

ADDICTION MEDICINE

GOVERNOR'S INSTITUTE

To Pee or Not to Pee: Urine Drug Screen Debate

Nathan Mullins, MD

Michael Baca-Atlas, MD

4/11/26

Asheville, NC

Disclosure Information

- ◆ Michael Baca-Atlas, MD:
 - ◆ No Disclosures

- ◆ Nathan Mullins, MD:
 - ◆ No disclosures

Learning Objectives

1. Describe two principled viewpoints on toxicology testing in MOUD (access/engagement vs safety/objective data).
2. Apply a simplified decision framework to decide when toxicology testing is clinically indicated.
3. Implement an 8-point “minimum standard” to reduce harm when testing is used (consent, interpretation, and non-punitive response).

Background



Dr. Corey Waller, MD, MS, DFASAM



Dr. Stephen Martin, MD, M.Ed

Debate Question & Ground Rules

In MOUD care, should toxicology testing be a default expectation—or a selective tool used only when it changes clinical care?

Ground Rules:

- Non-punitive stance: toxicology results should prompt conversation and safety planning—not automatic loss of care.
- We are debating the default policy and workflow—not whether toxicology can ever be useful.

Opening - MBA

- ◆ Minimal to no data
- ◆ Harms are VERY real
- ◆ Tests are still incorrectly ordered, interpreted, and applied on a routine basis



Opening - NM



- ◆ Objective data
- ◆ Guide treatment management, counseling, mitigate risk
- ◆ Adequate training and interpretation skills

Case 1 - Low Threshold Start

A patient is starting buprenorphine in a primary care clinic. They want low-barrier access and have transportation and work constraints. They report occasional stimulant use, last use of illicit opioids 5-7 days ago, and ask to start treatment today.

- Do you test at intake? If yes: what test, what panel, and what decision will the result change?
- What is the harm if testing becomes the price of entry into care?
- If an unexpected result returns, what is your non-punitive next step?

Case 2 - ADHD, Hx StUD

A patient has a history of ADHD and stimulant use disorder in remission (methamphetamines) on long-acting PO stimulant for the past 3 months for ADHD. Clinically doing well and presents for follow up.

- Is UDS testing indicated?
- Frequency?

Minimum Standard Checklist

- 1) State the clinical purpose**
- 2) Consent + transparency**
- 3) Non-punitive response plan**
- 4) Right test, right interpretation**

Minimum Standard Checklist

5) Confirm before modifying plan

6) Minimize burden

7) Equity check

8) Document the monitoring plan

Final Takeaways

◆ MBA

- ◆ Potential for bias if more selective testing
- ◆ Impact on Retention in Care
- ◆ Abstinence as an “outcome”

◆ NM

- ◆ Potential to improve outcomes if used consistently/correctly
- ◆ Can be used in patient centered approach

References

- ◆ Beliveau C, Baca-Atlas M. Do No Harm? Rethinking Urine Drug Screens in Treatment of Opioid Use Disorder. *J Am Board Fam Med*. 2026;38(6):974-976. Published 2026 Feb 27.
- ◆ Incze MA. Reassessing the Role of Routine Urine Drug Screening in Opioid Use Disorder Treatment. *JAMA Intern Med*. 2021;181(10):1282-1283.
- ◆ Jarvis M, Williams J, Hurford M, et al. Appropriate Use of Drug Testing in Clinical Addiction Medicine. *J Addict Med*. 2017;11(3):163-173.
- ◆ Khatri UG, Aronowitz SV. Considering the harms of our habits: The reflexive urine drug screen in opioid use disorder treatment. *J Subst Abuse Treat*. 2021;123:108258.
- ◆ Martin (Aug 12, 2025). "One of These Things Is Not Like the Others." ASAM Weekly. <https://www.asam.org/publications-resources/the-asam-weekly/detail/2025/08/12/one-of-these-things-is-not-like-the-others>
- ◆ Waller (Nov 25, 2025). "Guest Editorial - A Reality Check." ASAM Weekly. <https://www.asam.org/publications-resources/the-asam-weekly/detail/2025/11/25/guest-editorial--a-reality-check>

ADDICTION MEDICINE

GOVERNOR'S INSTITUTE

Thank you!