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News for policy and program decision-makers

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In This Issue...

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CADCA Newsmaker Award
Alison Knopf, Editor

SIPAwards Third Place Winner
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Beacon calls for primary care and MAT to expand opioid treatment access

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 *ADAW* 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).

Bottom Line...
A managed behavioral health care giant is recommending that opioid use disorders be treated by primary care with medications.

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-

See Beacon page 2

The Business of Treatment

Field still lacks inventory, details on alternative supports to AA

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"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."

Bottom Line...
The "many paths to recovery" message that remains prevalent in the addiction treatment community has some providers seeking alternatives to 12-Step-based support groups for their patients, but a lack of data can make information gathering a challenge.

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-

See Alternatives page 7

Beacon from page 1

cation services."

The paper criticizes providers of detox for not participating in the continuum of care that is needed for chronic conditions. "For example, a facility may offer just detox services with the incentive to keep the beds full," the report states, adding that as a result, the "facility will likely have a limited responsibility and accountability for the patient's movement along the continuum" of care. "In brief, whether the patient recovers or relapses has no consequence for the detox provider," the report said.

Steve Bentsen, M.D., Beacon regional chief medical officer, said that although the report supports all MAT, including oral naltrexone, Vivitrol, methadone and buprenorphine, accessibility is limited for both methadone and buprenorphine. Naltrexone, however, can be administered within a primary care setting, and even comports with the abstinence-based philosophy of many providers, he told *ADAW*. But patients should know what their options are, he said.

"Abstinence-based treatment can be a treatment, but it is not the only treatment," Bentsen told *ADAW*. "Consumers need to have this explained."

"There are things we could be doing differently," Stanton added. For example, the report recommends 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 readmission, 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

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specialty.

- Change the 42 CFR Part 2 confidentiality regulation to allow providing sharing of addiction-related information about patients.
- Mandate addictions treatment and education in prisons, including MAT.
- Develop a registry of MAT recipients and prescribers.

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.

> **'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.'**
>
> Stuart Gitlow, M.D.

"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. •

For the white paper, go to http://beaconlens.com/wp-content/uploads/2015/06/Confronting-the-Crisis-of-Opioid-Addiction.pdf.

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 —

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Continued from previous page

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. 1395jjj), 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 prevails, once the discrimination ensues, higher-functioning users will shy away from admitting the truth," he said. "The integrated system cannot protect patients' confidentiality or privacy. And, there is zero discussion about the harm to patients when privacy is breached."

There are also questions about SUD information and the criminal justice system. HIPAA already allows the criminal justice community access to medical records with minimal justification, said Clark. The non-applicability clause about 42 CFR Part 2 in the bill could "open the floodgates to criminal prosecution."

The original intent of 42 CFR Part 2 was to keep law enforcement from literally following patients into treatment programs — in particular, opioid treatment programs, which is what happened in New York City.

"I just want people to get treatment that works without fear of retribution," said Clark.

Sen. Scott "Chris" Murphy (D-Connecticut) is interested in a companion bill. If this happens, the bill from the House side may go further than it did two years ago, before it included the confidentiality change. •

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 (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

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FROM THE FIELD

No more free passes — Step up, Congress!

By James Copple

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

Continues on next page

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Continued from previous page
receive an increase. Rep. John Carter (R-Texas) is a member of the House Addiction, Treatment, and Recovery Caucus, yet he sits on the subcommittee that authored this bill. Also on the subcommittee responsible for this bill is Rep. Steven Palazzo (R-Miss.). In 2012 he joined in the celebration as a residential and workforce training center for children struggling with emotional, mental and substance abuse problems was opened in his district. Now, his committee produces legislation that will do anything but assist those with a substance abuse problem in great need of help.

It's time for Congress to step up to the plate and fund the programs that will bring us closer to a healthier nation that fights substance abuse with every weapon in its arsenal — including appropriations.

James Copple is co-founder and CEO of Strategic Applications International (www.sai-dc.com).

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," he said. "I got lucky. I found recovery that works." 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 provid-

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/capphome.cfm] on the OASAS website for information about how to apply for certification to operate in the state."

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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 30 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.

Alternatives from page 1

tual-support groups that was released in 2008, and the availability of other programs has been known for years (see *ADAW*, March 16, 2009).

Yet at a time when addiction field leaders increasingly emphasize the existence of multiple pathways to recovery, treatment programs often have to do a lot of digging to learn more about options for those clients in early recovery for whom AA might not be the ideal match. That is partly because there has been no national research comparing the effectiveness of the various mutual-support models out there — and in fact little research at all about the presence of alternatives to AA in communities.

"We have not supported any studies that have asked programs if they have alternatives to AA as part of their program, or if they have referred to any," Robert Huebner, M.D., chief of the Division of Treatment and Recovery Research at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), told *ADAW*. "There are opportunities for research."

As has been the case for years, organizations such as SMART Recovery and LifeRing Secular Recovery are prominent in certain pockets of the country and completely absent in others. Of course, many of these organizations have leveraged the power of the Internet to make meetings more accessible through online channels.

"We've had an increase in the number of treatment facilities wanting to have SMART present trainings to their staff," SMART Recovery President A. Thomas Horvath, Ph.D., told *ADAW*. What does Horvath believe is precipitating some of the interest among those in the treatment community? "Callers to facilities are indicating that they want an approach like this, and are inquiring," he said. "The programs are trying to respond to the callers."

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

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Horvath. This is something on which participants rely.

AA and similar mutual-help groups have a fairly extensive research base, with most of the studies showing a correlation between participation and positive recovery outcomes, Huebner said. "Studies have shown that participation in a mutual-help group is predictive of later increases in abstinence, and this is important early in an abstinence career," he said. In addition, more frequent attendance and a longer overall 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 Facilitation, 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 respondents reported using Twelve-Step Facilitation at least often.

While the research base for the alternative mutual-help groups is largely nonexistent, Huebner suspects 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 increased interest among treatment organizations in offering alternative mutual-help options for patients, the growth in the number of meetings has been more deliberate than exponential. "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 accelerate and the number of meetings will reach a critical mass. Horvath, who also is founder of the San Diego–based Practical Recovery residential and outpatient treatment organization, 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 treatment community regarding alternatives, Horvath said. "If a 12-Step participant has an option that's working for them, that's good." However, information 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 recovery communities. "The hallmark of alcohol use disorders is heterogeneity," he said. "If we have a number of options with a broader reach, there is a greater probability of getting at the problem." •

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 Addiction Medicine (ASAM) on June 2 released its National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. The guideline "will assist clinicians prescribing pharmacotherapies 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 evidence-based coverage standards by payers." ASAM worked with the Treatment Research Institute to develop the guideline "using the RAND/UCLA Appropriateness Method (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-support/guidelines-and-consensus-docs/national-practice-guideline.pdf?sfvrsn=18.

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/story/29106910/state-attorneys-weigh-in-on-drug-test-controversy.