Beacon Health Options — formerly ValueOptions — has issued a white paper, “Confronting the Crisis of Opioid Addiction,” that calls for a focus on outpatient medication-assisted treatment by primary care. The paper is meant to “start a dialogue,” said Emma Stanton, M.D., associate chief medical director of Beacon, a managed behavioral health care company. Stanton, who is also CEO of Beacon UK, said that there is a “variation in practice” in which providers “champion one form over another.” What Beacon wanted to do with the white paper was to talk about reducing this variation, she told ADNW in an interview after the paper came out earlier this month. The paper met with swift criticism from the addiction medicine specialty field (see “ASAM objections,” page 3).

The paper focuses on the need to treat opioid addiction as a chronic, not acute, condition, noting that in many cases, multiple episodes of inpatient treatment still do not result in permanent recovery. “Unfortunately, our health care system is currently organized to treat this addiction primarily with acute care services and the hope of abstinence upon discharge,” the report states. “Evidence tells us that this approach typically leads to treatment failures and readmissions to acute detoxifi-

The most widely available mutual support groups are 12-Step groups, such as Alcoholics Anonymous (AA), but other mutual support groups such as Women for Sobriety (WFS), SMART Recovery (Self-Management and Recovery Training), and Secular Organizations for Sobriety/Save Our Selves (SOS) are also available.”

It should hardly come as news to addiction treatment programs and referring professionals in 2015 that alternatives to AA and its related mutual-help organizations might constitute an option for their patients. The above quote is taken from a federal Center for Substance Abuse Treatment (CSAT) fact sheet on mu-
Bentsen told Alcoholism & Drug Abuse Weekly that methadone should be provided as an addiction treatment in primary care in an office-based setting, rather than the highly regulated opioid treatment programs (OTPs) as is required under current law. “Where I practice, that’s the norm,” she said of office-based methadone.

Beacon does currently cover treatment in OTPs in the United States, said Bentsen, adding that the company wants to expand this. Treatment providers should be required to give verbal and written explanation of available MAT to treat opioid addiction — methadone, buprenorphine, buprenorphine-naloxone, oral naltrexone and long-acting injectable naltrexone, according to the paper.

In addition, Beacon wants to lift the physician cap on buprenorphine patients; however, this cap should be lifted only for those “providers that demonstrate clear evidence-based protocols and provide full wrap-around services for their addictions patients,” the paper states. Finally, midlevel practitioners should be able to prescribe methadone and buprenorphine, the paper states.

Reimbursement models

Beacon favors capitated reimbursement models that put providers at risk, and that “focus on quality, rather than quantity, of service.” The specifications for provider performance would “target outcomes, member engagement and movement along the continuum to less restrictive, intensive, community-based services, and ultimately, maintenance treatment.”

An “episode bundle” would pay a provider a flat set amount for a continuum — for example, detox, rehabilitation step-down and two months of outpatient treatment, followed by a year. Over that continuum, the provider would be held to quality outcomes, such as detox re-admission, therapy completion and self-reports by members. Beacon would like this kind of reimbursement to be required.

The paper supports the 10 levels of care of the American Society of Addiction Medicine (ASAM), which “allow the flexibility to provide person-centric care in the least restrictive, most effective setting, with the goal to achieve recovery in the community.”

Low reimbursements have prevented some providers from offering extended-release injectable naltrexone, the report states. At the same time, fee-for-service has led to the “overuse of laboratory testing.”

Other recommendations from the paper:

• Make overdose-reversal medication naloxone widely available without a prescription.
• Make addiction a primary care...
Murphy reintroduces bill to gut SAMHSA, adding 42 CFR Part 2

There’s little specific to substance use disorders (SUDs) in the “Helping Families in Mental Health Crisis Act of 2015,” a bill from 2013 reintroduced June 4 by Rep. Tim Murphy (R-Pennsylvania) (see ADAW, Dec. 16, 2013). Like its predecessor, the bill seeks to encourage outpatient commitment, which mental health patient advocates oppose, but at the same time funds mental health programs, especially those based in psychiatry and psychology and medications. But there is one item affecting patients with SUDs: a provision that specifically would weaken 42 CFR Part 2, the confidentiality regulation banning the release of information on patients treated for SUDs. The bill wouldn’t change 42 CFR Part 2 itself, but rather make certain information inapplicable to it. And it would be retroactive —

Continues on next page

ASAM objections

Stuart Gitlow, M.D., immediate past president of ASAM, had plenty of criticism for the paper. First, he said there was no evidence for the recommendation that only providers who gave wrap-around addiction services should be able to prescribe buprenorphine without a cap. “There is no research to indicate that providing wrap-around services for addiction patients has any relationship to quality of care that can be provided by a physician in these cases,” he told ADAW.

Gitlow said that there is a need for more addiction specialist physicians, something the Beacon paper fails to address. Instead, Beacon suggests that including primary care is a more immediate way to expand access. “Here again, there is little to suggest that primary care approaches result in successful treatment of those with addictive disease,” said Gitlow. “If we suddenly had a crisis in which millions of people suddenly fell and hit their heads, we would not suggest that primary caregivers should provide neurosurgery,” he said. “Rather, we would want an increase in the number of well-trained high-quality neurosurgeons.” The solution is “an increased number of well-trained high-quality addiction specialists,” he said, not primary care for the treatment of addiction.

Finally, Gitlow said that the paper is incorrect in suggesting that the fee-for-service model of payment is part of the opioid crisis. “There is no evidence to suggest that payment structure has anything to do with this issue, or that alternative models would do anything to improve the situation,” he said. “The addiction medicine community has always described addictive illness as requiring a chronic care model.” Indeed, it is the insurance companies that have been focusing on the acute phase. “It has only been third parties, outside the physician-patient relationship, which have been attempting — and failing — to treat addictive disease as if it is a series of acute episodes,” he said. “In fact, the acute episodes generally revolve around intoxication and withdrawal, states in which the addictive illness can barely begin to be addressed.”

Gitlow noted that it was in the 1950s and early 1960s that Marvin Block, M.D., of the American Medical Association, wrote that patients with addiction require lifelong, ongoing treatment. “His efforts, and other efforts like his, were largely ignored by the growing payer community, and nothing has changed,” he said.

Finally, we asked Stanton why a behavioral health carveout like Beacon would be recommending addiction treatment delivery in primary care. “We don’t see ourselves as a carveout,” said Stanton. “This partly relates to issues of stigma which the white paper calls out as being a major barrier.” She said the field of addictionology would not be able to scale up fast enough to meet the need. However, the proposal of treating addictions in primary care with medications raises questions about whether payment would come from the patient’s medical-surgical and pharmacy benefit, rather than the behavioral health benefit — questions the white paper did not address.

people who thought they had been protected by 42 CFR Part 2 would not be protected anymore.

Like its predecessor in 2013, the bill eliminates the Substance Abuse and Mental Health Services Administration (SAMHSA) and adds a bureaucracy within the Department of Health and Human Services at the assistant secretary level.

The bill focuses primarily on mental health — except for the provision removing the privacy protections for people in treatment for SUDs, by saying that SUD information doesn’t apply to 42 CFR Part 2 if treatment took place in an integrated health system.

The bill amends section 543(e) of the Public Health Service Act (42 U.S.C. 290dd–2(e)) by inserting that information may be shared “within accountable care organizations described in section 1899 of the Social Security Act (42 U.S.C. 1395jj), health information exchanges (as defined for purposes of section 3013), health homes (as defined in section 1945(h) (3) of such Act 42 U.S.C. 1396w–4(h) (3)), or other integrated care arrangements (in existence before, on, or after the date of the enactment of this paragraph) involving the interchange of electronic health records (as defined in section 13400 of division A of Public Law 111–5) (42 U.S.C. 17921(5)) containing information described in subsection (a) for purposes of attaining interoperability, improving care coordination, reducing health care costs, and securing or providing patient safety.”

**Retroactivity**

Not only does the bill change the meaning of 42 CFR Part 2, but it would change it retroactively for all “integrated care arrangements,” including those “in existence before” the date of enactment. That means that people in treatment decades years ago, who did not consent to the release of their information, might not be protected. It also could discourage anyone in an integrated system from seeking treatment for an SUD.

This is of great concern to H. Westley Clark, M.D., until last fall director of SAMHSA’s Center for Substance Abuse Treatment, which promulgates 42 CFR Part 2.

Clark calls the provision, which makes SUD information inapplicable to 42 CFR Part 2 if it occurred in an integrated health system, an “all-encompassing privacy buster.” The provision “nullifies the understanding that past patients had when they entered treatment, even if that treatment was 20 years ago,” said Clark, now a professor of public health at Santa Clara University in California. “People in recovery will be stripped of their autonomy to decide whether they want to share their past history.”

The argument for the change is that releasing information is “for their own good,” said Clark, adding that he hasn’t seen any studies that indicate that this release of information “for their own good” was warranted. “People with SUDs are an inconvenient afterthought in this bill,” said Clark. They are “given nothing, but forced to give up the most private of rights — personal autonomy.”

**Harm to patients**

Clark thinks people will deny having a problem with alcohol or drugs, “once it becomes known that anything you say will be held against you.” He may be wrong, he admitted. “But I know that once logic pre-

---

**What 42 CFR Part 2 says**

What follows is from subsection (a) from 42 CFR Part 2, which the Murphy bill would make inapplicable for information related to integrated — itself a vague term — health care:

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (c) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.
I have spent a career working on the issues of crime and substance abuse, including a time as vice president and chief operating officer of the National Crime Prevention Council. It is undeniable that substance abuse treatment for the incarcerated not only reduces recidivism, but in turn it allows its participants to at least have a chance at a productive life upon release. Based on my time working with states and communities on model state statutes and local ordinances related to drug abuse and gang violence, I can say this unequivocally.

Some members of Congress are to be praised for their efforts in the fight against substance abuse, and their recognition of the importance of treatment within the criminal justice system. In the Senate, Senators Rob Portman (R-Ohio) and Sheldon Whitehouse (D-R.I.) introduced the Comprehensive Addiction and Recovery Act (CARA), in both 2014 and 2015. Rep. Jim Sensenbrenner (R-Wis.) introduced a companion bill to CARA in the House. Senator Ed Markey (D-Mass.) introduced legislation that would expand access to medication-assisted treatment. Rep. Hal Rogers (R-Ky.), chair of the appropriations committee, remains committed to funding programs at the Department of Justice that screen for prescription drug abuse.

Yet when it comes to health policy, there is only one reality: funding. While rhetoric for increasing the amount of attention paid to substance abuse has been at an all-time high, the commitment to funding by Congress has not kept up. Congressional funding for the Substance Abuse and Mental Health Services Administration’s Substance Abuse Prevention and Treatment block grant has not kept up with inflation and, as a result, would need a $450 million increase just to bring its purchasing power back to where it was in 2010. There are no signs on the horizon that this negative trend will change any time soon.

**RSAT slashed**

Many members of Congress have uttered the phrase, or paraphrased, “We cannot arrest our way out of this problem.” They realize the law-and-order approach is not an effective deterrent to drug use. As a result, there has been much support in the past for the treatment of those in need who end up in the criminal justice system. One such program is the Residential Substance Abuse Treatment (RSAT) program housed by the Bureau of Justice Assistance in the Department of Justice.

According to the Bureau of Justice Assistance, 68 percent of jail inmates report substance abuse dependence prior to incarceration, with 29 percent being under the influence of drugs at the time of the offense and 16 percent committing offenses in order to obtain money for drugs. Of all jail inmates, over two-thirds were found to be dependent on or abusing alcohol or drugs. RSAT exists to help address the issue of substance abuse dependence and the direct link to public safety, crime and victimization by providing comprehensive treatment and services within the institution and in the community after a prisoner is released. RSAT funds are allocated to each state, the District of Columbia and territories based upon the respective prison population in relationship to the total prison population of all states combined.

So now, in 2015, when so many members of Congress are saying one thing, why are they doing another? Unless there is funding for programs that will benefit those in need, the words of support for treatment ring hollow. The appropriations subcommittee for Commerce, Justice, and Science (CJS) is guilty of this very hypocrisy. In their FY 2016 markup, they proposed the RSAT program be zeroed out. In layman’s terms, their recommendation was that funding for the program go from $11 million to nothing.

The CJS subcommittee slashed and burned in other places as well, and many of the programs impacted play a great role in reducing substance abuse or behavior that leads to it. Juvenile Justice programs overall are decimated, with a cut of $68 million below FY 2015 and $155.9 million below the White House request. This includes the proposed elimination of the Community-Based Violence Initiative, the National Forum on Youth Violence, the Local Delinquency Prevention Incentive grant program, the Children of Incarcerated Parents program, and a program targeting girls in the justice system.

Some politicians will recite the same tired lines. They need to prioritize. They hate to cut any programs, but in this fiscal environment, something has to go. What they are saying when they zero out a program such as RSAT is that substance abuse treatment is not a priority, especially among the incarcerated and the underserved. Such an act flies in the face of everything Congress has been telling us for the past year — that opioid abuse is the single greatest threat to our public health. If the members of the CJS subcommittee, led by Rep. John Culberson (R-Texas), truly believed this, the RSAT program would not only be fully funded, it would...
Recovery Brands’ co-founder on changes in Internet marketing

As a result of the lawsuit by Seabrook House against Recovery Brands and Elements, there have been changes in Internet marketing of addiction treatment programs. The lawsuit was dismissed, but it brought up the need for change (see *ADAW*, Nov. 2, 2014, and March 16, 2015).

We asked Recovery Brands’ co-founder Abhilash Patel to discuss some of the changes that have taken place on the Internet in terms of treatment center marketing. He also disclosed his own problems finding help many years ago.

Recovery Brands has a mission statement and an ethics statement as well as a white paper on Internet marketing, which it presented at the annual meeting of the National Association of Addiction Treatment Providers (NAATP). As NAATP Ethics Committee Chair Bob Ferguson told us, there will be a voluntary rather than an enforcement approach to problems (see *ADAW*, May 25). Patel approves of this.

Patel started Recovery Brands because of his problems finding help when he needed it. “I didn’t know where to go, and I found a lot of noise,” he said — “noise” being bait-and-switch and call centers. “We built Recovery Brands as a solution to that,” he said. “I made the wrong decisions because I didn’t know where to go.” Now, with more than 11 years in recovery, Patel said he has a “very personal relationship” with the business of treatment marketing.

The lawsuit by Seabrook House against Recovery Brands and Elements accelerated the need to find a solution, said Patel. “The lawsuit was without merit,” said Patel, but without it, there would not have been the attention paid to the problems of digital marketing of treatment programs.

Someone looking for help on the Internet today will still encounter the “noise” Patel met with when he was looking for help, he said. “Anyone can do a website,” he said, noting that at NAATP, Ferguson’s presentation included many examples of “defective behavior” in which websites stole Ferguson’s brand.

**White paper**

In the white paper presented at NAATP, which is currently undergoing revisions but which Patel shared with *ADAW*, Recovery Brands said its website does not allow advertisers to promise cures.

In addition, Recovery Brands promises to “clearly distinguish ads from content,” to “fully disclose site ownership and sponsorships,” and to “use pop-up explanations to clearly explain how our sponsored helplines operate.” Recovery Brands doesn’t sell or broker admissions, or engage in “consultant contracts” aimed to circumvent state regulations.

In the white paper, Recovery Brands also details the ethical obligations of treatment providers, including avoiding “bait-and-switch” in which one program substitutes for another in “search,” stealing calls, branding fraud or other tactics.

Examples of unethical digital marketing practices, according to the white paper, include:

- A company bids on a treatment provider’s name as a Google search term, using that provider’s name as a Google search term, using that provider’s name as a Google search term,...

**OASAS says it welcomes new providers to N.Y.**

In last week’s issue, several providers discussed problems with siting facilities in the Northeast — in particular, New York (see *ADAW*, June 8). In response, the state sent us this statement:

“The New York State Office of Alcoholism and Substance Abuse Services (OASAS) welcomes new providers of alcohol and substance abuse services to apply for certification to operate in New York State. OASAS has no policy against new providers coming into the state. There is also no policy against for-profit providers coming into the state. Any new provider application from in-state or out-of-state is carefully reviewed and is subject to review and approval by the State’s Behavioral Health Services Advisory Council. New providers are encouraged to visit this link [www.oasas.ny.gov/legal/CertApp/caphome.cfm] on the OASAS website for information about how to apply for certification to operate in the state.”
er’s name in its ad text. This is not only a violation of guidelines and trademark rules, but it also confuses consumers.

- A low-quality directory site lists thousands of facilities but only uses one phone number to funnel calls to its own call-center referral service or a treatment center owned by the same person running the directory site. This is bait-and-switch. It purposely confuses consumers into believing they are reaching one facility when they actually are contacting another.

- Facility X builds a large advertising campaign and subsequently constructs “contracts” with other facilities to refer inadmissible clients for a fee. Such kickbacks and patient brokering may be illegal and are always unethical, and drive up health care costs.

Examples of deceitful marketing practices include:

- Facility X stacks its Google, Yelp or Rehabs.com reviews with false entries made by employees or an offshore team. Most large, reputable third-party websites have strict rules against this practice.

- Facility Y’s website claims that it offers ultra-luxury beachfront amenities when the facility is actually located 20 miles from the beach.

- Facility Z sets up myriad false business names/locations in an attempt to drive nationwide local calls into its single call center.

Florida market

If it weren’t for the Internet, most patients would probably be looking locally for treatment. Asked why so many patients are diverted out of the Northeast to other states — in particular, Florida and California — Patel said the largest concentration of private programs is in those two states. “There’s a lot of competition in Florida,” he said. “They’re competing for a finite number of people.”

But no matter where a program is located, the cost of getting a good number of patients from Google — especially in the field of addiction treatment, which is one of the most expensive on the Internet — is keeping some providers from signing on. “I know the hard reality when it comes to online marketing,” said Patel. “But people don’t have to pay a million dollars to have a trusted website.” Rather, programs can “create sustainability” by owning their own brand, he said. “You just have to do good work,” he said.

For Recovery Brands’ mission and ethics statements, go to http://recoverybrands.com/mission.

Common elements

The mutual-support organizations that offer an alternative to the AA approach tend to de-emphasize disease language around addiction. For example, SMART Recovery looks at substance dependence as a learned behavior that can be modified through cognitive behavioral techniques. Alternative groups also do not tend to emphasize the presence of a directive higher power in one’s life.

Horvath said there are now around 1,500 SMART Recovery meeting groups worldwide, with around one-third of those in the United States (online meetings make up the majority of the meetings overall). He explained that the organization recently restructured its meeting format, partly in an attempt to attract more facilitators and a greater reach. The meetings now are structured more around exercises introduced by the host followed by discussion, rather than a much more open format throughout the meeting. Yet the meetings still include “periods of open discussion that would be called ‘cross-talk’ in a 12-Step group,” said Horvath.

Continues on next page
Increased interest among treatment or-
accountability and an emphasis on
mutual help,” he said. “Professionals are expected
to keep up with the field.”

He remains uncertain over
whether the pace of growth will ac-
celerate and the number of meetings
will reach a critical mass. Horvath,
who also is founder of the San Di-
ego–based Practical Recovery resi-
dential and outpatient treatment or-
ganization, has talked in the past
about reaching a goal of 5,000
SMART Recovery groups worldwide
less than a decade from now.

“I have come across what I view as willful ignorance” in the treat-
ment community regarding alterna-
tives, Horvath said. “If a 12-Step par-
ticipant has an option that’s working
for them, that’s good.” However, in-ormation about alternatives that
may appeal more to some patients
“has been out there for a long time,”
he said. “Professionals are expected
to keep up with the field.”

Huebner sees the slow but
steady growth of alternatives as a
positive for the treatment and recov-
er communities. “The hallmark of
alcohol use disorders is heterogene-
ity,” he said. “If we have a number of
options with a broader reach, there
is a greater probability of getting at
the problem.” •

For more information on addiction
and substance abuse, visit
www.wiley.com

ASAM releases practice guideline
on medications for opioid use
disorders

The American Society of Addic-
tion Medicine (ASAM) on June 2 re-
leased its National Practice Guide-
line for the Use of Medications in
the Treatment of Addiction Involv-
ing Opioid Use. The guideline “will
assist clinicians prescribing pharma-
cotherapies to patients with addiction
related to opioid use,” according
to a press release. “It addresses
knowledge gaps about the benefits
of treatment medications and their
role in recovery, while guiding evi-
dence-based coverage standards by
payers.” ASAM worked with the
Treatment Research Institute to de-
velop the guideline “using the RAND/UCLA Appropriateness Meth-
od (RAM), a consensus process that
combines scientific evidence with
clinical knowledge,” according
to the press release. To access the
guideline, go to www.asam.org/
docs/default-source/practice-sup-
port/guidelines-and-consensus-
docs/national-practice-guideline.
pdf?sfvrsn=18.

Continued from previous page

Horvath. This is something on which
participants rely.

AA and similar mutual-help
groups have a fairly extensive re-
search base, with most of the studies
showing a correlation between par-
ticipation and positive recovery out-
comes, Huebner said. “Studies have
shown that participation in a mutu-
al-help group is predictive of later
increases in abstinence, and this is
important early in an abstinence ca-
reer,” he said. In addition, more fre-
quent attendance and a longer over-
all duration of attendance result in
greater benefit, he said.

Twelve-Step support, which is
not a form of treatment, should not
be confused with Twelve-Step Facili-
tation, an evidence-based treatment
intervention. Huebner said that an
annual provider survey conducted
by the Substance Abuse and Mental
Health Services Administration in
2013 indicated that nearly half of re-
spondents reported using Twelve-
Step Facilitation at least often.

While the research base for the
alternative mutual-help groups is
largely nonexistent, Huebner sus-
ppects that they arguably would show
effectiveness because of some of the
characteristics they share with AA-
type groups. These include group
accountability and an emphasis on
building coping skills, he said.

“There’s something powerful about
mutual help,” he said.

Tipping point?

Although there has been an in-
creased interest among treatment or-
ganizations in offering alternative
mutual-help options for patients, the
growth in the number of meetings
has been more deliberate than ex-
ponential. “What I have seen for
years is that therapists refer to
SMART, but facilities are slower to
come on board,” said Horvath.

He remains uncertain over
whether the pace of growth will ac-
celerate and the number of meetings
will reach a critical mass. Horvath,
who also is founder of the San Di-
ego–based Practical Recovery resi-
dential and outpatient treatment or-
ganization, has talked in the past
about reaching a goal of 5,000
SMART Recovery groups worldwide
less than a decade from now.

“I have come across what I view
as willful ignorance” in the treat-
ment community regarding alterna-
tives, Horvath said. “If a 12-Step par-
ticipant has an option that’s working
for them, that’s good.” However, in-
formation about alternatives that
may appeal more to some patients
“has been out there for a long time,”
he said. “Professionals are expected
to keep up with the field.”

Huebner sees the slow but
steady growth of alternatives as a
positive for the treatment and recov-
er communities. “The hallmark of
alcohol use disorders is heterogene-
ity,” he said. “If we have a number of
options with a broader reach, there
is a greater probability of getting at
the problem.” •

For more information on addiction
and substance abuse, visit
www.wiley.com

ASAM releases practice guideline
on medications for opioid use
disorders

The American Society of Addic-
tion Medicine (ASAM) on June 2 re-
leased its National Practice Guide-
line for the Use of Medications in
the Treatment of Addiction Involv-
ing Opioid Use. The guideline “will
assist clinicians prescribing pharma-
cotherapies to patients with addiction
related to opioid use,” according
to a press release. “It addresses
knowledge gaps about the benefits
of treatment medications and their
role in recovery, while guiding evi-
dence-based coverage standards by
payers.” ASAM worked with the
Treatment Research Institute to de-
velop the guideline “using the RAND/UCLA Appropriateness Meth-
od (RAM), a consensus process that
combines scientific evidence with
clinical knowledge,” according
to the press release. To access the
guideline, go to www.asam.org/
docs/default-source/practice-sup-
port/guidelines-and-consensus-
docs/national-practice-guideline.
pdf?sfvrsn=18.

Coming up…

The National Conference on Addiction Disorders will be held August 1–4 in St.
Louis, Missouri. For more information, go to www.addictionpro.com/ncad-
conference/national-conference-addiction-disorders.

The American Psychological Association will hold its annual convention August
6–9 in Toronto, Ontario, Canada. Go to www.apa.org/convention for more
information.

Resources

ASAM releases practice guideline
on medications for opioid use
disorders

The American Society of Addic-
tion Medicine (ASAM) on June 2 re-
leased its National Practice Guide-
line for the Use of Medications in
the Treatment of Addiction Involv-
ing Opioid Use. The guideline “will
assist clinicians prescribing pharma-
cotherapies to patients with addiction
related to opioid use," according
to a press release. "It addresses
knowledge gaps about the benefits
of treatment medications and their
role in recovery, while guiding evi-
dence-based coverage standards by
payers."

According to the investigation, some of the false positives included a chocolate
bar mistaken for marijuana, and over-the-counter cough medicine testing positive
for heroin and morphine. Scientists say the tests are unreliable, but state attorneys
stand by them. For the latest in the FOX 13 series, go to www.myfoxtampabay.com/

In case you haven’t heard…

Mobile drug tests used by law enforcement have so many false positives that they
should be stopped, according to a FOX 13 investigation. Prosecutors like them,
however, because they get to make arrests and convictions based on them.

According to the investigation, some of the false positives included a chocolate
bar mistaken for marijuana, and over-the-counter cough medicine testing positive
for heroin and morphine. Scientists say the tests are unreliable, but state attorneys
stand by them. For the latest in the FOX 13 series, go to www.myfoxtampabay.com/