negative result
- Other
- Frequency and timing of drug testing. Random, versus scheduled, drug tests are preferred, though may not always be feasible/possible. Frequency takes into account: the level of care, client's progress, program/clinic expectations, cost, regulatory requirements, client choice, and other factors.
 - In general, testing will be more frequent (weekly or more often) at the beginning of treatment, or following a relapse, and then decrease in frequency.
 - For those in maintenance treatment a monthly drug screen is within the standard of care.
- If urine drug testing is to be supervised, programs will have a written policy or procedure that addresses: client dignity, privacy, and staff training.
- If it is believed that a sample has been tampered with, a repeat is recommended.
- Results of drug tests should be communicated to clients in a timely fashion.
- Language used by all staff communicates the therapeutic function of drug testing. Results are reported as being positive or negative and never "dirty" or "clean".

Reference:

ASAM Expert Panel: *Consensus Statement: Appropriate Use of Drug Testing in Clinical Addiction Medicine*. American Society of Addiction Medicine. April 5, 2017