Pathways to Success
An Implementation Guide for Level II 4+ Services

Anjali Nandi & David Timken
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AUTHOR BIOGRAPHIES

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In addition to this clinical and consulting work, Anjali Nandi has co-authored five books including Probation and Parole Treatment Planner published by Wiley (2003), Interlock Enhancement Counseling (2012), two books on Motivational Interviewing published by the National Institute of Corrections and available at http://nicic.gov/Library/025556 and http://nicic.gov/Library/025557, and Enliven Your Groups: A Guide to Re-Imagining and Re-Energizing Manualized Curricula (2014). She has also published articles in journals such as Federal Probation and Traffic Injury Research Foundation.

David S. Timken, Ph.D., is Director and Principal Research Scientist of the Center for Impaired Driving Research and Evaluation (CIDRE), Boulder, Colorado. He is recognized internationally for his work in the areas of diagnosis and treatment for substance abusing drivers, and has over 51 years’ experience in the field. Dr. Timken has over 70 publications to his credit and has presented at numerous national and international conferences in the area of differential assessment and treatment, program evaluation and applied research with mental health, alcohol and drug abuse problems. He is a member of numerous professional organizations including the International Council on Alcohol, Drugs and Traffic Safety, the American Counseling Association, the International Motivational Interviewing Network of Trainers, and the Society of Addiction Professionals, Division 50 of the American Psychological Association. He has an extensive background as a trainer, researcher and clinician and has served as an adjunct at several institutions of higher learning. He is a consultant to numerous Federal, State and other entities.
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SECTION I: PREFACE AND INTRODUCTION

In 2015, legislators passed House Bill 15-1043 that classifies a violation of driving under the influence as a class 4 felony if it occurs after three or more prior convictions for DUI. Specifically, the Act states that this DUI violation is "a class 4 felony if the violation occurred after three or more prior convictions, arising out of separate and distinct criminal episodes, for DUI, DUI PER SE, or DWAI; vehicular homicide, vehicular assault, or any combination thereof" which includes Flying Under the Influence (FUI) and Boating Under the Influence (BUI). To read the Act in its entirety, follow this link: http://www.leg.state.co.us/clics/clics2015a/csl.nsf/fsbillcont2/A75F41EF2AF63A8D87257D90007813CD/$FILE/1043_enr.pdf.

In response to this legislation, the Office of Behavioral Health (OBH), in collaboration with a work group of the Colorado Task Force on Drunk & Impaired Driving, established rules for the treatment for these individuals with 4 or more impaired driving offenses, also called DUI Level II Four Plus, because the existing services available to these individuals did not adequately address their complex needs. This implementation guide is designed to assist treatment providers with the implementation of the revised OBH Rules regarding the screening, assessment and treatment of Individuals with four or more impaired driving offenses.

COMPLEXITIES OF INDIVIDUALS WITH FOUR OR MORE IMPAIRED DRIVING OFFENSES

Attending to the needs of the repeat impaired driver is paramount given that approximately 80% of impaired driving episodes across the country are committed by about 3% to 5% of drivers (Beirness, Simpson, & Desmond, 2002, 2003). Research suggests that the repeat impaired driver population has a certain constellation of complex issues that may not be adequately addressed by traditional education and therapy programs. The repeat impaired driver population has a higher rate of mental health issues, higher levels of disruption from alcohol and/or drug use, higher rates of trauma, and higher instances of cognitive impairments than first-time offenders (Maldonado-Bouchard et al. 2012; Wanberg et al. 2005). Further, there is research to support the argument that impaired driving is less about substance use issues and more about risky decision-making involving attitudes, values and beliefs that legitimize impaired driving.

Given the evidence on repeat impaired drivers, treatment programs need to attend to the following issues:

- Alcohol and drug use
- Criminality, and attitudes, values and beliefs that support impaired driving
- Low impulse control and impulsive decision-making
- Co-occurring mental health disorders
- Trauma
- Grief and loss
- Cognitive impairments including low cognitive functioning and traumatic brain injuries
This implementation guide provides an overview of resources and tools available to effectively address these aforementioned issues.

**SUMMARY OF OBH RULE CHANGES**

**Length of treatment:** Level II Four Plus Treatment must consist of not less than eighteen (18) months of attendance which includes a minimum of one-hundred eighty (180) hours of treatment.

**Type of treatment:** All Level II Four Plus Treatment shall be driven by the individual’s clinical assessment and modalities shall include:

- Individual counseling;
- Group therapy, unless clinically contraindicated;
- Family/other supportive adult therapy, if applicable;
- Interlock counseling, if the individual has an ignition interlock installed;
- DUI Level II Education or Level II Therapy, if applicable;
- Education, if applicable;
- Medication assisted treatment, if applicable;
- Residential treatment, if applicable;
- Other treatment as indicated by the initial and ongoing clinical assessment.

**Clinical assessment:** In addition to the established OBH rules regarding assessment, agencies shall utilize an assessment tool specifically designed to address co-occurring mental health issues in the impaired driver and document results and coordinate further services as appropriate. Assessment must also contain information on:

1. Cognitive functioning;
2. Traumatic brain injury;
3. Adverse childhood experiences (ACEs);
4. Grief and loss; and,
5. Co-occurring mental health issues.

**Service plans:** In addition to the established OBH rules regarding service plans and reviews, agencies shall conduct service plan reviews at a minimum of every sixty (60) days in collaboration with supervising probation officers and consideration shall be given to clients' needs for aftercare and peer recovery support services.

**Testing/Monitoring:** All Level II Four Plus individuals shall be tested and monitored for alcohol/drug use either by the treating agency in collaboration with probation or an outside provider with documented efforts to obtain test results.

**STAFF QUALIFICATIONS**

According to the revised OBH Rules for Level II Four Plus treatment, the qualifications for staff are as follows:
1. Staff providing Level II Four Plus Treatment must meet the requirements in Section 21.240.3(D), and:
   a. CAC II credentialed staff must be receiving clinical supervision by a CAC III or LAC; or,
   b. Licensed staff must have at least one (1) year of documented addiction counseling experience.
2. Staff providing specialized treatment services must hold current and valid credentials and/or licensure in the area of service provision.
3. Staff providing assessment must hold current and valid credentials and/or licensure in the area of service provision.

All OBH training requirements that apply to people who are screening and assessing and those providing treatment services for clients who are in Level II Four Plus program must be met. Further, there must be training in the use of instrumentation if required by the test(s) author(s). It is extremely important that those administering the screening and assessments know not only how to administer the instrument, but also how to interpret the results of testing. This is particularly critical for those measuring cognitive functioning and traumatic brain injury. If the assessment driven treatment approach(s) also require special training then such training is required. It is the responsibility of the treatment agency to assure that these requirements are being met.
**SUMMARY OF COLORADO DATA**

The following data is from the ADDSCODS entered by Probation for 2016.

<table>
<thead>
<tr>
<th>Total DUI/DWAI for 2016</th>
<th>No. of 4+ for 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 19,677 (100%)</td>
<td>N = 1,408 (7%)</td>
</tr>
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</table>

Among the population of individuals with 4 or more DUI/DWAIs in 2016, the demographic information is as follows:

**Gender**

- Male   N = 1213 (87%)
- Female N = 183 (13%)

**Race/Ethnicity**

- White  N = 1163 (82.6%)
- American Indian  N = 24 (1.7%)
- Black   N = 74 (5.26%)
- Asian   N = 7 (0.5%)
- Hispanic N = 119 (8.45%)
- Other   N = 8 (0.57%)

**Age**

- 21-34  N = 226 (16.05%)
- 35-49  N = 570 (40%)
- 50-64  N = 558 (39.63%)
- 65+    N = 54 (3.83%)

**4+ numbers by Judicial District and % of total # of cases**

- 1 – N = 163 (8.3%)
- 2 – N = 102 (5.7%)
- 3 – N = 9 (0.8%)
- 4 – N = 159 (6.7%)
- 5 – N = 20 (4.9%)
- 6 – N = 31 (7.9%)
- 7 – N = 22 (6.0%)
- 8 – N = 95 (6.3%)
- 9 – N = 24 (4.7%)
- 10 – N = 58 (10.8%)
- 11 – N = 28 (9.0%)

- 12 – N = 42 (20.2%)
- 13 – N = 30 (12%)
- 14 – N = 21 (6.3%)
- 15 – N = 6 (5.2%)
- 16 – N = 5 (16.7%)
- 17 – N = 214 (9%)
- 18 – N = 161 (4.7%)
- 19 – N = 107 (10%)
- 20 – N = 46 (4.7%)
- 21 – N = 47 (8.8%)
- 22 – N = 18 (12.6%)

*Average % of 22 districts = 8.7%*
SECTION II: ASSESSMENT

This section on assessment includes definitions, components of assessment, a brief description of areas to be assessed in addition to the requirements set forth in the Level II Four Plus standards, a menu of instruments both those that are required and those that can be used from the approved list, and information on each instrument.

Assessment will be used as an umbrella term in this document, and will adhere to the definition in the current edition of the Colorado Department of Human Services (CDHS), Office of Behavioral Health (OBH) Code of Colorado Regulations, Official Publication of the State Administrative Rules (2 CCR 502-1). This document pertains to standards and regulations for all programs under purview of CDHS including those for alcohol and drug misuse and persons employed by such programs. The term, as used here, includes screening as a component, and is somewhat different and briefer than the terminology used in other publications (Hester & Miller, 1995).

Screening in this document is defined as “a brief process used to determine current behavioral health or health needs and is typically documented through the use of a standardized instrument”. Screening is used to “determine the need for further assessment, referral, or immediate intervention services” (Code of Colorado Regulations, Department of Human Services, Office of Behavioral Health, 2017). Assessment is defined as “a formal and continuous process of collecting and evaluating information about an individual for service planning, treatment and referral. Assessments establish justification for services” (Code of Colorado Regulations Department of Human Services, Office of Behavioral Health, 2017).

In essence, assessment is a dynamic process from admission to discharge, and means that all services are to be assessment driven.

An area in which diligence is required during the assessment process, as well as the initial intake, is to be fully aware that your questions during an interview, as well as the completion of various instruments may trigger some trauma. An example would be a client’s adverse reaction to questions in the Adverse Childhood Experiences (ACE) questionnaire. Regardless though, of what triggers a trauma-response, be aware that it can happen, and if it isn’t addressed, the results may be very negative.

The Level II Four Plus assessment requirements (21.240.85 F2) require the following to be assessed: cognitive functioning; traumatic brain injury; adverse childhood experiences; grief and loss; and, co-occurring mental health issues. The overall assessment requirements (21.190.3D) applicable include: identification and demographics; problem duration and treatment readiness; substance use; physical and dental health; diagnosis; treatment history; capacity for self-sufficiency and daily functioning; cultural factors; education, vocational training; family and social relationships; physical/sexual abuse or perpetration, and current risk; legal issues; older adult issues; strengths, abilities, skills, and interests; and, barriers to treatment.

In performing assessments all procedures must be developmentally and age appropriate, culturally responsive and conducted in the individual’s preferred language and/or mode of communication (21.190.3C).
INSTRUMENTATION

Reliable and valid instrumentation needs to be utilized along with a clinical interview using motivational interviewing. Some areas will require a full assessment without preliminary screening of any type, whereas, others will require both screening and, if needed, an in-depth, differential assessment. If the agency does not have the capability/qualifications to perform it, referral must be made to a qualified professional. This will be the case when either in-depth screening and/or differential assessment is indicated in the area of cognitive functioning including traumatic brain injury.

ALCOHOL AND OTHER DRUG ASSESSMENT INSTRUMENTS

Comprehensive Differential Assessment

ACAP is a combination of the Adult Substance Abuse Profile (ADSAP) and the Rating Adult’s Problem Scales (RAPS)


- **ADSAP** is a self-report instrument that measures life-time adjustment problems as reported by the client.
- **RAPS** is an other-report instrument completed by the clinical evaluator and measures the same life-time adjustment problems.

Together they provide the basis for a convergent validation assessment of the client’s life adjustment problems. Training is available. Currently available in paper/pencil format, with automated version coming soon.

For more information contact AODASSESS.com

OR

Addiction Severity Index (ASI) (6th Edition)


The ASI was introduced in the United States in 1980 as a comprehensive instrument designed to assess the impairments that commonly occur in individuals with substance use disorders (SUDs). Basically, while some earlier items were retained, in this version 6, the instrument was enhanced with additional content (i.e., new items) and items were reworded to increase reliability and validity.

The ASI, the ASI Manual, and Question by Question Guide, are available from The Treatment Institute ([www.tresearch.org](http://www.tresearch.org)) at no cost.
CO-OCCURRING DISORDERS

SCREENS

*Computerized Assessment and Referral System (CARS)*

The Computerized Assessment and Referral System (CARS) screen comes in two formats. There is a CARS screener that takes 15-20 minutes to complete, and a self-administered screen that takes 14-40 minutes. These should be used to screen for any co-occurring disorders, including anxiety disorders, post-traumatic stress disorder, depression, bipolar disorder, and conduct disorder. If the screen indicates a co-occurring disorder may be present, the full CARS assessment must be done. If it is already known that a co-occurring disorder exists, skip screen and go right to the full CARS assessment.

CARS was developed jointly by the Cambridge Health Alliance, Division on Addiction, and Harvard Medical School, Teaching Hospital with support from the National Institute on Alcohol And Alcoholism (NIAAA).

The CARS will be available in 2017. For more information contact Sarah Nelson, PhD. at Harvard Medical School, Teaching Hospital (snelson@hms.harvard.edu), or the Colorado Office of Behavioral Health. Contact OBH for training information.

If the CARS screen and/or other information indicate the likelihood of severe Antisocial Personality or Conduct Disorder, it is recommended that the Hare Screen (described below) be administered.

*Hare Psychopathy Checklist-Screening Version (PCL-SV)*

R.D. Hare, (1991)

Originally developed in the early 1970’s, the Hare Psychopathy Checklist was revised in 1991, and several questions were added. This is shorter than the PCL-R (see below) and takes approximately half the time to complete.

If there is evidence that psychopathy may be present, or if the screen indicates that psychopathy may be present, the full Hare PCL-R should be administered.

Users should meet the requirements for training.

Darkstone Research Group is responsible for training. Find it at gifrinc.com/pcl-r/

Contact Multi-Health Systems (MHS.com) for ordering information. Although expensive, both hand-scored and computerized versions are available.

COMPREHENSIVE DIFFERENTIAL ASSESSMENT

*Full Computerized Assessment and Referral Assessment (CARS)*

Full Computerized Assessment and Referral (CARS) Assessment takes 1-2 hours to complete and should be used when a co-occurring disorder is found. It provides immediate diagnostic information for up to 15 major psychiatric disorders, provides user friendly reports, helps with supervision and treatment decisions, runs on free open source software, and can be used by non-clinicians.
CARS was developed jointly by the Cambridge Health Alliance, Division on Addiction, and Harvard Medical School, Teaching Hospital with support from the National Institute on Alcohol And Alcoholism (NIAAA).

The CARS will be available in 2017. Contact OBH for training information. For more information contact Sarah Nelson, PhD. at the Harvard Medical School, Teaching Hospital (snelson@hms.harvard.edu) or OBH.

**Hare Psychopathy Checklist-Revised (PCL-R)**
R.D. Hare, (1991)

Originally developed in the early 1970’s, the Hare Psychopathy Checklist was revised in 1991, and several questions were added. Several versions of the checklist have been developed over the years, including a screening version, youth version, and Scan Research Version. It remains the single best predictor of violent behavior currently available. The user should meet requirements and be trained in the use of the PCL-R.

Users must meet the requirements for training.

Darkstone Research Group is responsible for training. Find it at gifrinc.com/pcl-r/

Contact Multi-Health Systems (MHS.com) for ordering information. Although expensive, both hand-scored and computerized versions available.

**COGNITIVE FUNCTIONING, INCLUDING TRAUMATIC BRAIN INJURY**

Much of the research that is included in this part of the assessment section was done by graduate students in psychology at the University of Denver. These men and women were students of Dr. Kim Gorgens and were under her supervision. Judy Dettmer, director of the Colorado Brain Injury Program, and Karen Ferrington of that office were also involved with the students and, along with Dr. Gorgens, contributed significantly to this section.

There were a number of specific components/topics in which teams of students contributed. Listed below are the topic areas, the names of the students who contributed and whether the specific material is part of this document. Some components were not included because the authors believe that certain material is best left in the hands of OBH staff involved in Level II Four Plus implementation. This decision has nothing to do with the quality of the students’ work.

**Literature Review:** Amber Graf, Victoria Halpern, Jasmin Montalvo, Kelsi Pratt, and Kristin Yeager

**Cognitive Functioning Instruments (Included):** Morgan Gieck, Kourtney Osentoski, Olivia Pait, and Caitlyn Winn

**Traumatic Brain Injury (TBI) Instrumentation (Included):** Laura Blackmond, Nicole Bozas, Carolyn Raffel, Kristina Smith, and Rebecca Wierman

**TBI Neuropsychological Evaluation Referral:** Haley Potts, Shelby Mandeville, and Tyler Stephens

- Decision-Making Matrix (Included)
- Referral Questions (Included)
- Referral Map

**Resources for Treatment:** Katie Glauner, Cory Marchi, Haley Patin and Mary Thompson

**Best Practices for Persons with Comorbid TBI and Substance Use** (Appendix B): Jordyn Schneider, Kristina Ray, Kayte Reaves, and Katelyn Pegher

**Funding and Sustainability Resources:** Abigail Jay, Miriam Nowrouzi, Paige Schultz, and Laura Thaubergen

**COGNITIVE FUNCTIONING INSTRUMENTATION**

It is necessary to use both of the following instruments when assessing cognitive functioning.

**Montreal Cognitive Assessment (MoCA)**
Nasreddine, Z. (2005)

The MoCA test is a one-page 30-point test that can be administered in approximately 20 minutes. The test and administration instructions are available for clinicians at no cost online. The MoCA is intended for a population of 18 to 85 years of age, currently available in 46 languages and dialects, and has applications for individuals with co-occurring disorders. Currently there are several versions available for assessing cognitive functioning for dementia, Parkinson’s, TBI, depression, schizophrenia, and others.

There is a start-up cost of $125 certification fee to train each proctor. Test can be ordered from: [www.mocatest.org](http://www.mocatest.org)

AND (both must be used)

**Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)**

The RBANS is a brief standardized screening tool to measure neuropsychological status in adults aged 20 to 89 that was introduced in 1998 by Christopher Randolph, Neuropsychologist. It is comprised of 12 subtests that takes approximately 30 minutes to administer. Training is required. The RBANS is available in English and Spanish.

The test measures the following components:

- Immediate memory
- Visuospatial/constructional
- Attention
- Language
- Delayed Memory

Available from: [www.pearsonclinical.com](http://www.pearsonclinical.com) A kit that includes Stimulus Books A-D and Manual is $615. Additional record forms are available is lots of 25. Price per administration is $6.25.
**TRAUMATIC BRAIN INJURY INSTRUMENTATION**

**Ohio State University Traumatic Brain Injury Identification (OSU-TBI)** (Modified for Colorado)


The Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID) is a standardized, short, structured interview that takes 3-5 minutes, and was designed to elicit a rich lifetime TBI history. Research indicates that a person’s lifetime history of TBI is useful for judging current cognitive and emotional states, particularly behavior associated with the executive functioning of the frontal parts of the brain (e.g., planning, impulsivity, addiction, interpersonal abilities). Due to how TBI damages the brain, more exposure (i.e., a worse history of lifetime TBI) increases the likelihood that an individual will struggle with current life stressors, whatever they are.

Available on line: For more information contact Brainline.org or Ohio Valley Center at OSU
www.ohiovalleyinformationeducation

**Referral for Neuropsychological Assessment**

If the results of the screening or other data and information indicates that further evaluation of cognitive functioning or Traumatic Brain Injury is in order, the following Decision Making Matrix should be used. In turn, when making the actual referral to a neuropsychologist, the list of the below questions should be part of the referral packet.

**Extended Referral Questions for a Neuropsychological Full Battery Assessment**

Potts, H., Mandeville, S., & Stephens, T.

*Refer client for a full neuropsychological evaluation. Please note that the referral process should be navigated as collaboration between the client and provider team, rather than the task being placed solely on the client. The following information should be provided to neuropsychologists upon referral:*

1. Please provide a description of the individual’s strengths and deficits.
2. Please provide a description of how the individual’s cognitive functioning will impact substance abuse treatment as well as the client’s potential eligibility for other resources and benefits.
3. Please provide a list of recommendations for accommodations that would be useful to help ensure successful substance abuse treatment outcomes for this individual, given his or her neuropsychological functioning.

Please see Appendix C for a list of neuropsychologists in Colorado who may be contacted to perform a complete neuropsychological exam.
Neuropsychological Evaluation Decision-Making Matrix
Potts H., Mandeville S., & Stephens T.

1. Conduct lifetime hx screen, positive?
   - No
     - Continue care as planned
     - E.g. Would more specific information about cognitive functioning be useful for treatment modification or for making determinations about eligibility for other benefits?
     - What specific accommodations would be useful for substance abuse treatment given XYZ's neuropsychological functioning?
   - Yes
     - Conduct neuropsychological screen
     - Were the screen results 2 SD below the mean?
       - No
         - Write care plan to accommodate for tx interventions based on deficits/strengths
       - Yes
         - Is client responding to tx interventions?
           - No
             - Will full neuropsychological evaluation help inform tx?
               - Yes
                 - Refer client for neuropsychological evaluation with referral questions
               - No
                 - Continue care as planned
           - Yes
             - Continue care as planned

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ADVERSE CHILDHOOD EXPERIENCES

Adverse childhood experiences (ACEs) are a significant risk factor for substance use disorders. They are stressful or traumatic events, including abuse and neglect, and include physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, mother treated violently, substance misuse within household, household mental illness especially of a parent, parental separation or divorce, or having a family/household member incarcerated. The ACE study by the Center for Disease Control began in 1980 shortly after the Surgeon General identified violent behavior as a key public health priority. In 1980, the CDC began studying patterns of violence, and the link between childhood experiences and adult violence. A 10 item questionnaire was developed to screen for these experiences. There are many others, however, they are almost the same.

**Adverse Childhood Experiences (ACE) – Self Administered 10 item Questionnaire**
Center for Disease Control (CDC)

Available from: [www.cdc.gov/violenceprevention/acestudy/index/html](http://www.cdc.gov/violenceprevention/acestudy/index/html) - no cost

GRIEF AND LOSS

**Brief Grief Questionnaire**

This is a short (5 item) self-administered questionnaire asking about how a person is coping with the grief of the death of a loved one. For permission to use, contact author, Katherine Shear at ks2394@columbia.edu

**Complicated Grief Assessment**

This is a short, self-administered questionnaire, and takes only a short time to complete. Questions ask about the person’s feelings over the previous month and past six months.

Available from the National Palliative Care Research Center (NPCRC) at [www.npcrc.org](http://www.npcrc.org). no cost.

**Grief/Depression Assessment Inventory**
J.M. Schneider (2001)

This is a 7 question self-administered questionnaire. Each question contains a series of paragraphs that are paired, with one response describing how a person who is depressed might respond and the other describing how a person grieving might respond.
SECTION III: PLACEMENT CRITERIA

The ASAM Criteria – Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions – Third Edition (Mee-Lee, et al., 2013) is to be used when making placement decisions. This third edition ASAM publication incorporates and supersedes all previous placement criteria published by the American Society of Addiction Medicine. The complete ASAM Criteria book is available from the Change Companies (Change Company, 2017). Training is also provided by either qualified staff of that organization or by designees, as well as other practitioners.

A credentialed counselor, clinician, psychologist or a physician may use the ASAM manual but the interpretation of it must be within the assessor’s scope of practice and the assessor must be trained in the use of ASAM. In order to determine placement, there are six dimensions, or biopsychosocial areas of assessment, that need to be paid attention to. They are as follows: 1) Acute Intoxication and/or Withdrawal Potential; 2) Biomedical Conditions and Complications; 3) Emotional, Behavioral or Cognitive Conditions and Complications; 4) Readiness to Change; 5) Relapse, Continued Use, or Continued Problem Potential; and 6) Recovery Living Environment. Assessment across these six dimensions then provide information for placement along a continuum of care from early intervention to medically managed inpatient services.

Given that individuals with four or more DUI/DWAIs would have already completed a Level II education and treatment program at least once, if not several times, caution must be used in having a four or more time DUI, DWAI, BUI or FUI offender having a Level II Education and Treatment program as part of their Level II Four Plus requirement. Doing so may well give the perception that the provider may not be doing what is clinically indicated and appropriate. Recall, that all decisions must be assessment driven. A scenario where Level II Education and Treatment might be appropriate for a client in a Level II Four Plus program would be where the client had never satisfactorily completed Level II Education and Therapy, or completed it many years ago.

While using the ASAM, one still has to adhere to the minimum length of stay and minimum treatment hours for individuals with four or more DUI/DWAIs, which is 18 months and 180 hours of actual treatment services, as required by Colorado Statute (21.240.85C, Code of Colorado Regulations). Due to this regulatory requirement of a minimum of 180 hours of treatment conducted over an 18 month period of time, a number of clients will be involved in more than one level of care over the course of treatment.

ASAM CRITERIA: COLORADO MODIFICATIONS

The only modifications to the current edition of the American Society of Addiction Medicine (ASAM) Criteria for Level II Four Plus clients are (1) the minimum level of care is Level I Outpatient Services; (2) Level 0.5 Early Intervention may only be used if deemed clinically appropriate, and in Colorado this is the Level II Education component; and, (3) that the overall minimum length of stay is set by OBH Regulations. What places an individual in Level II four plus is the fact that they have four or more offenses over a lifetime. The individual’s ASUDS or ASUDS-R test scores; BAC or drug level scores; and, test refusals do not determine placement in Level II Four Plus level of care, even though there is clinical relevancy.
ASAM CRITERIA CONTENT

The ASAM Criteria – Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (ASAM, 2013) has an introduction, nine chapters, appendices, references, and list of contributors. The introduction contains a cautionary statement, preface, acknowledgements and information about how to use the material. The Nine chapters are as follows:

1. **The ASAM Criteria: Then and Now.** This provides some history, guiding principles, new content information and new technology.

2. **Applications:** Real world considerations are discussed along with fidelity to the spirit, integration with both general and mental health and implementation.

3. **Intake and Assessment:** A brief description of the six dimensions is presented along with a multi-dimensional risk profile. Ascertaining dimensional interaction or configural analysis is discussed along with addressing immediate needs and imminent danger.

4. **Matching Multidimensional Severity and Level of Functioning with Type and Intensity of Service:** This covers the basics of matching the severity of the illness and the Level of functioning with the appropriate type and level of service needed.

5. **Service Planning and Placement:** Chapter 5 provides further descriptions of levels of care and how to understand and determine them. ASAM Criteria software is discussed, and the author’s state that you must use both the book and the software to assign the appropriate level of care. The chapter concludes with a discussion on working with managed care and health care reform.

6. **Addressing Withdrawal Management and Intoxication Management:** When a person’s use has progressed to the point that physical dependence has developed, intoxication and withdrawal management becomes the first priority in treatment planning. Except in the most severe cases, this can be done on an outpatient basis and can be done concurrently with treatment. The chapter covers dimensional admission and treatment considerations, variable withdrawal risk by substance, withdrawal decision rules in the ASAM software, and the six levels. They are: Level 1-WM, Ambulatory Withdrawal Management Without Extended On-Site Monitoring; 2-WM, Ambulatory Withdrawal Management With Extended On-Site Monitoring; 3-WM, Residential/Inpatient Withdrawal Management; 3.2-WM, Clinically Managed Residential Withdrawal Management; 3.7-WM, Medically Monitored Inpatient Withdrawal Management; and, 4-WM, Medically Managed Intensive Inpatient Withdrawal Management.

7. **Level of Care Placement:** This section provides detail on all the dimensions including both substance use and co-occurring indicators in each of them. Opioid Treatment Services (OTS) are also addressed as are continued service and transfer criteria for both adults and adolescents. The specific levels are: Level 0.5 - Early Intervention; Level 1 – Outpatient Services (OP/EOP); Level 2.1 – Intensive Outpatient; Level 2.5 – Partial Hospitalization (Daycare); Level 3.1 – Clinically Managed Low-Intensity Residential Services (Halfway House); Level 3.3 – Clinically Managed Population Specific High-Intensity Residential Services (adults and adolescents); Level 3.5 - Clinically Managed High-Intensity Residential Services (Adults and Adolescents - TC); Level 3.7 - Medically
Monitored Intensive Residential (Adults and Adolescents); and, Level 4 – Medically Managed Intensive Inpatient Services

8. **Application to Adult Special Populations:** Older adults are discussed as are parents or prospective parents receiving treatment concurrently with children. Also included is a section on treating people in safety-sensitive jobs and those in criminal justice settings.

9. **Emerging Understandings of Addiction:** Here gambling and tobacco use as disorders is discussed.
SECTION IV: SERVICE PLANNING

Service planning is a collaborative process of exchange between the care/treatment team and client that focuses on identifying targets for change, generating steps and resources, and developing a plan that will increase the client's success in meeting the mutually agreed upon goals. A service plan is a dynamic document that provides a map about how to explore, develop and work with certain priorities that are incapacitating, or subtly sabotaging, the client from session to session. It offers reference points that are usable by the counselor and client and provides a shared understanding about the direction of treatment. OBH Rules regarding service planning are found in the Code of Colorado regulations (2 CCR 502-1, Volume 21 CDHS Behavioral Health Rules, 21.190.4) as well as in the appendices.

While the product of this process is a service plan document, the development of the document should not supersede engaging the client in the service plan conversation. If done well, service planning utilizes information from a variety of sources including the client, the counselor, collateral information and the assessment tools, and generates enough information to complete a service plan document that provides a roadmap of change for the client. Service planning can be organic (i.e., arising informally from a conversation with the client), or planned and driven by attention to time or event factors, however, it is seldom a linear process. Most often, there is a great deal of negotiation about what the targets for change are and how to go about meeting the goals set based on those targets. Further, it is helpful to limit the number of goals in a service plan so that it is not an overwhelming feat for the client. Usually anywhere between one and three goals are recommended. Ultimately, service planning requires a great deal of flexibility within certain parameters and this section serves to describe those parameters.

Unfortunately, due to a variety of reasons, service plans are poorly utilized in the field. There is a historical, system view that service plans are an event that takes place in a linear fashion and once complete gets reviewed in a time-driven manner (i.e., every 6 months). This has led to some counselors viewing the service plan as an inert, generic document that gets completed using universal goals (like complete treatment successfully) and then put away until it is time to update the plan again. Other problems with service planning are highlighted below.

CURRENT CHALLENGES WITH SERVICE PLANNING

- There is a lack of clarity about the intent of a service plan
- The six-month update schedule creates confusion about usefulness of a service plan
- Service plans are not easily accessible (they reside in a file somewhere) and therefore difficult to reference while with the client
- A copy of the service plan is rarely given to a client, yet the client is expected to follow through on it
- Service plans are often inert, generic documents that have little added value
- Service plans may not reflect the positive and powerful process of collaboration that the counselor walks the client through
- There may be a lack of clarity or expertise about how to address certain client needs and therefore these get avoided in the service planning process
Many of the current service plan formats are worksheets to help in the development of a service plan but are not service plans themselves.

Counselors report struggling with prioritizing goals.

Counselors report struggling with stating behavioral-based goals in service plans.

**COMPONENTS OF AN EFFECTIVE SERVICE PLAN**

In reviewing a myriad service plan formats available in the field, many commonalities in terms of components were found. Several referenced SMART goals (Specific, Measurable, Attainable, Relevant/Realistic, Timely) and used formats that lent themselves to a collaborative effort between counselor and client. A summary of components found in service plans are as follows:

- Behavior-based goal(s)
- Specific client need(s) addressed
- Action steps for client
- Action steps for counselor
- Incentives for completion of steps
- Dates for initiation, review and completion
- Obstacles
- Ideas to help with obstacles
- Strengths internal and external of client to support this goal
- Restorative components if present
- Updates
- Potential areas for future planning
- Signatures

**USING SCREENING AND ASSESSMENT INFORMATION**

The client’s screening and assessments provide us a good starting point about what areas we need to attend to. Assessment tools provide us with four types of information. They give us the client’s level of risk for relapse/recidivism which informs us about the level of treatment or containment needed. They help prioritize the client’s needs, be they stability, substance or mental health, particular to that client. They provide us with information about the strengths and protective factors relevant in a client’s life. And they provide us with an excellent opportunity to share this information with the client to develop discrepancy and clarify targets for change.

**PRIORITIZING CLIENT’S NEEDS**

While there are certain needs related to recidivism that are more potent than others (e.g., antisocial thinking, criminal peers, co-occurring disorders, cognitive problems), what is of crucial importance is the relevant priorities of the client we are service planning with. It is these relevant needs that will provide us the best bang for our buck when addressed. We gather this information by looking at assessments as well as through a conversation with the client. Consider the following ideas to help you prioritize the needs:

a) Start with the need that drives relapse or recidivism behavior the strongest (anti-social attitudes/cognitions, behaviors, personality, and companions)
b) Start with the need that the client is most motivated to change or the most concerned about

c) Start with what you think the client might have the most immediate success with

d) Start with the need that might be connected to other needs (e.g., addressing peers may also address substance abuse issues and difficulties with the family)

MAXIMIZING STRENGTHS AND PROTECTIVE FACTORS

Sometimes, focusing only on treatment needs means that we are emphasizing the pathology of the client or only focusing on what is wrong. Therefore, it is helpful to highlight and develop strengths and protective factors in the client, both internally and externally. We gather a client’s strengths and protective factors through their assessments but also through conversations with them. In the literature on what helps clients desist (or stay away) from crime in the long run, there is an emphasis on strengthening the internal world of the client by developing human capital and supporting the external world of the client by supporting their social capital. Developing human capital means supporting the client’s strengths, encouraging the client to recruit their strengths in the attainment of their goals, supporting their skill development and their motivation and efficacy related to change. Developing social capital means developing social bonds and networks that support change.

In service planning, strengths and protective factors can play the following roles:

a) Developing or strengthening protective factors can be one focus of a service plan
b) Existing strengths can drive the conversation about the steps that the client will take in meeting certain goals
c) Protective factors can be sources of support when obstacles to the steps in the service plan are encountered

SHARING FEEDBACK

Providing feedback that is normative and well-timed can be an excellent tool to developing discrepancy and helping build a client’s motivation to change. Studies have found that just the process of providing feedback can result in a change in behavior (DiClemente et al, 2001). Providing assessment feedback helps uncover what the client’s motivations are for change and engages the client in a dialogue about change. A simple strategy for providing feedback is using the Elicit-Provide-Elicit format where the counselor first elicits from the client permission to provide assessment feedback, then provides small chunks of information at a time, and follows up each chunk of information with eliciting from the client what he/she has understood. Here are some guidelines when providing feedback:

- Be familiar with the assessment you are providing the client so you can answer any questions they may have
- Avoid getting defensive or defending the assessment if they disagree or say the assessment is a bunch of nonsense – the point is having the client think about the information, not proving that the assessment is right
- Allow time for the client to respond verbally to the feedback you are providing by pausing while giving feedback. Some questions that might help are:
  - What do you make of this?
ATTENDING TO THE CLIENT’S PRIORITIES

Clients come in with their own ideas about what needs to change in their lives. There will be times when the target you pick as a service plan goal is only tangentially related to a treatment need, but is clearly causing the client the most consternation (e.g., quitting smoking, changing jobs, getting a new car). These non-treatment priorities would also include paying attention to certain stability factors that might be getting in the way of the client moving forward like lack of accommodation, need for food, medication issues, childcare issues, etc. Addressing these stability factors will provide the client a stable platform from which to address their criminogenic needs. However, solely addressing these stability factors without attending to criminogenic issues will not reduce the likelihood of future DUI activity. Mutual agenda setting is a process that will help delve into what the client sees as his/her priorities. The process involves being transparent about what the assessments are indicating as change priorities and asking what the client believes their change priorities are. Some questions that help this process include:

- “What would you like to accomplish in the next month?”
- “What are some things that are getting in the way of you being successful in treatment?”
- “What are the top three things that you would like support with?”

It is definitely a client-centered approach to include these goals in the service plan, with the following two cautions:

a) The goal is not realistic, in which case help the client break the goal down into smaller, more attainable goals
b) The goal is not prosocial, in which case redirecting the client and reframing the goal will be necessary

STRUCTURING GOALS AND STEPS

Once the target area has been identified (based on assessment information, the client’s strengths/protective factors, or the client’s priorities), the next step is to develop a tangible, behavior-based goal related to the target area and then to develop steps that the client might take to meet the goal. Articulating what exactly the goal is requires some negotiation with the client. Helpful things to ask are:

- “What specifically do you want to have happen?”
- “You’ve identified something that’s really important. If we had to break it down, what might be a small goal you would be willing to work towards?”
- “How might we phrase this so we can write it down?”

- Watch for any change talk that arises from the client, because this will support the development of a service plan.
- When you are done, summarize before going to the next task and ask, “Are you ready to go on?”
Once the goal is articulated (knowing that it may change as you proceed), begin the brainstorming process around what might be some steps the client could take toward achieving this goal. Again, the elicit-provide-elicit format and using other MI techniques such as expressing concern and providing a menu of options will be helpful.

Example #1: The assessment indicates that the need most driving crime for the client is involvement with antisocial peers. In your conversation with the client as you provide assessment feedback to him, you ask how his peers may have caused him problems. He responds that he doesn't think he has problem, but that sometimes it is hard to say no to them. Here is a goal and corresponding steps you and the client come up with:

**GOAL:** Develop strong refusal skills I can use when my friends invite me to use.

**STEPS:** Between now and my next meeting with my counselor, I will:
- Learn skills in group that will help me be assertive and say no
- Role-play these skills with my wife (engaging social capital)
- Utilize the skills I have learned in group therapy and write down what I tried and what the results were
- Make a list of the thoughts that go through my head when I can’t say no and share this list with my counselor
- Look at the “50 ways to say no” worksheet and pick 5 that I am willing to try

Example #2: You would like to work on developing some strengths with your client. The client identifies her strength as her pride in her work ethic and in conversation with you relates that she would like find stable employment. Together, you develop the following plan:

**GOAL:** Find stable employment offering more than 20 hours per week in the next two months

**STEPS:** Between now and my next meeting with my counselor, I will:
- Turn in 4 job applications
- Make an appointment with the local workforce office
- Tell my group members and support group that I am looking for a job (engaging social capital)
- Ask my sponsor to practice interviewing skills with me (engaging social capital)

Example #3: Client identifies that getting off probation is his only goal. You affirm this goal and ask what he needs to do in order to complete probation successfully. He says that he needs to stay sober. In conversation with the client, you both develop this plan:

**GOAL:** To maintain abstinence from drugs and alcohol for the next 60 days.

**STEPS:** Between now and my next meeting with my counselor, I will:
- Discard all drug and alcohol-related paraphernalia scattered around my house
- Attend group therapy weekly
- Identify my triggers for use
- Practice urge surfing
- Review my contacts in my phone and delete people with whom I use
SERVICE PLAN UPDATES

At subsequent sessions with the client, it is helpful to check in about any particular steps the client was to have completed or to find out about how the process is going for the client. Often, the plan needs to be updated and changed due to changing priorities for you or the client. Service plan updates can be either time-driven (e.g., every 60 days) or event driven (something changes for the client). The requirements set by OBH for service planning reviews at 60 days is a minimum. More frequent service plan updates could be driven by events that occur in the client’s life, through collaborating with the supervising probation officer, or based on feedback from other providers treating the client in different agencies.

FOLLOWING UP ON PROGRESS

It is helpful to assess the client’s level of engagement with the plan as this is predictive of whether they will continue to follow through. Respond to any resistance or change talk that the client has to offer in relation to the change plan and his/her progress. Brainstorm solutions to any obstacles the client has encountered. Sometimes it can be frustrating when you have spent a great deal of time engaging the client in a service plan and the client does nothing to follow through. However, this can happen for a variety of reasons, and it may be important to understand what caused the interruption in the process. It could be that there is something else going on that is distracting the client from his/her goal; the client may have a different goal that is competing with the one he/she set with you; or, the client may be up against some old patterns that he/she wasn’t able to identify at first. If the client has followed through with the steps laid out in the plan, provide affirmations and discuss what some of the changes the client is experiencing as a result. This will also help highlight any unpredicted benefits that the client is enjoying because of this change.

Example #1: Clarifying expectations:

Client: “I know signing up for UA monitoring was on my plan, but I thought you were going to send a referral first”.

COUNSELOR: “It seems that we had a misunderstanding, so let me clarify; my expectation is that you call the monitoring agency and schedule with them. You can expect from me that I will send them referral paperwork but that is entirely separate from you calling them. Based on what I’ve said, tell me what your next step is.”

Example #2: Brainstorming solutions:

Client: “I did what we agreed on and tried going to AA, but I don’t like the people in it and I don’t feel like I’m getting anything out of it.”

COUNSELOR: “It’s a difficult situation. I hear that you’d really prefer not to go as it’s not benefitting you right now.”
Client: “Yeah, why should I have to do something I’m not getting anything out of. What’s the point? It’s a waste of time.”

COUNSELOR: “It sounds really frustrating and I can see your point. I would like to see you be successful in treatment. I wonder if we can brainstorm some other ways to support you apart from attending this group once a week.”

Client: “I guess it would be helpful to brainstorm. I do want to finish up with treatment successfully.”

Example #3: Competing concerns

Client: “Well I’ve just been stressed out. I’m really worried about being able to pay all my fees. And I don’t want to get in trouble. I know you probably think I’m just trying to get away with not paying my treatment costs.”

COUNSELOR: “Actually, I appreciate that you are thinking about these things. Let’s not get ahead of ourselves and instead let’s focus on the things that need to get done more immediately so you can pay your costs.”

Example #4: Distraction

Client: “I know I messed up and didn’t do what we agreed last time. So now I’m probably going to get more treatment.”

COUNSELOR: “You seem worried about what my response is going to be.”

Client: “Well, yeah. Of course! I messed up and now you’re probably upset with me.”

COUNSELOR: “Actually, I’m not upset but I am concerned about you. How is that for you to hear?”

Client: “Well…it feels good… I have been going through a hard time lately.”

COUNSELOR: “I’d like to hear more about that if you’re willing to share.”

Example #5: Affirming progress

Client: “Yes, I followed through and did the four steps we agreed upon.”

COUNSELOR: “That is excellent. Well done!”

Client: “I told you I’d do it.”

COUNSELOR: “How does it feel to have set your mind to something and been successful?”
COORDINATION OF CARE

As treatment providers for clients with multiple DUlS, it is our responsibility to coordinate care and involve the client’s referral source (e.g., probation) as well as other providers treating the client in the development of the service plan. If the client is engaged in multiple treatments across multiple agencies, coordination of care is essential for the success of the client. This might include coordinating service plans across the different agencies before sharing it with referral sources. Once the appropriate releases of information are in place, the key areas that need to be communicated about in the service plan includes goals, progress toward goals, barriers and how to facilitate removal of barriers.

DEVELOPING SERVICE PLANS IN GROUP

Depending on the policies of the agency or schedule of treatment, treatment providers may have to develop or update service plans in a group setting. Here are some ideas regarding individualizing service plan development in a group format:

**Relevancy:** Start by engaging the group in a discussion about the importance of setting goals. This will help clarify the relevancy of the topic. When the topic is not relevant, client lose interest, so establish relevancy immediately. If it helps, have clients respond to some quotes on goals. For example, some quotes that clients have positively responded to are:

- **Setting goals is the first step in turning the invisible into the visible.** Tony Robbins
- **Goals allow you to control the direction of change in your favor.** Brian Tracy
- **I don't focus on what I'm up against. I focus on my goals and I try to ignore the rest.** Venus Williams
- **Set your goals high, and don’t stop till you get there.** Bo Jackson

**Foundation:** Brainstorm examples of goals. Ask clients about goals they have accomplished as well as what they want to accomplish. Use these examples to teach treatment and non-treatment related goals, the difference between goals and steps, and the importance of having specific, measurable, attainable, relevant/realistic, and timely goals and steps.

**Activity:** Create an activity for the clients to complete their service plans. Here are some examples:  
*Think, pair, share*: provide clients five minutes to develop their plans individually (think), five minutes to share these with one other person (pair) for feedback and revision, and then ask the pairs to pair up so you have groups of four people and share their goals and steps (share).

*Dyad work:* Pair up group members to interview each other using open questions and reflections (skill practice) to complete service plans for each other using information gathered during the interview. This is also helpful if you have group members who cannot read or write.
Group think: As a group, have clients shout out goals they are thinking about. Write these on the board. Then as a group brainstorm steps the clients could take to achieve these goals. This activity is also helpful if no one (or very few people) in your group can write.

Summary: Bring the group back together to share insights and comments on the process. Discuss barriers to meeting goals and supports they need from each other to remain accountable. Be sure that you review all the service plans developed and that they are signed by the client.

CONCLUSION

The Service Plan must be individualized and involve the client, the treatment provider, and the treatment team. It should be goal focused and these goals have to be strength-based, gender appropriate, culturally appropriate, contain measurable related objectives and be realistic. Further they must be age and/or developmentally appropriate. The plan, when appropriate, must include family and supportive individuals (21.190.41 Code of Colorado Regulations). The Service Plan must be reviewed and revised in accord with OBH Regulations, and include progress, change in focus, conducted collaboratively with the client, and as with the original plan, offered in writing to the client. Documentation of such offering along with a notation as to whether a client signature was obtained (21.190.42, Code of Colorado Regulations).

The process of service planning is a difficult one and is often a repetitive process. We plan, and re-plan with the client when things don’t go the way we hope. It is this flexibility about how we help clients get to goals that is the marker of a strong working alliance. Capitalizing on the organic process of service-planning means recognizing in the moment that the client is ready to take some steps – this is more of an art than a science and learning this takes experience and time. However, good service-planning about relevant issues (versus non-specific or overly broad goals) increases client engagement, solidifies motivation and supports success with behavior change. Treatment providers also benefit from good service-planning because clients get more out of treatment, clients are more goal-focused in individual and group sessions, groups are easier to conduct, and documentation becomes easier when clients are familiar with, and attending to, their goals.
SECTION V: TREATMENT OPTIONS

The length of stay and required hours for the treatment of individuals with four or more impaired driving offenses are set by regulations. The minimum of 180 hours of treatment conducted over a minimum of 18 months is not negotiable. However, although the timeframes are mandatory, the individual’s clinical profile and assessment information drives how these requirements are structured and what treatment is provided.

Provided below is a sample of approved treatment approaches. There are other approaches available for use, however it is important to remember that programming must always be assessment driven. Group and/or individual sessions may be used, and medication assistance, if applicable, may be part of the service plan. Case management may also be applicable to assist the client in meeting treatment goals as well as to assist in service coordination and continuity of care. Combinations of various types of treatment may likely be required due to clinical presentation and the required length of treatment. All such treatments must be evidence-based or shown to be of significant promise. Further, any treatment must be provided by persons qualified to present such treatment. In many cases referral to a different agency or even agencies will be needed to assure that client needs are being met. Communication between providers is essential.

The menu of different approaches that appears on the following pages provides a brief description of the program/modality, the author(s) cost and where it may be obtained. The recommended approaches come in several formats. Some are manualized, either all or in part; whereas, others are books from which information may be obtained in order to assist one in developing a treatment program. The list is not exhaustive, and other approaches may be used providing they are also evidence-based or promising. There are currently 25 areas listed in the menu. Some have a number of different approaches; whereas, others have only one. The 25 areas are: Antisocial-Criminal Behavior; Road Rage; Anger Control; Mood disorders; Co-occurring and Substance Use Disorders; Anxiety Disorders; Trauma Disorders; Grief and Loss; Motivational Enhancement; Pro-Social Enhancement; Mutual-Self Help Group; Contemplative Frame of Reference; Adult Attention Deficit Hyperactivity Disorder; Cognitive Problems and/or Physical Disabilities; Autism Spectrum Disorder; Suicidal Risk; Obsessive-Compulsive Disorder; Schizophrenia; General Adolescent Substance Use Treatment; Adolescent Marijuana Treatment; Relapse Prevention; Chronic Pain Management; Clients Using Interlocks; and LGBT Counseling. Descriptions are not necessarily in above order.

The treatments below could certainly be applicable to clients in Tracks B, C, and D as well as in Level II Four Plus.

If you have other approaches that you believe would be appropriate, please submit to the author(s) and OBH staff for their review and possible inclusion. Supportive evidence must be included. In addition to those listed in this document, additional evidence-based approaches can be found at the following link. (https://www.samhsa.gov/data/evidence-based-programs-nrepp).
ANTISOCIAL-CRIMINAL BEHAVIOR

**Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change**


Designed for providers who work with judicial clients, the Providers Guide presents effective cognitive-behavioral treatment approaches. The Second Edition of this bestseller unveils a state-of-the-art approach for effectively preventing criminal recidivism and substance abuse relapse within community based and correctional settings.

The accompanying Participant’s Workbook to the SSC is written to engage clients and encourage active participation in treatment and responsible living. Available from Sage Pub. $22.00

- Phase I: Challenge to Change: Building Knowledge and Skills for Responsible Living
- Phase II: Commitment to Change: Strengthening Skills for Self-Improvement, Change, and Responsible Living
- Phase III: Taking Ownership of Change: Lifestyle Balance and Healthy Living

Also available - **Criminal Conduct and Substance Abuse Treatment for Women in Correctional Settings** $49.00

Sage Publications, Thousand Oaks, CA


Designed as an adjunct to the Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change (SSC) curriculum, this provider’s guide uses female-focused examples, exercises, role plays, and content enhancements that pinpoint women’s treatment issues.

**The R & R Program - Reasoning & Rehabilitation**


Cost of a Program Kit is $470.00. Training is required before purchase.

The (R&R) program is an internationally accredited, evidence-based, multi-faceted, cognitive-behavioral program for teaching the cognitive skills, social skills and values that are required for prosocial competence. R&R provides 35, highly structured, manualized, two hour sessions for groups of 6-12 youths or adults who are evidencing antisocial behaviors or delinquent or criminal behavior.
Thinking for a Change 4.0
Bush, J., Glick, B., & Taymans, J. (2016)

Training is required and is available at no cost to qualified persons from National Institute of Corrections. Thinking for a Change 4.0 (T4C) is an integrated cognitive behavioral change program developed under a cooperative agreement with the National Institute of Corrections (NIC). T4C incorporates research from cognitive restructuring theory, social skills development, and the learning and use of problem solving skills. Available from the National Institute of Corrections, Washington, DC.

The Matrix Model

The Matrix Model provides a framework for engaging stimulant (e.g., methamphetamine and cocaine) abusers in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, and become familiar with self-help programs. Training is available and cost varies by Provider.


MRT is a cognitive-behavioral counseling program that combines education, group and individual counseling, and structured exercises designed to foster moral development in treatment resistant clients. Training is required in order to purchase material, current cost unavailable.

Cognitive Behavioral Approaches to Treating Children and Adolescents with Conduct Disorder.

This short book (140 pgs) explains CBT in the treatment of conduct disorder, and demonstrates effective treatment approaches for young people many of whom have multiple difficulties that often include neurological problems, PTSD, ADHD, and others.

London Family Court Clinic - Centre for Children and Families in the Justice system. Ontario, CA. Can be downloaded free of charge from lfcc.on.ca or a bound copy can be purchased for $30. (Canadian)

Effecting Change: A Cognitive Behavioral Approach to Working with Youths in Custody
This no-nonsense work is a training manual and companion video with an emphasis on how to modify your existing skills as well as developing new methods to work with youth in the criminal justice system.

London Family Court Clinic - Centre for Children and Families in the Justice system. Ontario, CA. $120 (Canadian). lfcc.on.ca for order form.

**Guidelines for Psychopathy Treatment Program**


The *Guidelines for a Psychopathy Treatment Program* focus on adult and adolescent psychopathic offenders. Rather than attempting to modify personality characteristics, the proposed treatment is a strategy of self-management that helps the participant develop a prosocial lifestyle, reducing the frequency and the extent of violent behavior. Available through Multi-Health Systems (www.mhs.com) $40.

**Pathways to Self-Discovery and Change: A Guide for Responsible Living**


Pathways to Self-Discovery and Change supplies adolescent clients with a visual and written record of all treatment objectives, content information, modeling and role-plays, discussion points, interactive exercises, and reflective assignments and a place to record their ideas, insights, short- and long-term goals, and progress during the entire treatment episode. Available from Sage Pub. ($24.)

**Multisystemic Family Therapy**

Henggeler, S.W. et.al. (1997)

**Multisystemic Therapy** (MST; Henggeler et al., 1998) is a family- and home-based treatment that addresses the known factors associated with serious antisocial behavior in children and adolescents.

Cost unknown, more information available from the National Institute on Drug Abuse and the MST Institute. Training is rigorous and needed. Training is required. $7,950 for entire agency or $997 for individual.

**Integrated Treatment for Personality Disorder: A Modular Approach**


Rather than arguing for one best approach for treating personality disorder, this pragmatic book emphasizes the benefits of weaving together multiple well-established intervention strategies to meet each patient's needs. A framework is provided for constructing a comprehensive case formulation, planning treatment, and developing a strong therapeutic alliance.

Guilford Press, NY $34.00 paperback, $72.25 hardcover
ROAD RAGE

Road Rage: Assessment and Treatment of the Angry, Aggressive Driver.

The book is divided into 3 parts. Part I provides background, Part 2 provides information on aggressive drivers, and Part 3 focuses on treatment of aggressive drivers. Authors provide information of clinical value to treatment providers and also a summary of available information on aggressive drivers to guide future research. $24.95.

ANGER CONTROL

Anger Control: The Development and Evaluation of an Experimental Treatment


This book provides an innovative framework for understanding and treating intimate partner violence. Integrating a variety of theoretical and empirical perspectives, Donald G. Dutton demonstrates that male abusiveness is more than just a learned pattern of behavior—it is the outgrowth of a particular personality configuration.

Guilford Press, NY. $29.75 paperback, $68.00 hardcover

Taking Charge of Anger, Second Edition: Six Steps to asserting Yourself with Losing Control

This work helps the reader to figure which “faces-of-anger” are a problem, from passive-aggression to all-out rage, recognize early warning signs of anger, master cooling-off strategies, and communicate effectively when differences arise.

Guilford Press, NY. $14.41 paperback, $44.20 hardcover

MOOD DISORDERS

Cognitive Therapy of Depression.

This classic work offers a definitive presentation of the theory and practice of cognitive therapy for depression. Aaron T. Beck and his associates set forth their seminal argument that depression arises from a "cognitive triad" of errors and from the idiosyncratic way that one infers, recollects, and generalizes. Guidance is provided for working with individuals and groups to address the full range of problems that patients face, including suicidal ideation and possible relapse.
**Cognitive Behavioral Treatment for Bi-Polar Disorder**

This pragmatic, accessible book provides a complete framework for individualized assessment and treatment of bipolar disorder. The second edition is a complete revision of the original volume, updated and restructured to be even more user friendly for clinicians.

Guilford Press, NY. $40.80 paperback, $70.79 hardcover

**Mind over Mood**

This book uses cognitive-behavioral therapy—uses one of today's most effective forms of psychotherapy—to conquer depression, anxiety, panic attacks, anger, guilt, shame, low self-esteem, eating disorders, substance abuse, and relationship problems. Revised and expanded to reflect significant scientific developments of the past 20 years; includes journals, innovative exercises focused on mindfulness, acceptance, and forgiveness; 25 new worksheets; and much more.

Guilford Press, NY. $34.00 paperback, $72.25 hardcover

**Mindfulness-Based Cognitive Therapy for Depression, Second Ed.**
Segal, Z., Williams, M, & Teasdale, J. (2012)

Step by step, the authors explain the "whys" and "how-tos" of conducting mindfulness practices and cognitive interventions that have been shown to bolster recovery from depression and prevent relapse.

Guilford Press, NY. $51.00

**Acceptance and Commitment Therapy Second Edition**
Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (2016)

ACT is based on the idea that psychological rigidity is a root cause of a wide range of clinical problems. The authors describe effective, innovative ways to cultivate psychological flexibility by detecting and targeting six key processes: defusion, acceptance, attention to the present moment, self-awareness, values, and committed action.

Guilford Press, NY. $29.75, paperback, $68.00 hardcover

**Mindfulness and Psychotherapy, Second Edition**
Germer, C.K., Siegal, R.D., & Fulton, P.R. (2016)

The book describes the philosophical underpinnings of mindfulness and reviews the growing body of treatment studies and neuroscientific research. Leading practitioners and researchers present clear-cut procedures for implementing mindfulness techniques and teaching them to patients experiencing depression, anxiety, chronic pain, and other problems.
**Treating Bipolar Disorder: A Clinicians Guide to Interpersonal and Social Rhythm Therapy**

Frank, E. (2007)

This manual presents a powerful approach for helping people manage bipolar illness and protect against the recurrence of manic or depressive episodes. Among the special features are reproducible assessment tools and a chapter on how to overcome specific treatment challenges.

This title is part of the *Guides to Individualized Evidence-Based Treatment Series*, edited by Jacqueline B. Persons.

**Integrated Group Therapy for Bi-Polar Disorder and Substance Abuse**


This book presents an empirically supported treatment expressly designed for clients with both bipolar disorder and substance use disorders. The volume provides a complete session-by-session overview of the approach, including clear guidelines for setting up and running groups, implementing the cognitive-behavioral treatment techniques, and troubleshooting frequently encountered problems.

**Treatment Plans and Interventions for Depression and Anxiety Disorders**


This book is packed with indispensable tools for treating the most common clinical problems encountered in outpatient mental health practice. Provides basic information on depression and the six major anxiety disorders; step-by-step instructions for evidence-based assessment and intervention.

**Rumination Focused Cognitive-Behavioral Treatment for Depression**


RFCBT is a natural and useful extension of CBT that is applicable to many, if not most, chronically or recurrently depressed individuals. Watkins has translated lessons from the laboratory and clinical work into a well-formulated, clearly described intervention.
**CBT for Depression in Children and Adolescents**
Kennard, B.D., Hughes, J.L., & Foxwell, A.A. (2016)

Despite the availability of effective treatments for child and adolescent depression, relapse rates in this population remain high. This innovative manual presents an evidence-based brief therapy for 8- to 18-year-olds who have responded to acute treatment but still have residual symptoms.

Guilford Press, NY $29.75

**Mindfulness and the Transformation of Despair: Working with People at Risk of Suicide**
Williams, M., Fennell, M., Barnhofer, T., Crane, R., & Silverton, S. (2015)

Grounded in extensive research and clinical experience, this book describes how to adapt mindfulness-based cognitive therapy (MBCT) for participants who struggle with recurrent suicidal thoughts and impulses. Clinicians and mindfulness teachers are presented with a comprehensive framework for understanding suicidality and its underlying vulnerabilities.

Guilford Press NY. $23.80 paperback, $28.25 hardcover

**CO-OCCURRING AND SUBSTANCE USE DISORDER TREATMENT**

**Integrated Treatment for Co-Occurring Disorders – Evidence Based Practices (EBK) Kit**
SAMHSA (2010)

Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders.

U.S. Department of Health and Human Services MD. Free, shipping may apply

**ANXIETY DISORDERS**

**Anxiety Disorders and Phobias a Cognitive Perspective**

Perseus Books Group, NY. $13.39 paperback

The founder of cognitive therapy and two colleagues apply the concepts of cognitive therapy, used successfully in treating depression, to the treatment of anxiety disorders and phobias.

**The Anxiety & Worry Workbook: The Cognitive Behavioral Solution**

This is grounded in cognitive behavior therapy, the proven treatment approach developed and tested over more than 25 years by pioneering clinician-researcher Aaron T. Beck. Now Dr. Beck and fellow cognitive therapy expert David A. Clark put the tools and techniques of cognitive behavior therapy at your fingertips in this guide.
Cognitive Therapy of Anxiety Disorders

Updating and reformulating Aaron T. Beck’s pioneering cognitive model of anxiety disorders, this book is both authoritative and highly practical. The authors synthesize the latest thinking and empirical data on anxiety treatment and offer step-by-step instruction in cognitive assessment, case formulation, cognitive restructuring, and behavioral intervention.

Anxiety and Its Disorders: The Nature and Treatment of Anxiety and Panic

This work is indispensable for anyone studying anxiety or seeking to deliver effective psychological and pharmacological treatments. David H. Barlow comprehensively examines the phenomena of anxiety and panic, their origins, and the roles that each plays in normal and pathological functioning.

Progressive Relaxation

The author’s purpose is the overcoming of the high nervous tension which is so prevalent in America, and in this manual he describes for the layman his experiments on relaxation. He gives detailed directions (with pictures) for complete and differential relaxation, the latter implying "a minimum of tension in the muscles requisite for an act along with the relaxation of other muscles."

Information is available from a number of sources, including the American Psychological Association.

Treatment Plans and Interventions for Depression and Anxiety Disorders

This book is packed with indispensable tools for treating the most common clinical problems encountered in outpatient mental health practice. Chapters provide basic information on depression and the six major anxiety disorders; step-by-step instructions for evidence-based assessment and intervention; illustrative case examples; and practical guidance for writing reports and dealing with third-party payers.

Motivational Interviewing in the Treatment of Anxiety
This practical book provides effective strategies for helping therapy clients with anxiety resolve ambivalence and increase their intrinsic motivation for change.

Guilford Press, NY $23.80 paperback, $62.05 hardcover

**Promoting Emotional Resilience: Cognitive-Affective Stress Management Training**

Smith, R.E., & Ascough, J.C. (2016)

“*Promoting Emotional Resilience* presents a powerful, detailed, evidence-based brief intervention program designed to help clients both experience and cope with life stress and negative emotions.

**Acute Stress Disorder: What it is and How to Treat it**

Bryant, R.A. (2016)

Drawing on extensive research and clinical experience, leading authority Richard A. Bryant explores what works—and what doesn’t work—in managing acute traumatic stress.

Guilford Press NY $38.25 Hardcover

**TRAUMA DISORDERS**

**Cognitive-Behavioral Therapy for PTSD**


This is a useful, clearly and coherently written book about how to use a case formulation approach to treat post-traumatic stress disorder in adults using cognitive-behavioral therapy.

Guilford Press, NY. $25.50 paperback, $63.75 hardcover

**Clinicians Guide to PTSD**


Grounded in current clinical and neurobiological research, this book provides both an understanding of posttraumatic stress disorder (PTSD) and a guide to empirically supported treatment. Coverage includes different conceptual models of PTSD, approaches to integrating psychopharmacology into treatment, and strategies for addressing frequently encountered comorbid conditions. Illustrated with helpful case examples, the book features over a dozen reproducible handouts and forms.

Guilford Press, NY. $30.60 paperback, $68.85 hardcover

**Seeking Safety**


Grounded in current clinical and neurobiological research, this book provides both an understanding of posttraumatic stress disorder (PTSD) and a guide to empirically supported treatment. The author offers well-documented, practical recommendations for planning and implementing cognitive-behavioral therapy with people who have experienced different types of
trauma—sexual assault, combat, serious accidents, and more—and shows how to use a case formulation approach to tailor interventions to the needs of each patient. The book features over a dozen reproducible handouts and forms.

Guilford Press, NY. $51.00 paperback

**Overcoming Trauma of your Motor Vehicle Accident**


First workbook for the thousands of individuals who suffer emotional trauma due to a motor vehicle accident. It includes evidence-based therapy techniques to successfully treat Posttraumatic Stress Disorder caused by involvement in a car accident.

Oxford University Press, NY & NC. $31.95 paperback

**Treatment of Post-Traumatic Stress Disorder in Special Populations: A Cognitive Restructuring Program.**


The program emphasizes the use of cognitive restructuring to help clients recognize, challenge, and change negative and unhelpful thoughts and feelings related to their past traumatic experiences. The program is brief—just 12–16 sessions—and focuses on building lasting skills that can be applied to treating the aftereffects of past traumas, lessening the impact of ongoing stressors, and helping clients to more effectively manage their lives.

American Psychological Association, Washington DC. $29.95

**Handbook of PTSD: Science and Practice, 2nd Edition**


Widely regarded as the definitive reference, this handbook originally published in 2007, brings together foremost authorities on posttraumatic stress disorder (PTSD). Diagnostic, conceptual, and treatment issues are reviewed in depth. The volume examines the causes and mechanisms of PTSD on multiple levels, from psychological processes to genes and neurobiology. Risk and resilience processes are addressed across development and in specific populations. Contributors describe evidence-based assessment and treatment approaches as well as promising emerging interventions.

Guilford Press, NY. $46.75 paperback, $93.50 hardcover

**Treatment of Complex Trauma**

This insightful guide provides a pragmatic roadmap for treating adult survivors of complex psychological trauma.

Guilford Press, NY. $23.80 paperback, $62.05 hardcover

**Trauma and Stressor-Related Disorders: A Handbook for Clinicians**

Casey, P.R., & Strain, M.D. (Eds.) (2015)

Both academically rigorous and clinically practical, *Trauma- and Stressor-Related Disorders* is fully informed by the new DSM-5 category that includes adjustment disorders, acute stress disorder, and posttraumatic stress disorder. Stress and trauma have long been recognized as playing a role in the etiology of certain psychiatric disorders, and this book delineates normal and pathological responses to stress, providing a conceptual framework for understanding trauma- and stressor-related disorders.

American Psychological Association, Washington DC, $61.00.

**Adaptive Disclosure: A New Treatment for Military Trauma, Loss, and Moral Injury**


A complete guide to an innovative, research-based brief treatment specifically developed for service members and veterans, this book combines clinical wisdom and in-depth knowledge of military culture. Adaptive disclosure is designed to help those struggling in the aftermath of traumatic war-zone experiences, including life threat, traumatic loss, and moral injury, the violation of closely held beliefs or codes.

Guilford Press, NY. $29.75 hardcover

**Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols and Procedures, 2nd Ed.**

Shapiro, F. (2001)

This is the definitive guide to Eye Movement Desensitization and Reprocessing (EMDR), the psychotherapeutic approach developed by Francine Shapiro. EMDR is one of the most widely investigated treatments for posttraumatic stress disorder, and many other applications are also being explored.

Guilford Press, NY. $55.00 paperback More information available from EMDR Institute, CA.

**Cognitive Processing Therapy for PTSD**


The culmination of more than 25 years of clinical work and research, this is the authoritative presentation of cognitive processing therapy (CPT) for posttraumatic stress disorder (PTSD). Written by the treatment’s developers, the book includes session-by-session guidelines for implementation, complete with extensive sample dialogues and 40 reproducible client handouts.

Guilford Press, NY $29.75 paperback
Treating Trauma and Traumatic Grief in Children and Adolescents 2nd Ed.


This authoritative guide, first published in 2006, has introduced many tens of thousands of clinicians to Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), a leading evidence-based treatment for traumatized children and their parents or caregivers. Preeminent clinical researchers provide a comprehensive framework for assessing posttraumatic stress disorder (PTSD), other trauma-related symptoms, and traumatic grief in 3- to 18-year-olds; building core coping skills; and directly addressing and making meaning of children’s trauma experiences.

Guilford Press, NY. $38.25 hardcover

Trauma-Focused CBT for Children and Adolescents


This book facilitates implementation of Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) in a range of contexts. It demonstrates how assessment strategies and treatment components can be tailored to optimally serve clients’ needs while maintaining overall fidelity to the TF-CBT model. Coverage includes ways to overcome barriers to implementation in residential settings, foster placements, and low-resource countries.

Guilford Press, NY. $23.80 paperback, $62.05 hardcover

Attachment, Trauma, and Healing (2nd Ed.)

Orlans, M., & Levy, T. M. (2014)

This work was first published in 1998; a second edition was done in 2014. Since the first volume was published there have been advances in the fields of child and family psychology, psychotherapy, and the evolution of work with traumatized children, adults and family systems. The authors describe how attachment styles learned in childhood affect the quality of adult attachment relationships and, in turn, emotional and physical health. In addition to a treatment program of children, parents, and families, they provide therapy for adults and couples experiencing attachment problems.

GRIEF AND LOSS TREATMENT

Complicated Grief Treatment


Complicated Grief Treatment is a 16-session intervention for complicated grief. Complicated grief is a term that describes those who have lost someone close and are caught in a relentless cycle of pain that dominates their lives. This manual can help you administer a simple, highly effective treatment that can change lives.

For more information and permission to use contact: The Columbia Center for Complicated Grief, The Trustees of Columbia University in the City of New York. http://complicatedgrief.columbia.edu
MOTIVATIONAL ENHANCEMENT

Motivational Enhancement Therapy (MET)

NIHAA - Project Match. (1989)

Project MATCH began in 1989 in the United States and was sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The project was an 8-year, multi-site, $27-million investigation that studied which types of alcoholics respond best to which forms of treatment. MATCH studied whether treatment should be uniform or assigned to patients based on specific needs and characteristics. The Project Match manuals (there are 8) are available from the National Institute on Alcohol Abuse and Alcoholism.

NIAAA, Rockville MD. $6.00 for each manual.

Group Therapy for Substance Use Disorders


This authoritative book presents a groundbreaking evidence-based approach to conducting therapy groups for persons with substance use disorders. The approach integrates cognitive-behavioral, motivational interviewing, and relapse prevention techniques, while capitalizing on the power of group processes. Clinicians are provided with a detailed intervention framework and clear-cut strategies for helping clients to set and meet their own treatment goals.

Guilford Press, NY. $35.70 paperback

Group Treatment for Substance Abuse: A Stage-of Change Therapy Manual


The leading manual on group-based treatment of substance use disorders, first published in 2001, is highly practical book, grounded in the transtheoretical model and emphasizes the experiential and behavioral processes of change. The program helps clients move through the stages of change by building skills for acknowledging a problem, deciding to act, developing and executing a plan, and accomplishing other critical tasks.

Guilford Press, NY. $34.00

PROSOCIAL ENHANCEMENT

Clinical Guide to Alcohol Treatment: The Community Reinforcement Approach (CRA)


The Community Reinforcement Approach (CRA) is a comprehensive behavioral program for treating substance-abuse problems. It is based on the belief that environmental contingencies can play a powerful role in encouraging or discouraging drinking or drug use.
Community Reinforcement with Vouchers

National Institute on Drug Abuse (NIDA), Higgins, et al. (1993)

Community Reinforcement Approach (CRA) Plus Vouchers is an intensive 24-week outpatient therapy for treating people addicted to cocaine and alcohol. It uses a range of recreational, familial, social, and vocational reinforcers, along with material incentives, to make a non-drug-using lifestyle more rewarding than substance use.

NIDA – More information available from NIH-NIDA https://drugpubs.drugabuse.gov

Adolescent Community Reinforcement Treatment Manual


The Adolescent Community Reinforcement Approach (A-CRA) is a developmentally-appropriate behavioral treatment for youth and young adults 12 to 24 years old with substance use disorders. A-CRA seeks to increase the family, social, and educational/vocational reinforcers to support recovery.

SAMHSA – Information available from www.samhsa.gov

MUTUAL/SELF-HELP GROUP CANDIDATES


This is Monograph #1 in the NIAAA Project Match Series.

NIAAA ($6)

CONTEMPLATIVE FRAME OF REFERENCE

Dialectical Behavior Therapy (DBT), (2nd ed)

Linehan, M. M. (2014)

This comprehensive resource (1st ed. 1993) provides vital tools for implementing DBT skills training. The reproducible materials used for over two decades by hundreds of thousands of practitioners have been significantly revised and expanded to reflect important research and clinical advances. The book gives complete instructions for orienting clients to DBT, plus teaching notes for the full range of mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance skills.

Guilford Press, NY. $42.50 paperback
**DBT Principles in Action: Acceptance, Change, and Dialectics**

Swenson, C.R. (2016)

This guide from leading DBT authority Charles R. Swenson offers clinicians a compass for navigating challenging clinical situations and moving therapy forward—even when change seems impossible.

Guilford Press, NY. $45.00 paperback

**DBT Skills Training Manual, Second Ed.**


This comprehensive resource provides vital tools for implementing DBT skills training. The teaching notes, handouts, and worksheets used for over two decades by hundreds of thousands of practitioners have been significantly revised and expanded to reflect important research and clinical advances. The companion volume (containing handouts and worksheets) is available separately.

Guilford Press, NY. $40.00. Handouts and Worksheets available on line with purchase.

**Doing Dialectical Behavior Therapy: A Practical Guide**

Koerner, K. (2012)

This book demonstrates the nuts and bolts of dialectical behavior therapy (DBT). DBT is expressly designed for—and shown to be effective with—clients with serious, multiple problems and a history of treatment failure.

Guilford Press, NY. $32.00 hardcover

**Changing Behavior in DBT**


This book delves into problem solving, one of the core components of dialectical behavior therapy (DBT). Particular attention is given to common pitfalls that therapists encounter in analyzing target behaviors. Guidelines are provided for successfully implementing the full range of DBT problem-solving strategies, including skills training, stimulus control and exposure, cognitive restructuring, and contingency management.

**ADULT ATTENTION DEFICIT HYPERACTIVITY DISORDERS (ADHD)**

**Cognitive-Behavioral Therapy for Adult Hyperactivity Disorder: Targeting Executive Dysfunction**

Solanto, M.V. (2011)

This highly practical book provides evidence-based strategies for helping adults with ADHD build essential skills for time management, organization, planning, and coping.

Guilford Press, NY. $23.80 paperback
Attention-Deficit Hyperactivity Disorder: A Handbook for Diagnosis & Treatment


Widely regarded as the standard clinical reference, this volume provides the best current knowledge about attention-deficit/hyperactivity disorder (ADHD) in children, adolescents, and adults.

Guilford Press, NY. $72.95 paperback

COGNITIVE PROBLEMS AND/OR PHYSICAL DISABILITIES

The Emotion Regulation Skills System for Cognitively Challenged Clients: A DBT-Informed Approach


Informed by the principles and practices of dialectical behavior therapy (DBT), this book presents skills training guidelines specifically designed for adults with cognitive challenges. Clinicians learn how to teach core emotion regulation and adaptive coping skills. This is a 12-week group curriculum.

Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities

SAMHSA, (2012)

Offers treatment providers guidelines on caring for people with physical disabilities or cognitive disabilities, as well as drug abuse or alcohol abuse problems. Discusses screening, treatment planning and counseling, and linkages with other service providers.

SAMHSA (contact Publications Ordering) $Free

Parent-Teen Therapy for Executive Function Deficits and ADHD

Sibley, M.H. (2016)

This manual is user friendly, and presents an innovative, tested approach to helping teens overcome the frustrating organizational and motivation problems associated with executive function deficits and attention-deficit/hyperactivity disorder (ADHD).

Guilford Press, NY. $25.50 Paperback

The Brain Injury Rehabilitation Workbook


Packed with practical tools and examples, this state-of-the-art workbook provides a holistic framework for supporting clients with acquired brain injury.

Guilford Press, NY. $38.25 Paperback

Effective Psychotherapy for Individuals with Brain Injury.

The book shows how standard psychotherapeutic interventions can be adapted for the brain-injured population, as well as which approaches may be contraindicated. It presents a biopsychosocial framework for assessment and treatment that integrates emotional support, cognitive-behavioral techniques, and acceptance- and mindfulness-based strategies.

Guilford Press, NY $39.10 Hardcover

**Psychotherapy after Brain Injury: Principles and Techniques**


While this book is designed for clinicians working in structured program settings, most of its lessons can be productively applied by clinicians working in outpatient, office-based settings.

Guilford Press, NY $45.90 Hardcover

**Group Work with Persons with Disabilities**

Baumann, S. & Shaw, L.R. (2016)

This manual provides direction for leading groups of people with disabilities or groups that have members with disabilities. Viewing disability as a single aspect of a multifaceted person, Drs. Bauman and Shaw emphasize practical skill building and training.

Wiley, NJ. $39.99

**AUTISM SPECTRUM DISORDER**

**CBT for Children and Adolescents with High-Functioning Autism Spectrum Disorders**

Scarpa, A., Williams, S.W., & Attwood, T. (Eds.) (2013)

Leading treatment developers describe promising approaches for treating common challenges faced by young people with ASD—anxiety and behavior problems, social competence issues, and adolescent concerns around sexuality and intimacy. Chapters present session-by-session overviews of each intervention program, review its evidence base, and address practical considerations in treatment.

Guilford Press, NY. $25.50

**EATING DISORDERS**

**Cognitive-Behavioral Treatment and Eating Disorders**

Fairburn, C.G. (2008)

Provides the first comprehensive guide to the practice of "enhanced" cognitive behavior therapy (CBT-E), the latest version of the leading empirically supported treatment for eating disorders. Written with the practitioner in mind, the book demonstrates how this transdiagnostic approach can be used with the full range of eating disorders seen in clinical practice.

Guilford Press, NY. $40.80 Hardcover
**Eating Disorders and Obesity**


This handbook synthesizes current knowledge and clinical practices in the fields of both eating disorders and obesity. The significantly revised third edition features more than 100 concise, focused chapters with lists of key readings in place of extended references. All aspects of eating disorders and obesity are addressed by foremost clinical researchers: classification, causes, consequences, risk factors, and pathophysiology, as well as prevention, treatment, assessment, and diagnosis.

Guilford Press, NY. $75.00, hard cover

**Treatment Plans and Interventions for Bulimia and Binge-Eating Disorders**


This book offers a session-by-session map of how common problems might be addressed, from initial assessment including motivational assessment and psycho-education through behavioral methods, cognitive methods, and development of alternative coping strategies, constituting a 20-session treatment plan for adolescent and adult patients.

Guilford Press, NY $32.30 Paperback

**SUICIDAL RISK**

**Managing Suicidal Risk: A Collaborative Approach (2nd Ed.)**

Jobes, D.A. (2016)

This extensively revised manual provides a proven therapeutic framework for evaluating suicidal risk and developing and implementing a suicide-specific treatment plan that is respectful, empathic, and empowering.

Guilford Press, NY $34.00 Paperback

**Mindfulness and the Transformation of Despair: Working with People at Risk of Suicide**


Guilford Press, NY $23.80 Paperback; $38.25 Hardcover

**OBSESSIVE-COMPULSIVE DISORDER**

**Treatment Plans and Interventions for Obsessive-Compulsive Disorder**

Rego, S.A. (2016)

This extensively revised manual provides a proven therapeutic framework for evaluating suicidal risk and developing and implementing a suicide-specific treatment plan that is respectful, empathic, and empowering.

Guilford Press, NY $29.75 Paperback
SCHIZOPHRENIA

Cognitive-Behavioral Social Skills Training for Schizophrenia: A Practical Treatment Guide

This unique manual presents cognitive-behavioral social skills training (CBSST), a step-by-step, empirically supported intervention that helps clients with schizophrenia achieve recovery goals related to living, learning, working, and socializing. CBSST interweaves three evidence-based practices—cognitive-behavioral therapy, social skills training, and problem-solving training—and can be delivered in individual or group contexts.

Guilford Press, NY. $34.00 Paperback

GENERAL ADOLESCENT SUBSTANCE USE TREATMENT

Group-Based Outpatient Treatment for Adolescent Substance Abuse

This manual describes a moderate-intensity group-based approach to adolescent outpatient substance abuse treatment, implemented by the Epoch Counseling Center, Baltimore County, Maryland. The Group-Based Outpatient Treatment for Adolescent Substance Abuse (GBT) program combines a 20-week group counseling intervention with individual and family therapy and is designed to address the issues and problems commonly facing adolescent substance abusers ages 14 to 18 years old.

The Social Research Center, Baltimore, MD & Epoch Counseling Center, Catonsville, MD

Available online at researchgate/met/publication/228369388_Group-Based_Outpatient_Treatment $0.00

Triad Girls’ Group Treatment Manual

Although gender role expectancies become intensified during adolescence for both sexes, girls are more likely to become aware of their inner states, more reflective, and more publicly self-conscious. Programs that emphasize relational content using positive female role models and peer group connectedness are likely to be more successful for at risk girls.

Available on line. $0.00 More information available from the University of south Florida.

Voices – A Program of Self-Discovery and Empowerment for Girls
VOICES was created to assist girls ages 12 to 18 in exploring themes of self, connection with others, health and their journeys ahead. A comprehensive, supporting Facilitator's Guide is available to provide background information about working with girls, detailed instruction for program facilitation, facilitation strategies and resource information.


**ADOLESCENT MARIJUANA TREATMENT**

*Cannabis Youth Treatment Series, 1-5*

SAMHSA (2015)

The Cannabis Youth Treatment (CYT) was designed to adapt 5 promising adolescent treatments for use in clinical practice, and then to field test their effectiveness in the largest randomized experiment ever conducted with adolescent marijuana users seeking outpatient treatment. Preliminary results suggested that all five of the CYT treatments were more effective than current practice, so CSAT released the manuals to the field in 2000. These volumes are often out of stock from SAMHSA, however are available in libraries and from Amazon.

**RELAPSE PREVENTION**

*Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors*


This relapse prevention model was developed as a behavioral maintenance program for use in the treatment of addiction problems such as alcohol and other drug dependencies.

No longer easily available, though Amazon carries used copies. Available in libraries.

*Relapse Prevention: (2nd Ed.): Maintenance Strategies in the Treatment of Addictive Behaviors*


This important work elucidates why relapse is so common for people recovering from addictive behavior problems—and what can be done to keep treatment on track. It provides an empirically supported framework for helping people with addictive behavior problems develop the skills to maintain their treatment goals, even in high-risk situations, and deal effectively with setbacks that occur.

Guilford Press, NY. $38.25 paperback, $76.50 hardcover.
Relapse Prevention Therapy with Chemically Dependent Criminal Offenders: A Guide for Counselors Therapists and Criminal Justice Professionals


This manual is designed for criminal justice system workers including counselors, probation and parole officers, and other paraprofessionals who work with criminal offenders developing basic relapse prevention plans. It provides specific instructions on how to guide a criminal offender in successfully completing The Relapse Prevention Workbook for the Criminal Offender. Guidelines are presented for establishing one-on-one sessions and discussion groups. There is a workbook available.

Published by Herald House/Independence Press. Cost: Guide, $14.95, Workbook, $16.00,

CHRONIC PAIN MANAGEMENT

Cognitive Behavioral Treatment for Chronic Pain Among Veterans: Therapist Manual

Murphy, J.L., Raffa, S.D., Clark, M.E., Kerns, R.D., & Karlin, B.E. (2014)

Though developed to help Veteran’s cope with chronic pain, this approach presents CBT and coping skills that can benefit anyone experiencing chronic pain.

U.S. Department of Veterans Affairs, Washington, DC. Available on line.

The Relaxation Response


One of the early studies of the relationship between mind and body, this work helps to manage stress and pain using relaxation techniques. Originally published by William Morrow and Company in 1975 The Relaxation Response was by written by Benson & Klipper. This is the 25th Anniversary edition and contains updated and expanded material as well as a foreward discussing societal changes taking place since original publication.

Quill, an imprint of Harper Collins Publishers, NY. $14.95 paperback

Living Beyond your Pain: using Acceptance and Commitment Therapy to Ease Chronic Pain.


Based on acceptance and commitment therapy (ACT), one of the most promising and fastest growing psychotherapies in use today, this book breaks with conventional notions of pain management, the traditional “feel good” approaches—including the use of pain-killing medication—that work to prevent painful sensations.
Pain Management Psychotherapy: A Practical Guide

Pain Management Psychotherapy is the most up-to-date comprehensive guide available for the psychological treatment of chronic pain. It addresses the behavioral, emotional, sensory-physiological, cognitive, and interpersonal aspects of pain problems and provides accessible technical knowledge that enables practitioners to alleviate unnecessary pain and suffering.

Fordyce’s Behavioral Methods for Chronic Pain and Illness.

Nearly 40 years after its original Fordyce’s Behavioral Methods for Chronic Pain and Illness blends Dr. Fordyce’s pioneering behavioral concepts with modern research and clinical practice. This innovative title is ideal for clinicians and researchers involved in the multidisciplinary assessment, treatment, and management of pain and pain-associated disorders, as well as anyone interested in behavioral approaches to chronic pain and illness.

Otis, J. (2007)

By presenting the basic, proven-effective CBT methods used in each treatment, such as stress management, sleep hygiene, relaxation therapy and cognitive restructuring, this guide can be used to treat all chronic pain conditions with success

Interlock Enhancement Counseling (IEC): Enhancing Motivation for Responsible Driving
Interlock Enhancement Counseling was developed to aid drivers who are required (or who choose) to have an interlock on their vehicle. IEC combines alcohol treatment with use of an interlock as a way to extend the effectiveness of the interlock after the device is removed.
Based partly on Motivational Interviewing, it helps participants learn to avoid future DUI behavior.

For information about IEC contact: The Center for Impaired Driving Research and Evaluation (CIDRE), Boulder CO. or Colorado Department of Human Services, Office of Behavioral Health, (CDHS-OBH) Denver, CO.

**LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER OR QUESTIONING AND INTERSEX (LGBTQI) COUNSELING**

**Affirmative Counseling with LGBTQI + People**


This is a current and comprehensive resource designed to help educators, students, and clinicians develop the awareness and knowledge needed to work productively with LGBTQI populations.

American Counseling Association (ACA). Alexandria, VA. Members $50.95, Non-members $72.95

**A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals (4th Ed)**

Substance Abuse and Mental Health Services (SAMHSA): Center for Substance Abuse Treatment. (2012)

This publication presents information to assist providers in improving substance abuse treatment for lesbian, gay, bisexual, and transgender (LGBT) clients by raising awareness about the issues unique to LGBT clients.

SAMHSA, Rockville, MD. Available on line at no cost.

**BOOSTER SESSIONS**

Brief sessions of 20-30 minutes in length may be used in combination with monitoring for clients who have successfully completed all components of the service plan prior to completion of the minimum number of hours and months required. Such sessions can support as well as increase and maintain the goals established for the client. These sessions must also be assessment driven and specifically tailored to the client. They can certainly be used in conjunction with Peer Support services and coaching. These adjunctive services must also be assessment driven and should be a component of a case management approach utilizing a collaborative, integrated case model.

Another place where a booster or brief intervention is of critical import is the time period between the initial intake, and the sessions where the screenings and/or various comprehensive differential assessments are done and the initial service plan is developed. The time period will
vary based on a number of factors including staff availability, etc., and the fact that the clients can become over-loaded with testing. This can skew results and increase defensiveness. The utilization of these interventions must be combined with monitoring.
CO-OCCURRING DISORDERS, MEDICATIONS, AND MEDICATION-ASSISTED TREATMENT

The term co-occurring or comorbid means that two disorders (e.g., mental and physical; mental and substance use) are existing at the same time in an individual regardless of how the disorders are linked or in what order they occurred. In this section, we discuss, and provide extensive resources for, co-occurring mental and substance use disorders, co-occurring physical and substance use disorders, and medication assisted therapies. Please note that this is for informational use only and does not constitute medical advice or a summary of complete information available, nor does it replace material provided by the client or the client’s physician.

CO-OCCURRING MENTAL AND SUBSTANCE USE DISORDERS

According to a national survey on mental health and drug abuse (Center for Behavioral Health Statistics and Quality, 2015), over 50% of people with severe mental health issues also have diagnosable substance use disorders. Close to 40% of those who abuse alcohol and over 50% of those who abuse drugs are diagnosed with at least one mental health condition. Over 9 million people are affected by co-occurring disorders but less than 8% of them receive the treatment needed. Mental health disorders include changes in thought, mood, and behavior that result in some level of an impaired ability to function in daily life. The most common mental health disorders comorbid with substance use disorders include anxiety, bipolar, depression, trauma-related, conduct-related, and attention deficit disorders.

Integrated approaches are an evidence-based practice to treating both mental health and substance use disorders. Integrated services are those where the treatment for both conditions (mental and substance) are combined or provided in a cohesive manner. SAMHSA lays out the standards of integrated care which require the use of cross-trained practitioners who use motivational interventions and cognitive-behavioral approaches to provide treatment that is matched to the client’s stage of recovery. Further, treatment needs to be available in multiple formats including group, individual, couples, or family. Lastly, practitioners must facilitate a coordinated approach to care by communicating closely with the client’s medication prescriber.

For more information on co-occurring disorders, use the following links:
http://www.dualdiagnosis.org/dual-diagnosis-treatment/important-statistics/
https://www.samhsa.gov/treatment#co-occurring

We have provided a chart of commonly used psychotropic medications to treat mental health disorders. This chart is by no means all-inclusive but is provided as an initial resource. For additional information on specific medications, clients or practitioners can access the following link: https://medlineplus.gov/druginformation.html
## Quick Chart for Commonly Used Psychotropic Medication

### Antipsychotics

**Typical Antipsychotics**
(used in the treatment of schizophrenia and mania)

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haldol</td>
<td>Haloperidol</td>
</tr>
<tr>
<td>Loxitane</td>
<td>Loxapine</td>
</tr>
<tr>
<td>Mellaril</td>
<td>Thioridazine</td>
</tr>
<tr>
<td>Moban</td>
<td>Molindone</td>
</tr>
<tr>
<td>Navane</td>
<td>Thiothixene</td>
</tr>
<tr>
<td>Prolixin</td>
<td>Fluphenazine</td>
</tr>
<tr>
<td>Serentil</td>
<td>Mesoridazine</td>
</tr>
<tr>
<td>Stelazine</td>
<td>Trifluoperazine</td>
</tr>
<tr>
<td>Thorazine</td>
<td>Chlorpromazine</td>
</tr>
<tr>
<td>Trilafon</td>
<td>Perphenazine</td>
</tr>
</tbody>
</table>

**Atypical Antipsychotics**
(used in the treatment of schizophrenia and bipolar disorder)

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify</td>
<td>Aripiprazole</td>
</tr>
<tr>
<td>Clozaril</td>
<td>Clozapine</td>
</tr>
<tr>
<td>Geodon</td>
<td>Ziprasidone</td>
</tr>
<tr>
<td>Risperdal</td>
<td>Risperidone</td>
</tr>
<tr>
<td>Seroquel</td>
<td>Quetiapine</td>
</tr>
<tr>
<td>Zyprexa</td>
<td>Olanzapine</td>
</tr>
</tbody>
</table>

### Mood Stabilizers

(used in the treatment of bipolar disorder)

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depakene</td>
<td>Valproic acid</td>
</tr>
<tr>
<td>Depakote</td>
<td></td>
</tr>
<tr>
<td>Eskalith</td>
<td></td>
</tr>
<tr>
<td>Lithobid</td>
<td>Lithium</td>
</tr>
<tr>
<td>Lithionate</td>
<td></td>
</tr>
<tr>
<td>Lithotabs</td>
<td></td>
</tr>
<tr>
<td>Lamictal</td>
<td>Lamotrigine</td>
</tr>
<tr>
<td>Neurontin</td>
<td>Gabapentin</td>
</tr>
<tr>
<td>Tegetrol</td>
<td>Carbamazepine</td>
</tr>
<tr>
<td>Topamax</td>
<td>Topiramate</td>
</tr>
</tbody>
</table>

### Anti-Depressants

#### Tricyclics

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anafranil</td>
<td>Clomipramine</td>
</tr>
<tr>
<td>Asendin</td>
<td>Amoxapine</td>
</tr>
<tr>
<td>Elavil</td>
<td>Amitriptyline</td>
</tr>
<tr>
<td>Norpramin</td>
<td>Desipramine</td>
</tr>
<tr>
<td>Pamelaor</td>
<td>Nortriptyline</td>
</tr>
<tr>
<td>Sinequan</td>
<td>Doxepin</td>
</tr>
<tr>
<td>Surmontil</td>
<td>Trimipramine</td>
</tr>
<tr>
<td>Tofranil</td>
<td>Imipramine</td>
</tr>
<tr>
<td>Vivactil</td>
<td>Protriptyline</td>
</tr>
</tbody>
</table>

#### SSRIs

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Celexa</td>
<td>Citalopram</td>
</tr>
<tr>
<td>Lexapro</td>
<td>Escitalopram</td>
</tr>
<tr>
<td>Luvox</td>
<td>Fluvoxamine</td>
</tr>
<tr>
<td>Paxil</td>
<td>Paroxetine</td>
</tr>
<tr>
<td>Prozac</td>
<td>Fluoxetine</td>
</tr>
<tr>
<td>Zoloft</td>
<td>Sertraline</td>
</tr>
</tbody>
</table>

#### MAOIs

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nardil</td>
<td>Phenelzine</td>
</tr>
<tr>
<td>Parnate</td>
<td>Tranylcypromine</td>
</tr>
</tbody>
</table>

### Anti-Panic

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Klonopin</td>
<td>Clonazepam</td>
</tr>
<tr>
<td>Paxil</td>
<td>Paroxetine</td>
</tr>
<tr>
<td>Xanax</td>
<td>Alprazolam</td>
</tr>
<tr>
<td>Zoloft</td>
<td>Sertraline</td>
</tr>
</tbody>
</table>

### Anti-Anxiety

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ativan</td>
<td>Lorazepam</td>
</tr>
<tr>
<td>BuSpar</td>
<td>Buspirone</td>
</tr>
<tr>
<td>Centrax</td>
<td>Prazeprone</td>
</tr>
<tr>
<td>Inderal</td>
<td>Propranolol</td>
</tr>
<tr>
<td>Klonopin</td>
<td>Clonazepam</td>
</tr>
<tr>
<td>Lexapro</td>
<td>Escitalopram</td>
</tr>
<tr>
<td>Librium</td>
<td>Chlordiazepoxide</td>
</tr>
<tr>
<td>Serax</td>
<td>Oxazepam</td>
</tr>
<tr>
<td>Tenormin</td>
<td>Atenolol</td>
</tr>
<tr>
<td>Tranxene</td>
<td>Clorazepate</td>
</tr>
<tr>
<td>Valium</td>
<td>Diazepam</td>
</tr>
<tr>
<td>Xanax</td>
<td>Alprazolam</td>
</tr>
</tbody>
</table>

### Stimulants

(used in the treatment of ADHD)

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adderall</td>
<td>Amphetamine and dextroamphetamine</td>
</tr>
<tr>
<td>Cylert</td>
<td>Pemoline</td>
</tr>
<tr>
<td>Dexedrine</td>
<td>Dextroamphetamine</td>
</tr>
<tr>
<td>Ritalin</td>
<td>Methylphenidate</td>
</tr>
</tbody>
</table>

---

**Note:** This chart is a simplification and should be used for reference only. For precise information, consult a healthcare professional or a reliable medical resource.
For additional information on psychotropic medications for mental health disorders, some links are:

http://www.namihelps.org/assets/PDFs/fact-sheets/Medications/Commonly-Psyc-Medications.pdf
http://www.psychceu.com/Quick_Reference_BW.pdf
http://www.nami.org/FAQ/Mental-Health-Medication-FAQ
http://www.nami.org/Learn-More/Fact-Sheet-Library

**CO-OCCURRING PHYSICAL AND SUBSTANCE USE DISORDERS**

People suffering from substance use disorders are at higher risk for certain medical conditions that can develop with, or as a result of, substance use. Indeed, a synthesis of data gathered by the National Comorbidity Survey indicates that 68% of people with mental health disorders also suffer from medical conditions (Druss & Walker, 2011). When narrowed down to those with substance use disorders, the most problematic medical conditions include the following:

**Viral hepatitis** – there are three kinds of commonly found strains of hepatitis, A, B and C. While there are vaccinations to prevent Hepatitis A (a food-borne pathogen), and Hepatitis B (transmitted through body fluid), there are currently no vaccinations to prevent Hepatitis C. Injection drug use is the most common way that Hepatitis C is contracted and transmitted. For more information, use the following links:

- [Hepatitis Infection in the Treatment of Opioid Dependence and Abuse. Substance Abuse: Research and Treatment – 2008](link is external)
- [Integrating Hepatitis Services into Substance Abuse Treatment Programs: New Initiatives from SAMHSA. Public Health Reports – 2007](link is external)
- [Take Action Against Hepatitis C: For People in Recovery from Mental Illness or Addiction – 2014](link is external)
- [TIP 53: Addressing Viral Hepatitis in People With Substance Use Disorders – 2011](link is external)
- [Viral Hepatitis and Injection Drug Users at the CDC](link is external)

**HIV/AIDS** – Injection drug users contribute to approximately 9% of all new HIV cases per year. Further, the practice of unsafe sex is higher while under the influence of alcohol and other drugs which can further the spread of HIV infections. For more information on HIV screening, prevention, and treating people with HIV, use the following links:

- [Advisory: Rapid HIV Testing in Substance Abuse Treatment Facilities – 2011](link is external)
- [HIV Prevention Among Injection Drug Users from CDC](link is external)
- [TIP 37: Substance Abuse Treatment for Persons with HIV/AIDS – 2008](link is external)

**COLLABORATIVE CARE**

Collaborative care has been found to be the most effective and cost-efficient management of all comorbid conditions (Druss & Walker, 2011). Collaborative care means multidisciplinary teams
working together sharing information and jointly contributing to service/treatment plans. Collaborative care could include a fully integrated one-stop shop, a partnership across two agencies, or a referral system with key points of contact and case coordination.

It is imperative that as treatment providers we facilitate this collaborative care model. Most commonly, this will mean coordinating with our referral sources (probation, parole, etc.) and communicating with the clients’ physicians. Once the appropriate releases of information are in place, the key areas that need to be communicated about include:

- Service plans: goals, progress toward goals, barriers and how to facilitate removal of barriers
- Treatment progress: engagement and participation in treatment, impact of medications on their behavior (e.g., nodding off in group), what referral sources or physicians could do to facilitate their progress in treatment
- Discharge planning: prognosis, aftercare plan, resources

**MEDICATION ASSISTED TREATMENT**

Medication Assisted Treatment (MAT) is using a combination of medication and counseling to treat a substance use disorder.

**For Alcohol Use Disorders**

MAT is usually considered for clients with a moderate or severe alcohol use disorder, or for those struggling with cravings and relapse. Medications that are most commonly prescribed and approved for treating alcohol use disorders include:

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand name</th>
<th>Drug effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disulfiram</td>
<td>Antabuse</td>
<td>Causes a significant physical reaction when alcohol is consumed</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>Vivitrol</td>
<td>Blocks opiate receptors thereby limiting the reward circuity activated when drinking or craving</td>
</tr>
<tr>
<td></td>
<td>Revia</td>
<td>Available orally or as a monthly injectable</td>
</tr>
<tr>
<td>Acamprosate</td>
<td>Campral</td>
<td>Supports the rebalancing of neurotransmitters GABA and glutamate</td>
</tr>
</tbody>
</table>

These medications can be prescribed by anyone licensed to prescribe medication.

For additional information, use the following links:
- [http://improvinghealthcolorado.org/medication-assisted-treatment/](http://improvinghealthcolorado.org/medication-assisted-treatment/)
For Opioid Use Disorders
Combining medication with behavior therapies is the most effective method of treating opioid use disorders. The different types of medications used to treat opiate use disorders vary in their target population and effectiveness, so a thorough assessment and medical plan is needed.

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand name</th>
<th>Drug information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naltrexone</td>
<td>Vivitrol</td>
<td>Blocks opiate receptors thereby limiting the reward circuitry activated when drinking or craving Available as a monthly injectable Can be prescribed by anyone licensed to prescribe medications</td>
</tr>
<tr>
<td></td>
<td>Revia</td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td>Methadose</td>
<td>Acts as an opiate agonist</td>
</tr>
<tr>
<td></td>
<td>Diskets</td>
<td>Can only be dispensed by certified and approved opioid treatment programs</td>
</tr>
<tr>
<td></td>
<td>Dolophine</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Butrans</td>
<td>Relieves the symptoms of</td>
</tr>
<tr>
<td></td>
<td>Buprenex</td>
<td>Can only be prescribed by physicians who have completed special training to prescribe buprenorphine</td>
</tr>
<tr>
<td>Buprenorphine/Naloxone</td>
<td>Suboxone</td>
<td>Relieves symptoms of opiate withdrawal; the addition of naloxone reduces the likelihood of abuse Can only be prescribed by physicians who have completed special training to prescribe buprenorphine</td>
</tr>
</tbody>
</table>

For additional information, use the following links:
- [http://improvinghealthcolorado.org/medication-assisted-treatment/](http://improvinghealthcolorado.org/medication-assisted-treatment/)
- [TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs – 2008](http://store.samhsa.gov/product/Medication-Assisted-Treatment-of-Opioid-Use-Disorder-Pocket-Guide/SMA16-4892PG)

**APPROVED MAT PROVIDERS**

A list of approved MAT providers is below, however, for up-to-date information, please contact OBH, as program information changes frequently.
<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Agency Office Contact</th>
<th>Agency Address</th>
<th>Agency City</th>
<th>Agency Zip Code</th>
<th>Agency Telephone Number</th>
<th>Agency Business Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHG Centennial Treatment Center</td>
<td>Tina Beckley</td>
<td>7286 South Yosemite Street</td>
<td>Centennial</td>
<td>80112</td>
<td>214.477.5308</td>
<td></td>
</tr>
<tr>
<td>BHG Denver Treatment Center</td>
<td>Derek Walsh</td>
<td>5250 Leetsdale Drive, Suite 220</td>
<td>Denver</td>
<td>80246</td>
<td>303-629-5293</td>
<td>303.629.5293</td>
</tr>
<tr>
<td>BHG Ft Collins Treatment Center</td>
<td>Susan Kanamatsu</td>
<td>2114 Midpoint Drive, Suite 4</td>
<td>Fort Collins</td>
<td>80525</td>
<td>303-245-0123</td>
<td>214.477.5308</td>
</tr>
<tr>
<td>BHG Longmont Treatment Center</td>
<td>Derek Walsh</td>
<td>850 23rd Avenue</td>
<td>Longmont</td>
<td>80501</td>
<td>303-245-0123</td>
<td>303-245-0123</td>
</tr>
<tr>
<td>BHG Westminster Treatment Center</td>
<td>Janelle Blake</td>
<td>8402 Clay Street</td>
<td>Westminster</td>
<td>80031</td>
<td>303-487-7776</td>
<td>303-487-7776</td>
</tr>
<tr>
<td>Boulder Integrated Health LLC</td>
<td>Mae Martin</td>
<td>311 Mapleton Avenue</td>
<td>Boulder</td>
<td>80302</td>
<td>720-289-0606</td>
<td></td>
</tr>
<tr>
<td>Centennial Peaks Hospital *</td>
<td>Teresa Abts</td>
<td>2255 S 88th Street</td>
<td>Louisville</td>
<td>80027</td>
<td>303-673-9990</td>
<td>303-673-9990</td>
</tr>
<tr>
<td>Center for Dependency Addiction and Rehabilitation CeDAR</td>
<td>Gary Kushner</td>
<td>1693 N Quentin Street, PO BOX 6510 Mail Stop F786</td>
<td>Aurora</td>
<td>80045</td>
<td>720-848-3016</td>
<td>720-848-3016</td>
</tr>
<tr>
<td>Colorado Treatment Services Colorado Springs</td>
<td>Ingrid Contreras Program Director</td>
<td>2010 E Bijou</td>
<td>Colorado Springs</td>
<td>80909</td>
<td>719-475-7052</td>
<td>719.434.2061</td>
</tr>
<tr>
<td>Colorado Treatment Services Greeley</td>
<td>Bryan Tabakian</td>
<td>1624 East 17th Avenue</td>
<td>Greeley</td>
<td>80631</td>
<td>970.978.4386</td>
<td></td>
</tr>
<tr>
<td>Colorado Treatment Services Montrose</td>
<td>Bruan Tabakian</td>
<td>2350 South Townsend</td>
<td>Montrose</td>
<td>81401</td>
<td>918.282.0649</td>
<td></td>
</tr>
<tr>
<td>Colorado Treatment Services Pueblo</td>
<td>Bryan Tabakian</td>
<td>511 West 29th Street</td>
<td>Pueblo</td>
<td>81008</td>
<td>918.282.0649</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Behavioral Health Center *</td>
<td>Laura Erkaev</td>
<td>2217 Champa Street</td>
<td>Denver</td>
<td>80205</td>
<td>303-502-4509</td>
<td>720.398.9666</td>
</tr>
<tr>
<td>Crossroads Treatment Center Denver, PC</td>
<td>Kim Deal</td>
<td>1801 West 13th Avenue</td>
<td>Denver</td>
<td>80204</td>
<td>864.527.3145</td>
<td></td>
</tr>
<tr>
<td>Crossroads' Turning Points Inc</td>
<td>Karen Irick</td>
<td>509 East 13th Street</td>
<td>Pueblo</td>
<td>81001</td>
<td>719-546-6666</td>
<td>719.544.3150</td>
</tr>
<tr>
<td>Crossroads Turning Points Inc Alamosa</td>
<td>Karen Irick</td>
<td>2265 Lava Lane</td>
<td>Alamosa</td>
<td>81101</td>
<td>719-546-6667</td>
<td>719-589-5176</td>
</tr>
<tr>
<td>Agency Name</td>
<td>Agency Office Contact</td>
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<td>Denver Recovery Group *</td>
<td>Jan Morgan</td>
<td>2822 E Colfax</td>
<td>Denver</td>
<td>80206</td>
<td>303-953-2299</td>
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<td>Denver Recovery Group South *</td>
<td>Carol Howard</td>
<td>72 East Arapahoe Road</td>
<td>Littleton</td>
<td>80122</td>
<td>720-283-3055</td>
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<td>Jan Morgan</td>
<td>5330 Manhattan Circle Unit H</td>
<td>Boulder</td>
<td>80301</td>
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<td>Harmony Foundation</td>
<td>Lynn Milosevic 970.577.3152</td>
<td>1600 Fish Hatchery Road</td>
<td>Estes Park</td>
<td>80517</td>
<td>970-586-4491</td>
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<td>Mental Health Partners</td>
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<td>3180 Airport Road</td>
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<td>80301</td>
<td>303-441-1281</td>
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<td>Metro Treatment of Colorado *</td>
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<td>81501</td>
<td>970-208-1130</td>
<td>407-351-7080 (x11126)</td>
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<td>Parkview Medical Center *</td>
<td>Lisa Gawenus</td>
<td>667 Bannock St.</td>
<td>Denver</td>
<td>80204</td>
<td>303-436-3636</td>
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<td>Recovery Village at Palmer Lake LLC</td>
<td>Belina Surujon</td>
<td>443 S Highway 105</td>
<td>Palmer Lake</td>
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<td>754-300-3120 ext 4000</td>
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<td>Shadow Mountain Recovery *</td>
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<td>Colorado Springs</td>
<td>80918</td>
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<td>Southern Rockies Addiction Treatment Services *</td>
<td>Dan Caplin</td>
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<td>Durango</td>
<td>81301</td>
<td>970-903-3716</td>
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<td>Strategic Behavioral Health, dba North Denver LLC * or Clearview Behavioral Health</td>
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<td>UC Health Mountain Crest Behavioral Health</td>
<td>Monica Smith</td>
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<td>Fort Collins</td>
<td>80528</td>
<td>970-207-4800</td>
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<td>University of Colorado Health &amp; Science Center-Addiction Recovery Treatment Services-Parkside Parkside Clinic</td>
<td>Angel Bonaguidi</td>
<td>1620 Gaylord Street</td>
<td>Denver</td>
<td>80206</td>
<td>303-388-5894</td>
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<td>University of Colorado Health &amp; Sciences Center Addiction Recovery Treatment Services-WestSide Center for Change</td>
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<td>303-935-7004</td>
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<tr>
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<td>303-841-7857</td>
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<td>Parker Valley Hope</td>
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<td>WheatRidge</td>
<td>80033</td>
<td>303-467-4009</td>
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SECTION VI: TESTING AND MONITORING

According to the National Institute on Drug Abuse, monitoring alcohol/drug use during treatment is one of the research-based principles for alcohol/drug treatment for criminal justice populations. It provides a level of accountability for the client, as well as crucial information about the client’s progress in treatment. This section provides a summary of the OBH rules regarding the monitoring and testing of individuals with four or more impaired driving offenses, covers the different types of monitoring options available as well as how to use testing results in treatment, and information on coordination of care. This is not a how-to on conducting monitoring or testing at your facility, nor is it all-encompassing or an exhaustive review of testing and monitoring. While treatment facilities are not required to conduct testing/monitoring in-house, every attempt must be made by treatment providers to obtain the results of drug tests and use these results in treatment. For the purposes of this section, we will use the term drug testing to include monitoring and testing of alcohol and other drugs.

OBH RULES ON TESTING AND MONITORING

OBH Rules regarding testing and monitoring can be found in the Code of Colorado regulations (2 CCR 502-1, Volume 21 CDHS Behavioral Health Rules, 21.190.4 and 21.240.85) and are quoted here as well:

1. All clients shall be tested and/or monitored for alcohol and drug use. Testing and/or monitoring may include the following:
   A. Urinalysis;
   B. Breath analysis;
   C. Continuous alcohol monitoring;
   D. Mobile/remote breath testing;
   E. Direct and indirect biomarker testing;
   F. Drug and other testing as appropriate.

2. Agency drug and alcohol toxicology collection shall be observed by trained staff.
3. If testing is not done by the agency, there must be documentation of the efforts to obtain test results.
4. Testing and sharing of results shall be coordinated with probation.

WHY DRUG-TEST CLIENTS AND WHAT DO I DO WITH THE RESULTS?

Drug testing can provide information about the accuracy of the client’s treatment placement level, the client’s progress in treatment and how well targeted the service plan is.
Similar to conducting a blood test to check levels of thyroid when providing medication for a thyroid disease, drug testing tells us whether treatment and ancillary services are working or need to be modified.

Drug testing can help keep clients accountable for their behavior, their choices, their service plan, and their relapse prevention plan.

Drug testing acts as a deterrent for future drug use.

Drug testing acts as an incentive when clients are drug-free, and can be a source of reinforcement and support especially when the client is still building refusal skills.

Respond as immediately as possible to the drug-test result with incentives or sanctions as needed. The more timely your response (even if it is just a phone call to the client, the more impact it will have on the client’s behavior).

The issue to discuss with the client is not how the drug got into the client’s system, but what supports the client needs to maintain sobriety and what the client needs to change in order to provide a drug-free sample.

Interpret the results in the context of the client as a whole, including any behavioral changes you are seeing or progress as reported by everyone involved in the client’s care.

Drug concentration levels do not provide information on amount of drug use. It provides information about the concentration in that particular sample and is influenced by the client’s physiological make-up. So asking questions about the client’s level of use, whether the levels are going up or down, etc. are not answerable by a urine test. For more information on this, please follow this link (http://www.ndcrc.org/sites/default/files/urine_drug_concentrations_2.pdf)

Although drug testing is a helpful tool, it is not the only tool we have and should be used in conjunction with the client’s self-report, monitoring behavioral changes, and information from collateral sources like the client’s family and/or referral source.

**MISCONCEPTIONS OF DRUG AND ALCOHOL MONITORING/TESTING**

Drug tests will tell me everything a client is using!

   **FACT:** drug tests are targeted to identify certain predetermined substances, and only when they are present in amounts greater than a pre-established cut-off amount.

Drug tests can tell me when the client used!

   **FACT:** drug tests cannot determine the dosage, when the drug was administered, how it was administered, or the degree of impairment from the use of the drug. As mentioned previously, drug concentration levels frequently reported on urine test results, tell us nothing about the client’s drug use; all it reveals is how much of the substance or its metabolites were present in that particular sample.
Drug tests look for the presence of the exact drug the client is using!

FACT: most often drug tests identify the metabolites of a particular drug, not the drug itself.

BIOMARKER TESTING TYPES

Alcohol and drug testing methods are frequently known as biomarker tests because they look for certain markers of substances or their metabolites in whatever sample is provided. The most common tests used are urine, breath, saliva, and hair. Please always assume that clients know more about drug testing and how to beat the system than we do. Therefore, testing must be random, must be at least twice a week, and must be observed. This greatly reduced the likelihood of missing periods of use, tampering, or invalid samples. Further, if your tests are not random and you have a testing schedule, then clients might resort to a corresponding drug-using schedule that works around your testing schedule.

**Urine:** urinalysis is currently the specimen of choice in drug testing because urine is readily available, contains metabolites of most drugs we want to test for, and can test for recent and past use. Urinalysis is done in two steps. The initial test is a screening often using immunoassay technology. This quickly and cost-effectively separates negatives from maybe-positives. If the substance or its metabolites are found in an initial test, it is called a presumptive positive. Only positive results will then go to step two where a confirmation test is conducted using gas chromatography / mass spectrometry (GC/MS) or liquid chromatography / mass spectrometry (LC/MS). This confirmatory test identifies substances based on their unique chemical fingerprint. Confirmation reduces false positives that are frequently seen with drugs like amphetamines and benzodiazepines.

There are several different urinalysis panels available. The client’s drugs of choice will help you determine which panel to use. For example, a commonly used 5-panel urinalysis tests for amphetamines, cocaine, heroin, THC, and PCP. You can choose broader panels to include benzodiazepines and barbiturates, as well as add EtG/EtS to test for alcohol.

**Approximate drug detection windows in urine:**

- Amphetamines: up to 4 days
- Cocaine: up to 3 days
- Opiates: up to 5 days
- Benzos and barbiturates: up to 7 days
- Marijuana: depends on the history and frequency of use, anywhere between 3 days for a single use to 21 days for a heavy and chronic user (for more information follow this link: [http://www.ndci.org/sites/default/files/ndci/THC_Detection_Window_0.pdf](http://www.ndci.org/sites/default/files/ndci/THC_Detection_Window_0.pdf))
- Alcohol: up to 3 days because urinalysis detects Ethyl Glucuronide and Ethyl Sulfate (EtG/EtS), the primary metabolites of alcohol. Otherwise, the detection window for actual alcohol in urine, breath, blood, and saliva is approximately only 10-12 hours.
Dilution is the most common way to tamper with a urine drug test. The two most common ways to dilute a sample is to either consume an excessive amount of water just prior to the drug test, or to add water to a urine sample. Creatinine is a substance naturally secreted from our bodies in urine and so creatinine levels help establish whether urine specimens are being diluted or not. Low creatinine levels (lower than 20mg/dL) are extremely rare in the general population and average at approximately 1%, meaning only 1% of the general population will provide a dilute urine sample on any given day.

Other ways that clients will tamper with urine samples is by providing someone else’s urine, by adding vinegar or bleach to urine, or by consuming different masking agents. Observing testing is therefore necessary to reduce the likelihood of tampering.

**Breath**: breathalyzers, or breath testing devices, estimate blood alcohol level by detecting the amount of alcohol in a breath sample. However, because alcohol gets out of the system quickly, the detection window is only about 10-12 hours. Although there are breath testing devices that can detect drugs currently being developed and tested, as of the publication of this document, none are being used for criminal justice clientele.

**Hair**: hair tests have the longest test-window and can go back as far as 90 days, but unfortunately, hair tests tell us nothing about the most immediate past two weeks. This is because of the time it takes for hair to grow out of the follicle. Hair testing places us in a minimum of a two week time delay so if I take a sample from a client today, I am testing what the client consumed between two weeks and up to 90 days ago, but not the most immediate past two weeks and this does not allow for immediate tests resulting in a more immediate intervention.

**Saliva**: saliva tests are easy to use, non-invasive, and are frequently used as a rapid detection technology. The downside of saliva is that the drug detection window is only 24 hours for most drugs so saliva tests only reveal use in the past 24 hours.

**Sweat**: sweat is most often tested using a patch that adheres to the skin and can be worn for an extended period of time. Although this is a relatively non-invasive option, that has some tamper-detection built into the adhesive, there have been reports of clients removing the patch using certain solvents to evade the detection of drug use.

A common device used to detect alcohol in sweat is a transdermal alcohol detection device. These devices continuously monitor the levels of alcohol being excreted through the skin in the form of perspiration. Examples of these devices are SCRAM® (secure continuous remote alcohol monitoring) and TAD® (transdermal alcohol detection) that are worn like bracelets around the client’s leg.

**COORDINATION OF CARE AND CLARITY OF EXPECTATIONS**

Drug testing is not just to ensure client compliance with court conditions and supervision, it is information about the effectiveness of treatment. Therefore, it is critical to communicate with referral sources and other treatment providers involved in the client’s service provision about their drug testing results.
Be clear about expectations of the client while testing. It is helpful to have a clear treatment contract that addresses testing so the client understands what the expectations are. For example, you could include the following in this contract:

- I understand that I will be randomly drug tested throughout treatment.
- I understand that the purpose of drug testing is to support my compliance with conditions of supervision and to tailor my treatment to meet my relapse prevention needs.
- It is my responsibility to understand the calling system and show up at the right location on the right day to provide a sample.
- I understand the consequences associated with missing a test.
- I understand the precautions I need to take in order to provide a viable sample that is not dilute and free from any substances that mask drug use.
- I understand that a dilute urinalysis, or one that is tampered with, will have negative consequences.
- I understand that the treatment team will communicate with my referral agent as well as with any other practitioners involved in my care regarding my drug testing results.
RECOVERY SUPPORT GROUPS

Research has shown that recovery is facilitated by social support (McLellan et al., 1998). Peer support can encompass a wide array of help (Loveland, D., & Boyle, M. 1993). Group members share their stories, offer each other encouragement, and often include tips for job referral, preparation for interviews, and where to find help such as transportation, parenting classes, child care, etc. AA (Alcoholics Anonymous, 1935) pioneered a spiritual, 12-step program of recovery that has become a model and adapted for other problems (White, 2009).

The OBH rules for this population of individuals with four or more impaired driving offenses specify that while support groups such as AA may certainly be used in conjunction with treatment, the hours spent in such groups, including hours spent with a peer mentor or coach, must not be counted toward the required minimum number of treatment hours. Referral to support groups, as with actual treatment must be assessment driven (Wanberg, Milkman & Timken, 2005; Timken, Nandi & Wanberg, 2015). The AOD support group must be abstinence oriented, and a major consideration when making a referral must be whether it matches the client’s frame of reference in terms of locus of control. Clients with an external locus are a far better match for support groups than are those whose locus is internal.

In addition to abstinence oriented supports groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) there are also a number of different types of groups for people with co-occurring disorders, cognitive problems, including traumatic brain injury (TBI), adverse childhood experiences, and grief and loss issues. Not all groups are the same even when they are designed to help people with AOD and other problems. If a client does not like a particular support group, do not give up trying to find a good fit. It is a good idea to have clients sample several different groups in order to find the best fit.

Just as in the case of treatment, a client may well need to be in several different kinds of support groups to assist them in having a successful treatment experience and outcome.

PEER MENTORING OR COACHING

Peer mentoring or coaching offers similar aid, usually on a one-to-one basis. For instance, when helping with employment needs this might go beyond job referrals and address other related needs, such as coaching to prepare for an interview or coaching the person on how to handle sensitive questions about their legal situation. Peer mentoring and the duration of the relationship can last for an indefinite period of time, and depends on how much recovery time the peer has, how much other support the peer has, or how quickly the peer’s most pressing problems can be addressed.

Peer mentors are able to devote more time than the typical 12-step program, and are often able to help with housing needs, employment, and education and often have more specific knowledge about a large range of available resources.
CASE MANAGEMENT

A sizable percentage if not the majority of individuals in Level II Four Plus treatment will be enrolled in more than one type of intervention. A number may be in medication assisted treatment or on medications that may affect behavior including driving. The clinical complexity coupled with public safety and health risks will require that a strong case management plan be in effect to coordinate the services and monitor compliance by the client.

In these cases, it is a must that there be a trained clinical case-manager with significant experience in coordinating services and monitoring criminal justice client services. In doing so, all related OBH standards must be met. These clients are at high risk for reoffending and everything must be done in order to not only protect public safety and health, but also to protect the client.

INTEGRATED HEALTH SERVICES

The goal of an Integrated Health is improving the physical health status of people with mental illnesses and addictions. SAMHSA (Substance Abuse and Mental Health Services Administration, 2013) developed the Primary and Behavioral Health Care Integration (PBHCl) Program. Through this program, SAMHSA provides support to communities to coordinate and integrate primary care services into publicly funded, community-based behavioral health settings, resulting in:

- Improved access to primary care services;
- Improved prevention, early identification, and intervention to reduce the incidence of serious physical illnesses, including chronic disease;
- Increased availability of integrated, holistic care for physical and behavioral disorders; and,
- Improved overall health status of clients.

Colorado Problem Solving Courts were developed in 1994, and were modeled originally after the first Drug Court started in Miami, FL in 1989. Participants engage voluntarily and agree to follow the rules of the program. They are closely supervised by probation officers and case managers, tested for drugs and/or alcohol frequently and randomly, subjected to frequent home and probation office visits, engaged in enhanced or intensive drug treatment as well as other treatment necessary to achieve their goals, assisted in their compliance with efforts to achieve stability, and required to come to court on at least a bi-weekly basis (although this may change to once per month as the participant progresses in the program). The entire Colorado Problem-solving Courts Best Practices Manual can be accessed here. (https://www.courts.state.co.us/.../Court.../Colorado%20PSC%20Best%20Practices%20
APPENDIX A

CODE OF COLORADO REGULATIONS

LEVEL II FOUR PLUS TREATMENT
(2 CCR 502-1)

21.240 DUI/DWAI, BUI, AND FUI EDUCATION AND TREATMENT

21.240.1 DEFINITIONS [Eff. 7/1/17]

“Level I and Level II Education, Therapy or Treatment” means an approved alcohol and drug driving safety education or treatment program as defined in 42-4-1301.3(3)(c)(IV) C.R.S.

21.240.85 LEVEL II FOUR PLUS TREATMENT [Eff. 7/1/17]

A. Level II Four Plus Treatment is an approved alcohol and drug driving safety education or treatment program as defined in Section 42-4-1301.3(3)(c)(IV) C.R.S. (2016), intended for someone who has four (4) or more alcohol and/or drug impaired driving offenses.

B. In order to provide Level II Four Plus Treatment an agency must be licensed to provide:

1. Level II Therapeutic Education; and,
2. Level II Therapy.

C. Level II Four Plus Treatment must consist of not less than eighteen (18) months of attendance which includes a minimum of one-hundred eighty (180) hours of treatment.

D. All Level II Four Plus Treatment shall be driven by the individual’s clinical assessment.

E. Level II Four Plus Staff Requirements

1. Staff providing Level II Four Plus Treatment must meet the requirements in Section 21.240.3(D), and:
   a. CAC II credentialed staff must be receiving clinical supervision by a CAC III or LAC; or,
   b. Licensed staff must have at least one (1) year of documented addiction counseling experience.

2. Staff providing specialized treatment services must hold current and valid credentials and/or licensure in the area of service provision.

3. Staff providing assessment must hold current and valid credentials and/or licensure in the area of service provision.

F. Level II Four Plus Clinical Assessment(s)

1. A full assessment must be administered in accordance with section 21.190.3.

2. In addition to the requirements in Section 21.190.3(D), the assessment must contain information on:
   a. Cognitive functioning;
b. Traumatic brain injury;

c. Adverse childhood experiences (ACES);

d. Grief and loss; and,

e. Co-occurring mental health issues.

3. Agencies shall utilize an assessment tool specifically designed to address co-occurring mental health issues in the impaired driver population.

4. Agencies shall document results and coordinate further services as appropriate.

G. Level II Four Plus Service Planning and Reviews

1. Level II Four Plus service planning and reviews must be administered in accordance with Section 21.190.4.

2. Agencies providing Level II Four Plus Treatment shall conduct service plan reviews at a minimum of every sixty (60) days in collaboration with supervising probation officers.

3. Consideration shall be given to clients’ needs for aftercare and peer recovery support services.

H. Level II Four Plus Discharge Planning

Level II Four Plus discharge planning must be administered in accordance with Section 21.190.6.

I. Provision of Level II Four Plus services shall:

1. Be determined by the results of the screenings and clinical assessment.

2. Be a combination of education and treatment strategies that include, but not limited to:
   a. Individual counseling;
   b. Group therapy, unless clinically contraindicated;
   c. Family/other supportive adult therapy, if applicable;
   d. Interlock counseling, if the individual has an ignition interlock installed;
   e. DUI Level II Education or Level II Therapy, if applicable;
   f. Education, if applicable;
   g. Medication assisted treatment, if applicable;
   h. Residential treatment, if applicable;
   i. Other treatment as indicated by the initial and ongoing clinical assessment.

3. Agencies providing Level II Four Plus Treatment shall provide case management activities, where applicable, to ensure the coordination of client services and needs, and the continuity of care, with other services.
J. Testing and Monitoring

1. All clients shall be tested and/or monitored for alcohol and drug use. Testing and/or monitoring may include the following:
   a. Urinalysis;
   b. Breath analysis;
   c. Continuous alcohol monitoring;
   d. Mobile/remote breath testing;
   e. Direct and indirect biomarker testing;
   f. Drug and other testing as appropriate.

2. Agency drug and alcohol toxicology collection shall be observed by trained staff.

3. If testing is not done by the agency, there must be documentation of the efforts to obtain test results.

4. Testing and sharing of results shall be coordinated with probation.
APPENDIX B

BEST PRACTICES FOR PERSONS WITH COMORBID TBI AND SUBSTANCE USE
TBI-Related Deficits

When delivering substance abuse treatment to an individual with a TBI-related cognitive disability, the following impairments may require modification of those therapies (Khan, Baguely & Cameron, 2003)

Neurological Impairments
- Motor function impairment – coordination, balance, walking, hand function, speech
- Sensory loss – taste, touch, hearing, vision, smell
- Sleep disturbance – insomnia, fatigue
- Medical complications – spasticity, post-traumatic epilepsy

Personality and behavior changes
- Impaired social and coping skills, reduced self-esteem
- Altered emotional control; poor frustration tolerance and anger management; denial, and self-centredness
- Reduced insight, disinhibition, impulsivity
- Psychiatric disorders – anxiety, depression, Post-Traumatic Stress Disorder, psychosis
- Apathy, amotivational state

Interpersonal problems
- Difficulties maintaining interpersonal relationships

Cognitive Impairments
- Memory impairment, difficulty with new learning, attention and concentration; reduced speed and flexibility of thought processing; impaired problem-solving skills
- Problems in planning, organizing, and making decisions
- Language problems – dysphagia, problems finding words, and impaired reading and writing skills
- Impaired judgement and safety awareness

Suggested Interventions

Attention:

- For clients who demonstrate an inability to focus on more than one task at once (Park, Moscovitch, & Robertson, 1999)
  - Adjust the treatment setting to have minimal distractions (DeLambo et al., 2009)
  - Ensure there is good eye contact when beginning a session (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
- Movement can increase attention (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
- Consider using demonstrations that require participation
- Consider prescribing exercise (Ussher et al., 2004)

- Provide sufficient time for response (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
  - Count silently after questions to allow extra time for client to respond
  - Announce when you are moving to a new topic
    - Allow extra time for that transition

- Keep instructions brief and simple (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
- Keep discussions simplified (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
  - Critical points should be presented one at a time
  - Set a goal and have an outline on how to accomplish that goal (Bombardier & Turner, 2009)
    - Goal examples
      - A better understanding of how TBI can make drinking and drug use dangerous
      - Better relationships with family
      - Fewer calls to emergency health services
      - Reduced need for therapeutic visits and interventions
    - Consider setting rewards for meeting the goal (Bombardier & Turner, 2009)

- Consider scheduling shorter sessions
- Be silent during times client is recording material in notebook
  - Persons with cognitive deficits have trouble listening, comprehending, and writing simultaneously
- Create and use a signal for when clients begin to stray from the topic
- Use multimodal materials
  - e.g., Tapes, videos, art, music, handouts, charts
  - Art can be an easy way to make abstract concepts concrete
    - Especially helpful when discussing feelings

**Memory:**

- For clients who demonstrate an inability to remember appointment dates, poor compliance with homework and little recall of material discussed at previous appointments (Park, Moscovitch & Robertson, 1999)
  - Review expectations for treatment
  - Frequently ask client to repeat recent information (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
  - Provide pencil/paper or encourage note-taking
  - When possible, provide a written summary of the information (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
    - Write down expectations for substance use reduction each session
    - Write down appointments
    - Write down any action items or homework
Cue them to write appointments in their calendar
  ○ Use visual imagery to promote retention (Cicerone et al., 2005)
    ■ For example, use flashcards and workbooks
  ○ Encourage client to maintain consistent daily routines (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)

Communication and Language:

- Changes in emotional and social behavior are relatively common following traumatic brain injury (Milders, Fuchs, & Crawford, 2003)
- Ask the client explicitly about their abilities to read and write
  - Adjust treatment plan as needed
    ■ e.g., If the client can’t read or write, provide visual aids instead
- Role play conversations to build confidence (Cicerone et al., 2005)
  - e.g., How to refuse a drink when out with friends
  - Write down action plans for when problematic situations arise
    ■ e.g., What to do when in a situation when social drinking/drug use is common

Impulsivity:

- Emphasize personal responsibility for their actions regarding drinking/drug use in relation to taking care of family, upholding work and other life responsibilities.
- Working with the client to reduce impulsivity can also help to curb substance cravings (Corrigan & Cole, 2008)
- Impulsiveness in a client may indicate a desire for immediate reinforcement (Corrigan & Cole, 2008)
  - Reinforce attendance at the first couple of sessions (Corrigan & Cole, 2008)
    ■ e.g., Distribute vouchers for the client to use toward community services (Lussier et al., 2006)
- Teach “Stop, Think, Act” to encourage the client to slow down and think about consequences before acting (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
  - Stop
    ■ First, stop long enough to consider the situation
  - Think
    ■ Think about the choices
      - Alternatives
      - Behavior
      - Consequences
  - Act
    ■ Make the choice and act on it
  - Encourage client to think about the following:
    ■ “Is this a good idea or a bad idea?”
    ■ “What could happen?”
    ■ “Does this fit with my goals?”
- Add additional structure to therapies
  - e.g., Written treatment plans and step by step handbooks that explain treatment goals and activities
- Add reinforcement where possible
  - e.g., Continual feedback regarding progress in treatment and needed improvements
- If applicable, involve family members in treatment and provide them with the following (Taylor, et al., 2003):
  - Substance abuse policies within the program
  - Information regarding the signs of substance abuse
  - Information about the risks of drinking/drug use with a TBI
    - Dangerous interactions with prescribed medications
    - Increase in cognitive difficulties stated above
    - Likelihood of longer treatment requirement due to poorer cognitive functioning

Social Deficits:

- Clients may demonstrate poor compliance with social norms (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
- Don’t assume something learned in therapy will generalize to outside environment (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
  - Rehearse in multiple environments with different persons
- Reinforce positive behavior (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
  - Immediately stop and address negative behavior observed in therapy
    - e.g., Identify when the client positively refers to substance abuse
    - Identify alternative and desired choices

Initiation and Completion of Tasks:

- A lack of motivation, an inability to achieve goals, and trouble starting tasks are common problems in this population (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
  - Simplify material presented
    - Help create lists so the client can cross items off and maintain organization and productivity
    - Smartphone and tablet apps can aid in organization
- Emphasize and repeat the dangers of future drug/alcohol use (Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 2005)
  - Alcohol/drugs can have negative effects on memory and thinking flexibility
  - Depression
  - Increased risk for seizures
  - Increased risk for another TBI
  - Lowered sexual desire
Helpful Links

Brain Injury and Substance Abuse: The Cross Training Advantage

Substance Abuse/Brain Injury Client Workbook: Carolyn Lemsky, Heather Chisven, Tim Godden, Denis James, Jerry Schwalb, Pamela Kaufman, Kelly Greer
http://www.brainline.org/content/2009/10/subi-client-workbook.html

The Clinical Presentation of Co-Occurring TBI and Substance Abuse: Carolyn Lemsky, PhD, C.Psych

Models for Treating Co-Occurring TBI and Substance Abuse: Carolyn Lemsky, Tim Schilling, Annette Pearson

Ohio Valley Center for Brain Injury Prevention and Rehabilitation
http://ohiovalley.org/informationeducation/substanceuseinformation/substanceusetreatment/

Addressing the Challenges: Brain Injury and Substance Use Disorders - Annette Pearson MS, LADC, CBIS

The Problem of Substance Abuse and TBI: John Corrigan

US Department for Veteran Affairs: National Center for PTSD

Veterans Health Initiative: TBI and Substance Abuse

Toolkit for Providers of Clients with Co-Occurring TBI and Mental Health Symptoms
https://www.mirecc.va.gov/visn19/tbi_toolkit/
APPENDIX C

COLORADO REFERRAL SOURCES FOR NEUROPSYCHOLOGISTS
Colorado Referral Sources for Neuropsychologists

“Clinical Neuropsychologists have specialized knowledge and training in the applied science of brain-behavior relationships. Clinical Neuropsychologists use this knowledge in the assessment, diagnosis, treatment, and rehabilitation of patients across the lifespan who have neurological, medical, developmental, or psychiatric conditions” (American Board of Professional Psychology).

The following list is not exhaustive, there are many others within Colorado who are licensed neuropsychologists. The following agencies and psychologists have expressed an interest in the Level II Four Plus treatment and indicated a willingness to participate. This list continues to change and grow. For additional referrals, contact Judy Dettmer, Director, Colorado Brain Injury Program, 1575 Sherman St. 4th Floor, Denver, CO. 80203, 303-866-4085, the Colorado Neuropsychological Society [https://coloradoneuropsych.org/member-directory](https://coloradoneuropsych.org/member-directory) or The Brain Injury Alliance of Colorado, 1325 S. Colorado Blvd B-300, Denver, CO 80222.

Dr. J. Michael Kerrigan
3649 S. Newland St.
Denver, CO 80235
303-257-2920
drmichaelkerrigan@gmail.com

Brain and Behavior Clinic, Dr. Stephen Schmitz, Dr. Mark Zacharewicz
2523 Broadway
Boulder CO 80304
Phone: 303-938-9244
Email: mail@bbcneuro.com
Website: healthybrain.clinic/

Blue Sky Neurology, Dr. Mimi Castello or Dr. Katrina Giles
499 E. Hampton Ave, Ste. 360
Englewood, CO 80113
303-781-4485
Blueskyneurology.com
This is the main site. Other locations are in Aurora, Lafayette, Lone Tree, Wheat Ridge, Greenwood Village, and Denver. Use same phone number to contact.

Jordan Wolfsohn, Psy.D. LLC.
1776 S. Jackson St. Ste. 601
Denver, CO 80210
720-460-0258
Jordan.wolfsohn@gmail.com

Rehabilitation Associates of Colorado
3333 S. Bannock St.
Denver, CO 80222
303-788-9332 & 720-907-0420
There are several additional sites. Call for more information

Gray Neuropsychological Associates, P.C.
Steven Gray, Ph.D.
6270 Lehman Dr. Ste. 200C
Colorado Springs, CO 80918
719-487-1760
Gray.matter@mindspring.com

Eric Westfried
P.O. Box 1932
Durango, CO 81302
970-375-1427
http://neuropsychforensics.com

Dr. John Kirk
400 McCaslin Blvd. Ste. 212
Louisville, CO 80027
303-915-0108
Drjohnkirk.com/neuropsychology.html

Jan Lemmon, Ph.D.
777 29th St. Ste. 102
Boulder CO 80303
303-443-3557

Helena Huckabee, Ph.D.
400 S. Colorado Blvd. Ste. 860
Glendale, CO 80246
303-322-9000
helenahuck@aol.com

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drmirich@gmail.com

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303-200-4780
kbpowellphd@gmail.com

Jose G. Vega, Ph.D.
803 W. 4th St. Ste. H
Pueblo, CO 81003
719-544-8520

Lisa Brenner, Ph.D. & Catie Johnston-Brooks
1055 S. Clermont St.
Denver, CO 80220
303-399-8020
Lisa.brenner@va.gov and Catharine.johnston-brooks@va.gov

Institute for Clinical Neurosciences
Dr. Bob Gant
255 Canyon Blvd. Ste. 200
Boulder, CO 80302
303-720-6092

Valerie Stone, Ph.D.
601-C S. 16th St. Ste. 191
Golden, CO 80401
303-669-8528
www.assesscompetency.com

Brad Martin, Ph.D.
4405 Northpark Dr.
Colorado Springs, CO 80907
719-471-3125
martenint@msn.com

Victor Neufeld, Ph.D.
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Colorado Springs, CO 80906
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victoraneufeld@comcast.net

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Boulder, CO 80301
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Michelegerardphd.com

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7400 E. Arapahoe Rd.
Centennial, CO 80112
303-741-1077
raccolo@aol.com
APPENDIX D

REFERENCES


Center for Substance Abuse Treatment (US). (2012). A provider's introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals. US Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.


