

**ALCOHOL AND DRUG ABUSE DIVISION (ADAD)  
SUBSTANCE USE DISORDER TREATMENT RULES**

**Colorado Department of Human Services  
Alcohol and Drug Abuse Division (ADAD)  
4055 South Lowell Blvd.  
Denver, Colorado 80236  
Phone: 303-866-7480  
Fax: 303-866-7481**

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### **Please Note**

Alcohol and Drug Abuse (ADAD) Substance Use Disorder Treatment Rules is designated 6 CCR 1008-1 Alcohol and Other Drug Abuse/Dependence Treatment Rules in the Colorado Code of Regulations (CCR) and appears there in the format required by the CCR. This version of the treatment rules has been re-formatted for general distribution.

On-line versions of all Colorado Department of Human Services rules and regulations can be viewed at <http://www.cdhs.state.co.us> and are the most current versions available; however, they are not considered to be the official publication. For the official publication of these and all State of Colorado regulations, please consult the Code of Colorado Regulations (CCR) or Weil Publishing at 1-800-877-9345 or at <http://www.weilpublishing.com>. State regulations may also be obtained from the Secretary of State Information Center at 303-894-2200, x6418.

Alcohol and Drug Abuse (ADAD) Substance Use Disorder Treatment Rules and other ADAD treatment licensing documents are available for viewing and downloading at <http://www.cdhs.state.co.us/ohr/adad/index/html>.

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**15.200 ALCOHOL AND DRUG ABUSE DIVISION (ADAD) SUBSTANCE USE DISORDER TREATMENT RULES****15.210 ADMINISTRATIVE PROCEDURES**

- A. The Alcohol and Drug Abuse Division (ADAD) is authorized by statute (Title 25, Article 1, Parts 207, 306 and 1102; Title 12, Article 22, Part 322; and Title 42, Article 4, Part 1301.3(3)(a)(IV); Colorado Revised Statutes) to establish minimum rules by which it licenses and monitors the administration and provision of treatment services for substance use disorders. ADAD licenses shall not authorize or endorse any other services provided by licensed treatment agencies.
- B. All applicants for ADAD licenses shall demonstrate compliance with sections 15.211 - 15.219.
- C. Applicants for ADAD licenses to provide specialized treatment services to specific client populations, as described in sections 15.221 - 15.230, shall demonstrate compliance with each section for which licenses are requested.
- D. Treatment agencies funded by ADAD or by a designated Managed Service Organizations (MSO) shall be licensed to treat clients involuntarily committed to treatment in accordance with section 15.227, Involuntary Commitments.
- E. Requests to waive specific rules shall be submitted in formats acceptable to ADAD. Requests shall document how undue financial hardship or inability to meet unique treatment needs will result if waiver requests are denied and how health, safety and welfare of clients and staff will not be put at risk if waiver requests are granted.
- F. Waivers shall not exceed time frames specified by ADAD, or expiration dates of current licenses.
- G. Licensing and routine monitoring site visits shall be scheduled and conducted by ADAD during normal treatment site business hours to the extent possible.
- H. ADAD shall conduct unscheduled site visits for specific monitoring purposes and investigation of complaints and critical incidents involving ADAD-licensed treatment agencies in accordance with:
  - 1. ADAD policies and procedures;
  - 2. Statutes and regulations that protect the confidentiality of client-identifying information, including 42 Code of Federal Regulations Part 2 (42 CFR Part 2), Confidentiality of Alcohol and Drug Abuse Patient Records, and 45 CFR Parts 142, 160, 162 and 164, Health Insurance Portability and Accountability Act (HIPAA). These regulations are available from the U.S. Department Of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201 (no later editions are incorporated); or, the Colorado Department of Human Services, Alcohol And Drug Abuse Division, 4055 S. Lowell Blvd., Bldg.

KA, Denver, Colorado 80236; or, at any state publication depository library.

- I. ADAD shall have access to all individuals, agencies, client and staff records and any other relevant documentation required to determine compliance with these rules and to coordinate client placement and care.

## **15.211 LICENSING PROCEDURES**

### **15.211.1 General Provisions**

- A. Individuals or organizations shall obtain ADAD licenses if:
  1. Required by statute to be ADAD-licensed;
  2. They receive public funds to provide substance use disorder treatment;
  3. They provide such treatment to client populations whose referral sources require them to be treated in ADAD-licensed agencies; or,
  4. They are acquiring existing ADAD-licensed treatment agencies or sites.
- B. ADAD licenses shall only be associated with the provision of substance use disorder treatment services and modalities described in ADAD rules.
- C. Treatment agencies whose ADAD licenses are not currently in effect shall not indicate in any form or manner that they are ADAD-licensed and shall not provide substance use disorder treatment services requiring an ADAD license.
- D. Hours of education and treatment provided by treatment agencies whose ADAD licenses are not currently in effect may not count toward fulfilling client obligations to courts, probation, parole, motor vehicle division and other referral sources.
- E. ADAD licenses may be granted to all treatment sites, services or modalities within a treatment agency, or to individual treatment sites, services or modalities.
- F. ADAD licenses are not transferable from one licensed treatment agency to another, from one licensed treatment site to another, or from a licensed treatment agency to an unlicensed organization or individual.
- G. Current ADAD licenses shall remain in effect during the licensing process when license applications are received by ADAD on or before current license expiration dates.
- H. Treatment agencies shall be solely responsible for monitoring the expiration dates of their ADAD licenses.
- I. Applicants may appeal licensing decisions in accordance with the State Administrative Procedures Act, as found in section 24-4-104, C.R.S.

**15.211.2 Initial Licenses**

- A. Applicants for ADAD initial licenses to provide substance use disorder treatment services shall submit completed ADAD license applications with required written documentation and application fees established by ADAD.
- B. Initial license applications received by ADAD that are not completed according to instructions, do not include application fees, or lack required written documentation shall be returned by certified mail to applicants with submitted application fees and written summaries of deficiencies.
- C. ADAD shall review complete initial license applications with written documentation and application fees and shall conduct on-site inspections to determine applicant compliance with applicable sections of these rules.
- D. Applicants that are in full compliance shall be granted ADAD licenses to provide substance use disorder treatment services that shall remain in effect for three (3) consecutive years from the dates licenses are granted.
- E. Applicants not in full compliance shall have their license applications returned by certified mail with written summaries of deficiencies and notification that their ADAD license applications are denied. Application fees shall not be refunded. Applicants may re-apply for initial licenses in accordance with section 15.211.2 of these rules.

**15.211.3 License Renewal**

- A. ADAD licenses shall expire three (3) consecutive years from dates licenses are granted. ADAD-licensed treatment agencies wishing to continue their ADAD licenses shall submit license renewal applications to ADAD prior to expiration dates of their current three-year ADAD licenses.
- B. License Renewal applications that are received by ADAD after expiration dates of current three-year ADAD licenses shall be returned to applicants by certified mail with submitted application fees and written notification that their ADAD licenses are no longer in effect as of the dates certified mail is received. Applicants may re-apply for initial licenses in accordance with section 15.211.2 of these rules.
- C. License renewal applications that are received by ADAD on or before expiration dates of current three-year ADAD licenses shall be reviewed and on-site inspections may be conducted to determine applicant compliance with applicable sections of these rules.
- D. Applicants that are in full compliance shall be granted renewal of their three-year ADAD licenses which shall be effective as of the expiration dates of the applicants' current three-year ADAD licenses.
- E. Applicants not in full compliance shall have their applications for renewal of three-year ADAD licenses denied and returned by certified mail with written summaries of deficiencies and notification that their current ADAD licenses

are no longer in effect as of the dates certified mail is received. Application fees shall not be refunded. Applicants may re-apply for initial ADAD licenses in accordance with section 15.211.2 of these rules.

#### **15.211.4 Provisional Licenses**

- A. ADAD may grant provisional ADAD licenses to applicants applying for initial ADAD licenses or to renew three-year ADAD licenses if it is determined that identified deficiencies may be remedied and do not appear to immediately jeopardize the health, safety, or welfare of clients or staff.
- B. Provisional ADAD licenses shall maintain the rights and responsibilities of three-year ADAD licenses, shall be in effect for not more than ninety (90) consecutive calendar days from dates granted, and may be renewed one (1) time.
- C. Prior to the expiration dates of provisional ADAD licenses, applicants shall submit applications for three-year ADAD licenses with written documentation of progress made toward completing all provisions. Application fees shall not be required.
- D. Applications for three-year ADAD licenses that are received by ADAD after expiration dates of provisional ADAD licenses shall be returned to applicants by certified mail with written notification that their provisional ADAD licenses are no longer in effect as of the dates certified mail is received. Applicants may re-apply for initial ADAD licenses in accordance with section 15.211.2 of these rules.
- E. Applications for three-year licenses that are received by ADAD on or before expiration dates of provisional ADAD licenses shall be reviewed and on-site inspections may be conducted to determine if applicants have completed all provisions.
- F. Initial applicants that have completed all provisions shall be granted ADAD licenses that shall remain in effect for three (3) consecutive years from the dates their provisional licenses were granted.
- G. Renewing applicants that have completed all provisions shall be granted renewal of their three-year ADAD licenses that shall be in effect as of the expiration dates of the applicants' most recent three-year licenses.
- H. Provisional ADAD licenses may be renewed if it is determined that circumstances beyond the applicants' control may be responsible for provisions not being completed. Renewed provisional ADAD licenses shall be in effect as of the expiration dates of original provisional ADAD licenses.
- I. Prior to the expiration dates of renewed provisional ADAD licenses, applicants shall submit applications for three-year ADAD licenses with written documentation of progress made toward completing all provisions. Application fees shall not be required.

- J. Applications for three-year ADAD licenses received by ADAD after renewed provisional ADAD license expiration dates shall be returned to applicants by certified mail with written notification that the applicants' renewed provisional ADAD licenses are no longer in effect as of the dates certified mail is received. Applicants may re-apply for initial ADAD licenses in accordance with section 15.211.2 of these rules.
- K. Applications for three-year licenses that are received by ADAD on or before expiration dates of renewed provisional ADAD licenses shall be reviewed and on-site inspections may be conducted to determine if applicants have completed all provisions.
- L. Initial applicants that have completed all provisions shall be granted ADAD licenses that shall be in effect for three (3) consecutive years from the dates their original provisional licenses were granted.
- M. Renewing applicants that have completed all provisions shall be granted renewal of their three-year ADAD licenses that shall be in effect as of the expiration dates of the applicants' most recent three-year licenses.
- N. Applicants that have not made satisfactory progress toward completing all provisions by the expiration dates of original provisional ADAD licenses, or have not completed all provisions by the expirations dates of renewed provisional ADAD licenses, shall have their applications for three-year ADAD licenses denied and returned by certified mail with written summaries of deficiencies and notification that their provisional ADAD licenses are no longer in effect as of the dates the certified mail is received. Original application fees shall not be refunded. Applicants may re-apply for initial ADAD licenses in accordance with section 15.211.2 of these rules.

#### **15.211.5 Probationary Licenses**

- A. Probationary licenses may be imposed by ADAD on treatment agencies that are discovered to be out of compliance with ADAD rules during a three-year license period.
- B. Duration of probationary licenses shall be established by ADAD at the time they are imposed.
- C. Administrative and treatment activities may be limited by probationary ADAD licenses while treatment agencies address corrective actions.
- D. Prior to the expiration dates of probationary ADAD licenses, treatment agencies shall submit applications for three-year ADAD licenses with written documentation of progress made toward completing corrective actions. Applications fees shall not be required.
- E. Applications for three-year ADAD licenses received by ADAD after expiration dates of probationary ADAD licenses shall be returned to applicants by certified mail with written notification that their probationary ADAD licenses are no longer in effect as of the dates the certified mail is received.

Applicants may re-apply for initial ADAD licenses in accordance with section 15.211.2 of these rules.

- F. Applications for three-year licenses that are received by ADAD on or before expiration dates of probationary ADAD licenses shall be reviewed and on-site inspections may be conducted to determine if applicants have completed all corrective actions.
- G. Applicants that have completed all corrective actions shall be granted ADAD licenses for the remainder of the original three-year license period that shall be effective as of the dates probationary ADAD licenses were granted.
- H. Applicants that have not completed corrective actions shall have their applications for three-year ADAD licenses denied and returned by certified mail with summaries of deficiencies and written notification that their probationary ADAD licenses are no longer in effect as of the date the certified mail is received. Applicants may re-apply for initial licenses in accordance with 15.211.2 of these rules

#### **15.211.6 License Modification**

- A. ADAD-licensed treatment agencies shall submit license modification applications and written documentation demonstrating compliance with all applicable ADAD rules, policies and procedures required to carry out the following actions:
  - 1. Adding, selling, moving or closing treatment agencies, sites, services and/or modalities;
  - 2. Changing agency name;
  - 3. Changing agency governance.
- B. Treatment agencies or sites moving to new geographic locations shall retain their current license numbers. If licensed to provide Driving Under the Influence (DUI) education and treatment services, treatment agencies shall also retain Discharge Referral Summary (DRS) numbers.
- C. ADAD shall retire and not re-issue license numbers of treatment agencies or sites that have been sold or closed. If treatment agencies or sites are licensed to provide DUI treatment and education services, ADAD shall also retire and not re-issue their DRS numbers.
- D. Treatment agencies or sites that are sold or closed shall return license certificates to ADAD.
- E. License modification application fees shall not be required.
- F. Failure to submit license modification applications and required documentation within time frames established by ADAD shall result in newly

acquired treatment agencies, sites, services and/or modalities not being ADAD-licensed.

**15.212 LICENSE REVOCATION, DENIAL, SUSPENSION, LIMITATION, ANNULMENT OR MODIFICATION**

- A. ADAD may revoke, deny, suspend, annul, modify, or limit licenses based on the following:
1. Non-compliance with these rules;
  2. Non-compliance with applicable state and federal statutes and regulations;
  3. Negligence resulting in risk to client and/or staff health or safety;
  4. Failure to implement ADAD-imposed corrective actions;
  5. Failure to submit required data in an accurate and timely manner to ADAD or its authorized representatives;
  6. Knowingly using or disseminating misleading, deceptive, or false information about treatment agencies including, but not limited to, advertising;
  7. Exercising undue influence on or otherwise exploiting clients to obtain or sell services, goods, property, or drugs for financial or personal gain;
  8. Failure to provide for support services when indicated by client assessments or adjunct services by court order;
  9. Accepting commissions, rebates, or other forms of remuneration for referring clients solely to particular treatment agencies or support services;
  10. Failure to provide for adequate supervision of treatment staff as outlined in Addiction Counselor Certification and Licensure Standards (6 CCR 1008-3);
  11. Evidence of agency fraud or misrepresentation;
  12. Failure to provide clients with information required by these rules;
  13. Failure to provide ADAD access to clients, staff and/or administrative information when requested;
  14. Sale, use or distribution of alcohol or illicit drugs, or unauthorized sale or distribution of prescription or over-the-counter drugs on treatment premises or during treatment activities off premises;
  15. Failure to protect and resist unlawful attempts to obtain client

Identifying information;

16. Knowingly using, and/or disseminating false information about these rules, ADAD policies and procedures, state or federal statutes and regulations, or other information essential to interpreting or managing client status, case management or interagency coordination.

B. Written notification of actions to revoke, deny, suspend, annul, modify, or limit licenses shall be sent by ADAD via certified mail to last known addresses of treatment agencies at least 10 working days prior to dates such actions go into effect. Written notification shall include:

1. Reasons for actions, citing applicable ADAD rules and state and federal statutes and regulations;
2. Rights of appeal in accordance with the State Administrative Procedures Act, section 24-4-104, C.R.S.

## 15.213 DEFINITIONS

"ADAD": Alcohol and Drug Abuse Division.

"ADAD License": authorization by ADAD to provide treatment services to persons with substance use disorders, authenticated by a license certificate.

"ADDS": Alcohol and Drug Driving Safety Program, established under section 42-4-1301.3, CRS. The Judicial Department administers an alcohol and drug driving safety program in each judicial district that provides pre-sentence and post-sentence alcohol and drug evaluations on all persons convicted of driving, flying, and boating under the influence (DUI, FUI, BUI) and driving with ability impaired (DWAI).

"ADES": Alcohol and Drug Evaluation Specialists within the criminal justice system, qualified to conduct pre- and post-sentence evaluations on, and provide supervision for, persons convicted of driving, flying, and boating under the influence (DUI, FUI, BUI) and driving with ability impaired (DWAI).

"Adjunct Services": services for DUI and other offenders that are identified as being needed in the assessment process or are ordered by the criminal justice system and that are provided by offender education and treatment services agencies on-site or through referral. Adjunct services may include, but are not limited to, random urine screens, monitoring ingestion of prescription disulfiram and naltrexone, opioid replacement treatment, random breath testing, and exposure to victim impact and self-help programs.

"Administer": 1) to apply controlled substances, whether by injection, inhalation, ingestion, or any other means, directly to the body; 2) to manage or direct the provision of treatment services.

"Admission Summary": a brief review of assessments and other relevant intake data that summarizes client status and provides a basis for individualized treatment planning.

"AIDS": Acquired Immune Deficiency Syndrome.

"Approved Controlled Substances": drugs, including methadone and buprenorphine which are regulated and specifically approved for treating opioid abuse by federal and state statutes, rules and regulations.

"ASAM": The American Society of Addiction Medicine that developed the "ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders," as a guide for assessing and placing clients in the appropriate level of care.

"Best Practice": treatment approaches that are well accepted by treatment agencies and clients and have some quantitative data showing positive treatment outcomes over a period of time, but do not have enough research or replication to support generalizations based on treatment outcomes.

"BUI": Boating Under the Influence: Title 33, Article 13, Part 1, C.R.S.

"Case Management": the administration and evaluation of an array of services that may include assessment of client and client family needs, service planning, referral/linkage to other services, client advocacy, monitoring service provision, and crisis control.

"Client": 1) person enrolled in treatment for substance abuse disorders, 2) in accordance with federal confidentiality regulations, any person who has contacted or has been contacted by a treatment agency for purposes of communicating alcohol and other drug abuse information, availability of treatment services, or for initial screening for treatment that takes place in a medical setting, such as opioid replacement treatment, the term "patient" is used instead of "client."

"Client Placement Criteria": indicators generated from initial assessments and other intake information by which clients are placed in the most appropriate and least restrictive treatment modalities.

"Client Record": all documentation of individual client treatment.

"Clinical Supervision": clinical practice by which treatment provided by counselors is evaluated and either modified or approved by supervisors. Clinical supervision is conducted face-to-face in either group or individual settings. Group clinical supervision is limited to no more than 6 individuals. Clinical supervision includes client record reviews and observations of clinical practice, according to counselors' levels of professional certification and/or licensing.

"Colorado Criminal Justice System": Department of Corrections; State Judicial; Division of Criminal Justice; Department of Public Safety; and District, County and Municipal Courts.

"Compliance": demonstration that these rules, ADAD policies and procedures and applicable federal and state statutes, and regulations are observed.

"Continuing Care Planning": process addressing post-treatment issues such as

additional treatment, relapse prevention, life skills, employability, education, training, socialization, and support systems.

"Controlled Substance": any drug whose general availability is restricted or any substance that is strictly regulated or outlawed because of its potential for abuse or dependence. Controlled substances include narcotics, stimulants, depressants, hallucinogens, and cannabis.

"Co-occurring Disorders": concurrent substance use and psychiatric disorders, identified through a differential assessment that a professional, qualified to make mental health diagnoses, can verify.

"Corrective Action": time-limited remedial measure, usually connected to a probationary ADAD license, applied to treatment agencies that are out of compliance during a three-year licensing period.

"Court": 1) district court in the county in which individuals named in petitions, filed in reliance on section 12.2 and applicable statutes, reside or are physically present, 2) probate court in the City and County of Denver, 3) county or municipal courts for DUI offenders and offenders described in Title 16, Article 11.5, Part 1, Colorado Revised Statutes.

"Credential": certificate, license, or academic degree that may qualify staff to provide treatment services within ADAD-licensed treatment agencies.

"Critical Incident": significant event or condition, which may be of public concern, which jeopardizes the health, safety, and/or welfare of staff and/or clients including client deaths on or off treatment agency premises (if relevant to current or previous treatment) and theft or loss of controlled substances prescribed for clients and dispensed, administered, and/or monitored by licensed treatment agencies.

"DUI": Driving Under the Influence; Title 42, Article 4, Part 13, C.R.S.

"DWAI": Driving With Ability Impaired; Title 42, Article 4, Part 13, C.R.S.

"Differential Assessment": systematic collection and analysis of client data including: functional and dysfunctional aspects of psychological patterns and family and social structures including histories of physical, emotional, and sexual abuse; biological systems including current physical and mental health status and client and family health histories; client and family alcohol and other drug use and abuse/dependence histories; leisure-time activities; education and vocational history; religious or spiritual life; legal status; life skill acquisition including level of parenting proficiency; information from previous treatment experiences; cultural factors including racial and ethnic background, age, gender, sexual orientation, and linguistic abilities; physical and cognitive disabilities; personal strengths; and motivation for treatment. Differential assessments are ongoing throughout treatment and instruments used in gathering client data are developmentally appropriate.

"Discharge Summary": brief review of client treatment including assessment of client problems at admission, expected treatment outcomes, treatment plans and strategies, client status at discharge including treatment progress, and summaries of

continuing care plans including referrals for further treatment.

"Dispense": preparing a controlled or non-controlled substance pursuant to a lawful prescription order of a licensed practitioner together with an appropriate label in a suitable container for subsequent administration or use by a client entitled to receive the prescription order.

"Dosing": dispensing or administering controlled or non-controlled substances pursuant to a lawful prescription.

"Evidence-Based Treatment": interventions, techniques and treatment methods that have proven to produce consistently positive treatment outcomes and are validated by rigorous and systematically conducted scientific research.

"Federal Client Confidentiality Regulations": 42 Code of Federal Regulations Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, that protect information that directly or indirectly identifies individuals as current or former substance use disorder treatment clients. These regulations are available from the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201 (no later editions are incorporated) or the Colorado Department of Human Services, Alcohol and Drug Abuse Division, 4055 S. Lowell Blvd., Bldg. KA, Denver, Colorado 80236; or, at any state publication depository library.

"Federal Health Care Information Privacy Regulations": 45 Code of Federal Regulations Parts 142, 160, 162, 164, the Health Insurance Portability and Accountability Act (HIPAA) that protects the privacy of all health care information including treatment for substance use disorders, retained by health plans, health care clearinghouses and treatment agencies. These regulations are available from the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201 (no later editions are incorporated); or, the Colorado Department of Human Services, Alcohol and Drug Abuse Division, 4055 S. Lowell Blvd., Bldg. KA, Denver, Colorado 80236; or, at any state publication depository library.

"FUI": Flying Under the Influence; Title 41, Article 2, Part 1, C.R.S.

"Governance": overall management, oversight, supervision, command, or control of the administration and provision of treatment for substance use disorders.

"Hepatitis A": inflammation of the liver caused by Hepatitis A virus that does not lead to chronic disease and is transmitted by fecal and oral routes through close person to person contact, oral sex, or ingestion of contaminated food or water.

"Hepatitis B": inflammation of the liver caused by Hepatitis B virus that can lead to cirrhosis, chronic liver disease and/or liver cancer and that is transmitted via contact with infected blood, semen and vaginal fluid through unprotected sex, injection drug use, human bites or from infected mothers to babies at birth.

"Hepatitis C": inflammation of the liver caused by Hepatitis C virus that can lead to cirrhosis, chronic liver disease and/or liver cancer and that is transmitted when infected blood from one person enters the body of another person, primarily through

sharing paraphernalia used to take street drugs intravenously.

"HIV": Human Immunodeficiency Virus.

"Intervention": short-term evaluation, information dissemination, and referral activities designed to immediately interrupt the progression of substance use disorders.

"Legal Guardian": person(s) or agencies, including treatment agencies, granted the rights and responsibilities of legal custody of individuals in accordance with applicable state statutes.

"Mental Health Services": a variety of services for preventing and treating psychiatric disorders that include, but are not limited to, emergency services, medication management, assessment, clinical treatment services, case management, family support and consumer advocacy.

"Minor": individual under 18 years of age.

"Monitor": 1) to supervise self-administration of medications prescribed for specific clients, 2) to assess whether treatment agencies are meeting minimum treatment rules.

"Opioid": any substance having an addiction forming or addiction sustaining liability similar to morphine, or being capable of conversion into a drug having an addiction forming or addiction sustaining liability.

"Opioid Dependent Person": individual physiologically dependent on an opiate, as defined in Title 12, Article 22, C.R.S., whose dependence includes regular use of legal or illegal opiate substances demonstrated by appropriate observations and tests performed by a licensed practitioner, pursuant to Title 12, Article 36, C.R.S.

"Opioid Replacement Detoxification Treatment": process by which an opiate dependent person is withdrawn from physiological addiction over a period of up to 6 months using a prescribed schedule of decreasing dosages of methadone, buprenorphine, or other approved controlled substance.

"Opioid Replacement Maintenance Treatment": treatment of more than 6 months duration during which methadone, buprenorphine, or other approved controlled substance is administered or dispensed to an opiate dependent person for purposes of decreasing or eliminating dependence on opioid substances either obtained and used illegally or legally by prescription.

"ORT": opioid replacement treatment.

"OTP": opioid treatment program.

"Qualified Service Organization Agreement (QSOA)": a written understanding between treatment agencies and non-treatment agencies pursuant to which the latter acknowledge that in receiving, storing, processing, or otherwise handling any information about past and present clients, they are fully bound by the provisions of

state and federal confidentiality statutes and regulations, including confidentiality of alcohol and drug abuse records.

"Quality Improvement": the routine monitoring, evaluation and adjustment of administrative operations and clinical practices for purposes of improving client care.

"Referral": process of linking clients to appropriate treatment and support services

"Release of Information": signed client authorization to exchange specific treatment information to a specified person or agency.

"Rules": requirements promulgated according to the Administrative Procedure Act (section 24-1-101, C.R.S., et seq.) through the Colorado Department of Human Services rule-making process, and adoption by State Board of Human Services pursuant to Title 26, Article 1, Part 107(5)(g), C.R.S.

"Split Dose": daily dose or take home dose of methadone, or other approved controlled substances that are divided into two or more smaller doses for purposes of improved client management.

"Staff": all persons working in substance use disorder treatment settings whether full-time, part-time, contracted, trainee, volunteer, or intern, and whether directly or indirectly involved in client treatment.

"Strength-Based Treatment": treatment that focuses on client strengths, including the capacity to cope with difficult situations; maintain functioning under stress; rebound from significant trauma; use external challenges as opportunities for growth; and, use support systems as a basis for resilience.

"Substance Abuse": a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. Criteria for this disorder are listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders. This manual is available from The American Psychiatric Association, 1400 K Street N.W., Washington D.C. 20005 (no later editions are incorporated) and may be examined at the Colorado Department of Human Services, Alcohol and Drug Abuse Division, 4055 S. Lowell Blvd., Bldg. KA, Denver, Colorado 80236; or, at any state publication depository library.

"Substance Dependence": a cluster of cognitive, behavioral and physiological symptoms indicating continuous use of substances despite significant substance-related problems, and a pattern of repeated self-administration that results in physical tolerance to substances, withdrawal and compulsive drug-taking behavior. Criteria for this disorder are listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders. This manual is available from The American Psychiatric Association, 1400 K street N.W., Washington D.C. 20005 (no later editions are incorporated) and may be examined at the Colorado Department of Human Services, Alcohol and Drug Abuse Division, 4055 S. Lowell Blvd., Bldg. KA, Denver, Colorado 80236; or, at any state publication depository library.

"Substance Use Disorder": a term inclusive of substance abuse and dependence, that also encompasses problematic use of substances that does not meet the

criteria for substance abuse or dependence (see “Definitions” in this section).

"Substance Use Disorder Screening": an activity employing specific instruments and/or procedures to determine the presence of alcohol and other drug problems and appropriateness for treatment at a particular treatment agency, prior to administering differential assessments.

"Support Services": services addressing client problems and/or conditions determined through assessments that are made available by treatment agencies, frequently through case management, either on-site or by referral. Support services may include, but are not limited to, medical and mental health treatment, drug screens, disulfiram and naltrexone monitoring, vocational counseling and rehabilitation, supportive housing, anger management, self-help programs, life skills training, and recreational activities.

"Take-home Dose": 1-day dose of methadone or other approved controlled substance authorized for specific patient use through self-administration on subsequent day(s) and dispensed in quantities not less than 1 fluid ounce and in an oral dosage formulated to minimize misuse by injection.

"Treatment Agency": an administrative unit that governs the provision of treatment to persons with substance use disorders. A treatment agency may provide other services as well, such as a hospital or mental health center. For purposes of these rules, treatment agency shall mean both the administration and treatment of substance use disorders.

"Treatment Contact": structured group or one-to-one interaction, between clients and appropriately credentialed treatment staff that assesses for, increases awareness of, and supports recovery from substance use disorders.

"Treatment Goals": key components of treatment plans, based on client problems or needs identified through assessment, and reasonably achievable in the active treatment phase.

"Treatment Interventions": treatment strategies or activities that staff will undertake to assist clients to achieve their targeted treatment goals.

"Treatment Lock In": limiting a patient's treatment to one opioid treatment program (OTP) based on, but not limited to: patient continually transferring from OTP to OTP and not engaging in treatment; patient having medical or psychiatric issues that only certain OTPs are capable of monitoring. Decisions to lock a patient into treatment and removing a patient's lock in status are made by the ADAD Controlled Substance Administrator in consult with appropriate, designated OTP staff.

"Treatment Lock Out": preventing a patient from receiving treatment from any opioid treatment program (OTP) in Colorado based on but not limited to: threats to kill or injure staff or other patients; diversion or attempts to divert medication received from an OTP; receiving methadone from more than one source; continually refusing to follow federal and or state rules and regulations pertaining to opioid treatment. Decisions to lock a patient out of treatment and removing a patient's lock out status are made by the ADAD Controlled Substance Administrator in consult with

appropriate, designated OTP staff.

"Treatment Notes": written chronological record of client treatment progress in relation to planned treatment outcomes.

"Treatment Objectives": actions, steps, activities or tasks clients will undertake to accomplish their targeted treatment goals.

"Treatment Planning": process based on differential assessments and other relevant client data that produces a written treatment plan, individualized for each client, that establishes measurable treatment outcomes described in behavioral terms, developmentally appropriate, strength-based, achievable within expected lengths of stay in treatment, and specifies time-limited therapeutic activities designed to support treatment outcomes.

"Treatment Plan Review": documented examination of treatment plans at regular intervals throughout the course of treatment to assess client progress in relation to planned treatment outcomes and make treatment plan adjustments as necessary.

"Treatment Program": coordinated array of treatment services that are designed for and systematically provided to clients with substance use disorders. A program located in an agency that provides other services as well, may have its own identity, including a name that's different from the agency's and a separate administration that oversees treatment service delivery.

"Treatment Site": geographic location where treatment services are delivered.

"Treatment Staff": treatment agency personnel who are Certified Addiction Counselors or otherwise possess clinical credentials and experience with client populations served, or are counselor trainees, who independently or as co-counselors provide, but are not limited to: client screening, assessment and placement; case management; treatment planning and review; client education; group, individual, and family therapy; continuing care planning; and crisis intervention. In residential programs, this includes staff that has regular contact with clients in the residential environment.

"Tuberculosis (TB)": an infectious disease caused by mycobacterium and transmitted via aerosolized respiratory secretions.

## **15.214 GOVERNANCE**

- A. Governing ADAD-licensed treatment agencies shall be the responsibility of legally established sole owners, partnerships or corporations, recognized by and allowed to do business in the State of Colorado.
- B. Governance shall provide for and maintain:
  1. Organizational structures that clearly delineate substance use disorder treatment services and lines of authority and supervision;
  2. Adequate financial resources to maintain treatment agency personnel,

physical facilities, and operations;

3. Physical facilities that meet all current and applicable local and state health, safety, building, plumbing and fire codes and zoning ordinances;
4. Property liability insurance;
5. Professional liability (malpractice) insurance;
6. Accurate and timely submission of required data to ADAD or its authorized representatives, including Drug Alcohol Coordinated Data System (DACODS) client treatment admission and discharge records, and Driving Under the Influence (DUI) education and therapy Discharge Referral Summaries (DRS).
7. Qualified and appropriately supervised staff;
8. Duties assigned to clinical and non-clinical personnel that are commensurate with documented education, training, work experience, and professional licenses and certifications;
9. Compliance with these rules, ADAD policies and procedures and federal and state statutes and regulations, applicable to providing substance use disorder treatment services;
10. Process for addressing client and counselor complaints including mechanisms for appealing unresolved complaints to higher levels of authority;
11. Treatment agency operating policies and procedures based on these rules, ADAD policies and procedures, and applicable state and federal statutes and regulations;
12. Evidence-based or best practice treatment;
13. Accurate, up-to-date client attendance and payment records.

#### **15.215 QUALITY IMPROVEMENT**

- A. Treatment agencies shall develop, implement, maintain and document the operation of quality improvement systems that are in accordance with written treatment agency policies and procedures and these rules that are reviewed at least annually. Quality improvement systems shall monitor, evaluate and document treatment agency treatment and administrative activities including, but not limited to:
  1. Treatment agency investigations of complaints and critical incidents;
  2. Staff knowledge of and adherence to these rules, ADAD policies and procedures and applicable federal and state statutes and regulations;

3. Emergency procedures;
  4. Treatment effectiveness;
  5. Treatment practices and professional conduct;
  6. Staff qualifications, competence, and supervision;
  7. Use of restraints and seclusions.
- B. Evaluations of counselor performance shall be performed at least annually. Performance evaluations shall include verifications of Colorado addiction counselor certification or licensing and status with other credentialing agencies.

## **15.216 STAFF REQUIREMENTS**

### **15.216.1 Background Investigations**

- A. Background investigations shall be required for all staff who have direct contact with clients or client records and shall include, at a minimum, name searches by Colorado Bureau of Investigation and Colorado Department of Human Services' Criminal Background Check Unit.
- B. Criteria shall be developed and implemented specifying convictions or complaints that make an applicant unacceptable for hiring or a staff person unacceptable for retention in terms of staff and client safety as well as appropriate counselor/client interactions.

### **15.216.2 Staff Qualifications and Competencies**

- A. Qualifications referred to in this section, including education, professional credentials, training and supervision, are in accordance with Addiction Counselor Certification and Licensure Standards (6 CCR 1008-3).
- B. At least 50% of all treatment staff at each treatment site, excluding non-hospital residential detoxification, shall be certified as Level II, Level III or shall be Licensed Addiction Counselors.
- C. Certified Level I Addiction Counselors and other counselor trainees shall not independently counsel, sign clinical documentation or carry out other duties relegated solely to certified Level II or III or Licensed Addiction Counselors and shall not comprise more than 25% of total treatment staff.
- D. Addiction counselor certifications and licenses shall be current and in good standing.
- E. Uncertified treatment staff who are not trainees shall have acquired clinical masters or doctoral degrees and/or maintained Colorado licenses that are current and in good standing to practice medicine, psychiatry, clinical

psychology, clinical social work, registered nursing, professional counseling, or marriage and family therapy and shall demonstrate knowledge of substance use disorders and their treatment through documented education and experience to include, at a minimum:

1. Baccalaureate or master's degrees with major or minor hours in addictions counseling and/or passing scores on NAADAC NCAC II or MAC examinations or other ADAD-approved measures of such knowledge;
  2. At least 1000 hours of addictions counseling experience, supervised by Level III Certified Addictions Counselors, Licensed Addictions Counselors or other ADAD-approved substance use disorder treatment professionals, at a minimum frequency of three (3) hours per month.
- F. Treatment agencies shall demonstrate that all treatment staff are qualified and competent to treat all client populations served and that relevant needs of culturally diverse clients, as well as clients with disabilities, are incorporated into planning and providing treatment, including effective and appropriate use of support services.
- G. Staff shall be provided initial training in methods of preventing and controlling infectious diseases and in universal precautions providing protection from possible infection when handling blood, other body fluids, and excreta. Annual refresher training, including updates, shall also be provided.
- H. Staff collecting urine, breath, and blood samples shall be knowledgeable of collection, handling, recording and storing procedures assuring sample viability for evidentiary and therapeutic purposes.
- I. Treatment agencies administering and/or monitoring client medications shall maintain at least one staff person per shift who is currently qualified by certification and/or training to perform those functions in accordance with applicable ADAD policies and procedures and state and federal statutes, and regulations.
- J. At least one residential treatment staff person per shift shall be currently certified in cardiopulmonary resuscitation and basic first aid.
- K. All staff shall be knowledgeable of treatment agency policies and procedures and federal and state statutes, rules and regulations delineating actions, relationships, and affiliations which violate therapeutic boundaries between staff and clients or are considered conflicts of interest. Staff shall also be knowledgeable of corrective actions to be applied by the treatment agency and/or state and federal regulatory agencies when such violations and conflicts occur.

**15.217 CLIENT RECORDS****15.217.1 Client Record Content**

- A. Treatment documents shall include, if applicable:
1. Screening and evaluations;
  2. Differential assessments;
  3. Admission summaries;
  4. Treatment plans;
  5. Treatment notes;
  6. Treatment plan reviews;
  7. Records of medication monitoring or administration;
  8. Records of vital signs monitoring;
  9. Continuing care plans (may be combined with discharge summaries);
  10. Discharge summaries.
- B. Client consents shall include:
1. Consent to treatment;
  2. Consent to treatment follow-up;
  3. Consent to release confidential client information.
- C. Client acknowledgments shall include:
1. Acknowledgment of protection afforded client records and client identity by federal alcohol and drug client confidentiality regulations, and the circumstances in which such regulations may be waived;
  2. Acknowledgment of client rights and responsibilities;
  3. Acknowledgment of chargeable fees and collection procedures;
  4. Acknowledgment of risk factors associated with substance use disorder for acquiring and transmitting Hepatitis A, B, C, HIV/AIDS, TB and other infectious diseases, and for pregnancy;
  5. Acknowledgment of counselor credentials, appropriate therapeutic practices and boundaries and complaint procedures including phone numbers and addresses of ADAD and Department of Regulatory

## Agencies (DORA).

- D. Other documents shall include:
  - 1. Out of state adult offender screen;
  - 2. Personal belongings inventories;
  - 3. Court documents;
  - 4. Copies of client data required by ADAD or its authorized representatives, including but not limited to the Drug/Alcohol Coordinated Data System (DACODS) and, if providing DUI services, the Discharge/Referral Summary (DRS);
  - 5. Records of required communication with referral sources such as court, probation, child welfare, and parole.
- E. Client records shall be legible, accurate, current, complete, and stored in a secure and orderly manner. Organization of documents in client records shall be consistent within each treatment modality.

**15.217.2 Counselor and Client Signatures**

- A. Counselor signatures shall be required on the following treatment documents:
  - 1. Screening and evaluations;
  - 2. Differential assessments;
  - 3. Admission summaries;
  - 4. Treatment plans;
  - 5. Treatment notes;
  - 6. Treatment plan reviews;
  - 7. Continuing care plans (may be combined with discharge summaries);
  - 8. Discharge summaries.
- B. Credentialed counselors authorized by treatment agencies to counsel independently shall sign treatment documents with at least first initial, last name, and Colorado addiction counselor credential, other professional credential, or academic degree.
- C. Counselors not credentialed may sign treatment documents if countersigned by supervising credentialed counselors.
- D. Signature stamps shall be permissible in lieu of written signatures if initialed

by the counselors whose signatures they represent. Electronic signatures shall be permissible for computerized client records.

- E. Client signatures shall be required on treatment plans and treatment plan reviews and adjustments, client consents, client acknowledgments, and other documents needing client authorization, such as personal belongings inventories.

### **15.217.3 Client Records Retention, Disposal and Confidentiality**

- A. Client records shall be retained for 5 years from date of treatment discharge. Discharge summaries shall be retained for an additional 5 years.
- B. Client records whose retention time has expired shall be disposed of in accordance with state and federal confidentiality statutes and regulations.
- C. Disposal services commissioned by treatment agencies to dispose of client records shall sign Qualified Service Organization Agreements (QSOAs).
- D. Records of active and discharged clients shall be maintained and stored in a manner that minimizes unauthorized access in accordance with state and federal confidentiality statutes and regulations.
- E. Treatment agencies shall assure that staff having access to clients or client records shall be knowledgeable of policies and procedures which protect client identity and treatment information from unauthorized disclosure in accordance with federal and state confidentiality statutes and regulations.
- F. Computerized client records shall comply with state and federal confidentiality statutes and regulations and be maintained in a manner that minimizes the risk of unauthorized access and destruction.

### **15.217.4 Client Access to Records**

- A. Clients shall have the right to view and obtain copies of their records.
- B. Treatment agencies may deny access to information judged to be potentially damaging to clients and shall document such decisions in client records.
- C. If decisions to deny access to information are challenged, treatment agencies shall cooperate in providing the disputed information (with written client permission) to independent treatment professionals qualified to evaluate potential damage.

## **15.218 TREATMENT MODALITIES**

### **15.218.1 General Provisions**

- A. Treatment agencies shall document that counselors are appropriately credentialed and qualified to provide treatment services in the modalities described in this section and the client populations they serve.

- B. All modalities shall give special consideration to clients' identified medical and psychiatric needs in planning treatment.
- C. Residential facilities shall construct and maintain sound and sight barriers between male and female clients, and between adult and adolescent clients in bathrooms and sleeping quarters.
- D. Client/counselor ratios in education and treatment groups shall not regularly exceed twelve to one (12:1).
- E. Emergency procedures, including map of fire exits, client rights and responsibilities and client complaint procedures shall be conspicuously posted in each site and modality.
- F. Treatment modalities shall offer a range of treatment approaches and support services based on client readiness to change and focus on identified substance use disorder education and treatment needs. Treatment approaches and support services may include:
  - 1. Group and individual therapy and education;
  - 2. Relapse prevention;
  - 3. Building support systems;
  - 4. Developing coping skills;
  - 5. Education on substance use disorders;
  - 6. Vocational counseling;
  - 7. Life skills training;
  - 8. Self-help groups;
  - 9. Milieu therapy (therapeutic community, intensive residential).

#### **15.218.2 Outpatient Treatment (ASAM Level I)**

- A. Outpatient treatment shall generally be intended for clients who may or may not have supportive resources during the course of treatment in the form of family, friends, employment or housing but are assessed as not appropriate for more intensive levels of treatment. Traditional outpatient treatment may also be a transition from more intensive treatment settings.
- B. Outpatient treatment shall be conducted with a frequency of eight (8) or less substance use disorder education/treatment contact hours per week for adults, and five (5) or less substance use disorder education/treatment contact hours per week for minors.

- C. Minimum frequency of treatment contact shall be one (1) time per thirty (30) consecutive calendar days.

### **15.218.3 Intensive Outpatient Treatment (ASAM level II.1)**

- A. Intensive outpatient treatment shall generally be intended for clients who require a more structured substance use disorder outpatient treatment experience than can be received from traditional outpatient treatment. Clients may or may not have resources in the form of family, friends, employment or housing that provides support during the course of treatment. Intensive outpatient treatment may reflect an increase in treatment intensity, such as outpatient to intensive outpatient, or a decrease in treatment intensity, such as residential to intensive outpatient treatment.
- B. Intensive outpatient treatment shall be conducted with a minimum frequency of nine (9) treatment contact hours per week for adults and a minimum frequency of six (6) treatment contact hours per week for minors.

### **15.218.4 Day Treatment (ASAM Level II.5)**

- A. Day treatment shall generally be intended for clients who require more structured treatment for substance use disorders than can be provided by intensive outpatient treatment, but are not assessed as needing treatment in a residential setting. Clients may or may not have resources in the form of family, friends, employment or housing that provides support during the course of treatment. Day treatment may be a transition to or from more intensive residential settings.
- B. Day treatment shall be conducted with a minimum frequency of twenty (20) treatment contact hours per week.

### **15.218.5 Transitional Residential Treatment (ASAM Level III.1)**

- A. This level of treatment shall generally be intended for clients who are transitioning to higher-intensity or lower-intensity levels of care and/or are reintegrating with the community, and whose history of chronic substance use disorders, lack of functional and supportive living situations, possible unemployment, levels of social or psychological dysfunction and lack of housing necessitate low-intensity residential treatment.
- B. Transitional residential treatment shall be conducted with a minimum frequency of five (5) treatment contact hours per week.
- C. Client/staff ratios shall not exceed twenty to one (20:1) during nighttime hours.

### **15.218.6 Intensive Residential Treatment (ASAM Level III.7)**

- A. Intensive residential treatment shall generally be intended for clients with significant substance use disorders who may also have extensive criminal and treatment histories, treatment failures in less intensive settings, psychological

problems and impaired functioning meriting short-term, high-intensity residential treatment that may include a community re-entry phase.

- B. Intensive residential treatment shall be conducted with a minimum frequency of twenty (20) treatment contact hours per week.
- C. Nighttime client/staff ratios shall not exceed twenty to one (20:1) per treatment agency site.

#### **15.218.7 Therapeutic Community (ASAM Level III.5)**

- A. Therapeutic communities shall generally be intended for clients whose chronic substance use disorders, social dysfunction, extreme impulsivity, and possible extensive criminal and previous treatment histories necessitate long-term, highly structured treatment that may include a community re-entry phase. The treatment environment is created by counselors and clients and facilitates changes in attitudes, perceptions and behaviors associated with substance use disorders and criminality.
- B. Substance Use Disorder treatment shall be conducted by appropriately credentialed counselors with a minimum frequency of five (5) treatment contact hours per week, in addition to routine therapeutic community activities.
- C. A minimum of twenty (20) clients shall constitute a therapeutic community.
- D. All clients upon entry to a therapeutic community shall participate in an orientation program that is a minimum of two weeks in length with seven hours of instruction per day.
- E. Clients in the therapeutic community may not work more than forty (40) hours per week.
- F. The therapeutic community shall assure that any work being done by clients either in the facility and/or in the community is being done following all Occupational Safety and Health Administration (OSHA), state and/or local health and safety regulations and codes.

### **15.219 CLIENT TREATMENT**

#### **15.219.1 General Provisions**

- A. Treatment agencies shall advise prospective clients of all fees, charges and payment and collection procedures prior to admission to treatment.
- B. Sliding fee scales shall be applied equally to all prospective clients.
- C. Treatment agencies shall be cognizant of clients' diverse cultural backgrounds, sexual orientation, gender and disabilities and structure treatment accordingly, including the use of effective support services.

- D. Treatment shall involve families and significant others with written client consent, unless clinically contraindicated.
- E. Treatment shall be evidence-based or best practice.
- F. Agencies shall document reasonable efforts to identify mental health issues and provide, or refer to, appropriate treatment.

## **15.219.2 Assessing Client Level of Care**

### **15.219.21 Screening**

- A. ADAD-approved screening instruments and/or procedures shall be developed and applied to all potential clients.
- B. Female clients of childbearing age shall be screened for pregnancy.
- C. Clients shall be screened for past and present risk factors associated with substance use disorders that contribute to:
  - 1. Becoming pregnant;
  - 2. Acquiring and transmitting HIV/AIDS, TB, Hepatitis A, B, C;
  - 3. Acquiring and transmitting other infectious diseases.
- D. Clients shall be apprised of risk factors considered to be significant and appropriate testing and pre/post-test counseling shall be offered on-site or through referral. Policies and procedures shall be developed and implemented for dealing with clients diagnosed with infectious diseases including staff knowledge of universal precautions providing protection against exposure and infection.
- E. Criminal justice system referrals for alcohol and other drug offenses, such as DUI/DWAI, BUI, FUI, and/or controlled substance violations, may be exempt from screening if already diagnosed, assessed, or evaluated as having alcohol and other drug problems.
- F. Adult clients shall be screened for past and present criminal charges in any state. Offenders with out-of-state charges must be registered by the treatment agency with Interstate Compact Office in accordance with Title 24, Article 60, Part 3, Colorado Revised Statutes.

### **15.219.22 Admission Criteria**

- A. Admission criteria shall be developed and implemented to determine treatment eligibility and ineligibility.
- B. Relapses or leaving previous treatment against advice shall not be the sole reasons for treatment ineligibility.

- C. Restrictions, priorities, or special admission criteria shall be applied equally to all potential clients.

#### **15.219.23 Assessment**

- A. Placement of offenders referred through Colorado's criminal justice system shall be based upon current standardized offender assessment and placement criteria, or Alcohol, Drug Driving Safety referral and placement criteria for DUI offenders.
- B. Differential assessments shall be conducted using ADAD-approved assessment instruments and procedures that shall justify client level of care and length of stay. Client assessment shall continue throughout the course of treatment.
- C. Admission summaries shall be completed based on differential assessments and other relevant intake data.
- D. Clients shall be placed in the least restrictive and most appropriate treatment modalities according to ADAD-approved client placement criteria.
- E. Treatment facilities and services shall be reasonably accessible to all client populations served. Accessibility for clients with disabilities shall comply with the Americans with Disabilities Act (ADA). Accessibility for other specific client populations shall be demonstrated by appropriate location of treatment sites and outreach activities.

#### **15.219.3 Treatment Management**

- A. A primary counselor or case manager shall be assigned to each client to assure performance, consistency, and coordination of treatment and support services.
- B. Case management services shall be provided to clients and their families/significant others when clinically indicated and with written client consent, if applicable.
- C. Client to counselor ratios during therapeutic activities shall not regularly exceed twelve to one (12:1).

#### **15.219.4 Client Notifications**

- A. Clients shall be given written notification of the following:
  - 1. Client complaint procedures, including phone numbers and addresses for ADAD and the Department of Regulatory Agencies (DORA);
  - 2. Client rights and responsibilities.
- B. Notifications shall be signed by clients and placed in their records.

**15.219.5 Recording Treatment****15.219.51 Treatment Plans**

- A. Treatment plans shall apply intervention, treatment, rehabilitation, support services and continuing care strategies to the degree indicated by client assessments, that may include, but are not limited to:
  - 1. Refusal skills and problem solving activities;
  - 2. Recreational, social, and cultural activities as alternatives to alcohol/other drug use/abuse;
  - 3. Peer support groups;
  - 4. Corrective educational activities;
  - 5. Employability training;
  - 6. Group and individual therapy;
  - 7. Education and treatment curricula.
- B. Treatment plans shall be collaboratively developed, reviewed and revised by counselors and clients.
- C. Treatment plans shall be individualized to each client based on differential assessments and other relevant client data.
- D. Treatment plans shall exhibit the following characteristics:
  - 1. Treatment goals based on problems or needs identified through assessment that are reasonably achievable in the active treatment phase;
  - 2. Treatment objectives and interventions that are specific, goal-focused, measurable, attainable, realistic and time-limited;
  - 3. Culturally sensitive;
  - 4. Developmentally appropriate;
  - 5. Based on client strengths;
  - 7. Evidence-based treatment or best practice;
  - 8. Appropriate application of support services;
  - 9. Referrals to appropriate, qualified practitioners, when co-occurring disorders are determined.

- E. Treatment plans shall not be required in cases where the sole expected outcomes are crisis intervention and referral.

#### **15.219.52 Treatment Notes**

- A. Treatment notes shall relate directly to treatment plans.
- B. Treatment notes shall be completed with a minimum frequency of:
  - 1. One note per session for outpatient and intensive outpatient treatment;
  - 2. Daily note for intensive residential treatment;
  - 3. Weekly summary note for day treatment, transitional residential treatment and therapeutic community.

#### **15.219.53 Treatment Plan Review**

- A. Treatment plan reviews shall be conducted at regular intervals during treatment to measure and document client progress in relation to planned treatment outcomes and make adjustments to treatment plans and client length of stay, as necessary.
- B. Treatment plan reviews shall occur, following initial treatment planning, with a minimum frequency of:
  - 1. Outpatient treatment - forty-five (45) days;
  - 2. Intensive outpatient treatment - fourteen (14) days;
  - 3. Day treatment - fourteen (14) days;
  - 4. Transitional residential treatment - forty-five (45) days;
  - 5. Intensive residential treatment - seven (7) days for first thirty (30) days, fourteen (14) days thereafter;
  - 6. Therapeutic communities – ninety (90) days;
  - 7. Opioid replacement treatment – ninety (90) days.
- C. Treatment plan reviews shall also occur when there are changes in client condition, treatment focus or as indicated by on-going differential assessments.
- D. Treatment plan reviews and any ensuing treatment adjustments shall be carried out collaboratively by counselors and clients.

**15.219.54 Treatment Discharge**

- A. Discharge criteria shall be developed and implemented which delineate grounds for client discharge from treatment.
- B. Voluntary clients shall be discharged from treatment immediately at their request unless emergency commitments or emergency mental health holds are in effect.
- C. Continuing care plans shall be collaboratively developed by counselors and clients prior to treatment discharge.
- D. Discharge summaries shall be completed at time of or following treatment discharge.

**15.219.6 Support Services**

- A. Policies and procedures shall be developed and implemented that govern the provision of support services.
- B. Identification of the need for support services shall be in accordance with ADAD-approved differential assessments and placement criteria.
- C. Support services shall be provided either on-site or through direct referral and close coordination with off-site agencies.

**15.219.7 Medications and Sample Collection**

- A. Medications shall be dispensed, administered, and monitored according to applicable state statutes and regulations, and ADAD rules, policies and procedures.
- B. Appropriate and approved samples for drug testing shall be collected and analyzed in accordance with applicable state and federal statutes and regulations, and ADAD rules, policies and procedures.

**15.219.8 Emergency Procedures**

- A. Procedures outlining responses to emergency situations shall be developed and implemented and conspicuously posted in every modality and treatment site.
- B. Residential sites shall provide for emergency medical services available to clients 24 hours per day, 7 days per week.
- C. Outpatient sites shall make emergency services accessible to clients during non-business hours by providing pager or emergency room contact information on voice mail or through voice messaging services, 24 hours per day, 7 days per week.

**15.219.9 Physical Restraints and Seclusion**

- A. Treatment agencies using physical restraints/seclusion shall develop and implement policies and procedures governing their application in accordance with state and federal regulations, including Child Care Licensing Rules, section 7.714.94, A and B (12 CCR 2509-8). Such policies and procedures shall be developed with medical and legal consultation, shall be maintained through periodic review and revision and shall be available to treatment staff at all times.
- B. Restraints/seclusion shall not be used as discipline, or solely for the convenience of staff.
- C. Restraints/seclusion shall be used only in extreme circumstances when it appears that clients or staff are at imminent risk for injury and other measures taken to reduce the risk have not proven sufficient. Measures taken to reduce risk prior to using restraints/seclusion shall be documented in client records.
- D. Initial orders to use restraints and seclusion, their subsequent re-evaluation and new orders shall be given by clinical directors knowledgeable about restraints and seclusion procedures or, with their written authorization, medical or clinical supervisors who are also knowledgeable about restraints and seclusions, and shall be documented in client records. All orders shall include justifications for using restraints and seclusion.
- E. Verbal orders for restraints and seclusions, received from persons authorized to give such orders, shall be documented in client records and shall be countersigned by those authorized persons within twenty-four (24) hours.
- F. Orders to use restraints/seclusion shall be carried out by staff trained in restraints and seclusion procedures.
- G. Clients restrained or secluded shall be monitored at least every fifteen (15) minutes to determine physical status. Monitoring shall be recorded in restraints and seclusion monitoring logs and may be recorded in client records.
- H. Use of restraints/seclusion exceeding one (1) hour in duration shall be reported to and re-evaluated by authorized personnel (see section 15.219.12, D.), continued if justified, re-evaluated at least one (1) time every four (4) hours thereafter, and require justification and new orders for continued use specifically designated staff.
- I. Seclusion areas shall be equipped with closed circuit TV or observation windows made of shatter-resistant material that provides unobstructed views of clients in seclusion.

**15.220 RULES FOR PROVIDING SPECIALIZED TREATMENT SERVICES****15.220.1 General Provisions**

- A. Treatment agencies offering specialized treatment services to individual client populations shall comply with core treatment rules (sections 15.210 – 15.219) in addition to applicable sections of rules for providing specialized treatment services (sections 15.220 – 15.230).
- B. Treatment agencies shall develop and implement treatment approaches that are:
  - 1. Developmentally, culturally and gender appropriate;
  - 2. Take into account different degrees of client motivation for treatment; and,
  - 3. Are evidence-based or best practice.
- C. ADAD-approved education and treatment curricula developed specifically for individual client populations shall not be altered without the express written permission of the authors.
- D. Treatment staff shall meet requirements stated in section 15.216, Staff Requirements, and be able to demonstrate, through documented education and experience, knowledge of individual client populations served and ability to provide specialized treatment services targeted to those populations.

**15.221 OFFENDER EDUCATION, TREATMENT, AND ADJUNCT SERVICES****15.221.1 General Provisions**

- A. Education, treatment and adjunct services shall be provided to persons convicted of misdemeanors and felonies who are assessed as needing substance use disorder treatment as provided by Title 16, Article 11.5, Part 1, Colorado Revised Statutes (C.R.S.) in accordance with the current standardized offender assessment and placement protocol and a differential assessment.
- B. Adjunct services, as clinically indicated, shall be provided for on-site or through referrals and shall include, but not be limited to:
  - 1. Random urinalysis;
  - 2. Naltrexone monitoring;
  - 3. Disulfiram monitoring;
  - 4. Opioid replacement treatment;
  - 5. Self-help programs;

6. Random breath testing;
  7. Victim impact panel (if available);
  8. Other medication.
- C. Clients shall be engaged in education and treatment for a minimum of nine (9) months or as required by the referring criminal justice agency.
- D. Frequency and intensity of education and treatment services shall be based on client assessments or as required by referring criminal justice agencies, but shall not be less than two (2) hours per week.
- E. Services shall be based on the results of screening and differential assessments.
1. Screening and differential assessments shall be conducted using ADAD-approved instruments;
  2. Agencies admitting offenders referred through Colorado's criminal justice system shall assure offenders are placed according to current standardized offender assessment (SOA) screening and placement criteria.

#### **15.221.2 Offender Education and Treatment Services**

- A. Treatment agencies shall develop and implement specialized offender treatment curricula that are written in manual format and approved by ADAD.
- B. The following content/topics, at a minimum, shall be presented during offender treatment:
1. Physiological and psychological effects of:
    - a. Alcohol;
    - b. Marijuana;
    - c. Stimulants;
    - d. Other drugs.
  2. Signs and symptoms of substance use disorders.
  3. Stress management and substance use disorders.
  4. Anger management and substance use disorders.
  5. Behavioral triggers leading to substance use disorders.

6. Drugs in the work place.
  7. Legal issues and substance use disorders.
- C. Offender education can be substituted for Level I or Level II education if there is a DUI/DWAI/BUI/FUI offense concurrent with the felony, drug misdemeanor or drug petty offense.

### **15.221.3 Enhanced Outpatient Offender Education and Treatment**

- A. Agencies may qualify to provide enhanced outpatient offender services if:
1. They are ADAD approved for offender education and treatment;
  2. They meet all requirements in ADAD treatment rules, sections 15.211 through 15.219;
  3. They are able to provide at least three (3) hours but less than nine (9) hours of scheduled education and treatment per week.
- B. Frequency and intensity of education and treatment activities shall be based on client assessments, but shall not be less than three (3) hours per week, conducted in at least two (2) sessions.
- C. Education and treatment activities shall be conducted for a minimum of nine (9) months or as required by the referring criminal justice agency.
- D. Changes in frequency and intensity of education and treatment activities shall be based on treatment plan reviews.
- E. If, upon discharge from enhanced outpatient offender education and treatment, the minimum number of months required to fulfill offender obligations to referring criminal justice agencies have not been met, offenders shall be transferred to the appropriate level of care where remaining months shall be completed.
- F. Enhanced outpatient shall be coded as "outpatient" when completing Drug/Alcohol Coordinated Data System admission and discharge forms.

## **15.222 DUI, DWAI, BUI AND FUI OFFENDER EDUCATION AND TREATMENT**

### **15.222.1 General Provisions**

- A. Alcohol and Drug Driving Safety (ADDS) education and treatment services shall be restricted to those arrested, convicted of or receiving deferred prosecutions, sentences, or judgments for alcohol/other drug offenses related to driving (Title 42, Article 4, Part 13, C.R.S.), boating (Title 33, Article 13, Part 1, C.R.S.), or flying (Title 41, Article 2, Part 1, C.R.S.).
- B. Driving Under the Influence (DUI), Driving While Ability Impaired (DWAI), Boating Under the Influence (BUI), and Flying Under the Influence (FUI)

offenders who are admitted, educated, or treated shall have been screened, referred and placed in accord with current ADDS program screening, referral, and placement procedures.

- C. Treatment agencies admitting DUI/DWAI, BUI, or FUI offenders referred by the criminal justice system shall place offenders based upon ADDS referral and placement criteria for DUI offenders.
- D. The ADDS referral and placement levels for substance abusing drivers is:
  - 1. Level I education;
  - 2. Level II education;
  - 3. Level II education and weekly non-intensive outpatient treatment;
  - 4. Enhanced or intensive outpatient, followed by Level II education and non-intensive outpatient treatment;
  - 5. Day treatment, followed by Level II education and weekly non-intensive outpatient treatment;
  - 6. Low intensity residential treatment, followed by Level II education, intensive outpatient and/or weekly non-intensive outpatient treatment;
  - 7. Transitional treatment, followed by Level II education, intensive outpatient and/or weekly non-intensive outpatient treatment;
  - 8. Intensive residential treatment, followed by Level II education, intensive outpatient and/or weekly non-intensive outpatient treatment;
  - 9. Hospital treatment, followed by Level II education, intensive outpatient and/or weekly non-intensive outpatient treatment;
  - 10. Therapeutic community followed by Level II education;
  - 11. No treatment.
- E. Levels 2. through 10. above are Level II programs.
- F. Agencies providing DUI services shall develop and implement policies, procedures, and individualized treatment planning demonstrating recognition of issues and treatment needs unique to this client population.
- G. Agencies may apply for approval to conduct Level I education only or approval to conduct Level I education, Level II therapeutic education and Level II therapy.
- H. Level I education, Level II therapeutic education, and Level II therapy shall be conducted in outpatient settings. Level II therapy may also be conducted in ADAD-approved residential settings.

- I. Level I education, Level II therapeutic education, and Level II therapy shall not be combined, nor shall hours completed in one count as hours completed in another.
- J. Agencies providing Level I education, Level II therapeutic education, and Level II therapy shall report to sentencing courts, ADAD, probation departments, ADES, and when appropriate, Department of Revenue Hearing Section, or Motor Vehicle Division, in a timely manner using reporting formats approved by ADAD. Reported client information shall include:
  1. Enrollment;
  2. Cooperation;
  3. Attendance;
  4. Treatment progress;
  5. Education/treatment levels;
  6. Fee payment;
  7. Discharge status.
- K. Agencies furnishing non-English education/treatment shall submit curricula and instructional materials, including handouts, and forms included in client records to ADAD for approval and provide translation if requested.
- L. Clients shall not be reported as finishing Level I education, Level II therapeutic education, or Level II therapy until all required sessions covering all required content/topics have been completed.
- M. Agencies shall furnish validated copies of ADAD-approved Discharge Referral Summaries (DRS) to clients within ten working days following client discharge from education/treatment.
- N. Agencies shall retain DRS for ten (10) years after date of treatment discharge and make them accessible to former clients upon request.
- O. Adjunct services shall be provided, either on-site or through referral, when clinically justified or court ordered, either concurrently with or consecutively to Level II education and treatment. Such services shall include but not be limited to the following:
  1. Random urine screens;
  2. Disulfiram monitoring;
  3. Naltrexone monitoring;

4. Opioid replacement treatment;
  5. Self/mutual help programs;
  6. Random breath testing;
  7. Victim impact panel (if available);
  8. Other medication.
- P. DUI/DWAI offenders shall not be educated or treated in groups with non-offenders or with non-driving offenders unless they need adjunct services in accordance with section 15.222.1, Q.
- Q. Level II program clients requiring adjunct services (e.g., therapy for other drug issues, mental health counseling, prenatal care, HIV/AIDS pre/post-test counseling, services for persons with disabilities) shall be referred to appropriate service agencies.
- R. Case management of adjunct service provision, including reporting to referring courts or their representatives, shall be the responsibility of the admitting Level II programs.
- S. Hours and weeks of some adjunct services that include treatment contact may be included with and reported as hours of Level II therapy, and shall be clinically justified and documented in client records, in accordance with ADAD policies and procedures.
- T. Level II programs not able to furnish or arrange for adjunct services required by court-ordered clients shall refer these clients back to the ADES with letters describing the nature of the problems and suggestions for alternative services.
- U. Level II programs shall assure that clients have access to court-ordered adjunct treatment services specified in section 15.222.1, O, and that these services are provided in compliance with ADAD rules, policies, and procedures, whether provided directly or through referral linkages.

#### **15.222.2 Level I Education**

- A. Level I education shall be restricted to DUI/DWAI, BUI, or FUI offenders who have been screened, referred, or placed in this level of education in accord with current ADDS program clinical procedures.
- B. Staff conducting Level I education shall be knowledgeable in all areas of Level I curricula, demonstrate instructional ability and meet the staff qualifications set forth in Section 15.216. State of Colorado Level I Addictions Counselor certification may be substituted for these requirements.
- C. Level I education shall be twelve (12) hours of instruction, including client intakes and pre/post tests. No more than six (6) hours shall be conducted in

one (1) calendar day.

- D. Level I education shall not be conducted in residential settings.
- E. The curriculum shall be written in a manual format and be approved by ADAD. The following content/topics shall be presented at a minimum during Level I education:
  - 1. Physiological effects of alcohol and other drugs, their effects on driving and their interactions;
  - 2. High risk behavior patterns;
  - 3. Psychological and sociological consequences of abuse of alcohol and/or other drugs;
  - 4. Blood alcohol concentration and effects on driving performance;
  - 5. Court penalties;
  - 6. Motor Vehicle Division laws and penalties, including potential incongruence between court sentence and Motor Vehicle Division requirements;
  - 7. Theories of addiction and common treatment approaches;
  - 8. Availability of local treatment and self help programs;
  - 9. Alternatives to drinking/drugging and driving;
  - 10. Impact of impaired driving on victims.
  - 11. Understanding behavioral triggers leading to substance use disorders;
  - 12. Concepts of relapse and relapse prevention;
  - 13. Stress management and substance use;
  - 14. Anger management and substance use;
  - 15. Decision making skills;
  - 16. Development of a personal change plan (Level II).
- G. No more than twenty (20) clients shall be present in a Level I education group.
- H. Individual records shall be maintained for Level I education clients and shall include:
  - 1. Court documents regarding referral and classification;

2. Attendance and course completion data;
3. Descriptions of content/topics covered during each session;
4. Relevant reports, information releases, and records of communication;
5. Assessment data (if assessment is performed);
6. Client performance and progress;
7. Copies of DRS (following client discharge).
8. Copies of Drug/Alcohol Coordinated Data System (DACODS) client admission and discharge forms.

### **15.222.3 Level II Therapeutic Education**

- A. Agencies applying for approval to conduct Level II therapeutic education must also apply for approval to conduct Level II therapy and meet the requirements of both.
- B. Level II therapeutic education shall be restricted to DUI/DWAI, BUI, or FUI offenders who have been screened, referred, and placed in accord with the current ADDS referral and placement criteria.
- C. Staff conducting Level II therapeutic education shall be appropriately credentialed, knowledgeable in the curriculum, demonstrate teaching ability, and be competent in group process.
- D. The curriculum shall be written in manual format, use techniques that motivate the client, and be approved by ADAD.
- E. The program shall adhere to the curriculum.
- F. Level II therapeutic education shall be conducted in outpatient settings, shall be twelve (12) weeks in length, and shall total twenty-four (24) hours in duration. No more than one (1) session shall be conducted per week without clinical justification.
- G. Level II therapeutic education shall present all Level I education contents/topics and at least half of each Level II therapeutic education session shall consist of therapeutically oriented activities, emphasizing group process.
- H. Attendance at Level II therapeutic education sessions shall not regularly exceed twelve (12) clients.
- I. Level II therapeutic education shall not be conducted concurrently with Level II therapy unless judged clinically appropriate. Such judgments shall be documented in client records. Total time in Level II therapeutic education and Level II therapy shall not be less than the minimum number of weeks required

for Level II therapy.

- J. Individual client records shall be maintained for Level II therapeutic education clients. In addition to the requirements in section 15.217, client records shall include:
1. Court documents regarding referral and classification;
  2. Attendance and completion data for all therapeutic education;
  3. Assessment results (if performed);
  4. Individual or individualized group treatment notes;
  5. Client's progress in therapeutic education;
  6. Relevant reports, information releases, and records of communication;
  7. Copy of DRS (following client discharge);
  8. Copy of Drug/Alcohol Coordinated Data System (DACODS) client admission and discharge data forms.

#### **15.222.4 Level II Therapy**

- A. Programs applying for approval to conduct Level II therapy must also apply for approval to conduct Level II therapeutic education and meet the requirements for both.
- B. Level II therapy shall be restricted to DUI, DWAI, BUI, or FUI offenders who have been screened, referred, and placed in accord with the current ADDS referral and placement criteria.
- C. Clients whose blood alcohol content was between .150% and .199% and who have one offense for DUI, DWAI, BUI, or FUI shall complete a minimum of forty-two (42) hours of group and/or individual Level II therapy conducted over a period not less than twenty-one (21) weeks.
- D. Clients whose blood alcohol content was .20% or more and who have one offense for DUI, DWAI, BUI, or FUI shall complete a minimum of fifty-two (52) hours of group and/or individual Level II therapy conducted over a period not less than twenty-six (26) weeks.
- E. Clients whose blood alcohol content was less than .20% and who have two or more offenses for DUI, DWAI, BUI, or FUI shall complete a minimum of sixty-eight (68) hours of group and/or individual Level II therapy conducted over a period not less than thirty-four (34) weeks.
- F. Clients whose blood alcohol content was .20% or more and who have two or more offenses for DUI, DWAI, BUI, or FUI shall complete a minimum of eighty-six (86) hours of group and/or individual Level II therapy conducted over a

period not less than forty-three (43) weeks

- G. Staff conducting Level II therapy shall have appropriate credentials, knowledge of and experience in working with DUI/DWAI offenders and be competent in group process and individual therapy. These requirements are in addition to the staff qualifications in section 15.216 of these rules.
- H. The treatment program shall be written in manual format, incorporate treatment approaches which have demonstrated effectiveness in the research literature and which are consistent with the client's readiness to change, and be approved by ADAD.
- I. Level II therapy shall be conducted only after Level II therapeutic education has been completed unless clinically justified and documented in client records.
- J. Level II therapy group sessions (except for intensive outpatient) shall not be less than ninety (90) minutes of therapeutic contact, not including administrative procedures and breaks. Clients shall attend one (1) time or more each week unless less frequent contact is clinically justified and documented, but shall not attend less than one (1) session per month. Attendance less than one (1) time per week shall require adjunct services contacts unless clinically justified and documented. Clients shall complete the minimum hours and weeks of group and/or individual Level II therapy required.
- K. Attendance at Level II therapy sessions shall not regularly exceed twelve (12) clients.
- L. Level II therapy clients shall be assessed in accord with the requirements in section 15.219.23.
- M. A comprehensive treatment plan shall be developed using the results of the clinical assessment the treatment plan shall be reviewed during the course of Level II therapy and shall be updated upon change in client condition or client completion of forty-two 42 hours of Level II therapy, if the client is continuing in Level II therapy.
- N. The treatment provided during the course of Level II therapy shall reflect the offender's progress toward change.
- O. Individual client records shall be maintained for Level II therapy clients in accordance with applicable sections of these rules. Client records shall include:
  - 1. Court documents regarding referral and placement;
  - 2. Attendance and completion data for all therapy sessions;
  - 3. Differential assessment documentation and results;

4. Revised treatment plans;
5. Individual or individualized group treatment notes which document progress in treatment;
6. Individual or individualized group treatment notes for every session;
7. Relevant reports, information releases, and records of communication;
8. Copy of DRS (following client discharge);
9. Copy of Drug/Alcohol Coordinated Data System (DACODS) client admission and discharge data forms.

#### **15.222.5 Level II Enhanced Outpatient Therapy**

- A. Level II outpatient programs may qualify to provide enhanced outpatient therapy if:
  1. They are ADAD approved for Level II therapy;
  2. They meet all requirements in ADAD treatment rules, sections 15.211 through 15.219, 15.222.1 and 15.222.4;
  3. They provide at least three (3) hours, but less than nine (9) hours of scheduled therapeutic activities per week.
- B. Frequency and intensity of therapeutic activities shall be based on client assessments but shall not be less than three (3) hours per week conducted in at least two (2) sessions.
- C. Therapeutic activities shall be conducted for a minimum of ninety (90) calendar days.
- D. Changes in frequency and intensity of therapeutic activities shall be based on treatment plan reviews.
- E. If, upon discharge from Level II enhanced outpatient therapy, the minimum number of weeks required for Level II therapy has not been fulfilled, the client shall be transferred to the appropriate level of care where the remaining therapy requirements shall be met.
- F. Enhanced outpatient shall be coded as “outpatient” when completing Drug/Alcohol Coordinated Data System admission and discharge forms and Discharge Referral Summary (DRS) forms.

#### **15.222.6 Level II Intensive Outpatient Therapy**

- A. Intensive outpatient programs include intensive outpatient and day treatment.
- B. Outpatient programs may qualify to provide intensive outpatient or day

treatment services if:

1. They are ADAD approved for Level II therapy;
  2. They meet all the requirements in sections 15.211 through 15.219, 15.222.1, and 15.222.4.
- C. The length of stay in Level II intensive outpatient or day treatment shall be four (4) to six (6) weeks.
- D. Offenders placed in intensive outpatient treatment shall receive a minimum of nine (9) hours of treatment per week over not less than three (3) calendar days per week.
- E. Offenders placed in day treatment shall receive a minimum of twenty (20) hours of treatment per week.
- F. If, upon discharge from Level II intensive outpatient or day treatment, the minimum number of weeks required for Level II therapy has not been fulfilled, the client shall be transferred to outpatient care, where the remaining education and therapy requirements shall be met.

#### **15.222.7 Level II Residential Therapy**

- A. Residential treatment programs may qualify to provide Level II therapy if:
1. They are ADAD-approved;
  2. They provide at least 5 hours of scheduled, daily, multiple therapeutic activities;
  3. They meet all the requirements in sections 15.211 through 15.219, 15.222.1, and 15.222.4;
  4. They are affiliated with ADAD approved outpatient DUI programs.
- B. If, upon discharge from Level II residential therapy, the minimum number of weeks required for Level II therapy has not been fulfilled, the clients shall be transferred to outpatient care, where the remaining education and therapy requirements shall be met.

### **15.223 OPIOID REPLACEMENT TREATMENT AND SUPPORTIVE SERVICES**

#### **15.223.1 General Provisions**

- A. Opioid replacement treatment and supportive services shall be provided to persons whose opioid addiction and subsequent related behaviors, as defined by the Diagnostic and Statistical Manual of Mental Disorders criteria, necessitate prescribed daily doses of approved controlled substances to prevent withdrawal symptoms, stabilize life styles, increase productivity and reduce risk of contracting and transmitting HIV/AIDS, TB, Hepatitis and other

life-threatening, infectious diseases. The current publication of Diagnostic and Statistical Manual of Mental Disorders, is available from The American Psychiatric Association, 1400 K Street N.W., Washington, D.C. 20005 (no later editions are incorporated); or, may be examined at the offices of the Alcohol and Drug Abuse Division, 4055 South Lowell Blvd., Bldg. KA, Denver, Colorado 80236; or, at any state publication depository library.

- B. Opioid treatment programs (OTP) providing opioid replacement treatment and supportive services shall:
  - 1. Become accredited as required by federal law;
  - 2. Obtain controlled substance licenses from the Alcohol and Drug Abuse Division (ADAD) in compliance with title 12, article 22, part 3, and Title 18, Article 18, Part 1, C.R.S.; and,
  - 3. Acquire registrations from the Drug Enforcement Administration (DEA).

## **15.223.2 Administrative and Medical Responsibility**

### **15.223.21 Opioid Treatment Program (OTP) Sponsors**

- A. OTPs shall have sponsors who shall be responsible for overall OTP operation.
- B. OTP sponsors shall ensure that:
  - 1. OTPS are in compliance with all applicable state and federal laws, rules, and regulations;
  - 2. Medical and counseling personnel are qualified to provide opioid replacement treatment as evidenced by documented education, experience and professional licenses and/or certifications;
  - 3. Patients are enrolled on their own volition;
  - 4. Full disclosure is made to patients about opioids and their use in opioid replacement treatment (ORT);
  - 5. Written, informed consents for opioid replacement treatment are signed by patients age eighteen (18) and older;
  - 6. Written, informed consents for opioid replacement treatment are signed by parents, legal guardians or other responsible adults designated by appropriate state authorities; for patients under age 18;
  - 7. Patient/counselor ratios do not exceed fifty to one (50:1) for full time counseling staff, forty (40) hours per week, and twenty-five to one (25:1) for half time counseling staff, twenty (20) hours per week;
  - 8. Written OTP policies and procedures are developed, implemented and maintained that are based on and in compliance with ADAD treatment

rules;

9. All reasonable and clinically indicated efforts are made to coordinate treatment with other healthcare providers, including seeking patients' consent to communicate with those practitioners;
10. Methadone or other OTP administered controlled substances are disposed in accordance with the federal regulations and in the presence of ADAD's Controlled Substance Administrator or that person's designee;
11. Printed acknowledgements are signed by patients and kept in patient records stating that they have been informed of the United States Department of Transportation regulation against the use of OTP prescribed methadone by commercial drivers and the possible loss of commercial driver's license if taking methadone for addiction is discovered;
12. Training for new OTP staff, documented in personnel records and including, but not limited to:
  - a. Federal opioid replacement treatment (ORT) regulations, state ORT treatment rules;
  - b. OTP policies and procedures;
  - c. Clinical practices including:
    - 1) Patient/staff boundaries;
    - 2) Take-home dose protocols.
  - d. Principles of methadone and addiction treatment.
13. On-going training for OTP staff including but not limited to:
  - a. New trends and methods in ORT;
  - b. Revisions of federal and state regulations and rules;
  - c. Revisions of OTP policies and procedures.

#### **15.223.22 OTP Medical Directors**

- A. OTPs shall have designated medical directors who shall authorize and oversee other OTP physicians, other appropriately licensed and/or certified OTP medical personnel and all medical services provided.
- B. OTP medical directors and other OTP physicians shall currently possess and maintain licenses to practice medicine in Colorado as provided by Article 36, Title 12, CRS.

- C. OTP medical directors shall ensure that OTPs are in compliance with all state and federal rules and regulations regarding medical treatment for opioid addiction.
- D. OTP medical directors, other OTP physicians and authorized OTP medical personnel shall ensure the following:
  - 1. Medical evaluations including evidence of current physiological dependence and/or history of addiction or exceptions to admission criteria that are documented prior to initial dosing;
  - 2. Appropriate medical evaluations and physical examinations are performed within fourteen (14) days following treatment admission;
  - 3. All appropriate laboratory tests are performed and reviewed within fourteen (14) days following treatment admission;
  - 4. All medical orders are properly signed or countersigned, including initial orders for approved controlled substances and other medications, subsequent dose increases or decreases, changes in take-home dose privileges, emergency situations and other special circumstances.
- E. OTP medical directors or other OTP physicians shall review, sign and date admission evaluations written by authorized OTP medical personnel before initial doses may be administered to patients. When OTP medical directors and other OTP physicians are not available on-site to review, sign and date evaluations for admission written by OTP medical personnel, required physician reviews may be conducted by telephone and initial doses may be administered to patients on OTP physicians' verbal or standing orders. In such cases, OTP medical personnel shall document in patient records that no OTP physicians were available on site and that physician reviews were conducted by telephone. OTP medical directors or other OTP physicians shall review and counter-sign all telephone or other verbal authorizations within seventy-two (72) hours following authorizations.

### **15.223.3 Patient Placement**

#### **15.223.31 Admission Criteria and Procedures**

- A. Persons shall be admitted to opioid replacement treatment if OTP medical directors or other OTP physicians determine, and subsequently document in patient records, that such persons are currently physiologically dependent on opioid drugs or were physiologically dependent on opioid drugs, continuously or episodically for most of the year immediately preceding admission.
- B. In the case of persons for whom the exact date on which physiological dependence began cannot be ascertained, OTP medical directors or other OTP physicians may, using reasonable clinical judgment, admit such persons to opioid replacement treatment if from the evidence presented and recorded

in patient records it is reasonable to conclude that such persons were physiologically dependent on opioid drugs approximately one year prior to admission.

- C. OTP medical directors or other OTP physicians may waive the one-year history of addiction requirement, if clinically appropriate, for the following:
  - 1. Persons released from penal institutions if admitted to treatment within six (6) consecutive months following release;
  - 2. Pregnant persons, if OTP physicians certify pregnancy;
  - 3. Former patients for up to two (2) consecutive years after discharge.
- D. Persons under age eighteen (18) shall have at least two unsuccessful attempts at short-term detoxification or drug-free treatment documented within a twelve-month period.
- E. OTPs offering short-term or long-term detoxification treatment shall follow all applicable state and federal laws, rules and regulations regarding admission criteria.
- F. OTPs shall not admit persons for more than two (2) detoxification treatment episodes per year.
- G. At time of admission, patients shall be oriented to OTP policies and procedures including, but not limited to:
  - 1. Benefits and risks of opioid replacement treatment;
  - 2. Fee structure and payment options;
  - 3. Requirements for dosing, counseling and toxicology sample collection;
  - 4. Take-home dose privilege phase system;
  - 5. Consequences for violating policies and procedures including, but not limited to:
    - a. Behavioral contracts;
    - b. Treatment lock-in;
    - c. Treatment lock-out;
    - d. Reductions in take-home dose privileges;
    - e. Administrative discharges.

**15.223.32 Interim Opioid Replacement Treatment**

- A. Public and private non-profit OTPs shall provide interim opioid replacement treatment to persons eligible for comprehensive opioid replacement treatment who cannot be placed within a reasonable geographic area within fourteen (14) consecutive calendar days following their treatment applications.
- B. OTPs shall develop and implement criteria for prioritizing admissions to interim treatment and transfers to comprehensive treatment. Such criteria shall give high priority to pregnant patients.
- C. Interim treatment may be provided for a maximum of 120 calendar days in any twelve-month period.
- D. An initial and at least two (2) subsequent toxicology screens shall be conducted during interim treatment.
- E. All requirements for comprehensive treatment shall apply to interim treatment except the following:
  - 1. Initial treatment plan;
  - 2. Primary counselor;
  - 3. Education and rehabilitative and other counseling services.
- F. Interim treatment patients shall not be eligible for take-home dose privileges.

**15.223.4 Prescribing, Dispensing, and Administering Approved Controlled Substances**

- A. OTP medical directors or other OTP physicians shall order approved controlled substances and document orders in patient records.
- B. Standing dosing orders shall be approved by OTP medical directors and ADAD.
- C. OTP physicians, nurse practitioners, or physician assistants shall administer approved controlled substances.
- D. Exceptions to dosing regimens outlined in federal regulations shall require ADAD approval prior to dosing.
- F. Approved controlled substances shall be administered by OTPs according to manufacturer's specifications found on product labels and/or in printed instructions accompanying the product.
- G. In circumstances where patients must be administratively withdrawn from methadone due to inability or unwillingness to pay treatment fees, OTPs shall provide a humane tapering detox. Pregnant women shall continue to be dosed regardless of ability to pay.

**15.223.5 Evaluations and Assessments****15.223.51 General Provisions**

- A. Patients re-admitted to treatment following treatment absences of six (6) months or more shall undergo medical evaluations, physical examinations and/or laboratory tests as deemed appropriate by OTP medical directors or other OTP physicians.
- B. Other medical concerns shall be addressed by OTPs or referred to other medical facilities when appropriate as determined by OTP medical directors or other OTP physicians.

**15.223.52 Medical Evaluations**

Persons admitted to OTPs shall have medical evaluations conducted by medical directors, other OTP physicians, nurse practitioners, or physician assistants. Evaluations shall include, at minimum, the following:

- A. Medical histories that include required opioid dependence chronologies;
- B. Evidence of current physiological dependence;
- C. History of opioid use.

**15.223.53 Physical Examinations**

- A. Thorough physical examinations shall be conducted, evaluated and documented in patient records by medical directors or other OTP physicians within fourteen (14) consecutive calendar days following treatment admission and every two (2) consecutive years from date of admission.
- B. At a minimum, physical examinations shall consist of:
  - 1. Examinations of organ systems for possible infectious diseases and pulmonary, liver, and cardiac abnormalities;
  - 2. Checks for dermatologic sequelae of addiction;
  - 3. Vital signs (temperature, pulse, blood pressure and respiratory rate);
  - 4. Evaluations of patients' general appearance;
  - 5. Inspections of head, ears, eyes, nose, throat (thyroid), chest (including heart and lungs), abdomen, extremities, and skin;
  - 6. Neurological assessments.

**15.223.54 Laboratory Tests**

- A. Laboratory tests shall be conducted either on-site or through referral, and

results shall be evaluated and documented in patient records within fourteen (14) consecutive calendar days following treatment admission. Laboratory tests shall include:

1. Serological test for syphilis;
  2. Tuberculin skin test and/or other tests for tuberculosis when clinically indicated;
  3. Urine toxicology or other ADAD-approved tests to determine current drug use;
  4. Complete blood count and differential;
  5. Routine and microscopic urinalysis;
  6. Liver function profile;
  7. Test for Hepatitis B, C and Delta when clinically indicated and with patient consent;
  8. Test for HIV/AIDS when clinically indicated and with patient consent.
- B. The following laboratory tests shall be conducted every two (2) consecutive years from date of admission.
1. Tuberculin skin test and/or other tests for tuberculosis when clinically indicated;
  2. Complete blood count and differential;
  3. Liver function profile.

#### **15.223.6 Toxicology Screens**

- A. OTPs shall develop and implement policies and procedures that ensure a random sample collection protocol that minimizes falsification.
1. Patients shall have no notification prior to the day they are required to give a sample;
  2. Patients shall not be allowed to give a sample on days they normally attend the clinic unless those days are coincidentally randomly assigned sample days.
- B. OTPs shall develop and implement policies and procedures that establish treatment responses to the following:
1. Evidence of unauthorized drugs in toxicology screens, including prescription medications;

2. Lack of OTP-administered controlled substances in toxicology screens.
- C. Procedures for toxicology screens shall be designed and implemented to ensure random sample collection in accordance with requirements for each phase of take-home dose privileges.
- D. Toxicology screens shall occur with the following frequencies:
1. One (1) toxicology screen at admission;
  2. Monthly random toxicology screens;
  3. An initial toxicology screen for patients undergoing short-term detoxification;
  4. An initial toxicology screen and at least one (1) random toxicology screen per month for patients undergoing long-term detoxification;
  5. At least one random toxicology screen during thirty-day reductions in take-home dose privileges.
- E. Refusal to provide samples for toxicology screens shall be considered to be positive toxicology screens.
- F. Toxicology screens shall be used to detect the presence of the following drugs:
1. All approved controlled substances and their metabolites, for which laboratory analyses are available;
  2. Alcohol;
  3. Morphine;
  4. Other opioids;
  5. Cocaine and its metabolite;
  6. Amphetamines;
  7. Benzodiazepines;
  8. Marijuana (THC);
  9. Other drugs when clinically indicated.

#### **15.223.7 Assessment, Treatment Planning and Service Provision**

- A. Differential assessments of patients shall be completed within thirty (30) consecutive calendar days following admission, reflect the elements delineated in the differential assessment definition found in section 15.213

of these rules and be periodically updated during treatment.

- B. Individualized treatment plans shall be collaboratively developed with patients that reflect the elements outlined in the definition of Treatment Planning found in section 15.213 of these rules.
- C. OTPs shall assure that patient service needs are identified and addressed on-site and/or off-site through referral, to the extent that community resources are available.
- D. Prenatal care and other specialized services for pregnant patients shall be provided by OTPs directly or through referral to appropriate healthcare and/or other relevant service agencies.

### **15.223.8 Take-Home Dose Privileges**

#### **15.223.81 Take-Home Dose Protocols**

- A. Patients may qualify to self-administer methadone doses at locations other than OTPs if they meet all the criteria for each of six (6) phases of take-home dose privileges. Patients shall qualify for each phase sequentially.
  - 1. Phase 1 permits a take-home dose for Sunday and one (1) additional take-home dose per week. Patients may qualify for Phase 1 during the first ninety (90) consecutive calendar days of treatment when the following criteria are met:
    - a. Most recent toxicology screen is negative;
    - b. Clinical assessments completed;
    - c. Minimum of one (1) hour of counseling per month;
    - d. No unexcused dosing absences;
    - e. No unexcused counseling absences;
    - f. Compliance with OTP policies and procedures;
    - g. No known recent criminal activity;
    - h. No alcohol abuse;
    - i. Competent to safely handle take-home doses;
    - j. Responsible behavior;
    - k. Stable living environments;
    - l. Stable social relationships;

- m. Adherence to treatment plans;
  - n. Compliance with on-site dosing schedules.
2. Phase 2 permits a take-home dose for Sunday and two (2) additional take-home doses per week. Patients shall receive no more than two (2) consecutive calendar days of take-home doses. Patients may qualify for Phase 2 when the following criteria are met:
- a. Completed three (3) or more consecutive months in treatment;
  - b. Most recent two (2) consecutive toxicology screens are negative;
  - c. Minimum of one (1) hour of counseling per month;
  - d. No unexcused dosing absences;
  - e. No unexcused counseling absences;
  - f. Compliance with OTP policies and procedures;
  - g. No known recent criminal activity;
  - h. No alcohol abuse;
  - i. Competent to safely handle take-home doses;
  - j. Responsible behavior;
  - k. Stable living environments;
  - l. Stable social relationships;
  - m. Adherence to treatment plans;
  - n. Compliance with on-site dosing schedules.
3. Phase 3 permits a take-home dose for Sunday and three (3) additional take-home doses per week. Patients shall receive no more than two (2) consecutive days of take-home doses. Patients may qualify for Phase 3 when the following criteria are met:
- a. Completed six (6) or more consecutive months in treatment;
  - b. Most recent three (3) consecutive toxicology screens are negative;
  - c. Minimum of one (1) hour of counseling per month;
  - d. No unexcused dosing absences;

- e. No unexcused counseling absences;
  - f. Compliance with OTP policies and procedures;
  - g. No known recent criminal activity;
  - h. No alcohol abuse;
  - i. Competent to safely handle take-home doses;
  - j. Responsible behavior;
  - k. Stable living environments;
  - l. Stable social relationships;
  - m. Adherence to treatment plans;
  - n. Compliance with on-site dosing schedules.
4. Phase 4 permits a take-home dose for Sunday and five (5) additional take-home doses per week. Patients may qualify for Phase 4 when the following criteria are met:
- a. Completed nine (9) or more consecutive months in treatment;
  - b. Most recent four (4) consecutive toxicology screens are negative;
  - c. Minimum of one (1) hour of counseling per month;
  - d. No unexcused dosing absences;
  - e. No unexcused counseling absences;
  - f. Compliance with OTP policies and procedures;
  - g. No known recent criminal activity;
  - h. No alcohol abuse;
  - i. Competent to safely handle take-home doses;
  - j. Responsible behavior;
  - k. Stable living environments;
  - l. Stable social relationships;
  - m. Adherence to treatment plans;

- n. Compliance with on-site dosing schedules.
5. Phase 5 permits thirteen (13) take-home doses per two-week period. Patients may qualify for Phase 5 when the following criteria are met:
- a. Completed one (1) or more years in treatment;
  - b. Most recent six (6) consecutive toxicology screens are negative;
  - c. Minimum of one (1) hour of counseling per month;
  - d. No unexcused dosing absences;
  - e. No unexcused counseling absences;
  - f. Compliance with OTP policies and procedures;
  - g. No known recent criminal activity;
  - h. No alcohol abuse;
  - i. Competent to safely handle take-home doses;
  - j. Responsible behavior;
  - k. Stable living environments;
  - l. Stable social relationships;
  - m. Adherence to treatment plans;
  - n. Compliance with on-site dosing schedules;
  - o. Phase 5 dose privileges have been approved by ADAD's Controlled Substance Administrator/State Methadone Authority.
6. Phase 6 permits twenty-eight (28) to thirty (30) take-home doses per month. Patients may qualify for Phase 6 when the following criteria are met:
- a. Completed two (2) or more years in treatment;
  - b. Most recent twelve (12) consecutive toxicology screens are negative;
  - c. Minimum of one (1) hour of counseling per month;
  - d. No unexcused dosing absences;
  - e. No unexcused counseling absences;

- f. Compliance with OTP policies and procedures;
  - g. No known recent criminal activity;
  - h. No alcohol abuse;
  - i. Competent to safely handle take-home doses;
  - j. Responsible behavior;
  - k. Stable living environments;
  - l. Stable social relationships;
  - m. Adherence to treatment plans;
  - n. Compliance with on-site dosing schedules.
  - o. Patient/clinic applications for Phase 6 take-home dose privileges have been reviewed and approved by ADAD's Controlled Substance Administrator/State Methadone Authority in consult with a take-home dose privilege board.
- B. Patient/clinic applications for Phase 6 take-home dose privileges shall be submitted to and approved by a privilege board comprised of the ADAD Controlled Substance Administrator or that person's designee and OTP directors or their designees.
- C. Take-home doses may be approved by OTPs for days clinics are closed, including Sundays and state and federal holidays.
- D. Take-home doses shall not be approved for patients undergoing short-term detoxification.
- E. Written agreements shall be developed and implemented for patients approved for take-home doses. Agreements shall be part of the treatment plan and shall explain the rationale for approving take-home dose privilege phases, stipulate dose amounts and set consequences for violating agreement conditions.
- F. Take-home doses shall be dispensed in medication containers that conform to state and federal poison prevention packaging requirements, including childproof lids.
- G. Labels shall be affixed to containers with the following information:
- 1. OTP names, addresses, and telephone numbers;
  - 2. Patient names;

3. Drug types;
  4. Dose amounts, if not physician-authorized blind doses;
  5. Directions for use.
- H. Take-home doses numbering twelve (12) or less shall be transported in a discrete and secure manner agreed upon by OTPs and patients.
- I. Take-home doses numbering thirteen (13) or more shall be transported in locked containers constructed of rigid materials that resist tampering.
- J. Take-home doses shall be securely and discretely stored where patients' reside, in a manner that reduces the risk for access by unauthorized persons.
- K. OTPS shall submit and obtain ADAD approval for the following:
1. Split doses with the exception of pregnant women;
  2. Take-home doses for patient detoxification lasting less than thirty (30) consecutive calendar days;
  3. Requests for eight (8) or more take-home doses for patients in Phases 1 and 2;
  4. Requests for fifteen (15) or more take-home doses for patients in Phases 3 and 4;
  5. Requests for twenty-one (21) or more take-home doses for patients in Phase 5;
  6. Requests for thirty-one (31) or more take-home doses for patients in Phase 6;
  7. Take-home doses that do not conform to take-home dose phase requirements outlined in section 15.223.9;
  8. Take-home medication doses for patients with unacceptable urine drug screen results within the last ninety (90) calendar days;
  9. Take-home doses for OTP patients admitted to extended health care facilities or ADAD-licensed residential substance abuse treatment facilities for disorders;
  10. Phase 5 take-home doses.
- L. Requests for thirty-one (31) take-home doses or more for patients in Phase 6 shall require the federal Center for Substance Abuse Treatment (CSAT) approval in addition to ADAD approval.
- M. Patients reporting loss or theft of take-home doses shall not be provided

replacement doses or daily doses, until the day after the last take-home dose would have been taken, or unless they are pregnant.

- N. OTPs shall have policies and procedures for transporting methadone or other approved controlled substances to patients in residential treatment or recovery facilities.

#### **15.223.82 Reductions In Take-Home Dose Privilege Phases**

- A. Positive toxicology screens and unexcused dosing and counseling absences shall result in thirty-day reductions in take-home dose privilege phases.
- B. Positive toxicology screens during thirty-day reduction periods shall result in further reductions in privilege phases.
- C. Privilege phases for which patients qualified prior to reductions may be sequentially restored at a rate of one (1) phase every thirty (30) consecutive calendar days if toxicology screens remain negative and all other requirements are met.

#### **15.223.9 Cooperation, Theft/Diversion and Central Registry**

- A. OTPs shall cooperate with ADAD in developing, implementing, updating, and adhering to, the Memorandum of Cooperation and all policies and procedures pertinent to the regulation of opioid replacement treatment.
- B. OTP directors and ADAD shall meet regularly to discuss treatment issues of mutual concern.
- C. OTPs shall provide effective controls and procedures to guard against theft and diversion of controlled substances.
- D. OTP accountability and record-keeping procedures for approved controlled substances shall be approved by ADAD.
- E. OTPs shall prevent simultaneous enrollment of patients in more than one clinic by fully participating in ADAD's central registry of opioid patients:
  - 1. Prior to admitting applicants to treatment, OTPs shall initiate a clearance inquiry to ADAD's Central Registry by submitting applicant information in formats acceptable to ADAD;
  - 2. Applicant information shall include:
    - a. Name;
    - b. Date of birth;
    - c. Social security number;
    - d. Proposed date of admission;

- e. Other information required by the patient clearance procedure.
3. Applicants shall not be admitted to treatment when ADAD's Central Registry shows them as currently enrolled in another OTP;
4. It is the responsibility of the admitting OTPs to verify that applicants are actually enrolled in the OTP indicated by ADAD's Central Registry;
5. OTPs shall report clinic admissions and discharges to ADAD's Central Registry within time frames set by ADAD.

## **15.224 MEDICAL DETOXIFICATION**

### **15.224.1 General Provisions**

- A. Medical detoxification services shall be provided by licensed medical staff qualified to supervise withdrawal from alcohol and other drugs through use of medication and/or medical procedures in residential or outpatient settings which possess controlled substances licenses in compliance with Title 12, Article 22, Part 3, Colorado Revised Statutes (C.R.S.), Controlled Substances Act.
- B. Procedures for responding to emergency situations shall be conspicuously posted in all settings and sites where medical detoxification services are provided.
- C. Agencies providing these services shall develop and implement policies, procedures, and individualized treatment planning demonstrating recognition of issues and treatment needs unique to this client population.

### **15.224.2 Admission and Evaluation**

- A. Specific admission criteria shall be developed and implemented that detail for which drugs, including alcohol, medical detoxification is provided.
- B. Informed consent to medical detoxification shall include:
  1. Medications to be used;
  2. Need to consult with primary care physicians.
- C. Medical evaluations by authorized physicians or authorized health-care professionals under the supervision of authorized physicians shall be required and shall consist of, at minimum:
  1. Medical histories including detailed chronologies of substance use disorders;
  2. Identification of current physical dependence including drug types;

3. Physical examinations to determine appropriateness for outpatient or inpatient medical detoxification;
  4. Appropriate laboratory tests including pregnancy tests, and other evaluations as indicated.
- D. Protocols for usual and customary detoxification from each drug delineated in admission criteria shall be developed in consultation with licensed physicians and other allied health-care professionals and shall be implemented in the form of individualized detoxification plans under direct supervision of program medical directors. Protocols shall include:
1. Types of intoxication;
  2. Tolerance levels for the patient's drug of choice;
  3. Degrees of withdrawal;
  4. Possible withdrawal and/or intoxication complications;
  5. Other conditions affecting medical detoxification procedures;
  6. Types of medications used;
  7. Recommended dosage levels;
  8. Frequency of visits (outpatient settings);
  9. Procedures to follow in the event of detoxification complications;
  10. Daily assessments including expected improvements as well as potential problems;
  11. Expected duration of detoxification.
- E. Medical detoxification programs using any controlled substances are required to have controlled substance licenses issued by the Colorado Department of Human Services' Alcohol and Drug Abuse Division (ADAD).
- F. Buprenorphine is the only medication that can be used for opioid dependent persons unless the medical detoxification program is licensed as an opioid treatment program.
- G. Physicians authorized to write prescriptions for buprenorphine can admit a patient to a hospital for inpatient detoxification and/or addiction treatment. The physician must prescribe the buprenorphine under his/her own Drug Enforcement Administration (DEA) registration number.

### **15.224.3 Clinical Staff**

- A. The following minimum clinical staff shall be provided:

1. One medical director;
  2. One R.N. or L.P.N. with at least one year of detoxification experience;
  3. Clinicians holding Colorado Addiction Counselor certifications at Levels II OR III or Colorado Addiction Counselor licenses.
- B. Medical directors' responsibilities shall include, at minimum:
1. Quarterly reviews and revisions of drug detoxification categories and protocols;
  2. Reviews of individual detoxification plans;
  3. Reviews of individual prescriptions that deviate from standard detoxification protocols;
  4. Five (5) hours minimum of monthly supervision of and consultation with staff providing detoxification services;
  5. Direct supervision of individual detoxification cases that deviate from standard protocols and/or experience complications;
  6. Developing and implementing back up systems for physician coverage when medical directors are unavailable and/or for emergencies.
- C. There shall be twenty-four (24) hour access to clinical staff by telephone and accommodation for unscheduled visits for crises or problem situations.

#### **15.224.4 Clinical Services**

- A. The following clinical services shall be provided in addition to medication dosing contacts:
1. Motivational counseling and support;
  2. Continuous evaluation and clinical intervention.
- B. There shall be a minimum of 1 daily clinical supportive services contact which shall be documented in client records.

#### **15.224.5 Dispensing and Administration Procedures**

- A. There shall be procedures for dispensing medications per standard detoxification protocols that are in accordance with applicable state and federal statutes and for the following:
1. Individual prescriptions filled and dispensed by a registered pharmacist at a designated pharmacy location;

2. Individual prescriptions from medical directors that are filled from stock quantities.

B. There shall be procedures in accordance with applicable federal and state statutes for storing and accounting for all drugs including controlled substances.

#### **15.224.6 Discharge Planning**

A. Discharge planning shall at a minimum consist of in-depth evaluations, recommendations and motivation to pursue further care and support after completing detoxification plans.

B. Discharge planning shall begin prior to discharge from medical detoxification.

#### **15.225 TREATING MINORS**

##### **15.225.1 General Provisions**

A. Treatment agencies shall demonstrate recognition of developmental, cultural, gender, psychological, family and legal issues unique to this client population.

B. Agencies shall demonstrate knowledge of Title 19, Article 1, Part 1; Title 19, Article 3, Part 1; and Title 19, Article 3, Part 3, Colorado Revised Statutes (CRS), Colorado Children's Code - Child Abuse and Neglect, and develop and implement procedures for reporting suspected child abuse (including suspected sexual abuse) and/or child neglect to county departments of social services.

C. Residential settings admitting minors under age 16 shall be licensed as Residential Child-Care Facilities (RCCF).

D. Licensed hospitals and agencies providing short-term, acute care, such as detoxification, for minors under age sixteen (16) shall be exempt from RCCF licensing.

E. Disulfiram may be administered to minors in conjunction with additional behavioral controls.

F. Administering or monitoring prescription medications to minors shall be done with guidance from qualified health care professionals.

G. Programs shall comply with child labor laws when assigning minors non-therapeutic, non personal care chores.

H. Programs shall comply with section 15.229, Gender- Specific Women's Treatment of these rules when treating pregnant minors.

##### **15.225.2 Admissions**

A. Minors may voluntarily apply for admission to alcohol/other drug abuse

treatment, regardless of their age, with or without parental or legal guardian consent providing the treatment agency demonstrates adherence to its policy regarding of admission of minors without parental or legal guardian consent.

- B. Minors' signatures shall suffice to authorize treatment, releases of information, fee payment (if minors have personal control of adequate financial resources), and other documents requiring client signatures.

### 15.225.3 Consents

- A. Written information about minors' treatment, including dates/times of admission or discharge, shall not be disclosed to parents or legal guardians without minors' express written consent, in accordance with federal and state confidentiality regulations.
- B. Policies governing whether programs shall treat minors with or without parental or legal guardian consent shall be developed and implemented.
- C. If minors refuse to sign written consent to contact parents or legal guardians for permission to treat, and program policies require such consent, the following options shall be available:
  - 1. Minors may be informed that they can be denied admission and referred to treatment programs not requiring parental or legal guardian consent to treat;
  - 2. In acute care situations, minors may be informed that emergency guardianships can be sought through the county department of social services that has proper jurisdiction.
- D. Parents or legal guardians shall be notified of minors' admission to treatment without minors' written consent if:
  - 1. In the judgment of the treatment director or designated staff, minors do not have the capacity to rationally decide whether to consent to notification due to age or medical and/or mental conditions;
  - 2. Disclosure is necessary to protect the lives or well being of minors or others;
  - 3. Essential medical information is necessary for parents or legal guardians to make informed medical decisions on behalf of minors.
- E. Parents or legal guardians who do not consent to minors' treatment shall not be billed for treatment services unless a fee is assessed by a court.
- F. If minors wish to remain in treatment and parents or legal guardians demand minors be release to their custody, programs shall have the option to request investigations by county departments of social services to determine whether minors are neglected or dependent children.

**15.225.4 Screening and Assessment**

- A. Treatment agencies shall use screening and assessment instruments developed specifically for minors that are comprehensive, culturally and developmentally appropriate, and approved by ADAD.
- B. Treatment agencies shall assess and identify safety issues such as current risk for or history of suicide, physical or sexual abuse, or perpetration of physical or sexual abuse on others. When appropriate, referral must be made immediately.
- C. Treatment agencies shall assess minors for potential mental health and/or emotional issues, trauma symptoms, and behavioral problems and address them on site or refer minors to other agencies or support services.
- D. Treatment agencies shall screen all female minors for pregnancy.

**15.225.5 Treatment of Minors**

In planning treatment, agencies shall apply prevention, intervention, treatment, rehabilitative, and continuing care strategies developed expressly for minors and their families that are gender and culturally appropriate. The use of age appropriate, evidence-based curricula is required and shall include, as appropriate:

- A. Recreational, social, and cultural activities as alternatives to alcohol/other drug use/abuse;
- B. Peer support groups;
- C. Academic/vocational programs;
- D. The impact of and recovery from violence and trauma;
- E. Relapse prevention including at a minimum:
  - 1. Refusal skills;
  - 2. Identifying high-risk situations;
  - 3. Relapse triggers;
  - 4. Role of anger and stress in the relapse process;
  - 5. Role of cognitive distortions in the relapse process.

**15.225.6 Treatment Plans**

- A. Treatment plans shall reflect the results of an ADAD-approved adolescent assessment and shall include collateral information from the referral source, care giver, school, family, social services and youth, when appropriate.

- B. Treatment plans shall be established in accordance with section 15.219.61 of these rules and shall be written in a manner that motivates clients and supports retention in treatment.

#### **15.225.7 Minors Sentenced to Treatment**

- A. Minors sentenced to treatment under adult alcohol/other drug criminal statutes or for purposes of completing court ordered education or treatment of substance use disorders shall be governed by the same rules as adults; however, when possible, the special needs of adolescents shall be taken into consideration.
- B. Minors shall be informed that non-compliance with treatment programs to which they are sentenced shall be reported to referring courts and/or their agents.
- C. Minors sentenced to treatment/education who are compliant but whose parents or legal guardians are non-compliant, may be accepted into treatment or education as provided by section 15.225.2.

#### **15.226 EMERGENCY COMMITMENTS**

- A. Emergency commitment policies and procedures, based on and in compliance with Title 25, Article 1, Part 3 and Title 25, Article 1, Part 11, Colorado Revised Statutes (C.R.S.), and these rules shall be developed and implemented by ADAD licensed detoxification programs to:
  - 1. Ascertain if grounds for commitment exist;
  - 2. Assure that clients or their legal representatives receive copies of commitment forms and have received and comprehend written notifications of rights to challenge commitments through the courts;
  - 3. Determine when grounds for emergency commitments no longer exist.
- B. Detoxification directors shall designate, in writing, qualified staff to assume responsibility for accepting, evaluating, informing, and providing treatment to emergency commitment clients.
- C. Applications for emergency commitments shall be prepared on forms approved by ADAD.
- D. Daily evaluations for emergency commitment continuance shall take place and shall be documented.
- E. If emergency commitment clients require treatment in other ADAD-approved detoxification programs, transfers may be managed by the programs which initially authorized the commitments.
- F. When transferring clients, detoxification programs shall use transfer forms approved by ADAD and completed copies shall be given to transferring clients

or their legal representatives and to detoxification programs to which clients are being transferred.

- G. When minors are transferred, parents or legal guardians who have given permission for treatment shall receive copies of transfer forms.
- H. When it is determined that grounds for emergency commitments no longer exist, clients shall be transferred to voluntary status and such transfers shall be communicated to clients and noted in client records.

#### **15.227 INVOLUNTARY COMMITMENTS**

- A. All agencies directly or indirectly funded by ADAD shall accept involuntary commitment clients.
- B. Involuntary commitment policies and procedures shall be developed and implemented based on and in compliance with Title 25, Article 1, Part 3 and Title 25, Article 1, Part 11, Colorado Revised Statutes (CRS), and these rules.
- C. ADAD shall be the legal custodian of persons involuntarily committed to treatment.
- D. Passes shall be issued to involuntarily committed clients treated in residential settings only if they are directly related to clinical processes. Passes shall not be issued during initial 30 days of treatment except in extreme emergencies and with ADAD's prior approval.
- E. The following client information shall be reported to ADAD:
  - 1. Non-compliance with program requirements and/or court orders;
  - 2. Failure to appear for admission to treatment;
  - 3. Leaving treatment in violation of court orders;
  - 4. Failure to return from passes;
  - 5. Treatment status every thirty (30) days.
- F. Discharge summaries shall be submitted to ADAD, the referring source and to the treatment agency of further treatment or aftercare.
- G. Requests for early discharge and/or transfer to other treatment programs shall be submitted to ADAD for approval.
- H. Primary counselors for involuntary commitment clients shall be Colorado-Certified Addictions Counselors at Levels II or III, or Colorado-Licensed Addictions Counselors, or possess clinical masters degrees, and shall have completed at least fourteen (14) hours of training in motivational interviewing or other ADAD-approved training on engaging clients in treatment. Copies of course certificates and other relevant documentation shall be retained in

counselor personnel files.

## **15.228 NON-HOSPITAL RESIDENTIAL DETOXIFICATION**

### **15.228.1 General Provisions**

- A. Non-hospital detoxification services shall provide 24-hour supervised withdrawal from alcohol and/or other drugs in a residential setting.
- B. Detoxification policies and procedures, including linkages with emergency mental health services, shall be developed and implemented in accordance with federal and state laws, and regulations and ADAD rules, and in consultation with medical professionals qualified in substance use disorders.
- C. Client/staff ratios shall not exceed ten to one (10:1) and procedures for responding to periods of high client-traffic and/or emergency situations shall be conspicuously posted. Each shift shall have a minimum of two (2) staff members.
- D. Detoxification agencies shall develop and implement service plans which address, at a minimum, safe withdrawal, motivational counseling and referral for treatment. Assessments of client readiness for treatment and clinical interventions based on the service plan shall be documented in client records. Additional service planning shall be required for managing clients with medical conditions, suicidal ideation, pregnancy, psychiatric conditions, and other conditions, which place clients at additional risk during detoxification.
- E. Policies and procedures shall be developed and implemented for handling clients who are assessed as being a current threat to themselves or others and shall include appropriate uses of law enforcement and monitor any use of client restraint and/or seclusion.

### **15.228.2 Admission and Monitoring**

- A. Clients admitted to detoxification services shall be intoxicated, under the influence, or in any stage of withdrawal from alcohol and/or other drugs.
- B. Detoxification admission procedures shall include at a minimum:
  - 1. Degree of alcohol and other drug intoxication as evidence by breathalyzer, urinalysis, self-report, observation or other accepted means approved by ADAD;
  - 2. Initial vital signs;
  - 3. Need for emergency medical and/or psychiatric services;
  - 4. Current state of substance use disorders including drug types and amounts;
  - 5. Inventorying and securing personal belongings;

6. Substance use disorder history and degree of personal and social dysfunction, as soon as clinically feasible following admission;
  7. Pregnancy screen;
  8. Administration of the Clinical Institute Withdrawal Assessment of Alcohol-Revised (CIWA-AR) or a comparable instrument.
- C. Detoxification monitoring procedures shall include:
1. Documentation of all monitoring activities in client records;
  2. Vital signs taken at least every two (2) hours until they remain in normal range for at least four (4) hours, then taken every eight (8) hours thereafter until discharge;
  3. Routine monitoring of physical and mental status.

### **15.228.3 Discharge**

- A. There shall be documentation in client records that information is communicated to clients prior to discharge about:
1. Effects of alcohol and other drugs;
  2. Risk factors associated with alcohol and other drug abuse for acquiring and transmitting HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome), tuberculosis, and other infectious diseases, and for pregnancy;
  3. Availability of testing and pre/post-test counseling for HIV/AIDS, TB, Hepatitis C and other infectious diseases, and pregnancy;
  4. Availability of alcohol and other drug abuse treatment services.
- B. Discharge policies and procedures shall be developed and implemented including:
1. Procedures that assure blood alcohol levels no greater than .04 prior to discharge and vital signs with normal range;
  2. Procedures for dealing with clients leaving treatment while intoxicated and against staff recommendations, including the use of emergency commitments;
  3. Circumstances under which clients shall be discharged, other than completing detoxification or leaving against staff recommendations;
  4. Assurances that clients have received information listed in section 15.228.3 A., 1- 4, and motivational counseling.

**15.228.4 Staff Requirements**

- A. At least fifty percent (50%) of detoxification staff including on-call staff shall consist of Certified Addiction Counselors or staff in the process of obtaining certification. Plans for certification shall be available for review. Full-time staff shall obtain at least a CAC I within 18 months of employment.
- B. Uncertified staff or staff without a plan for certification shall not comprise more than fifty percent (50%) of total detoxification staff.
- C. The staff person overseeing day-to-day operations shall be certified as a CAC III.
- D. There shall be documentation that all staff within ninety (90) consecutive calendar days of employment shall have formal training in, and/or be evaluated as having knowledge of, the following:
  - 1. Infectious diseases (AIDS/HIV, Hepatitis C, TB), including universal precautions against becoming infected;
  - 2. Administering CPR and first aid;
  - 3. Monitoring vital signs;
  - 4. Conducting assessment and triage, including identifying suicidal ideation;
  - 5. Emergency procedures and their implementation;
  - 6. Collecting urine, and breath samples;
  - 7. Cultural factors that impact detoxification;
  - 8. Clinical ethics and confidentiality;
  - 9. Clinical records systems;
  - 10. De-escalating potentially dangerous situations;
  - 11. Basic counseling and motivational interviewing skills.

**15.229 GENDER-SPECIFIC WOMEN'S TREATMENT****15.229.1 General Provisions**

- A. "Gender-Specific Women's Treatment" refers to a comprehensive package of services aimed at reducing substance use and associated problems among women.
- B. Programs that demonstrate compliance with the provisions contained in this section or, with ADAD's approval, sufficiently document the specific theory

base that allows for departure from these rules, shall be eligible to be designated as gender-specific women's treatment sites.

- C. Treatment staff shall have documented training, supervision and experience in women-specific issues and services.
- D. Treatment for substance use disorders shall be provided to the family as a whole, unless clinically contraindicated. Clinical contraindications to this provision must be documented in the client record.
- E. Programs shall screen all women seeking or being referred to substance use disorder treatment for pregnancy.
- F. Programs shall assure any pregnant woman admission to treatment within forty-eight (48) hours, and shall demonstrate compliance with section 15.229.5, E.
- G. Programs providing gender specific women's treatment shall include the following components:
  - 1. Emotional and physical safety of clients shall take precedence over all other considerations in the delivery of services;
  - 2. Services designed to increase women's access to care, and engagement and retention of clients (such as comprehensive case management, transportation, child care) shall be provided or arranged;
  - 3. Women-only therapeutic environments shall be made available;
  - 4. Women-specific service needs and topic areas shall be addressed in treatment and through support services (see section 15.229.4);
  - 5. Multiple modalities shall be offered that meet the specific needs of women (group and individual therapy, case management and opportunities for women to be in treatment with their children where possible).
- H. Program policy and procedures shall include the mandatory reporting of suspected child abuse, neglect and/or child safety issues, which shall include definitions of abuse and neglect under the Colorado Children's Code (19-1-103, C.R.S.), and which are consistent with the reporting of child abuse allowed under federal law.
- I. Programs shall document, through a written policy statement and program procedures, the philosophy, theory base, interventions and expected outcomes of services delivered.
- J. Program policies and procedures shall reflect that women's substance use disorders differs from that of men both in its etiology and the treatment and services required for its remediation.

- K. Program policies and procedures shall recognize the interplay between substance use and trauma symptoms because of the very high prevalence of trauma among women experiencing substance use disorders.
1. Program policies and procedures shall reflect an understanding of the effects of traumatic experiences and the unique vulnerabilities of trauma survivors so that re-victimization and misdiagnosis do not occur;
  2. Decisions about the course of treatment shall be considered with the understanding of the way symptoms of trauma shall affect treatment, progress in treatment, and the relationship between the program and the client;
  3. Symptoms of trauma shall be understood to include dissociation, flashbacks, feelings of being unsafe, reluctance to participate in social or group activities, and/or pervasive or situational sadness or hopelessness;
  4. Program services shall directly address trauma issues currently manifesting in the client's life.

#### **15.229.2 Assessment**

- A. Assessments shall conform to the program's statement of philosophy, theory base, interventions, and expected outcomes set forth in section 15.229.1, D.
- B. Assessment results and the specific service needs indicated shall be documented in the client record.
- C. Assessments shall include all of the following unless clinically contraindicated:
1. Assessment of substance use;
  2. Assessment of barriers to treatment and related services, including case management, transportation and child care needs;
  3. Assessment of client's current level of physical and emotional safety;
  4. Assessment of trauma sequelae (if delayed for clinical reasons, the expected date of this assessment shall be documented in the client record);
  5. Assessment and documentation of client's need for prenatal care (where applicable), primary medical care and family planning services;
  6. Assessment of client's mental health issues;
  7. Assessment of child safety issues utilizing an ADAD-approved instrument;

8. Assessment of developmental, emotional and medical needs of the children in the custody of the client presenting for treatment (if such assessments are performed by a third party agency, copies of these assessments shall be contained in the client record);
9. Assessment of appropriateness of family members being included in client's treatment;
10. Assessment of client's cultural needs, including need or preference for bilingual or monolingual non-English services;
11. Assessment and documentation of consumer's self-sufficiency needs.

### **15.229.3 Treatment**

- A. Treatment plans shall be established in accordance with section 15.219.6 of these rules, and shall address each of the need areas identified in section 15.229.2, C, above.
- B. Where not clinically contraindicated, the following topic areas shall be addressed in treatment or by referral:
  1. Reductions or elimination of substance use;
  2. Client safety issues;
  3. Child safety issues;
  4. Trauma issues;
  5. Parenting issues;
  6. Ways in which substance use disorders impact and are impacted by family and relationships;
  7. Medical and primary health issues;
  8. Mental health issues;
  9. Nutrition.
- C. Treatment plans and interventions shall include all issue areas identified during the assessment.

### **15.229.4 Support Services**

- A. Support service needs identified during or subsequent to the assessment, but not directly met within the program, shall be met through referral to outside programs or agencies.
- B. When trauma is identified in the assessment process, interventions to

ameliorate the effects of trauma shall be provided by the program or arranged through support services.

- C. Referrals to support services shall be documented in the client record.

#### **15.229.5 Services To Pregnant Women**

- A. Services for pregnant women shall be delivered in compliance with sections 15.229.1 through 15.229.4.
- B. Because treatment of pregnant women experiencing problems with substance use disorders and addiction impacts not only the woman herself but also the health and well-being of her fetus, pregnant women shall be given priority admission to treatment for substance use disorders.
- C. Programs shall develop policies and procedures for service delivery to pregnant women, which shall include circumstances under which pregnant women may be discharged from treatment:
  - 1. Pregnant women may not be discharged from treatment solely for failure to maintain abstinence from substance use;
  - 2. Every effort shall be made to retain pregnant women in treatment for the duration of their pregnancies in order to maintain an optimal period of abstinence from substance use.
- D. Pregnant women shall be admitted to treatment within forty-eight (48) hours of initial contact between the client and the treatment agency.
- E. If admission to treatment within forty-eight (48) consecutive hours of initial contact between the consumer and the treatment agency is denied for any reason, ADAD's Women's Treatment Coordinator shall be informed, and interim services shall be provided within the forty-eight (48) consecutive hours which include at a minimum:
  - 1. Referral for pre-natal care;
  - 2. Information on the effects of alcohol and drug use on the fetus; and,
  - 3. Daily phone contact with the client.
- F. Pregnant women shall be linked to prenatal care immediately and barriers to accessing prenatal care shall be addressed, including transportation to prenatal care.
- G. When a woman refuses to seek prenatal care or fails attempts to link her to care, this shall be documented in her record, as shall be continuing efforts to link her to prenatal care until this is accomplished.
- H. Pregnant women receiving methadone or other approved controlled substances from a treatment agency licensed to provide opioid replacement

treatment shall not be detoxified during pregnancy without the approval of either ADAD's Controlled Substance Administrator/State Methadone Authority or ADAD's Women's Treatment Coordinator.

1. Pregnant women who are opioid dependent shall be referred to a treatment agency licensed to provide opioid replacement treatment (ORT), unless the original referring treatment agency is also licensed for ORT;
  2. The relationship between the referring treatment agency and the treatment agency providing ORT shall be delineated in a written memorandum of understanding;
  3. The referring treatment agency may not transfer responsibility for other aspects of the client's treatment to the treatment agency providing ORT unless this is clinically indicated and documented and the ORT treatment agency is also licensed for women's gender-specific treatment.
- I. Disulfiram, naltrexone and other medications which may be contraindicated for pregnant women shall not be administered without an assessment by licensed medical professionals qualified in prenatal care.
  - J. Agencies receiving Medicaid funding for the treatment of pregnant women shall comply with applicable state and federal Medicaid regulations.

## **15.230 SERVICES TO CHILD WELFARE CLIENTS**

### **15.230.1 General Provisions**

- A. Treatment of clients who have involvement with child welfare agencies requires a specialized knowledge base and specialized tasks aimed at the coordination of care between the treatment agency and the county child welfare program:
  1. Treatment staff shall have documented completion of the introductory on-line course in child protection via the National Center on Substance Abuse and Child Welfare (NCSACW);
  2. Treatment staff shall have documented completion of at least 14 hours of continuing education per year in issues of child development, child safety and family dynamics, or equivalent continuing education units in solution focused philosophy.
- B. Programs providing services to child welfare clients shall include the following components:
  1. Emotional and physical safety of clients shall take precedence over all other considerations in the delivery of services;
  2. Program policies and procedures shall include the mandatory reporting

of suspected child abuse, neglect and/or child safety issues, which shall include definitions of abuse and neglect under the Colorado Children's Code (19-1-103, CRS), and which are consistent with the reporting of child abuse pursuant to federal law;

3. Program policies and procedures shall recognize the interplay between substance use disorder and trauma symptoms because of the very high prevalence of trauma among this population:
  - a. Program policies and procedures shall reflect an understanding of the effects of traumatic experiences and the unique vulnerabilities of trauma survivors so that re-victimization and misdiagnosis do not occur;
  - b. Decisions about the course of treatment shall be considered with the understanding of the way symptoms of trauma shall affect treatment participation, progress in treatment, and the relationship between the program and the client;
  - c. Symptoms of trauma shall be understood to include dissociation, flashbacks, feelings of being unsafe, reluctance to participate in social or group activities, and/or pervasive or situational sadness or hopelessness;
  - d. Program services shall directly address trauma issues currently manifesting in the client's life.

#### **15.230.2 Assessment**

- A. Assessment results and the specific service needs indicated shall be documented in the client record.
- B. Assessments shall consist of documented efforts to identify client needs related to the following areas:
  1. Substance use;
  2. Barriers to treatment and related services, including case management, transportation and child care needs;
  3. Client's current level of physical and emotional safety;
  4. Symptoms and/or behavior that can be attributed to exposure to trauma. If delayed for clinical reasons, the expected date of this assessment shall be documented in the client record;
  5. Client's need for prenatal care (where applicable), primary medical care and birth control services;
  6. Client's psychiatric issues;

7. Child safety issues utilizing an ADAD-approved instrument;
8. Developmental, emotional and medical needs of the children in the custody of the client presenting for treatment. If such assessments are performed by a third party agency, copies of these assessments shall be contained in the client record;
9. Appropriateness of family members being included in client's treatment;
10. Client's cultural needs, including need or preference for bilingual or monolingual non-English services;
11. Client's self-sufficiency needs.

### **15.230.3 Treatment**

- A. Treatment plans shall be established in accordance with section 15.219.6 of these rules and shall address each of the need areas identified in section 15.229.2, C.
- B. Where not clinically contraindicated, the following topic areas shall be addressed in treatment or by referral:
  1. Reduction or elimination of substance use;
  2. Client safety issues;
  3. Child safety issues;
  4. Trauma issues;
  5. Parenting issues;
  6. Ways in which substance use disorders impact and are impacted by family and relationships;
  7. Medical and primary health issues;
  8. Psychiatric issues;
  9. Nutrition.
- C. Treatment plans and interventions shall include all issue areas identified during the assessment.
- D. Client treatment records shall contain the following documentation:
  1. Reasonable efforts shall be made to obtain signed releases of information for the following parties when appropriate:

- a. Client's caseworker;
  - b. Caseworker's supervisor;
  - c. Guardian ad litem;
  - d. Court Appointed Special Advocate (CASA) worker; and,
  - e. Client's attorney through the dependency and neglect case.
2. Current copies of the child welfare comprehensive family assessment, family case service plan and case plan reviews;
  3. Documentation of screening for child safety (completed within thirty (30) consecutive calendar days of intake and at each treatment plan review thereafter) and documentation of discussions with client about child safety issues;
  4. Child safety information documented in the case file shall contain references to supervision, food, medical needs, shelter, educational needs, discipline practices and significant relationships;
  5. Each client record shall contain documentation of child placement and custody status of each child;
  6. Each client record shall contain documentation regarding the child's development and results of the developmental screen that the treatment agency used to attain this information, the date the screening took place, and the name of the person conducting the screening;
  7. Each client record shall contain documentation of visitation orders, custody orders, treatment orders, date of next hearing and the nature of next hearing;
  8. Each client record shall contain comprehensive progress notes including documentation of:
    - a. Each court hearing or summary;
    - b. Phone calls or conversations with the caseworker or caseworker supervisor;
    - c. Any conversation with an attorney.
  9. Each client record shall include documentation that plans have been made to assure child safety in case of substance use relapse; and,
  10. Each client record shall include documentation of discharge plan discussions with the child welfare caseworker.

- E. The assigned program counselor shall make reasonable efforts to attend child welfare staffing where appropriate. Communication between child welfare staff and the counselor shall be documented in the client record.