Title

Comprehensive Assessment and Treatment of Adults with Substance Use Disorders

Goal/What Do We Want to Achieve Through the Use of this Protocol?

To enhance the capacity of Arizona's behavioral health system to utilize evidence-based, recovery focused, and culturally relevant practices in the assessment, placement and treatment of individuals with substance use disorders.

Target Audience

This protocol is specifically targeted for Tribal and Regional Behavioral Health Authorities (T/RBHAs) and their subcontracted network and provider agency staff who complete assessments, participate in the service planning process, provide therapy, case management and other clinical services, or supervise staff that provide these services to adults with substance use disorders.

Target Population(s)

This practice protocol has been developed for adults who may have substance use disorders referred to the behavioral health system.

Attachments:

1. Attachment A: Principles of Effective Treatment
2. Attachment B: American Society of Addiction Medicine Patient Placement Criteria-Second Edition Revised (ASAM PPC-2R) Levels of Care
3. Attachment C: Decision Tree to Match Assessment and Treatment/Placement Assignment
4. Attachment D: ASAM PPC 2R Criteria Assessment Dimensions
5. Attachment E: List of Evidence Based Treatment Practices
6. Attachment F: Information/websites for Mutual Support Group

Background

Each day almost 8,000 Americans illegally consume a drug for the first time. The risks posed by their drug use, like that of the other 20 million Americans who already use drugs illegally, will radiate to their families and to the communities in which they live. The scale of the problem and the suffering it causes are immense. More than 7.6 million Americans have a diagnosable drug abuse disorder, drug overdoses approach car crashes as a leading cause of accidental death, drug abuse contributes to more than one in eight new human immunodeficiency virus (HIV) infections, and substance use disorders results in significant healthcare costs every year.[1]

Only a fraction of the money spent on health-related drug abuse costs is spent on identifying and intervening early in emerging cases of drug abuse or treating individuals with substance use disorders. Much of it is spent instead in the emergency room and in the rehabilitation of severe injuries. Abuse of drugs and alcohol are factors in many car crashes, home accidents, fires, and violent assaults. Enormous sums are also spent treating the infectious illnesses (e g,

Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome, (HIV/AIDS), hepatitis B and C) for which drug users are at high risk. Other financial and human costs result when undetected substance use disorder complicates the treatment of other illnesses, leading to misdiagnosis, poor adherence to medical advice, and unintended interactions with prescribed medications. [1]

Studies conducted by the Substance Abuse and Mental Health Service Administration (SAMHSA) and the National Survey of Drug Use and Health (NSDUH), as well as by independent researchers, estimate that the proportion of individuals with substance use disorders who receive specialty treatment is about 10 percent— lower than almost any other serious medical disorder in the United States. Low use of treatment is not solely due to limited supply; in some cases, the services available are not appealing to individuals because they are poorly structured, hard to access, and do not offer state-of-the-art behavioral therapies and medications. This situation comes about in part because substance use disorder treatment is the only specialty in medicine that is not an integral part of the rest of the healthcare system. There is a great divide between substance use disorder treatment programs and mainstream health care.[1]

Because substance use disorders have so many dimensions and disrupt so many aspects of an individual's life, treatment is not simple. Effective treatment programs typically incorporate many components, each directed to a particular aspect of the illness and its consequences. Substance use disorder treatment must help the individual to develop the skills needed to stop using drugs, maintain a drug-free lifestyle, and achieve productive functioning in the family, at work, and in society. Because substance use disorder is typically a chronic disease, people cannot simply stop using drugs for a few days and be cured. Most individuals require long-term or repeated episodes of care to achieve the ultimate goal of sustained abstinence and recovery of their lives. [2]

Guiding Principles of Effective Substance Use Disorder Treatment

Scientific research since the mid–1970s has shown that treatment can help individuals with substance use disorder to stop using substances, avoid relapse, and successfully recover their lives.[3] Based on this research, the National Institute on Drug Abuse identified key principles[4] that should form the basis of any effective substance use disorder treatment program:

1. Addiction is a complex but treatable disease that affects brain function and behavior.
2. No single treatment is appropriate for everyone.
3. Treatment needs to be readily available.
4. Effective treatment attends to multiple needs of the individual, not just his or her substance use disorders.
5. Remaining in treatment for an adequate period of time is critical.
6. Counseling—individual and/or group—and other behavioral therapies are the most common methodologies used in substance use disorders treatment.
7. Medications are an important element of treatment for many individuals, especially when combined with counseling and other behavioral therapies.

8. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
9. Many individuals with substance abuse disorders also have other mental health conditions/issues.
10. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term substance abuse.
11. Treatment does not need to be voluntary to be effective.
12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
13. Treatment programs should assess individuals for the presence of HIV/ AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling to help individuals modify or change behaviors that place them at risk of contracting or spreading infectious diseases.

For more information please refer to Attachment A: Principles of Effective Treatment

Procedures

Because of the unique challenges faced by persons with substance use disorders, including the potentially damaging and long-term consequences of substance use, it is critical that treatment programs be tailored to effectively screen, diagnose, and treat this population. The following nine elements must be incorporated into all substance use treatment programs:

1. Comprehensive Screening and Assessment
2. Use of ASAM Placement Criteria
3. Treatment Planning
4. Engagement, Retention and Re-engagement
5. Case Management
6. Therapeutic Interventions to Treat Substance Use Disorders
7. Self-help and Peer Support
8. Continuing Care
9. Family Involvement in Treatment

1. Comprehensive Screening and Assessment

Screening is a relatively brief process designed to identify individuals who are at increased risk of having substance use disorders that warrant immediate attention, intervention, or more comprehensive evaluation. A screening instrument does not enable a clinical diagnosis to be made, but rather merely indicates whether there is a probability that the condition looked for is present. Screening is a triage process, and should be employed with all individuals entering the system.

The substance abuse ***assessment*** process is a more comprehensive and individualized examination of the psychosocial needs and problems identified during the initial screening; this includes assessing for mental health and substance abuse disorders, other associated issues, and recommendations for treatment intervention. Individualized assessment is one of the foundations of quality care. The importance of assessment in evaluation, treatment planning and evolution of the treatment plan, safety, and provision of optimal care cannot be overstated. Quality assessment bridges the gap between diagnosis and the initiation of treatment, ensuring the accuracy of the initial diagnosis and identifying the most effective and efficient care.[5]

Substance use disorders typically affect varied domains of life and are affected in turn by many domains, including legal and licensure status, insurance eligibility, co-morbid medical and psychiatric conditions, and family relationships. [6] It is through a comprehensive, bio-psychosocial assessment that we are able to determine individuals' wants and needs, and structure a treatment protocol that will help them to achieve their stated goals.

Generally speaking, assessment of an individual with a substance use disorder is utilized to: establish a diagnosis, assess for physiologic dependence, stage disease severity, identify the domains of life affected by the disease, assess for additional medical or psychiatric diagnosis, quantify the disease-associated morbidity, identify characteristics of the disease that are important from a prognostic or a treatment-matching perspective, quantifying the impact of treatment on disease-associated morbidity, or attempting to determine subtypes of addictive disease.

The nature of the assessment process is influenced not only by personal factors but by clinician and organizational factors. [5] Therefore, the tools used in an assessment may change depending upon the clinical situation, the skills and resources available to the clinician, and the specific characteristics of an individual's presentation, but the basic areas to be assessed should remain fairly constant, which are-

- Why the person is seeking treatment and what they want
- Individual's strengths and recovery potential
- Assessment of culture and diversity
- History of Present Illness (symptomatology, frequency and duration)
- Risk Assessment (includes withdrawal potential, harm to self and/or others, and imminent medical needs)
- Past Psychiatric History and current psychiatric conditions and treatment
- Past Medical History and Current Medical Conditions
- Medication and allergy history
- Family, Educational and Social History
- Peer, family and natural recovery supports
- Substance Use History (including prior treatment experiences, what worked, and what did not)

- Quality of Life Indicators including Employment Status, Educational Participation, Primary Residence Type, and Criminal Activity
- Legal History, including custody/guardianship status, Court Order Evaluation/Court Order Treatment history, criminal justice record, including sex offender adjudication
- Labs/Diagnostic, if available
- Mental Status Examination
- Document the stage of change for each identified issue
- Axial Diagnoses I-V

As domains of an individual's life affected by substance use disorders include such varied areas as intrapersonal, interpersonal, avocations and hobbies, financial status, legal issues, employment or school performance, and physical damage, it becomes incumbent on the assessment process to gather information from many different—and at times atypical—sources.

Sources that commonly are utilized in assessing substance use disorders include history, physical exam, and laboratory results; toxicology testing; family interview; use of pharmacology (licit and illicit) with special emphasis on the controlled drug use history; psychiatric co-morbidity including trauma, medical-legal history questioning, educational; and occupational interview; and readiness for behavior change evaluation.

Substance use disorders are some of the most highly stigmatized disorders in our society. As a result, issues of the reliability of individual's self-report are even more suspect than with other health problems faced by clinicians. It is important to interview individuals in ways that avoid defensiveness about the behaviors resulting from their substance use disorders to allow the development of stage specific interventions.

Additionally, behavioral health providers, in conjunction with the person's team, must develop and implement service plans based on a person's initial and ongoing assessments. For additional information on Service Planning in our system please refer to the Provider Manual Section 3.9 Intake, Assessment and Service Planning.
http://www.azdhs.gov/bhs/provider/sec3_9.pdf

2. Use of ASAM PPC-2R Placement Criteria

Substance use disorders are complex illness, compulsive (at times uncontrollable) drug craving, seeking, and use, which persist even in the face of extremely negative consequences, characterizes the disorder. Because substance use disorders have so many dimensions and disrupts so many aspects of an individual's life, treatment for this illness is never simple; generally, a multimodal approach to treatment is required. Not only do substance use disorders treatments help the individual to stop using drugs and maintain a drug-free lifestyle but it also helps achieve productive functioning in the family, at work, and in society[7].

No single treatment is appropriate for all individuals at all times.[8] Therefore matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society. Measurement during treatment that tracks real-time outcomes and the quality of the individual's engagement and therapeutic alliance allows for modification of the strategies and level of care depending on individual's progress or lack of it [9] [10]

The development, refinement and implementation of standardized treatment matching guidelines to the needs of the individual are the dynamic trends in the field of substance use disorder treatment. Clinicians involved in planning and managing care have often lacked a common language and systematic assessment and treatment approach that allows for effective, individualized treatment plans. The Patient Placement Criteria of the American Society of Addiction Medicine (ASAM) provides common language to help the field develop a broader continuum of care.

Functionally, the criteria are used to match treatment settings, interventions and services to each individual's particular situation and often changing needs. The ASAM criteria advocates for individualized, assessment-driven treatment and the flexible use of services across a broad continuum of care[11]. Four features characterize ASAM patient placement criteria:

1. Comprehensive, individualized treatment planning
2. Ready Access to services
3. Attention to multiple treatments needs
4. Ongoing reassessment and modification of the individualized service plan

The ASAM patient placement criteria describes treatment as a continuum marked by five basic levels of care (Levels I through IV).Within each level, a decimal number (ranging from 1 to .9) expresses gradations of intensity within the existing levels of care. The levels of care as outlined in the criteria are (for additional information please refer to Attachment B: ASAM PPC-2R Levels of Care):

- Level 0.5: Early intervention
- Level I: Outpatient services
- Level II: Intensive outpatient/partial hospitalization services
- Level III: Residential/inpatient services
- Level IV: Medically managed intensive inpatient services

Adult detoxification- When making the placement and treatment decisions, careful attention should be paid to the intensity of intoxication and/or withdrawal potential. Detoxification refers not only to the attenuation of the physiological and psychological features of withdrawal syndromes, but also to the process of interrupting the momentum of compulsive use in persons diagnosed with substance dependence. The detoxification services across treatment levels are-

- Level ID: Ambulatory Detoxification without Extended On-Site Monitoring
- Level IID: Ambulatory Detoxification with Extended On-Site Monitoring
- Level III.2D: Clinically Managed Residential Detoxification
- Level III.7D: Medically Monitored Inpatient Detoxification
- Level IV-D: Medically Managed Inpatient Detoxification

The ASAM patient placement criteria is based on a philosophy that effective treatment attends to multiple needs of each individual, not just his or her alcohol or drug use. To be effective, treatment must address any associated medical, psychological, social, vocational, legal problem and environmental problems. Through its six assessment dimensions, the ASAM criteria underscore the importance of multidimensional assessment and treatment. To engage the individual in a collaborative therapeutic alliance, the assessment is in the service of what the individual wants (e.g., ―Get my children back). It serves to identify obstacles and resources; liabilities and strengths within each of the assessment dimensions.[12] (For additional information please refer to Attachment C- Decision tree).

The six assessment dimensions as outlined in the ASAM placement criteria used in making placement decisions are listed below (For additional information please refer to Attachment D: ASAM Criteria Assessment Dimensions):

- Dimension 1: Acute Intoxication and/or Withdrawal Potential
- Dimension 2: Biomedical Conditions and Complications
- Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
- Dimension 4: Readiness to Change (formerly ―Treatment Acceptance/Resistance‖)
- Dimension 5: Relapse, Continued Use, or Continued Problem Potential
- Dimension 6: Recovery/Living Environment

As a individual with substance use disorder moves through treatment in any level of care, his or her progress in all six dimensions should be continually assessed to ensure that treatment is addressing the individual's changing needs.[13]

In the process of assessment, certain problems and priorities are identified as justifying admission to a particular level of care. The resolution of those problems by meeting the individual goals determines when an individual with substance use disorder can be treated at a different level of care or discharged from treatment. The appearance of new problems may require services that can be effectively provided at the same level of care, or that require a more or less intensive level of care.[11] [14]

The ASAM PPC-2R emphasizes the change from program-driven to client-driven services. There should be ongoing relationships between assessment, level of care determinations, and treatment planning. Once an individual is placed into a service level, and the provider should partner with the individual to develop the treatment plan, the individual's progress should be monitored continuously to determine if the individual meeting the ASAM continued stay criteria. This ongoing review determines whether the individual will stay at the current

placement, will need to be transferred, or is ready for discharge. Documentation should identify reasons for continued stay, transfer, and discharge.

The ASAM PPC-2R identifies the following as ***continued stay criteria***. The individual:

- Is making progress but has not yet achieved goals articulated in the individualized treatment plan. Continued treatment at present level of care is necessary to permit the individual to continue to work toward his or her treatment goals; or

- Is not yet making progress but has the capacity to resolve his or her problems. The individual is actively working on goals articulated in the individualized treatment plan. Continued treatment at present level of care is assessed as necessary to permit the client [individual] to continue to work toward his or her treatment goals; and/or

- New problems have been identified that are appropriately treated at the present level of care. This level of care is the least intensive at which the [individual's] new problems can be addressed effectively.

The ASAM PPC-2R identifies the following as ***transfer or discharge criteria***. The individual:

- Has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to present level of care; or

- Has been unable to resolve the problems that justified admission to present level of care, despite amendments to the treatment plan. Therefore, treatment at another level of care or with another type of service is indicated; or

- Has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated; or

- Has experienced intensification of his or her problems or has developed new problem(s) and can be treated effectively only at a more intensive level of care.

The individual's progress toward achieving his or her treatment plan goals and objectives determines length of stays or service level. Fixed length of stay or program-driven treatment is not individualized and does not respond to the particular problems of a given individual. Although fixed length of stay programs are more convenient and predictable for the provider, they may be less effective for individuals.[11 14 15]

3. Treatment Planning

Treatment planning is an opportunity for the clinician to partner with an individual and identify the focus of the treatment process. If properly used, a treatment plan (individualized service plan) can function as a clinical roadmap for the contract between the person seeking services and the clinical team. The plan should document what is being done in treatment, by whom, and what the individual and the treatment team anticipates as outcomes for each intervention. The process of treatment planning is crucial to the recovery process. Because it is easy to lose sight of the issue that brings people into treatment, a treatment plan is needed

to provide structure to the therapeutic process. The treatment planning process begins with assessment and should be a dynamic process that reflects changes in an individuals' progress toward their goals and objectives. At the minimum individualized service plan should be:

- Developed in collaboration with the individual and includes family participation, whenever possible.
- Individualized, strengths-based, stage-specific, measurable, achievable, and progressive and written in an individual's own terminology.
- Inclusive of interventions for both the treatment team and the individual member.
- Inclusive of recovery supports and community engagement.
- Inclusive of self-help supports, if indicated and accepted.

4. Engagement, Retention and Re-engagement

What moves people to start therapy, continue, progress in therapy and continue to progress after therapy? Given that substance use disorders are among the costliest of contemporary conditions, it is crucial to understand and to motivate many more persons to participate in appropriate treatment. [16]

Research has shown that motivation-enhancing approaches are associated with greater participation in treatment and positive treatment outcomes. Such outcomes include reductions in consumption, increased abstinence rates, social adjustment, and successful referrals to treatment.[17] [18] A positive attitude toward change and a commitment to change are also associated with positive treatment outcomes.[19] [20] The benefits of employing motivational enhancement techniques include:

- Inspiring motivation to change
- Preparing individuals to enter treatment
- Engaging and retaining individuals in treatment
- Increasing participation and involvement
- Improving treatment outcomes
- Encouraging a rapid return to treatment if symptoms recur

Engagement begins the first time contact is made with the T/RBHA or service provider and continues throughout a person's involvement in substance use treatment and recovery. Basic requirements for engagement and reengagement of all behavioral health recipients may be found in the ADHS/DBHS provider manual, section 3.8.7. Outreach, Engagement, Re-Engagement, and Closure at http://www.azdhs.gov/bhs/provider/sec3_8.pdf and in the ADHS/DBHS practice protocol on Comprehensive Assessment and Treatment of Children and Adolescents with Substance Use Disorders section on Engagement and Retention in Treatment at http://www.azdhs.gov/bhs/guidance/catsu.pdf

Active engagement results in improved treatment outcomes. Individuals appear to need and use different kinds of help, depending on which stage of readiness for change they are

currently in and to which stage they are moving towards.[21] Services should be tailored to the stage of change of the individual. The Stages of Change model is designed to meet the individual where they are in their recovery process, and design interventions to help them move to the next stage. It is important to note that individuals who are in the early stages of readiness need and use different kinds of interventions and motivational support than do individuals who are at later stages of the change cycle.

The National Quality Forum (NQF) consensus report on the National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices identifies engagement in treatment, as a practice which has significant impact on improving care. The NQF recommends specific interventions for both the organizational and individual levels, resulting in increased engagement and retention.

Organizational level:

1 Identification of organizational system barriers to the initiation of treatment after first contact/inquiry and continuation of treatment beyond the admission/intake/assessment and also after transfer from one level of care to another.

2 Implementation of clinical processes or organizational systems that promote flexibility, immediacy/timeliness, continuity, openness, and efficiency.

Individual level:

1 Multidimensional assessment that identifies potential barriers to participating in treatment (for example, living environment, employment, support system, readiness for treatment, co-existing general medical and mental health conditions).

2 Provision of, or referral to, supportive services (for example, housing, legal, employment, child care, medical, or mental health services).

3 Plan developed with individual and family input, which is responsive to the individuals' culture, language, and health literacy.

4 Empathic, supportive approach.

5 Active promotion of involvement with community support (some examples include family, 12-step, or other mutual help groups, spiritual support, peer support specialists and recovery coaches).

5. Case Management

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services needed to meet an individual's health needs.[22] It uses communication and available resources to promote quality, cost-effective outcomes. Case management, although difficult to assess for effectiveness in a rigorous fashion, has been shown to be an effective adjunctive treatment for individuals with substance use disorders and for individuals with substance use disorders co-occurring with psychiatric disorders.[23] [24]

Case management support is provided to individuals who have social and complex needs, to help them actively engage in their treatment and continuing care. Basic needs are often met as part of the service array, which includes as psycho-education and assistance in comprehension of the extent and nature of the disease for which treatment is provided and advocated. [25] [26]

When implemented to its fullest, case management will enhance the scope of addictions treatment and the recovery continuum. A treatment professional utilizing case management will:

- Provide the individual a single point of contact for multiple health and social services systems
- Advocate for the individual
- Be flexible, community-based, and individually-oriented
- Assist the individual with needs generally thought to be outside the realm of substance use disorder treatment

Research puts forward two reasons why case management is effective as an adjunct to substance use disorder treatment. *First,* retention in treatment is associated with better outcomes, and a principal goal of case management is to keep individuals engaged in treatment and moving toward recovery. *Second,* treatment may be more likely to succeed when an individual's other problems are addressed concurrently with substance use disorder. Case management as a practice focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of a individual's life. Comprehensive substance use disorder treatment often requires that individuals move to different levels of care or systems; case management facilitates such movement.

While distinct goals and treatment activities are associated with each point on the continuum, an individual's' needs seldom fit neatly into any one area at a given time. For example, an individual may need residential treatment for a serious substance use disorder problem, but only be motivated to receive assistance for a housing problem. Case management should be designed to span individual's needs and program structure and treatment plan.

6. Therapeutic Interventions to Treat Substance Use Disorders

Treatment for individuals with substance use disorders varies depending upon specific drugs of abuse. Treatment also varies depending on the characteristics of the individual. There are a variety of scientifically based approaches to substance use disorder treatment, including behavioral therapy (such as counseling, cognitive therapy, or psychotherapy), medications, or their combination. Behavioral therapies offer people strategies for coping with their drug cravings, teach them ways to avoid drugs and prevent relapse, and help them deal with relapse if it occurs.

Effective treatment programs typically incorporate many components, each directed to a particular aspect of the illness and its consequences. In practice, specific pharmacologic and psychosocial treatments are often combined because this leads to better treatment retention and outcomes.[27] The combination of therapies and other services are focused on meeting the needs of the individual, which are shaped by such issues as the substance used, age, race, culture, sexual orientation, gender, pregnancy, parenting, housing, and employment, as well as physical and sexual abuse.

Treatment can occur in a variety of settings, in many different forms, and for different lengths of time. Because drug addiction is typically a chronic disorder characterized by occasional relapses, a short term, one-time treatment often is not sufficient. For many, treatment is a long-term process that involves multiple interventions and attempts at abstinence. [3]

Behavioral Therapy: Behavioral treatments help engage people in drug abuse treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to drug abuse, and increase their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive abuse. Group therapy and individual therapies can be utilized based upon defined Evidence Based Treatment Practices. (For more information please refer to Attachment E: List of Evidence Based Treatment Practices.)

Medication Assisted Treatment (MAT): MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a holistic approach to the treatment of substance use disorders. Medications can be useful adjuncts to the treatment process.

Medications offer help in suppressing withdrawal symptoms during detoxification. However, medically assisted withdrawal is not in itself "treatment"—it is only the first step in the treatment process. Individuals who go through medically assisted withdrawal but do not receive any further treatment show drug abuse patterns similar to those who were never treated.[2]

Medications can also be used to help re-establish normal brain function and to prevent relapse and diminish cravings. Food and Drug Administration (FDA) approved Medications for opioid, nicotine, and alcohol addiction are currently available whereas medications to treat stimulant and cannabis addiction are currently in development. Medications should be used as an adjunct to, not a replacement for, psychosocial treatment.

For additional information and guidelines for using these medications refer to U.S. Department of Health and Human Services Treatment Improvement Protocol series 49,[28] ADHS/DBHS Practice Protocol on Buprenorphine, and the American Psychiatric Association Practice Guidelines on Substance Use Disorders.

At this time Food and Drug Administration (FDA) has approved four medications, namely Acamprosate, Disulfiram, Oral Naltrexone, and Extended-release injectable Naltrexone to

treat Alcohol Use Disorders. As with any other MAT these medications should be used as an adjunct to, not a replacement for, psychosocial treatment, including specialty substance use treatment programs. For additional information and guidelines for using these medications refer to U.S. Department of Health and Human Services Treatment Improvement Protocol series 49.

Approved medications for treatment of opioid addiction are the opioid agonist Methadone, the partial opioid agonist Buprenorphine, and opioid antagonist Naltrexone. Opioid maintenance therapy is provided under a defined set of policies and procedures, including admission, discharge and continued service criteria stipulated by state law and regulation and the federal regulation at FDA 21 CFR Part 291. For additional information and guidelines for using these medications refer to U.S. Department of Health and Human Services Treatment Improvement Protocol series 43.[29]

7. Self-help and Peer Support

Mutual support (also called self-help) is an important part of recovery from substance use disorders (SUDs). [30] Mutual support groups are nonprofessional groups comprised of individuals who share the same problem, and voluntarily support one another in the recovery from that problem.[31] Research on mutual support groups indicates that active participation in any type of mutual support group significantly increases the likelihood of maintaining abstinence[32]. Previous research has shown that participating in 12-Step programs [33] [34] [35] [36] is related to abstinence from alcohol and drug use.

A technical report[37] on consumer/survivor- operated self help groups, prepared by SAMSHA, outlines many tangible benefits that are cited by self-help group members as promoting their continued participation:

- Peer Support: The ability of group members to be empathic and compassionate based on a common experience assists participants in feeling better by helping them to realize that they are not alone. Self-help actualizes the concept of ―strength in numbers. The sense of solidarity, encouragement, and power derived from the group imbues participants with the sense that they can persevere. Being a member of a group or community also instills a sense of belonging and of being accepted for whom one is.
- Coping Strategies: Self-help group members share information and insights developed as a result of their own experiences to help each other ―get through tough times.
- Role Models: Self-help group members serve positive role models to one another. Group members who see that others are able to overcome problems and conditions like their own have a renewed sense of hope and energy that ―if they can do it, so can I.
- Affordability: Self-help is often free or inexpensive, which makes it a very attractive alternative to high-cost and frequently time-limited ―professional services.

- Education. Self-help groups serve as a valuable forum for not only exchanging information about members' common concerns, but also for learning about other resources available in the community. For example, self-help groups often invite speakers to discuss issues of special relevance to their membership such as the Social Security Administration's SSI/SSDI benefits.
- Advocacy: Case and systems-change advocacy are other attractive features of self-help programs. Through group advocacy efforts, many group members are able to access previously unavailable resources. In addition, members gain intrinsic rewards from joining together to change systems or external environmental conditions that are negatively affecting the self-help community.
- Non-Stigmatizing: Self-help avoids the stigma and negative connotations that are often associated with seeking traditional, professional support (i.e., those who seek professional services are somehow weak in mind or body). This may be related to self-help's emphasis on rugged individualism and self-reliance, traits that the larger society seems to value.
- "Helper's Principle" Proponents of self-help believe that those who are able to provide some support or assistance to others experience a heightened sense of self-worth and self-esteem themselves. This belief is known in the consumer/ survivor community as the "helper's principle", and, in various forms, is a mainstay of the self-help movement.

In addition to the benefits attributed to self-help by its members, it also possesses a number of other features that distinguish it from traditional forms of professional services. Furthermore, self help groups' emphasize self-determination and empowerment, are voluntary in nature, egalitarian and peer based and importantly are also non-judgmental in nature. [37]

During treatment, the provider should facilitate involvement in a mutual support groups. Matching individuals to treatment based solely on gender, motivation, cognitive impairment, or other such characteristics has not been proved to be effective. Individuals who are "philosophically well matched" to a mutual support group, however, are more likely to actively participate in that group. Thus, the best way to help an individual benefit from mutual support groups is to encourage increased participation in his or her chosen group. [30]

Providers can increase their knowledge of mutual support groups, and thus their ability to make informed referrals, by doing the following:

- Different types of support groups and their philosophies. Most groups' Web sites describe their philosophies and have online publications (Please refer to Attachment F: List of Mutual Support Groups).
- Determine which groups are active locally. Most groups' Web sites have meeting locator services.
- Find out about the different types of meetings available within local mutual support groups (e.g., which meetings are for women only).

- Establish contacts in local mutual support groups. AA and NA in particular have committees whose members work with healthcare and social service providers to get individuals to meetings and to provide information to providers.
- Attend open meetings to expand knowledge of mutual support groups and how local meetings are conducted.
- Offer space within the facility to host 12 Step support meetings

To improve the individual's chances of attending a meeting, provider's can[30]:

- Provide information about the value of self help groups, including education about the different type of groups' available, sponsorship, and why it is so important. Present more than one choice when making referrals and encourage individuals to attend several meetings before making any judgments about the groups. Individuals should be encouraged to attend different groups until they find one in which they are comfortable.
- Initiate the first conversation between an individual and a support group contact person. Having a mutual support group member speak to an individual by phone during the office visit may increase the likelihood that the individual will attend the support group meeting.
- Refer family members or others who may be affected by the individuals' substance use. Their involvement may encourage participation by providing social support. Participation can also serve to educate the family, garner its support, and address some of the anger family members may be feeling.

8. Continuing Care Services

Continuing care services, often referred to as aftercare, are substance use disorders services that occur after initial treatment. Continuing care is designed to provide less intensive services as the individual progresses in treatment and establishes greater duration of abstinence. The focus of continuing care should be to decide what an individual needs for a seamless transition from one level of care to another, based on the needs of the person served, in order to support on-going recovery, treatment/service gains, or increased community inclusion.

Additionally, ADHS/DBHS believes that each person receiving behavioral health services should receive services in a ―team model. At a minimum, the team consists of the individual being served, a qualified behavioral health clinician, a peer specialist or coach, and if appropriate and permitted: family, legally authorized representative/guardian, referral source, community services, and other supports as warranted. The Adult Clinical Team should provide clinical oversight to ensure continuity of care, by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist individuals who are moving to a different level of care, changing behavioral health providers and/or transferring to another service delivery system.

According to CSAT [38] the following strategies should be used to plan and implement follow-up and continuing care services including but not limited to:

- Educating the individual about continuing care options, including pharmacotherapy,
- Providing some continuing care services as an in-house adjunct to the treatment program that incorporate some of the earlier program elements (e.g., individual counseling on a less frequent basis) and offer new elements (e.g., continuing care support group),
- Linking individuals with relevant supportive services in the community at discharge when the program itself does not have these services available,
- Following up with the individual at regular intervals following discharge (e.g., 30 days, 6 months, or 1 year) for a minimum of 1 year,
- Collecting follow-up information by using a survey mailed to the individual or making an appointment for the individual to visit the therapist who provided earlier treatment,
- Linkages to Peer Support Specialists.

9. Family Involvement in Treatment

Given that the lifetime prevalence of substance use disorders is quite common, and the tendency of substance use disorders to manifest initially in late adolescence and early adulthood, substance use disorders have a proportionately larger effect on family systems during the prime of family life. At least 25% of the population is part of a family that is affected by a substance use disorder in a first-degree relative.

It is vital to address family issues with the individual who has an alcohol or drug use disorder, some of the reasons are:

- Substance use disorders are very prevalent, produce a significant amount of morbidity (and, not uncommonly, mortality) in family members, and often are overlooked by treatment providers.
- Denial or deception might make it difficult for the clinician to initially discover a substance use disorder and later to stay current on the relapse/recovery status of the individual.
- Substance use disorders can be seen as a prototype for chronic illnesses that affect families.
- Substance use disorders overwhelmingly are familial in origin, both genetically and environmentally, and heavily cluster in certain families.
- Family members can have a significant impact on treatment engagement, identification of relapse warning signs, and retention in treatment. Issues related to enabling the addiction to progress must also be assessed.
- Family education and therapy as part of substance use disorder treatment have been shown to have substantial therapeutic value for the individual with substance use disorders as well as the other family members.

- A number of simple, straightforward interventions are available to help family members of individuals with substance use disorders.

Living in a family affected by addiction can lead to induction of alcohol or other drug abuse in additional family members. For example, studies have shown that heterosexual women who are married to or who live with addicted men are more likely to become addicted themselves[39] [40] [41] [42] Conversely, many heavily drinking women who separate from or divorce addicted partners subsequently reduce their own drinking or drug use or seek treatment. Among urban African American women, early family discipline and family cohesion have been found to be related to abstention and lower rates of drug and alcohol use in adulthood.[43]

Families have a strong influence on attitudes towards substance use. Research has shown that families that react in an accepting manner to outward display of intoxication in a member transmit to their offspring the idea that getting intoxicated is acceptable behavior; families that reject such displays send the opposite message; these messages affect subsequent life decisions including use of intoxicants and partner selection[44] [45]

It is important to understand the complex role that families can play in substance use treatment. They can be a source of help to the treatment process, but they also must manage the consequences of the individual's addictive behavior. Individual family members are concerned about the individual substance use, but they also have their own goals and issues. Providing services to the whole family can improve treatment effectiveness. [46]

Family involvement and therapy in substance use disorder treatment has two main purposes. *First*, it seeks to use the family's strengths and resources to help find or develop ways to live without substances of abuse. *Second*, it ameliorates the impact of chemical dependency on both the individual and the family. [46]

One main goal of involving families in treatment is to increase family members' understanding of the individual's substance use disorder as a chronic disease with related psychosocial components. Research [47] [48] states that family-based services can have the following effects:

- *Utilize the family strengths.* Family members who demonstrate positive attitudes and supportive behaviors encourage the individual's recovery. It is important to identify and build on strengths to support positive change.
- *Increase family support for the individual's recovery*. Family sessions can increase a individual's motivation for recovery, especially as the family realizes that the individual's substance use disorder is intertwined with problems in the family.
- *Identify and support change of family patterns that work against recovery*. Relationship patterns among family members can work against recovery by supporting the individual's substance use, family conflicts, and inappropriate coalitions.

- *Prepare family members for what to expect in early recovery*. Family members unrealistically may expect all problems to dissipate quickly, increasing the likelihood of disappointment and decreasing the likelihood of helpful support for the individual's recovery.
- *Educate the family about relapse warning signs*. Family members who understand warning signs can help prevent the individual's relapses.
- *Help family members understand the causes and effects of substance use disorders from a family perspective.* Most family members do not understand how substance use disorders develop or that patterns of behavior and interaction have developed in response to the substance-related behavior of the family member who is in treatment. It is valuable for individuals in the family to gain insight into how they may be maintaining the family's dysfunction. Counselors should help family members address feelings of anger, shame, and guilt and resolve issues relating to trust and intimacy.
- *Encourage family members to obtain long-term support*. As the individual begins to recover, family members need to take responsibility for their own emotional, physical, and spiritual recovery.

Training and Supervision Expectations

It is the expectation of ADHS/DBHS that behavioral health staff who complete evaluations and provide interventions for the treatment of adults with substance use disorders be adequately trained and clinically supervised in the tenets of this protocol. Each T/RBHA shall establish their own process for ensuring that clinical staff working with this population follows the recommended process and procedures and whenever this Practice Protocol is updated or revised ensures that their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes.

Anticipated Outcomes include:

Improved assessment, treatment planning and placement of individuals with substance use disorders in through the use of ASAM PPC-2R leading to improved outcomes

Improved treatment of adults with substance use disorders through implementation of EBP leading to improved outcomes

How Will Outcomes/Fidelity Be Measured?

Facilities providing treatment to adults with substance disorder will be monitored with the T/RBHA Substance Treatment Program Evaluation Tool.

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Attachment A: Principles of Effective Treatment[1]

1. **Addiction is a complex but treatable disease that affects brain function and behavior**. Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.
2. **No single treatment is appropriate for everyone**. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
3. **Treatment needs to be readily available.** Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.
4. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse**. To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.
5. **Remaining in treatment for an adequate period of time is critical**. The appropriate duration for an individual depends on the type and degree of his or her problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a longterm process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.
6. **Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment**. Behavioral therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies**. For example, methadone and buprenorphine are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opioid-addicted individuals and some patients with alcohol dependence. Other medications for

alcohol dependence include acamprosate, disulfiram, and topiramate. For persons addicted to nicotine, a nicotine replacement product (such as patches, gum, or lozenges) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program.

8. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs**. A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to a person's changing needs.
9. **Many drug-addicted individuals also have other mental disorders.** Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.
10. **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.** Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and, for some, can pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.
11. **Treatment does not need to be voluntary to be effective**. Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.
12. **Drug use during treatment must be monitored continuously, as lapses during treatment do occur.** Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.
13. **Treatment programs should assess patients for the presence of HIV/ AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases**. Typically, drug abuse treatment addresses some of the drug-related behaviors that put people at risk of infectious diseases. Targeted counseling specifically focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical

treatments. Patients may be reluctant to accept screening for HIV (and other infectious diseases); therefore, it is incumbent upon treatment providers to encourage and support HIV screening and inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drugabusing populations.

[1] http://www.drugabuse.gov/PODAT/Principles.html

Attachment B: ASAM PPC-2R Levels of Care

- **Level 0.5: Early Intervention:** Early intervention (Level 0.5) constitutes a service for specific individuals who, for a known reason, are at risk of developing substance-related problems or for those for whom there is not yet sufficient information to document a substance use disorder.

- **Level I: Outpatient Treatment:** Level I encompasses organized, nonresidential services that may be delivered in a variety of settings. Addiction or mental health treatment personnel provide professionally directed evaluation, treatment, and recovery services. Such services are provided in regularly scheduled sessions and follow a defined set of policies and procedures or medical protocols.

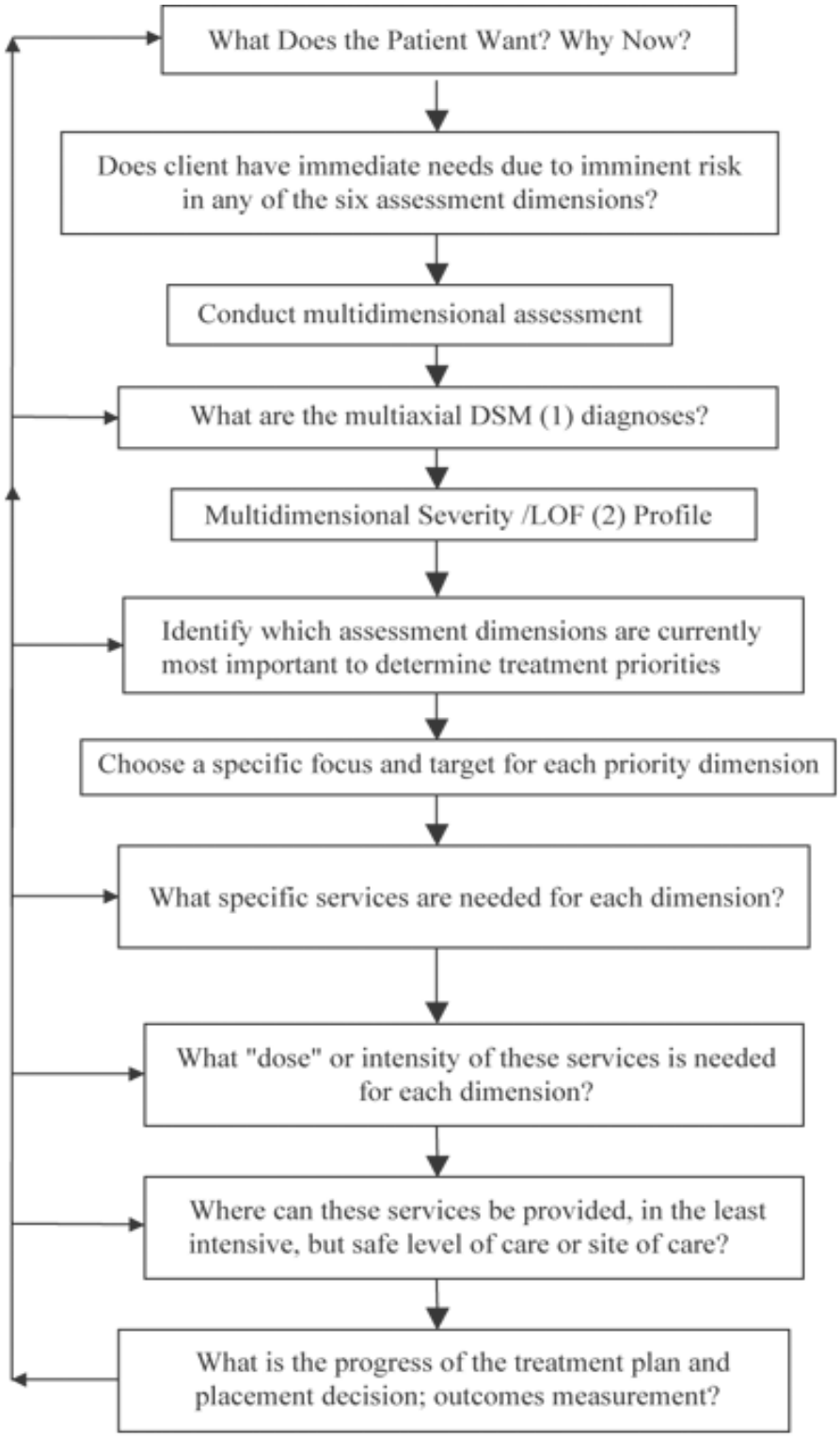
- **Level II: Intensive Outpatient/Partial Hospitalization Treatment:** Level II is an organized outpatient service that delivers treatment services during the day, before or after work or school, in the evening, or on weekends. For appropriately selected patients, such programs provide essential education and treatment components while allowing patients to apply their newly acquired skills within "real-world" environments. Programs have the capacity to arrange for medical and psychiatric consultation, psychopharmacologic consultation, medication management, and 24-hour crisis services.

- **Level III: Residential/Inpatient Treatment:** Level III encompasses organized services staffed by designated addiction treatment and mental health personnel, who provide a planned regimen of care in a 24-hour live-in setting. Such services conform to defined policies and procedures. They are housed in, or affiliated with, permanent facilities wherein patients can reside safely. They are staffed 24 hours a day. Mutual and self-help group meetings generally are available on-site.

- **Level IV: Medically Managed Intensive Inpatient Treatment:** Level IV programs provide care to patients whose mental and substance-related problems are so severe that they require primary biomedical, psychiatric, and nursing care. Treatment is provided 24 hours a day, and the full resources of a general acute care hospital or psychiatric hospital are available. They are staffed by designated addiction-credentialed physicians, including psychiatrists, and other mental health- and addiction-credentialed clinicians. Such services are delivered under a defined set of policies and procedures and have permanent facilities that include inpatient beds.

- **Opioid maintenance therapy** (OMT, so named to broaden the service beyond methadone maintenance) is best conceptualized as a separate service that can be provided at any level of care. OMT, therefore, has not been included under any of the broad levels of service (I through IV). However, the OMT criteria are included in the format of a Level I outpatient service, as most opioid maintenance therapy is delivered in an ambulatory setting.

Attachment C: Decision Tree to Match Assessment and Treatment and Placement Assignment



(1) = Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association
(2) = Level of Function

Attachment D: ASAM Criteria Assessment Dimensions

Assessment Dimension	Assessment and Treatment planning focus
1. Acute intoxication and/or withdrawal potential	Assessment for intoxication or withdrawal management. Detoxification in a variety of levels of care and preparation for continued addiction services.
2. Biomedical conditions and complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services.
3. Emotional, behavioral, or cognitive conditions and complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services.
4. Readiness to change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change.
5. Relapse, continued use, or continued problem potential	Assess readiness for relapse prevention use, or continued services and teach where problem potential appropriate. Identify previous periods of sobriety or wellness and what worked to achieve this. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies.
6. Recovery environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services. Identify any supports and assets in any or all of the areas.

Part I: Evidence-based Practices

For Adult Substance Abuse Treatment Programs

Induction (Intake and Assessment)		
EBPs	**Description**	**Source for Information**
Addiction Severity Index (ASI)	Many forms (for difference population groups) of this assessment instrument are available to assess the frequency and severity of substance abuse as well as the type and severity of psychosocial problems that typically accompany substance abuse (e.g., medical, legal, family/ social, employment, psychiatric).	http://www.tresearch.org/resources/instruments.htm **Note:** The Addiction Severity Index (ASI), has been established as the standard assessment tool for alcohol and other addictions (Leonhard et al, 2000). The ASI is an interview that assesses history, frequency, and consequences of alcohol and drug use, as well as five additional domains that are commonly associated with drug use: medical, legal, employment, social/family, and psychological functioning. The higher the score on the ASI indicates a greater need for treatment in each of these areas. The ASI scores can be used to profile patients' problem areas and then plan effective treatment. In a recent study, Makela, K., (2004) reviewed the available literature to determine the reliability and validity of the ASI. The results show that high internal consistencies have been reported for only three of the seven composite scores. The instruments developer(s), McClellan et al (2004) agree with some of the issues raised, though they feel the ASI is still a valid assessment tool. Feedback from ASI users has suggested a major revision is needed and an ASI-6 is currently in development.
ASAM Patient Placement Criteria 2nd Edition-Revised	ASAM Patient Placement Criteria comprise of a system for treatment matching to level of care based on need and is the most widely used and comprehensive national guidelines for placement, continued stay and discharge of patients with alcohol and other drug problems.	The ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders is an essential tool for use in treatment planning and in working with managed care organizations, and public and private treatment providers. To place an order, contact the ASAM Publications Distribution Center at 1-800-844-8948. It is available at a cost of $70 for ASAM members and $85 for nonmembers. Quantity discounts are also available. SHIPPING: 12% for U.S. orders; 15% for Canada. International orders will be billed actual cost.

EBPs	Description	Source for Information
Brief Alcohol Screening and Intervention for College Students (BASICS)	Designed to help students make better alcohol-use decisions. BASICS is an alcohol skills training program (ASTP) that aims to reduce harmful consumption and associated problems in students who drink alcohol. Specifically, hazardous drinking behaviors in college students. The key elements underlying the ASTP approach include 1) the application of cognitive-behavioral self-management strategies (based on the relapse prevention model); 2) the use of motivational enhancement techniques; and, 3) the use of harm reduction principles. As a harm reduction approach, BASICS aims to motivate students to reduce risky behaviors rather than focus on a specific drinking goal such as abstinence or reduced drinking. For maximal flexibility, each session is tailored to the client's own risk factors and circumstances, as well as to the severity of the client's abuse or dependence. Also, to minimize program cost, the intervention can be easily modified for implementation by a wide variety of care providers with ranges of clinical experience.	Purchase from: The Guilford Press, 72 Spring Street, New York, NY 10012. **URL:** http://www.guilford.com. Price per manual is $30.00
Change Assessment Scale	Assesses the patient's current position on readiness for change (e.g., precontemplation, contemplation, commitment), which may be an important predictor of response to substance abuse treatment).	http://casaa.unm.edu/inst/University%20of%20Rhode%20Island%20Change%20Assessment%20(URICA).pdf **Note**: The scale is designed to be a continuous measure. Thus, subjects can score high on more than one of the four stages. Because the scale is still being validated, it is only available for research purposes. Therefore, to date there have been no cut-off norms established to determine what constitutes high, medium or low on a particular stage. Again, the stages are considered to be continuous and not discreet.

EBPs	Description	Source for Information
Drinker Inventory of Consequences (DrlnC)	The DrInC is a self-administered 50-item questionnaire designed to measure adverse consequences of alcohol abuse in five areas: Interpersonal, Physical, Social, Impulsive, and Intrapersonal. Each scale provides a lifetime and past 3-month measure of adverse consequences, and scales can be combined to assess total adverse consequences. Normative data are available for interpretation of client scale scores, and a brief version of the DrInC, the Short Index of Problems (SIP), is available when assessment time is limited.	Volume 4-The Drinker Inventory of Consequences (DrlnC) http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/InstrumentPDFs/24_DrInC.pdf http://pubs.niaaa.nih.gov/publications/match.htm Cost: $6.00 per copy cost recovery fee - includes shipping and handling. Presents a psychometric instrument, the Drinker Inventory of Consequences (DrInC), developed in support of Project MATCH to assess the adverse consequences of drinking. Presents the background and rationale for the development of the DrInC, the scale construction and item analysis, its test-retest reliability, test procedures, and the test forms.
Form 90: A Structured Assessment Interview for Drinking and Related Behaviors Test Manual	This publication was originally developed for use in Project MATCH, a multisite clinical trial of three psychological treatments for alcohol abuse and dependence, funded by the National Institute on Alcohol Abuse and Alcoholism. Form 90 is a family of assessment interview instruments designed to provide primary dependent measures of alcohol consumption and related variables. The interviews produce a continuous daily record of drinking and documentation of related variables from a 90-day baseline period through the last follow-up point.	Volume 5-Form 90: A Structured Assessment Interview for Drinking and Related Behaviors Test Manual http://pubs.niaaa.nih.gov/publications/match.htm Cost: $6.00 per copy cost recovery fee - includes shipping and handling.

EBPs	Description	Source for Information
Global Appraisal of Individual Needs (GAIN)	The GAIN has 8 core sections containing questions on the recency of problems, breadth of symptoms, and recent prevalence as well as lifetime service utilization, recency of utilization, and frequency of recent utilization. The items are combined into over 100 scales and subscales that can be used for DSM-IV based diagnoses, ASAM-based level of care placement, and outcome monitoring.	Michelle White Research Scientist Assistant Director of GAIN Coordinating Center Chestnut Health systems 722 W. Chestnut St. Bloomington, IL 61701 (309)820-3543 x 83439 Email: MWhite@chestnut.org URL: http://www.chestnut.org/LI/GAIN/index.html
Global Appraisal of Individual Needs – Quick (GAIN-Q)	A shorter, general assessment used to identify various life problems among clients in the general population when a full biopsychosocial is not needed. Designed for use by personnel in diverse settings (e.g., Employee Assistance Programs, health clinics, corrections,), the instrument is used to identify those in need of a longer, more detailed assessment; identify those who may benefit from a brief intervention; and guide staff to make effective referral and placement decisions.	Michelle White Research Scientist Assistant Director of GAIN Coordinating Center Chestnut Health systems 722 W. Chestnut St. Bloomington, IL 61701 (309)820-3543 x 83439 Email: MWhite@chestnut.org URL: http://www.chestnut.org/LI/GAIN/index.html
Mini International Neuropsychiatric Interview (M.I.N.I.)	The M.I.N.I is a short, structured diagnostic interview for DSM-IV and ICD-10 psychiatric disorders. With an administration time of approximately 15 minutes, the M.I.N.I is a structured psychiatric interview for diagnostic evaluation and outcome tracking.	Juris Janavs, M.D. Email: jjanavs@hsc.usf.edu University of South Florida College of Medicine Department of Psychiatry and Behavioral Medicine 3515 East Fletcher Ave Tampa, FL 33163 Phone: (813)974-4544 URL: http://www.medical-outcomes.com

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Produced by the Southern Coast Addiction Technology Transfer Center, www.scattc.org

EBPs	Description	Source for Information
Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR)	SAFERR is based on the premise that when parents misuse substances and maltreat their children, the only way to make sound decisions for these families is to draw from the talents and resources of at least three systems; child welfare, substance abuse treatment, and the courts. The SAFERR model and this guidebook were developed by the National Center on Substance Abuse and Child Welfare (NCSACW). The model includes screening and assessment tools and efficient communication strategies that support sound and timely decisions about the safety of children and about the treatment and recovery of parents. It includes guidance for developing collaborative relationships between the systems to help improve outcomes for these families.	For a free download of the manual, go to URL: www.ncsacw.samhsa.gov/files/SAFERR.pdf

Early Engagement		
EBPs	**Description**	**Source for Information**
Brief Alcohol Screening and Intervention for College Students (BASICS)	Because this is a combined screening, engagement, intervention, and social skills training tool, it also appears under several other sections of this inventory. See description on page 2.	Purchase from: The Guilford Press, 72 Spring Street, New York, NY 10012. **URL:** http://www.guilford.com. Price per manual is $30.00
Downward Spiral	This is a board game, similar to "Monopoly". Players take on the role of someone who has decided to continue to abuse substances and the subsequent effects to one's health, social support network, and financial/legal situation. The purpose is to enhance a client's motivation and engagement into treatment. It is designed to work in a group setting, making it especially useful in community treatment programs. Clients in substance abuse treatment often have difficulty associating behavior with consequences, complicating both treatment and recovery. This game was developed to assist that process and to encourage motivation and openness to treatment.	Downward Spiral: The Game You Really Don't Want to Play. Forth Worth, TX: TCU Institute of Behavioral Research, 1998. (188 p.) Purchase for $20 from Chestnut Health Systems, Lighthouse Institute Publications, 702 W. Chestnut Street, Bloomington, IL 61701. TEL: 309-827-6026 FAX: 309-829-4661. **URL:** http://www.chestnut.org/LI/bookstore/index.html
Mapping New Roads to Recovery	A collection of materials for exploring needs and planning treatment, improving communication, and reviewing treatment progress.	The entire manual or sections are available free: http://www.ibr.tcu.edu/pubs/trtmanual/manuals.html

EBPs	Description	Source for Information
Mapping New Roads to Recovery: Cognitive Enhancements to Counseling	This self-paced training manual is designed for substance abuse counselors and case workers interested in **node-link mapping**, a visual representation technique for helping clients improve problem-solving and decision making skills. A step-by-step format is used to explain both the theory and application of node-link mapping for both individual and group counseling. Studies by the authors suggest that incorporation of node-link mapping in counseling enhances client commitment to treatment, counseling efficiency, and therapeutic alliance.	The entire manual or sections are available free: http://www.ibr.tcu.edu/pubs/trtmanual/manuals.html Printed copies of ***Mapping New Roads to Recovery*** are available through **Lighthouse Institute**, a nonprofit division of Chestnut Health Systems in Bloomington, Illinois. Price per manual is $15, plus $4 shipping and handling. To order, contact the **Lighthouse Publications Web Site**, phone toll-free **(888) 547-8271**, or **FAX (309) 829-4661**.
Motivational Enhancement Therapy (MET) Also called MET for Problem Drinkers)	Motivational Enhancement Therapy (MET) is a systematic intervention approach for evoking change in problem drinkers. It is based on principles of motivational psychology and is designed to produce rapid, internally motivated change. MET consists of four carefully planned and individualized treatment sessions. The first two focus on structured feedback from the initial assessment, future plans, and motivation for change. The final two sessions at the midpoint and end of treatment provide opportunities for the therapist to reinforce progress, encourage reassessment, and provide an objective perspective on the process of change.	Hundreds of references on MET are available on an annotated bibliography at: http://www.motivationalinterview.org/library/abstractsemp.html TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment available electronically at: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.61302 Author's email: wrmiller@unm.edu **Volume 2-Motivational Enhancement Therapy Manual,** 121 pp. NIH Pub. No. 94-3723. 1994. http://pubs.niaaa.nih.gov/publications/match.htm#ordering Cost: $6.00 per copy cost recovery fee - includes shipping and handling.

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EBPs	Description	Source for Information
Motivational Interviewing (MI)	Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.	Thousands of references are readily available which reference this practice. Many websites are found which talk only of Motivational Interviewing Techniques. An excellent site with multiple links is: http://www.motivationalinterview.org/library/abstractsemp.html. Several manuals are available to accessed on line from http://www.motivationalinterview.org/clinical/METDrugAbuse.PDF Author's email: wrmiller@unm.edu
Preparation for Change	Introduces two card-sorting activities that counselors can use with their clients to help them enrich self-esteem, maintain motivation (The Tower of Strengths), and remember personal goals through quotes (The Weekly Planner). Both activities are meant to be used early in treatment to enhance motivation and encourage openness to treatment.	The entire manual or sections are available free: http://www.ibr.tcu.edu/pubs/trtmanual/manuals.html Printed copies of ***Preparation for Change*** are available through **Lighthouse Institute**, a nonprofit division of Chestnut Health Systems in Bloomington, Illinois. Price per manual is $15, plus $4 shipping and handling. To order, contact the **Lighthouse Publications Web Site**, phone toll-free **(888) 547-8271**, or **FAX (309) 829-4661**.
Solution-Focused Brief Therapy	Brief therapy approach developed over the past 20 years at the Brief Family Therapy Center in Milwaukee, WI. Primarily, the model is designed to help clients engage their own unique resources and strengths in solving the problems that bring them into treatment. Because the model stresses that the problem and solution are not necessarily related, the type of drug is not seen as a critical factor in determining differential treatment.	Manual available: Berg, Insoo K; Miller, Scott D. Working with the Problem Drinker: A Solution-Focused Approach. New York: W.W. Norton & Co., 1992, 216p. ISBN: 0393701344, $27.00. Training is available: Institute for the Study of Therapeutic Change / P.O. Box 578264 / Chicago, IL 60657 **URL:** http://www.talkingcure.com/

EBPs	Description	Source for Information
Twelve Step Facilitation Therapy	Manual is available that describes twelve step facilitation therapy in which the overall goal is to facilitate patients' active participation in the fellowship of Alcoholics Anonymous. The therapy regards such active involvement as the primary factor responsible for sustained sobriety ("recovery") and therefore as the desired outcome of participation in this treatment program. This therapy is grounded in the concept of alcoholism as a spiritual and medical disease.	**http://www.niaaa.nih.gov/publications/match.htm** Cost: $6.00 per copy (includes shipping and handling).
Buprenorphine Detoxification	The NIDA Center for Clinical Trials Network (CTN) sponsored two clinical trials assessing buprenorphine-naloxone for short-term opioid detoxification. Overall, data from the CTN field experience found that buprenorphine-naloxone is practical and safe for use in diverse community treatment settings, including those with minimal experience providing opioid-based pharmacotherapy and/or medical detoxification for opioid dependence. This protocol is a specific intervention for using buprenorphine to taper opioid addiction over a 13-day period. Training on the use of this protocol and the detox technical manual are available from any of the ATTCs.	**http://www.nattc.org** - the National ATTC website has links to all ATTCs **http://www.scattc.org** – Southern Coast ATTC serves Alabama and Florida

Behavioral Change/Management		
EBPs	**Description**	**Source for Information**
Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual/ Workbook	Designed for use by qualified substance abuse and mental health clinicians who work with substance abuse and mental health clients who have concurrent anger problems. Each of the weekly sessions is described in detail with specific instructions for the group leader, tables and figures that illustrate the key conceptual components of the treatment, and homework assignments for the group participants.	Manual site: http://www.scattc.org/pdf_upload/angermanagement1.pdf Workbook Site: http://www.scattc.org/pdf_upload/angermanagement2.pdf Both are public domain and may be downloaded free.
Behavioral Couples (Marital) Therapy	BCT is a couples' therapy that utilizes a sobriety/abstinence contract and behavioral principles to reinforce abstinence from drugs and alcohol. BCT has been studied as an add-on to individual and group cognitive-behavioral treatment, and typically involves 12 weekly couples' sessions lasting approximately 60 minutes each.	These and other BCT manuals can be obtained free by downloading from the Addiction and Families Research Group web site: **URL:** http://www.addictionandfamily.org or by emailing a request to: devans@addictionandfamily.org • Behavioral Couples Therapy for Drug Abuse & Alcoholism: A 12-Session Manual (also available in a 10-session manual) • Brief Behavioral Couples Therapy for Drug Abuse & Alcoholism: A 6-Session Manual • Group Behavioral Couples Therapy for Drug Abuse & Alcohol: A 9-Session Manual • The Facilitators Guide – How to Incorporate Behavioral Couples Therapy into Your Practice

EBPs	Description	Source for Information
Behavioral Self-Control Training	This approach used to pursue either abstinence or moderate / non-problematic drinking. It consists of behavioral techniques of goal setting, self-monitoring, and managing consumption, rewarding goal attainment, functionally analyzing drinking situations, and learning alternate coping skills. The client maintains primary responsibility for making decisions throughout the training. BSCT may not be successful for severely dependent alcoholics. If used with a goal of moderation, it is contraindicated for: women who are pregnant or trying to become pregnant; clients who have medical or psychological problems that worsened by any drinking; where abstinence is mandated; and where strong family pressures exist for the client to abstain.	No specific manual. Supporting documentation: • Miller, William R.; Munoz, Ricardo F. How to Control Your Drinking: A Practical Guide to Responsible Drinking. Albuquerque: University of New Mexico Press, 1982. (revised ed. in press; email dyao@unm.edu for current information) • Hester, Reid K. Behavioral Self-Control Program for Windows (BSCPWIN). Interactive computer software program available in Therapist of Single User version. **URL:** http://www.behaviortherapy.com/software.htm. • Robertson I, Heather N. Let's Drink to Your Health: A Self-Help Guide to Sensible Drinking. British Psychological Society, 1986. • Sanchez-Craig, Martha. A Therapist's Manual: Secondary Prevention of Alcohol Problems. Toronto: Addiction Research Foundation, 1996. **URL:** http://www.camh.net/publications/counselling.html. • Sanchez-Craig, Martha. Saying When: How to Quit Drinking or Cut Down; An A.R.F. Self-Help Book. Toronto: Addiction Research Foundation, 1993. • Sobell, Mark B.; Sobell, Linda C. Problem Drinkers: Guided Self-Change Treatment. (Treatment Manuals for Practitioners) New York: Guilford Press, 1993. **URL:** http://nova.edu/~gsc • Vogler, Roger E; Bartz, WR. The Better Way to Drink. New York: Simon & Schuster, 1982 (now available from New Harbinger Publications, Oakland, CA)
Brief Alcohol Screening and Intervention for College Students (BASICS)	Because this is a combined screening, engagement, intervention, and social skills training tool, it also appears under several other sections of this inventory.	Purchase from: The Guilford Press, 72 Spring Street, New York, NY 10012. **URL:** http://www.guilford.com. Price per manual is $30.00

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EBPs	Description	Source for Information
Brief CBT Intervention for Amphetamine Users	This approach consists of four individual sessions focused on developing skills directed at reducing amphetamine use. Sessions are conducted weekly and last 45-60 minutes. Following an initial assessment, the sessions are, in the following order: motivational interviewing; coping with cravings and lapses; controlling thoughts about amphetamine use and pleasurable activities; amphetamine refusal skills and preparation for future high-risk situations. The manual presents a guide for a four-session intervention. However, the intervention may be offered in either a two- or four-session format, in accordance with individual client needs.	A Brief Cognitive Behavioral Intervention for Regular Amphetamine Users: A Treatment Guide. Baker, Amanda; Kay-Lambkin, Frances; Lee, Nicole K; Claire, Melissa; Jenner, Linda. [Canberra]: Commonwealth of Australia, Department of Health and Ageing, 2003. **URL:** http://www.nationaldrugstrategy.gov.au/pdf/cognitive.pdf.
Brief Intervention	Targeted at people drinking excessively but not yet experiencing major problems from their consumption. The aim of the intervention is to reduce the risk of future health problems by assisting the drinker in recognizing that they are drinking at levels that could be harmful to their health and encourage them to reduce consumption to reasonable limits. Brief Intervention is designed to be conducted by health professionals- not addiction professionals. The intervention is generally less than 4 sessions, each session lasting from a few minutes to one hour.	Primary care health professionals: 22 page brochure on the NIAAA web site titled *Helping Patients With Alcohol Problems: A Health Practitioner's Guide*, as well as the companion *Pocket Guide: Alcohol Screening and Brief Intervention.* Available on-line: **URL:** http://www.niaaa.nih.gov/publications/Practitioner/HelpingPatients.htm College health clinics: *College Drinking Prevention Curriculum for Health Care Providers*, Module 3, "Brief Intervention." Developed by NIAAA, available online: **URL:** http://www.collegedrinkingprevention.gov/reports/trainingmanual/contents.asp SAMHSA/CSAT TIP 34: *Brief Interventions and Brief Therapies for Substance Abuse* – can be accessed electronically free at: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.59192

EBPs	Description	Source for Information
Brief Marijuana Dependence Counseling (BMDC)	Brief Marijuana Dependence Counseling (BMDC) is a 12-week intervention designed to treat adults with a diagnosis of cannabis dependence. Using a client-centered approach, BMDC targets a reduction in the frequency of marijuana use, thereby reducing marijuana-related problems and symptoms. BMDC is based on the research protocol used by counselors in the Center for Substance Abuse Treatment's Marijuana Treatment Project conducted in the late 1990s. A treatment manual provides guidelines for counselors, social workers, and psychologists in both public and private settings. BMDC is implemented as a 9-session multi-component therapy that includes elements of motivational enhancement therapy (MET), cognitive behavioral therapy (CBT), and case management.	Karen Steinberg, Ph.D. Assistant Professor of Psychiatry University of Connecticut Medical School 263 Farmington Avenue Farmington, CT 06030 E-mail: steinberg@psychiatry.uchc.edu
Cognitive-Behavioral Coping Skills Therapy	Describes cognitive-behavioral coping skills therapy, based on the principles of social learning theory and views drinking behavior as functionally related to major problems in the patient's life. The program consists of 12 sessions aimed at training the patient to use active behavioral or cognitive coping methods to deal with problems rather than relying on alcohol as a maladaptive coping strategy.	http://pubs.niaaa.nih.gov/publications/match.htm Manual Cost: $6.00 per copy (includes shipping and handling).

EBPs	Description	Source for Information
Cognitive Behavioral Therapy: Treating Cocaine Addiction	Cognitive-behavioral coping skills treatment (CBT) is a short-term, focused approach to helping cocaine-dependent individuals become abstinent from cocaine and other substances. This manual describes a sequence of sessions to be delivered to patients; each focuses on a single or related set of skills (e.g., craving, coping with emergencies). The order of presentation of these skills has evolved with experience with the types of problems most often presented by cocaine-abusing patients coming into treatment.	This manual can be downloaded at the following website: www.drugabuse.gov/TXManuals/CBT/CBT1/html It is a public domain document.
Combined Behavioral & Nicotine Replacement Therapy	Combines two main components: a behavioral treatment and a pharmacological treatment consisting of nicotine replacement therapy. Combined treatment is based on the rationale that behavioral and pharmacological treatments operate by different yet complementary mechanisms. Nicotine replacement therapy reduces symptoms of withdrawal, producing better initial abstinence, while the behavioral therapy concurrently provides support and reinforcement of coping skills, yielding better long-term abstinence.	U.S. Department of Health and Human Services, Public Health Services. Treating tobacco use and dependence. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service; 2000 Jun. 197 p. [311 references] AVAILABILITY: Print copies: Available by calling (800) 358-9295 or electronically at **URL:** http://www.surgeongeneral.gov. Available online: **URL:** http://www.guideline.gov/summary/summary.aspx?doc_id=2360&nbr=1586&string=tobacco.

EBPs	Description	Source for Information
Combined Behavioral Intervention Manual: A Clinical Research Guide for Therapists Treating People With Alcohol Abuse and Dependence	Highlights the use of Combined Behavioral Intervention, an intensive treatment that combines several successful features from previously evaluated interventions. It is suitable for delivery by trained psychotherapists working in specialized alcoholism treatment facilities.	http://pubs.niaaa.nih.gov/publications/COMBINE.htm *There is a fee for ordering these manuals Vol.1 $10.00*
Combined Scheduled Reduced Smoking & CBT	Combines two main components: a behavioral treatment and a pharmacological treatment consisting of nicotine replacement therapy. Combined treatment is based on the rationale that behavioral and pharmacological treatments operate by different yet complementary mechanisms. Nicotine replacement therapy reduces symptoms of withdrawal, producing better initial abstinence, while the behavioral therapy concurrently provides support and reinforcement of coping skills, yielding better long-term abstinence.	U.S. Department of Health and Human Services, Public Health Services. Treating tobacco use and dependence. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service; 2000 Jun. 197 p. [311 references] AVAILABILITY: Print copies: Available by calling (800) 358-9295 or electronically at **URL:** http://www.surgeongeneral.gov. Available online: **URL:** http://www.guideline.gov/summary/summary.aspx?doc_id=2360&nbr=1586&string=tobacco.

EBPs	Description	Source for Information
Community Reinforcement Approach (CRA) with Vouchers	Stephen Higgins and colleagues at the University of Vermont paired Community Reinforcement Approach (CRA), an individual counseling approach originally developed for alcoholism, with Contingency Management (CM) in the form of a voucher program to produce the CRA with Vouchers intervention. The alcoholism CRA included a Job Club, Marital Counseling, Social Skills/Relapse Prevention training and Disulfiram (Antabuse). This CRA component consisted of twice weekly hour-long individual counseling sessions during weeks 1-12 weeks and once weekly sessions of the same duration for weeks 13-24.	A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction. (NIDA Therapy Manuals for Drug Addiction No. 2; NIH publication no. 98-4309) Rockville: National Institute on Drug Abuse, April 1998. Available to download free from NIDA online: http://www.drugabuse.gov/TXManuals/CRA/CRA1.html
Contingency Management without CRA	Following Higgins' success with a community reinforcement approach with cocaine users, researchers in Baltimore examined the utility of voucher programs with methadone-maintained cocaine-abusing patients. The abstinent contingent voucher group gave cocaine positive urines approximately 40% less often than the random voucher group suggesting this approach is efficacious for treating cocaine use in a methadone-maintained population.	No specific manual. Supportive documentation: 1. Silverman K, Higgins ST, Brooner RK, Montoya ID, Cone EJ, Schuster CR, Preston KL. (1996). Sustained cocaine abstinence in methadone maintenance patients through voucher-based reinforcement therapy. Archives of General Psychiatry, 53, 409-415. 2. Silverman K, Wong CJ, Higgins ST, Brooner RK, Montoya ID, Contoreggi C, Umbricht-Schneiter A, Schuster CR, Preston KL. (1996). Increasing opiate abstinence through voucher-based reinforcement therapy. Drug and Alcohol Dependence, 41, 157-165. 3. Silverman K, Wong CJ, Umbricht-Schneiter A, Montoya ID, Schuster CR, Preston KL. (1998). Broad beneficial effects of cocaine abstinence reinforcement among methadone patients. Journal of Consulting and Clinical Psychology, 66, 811-24.

EBPs	Description	Source for Information
Day Treatment with Abstinence Contingencies and Vouchers	Developed to treat homeless crack addicts. For the first 2 months, participants must spend 5.5 hours daily in the program, which provides lunch and transportation to and from shelters. Interventions include individual assessment and goal setting, individual and group counseling, multiple psycho-educational groups and community meetings during which patients review contract goals and provide support and encouragement to each other. Individual counseling occurs once a week, and group therapy sessions are held three times a week. After 2 months of day treatment and at least 2 weeks of abstinence, participants graduate to a 4-month work component that pays wages that can be used to rent inexpensive, drug-free housing. A voucher system also rewards drug-free related social and recreational activities.	No specific manual. Supportive Documentation: 1. Milby JB, Schumacher JE, Raczynski JM, Caldwell E, Engle M, Michael M, Carr J. Sufficient conditions for effective treatment of substance abusing homeless. Drug & Alcohol Dependence 43: 39-47, 1996. 2. Milby JB, Schumacher JE, McNamara C, Wallace D, McGill T, Stange D, Michael M. Abstinence contingent housing enhances day treatment for homeless cocaine abusers. National Institute on Drug Abuse Research Monograph Series 174, Problems of Drug Dependence: Proceedings of the 58th Annual Scientific Meeting. The College on Problems of Drug Dependence, Inc., 1996.
Dialectical Behavior Therapy (DBT)	Applies a broad array of cognitive and behavior therapy strategies to the problems of Borderline Personality Disorder (BPD), including suicidal behaviors. Emotion regulation, interpersonal effectiveness, distress tolerance, core mindfulness, and self-management skills are actively taught. In all modes of treatment, the application of these skills is encouraged and coached.	No specific manual available for using DBT in substance abuse treatment. The essential reference for DBT is: Linehan's "Cognitive-Behavioral Treatment of Borderline Personality Disorder," Guilford Press, 1993. ($58.00) ISBN: 0898620341. Some materials about using DBT for substance abuse treatment are available to download from the Behavioral Tech web site: **URL:** http://behavioraltech.com

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EBPs	Description	Source for Information
Forever Free	Forever Free is a drug treatment program for women who abuse drugs and are incarcerated. The intervention aims to reduce drug use and improve behaviors of women during incarceration and while they are on parole. While they are incarcerated, women participate in individual substance abuse counseling, special workshops, educational seminars, 12-Step programs, parole planning, and urine testing. Counseling and educational topics include self-esteem, anger management, assertiveness training, information about healthy versus dysfunctional relationships, abuse, posttraumatic stress disorder, codependency, parenting, and sex and health. The program lasts 4-6 months.	David Conn, Ph.D. Vice President, Corrections and Rehabilitation Division Mental Health Systems, Inc. 9465 Farnham Street San Diego, CA 92123 Phone: (858) 573-2600 E-mail: dconn@mhsinc.org
Holistic Harm Reduction Program (HHRP+)	HHRP is a 12-session, manual-guided, group level program to reduce harm, promote health, and improve quality of life of HIV positive intravenous drug users. The primary goal of HHRP is to provide group members with the resources (i.e., knowledge, motivation, and skills) they need to make choices that reduce harm to themselves and others. HHRP+ also addresses medical, emotional, and social problems that may impede harm reduction behaviors.	Manuals and workbooks are free distribution only. Otherwise, all rights reserved. The entire HHRP+ Counselor's Manual can be downloaded as Adobe PDF files (for the script for counselors and the client handouts) and as MS PowerPoint files (for the visual presentation included in each HHRP+ group). **URL:** http://info.med.yale.edu/psych/3s/HHRP+_manual.html.

EBPs	Description	Source for Information
Individual Drug Counseling to Treat Cocaine Addiction	Individual 12-step drug counseling focuses on the symptoms of drug addiction and related areas of impaired functioning and the content and structure of the patient's ongoing recovery program. It gives the patient coping strategies and tools for recovery and promotes 12-step ideology and participation. IDC is planned to span 6 months and offer 36 sessions (approximately 45 minutes each) during the active treatment phase and then provide once-a-month follow-up sessions for 3 months.	NIDA Manual 3 - An Individual Drug Counseling Approach to Treat Cocaine Addiction: The Collaborative Cocaine Treatment Study Manual (NIDA Therapy manuals for drug addiction no. 3 NIH publication no. 99-4380) Bethesda: National Institute on Drug Abuse, September 1999. NIDA online: **URL:** http://www.drugabuse.gov.
Living in Balance (LIB): Moving From a Life of Addiction to a Life of Recovery	Living in Balance (LIB is a manual-based, comprehensive addiction treatment program that emphasizes relapse prevention. LIB consists of a series of 1.5- to 2-hour psychoeducational and experiential training sessions. LIB can be delivered on an individual basis or in group settings with relaxation exercises, role-play exercises, discussions, and workbook exercises. The psychoeducational sessions cover topics such as drug education, relapse prevention, available self-help groups, and sexually transmitted diseases. The experientially based sessions are designed to enhance level of functioning in life areas that are often neglected with prolonged drug use.	Roxanne Schladweiler Director of Sales Hazelden Publishing and Educational Services 15251 Pleasant Valley Road Center City, MN 55012 Phone: (800) 328-9000 E-mail: rschladweiler@hazelden.org URL: http://www.hazelden.org/bookstore

EBPs	Description	Source for Information
Lower-Cost Contingency Management (LCCM)	Because of concerns with the sustainability of existing contingency management programs, Nancy Petry and colleagues at the University of Connecticut developed an approach to treating alcohol abuse known as Lower-Cost Contingency Management (LCCM). This approach takes advantage of the fact that people will work for the chance to win a tangible prize intermittently. Prizes range in value from $1-$100. The value of prizes earned on average was $137.00. Patients in the prize group condition achieved longer durations of continuous abstinence than patients in the standard treatment condition, and these effects were maintained throughout a 6-month follow-up period.	No manual identified. Instead, see: Petry, N.M. (2000). A comprehensive guide for the application of contingency management procedures in standard clinic settings. Drug & Alcohol Dependence, 58, 9-25. This paper provides practical advice and a guideline for clinicians and researchers to use when designing and administering contingency management interventions. The recommendations are based on empirically validated manipulations
Matrix Intensive Outpatient Program for the Treatment of Stimulant Abuse	Provides a framework for engaging stimulant 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, become familiar with self-help programs, and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction.	Therapist and patient manuals are available. The manuals can be purchased from the Matrix Institute. ($25 - $60) **URL:**http://www.matrixinstitute.org/Intensive%20Outpatient%20Manuals.htm

EBPs	Description	Source for Information
Medical Management Treatment Manual: A Clinical Research Guide for Medically Trained Clinicians Providing Pharmacotherapy as Part of the Treatment for Alcohol Dependence	Describes the use of medical management and brief counseling sessions to enhance medication adherence and abstinence from alcohol. This brief session therapy might be suitable for delivery in primary care settings.	http://pubs.niaaa.nih.gov/publications/COMBINE.htm *There is a fee for ordering these manuals Vol 2 $6.00*
Methadone Maintenance Treatment	Methadone is an opiate agonist. When used in maintenance, it is usually dispensed in a liquid oral solution by Opiate Treatment Programs (OTP). In "good" treatment programs using adequate doses (80 to 150mg/d), voluntary retention in treatment at one year is 50-80%; continuing use of illicit heroin is 5-20%.	SAMHSA/CSAT TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs Free electronic copy at: http://ncadi.samhsa.gov/media/Prevline/pdfs/bkd524.pdf

EBPs	Description	Source for Information
Prize Incentives Contingency Management for Substance Abuse	Prize Incentives Contingency Management for Substance Abuse is a variation of contingency management, or reinforcement that awards prizes for abstinence and treatment compliance. The program augments existing, usual-care services in community-based treatment settings for adults who primarily abuse stimulants or opioids or who have multiple substance use problems. Over a period of 3 months, urine and breath samples are collected two or three times a week for at least the first 6 weeks and once or twice weekly thereafter. For each sample that tests negative for the target drug, clients can draw slips of paper or plastic chips from a bowl for the chance of winning a prize valued from $1 to $100. Clients may also receive draws from the prize bowl for attending counseling/group therapy sessions and completing weekly goal-related activities. The number of draws from the prize bowl increases from 1 to as many as 15 with consecutive negative test results and/or attendance at consecutive sessions. A drug-positive sample or an unexcused absence resets the number of draws to one.	Nancy M. Petry, Ph.D. Professor; Lead Contact for Prize Incentives Contingency Management for Substance Abuse Department of Psychiatry University of Connecticut School of Medicine University of Connecticut Health Center (MC 3944) 263 Farmington Avenue Farmington, CT 06030 Phone: (860) 679-2593 E-mail: petry@psychiatry.uchc.edu

EBPs	Description	Source for Information
Reinforcement-Based Therapeutic Workplace	Reinforcement-Based Therapeutic Workplace is a practical application of voucher-based abstinence reinforcement therapy. When a voucher-based reinforcement is applied to a Therapeutic Workplace, the patients are hired, trained, and paid to work in a supportive environment. They earn escalating base-pay vouchers while they remain abstinent from cocaine (and sometimes opiates) as verified by negative urine samples. Eligibility for participation in the Therapeutic Workplace is dependent on a client providing evidence of enrollment in either a community methadone treatment program or a comprehensive drug abuse treatment program for pregnant and postpartum women.	Kenneth Silverman, Ph.D. Professor, Department of Psychiatry and Behavioral Sciences Director, Center for Learning and Health, Johns Hopkins Bayview Medical Center The Johns Hopkins University School of Medicine 5200 Eastern Avenue, Mason F. Lord, Suite 142 West Baltimore, MD 21224 Phone: (410) 550-2694 E-mail: ksilverm@jhmi.edu
Relapse Prevention Therapy	Individuals learn to identify and correct problematic behaviors. RPT encompasses several cognitive-behavioral strategies that facilitate abstinence as well as provide help for people who experience relapse.	Clinical Guidelines for Implementing Relapse Prevention Therapy. Illinois: The Behavioral Health Recovery Management Project. Download free: http://www.bhrm.org/guidelines/RPT%20guideline.pdf.
Seeking Safety: A Psychotherapy for Trauma/PTSD and Substance Abuse	The treatment is available as a book, providing both client handouts and guidance for clinicians. It has been conducted in group and individual format; for women, men, and mixed-gender; using all topics or fewer topics; in a variety of settings and for both substance abuse and dependence.	Ordered from the Seeking Safety web site**:** http://www.seekingsafety.org/ for $18.95. The web site lists other sources for ordering it as well. (Discounts for multiple copies are available from Guilford Press (1-800-365-7006, extension 223).

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EBPs	Description	Source for Information
Supportive-Expressive Psychotherapy (SE)	Supportive-Expressive Psychotherapy (SE) is an analytically oriented, time-limited form of focal psychotherapy that has been adapted for use with individuals with heroin and cocaine addiction. Particular emphasis is given to themes related to drug dependence, the role of drugs in relation to problem feelings and behaviors, and alternative, drug-free means of resolving problems. SE comprises two main components. The first component uses supportive techniques designed to allow patients to feel comfortable in discussing their own personal experiences. The second component involves the use of expressive techniques to assist the patient in understanding his or her problematic relationship patterns, so that the patient can work through these themes within the context of the patient-therapist relationship.	George E. Woody, M.D. Professor and Vice Chair of Psychiatry Department of Psychiatry University of Pennsylvania 600 Public Ledger Building, 150 South Independence Mall West, Philadelphia, PA 19106 E-mail: woody@tresearch.org
TCU Guide Maps: A Resource for Counselors	The manual is a compilation of over 50 structured guide maps that have been used successfully with probationers in residential treatment programs. For use in both individual and group counseling settings covering a variety of recovery issues such as self-esteem, goal setting, managing feelings, getting along with others, health issues, and problem solving.	The entire manual or sections are available free: http://www.ibr.tcu.edu/pubs/trtmanual/manuals.html Printed copies of ***TCU Guide Maps*** are available through **Lighthouse Institute**, a nonprofit division of Chestnut Health Systems in Bloomington, Illinois. Price per manual is $25, plus $5 shipping and handling. To order, contact the **Lighthouse Publications Web Site**, phone toll-free **(888) 547-8271**, or **FAX (309) 829-4661**.

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EBPs	Description	Source for Information
The Group Drug Counseling for Cocaine Addiction: The Collaborative Cocaine Treatment Study Model	Includes an initial stabilization/detoxification period and 24 group therapy sessions during a six-month period. Group treatment is provided in two phases, coinciding approximately with clients' needs in recovery, although individuals progress at their own pace. The treatment groups have a rolling admissions policy, i.e., a client may enter the group at any session because a single recovery topic is covered completely within each session during Phase I.	Drug Counseling for Cocaine Addiction: The collaborative Cocaine Treatment Study Model (NIDA Therapy Manuals for Drug Addiction no. 4; NIH publication no. 02-4381) Bethesda: National Institute on Drug Abuse, September 2002. AVAILABILITY: Download from NIDA web site, **URL**: http://www.drugabuse.gov.
Treating Tobacco Use and Dependence: Clinical Practice Guideline	This guideline was written to be relevant to all tobacco users -- those using cigarettes as well as other forms of tobacco. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence.	This guideline is available in several formats suitable for health care practitioners, the scientific community, educators, and consumers. The "Clinical Practice Guideline" presents recommendations for health care providers with brief supporting information, tables and figures, and pertinent references. The "Quick Reference Guide" is a distilled version of the clinical practice guideline, with summary points for ready reference on a day-to-day basis. The "Consumer Version" is an information booklet for the general public to increase consumer knowledge and involvement in health care decision-making. Full text versions of all three documents are available on the Surgeon General's web site: **URL:** http://www.surgeongeneral.gov/tobacco/default.htm.
A Woman's Path to Recovery (Based on A Woman's Addiction Workbook)	A Woman's Path to Recovery is a clinician-led program for women with substance use disorders. The model uses chapters from "A Woman's Addiction Workbook: Your Guide to In-Depth Healing" as the basis for 12 90-minute sessions conducted by clinicians over 8 weeks.	Lisa M. Najavits, Ph.D. Director, Treatment Innovations Professor of Psychiatry, Boston University School of Medicine Lecturer, Harvard Medical School 12 Colbourne Crescent Brookline, MA 02445 Phone: (617) 731-1501 E-mail: Lnajavits@hms.harvard.edu URL: http://www.seekingsafety.org

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Social Skills Training		
EBPs	**Description**	**Source for Information**
Brief Alcohol Screening and Intervention for College Students (BASICS)	Because this is a combined screening, engagement, intervention, and social skills training tool, it also appears under several other sections of this inventory.	Purchase from: The Guilford Press, 72 Spring Street, New York, NY 10012. **URL:** http://www.guilford.com. Price per manual is $30.00
Brief CBT Intervention for Amphetamine Users	This model has also been proven effective with behavior change and management.	**URL:** http://www.nationaldrugstrategy.gov.au/pdf/cognitive.pdf.
Cognitive-Behavioral Coping Skills Therapy Manual	This model has also been proven effective with behavior change and management.	http://pubs.niaaa.nih.gov/publications/match.htm Cost: $6.00 per copy cost recovery fee - includes shipping and handling.
TCU Guide Maps: A Resource for Counselors	This model has also been proven effective with behavior change and management.	The entire manual or sections are available free: http://www.ibr.tcu.edu/pubs/trtmanual/manuals.html
Buprenorphine Treatment	Buprenorphine is the latest medication for use in the treatment of opiod addiction. Outcome measures of illicit opioid use, retention in treatment, and assessment for adverse events have shown that buprenorphine treatment reduces opioid use, retains patients in treatment, has few side effects, and is acceptable to most patients.	SAMHSA has available a Treatment Improvement Protocol (TIP) 40, the first clinical practice consensus guide (for physicians) produced on the use of buprenorphine for the treatment of patients addicted or dependent on heroin or prescription pain medications. This TIP is available at: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.72248

Social Skills Training		
EBPs	**Description**	**Source for Information**
Time Out! For Me! An Assertiveness and Sexuality Workshop for Men	The **Time Out!** This series consists of separate manuals for leading women-only and men-only workshops that address the sensitive topics of relationships, sexuality, and intimacy. Provides substance abuse counselors or case workers with a curriculum for leading a 6-session workshop for women in their treatment programs. Issues addressed include sexuality, gender stereotypes, self-esteem, assertiveness skills, and reproductive health. The structured format for the workshop includes information sharing, discussion, exercises and activities, and role play. The manual provides a comprehensive reference section on human sexuality, a resource directory, and handout materials for participants. Studies by the authors suggest that this intervention increases knowledge, self-esteem, and treatment tenure.	The entire manual or sections are available free: http://www.ibr.tcu.edu/pubs/trtmanual/manuals.html Printed copies of ***Time Out! For Me*** are available through **Lighthouse Institute**, a nonprofit division of Chestnut Health Systems in Bloomington, Illinois. Price per manual is $19, plus $4 shipping and handling. To order, contact the **Lighthouse Publications Web Site**, phone toll-free **(888) 547-8271**, or **FAX (309) 829-4661**.

EBPs	Description	Source for Information
Time Out! For Me! An Assertiveness and Sexuality Workshop for Women	The **Time Out!** series consists of separate manuals for leading women-only and men-only workshops that address the sensitive topics of relationships, sexuality, and intimacy. Provides substance abuse counselors or case workers with a curriculum for leading a 6-session workshop for women in their treatment programs. Issues addressed include sexuality, gender stereotypes, self-esteem, assertiveness skills, and reproductive health. The structured format for the workshop includes information sharing, discussion, exercises and activities, and role play. The manual provides a comprehensive reference section on human sexuality, a resource directory, and handout materials for participants. Studies by the authors suggest that this intervention increases knowledge, self-esteem, and treatment tenure.	The entire manual or sections are available free: http://www.ibr.tcu.edu/pubs/trtmanual/manuals.html Printed copies of ***Time Out! For Me*** are available through **Lighthouse Institute**, a nonprofit division of Chestnut Health Systems in Bloomington, Illinois. Price per manual is $19, plus $4 shipping and handling. To order, contact the **Lighthouse Publications Web Site**, phone toll-free **(888) 547-8271**, or **FAX (309) 829-4661**.

Psycho Social Services		
EBPs	**Description**	**Source for Information**
Anger Management for Substance Abuse and Mental Health Clients: Cognitive-Behavioral Therapy	Anger Management is based on social learning theory; it may be useful for counselors who work with substance abuse and mental health clients with concurrent anger problems. The manual describes a 12-week cognitive behavioral anger management group treatment, and covers the anger cycle, conflict resolution, assertiveness skills, and anger control plans. The treatment model is a combined CBT approach that employs relaxation, cognitive, and communication skills interventions.	The therapy manual and a participant workbook can be ordered for free from the National Clearinghouse for Alcohol and Drug Information (800-729-6686 or 240-221-4017, Inventory # BKD444 and BKD4445), or downloaded from the web: URL: http://kap.samhsa.gov/products/manuals/ A Spanish-language version is also available free from NCADI at: 877-767-8432 (toll free) Hablamos Español (NCADI No. BKD444S and BKD445S) or downloaded from the web: URL: http://kap.samhsa.gov/mli/index.htm.
Cognitive-Behavioral Coping Skills Therapy Manual	This model has also been proven effective with behavior change and management.	**http://pubs.niaaa.nih.gov/publications/match.htm** Cost: $6.00 per copy cost recovery fee - includes shipping and handling.
Motivational Enhancement Therapy Manual	This practice is listed and described under the Engagement section of this inventory.	**Volume 2-Motivational Enhancement Therapy Manual,** 121 pp. NIH Pub. No. 94-3723. 1994. http://pubs.niaaa.nih.gov/publications/match.htm#ordering Cost: $6.00 per copy cost recovery fee - includes shipping and handling.

EBPs	Description	Source for Information
Pathways' Housing First Program	Housing First, a program developed by Pathways to Housing, Inc., is designed to end homelessness and support recovery for individuals who are homeless and have severe psychiatric disabilities and co-occurring substance use disorders. Pathways' Housing First model is based on the belief that housing is a basic right and on a theoretical foundation that emphasizes consumer choice, psychiatric rehabilitation, and harm reduction. The program addresses homeless individuals' needs from a consumer perspective, encouraging them to define their own needs and goals, and provides immediate housing (in the form of apartments located in scattered sites) without any prerequisites for psychiatric treatment or sobriety. Treatment and support services are provided through an Assertive Community Treatment (ACT) team consisting of social workers, nurses, psychiatrists, vocational and substance abuse counselors, peer counselors, and other professionals. These services may include psychiatric and substance use treatment, supported employment, illness management, and recovery services.	Ana Stefancic, M.A. Director of Research Pathways to Housing, Inc. 55 West 125th Street, 10th Floor New York, NY 10027 Phone: (212) 289-0000 ext 1112 E-mail: stefancic@pathwaystohousing.org

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EBPs	Description	Source for Information
Supportive-Expressive Psychotherapy	Time-limited, focused psychotherapy that has been adapted for heroin- and cocaine-addicted individuals. The therapy has two main components: Supportive techniques to help patients feel comfortable in discussing their personal experiences & expressive techniques to help patients identify and work through interpersonal relationship issues. Focus is given to the role of drugs in relation to problem feelings and behaviors, and how problems may be solved without using to drugs.	Luborsky, L. Principles of Psychoanalytic Psychotherapy: A Manual for Supportive-Expressive (SE) Treatment. New York: Basic Books, 2000. Purchase from Basic Books ($27).
TCU Guide Maps: A Resource for Counselors	This model has also been proven effective with behavior change and management.	The entire manual or sections are available free: http://www.ibr.tcu.edu/pubs/trtmanual/manuals.html
Trauma Affect Regulation: Guide for Education and Therapy (TARGET)	TARGET is a strengths-based approach to education and therapy for survivors of physical, sexual, psychological, and emotional trauma. TARGET teaches a set of seven skills (summarized by the acronym FREEDOM--Focus, Recognize triggers, Emotion self-check, Evaluate thoughts, Define goals, Options, and Make a contribution) that can be used by trauma survivors to regulate extreme emotion states, manage intrusive trauma memories, promote self-efficacy, and achieve lasting recovery from trauma. TARGET can be adapted to assist men and women from various age groups, cultures, and ethnicities.	Eleanor Tandler Chief Executive Officer Advanced Trauma Solutions, Inc. 406 Farmington Avenue Farmington, CT 06032 Phone: (860) 676-7788 E-mail: elt@uconnrd.com Web site: http://www.ptsdfreedom.org

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EBPs	Description	Source for Information
Trauma Recovery and Empowerment Model (TREM)	The Trauma Recovery and Empowerment Model (TREM) is a fully manualized group-based intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse. Drawing on cognitive restructuring, psychoeducational, and skills-training techniques, the gender-specific 24-29 session group emphasizes the development of coping skills and social support. It addresses both short- and long-term consequences of violent victimization, including mental health symptoms, especially posttraumatic stress disorder (PTSD) and depression, and substance abuse. TREM has been successfully implemented in a wide range of service settings (mental health, substance abuse, criminal justice) and among diverse racial and ethnic populations.	Rebecca W. Berley, M.S.W. Director of Trauma Education Community Connections 801 Pennsylvania Avenue, SE, Suite 201 Washington, DC 20003 Phone: (202) 608-4735 E-mail: rwolfson@ccdc1.org Web site: http://www.ccdc1.org

Personal Health Services		
EBPs	**Description**	**Source for Information**
Approaches to HIV/AIDS Education in Drug Treatment	This is an easy-to-follow manual designed to assist counselors in leading educational groups on HIV/AIDS. The manual offers a 4-session core curriculum that addresses HIV transmission, safer sex and injection practices, HIV testing, and personal risk reduction. Stand-alone teaching outlines also are provided for additional creative exercises and activities that promote HIV/AIDS awareness and prevention.	The entire manual or sections are available free: http://www.ibr.tcu.edu/pubs/trtmanual/manuals.html Printed copies of ***Approaches to HIV/AIDS Education in Drug Treatment*** are available through **Lighthouse Institute**, a nonprofit division of Chestnut Health Systems in Bloomington, Illinois. Price per manual is $17, plus $5 shipping and handling. To order, contact the **Lighthouse Publications Web Site**, phone toll-free **(888) 547-8271**, or **FAX (309) 829-4661**.

Family and Friends		
EBPs	**Description**	**Source for Information**
Behavioral Couples (Marital) Therapy	BCT is described previously in this inventory.	These and other BCT manuals can be obtained free by downloading from the Addiction and Families Research Group web site: **URL:** http://www.addictionandfamily.org or by emailing a request to: devans@addictionandfamily.org
Network Therapy	Network Therapy is a substance-abuse treatment approach that engages members of the patient's social support network to support abstinence. Key elements of the approach are: (1) a cognitive-behavioral approach to relapse prevention in which patients learn about cues that can trigger relapse and behavioral strategies for avoiding relapse; (2) support from the patient's natural social network; and (3) community reinforcement techniques engaging resources in the social environment to support abstinence. Network Therapy patients typically participate in outpatient treatment twice per week for 12-24 weeks. The patient participates in weekly individual therapy sessions and weekly sessions attended by network members approved by the therapist. Patients agree to contingency contracts agreeing to aversive consequences if they use targeted drugs. Some practitioners ask patients to submit urine samples for testing.	Marc Galanter, M.D. Professor, Department of Psychiatry Director, Division of Alcoholism and Drug Abuse New York University School of Medicine 550 First Avenue New York, NY 10016 Phone: (212) 263-6960 E-mail: marcgalanter@nyu.edu

Supportive Networks		
EBPs	**Description**	**Source for Information**
Cognitive Behavioral Therapy: Treating Cocaine Addiction	Descriptive info is available previously in this inventory. **Supportive networks are discussed throughout the treatment process.*	This manual can be downloaded at the following website: www.drugabuse.gov/TXManuals/CBT/CBT1/html It is a public domain document.
Community Reinforcement Approach (CRA) with Vouchers	This model has been utilized successfully for behavioral change and management.	Available to download free from NIDA online: http://www.drugabuse.gov/TXManuals/CRA/CRA1.html
Double Trouble in Recovery (DTR)	Double Trouble in Recovery (DTR) is a mutual aid, self-help program for adults ages 18-55 who have been dually diagnosed with mental illness and a substance use disorder. In a mutual aid program, people help each other address a common problem, usually in a group led by consumer facilitators rather than by professional treatment or service providers. DTR is adapted from the Twelve Steps of Alcoholics Anonymous. DTR meetings follow the traditional 12-step format, which includes group member introductions, a presentation by a speaker with experiences similar to those of the meeting attendees, and time for all attendees to share their experiences with the group. Meetings typically last 60-90 minutes.	Howard Vogel, M.S.W. Executive Director Double Trouble in Recovery, Inc. P.O. Box 245055 Brooklyn, NY 11224 Phone: (718) 373-2684 E-mail: information@doubletroubleinrecovery.org Web site: http://www.doubletroubleinrecovery.org

EBPs	Description	Source for Information
Mapping Your Steps	Provides mapping templates for helping clients work their 12-step program and contemplate the deeper, personal relevance of each step. This manual is an excellent resource for counselors who want to assist clients interested in immersing themselves in the steps and traditions of groups like Alcoholics Anonymous, Narcotics Anonymous, or Cocaine Anonymous. The approach is suitable for both "old-timers" and for clients who are new to 12-step work. The maps encourage reflection and serious consideration of the foundational ideas of 12-step programs such as powerlessness, concepts of a Higher Power, moral inventories, making amends, and helping others. In addition, the manual includes maps to explore popular AA slogans, the Twelve Traditions, and the *Serenity Prayer*.	The entire manual or sections are available free: http://www.ibr.tcu.edu/pubs/trtmanual/manuals.html
Twelve Step Facilitation Therapy	As this process is also successfully utilized to enhance engagement in treatment, it is listed and described under the Engagement section of this inventory	**http://www.niaaa.nih.gov/publications/match.htm** Cost: $6.00 per copy (includes shipping and handling).

Post Treatment		
EBPs	**Description**	**Source for Information**
Cognitive-Behavioral Coping Skills Therapy	**Discussion of relapse is part of the sessions.* This model has also been proven effective with behavior change and management and is described previously in this inventory.	http://pubs.niaaa.nih.gov/publications/match.htm Cost: $6.00 per copy (includes shipping and handling).
Motivational Enhancement Therapy	**Some discussion of relapse.* This model has also been proven effective with engagement and is described previously in this inventory..	***Volume 2-Motivational Enhancement Therapy Manual,*** 121 pp. NIH Pub. No. 94-3723. 1994. http://pubs.niaaa.nih.gov/publications/match.htm#ordering Cost: $6.00 per copy cost recovery fee - includes shipping and handling.
Relapse Prevention Therapy	Individuals learn to identify and correct problematic behaviors. RPT encompasses several cognitive-behavioral strategies that facilitate abstinence as well as provide help for people who experience relapse.	Clinical Guidelines for Implementing Relapse Prevention Therapy. Illinois: The Behavioral Health Recovery Management Project. Download free: http://www.bhrm.org/guidelines/RPT%20guideline.pdf.
Straight Ahead: Transition Skills for Recovery	Provides substance abuse treatment professionals with a step-by-step curriculum for leading a 10-session workshop designed to reinforce key recovery concepts.	The entire manual or sections are available free: http://www.ibr.tcu.edu/pubs/trtmanual/manuals.html Printed copies of ***Straight Ahead: Transition Skills for Recovery*** are available through **Lighthouse Institute**, a nonprofit division of Chestnut Health Systems in Bloomington, Illinois. Price per manual is $19, plus $4 shipping and handling. To order, contact the **Lighthouse Publications Web Site**, phone toll-free **(888) 547-8271**, or **FAX (309) 829-4661**.
Twelve Step Facilitation Therapy	As this process is also successfully utilized to enhance engagement in treatment, it is listed and described under the Engagement section of this inventory.	**http://www.niaaa.nih.gov/publications/match.htm** Cost: $6.00 per copy (includes shipping and handling).

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Part II: Evidence-based Practices

For Adolescent Substance Abuse Treatment Programs

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Screening and Assessment		
EBPs	**Description**	**Source for Information**
ASAM Patient Placement Criteria 2nd Edition-Revised	ASAM Patient Placement Criteria comprise of a system for treatment matching to level of care based on need and is the most widely used and comprehensive national guidelines for placement, continued stay and discharge of patients with alcohol and other drug problems.	The ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders is an essential tool for use in treatment planning and in working with managed care organizations, and public and private treatment providers. To place an order, contact the ASAM Publications Distribution Center at 1-800-844-8948. It is available at a cost of $70 for ASAM members and $85 for nonmembers. Quantity discounts are also available. SHIPPING: 12% for U.S. orders; 15% for Canada. International orders will be billed actual cost.
Adolescent Diagnostic Interview	Based on DSM-IV, this interview provides a diagnosis for psychoactive substance use disorders in adolescents. The *ADI* systematically assesses psychoactive substance use disorders in 12- to 18-year-olds. This structured interview also evaluates psychosocial stressors, school and interpersonal functioning, and cognitive impairment. In addition, it screens for specific problems commonly associated with substance abuse.	Dr. Ken Winters Phone: (612)273-9815 Email: winte001@umn.edu Professor in the Department of Psychiatry and Director of the Center for Adolescent Substance Abuse Research at the University of Minnesota URL: http://www.wpspublish.com
Adolescent Drug Abuse Diagnosis (ADAD)	ADAD is a 150-item instrument for structured interviewer administration that produces a comprehensive evaluation of the client and provides a 10-point severity rating for each of nine life problem areas.	For a free download of the instrument and manual: URL: http://eib.emcdda.europa.eu/html.cfm/**index3530EN.html**
Adolescent Drinking Index (ADI)	ADI is a 24-item rating scale that quickly assesses alcohol use disorders in adolescents with psychological, emotional, or behavioral problems. It also identifies adolescents who need further alcohol evaluation or treatment. ADI defines the type of drinking problem and can help develop treatment plans and recommendations.	Psychological Assessment Resources, Inc. PO Box 998 Odessa, FL 33556 Phone: (800) 331-8378 URL: http://www.parinc.com

EBPs	Description	Source for Information
Comprehensive Adolescent Severity Inventory (CASI)	This instrument is designed to provide a comprehensive, in-depth assessment of the severity of an adolescent's substance use and other related areas.	Alicia Webb Center for Studies of Addiction VA Medical Center University and woodland Building 7 Philadelphia, PA 19104 (215)823-4674
Drug Use Screening Inventory – Revised (DUSI-R)	DUSI-R is a 159-item instrument that documents the level of involvement with a variety of drugs and quantifies severity of consequences associated with drug use. The profile identifies and prioritizes intervention needs and provides an informative and facile method of monitoring treatment and aftercare.	Dave Gorney The Gordian Group PO Box 1587 Hartsville, SC 29950 Phone (843)383-2201
Brief Alcohol Screening and Intervention for College Students (BASICS)	Designed to help students make better alcohol-use decisions. BASICS is an alcohol skills training program (ASTP) that aims to reduce harmful consumption and associated problems in students who drink alcohol. Specifically, hazardous drinking behaviors in college students. The key elements underlying the ASTP approach include 1) the application of cognitive-behavioral self-management strategies (based on the relapse prevention model); 2) the use of motivational enhancement techniques; and, 3) the use of harm reduction principles. As a harm reduction approach, BASICS aims to motivate students to reduce risky behaviors rather than focus on a specific drinking goal such as abstinence or reduced drinking. For maximal flexibility, each session is tailored to the client's own risk factors and circumstances, as well as to the severity of the client's abuse or dependence. Also, to minimize program cost, the intervention can be easily modified for implementation by a wide variety of care providers with ranges of clinical experience.	Purchase from: The Guilford Press, 72 Spring Street, New York, NY 10012. URL: http://www.guilford.com. Price per manual is $30.00

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EBPs	Description	Source for Information
Global Appraisal of Individual Needs (GAIN)	The GAIN has 8 core sections containing questions on the recency of problems, breadth of symptoms, and recent prevalence as well as lifetime service utilization, recency of utilization, and frequency of recent utilization. The items are combined into over 100 scales and subscales that can be used for DSM-IV based diagnoses, ASAM-based level of care placement, and outcome monitoring.	Michelle White Research Scientist Assistant Director of GAIN Coordinating Center Chestnut Health systems 722 W. Chestnut St. Bloomington, IL 61701 (309)820-3543 x 83439 Email: MWhite@chestnut.org URL: http://www.chestnut.org/LI/GAIN/index.html
Global Appraisal of Individual Needs – Quick (GAIN-Q)	A shorter, general assessment used to identify various life problems among adolescents in the general population when a full biopsychosocial is not needed. Designed for use by personnel in diverse settings (e.g., Student Assistance Programs, health clinics, juvenile justice,), the instrument is used to identify those in need of a longer, more detailed assessment; identify those who may benefit from a brief intervention; and guide staff to make effective referral and placement decisions.	Michelle White Research Scientist Assistant Director of GAIN Coordinating Center Chestnut Health systems 722 W. Chestnut St. Bloomington, IL 61701 (309)820-3543 x 83439 Email: MWhite@chestnut.org URL: http://www.chestnut.org/LI/GAIN/index.html
Mini International Neuropsychiatric Interview (M.I.N.I. – Kid)	The M.I.N.I.-Kid is a short, structured diagnostic interview for DSM-IV and ICD-10 psychiatric disorders. With an administration time of approximately 15 minutes, the M.I.N.I.-Kid is a structured psychiatric interview for diagnostic evaluation and outcome tracking.	Juris Janavs, M.D. Email: jjanavs@hsc.usf.edu University of South Florida College of Medicine Department of Psychiatry and Behavioral Medicine 3515 East Fletcher Ave Tampa, FL 33163 Phone: (813)974-4544 URL: http://www.medical-outcomes.com
Problem Oriented Screening Instrument for Teenagers (POSIT)	POSIT is a screening tool designed to identify potential problem areas that require further in-depth assessment. Depending on the results of the in-depth assessment, early therapeutic intervention or treatment and related services may be necessary. POSIT can be utilized by school personnel, juvenile and family court personnel, medical and mental health care providers, and staff in substance use disorder treatment programs.	For a free download of the instrument : http://eib.emcdda.europa.eu/html.cfm/index3654EN.html

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EBPs	Description	Source for Information
Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR)	SAFERR is based on the premise that when parents misuse substances and maltreat their children, the only way to make sound decisions for these families is to draw from the talents and resources of at least three systems; child welfare, substance abuse treatment, and the courts. The SAFERR model and this guidebook were developed by the National Center on Substance Abuse and Child Welfare (NCSACW). The model includes screening and assessment tools and efficient communication strategies that support sound and timely decisions about the safety of children and about the treatment and recovery of parents. It includes guidance for developing collaborative relationships between the systems to help improve outcomes for these families.	For a free download of the manual, go to URL: www.ncsacw.samhsa.gov/files/SAFERR.pdf

Early Engagement		
EBPs	**Description**	**Source for Information**
Brief Alcohol Screening and Intervention for College Students (BASICS)	Because this is a combined screening, engagement, intervention, and social skills training tool, it also appears under several other sections of this inventory.	Purchase from: The Guilford Press, 72 Spring Street, New York, NY 10012. URL: http://www.guilford.com. Price per manual is $30.00
Cannabis Youth Treatment (CYT)	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. These treatments vary in terms of length (6-14 weeks), mode (individual, group, and family), planned number of sessions (5 to 23), theoretical orientation, and their approach to resource utilization and cost.	The manual is available to download free on the Chestnut Health Systems web site, **URL:** http://www.chestnut.org/LI/cyt/products/index.html#treatment. Print copies can be ordered free from SAMHSA's National Clearinghouse for Alcohol & Drug Information. http://ncadi.samhsa.gov/
Motivational Interviewing (MI)	Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.	Thousands of references are readily available which reference this practice. An excellent site with multiple links is: http://www.motivationalinterview.org/library/abstractsemp.html. Several manuals are available to accessed on line from http://www.motivationalinterview.org/clinical/METDrugAbuse.PDF

Behavioral Change / Management		
EBPs	**Description**	**Source for Information**
Adolescent Portable Therapy: A Practical Guide for Service Providers	This is an intensive family-and community-based intervention developed to treat adolescents who are heavy substance abusers. It was created to serve juvenile justice-involved adolescents and their families as the young people move through the justice system and reenter the community. The model is designed to be flexible enough to be adapted to other environments and with other client populations where a home-based family therapy intervention is indicated. The manual emphasizes: strength-based approaches to assessment and treatment, integrating Cognitive Behavioral and Family Therapy techniques, and techniques for helping the adolescent and family to function within larger systems.	Download a free copy of the manual from: www.chestnut.org/LI/downloads/Manuals/APT_Manual_august_2005.pdf. Contact Information: Evan Elkin, M.A. Phone: (212) 376-3036 E-Mail: eelkin@vera.org Web Site: www.vera.org/APT
Behavioral Therapy for Adolescents	Incorporates the principle that unwanted behavior can be changed by clear demonstration of the desired behavior and consistent reward of incremental steps toward achieving it. Therapeutic activities include fulfilling specific assignments, behavior rehearsal, and recording and reviewing progress. Positive reinforcement is given for meeting assigned goals. Urine samples are collected regularly to monitor drug use. The therapy aims to equip the patient to gain three types of control: Stimulus Control, Urge Control & Social Control. A parent or significant other attends treatment sessions when possible and assists with therapy assignments and reinforcing desired behavior.	There is not a specific manual. Supporting information can be found through the following resources: • Azrin NH, Acierno R, Kogan E, Donahue B, Besalel V, McMahon PT. Follow-up results of supportive versus behavioral therapy for illicit drug abuse. Behavioral Research & Therapy 34(1): 41-46, 1996. • Azrin NH, McMahon PT, Donahue B, Besalel V, Lapinski KJ, Kogan E, Acierno R, Galloway E. Behavioral therapy for drug abuse: a controlled treatment outcome study. Behavioral Research & Therapy 32(8): 857-866, 1994. • Azrin NH, Donohue B, Besalel VA, Kogan ES, Acierno R. Youth drug abuse treatment: A controlled outcome study. Journal of Child & Adolescent Substance Abuse 3(3): 1-16, 1994.

EBPs	Description	Source for Information
Brief Alcohol Screening and Intervention for College Students (BASICS)	Because this is a combined screening, engagement, intervention, and social skills training tool, it also appears under several other sections of this inventory.	Purchase from: The Guilford Press, 72 Spring Street, New York, NY 10012. URL: http://www.guilford.com. Price per manual is $30.00
Brief Strategic Family Therapy (BSFT)	This is a brief intervention used to treat adolescent drug use that occurs in conjunction with other problem behaviors. These behaviors include things such as conduct problems at home and at school, oppositional behavior, and delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior. Family interactions are thought to maintain or exacerbate adolescent drug abuse and other behavioral problems are targeted. Treatment typically involves 12-24 sessions, each 90 minutes in length, for 4 months. Additionally, there ay be up to 8 "booster" sessions. The number of sessions needed depends on the severity of the problem.	Available from NIDA online: **URL:** http://www.drugabuse.gov/TXManuals/bsft/BSFtIndex.html
Cannabis Youth Treatment (CYT)	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. These treatments vary in terms of length (6-14 weeks), mode (individual, group, and family), planned number of sessions (5 to 23), theoretical orientation, and their approach to resource utilization and cost.	The manual is available to download free on the Chestnut Health Systems web site, **URL:** http://www.chestnut.org/LI/cyt/products/index.html#treatment. Print copies can be ordered free from SAMHSA's National Clearinghouse for Alcohol & Drug Information. http://ncadi.samhsa.gov/

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EBPs	Description	Source for Information
Chestnut Health Systems – Bloomington Adolescent Outpatient (OP) and Intensive Outpatient (IOP) Treatment Model	This treatment model is designed for youth between the ages of 12 and 18 who meet ASAM criteria for Level I or Level II placement. The model incorporates outpatient and intensive outpatient programs and is based on four theoretical frameworks (Rogerian, behavioral, cognitive, and reality) for behavioral and emotional change. The program emphasizes an individualized treatment plan that includes the family unit as well as the adolescent. The two primary treatment approaches in this model are skill-building and counseling groups.	Susan H. Godley, Rh.D. Senior Research Scientist Chestnut Health Systems, Inc. 720 West Chestnut Street Bloomington, IL 61701 Phone: (309)820-3543 ext 83343 Email: sgodley@chestnut.org URL: http://www.chestnut.org
Family Behavior Therapy (FBT)	FBT is an outpatient behavioral treatment aimed at reducing drug and alcohol use in adults and youth along with common co-occurring problem behaviors such as depression, family discord, school and work attendance, and conducts problems in youth. This treatment approach owes its theoretical underpinnings to the Community Reinforcement Approach and includes a validated method of improving enlistment and attendance. Participants attend therapy sessions with at least one significant other, typically a parent.	Bradley Donohue, Ph.D. Associate Professor – Dept. of Psychology University of Nevada, Las Vegas 4505 Maryland Parkway Box 455030 Las Vegas, NV 89154 Phone: (702) 895-3305 Email: Bradley.Donohue@unlv.edu URL: http://www.unlv.edu/centers/achievement
Family Support Network (FSN) for Adolescent Cannabis Users	This intervention seeks to extend the focus of treatment beyond the world of the adolescent by engaging the family, a major system in his or her life. FSN consists of several components, each designed to achieve specific objectives: • Case management • Six parent education (PE) groups • Three or four in-home family therapy sessions. The FSN process is a family intervention designed to be used in conjunction with any standard adolescent treatment approach.	Family Support Network for Adolescent Cannabis Users, Cannabis Youth Treatment (CYT) Series, Volume 3. (DHHS Pub. No. (SMA) 01-3488.) Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2001. Order from the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686 or 1-800-487-4889 (TDD) Download from the SAMHSA KAP web site: **URL:** http://kap.samhsa.gov/products/manuals/cyt

EBP	Description	Source for Information
Group-Based Outpatient Treatment for Adolescent Substance Abuse	This manual describes a moderate-intensity group-based approach to adolescent outpatient substance abuse treatment. The 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 14-18). The program has its foundations in social learning theory and conditioning. The manual includes information on topics including: theoretical orientation, overview of the group-based treatment, relapse prevention, organizational overview, drug education, and parent education and support group curricula	The manual can be downloaded for free from: www.chestnut.org/LI/downloads/Manuals/Catonsville(DRAFT).pdf Author Contact Information: Ms. Emily Sears (410) 837-3977
Motivational Interviewing (MI)	Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.	Thousands of references are readily available which reference this practice. An excellent site with multiple links is: http://www.motivationalinterview.org/library/abstractsemp.html. Several manuals are available to accessed on line from http://www.motivationalinterview.org/clinical/METDrugAbuse.PDF
Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users	CYT Vol. 1: MET/CBT5 - This is a five-session treatment composed of two individual sessions of Motivational Enhancement Therapy (MET) and three weekly group sessions of Cognitive-Behavioral Therapy (CBT). The MET sessions focus on factors that motivate participants who abuse substances to change. Participants learn skills to cope with problems and meet needs in ways that do not involve turning to marijuana or alcohol. CYT Vol. 2: MET/CBT12 - This treatment is composed of 2 sessions of MET and 10 weekly group sessions of CBT. It is designed to provide more of the same kind of treatment as MET/CBT5 to test for dosage effects and is more in line with what many providers try to provide.	AVAILABILITY: While supplies last, hard copies of the CYT treatment manuals are available for free from the National Clearinghouse for Alcohol and Drug Information (NCADI) at http://www.health.org, or by calling 1-800-729-6686 or 1-800-487-4889 (TDD). The manuals can also be downloaded from the Chestnut Health Systems web site: URL: http://www.chestnut.org/LI/cyt/products/index.html#treatment.

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EBP	Description	Source for Information
Multidimensional Family Therapy (MDFT)	Meant to treat polydrug-abusing adolescents by targeting the individual adolescent, the parent(s), the relationship between children and parents, and other systems (school, peers, juvenile justice, etc.). Interventions work within the multiple ecologies of adolescent development, and they target the processes known to produce and/or maintain drug taking and related problem behaviors. MDFT typically involves 14-16 weekly sessions, ranging from 60-90 minutes each, and incorporating both individual and family formats.	Multidimensional family therapy for adolescent cannabis users. Cannabis Youth Treatment (CYT) Series, vol 5. (DHHS Pub. No. 02-3660). Rockville, MD: SAMHSA, Center for Substance Abuse Treatment, 244p. Order free print copy from National Clearinghouse for Alcohol & Drug Information (Inventory #BKD388); or purchase print copy ($30) or download free from Chestnut Lighthouse **URL:** www.chestnut.org/LI/cyt/products/index.html#treatment
Multisystemic Therapy (MST): Primary Manual for Treating Serious Antisocial Behavior in Adolescents	MST is a family and community-based treatment for adolescents presenting serious antisocial behavior and who are at imminent risk of out-of-home placement. It is a manualized treatment that includes a comprehensive set of risk factors targeted through individualized interventions. The interventions integrate empirically-based clinical techniques into a broad-based ecological framework that addresses relevant factors across family, peer, school and community contexts. Interventions focus on promoting behavioral changes in the youth's natural ecology by empowering caregivers with skills and resources to address difficulties that will arise in raising adolescents	**Primary Manual for Treating Serious Antisocial Behavior in Adolescents.** Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowand, M.D., & Cunningham, P.B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents.* New York: Guilford Press. To purchase the manual, ($38) from Guilford Press (Catalogue number 0106), go to URL: www.guilford.com/cgi-bin/cartscript.cgi?page=pr/henggeler.htm&dir=pp/cpap

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EBPs	Description	Source for Information
Multisystemic Therapy (MST) for Juvenile Offenders	This treatment intervention addresses the multidimensional nature of behavior problems in troubled youth. Treatment focuses on those factors in each youth's social network that are contributing to his or her antisocial behavior. The primary goals of MST programs are to decrease rates of antisocial behavior and other clinical problems, improve functioning (e.g., family relations, school performance), and achieve these outcomes at a cost savings by reducing the use of out-of-home placements such as incarceration, residential treatment, and hospitalization. The ultimate goal of MST is to empower families to build a healthier environment through the mobilization of existing child, family, and community resources. MST is delivered I the natural environment (in the home, school, or community). The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring weekly. Specific treatment techniques used to facilitate these gains are based on empirically supported therapies, including behavioral, cognitive behavioral and pragmatic family therapies.	Melanie Duncan, Ph.D. Program Development Coordinator MST Services, Inc. 710 Johnnie Dodds Boulevard Suite 200 Mt. Pleasant, SC 29464 Phone: (843) 856-8226 Fax: (843) 856-8227 E-mail: melanie.duncan@mstservices.com
Partners in Parenting	Contains materials for an 8-session structured workshop that allows participants to practice parenting strategies and discuss their experiences with others.	The entire manual or sections are available free: www.ibr.tcu.edu/pubs/trtmanual/manuals.html Printed copies are available through Lighthouse Institute, a nonprofit division of Chestnut Health Systems in Bloomington, Illinois. Price per manual is $25, plus $5 shipping and handling. To order, contact Lighthouse Publications toll free (888) 547-8271, or FAX (309) 829-4661.

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EBPs	Description	Source for Information
Phoenix Academy Clinical Manual	The Phoenix Academy is a modified therapeutic community treatment model for adolescent substance abusers. It is one of the few approaches shown to be effective with substance abusing adolescents. The effective treatment model includes program philosophy, treatment structure, sanctions and privileges, treatment admissions processes, resident job functions and hierarchy, school as a therapeutic intervention, clinical approach, program staffing and training, family programming, and group and individual interventions.	The Phoenix Academy Clinical Manual can be downloaded free from URL: www.chestnut.org/LI/downloads/Manuals/Phoenix_Academy_Manual_merged.pdf
Project Towards No Tobacco Use (Project TNT)	Project TNT is a classroom-based curriculum that aims to prevent and reduce tobacco use by students in grades 5-9 (10-14 years old). The intervention was developed for a universal audience and has served students with a wide variety of risk factors. Project TNT is based on the theory that youth will be better able to resist tobacco use if they are aware of misleading information that facilitates tobacco use, have skills that counteract the social pressures to obtain approval by using tobacco, and appreciate the physical consequences of tobacco use. Project TNT comprises 10 core lessons and 2 booster lessons, all 40-50 minutes in duration.	Jim Miyano Institute for Health Promotion and Disease Prevention Research University of Southern California 1000 South Fremont Avenue, Unit 8, suite 4112 Alhambra, CA 91803 Phone: (800)400-8461 Email: miyano@usc.edu URL: http://www.und.usc.edu/tnt/
Seeking Safety	Seeking Safety is a present-focused treatment for adolescents with a history of trauma and substance abuse. The treatment is designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on coping skills and psychoeducation and has 5 key principles: (1) safety as the overarching goal; (2) integrated treatment; (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; (4) content areas of cognitive, behavioral, interpersonal, and case management; and (5) attention to clinician processes.	Lisa Najavits, Ph.D. Director, Treatment Innovations Professor of Psychiatry, Boston University School of Medicine Lecturer, Harvard Medical School 12 Colbourne Crescent Brookline, MA 02445 Phone: (617)731-1501 Email: Lnajavits@hms.harvard.edu URL: http://www.seekingsafety.org

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EBPs	Description	Source for Information
Teen Intervene	Teen Intervene is an early intervention program targeting 12-19 year olds who display the early stages of alcohol or drug use problems but do not use these substances daily or demonstrate substance dependence. Integrating stages of change theory, motivational enhancement, and cognitive-behavioral therapy, this intervention aims to help teens reduce and ultimately eliminate their alcohol and other drug use. The program is administered in a school setting in two or three 1-hour sessions conducted 10 days apart.	Roxanne Schladweiler Director of Sales Hazelden Publishing and Educational Services 15251 Pleasant Valley Road Center City, MN 55012 Phone: (800)328-9000 Email: rschladweiler@hazelden.org URL: http://www.hazelden.org/bookstore
The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users	This evidence-based practice outlines 12-individual sessions for adolescents and their parents or caregivers that utilize an individual, flexible, behavioral approach. The manual provides detailed instructions on how to help the client learn more effective coping skills and can be used in rural areas or where forming therapy groups may be difficult.	You can obtain free copies of this manual by contacting SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI): Phone: (800) 729-6686 or URL: http://store.health.org Ask for DHHS Publication No. (SMA) 01-3489

Attachment- Mutual Self-help Groups

For People Who Have a Substance Use Disorder

- Alcoholics Anonymous: **http://www.alcoholics-anonymous.org**
- Chemically Dependent Anonymous: **http://www.cdaweb.org**
- Cocaine Anonymous: **http://www.ca.org**
- Crystal Meth Anonymous: **http://www.crystalmeth.org**
- Heroin Anonymous: **http://www.heroin-anonymous.org**
- LifeRing Secular Recovery: **http://www.unhooked.com**
- Marijuana Anonymous: **http://www.marijuana-anonymous.org**
- Methadone Anonymous: **http://www.methadone-anonymous.org**
- Narcotics Anonymous: **http://www.na.org**
- Secular Organizations for Sobriety/Save Our Selves: **http://www.sossobriety.org**
- SMART Recovery: **http://www.smartrecovery.org**
- Women for Sobriety: **http://www.womenforsobriety.org**

For People With Co-Occurring Disorders

- Double Trouble in Recovery: **http://www.doubletroubleinrecovery.org**
- Dual Recovery Anonymous: **http://www.dualrecovery.org**

For Families, Friends, and Significant Others

- Al-Anon/Alateen: **http://www.al-anon.alateen.org**
- Co-Anon: **http://www.co-anon.org**
- Families Anonymous: **http://www.familiesanonymous.org**
- Nar-Anon: **http://nar-anon.org**