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Medication-Assisted Treatment
for Opioid Addiction in a Criminal
Justice Context:
An Implementation Brief for Community
Supervision

Medication-Assisted Treatment for Opioid Addiction in a Criminal Justice Context

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Introduction

The number of individuals with a substance use disorder within the justice system has been shown to be up to three times that of the general population (Karberg et al., 2005). Such a significant problem is a primary contributor to the high re-offense rate seen in our justice-involved population. Despite this, when intensive supervision is combined with evidence-based treatment, the rate of recidivism for this population can decrease up to 20% compared to individuals who receive no treatment (Aos et al., 2006). The rising use of illicit opiates over the past 10 years has exacerbated the problems associated with drug use; however criminal justice officials can play an important role in facilitating access to treatment for individuals with this disorder thereby improving community safety.

This implementation brief was developed to assist criminal justice practitioners in realizing the clinical, practical, logistical, and financial benefits of using medication-assisted therapies (MAT) with their opiate-involved adult populations. The science of MAT as a tool for criminal justice practitioners is evolving. Research, however, has consistently demonstrated the value of these therapies in decreasing the symptoms of detoxification, improving offender management and the attendant cost savings, and increasing an opiate-involved offender's overall prospects for success and compliance with the terms of their sentence and other treatment mandates. Simply put, the goal of this brief is to assist community corrections with achieving greater cost efficiencies and more positive long-term outcomes with opiate-involved populations.

MAT is a clinical undertaking. Medical professionals must be involved. Opportunities for discontinuity between stages of justice involvement exist. New modalities for administration are emerging. The nature of these therapies underscores the need for partnership and participation by myriad stakeholder entities, including the criminal justice system, physicians and nurses, community-based treatment, and state oversight agencies.

For criminal justice practitioners, this document will give you a basic overview of medication-assisted treatment and will guide the partnership and planning process as you consider how to implement such a strategy.



What is MAT?

The use of medication-assisted treatment (MAT), when combined with other counseling and behavioral therapies, has emerged over the years as an effective intervention for opiate-involved adult individuals to increase their chances of successful recovery*. Studies have shown that MAT can positively reduce illicit opioid use and also improve treatment retention rates. (Weiss, 2011; Thomas, 2013). The National Institute on Drug Abuse (NIDA) states that MAT can “improve social functioning, reduce criminal activity, and lessen the risk of transmitting infectious diseases like HIV” (NIDA, 2014).



The decision to begin or end MAT is made between the individual and the medical provider, but the criminal justice system can play a key role in facilitating an individual’s recovery process and reducing the likelihood of recidivism. This implementation brief provides information on MAT, as well as a roadmap that practitioners can use to orient their criminal justice supervision activities for clients on MAT. Considerations for criminal justice practitioners include identifying partners, establishing communication protocols, and using incentives or sanctions.

***What is Recovery?** According to SAMHSA, recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment, including MAT, and recovery support services for all populations.

Medications Prescribed for Opioid Treatment

There are a number of FDA-approved medications to help treat opiate addiction.

Methadone is a long acting medicine that reduces opiate craving and blocks the effect of opiates. Methadone blocks the receptors in the brain that are affected by opiates such as heroin, enabling users to gradually detoxify from opiates without experiencing painful withdrawal symptoms (AddictionRecovery.org, 2015).

Buprenorphine is a long-acting partial agonist that acts on the same receptors as heroin and morphine, relieving drug cravings without producing the same intense “high” or dangerous side effects (NIDA, 2012). Buprenorphine alone and the combination of buprenorphine and naloxone prevent withdrawal symptoms when someone stops taking opioid drugs by producing similar effects to these drugs (NIH, 2012). The Suboxone® sublingual film and the Zubsolv® sublingual

tablet are examples of current FDA-approved medications which feature the combination of buprenorphine and naloxone to treat opiate addiction (FDA, 2014).

Naltrexone is an opioid antagonist medication that binds to opioid receptors but does not activate them. It may be most useful for highly motivated, recently detoxified patients who want total abstinence, as well as individuals at the experimenting stage of opioid use or those who are in early stages of their addiction. Naltrexone blocks the opioid receptors in the brain, thereby preventing the pleasure that one might otherwise feel when using heroin. It can be taken by mouth once daily or every other day, has minimal side effects, and is not addicting (AddictionRecovery.org, 2015).

Vivitrol® is an extended release naltrexone shot that lasts up to a month.

Naloxone: FDA-approved Medication to Prevent Overdose Death. Naloxone is an emergency medication that reverses an overdose, preventing death.

- When distributed in communities, naloxone can reduce overdose deaths by 50% (StopOverdose, 2015).
- Intranasal naloxone can reverse heroin overdose 87% of the time while eliminating the risks associated with needle sticks presented by traditional intramuscular (injectable) naloxone (Kerr et. al. 2009).

Including medications on a formulary does not guarantee access; doctors still need to prescribe them. One national study found that only 58% of physicians qualified to prescribe buprenorphine for office-based opioid treatment were doing so (Kissin et. al. 2006).

What other treatment can be used in combination with MAT?

According to NIDA, the goal of treatment planning is to match evidence-based interventions to the needs of the drug addicted individual (2014). The forms of treatment can vary over time as the needs of the individual change. Current evidence-based interventions identified by NIDA include cognitive-behavior therapy to learn positive coping skills, contingency management to reinforce behavioral change, and motivational enhancement to encourage treatment compliance (NIDA, 2014). Medication-assisted treatment should be considered for opioid addicted individuals in order to normalize brain function and encourage abstinence so that the individual can fully benefit from other psychosocial treatment interventions mentioned above.

Probation

For the purposes of this section, *probation* refers to a sentence of supervision in the community, whereby the offender has regular contact with a probation officer and a series of conditions or mandates has been included as part of the sentence. Generally, a sentence to probation is expected to last from six months up to three years. This discussion assumes that MAT is added as a complement to a sentence that includes substance use treatment participation, and that the probationer is receiving the necessary biopsychosocial care. MAT should not be used absent a community-based treatment plan.

Core Benefits

Benefits of MAT in a probation setting include improving the capacity of participants to successfully fulfill other conditions of court involvement, including participation in treatment. MAT also provides support and stabilization for ongoing recovery.



Roadmap for Implementation

1. Identify operational partners

- Sentencing judge
- Probation authority
- Community treatment provider (if responsible for MAT administration)
- Physician or federally-qualified health center (FQHC), if licensed for MAT administration
- Case management entity such as TASC or other neutral provider

2. Identify other stakeholders

- Community corrections / jail
- Pretrial authority
- Prosecuting attorney
- Public defender
- Single state agency overseeing substance use treatment
- Community treatment
- Corrections

3. Define target population and expectations

- Target population as determined by:
 - Prevalence of opiate use among the probation population
 - Clinical diagnosis of the offender
 - Capacity of community treatment or certified physicians
 - Capacity of other medical and observation staff

Overall, expectations for MAT in this setting should include stable participation in a maintenance regimen. It may be possible to see a decrease of dosing over the length of supervision.

However, MAT must be considered in the overall context of probation supervision, with the assumption that the application of MAT as a complement will promote higher rates of compliance and success.

The length of MAT will vary from individual to individual as courses of substance use treatment vary. Transition planning into the community will be a critical factor in long-term success.

4. Define clinical process

As part of the probation program, MAT may be administered either by the acting treatment provider, if so qualified, or in partnership with a physician or federally-qualified health center (FQHC). In general, participants already will have moved out of a detoxification phase, so MAT in a probation context will consist largely of a maintenance regimen.

Clinical processes include:

- Initial screening by pretrial authority
- Eligibility determination by judge and probation authority
- Full clinical assessment by qualified treatment or case management provider, partner physician, or licensed professional in pretrial authority or probation
- Service decision-making, by judge and probation authority, along with properly-qualified treatment or case management provider, or via partnership with a physician or federally-qualified health center
- Induction, dosing protocol and ongoing supervision at properly-qualified treatment or case management provider, or via partnership with a physician or FQHC, in cooperation with the probationer
- Linkage to traditional psycho-social treatment as suggested by the assessment, and in cooperation with the probationer

5. Define role of toxicology

Toxicology should be utilized consistent with the overall treatment and compliance protocol. Some considerations for the drug testing process for individuals on MAT from the Treatment Improvement Protocol manual published by the Center for Substance Abuse Treatment include (2005):

- Drug testing should be performed by the treatment facility to detect substance use and monitor treatment compliance.
- At a minimum, samples from patients maintained on methadone should be tested for methadone and its metabolites to prevent patients from simply adding methadone to the sample.
- Drug testing for the presence of medication should be nearly 100% positive because lower percentages could indicate medication diversion, which requires investigation by the treatment provider.
- A combination of drug testing and self-report should be used to detect substance abuse or monitor compliance, as this has been found to be more useful than either alone.

6. Determine drug testing methods

There are multiple forms of drug testing to detect the presence of illicit substances, including tests of urine, oral-fluid, blood, sweat, and hair. The most prominent method has been urine testing because obtaining specimens is relatively easy and testing is affordable. The types of urine testing include:

- **Instant Cups:** This is a quick drug screen that can be performed in a facility upon suspicion of drug use. This method is the least costly option to screen individuals for drug use; however, the accuracy of the cups is lower than other methods. Some screens read too high, giving a false negative, or read too low, providing a false positive, leading to incorrect sanctions.
- **Lab Screening Tests:** These are generally much more accurate in producing positive or negative drug screen results. This test's limitation is that it provides an indirect measurement of the drug meant to indicate the presence of the drug and not the exact amount of an illicit substance in the person's system.
- **Lab Confirmation Tests:** This is the most accurate method for detecting illicit drugs with the capability of determining the exact amount of an illicit substance in a sample. However, these tests take the longest time to conduct and, as a result, are the most time- and cost-consuming of the options.

7. Identify possible incentives for compliance

The possible use of incentives should be considered in the context of other treatment and supervisory activities, and consistent with other conditions and mandates. They may include decrease in probation officer contact or step-down in intensity and type of treatment.

Note: Increase in dosage of the treatment medication is not to be considered an incentive for compliance as that decision is made by the medical provider. In addition, "coming off" of MAT should not be considered a condition of supervision necessary prior to release from probation.

8. Identify possible sanctions for non-compliance

Sanctions for non-compliance need to be considered in the context of other treatment and supervisory activities, and consistent with other conditions and mandates, but may include increase in probation officer contact, restricted movement schedules, electronic monitoring, placement in halfway back facilities (without interrupting the MAT regimen), or step-up in intensity and type of treatment.

Note: Reduction in dosage of the treatment medication is not to be considered as a punishment for non-compliance; dosage decisions are made by the medical provider.

9. Establish communication flow

Exchange information between the MAT provider and the probation authority on the individual's treatment participation and compliance. In order to obtain this information from the treatment provider, it will be necessary to have the client sign consent to release of information between the probation office and treatment agency.

If the probation office does not have a standard release of information form, templates are available online by searching for the Health Insurance Portability and Accountability Act (HIPAA) Release of Information Form.

10. Plan for transition

Transitioning off of probation, the clinical focus for the participant needs to be long-term, durable recovery: positioning ex-offenders to succeed beyond justice supervision.

If individuals successfully complete the conditions and mandates of their probation sentence, they are likely to be released to their communities with little or no further justice accountability.

Nonetheless, it is possible that they will continue their MAT regimen, in which case they need to be referred to a community-based provider, physician, or FQHC that can assist in ongoing administration. (Similar to medications to manage other chronic conditions such as diabetes or hypertension, MAT for addiction recovery may be continued indefinitely, based on medical advice). It is also critical to build durable recovery through access to other services and providers, using the recovery-oriented system of care model as a guide.

If the individual is reincarcerated for any reason, the expectations for a total cessation of traditional treatment (and therefore MAT) are high. However, the judge and probation authority may be able to coordinate with the department of corrections or medical director of the prison to continue the MAT regimen.

11. Identify and address potential barriers

- Variability of lengths of sentence
- Certification of medical staff
- Availability of space for administration within the community and accessibility to all participants
- Access to other supportive services, such as mental health services, employment assistance, housing, and family and life skills
- Transition planning

Parole / Reentry

For the purposes of this section, *parole* and *reentry* refer to the release of an individual from a corrections institution and back into the community, but still under the supervision of, and accountability to, a justice authority, and with regular contact with an officer of that authority. Violations of parole may result in return to the institution.

Parolees with opiate addictions will typically fall into one of three categories. First, and ideally, they will have participated in treatment with a MAT maintenance regimen within the institution, and will have been involved in a pre-release planning process that includes consideration of their needs as related to MAT. In these circumstances, implementation of MAT in a parole or reentry setting is a continuation of the treatment process begun in the institution, and an existing treatment plan should be consulted.

Second are parolees with a presenting opiate addiction who received no MAT treatment in the institution but for whom some treatment planning was conducted pre-release and referrals were given to an agency to begin MAT upon reentry into the community.

Third, and much more common, are parolees who received no MAT treatment in the institution, but for whom prior opiate use or addiction is a presenting problem, and for whom MAT will begin in the community. In these circumstances, the roadmap presumes that there has been little to no reentry planning within the institution related to community-based treatment or MAT.

Core Benefits

Benefits of MAT in a parole setting include support and stabilization for ongoing, stable reentry and recovery upon release, and reducing the risk of relapse to illicit opiate use, crime, and overdose death, the risk of which is especially high in the weeks after release.

In a study conducted in Washington State in 2007, during the first two weeks of release from prison, prior inmates were 12 times more likely to die than compared to other state residents, with the leading cause of death being overdose (Binswanger et al., 2007). In most cases, these individuals returned to using the same amount of opiates as they had prior to detoxification; however, due to a decrease in their body's ability to tolerate the drug, they overdosed. For people with opiate addictions who are being released from incarceration, the continuation of MAT, along with close monitoring and case management, are especially important during the period immediately following release.

Roadmap for Implementation



1. Identify operational partners

- Corrections authority
- Parole authority (if different)
- Community treatment provider or physician administrator
- Case management entity such as TASC or other neutral provider

2. Identify other stakeholders

- Sentencing judge
- Single state agency overseeing substance use treatment

3. Define target population and expectations

- Target Population as determined by:
 - Prevalence of participation in a MAT program within the institution
 - Clinical diagnosis of the offender
 - Capacity of community treatment or certified physicians
 - Capacity of other medical and observation staff

Expectations should be defined by the length of parole supervision. In the event of shorter lengths of supervision, it should be assumed that participants will not have completed MAT by the time they complete their sentence. The length of time in MAT should not be related to the length of supervision. Decisions related to a parolee's ongoing treatment regimen should only be made by a medical professional.

4. Define clinical process

As part of the parole program, MAT will be managed by a community-based provider or physician consistent with the maintenance regimen used within the institution. Functions of the clinical process include:

- Eligibility determination, decision-making and ongoing supervision conducted by parole authority in collaboration with treatment provider or physician
- In the case of parolees who have not participated in a MAT regimen within the institution, induction will be conducted by a properly-qualified treatment provider, or via partnership with a physician or FQHC
- Dosing protocol and ongoing supervision conducted by a properly qualified treatment provider, or via partnership with a physician or FQHC, in cooperation with the parolee
- Linkage to traditional psycho-social treatment as suggested by the assessment

5. Define role of toxicology

Toxicology should be utilized consistent with the overall treatment and compliance protocol. (See discussion in this paper's probation section as well).

6. Identify possible incentives for compliance

The possible use of incentives should be considered in the context of other treatment and supervisory activities, and consistent with other conditions and mandates. They may include a decrease in parole officer contact or a step-down in intensity and type of treatment.

Note: Increase in dosage of the treatment medication is not to be considered an incentive for compliance as that decision is made by the medical provider. In addition, “coming off” of MAT should not be considered a condition of supervision necessary prior to release from probation.

7. Identify possible sanctions for non-compliance

Possible sanctions for non-compliance need to be considered in the context of other treatment and supervisory activities, and consistent with other conditions and mandates. They may include an increase in parole officer contact, restricted movement schedules, electronic monitoring, placement in halfway back facilities (without interrupting the MAT regimen), or step-up in intensity and type of treatment.

Note: Reduction in dosage of the treatment medication is not to be considered as a punishment for non-compliance. Dosage decisions are made by the medical provider.

8. Establish communication flow

Exchange information between the MAT provider and the parole authority on the individual’s treatment participation and compliance. In order to obtain this information from the treatment provider, it will be necessary to have the client sign a consent to release of information between the parole office and treatment agency.

If the parole office does not have a standard release of information form, templates are available online by searching for the Health Insurance Portability and Accountability Act (HIPAA) Release of Information Form.

9. Plan for transition

The release of an individual from prison is likely to have a tremendous destabilizing effect on the individual’s coping mechanisms. As a result, planning for continuity of MAT should begin prior to release, with the identification of an appropriate community-based licensed treatment provider, physician or FQHC, and supervision by the parole authority.

If the individual successfully completes the conditions and mandates of parole involvement, they are likely to be released to their communities with little or no further justice accountability. However, based on the length of their sentence, the length of their community supervision, and their current clinical need, it is possible that they will not have fully completed their MAT regimen. As a result, they need to be referred to a community-based provider, physician or FQHC that can assist in ongoing administration.

10. Identify and address potential barriers

- Variability of lengths of sentence
- Equitable access to community-based MAT with the geographic dispersal of parolees
- Access to other supportive services, such as mental health services, employment assistance, housing, and family and life skills

Promising Practices

There are currently a number of pilot programs nationwide that are utilizing MAT for individuals on probation or parole. A program in Winnebago County (Rockford), Illinois, is currently utilizing Vivitrol for opiate-addicted individuals in the criminal justice system:

A program that uses medication to address heroin and other opiate addiction is showing promising results for defendants in the Winnebago County Adult Drug Court program. The program helps participants avoid relapse, improve their engagement in treatment, and get on the path to maintaining long-term abstinence and recovery.

Since January 2014, eligible defendants who are addicted to heroin have been offered the option to receive Vivitrol®, a medication which reduces cravings and blocks the effects of opiates. The program is completely voluntary. Participants who consent to the program requirements participate in an intensive regimen of counseling and meetings, and also receive a monthly, extended-release injection of Vivitrol, in addition to the other structured requirements of the Winnebago County Drug Court.

“Heroin and opiate use in our community is incredibly destructive and is flooding our criminal justice system with people who are committing crimes because of their addiction to this category of drugs. Having the opportunity to offer Vivitrol to defendants in Drug Court to suppress their urge to use heroin and opiates and to help them focus on changing their ways of thinking and their behaviors through intensive treatment and supports is already resulting in people moving forward in their path to recovery,” said Judge Janet R. Holmgren, presiding judge of Juvenile and Problem-Solving Courts for the 17th Judicial Circuit Court. “The benefits flow not only to the individuals who are able to reclaim their lives but to the community where they will not be committing new crimes to fund their addiction.”

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Online Resources

- Addiction Treatment Forum. Publishes newsletters and other information on substance abuse and addiction research, therapies, news: <http://atforum.com/>
- Addiction Technology Transfer Network. Find resources on substance use disorders and treatment including a course on medication-assisted treatment: <http://www.attcnetwork.org>
- American Association for the Treatment of Opioid Dependence: <http://www.aatod.org/>
- National Institute on Drug Abuse: <http://www.drugabuse.gov/>
- Office of National Drug Control Policy: <http://www.whitehouse.gov/ondcp>
- Substance Abuse and Mental Health Services Administration. Learn more about the new federal regulations governing methadone treatment programs: <http://dpt.samhsa.gov/medications/medsindex.aspx>