

**Detoxification and Substance Abuse Treatment**

**A Treatment Improvement Protocol**

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Substance Abuse and Mental Health Services Administration

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Patients undergoing detoxification frequently present with medical and psychological conditions that can greatly affect their overall well­ being and the process of detoxification. These may simply be pre­ existing medical conditions not related to substance use or the direct outcome of the substance abuse. In either case, the detoxification pro­ cess can negatively affect the co-occurring disorder or vice versa.

Furthermore, people who abuse substances often present with medical conditions in advanced stages or in a medical crisis. Co-occurring mental disorders also are likely to be exacerbated by substance abuse. For more on treating patients with co-occurring psychiatric disorders, the reader should refer to TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT] 2005c).

This chapter is intended primarily for medical personnel treating patients in detoxification settings, though nonmedical staff may find it informative as well. This chapter is not meant to take the place of authoritative sources from internal medicine. Rather, it presents a cursory overview of special conditions, modifications in protocols, and the use of detoxification medications in patients with co-occurring conditions or disorders. Overall treatment of specific conditions is not addressed unless modification of such treatment is needed.

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# General Principles of Care for Patients With Co-Occurring Medical Conditions

Patients who use substances can present with any of the conditions or combinations of con­ ditions that can be found in the general popu­ lation. In most cases, the management of the medical condition in the patient with a sub­ stance use disorder diagnosis does not differ from that of any other patient. However, the medication used for detoxification and the actual detoxification protocol may need to be modified to minimize potentially harmful effects relevant to the co-occurring condition.

Detoxification staff providing support should be familiar with the signs and symptoms of common co-occurring medical disorders.

Likewise, personnel at medical facilities (i.e., emergency rooms, physicians' offices) should be aware of the signs of withdrawal and how it affects the treatment of the presenting med­ ical conditions.

The setting in which detoxification is carried out should be appropriate for the medical conditions present and should be adequate to provide the degree of monitoring needed to ensure safety (e.g., oximetry [a measurement of the amount of oxygen present in the blood], greater frequency of taking vital signs, etc.). Acute, life-threatening conditions need to be addressed concurrently with the withdrawal process and intensive care unit monitoring may be indicated.

Clinicians should keep in mind that consulta­ tion with specialists in infectious diseases, cardiology, pulmonary medicine, hematology, neurology, and surgery may be warranted.

Whenever possible, consent should be sought to involve the patient's primary healthcare provider in the coordination of care.

Attending medical staff should be aware that co-occurring medical conditions present an opportunity to engage patients. By focusing on the adverse effects of the substance abuse

on the overall health of patients, staff mem­ bers are in a position to help patients see the importance of engaging in treatment for their substance use disorders. Patients should have appointments for followup care made prior to detoxification discharge for all chronic medi­ cal conditions, conditions needing further evaluation, and substance abuse treatment.

This section highlights the conditions most frequently seen in individuals who abuse sub­ stances, though it is not inclusive. Disorders of the following systems will be covered: gas­ trointestinal (including the gastrointestinal [GI] tract, liver, and pancreas), cardiovascu­ lar system, hematologic (blood) abnormali­ ties, pulmonary (lung) diseases, diseases of the central and peripheral nervous system, infectious diseases, and special miscellaneous disorders. Where special considerations are needed for a patient presenting with a given disorder in a detoxification setting they are listed following the heading "Special Considerations."

### Gastrointestinal Disorders

Frequently, the use of substances can present a range of gastrointestinal problems. Cocaine use, for example, can result in various gas­ trointestinal complications, including gastric ulcerations, retroperitoneal fibrosis, visceral infarction, intestinal ischemia, and gastroin­ testinal tract perforations (Linder et al.

2000). Gastrointestinal disorders may affect many different organs and organ systems (e.g., liver, pancreas), making diagnosis diffi­ cult. Since symptoms can be vague and patients are not always able to articulate the specific problem, diagnosis can be difficult.

For a simple rule of thumb, urgent attention is needed if the patient is diagnosed with any of the following:

* Appendicitis
* Abdominal aortic aneurysm
* Perforated peptic ulcer
* Boerhaave's Syndrome (spontaneous esophageal rupture)
* Obstructed or strangulated bowel
  + lschemic bowel disease (a condition that results from inadequate blood supply to the intestines)
  + Abcess of the pancreas or liver
  + Ruptured spleen or other trauma to the abdominal area

Other possible diagnoses of abdominal pain include:

* + Hepatitis
  + Peptic ulcer (nonperforating)
  + Peritonitis
  + Acute pancreatitis
  + Pelvic inflanmrntory disease
  + Endometriosis
  + Nephrolithiasis (kidney stones)
  + Inflammatory bowel disease
  + Ovarian cysts

Clinicians should also be aware of some decep­ tive causes of abdominal pain:

* + Myocardial infarction
  + Pulmonary emholi
  + Herpes zoster (shingles)
  + Acute pylonephritis (kidney infection)

Specific co-occurring gastrointestinal disorders requiring special attention in patients undergo­ ing detoxification are discussed below.

#### *Reflux esophagitis*

Reflux esophagitis can be a result of alcohol's effect on the lower esophageal sphincter (i.e., relaxation) and a decrease in peristalsis of the distal esophagus, allowing gastric contents to come into contact with the lower esophagus. Typical symptoms include burning in the epi­ gastric or retrosternal area (commonly called "heartburn" or "indigestion"). Esophageal bleeding can result from reflux esophagitis and esophageal varices (resulting from portal hypertension).

##### *Special considerations*

Several drugs used in typical protocols, such as beta blockers and calcium channel blockers,

may decrease lower esophageal sphincter pres­ sure and aggravate reflux (Dell'ltalia 1994).

#### *Mallory-Weiss Syndrome*

Mallory-Weiss Syndrome is caused by torn mucosa of the esophagus at the gastro­ esophageal junction due to protracted or vio­ lent vomiting. Mallory-Weiss Syndrome is the etiology of 5 to 15 percent of all upper GI bleeds (Schuylze-Delrieu and Smmners 1994).

#### *Boerhaave's* syndrome

Co-occurring medical conditions present an opportunity to engage patients in treatment for their substance use disorders.

Boerhaave's syn- drome is manifested by rupture of the esophagus. Patients presenting with this condition complain of acute epigastric pain (83 percent of patients), vmniting (79 percent), and shortness of breath (39 percent) as the predominant, nonspe­ cific symptoms. This lack of specificity can delay making the cor­ rect diagnosis (Brauer et al. 1997).

Tachycardia, cyanosis, and subcu- taneous emphysema also can be seen. If this condition is left

untreated, the prognosis is severe.

#### *Gastritis*

Gastritis is described as the disruption of the gastric mucus lining that allows gastric acid to contact the mucosa with resultant inflanmrntion and possible bleeding. The patient presents with nausea, vomiting, and abdominal pain (Ivey 1981). Alcohol increases gastric acid secretion and reduces the mucosa! cell barrier,

allowing back-mffusion of the gastric acid into the mucosa. This frequently causes an occur­ rence of erosive gastritis in the individual with an alcohol use disorder (Fenster 1982).

##### *Special considerations*

Aspirin and nonsteroidal medications should be avoided in the withdrawal protocols.

#### *Pancreatitis*

Detoxification staff providing support should be familiar with the signs and symptoms of com- mon co-occurnng

medical conditions.

Pancreatitis can be caused by many fac­ tors, although stud­ ies suggest that alco­ hol may be a factor in anywhere from 5 to 90 percent of all cases (Apte et al.

1997), with some experts suggesting about 60 percent of all cases result from excessive alcohol consumption (Yakshe 2004). The acute condition pre­ sents with abdomi­ nal pain, which is described as sharp, burning, and con­ stant and is located in the epigastric area of the

abdomen with radiation to the back. Presenting symptoms and signs can include abdominal tenderness, decreased bowel sounds, low-grade fever, tachycardia, nausea, and vomiting. Pancreatitis can proceed to a chronic condition where pancreatic calcifica­ tion, diabetes mellitus, malabsorption, and chronic abdominal pain occur.

##### *Special considerations*

There may be a need to forbid oral intake of food and medications, necessitating a change of route of administration of both food and medications to intravenous forms. In alcohol withdrawal protocols, Ativan might be consid-

ered as an appropriate agent, as it can be administered intravenously or intramuscular­ ly. Opioids may have to be used to control pain.

#### *Liver disorders*

Liver disease can range from fairly benign *fatty liver,* which presents usually as an asymptomatic enlargement of the liver associ­ ated with mild elevation of the serum liver enzymes, to a broad spectrum of viral infec­ tions and the toxic consequences of alcohol and other drug use. The end point of liver disease is liver necrosis or failure. Midway in the progression of liver disease is *acute alco­ lwlic hepatitis.* The presentation is one of liver tenderness, jaundice, fever, ascites, and an enlarged liver. The patient is quite sick and frequently has nausea and vomiting.

##### *Special considerations*

Alcoholic hepatitis usually needs acute medi­ cal treatment to prevent electrolyte imbalance and dehydration. Protocols may have to be adapted if the patient cannot take oral agents.

#### *Portal hypertension*

Portal hypertension is a frequent conse­ quence of liver disease. If elevation of the portal pressure goes untreated, esophageal varices develop and hemorrhage can ensue. Treatment of acute hemorrhage includes endoscopic sclerotherapy or ligation. Initial therapy should include prompt and adequate intravascular volume replacement, correction of severe anemia and coagulopathies, and adequate airway management.

##### *Special considerations*

Propranolol or isosorbide therapy is effective in the prophylaxis of variceal bleeding (Trevillyan and Carroll 1997), though beta blockers can interfere with measuring the true heart rate that determines the content of many detoxification protocols. If bleeding is

present, changeover to intravenous medica­ tion protocols is recommended, as the patient will not be able to take oral medications.

#### *Cirrhosis*

Cirrhosis, or the formation of fibrous tissue in the liver, leads to a state of increased resis­ tance in the hepatic venous circulation. The inability of blood to flow freely gives rise to portal hypertension with ensuing esophageal varices, splenomegaly, ascites, dilatation of superficial veins, peripheral edema, and hem­ orrhoids.

Liver necrosis can be seen in patients who use inhalants, particularly chronic use of benzene and carbon tetrachloride. African Americans and Hispanics/Latinos have higher mortality rates from cirrhosis of the liver resulting from alcohol abuse than do Caucasians and Asians and Pacific Islanders (Sutocky et al. 1993).

Liver function test abnormality and jaundice can occur in individuals who use anabolic steroids, but this usually resolves on cessation of the drugs. Studies in the elderly show that 1-year mortality was 50 percent among patients over age 60 with cirrhosis, versus 7 percent for those under age 60 (Potter and James 1987). Great care needs to be used when giving diuretics to elderly patients with cirrhosis, since their total body water may already be decreased, making them more sus­ ceptible to fluid and electrolyte depletion (Scott 1989).

Alcohol-related hepatic injury is seen in a higher proportion of women due to a possible potentiation (strengthening) of this effect by estrogen (Brady and Randall 1999).

## *Special considerations*

For the treatment of alcohol withdrawal lorazepam (Ativan) is well tolerated **in** patients with severe liver disease (D'Onofrio et al. 1999) as is oxazepam (Serax), with its short half-life of 6 to 8 hours and simple metabolism with no metabolites.

'

**Cardiovascular Disorders**

The presentation of chest pain or discomfort remains one of the most difficult differential diagnoses to sort through, as disorders of sev­ eral systems can cause this single complaint. Inability to correctly diagnose this symptom can be brought about by the patient's inabili­ ty to be interviewed and give succinct symp­ toms (the intoxicated or severely withdrawing patient), a sociocultural or educational level that does not allow for the verbal nuances necessary to making a diagnosis, or fabrica­ tion of symptoms by a patient seeking to obtain pain medications or other drugs.

A normal resting electrocardiogram does not rule out the presence of organic heart disease and the presence of nonspecific changes does not necessarily mean that heart disease is pre­ sent. Final diagnoses can range from reflux to myocardial infarction brought about by underlying ischemic heart disease or the use of cocaine. Frequently, lung diseases can have as their presenting symptom chest discomfort. The consensus panel believes that this condi­ tion should never be overlooked or minimized and it is imperative that an especially prompt diagnosis be made and treatment be under­ taken to ensure patient safety.

Underlying cardiac illness could be worsened by the presence of autonomic arousal (elevat­ ed blood pressure, increased pulse and sweat­ ing) as seen in alcohol, sedative, and opioid withdrawal. Thus prompt attention to these findings and aggressive withdrawal treatment is indicated. Special considerations for the treatment of specific cardiac conditions are outlined below.

#### *Hypertension*

Hypertension frequently is seen in the detoxi­ fication patient. Evaluation should include a complete history to determine if the elevated blood pressure predated the present with­ drawal status. Consideration should be given to include serum electrolytes, urinalysis, BUN/creatinine, and an EKG in the detoxifi-

cation unit's initial workup. More elaborate workup can be carried out after completion of detoxification.

Propranolol (lnderal), labetalol (Trandate) and metoprolol (Lopressor) are the beta blockers of choice for treating hypertension during pregnancy (McElhatton 2001), howev­ er, the impact of using them for alcohol detoxification during pregnancy is unclear. If treating African Americans with beta block­ ers, clinicians should be aware that propra­ nolol is less effective in this population than it is in Caucasians (Pi and Gray 1999). Asians require much lower doses of beta blockers than Caucasians, inasmuch as they tend to be very sensitive to the blood pressure and heart rate effects (Pi and Gray 1999).

##### *Special considerations*

The presence of a hypertensive history and poorly controlled blood pressures may have an effect on the proper evaluation of with­ drawal as the examiner would have difficulty determining whether the elevated blood pres­ sure was due to withdrawal or to the underly­ ing hypertensive history. Thus modifications of the usual parameters and schedulino- of detoxification medications should he consid- ered. In any event, severe elevation of blood pressure should he treated concurrently with, at minimum, salt restriction and rest. If the blood pressure is still elevated in several days despite a reduction in other withdrawal parameters and symptoms, then medication is warranted.

*"'*

Beta blockers and clonidine have been used in the treatment of alcohol withdrawal and clonidine also has been used in opioid proto­ cols. These medications can help control blood pressure and also work well in the pro­ tocol. Calcium channel antagonists have also been used to ameliorate some of the symptoms of alcohol withdrawal and can be used con­ currently for blood pressure control.

***lschemic heart disease***

lschemic heart disease presents as chest pain or pressure, palpitations, dizziness, and/or shortness of breath and requires immediate attention, which will dictate what settino- is appropriate for the detoxification.

*"'*

Cocaine use is associated with various cardio­ vascular complications including angina pec­ toris, myocardial infarction, and sudden death. It is estimated that over half of the 64,000 patients evaluated annually for cocaine-associated chest pain will he admitted to hospitals for evaluation of myocardial ischemia. Only about 6 percent of patients will demonstrate biochemical evidence of myocardial infarction (Hoffman and Hollander 1997). The typical patient with cocaine-related myocardial infarction is a male in his mid-30s with a history of chronic tobacco and repetitive cocaine use (Hollander 1995). This effect of cocaine appears to be increased because the drug causes an increase in myocardial oxygen demand and thus a decrease in oxygen supply. These two factors, which are caused by vasospasm and vasocon­ striction of the coronary arteries, may lead to cardiovascular disorders.

Patients with recent cocaine use can experi­ ence persistent cardiac complications such as prolonged QT interval and vulnerability for arrhythmia and myocardial infarction (Chakko and Myerhurg 1995). (QT is the Q to T interval measured on EKGs. If the interval is prolonged, it can lead to cardiac rhythm disturbances.) Amphetamines are rarely reported as the cause of myocardial infarc­ tion, though a case report shows that a patient subsequently experienced a non-Q­ wave anterior wall infarction associated with amphetamine use (Waksman et al. 2001).

Cocaine use and HIV infection have been associated with an increased incidence of car­ diac dysfunction, but concomitant exposure may cause a synergistic effect (Soodini and Morgan 2001).

##### *Special considerations*

Beta-adrenergic blocking agents may exacer­ bate cocaine-induced coronary arterial vaso­ constriction and thereby increase the myocar­ dial ischemia. Nitroglycerin and verapamil reverse cocaine-induced hypertension and coronary arterial vasoconstriction and are

the medications of choice in the patient who uses cocaine and presents with chest pain (Pitts et al. 1999). Cocaine may cause platelet activation leading to acute coronary events­ thus more aggressive antiplatelet therapy may be indicated (Callahan et al. 2001).

#### *Cardiomyopathy*

Cardiomyopathy is caused by degenerative changes of the cardiac muscle with enlarge­ ment of the heart (cardiomegaly) and left ven­ tricular failure. Alcoholic cardiomyopathy presents with a similar picture as cardiac fail­ ure from other etiologies, with shortness of breath on exertion, shortness of breath when the patient is lying flat, and edema of the lower extremities.

Besides alcohol as the etiology, a dilated car­ diomyopathy can be seen with use of the inhalant trichlorethylene. Cardiomyopathy in the elderly patient with an already underlying ischemic or atherosclerotic heart disease can be quite debilitating. Women have shown alcohol metabolism different from that of men and distinct pathophysiologic mechanisms, which frequently lead to a higher sensitivity to alcohol-induced heart damage. The preva­ lence of cardiomyopathy in women is equal to that in men, despite cases in which women have consumed far less ethanol (Fernandez­ Sola and Nicolas-Arfelis 2002).

##### *Special considerations*

Alcoholic cardiomyopathy may respond poor­ ly to digitalis with increased likelihood of digi­ talis toxicity (Zakhari 1991).

#### *Arrhythmias*

Arrhythmias (irregular heartbeats) can be seen in the presence of ischemia and car­ diomyopathy. Two specific cases of arrhyth­ mogenic disorders are "holiday heart," where the patient who has ingested alcohol presents with supraventricular arrhythmia

(Greenspon and Schaal 1983), and the indi­ vidual who uses cocaine with the stimulant leading to significant atrial and ventricular arrhythmias. Consumption of anabolic steroids also has

been associated with hypertension, ischemic heart dis­ ease, cardiomyopa­ thy, and arrhythmia (Sullivan et al.

Cocaine use is associated with various cardiovascular complications including angina pectoris, myocardial infarction, and sudden death.

1999).

##### *Special consider­* ations

Treatment of arrhyth­ mia in the person who abuses substances is similar to that for the patient who does not abuse substances, though the setting of detoxification may have to be altered to allow for cardiac monitoring (teleme­ try).

### Hematologic Disorders

Hematologic (blood) disorders can be seen due to several factors, such as a direct toxic effect of the drug on the bone marrow, as seen in alcohol and benzene use, or as a result of mal­ absorption of essential nutrients (Bl2, folate), or as a general poor state of nutrition.

#### *Anemia*

Anemia can be seen due to folate deficiency, iron deficiency, Bl2 deficiency, acute blood loss, or more frequently as a combination of factors. *Folate deficiency* can cause a mega­ loblastic anemia, which is diagnosed by macroovalocytes and hypersegmented neu­ trophils seen on a peripheral blood smear. *Iron deficiency anemia* results from blood loss and thus subsequent iron loss. This can be

seen in low-level gastrointestinal bleeding, after childbirth, and as a result of menstrual blood loss. The pre- sentation of anemia usually is nonde­ script with general­ ized fatigue and weakness. With severe anemia, shortness of breath on exertion and an elevated heart rate can be seen.

Traumatic brain injury (TBI) should always be considered in patients with neurological impairment.

Specific to the megaloblastic ane­ mias (Bl2 and folate deficiency) one can see neuro­ logic complications such as peripheral neuropathy.

#### *White blood cell disorders*

White blood cell disorders can occur due to malnutrition and liver disease. Lymphopenia may be present in the patient with HIV disease.

#### *Platelet disorders*

Platelet disorders frequently are attributable to the direct effect on the bone marrow by the substance being abused or, as seen in alcohol­ related thrombocytopenia, are due to bone marrow suppression. Splenomegaly caused by portal hypertension also can cause a low

platelet count (thrombocytopenia), which is due to enlargement of the spleen and abnor­ mally high platelet storage. Thrombocyto­ penia also can be seen in cases of vitamin Bl2 and folate deficiency.

The African-American patient with sickle cell disease or trait can be severely affected (inas­ much as the patient already has an impaired oxygen delivery system) if other harm threat­ ens the bone marrow.

## *Special considerations*

Elevated heart rates can hinder the use of the heart rate as a parameter in various detoxifica­ tion protocols.

### Pulmonary Disorders (Other Than Infectious)

Pulmonary disorders are common in people who abuse substances, in part because of the high rate of nicotine use in this population (Graham et al. 2003).

#### *Aspiration pneumonia*

Alcohol or other drug ingestion may reduce a patient's gag reflex, leading to the blockage of the airways. Aspiration pneumonia occurs when oro-pharyngeal secretions and/or gastric contents enter into the lower airways. This seri­ ous condition may require prolonged hospital­ ization.

#### *Asthma*

Asthma, a chronic condition characterized by exacerbations of bronchial spasm manifested by wheezing, should be differentiated from bronchospasm, which is related to inhaled drugs and usually is self-limited. Treatment is similar to that provided to patients who do not use substances, with the addition of cessa­ tion of the substance use.

The patient with underlying chronic asthma can be severely compromised if the use of a smokeable drug causes exacerbation of an already impaired system.

##### *Special considerations*

Asthma medications can cause a significant increase in heart rate, which can affect the evaluation of withdrawal protocols that use heart rate as oneof the parameters.

#### *Chronic Obstructive* Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) (emphysema, chronic bronchitis) fre­ quently is due to cigarette use and the result­ ing alterations of the pulmonary immune sys­ tem, inflammation, and destruction of lung parenchyma. Presentation includes shortness of breath on exertion, a cough producing mucous, and wheezing.

African Americans who smoke cigarettes take in more nicotine, and therefore more tobacco smoke toxins per cigarette, than Caucasians (Perez-Stable et al. 1998).

Daily marijuana smoking has been shown to have adverse effects on lung function includ­ ing a productive cough, wheezing, and exces­ sive sputum production. However, the habitu­ al marijuana-only smoker, in the absence of alpha-1-antitrypsin deficiency, would have to smoke four to five marijuana cigarettes per day for a span of at least 30 years to develop overt manifestations of COPD (Van Hoozen and Cross 1997).

##### *Special considerations*

During nicotine withdrawal and cessation treatment, different levels of nicotine absorp­ tion, as seen in some groups, will affect dosing for nicotine replacement therapies (Perez­ Stable et al. 1998). The patient with COPD, especially if elderly, would be sensitive to the sedating effects of many of the detoxification protocol medications, especially the benzodi­ azepines, which may have to be reduced in dosage to avoid respiratory depression and worsening hypoxemia and hypercarbia (decrease in oxygen and increase in carbon dioxide). For smokers, always consider the use of the nicotine replacement agents, partic-

ularly in hospitalized patients. Evaluation for infections and the use of oxygen, steroids, and inhalers is dictated by the clinical pic­ ture. During detoxification, if nicotine use is not allowed, there can be significant effects on drug levels (see chapter 4).

### Neurologic System

The neurologic system of patients with sub­ stance use disorders is affected directly in the toxic effects on cell membranes, effects on neurotransmitters, associated metabolic changes from other underlying disorders, and changes in blood flow. Researchers have found that the majority of those with an alco­ hol use disorder (75 percent) have some degree of cognitive impairment (Goldstein 1987). Specific disorders found in patients with substance use disorders can affect the central nervous system and the peripheral system. For example, a broad array of neu­ ropathologic changes are seen in the brains of people who use heroin. The main findings are due to infections as a result of endocarditis or HIV infection. Other complications include hypoxic-ischemic changes with cerebral edema, ischemic neuronal damage thought to he due to heroin-induced respiratory depres­ sion, stroke due to thromhoembolism, vas­ culitis, septic emboli, and hypotension.

Myelopathy occurs as a result of possible iso­ lated vascular accident in the spinal cord, and a distinct condition, leukoencephalopa­ thy, has been described after the inhalation of pre-heated heroin (Buttner et al. 2000).

As a final note, traumatic brain injury (TBI) should always be considered in patients pre­ senting with neurological impairment. People who abuse substances are at high risk of falls, motor vehicle accidents, gang violence, domestic violence, etc., which may result in head injury (Graham et al. 2003).

Unrecognized TBI can affect the treatment outcon1e.

#### *Wernicke-Korsakoff's* Syndrome

Wernicke-Korsakoff's Syndrome is composed of Wernicke's encephalopathy and Korsakoff's psychosis. Wernicke's encephalopathy is an acute neurological dis­ order with a triad of

* Oculomotor dysfunction (bilateral abducens nerve palsy-eye muscle paralysis)
* Ataxia (loss of muscle coordination)

•Confusion

Weakness and nystagmus are also seen in this syndrome on examination of the eyes.

Wernicke's encephalopathy is clearly related to thiamine deficiency.

Korsakoff's psychosis is a chronic neurologi­ cal condition resulting from thiamine defi­ ciency that includes retrograde and antegrade amnesia (profound deficit in new learning and remote memory) with confabulation (patients make up stories to cover memory gaps).

##### *Special considerations*

Thiamine initially is given parenterally and then oral administration is the treatment of choice. Always give thiamine prior to glucose administration.

#### *Alcohol and sedative* withdrawal seizures

Alcohol and sedative withdrawal seizures rep­ resent a significant medical challenge (Ahmed et al. 2000), since no large clinical studies have been conducted to firmly establish the best treatment practices. Up to 90 percent of alcohol withdrawal seizures occur in the first 48 hours and usually are single and nonfocal. Repeated episodes of drinking and withdraw­ al are thought to predispose people to seizures due to a kindling phenomenon (Post et al. 1987). Patients with a history of with­ drawal seizures are at greatest risk and should receive prophylactic doses of a long­ acting benzodiazepine (e.g., chlordiazepoxide

50mg every 6 hours for 24 hours) when detox­ ifying from alcohol.

Individuals with an alcohol use disorder show an increase in seizures due to withdrawal, metabolic insults such as hypoglycemia or electrolyte imbalance, or head trauma. In one study, researchers found that of 195 cases of seizures in those with an alcohol use disorder, 59 percent were due to alcohol withdrawal, 20 percent to head trauma, and 5 percent to vas­ cular disorders (Earnest et al. 1988).

##### *Special considerations*

Evaluation of a first seizure should include a neurological evaluation and evaluation for head trauma. Metabolic etiologies, such as low magnesium levels, should be considered.

Mayo-Smith (1997) has shown that benzodi­ azepines confer protection against alcohol withdrawal seizures and thus patients **with** previous seizures should be treated early with this class of medications. The consensus panel suggests that anti-epileptic drug therapy should be considered in alcohol withdrawal patients with multiple past seizures (of any cause), a history of recent head injury, past meningitis, encephalitis, or a family history of seizures.

Clinicians should be aware that treatment of the first seizure with benzodiazepines does not prevent the likelihood of a second seizure (D'Onofrio et al. 1999). Slower medication tapers should be considered when this condi­ tion co-occurs with detoxification.

Lorazepam, which can be used in patients with liver disease, has been suggested as appropriate, but it and other short-acting benzodiazepines may not prevent late-occur­ ring withdrawal seizures (Shaw 1995).

Dosages of anticonvulsant medications should be stabilized before sedative-hypnotic with­ drawal begins. Adequate treatment with a long-acting benzodiazepine is effective in pre­ venting withdrawal seizures (Mayo-Smith and Bernard 1995). D'Onofrio and colleagues (1999) found that a one-time dose of the rela-

tively shorter acting agent lorazepam also reduced the risk of a subsequent seizure com­ pared to placebo. However, in D'Onofrio's study doses were small and the results were limited somewhat by use in an emergency room setting.

Older, first-generation anticonvulsants have limitations in that they have only been stud­ ied in mild to moderate withdrawal, on rare occasions they can cause serious hepatic and bone marrow toxicities, and they can interact with other classes of medication. Newer drugs, such as gabapentin (Neurontin) and oxcarbazepine (Trileptal), do not appear to have these liabilities, but sufficient studies to show this have not yet been done. There is lit­ tle evidence that long-term use of phenytoin is helpful in the patient who does not have an underlying seizure disorder (Kasser et al.

2000). Medications that maylower the seizure threshold, including phenothiazines, such as prochlorperazine (Compazine), and several antidepressants, such as bupropion, should be used with great caution in the patient with a seizure history.

The use of anticonvulsants, such as valproic acid and barbiturates, has been studied in pregnant women. Valproic acid is associated with several malformations in the fetus. The use of any anticonvulsant medication should be discussed with the pregnant patient and risks and benefits explained (Robert et al.

2001).

#### *Cerebrovascular accidents*

Cerebrovascular accident (stroke) can be seen in alcohol and cocaine use, coagulation impair­ ment, and severe uncontrolled hypertension.

Patients with recent cocaine/amphetamine use may present with headaches, which could represent subarachnoid and/or intracerebral bleed, and therefore should be appropriately evaluated (Buxton and McConachie 2000).

Heavy alcohol consumption increases the risk for all major types of stroke by a variety of mechanisms (Hillbom and Numminen 1998).

There is a higher than normal incidence of hemorrhagic stroke and other intracranial bleeding among patients with heavy alcohol use, and a particular association of strokes within 24 hours of a drinking binge (Altura 1986).

##### *Special considerations*

Nifedipine and verapamil have been shown to prevent alcohol-induced vasospasm, which sug­ gests a possible therapeutic approach to hyper­ tension and stroke in the patient with heavy alcohol use (Altura 1986).

#### *Polyneu­* ropathy

Treatment of the first seizure with benzodiazepines does not prevent the likelihood of a second seizure.

Polyneuropathy fre­ quently is seen in nutritional deficien­ cies that occur in the patient with chronic alcohol use.

Presenting signs and symptoms include lower extremity pain, distal motor loss, numbness or tingling, and loss of reflexes.

Polyneuropathy can be seen in the inhalation of h-hex­ ane, methyl-n-butyl ketone, and toluene (Geller 1998).

#### *Hepatic encephalopathy*

*Hepatic encephalopathy* is a toxic brain syn­ drome that results from the accumulation of unmetabolized nitrogenous waste products in a patient with severe liver dysfunction.

Presenting signs and symptoms include an alteration in consciousness and behavior, fluctuating neurologic signs such as a flapping tremor (asterixis), and an elevated serum ammonia level. Clinicians should evaluate

patients for precipitating causes, which include the following:

* GI hemorrhage
* Electrolyte imbalance (metabolic alkalosis)
* Infections
* Excessive diuresis (dehydration)
* Use of sedatives
* Increase of dietary protein intake

Those patients who are infected with *Helicobacter pylori* may be more prone to hepatic encephalopathy (Duseja et al. 2003).

##### *Special considerations*

Clinicians should avoid the use of diuretics identify and treat factors that may have pre-

'

cipitated the encephalopathy, decrease dietary protein intake, and use Lactulose to decrease nitroge­ nous waste prod­ ucts via the GI tract. Protocols that use the benzo­ diazepines should be adjusted to use those specific medi­ cations that are hepatically metabo­ lized minimally or not at all.

**lmmuno-** compromised patients may not react to the tuberculin skin tests.

### Infectious Diseases

The viral causes of hepatitis are multiple, though the hepatitis B and C viruses are the predominant causative agents. Hepatitis C virus infection appears to be the most com­ mon form of infectious hepatitis in patients with substance use disorders. At least 76 per­ cent of patients who have used injection drugs for less than 7 years are positive for hepatitis C, while 25 percent of patients with alcohol use disorders and those who do not inject drugs show serologic evidence of infection (Fingerhood et al. 1993; National Institute on

Drug Abuse 2000). Hepatitis B infections are likely to present more often as a chronic infection than as an acute-stage phenomenon. Testing for chronic hepatitis B and C infec­ tion is appropriate during the detoxification period.

#### *Special considerations*

Followup for hepatitis B and C should be arranged for after discharge from the detoxi­ fication setting. Vaccination is recommended for hepatitis A and B in the patient with hep­ atitis C. The vaccination schedule is over a 6- month period, so it needs to be done after the detoxification program. If significant liver disease is present, use of shorter-acting medi­ cation with less liver metabolism should be considered. For more on infectious disease and substance abuse, see TIP 6, *Screening for Infectious Diseases Among Substance Abusers* (CSAT 1993c).

#### *Endocarditis*

*Endocarditis* is caused by the introduction of various bacterial species into the vascular system when the protective defense mecha­ nisms of the skin are bypassed through injec­ tion. The patient frequently will present with fever, cardiac murmur, anemia, enlargement of the spleen, petechiae, and peripheral embolic disease. The course can be subtle and indolent to fulminant, and if untreated can lead to a poor prognosis. In the patient who uses drugs intravenously, the tricuspid valve is affected in 70 percent of cases, followed by effects on the aortic valve and the mitral valve. Seventy-five percent of all cases are caused by *Staphylococcus aureus* and up to 15 percent are caused by gram negative aero­ bic bacilli (Aragon and Sande 1994).

Endocarditis always should be suspected in the febrile patient who uses intravenous drugs. Patients who use drugs intravenously are 300 times more likely to die suddenly from infectious endocarditis than patients who use drugs nonintravenously (Burke et al. 1997). Patients who use cocaine intravenously

may have a higher rate of endocarditis as a result of more frequent injections and the reduced need to solubilize cocaine solutions with heat (Chambers et al. 1987).

#### *Bacterial pneumonia*

Bacterial pneumonia can result from immune system dysfunction, interference with normal respiratory defense mechanisms (from alcohol or smoked drugs), direct toxicity, or aspiration.

The treating physician should be aware that the usual pathogens found in community­ acquired pneumonia (i.e., *Streptococcus pneumoniae)* may not be the causative agent in pneumonias seen in patients dependent on alcohol. *Haemophilis influenzae, Kl.ebsiella pneumoniae,* and other gram-negative microorganisms must be suspected and treat­ ment given until definitive culture results are reported. Among patients who use parenteral drugs, pneumonia is the most common reason for admission to the hospital, accounting for 38 percent of all hospitalizations in this popu­ lation (Marantz et al. 1987).

##### *Special considerations*

Careful use of respiratory depressants is rec­ ommended. Indications for hospitalization of the patient with pneumonia (Neu 1994) include the following:

* + Old age
  + Dehydration
  + Vomiting and inability to take in oral fluids and medications
  + Multilobar disease
  + Low white blood cell count
  + Respiratory acidosis
  + pO2 less than 55 mm Hg
  + Significant concomitant diseases

•HIV

#### *Tuberculosis*

Tuberculosis (TB) is caused by acid-fast rod *(Mycobacterium tuberculosis).* Transmission is by droplets spread through the air. The

infected patient presents with complaints of cough (most common finding), bloody spu­ tum, chest pain, fever, and weight loss.

Recent immigrants from countries where TB is prevalent, socioeconomically disadvantaged populations, homeless persons, people who use illicit drugs, incarcerated people, and people who live in areas where infection with HIV is prevalent, are at increased risk for this disease and should be tested. Further­ more, new strains of multidrug-resistant TB are appearing, especially among the homeless population (Borgdorff et al. 2000; Moss et al. 2000).

**TB** is endemic in many areas of the world (Asia, Africa, and South and Central America) (Gupta et al. 2004). As a public health concern, testing all patients is of the utmost importance, even more so for patients from regions where **TB** is endemic. It is important to remember that immunocompro­ mised patients may not react to the skin tests (anergy). Diagnosis is made with tuberculin skin testing, sputum smears and cultures, and radiographic findings. For more information on dealing with tuberculosis in detoxification and treatment settings see TIP 18, *The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers* (CSAT 1995i).

#### *Skin infections*

Skin infections frequently are seen as a result of the intravenous administration of drugs.

*Staphylococcus aureus* and *Streptococcus pyogenes* are frequently the infectious agents. The patient presents with tenderness, swelling, pain, erythema, and warmth in the injection area. The type and route of antibi­ otic is determined by the infecting organism and the extent and severity of the infection. Clinicians should remember that injection sites can be found virtually any place on the body where there is access to the venous sys­ tem.

Patients who use drugs intravenously, patients **with** peripheral vascular disease, **and**

patients with diabetes (particularly with infections of the feet) should all be evaluated carefully for skin disease.

#### *Sexually transmitted* diseases

Sexually transmitted diseases can be seen in the form of urethritis, vaginitis, cervicitis, and gen­ ital lesions. These disorders are caused by a variety of microorganisms, and a complete his­ tory and physical that includes examination of the genitalia is indicated in all patients. The clinical picture and cultures frequently can guide the treatment protocols. Patients who use drugs intravenously occasionally display a

false-positive serologic test for syphilis, possibly due to a nonspecific reaction to repeated expo­ sure of injected antigens (Hook 1992).

#### *HIV/AIDS*

HIV/AIDS is a serious and prevalent medical condition among persons with substance use disorders, especially those who inject drugs and may share needles with other users.

Patients with AIDS can present with a spec­ trum of complaints and illnesses ranging from an asymptomatic history to complaints of fever, enlargement of the lymph nodes, diffi­ culty swallowing, diarrhea, weight loss, skin lesions, shortness of breath (due to *Pneumocystis carinii* pneumonia), headaches (due to *Toxoplasma gondii),* seizures, and dementia. As a rule of **thumb,** no complaint in the patient infected with HIV should be dismissed as irrelevant.

Gay men and patients who use drugs intra­ venously may be at higher risk for HIV/AIDS than other groups; thus, testing or referral for testing should be done and appropriate counseling offered. All such patients should be tested for HIV/AIDS or referred for test­ ing. Some States, such as Colorado, require that a risk assessment be administered to all clients and that clients be advised of their

risk and referred for testing if they are at risk for HIV/AIDS. Patients who decline HIV test-

ing still should be educated about the risk and prevention.

Due to increased virulence of syphilis in patients who are HIV positive, as well as increased resistance to the treatments indicat­ ed in the usual treatment protocols, all such patients should be tested for syphilis and all patients who test positive for syphilis should be sent for HIV testing (McNeil et al. 2004).

## *Special considerations*

If methadone is being used in withdrawal pro­ tocols, or maintenance is being continued, the clinician should be aware that certain HIV medications can cause an increased metabolism of methadone:

* Efavirenz (Sustiva)
* Nevirapine (Viramune)
* Lopinavir/ritonavir (Kaletra)
* Rifampin (a drug to prevent mycobacterium avium complex, a serious bacterial infection, in HIV-positive clients)
* Amprenavir (Agenerase)
* Abacavir
* Ritonavir

**TIP** 37, *Substance Ahuse Treatment for Persons With HIV/AIDS* (CSAT 2000e) pro­ vides further information about substance abuse treatment for patients with HIV/AIDS.

### Other Conditions

#### *Cancer*

Cancer occurrence is increased in people with substance use disorders due to the carcino­ genicity of the drugs used. Cigarette smoking is linked to lung, larynx, oral cavity, esopha­ gus, stomach, bladder, and pancreatic can­ cer. Heavy alcohol consumption is associated with an increased incidence of oral, pharyn­ geal, esophageal, laryngeal, respiratory tract, and breast cancer (Polednak 2005).

Synergism is seen with alcohol and smoking being associated with even higher risks of cancer (Fagerstrom 2002). A history of weight

loss could suggest many chronic diseases, though cancer should be considered in the differential. There may be an increase in head and neck cancers in persons with heavy cannabis use (Donald 1991). Liver cancer may be seen in patients with hepatitis C and those using anabolic steroids (Socas et al.

2005). There is a particular interrelationship among alcohol intake, hepatitis C, and hepa­ tocellular carcinoma (Yoshihara et al. 1998).

#### *Diabetes*

Patients who use drugs intravenously may experience infections that affect diabetic con­ trol, though any infection in any detoxification patient needs to be addressed both from an infectious disease and diabetic viewpoint.

##### *Special considerations*

Several medications can lead to impaired glu­ cose tolerance and an elevated serum glucose (Garber 1994). Some examples include

* + Thiazide diuretics
  + Clonidine
  + Glucocorticoids
  + Haloperidol
  + Lithium carbonate
  + Phenothiazines
  + Tricyclic antidepressants
  + lndomethacin
  + Olanzapine
  + Risperdol

Antidiabetic agents in concert with alcohol may produce hypoglycemia and lactic acidosis.

Diabetes mellitus also is seen in patients who present with new-onset hyperglycemia (elevated glucose) or with a history of diabetes and poor control.

#### *Acute trauma/fractures*

Acute trauma/fractures can be seen in any patient with a substance use disorder due to an altered level of consciousness or impaired gait when intoxicated. Patients with substance use

disorders appear to be particularly prone to accidents of all kinds, with a spectrum of com­ plications from head trauma to falls with frac­ tures. Chronic pain frequently is seen in patients as a result of trauma (treated or untreated), poor health maintenance, or an inability to deal with pain without drug use.

Chronic pain treatment and the issues of opioid use have to be considered for each patient on an individual basis.

The surgeon should consider drug with­ drawal in the differ­ ential diagnosis of any physical or neu­ rologic symptoms or signs that emerge during the perioper­ ative period. There is a two- to threefold increase in postoper- ative morbidity in patients with alcohol use disorders, the most frequent com­ plications being infections, bleeding, cardiopulmonary insufficiency, and withdrawal compli-

Certain HIV medications can cause an increased metabolism of methadone.

cations (Tonnesen and Kehlet 1999).

##### *Special considerations*

Opioids may be used to control pain in the ini­ tial period of trauma. Detoxification protocols should be started prior to anticipated surgery and continued throughout the perioperative period. Pain that causes an increased heart rate, as well as postoperative temperature ele­ vation, may impact the detoxification parame­ ters.

Due to tolerance to opioids, the daily methadone dose in a methadone-maintained individual will not serve as an analgesic for pain relief from surgical or other illnesses. Full therapeutic doses of analgesic drugs should be given to methadone-maintained

patients who have co-occurring painful condi­ tions (CSAT 2005d; Ho and Dole 1979).

Since most medications for pain management are drugs with a high abuse potential, pro­ grams may need to alter their policies regard­ ing the use of such drugs. Pain patients do not require detoxification from prescribed medications unless they meet the criteria for opioid abuse or dependence described in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.* Treatments for

pain include physical therapy, transcutaneous electrical nerve stimulation, and therapeutic

heat and cold. Trials of nons­ teroidal anti-inflam­ matory agents or nerve block should be considered prior to the use of highly addictive and abus­ able medications.

The effects of drug toxicity and withdrawal often can mllTilc psychiatric disorders.

The use of acetaminophen in the patient with an alcohol use disorder always has been questioned, espe­ cially if there is evi- dence of liver dis­ ease. However, a review article of the medical literature showed that repeat-

ed ingestion of a therapeutic dose of acetaminophen over 48 hours by patients with severe alcoholism did not produce an increase in hepatic aminotransferase enzyme levels or any clinical manifestations as compared to a placebo group (Dart et al. 2000).

# Treatment of Co-Occurring

**Psychiatric Conditions**

Pharmacological agents can be used as indi­ cated for co-occurring psychiatric conditions in patients with substance use disorders.

Incidence of the co-occurrence of psychiatric conditions and substance use disorders is high; moreover, there is a higher rate of psy­ chiatric conditions in patients dependent on alcohol than that found in the general popula­ tion (Kessler et al. 2003; Modesto-Lowe and Kranzler 1999).

Comorbidity of substance use and co-occur­ ring mental disorders serves to complicate diagnosis and treatment for patients (Salloum and Thase 2000). It is difficult to accurately access underlying psychopathology in a per­ son undergoing detoxification. The effects of drug toxicity and withdrawal often can mimic psychiatric disorders. For this reason, it may be best to conduct psychiatric evaluations after several weeks of abstinence; however, this should be weighed against the time an individual has been in detoxification and what treatment plan is set up for him. Some patients also present to detoxification while

taking medications to treat underlying psychi­ atric disorders, such as depression and anxi­ ety. The risk of not treating a severe comor­ bid psychiatric disorder predisposes the patient to relapse; the decision needs to be weighed against the risk of prescribing medi­ cations when the clinician is not entirely cer­ tain that a comorbid condition exists. If a period of recent extended abstinence exists, the patient's mental condition when abstinent can be better evaluated.

Although it is the philosophy of some physi­ cians to discontinue all psychiatric medica­ tions upon entering a detoxification program, this course of action is not always in the best interest of the patient. Abrupt cessation of psychotherapeutic medications may cause withdrawal symptoms or the re-emergence of the psychiatric disorder. As a general rule,

therapeutic doses of medications should be continued through any withdrawal if the patient has been taking the medication as pre­ scribed. Decisions about discontinuing medi­ cations should be deferred until after the individual has completed detoxification. If, however, the patient has been abusing a medi­ cation or the psychiatric symptoms were clearly caused by substance abuse, then the rationale for discontinuing the medication is strengthened. Finally, practitioners should consider withholding medications that lower the seizure threshold (e.g., bupropion or con­ ventional antipsychotics) during the acute alcohol withdrawal period, or at a minimum prescribing a loading dose or scheduled taper of benzodiazepine.

During detoxification, some patients decom­ pensate and lapse into psychosis, depression, or severe anxiety. In such cases, careful observation of the withdrawal medication reg­ imen is of paramount importance. If the decompensation is a result of inadequate dos­ ing with withdrawal medication, the appro­ priate response is to increase the dose of med­ ication. If it appears that the withdrawal medication is adequate, other medications may be needed. Before choosing such an alternative, it is important to take into account additional considerations, such as the side effects of the added medication and the possibility of interaction with the withdrawal medication.

A patient with psychosis may need to take neuroleptics. Medications that have a minimal effect on the seizure threshold are recom­ mended, particularly if the patient is being withdrawn from alcohol or benzodiazepines. Small, frequent doses of Haldol, such as 1mg every 2 hours, may be used until the patient's symptoms of psychosis begin to disappear.

The case for emergency use of antidepres­ sants is weaker than for other psychiatric medications because of the 2- to 3-week lag time between initiation of medication and therapeutic response. After detoxification, the patient's need for medication should be reassessed. A trial without medications some-

times is the best way to assess the patient's need for the medication; however, it may not be the best practice or in the best interest of the patient, particularly for those with a seri­ ous mental illness. For more information on working with patients with co-occurring sub­ stance use and mental disorders, see TIP 42, *Substance Abuse Treatment for* Persons *With Co-Occurring Disorders* (CSAT 2005c).

### Treatment for Co-Occurring Conditions

The treatment of substance use disorders can be difficult without adequate treatment of any co-occurring mental disorders. For instance, a patient with schizophrenia who is halluci­ nating and delusional, but who also abuses substances, cannot participate in substance abuse treatment without adequate control over the psychosis. Likewise, patients with mania who are euphoric and delusional, patients who are depressed, or patients with agoraphobia who also have a substance use disorder, will have difficulty cooperating with substance abuse treatment. Treatment of the substance use disorder is necessary to improve the course of both the substance abuse and co-occurring mental disorder.

Psychotherapy should serve as one aspect of rehabilitation, initially focused around relapse prevention (Aviram et al. 2001).

Highly effective treatment programs may include a combination of therapeutic tech­ niques. Programs should be long-term and approach recovery in stages. Drake and col­ leagues (2001) suggest that treatment for co­ occurring substance use and other mental dis­ orders include skill building, illness manage­ ment, cultural sensitivity, and support to patients for the pursuit of practical goals.

#### *Limitations of pharmacologi­* cal agents in persons with substance dependence

Pharmacologic agents have limitations in the population of persons with substance use dis-

orders. Medications may impair cognition and blunt feelings, sometimes subtly. Clinicians treating substance use disorders advocate that clients need clear thinking and access to emotions in order to make fundamental changes in themselves. A person recovering from a substance use disorder must take an active part in changing attitudes and aban­ doning a long-held belief that alcohol or other drugs can "treat" life problems and uncom­ fortable psychological states. Although these are potential risks, the intent of pharma­ cotherapy is to enhance a person's ability to sustain abstinence and benefit fully from con­ current psychosocial interventions and treat­ ments. Still, many psychiatric disorders, if

untreated, result in mood, anxiety, or thought disorders that prevent or retard the behav­ ioral changes necessary to recover from sub­ stance use disorders.

Risks versus benefits of pharmacological agents need to be considered carefully.

Untreated anxiety, mood, or thought disor­ ders can be powerful relapse triggers, espe­ cially for people with a long-standing pattern of relying on alcohol or other drugs to man­ age their symptoms. In many instances, the benefits and reduced relapse risk that appro­ priate pharmacotherapy can provide far out­ weighs the risk of taking medications. Some clinicians believe that the "no pain, no gain" approach has far greater risk of interfering with recovery than of promoting it. Symptoms such as anxiety and depression in persons recovering from substance use disorders might be vital to recovery, and pharma­ cotherapy to treat such symptoms needs to be considered carefully in this context.

Clinically, anxiety and depression can pro­ vide the motivation to change when the patient otherwise has little awareness of the need to alter behavior.

# Standard of Care for Co-Occurring Psychiatric Conditions

After detoxification and stabilization with pharmacologic agents, the current treatment of choice for substance use disorders is non­ pharmacologic. Further, several studies have shown that treating substance use disorders with abstinence alone results in improvement of the psychiatric syndromes associated with the substance use (Anderson and Kiefer 2004). Severe syndromes induced by alcohol that may otherwise meet criteria for major depressive and anxiety disorders are best classified as substance-induced disorders if they resolve within days to weeks with absti­ nence. Likewise, manic syndromes induced by cocaine resolve within hours to days, and schizophrenia-like syndromes (e.g., hallucina­ tions and delusions) induced by cocaine and PCP often resolve within days to weeks with abstinence.

Further studies are needed to confirm the clinical experience that psychiatric symptoms (including anxiety, depression, and personali­ ty disorders) respond to specific treatment of the addiction. For example, cognitive-behav­ ioral techniques employed in the 12-Step treatment approach have been effective in the management of anxiety and depression associ­ ated with addiction. Although challenging, treatment of both addiction and co-occurring psychiatric conditions has proven cost-effec­ tive in some studies (Goldsmith 1999).

### Psychotropics for Co-Occurring Psychiatric Conditions

#### *General aspects*

Because alcohol and other drugs can induce almost any psychiatric symptom or sign or mimic any psychiatric disorder, their effects always must be considered before a co-occur­ ring condition diagnosis is established or treated.

**With** an understanding of the interactions between substance use and other mental dis­ orders, a rational approach can be applied to the use of pharmacologic therapies in co­ occurring conditions. The use of medications for psychiatric symptoms should begin only after the knowledge of the natural history of the addictive disorder and other psychiatric disorders is clarified. Further, it is important to be able to identify the respective roles of substance use and other mental disorders in the generation of psychiatric symptoms.

Generally, substance-induced psychiatric symptoms resolve within days to weeks of abstinence. In many studies, the prevalence rates for anxiety and affective disorders in persons dependent on alcohol were not greater than those for persons not dependent on alcohol (Schneider et al. 2001).

A retrospective history of psychiatric symp­ toms often can lead to an inflated diagnosis of these conditions because of rationalizations regarding drinking and drug use by the indi­ vidual. Typically, psychiatric symptoms are emphasized by both the patient and the psy­ chiatric examiner.

Longitudinal observation frequently clarifies the role of alcohol and other drugs in the pro­ duction of anxiety, affective, psychotic, or personality symptoms, particularly if objec­ tive criteria are relied on in addition to the subjective report of the person who is addict­ ed. Also, specific treatment of substance use disorders can result in improvement of mood, psychotic behavior, and personality distur­ bances if related to the alcohol or other drug use. Mood lability and personality states can be a manifestation of substance use disorders, and treatment of the addictive disorder can lead to stabilization of these psychiatric symptoms.

Furthermore, treatment plans and efficacy may rely on the gender of the patient. Women with a substance use disorder appear to have higher rates of co-occurring mental disorders, such as depression and anxiety, as well as higher rates of physical and sexual abuse,

panic and phobia disorders, posttraumatic stress disorder, victimization, and eating dis­ orders. Deficits in the management of mood disturbances may be self-medicated through alcohol consumption **in** females. It has been proposed that the outcomes of substance abuse in women are different when compared to those of men. For these reasons, the effica­ cy of treatment for substance use disorders needs to be assessed independently for both genders (Becker and Walton-Moss 2001; Brady and Randall 1999).

**Anxiety Disorders**

Major depressive and anxiety disorders are best classified as substance-induced disorders if they resolve within days to weeks with abstinence.

#### *General* approach

Prevalence rates for the co-occurrence of anxiety and sub­ stance use disorders in the general popu­ lation range from 5 to 20 percent in epi­ demiologic and clini­ cal studies (Merikangas et al.

1996).

Some antianxiety agents can overse­ date and dull the individual's reaction

to internal and external influences. Because anxiety in recovery can be critically impor­ tant for emotional growth, the individual will feel a certain amount of anxiety to motivate change in behavior, attitudes, and emotions. (The expression "emotional growth" is related to the anxiety or discomfort a recovering indi­ vidual feels while undergoing the process of change to reach a more mature state.) It is important for the clinician to distinguish between anxiety that can promote growth and anxiety that can impair a person's ability to make change. Adapting behavior in response to anxiety or other emotion requires coping

skills that may not be available to persons **in** early recovery. A fully symptomatic anxiety disorder may significantly limit a person's capacity to learn nonpharmacological coping strategies. Medications with minimal addic­ tion potential can be helpful and in some cases necessary if patients are to make progress in their recovery.

Depressants (e.g., alcohol) can produce anxi­ ety during withdrawal, and stimulants (e.g., cocaine) can produce anxiety during intoxica­ tion. Because people with substance use dis­ orders are in a relatively constant state of

withdrawal (it is impossible to main­ tain a constant blood level), they regularly experi­ ence anxiety as the result of pharmaco­ logical withdrawal from dependence. As the substance abuse becomes more chronic, the anxiety produced by withdrawal from pharmacologic dependence can become increasingly severe. Relapse and/or periods of abstinence (some­ times prolonged­ for weeks or months) should be considered (confirm

Medication is indicated when the anxiety is preventing the patient from participating in treatment.

abstinence with laboratory drug testing, if necessary) before the effects of depressant or stimulant drugs in inducing anxiety can be ruled out. It can take weeks or months for these effects to subside completely, although a period of only a few days to weeks often is sufficient in clinical practice.

Treatment is indicated when the anxiety per­ sists after adequate effort in a substance abuse treatment program, or when the clini­ cian suspects that anxiety is preventing the

patient from participating in treatment. A thorough evaluation to assess whether the individual is abstinent, involved in continuing treatment, and/or attending self-help meetings usually is necessary before a diagnosis of a

co-occurring psychiatric condition can be def­ initely established. After such an evaluation, treatment of the anxiety disorder can proceed separately from similar symptoms arising from the addictive disorder.

#### *Pharmacologic therapies*

The ideal medication works against abnormal anxiety but not against the "normal" anxiety needed for recovery. Some of the physical symptoms of anxiety include sweating, tremors, palpitations, muscle tension, and increased urination. Psychological symptoms include nervousness, feelings of dread or impending doom, unpleasant tenseness, and many more.

The most common agents used in anxiety dis­ orders are benzodiazepines and antidepres­ sants. The benzodiazepines most frequently used are alprazolam and lorazepam.

Diazepam and clonazepam are used less often. Because the benzodiazepines can cause significant problems in patients who are addicted as well as in patients who are not addicted, they generally are not recommend­ ed for people **with** substance use disorders or for long-term treatment of anxiety or depres­ sive disorders.

Antidepressants may be considered sooner if depression is a known pre-existing condition or historical experience and collateral infor­ mation suggests a comorbid depression. Again the risk of treating prematurely needs to be weighed against the risk of not treating a con­ dition that may prevent recovery from a sub­ stance use disorder. Antidepressants such as imipramine and nortriptyline and selective serotonin reuptake inhibitors (SSRis) such as fluoxetine (Prozac) have a low addiction potential and can be used with relative safety. They differ in their tendency to produce sedation and anxiety and have a withdrawal

syndrome of their own. Because of its anti­ cholinergic properties, imipramine is more sedating, but nortriptyline and the SSRis can produce anxiousness in some individuals and sedation in others. Not all individuals react the same way to these medications.

When medications are used, a specific target symptom should be the focus. Also, medica­ tions should be tried in time-limited intervals, such as weeks to months. A "drug holiday" (i.e., a brief period where the patient stops taking medications) should then be attempted to see if the medication is still necessary.

The patient should be instructed that the medications will not "cure" the addiction, that treatment of anxiety will not control the addiction, and that treatment of the addiction will not necessarily ameliorate the anxiety dis­ order. In essence, the substance use disorder must be treated independently of the anxiety disorder and vice versa.

### Depressive Disorders

#### *General approach*

Prevalence rates for the co-occurrence of depressive and addictive disorders range from 5 to 25 percent in epidemiologic and clinical studies. Depressive disorders include major depressive and dysthymic disorders, which can occur independently with addictive disorders, or similar depressive symptoms can be induced by substance use disorders.

Major depressive disorder is more common in older individuals and in women and can be difficult to distinguish from substance­ induced depression.

Depression can be viewed as protective and can be associated with "healing" in many con­ ditions involving emotions. For example, a grief reaction is an expected experience after loss, with depression an essential emotion in this process. Recovery from a substance use disorder has been compared to a grief reac­ tion because of losses (e.g., of the substance or relationships based on substance use) suf-

fered by the patient with an addictive disor­ der. Likewise, and analogous to the role of anxiety, depression also is a part of the heal­ ing process that the patient with a substance use disorder experiences during recovery.

Depressant drugs (e.g., alcohol) can produce depression during intoxication which often resolves following abstinence. A survey of 69 adults with alcohol use disorders showed a strong correlation between the reduction in cravings for alcohol over 2 weeks of absti­ nence and the lifting of depressive mood. The patients' cravings were assessed with the Obsessive-Compulsive Drinking Scale (OCDS) and their depressive symptoms measured with the Self-rating Depressive Scale (SDS).

Between day 1 and day 14, their cravings score dropped nearly a third, while the scores for severity of depression fell by about one fourth. The correlation between the reduction in cravings and the lifting of depression per­ sisted after controlling for sex, age, duration and extent of alcohol abuse, and the amount of clomethiazole administered (Anderson and Kiefer 2004).

Stimulant drugs (e.g., cocaine) can produce depression during withdrawal. These effects may be prolonged with certain drugs that linger in the body (i.e., are stored in fat), such as cannabis and benzodiazepines. These drugs can produce depression or anxiety that is indistinguishable from other psychiatric causes of depression. Therefore, they must be considered causative whenever depression is present, and the possibility of addiction needs to be assessed when these drugs are identi­ fied. While depression may persist for weeks or months, it often resolves within days with abstinence from these drugs.

#### *Pharmacologic therapies*

The use of medication is recommended if the depression persists beyond a few weeks of drug withdrawal or arises during confirmed abstinence (laboratory drug testing may be necessary to confirm abstinence). The risk of suppressing normal depressive processes dur-

ing recovery versus the benefit from sup­ pressing depression that is interfering with function should be weighed, as is the case with anxiety disorders.

Antidepressants are the main treatment for depression. The target symptoms are a sad mood, tearfulness, appetite and sleep distur­ bances, and other neurovegetative symptoms. Depression can be found in many conditions, including a variety of psychiatric and medical conditions. SSRls are the drug of choice for many physicians treating depressed patients with substance use disorders. Although some are costly, they provide adequate treatment of depression with fewer side effects than other medications commonly used (Thase et al. 2001).

Depressive disorders are thought to have a significant biological component, including deficiencies in such central nervous system neurotransmitters as serotonin, nore­ pinephrine, and dopamine. Interestingly, these neurotransmitters are also affected by substances of abuse. These agents are thought to act by increasing the activity of these neu­ rotransmitters, ultimately alleviating depres­ sion and stabilizing mood.

### Bipolar Disorders

#### *General approach*

Prevalence rates for the co-occurrence of bipolar and addictive disorders range from 30 to 60 percent, depending on the population studied, in epidemiologic and clinical studies (Chen et al. 1998; Sallom and Thase 2000; Sonne and Brady 1999; Strakowski and DelBello 2000).

Mania is a condition associated with elevated mood, grandiosity, hyperactive behavior, poor judgment, and lack of insight. The patient with mania will show excess such as spending sprees, sexual promiscuity, intru­ siveness, and abnormal alcohol and drug use. A manic episode can follow, precede, or alter­ nate with depressive moods.

Bipolar disorder may be complicated by the influence of substances (Sonne and Brady 1999). The manic state can be produced by stimulants (e.g., cocaine) during intoxication, and from depressants (e.g., alcohol) during withdrawal. A period of confirmed abstinence usually is necessary before mood-stabilizing drugs are started. Generally, a period of a week or two may be required for the role of drugs in inducing manic symptoms to be properly assessed.

#### *Pharmacologic therapies*

Mood stabilizers control bipolar disorders in patients with or without co-occurring sub­ stance use disorder. These medications can control either the manic or depressed phase, or both.

Manic episodes can occur cyclically, alterna- tively, and concurrently with depressive episodes. One theory of the pathogenesis of bipolar disorder involves the neurotransmit­ ter norepinephrine (i.e., excessive in mania and deficient in depression).

Lithium is a natural salt, available in the car­ bonate form and slow release preparations.

Its exact mechanism of action is unknown, but it can be effective in reducing or prevent­ ing the recurrence of manic and depressive episodes. Lithium carbonate must be taken daily in doses of 600 to 2,400mg to achieve plasma levels in the 0.5 to 1.5-m equiv/L range. It should be noted that studies have shown that lithium has no conclusively posi­ tive effect on rates of abstinence in either depressed or nondepressed patients.

Anticonvulsant mood stabilizers, such as divalproex sodium and carbamazepine, can be effective in controlling mania and, some evidence suggests, in co-occurring addictive conditions as well. Carbamazepine is known to be as effective as some benzodiazepines in inpatient treatment of alcohol withdrawal and, because of its anticonvulsant properties, it may be a good choice for treating those patients at high risk of withdrawal seizures

(Malcolm et al. 2001). One theoretical expla­ nation for the mechanism of action for carba­ mazepine involves suppression of mood cen­ ters in the limbic system that act like seizure foci. In this context, a "kindling" model has been proposed for both mood and addictive disorders (Gelenberg and Bassuk 1997).

### Psychotic Disorders

#### *General approach*

Prevalence rates for co-occurrence of schizophrenic and addictive disorders range from 40 to 80 percent, depending on the pop­ ulation studied, in epidemiologic and clinical studies.

Schizophrenia is a chronic illness character­ ized by bizarre thinking and behavior.

Hallucinations and delusions are "positive" symptoms of the psychotic process, while symptoms such as social withdrawal and poverty of emotions are "negative" symptoms (or deficit syndrome). Conventional neurolep­ tics are more effective for positive symptoms, whereas behavioral, group, and individual psychotherapy are more effective for negative symptoms. New agents such as clozapine and risperidone may be more effective in treating both the positive and negative symptoms.

Psychosis can be caused by stimulant drug use during intoxication and depressant drug/alcohol use during withdrawal. A period of weeks or months may be necessary to assess the effects of substances of abuse, but as with anxiety, depression, or mania, medi­ cations can be started at almost any time as the psychosis is persistent and waiting is not possible. Moreover, the greater the number of psychiatric admissions, the greater the proba­ bility of a chronic mental disorder associated with the co-occurring psychiatric disorder.

High- or moderate-potency neuroleptics (e.g., haloperidol or atypical agents) generally are the agents of choice in the treatment of schizophrenia. The clinical potency correlates with the drug's ability to block the action of

the neurotransmitter dopamine at its postsy­ naptic receptor sites.

### Adverse Effects

A period of confirmed abstinence usually 1s necessary before mood- stabilizing drugs are started.

#### *Antianxiety* agents

While benzodi­ azepines are useful in the short term, their efficacy wanes with long-term use, probably because of the development of pharmacologic toler­ ance and depen­ dence. It should be noted that benzodi­ azepines can be addicting, particu­ larly in those already addicted to other substances.

#### *Antipsychotic agents*

Antipsychotics can produce sedation and hypotension (at times causing lightheadedness in some individuals), particularly with postu­ ral changes. Conventional neuroleptics pro­ duce acute extrapyramidal reactions, which include pseudoparkinsonism, dystonia, and akathisia. Dystonia usually responds to treat­ ment with anticholinergic drugs such as ben­ ztropine or diphenhydramine. Akathisia is the subjective feeling of anxiety and tension, causing the patient to feel compelled to move about restlessly. This symptom usually requires beta blocker, as a decrease in the antipsychotic dose does not have the desired effect. Alternatively, switching to risperidone may accomplish the intended effect while avoiding intolerable neurologic syndromes.

***Antidepressants***

Antidepressants, particularly the tricyclics, can produce sedation, hypotension, syncope, and other anticholinergic effects. The SSRis can produce anxiousness, sedation, insomnia, and gastrointestinal upset. A withdrawal syn­ drome also has been reported with most antidepressant medications.

The SSRis are preferred in patients with addiction and co-occurring psychiatric condi­ tions because of their reduced side effect pro­ file and low risk of dangerous drug interac­ tions; for example, there are no anticholiner­ bo-ic effects on the senses and no risk of lethal effects from overdose.

### Cognitive State in Recovery

A person recovering from a substance use dis­ order must have a clear mind and a stable mood. Medications have a tendency, some­ times subtly and other times obviously, to dull the senses and thinking and blunt or disrupt the emotions. People with substance use dis­ orders must eventually change and control feelings to remain abstinent and also to com­ ply with psychiatric management. The ability of a person with a substance use disorder to

use the 12 steps of Alcoholics Anonymous (AA) and to accept psychiatric advice will depend on clear thinking and emotional bal­ ance, which is stressed as central to the recovery process in AA. In other cases-such as patients with traumatic brain injuries­ treatment venues should be adaptable to their cognitive abilities.

Accordingly, the use of medications should be conservative, taking into consideration the pros and cons of their expected positive and

neoo-ative effects. Unfortunately, few psychi- atric medications are totally free of mood- altering properties. However, the cognitive

state of individuals who have a serious mental illness often is more distorted when not medi­ cated appropriately. The very nature of their illness is a disruption to their cognitive pro­ cesses.

### Dosing

Because of inherent susceptibility to drug effects by people with substance use disorders, it is important to use the lowest effective doses possible. Also, the intervals for administration should be selected to reduce effects on cogni­ tion and feelings.

**Appendix A: Bibliography**

Abbott, P.J. Traditional and Western healing practices for alcoholism in American Indians and Alaska Natives. *Substance Use and Misuse* 33(13):2605-2646, 1998.

Abbott, P.J., Quinn, D., and Knox, L. Ambulatory medical detoxifi­ cation for alcohol. *American Journal of Drug and Alcolwl Abuse* 21(4):549-563, 1995.

Abbott, P.J., Weller, S.B., Delaney, H.D., and Moore, B.A. Community reinforcement approach in the treatment of opiate addicts. *American Journal of Drug and Alcohol Abuse* 24(1):17-30, 1998.

Adams, **J.B.,** and Wacher, A. Specific changes in the glycoprotein components of seromucoid in pregnancy. *Clinica Cl1imica Acta: International Journal of Clinical Chemistry* 21(1):155-157, 1968.

Addolorato, G., Balducci, G., Capristo, E., Attilia, M.L., Taggi, F., Gasbarrini, G., and Ceccanti, M. Gamma-hydroxybutyric acid (GHB) in the treatment of alcohol withdrawal syndrome: A ran­ domized comparative study versus benzodiazepine. *Alcolwlism: Clinical and Experimental Research* 23(10):1596-1604, 1999a.

Addolorato, G., Capristo, E., Gessa, G.L., Caputo, F., Stefanini, G.F., and Gasbarrini, G. Long-term administration of GHB does not affect muscular mass in alcoholics. *Life Sciences* 65(14):PL191-PL196, 1999b.

Addolorato, G., Caputo, F., Capristo, E., Janiri, L., Bernardi, M., Agabio, R., Colombo, G., Gessa, G.L., and Gasbarrini, G. Rapid suppression of alcohol withdrawal syndrome by baclofen.

*American Journal of Medicine* 112(3):226-229, 2002.

Administration for Children and Families. *SSBG 2002: Helping States Serve tlw Needs of America's Families, Adults, and Children.* Washington, DC: U.S. Department of Health and **Human** Services, 2002.

Ahijevych, K. *Nicotine Metabolism Variability and Nicotine Addiction.* Bethesda, **MD:** National Institutes of Health, 1998.

Ahmed, S., Chadwick, D., and Walker, R.J. Themanagement of alcohol-related seizures: An overview. *Hospital Medicine* 61(11):793-796, 2000.

Alan Guttmacher Institute. *Substance Abuse During Pregnancy.* State Policies in Brief. New York: Guttmacher Institute, 6-1- 2002.

Alen, M. Androgenic steroid effects on liver and red cells. *British Journal of Sports Medicine* 19(1):15-20, 1985.

Allen, K., and Dixon, M. Psychometric assessment of the Allen Barriers to Treatment Instrument. *International Journal of tlw Addictions* 29(5):545-563, 1994.

Allhoff, T., Renzing-Kohler, K., Scherbaum, N., Sack, S., and Kienbaum, P. Electrocardiographic abnormalities during recovery from ultra-short opiate detoxifi­ cation. *Addiction Biology* 4(3):337-344, 1999.

Alling, F.A. Detoxification and treatment of acute sequelae. In: Lowinson, J.H., Ruiz, P., and Millman, R.B., eds. *Substance Abuse: A Comprehensive Textbook.*

Baltimore: Williams & Wilkins, 1992. pp. 402-415.

Altarriba, J., and Bauer, L.M. Counseling the Hispanic client: Cuban Americans, Mexican Americans, and Puerto Ricans. *Journal of Counseling and Development* 76(4):389-396, 1998.

Alterman, A.I., Erdlen, F.R., and Murphy,

E. Alcohol abuse in the psychiatric hospi­ tal population. *Addictive Behaviors* 6(1):69-73, 1981.

Altura, **B.M.** Introduction to the symposium and overview. *Alcoholism: Clinical and Experimental Research* 10:557-559, 1986.

Amass, L., Ling, W., Freese, T.E., Reiber,

C., Annon, J.J., Cohen, A.J., McCarty,

D., Reid, M.S., Brown, L.S. Jr., Clark,

C., Ziedonis, D.M., Krejci, J., Stine, S., Winhusen, T., Brigham, G., Babcock, D., Muir, J.A., Buchan, B.J., and Horton, T. Bringing buprenorphine-naloxone detoxifi­ cation to community treatment providers: The NIDA clinical trials network field experience. *American Journal on Addictions* 13(Suppll):S42-S66, 2004.

American Academy of Pediatrics Committee on Drugs. The transfer of drugs and other chemicals into human milk. *Pediatrics* 108(3):776-789, 2001.

American Diabetes Association. Nutrition principles and recommendations in dia­ betes. *Diabetes Care* 27(Suppl 1):536-546, 2004.

American Medical Association. *Drug Dependencies as Diseases.* Policy Finder. H-95.983. Chicago: American Medical Association, 2002.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. Washington, DC: American Psychiatric Association, 1994.

American Psychiatric Association. Practice guideline for the treatment of patients with nicotine dependence. *American Journal of Psychiatry* 153(10):1-31, 1996.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. Text Revision.

Washington, DC: American Psychiatric Association, 2000.

American Psychiatric Association Task Force on Benzodiazepine Dependency.

*Benzodiazepine Dependence, Toxicity,*

*and Abuse.* Washington, DC: American Psychiatric Press, 1990.

American Society of Addiction Medicine.

*Patient Placement Criteria for tlw Treatment of Substance-Related Disorders: ASAM PPC-2.* 2d ed. Chevy Chase, **MD:** American Society of Addiction Medicine, 1996.

American Society of Addiction Medicine.

*Patient Placement Criteria for the Treatment of Substance-Related Disorders: ASAM PPC-2R.* 2d ed. Revised. Chevy Chase, **MD:** American Society of Addiction Medicine, 2001.

Anderson, C.B., and Wetter, D.W. Behavioral and pharmacologic approaches to smoking cessation. *Cancer and Metastasis Reviews* 16(3-4):393-404, 1997.

Anderson, D.J. Delivery of essential services to alcoholics through the "continuum of care." *Cancer Research* 39(7 pt 2):

2855-2858, 1979.

Anderson, **D.W.,** Bowland, **B.J.,** Cartwright, W.S., and Bassin, G. Service-level costing of drug abuse treatment. *Journal of Substance Almse Treatment*

15(3):201-211, 1998.

Anderson, F., and Kiefer, F. Depressive mood and craving during alcohol withdrawal: Association and interaction. *German Journal of Psychiatry* 7(2):6-11, 2004.

Anderson, F., Paluzzi, P., Lee, J., Huggins, G., and Huggins, G. Illicit use of clonidine in opiate-abusing pregnant women.

*Obstetrics and Gynecology* 90(5):790-794, 1997a.

Anderson, M., Elk, R., and Anderes, R.L. Social, ethical and practical aspects of perinatal substance use. *Journal of Substance Abuse Treatment*

14(5):481-486, 19971.

Andrulis, D., and Hopkins, S. Public hospi­ tals and substance abuse services for preg­ nant women and mothers: Implications for managed-care programs and Medicaid.

*Journal of Urban Health* 78(1):181-198, 2001.

Angres, D.H., and Easton, M. Treatment management for acute and continuing care. In: Smith, D.E., and Easton, M., eds. *Manual of Therapeutics for Addictions.* New York: Wiley-Liss, 1997. pp. 269-284.

Anton, R.F. What is craving?: Models and implications for treatment. *Alcohol Research and Health* 23(3):165-173, 1999.

Anton, R.F. Carbohydrate-deficient transfer­ rin for detection and monitoring of sus­ tained heavy drinking. What have we learned? Where do we go from here?

*Alcohol* 25(3):185-188, 2001.

Anton, R.F., Kranzler, H.R., McEvoy, J.P., Moak, D.H., and Bianca, R. *A* double­ blind comparison of abecarnil and diazepam in the treatment of uncomplicat­ ed alcohol withdrawal.

*Psychoplrnrmacology* 131:123-129, 1997.

Apte, M.V., Wilson, J.S., and Korsten, M.A. Alcohol-related pancreatic damage: Mechanisms and treatment. *Alcolwl Health and Research World* 21(1):13-20, 1997.

Aragon, T., and Sande, M.A. Infective endo­ carditis. In: Stein, J.H., ed. *Internal Medicine.* 4th ed. St. Louis, MO: Mosby, 1994. pp. 189-202.

Arfken, C.L., Klein, C., di Menza, S., and Schuster, C.R. Gender differences in problem severity at assessment and treat­ ment retention. *Journal of Substance Abuse Treatment* 20(1):53-57, 2001.

Argyropoulos, S.V., and **Nutt, D.J.** The use of benzodiazepines in anxiety and other disorders. *European Neuropsyclwpharmacology* 9(Suppl 6):

S407-S412, 1999.

Armenian, S.H., Chutuape, M.A., and Stitzer, M.L. Predictors of discharges against medical advice from a short-term hospital detoxification unit. *Drug and Alcohol Dependence* 56(1):1-8, 1999.

Ashton, C.H. Benzodiazepine abuse. *Drugs and Dependence,* 197-212. New York: Harwood Academic Publishers, 2002.

*Asociacion Mixta Progresista v. H.E.W.* Civil Number C72882 (N.D. Cal. 1976), 1976.

Aszalos, R., McDuff, D.R., Weintraub, E., Montoya, I., and Schwartz, R. Engaging hospitalized heroin-dependent patients into substance abuse treatment. *Journal of Substance Abuse Treatment*

17(1-2):149-158, 1999.

Atkinson, **R.M.** Alcohol problems of the elderly. *Alcohol and Alcoholism* 22(4):415-417, 1987.

Atkinson, **R.M.** Aging and alcohol use disor­ ders: Diagnostic issues in the elderly.

*International Psychogeriatrics* 2(1):55-72,

1990.

Atkinson, R.M., Ganzini, L., and Bernstein,

M.J. Alcohol and substance use disorders in the elderly. In: Birren, J.E., Sloane, R.B., and Cohen, G.D., eds. *Handbook of Mental Health and Aging.* 2d ed. San Diego, CA: Academic Press, 1992. pp.

515-555.

Atkinson, R.M., Ryan, S.C., and Turner,

J.A. Variation among aging alcoholic patients in treatment. *American Journal of Geriatric Psychiatry* 9(3):275-282, 2001.

Avants, S.K., Margolin, A., Holford, T.R., and Kosten, T.R. A randomized controlled trial of auricular acupuncture for cocaine dependence. *Arcl1ives of Internal Medicine* 160(15):2305-2312, 2000.

Avants, S.K., Margolin, A., Kosten, T.R., Rounsaville, B.J., and Schottenfeld, R.S. When is less treatment better? The role of social anxiety in matching methadone patients to psychosocial treatments.

*Journal of Consulting and Clinical Psychology* 66(6):924-931, 1998.

Aviram, **R.B., Rhum, M.,** and Levin, **F.R.** Psychotherapy of adults **with** comorbid attention deficit hyperactivity disorder and psychoactive substance use disorder. *Journal of Psychotherapy Practice and Researcl1* 10(3):179-186, 2001.

Ballenger, J.C., and Post, R.M. Kindling as a model for alcohol withdrawal syndromes. *Britisl1 Journal of Psychiatry* 133(1):1-14, 1978.

Balster, R.L. The pharmacology of inhalants. In: Graham, A.W., Schultz, T.K., Mayo­ Smith, M.F., Ries, R.K., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 3d ed. Chevy Chase, **MD:** American Society of Addiction Medicine, 2003. pp. 295-304.

Banys, P., Clark, H.W., Tusel, D.J., Sees,

K., Stewart, P., Mongan, L., Delucchi, K., and Callaway, E. An open trial of low dose buprenorphine in treating methadone withdrawal. *Journal of Substance Abuse Treatment* 11(1):9-15, 1994.

Barclay, D.M. Tuberculosis in the homeless. *Arcl1ives of Family Medicine* 4(6):541-546, 1995.

Bates, **J.H.,** and Stead, W.W. The history of tuberculosis as a global epidemic. *Medical Clinics of North America* 77(6):1205-1217, 1993.

Beck, A.J., Karberg, J.C., and Harrison,

**P.M.** *Prison and Jail Inmates at Midyear 2001.* NCJ 191702. Washington, DC: Bureau of Justice Statistics, 2002.

Becker, A.B., Strain, E.C., Bigelow, G.E., Stitzer, M.L., and Johnson, R.E. Gradual dose taper following chronic buprenor­ phine. *American Journal 011 Addictions* 10(2):111-121, 2001.

Becker, **K.L.,** and Walton-Moss, B. Detecting and addressing alcohol abuse in women.

*Nurse Practitioner* 26(10):13-16, 19-23;

quiz 24-25, 2001.

Beckley-Barrett, L.M., and Mutch, P.B. Position of the American Dietetic Association: Nutrition intervention in treatment and recovery from chemical dependency. *Journal of the American Dietetic Association* 90(9):1274-1277,

###### 1990.

Bell, K., Cramer-Benjamin, D., and Anastas,

J. Predicting length of stay of substance­ using pregnant and postpartum women in day treatment. *Journal of Substance Abuse Treatment* 14(4):393-400, 1997.

Bennefield, R.L. *Health Insurance Coverage:*

*1997.* Current Population Reports. Washington, DC: Bureau of the Census, 1998.

Benowitz, N.L. The use of biologic fluid sam­ ples in assessing tobacco smoke consump­ tion. In: Gravowksi, J., and Bell, C.S., eds. *Measurement in the Analysis and Treatment of Smoking Behavior.* NIDA Research Monograph Series, Number 48. Rockville, MD: National Institute on Drug Abuse, 1983. pp. 6-26.

Benowitz, N.L., and Gourlay, S.G. Cardiovascular toxicity of nicotine: Implications for nicotine replacement ther­ apy. *Journal of the American College of Cardiology* 29(7):1422-1431, 1997.

Benowitz, N.L., Perez-Stable, E.J., Herrera, B., and Jacob, P., III. Slower metabolism and reduced intake of nicotine from cigarette smoking in Chinese-Americans. *Journal of tl1e National Cancer Institute* 94(2):108-115, 2002.

Benowitz, N.L., Zevin, S., and Jacob, P., III. Sources of variability in nicotine and coti­ nine levels with use of nicotine nasal spray, transdermal nicotine, and cigarette smoking. *British Journal of Clinical Plrnrmacology* 43(3):259-267, 1997.

Beresford, T.P. Alcohol and aging: Looking ahead. In: Beresford, T.P., and Gomberg, E., eds. *Alcohol and Aging.* New York: Oxford University Press, 1995. pp.

###### 327-336.

Bernadt, M.W., and Murray, R.M. Psychiatric disorder, drinking and alco­ holism: What are the links? *British Journal of Psychiatry* 148:393-400, 1986.

Bernat, J.L. Informed consent. *Muscle and Nerve* 24(5):614-621, 2001.

Beuger, M., Tommasello, A., Schwartz, R., and Clinton, M. Clonidine use and abuse among methadone program applicants and patients. *Journal of Substance Abuse Treatment* 15(6):589-593, 1998.

Bickel, W.K., Stitzer, M.L., Bigelow, G.E., Liebson, I.A., Jasinski, D.R., and Johnson, R.E. A clinical trial of buprenor­ phine: Comparison with methadone in the detoxification of heroin addicts. *Clinical Pharmacology and Therapeutics*

###### 43(1):72-78, 1988.

Blachly, P., Casey, D., Marcel, L., and Denney, D. Rapid detoxification from heroin and methadone using naloxone. A model for the syndrome. In: Senay, E., Shortz, V., and Alkesne, H., eds.

*Development in the Field of Drug Abuse.* Cambridge, MA: Schenkman, 1975. pp. 327-336.

Blankfield, A. Psychiatric symptoms in alco­ hol dependence: Diagnostic and treatment implications. *Journal of Substance Abuse Treatment* 3(4):275-278, 1986.

Blechner, B., and Butera, A. Health Insurance Portability and Accountability Act of 1996 (HIPAA): A provider's overview of new privacy regulations.

*Connecticut Medicine* 66(2):91-95, 2002.

Blondal, T., Gudmundsson, **L.J.,** Olafsdottir, I., Gustavsson, G., and Westin, A. Nicotine nasal spray with nicotine patch for smoking cessation: Randomised **trial** with six year follow up. *British Medical Journal* 318:285-288, 1999.

Bobo, **J.K.,** and Davis, C.M. Cigarette smok­ ing cessation and alcohol treatment.

*Addiction* 88(3):405-412, 1993.

Booth, B.M., and Blow, F.C. The kindling hypothesis: Further evidence from a U.S. national study of alcoholic men. *Alcohol and Alcoholism* 28(5):593-598, 1993.

Booth, **B.M.,** Russell, D.W., Soucek, S., and Laughlin, P.R. Social support and out­ come of alcoholism treatment: An exploratory analysis. *American Journal of Drug and Alcohol Ahuse* 18(1):87-101, 1992.

Borgdorff, M.W., Behr, M.A., Nagelkerke, N.J., Hopewell, P.C., and Small, P.M. Transmission of tuberculosis in San Francisco and its association with immi­ gration and ethnicity. *International Journal of Tuberculosis and Lung Disease* 4(4):287-294, 2000.

Boucher, T.A., Kiesuk, T.J., and Trachtenberg, A.I. Complementary and alternative therapies. In: Graham, A.W., Schultz, T.K., Mayo-Smith, M.F., Ries, R.K., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 3d ed. Chevy Chase, MD: American Society of Addiction Medicine, 2003. pp. 509-532.

Bowles, T.M., Sommi, R.W., and Amiri, M. Successful management of prolonged gamma-hydroxybutyrate and alcohol with­ drawal. *Pharmacotherapy* 21(2):254-257,

2001.

Bradley, K.A., Boyd-Wickizer, J., Powell, S.H., and Burman, M.L. Alcohol screen­ ing questionnaires in women: A critical review. *Journal of the American Medical Association* 280(2):166-171, 1998.

Brady, K.T., Grice, D.E., Dustan, L., and Randall, C. Gender differences in sub­ stance use disorders. *American Journal of Psychiatry* 150(11):1707-1711, 1993.

Brady, K.T., and Randall, C.L. Gender dif­ ferences in substance use disorders.

*Psychiatric Clinics of North America*

22(2):241-252, 1999.

Brauer, R.B., Liebermann-Meffert, D., Stein, H.J., Bartels, H., and Siewert, J.R. Boerhaave's syndrome: Analysis of the lit­ erature and report of 18 new cases.

*Diseases of the Esophagus: Official Journal of the International Society for Diseases of the Esophagus* 10(1):64-68, 1997.

Brems, C. Cultural issues in psychological assessment: Problems and possible solu­ tions. *Journal of Psychological Practice* 4(2):88-117, 1998.

Brewer, C. Ultra-rapid, antagonist-precipitat­ ed opiate detoxification under general anesthesia or sedation. *Addiction Biology* 2(3):291-302, 1997.

Brouette, T., and Anton, R. Clinical review of inhalants. *American Journal on Addictions* 10(1):79-94, 2001.

Brower, **K.J., Mudd,** S., Blow, F.C., Young, J.P., and Hill, E.M. Severity and treat­ ment of alcohol withdrawal in elderly ver­ sus younger patients. *Alcolwlism: Clinical and Experimental Research*

18(1):196-201, 1994.

**Brown, M.E., Anton, R.F., Malcolm, R., and** Ballenger, J.C. Alcohol detoxification and withdrawal seizures: Clinical support for a kindling hypothesis. *Biological Psychiatry* 23:507-514, 1988.

Brown, P.J., Recupero, P.R., and Stout, R. PTSD substance abuse comorbidity and treatment utilization. *Addictive Behaviors* 20(2):251-254, 1995.

Brown, S.A., and Schuckit, M.A. Changes in depression among abstinent alcoholics.

*Journal of Studies on Alcohol*

49(5):412-417, 1988.

Brumbaugh, A.G. Acupuncture: New per­ spectives in chemical dependency treat­ ment. *Journal of Substance Abuse Treatment* 10(1):35-43, 1993.

Buchert, R., Obrocki, J., Thomasius, R., Vaterlein, 0., Petersen, K., Jenicke, L., Bohuslavizki, K.H., and Clausen, M. Long-term effects of "ecstasy" abuse on the human brain studied by FDG PET. *Nuclear Medicine Communications* 22(8):889-897, 2001.

Bucholz, **K.K.,** Sheline, Y., and Helzer, **J.E.** The epidemiology of alcohol use, prob­ lems, and dependence **in** elders: A review. In: Beresford, T.P., and Gomberg, E., eds. *Alcohol and Aging.* New York: Oxford University Press, 1995. pp. 19-41.

Budney, A.J., Hughes, J.R., Moore, B.A., and Novy, P.L. Marijuana abstinence effects in marijuana smokers maintained in their home environment. *Archives of General Psychiatry* 58(10):917-924, 2001.

Bureau of Justice Assistance. *Byrne Formula Grant Program Guidance and Application Kit.* Washington, DC: Bureau of Justice Assistance, 2002.

Burke, A.P., Kalra, P., Li, L., Smialek, J., and Virmani, R. Infectious endocarditis and sudden unexpected death: Incidence and morphology of lesions in intravenous addicts and non-drug abusers. *Journal of Heart Valve Disease* 6(2):193-202, 1997.

Burkett, G., Gomez-Marin, 0., Yasin, S.Y., and Martinez, M. Prenatal care in cocaine-exposed pregnancies. *Obstetrics and Gynecology* 92(2):193-200, 1998.

Burling, T.A., Burling, A.S., and Latini, D. A controlled smoking cessation trial for sub­ stance-dependent inpatients. *Journal of Consulting and Clinical Psychology* 69(2):295-304, 2001.

Burling, T.A., Marshall, G.D., and Seidner,

A.L. Smoking cessation for substance abuse inpatients. *Journal of Substance Abuse* 3(3):269-276, 1991.

Burnam, M.A., Hough, R.L., Karno, M., Escobar, J.I., andTelles, C.A. Acculturation and lifetime prevalence of psychiatric disorders among Mexican Americans in Los Angeles. *Journal of Health and Social Behavior* 28(1):89-102, 1937.

Butcher, J.N., Nezami, E., and Exner, J. Psychological assessment of people in diverse cultures. In: Kazarian, S.S., and Evans, D.R., eds. *Cultural Clinical Psychology: Theory, Research, and Practice.* New York: Oxford University Press, 1998. pp. 61-105.

Buttner, A., Mall, G., Penning, R., and Weis,

S. The neuropathology of heroin abuse. *Forensic Science International* 113(1-3): 435-442, 2000.

Buxton, N., and McConachie, N.S. Amphetamine abuse and intracranial haemorrhage. *Journal of the Royal Society of Medicine* 93(9):472-477, 2000.

Caetano, R., Clark, C.L., and Tam, T. Alcohol consumption among racial/ethnic minorities: Theory and research. *Alcolwl Health and Research World*

###### 22(4):233-238, 1998.

Callahan, **K.P.,** Malinin, A.I., Atar, D., and Serebruany, **V.L.** Platelet activation as a universal trigger in the pathogenesis of acute coronary events after cocaine abuse. *Swiss Medicine Weeldy* 131(33-

###### 34):437-439, 2001.

Canino, G.J., Bird, H.R., Shrout, P.E., Rubio-Stipec, M., Bravo, M., Martinez, **R.,** Sesman, M., Guzman, A., Guevara, **L.M.,** and Costas, **H.** The Spanish Diagnostic Interview Schedule. Reliability and concordance **with** clinical diagnoses in Puerto Rico. *Archives of General Psychiatry* 44(3):720-726, 1937.

Caraveo-Anduaga, J., Colmenares, B., Eduardo, S., and Gabriela, J. Psychiatric morbidity in Mexico City: Prevalence and comorbidity during a lifetime. *Salud Mental* 22:62-67, 1999.

Carey, K.B., Purnine, D.M., Maisto, S.A., Carey, M.P., and Barnes, K.L. Decisional balance regarding substance use among persons with schizophrenia. *Community Mental Health Journal* 35(4):289-299, 1999.

Carise, D., and McLellan, A.T. *Increasing Cultural Sensitivity of the Addiction Severity Index (ASI): An Example With Native Americans in Nortl1 Dakota.*

*Special Report.* Rockville, MD: Center for Substance Abuse Treatment, 1999.

Carroll, **K.M.,** ed. *Improving Compliance With Alcoholism Treatment.* Project MATCH Monograph Series Vol. 6. NIH Publication No. 97-4143. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1997.

Carter, N., Rutty, G.N., Milroy, C.M., and Forrest, A.R. Deaths associated with MBDB misuse. *International Journal of Legal Medicine* 113(3):168-170, 2000.

Castro, F.G., and Tafoya-Barraza, **H.M.** Treatment issues with Latinos addicted to cocaine and heroin. In: Garcia, J.G., and Zea, M.C., eds. *Psychological Interventions and Research With Latino Populations.* Boston: Allyn and Bacon, 1997. pp. 191-216.

Center for Substance Abuse Prevention.

*Communication Strategy Guide: A Look at Methamphetamine Use Among Three Populations.* Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 2000.

Center for Substance Abuse Treatment.

*Improving Treatment for Drug-Exposed Infants.* Treatment Improvement Protocol (TIP) Series 5. HHS Publication No. (SMA) 95-3057. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993a.

Center for Substance Abuse Treatment. *Pregnant, Substance-Using Women.* Treatment Improvement Protocol (TIP) Series 2. HHS Publication No. (SMA) 93- 1998. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993b.

Center for Substance Abuse Treatment.

*Screening for Infectious Diseases Among Substance Abusers.* Treatment Improvement Protocol (TIP) Series 6.

HHS Publication No. (SMA) 95-3060. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993c.

Center for Substance Abuse Treatment. *State Methadone Treatment Guidelines.*

Treatment Improvement Protocol **(TIP)** Series 1. HHS Publication No. (SMA) 93- 1991. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 1993d.

Center for Substance Abuse Treatment.

*Assessment and Treatment of Cocaine­ Abusing Methadone-Maintained Patients.* Treatment Improvement Protocol **(TIP)** Series 10. HHS Publication No. (SMA) 94- 3003. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994a.

Center for Substance Abuse Treatment. *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Otlwr Drug Abuse.* Treatment Improvement Protocol (TIP) Series 9.

HHS Publication No. (SMA) 94-2078. Rockville, MD: Substance Abuse and Mental Health Services Administration, 19941.

Center for Substance Abuse Treatment.

*Combining Substance Ahuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 12.

HHS Publication No. (SMA) 94-3004. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994c.

Center for Substance Abuse Treatment. *Intensive Outpatient Treatment for Alcohol and Other Drug Ahuse.* Treatment Improvement Protocol **(TIP)** Series 8.

HHS Publication No. (SMA) 99-3306. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994d.

Center for Substance Abuse Treatment.

*Screening and Assessment for Alcohol and Other Drug Ahuse Among Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 7.

HHS Publication No. (SMA) 94-2076. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994e.

Center for Substance Abuse Treatment.

*Simple Screening Instruments for Outreach for Alcohol and Other Drug Ahuse and Infectious Diseases.* Treatment Improvement Protocol **(TIP)** Series 11.

HHS Publication No. (SMA) 94-2094. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994£.

Center for Substance Abuse Treatment. *Alcohol and Other Drug Screening of Hospitalized Trauma Patients.* Treatment Improvement Protocol **(TIP)** Series 16.

HHS Publication No. (SMA) 95-3041. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995a.

Center for Substance Abuse Treatment. *Combining Alcolwl and Other Drug Treatment with Diversion for Juveniles in the Justice System.* Treatment Improvement Protocol (TIP) Series 21.

HHS Publication No. (SMA) 95-3051. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995b.

Center for Substance Abuse Treatment.

*Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Ahuse Treatment.* Treatment Improvement Protocol (TIP) Series 14. HHS Publication No. (SMA) 95-3031. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995c.

Center for Substance Abuse Treatment.

*Detoxification From Alcohol and Other Drugs.* Treatment Improvement Protocol (TIP) Series 19. HHS Publication No. (SMA) 95-3046. Rockville, MD: Center for Substance Abuse Treatment, 1995d.

Center for Substance Abuse Treatment.

*LAAM in the Treatment of Opiate Addiction.* Treatment Improvement Protocol (TIP) Series 22. HHS Publication No. (SMA) 95-3052. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995e.

Center for Substance Abuse Treatment.

*Matching Treatment to Patient Needs in Opioid Substitution Therapy.* Treatment Improvement Protocol (TIP) Series 20. HHS Publication No. (SMA) 95-3049.

Rockville, **MD:** Substance Abuse and

Mental Health Services Administration, 1995f.

Center for Substance Abuse Treatment. *Planning for Alcolwl and Other Drug Abuse Treatment for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 17. HHS Publication No. (SMA) 95-3039. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995g.

Center for Substance Abuse Treatment. *Tlie Role and Current Status of Patient Placement Criteria in tlie Treatment of Substance Use Disorders.* Treatment Improvement Protocol **(TIP)** Series 13.

HHS Publication No. (SMA) 95-3021. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 199511.

Center for Substance Abuse Treatment. *The Tuberculosis Epidemic: Legal and Etl1ical Issues for Alcolwl and Otlier Drug Abuse Treatment Providers.* Treatment Improvement Protocol **(TIP)** Series 18.

HHS Publication No. (SMA) 95-3047. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995i.

Center for Substance Abuse Treatment. *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing.* Treatment Improvement Protocol (TIP) Series 23. HHS Publication No. (SMA) 96-3113. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996.

Center for Substance Abuse Treatment. *A Guide to Substance Almse Services for Primary Care Clinicians.* Treatment Improvement Protocol **(TIP)** Series 24. HHS Publication No. (SMA) 97-3139. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 1997*a.*

Center for Substance Abuse Treatment.

*Substance Abuse Treatment and Domestic Violence.* Treatment Improvement Protocol (TIP) Series 25. HHS Publication No. (SMA) 97-3163. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997*b.*

Center for Substance Abuse Treatment. *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27. HHS Publication No. (SMA) 98-3222. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998a.

Center for Substance Abuse Treatment. *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community.* Treatment Improvement Protocol (TIP) Series 30. HHS Publication No. (SMA) 98-3245. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 1998b.

Center for Substance Abuse Treatment.

*Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers.* Technical Assistance Publication (TAP) Series 22. HHS Publication No. (SMA) 98-3173. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998c.

Center for Substance Abuse Treatment.

*Measuring the Cost of Substance Abuse Treatment Services: An Overview.*

Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998d.

Center for Substance Abuse Treatment.

*Naltrexone and Alcolwlism Treatment.* Treatment Improvement Protocol **(TIP)** Series 28. HHS Publication No. (SMA) 98- 3206. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998e.

Center for Substance Abuse Treatment.

*Substance Ahuse Among Older Adults.* Treatment Improvement Protocol (TIP) Series 26. HHS Publication No. (SMA) 98- 3179. Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, 1998£.

Center for Substance Abuse Treatment.

*Substance* Use *Disorder Treatment for People With Pl1ysical and Cognitive Disabilities.* Treatment Improvement Protocol (TIP) Series 29. HHS Publication No. (SMA) 98-3249. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998g.

Center for Substance Abuse Treatment. *Brief Interventions and Brief Tlierapies for Substance Ahuse.* Treatment Improvement Protocol (TIP) Series 34. HHS Publication No. (SMA) 99-3353. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999a.

Center for Substance Abuse Treatment. *Cultural Issues* ***in*** *Substance Ahuse Treatment.* HHS Publication No. (SMA) 99-3278. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 1999b.

Center for Substance Abuse Treatment. *Enhancing Motivation for Change* ***in*** *Substance Ahuse Treatment.* Treatment Improvement Protocol **(TIP)** Series 35. HHS Publication No. (SMA) 99-3354. Rockville, **MD:** Substance Abuse **and** Mental Health Services Administration, 1999c.

Center for Substance Abuse Treatment.

*Screening and Assessing Adolescents for Substance Use Disorders.* Treatment Improvement Protocol **(TIP)** Series 31. HHS Publication No. (SMA) 99-3282.

Rockville, **MD:** Substance Abuse and

Mental Health Services Administration, 1999d.

Center for Substance Abuse Treatment.

*Treatment for Stimulant Use Disorders.* Treatment Improvement Protocol **(TIP)** Series 33. HHS Publication No. (SMA) 99- 3296. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 1999e.

Center for Substance Abuse Treatment.

*Treatment of Adolescents Witl1 Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 32. HHS Publication No. (SMA) 99-3283. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999f.

Center for Substance Abuse Treatment.

*Changing The Conversation: Improving Substance Abuse Treatment. The National Treatment Improvement Plan Initiative: Panel Reports, Public Hearings, and Participant Acknowledgements.* HHS Publication No. (SMA) 00-3479. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2000a.*

Center for Substance Abuse Treatment.

*Changing Tlie Conversation: Improving Substance Abuse Treatment. The National Treatment Improvement Plan Initiative.*

HHS Publication No. (SMA) 00-3480. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2000b.*

Center for Substance Abuse Treatment.

*Integrating Substance Abuse Treatment and Vocational Services.* Treatment Improvement Protocol (TIP) Series 38. HHS Publication No. (SMA) 00-3470.

Rockville, **MD:** Substance Abuse and

Mental Health Services Administration, 2000c.

Center for Substance Abuse Treatment.

*Substance Abuse Treatment for Persons With Child Ahuse and Neglect Issues.*

Treatment Improvement Protocol (TIP) Series 36. HHS Publication No. (SMA) 00- 3357. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000d.

Center for Substance Abuse Treatment.

*Substance Abuse Treatment for Persons With HIV/AIDS.* Treatment Improvement Protocol (TIP) Series 37. HHS Publication No. (SMA) 00-3459. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000e.

Center for Substance Abuse Treatment. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.

Center for Substance Abuse Treatment.

*Clinical Guidelines for the Use of Buprenorphine in tlw Treatment of Opioid Addiction.* Treatment Improvement Protocol (TIP) Series 40. HHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004a.

Center for Substance Abuse Treatment.

*Substance Abuse Treatment and Family Therapy.* Treatment Improvement Protocol (TIP) Series 39. Rockville, MD: Substance Abuse and Mental Health Services Administration, 20041.

Center for Substance Abuse Treatment. *Substance Abuse Treatment: Group Therapy.* Treatment Improvement Protocol (TIP) Series 41. HHS Publication No. (SMA) 05-3991. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2005a.*

Center for Substance Abuse Treatment.

*Substance Almse Treatment for Adults in the Criminal Justice System.* Treatment Improvement Protocol **(TIP)** Series 44.

HHS Publication No. (SMA) 05-4056. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, *2005b.*

Center for Substance Abuse Treatment.

*Substance Abuse Treatment for Persons With Co-Occurring Disorders.* Treatment Improvement Protocol (TIP) Series 42. HHS Publication No. (SMA) 05-3992.

Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005c.

Center for Substance Abuse Treatment.

*Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol **(TIP)** Series 43. HHS Publication No. (SMA) 05- 4048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005d.

Center for Substance Abuse Treatment. *Improving Cultural Competence in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series.

Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *a.*

Center for Substance Abuse Treatment.

*Substance Abuse: Administrative Issues in Outpatient Treatment.* Treatment Improvement Protocol (TIP) Series.

Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *c.*

Center for Substance Abuse Treatment. *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment.*

Treatment Improvement Protocol **(TIP)** Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *d.*

Center for Substance Abuse Treatment.

*Substance Abuse Treatment: Addressing the Specific Needs of Women.* Treatment Improvement Protocol (TIP) Series.

Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *e.*

Center for Substance Abuse Treatment.

*Substance Ahuse Treatment: Men's Issues.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *g.*

Center for Substance Abuse Treatment.

*Substance Abuse and Trauma.* Treatment Improvement Protocol (TIP) Series.

Rockville, MD: Substance Abuse and Mental Health Services Administration, in development *h.*

Centers for Disease Control and Prevention. *HIV Prevention Community Planning for HIV Prevention Cooperative Agreement Recipients.* Atlanta, GA: Centers for Disease Control and Prevention, 1999.

Centers for Disease Control and Prevention. *HIV Prevention Strategic Plan Through 2005.* Atlanta, GA: Centers for Disease Control and Prevention, 2001.

Centers for Disease Control and Prevention. Cigarette smoking among adults-United States, 2000. *Morbidity and Mortality Weekly Report* 51(29):642-645, *2002a.*

Centers for Disease Control and Prevention.

*HIV/AIDS Surveillance Report, 2001*

13(2):1-44, *2002b.*

Centers for Disease Control and Prevention. Cigarette smoking among adults-United States, 2004. *Morbidity and Mortality Weekly Report* 55(44):1121-1124, 2005.

Centers for Disease Control and Prevention and Office of Minority Health. *Native Hawaiian* & *Other Pacific Islander (NHOPI) Populations.* 2004.

Centers for Medicare and Medicaid Services. *Your Medicare Coverage.* Baltimore: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2002.

Chakko, S., and Myerburg, R.J. Cardiac complications of cocaine abuse. *Clinical Cardiology* 18(2):67-72, 1995.

Chambers, H.F., Morris, D.L., Tauber, M.G., and Modin, G. Cocaine use and the risk for endocarditis in intravenous drug users. *Annals of Internal Medicine* 106(6):833-836, 1987.

Chan, A.W.K., Pristach, E.A., Welte, J.W., and Russell, M. Use of the TWEAK test in screening for alcoholism/heavy drinking in three populations. *Alcoholism, Clinical, and Experimental Research*

###### 17(6):1188-1192, 1993.

Chance, **J**.F. Emergency department treat­ ment of alcohol withdrawal seizures with phenytoin. *Annals of Emergency Medicine* 20(5):520-522, 1991.

Chang, **P.** Treating Asian/Pacific American addicts and their families. In: Krestan, J.A., ed. *Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment.* New York: Free Press, 2000. pp. 192-218.

Chappel, J.N., and DuPont, R.L. Twelve­ step and mutual help programs for addic­ tive disorders. *Psychiatric Clinics of North America* 22(2):425-446, 1999.

Charney, D.S., Heninger, G.R., and Kleber,

H.D. The combined use of clonidine and naltrexone as a rapid, safe, and effective treatment of abrupt withdrawal from methadone. *American Journal of Psychiatry* 143(7):831-837, 1986.

Charney, D.S., Riordan, C.E., Kleber, H.D., Murburg, M., Braverman, P., Sternberg, D.E., Heninger, G.R., and Redmond,

D.E. Clonidine and naltrexone. A safe, effective, and rapid treatment of abrupt withdrawal from methadone therapy. *Archives of General Psycl1iatry* 39(11):1327-1332, 1982.

Chavkin, W., Breitbart, V., Elman, D., and Wise, P.H. National survey of the states: Policies and practices regarding drug­ using pregnant women. *American Journal of Public Healtl1* 88(1):117-119, 1998.

Chen, Y.R., Swann, A.C., and Johnson, B.A. Stability of diagnosis in bipolar disorder. *Journal of Nervous & Mental Disease* 186(1):17-23, 1998.

Cherpitel, C.J. Screening for alcohol prob­ lems in the emergency room: A rapid alco­ hol problems screen. *Drug and Alcohol Dependence* 40(2):133-137, 1995.

Cherpitel, C.J. Comparison of screening instruments for alcohol problems between Black and White emergency room patients from two regions of the country.

*Alcoholism: Clinical and Experimental Research* 21(8):1391-1397, 1997.

Childress, A.R., Mozley, P.D., McElgin, W., Fitzgerald, **J.,** Reivich, M., and O'Brien,

C.P. Limbic activation during cue-induced cocaine craving. *American Journal of Psychiatry* 156(1):11-18, 1999.

Chiles, J.A., Von Cleve, E., Jemelka, R.P., and Trupin, E.W. Substance abuse and psychiatric disorders in prison inmates. *Hospital Community Psycl1iatry* 41(10):1132-1134, 1990.

Christophersen, A.S. Amphetamine designer drugs: An overview and epidemiology.

*Toxicology Letters* **(Mar** 15):

###### 112, 113-127, 131,2000.

Church, O.M., and Anderson, R. Managed care in the substance abuse arena: Challenges and choices. Part II. *Journal of Substance Use* 4(3):103-105, 2000.

Chutuape, M.A., Jasinski, D.R., Fingerhood, M.I., and Stitzer, M.L. One-, three-, and six-month outcomes after brief inpatient opioid detoxification. *American Journal of Drug and Alcohol Abuse* 27(1):19-44, 2001.

Ciraulo, D.A., Alderson, L.M., Chapron, D.J., Jaffe, J.H., Subbarao, B., and Kramer, P.A. lmipramine disposition in alcoholics. *Journal of Clinical Psychopharmacology* 2(1):2-7, 1982.

Ciraulo, D.A., and Jaffe, J.H. Tricyclic antidepressants in the treatment of depres­ sion associated with alcoholism. *Journal of Clinical Psychopharmacology*

###### 1(3):146-150, 1981.

Clark, **H.W.,** McClanahan, T.M., and Sees,

K.L. Substance abuse services in systems of care: Linkages and issues **in** serving cul­ turally diverse populations. In: Hernandez, M., and Isaacs, **M.R.,** eds. *Promoting Cultural Competence in Children's Mental Health Services.* Baltimore: **Paul H.** Brookes Publishing, 1998. pp. 207-227.

Closser, **M.H., and** Blow, F.C. Special popu­ lations: Women, ethnic minorities, and the elderly. *Psycl1iatric Clinics of North America* 16(1):199-209, 1993.

Cochran, S.D., and Mays, **V.M.** Relation between psychiatric syndromes and behav­ iorally defined sexual orientation in a sam­ ple of the US population. *American Journal of Epidemiology* 151(5):516-523, 2000.

Coffey, R.M., Mark, T., King, E., Harwood, H., McKusick, D., Genuardi, J., Dilonardo, J., and Chalk, M. *National Estimates of Expenditures for Substance Abuse Treatment, 1997.* HHS Publication No. SMA 01-3511. Rockville, MD: Center for Substance Abuse Treatment, 2001.

Coffey, S.F., Dansky, B.S., Carrigan, **M.H.,** and Brady, K.T. Acute and protracted cocaine abstinence in an outpatient popu­ lation: A prospective study of mood, sleep and withdrawal symptoms. *Drug and Alcohol Dependence* 59:277-286, 2000.

Collins, K.S., Hughes, D.L., Doty, M.M., Ives, B.L., Edwards, J.N., and Tenney, K. *Diverse Communities, Common Concerns: Assessing Health Care Quality For Minority Americans.* The Commonwealth Fund, 2002.

Comer, V.G., and Annitto, W.J. Buprenorphine: A safe method for detoxi­ fying pregnant heroin addicts and their unborn. *American Journal on Addictions* 13(3):317-318, 2004.

Comfort, M., Hagan, T., and Kaltenbach, K. *Psychosocial History.* Philadelphia: Family Center, Thomas Jefferson University, 1996.

Comfort, M., Zanis, D.A., Whiteley, **M.J.,** Kelly-Tyler, A., and Kaltenbach, K.A. Assessing the needs of substance abusing women: Psychometric data on the psy­ chosocial history. *Journal of Substance Abuse Treatment* 17(1-2):79-83, 1999.

Compton, W.M., III, Cottler, L.B., Ben Abdallah, A., Phelps, D.L., Spitznagel, E.L., and Horton, J.C. Substance depen­ dence and other psychiatric disorders among drug dependent subjects: Race and gender correlates. *American Journal on Addictions* 9(2):113-125, 2000.

Connors, G.J., Carroll, **K.M.,** DiClemente, C.C., Longabaugh, R., and Donovan,

D.M. The therapeutic alliance and its rela­ tionship to alcoholism treatment participa­ tion and outcome. *Journal of Consulting and Clinical Psychology* 65(4):588-598, 1997.

Connors, G.J., DiClemente, C.C., Dermen, K.H., Kadden, R., Carroll, K.M., and Frone, M.R. Predicting the therapeutic alliance in alcoholism treatment. *Journal of Studies on Alcohol* 61(1):139-149, 2000.

Conyne, **R.K.** What to look for in groups: Helping trainees become more sensitive to multicultural issues. *Journal for Specialists in Group Worl(* 23(1):22-32, 1998.

Cook, C.A., Booth, B.M., Blow, F.C., Gogineni, A., and Bunn, J.Y. Alcoholism treatment, severity of alcohol-related med­ ical complications, and health services uti­ lization. *Journal of Mental Healtl1 Administration* 19(1):31-40, 1992.

Cook, **J.W.,** Spring, B., McChargue, D.E., Borrelli, B., Hitsman, B., Niaura, R., Keuthen, N.J., Kristeller, J. Influence of fluoxetine on positive and negative affect in a clinic-based smoking cessation trial. *Psychopliarmacology* 173:153-159, 2004.

Cooper-Patrick, L., Gallo, J.J., Powe, N.R., Steinwachs, D.S., Eaton, W.W., and Ford,

D.E. Mental health service utilization by African Americans and Whites: The Baltimore Epidemiologic Catchment Area Follow-Up. *Medical Care* 37(10):

###### 1034-1045, 1999.

Corcoran, K., and Vandiver, V. *Maneuvering the Maze of Managed Care: Skills for Mental Health Practitioners.* New York: The Free Press, 1996.

Costa, L.G., Guizzetti, M., Burry, M., and Oberdoerster, J. Developmental neurotox­ icity: Do similar phenotypes indicate a common mode of action? A comparison of fetal alcohol syndrome, toluene embryopa­ thy and maternal phenylketonuria.

*Toxicology Letters* 127(1-3):197-205,

###### 2002.

Cote, G., and Hodgins, S. Co-occurring men­ tal disorders among criminal offenders.

*Bulletin of the American Academy of Psychiatry and the Law* 18(3):271-281, 1990.

Cottler, L.B., Shillingtron, A.M., Compton, W.M.I., Mager, D., and Spitznagel, E.L. Subjective reports of withdrawal among cocaine users: Recommendations for DSM­

IV. *Drug and Alcohol Dependence*

###### 33:97-104, 1993.

Covey, L.S., Glassman, **A.H.,** Stetner, F., and Becker, **J.** Effect of history of alco­ holism or major depression on smoking cessation. *American Journal of Psychiatry* 150(10):1546-1547, 1993.

Covey, L.S., Sullivan, M.A., Johnston, J.A., Glassman, A.H., Robinson, M.D., and Adams, D.P. Advances in non-nicotine pharmacotherapy for smoking cessation. *Drugs* 59(1):17-31, 2000.

Cox, G.B., Walker, R.D., Freng, S.A., Short, B.A., Meijer, L., and Gilchrist, L. Outcome of a controlled trial of the effec­ tiveness of intensive case management for chronic public inebriates. *Journal of Studies on Alcohol* 59(5):523-532, 1998.

Coyhis, D. Culturally specific addiction recovery for Native Americans. In: Krestan, J., ed. *Bridges To Recovery: Addiction, Family Therapy, and Multicultural Treatment.* New York: The Free Press, 2000. pp. 77-114.

Craig, T.J., and DiBuono, M. Recognition of comorbid psychopathology by staff of a drug detoxification unit. *Tlw American Journal on Addictions* 5(1):76-80, 1996.

Crits-Christoph, P., Siqueland, L., Blaine, J., Frank, A., Luborsky, L., Onken, L.S.,

Muenz, L.R., Thase, M.E., Weiss, R.D., Gastfriend, D.R., Woody, G.E., Barber, J.P., Butler, S.F., Daley, D., Salloum, I.,

Bishop, S., Najavits, L.M., Lis, J., Mercer, D., Griffin, M.L., Moras, K., and Beck, A.T. Psychosocial treatments for cocaine dependence: National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Archives of General Psychiatry* 56(6):493-502, 1999.

Crystal M. Ferguson, et al., *Petitioners v.*

*City of Charleston* et *al.* No. 99-936

Supreme Court of the United States, 1999.

Cunradi, C.B., Caetano, R., and Schafer, J. Alcohol-related problems, drug use, and male intimate partner violence severity among U.S. couples. *Alcoholism: Clinical and Experimental Researcl1*

###### 26(4):493-500, 2002.

Curley, B. *Arcane Laws Hinder ER Interventions for Alcohol, Other Drugs.* Join Together Online. 2002.

Curran, **H.V.,** and Monaghan, L. In and out of the K-hole: A comparison of the acute and residual effects of ketamine in fre­ quent and infrequent ketamine users.

*Addiction* 96(5):749-760, 2001.

Dadds, C.A. A commentary on "The role of laboratory tests for alcoholism treatment." *Journal of Substance Abuse Treatment* 20(1):87-88, 2001.

Dackis, C.A., and Gold, M.S. Inpatient treat­ ment of drug and alcohol addiction. In: Miller, N.S., ed. *Comprehensive Handbool( of Drug and Alcohol Addiction.* New York: Marcel Dekker, Inc., 1991. pp.

###### 1233-1244.

Dackis, C.A., Gold, M.S., and Estroff, T.W. Inpatient treatment of addiction. In: *Treatments of Psychiatric Disorders: A Task Force Report of tlw American Psychiatric Association.* Arlington, VA: American Psychiatric Association, 1989. pp. 1359-1379.

Dackis, C.A., and O'Brien, C.P. Cocaine dependence: A disease of the brain's reward centers. *Journal of Substance Abuse Treatment* 21:111-117, 2001.

Dadds, C.A., and O'Brien, C.P. Cocaine dependence: The challenge for pharma­ cotherapy. *Current Opinion in Psychiatry* 15:261-267, 2002.

Dale, L.C., Hurt, R.D., Offord, K.P., Lawson, G.M., Croghan, LT., and Schroeder, D.R. High-dose nicotine patch therapy: Percentage of replacement and smoking cessation. *Journal of the American Medical Association* 274(17):1353-1358, 1995.

Daley, M., Argeriou, M., and McCarty, D. Substance abuse treatment for pregnant women: A window of opportunity?

*Addictive Behaviors* 23(2):239-249, 1998.

Daley, M., Argeriou, M., McCarty, D., Callahan, J., Shepard, D., and Williams,

C. The impact of substance abuse treat­ ment modality on birth weight and health care expenditures. *Journal of Psyclwactive Drugs* 33(1):57-66, 2001.

Dansky, B.S., Saladin, M.E., Brady, K.T., Kilpatrick, D.G., and Resnick, H.S. Prevalence of victimization and posttrau­ matic stress disorder among women with substance use disorders: Comparison of telephone and in-person assessment sam­ ples. *International Journal of tlie Addictions* 30(9):1079-1099, 1995.

D'Archangelo, E. Substance abuse in later life. *Canadian Family Physician* 39:1986-1988, 1991-1993, 1993.

Dart, R.C., Kuffner, E.K., and Rumack,

B.H. Treatment of pain or fever with paracetamol (acetaminophen) in the alco­ holic patient: A systematic review. *American Journal of Tl1erapeutics* 7(2):123-134, 2000.

D'Aunno, T. Linking of substance-abuse treatment and primary health care. In: Egertson, J.A., Fox, D.M., and Leshner, A.I., eds. *Treating Drug Abusers Effectively.* Malden, MA: Blackwell Publishers, 1997. pp. 311-331.

D'Avanzo, C.E. Southeast Asians: Asian­ Pacific Americans **at** risk for substance misuse. *Substance Use and Misuse* 32(7-8):829-848, 1997.

Dean, M., Stock, **B.,** Patterson, **R.J.,** and Levy, G. Serum protein binding of drugs during and after pregnancy in humans. *Clinical Pliarmacology and Tl1erapeutics* 28(2):253-261, 1980.

Dell'ltalia, L. Chest pain. In: Stein, J.H., ed. *Internal Medicine.* 4th ed. St. Louis, MO: Mosby, 1994. pp. 86-92.

Dempsey, D.A., and Benowitz, N.L. Risks and benefits of nicotine to aid smoking ces­ sation in pregnancy. *Drug Safety* 24(4):277-322, 2001.

Denning, P. Strategies for implementation of harm reduction in treatment settings.

*Journal of Psyclwactive Drugs*

33(1):23-26, 2001.

Dennison, S.J. Clonidine abuse among opiate addicts. *Psycl1iatric Quarterly*

72(2):191-195, 2001.

Department of Veterans Affairs. *CHAMPVA Handbook.* Denver, CO: Department of Veterans Affairs, Health Administration Center, 2001.

Deutsch, J.A., and Walton, **N.Y.** Diazepam maintenance of alcohol preference during alcohol withdrawal. *Science* 198(4314): 307-309, 1977.

Diamant, K., Fischer, G., Schneider, C., Lenzinger, E., Pezawas, L., Schindler, S., and Eder, H. Outpatient opiate detoxifica­ tion treatment with buprenorphine: Preliminary investigation. *European Addiction Research* 4(4):198-202, 1998.

Dickinson, W.E., Mayo-Smith, M.F., and Eickelberg, S.J. Management of sedative­ hypnotic intoxication and withdrawal. In: Graham, A.W., Schultz, T.K., Mayo­ Smith, M.F., Ries, R.K., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 3d ed. Chevy Chase, MD: American Society of Addiction Medicine, 2003. pp. 633-649.

DiClemente, C.C. Motivation for change: Implications for substance abuse treat­ ment. *Psychological Science* 10(3):

209-213, 1999.

DiClemente, C., and Prochaska, J.D. Toward a comprehensive, theoretical model of change: Stages of change and addictive behavior. In: Miller, W.R., and Heather, N., eds. *Treating Addictive Behaviors.* 2d ed. New York: Plenum Press, 1998. pp.

3-24.

DiMartini, A., Day, N., Lane, T., Beisler, A.T., Dew, M.A., and Anton, R. Carbohydrate deficient transferrin in abstaining patients with end-stage liver disease. *Alcoholism: Clinical and Experimental Research* 27(12):1729-1733,

2001.

Dinges, M.M., and Oetting, E.R. Similarity in drug use patterns between adolescents and their friends. *Adolescence* 28(110):

253-266, 1993.

Donald, **P.J.** Advanced malignancies in the young marijuana smoker. *Advances in Experimental Medicine and Biology* 288:33-46, 1991.

D'Onofrio, G., Rathlev, N.K., Ulrich, A.S., Fish, S.S., and Freeland, E.S. Lorazepam for the prevention of recurrent seizures related to alcohol. *New England Journal of Medicine* 340(12):915-919, 1999.

Dorus, W., Ostrow, D.G., Anton, R., Cushman, P., Collins, J.F., Schaefer, M., Charles, **H.L.,** Desai, P., Hayashida, **M.,** and Malkerneker, U. Lithium treatment of depressed and nondepressed alcoholics.

*Journal of tl1e American Medical Association* 262(12):1646-1652, 1989.

Downes, M.A., and Whyte. I.M. Amphetamine-induced movement disorder. *Emergency Medicine Australasia*

17(3):277-280, 2005.

Drake, R.E., Essock, S.M., Shaner, A.,

Carey, K.B., Minkoff, K., Kola, L.,

Lynde, D., Osher, F.C., Clark, R.E., and Rickards, L. Implementing dual diagnosis services for clients with severe mental ill­ ness. *Psychiatric Services* 52(4):469-476, 2001.

Drake, R.E., and Mueser, K.T. Psychosocial approaches to dual diagnosis.

*Schizophrenia Bulletin* 26 (1):105-118,

2000.

Drake, R.E., Osher, F.C., and Wallach, M.A. Alcohol use and abuse in schizophrenia: A prospective community study. *Journal of Nervous and Mental Disease*

177(7):408-414, 1989.

Drozdick, J., III, Berghella, V., Hill, M., and Kaltenbach, K. Methadone trough levels in pregnancy. *American Journal of Obstetrics and Gynecology*

187(5):1184-1188, 2002.

Dupont, I., Bodenez, P., Berthou, F., Simon, B., Bardon, L.G., and Lucas, D. Cytochrome P-450 2El activity and oxida­ tive stress in alcoholic patients. *Alcohol and Alcolwlism* 35(1):98-103, 2000.

Duseja, A., Sachdev, A., Dhiman, **R.K.,** and Chawla, **Y,K.** Helicobacter pylori and hep­ atic encephalopathy. *Indian Journal of Gastroenterology* 22 Suppl 2:S31-32,

2003.

Duyff, **R.L.** *The American Dietetic Association's Complete Food and Nutrition Guide.* Minneapolis, MN: Chronimed Publishing, 1996.

Earnest, M.P., Feldman, H., Marx, J.A., Harris, J.A., Biletch, M., and Sullivan,

L.P. lntracranial lesions shown by CT scans in 259 cases of first alcohol-related seizures. *Neurology* 38(10):1561-1565, 1988.

Eickelberg, S.J., and Mayo-Smith, M.F. Management of sedative-hypnotic intoxica­ tion and withdrawal. In: Graham, A.W., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 2d ed. Chevy Chase, **MD:** American Society of Addiction Medicine, 1998. pp. 441-456.

Elderly Alcoholic Men and Women in Treatment. Paper presented at the Research Society on Alcoholism Annual Scientific Meeting, San Diego, California, 1992.

Elman, I., D'Ambra, M.N., Krause, S., Breiter, H., Kane, M., Morris, R., Tuffy, L., and Gastfriend, D.R. Ultrarapid opi­ oid detoxification: Effects on cardiopul­ monary physiology, stress hormones and clinical outcomes. *Drug and Alcohol Dependence* 61(2):163-172, 2001.

Ernst, M., Moolchan, E.T., and Robinson,

M.L. Behavioral and neural consequences of prenatal exposure to nicotine. *Journal of the American Academy of Child and Adolescent Psychiatry* 40(6):630-641, 2002.

Etter, J.F., and Perneger, T.V. Effectiveness of a computer-tailored smoking cessation program: A randomized trial. *Archives of Internal Medicine* 161(21):2596-2601,

2001.

Evans, A.C., and Raistrick, D. Phenomenology of intoxication with toluene-based adhesives and butane gas. *British Journal of Psychiatry*

150:769-773, 1987.

Fagerstrom, K. The epidemiology of smoking: health consequences and benefits of cessa­ tion. *Drugs* 62 Suppl 2(1):9, 2002.

Fagerstrom, K.O. Measuring degree of physi­ cal dependence to tobacco smoking with reference to individualization of treat­ ment. *Addictive Behaviors* 3(3-4):235-241, 1978.

Fagerstrom, K.O., and Schneider, N.G. Measuring nicotine dependence: A review of the Fagerstrom Tolerance Questionnaire. *Journal of Behavioral Medicine* 12(2):159-182, 1989.

Federal Bureau of Prisons. *Federal Bureau of Prisons Clinical Practice Guidelines: Detoxification of Chemically Dependent Inmates, December, 2000.* Washington, DC: U.S. Bureau of Prisons, 2000.

Fehr, B.J., Wenstein, S.P., Sterling, R.C., and Gottheil, E. "As soon as possible": An initial treatment engagement strategy.

*Substance Abuse* 12(4):183-189, 1991.

Fellows, J.L., Trosclair, A., and Adams, E.K. Annual smoking-attributable mortality, years of potential life lost, and economic costs-United States, 1995-1999.

*Morbidity and Mortality Weekly Report* Atlanta, GA: Centers for Disease Control and Prevention, 4-12-2002.

Fenster, L.F. Alcohol and disorders of the gastrointestinal system. In: Estes, N.J., andHeinemann, M.E., eds. *Alcoholism: Development, Consequences, and Interventions.* St. Louis, **MO:** C.V. Mosby Company, 1982. pp. 136-143.

Fenster, L.F. Alcohol and disorders of the gastrointestinal system. In: Estes, N.J., andHeinemann, M.E., eds. *Alcoholism Development, Consequences and Interventions.* 3d ed. St. Louis, MO: C.V. Mosby, 1986. pp. 145-152.

Ferguson, F.N. Stake theory as an explanato­ ry device in Navajo alcoholism treatment response. *Human Organization*

35(1):65-78, 1976.

Fergusson, D.M., Horwood, L.J., and Beautrais, A.L. Is sexual orientation relat­ ed to mental health problems and suicidal­ ity in young people? *Arcl1ives of General Psychiatry* 56(10):876-880, 1999.

Fernandez-Sola, J., and Nicolas-Arfelis, J.M. Gender differences in alcoholic cardiomy­ opathy. *The Journal of Gender-Specific Medicine* 5(1):41-47, 2002.

Fine, J., and Miller, N.S. Evaluation and acute management of psychotic symptoma­ tology in alcohol and drug addictions. In: Miller, N.S., and Stimmel, B., eds.

*Comorbidity of Addictive and Psychiatric Disorders.* New York: Haworth Medical Press, 1993.

###### Fingerhood, **M.I.,** Jasinski, **D.R.,** and Sullivan, J. T. Prevalence of hepatitis C **in** a chemically dependent population.

Fiore, M.C., Bailey, W.C., Cohen, S., Dorfman, S.F., Goldstein, M., Gritz, E.R., Heyman, R.B., Jaen, C.R., Kottke,

*Archives of Internal Medicine*

###### T.E., Lando, H.A., Mecklenburo0-'

R• E• '

###### 153(17):2025-2030, 1993.

Finigan, M. *Societal Outcomes and Cost Savings of Drug and Alcohol Treatment in the State of Oregon.* Salem, OR: Office of Alcohol and Drut:,o- Abuse Proo-rams

t, '

###### Oregon Department of Human Resources,

and Governor's Council on Alcohol and Drug Abuse Programs, 1996.

Finn, P. Addressing the needs of cultural minorities in drug treatment. *Journal of Substance Abuse Treatment*

###### 11(4):325-337, 1994.

Finnegan, L.P. Treatment issues for opioid.­ dependent women during the perinatal period. *Journal of Psychoactive Drugs* 23(2):191-201, 1991.

###### Finnegan, L.P., Hagan, T., and Kaltenbach,

K.A. Scientific foundation of clinical prac­ tice: Opiate use in pregnant women. *Bulletin of the New York Academy of Medicine* 67(3):223-239, 1991.

Finnegan, L.P., and Wapner, **R.J.** Narcotic addiction in pregnancy. In: Niebyl, **J.R.,** ed. *Drug Use in Pregnancy.* 2d ed.

Philadelphia: Lea and Febiger, 1988. pp. 203-222.

Fiore, M.C., Bailey, W.C., Cohen, S.J., Dorfman, S.F., Goldstein, M.G., Gritz, E.R., Heyman, R.B., Jaen, C.R., Kottke,

T.E., Lando, H.A., Mecklenburoc-,, R••E ,

Mullen, P.O., Nett, L.M., Robinson, L., Stitzer, M.L., Tommasello, A.C., Villejo, L., and Wewers, M.E. *Treating Tobacco Use and Dependence: Quick Reference Guide for Clinicians.* Rockville, MD: Public Health Service, 20001.

Mullen, P.O., Nett, L.M., Robinson, L., Stitzer, M.L., Tommasello, A.C., Villejo, L., Wewers, M.E., Baker, T., Fox, D.M., and Hasselblad, V. *Treating Tobacco Use and Dependence: A Clinical Practice Guideline.* Rockville, MD: Public Health Service, *2000a.*

###### Fiorentine, R., Nakashima, J., and Anglin,

M.D. Client engagement in drug treat­ ment. *Journal of Substance Abuse Treatment* 17(3):199-206, 1999.

First, M.B., Frances, A., and Pincus, H.A. *DSM-IV-TR Handhool.: of Differential Diagnosis.* Washington, DC: American Psychiatric Press, 2002.

###### Fischer, G., Johnson, R.E., Eder, **H.,** Jagsch, R., Peternell, A., Weninger, M., Langer, M., and Aschauer, H.N. Treatment of opioid-dependent pregnant women with lmprenorphine. *Addiction* 95(2):239-244, 2000.

Flynn, P.M., Porto, J.V., Rounds-Bryant, J., and Kristiansen, **P.L.** Costs and Benefits of Methadone Treatment in DATOS-Part 1: Discharged versus Continuing Patients. *Journal of Maintenance in the Addictions* 2(1/2):129-150, 2003.

###### Fontaine, K.R., Cheskin, L.J., Carriero, N.J., Jefferson, L., Finley, C.J., and Gorelick, D.A. Body mass index and effects of refeeding on liver tests in drug­ dependent adults in a residential research unit. *Journal of the American Dietetic Association* 101(12):1467-1469, 2001.

Ford, W.E. *Understanding the Purchase of Outcome in Substance Abuse Treatment.* Rockville, MD: Indian Health Service 2000.

'

Foster, J.H., Marshall, E.J., and Peters, T.J. Outcome after in-patient detoxification for alcohol dependence: A naturalistic com­ parison of 7 versus 28 days stay. *Alcolwl and Alcoholism* 35(6):580-586, 2000.

Fox, C.H. Cocaine use in pregnancy. *Journal of the American Board of Family Practice* 7(3):225-228, 1994.

Frances, R.J., and Miller, S.I., eds. *Clinical Textbool.: of Addictive Disorders.* 2d ed. New York: Guilford Press, 1998.

French, M.T. *Drug Abuse Treatment Cost Analysis Program (DATCAP): Program Version.* 8th ed. Miami, FL: University of Miami, 2003a.

French, M.T. *Drug Abuse Treatment Cost Analysis Program (DATCAP): User's Manual.* 8th ed. Miami, FL: University of Miami, 2003b.

French, M.T., Dunlap, L.J., Zarkin, G.A., McGeary, K.A., and McLellan, A.T. A structured instrument for estimating the economic cost of drug abuse treatment. The Drug Almse Treatment Cost Analysis Program (DATCAP). *Journal of Substance Abuse Treatment* 14(5):445-455, 1997.

French, M.T., Roebuck, M.C., McLellan, A.T., and Sindelar, J.L. Can the Treatment Services Review be used to esti­ mate the costs of addiction and ancillary services? *Journal of Substance Abuse* 12(4):341-361, 2000.

French, S.A., Jefferey, R.W., Klesges, L.M., and Forster, J.L. Weight concerns and change in smoking behavior over two years in a working population. *American Journal of Public Health* 85(5):720-722, 1995.

Fuller, R.K., and Gordis, E. Refining the treatment of alcohol withdrawal. *Journal of the American Medical Association* 272(7):557-558, 1994.

Galanter, M., Keller, D.S., Dermatis, H., and Egelko, S. The impact of managed care on substance abuse treatment: A report of the American Society of Addiction Medicine. *Journal of Addictive Diseases* 19(3):13-34, 2000.

Ganrot, **P.O.** Variation of the concentrations of some plasma proteins in normal adults, in pregnant women and in newborns.

*Scandinavian Journal of Clinical and Laboratory Investigation Supplementum* 124:83-88, 1972.

Garber, **A.J.** Diabetes mellitus. In: Stein, **J.H.,** ed. *Internal Medicine.* 4th ed. St. Louis, MO: Mosby, 1994. pp. 1391-1424.

Garbis, H., and McElhatton, P.R. Psychotropic, sedative-hypnotic and Parkinson drugs. In: *Drugs During Pregnancy and Lactation; Handbool.: of Prescription Drugs and Comparative Risl.: Assessment: With Updated Information on Recreational Drugs.* New York: Elsevier, 2001. pp. 182-191.

Gariti, P., Auriacombe, M., lncmikoski, R., McLellan, A.T., Patterson, L., Dhopesh, V., Mezochow, J., Patterson, M., and O'Brien, C. A randomized double-blind study of neuroelectric therapy in opiate and cocaine detoxification. *Journal of Substance Abuse* 4(3):299-308, 1992.

Garro, A.J., and Lieber, C.S. Alcohol and cancer. *Annual Review of Pharmacology and Toxicology* 30:219-249, 1990.

Garvey, R., and Fitzmaurice, B. Withdrawal delirium with dance drug "liquid ecstasy" (GHB). *Irish Journal of Psychological Medicine* 21(2): 73-75, 2004.

Gastfriend, D.R. When a substance use disor­ der is the cause of treatment resistance.

In: Pollack, M.H., and Otto, M.W., eds. *Challenges in Clinical Practice: Pharmacologic and Psychosocial Strategies.* New York: Guilford Press, 1996. pp. 329-354.

Gastfriend, D.R., Lu, S.H., and Sharon, E. Placement matching: Challenges and tech­ nical progress. *Substance Use and Misuse* 35(12-14):2191-2213, 2000.

Gastfriend, **D.R.,** and McLellan, A.T. Treatment matching: Theoretic basis and practical implications. *Medical Clinics of North America* 81(4):945-966, 1997.

Gatch, **M.B.,** and Lal, **H.** Pharmacological treatment of alcoholism. *Progress in Neuropsychopharmacology and Biological Psychiatry* 22(6):917-944, 1998.

Gates, **D.** *Medicaid Financing of Alcohol and Drug Abuse Treatment for Pregnant Women, Mothers, and Their Children.*

Washington, DC: National Health Law Program, 1992.

Gawin, F.H., and Kleber, H.D. Abstinence symptomatology and psychiatric diagnosis in cocaine abusers. *Archives of General Psychiatry* 43:107-118, 1986.

Gelenberg, A.J., and Bassuk, E.L., eds. *The Practitioner's Guide to Psyclwactive Drugs.* 4th ed. New York: Plenum Medical Book Co., 1997.

Geller, A. Neurological effects. In: Graham, A.W., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 2d ed. Chevy Chase, MD: American Society of Addiction Medicine, 1998. pp. 775-792.

Gerstein, D.R., Johnson, R.A., Harwood,

**H.,** Fountain, D., Suter, N., and Malloy,

**K.** *Evaluating Recovery Services: The California Drug and Alcolwl Treatment Assessment (CALDATA).* Sacramento, CA: Department of Alcohol and Drug Programs, 1994.

Giannini, **A.J.,** Miller, N., and Kocjan, **D.K.** Treating steroid abuse: A psychiatric per­ spective. *Clinical Pediatrics*

30(9):538-542, 1991.

Gill, K., Eagle Elk, M., Liu, Y., and Deitrich,

R.A. Examination of ALDH2 genotypes, alcohol metabolism and the flushing response in Native Americans. *Journal of Studies on Alcohol* 60(2):149-158, 1999.

Giovino, G.A., Henningfield, J.E., Tomar, S.L., Escobedo, L.G., and Slade, **J.** Epidemiology of tobacco use and depen­ dence. *Epidemiologic Reviews* 17(1):48-65, 1995.

Glover, E.D., and Glover, **P.N.** Pharmacologic treatments for the nicotine dependent smoker. *American Journal of Health* Behavior25(3):179-182, 2001.

Glover, E.D., Nilsson, F., Westin, A., and Glover, **P.N.** "Glover-Nilsson Smoking Behavioral Questionnaire (GN-SBQ)." Paper presented at the 8th Annual Meeting of the Society for Research on Nicotine and Tobacco, Savannah, GA, 2002.

Gold, C.G., Cullen, D.J., Gonzales, S., Houtmeyers, D., and Dwyer, **M.J.** Rapid opioid detoxification during general anes­ thesia: A review of 20 patients.

*Anesthesiology* 91(6):1639-1647, 1999.

Gold, M.S., Dackis, C.A., and Washton,

A.M. The sequential use of clonidine and naltrexone in the treatment of opiate addicts. *Advances in Alcohol and Substance Abuse* 3(3):19-39, 1984.

Gold, M.S., Redmond, D.E., Jr., andKleber,

**H.D.** Clonidine blocks acute opiate-with­ drawal symptoms. *Lancet*

2(8090):599-602, 1978.

Golden S.A., and Sakhrani, D.L. Unexpected delirium during Rapid Opioid Detoxification (ROD). *Journal of Addictive Diseases* 23(1):65-75, 2004.

Goldsmith, R.J. Overview of psychiatric comorbidity: Practical and theoretical considerations. *Psychiatric Clinics of North America* 22(2):331-349, 1999.

Goldstein, G. Recovery, treatment and reha­ bilitation in chronic alcoholics. In: Parsons, O.A., Butters, N., and Nathan, P.E., eds. *Neuropsychology of Alcoholism: Implications for Diagnosis and Treatment.* New York: Guilford Press, 1987.

Gondolf, E., Coleman, K., and Roman, S. Clinical-based vs. insurance-based recom­ mendations for substance abuse treatment level. *Substance Use and Misuse* 31(9):1101-1116, 1996.

Goodman, L., Koss, M., and Russo, N. Violence against women: Physical and mental health effects. Part I: Research. *Applied and Preventive Psyclwlogy* 2:79-89, 1993.

Gorelick, D.A., Gardner, E.L., and Xi, Z.X. Agents in development for the management of cocaine abuse. *Drugs* 64(14):1547-1573, 2004.

Gossop, M., Keaney, F., and Stewart, D. A short alcohol withdrawal scale (SAWS): Development and psychometric properties. *Addiction Biology* 7:37-43, 2002.

Gottheil, E., Sterling, R.C., and Weinstein,

S.P. Pretreatment dropouts: Characteristics and outcomes. *Journal of Addictive Diseases* 16(2):1-14, 1997.

Gottschalk, P.C., Jacobsen, L.K., and Kosten, T.R. Current concepts in pharma­ cotherapy of substance abuse. *Current Psychiatry Reports* 1(2):172-178, 1999.

Gouzoulis-Mayfrank, E., Daumann, J., Tuchtenhagen, F., Pelz, S., Becker, S., Kunert, H.J., Fimm, B., and Sass, H. Impaired cognitive performance in drug free users of recreational ecstasy **(MDMA).** *Journal of Neurology, Neurosurgery, and Psychiatry* 68(6):719-725, 2000.

Grabowski, **J.,** Rhoades, **H.,** Schmitz, **J.,** Stotts, A., AnnDaruzska, L., Creson, **D.,** and Moeller, F.G. Dextroamphetamine for cocaine-dependence treatment: A double­ blind randomized clinical trial. *Journal of Clinical Psychopharmacology*

21(5):522-526, 2001.

Graham, A.W., Schultz, T.K., Mayo-Smith, M.F., Ries, R.K., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 3d ed. Chevy Chase, MD: American Society of Addiction Medicine, 2003.

Graham, A.W., Schultz, T.K., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 2d ed. Chevy Chase, MD: American Society of Addiction Medicine, 1998.

Greenfeld, L.A., and Snell, T.L. *Women Offenders.* Bureau of Justice Statistics Special Report. NCJ 175688. Washington, DC: Bureau of Justice Statistics, 1999.

Greenspon, A.J., and Schaal, S.F. The "holi­ day heart": Electrophysiologic studies of alcohol effects in alcoholics. *Annals of Internal Medicine* 98(2):135-139, 1983.

Greer, B.G. Substance abuse among people with disabilities: A problem of too much accessibility. *Journal of Rehabilitation* 14(1):34-37, 1986.

Griffith, J.D., Joe, G.W., Chatham, L.R., and Simpson, D.D. The development and validation of a Simpatia Scale for Hispanics entering drug treatment.

*Hispanic Journal of Behavioral Sciences*

20(4):468-482, 1998.

Gritz, E.R., Klesges, R.C., and Meyers, A.W. The smoking and body weight relation­ ship: Implications for intervention and post-cessation weight control. *Annals of Behavioral Medicine* 11(4):144-153, 1989.

Gross, **M.M.,** Rosendlatt, **S.M.,** Lewis, E., Chartof, S., and Malenowski, **B.** Acute alcoholic psychoses in related syndromes: Psychosocial and clinical characteristics and their implications. *British Journal of Addiction* 65:15-31, 1972.

Gulliver, S.B., Rohsenow, D.J., Colby, S.M.,

Dey, A.N., Abrams, D.B., Niaura, R.S., and Monti, P.M. Interrelationship of smoking and alcohol dependence, use and urges to use. *Journal of Studies on Alcohol* 56(2):202-206, 1995.

Gupta, R., Espinal, M.A., and Raviglione,

M.C. Tuberculosis as a major global health problem in the 21st century: A WHO perspective. *Seminars in Respiratory and Critical Care Medicine* 25(3):245-253, 2004.

Gupta, S.K., Hwang, S.S., Causey, D., Rolf, C.N., and Gorsline, J. Comparison of the nicotine pharmacokinetics of Nicoderm (nicotine transdermal system) and half­ hourly cigarette smoking. *Journal of Clinical Pliarmacology* 35(10):985-989,

1995.

Guthmann, D.S. *An Analysis of Variables That Impact Treatment Outcomes of Chemically Dependent Deaf and Hard of Hearing Individuals.* Minneapolis, MN: Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, 2002.

Hall, S.M., Tunstall, C.D., Vila, K.L., and Duffy, J. Weight gain prevention and smoking cessation: Cautionary findings. *American Journal of Public Health* 82(6):799-803, 1992.

Haller, D.L., Knisely, J.S., Dawson, K.S., and Schnoll, S.H. Perinatal substance abusers. Psychological and social charac­ teristics. *Journal of Nervous and Mental Disease* 181(8):509-513, 1993.

Handelsman, L., Cochrane, K.J., Aronson, **M.J.,** Ness, **R.,** Rubinstein, **K.J.,** and Kanof, **P.D.** Two new rating scales for opi­ ate withdrawal. *American Journal of Drug and Alcohol Abuse* 13(3):293-308, 1987.

Haney, M., Ward, A.S., Comer, S.D., Foltin, R.W., and Fischman, M.W. Abstinence symptoms following smoked marijuana in humans. *Psychopl1armacology*

141(4):395--404, 1999.

Harrison, P.M., and Beck, A.J. Prison and jail inmates at midyear 2004. *Bureau of Justice Statistics Bulletin* (April):NCJ 208801. Washington, DC: Bureau of Justice Statistics, 2005.

Hayashida, M. An overview of outpatient and inpatient detoxification. *Alcohol Health and Research World* 22(1):44--46, 1998.

Heath, D.B. American Indians and alcohol: Epidemiological and sociocultural rele­ vance. In: Spiegler, D., Tate, D., and Aitkin, S., eds. *Alcohol Use Among US Ethnic Minorities. Proceedings of a Conference 011 the Epidemiology of Alcohol Use and Abuse Among Etlmic Minority Groups.* NIDA Research Monograph 18. HHS Pub. No. (ADM) 89- 1435. Washington, DC: U.S. Government Printing Office, 1989. pp. 207-222.

Heatherton, T., Kozlowski, L., Frecker, **R.,** and Fagerstrom, **K.O.** The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire. *British Journal of Addiction* 86(9):1119-1127, 1991.

Hedlund, L., and Wahlstrom, G. The effect of diazepam on voluntary ethanol intake in a rat model of alcoholism. *Alcohol and Alcoholism* 33(3):207-219, 1998.

Helms, J.E., and Parham, T.A. The racial identity attitude scale (RAIS). In: Jones, R.L., ed. *Handbool.: of Tests and Measurements for Black Populations.*

Hampton, VA: Cobb and Henry, 1996. pp. 167-174.

Helzer, J.E. Psychiatric diagnosis, family psychiatric history. In: Rounsaville, B.J., Tims, F., Horton, A.M., and Sowder, B.J., eds. *Diagnostic Source Book 011 Drug Abuse Research and Treatment.*

Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service, National Institutes of Health, National Institute on Drug Abuse, 1993.

Helzer, J.E., Bucholz, K., and Robins, L.N. Five communities in the United States: Results of the Epidemiologic Catchment Area Survey. In: Helzer, J.E., and Canino, G.J., eds. *Alcoholism in Nortl1 America, Europe, and Asia.* New York: Oxford University Press, 1992. pp. 71-95.

Helzer, J.E., and Canino, G., eds. *Alcoholism in North America, Europe, and Asia.* New York: Oxford University Press, 1992.

Henningfield, J.E., Chait, L.D., and Griffiths, R.R. Effects of ethanol on cigarette smoking by volunteers without histories of alcoholism.

*Psyclwplrnrmacology* 82(1-2):1-5, 1984.

Higgins, S.T., Delaney, D.D., Budney, A.J.,

Bickel, W.K., Hughes, J.R., Foerg, F., and Fenwick, J.W. A behavioral approach to achieving initial cocaine abstinence.

*American Journal of Psychiatry* 148 (9):1218-1224, 1991.

Hillbom, M., and Numminen, **H.** Alcohol and stroke: Pathophysiologic mechanisms.

*Neuroepidemiology* 17(6):281-287, 1998.

Hillbom, M.E., and Hjelm-Jager, M. Should alcohol withdrawal seizures be treated with anti-epileptic drugs? *Acta Neurologica Scandinavica* 69(1):39-42,

###### 1984.

Hitsman, B., Pingitore, R., Spring, B., Mahableshwarkar, A., Mizes, J.S., Segraves, K.A., Kristeller, J.L., and Xu,

W. Antidepressant pharmacotherapy helps some cigarette smokers more than others. *Journal of Consulting and Clinical Psyclwlogy* 67(4):547-554, 1999.

Ho, A., and Dole, V.P. Pain perception in drug-free and in methadone-maintained human ex-addicts. *Proceedings of the Society for Experimental Biology and Medicine* 162(3):392-395, 1979.

Hoffman, N.G., and American Society of Addiction Medicine. Adult Criteria Task Force, Adolescent Criteria Task Force. *ASAM Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders.* Washington, DC: American Society of Addiction Medicine, 1991.

Hoffman, N.G., and Miller, N.S. Treatment outcomes for abstinence based programs. *Psychiatric Annals* 22(8):402-408, 1992.

Hoffman, R.S., and Hollander, J.E. Evaluation of patients with chest pain after cocaine use. *Critical Care Clinics* 13(4):809-828, 1997.

Holder, H.D. Cost benefits of substance abuse treatment: An overview of results from alcohol and drug abuse. *Journal of Mental Health Policy and Economics* 1(1):23-29, 1998.

Holder, **H.D.,** and Blose, **J.O.** Alcoholism treatment and total health care utilization and costs. A four-year longitudinal analy­ sis of Federal employees. *Journal of the American Medical Association* 256(11):1456-1460, 1986.

Holder, H.D., and Blose, J.O. Mental health treatment and the reduction of health care costs: A four-year study of U.S. Federal employees enrollment with the Aetna Life Insurance Company. *Advances in Health Economics and Healtl1 Services Researcl1* 8(157-74):157-174, 1987.

Holder, H.D., Boyd, G., Howard, J., Flay, B., Voas, R., and Grossman, M. Alcohol­ problem prevention research policy: The need for a phases research model. *Journal of Public Health Policy* 16(3):324-346, 1995.

Hollander, J.E. Themanagement of cocaine­ associated myocardial ischemia. *New England Journal of Medicine* 333(19):1267-1272, 1995.

Hook, E.W. Management of syphilis in human immunodeficiency virus-infected patients. *American Journal of Medicine* 93:477-479, 1992.

Hopewell, P.C., and Small, P.M. Tuberculosis and nontuberculous mycobaterial infec­ tions. In: Stein, J.H., ed. *Internal Medicine.* 4th ed. St. Louis, MO: Mosby, 1994. pp. 2193-2212.

Hopkins, H.S., and Gelenberg, A.J. Bipolar disorder. In: Gelenberg, A.J., and Bassuk, E.L., eds. *The Practitioner's Guide to Psychoactive Drugs.* New York: Plenum Medical Book Co, 1997. pp. 123-151.

Horvath, A.O., and Luborsky, L. The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology* 61(4):561-573, 1993.

House, R.M., and Pinyuchon, M. Counseling Thai Americans: An emerging need.

*Journal of Multicultural Counseling and Development* 26(3):194-204, 1998.

Hser, Y.I., Polinsky, M.L., Maglione, M., and Anglin, M.D. Matching clients' needs with drug treatment services. *Journal of Substance Abuse Treatment*

16(4):299-305, 1999.

Hsu, L.C., Tani, K., Fujiyoshi, T., Kurachi, K., and Yoshida, A. Cloning of cDNAs for human aldehyde dehydrogenases 1 and 2. *Proceedings of the National Academy of Sciences of the United States of America* 82(11):3771-3775, 1985.

Huff, R.M., and Kline, M.V. Tips for working with Hispanic populations. In: Huff, R.M., and Kline, M.V., eds. *Promoting Healtl1 in Multicultural Populations: A Handbook for Practitioners.* Thousand Oaks, CA: Sage Publications, 1999. pp.

189-197.

Hughes, **J.R.** Dependence potential and abuse liability of nicotine replacement therapies. *Biomedicine and Pharmacotherapy* 43(1):11-17, 1989.

Hughes, **J.R.** Combining behavioral therapy and pharmacotherapy for smoking cessa­ tion: An update. In: Onken, L.S., Blaine, J.D., and Boren, J.J., eds. *Integrating Behavioral Tlierapies with Medications in tlw Treatment of Drug Dependence.* **NIDA** Research Monograph 150. NIH Publication No. 95-3899. Rockville, **MD:** National Institute on Drug Abuse, 1995. pp. 92-109.

Hughes, J.R., and Hatsukami, D.K. The nicotine withdrawal syndrome: A brief review and update. *International Journal of Smoldng Cessation* 1:21-26, 1992.

Hughes, J.R., Lesmes, G.R., Hatsukami, D.K., Richmond, R.L., Lichtenstein, E., Jorenby, D.E., Broughton, J.O., Fortmann, S.P., Leischow, S.J., McKenna, J.P., Rennard, S.I., Wad.land, W.C., and Heatley, S.A. Are higher doses of nicotine replacement more effective for smoking cessation? *Nicotine and Tobacco* Researcl11(2):169-174, 1999.

Hughes, T.L., and Wilsnack, S.C. Use of alcohol among lesbians: Research and clin­ ical implications. *American Journal of Orthopsychiatry* 67(1):20-36, 1997.

Humphreys, K., and Moos, R.H. Reduced substance-abuse-related health care costs among voluntary participants in Alcoholics Anonymous. *Psychiatric Services* 47(7):709-713, 1996.

Hurt, R.D., Dale, L.C., Croghan, G.A., Croghan, I.T., Gomez-Dahl, L.C., and Offord, **K.P.** Nicotine nasal spray for smoking cessation: Pattern of use, side effects, relief of withdrawal symptoms, and cotinine levels. *Mayo Clinic Proceedings* 73(2):118-125, 1998.

Hurt, R.D., Dale, L.C., Offord, K.P., Bruce,

B.K., McClain, F.L., and Eberman, K.M. Inpatient treatment of severe nicotine dependence. *Mayo Clinic Proceedings* 67(9):823-828, 1992.

**Hurt, R.D.,** Eberman, **K.M.,** Croghan, **LT.,**

Offord, **K.P.,** Davis, **L.J., Jr.,** Morse,

**R.M.,** Palmen, M., and Bruce, **B.K.** Nicotine dependence treatments during inpatient treatment for other addictions: A prospective intervention trial. *Alcoholism: Clinical and Experimental Researcl1* 18(4):867-872, 1994.

Institute on Black Chemical Abuse. *Overview of Cultural Sensitivity and Specificity: IBCA Definitions and Perspectives.*

Minneapolis, MN: Institute on Black Chemical Abuse, 1992.

Ivey, K.J. Drugs, gastritis, and peptic ulcer.

*Journal of Clinical Gastroenterology*

3(suppl 2):29-34, 1981.

Ja, D.Y., and Aoki, B. Substance abuse treat­ ment: Cultural barriers in the Asian American community. In: Organista, P.B., Chun, K.M., and Marin, G., eds.

*Readings in Ethnic Psychology.* New York: Routledge, 1998. pp. 386-401.

Jackson, M.S., Stephens, R.C., and Smith,

R.L. Afrocentric treatment in residential substance abuse care: The lwo San. *Journal of Substance Abuse Treatment* 14(1):87-92, 1997.

James, W. Examining racial and ethnic differ­ ences in Asian adolescent drug use: The contributions of culture, background and lifestyle. *Drugs: Education, Prevention, and Policy* 4(1):39-52, 1997.

Janicak, P.G. *Principles and Practice of Psyclwpharmacotherapy.* Baltimore: Williams & Wilkins, 1993.

Jauhar, P., and Anderson, J. Is daily single dosage of diazepam as effective as chlor­ diazepoxide in divided doses in alcohol withdrawal-a pilot study. *Alcolwl and Alcoholism* 35(2):212-214, 2000.

Javors, M.A., Pichot, J.T., King, T.S., and Anton, R.S. Search for biological mark­ ers. In: Johnson, B.A., and Roache, J.D., eds. *Drug Addiction and its Treatment: Nexus of Neuroscience and Behavior.*

Philadelphia: Lippincott-Raven, 1997. pp. 205-231.

Joe, G.W., Brown, B.S., and Simpson, D. Psychological problems and client engage­ ment in methadone treatment. *Journal of Nervous and Mental Disease*

183(11):704-710, 1995.

Johnson, R.E., Chutuape, M.A., Strain, E.C., Walsh, S.L., Stitzer, M.L., and Bigelow, G.E. A comparison of lev­ omethadyl acetate, buprenorphine, and methadone for opioid dependence. *New England Journal of Medicine* 343(18):1290-1297, 2000.

Johnson, R.E., Jones, H.E., Jasinski, D.R.,

Svikis, D.S., Haug, N.A., Jansson, L.M.,

Kissin, W.B., Alpan, G., Lantz, M.E.,

Cone, E.J., Wilkins, D.G., Golden, A.S., Huggins, G.R., and Lester, B.M. Buprenorphine treatment of pregnant opi­ oid-dependent women: Maternal and neonatal outcomes. *Drug and Alcohol Dependence* 63(1):97-103, 2001.

Johnston, L.D., O'Malley, P.M., and Bachman, J.G. *National Survey Results 011 Drug Use From tlie Monitoring the Future Study, 1975-1995: Volume II, College Students and Young Adults.* NIH Publication No. 01-4925. Bethesda, MD: National Institute on Drug Abuse, 1997.

Jones, A.W., and Andersson, L. Influence of age, gender, and blood-alcohol concentra­ tion on the disappearance rate of alcohol from blood in drinking drivers. *Journal of Forensic Science* 41(6):922-926, 1996.

Jones, A.W., and Sternebring, B. Kinetics of ethanol and methanol in alcoholics during detoxification. *Alcohol and Alcoholism* 27(6):641-647, 1992.

Jones, H.E., and Balster, R.L. Inhalant abuse in pregnancy. *Obstetrics and Gynecology Clinics of North America* 25(1):153-167, 1998.

Jones, H.E., Haug, N., Silverman, K., Stitzer, M., and Svikis, **D.** The effective­ ness of incentives in enhancing treatment attendance and drug abstinence in methadone-maintained pregnant women. *Drug and Alcohol Dependence*

61:297-306, 2001a.

Jones, H.E., and Johnson, R.E. Pregnancy and substance abuse. *Current Opinion in Psychiatry* 14:187-193, 2001.

Jones, H.E., Johnson, R.E., and Tuten, M. *Methadone Detoxification of Pregnant Opiate Addicted Women: Safety and Efficacy.* 2001b.

Jones, H.E., Velez, M.L., McCaul, M.E., and Svikis, D.S. Special treatment issues for women. In: Strain, E.C., and Stitzer, M., eds. *Methadone Treatment for Opioid Dependence.* Baltimore: Johns Hopkins University Press, 1999. pp. 251-280.

Jorenby, D.E., Leischow, S.J., Nides, **M.A.,** Rennard, S.I., Johnston, J.A., Hughes, A.R., Smith, S.S., Muramoto, M.L.,

Daughton, D.M., Doan, K., Fiore, M.C., and Baker, T.B. A controlled trial of sus­ tained-release bupropion, a nicotine patch, or both for smoking cessation. *New England Journal of Medicine*

340(9):685-691, 1999.

Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits 2003 Annual Survey.* Menlo Park, CA: Henry J. Kaiser Family Foundation, 2003.

Kaltenbach, K., Berghella, V., and Finnegan,

L. Opioid dependence during pregnancy: Effects and management. *Obstetrics and Gynecology* 25(1):139-151, 1998.

Kampman, K.M., Alterman, A.I., Volpicelli, J.R., Maany, I., Muller, E.S., Luce, D.D., Mulholland, E.M., Parikh, G.A., Mulvaney, F.D., Weinrieb, R.M., and O'Brien, C.P. Cocaine withdrawal symp­ toms and initial urine toxicology results predict treatment attrition in outpatient cocaine dependence treatment. *Psychology of Addictive Behaviors* 15(1):52-59, 2001b.

Kampman, K.M., Volpicelli, J.R., Alterman, A.I., Cornish, J., and O'Brien, C.P. Amantadine in the treatment of cocaine­ dependent patients with severe withdrawal symptoms. *American Journal of Psychiatry* 157(12):2052-2054, 2000.

Kampman, K.M., Volpicelli, J.R., McGinnis, D.E., Alterman, A.I., Weinrieb, R.M., D'Angelo, L., and Epperson, L.E. Reliability and validity of the cocaine selective severity assessment. *Addictive Behaviors* 23(4):449-461, 1998.

Kampman, K.M., Volpicelli, J.R., Mulvaney, F., Alterman, A.L., Cornish, J., Gariti, P., Cnaan, A., Poole, S., Muller, E., Acosta, T., Luce, D., and O'Brien, C. Effectiveness of propranolol for cocaine dependence treatment may depend on cocaine withdrawal symptom severity.

*Drug and Alcohol Dependence*

63(1):69-78, 2001a.

Kandall, S.R. Women and addiction in the United States-1920 to the present. In: Wetherington, C.L., and Roman, A.B., eds. *Drug Addiction Research and the Health of tlie Women.* NIH Publication No. 98-4290. Rockville, MD: National Institute on Drug Abuse, 1998. pp. 53-80.

Kandall, S.R., Albin, S., Gartner, L.M., Lee, K.S., Eidelman, A., and Lowinson, J. The narcotic-dependent mother: Fetal and neonatal consequences. *Early Human Development* 1(2):159-169, 1977.

Kaplan, H.I., Sadock, B.J., and Cancro, R., eds. *Comprehensive Textbool.: of Psychiatry.* 6th ed. Baltimore: Williams & Wilkins, 1995.

Kashner, T.M., Rodell, D.E., Ogden, S.R., Guggenheim, F.G., and Karson, C.N. Outcomes and costs of two VA inpatient treatment programs for older alcoholic patients. *Hospital and Community Psychiatry* 43(10):985-989, 1992.

Kasser, C., Geller, A., Howell, E., and Wartenberg, A. *Detoxification: Principles and Protocols.* Chevy Chase, MD: American Society of Addiction Medicine, 2000.

Kaufman, E. Diagnosis and treatment of drug and alcohol abuse in women. *American Journal of Obstetrics and Gynecology* 174:21-27, 1996.

Kazarian, S.S., and Evans, D.R. *Cultural Clinical Psychology: Theory, Research, and Practice.* New York: Oxford University Press, 1998.

Keilitz, I., and Hall, D. Some statutes govern­ ing involuntary outpatient civil commit­ ment. *Maryland Law Review* 9(5):378-397, 1985.

Keller, M., and Rosenberg, S.S., eds. *Alcohol and Health: Report from the Secretary of Healtl1, Education, and Welfare.* New York: Scribner, 1973.

Kertesz, S.G., Horton, N.J., Friedmann, P.D., Saitz, R., and Samet, J.H. Slowing the revolving door: Stabilization programs reduce homeless persons' substance use after detoxification. *Journal of Substance Abuse Treatment* 24(3):197-207, 2003.

Keso, L., and Salaspuro, M. Inpatient treat­ ment of employed alcoholics: A random­ ized clinical trial on Hazelden-type and traditional treatment. *Alcoholism: Clinical and Experimental Research*

###### 14(4):584-589, 1990.

Kessler, R.C., Barker, P.R., Colpe, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J., Normand, L.T., Mandersheid, R.W., Walters, E.E., and Zaslavsky, A.M. Screening for serious mental illness in the general population. *Archives of General Psychiatry* 60(2):184-189, 2003.

Kessler, R.C., Crum, R.M., Warner, L.A., Nelson, C.B., Schulenberg, J., and Anthony, J.C. Lifetime co-occurrence of DSM-111-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Survey. *Archives of General Psycl1iatry* 54(4):313-321, 1997.

Kessler, R.C., Nelson, C.B., McGonagle, K.A., Edlund, M.J., Frank, R.G., and Leaf, P.J. The epidemiology of co-occur­ ring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry* 66(1):17-31, 1996.

Kessler, R.C., Nelson, C.B., McGonagle, K.A., Liu, J., Swartz, M., and Blazer,

D.G. Comorbidity of DSM-111-R major depressive disorder in the general popula­ tion: Results from the US National Comorbidity Survey. *British Journal of Psychiatry Supplement* (30):17-30, 1996.

Kienbaum, P., Scherbaum, N., Thurauf, N., Michel, M.C., Gastpar, M., and Peters, J. Acute detoxification of opioid-addicted patients with naloxone during propofol or methohexital anesthesia: A comparison of withdrawal symptoms, neuroendocrine, metabolic, and cardiovascular patterns. *Critical Care Medicine* 28(4):969-976, 2000.

Killen, J.D., Fortmann, S.P., Davis, L., Strausberg, L., and Varady, A. Do heavy smokers benefit from higher dose nicotine patch therapy? *Experimental and Clinical Psychopharmacology* 7(3):226-233, 1999.

Kirchner, J.E., Booth, B.M., Owen, R.R., Lancaster, A.E., and Smith, G.R. Predictors of patient entry into alcohol treatment after initial diagnosis. *Journal of Behavioral Healtl1 Services and Research* 27(3):339-446, 2000.

Kleber, H.D., Topazian, M., Gaspari, J., Riordan, C.E., and Kosten, T. Clonidine and naltrexone in the outpatient treatment of heroin withdrawal. *American Journal of Drug and Alcohol Abuse* 13(1-2):1-17, 1987.

Klein, M., Calderon, S., and Hayes, B. Abuse liability assessment of neuroprotectants.

*Annals of the New York Academy of Sciences* 890:515-525, 1999.

Kleinman, B.P., Millery, M., Scimeca, M., and Polissar, N.L. Predicting long-term treatment utilization among addicts enter­ ing detoxification: The contribution of help-seeking models. *Journal of Drug Issues* 32(1):209-230, 2002.

Kleinman, P.H., Woody, G.E., Todd, T.C.,

Millman, R.B., Kang, S.Y., Kemp, J., and Lipton, D.S. Crack and cocaine abusers in outpatient psychotherapy. In: Onken, L.S., and Blaine, J.D., eds.

*Psychotherapy and Counseling in the Treatment of Drug Abuse.* HHS Publication No. (ADM) 90-1722.

Rockville, MD: National Institute on Drug Abuse, 1990. pp. 24-35.

Klijnsma, M.P., Cameron, M.L., Burns, T.P., and McGuigan, S.M. Outpatient alcohol detoxification outcome after 2 months.

*Alcohol and Alcoholism* 30(5):669-673, 1995.

Kline, A. Pathways into drug user treatment: The influence of gender and racial/ethnic identity. *Substance Use and Misuse* 31(3):323-342, 1996.

Koenig, L., Denmead, G., Nguyen, R., Harrison, M., and Harwood, H. *The Costs and Benefits of Substance Abuse Treatment: Findings from the National Treatment Improvement Evaluation Study (NTIES).* Fairfax, VA: Caliber Associates, National Evaluation Data Services, 1999.

Kofoed, L., Kania, J., Walsh, T., and Atkinson, R.M. Outpatient treatment of patients with substance abuse and coexist­ ing psychiatric disorders. *American Journal of Psychiatry* 143(7):867-872, 1986.

Kofoed, L.L., Tolson, R.L., Atkinson, R.M., Toth, R.L., and Turner, **J**.A. Treatment compliance of older alcoholics: An elder­ specific approach is superior to "main­ streaming." *Journal of Studies 011 Alcohol* 48(1):47-51, 1987.

Kolodner, G. Ambulatory detoxification as an introduction to treatment. *Currents in Alcoholism* 1:311-317, 1977.

Kongsakon, R., Papadopoulos, K.I., and Saguansiritham, R. Mirtazapine in amphetamine detoxification: A placebo­ controlled pilot study. *International Clinical Psychopharmacology* 20(5):253-256, 2005.

Kosten, T.R., and McCance-Katz, E. New pharmacotherapies. *American Psychiatric Press Review of Psychiatry* 14:105-126, 1995.

Kosten, T.R., Rounsaville, B.J., and Kleber,

H.D. Concurrent validity of the Addiction Severity Index. *Journal of Nervous and Mental Disease* 171(10):606-610, 1983.

Kranzler, H.R., and Jaffe, J.H. Pharmacologic interventions for alco­ holism. In: Graham, A.W., Schultz, T.K., Mayo-Smith, M.F., Ries, R.K., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 3d ed. Chevy Chase, **MD:** American Society of Addiction Medicine, 2003. pp. 701-720.

Krestan, J. Addiction, power, and powerless­ ness. In: Krestan, J.A., ed. *Bridges To Recovery: Addiction, Family Therapy, and Multicultural Treatment.* New York: Free Press, 2000. pp. 15-44.

Kuhnz, W., Koch, S., Helge, **H.,** and Nau, H. Primidone and phenobarbital during lac­ tation period in epileptic women: Total and free drug serum levels in the nursed infants and their effects on neonatal behavior. *Developmental Pharmacology and Therapeutics* 11(3):147-154, 1988.

Lader, **M.H.** Limitations of the use of benzo­ diazepines in anxiety and insomnia: Are they justified? *European Neuropsychopharmacology* 9(Suppl 6):S399-S405, 1999.

Lahti, A.C., Weiler, M.A., Michaelidis, B.A., Parwani, A., and Tamminga, C.A. Effects of ketamine in normal and schizophrenic volunteers. *Neuropsychopharmacology* 25(4):455-467, 2001.

Lambert, M.T. Linking mental health and addiction services: A continuity-of-care team model. *Journal* of *Behavioral Health Services and Research* 29(4):433-444, 2002.

Landau, J., Garrett, J., Shea, R.R., Stanton, M.D., Brinkman-Sull, D., and Baciewicz,

G. Strength in numbers: The ARISE method for mobilizing family and network to engage substance abusers in treatment. A Relational Intervention Sequence for Engagement. *American Journal* of *Drug and Alcohol Abuse* 26(3):379-398, 2000.

Lapham, S., Hall, M., Snyder, J., Skipper, B., McMurray-Avila, M., Pulvino, S., and Kozeny, T. Demonstration of a mixed social/medical model detoxification pro­ gram for homeless alcohol abusers.

*Contemporary Drug Problems*

23(Summer):301-330, 1996.

Lash, S.J. Increasing participation in sub­ stance abuse aftercare treatment.

*American Journal* of *Drug and Alcohol Abuse* 24(1):31-36, 1998.

Lawson, G.M., Hurt, R.D., Dale, L.C., Offord, K.P., Croghan, LT., Schroeder, **D.R.,** and Jiang, **N.S.** Application of serum nicotine and plasma cotinine con­ centrations to assessment of nicotine replacement in light, moderate, and heavy smokers undergoing transdermal therapy. *Journal* of *Clinical Pharmacology* 38(6):502-509, 1998.

Lechtenberg, R., and Worner, T.M. Seizure risk with recurrent alcohol detoxification. *Archives* ofNeurology47(5):535-538, 1990.

Lechtenberg, R., and Worner, **T.M.** Relative kindling effect of detoxification and non­ detoxification admissions in alcoholics.

*Alcohol and Alcoholism* 26(2):221-225, 1991.

Lechtenberg, R., and Worner, **T.M.** Total ethanol consumption as a seizure risk fac­ tor in alcoholics. *Acta Neurologica Scandinavica* 85(2):90-94, 1992.

Legarda, J., and Gossop, M. A 24-hour inpa­ tient detoxification treatment for heroin addicts: A preliminary investigation. *Drug and Alcohol Dependence* 35(2):91-93, 1994.

Lehman, A.F., Myers, C.P., and Corty, E. Assessment and classification of patients with psychiatric and substance abuse syn­ dromes. 1989. *Psycl1iatric Services* 51(9):1119-1125, 2000.

Lejoyeux, M., Solomon, J., and Ades, J. Benzodiazepine treatment for alcohol­ dependent patients. *Alcohol and Alcoholism* 33(6):563-575, 1998.

Lerner, W.D., and Barr, M.A., eds.

*Handbook* of *Hospital Based Substance Abuse Treatment.* New York: Pergamon Press, 1990.

Lesser, I.M., Smith, M., Poland, R.E., and Lin, K.M. Psychopharmacology and eth­ nicity. In: Friedman, S., ed. *Cultural Issues in the Treatment* of *Anxiety.* New York: Guilford Press, 1997. pp. 199-224.

Levin, S.M., and Greene, J.A., eds. *Linking Substance Ahuse Treatment and Domestic Violence Services: A Guide for Administrators. Concise Desk Reference Guide.* HHS Publication No. (SMA)

00-3391. Rockville, MD: Center for Substance Abuse Treatment, 2000.

Li, J.X., Han, R., Deng, Y.P., Chen, S.Q.,

and Liang, J .H. Different effects of val­ proate on methamphetamine- and cocaine­ induced behavioral sensitization in mice. *Belrnvioural Brain Research*

161(1):125-132, 2005.

Liberto, J.G., Oslin, D.W., and Ruskin, P.E. Alcoholism in older persons: A review of the literature. *Hospital and Community Psychiatry* 43(10):975-984, 1992.

Liepman, M.R. Using family influence to motivate alcoholics to enter treatment: The Johnson Institute Intervention approach. In: O'Farrell, T.J., ed.

*Treating Alcolwl Problems: Marital and Family Interventions.* New York: Guilford Press, 1993. pp. 54-77.

Linder, J.D., Monkemuller, K.E., Raijman, I., Johnson, L., Lazenby, A.J., and Wilcox, C.M. Cocaine-associated ischemic colitis. *Southern Medical Journal* 93(9):909-913, 2000.

Liskow, B.I., and Goodwin, D.W. Pharmacological treatment of alcohol intoxication, withdrawal and dependence: A critical review. *Journal of Studies on Alcohol* 48(4):356-370, 1987.

Livneh, H., and Male, R. Functional limita­ tions: A review of their characteristics and vocational impact. *Journal of Rehabilitation* 59(4):44-50, 1993.

Loimer, N., Lenz, K., Schmid, R., and Presslich, 0. Technique for greatly short­ ening the transition from methadone to naltrexone maintenance of patients addict­ ed to opiates. *American Journal of Psycl1iatry* 148(7):933-935, 1991.

Loimer, N., Schmid, R., Presslich, 0., and Lenz, K. Naloxone treatment for opiate withdrawal syndrome. *British Journal of Psychiatry* 153:851-852, 1988.

Longabaugh, R., Beattie, M., Noel, N., Stout, R., and Malloy, P. The effect of social investment on treatment outcome. *Journal of Studies on Alcohol* 54(4):465-478, 1993.

Lopez, F. *Confidentiality of Patient Records for Alcohol and Otl1er Drug Treatment.* Technical Assistance Publication Series

13. HHS Publication No. (SMA) 99-3321. Rockville, MD: Center for Substance Abuse Treatment, 1994.

Lovejoy, A., Ryan, E.M., Johnson, K., and Tucci, A.S. *Federal Funding for Substance Ahuse Treatment and Support Services: Sources and Uses.* Washington, DC: American Public Health Services Association, 1999.

Luborsky, L. A pattern-setting therapeutic alliance study revisited. *Psychotherapy Researcl1* 10(1):17-29, 2000.

Luborsky, L., Barber, J.P., Siqueland, L., McLellan, A.T., and Woody, G. Establishing a therapeutic alliance with substance abusers. In: Onken, L.S., Blaine, J.D., and Boren, J.J., eds.

*Beyond the Therapeutic Alliance: Keeping tl1e Drug Dependent Individual in Treatment.* NIDA Research Monograph

165. NIH Publication No. 97-4142. Rockville, MD: National Institute on Drug Abuse, 1997. pp. 233-244.

Luborsky, L., Crits-Christoph, P., Mintz, J., and Auerbach, A. *Who Will Benefit From Psychotherapy? Predicting Therapeutic Outcomes.* New York: Basic Books, 1988.

Lukas, S.E. The pharmacology of steroids. In: Graham, A.W., and Shultz, T.K., eds. *Principles of Addiction Medicine.* 2d ed. Chevy Chase, MD: American Society of Addiction Medicine, 1998.

Lundgren, L., Amodeo, M., Schneider, R., Ellis, M., Fitzgerald, T., and Stevens, R. African-American injection drug users: Association between pre-treatment services and entry into and completion of detoxifi­ cation. *Evaluation and Program Planning* 22(3):259-267, 1999.

Mail, P.D., and Johnson, S. Boozing, sniff­ ing, and toking: An overview of the past, present, and future of substance use by American Indians. *American Indian and Alaska Native Mental Health Researcl1* 5(2):1-33, 1993.

Malcolm, R., Myrick, H., Brady, K.T., and Ballenger, J.C. Update on anticoagulants for the treatment of alcohol withdrawal. *American Journal on Addictions* l0(Suppl):16-23, 2001.

Malcolm, R., Myrick, H., Roberts, J., Wang, W., Anton, R.F., and Ballenger, J.C. The effects of carbamazepine and lorazepam on single versus multiple previous alcohol withdrawals in an outpatient randomized trial. *Journal of General Internal Medicine* 17(5):349-355, 2002.

Malcolm, R., Roberts, J.S., Wang, W., Myrick, H., and Anton, R.F. Multiple pre­ vious detoxifications are associated with less responsive treatment and heavier drinking during an index outpatient detox­ ification. *Alcohol* 22(3):159-164, 2000.

Mancall, P.C. *Deadly Medicine: Indians and Alcohol in Early America.* Ithaca: Cornell University Press, 1995.

Marantz, P.R., Linzer, M., Feiner, C.J., Feinstein, S.A., Kozin, A.M., and Friedland, G.H. Inability to predict diag­ nosis in febrile intravenous drug abusers. *Annals of Internal Medicine*

106(6):823-828, 1987.

Margolis, **R.D.,** and Zweben, **J.E.** *Treating Patients with Alcohol and Other Drug Problems: An Integrated Approach.*

Washington, DC: American Psychological Association, 1998.

Mark, T.L., Buck, J.A., Dilonardo, J.D., Coffey, R.M., and Chalk, M. Medicaid expenditures on behavioral health care. *Psychiatric Services* 54(2):188-194, *2003a.*

Mark, T.L., Dilonardo, J.D., Chalk, M., and Coffey, **R.M.** *Substance Abuse Detoxification: Improvements Needed in Linkage to Treatment.* HHS Pub. No. (SMA) 02-3728. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2002.

Mark, T.L., Dilonardo, J.D., Chalk, M., and Coffey, R.M. Factors associated with the receipt of treatment following detoxifica­ tion. *Journal of Substance Abuse Treatment* 24(4):299-304, *2003b.*

Markarian, M., and Franklin, J. Substance abuse in minority populations. In: Frances, R.J., and Miller, S.I., eds.

*Clinical Textbook of Addictive Disorders.* 2d ed. New York: Guilford Press, 1998. pp. 397-412.

Markowitz, J.S., Myrick, H., and Hiott, W. Clonidine dependence. *Journal of Clinical Psychoplrnrmacology* 17(2):137-138, 1997.

Marlatt, G.A., Blume, A.W., and Parks, G.A. Integrating harm reduction therapy and traditional substance abuse treatment.

*Journal of Psychoactive Drugs*

33(1):13-21, 2001.

Marlatt, G.A., and Gordon, J. Determinants of relapse: Implications for the mainte­ nance of behavior change. In: Davidson, P., and Davidson, S., eds. *Behavioral Medicine: Changing Health Lifestyles.* New York: Brunner/Maze!, pp. 410-452, 1980.

Marlatt, G.A., Tucker, J.A., Donovan, D.M., and Vuchinich, R.E. Help-seeking by sub­ stance abusers: The role of harm reduc­ tion and behavioral-economic approaches to facilitate treatment entry and retention. In: Onken, L.S., Blaine, **J.D.,** and Boren, J.J., eds. *Beyond the Therapeutic Alliance: Keeping the Drug Dependent Individual in Treatment.* NIDA Research Monograph 165. NIH Publication No. 97- 4142. Rockville, MD: National Institute on Drug Abuse, 1997, pp. 44-84.

Marsden, **J.,** Gossop, M., Stewart, D., Rolfe, A., and Farrell, M. Psychiatric symptoms among clients seeking treatment for drug dependence: Intake data from the National Treatment Outcome Research Study. *British Journal of Psycl1iatry*

l 76(March):285-289, 2000.

Marsella, A.J. Thoughts on cross-cultural studies on the epidemiology of depression. *Culture, Medicine and Psychiatry* 2(4):343-357, 1978.

Martin, A.C., Schaffer, S.D., and Campbell,

**R.** Managing alcohol-related problems in the primary care setting. *Nurse Practitioner* 24(8):14-18, 1999.

Mattick, R.P., Bell, **J.,** and Daws, L.C. *Review of the Evidence 011 the Effectiveness of Antagonists in Managing Opioid Dependence.* National Drug and Research Centre, University of New South Wales, Australia, 1998.

Mattick, R.P., and Hall, W. Are detoxifica­ tion programmes effective? *Lancet* 347(8994):97-100, 1996.

Mayo-Smith, M.F. Pharmacological manage­ ment of alcohol withdrawal. A meta-analy­ sis and evidence-based practice guideline. *Journal of the American Medical Association* 278(2):144-151, 1997.

Mayo-Smith, M.F., and Bernard, D. Late­ onset seizures in alcohol withdrawal.

*Alcoholism: Clinical and Experimental Research* 19(3):656-659, 1995.

McCarty, D., Caspi, Y., Panas, L., Krakow, M., and Mulligan, D.H. Detoxification centers: Who's in the revolving door?

*Journal of Behavioral Health Services and Researcl1* 27(3):245-257, 2000.

McCorry, F., Garnick, D.W., Bartlett, J., Cotter, F., and Chalk, M. Developing per­ formance measures for alcohol and other drug services in managed care plans.

Washington Circle Group. *Joint Commission Journal on Quality Improvement* 26(11):633-643, *2000a.*

McCorry, F., Garnick, D.W., Bartlett, J., Cotter, F., and Chalk, M. *Improving Performance Measurement for Alcohol and Other Drug Services.* Rockville, **MD:** Substance Abuse and Mental Health Services Administration, *2000b.*

McCrady, B.S., and Delaney, S.I. Self-help groups. In: Hester, R.K., and Miller, W.R., eds. *Handbool.: of Alcoholism Treatment Approaches.* 2d ed. Boston: Allyn and Bacon, 1995. pp. 160-175.

McCrady, B.S., Epstein, E.E., and Hirsch,

L.S. Issues in the implementation of a ran­ domized clinical trial that includes Alcoholics Anonymous: Studying AA-relat­ ed behaviors during treatment. *Journal of Studies on Alcolwl* 57:604-612, 1996.

McDonald, J.D., Morton, R., and Stewart, C. Clinical concerns with American Indian patients. In: VandeCreek, L., and Knapp, S., eds. *Innovations in Clinical Practice: A Source Boole* Sarasota, FL: Professional Resource Press/Professional Resource Exchange, 1993. pp. 437-454.

McElhatton, P.R. Heart and circulatory sys­ tem drugs. In: Schaefer, C.H., ed. *Drugs During Pregnancy and Lactation: Handbool.: of Prescription Drugs and Comparative Risk Assessment: With Updated Information on Recreational Drugs.* Amsterdam: Elsevier, 2001. pp.

116-131.

McElhatton, P.R., Bateman, D.N., Evans, C., Pughe, K.R., and Thomas, S.H. Congenital anomalies after prenatal ecsta­ sy exposure. *Lancet* 354(9188):1441-1442, 1999.

McGee, M.D., and Mee-Lee, D. Rethinking patient placement: The human service matrix model for matching services to needs. *Journal of Substance Abuse Treatment* 14(2):141-148, 1997.

McGinnis, J.M., and Foege, W.H. Actual causes of death in the United States. *Journal of the American Medical Association* 270(18):2207-2212, 1993.

McLaughlin, L.A., and Braun, K.L. Asian and Pacific Islander cultural values: Considerations for health care decision making. *Health and Social Work* 23(2):116-126, 1998.

McLellan, A.T., Alterman, A.I., Metzger, D.S., Grissom, G.R., Woody, G.E., Luborsky, L., and O'Brien, C.P. Similarity of outcome predictors across opiate, cocaine, and alcohol treatments: Role of treatment services. *Journal of Consulting and Clinical Psychology* 62(6):1141-1158, 1994.

McLellan, A.T., Grissom, G.R., Brill, P., Durell, J., Metzger, D.S., and O'Brien,

C.P. Private substance abuse treatments: Are some programs more effective than others? *Journal of Substance Abuse Treatment* 10(3):243-254, 1993.

McLellan, A.T., Hagan, T.A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., and Durell, J. Supplemental social ser­ vices improve outcomes in public addiction treatment. *Addiction* 93(10):1489-1499,

1998.

McLellan, A.T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., Pettnati, H., and Argeriou, M. The fifth edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment* 9(3):199-213, 1992.

McLellan, A.T., Lewis, D., O'Brien, C.P., Hoffmann, N.G., and Kleber, H.D. *Is Drug Dependence a Chronic Medical Illness: Implications for Treatment, Insurance and Outcome Evaluation.*

Philadelphia: Treatment Research Institute, 2002.

McLellan, A.T., Lewis, D.C., O'Brien, C.P., and Kleber, **H.D.** Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evalu­ ation. *Journal of tlie American Medical Association* 284(13):1689-1695, 2000.

McLellan, A.T., Luborsky, L., Cacciola, J., Griffith, J., Evans, F., Barr, H.L., and O'Brien, C.P. New data from the Addiction Severity Index: Reliability and validity in three centers. *Journal of Nervous and Mental Disease*

173(7):412-423, 1985.

McLellan, A.T., Luborsky, L., Woody, G.E., and O'Brien, C.P. An improved diagnostic evaluation instrument for substance abuse patients: The Addiction Severity Index.

*Journal of Nervous and Mental Disease*

168(1):26-33, 1980.

McLellan, A.T., and McKay, J.R. Components of successful treatment pro­ grams: Lessons from the research litera­ ture. In: Graham, A.W., Schultz, T.K., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 2d ed. Chevy Chase, MD: American Society of Addiction Medicine, 1998. pp. 327-343.

McNiel, J., Sheffield, J.V.L., and Bartlett, J.G. Core elements of HIV primary care. In: Bartlett, J.G., Cheever, L.W.,

Johnson, M.P., and Paauw, D.S. *A Guide to Primary Care of People with HIV/AIDS.* Rockville, MD: Health Resources and Services Administration, 2004.

Merikangas, K.R., Angst, J., Eaton, W., Canino, G., Rubio-Stipec, M., Wacker, **H.,** Wittchen, H.U., Andrade, L., Essau, C., Whitaker, A., Kraemer, H., Robins,

L.N., and Kupfer, D.J. Comorbidity and boundaries of affective disorders with anx­ iety disorders and substance misuse: Results of an international task force. *The British Journal of Psycl1iatry* (Supplement) (30):58-67, 1996.

Merrick, E.L., Garnick, D.W., Horgan, C.M., Goldin, D., Hodgkin, D., and Sciegaj, M. Benefits in behavioral health carve-out plans of Fortune 500 firms.

*Psychiatric Services* 52(7):943-948, 2001.

Meyers, R.J., Miller, W.R., Hill, D.E., and Tonigan, J.S. Community reinforcement and family training (CRAFT): Engaging unmotivated drug users in treatment.

*Journal of Substance Abuse*

###### 10(3):291-308, 1998.

Miles, D.R., Svikis, D.S., Kulstad, J.L., and Haug, N.A. Psychopathology in pregnant drug-dependent women with and without comorbid alcohol dependence. *Alcoholism: Clinical and Experimental Researcl1* 25(7):1012-1017, 2001.

Miller, N.S. Psychiatric consequences of alco­ hol and drugs of abuse and addiction. In: Miller, N.S., ed. *Pharmacology of Alcohol and Drugs of Abuse and Addiction.* New York: Springer-Verlag, 1991. pp. 77-87.

Miller, N.S. Comorbidity of psychiatric and alcohol/drug disorders: Interactions and independent status. *Journal of Addictive Diseases* 12(3):5-16, 1993.

Miller, N.S., Belkin, B.M., and Gold, M.S. Multiple addictions: Co-synchronous use of alcohol and drugs. *New York State Journal of Medicine* 90(12):596-600, 1990a.

Miller, N.S., and Chappel, J.N. History of the disease concept. *Psychiatric Annals* 21(4):196-205, 1991.

Miller, N.S., and Flaherty, J.A. Effectiveness of coerced addiction treatment (alternative consequences): A review of the clinical research. *Journal of Substance Abuse Treatment* 18(1):9-16, 2000.

Miller, N.S., and Gold, M.S. Organic solvents and aerosols: An overview of abuse and dependence. *Annals of Clinical Psychiatry* 2:85-92, 1990.

Miller, N.S., and Gold, M.S. Abuse, addic­ tion, tolerance, and dependence to benzo­ diazepines in medical and nonmedical pop­ ulations. *American Journal of Alcohol Abuse* 17(1):27-37, 1991a.

Miller, N.S., and Gold, M.S. Dual diagnoses: Psychiatric syndromes in alcoholism and drug addiction. *American Family Physician* 43(6):2071-2076, 1991b.

Miller, N.S., and Gold, M.S. The psychia­ trist's role in integrating pharmacological and nonpharmacological treatments for addictive disorders. *Psychiatric Annals* 22(8):436-440, 1992.

Miller, N.S., and Gold, M.S. Dissociation of "conscious desire" (craving) from and relapse in alcohol and cocaine depen­ dence. *Annals of Clinical Psychiatry* 6(2):99-106, 1994.

Miller, N.S., and Gold, M.S. Management of withdrawal syndromes and relapse preven­ tion in drug and alcohol dependence.

*American Family Physician* 58(1):139-146, 1998.

Miller, N.S., Mahler, J.C., Belkin, B.M., and Gold, M.S. Psychiatric diagnosis in alco­ hol and drug dependence. *Annals of Clinical Psychiatry* 3:79-89, 1991a.

Miller, N.S., Mahler, J.C., and Gold, M.S. Suicide risk associated with drug and alco­ hol dependence. *Journal of Addictive Diseases* 10(3):49-61, 1991b.

Miller, N.S., Owley, T., and Eriksen, A. Working with drug/alcohol-addicted patients in crisis. *Psychiatric Annals* 24(11):592-597, 1994.

Miller, S.I., Frances, R.J., and Holmes, D.J. Psychotropic medications. In: Miller, W.R., ed. *Alcoholism Treatment Approaches.* New York: Pergamon Press, 1990b. pp. 231-241.

Miller, W.R., Brown, **J.M.,** Simpson, T.L., Handmaker, N.S., Bien, T.H., Luckie, L.F., Montgomery, H.A., Hester, **R.K.,** and Tonigan, J.S. What works? A method­ ological analysis of the alcohol treatment outcome literature. In: Hester, **R.K.,** and Miller, W.R., eds. *Handbook of Alcoholism Treatment Approaches: Effective Alternatives.* 2d ed. Boston: Allyn and Bacon, 1995. pp. 12-44.

Miller, W.R., Meyers, R.J., and Tonigan,

J.S. Engaging the unmotivated in treat­ ment for alcohol problems: A comparison of three strategies for intervention through family members. *Journal of Consulting and Clinical Psychology* 67(5):688-697, 1999.

Miller, W.R., and Rollnick, S. *Motivational Interviewing: Preparing People for Change.* 2d ed. New York: Guilford Press, 2002.

Miller, W.R., and Rollnick, S. *Motivational Interviewing: Preparing People to Change Addictive Behavior.* New York: Guilford Press, 1991.

Miller, W.R., and Sanchez, V.C. Motivating young adults for treatment and lifestyle change. In: Howard, G.S., and Nathan, P.E., eds. *Alcolwl Use and Misuse by Young Adults.* Notre Dame, IN: Notre Dame University Press, 1994. pp. 55-81.

Minnis, J .R. Toward an understanding of alcohol abuse among the elderly: A socio­ logical perspective. *Journal of Alcohol and Drug Education* 33(3):32-40, 1988.

Miotto, K., Roth, B., and Texas Commission on Alcohol and Drug Abuse. *GHB Withdrawal Syndrome.* Austin, TX: Texas Commission on Alcohol and Drug Abuse, 2001.

Mitchell, E.R. *Fighting Drug Abuse Witl1 Acupuncture: Treatment Tliat Works.* Berkeley, CA: Pacific View Press, 1995.

Mizes, J.S., Sloan, **D.M.,** Pingitore, **R.,**

Seagraves, K., Spring, B., and Kristellar,

**J.** The influence of weight-related vari­ ables on smoking cessation. *Behavior Therapy* 29:371-385, 1998.

Moak, D.H., and Anton, R.F. Alcohol-related seizures and the kindling effect of repeated detoxifications: The influence of cocaine. *Alcohol and Alcoholism* 31(2):135-143, 1996.

Modesto-Lowe, V., and Kranzler, H.R. Diagnosis and treatment of alcohol-depen­ dent patients with comorbid psychiatric disorders. *Alcohol Research and Health* 23(2):144-149, 1999.

Moffic, H.S., and Kinzie, J.D. The history and future of cross-cultural psychiatric services. *Community Mental Health Journal* 32(6):581-592, 1996.

Moggi, F., Ouimette, P.C., Finney, J.W., and Moos, R.H. Effectiveness of treatment for substance abuse and dependence for dual diagnosis patients: A model of treatment factors associated with one-year outcomes. *Journal of Studies 011 Alcohol*

60(6):856-866, 1999.

Mojtabai, R., and Zivin, J.G. Effectiveness and cost-effectiveness of four treatment modalities for substance disorders: A propensity score analysis. *Healtl1 Services Research* 38(1):233-259, 2003.

Moller, **H.J.** Effectiveness and safety of ben­ zodiazepines. *Journal of Clinical Psychopharmacology* 19(6):2S-11S, 1999.

Morey, L. Patient placement criteria: Linking typologies to managed care. *Alcohol Health and Research World* 20(1):36-44, 1996.

Moss, A.R., Hahn, J.A., Tulsky, J.P., Daley,

C.L., Small, P.M., and Hopewell, P.C. Tuberculosis in the homeless. A prospec­ tive study. *American Journal of Respiratory and Critical Care Medicine* 162(2 Pt 1):460-464, 2000.

Motet-Grigoras, C.N., and Schuckit, M.A. Depression and substance abuse in handi­ capped young men. *Journal of Clinical Psychiatry* 47(5):234-237, 1986.

Moylan, P.L., Jones, H.E., Haug, N.A., Kissin, W.B., and Svikis, D.S. Clinical and psychosocial characteristics of sub­ stance-dependent pregnant women with and without PTSD. *Addictive Behaviors* 26:469-474, 2001.

Mulvaney, F.D., Alterman, A.I., Boardman, C.R., and Kampman, K. Cocaine absti­ nence symptomatology and treatment attrition. *Journal of Substance Abuse Treatment* 16(2):129-135, 1999.

Mumola, C.J. *Substance Abuse and Treatment, State and Federal Prisoners, 1997.* Bureau of Justice Statistics Special Report. NCJ 172871. Washington, DC: Bureau of Justice Statistics, 1999.

Najavits, L.M., Gastfriend, D.R., Barber, J.P., Reif, S., Muenz, L.R., Blaine, J., Frank, A., Crits-Christoph, P., Thase, M., and Weiss, R.D. Cocaine dependence with and without PTSD among subjects in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study.

*American Journal of Psychiatry*

###### 155(2):214--219, 1998.

National Center on Addiction and Substance Abuse. *Slwveling Up: The Impact of Substance Abuse on State Budgets.* New York: National Center on Addiction and Substance Abuse, 2001.

National Conference of Commissioners on Uniform State Laws. *Uniform Alcoholism and Intoxication Treatment Act.* Vail, CO: Commissioners on Uniform State Laws, 1971.

National Institute on Drug Abuse. *Principles of Drug Addiction Treatment: A Research­ Based Guide.* NIH Publication No. 00- 4180. Bethesda, MD: National Institutes of Health, 1999.

National Institute on Drug Abuse. Facts about drug abuse and hepatitis c. *NIDA Notes* 15(1):1-3. Rockville, MD: National Institute on Drug Abuse, 2000.

National Institute on Drug Abuse. *Inhalant Abuse.* NIH Publication No. 05-3818.

Bethesda, MD: National Institutes of Health, 2005.

National Institutes of Health. *Acupuncture.* NIH Consensus Statement 1997 Nov 3-5. Bethesda, MD: National Institutes of Health, 1997.

Nazrul Islam, S.K., Jahangir Hossain, K., Ahmed, A., and Ahsan, M. Nutritional status of drug addicts undergoing detoxifi­ cation: Prevalence of malnutrition and influence of illicit drugs and lifestyle.

*British Journal of Nutrition*

###### 88(5):507-513, 2004.

Nazrul Islam, S.K., Jahangir Hossain, K., and Ahsan, M. Serum vitamin E, C and A status of the drug addicts undergoing detoxification: Influence of drug habit, sexual practice and lifestyle factors.

*European Journal of Clinical Nutrition*

###### 55(11):1022-1027, 2001.

Nebelkopf, E. Holistic program for the drug addict and alcoholic. *Journal of Psychoactive Drugs* 13(4):345-351, 1981.

Nebelkopf, E. Herbal therapy in the treat­ ment of drug use. *International Journal of the Addictions* 22(8):695-717, 1987.

Nebelkopf, E. Herbs and substance abuse treatment: A 10-year perspective. *Journal of Psychoactive Drugs* 20(3):349-354, 1988.

Nelipovich, M., and Buss, E. Alcohol abuse and persons who are blind: Treatment considerations. *Alcolwl Health and Research World* 13(2):129-131, 1989.

Neu, H.C. Pneumonia. In: Stein, J.H., ed. *Internal Medicine.* 4th ed. St. Louis, MO: Mosby, pp. 1868-1876. 1994.

Newman, C.F. Establishing and maintaining a therapeutic alliance with substance abuse patients: A cognitive therapy approach.

In: Onken, L.S., Blaine, J., and Boren, J.D., eds. *Beyond the Therapeutic Alliance: Keeping tlw Drug-Dependent Individual in Treatment.* NIDA Research Monograph 165. NIH Publication No. 97- 4142. Rockville, **MD:** National Institute on Drug Abuse, 1997. pp. 181-206.

News and Notes. Study finds widespread implementation of managed behavioral health care programs in the public sector. *Psycl1iatric Services* 50(2):278, 1999.

Niaura, R., Spring, B., Borrelli, B., Redeker, D., Goldstein, M.G., Keuthen, N., DePue, **J.,** Kristeller, J., Ockene, J., Prochazka, A., Chiles, J.A., and Abrams,

D.B. Multicenter trial of fluoxetine as an adjunct to behavioral smoking cessation treatment. *Journal of Consulting and Clinical* Psychology 70(4):887-896, 2002.

Nordahl, T.E., Salo, R., Natsuaki, Y.,

Galloway, G.P., Waters, C., Moore, C.D., Kile, S., and Buonocore, M.H. Methamphetamine users in sustained abstinence: a proton magnetic resonance spectroscopy study. *Archives of General Psychiatry* 62(4):444-452, 2005.

*NIH Panel Issues Consensus Statement on Acupuncture.* NIH News Release.

Bethesda, MD: National Institutes of Health, 1997.

Nutt, D., Adinoff, B., and Linnoila, M. Benzodiazepines in the treatment of alco­ holism. *Recent Developments in Alcoholism* 7:283-313, 1989.

O'Connor, P.G., and Kosten, T.R. Rapid and ultrarapid opioid detoxification tech­ niques. *Journal of the American Medical Association* 279(3):229-234, 1998.

Office of Applied Studies. *Summary of Findings from the 2000 National Household Survey on Drug Abuse.* **HHS** Publication No. (SMA) 01-3549. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.

Office of Applied Studies. *Results from the 2001 National Household Survey on Drug Abuse: Vol.1. Summary of National Findings.* National Household Survey on Drug Abuse Series: H-17. HHS Publication No. (SMA) 02-3758. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2002a.*

Office of Applied Studies. *National Survey of Substance Abuse Treatment Services*

*(N-SSATS): 2000. Data 011 Substance Abuse Treatment Facilities.* DASIS Series: S-16. HHS Publication No. (SMA) 02- 3668. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, *2002b.*

Office of Applied Studies. *Treatment Episode Data Set (TEDS): 1992-2000. National Admissions to Substance Abuse Treatment Services.* Drug and Alcohol Services Information System Series: S-17.

Rockville, MD: Substance Abuse and Mental Health Services Administration, 2002c.

Office of Applied Studies. *The National Survey of Substance Abuse Treatment Services (N-SSATS).* The DASIS Report. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2003a.

Office of Applied Studies. *Overview of Findings from the 2002 National Survey on Drug Use and Health.* NHSDA Series H-21. HHS Publication No. (SMA)

03-3774. Rockville, MD: Substance Abuse and Mental Health Services Administra­ tion, 2003b.

Office of Applied Studies. *Treatment Episode Data Set (TEDS): 1992-2001. National Admissions to Substance Abuse Treatment Services, DASIS Series: S-20* HHS Publication No. (SMA) 03-3778 Rockville, MD: Substance Abuse and Mental Health Services Administration 2003c.

Office of Applied Studies. *Treatment Episode Data Set (TEDS): 1992-2002. Chapter 3- Characteristics of Admissions: 2002.*

*National Admissions to Substance Abuse Treatment Services, DASIS Series: S-23* HHS Publication No. (SMA) 04-3965 Rockville, **MD:** Substance Abuse and Mental Health Services Administration 2004.

Office of Applied Studies. *Overview of Findings from the 2004 National Survey on Drug Use and Health.* HHS Publication No. (SMA) 05-4061. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005a.

Office of Applied Studies. *Polydrug Admissions: 2002.* The DASIS Report. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005b.

Office of Applied Studies. *Results from the 2004 National Survey on Drug Use and Health: National Findings.* HHS Publication No. (SMA) 05-4062. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 2005c.

Office of Applied Studies. *Treatment Episode Data Set (TEDS): 1993-2003. National Admissions to Substance Abuse Treatment Services, DASIS Series: S-29* HHS Publication No. (SMA) 05-4118 Rockville, MD: Substance Abuse and Mental Health Services Administration 2005d.

Office of the Inspector General. *Follow-up to Detoxification Services for Medicaid Beneficiaries.* OEI-07-97-00270.

Washington, DC: Department of Health and Human Services, Office of Inspector General, 1998.

Office of National Drug Control Policy.

*National Drug Control Strategy.* Washington, DC: Office of National Drug Control Policy, 1998.

Office of National Drug Control Policy. *National Drug Control Strategy.* NCJ 192260. Washington, DC: Office of National Drug Control Policy, 2002.

Okuyemi, K.S., Ahluwalia, J.S., and Harris,

K.J. Pharmacotherapy of smoking cessa­ tion. *Arcl1ives of Family Medicine* 9(3):270-281, 2000.

Onken, L.S., Blaine, **J.,** and Boren, **J.D.,** eds. *Beyond tl1e Tl1erapeutic Alliance: Keeping the Drug-Dependent Individual in Treatment.* NIDA Research Monograph

165. NIH Publication No. 97-4142. Rockville, MD: National Institute on Drug Abuse, 1997.

Oss, M.E., and Clary, J.H. *Managed Behavioral Health Marketshare in the United States, 1998-1999.* Gettysburg, PA: Open Minds, 1999.

Parker, J.D. A brief telephone intervention targeting treatment engagement from a substance abuse program wait list. *Journal of Behavior Health Services and Research* 29(3):288-303, 2002.

Parra, G. *Welfare Reform and Substance Abuse: Innovative State Strategies.* NHPF Issue Brief. Washington, DC: National Health Policy Forum, 2002.

Parrott, A.C., Sisk, E., and Turner, J.J. Psychobiological problems in heavy 'ecsta­ sy' (MDMA) polydrug users. *Drug and Alcohol Dependence* 60(1):105-110, 2000.

Pelican, S., Batchelor, B., Belshaw, J., Osborn, W., Pearce, J., Przekurat, C., Schumacher, P., and Strauss, K. Nutrition services for alcohol/substance abuse clients. Indian Health Service's tribal sur­ vey provides insight. *Journal of the American Dietetic Association*

###### 94(8):835-836, 1994.

Pena, J.M., Bland, I.J., Shervington, D., Rice, J.C., and Foulks, E.F. Racial identi­ ty and its assessment **in** a sample of African-American men in treatment for cocaine dependence. *American Journal of Drug and Alcohol Ahuse* 26(1):97-112, 2000.

Penick, E.C., Powell, **B.J.,** Nickel, E.J., Bingham, S.F., Riesenmy, K.R., Read, **M.R.,** and Campbell, **J.** Comorbidity of lifetime psychiatric disorder among male alcoholic patients. *Alcoholism: Clinical and Experimental Research*

###### 18(6):1289-1293, 1994.

Perez-Stable, E.J., Herrera, **B.,** Jacob, **P.,** and Benowitz, N.L. Nicotine metabolism and intake in black and white smokers. *Journal of the American Medical Association* 280(2):152-156, 1998.

Perine, J.L., and Schare, M.L. Effect of counselor and client education in nicotine addiction on smoking in substance abusers. *Addictive Behaviors*

###### 24(3):443-447, 1999.

Perkins, **K.A.** Smoking cessation in women.

Special considerations. *CNS Drugs*

###### 15(5):391-411, 2001.

Perkins, K.A., Marcus, M.D., Levine, M.D.,

D'Amico, D., Miller, A., Broge, M., Ashcom, J., and Shiffman, S. Cognitive­ behavioral therapy to reduce weight con­ cerns improves smoking cessation outcome in weight-concerned women. *Journal of Consulting and Clinical Psychology* 69(4):604-613, 2001.

Perrin, E.B., and Koshel, J.J., eds.

*Assessment of Performance Measures for Public Health, Substance Abuse, and Mental Health.* Washington, DC: National Academy Press, 1997.

Perucca, E., and Crema, A. Plasma protein binding of drugs in pregnancy. *Clinical Pharmacokinetics* 7(4):336-352, 1982.

Peters, R.G., May, R.L., and Kearns, W.D. Drug treatment in jails: Results of a nationwide survey. *Journal of Criminal Justice* 20(4):283-295, 1992.

Pfab, R., Hirtl, C., and Zilker, T. Opiate detoxification under anesthesia: No appar­ ent benefit but suppression of thyroid hor­ mones and risk of pulmonary and renal failure. *Journal of Toxicology. Clinical Toxicology* 37(1):43-50, 1999.

*Physicians' Desk Reference.* 58th ed.

Oradell, NJ: Medical Economics, 2004.

**Pi, E.H., and** Gray, G.E. A cross-cultural perspective on psychopharmacology. **In:** *The Hatherleigh Guide to Psychopharmacology.* New York: Hatherleigh Press, 1999. pp. 327-358.

Pires, S., Stroul, B., and Armstrong, M. *Health Care Reform Tracking Project: Tracking State Managed Care Reforms as They Affect Children and Adolescents with Behavioral Health Disorders and Their Families* - *1999 Impact Analysis.* Tampa, FL: Louis de la Parte Florida Mental Health Institute, 2000.

Pitts, W.R., Lange, R.A., Cigarroa, J.E., and Hillis, L.D. Cocaine-induced myocardial ischemia and infarction: Pathophysiology, recognition, and management. *Progress in Cardiovascular Diseases* 40(1):65-76,

###### 1999.

Pokorny, A.D., Miller, B.A., and Kaplan,

H.B. The brief MAST: A shortened ver­ sion of the Michigan Alcoholism Screening Test. *American Journal of Psychiatry* 129(3):342-345, 1972.

Polednak, A.P. Recent trends in incidence rates for selected alcohol-related cancers in the United States. *Alcohol and Alcoholism* 40(3):234-238, 2005.

Pond, S.M., Kreek, M.J., Tong, T.G., Raghunath, J., and Benowitz, N.L. Altered methadone pharmacokinetics in methadone-maintained pregnant women. *Journal of Pharmacology and Experimental Tlwrapeutics* 233(1):1-6,

1985.

Pope, H.G., Katz, D.L., and Hudson, J.I. Anorexia nervosa and "reverse anorexia" among 108 male bodybuilders.

*Comprehensive Psychiatry* 34(6):406-409,

1993.

Post, R.M., Uhde, T.W., Roy-Byrne, P.P., and Joffe, R.T. Correlates of antimanic response to carbamazepine. *Psychiatry Research* 21(1):71-83, 1987.

Potter, J.F., and James, O.F. Clinical fea­ tures and prognosis of alcoholic liver dis­ ease in respect of advancing age.

*Gerontology* 33(6):380-387, 1987.

Prater, C.D., Miller, K.E., and Zylstra, R.G. Outpatient detoxification of the addicted or alcoholic patient. *American Family Physician* 60(4):1175-1183, 1999.

Project MATCH Research Group. Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH posttreat­ ment drinking outcomes. *Journal of Studies on Alcohol* 58(1):7-29, 1997.

Rathlev, N.K., D'Onofrio, G., Fish, S.S., Harrison, P.M., Bernstein, E., Hossack, R.W., and Pickens, L. The lack of efficacy of phenytoin in the prevention of recur­ rent alcohol-related seizures. *Annals of Emergency Medicine* 23(3):513-518, 1994.

Rawson, R., McCann, M., Huber, A., and Shoptaw, S. Contingency management and relapse prevention as stimulant abuse treatment interventions. In: Higgins, S.T., ed. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999. pp. 57-74.

Reilly, P.M., and Shopshire, M.S. *Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Tl1erapy Manual.* HHS Publication No. (SMA) 02-3756.

Rockville, **MD:** Center for Substance Abuse Treatment, 2002.

Remler, **D.K.,** Gray, **B.M.,** and Newhouse,

**J.P.** Does managed care mean more hassle for physicians? *Inquiry* 37(3):304-316, 2000.

Reoux, J.P., Saxon, A.J., Malte, C.A., Baer, J., and Sloan, K. Divalproex Sodium in alcohol withdrawal: A randomized double­ blind placebo-controlled clinical trial.

*Alcoholism: Clinical and Experimental Research* 25(9):1324-1329, 2001.

Resnick, **R.B.,** Kestenbaum, R.S., Washton, A., and Poole, D. Naloxone-precipitated withdrawal: A method for rapid induction onto naltrexone. *Clinical Pharmacology and Therapeutics* 21(4):409-413, 1977.

Rhem, K.T. *Drug, Alcohol Treatment Available to DoD Beneficiaries.* American Forces Information Service News Articles. Washington, DC: U.S. Department of Defense, 2001.

Rickels, K., Demartinis, N., Rynn, M., and Mandos, **L.** Pharmacologic strategies for discontinuing benzodiazepine treatment. *Journal of Clinical Psychopharmacology* 19(6 Suppl 2):12S-16S, 1999.

Rickels, K., Schweizer, E., Case, W.G., and Greenblatt, D.J. Long-term therapeutic use of benzodiazepines. I. Effects of abrupt discontinuation. *Archives of General Psychiatry* 47(10):899-907, 1990.

Riordan, C.E., and Kleber, **H.D.** Rapid opi­ ate detoxification with clonidine and naloxone. *Lancet* 1(8177):1079-1080,

###### 1980.

Ro, M. Moving forward: Addressing the health of Asian American and Pacific Islander women. *American Journal of Public Health* 92(4):516-519, 2002.

Robert, E., Reuvers, M., and Shaefer, C. Antiepileptics. In: Schaefer, C.H., ed. *Drugs During Pregnancy and Lactation: Handbook of Prescription Drugs and Comparative Risk Assessment: With Updated Information on Recreational Drugs.* Amsterdam: Elsevier, 2001. pp. 46-57.

Robert Wood Johnson Foundation. *Substance Abuse: Tlie Nation's Number One Health Problem. Key Indicators for Policy.*

Princeton, NJ: The Robert Wood Johnson Foundation, 2001.

Robins, L.N., and Regier, D.A., eds.

*Psycl1iatric Disorders in America: The Epidemiologic Catchment Area Study.* New York: Free Press, 1991.

Rodgers, **J.** Cognitive performance amongst recreational users of "ecstasy." *Psycl10pl1armacology* 151(1):19-24, 2000.

Rodgers, **J.H.,** and Barnett, P.G. Two sepa­ rate tracks? A national multivariate analy­ sis of differences between public and pri­ vate substance abuse treatment programs. *American Journal of Drug and Alcohol Abuse* 26(3):429-442, 2000.

Roman, P.M., Blum, T.C., and Johnson, A. *National Treatment Center Study: Six and Twelve Month Follow-up Summary Report.* Athens, GA: University of Georgia, Institute for Behavioral Research, 1997.

Ron, M.A. Volatile substance abuse: A review of possible long-term neurological, intellec­ tual and psychiatric sequelae. *British Journal of Psychiatry* 148:235-246, 1986.

Rosenbaum, S., Teitelbaum, **J.,** and Manery,

D.R. *An Analysis of tlw Medicaid IMD Exclusion.* Washington, DC: GWU School of Public Health and Health Services, 2002.

Rosenberg, **M.H.,** Deerfield, **L.J.,** Baruch,

E.M. Two cases of severe gamma-hydroxy­ butyrate withdrawal delirium on a psychi­ atric unit: Recommendations for manage­ ment. *American Journal of Drug and Alcohol Abuse* 29(2):487-496, 2003.

Rosin, A.J., and Glatt, M.M. Alcohol excess in the elderly. *Quarterly Journal of Studies on Alcohol* 32 (1):53-59, 1971.

Rouse, B.A., Carter, **J.H.,** and Rodriguez­ Andrew, S. Race/ethnicity and other socio­ cultural influences on alcoholism treat­ ment for women. In: Galanter, M., ed.

*Recent Developments* ***in*** *Alcoholism, Vol. 12: Alcoholism and Women.* New York: Plenum Press, 1995. pp. 343-367.

Royer, C.M., Dickson-Fuhrmann, E., McDermott, C.H., Taylor, S., Rosansky, J.S., and Jarvik, L.F. Portraits of change: Case studies from an elder-specific addic­ tion program. *Journal of Geriatric Psychiatry and Neurology* 13(3):130-133, 2000.

Rubin, A., and Gastfriend, D.R. Patient placement criteria and their relation to access to appropriate level of care and engagement in alcoholism treatment.

*Recent Developments in Alcoholism*

###### 15:157-76:157-176, 2001.

Rubinstein, G. *The State of State Policy on TANF & Addiction: Findings from the Survey of State Policies and Practices to Address Alcohol and Drug Problems Among TANF.* Washington, DC: The Legal Action Center, 2002.

Russell, M., Martier, S.S., Sokol, R.J., Mudar, P., Bottoms, S., Jacobson, S., and Jacobson, J. Screening for pregnancy risk­ drinking. *Alcolwlism, Clinical and Experimental Research* 18(5):1156-1161,

###### 1994.

Rychtarik, R.G., Connors, G.J., Whitney, R.B., McGillicuddy, N.B., Fitterling, J.M., and Wirtz, P.W. Treatment settings for persons with alcoholism: Evidence for matching clients to inpatient versus outpa­ tient care. *Journal of Consulting and Clinical Psychology* 68(2):277-289, 2000.

Sadd, S., and Young, D.W. Nonmedical treat­ ment of indigent alcoholics: A review of recent research findings. *Alcohol Health and Research World* (Spring):48-53, 1987.

Saitz, R., Mayo-Smith, M.F., Roberts, M.S., Redmond, H.A., Bernard, D.R., and Calkins, D.R. Individualized treatment for alcohol withdrawal. A randomized double­ blind controlled trial. *Journal of the American Medical Association*

272(7):519-523, 1994.

Salloum, I.M., and Thase, M.E. Impact of substance abuse on the course and treat­ ment of bipolar disorder. *Bipolar Disorders* 2(3 Pt. 2):269-280, 2000.

Samet, J.H., Friedmann, P.D., and Saitz, R. Benefits of linking primary medical care and substance abuse services: Patient, provider, and societal perspectives.

*Archives of Internal Medicine*

161(1):85-91, 2001.

Santolaria-Fernandez, F.J., Gomez-Sirvent, J.L., Gonzalez-Reimers, C.E., Batista­ Lopez, J.N., Jorge-Hernandez, J.A., Rodriguez-Moreno, F. , Martinez-Riera, A., and Hernandez-Garcia, M.T. Nutritional assessment of drug addicts.

*Drug and Alcohol Dependence*

38(1):11-18, 1995.

Saremi, A., Hanson, R.L., Williams, D.E.,

Roumain, J., Robin, R.W., Long, J.C., Goldman, D., and Knowler, W.C. Validity of the CAGE questionnaire in an American Indian population. *Journal of Studies on Alcohol* 62(3):294-300, 2001.

Satel, S.L., Price, L.H., Palumbo, J.M.,

McDougle, C.J., Krystal, J.H., Gawin, F., Charney, D.S., Heninger, G.R., and Kleber, H.D. Clinical phenomenology and neurobiology of cocaine abstinence: A prospective inpatient study. *American Journal of Psycl1iatry* 148:1712-1716, 1991.

Saunders, **J.B.,** Aasland, O.G., Babor, T.F., de la Fuente, J.R., and Grant, M. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collab­ orative project on early detection of per­ sons with harmful alcohol

consumption-II. *Addiction*

88(6):791-804, 1993.

Saunders, P.A. Epidemiology of alcohol prob­ lems and drinking patterns. In: John, R.M., Copeland, M.T., Aboou-Saleh, **M.T.,** and Blazer, D.G., eds. *Principles and Practice of Geriatric Psychiatry.* New York: Wiley, 1994. pp. 801-805.

Schaefer, C.H. Recreational drugs. In: Schaefer, C.H., ed. *Drugs During Pregnancy and Lactation: Handbook of Prescription Drugs and Comparative Risk Assessment: With Updated Information on Recreational Drugs.* Amsterdam: Elsevier, 2001. pp. 214-224.

Schatz, B., and O'Hanlan, K. *Anti-Gay Discrimination in Medicine: Results of a National Survey of Lesbian, Gay and Bisexual Physicians.* San Francisco: American Association of Physicians for Human Rights (AAPHR), 1994.

Schneider, U., Altmann, A., Baumann, M., Bernzen, J., Bertz, B., Bimber, U., Broese, T., Broocks, A., Burtscheidt, W., Cimander, K.F., Degkwitz, P., Driessen, M., Ehrenreich, **H.,** Fischbach, E., Folkerts, H., Frank, **H.,** Gurth, D., Havemann-Reinecke, U., Heber, W., Heuer, J., Hingsammer, A., Jacobs, S., Krampe, **H.,** Lange, W., Lay, T.,

Leimbach, M., Lemke, M.R., Leweke, M., Mangholz, A., Massing, W., Meyenberg, R., Porzig, J., Quattert, T., Redner, C., Ritzel, G., Rollnik, J.D., Sauvageoll, R., Schlafke, D., Schmid, G., Schroder, H., Schwichtenberg, U., Schwoon, D., Seifert, J., Sickelmann, I., Sieveking, C.F., Spiess, C., Stiegemann, H.H., Stracke, R., Straetgen, H.D., Subkowski, P., Thomasius, R., Tretzel, H., Verner, L.J., Vitens, J., Wagner, T., Weirich, S., Weiss, I., Wendorff, T., Wetterling, T., Wiese, B., and Wittfoot, J. Comorbid anxiety and affective disorder in alcohol-dependent patients seeking treatment: The first multi­ centre study in Germany. *Alcohol and Alcoholism* 36(3):219-223, 2001.

Schoenbaum, **M.,** Zhang, W., and Sturm, R. Costs and utilization of substance abuse care **in** a privately insured population under managed care. *Psychiatric Services* 49(12):1573-1578, 1998.

Schonfeld, L., and Dupree, L.W. Treatment approaches for older problem drinkers. *International Journal of tlie Addictions* 30(13-14):1819-1842, 1995.

Schuckit, M.A. Alcoholism and other psychi­ atric disorders. *Hospital and Community Psychiatry* 34(11):1022-1027, 1983.

Schuckit, M.A. Dual diagnosis: Psychiatric picture among substance abusers. In: Miller, N.S., ed. *Principles of Addiction Medicine.* 1st ed. Chevy Chase, MD: American Society of Addiction Medicine, 1994.

Schuckit, M.A. *Drug and Alcohol Abuse: A Clinical Guide to Diagnosis and Treatment.* 5th ed. New York: Kluwer Academic/Plenum Publishers, 2000.

Schuckit, M.A., and Monteiro, M.G. Alcoholism, anxiety and depression. *Britisl1 Journal of Addiction* 83(12):1373-1380, 1988.

Schuh, K.J., Schuh, L.M., Henningfield, J.E., and Stitzer, M.L. Nicotine nasal spray and vapor inhaler: Abuse liability assessment. *Psyclwpharmacology* 130(4):352-361, 1997.

Schuylze-Delrieu, K.S., and Summers, R.W. Esophageal diseases. In: Stein, J.H., ed. *Internal Medicine.* 4th ed. St. Louis, MO: Mosby, 1994. pp. 390-402.

Schweizer, E., Rickels, **K.,** Case, W.G., and Greenblatt, **D.J.** Long-term therapeutic use of benzodiazepines. II. Effects of grad­ ual taper. *Archives of General Psychiatry* 47(10):908-915, 1990.

Schweizer, E., Rickels, **K.,** Weiss, S., and Zavodnick, S. Maintenance drug treat­ ment of panic disorder: I. Results of a prospective, placebo-controlled compari­ son of alprazolam and imipramine.

*Arcl1ives of General Psycl1iatry* 50(1):51- 60, 1993.

Scialli, A. Hormones. In: Schaefer, C.H., ed. *Drugs During Pregnancy and Lactation: Handbook of Prescription Drugs and Comparative Risl.: Assessment: With Updated Information on Recreational Drugs.* Amsterdam: Elsevier, 2001. pp.

132-143.

Scott, R.B. Alcohol effects in the elderly.

*Compreliensive Therapy* 15(6):8-12, 1989.

Sees, K.L., and Clark, H.W. When to begin smoking cessation in substance abusers. *Journal of Substance Abuse Treatment* 10(2):189-195, 1993.

Sees, K.L., Delucchi, K.L., Masson, C., Rosen, A., and Clark, H.W. Methadone maintenance vs. 180-day psychosocially enriched detoxification for treatment of opioid dependence. *Journal of tlie American Medical Association* 283(10):1303-1310, 2000.

Self-reported frequent mental distress among adults-United States, 1993-1996.

*Morbidity and Mortality Weeldy Report*

47(16):326-331, 1998.

Sellers, E.M., and Naranjo, C.A. Strategies for improving the treatment of alcohol withdrawal. In: Naranjo, C.A., and Sellers, E.M., eds. *Researcl1 Advances in New Psychopharmacological Treatments for Alcoholism.* New York: Elsevier Science Publishers, 1985. pp. 157-170.

Semansky, **R.M.,** Koyanagi, C., and Vandivort-Warren, R. Behavioral health screening policies in Medicaid programs nationwide. *Psycl1iatric Services* 54(5):736-739, 2003.

Seoane, A., Carrasco, G., Cabre, L., Puiggros, A., Hernandez, E., Alvarez, M., Costa, J., Molina, R., and Sobrepere, G. Efficacy and safety of two new methods of rapid intravenous detoxification in heroin addicts previously treated without success. *British Journal of Psycl1iatry*

171:340-345, 1997.

Seppa, K., and Sillanaukee, P. Women, alco­ hol, and red cells. *Alcoholism: Clinical and Experimental Researcl1*

18(5):1168-1171, 1994.

Serfaty, M., and Masterton, G. Fatal poison­ ings attributed to benzodiazepines in Britain during the 1980s. *British Journal of Psyclliatry* 163:386-393, 1993.

Seymour, R.B., and Smith, D.E. *Drugfree: A Unique, Positive Approacl1 to Staying Off Alcohol and Other Drugs.* New York: Facts on File Publications, 1987.

Shaffer, H.J., and Simoneau, G. Reducing resistance and denial by exercising ambivalence during the treatment of addiction. *Journal of Substance Abuse Treatment* 20(1):99-105, 2001.

Shannon, M., and Quang, L.S. Gamma­ hydroxybutyrate, gamma-butyrolactone, and 1,4-butanediol: A case report and review of the literature. *Pediatric Emergency Care* 16(6):435-440, 2000.

Shaw, G.K. Detoxification: The use of benzo­ diazepines. *Alcohol and Alcoholism* 30(6):765-770, 1995.

Shaw, G.K., Waller, S., Latham, C.J., Dunn, G., and Thomson, A.D. The detoxification experience of alcoholic in-patients and predictors of outcome. *Alcohol and Alcoholism* 33(3):291-303, 1998.

Shiffman, S.M. Relapse following smoking cessation: A situational analysis. *Journal of Consulting and Clinical Psychology* 50(1):71-86, 1982.

Shiffman, S.M., Paty, J.A., Rohay, J.M., Di Marino, M.E., and Gitchell, J. The effica­ cy of computer-tailored smoking cessation material as a supplement to nicotine polacrilex gum therapy. *Archives of Internal Medicine* 160(11):1675-1681,

2000.

Shulman, G.D. Substance abuse treatment: The missing link. Managed care hates overtreatment and providers despise "undertreatment." *Behavioral Health Management* 18(4):34-36, 1998.

Shwartz, M., Sahz, R., Mulvey, R., and Brannigan, P. Value of acupuncture detox­ ification programs in a substance abuse treatment system. *Journal of Substance Abuse Treatment* 17(4):305-312, 1999.

Silagy, C., Mant, D., Fowler, G., and Lancaster, T. Nicotine replacement thera­ py for smoking cessation. *Cochrane Database of Systematic Reviews* (3):CD000146, 2000.

Simko, M.D., Cowell, C., and Gilbride, J.A. *Nutrition Assessment: A Comprehensive Guide for Planning Intervention.* 2nd ed. Gaithersburg, MD: Aspen Publishers, 1995.

Simpson, D.D., Joe, G.W., Rowan-Szal, G.A., and Greener, J.M. Drug abuse treat­ ment process components that improve retention. *Journal of Substance Abuse Treatment* 14(6):565-572, 1997.

Singer, J., and Lindamood, K. Crisis of Access II: Fewer addiction services deliv­ ered through managed care; Medicaid managed care weakens public addiction treatment system. *Tl1e Abell Report* 13(5):1-12, 2000.

Sivilotti, **M.L.,** Burns, **M.J.,** Aaron, C.K., and Greenberg, **M.J.** Pentobarbital for severe gamma-butyrolactone withdrawal. *Annals of Emergency Medicine* 38(6):660-665, 2001.

Sladen, B.J., and Mozdzierz, G.J. An MMPI scale to predict premature termination from inpatient alcohol treatment. *Journal of Clinical Psychology* 41(6):855-862, 1985.

Smart, R.G. Young alcoholics in treatment: Their characteristics and recovery rates at follow-up. *Alcoholism: Clinical and Experimental Research* 3(1):19-23, 1979.

Smith, M., and Lin, K.M. A biological, envi­ ronmental, and cultural basis for ethnic differences in treatment. In: Kato, P.M., and Mann, T., eds. *Handbook of Diversity Issues in Health Psychology.* New York: Plenum Press, 1996. pp. 389-406.

Socas, L., Zumbado, M., Perez-Luzardo, 0., Ramos, A., Perez, C., Hernandez, J.R., and Boada, L.D. Hepatocellular adenomas associated with anabolic androgenic steroid abuse in bodybuilders: A report of two cases and a review of the literature.

*British Journal of Sports Medicine*

39(5):e27, 2005.

Sonne, S.C., and Brady, K.T. Substance abuse and bipolar comorbidity.

*Psychiatric Clinics of North America*

22(3):609-627, 1999.

Soodini, G., and Morgan, J.P. Can cocaine abuse exacerbate the cardiac toxicity of human immunodeficiency virus? *Clinical Cardiology* 24(3):177-181, 2001.

Spencer, S.S. Tuberculosis: Facing new threats from an old enemy. *Corrections Today* 54(7):98, 100, 102-103, 1992.

Spiegel, D.A. Psychological strategies for dis­ continuing benzodiazepine treatment.

*Journal of Clinical Psychopharmacology*

19(6 Suppl 2):l7S-22S, 1999.

Spray, **J.R.,** and Jones, S.M. *The Use of Acupuncture in Drug Addiction Treatment.* News Briefs. Washington, DC: National Drug Strategy Network, 1995.

Stark, M.J., Campbell, B.K., and Brinkerhoff, C.V. "Hello, may we help you?" A study of attrition prevention at the time of the first phone contact with substance-abusing clients. *American Journal of Drug and Alcohol Abuse* 16(1 and 2):67-76, 1990.

Stedman, T.L. *Stedman* 's *Medical Dictionary.*

25th ed. Baltimore: Williams & Wilkins, 1990.

Steenrod, S., Brisson, A., McCarty, D., and Hodgkin, D. Effects of managed care on programs and practices for the treatment of alcohol and drug dependence. *Recent Developments in Alcoholism* 15:51-71, 2001.

Stein, B., Orlando, M., and Sturm, R. The effect of copayments on drug and alcohol treatment following inpatient detoxifica­ tion under managed care. *Psyclliatric Services* 51(2):195-198, 2000.

Stein, J.H., ed. *Internal Medicine.* 4th ed. St. Louis, MO: Mosby-Year Book, Inc., 1994.

Stevens, S.J., Estrada, A.L., Glider, P.J., and McGrath, R.A. Ethnic and cultural differences in drug-using women who are

in and out of treatment. *Drugs and Society*

13(1-2):81-95, 1997.

Stine, S.M., Greenwald, M.K., and Kosten,

T.R. Ultra Rapid Opiate Detoxification. In: Graham, A.W., Schultz, T.K., Mayo­ Smith, M.F., Ries, R.K., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 3d ed. Chevy Chase, MD: American Society of Addiction Medicine, 2003. pp. 668-669.

Stitzer, M.L., and Higgins, S.T. Behavioral treatment of drug and alcohol abuse. In: Bloom, F.E., and Kupfer, D., eds.

*Psyclwpharmacology: The Fourth Generation of Progress.* New York: Raven Press, 1995. pp. 1807-1819.

Strakowski, S.M., and DelBello, M.P. The co­ occurrence of bipolar and substance use disorders. *Clinical Psychology Review* 20(2):191-206, 2000.

Strobbe, S., Brower, K.J., and Galen, L.W. Predicting completion of outpatient opioid detoxification with clonidine. *American Journal 011 Addictions* 12(3):260-269,

2003.

Stuyt, E.B. Recovery rates after treatment for alcohol/drug dependence: Tobacco users vs. non-tobacco users. *American Journal 011 Addictions* 6(2):159-167, 1997.

Substance Abuse and Mental Health Services Administration. *The Drug Addiction Treatment Act of 2000 (DATA 2000).*

Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 2002.

Substance Abuse and Mental Health Services Administration. *Summary Report-A National Call to Action: Eliminating the Use of Seclusion and Restraint. SAMHSA Matrix: Seclusion and Restraint.*

Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 2003.

Sue, **D.** Multicultural training. *International Journal of Intercultural Relations* 21(2):175-193, 1997.

Sue, D.W., and Sue, D. *Counseling the Culturally Different: Theory and Practice.* 3d ed. New York: John Wiley and Sons, 1999.

Sue, S. Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist* 32(8):616-624, 1977.

Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C.A., and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *Britisl1 Journal of Addiction*

84(11):1353-1357, 1989.

Sullivan, M.L., Martinez, C.M., and Gallagher, E.J. Atrial fibrillation and anabolic steroids. *Journal of Emergency Medicine* 17(5):851-857, 1999.

Summers, J., Zisook, S., Atkinson, J.H., Sciolla, A., Whitehall, W., Brown, S., Patterson, T., and Grant, I. Psychiatric morbidity associated with acquired immune deficiency syndrome-related grief resolution. *Journal of Nervous and Mental Disease* 183(6):384-389, 1995.

Sutocky, J.W., Shultz, J.M., and Kizer, K.W. Alcohol-related mortality in California, 1980 to 1989. *American Journal of Public Health* 83(6):817-823, 1993.

Sutton, L.R., and Hinderliter, S.A. Diazepam abuse in pregnant women on methadone maintenance. Implications for the neonate. *Clinical Pediatrics* 29(2):108-111, 1990.

Svikis, D.S., Golden, A.S., Huggins, G.R., and Pickens, R.W. Cost-effectiveness of treatment for drug-abusing pregnant women. *Drug and Alcohol Dependence* 45(1-2):105-113, 1997.

Swift, R.M., and Miller, N.S. Integration of health care economics for addiction treat­ ment in clinic care. *Journal of Psyclwactive Drugs* 29(3):255-262, 1997.

Tamerin, J.S., and Mendelson, **J.H.** The psy­ chodynamics of chronic inebriation: Observations of alcoholics during the pro­ cess of drinking in an experimental group setting. *American Journal of Psychiatry* 125(7):886-899, 1969.

Tang, W.W.H., and Bigby, J. Cultural per­ spectives on substance abuse. In: Friedman, L., Fleming, N., Roberts, D., and Hyman, S.E., eds. *Source Book of Substance Abuse and Addiction.*

Baltimore: Williams & Wilkins, 1996. pp. 41-36.

*Tarasoff v. Regents of Univ of CA.* 17 Cal.3d 425 (1976), 1976.

Thase, M.E., Salloum, I.M., and Cornelius,

J.D. Comorbid alcoholism and depression: Treatment issues. *Journal of Clinical Psycl1iatry* 62(Suppl 20):32-41, 2001.

Thomas-Knight, R. *Treating Alcoholism Among the Aged: The Effectiveness of a Special Treatment Program for Older Problem Drinkers.* Fayetteville, AR: University of Arkansas, 1978.

Thompson, M.P., and Kingree, J.B. Thefre­ quency and impact of violent trauma among pregnant substance abusers.

*Addictive Behaviors* 23(2):257-262, 1998.

Thornton, C.C., Gottheil, E., Weinstein, S.P., and Kerachsky, R.S. Patient-treat­ ment matching in substance abuse: Drug addiction severity. *Journal of Substance Abuse Treatment* 15(6):505-511, 1998.

Thurman, P.J., Swaim, R.C., and Plested, B. Intervention and treatment of ethnic minority substance abusers. In: Aponte, J.F., and Rivers, R.Y., eds. *Psyclwlogical Interventions and Cultural Diversity.*

Boston: Allyn and Bacon, 1995. pp. 215-233.

Tonigan, J.S., Toscova, R., and Miller, W.R. Meta-analysis of the literature on Alcoholics Anonymous: Sample and study characteristics moderate findings. *Journal of Studies 011 Alcolwl* 57(1):65-72, 1996.

Tonnesen, H., and Kehlet, H. Preoperative alcoholism and postoperative morbidity. *British Journal of Surgery* 86(7):869-874, 1999.

Trachtenberg, A.I. *Testimony to the White House Commission on Complementary and Alternative Medicine Policy, December 18, 2000.* Rockville, MD: Substance Abuse

and Mental Health Services Administration, 2000.

Trevillyan, **J.,** and Carroll, **P.J.** Management of portal hypertension and esophageal varices in alcoholic cirrhosis. *American Family Physician* 55(5):1851-1858, 1997.

Trudeau, D.L., Isenhart, C., and Silversmith, D. Efficacy of smoking cessa­ tion strategies in a treatment program.

*Journal of Addictive Diseases*

14(1):109-116, 1995.

Tsai, G.E., Ragan, P., Change, R., Chen, S., Linnoila, M.I., and Coyle, J. T. Increased glutamatergic neurotransmission and oxidative stress after alcohol withdrawal. *American Journal of Psychiatry* 155(6):726-732, 1998.

U.S. Department of Health and Human Services. *The Health Benefits of Smoldng Cessation: A Report of the Surgeon General.* HHS Publication No. (CDC) 90- 8416. Rockville, MD: U.S. Department of Health and Human Services, Centers for Disease Control, Office on Smoking and Health, 1990.

U.S. Department of Health and Human Services. *Tobacco Use Among U.S. Racial/Ethnic Minority Groups-African Americans, American Indians and Alaslrn Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1998.

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health.* Washington, DC: U.S. Government Printing Office, *2000a.*

U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, *2000b.*

U.S. Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse

and Mental Health Services Administration, Center for Mental Health Services, 2001.

U.S. Department of Health and Human Services. *Regional Differences in Indian Health 1998-99.* Rockville, MD: Indian Health Service, *2002a.*

U.S. Department of Health and Human Services. *Substance Abuse-A National Challenge Prevention, Treatment and Research at HHS.* Washington, DC: U.S. Department of Health and Human Services, 2-27-2002b.

U.S. Department of Health and Human Services. *Substance Abuse-A National Challenge: Prevention, Treatment and Research at HHS.* Fact Sheet. Washington, DC: U.S. Department of Health and Human Services, 2003.

Van Hoozen, B.E., and Cross, C.E. Marijuana. Respiratory tract effects. *Clinical Reviews in Allergy and Immunology* 15(3):243-269, 1997.

Vega, W.A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., and Caraveo­ Anduaga, J. Lifetime prevalence of DSM- 111-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry* 55(9):771-778, 1998.

Victor, M., and Adams, **R.D.** The effects of alcohol on the nervous system.

*Proceedings of the Association for Research in Nervous and Mental Disease* 32:525-573, 1953.

Vining, E., Kosten, T.R., and Kleber, H.D. Clinical utility of rapid clonidine-naltrex­ one detoxification for opioid abusers.

*British Journal of Addiction*

###### 83(5):567-575, 1988.

Voas, R.B., and Fisher, D.A. Court proce­ dures for handling intoxicated drivers. *Alcohol Research and Healtl1* 25(1):32-42, 2002.

Volk, R.J., Steinbauer, J.R., Cantor, S.B., and Holzer, C.E., III. TheAlcohol Use Disorders Identification Test (AUDIT) as a screen for at-risk drinking in primary care patients of different racial/ethnic back­ grounds. *Addiction* 92(2):197-206, 1997.

Waksman, J., Taylor, R.N., Bodor, G.S.,

Daly, F.F., Jolliff, H.A., and Dart, R.C. Acute myocardial infarction associated with amphetamine use. *Mayo Clinic Proceedings* 76(3):323-326, 2001.

Walsh, D.C., Hingson, R.W., Merrigan, D.M., Levenson, S.M., Cupples, L.A.,

Heeren, T., Coffman, G.A., Becker, C.A., Barker, T.A., and Hamilton, S.K. A ran­ domized trial of treatment options for alcohol-abusing workers. *New England Journal of Medicine* 325(11):775-782, 1991.

Walsh, S.L., Preston, K.L., Stitzer, M.L., Cone, E.J., and Bigelow, G.E. Clinical pharmacology of buprenorphine: Ceiling effects at high doses. *Clinical Pharmacology and Tlierapeutics* 55(5):569-580, 1994.

Wartenberg, A.A., Nirenberg, T.D., Liepman, M.R., Silvia, L.Y., Begin, A.M., and Monti, P.M. Detoxification of alco­ holics: Improving care by symptom-trig­ gered sedation. *Alcoholism: Clinical and Experimental Research* 14(1):71-75, 1990.

Washburn, A.M., Fullilove, R.E., Fullilove, M.T., Keenan, P.A., McGee, B., Morris,

K.A., Sorensen, J.L., and Clark, W.W. Acupuncture heroin detoxification: A sin­ gle-blind clinical trial. *Journal of Substance Abuse Treatment*

10(4):345-351, 1993.

Weddington, W.W., Brown, B.S., Haertzen, C.A., Cone, E.J., Dax, E.M., Herning, R.I., and Michaelson, B.S. Changes in mood, craving, and sleep during short­ term abstinence reported by male cocaine addicts: A controlled residential study.

*Archives of General Psycl1iatry*

47(September):861-868, 1990.

Weisner, C., Mertens, **J.,** Tam, T., and Moore, C. Factors affecting the initiation of substance abuse treatment in managed care. *Addiction* 96(5):705-716, 2001.

Wesson, D.R., and Smith, D.E. Cocaine: Treatment perspectives. In: Kozel, N.J., andAdams, E.H., eds. *Cocaine Use in America: Epidemiologic and Clinical Perspectives.* NIDA Research Monograph No. 61. HHS Publication No. ADM 85- 1414. Rockville, MD: National Institute on Drug AJmse, 1985. pp. 193-203.

West, P.M., and Graham, K. Clients speak: Participatory evaluation of a noncon­ frontational addictions treatment program for older adults. *Journal of Aging and Health* 11(4):540-564, 1999.

Westermeyer, J. Substance-related disorders.

In: Ammerman, R.T., and Hersen, M., eds. *Handbook of Prevention and Treatment With Children and Adolescents: Intervention in the Real World Context.* New York: John Wiley and Sons, 1997. pp. 604-628.

Westermeyer, J., and Neider, J. Predicting treatment outcome after ten years among American Indian alcoholics. *Alcolwlism: Clinical and Experimental Research* 8(2):179-184, 1984.

Westermeyer, J., Specker, S., Neider, **J.,** and Lingenfelter, **M.A.** Substance abuse and associated psychiatric disorder among 100 adolescents. *Journal of Addictive Diseases* 13(1):67-89, 1994.

Western Interstate Commission for Higher Education. *Cultural Competence Standards in Managed Mental Health Care for Four Under.served/Underrepresented Racial/Ethnic Groups.* Boulder, CO: Western Interstate Commission for Higher Education, 2000.

Westmaas, J.L., Nath, V., and Brandon, T.H. Contemporary smoking cessation. *Cancer Control* 7(1):56-62, 2000.

Westman, E.C., Tomlin, K.F., and Rose, J.E. Combining the nicotine inhaler and nico­ tine patch for smoking cessation.

*American Journal of Health Behavior*

24(2):114-119, 2000.

Wetterling, **T.,** Rolf-Dieter, K., and Bester, B.

A new rating scale for the assessment of the alcohol withdrawal syndrome (AWS) scale. *Alcohol and Alcoholism*

32(6):753-760, 1997.

Wetterling, **T.,** Veltrup, C., Driessen, M., and John, U. Drinking pattern and alcohol­ related medical disorders. *Alcohol and Alcoholism* 34(3):330-336, 1999.

Whitfield, C.L., Thompson, G., Lamb, A., Spencer, V., Pfeifer, M., and Browning­ Ferrando, M. Detoxification of 1,024 alco­ holic patients without psychoactive drugs. *Journal of the American Medical Association* 239(14):1409-1410, 1978.

Whittington, R.A., Collins, E.D., and Kleber,

**H.D.** Rapid opioid detoxification during general anesthesia: Is death not a signifi­ cant outcome? *Anesthesiology* 93(5):1363-1364, 2000.

Wiesbeck, G.A., Schuckit, M.A., Kalmijn, J.A., Tipp, J.E., Bucholz, K.K., and Smith, T.L. An evaluation of the history of a marijuana withdrawal syndrome in a large population. *Addiction*

91(10):1469-1478, 1996.

Wilbur, R., and **Kulik,** F.A. Anticonvulsant drugs in alcohol withdrawal: Use of pheny­ toin, primidone, carbamazepine, valproic acid, and the sedative anticonvulsants.

*American Journal of Hospital Pharmacy*

38(8):1138-1143, 1981.

Wilkins, J.N., Conner, B.T., and Gorelick,

D.A. Management of stimulant, hallucino­ gen, marijuana and phencyclidine intoxi­ cation and withdrawal. In: Graham, A.W., Schultz, T.K., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 2d ed. Chevy Chase, **MD:** American Society of Addiction Medicine, 1998. pp. 465--485.

Wojnar, M., Bizon, Z., and Wasilewski, D. Assessment of the role of kindling in the pathogenesis of alcohol withdrawal seizures and delirium tremens.

*Alcoholism: Clinical and Experimental Research* 23(2):204-208, 1999.

Wolff, P.H. Ethnic differences in alcohol sen­ sitivity. *Science* 175(20):449--450, 1972.

Wolff, P.H. Vasomotor sensitivity to alcohol in diverse Mongoloid populations.

*American Journal of Human Genetics*

25(2):193-199, 1973.

World **Health** Organization. *International Classification of Impairments, Disabilities, and Handicaps: A Manual of Classification Relating to the Consequences of Disease.*

Geneva: World Health Organization, 1980.

Worner, T.M. Relative kindling effect of read­ missions in alcoholics. *Alcohol and Alcoholism* 31(4):375-380, 1996.

Yakshe, P. *Pancreatitis, Cl1ronic.* eMedicine.

Omaha, NE: eMedicine.com, 2004.

Yates, B.T. *Analyzing Costs, Procedures,* Processes, *and Outcomes in Human Services.* Applied Social Research Methods Series V. 42. Thousand Oaks, CA: Sage, 1996.

Yates, B.T. *Measuring and Improving* Cost, *Cost-Ef1'ectiveness, and Cost-Benefit for Substance Abuse Treatment Programs: A Manual.* NIH Publication Number 99- 4518. Rockville, MD: National Institute on Drug Abuse, 1999.

Yen, S., Robins, C.J., and **Lin, N.** A cross­ cultural comparison of depressive symp­ tom manifestation: China and the United States. *Journal of Consulting and Clinical Psychology* 68(6):993-999, 2000.

Yesalis, C.E., Kennedy, N.J., Kopstein, A.N., and Bahrke, M.S. Anabolic-androgenic steroid use in the United States. *Journal of tlie American Medical Association* 270(10):1217-1221, 1993.

Yeung, A., Neault, N., Sonawalla, S., Howarth, S., Fava, M., and Nierenberg,

A.A. Screening for major depression **in** Asian-Americans: A comparison of the Beck and the Chinese Depression Inventory. *Acta Psycl1iatrica Scandinavica* 105 (4):252-257, 2002.

Yoshida, A., lkawa, **M.,** Hsu, L.C., and Tani,

K. Molecular abnormality and DNA cloning of human aldehyde dehydrogenas­ es. *Alcohol* 2(1):103-106, 1985.

Yoshihara, **H.,** Noda, K., and Kamada, **T.** Interrelationship between alcohol intake, hepatitis C, liver cirrhosis, and hepatocel­ lular carcinoma. *Recent Developments in Alcoholism* 14:457-469, 1998.

Yoshikawa, T., Sugiyama, Y., Sawada, Y., lga, T., Hanano, M., Kawasaki, S., and Yanagida, M. Effect of late pregnancy on salicylate, diazepam, warfarin, and pro­ pranolol binding: Use of fluorescent probes. *Clinical Plrnrmacology and Therapeutics* 36(2):201-208, 1984.

Zador, D., Lyons Wall, P.M., and Webster, I. High sugar intake in a group of women on methadone maintenance in south western Sydney, Australia. *Addiction*

###### 91(7):1053-1061, 1996.

Zakhari, S. Vulnerability to cardiac disease.

*Recent Developments in Alcoholism*

###### 9:225-260, 1991.

Zarkin, G.A., Dunlap, L.J., and Homsi, G. The substance abuse services cost analysis program (SASCAP): A new method for estimating drug treatment services costs. *Evaluation and Program Planning* 27(1):35-43, 2004.

Zevin, S., and Benowitz, N.L. Drug interac­ tions with tobacco smoking. An update. *Clinical Pharmacokinetics* 36(6):425-438,

###### 1999.

Zhang, A.Y., and Snowden, L.R. Ethnic characteristics of mental disorders in five

U.S. communities. *Cultural Diversity and Ethnic Minority Psychology* 5:134-146, 1999.

Zimberg, S. Two types of problem drinkers: Both can be managed. *Geriatrics* 29(8):135-139, 1974.