



**A Drug Court Team
Member's Guide**
to Medication in
Addiction Treatment

Introduction

This pocket guide is intended for non-clinical drug court team members (e.g., court coordinators, judges, defense attorneys, prosecutors, parole officers, case managers, peer mentors, recovery coaches). It will describe how the team member can support both the provider and those participants prescribed or considering medication-assisted treatment (MAT).

This pocket guide was produced by the American Society of Addiction Medicine (ASAM) and the National Association of Drug Court Professionals (NADCP). It reflects up-to-date, evidence-based information and has been created by addiction medicine specialists and criminal justice experts to help support optimal outcomes for justice-involved individuals.

Readers will:

- Understand the effectiveness of MAT for opioid use disorder (OUD) and reasons to include MAT in services offered to drug court participants.
- Review characteristics of state of the art addiction treatment and evidence-based practices related to MAT to effectively refer to MAT providers.
- Discuss how to support assessment, diagnosis, and treatment of participants' OUD.
- Review specific treatment issues, including opioid overdose and withdrawal, the use of MAT, and psychosocial treatments.
- Apply knowledge and skills about evidence-based practices to support drug court participants and MAT providers.
- Understand best practices and procedures to help support treatment adherence.

Understanding Addiction and Medication in Addiction Treatment

Addiction is “a primary, chronic disease of brain reward, motivation, memory, and related circuitry,” with a “dysfunction in these circuits” leading to “characteristic biological, psychological, social, and spiritual manifestations.” Brain changes result in the pathologic behavior of pursuing reward and/or relief by substance use and other maladaptive behaviors.¹

Addiction is about a physiologic change in the brain – not just about behaviors. While it is crucial to consider psychosocial and behavioral interventions in addiction treatment due to their efficacy, it is also crucial to consider the use of medications necessary to address the changes in brain circuitry and improve outcomes in conjunction with comprehensive psychosocial treatment.

“National Institute on Drug Abuse (NIDA) Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide” identifies 13 principles, including:

Principle #2 states that recovery from drug addiction requires effective treatment, followed by management of the problem over time.

Principle # 5 indicates the need to tailor services to fit the needs of the individual as an important part of effective addiction treatment for criminal justice populations.

Principle # 12 identifies that medications are an important part of treatment for many people in the criminal justice system suffering from addiction.²

Medication-assisted Treatment:

- Represents scientifically supported treatment shown to reduce drug use and foster meaningful recovery. When appropriately dosed, medication should result in neither euphoria (“high”) nor sedation.
- Can help participants feel normal and prepare them for working on their recovery.
- Helps participants focus on their ongoing recovery by reducing cravings. Thus, participants should be supported in understanding and taking medication.
- Is **not** substituting one addictive drug for another. Medication has specific actions on neurotransmitter receptor sites to decrease cravings to use, shorten the length of any relapses, and improve overall addiction and recovery outcomes. Medication saves lives.
- Significantly increases treatment entry and retention among individuals on probation and parole.
- Combined with addiction counseling, is essential for the typical drug court participant with OUD and provides the best hope for recovery.
- Does not preclude drug court program progression or completion when used by a participant in ongoing addiction treatment.



Medication for Initial and Continued Treatment of OUD

Medication has been shown to be effective and is recommended for most people with moderate to severe OUD who are on parole or who are incarcerated, detained in jail, or on probation (regardless of the length of their sentence term).

- Individuals with OUD within the criminal justice system should have integrated care, and most should be treated with some type of medication in addition to psychosocial treatment.
- Please note that NADCP recommends against requiring participants to agree to addiction medications as a prerequisite for drug court program participation or advancement.
- Opioid agonists (methadone), partial agonists (buprenorphine), and antagonists (naltrexone) may be considered for treatment.

Agonists	Act on the opioid receptor but have effects which are less intense, slower, and longer-lasting than opioids like heroin. This means that agonists alleviate withdrawal and craving but don't provide the same euphoria, or "high," of the misused opioid.
Partial agonists	Produce effects that are similar to but weaker than those of full agonists
Antagonists	Work by blocking the action of receptors. Should a participant undergoing treatment with an antagonist-type medication relapse and use the formerly misused opioid, that drug's power to trigger the receptors is often blocked or greatly diminished. All participants, including those in drug courts, should have access to all three types of medication with treatment based on participant preference and clinical assessment.

- Buprenorphine and naltrexone can be prescribed in an office-based setting and can also be dispensed in an Opioid Treatment Programs (OTP) setting.
- Methadone can only be dispensed in regulated settings, such as OTPs. OTPs provide medication treatment, including methadone, and counseling to participants with OUD. They are approved by the Substance Abuse and Mental Health Administration (SAMHSA), accredited by a licensing body, licensed by the state, and registered with the Drug Enforcement Agency (DEA).
- As with medication for other illnesses that need ongoing treatment, there is no recommended length of time for medication in addiction treatment. Treatment continues depending on severity of illness and outcomes and response to treatment. The continued use of medication should not preclude drug court program progress or completion.
- When medication is indicated, it should be initiated a minimum of 30 days prior to release from jail or prison and be accompanied by assertive efforts of reentry or other drug court case managers to find providers to continue such treatment post-release.
- “Decisions about the appropriate type, modality and duration of treatment should remain the purview of the treatment provider and the participant, working in collaboration to achieve shared treatment goals.”³

Assessment, Diagnosis, and Treatment Setting Decisions for OUD

Assessment

The multidimensional assessment must be conducted by a skilled clinician using a valid assessment tool that facilitates the following of an ASAM Criteria multidimensional assessment. An ASAM Criteria assessment includes evaluating the individual’s needs related to withdrawal management, other medical conditions, mental health needs, motivation, relapse risk, and living environment.

Diagnosis

- The clinician will verify a diagnosis of OUD before prescribing pharmacotherapy for OUD.
- Diagnosis and/or referral for evaluation are conducted for any suspected mental health or medical disorders.

Referring to an Appropriate Treatment Setting

- Counselors collaborate in shared decision-making between the prescribing clinician and participant to choose from available treatment options after discussing potential benefits and risks for different options available to the drug court participant.
- Prescribing clinicians consider participant preferences, past treatment history, and setting when deciding between use of methadone, buprenorphine, or naltrexone for OUD.
- Some participants are linked to an OTP with methadone if they may benefit from daily dosing, the structure of the OTP model, and supervision to increase adherence. Participants may also be linked to an OTP with methadone if other forms of MAT have been unsuccessful in an OTP or office-based setting or if other forms of MAT are not available (e.g., no prescribing physician in the community).



Specific Issues in Caring for Participants with OUD

These include opioid overdose and withdrawal; use of methadone, buprenorphine or naltrexone; psychosocial treatments; and special populations.

Responding to an Opioid Overdose

- Naloxone, available as an injection or an intranasal spray, should be given in known or suspected opioid overdose.
- Naloxone can and should be administered to pregnant women in overdose to save the mother's life.
- Participants being treated for OUD and their family and significant others should be given prescriptions for naloxone.
- First responders, such as emergency medical services personnel, police officers, and firefighters, should be trained and authorized to administer naloxone.

Steps in Addressing Overdose⁴

1 Call for Help (Dial 911)

2 Recognize the Signs of Overdose

- Inability to awaken verbally or upon sternal rub (the application of painful stimuli with the knuckles of closed fist to the center chest of a person who is not alert and does not respond to loud voice)
- Slow or shallow breathing
- Fingernails or lips turning blue/purple
- Extremely small pupils – “pinpoint pupils”
- Slow heartbeat and/or low blood pressure

3 **Administer Naloxone**

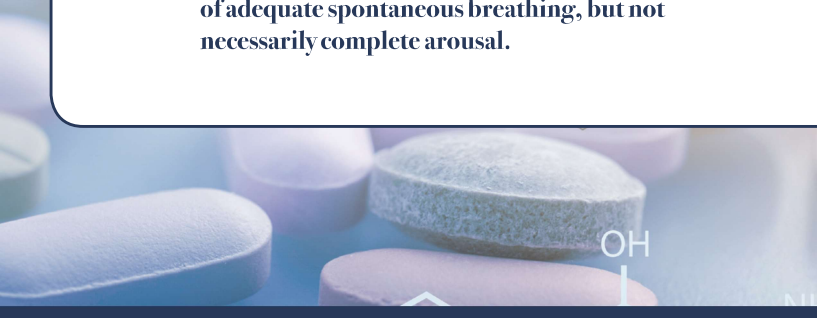
- Naloxone is available as an intranasal spray or an injection that can be given intravenously or intramuscularly.
- More than one dose of naloxone may be required to revive the person.

4 **Support Respiration**

- Verify that the airway is clear.
- With one hand on the person's chin, tilt the head back and pinch the nose closed.
- Place your mouth over the person's mouth to make a seal and give two slow breaths (the person's chest should rise, but not the stomach).
- Follow up with one breath every five seconds.

5 **Monitor the Person's Response**

- Most people respond to naloxone by returning to spontaneous breathing, with mild withdrawal symptoms within 3-5 minutes. (Rescue breathing should continue while waiting for the naloxone to take effect.)
- The duration of the effect of naloxone is 30-90 minutes. People should be observed after that time for reemergence of overdose symptoms.
- Stay with the person until emergency services arrive.
- **The goal of naloxone therapy should be restoration of adequate spontaneous breathing, but not necessarily complete arousal.**



Managing Opioid Withdrawal

Opioid Withdrawal

- Opioid withdrawal refers to the wide range of symptoms that occur after stopping the use of opioid drugs. Withdrawal can last up to 10 days, but most often lasts between 3-5 days.
- Although withdrawal can cause very troubling symptoms (such as vomiting, cramps, and sweating), it is rarely life-threatening when treated appropriately.

Opioid Withdrawal Management (WM)

- Using medications to control withdrawal, such as methadone or buprenorphine (also called withdrawal management) is almost always recommended over trying to quit “cold turkey.” When participants try to quit “cold turkey,” it can lead to risky complications, stronger cravings, and continued use.
- WM on its own is not a treatment method. Abrupt cessation of opioids may lead to strong cravings, which can lead to continued use. In addition, the risk of death from fatal overdose is markedly increased after WM due to the loss of tolerance and high likelihood of relapse.
- Initiation of methadone or buprenorphine does not require preceding WM. These medications when initiated will resolve withdrawal symptoms and can then be continued for maintenance treatment.
- In the event that a participant is not initiating maintenance treatment, using medications for opioid WM is recommended over abrupt cessation of opioids. However, it should always be followed by the initiation of long-term treatment.
- Opioid withdrawal should be avoided during pregnancy due to fetal risk and potential for relapse.
- Multidimensional assessment for further treatment is necessary for participants in opioid WM.

Types of Medication-assisted Treatment

Methadone (Agonist)

- Methadone is a treatment option recommended for participants with moderate to severe OUD who may benefit from daily dosing and supervision to increase adherence, and/or for those for whom buprenorphine has been unsuccessful.
- The administration of methadone is monitored until the participant's clinical response and behavior demonstrate that the prescribing of nonmonitored doses is appropriate. These nonmonitored doses are called "take homes" and allow a participant to manage a certain number of days of medication at home.
- Methadone should be reinstated immediately if relapse occurs, or when an assessment determines that the risk of relapse is high for participants who previously received methadone in OUD treatment, but who are no longer prescribed such treatment.
- Abrupt discontinuation of methadone precipitates acute withdrawal. Participants should be warned about this and encouraged not to miss appointments.
- Participants who discontinue therapy with methadone or buprenorphine and then resume opioid use should be made aware of the risks associated with opioid overdose, especially the increased risk of death.
- Participants and treating clinicians should be aware that acute pain requiring hospitalization, such as surgery or major trauma, often requires higher doses of opioids in order to overcome opioid tolerance.

Buprenorphine (Partial Agonist)

- To reduce the risk of precipitated withdrawal, participants should wait until they are experiencing mild to moderate opioid withdrawal before taking the first dose of buprenorphine.
- Buprenorphine may be started in a medical office or at home.
- Psychosocial treatment should be provided in conjunction with the use of buprenorphine in the treatment of OUD. Because most physicians who prescribe buprenorphine do not provide psychosocial treatment, the drug court will likely need to assist the participant to secure that treatment elsewhere in the community.
- Clinicians should take steps to reduce the chance of buprenorphine diversion.

Recommended strategies include frequent office visits (weekly in early treatment), toxicology testing, including testing for buprenorphine and metabolites, recall visits for pill counts, and formulations of buprenorphine that reduce diversion risk.

- Participants should be tested frequently for buprenorphine, as well as for illicit use of other substances, including prescription medications. Such testing is common in drug court programs and treatment providers will likely be able to access these test results from the court.
- Participants should be seen frequently at the beginning of their treatment. Weekly visits (at least) are recommended until participants are determined to be stable.

There is no recommended time limit for treatment.

- Some participants who are stable after long-term treatment may decide to try tapering off of the medication. Buprenorphine taper and discontinuation is a slow process and close monitoring is recommended.

Buprenorphine tapering is generally accomplished over several months. Participants should be encouraged to remain in treatment for ongoing monitoring past the point of discontinuation.

- Abrupt discontinuation of buprenorphine precipitates acute withdrawal. Participants should be warned about this and encouraged not to miss appointments.

- Participants who discontinue partial agonist therapy and resume opioid use should be made aware of the risks associated with an opioid overdose, especially the increased risk of death. Overdose education and naloxone distribution should be made available.
- Participants and treating clinicians should be aware that acute pain requiring hospitalization, such as surgery or major trauma, often requires higher doses of opioids and/or stopping buprenorphine in order to overcome opioid tolerance.

Extended-release Naltrexone (Antagonist)

- Naltrexone is an antagonist medication. It is a treatment option for preventing relapse in OUD, particularly among participants who become highly motivated during the treatment process and are therefore likely to continue to adhere to treatment following the completion of criminal justice monitoring. To start naltrexone, a person must be abstinent from opioids for 7-10 days.

Extended-release injectable naltrexone is a monthly injection, which has been shown to be more effective than no medication at reducing relapse risk.

Naltrexone has no risk for diversion or overdose. However, individuals who stop taking naltrexone and experience a relapse are at increased risk for overdose.

Use of naltrexone results in loss of opioid tolerance, potentially exposing participants who relapse to a fatal overdose similar to that observed following completing of withdrawal (“detox”) or following release from prison. This risk for relapse and overdose must be carefully considered, particularly following the end of court monitoring, when there may be less incentive for the individual to continue with naltrexone. Participants should be warned about this loss of tolerance.

- Psychosocial treatment, including relapse prevention, is recommended in conjunction with treatment with naltrexone.
- There is no recommended length of treatment with extended-release injectable naltrexone.

Duration depends on clinical judgment and the participant’s individual circumstances. Because there is no physical dependence associated with naltrexone, it can be stopped abruptly without withdrawal symptoms, although there is an increased risk of overdose with relapse due to decreased tolerance to opioids during the period of abstinence.

- Participants who discontinue antagonist therapy and resume opioid use should be made aware of the increased risks associated with an opioid overdose, and especially the increased risk of death from loss of opioid tolerance and hypersensitivity to opioids.
- When participants have been maintained on naltrexone, they will be more sensitive to opioids if they stop taking naltrexone. This means that they won't need as large of a dose of opioids to get the same effect as before. The danger in this is that if they relapse and take an amount of opioids that once gave them a high, that dose may be too large of a dose now and they can overdose and even die. As a result, the drug court must work with them to ensure they have the support they need once the court is no longer supervising participants.
- Participants should be made aware that acute pain requiring hospitalization, such as surgery or major trauma, often requires non-opioid analgesia and is best managed in conjunction with an anesthesiologist or pain management expert. When feasible, injectable naltrexone should be discontinued at least 30 days prior to planned surgery.

Levels of Care for Substance Use Disorder (SUD) Treatment in the Criminal Justice System

- When The ASAM Criteria is skillfully applied to the criminal justice system, the full continuum of levels of care can and should be available to participants.
- The level of care a participant receives for treatment should match that person's severity of illness and functional level. A one-size-fits-all approach should not be taken when determining the appropriate level of care for participants. The participant should not be placed in a residential setting solely for public safety reasons or as an extension of the correctional system if there is no clinical reason that requires a 24-hour setting.
- Specific provision of services, including medication, should be available in every level of care if needed.

- In particular, participants and clinicians should carefully consider the decision to terminate treatment with agonist or antagonist medications (e.g., methadone, buprenorphine, or naltrexone), as discontinuing treatment risks withdrawal, relapse, and overdose. Withdrawing addiction medication while incarcerated or in prison undermines treatment and is strongly discouraged.
- For all participants in drug court, treatment should be given in a level of care that matches the clinical assessment and progress of the participant.

Medications to Treat Opioid Addiction

Medication	Brand names
Buprenorphine	Probuphine® (implant) *, generics, Sublocade™ (extended-release injection)
Buprenorphine and naloxone	Suboxone® (under tongue film), Zubsolv® (tablets), Bunavail® (check film), generics
Methadone	Generics
Extended-release naltrexone	Vivitrol® (injection)

* Other extended-release buprenorphine formulations expected to come to market



Psychosocial Treatment

- Psychosocial treatment is recommended in conjunction with any pharmacological treatment of OUD. At a minimum, psychosocial treatment should include the following: psychosocial needs assessment, supportive counseling, links to existing family supports, and referrals to community services. Examples include counseling during medication management visits, adjunctive mental health treatment, and referral to community agencies to assist with housing or food, and vocational training or education and job placement. For the typical drug court participant with high needs and related risk factors, treatment designed to enhance intrinsic motivation, improve insight, and develop new skills is also likely to be needed.
- Treatment planning should include collaboration with qualified behavioral health care providers to determine the optimal type and intensity of psychosocial treatment and for renegotiation of the treatment plan for circumstances in which participants do not adhere to recommended plans for, or referrals to, psychosocial treatment.

Linking Participants to MAT

- Many drug courts rely on their treatment team members or local SUD treatment programs to determine whether medication is indicated and to identify qualified medical practitioners.
- However, many treatment programs do not have physicians and nurses on staff and may have limited access to or familiarity with medication. In some cases, programs may even be biased against medication. Nonetheless, in order to effectively provide services to drug court participants, drug court clinicians must develop the ability to connect participants with programs and professionals who administer medication.
- The following websites provide directories of physicians, nurse practitioners, physician assistants, and treatment agencies specializing in addiction medicine and addiction psychiatry. Most of the websites can be queried by city, state, and zip code to identify medical practitioners located close to a drug court.

Finding a MAT provider:

American Society of Addiction Medicine:

community.asam.org/search

American Board of Addiction Medicine:

abam.net/find-a-doctor

American Board of Preventive Medicine

<https://certification.theabpm.org/physician-lookup>

American Board of Psychiatry and Neurology:

<https://www.abpn.com/check-physician-status/search-board-certified-physician/>

American Academy of Addiction Psychiatry:

aaap.org/patient-resources/find-a-specialist

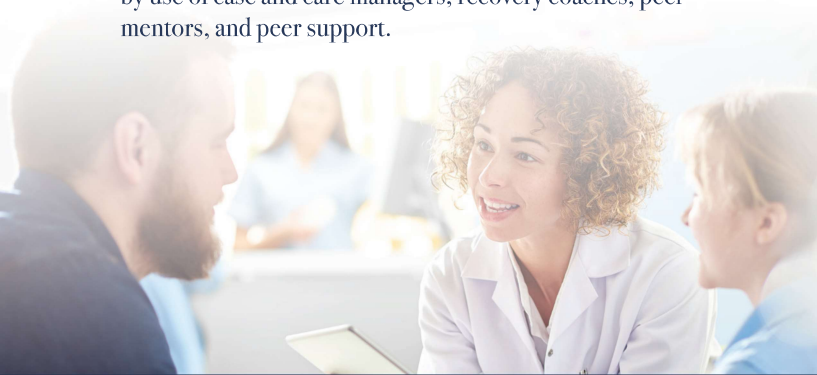
SAMHSA Buprenorphine Treatment Physician

Locator: findtreatment.samhsa.gov

SAMHSA Behavioral Health Treatment Services

Locator: samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

- Local, single-state agencies for addiction treatment usually maintain lists of credentialed providers, including those authorized to provide office-based treatment with buprenorphine.
- Contact state or county boards of health to identify medical practitioners offering addiction treatment in the local area.
- Once a clinician has been located, it is important to *link* the participant to medication, not simply *refer* a person. This includes engaging the participant in understanding and consenting to medication and ensuring continuity of care by use of case and care managers, recovery coaches, peer mentors, and peer support.



Procedures to Assure Treatment Adherence

The following standards and procedures are adapted from the NADCP Adult Drug Court Best Practice Standards Volume II.⁵

I. Multidisciplinary Team

A dedicated multidisciplinary team of professionals manages the day-to-day operations of the drug court, including reviewing participant progress during pre-court staff meetings and status hearings, contributing observations and recommendations within team members' respective areas of expertise, and delivering or overseeing the delivery of legal, treatment, and supervision services.

A. Team Composition

The drug court team comprises representatives from all partner agencies involved in the creation of the program, including but not limited to a judge or judicial officer, program coordinator, prosecutor, defense counsel representative, treatment representative (knowledgeable about the participants' progress with the addiction medication prescriber and treatment program), community supervision officer, and law enforcement officer.

B. Pre-court Staff Meetings

Team members consistently attend pre-court staff meetings to review participant progress, determine appropriate actions to improve outcomes, and prepare for status hearings in court.

C. Sharing Information

Team members share information as necessary to appraise participants' progress in treatment and compliance with the conditions of the drug court. Partner agencies execute memoranda of understanding (MOUs) specifying what information will be shared among team members. Participants provide voluntary and informed consent, permitting team members to share specified data elements relating to participants' progress in treatment and compliance with program requirements. Defense attorneys make it clear to participants and other team members whether they will share communications from participants with the drug court team.

Information shared should focus on attendance, adherence, and whether the participant is changing his or her attitudes, thinking, and behavior in areas that previously threatened public safety, legal recidivism, and safety for children and families.

- Treatment providers share whether and how the participant is responding to addiction medication.
- Treatment reports should broaden information beyond mere attendance at all prescribed activities, participation in drug testing, and signed verifications of attendance at mutual/self-help support groups.
- To be proactive about public safety and the safety of children and families, all members of the multidisciplinary team share observations on whether the participant is demonstrating improvement.
- Team members contribute relevant insights, observations, and recommendations based on their professional knowledge, training, and experience. The judge considers the perspectives of all team members before making decisions that affect participants' welfare or liberty interests and explains the rationale for such decisions to team members and participants.



II. Drug and Alcohol Testing

Drug and alcohol testing provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout participants' enrollment in the drug court.

- Drug testing should be used in conjunction with participant self-report and should never be used as the sole means for assessing substance use. It is crucial to tailor the choice of test and frequency to the clinical needs of the participant and avoid unnecessarily frequent or expansive testing, which is wasteful. The clinician ordering and interpreting the toxicology testing must understand the characteristics of the test. Definitive testing should always be used when the results will influence clinical or drug court decision-making. Positive testing alone should almost never result in punitive sanctions or detention for participants with moderate to severe SUD. The focus of any sanctions must be related to treatment adherence and candor, not solely ongoing substance use.
- ASAM has guidelines outlining best practices for drug testing in addiction settings: "ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine."⁶
- NADCP has developed a set of standards outlining how drug testing is applied in drug court settings.⁵



Abbreviations

ASAM	American Society of Addiction Medicine
COWS	Clinical Opioid Withdrawal Scale
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
FDA	Food and Drug Administration
HIV	Human immunodeficiency virus
OBOT	Office-Based Opioid Treatment
OD	Opioid use disorder
OOWS	Objective Opioid Withdrawal Scale
OTP	Opioid Treatment Program
SOWS	Subjective Opioid Withdrawal Scale
TB	Tuberculosis
WM	Withdrawal management



Endnotes

¹ ASAM Definition of Addiction. www.asam.org/for-the-public/definition-of-addiction

² National Institute on Drug Abuse. Principles of Drug Abuse Treatment for Criminal Justice Populations. <https://www.drug-abuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles>

³ The ASAM Criteria, ASAM Public Policy Statement: Opioid Treatment Services, 2013, pp. 290 - 298.

⁴ Substance Abuse and Mental Health Services Administration (SAMHSA). Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 14-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

⁵ National Association of Drug Court Professionals (NADCP), Adult Drug Court Best Practice Standards Volume II.

⁶ The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine. <https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing>



Additional Resources

- ASAM's Website to see pocket guide evaluation and treatment figure: <https://my.guidelinecentral.com/admin/builder/img/7d1296e996f433307883cc7cf-77b2eb87818389d.png>
- “The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use” American Society of Addiction Medicine (ASAM) Pocket Guide. *The ASAM Criteria*, 2013 pp. 43-53.
- Mee-Lee D, Shulman GD, Fishman MJ, and Gastfriend DR, Miller MM, eds. (2013). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. Third Edition. Carson City, NV: The Change Companies. Appendix A, The ASAM Criteria, 2013, pp. 393-400.
- National Association of Drug Court Professionals (NADCP), Adult Drug Court Best Practice Standards Volume I. <http://www.nadcp.org/wp-content/uploads/2018/03/Best-Practice-Standards-Vol.-I.pdf>
- National Association of Drug Court Professionals (NADCP), Adult Drug Court Best Practice Standards Volume II. http://www.nadcp.org/sites/default/files/2014/Best%20Practice%20Standards%20Vol.%20II._0.pdf
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Arlington, VA, American Psychiatric Association, 2013.
- ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine. <https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing>
- Free webinars and additional material about treatment at ASAM; link to the National Practice Guideline and the ASAM Criteria at ASAM.org
- ASAM has guidelines outlining best practices for drug testing in addiction settings: “ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine.” <https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing>

