

Stimulants: Cocaine and Methamphetamine

CRIT program – April 2014

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Learning objectives

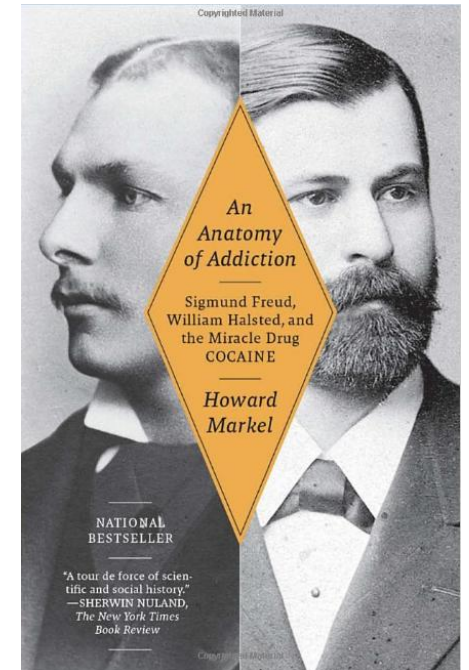
At the end of this session, participants will be able to:

1. Understand how and why people use stimulants
2. Know the characteristics of stimulant intoxication and withdrawal syndromes
3. Understand the consequences of these drugs
4. Know the current options for treatment of stimulant dependence



History: Cocaine

- From erythroxyton coca leaves in Andes
- Leaves chewed for thousands of years as stimulant
- 1884 Freud published, *Uber Coca*, describing cocaine's effects on Freud and its potential to treat opiate addiction
- 1885 Halsted published study about anesthetic uses
- 1886 Halsted raided ship medicine cabinet for fix
- Used in medicines and beverages until early 1900s
- Street preparations 10-50% cocaine
 - Hydrochloride powder is snorted or injected
 - Alkaline rocks (aka crack) are smoked
 - *Crack, Rock, Base*



History: Methamphetamine

- 1893 methamphetamine first synthesized in Japan as decongestant
- Used by German, English, American, and Japanese military in WWII for performance enhancement.
- First epidemic occurred in Japan when the military dumped large quantities into the civilian market
- Popular among truckers and west coast bikers in 1970s
- DESOXYN to treat ADHD and obesity
- *Speed, Crystal, Crank, Ice, Meth, Tina*



Lineberry 2006



When he sits before temptation



... prescribe
Desoxyn
HYDROCHLORIDE
(Methamphetamine Hydrochloride, Abbott)

THE SYMPHETOMIMETIC AMINES HAVE BEEN FOUND to be effective in the treatment of obesity. The effect of these drugs is the stimulation of the sympathetic nervous system, resulting in the burning of fat in the adipose tissue. In addition to increasing the appetite, these drugs also increase metabolism and increase energy and decrease activity in such a way as to reduce the feeling of starvation and hunger which is often the limiting factor in dieting.

SMALLER DOSEAGE, LONGER EFFECT. It is consistently agreed that a lower percentage, achieved by smaller doses, is more effective than amphetamine. The stimulation desired is achieved with a smaller dose, the result of effect is more rapid, and the duration longer. Doses exceeding these recommendations may produce side effects that outweigh the benefits of stimulation. With ordinary doses, little or no significant weight gain has been observed.

Desoxyn tablets should not be relied upon to induce weight reduction but should be used only under the direction of a physician in conjunction with the prescription of a general hygienic regime and a normal diet.

DOSEAGE AND EFFECTS—THE Doses of Desoxyn must be adjusted in accordance with the requirements and response of the individual patient. When the stimulant effect of the drug is desired, an effective dosage is an average of 10 mg. Desoxyn should be administered one-half to one hour before meals, in order to maintain the sympathetic effect of the drug until just before the evening meal. Desoxyn should be administered with meals to immediately alter hunger.

Usually, the initial dose should be 5 to 6 mg. in two to three divided doses. Larger doses may be required in some cases, and should be adjusted accordingly. They may be continued as long as the desired results are obtained. There are no untoward effects. Individual drug doses in excess of 10 mg. are likely to produce unusual central stimulation. Moderate is not recommended after 4 p.m. or at night, because of the possibility that the drug may interfere with sleep. It is not advised to drive or operate machinery while under the influence of the drug. The maximum dose may be limited by the excessive stimulation associated with the use of excessive amounts, such as 40 mg. daily.

OTHER INDICATIONS—DEFENSIVE STATES. Desoxyn Hydrochloride is indicated for oral administration in the treatment of nervousness, restlessness, and mild depression, anorexia, or in the treatment of prolonged fatigue, nervousness, or fatigue, or in the treatment of fatigue, and increased energy will probably be produced in the patient. This means that the drug will not be effective in the treatment of severe anxiety disorder.

Acceptable results have also been reported following the use of methamphetamine hydrochloride, as well as in the treatment of postoperative depression, anorexia, depression, and generally in conditions for which stimulants are used. In some cases, methamphetamine hydrochloride may be used in conjunction with other drugs. The drug has no effect on the metabolism of a patient's own drugs.

INDICATIONS—DESOXIN HYDROCHLORIDE should be used with caution in the treatment of patients with a history of hypertension, arteriosclerosis, or in patients at advanced age. The recommended dose is 10 mg. daily in two divided doses in patients with hypertension or arteriosclerosis.

DESOXIN HYDROCHLORIDE is similar to amphetamine in its action. Like the latter, it stimulates the central nervous system, increases the rate of metabolism, and increases the rate of fat burning in most persons. It does not produce any marked peripheral vasoconstrictive effects, and does not affect the heart.

ONSET OF EFFECT—WITH DESOXIN comes in from 20 minutes to one hour. The duration of action of a single dose of 10 mg. usually varies from one to 12 hours, though in exceptional cases it may be noted for as long as 24 hours. There is a marked, but slight, increase in the rate of fat burning in some subjects. By giving the drug, patients may readily be advised. The dosage of other stimulants, the effect of the drug, and the intensity of stimulant effect is somewhat greater in normal cases in dependent in individual cases.

BLOOD PRESSURE, PULSE RATE AND RESPIRATORY RATE usually are only slightly or temporarily affected, and rise and fall according to the dose.

THE PARENTERAL ADMINISTRATION OF DESOXIN Hydrochloride is suggested for patients and conditions in which greater systemic stimulation is desired. The drug should be injected into the muscle. The rate of absorption is rapid, and the effect is rapid. The drug is rapidly metabolized, and the effect is short-acting. The drug is not recommended for patients with a history of hypertension or who are considered poor surgical risks.

TOLERANCE NOT DEVELOPED. WHILE THE DRUG is not habit forming in the true sense of the word, some dependent cases have been reported. The stimulation of central nervous system may be obtained to some extent by relief of hunger. Tolerance to the drug is not developed. The euphoric and waking effects decrease with prolonged use of the drug in accordance with the normal rate of absorption. As a result, a larger dose is required to maintain the desired effect. It is the hope that the physician, the pharmacist, and the patient will cooperate in the use of the drug to obtain the desired results. A physician's supervision is advised in the use of the drug.



he needs to blow his top...

WEIGHT REDUCTION WITHOUT JITTERS

AMBAR TABLETS AND EXTENTABS

Weight Reduction: Obese patients may resist weight reduction because they fear losing the emotional security involved in overeating. Ambar Tablets or Tablets help them hold the diet line by giving them a more alert, brighter outlook. Ambar adds incentive to weight reduction, gives the patient a better chance of holding off the disabling effects of continued overweight.

Without Jitters: Methamphetamine, a more potent CNS stimulant than amphetamine, but producing less cardiovascular effect, is combined in AMBAR with phenobarbital. The combination subdues CNS effects just enough to protect the patient from overstimulation. Result: mood exhilaration with no undesirable excitation—weight reduction without jitters.

Ambar Tablets: 10 to 12 hours of appetite suppression in one contracted release, no marked action habit.
Methamphetamine hydrochloride . . . 32.0 mg.
Phenobarbital (1 gr.) . . . 64.8 mg.
Ambar Tablets for conventional dosage or sublingual use only.
Methamphetamine hydrochloride . . . 3.20 mg.
Phenobarbital (1/4 gr.) . . . 21.6 mg.

A. H. ROBBINS CO., INC.
Rutland 35, Virginia
Special Pharmaceuticals
of Merck Since 1875.



1957

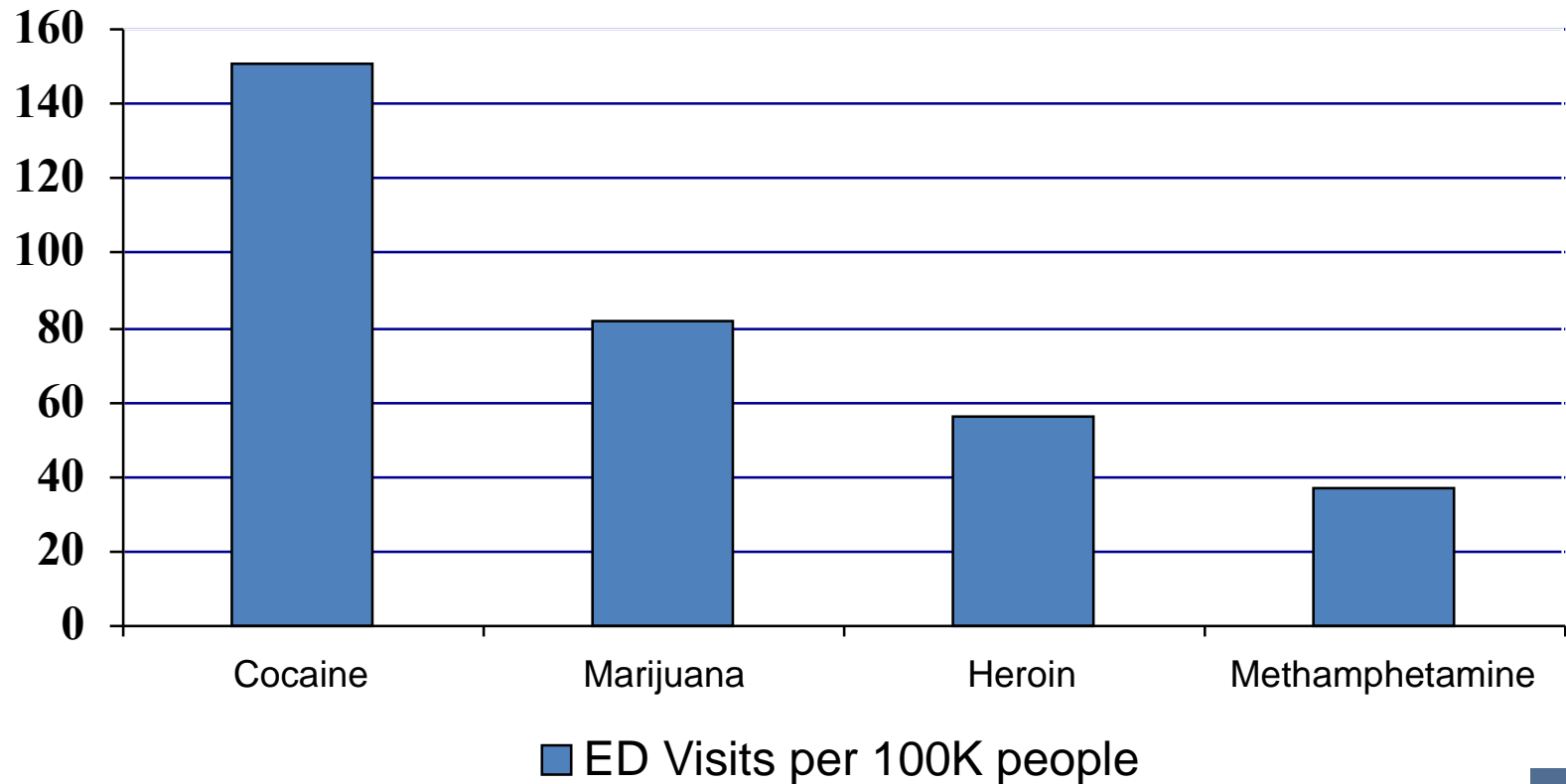
1959



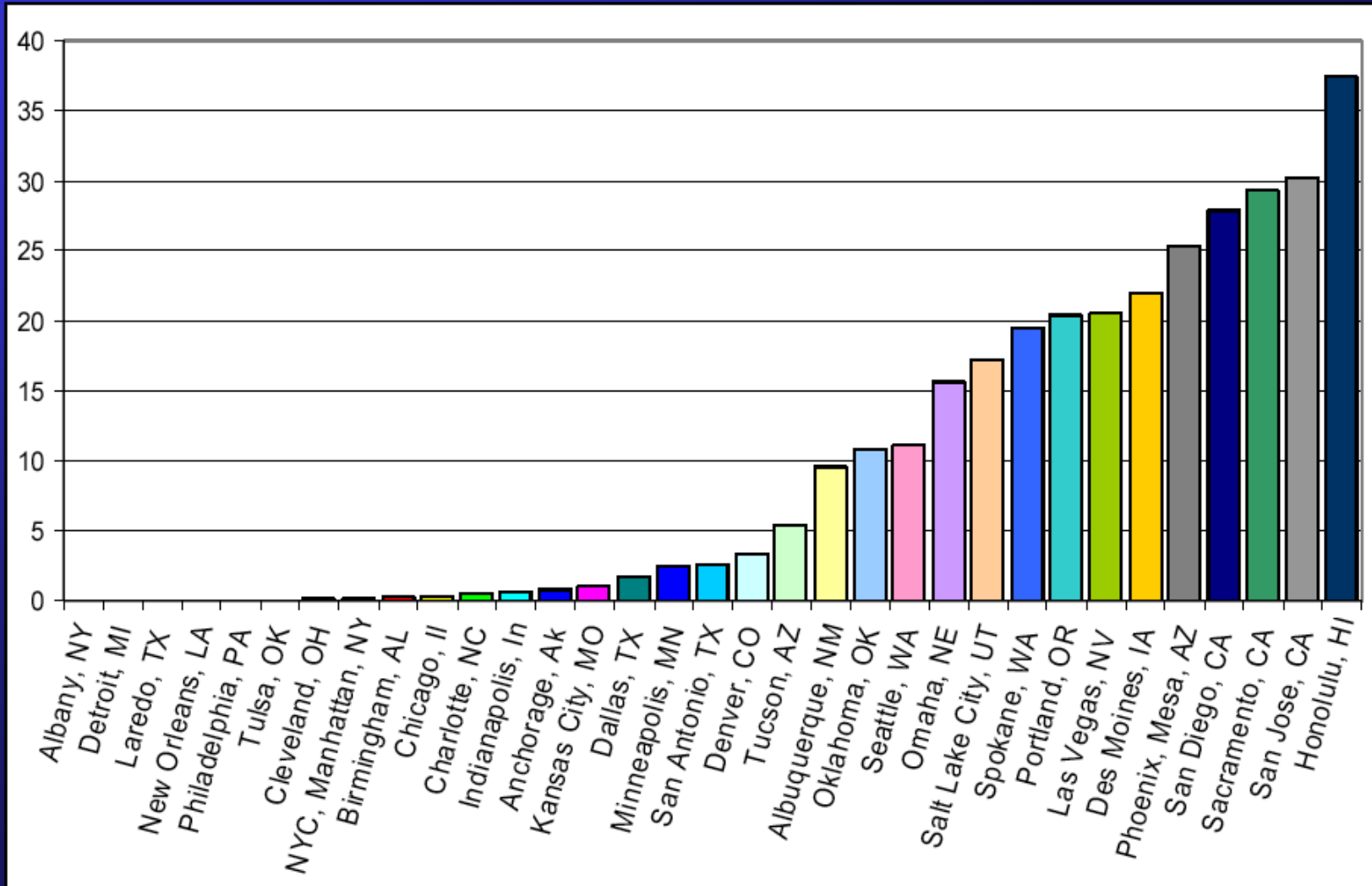
Clinical Addiction Research and Education

Epidemiology

2005 drug-related ED visits



Percent Male Arrestees Testing Positive for Meth (for 33 ADAM sites, 2001)



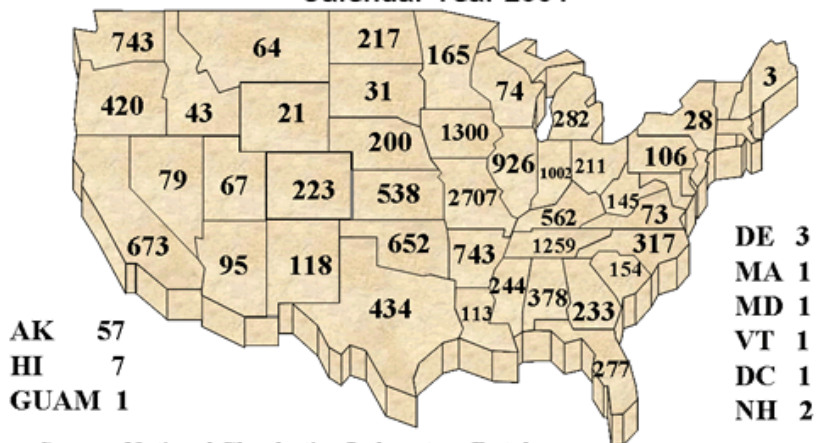
From where do these drugs come?

- Methamphetamine
 - Super labs – Primarily Mexico and California
 - Local clandestine labs - 1 pound of MA creates 6 pounds of toxic waste
 - Holton WC. Unlawful lab leftovers. *Environ Health Perspect.* 2001;109:A576
- Cocaine -
 - 75% grown in Colombia with 75% via Mexico/ Central America



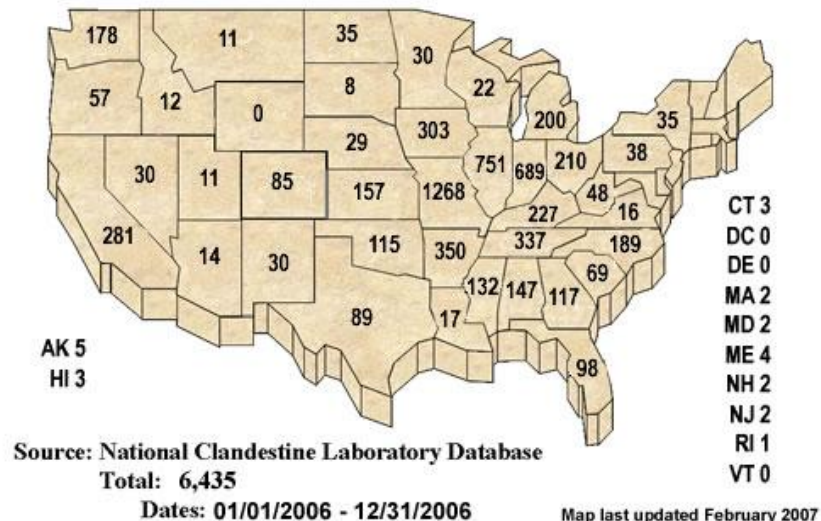
Clandestine lab incidents

**Total of All Meth Clandestine Laboratory Incidents
Including Labs, Dumpsites, Chem/Glass/Equipment
Calendar Year 2004**



Source: National Clandestine Laboratory Database
Total: 15,994 / 49 States Reporting
Dates: 01/01/04 to 12/31/04

**Total of All Meth Clandestine Laboratory Incidents
Including Labs, Dumpsites, Chem/Glass/Equipment
Calendar Year 2006**



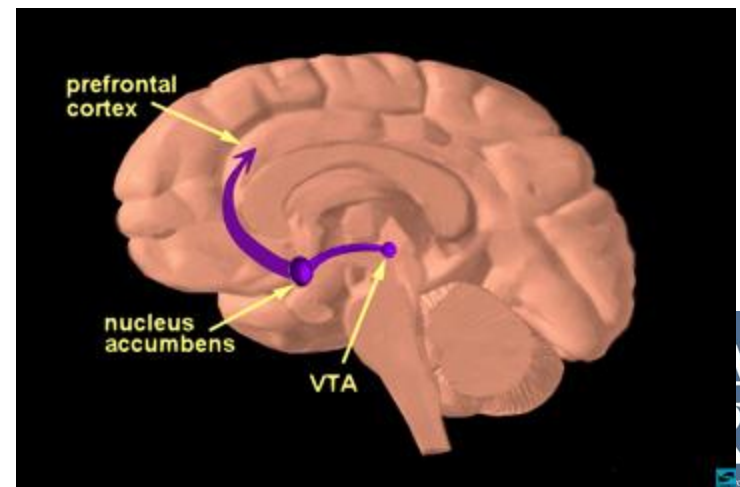
Source: National Clandestine Laboratory Database
Total: 6,435
Dates: 01/01/2006 - 12/31/2006

Map last updated February 2007

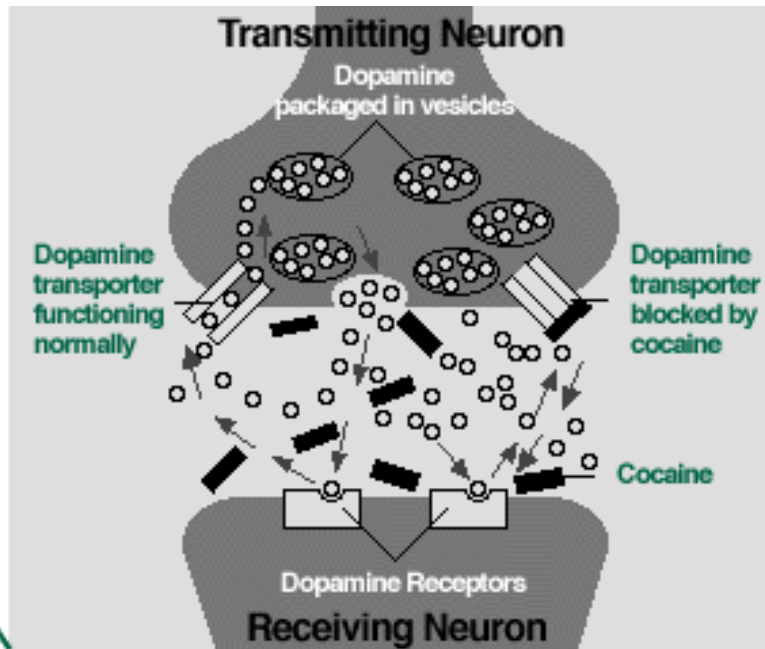
Stimulant Effects

Why do people use stimulants?

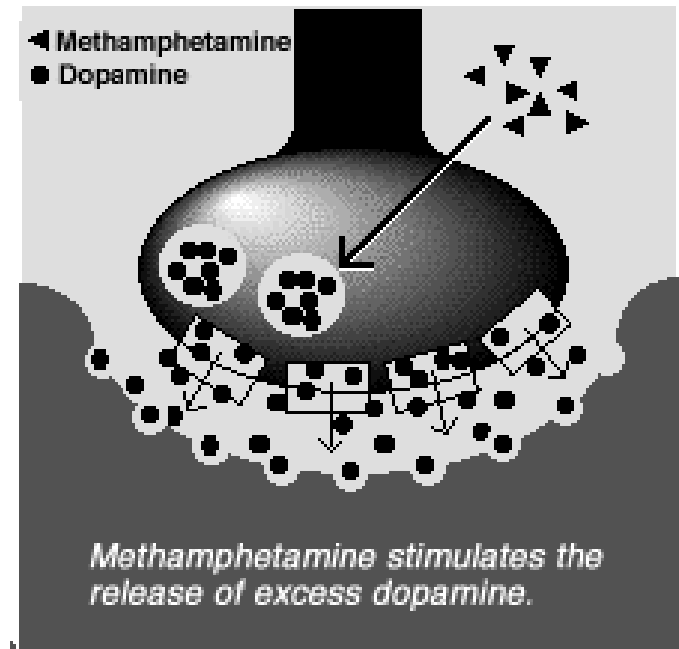
- Euphoria - Rush
 - Onset and intensity depends on delivery method
- Increased energy, alertness, libido
- Diminished social inhibition
- Decreased appetite



Cocaine



Methamphetamine



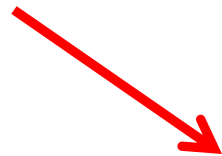
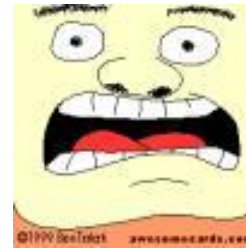
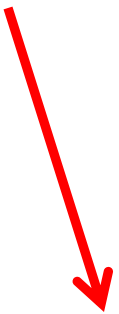
PK: Cocaine

	IV	Smoked	Snorted
Time to effect	10-60sec	3-5sec	1-5min
Peak concent.	3-5min	1-3min	15-20min
Half-life	20-60min	5-15min	60-90min

Lange, R. A. and L. D. Hillis (2001). "Cardiovascular complications of cocaine use." *N Engl J Med* **345**(5): 351-8.

PK: Methamphetamine

	IV	Smoked	Snorted	Ingested
Time to effect	15-30 sec	Immediate	3-5 min	15-20 min
Peak concent.	2-4 h	2-4 h	2-4 h	2-4 h
Half-life	10-12 h	10-12 h	10-12 h	10-12 h



Binges

- 2-3 day binges are typical, called runs
- Regular re-dosing to maintain rush or high in setting of acute tolerance
- Ends when drug or money runs out, or paranoia/ disorganized thinking sets in



Acute Toxicity



- Elevated BP and HR
- Arrhythmia
- Vasoconstriction
- Hyperthermia
- Agitation
- Rhabdomyolysis
- Seizure
- Acute psychosis → prolonged psychosis
 - Paranoid delusions
 - Visual, sensory, and auditory hallucinations
 - ie formications

Intoxication Treatment

- Minimize sensory stimulation
- Neuroleptics (ie haldol) for agitation
- Benzos to control seizures
- Treat hyperthermia (external cooling)
- For increased BP+HR, use vasodilators and CCB or non-selective beta-blockers

Is there stimulant withdrawal?

- Intense craving
 - Depression
 - Fatigue
 - Unpleasant dreams
 - Hypersomnia, then insomnia
 - Increased appetite
 - Limited ability to experience pleasure
- >> All results of relative dopamine depletion

Health Consequences

Dental

- Darkened teeth
- Caries
- Periodontal disease

Pulmonary

- Acute pulmonary edema
- Pulmonary HTN
- Inhalation injury

Cardiovascular

- Hypertension
- DCM
- Arrhythmia/ Tachycardia
- Acute Coronary Syndrome
- Aneurysm/ dissection
- Erectile dysfunction

Infectious

- HIV risk
- HCV/ HBV
- STDs



Neuro-psychiatric

- Stroke
- Seizure
- Depression
- Anxiety
- Mania
- Impulsivity
- Paranoia
- Auditory/ visual hallucinations + formications
- Violence

Renal/Metabolic

- Rhabdomyolysis
- Dehydration
- Acute Renal Failure
- Acidosis
- Hyperthermia

Skin

- Cellulitis/ abscess
- Excoriations
- Chemical burns

Cocaethylene

- Psychoactive substrate from EtOH+cocaine
- ETOH commonly used as “landing gear”
- ETOH before cocaine inhibits cocaine metabolism, producing cocaethylene
- 60-90% of cocaine abusers abuse ETOH
- Greater cardiac toxicity
- Greater rates of seizures, hepatic damage

Treatment

Pharmacologic Treatment

- Antipsychotics
 - Amato. Cochr Database Syst Rev. 2007 Jul 18;(3):
- Anticonvulsants - GABA modulators
 - Carbamazepine, Phenytoin, Valproic Acid, Tigabine, Gabapentin, Lamotrigine – Alvarez. JSAT 2010: 38; 66-73.
 - Baclofen – Heinzerling. Drug Alcohol Depend. 2006 Dec 1;85(3):177-84.
 - Vigabatrin – Brodie. Am J Psychiatry. 2009;166:1269-77.
 - Topiramate – Ekashef Addiction 2012: 107;1297-1306.
- Stimulant replacement
 - Modafinil – Shearer. Addiction. 2009 Feb;104(2):224-33.
 - Dexamphetamine – Longo. Addiction 2009, 105, 146–154
- Vaccine
 - Martell. Arch Gen Psychiatry. 2009 Oct;66(10):1116-23.
- Disulfiram – Pani. Cochr Database Syst Rev. 2010. Oliveto. Drug Alcohol Depend 2010

Non-Pharma Treatment

- Brief Intervention?
 - Bernstein et al. DAD 2005: 77; 49.
- Cognitive behavioral therapy
- Community Reenforcement Approach
- Contingency management
 - Schierenberg et al. Current Drug Abuse Reviews 2012: 5; 320-331.
- Self-help/ 12 step facilitation

Contingency Management

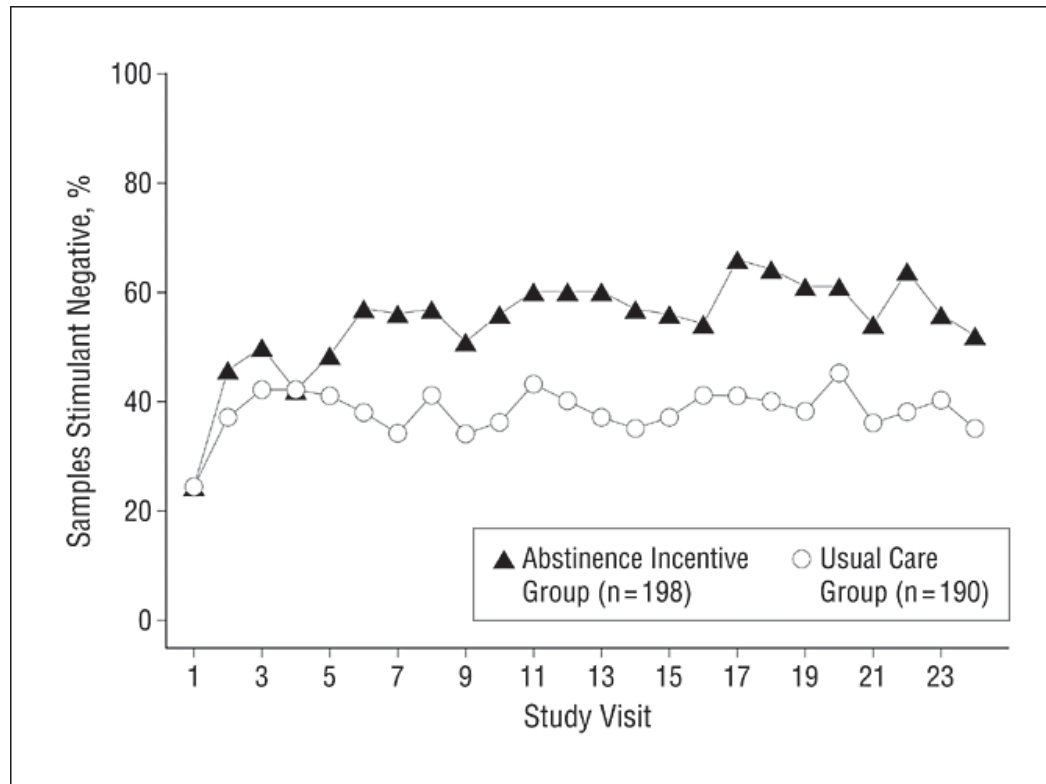
Method	Positive Stimulus	Negative Stimulus
<i>Reinforcement:</i> Increase desirable behavior	<i>Positive Reinforcement:</i> Delivery of a desired consequence contingent on desirable behavior	<i>Negative Reinforcement:</i> Removing an aversive or confining circumstance contingent on desirable behavior
<i>Punishment:</i> Decrease undesirable behavior	<i>Positive Punishment:</i> Punishing consequence contingent on evidence of undesirable behavior	<i>Negative Punishment:</i> Removing a positive circumstance or condition contingent on evidence of undesirable behavior

RCT in 6 community methadone programs of CM among stimulant users

- Usual Care vs.
- Intermittent, escalating re-enforcement
 - 1000 chips
 - 500 “Good job”
 - 250 “Small” - \$1 value – i.e. toiletries
 - 209 “Large” - \$20 value – i.e. kitchenware
 - 1 “Jumbo” – \$80-100 value – tv, stereo
 - # of draws = # of weeks with clean urine

Peirce et al. Arch Gen Psychiatry. 2006;63:201-208.

Contingency Management



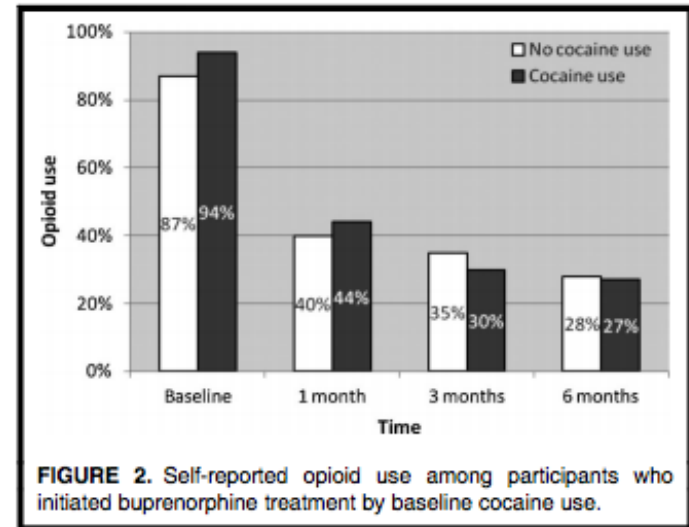
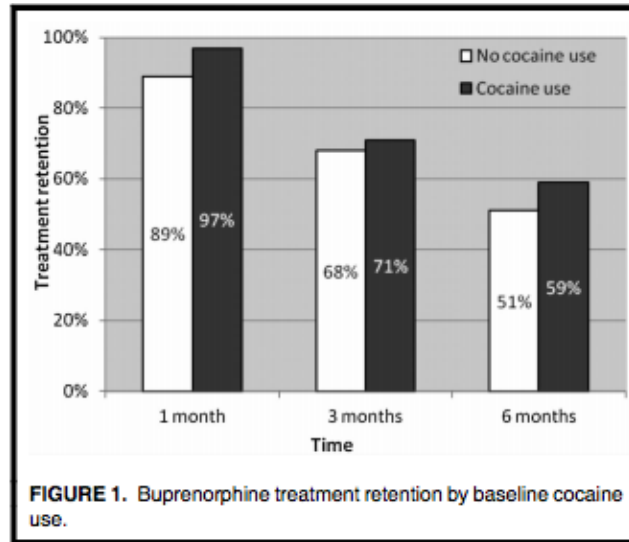
The mean percentage of submitted samples testing negative for target drugs (stimulants and alcohol) is shown for abstinence incentive and usual care participants at each of 24 study visits.

Average cost = \$1.46 per person/day

What should we do with our stimulant-using patients?

- For both inpatients and outpatients
 - Ask about medical complications, overdose
 - Harm reduction – safer use techniques
 - Motivational interviewing to develop a decisional balance that favors safer use, quitting and engaging in available treatment
- Refer or provide
 - Cognitive Behavioral Therapy
 - Community Reenforcement Approach
 - Contingency Management
 - 12 step facilitation

Cocaine use at beginning of buprenorphine treatment



Cunningham et al. Am Journal Addictions 2013: 22; 352-357.

AHA 2011 Updated Scientific Statement on cocaine and methamphetamine unstable angina/NSTEMI

- **Class I: Benefit >>> Risk**
 - NTG and CCB for ST changes (Level C)
 - Immediate cath if ST remain elevated after NTG and CCB (Level C)
 - Fibrinolytics if cath not available
- **Class IIa: Benefit >> Risk**
 - NTG + CCB for normal ECGs or minimal ST changes (Level C)
 - Cath for new persistent ST changes after NTG + CCB (Level C)
 - Manage methamphetamine similarly to cocaine UA
- **Class IIb: Benefit \geq Risk**
 - Non-selective beta-blockers for bp > 150/100 or HR > 100 after NTG or CCB
- **Class III: Risk \geq Benefit**
 - Cath with no ST changes and negative stress test and troponins

Wright et al. JACC. 2011; 57; e215-367

All guidelines are Class 3 LIMITED evidence

Beta-Blockers in Cocaine Chest Pain

331 patients with chest pain and cocaine-positive urine test results admitted to San Francisco General Hospital between 2001-05

- 151 patients received a beta-blocker in ED
 - 85% received metoprolol
- During the hospitalization
 - SBP decreased more in ED beta-block group
 - No differences in ECG results, troponin levels, intubation rates, vasopressor use, malignant ventricular arrhythmia rates, or death were found.
- 45 deaths over a median follow-up of 972 days
 - Discharge on a beta-blocker regimen was associated with a lower risk of cardiovascular-specific death but not all-cause mortality

Rangel C, Shu RG, Lazar LD, et al. [Beta-blockers for chest pain associated with recent cocaine use](#). *Arch Intern Med*. 2010;170(10):874–9.

Thanks!

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Does crack make people more violent than powder cocaine?

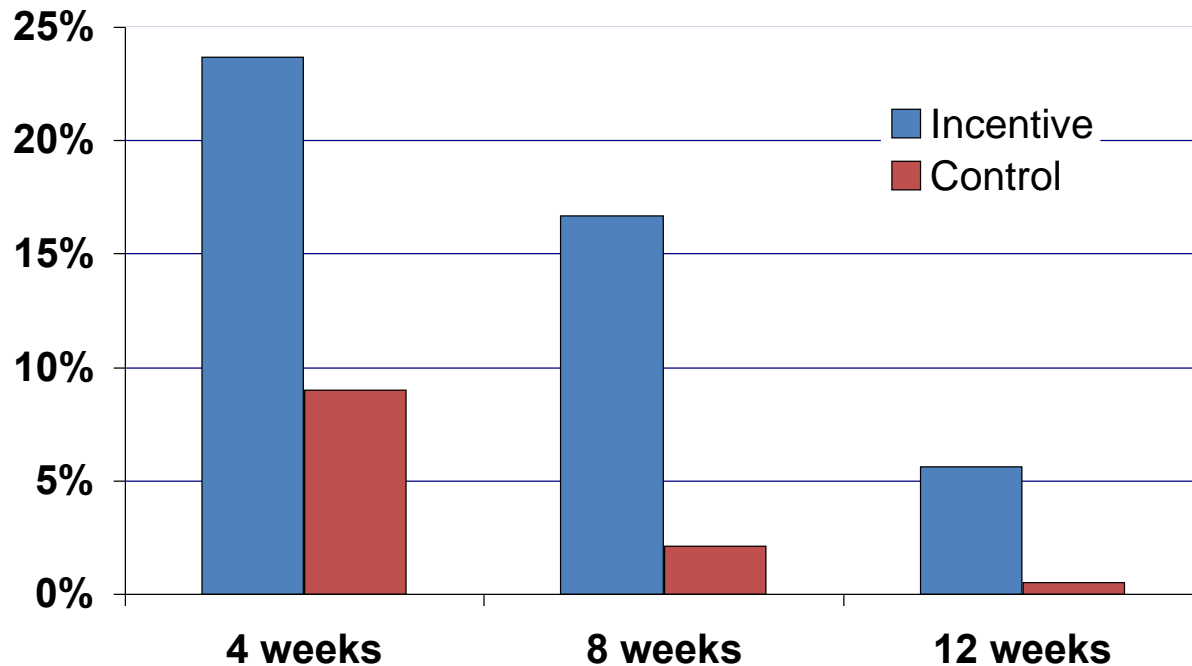
TABLE 2.
Violent behaviors of adults with a lifetime history of crack cocaine or powder cocaine use.

Violent behaviors	Powdered Cocaine % (95% CI) ^a	Crack Cocaine % (95% CI)	Odds Ratio ^b (unadjusted) (95% CI)	Odds Ratio ^c (adjusted) (95% CI)
Bully/push people	17.44(15.26–19.87)	23.27(19.01–28.17)	1.44 (1.04–1.97)	.82(.57–1.19)
Do things that could have easily hurt you/others	46.01(42.66–49.41)	55.26(49.02–61.33)	1.45 (1.07–1.96)	1.24(.84–1.84)
Rob/mug someone or snatch a purse	1.78(1.19–2.64)	4.55(2.66–7.71)	2.63 (1.35–5.12)	.89(.41–1.93)
Force someone to have sex	.63(.33–1.20)	2.36(.91–5.93)	3.78(1.19–12.00)	2.56(.71–9.21)
Get into lots of fights that you started	9.42(7.90–11.20)	15.36(12.01–19.44)	1.74(1.24–2.45)	.85(.56–1.29)
Get into a fight that came to swapping blows with husband/wife or boyfriend/girlfriend	17.98(15.59–20.66)	34.47(29.19–40.16)	2.40 (1.76–3.27)	1.55 (1.05–2.28)
Use a weapon in a fight	8.92(7.48–10.60)	19.87(15.84–24.63)	2.53 (1.83–3.50)	1.18(.80–1.73)
Hit someone so hard that you injure them	20.48(18.16–23.01)	30.01(24.57–36.07)	1.66 (1.23–2.25)	.79(.53–1.18)
Harass/threaten/blackmail someone	6.80(5.56–8.29)	12.27(9.20–16.20)	1.92 (1.34–2.74)	.93(.59–1.46)
Hurt an animal on purpose	5.59(4.44–7.02)	8.78(6.09–12.51)	1.63 (1.04–2.54)	.88(.55–1.40)

Note: ^aCI: confidence interval, ^bOR: odds ratio, ^cOdds ratios adjusted for sociodemographic characteristics, lifetime mood and alcohol and substance use disorders, OR values in bold are statistically significant.

Contingency Management

Methadone Maintenance Patients With Specified Weeks of Continuous Stimulant/Alcohol-Negative Samples (n=388)



Average cost = \$1.46 per person/day

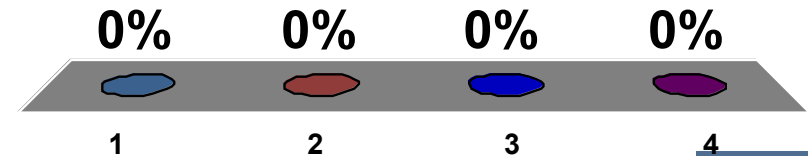
Pierce et al. Arch Gen Psychiatry. 2006;63:201-208.

Studies of the treatment for cocaine-related unstable angina with beta-blockers...

1. include randomized controlled trials that demonstrate that they save lives
2. include randomized controlled trials that demonstrate that they cause harm
3. include catheter studies in humans that show improved vasospasm with propranolol
4. include observational studies that show no increased adverse events among people receiving beta-blockers in the ED

Which statement is true about stimulants?

1. Methamphetamine is only used intravenously or smoked
2. Methamphetamine has a longer half-life than cocaine
3. Intravenous injection results in the fastest onset of action
4. Cocaine's peak concentration occurs in about 1 hour



5 things about stimulants

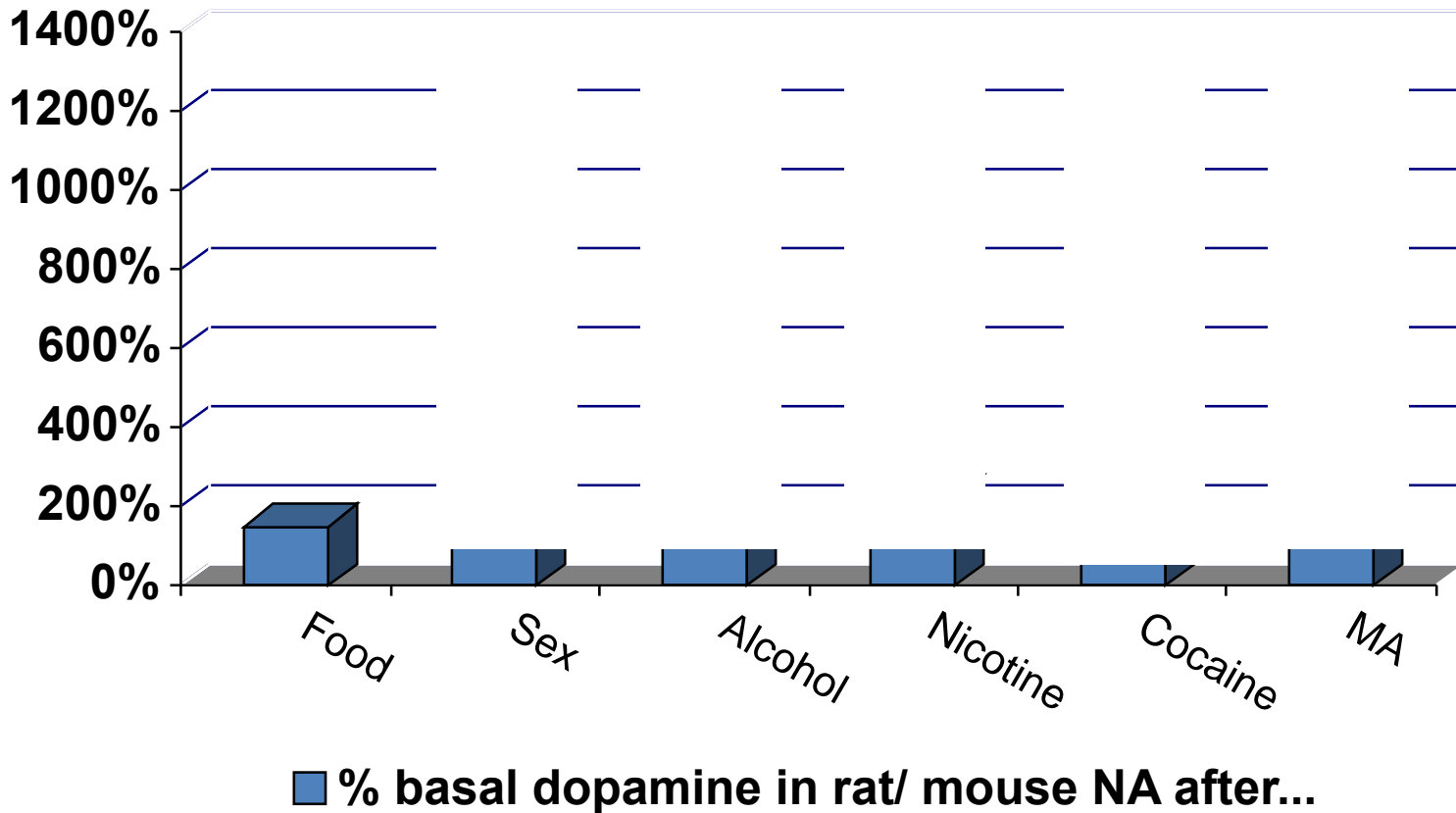
1. Easily available
2. Directly activate the mesolimbic pleasure center
3. Binge use often ends with dysphoria or lack of funds
4. Social and medical consequences
5. Treatment can work if you can find it

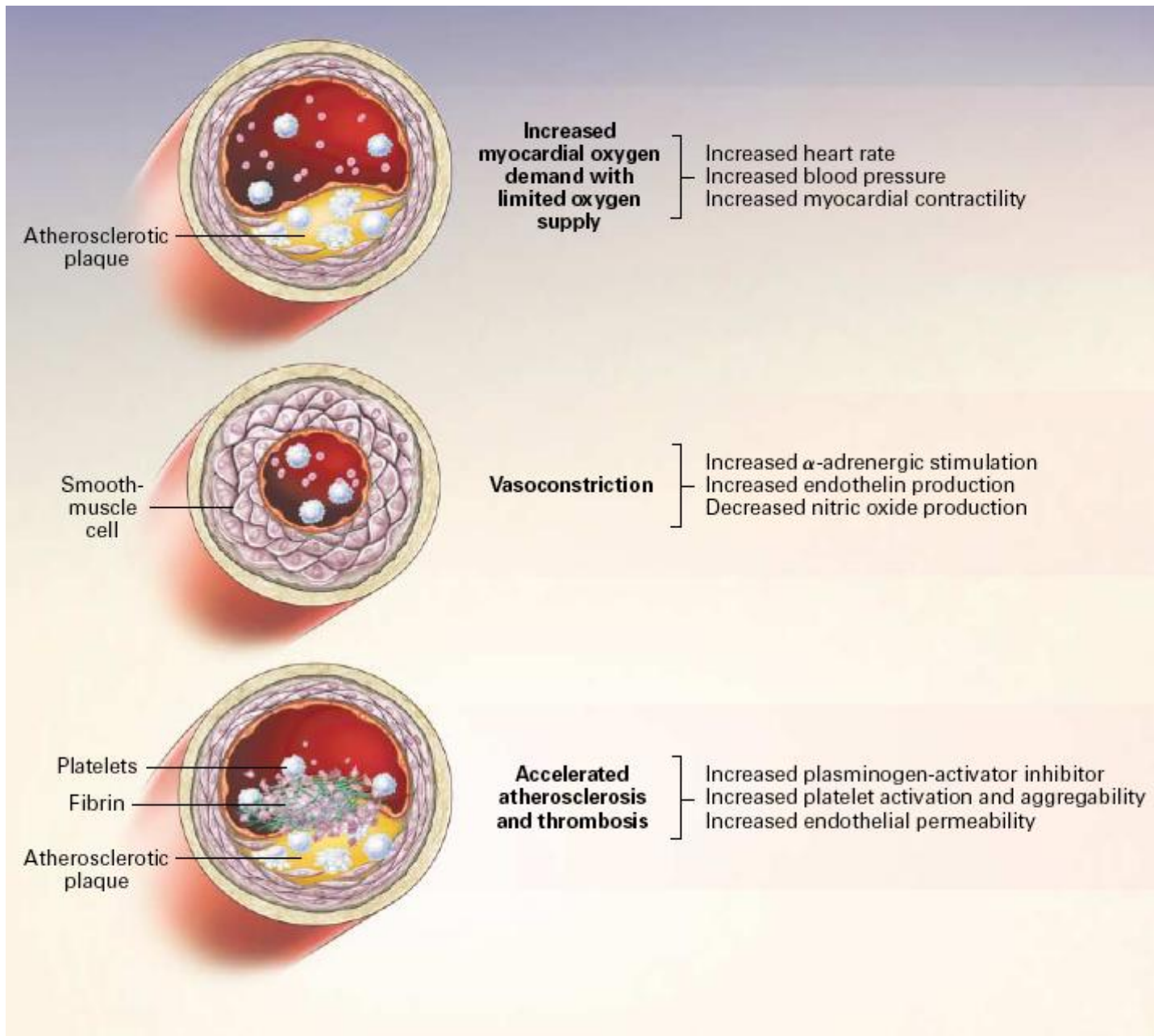
Learning objectives

At the end of this session, participants will be able to:

1. Understand how and why people use stimulants
2. Know the characteristics of stimulant intoxication and withdrawal syndromes
3. Understand the consequences of these drugs
4. Know the current options for treatment of stimulant dependence

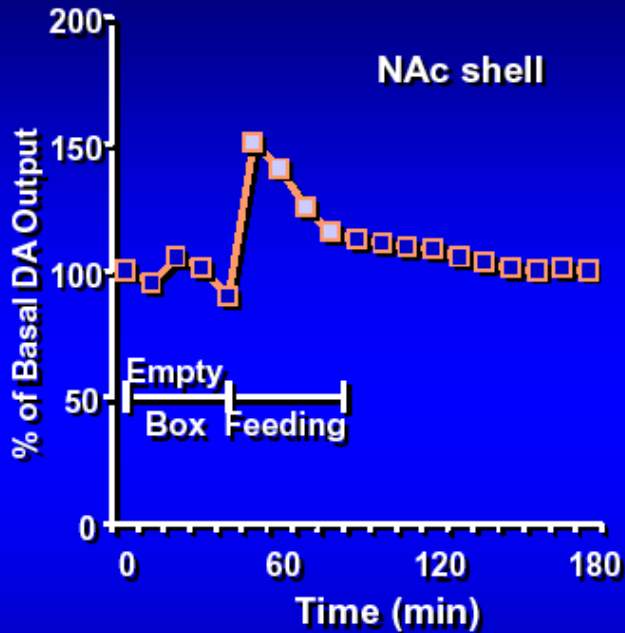
Dopamine release: nucleus accumbens





Natural Rewards Elevate Dopamine

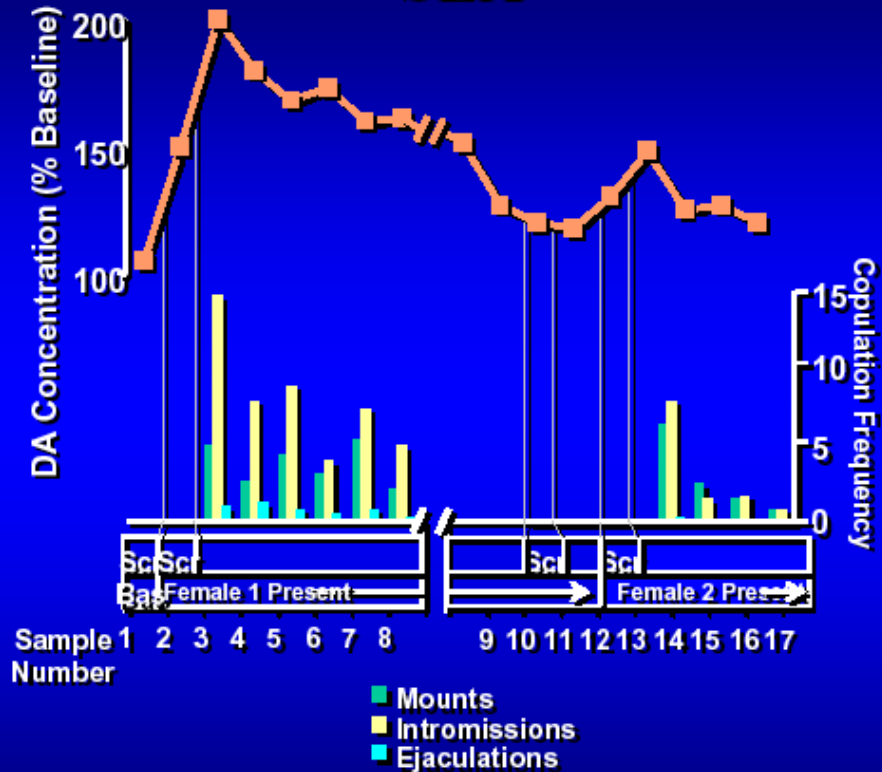
FOOD



Source: Di Chiara et al.

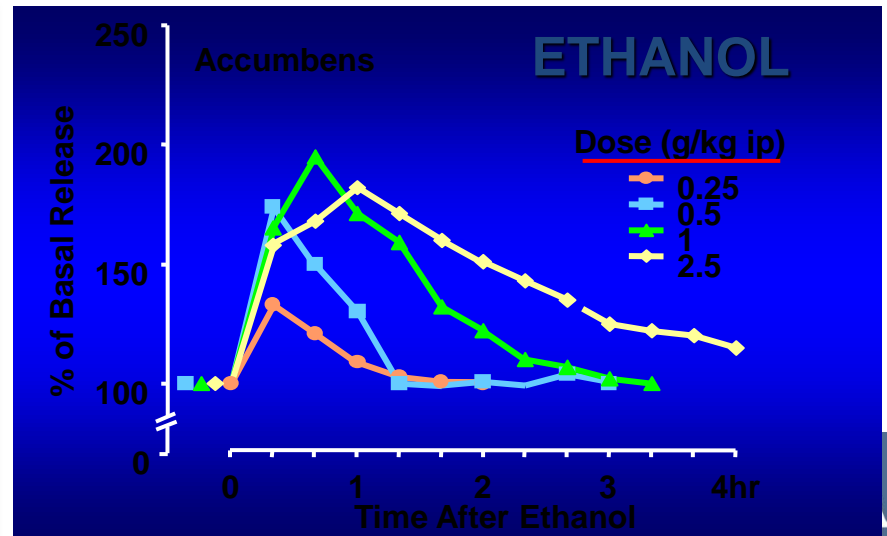
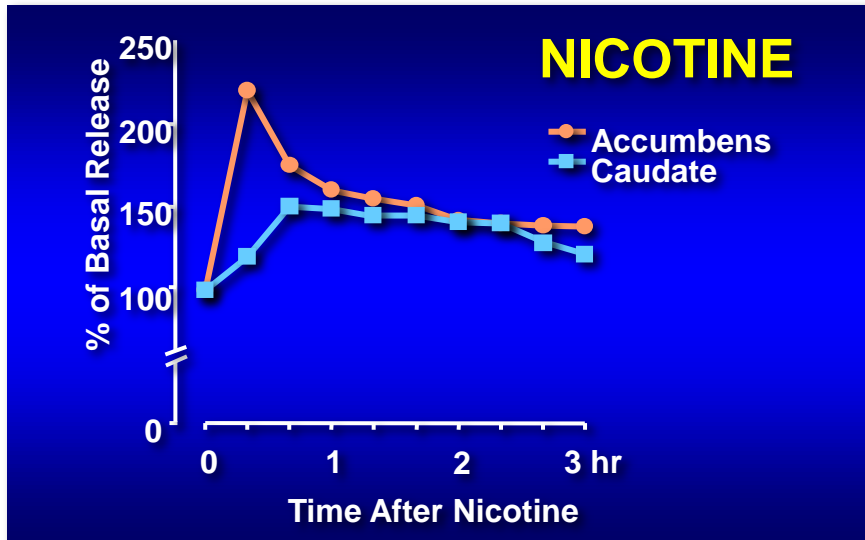
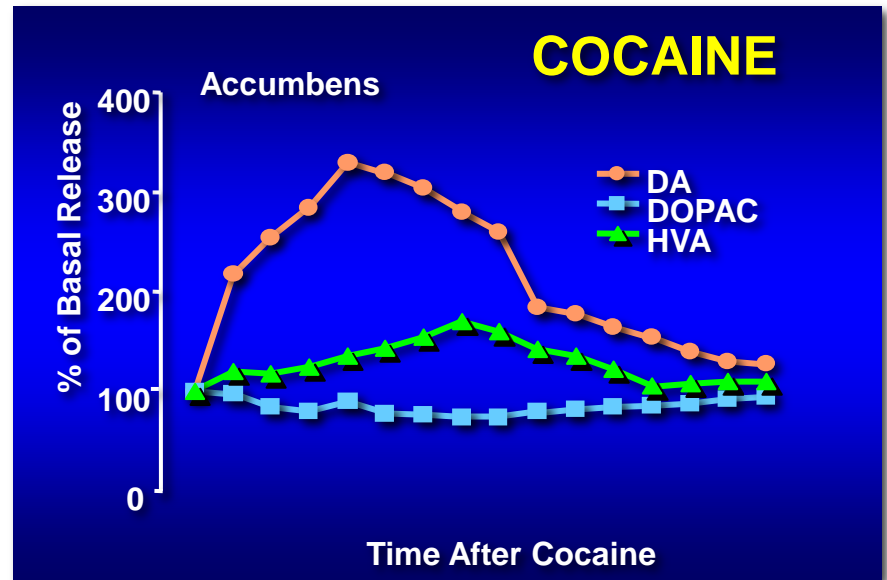
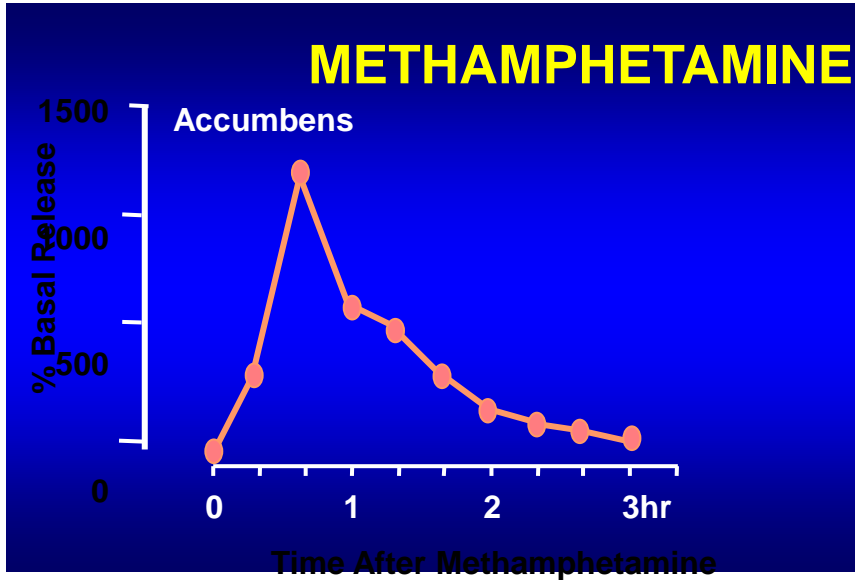
Levels

SEX



Source: Fiorino and Phillips

Effects of Drugs on Dopamine Release



Source: Shoblock and Sullivan; Di Chiara and Imperato
 Slide from Richard Rawson

Pregnancy

- More common in stimulant users:
 - Mental illness, seizure, injury, hypertension
 - Premature membrane rupture and labor, placenta previa, placental abruption, intrauterine death
- 1998-2004
 - Cocaine-related hosp decreased: 0.74>>0.41 per 100
 - MA-related hosp increased: 0.11>>0.22 per 100
- Cocaine vs. MA related pregnancy
 - More common for cocaine: mental illness, poor fetal growth, and premature delivery
 - More common for MA: hypertension, placenta previa

Cardiomyopathy and Methamphetamine

- In a case-control study, researchers examined the association between methamphetamine use and cardiomyopathy (CM).
- Subjects included patients aged 45 years or younger discharged from a tertiary care medical center in Honolulu.
- Through medical record review, researchers identified...
 - 107 cases (had a discharge diagnosis of CM or congestive heart failure) and
 - 114 controls (ejection fraction $\geq 55\%$ and no wall motion abnormalities).

Yeo K-K, et al. *Am J Med.* 2007;120(2):165-171.

Cardiomyopathy and Methamphetamine

- 42% of cases and 20% of controls had ever used methamphetamine.
- Methamphetamine use was significantly more common in cases than in controls.
- OR in analyses adjusted for age, body mass index, and renal failure, 3.7

“No lies here folks this recipe will manufacture methamphetamine this will get you into trouble if you do this BE CAREFUL!”

First of all let's talk about supplies:

- 1 Case Regular Pint size Mason Jars (Used for canning)
- 2 Boxes Contact 12 hour time released tablets.
- 3 Bottles of Heet.
- 4 feet of surgical tubing.
- 1 Bottle of Rubbing Alcohol.
- 1 Gallon Muriatic Acid (Used for cleaning concrete)
- 1 Gallon of Coleman's Fuel
- 1 Gallon of Aceton
- 1 Pack of Coffee Filters
- 1 Electric Skillet
- 2 Bottles of Hydrogen peroxide
- 3 20 Oz Coke Bottles (Plastic type)(with Lids/caps)
- 1 Can Red Devils Lye
- 1 Pair of sharp scissors
- 4 Boxes Book Matches (try to get the ones with brown/red striker pads)
- 1 pyrodex baking dish
- 1 Box exacto razor blades single sided
- 1 digital scale that reads grams
- 2 gallons distilled water
- 1 Roll Aluminum foil tape

“That's what you would have to go buy if you wanted to make meth.”



Cocaine and HIV

- Crack cocaine use is associated
 - increased number of sex partners
 - sex work
 - HIV infection, independent of IVD use
- IV cocaine leads to HIV through frequent injection Chaisson. JAMA. 1989 Jan 27;261(4):561-5.

MA and HIV

- Increased libido, social disinhibition, increased energy >> riskier sex behaviors
- PDE5 inhibitors (sildenafil) can be used to mitigate MA-induced erectile dysfunction

Methamphetamine and Trauma

To assess the prevalence and impact of methamphetamine use (MU) in trauma patients, researchers surveyed the records of...

- 4932 patients who presented to
 - San Diego trauma center between 2003–2005
 - urine toxicology screening during their visit

Results

- The rate of MU (defined as a positive urine screen), but not other illicit drug use, increased from 2003 to 2005 (from 9% to 15%).
- In adjusted analyses, patients with MU were more likely to have...
 - been injured in a violent way (OR, 2.0),
 - attempted suicide (OR, 1.7),
 - been a victim of domestic violence (OR, 2.5),
 - required more medical care (e.g., ≥ 1 operations [OR, 1.5], mechanical ventilation [OR, 1.6]), and
 - died from their injuries (OR, 2.3).

Swanson SM, et al. *J Trauma*. 2007;63(3):531

Cognitive Behavioral Therapy

16 week RCT of cocaine-dependent methadone patients of:

CBT vs. CM vs. CBT+CM vs. TAU

30 patients per group

Cognitive Behavioral Therapy

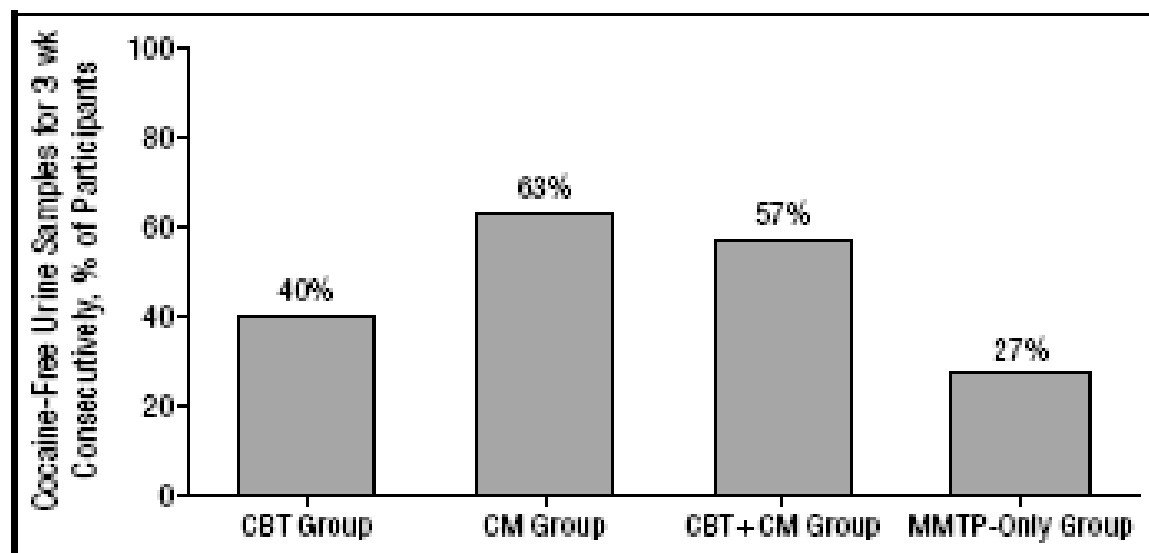


Figure 5. Percentage of patients achieving 3 consecutive weeks of cocaine-free urine samples by group ($\chi^2_3=9.9$; $P=.02$). CBT indicates cognitive-behavioral therapy; CM, contingency management; and MMTP, methadone maintenance treatment program.

Cognitive Behavioral Therapy

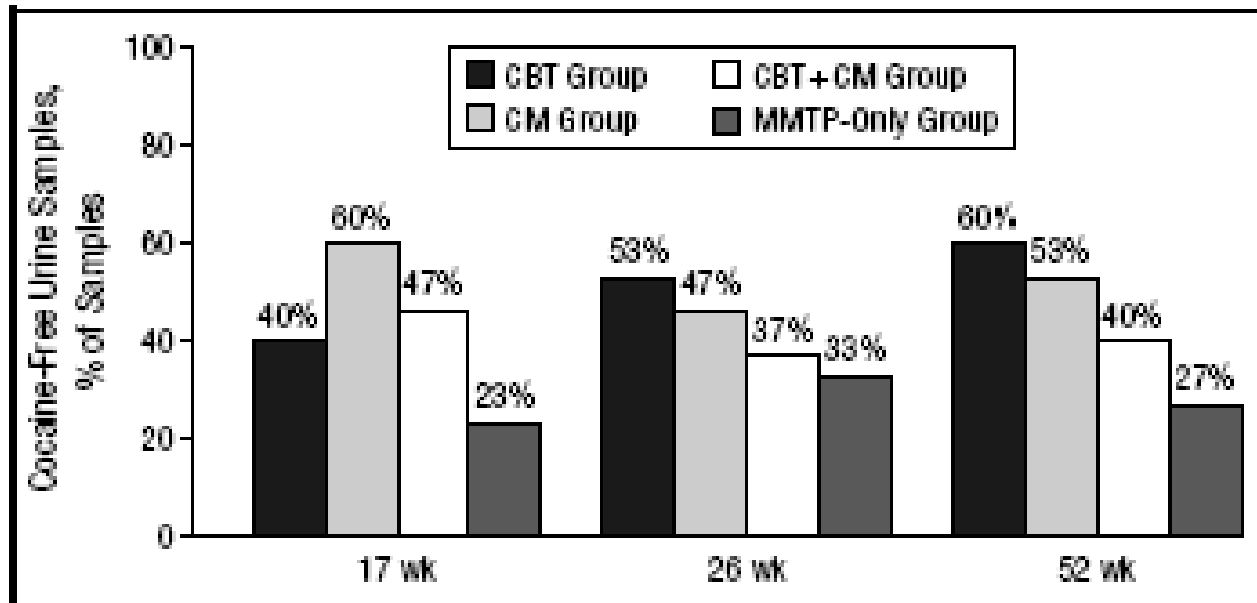


Figure 6. Percentage of 30 possible cocaine-free urine samples at the 17-week, 26-week, and 52-week follow-up points. CBT indicates cognitive-behavioral therapy; CM, contingency management; and MMTP, methadone maintenance treatment program.