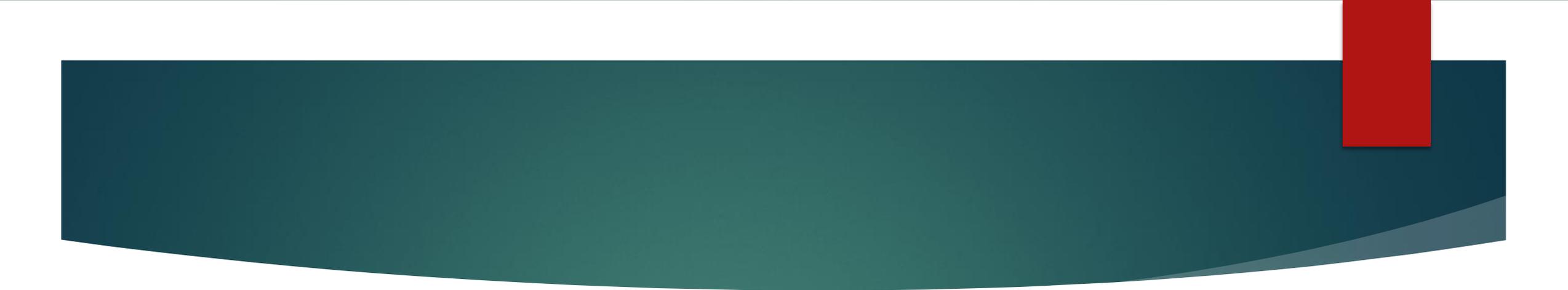
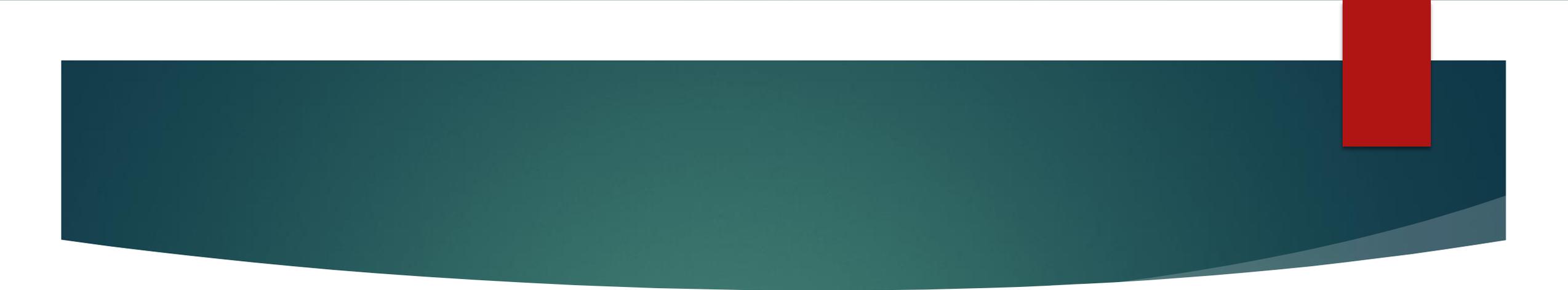


Shifting the Lens: Alternative Approaches in Drug Treatment Courts

CHRISTA M. MARSHALL, PSY.D.

10/24/2017

- 
- ▶ Dr. Marshall has no financial conflicts to disclose.

- 
- ▶ Questions for the group:
 - ▶ What is your community's impression of MAT?
 - ▶ How many of your courts are using MAT?

Addiction to Opioids is Prevalent and Lethal

- ▶ 20.5 million Americans 12 or older had a substance use disorder in 2015
 - ▶ 2 million involving prescription pain relievers
 - ▶ 591,000 had a substance use disorder involving heroin
- ▶ Four in five new heroin users started out misusing prescription painkillers.
- ▶ Drug overdose is the leading cause of accidental death in the U.S. in 2015
 - ▶ 52,404 lethal drug overdoses
 - ▶ 20,101 overdose deaths related to prescription pain relievers
 - ▶ 12,990 overdose deaths related to heroin



(Center for Behavioral Statistics and Quality, 2015; Jones 2013)

Heroin Withdrawal Symptoms

STAGE 1

Up to 8 hours after last dose



Drug cravings



Moodiness

Anxiety
Fear of withdrawal
Depression

STAGE 2

8 to 24 hours after last dose



Stomach cramps

Runny nose

Tears



Sweat

Upper body secretions

Yawning



Restlessness

Insomnia

STAGE 3

Up to 3 days after last dose



Diarrhea



Fever / Chills

Joint pain



Muscle spasms

Tremor



Nausea / Vomiting



Cardiovascular problems

↑ Heart rate

↑ Blood pressure

Source: Kosten TR, O'Connor PG. Management of drug and alcohol withdrawal. New England Journal of Medicine, 2003; 348:1786.

Symptoms of Opioid Withdrawal

Early Withdrawal Symptoms

These usually start within 6-12 hours for short-acting opiates, and they start within 30 hours for longer-acting ones:

- ▶ Tearing up
- ▶ Muscle aches
- ▶ Agitation
- ▶ Trouble falling and staying asleep
- ▶ Excessive yawning
- ▶ Anxiety
- ▶ Nose running
- ▶ Sweats
- ▶ Racing heart
- ▶ Hypertension
- ▶ Fever

Late Withdrawal Symptoms

These peak within 72 hours and usually last a week or so:

- ▶ Nausea and vomiting
- ▶ Diarrhea
- ▶ Goosebumps
- ▶ Stomach cramps
- ▶ Depression
- ▶ Drug cravings

(American Addiction Centers, 2017)

Medication Assisted Treatment

- ▶ FDA approved medications to treat opioid, alcohol, and stimulant use disorders
 - ▶ Goals - to use medication to:
 - ▶ normalize brain chemistry
 - ▶ relieve withdrawal symptoms and psychological cravings
 - ▶ block euphoric effects of substances
 - ▶ normalize bodily functions without substances
 - ▶ MAT requires conjoint behavior therapy and education in addition to medication
- ▶ Combining MAT with anxiety medication, especially benzodiazepines (e.g., Xanax, valium) can be fatal.

(SAMHSA, 2015)

Phases of MAT

1. Acute
 2. Rehabilitative
 3. Supportive-care
 4. Medical maintenance
 5. Tapering (optional)
 6. Continuing-care
- *Not a linear model – relapse is part of recovery



(Center for Substance Abuse Treatment, 2005)

Phases of MAT

- ▶ Acute (Detox or admission to comprehensive MAT)
 - ▶ Medication to minimize sedation and other undesirable side effects
 - ▶ Assessing the safety and adequacy of each dose after administration
 - ▶ Rapidly but safely increasing dosage to suppress withdrawal symptoms and cravings
 - ▶ Referrals for co-occurring disorders and medical, social, legal, family, and other problems associated with opioid addiction
 - ▶ Develop alternative strategies for coping with cravings or compulsions to abuse substances

(Center for Substance Abuse Treatment, 2005)

Phases of MAT

- ▶ Rehabilitation Phase Main Goal: Deal with current major life problems so that patient can address bigger life goals (e.g., education, employment, reconciliation with family)
 - ▶ Increase participation in constructive activities (employment, education, vocational training, child rearing)
 - ▶ Medication administration more flexible to allow for participation in activities
 - ▶ Participate in support groups, as long as they support MAT (e.g., faith based, 12-step)
 - ▶ Develop skills to cope with triggers
 - ▶ Focus on getting the body healthy
 - ▶ Build social support system
 - ▶ Address legal problems
 - ▶ Address mental health problems

(Center for Substance Abuse Treatment, 2005)

Phases of MAT

- ▶ Supportive-care phase (typically lasts 2 - 3 years; estimate)
 - ▶ Decreased frequency of visits to OTP clinics
 - ▶ Abstinence from alcohol and illicit drugs
 - ▶ Medical conditions stable
 - ▶ Stable source of income
 - ▶ Family relationships/support system stable
 - ▶ Legal issues have been resolved

(Center for Substance Abuse Treatment, 2005)

Phases of MAT

- ▶ Medical Maintenance
 - ▶ 2-years of treatment and compliance necessary to receive full 30-day supply of methadone
 - ▶ Clinic continues to make dosage adjustments as needed
 - ▶ Random drug testing and medication recall (prevents medication diversion)
 - ▶ Important to celebrate accomplishments and treat this as a legitimate recovery option

(Center for Substance Abuse Treatment, 2005)

Phases of MAT

- ▶ Tapering
 - ▶ Medically supervised withdrawal
 - ▶ A number of medical, psychological, and social factors should be considered before deciding on tapering
 - ▶ Should increase supportive services during this time
 - ▶ Therapy for 3 – 12 months focusing on coping and relapse prevention

(Center for Substance Abuse Treatment, 2005)

Phases of MAT

- ▶ Continuing-care (after Tapering)
 - ▶ Continued f/u care with physicians
 - ▶ Continued participation in recovery and support groups
 - ▶ Continued contact with mental health and case management professionals, although at longer intervals

(Center for Substance Abuse Treatment, 2005)

Medication Assisted Treatment

- ▶ Benefits of treatment:
 - ▶ Improve patient survival
 - ▶ Increase retention in treatment
 - ▶ Decrease illicit opiate use and other criminal activity among people with substance use disorders
 - ▶ Increase patients' ability to gain and maintain employment
 - ▶ Improve birth outcomes among women who have substance use disorders and are pregnant
 - ▶ Decreased potential for relapse decreases likelihood of contracting HIV or Hepatitis

(SAMHSA, 2015)

Goals of Opioid Replacement Therapy

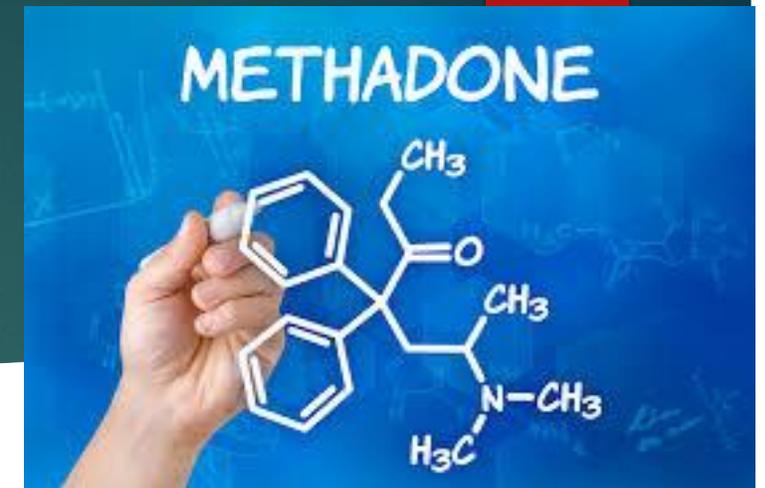
1. Eliminate opioid withdrawal symptoms throughout the 24-h following administration
2. Abolish cravings or urges to use other opioids
3. Establish adequate tolerance to preclude euphoria caused by use of illicit opioids
4. Eradicate use of illicit opioids as demonstrated by self-report and urine toxicology testing
5. Minimize side effects so that the patient does not experience any intoxication and can function normally

(Buchholz & Saxon, 2016)

A group of five business professionals (three men and two women) are smiling and looking towards the camera. They are dressed in professional attire, including suits and blouses. The background is a blurred office environment with a window and some office equipment.

Happy, Healthy, Productive!

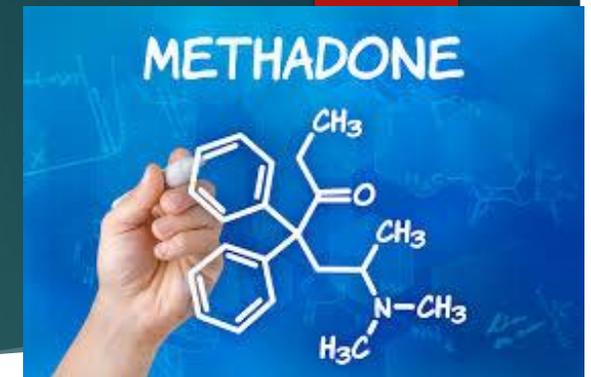
Methadone



- ▶ Requirements for participation
 - ▶ One year documented opioid use disorder
 - ▶ This can be waived for patients who are pregnant, recently released from incarceration, or had previous treatment in last 2 year
- ▶ Available in tablet, rapidly dissolving wafer, and liquid.
 - ▶ Early in treatment must present daily, but eventually may get doses in week-long supply.
 - ▶ Can be significant drug interactions – especially with other CNS depressants (e.g., alcohol, benzodiazepines)

(Buchholz & Saxon, 2016)

Methadone



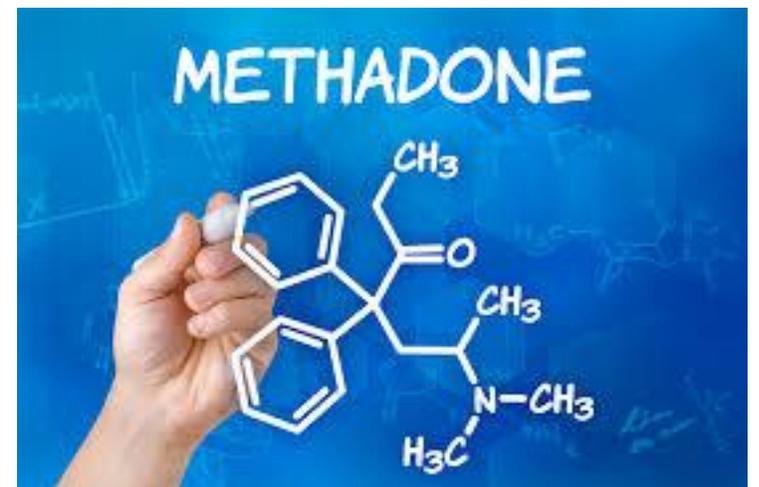
- ▶ Side effects include: pupillary constriction, constipation, sedation, respiratory depression, QT interval prolongation, increased sensitivity to pain, tolerance
- ▶ Initial dosage: 5 – 30mg
- ▶ Clinical trials show that methadone maintenance doses of 80–100 mg per day have advantages over lower doses in reducing illicit opioid use and retaining patients in treatment (Strain, Bigelow, Lievson, & Stitzer, 1999).
- ▶ Maintenance doses are typically from 80mg – 120mg (although individual patients vary considerably from this depending on a number of factors)

(Buchholz & Saxon, 2016)

Methadone

- ▶ Not typically a good option for pain management – analgesic effects last 6 hours
- ▶ Some clinics split the dose for pain management purposes – but evidence to back up this practice minimal (Dunn, Brooner, & Clark, 2014).

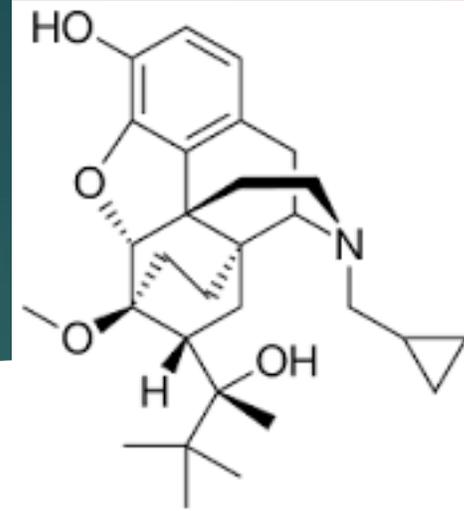
(Buchholz & Saxon, 2016)



Methadone Outcomes

- ▶ 11 clinical trials involving 1,969 people, methadone improved treatment retention and reduced heroin use compared with nonmedication treatment (Mattick, Breen, Kimber, & Davoli, 2009)
- ▶ If all eligible offenders offered methadone treatment, 3.3 million nondrug crimes could be averted (Bhati, Roman, & Chalm, 2008)
- ▶ Every dollar spent on ongoing methadone treatment yields almost \$38 in benefits through reduced crime, better health, and gainful employment (Zarkin, Dunlap, Hicks, & Mamo, 2004)

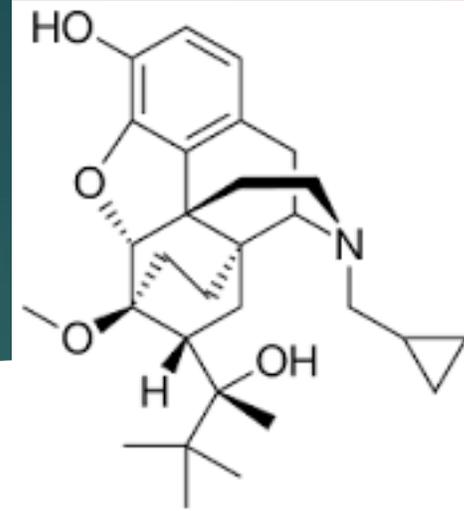
Buprenorphine



Brand Names: Suboxone, Buprenex, Butrans

- ▶ Better safety profile than methadone.
 - ▶ Partial opioid agonist with a ceiling effect: higher doses do not necessarily lead to increasing activity
 - ▶ Less risk of respiratory depression and overdose
 - ▶ Fewer drug-drug interactions
 - ▶ Less impact on cardiac functioning

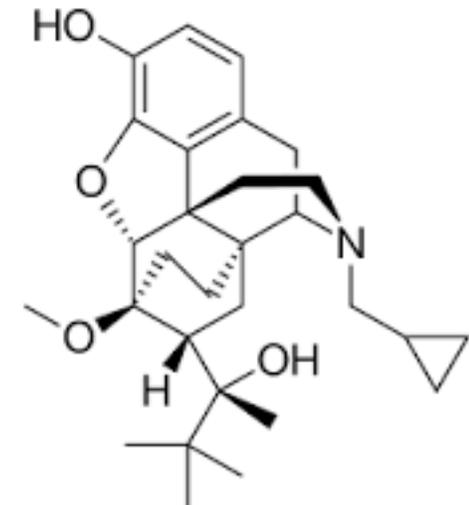
Buprenorphine



- ▶ Methods of delivery
 1. buprenorphine sublingual tablets
 2. buprenorphine/naloxone sublingual tablets
 3. buprenorphine/naloxone sublingual film
 4. buprenorphine/naloxone buccal film
 5. buprenorphine IM/IV (mainly used for acute pain)
 6. buprenorphine transdermal patch (approved for use in management of pain)
- ▶ Notice the use of naloxone combination – prevents misuse as activated when injected

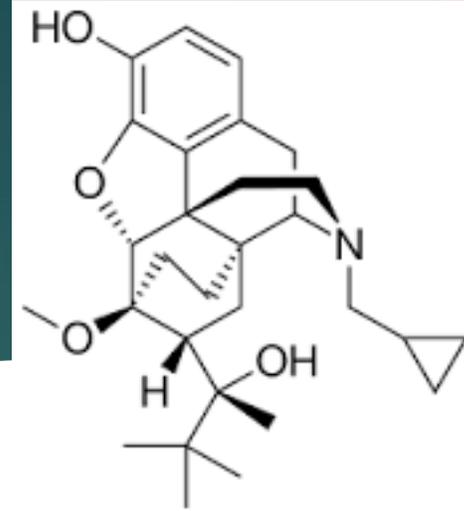
Buprenorphine

- ▶ Side effects: constipation, nausea, sweating, headaches, elevated liver enzymes, tolerance
- ▶ Risk of precipitated opioid withdrawal
 - ▶ Need to have abstained from opioids long enough to display moderate opioid withdrawal on Clinical Opiate Withdrawal Scale
 - ▶ Initial dose of buprenorphine 2 -4 mg
 - ▶ Subsequent doses may be between 2 – 32mg
 - ▶ Finding a stable dose may take days or weeks



(Buchholz & Saxon, 2016)

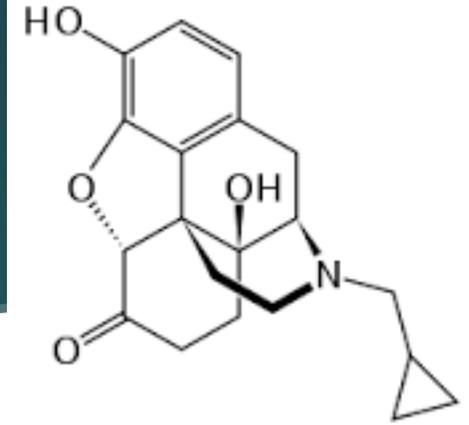
Buprenorphine



- ▶ More effective than placebo
- ▶ As effective as *moderate* doses of methadone
- ▶ Unlikely to be as effective as *higher* doses of methadone
- ▶ May not be the treatment of choice for patients with higher levels of physical dependence

(Center for Substance Abuse Treatment, n.d.; Veilleux, Colvin, Anderson, York, & Heinz, 2010).

Naltrexone – Opioids and Alcohol



Brand Names: Revia, Vivitrol

- ▶ Oral medication and injectable
 - ▶ 50mg oral pills, 380 mg monthly injectable
- ▶ Highly effective opioid antagonist – blocks receptors (no high)
- ▶ Can produce withdrawal in individuals who have not been abstinent for 7 – 10 days.
- ▶ No narcotic effects – when someone stops taking this there are no withdrawal symptoms
- ▶ 50 mg blocks opioids for 24 hours
- ▶ Side Effects: nausea, vomiting, anxiety, nervousness, insomnia, headache, joint or muscle pain, and fatigue
- ▶ In criminal justice, multisite study, those who received 6 months of naltrexone injections had significantly fewer positive urine tests for opioids and lower recidivism than those who did not receive treatment (Coviello et al., 2012)

(Center for Substance Abuse Treatment, 2005)

Side Effects of Opioid Replacement Therapy

Whole Body Effects

- Weakness, loss of energy (asthenia)
- Back pain, chills
- Fluid accumulation (edema)
- Hot flashes
- Flu syndrome and malaise
- Weight gain

Gastrointestinal Effects

- Constipation
- Dry mouth
- Nausea and vomiting
- Abdominal pain

Musculoskeletal Effects

- Joint pain (arthralgia)
- Muscle pain (myalgia)

Nervous System Effects

- Abnormal dreams
- Anxiety
- Decreased sex drive
- Depression
- Euphoria
- Headache
- Decreased sensitivity to tactile stimulation (hypesthesia)
- Insomnia
- Nervousness
- Somnolence

Respiratory Effects

- Cough
- Rhinitis
- Yawning

Cardiac Effects

- Electrocardiogram changes

(possible QT prolongation with high doses of methadone)

doses of methadone)

- Postural hypotension
- Slowed heart rate (bradycardia)

Hepatic Effects

- Abnormal liver function tests

Endocrine Effects

- Hyperprolactinemia
- Absence of menstrual periods (amenorrhea)

Skin and Appendage Effects

- Sweating
- Rash

Special Sensory Effects

- Blurred vision

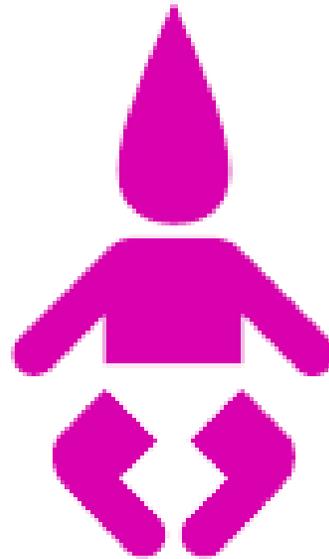
Urogenital Effects

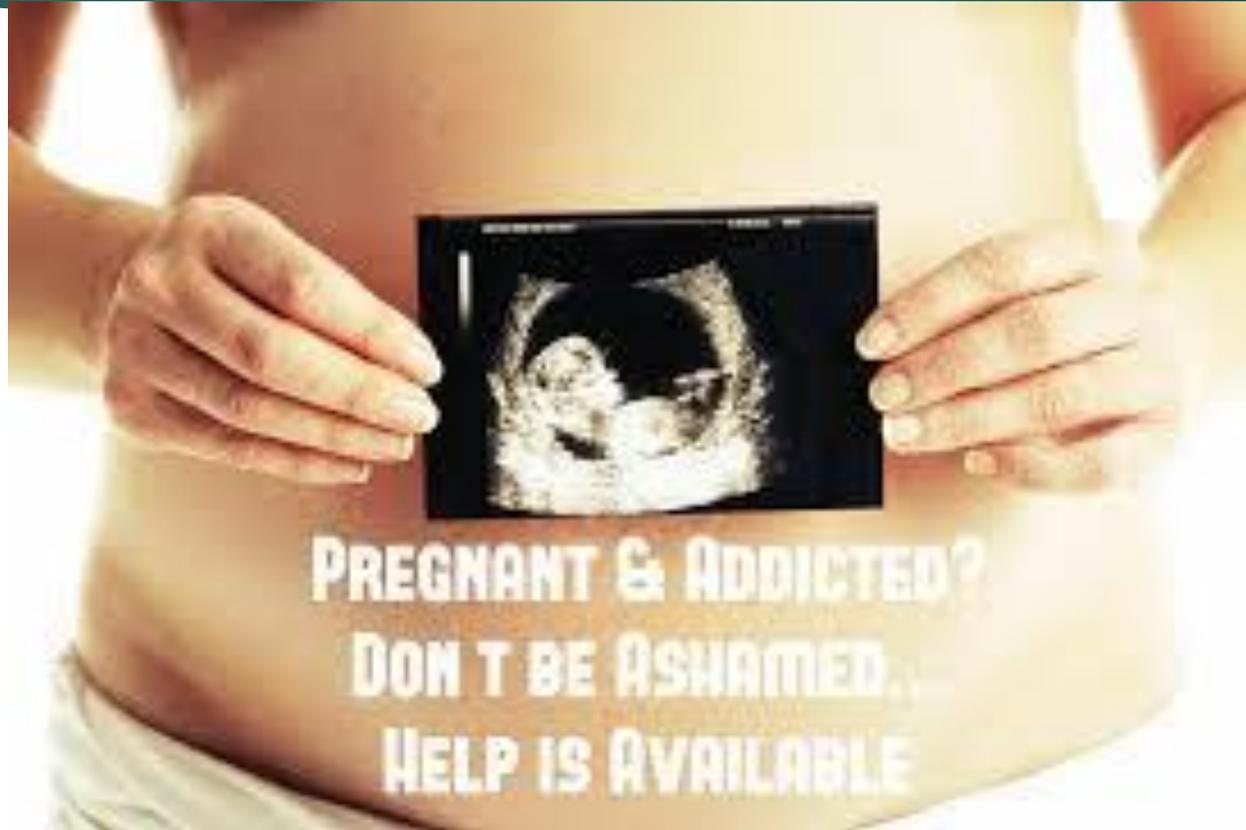
- Difficult ejaculation
- Impotence

(Center for Substance Abuse Treatment, 2005)



Every 19 minutes,
an opioid addicted
baby is born in the
United States.





**PREGNANT & ADDICTED?
DON'T BE ASHAMED...
HELP IS AVAILABLE**

MAT in Pregnant Women

- ▶ Pregnant opioid users especially marginalized
- ▶ Because opioid use causes cessation of periods, may interpret this as infertility
- ▶ Avoiding MAT in pregnant women increased risk of infections, STIs, HCV and HIV
- ▶ May interpret early signs of pregnancy as opioid withdrawal and increase opioid use
- ▶ Inducing even mild opioid withdrawal can cause premature labor and adverse effects on the fetus

(Center for Substance Abuse Treatment, 2005)

MAT in Pregnant Women

- ▶ Because MAT normalizes endocrine functioning, women need to be counseled about possibility of becoming pregnant
- ▶ When on methadone, as pregnancy progresses may need to increase dosage due to increased blood volume
- ▶ Decreases fetal death rate
- ▶ Increases birth weight
- ▶ Avoid use of Naloxone whenever possible – can induce acute opioid withdrawal in the fetus
- ▶ Women can breastfeed on methadone (assuming no other health complications)

(Center for Substance Abuse Treatment, 2005)

Neonatal Abstinence Syndrome (NAS)

- ▶ Infants exposed to opioids during gestation:
 - ▶ Hyperactivity of CNS and ANS
 - ▶ Changes in gastrointestinal tract and respiratory system
 - ▶ Uncoordinated/frantic sucking and feeding difficulties
 - ▶ Withdrawal symptoms – minutes up to 2 weeks (usually 72 hours)
 - ▶ May be treated with medications until eventual tapering
 - ▶ Can make baby's behavior more difficult to tolerate
 - ▶ Can impact bonding

(Center for Substance Abuse Treatment, 2005)

MAT and Parenting

- ▶ In a recent study of 596 parents abusing opioids in Child Welfare System
 - ▶ 9.2% receiving MAT
 - ▶ Increased months of MAT increased odds of parents maintaining custody of their children



(Martin, Wilfong, Huebner, Posze, & Willauer, 2016).

Prevalence of Alcohol Use Disorders

- ▶ 10-20% of patients seen in primary care and hospital settings have a diagnosable alcohol use disorder
- ▶ 2013 18 million people met criteria, but only 1.4 million got treatment
- ▶ MAT very underused in alcohol use disorders despite being a recommendation for patients suffering from moderate to severe alcohol use disorders
 - ▶ **Mild:** The presence of 2 to 3 symptoms
 - ▶ **Moderate:** The presence of 4 to 5 symptoms
 - ▶ **Severe:** The presence of 6 or more symptoms



(SAMHSA & NIAAA, 2015)

Criteria for Alcohol Use Disorder

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

- ▶ **Alcohol is often taken in larger amounts or over a longer period than was intended.**
- ▶ **There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.**
- ▶ **A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.**
- ▶ **Craving, or a strong desire or urge to use alcohol.**
- ▶ **Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.**
- ▶ **Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.**

(American Psychiatric Association, 2013)

Criteria for Alcohol Use Disorder

- ▶ Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
- ▶ Recurrent alcohol use in situations in which it is physically hazardous.
- ▶ Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
- ▶ Tolerance, as defined by either of the following:
 - ▶ A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
 - ▶ A markedly diminished effect with continued use of the same amount of alcohol.
- ▶ Withdrawal, as manifested by either of the following:
 - ▶ The characteristic withdrawal syndrome for alcohol
 - ▶ Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

(American Psychiatric Association, 2013)

Disulfiram

- ▶ Brand Name: Antabuse
- ▶ For patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may have best chance
 - ▶ Must have already gone through alcohol withdrawal
 - ▶ Ideally, willingness to take under supervision of family member or treatment program
- ▶ Daily administration: 500 mg first 1 – 2 weeks; maintenance 125mg – 500mg
- ▶ Causes nausea-vomiting, flushing, and heart palpitations to create deterrent to drinking
 - ▶ If high levels of alcohol are in the system, the symptoms can be much more severe
- ▶ Contraindicated for
 - ▶ severe myocardial disease or coronary occlusion, psychoses, pregnancy, high levels of impulsivity, suicidality

(SAMHSA & NIAAA, 2015)

Acamprosate

- ▶ Brand name: Campral
- ▶ Indicated for maintenance of abstinence from alcohol for those who are abstinent at treatment initiation
 - ▶ Counters imbalance between glutamatergic and GABAergic system in chronic alcohol abuse and withdrawal
- ▶ Administered 3 times per day; 666mg per dose
- ▶ Avoid in patients with kidney problems
- ▶ Not for use in pregnancy

(SAMHSA & NIAAA, 2015)

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- ▶ 50 mg blocks opioids for 24 hours
- ▶ Side Effects: nausea, vomiting, anxiety, nervousness, insomnia, headache, joint or muscle pain, and fatigue

(Center for Substance Abuse Treatment, 2005)

Stimulant Addiction

- ▶ Combination of naltrexone and buprenorphine is being used to treat cocaine addiction for some.
 - ▶ reducing overall drug cravings and managing withdrawal symptoms

Increasing MAT in Drug Courts

- ▶ Examine reasons that MAT is not being used (e.g., lack of knowledge, long-standing community beliefs about MAT, bureaucratic issues, potential cost)
- ▶ Learn more about the actions and benefits of MAT from the Center for Substance Abuse Treatment, state ASAM chapters, state Opioid Treatment Authorities, and the American Association for the Treatment of Opioid Dependence (see)
- ▶ Identify local providers of MAT
- ▶ Contact local OTP directors and discuss the effectiveness of MAT

Increasing MAT in Drug Courts

- ▶ Develop relationships providers/facilities that offer integrated substance use disorders and mental health treatment
- ▶ Consult regularly with treatment professionals; use their expertise to set the best course for each drug court participant
- ▶ Identify local physicians who can prescribe buprenorphine and extended-release injectable naltrexone and who are willing to coordinate such care with drug court staff
- ▶ Work with local substance abuse coalitions to educate the community and change attitudes about the treatment of opioid dependence, to increase understanding of MAT and change drug court policies

(SAMHSA, 2014)

Resources

American Association for the Treatment of Opioid Dependence

<http://www.aatod.org>

American Society of Addiction Medicine

<http://www.asam.org>

Behavioral Health Treatment Services Locator

<http://ndtreatment.samhsa.gov>

Buprenorphine Physician and Treatment Program Locator

http://buprenorphine.samhsa.gov/bwns_locator

Medication-Assisted Treatment for Substance Use Disorders

<http://www.dpt.samhsa.gov>

National Alliance for Medication Assisted Recovery

<http://www.methadone.org>

(SAMHSA, 2014)

National Alliance of Advocates for Buprenorphine Treatment

<http://www.naabt.org>

National Commission on Correctional Health Care

<http://www.ncchc.org>

National Drug Court Institute

<http://www.ndci.org>

Opioid Treatment Program Directory

<http://dpt2.samhsa.gov/treatment>

State Opioid Treatment Authorities

<http://dpt2.samhsa.gov/regulations/smalist.aspx>

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