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Down the drain: Reconsidering routine urine drug testing during the COVID-19 pandemic[☆]



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A B S T R A C T

The COVID-19 pandemic and the move to telemedicine for office-based opioid treatment have made the practice of routine urine drug tests (UDT) obsolete. In this commentary we discuss how COVID-19 has demonstrated the limited usefulness and possible harms of routine UDT. We propose that practitioners should stop using routine UDT and instead use targeted UDT, paired with clinical reasoning, as part of a patient-centered approach to care.

The COVID-19 pandemic has forced us to change our practices in substance use disorder (SUD) treatment and to re-examine what was once routine. Urine drug testing (UDT), which has been the backbone for monitoring patients with opioid use disorder (OUD) receiving medications for OUD (MOUD), is one such habit. In this commentary, we discuss how COVID-19 has ended the practice of “routine” UDT in office-based opioid treatment (OBOT), encouraged a more patient-centered approach, and why targeted, as opposed to routine, UDT should be a lesson learned for practitioners from this pandemic.

As OUD treatment expanded to OBOT with buprenorphine, treatment de-emphasized UDT, but the field still recommended it as a “routine” component of treatment ([Substance Abuse and Mental Health Services Administration, 2018](#)). To reduce the spread of COVID-19, federal regulators relaxed guidelines requiring in-person evaluation for the initiation of buprenorphine for OUD in the context of OBOT ([Prevoznik, 2020](#)). Instead, telemedicine, including voice-only (telephone) visits, are now sufficient to start treatment and monitor patients already receiving buprenorphine. As a result, UDT is no longer part of the routine. In our primary care practice, where we have offered OBOT since 2003 ([Soeffing et al., 2009](#)), the practice of routine UDT had already been de-emphasized prior to COVID-19, particularly among patients in sustained remission. Now the practice of routine UDT has stopped.

By necessity, we now rely on the traditional skills of observation and communication to guide OUD treatment. Telemedicine allows us to meet patients where they are and better understand the context in which they live. Through video we can see patients, their families, and

friends, or more importantly the absence of these social connections. Voice-only visits give us the opportunity to listen not only to the words that the patients speak, but the intonation and emotion of their speech. Applying these observational skills longitudinally provides evidence of treatment progression or deterioration.

A main argument for UDT among practitioners is that it can detect ongoing substance use that patients have not disclosed. Patients do not disclose substance use for many reasons, including feelings of judgment, stigma or shame; because they are not ready to make a change; or they are fearful of being cut off from treatment. Routine UDT, including random testing, has roots in a criminal justice approach designed to enforce abstinence and to “catch” illicit substance use that would then trigger punitive consequences. However, research has provided limited evidence that UDT improves patients' outcomes or safety ([Jarvis et al., 2017](#)). For many patients, their substance use will improve with the support of medication and resources outside of our office or will declare itself just as other untreated illnesses eventually do.

Patients' concurrent use of some substances with buprenorphine, particularly benzodiazepines, may increase their risks for adverse outcomes. However, this risk is less than when used with other opioids and the field recommends continued buprenorphine in this situation ([Martin et al., 2018](#)). Notably, the prevalence of nicotine dependence and co-occurring alcohol use disorder is 50% and 25%, respectively, among patients with OUD ([Jones & McCance-Katz, 2019](#)). However, these substances are not assessed in routine UDT despite the significant morbidity and mortality from their use. We typically assess for tobacco and alcohol use by simply asking patients. Why are illicit substances

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treated differently?

The field also recommends UDT to ensure compliance with buprenorphine and quantitative metabolite levels can be used to monitor for “spiking” urine. As with all medications, diversion of buprenorphine does occur. But research has increasingly found that patients use diverted buprenorphine therapeutically (Silverstein et al., 2020), and it may have some beneficial effects in the community (Carlson et al., 2020). The safety profile of buprenorphine, along with the therapeutic use of diverted medication, has led some to argue that it should be available without a prescription (Roy & Stein, 2019).

There are several benefits to reducing our reliance on routine UDT. First, by not performing UDT, the focus shifts to patient goals and how they have progressed in the domains of their lives that are important to them as opposed to the binary results of a UDT. This works well in primary care-based OBOT where there is a holistic and longitudinal approach to patient care. Second, there could be a reduction in health care costs for society in general and especially for patients who are burdened with substantial co-pays. Finally, the environmental impact of the production and disposal of the millions of plastic cups that are used for this practice is mitigated (Taddonio, 2020).

We should also consider the potential harms associated with UDT when the results are used to determine whether an individual is to be given access to buprenorphine. Research has recognized that a “medication-first” strategy of OUD treatment where buprenorphine is not contingent on substance use improves outcomes of patients with OUD (Winograd et al., 2019). More importantly, when practitioners stop MOUD, patients’ risk of returning to illicit opioid use significantly increases (Bentzley et al., 2015). In practices where UDT results dictate treatment decisions, patients may lose access to medication as a result. Such a practice was not aligned with evidence before COVID-19 and this is a good time to put an end to it.

Finally, for patients who are in long-term remission, routine UDT at arbitrary intervals is not helpful. While regulators and insurers encourage this practice, patients may wonder why they must continue to have UDT even though every test for years has been appropriate. Requiring patients to continuously provide UDT may result in their feeling untrusted, embarrassed, or further stigmatized. Moreover, there is the risk of false positive results that can be distressing for patients in long-term recovery and may foster distrust on both sides of the clinician-patient relationship.

During the COVID-19 pandemic, we have used targeted UDT, paired with diagnostic reasoning and a patient-centered plan for how we will use the results. Targeted UDT is helpful when evaluating a patient who is exhibiting potentially toxic effects of an unknown substance, to help guide treatment initiation for opioid agonist or antagonist therapy, or

for those patients who want or would benefit from the positive reinforcement of UDT.

COVID-19 and the transition to telemedicine in our primary care practice have forced us to question what we regarded as an essential part of OBOT. We hope obtaining routine UDT will become a relic of the past. This experience has reinforced our ability to tolerate uncertainty, and allowed us to refocus on building and maintaining relationships with our patients and to use targeted UDT as a part of patient-centered OUD care.

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